ARKANSAS CLAIMS COMMISSION

(501)682-1619
(501)682-2823 FAX

Questions? Send an email to
ascc.new.claims@arkansas.go

101 EAST CAPITOL AVENUE, SUITE 410
LITTLE ROCK, ARKANSAS 72201-3823

CLAIM FORM

1. Claimant. If a claim involves more than one claimant, additional pages may be attached with the other claimant name(s) and contact information.

(title	last name/compan	first name	(email)
	Christine McAuliffe, as special administrator of the Estate		[redacted]

[redacted]
(address)

(city)	(state)	(zip)	(primary phone)
[redacted]	[redacted]	[redacted]	[redacted]

2. Claimant's Legal Counsel. An individual claimant may act as his or her own attorney (which is known as proceeding pro se). Please review Ark. Code Ann. § 19-10-222 for information about when a business entity may file a pro se claim. If a claimant is proceeding pro se, this section may be left blank.

(title)	(last name)	(first name)	(email)
	Gillispie	Joshua	josh@greenandgillispie.com

1 Riverfront Place, Suite 605
(address) AR bar number

(city)	(state)	(zip)	(primary phone)
North Little Rock	AR	72114	(501) 244-0700

3. State Agency Involved. The Commission can only receive claims against agencies of the State of Arkansas. Please review the Commission's jurisdictional statutes, including Ark. Code Ann. § 19-10-204 and Ark. Code Ann. § 21-5-701, for more information. This information is required for any claim filed at the Commission.

Arkansas Department of Human Services

4. Incident Date 6/13/2020

5. Location of Incident _____

6. CHECK HERE if this claim involves damage to a motor vehicle. ☐

7. CHECK HERE if this claim involves damage to property other than a motor vehicle. ☐

8. Explanation of Incident Please provide an explanation of your claim, including why you believe the above-listed state agency is liable for your damages under Arkansas law. You may attach additional pages to this form.

This claim concerns the wrongful death of David Cains, who died during an incident at the Booneville Human Development Center. This claim is filed by his sister, Christine McAuliffe, who has been appointed Special Administrator. Claimant is mailing under separate cover a detailed Complaint describing her causes of action and the facts supporting those causes of action, as well as a duly certified copy of her Letters of Administration.

9. Insurance Coverage. For a claim involving damage to a vehicle or other property, you must submit a copy of your insurance declarations in effect at the time of the incident. This is not the same as an insurance card. You can obtain a copy of your insurance declarations from your insurer or insurance agent. Please review Ark. Code Ann. § 19-10-302 for more information.

****If you did NOT have insurance covering the damaged property or motor vehicle at the time of incident, CHECK HERE** ☐

10. Additional Required Documents for Property Damage Claim

You must submit (1) invoice(s) documenting the repair costs, (2) three estimates for repair, OR (3) an explanation why this documentation cannot be provided.

11. If a state vehicle was involved, please provide the following information

_____

(type of state vehicle involved) (license number) (driver)

12. If your claim involves personal injuries, please CHECK HERE ☐

13. Health insurance coverage. All personal injury claims require a copy of your health insurance information in place at the time of the incident. Please review Ark. Code Ann. § 19-10-302 for more information.

****If you did NOT have health insurance on the date of the incident, CLICK HERE** ☐

14. Amount of Damages, if known: $7,000,000.00

IMPORTANT!

A claim filed at the Commission is a lawsuit against a state agency. The Commission is the courthouse for these lawsuits. Please note that Commission staff can answer general questions about the claim process but cannot give legal advice. The Commission rules and a non-exhaustive list of statutes that relate to the Commission can be found on the Commission website (arclaimscommission.arkansas.gov). The Arkansas Rules of Civil Procedure can be found online (arcourts.gov) under “Info Resources.”

STOP!

This signature page must be completed in the presence of a Notary Public. Do not sign until you are directed to do so by the Notary Public. If there is more than one claimant involved in this claim, each claimant must complete a separate signature page.

If you are an ARKANSAS-LICENSED ATTORNEY submitting a claim on behalf of your client, there is a different signature page that must be used. Please call (501)682-1619 and ask for an attorney signature page.

If a BUSINESS OR CORPORATE ENTITY is filing a claim without an attorney (and meets the requirements of Ark. Code Ann. § 19-10-222 for doing so), there is a different signature page that must be used. Please call (501)682-1619 and ask for a corporate signature page.

The undersigned certifies that to the best of my knowledge, information, and belief, this claim is not being presented for any improper purpose; this claim is warranted by existing law or by a non-frivolous argument for extending, modifying, or reversing existing law or for establishing new law; and the factual contentions have evidentiary support of, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery.

_____

Claimant Signature

ACKNOWLEDGEMENT

State of _____

County of _____

On this the __ day of _____, 20___, before me, the undersigned notary, personally appeared _____ known to me (or satisfactorily proven) to be the person whose name is subscribed to this instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

_____

Signature of Notary Public [seal of office]

My Commission Expires: _____

From: Caitlin McDaniel
To: Joshua Gillispie
Subject: Copy of Completed Claim Form
Date: Monday, October 11, 2021 10:13:00 AM
Attachments: Recent.pdf

Dear Mr. Gillispie,

See attached document.

Thank you,
Caitlin

Caitlin McDaniel
Administrative Specialist II
Arkansas State Claims Commission
101 East Capitol Avenue Suite 410
Little Rock, 72201
(501) 682-1619
Caitlin.McDaniel@arkansas.gov

ARKANSAS STATE CLAIMS COMMISSION
-Claim Form-

Please note that all sections must be completed, or this form will be returned to you, which will delay the processing of your claim.

1. Claimant's Legal Counsel - __ (If representing yourself (Pro Se) please check this box and proceed to section 2)

Gillispie	Joshua		josh@greenandgillispie.com	
(last name)	(first name)		(email)	
1 Riverfront Place, Suite 605	North Little Rock	AR	72114	(501) 244-0700
(address)	(city)	(state)	(zip)	(primary phone)

Arkansas Bar Number: _____ *If not licensed to practice law in Arkansas, please contact the Claims Commission for more information.*

2. Claimant(s)

Ms McAuliffe Christine	[redacted]			
(title/last name/first name or company)		(email)		
[redacted]				
(address)	(city)	(state)	(zip)	(primary phone)

3. State Agency Involved: (must be an Arkansas state agency. The Arkansas Claims Commission has no jurisdiction over county, city, or other municipalities)

Arkansas Department of Human Services

(state agency involved)

4. Incident Date

6/13/2020

5. Claim Type

Please provide a brief explanation of your claim. If additional space is required please attach additional statements to this form.

This claim concerns the wrongful death of David Cains, who died during an incident at the Booneville Human Development Center. This claim is filed by his sister, Christine McAuliffe, who has been appointed Special Administrator. Claimant is mailing under separate cover a detailed Complaint describing her causes of action and the facts supporting those causes of action, as well as a duly certified copy of her Letters of Administration.

5a. Check here if this claim involves damage to a motor vehicle.

5b. Check here if this claim involves damage to property other than a motor vehicle.

All property damage claims require a copy of your insurance declarations covering the property or motor vehicle at the time of damage.

I did not have insurance covering my property/motor vehicle at the time of damage.

All property damage claims require ONE of the following (please attach):
1. **Invoice(s) documenting repair costs, OR**
2. **Three (3) estimates for repair of the damaged property, OR**
3. **An explaination why repair bill(s) or estimate(s) cannot be provided.**

6. Was a state vehicle involved? (If Yes, please complete the following section)

(type of state vehicle involved) (license number) (driver)

7. Check here if this claim involves personal injury.

All personal injury claims require a copy of your medical insurance information in place at the time of the incident.

I do not have health insurance

8. Amount Sought: $7,000,000.00

(Signature) (Date)

ARKANSAS STATE CLAIMS COMMISSION

(501) 682-1619
FAX (501) 682-2823

KATHRYN IRBY
DIRECTOR

101 EAST CAPITOL AVENUE
SUITE 410
LITTLE ROCK, ARKANSAS
72201-3823

Arkansas
State Claims Commission
OCT 12 2021
RECEIVED

CLAIM SUBMISSION SIGNATURE PAGE

The undersigned attorney certifies that to the best of my knowledge, information, and belief, this claim is not being presented for any improper purpose; this claim is warranted by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law or for establishing new law; and the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery.

Joshua D. Gillispie
Claimant Name (must be printed legibly)

Claimant Signature

Acknowledgement

State of Arkansas

County of Pulaski

On this the 12th day of October, 2021, before me, the undersigned notary, personally appeared Joshua Gillispie known to me (or satisfactorily proven) to be the person whose name is subscribed to this instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

Dana E. Henderson
Signature of Notary Public

[Seal of Office]

DANA E. HENDERSON
COMM. EXP.
7-06-2026
No. 12698310
LONOKE
COUNTY
NOTARY PUBLIC - ARKANSAS

My Commission expires: 7-6-26

ARKANSAS STATE CLAIMS COMMISSION
-Claim Form-

Please note that all sections must be completed, or this form will be returned to you, which will delay the processing of your claim.

1. Claimant's Legal Counsel - (If representing yourself (Pro Se) please check this box and proceed to section 2)

Gillispie	Joshua	josh@greenandgillispie.com		
(last name)	(first name)		(email)	
1 Riverfront Place, Suite 605	North Little Rock	AR	72114	(501) 244-0700
(address)	(city)	(state)	(zip)	(primary phone)

Arkansas Bar Number: *If not licensed to practice law in Arkansas, please contact the Claims Commission for more information.*

2. Claimant(s)

Ms McAuliffe Christine	[redacted]			
(title/last name/first name or company)		(email)		
[redacted]				
(address)	(city)	(state)	(zip)	(primary phone)

3. State Agency Involved: (must be an Arkansas state agency. The Arkansas Claims Commission has no jurisdiction over county, city, or other municipalities)

Arkansas Department of Human Services

(state agency involved)

4. Incident Date

6/13/2020

5. Claim Type

Please provide a brief explanation of your claim. If additional space is required please attach additional statements to this form.

This claim concerns the wrongful death of David Cains, who died during an incident at the Booneville Human Development Center. This claim is filed by his sister, Christine McAuliffe, who has been appointed Special Administrator. Claimant is mailing under separate cover a detailed Complaint describing her causes of action and the facts supporting those causes of action, as well as a duly certified copy of her Letters of Administration.

5a. Check here if this claim involves damage to a motor vehicle.

5b. Check here if this claim involves damage to property other than a motor vehicle.

All property damage claims require a copy of your insurance declarations covering the property or motor vehicle at the time of damage.

I did not have insurance covering my property/motor vehicle at the time of damage.

All property damage claims require ONE of the following (please attach):
1. **Invoice(s) documenting repair costs, OR**
2. **Three (3) estimates for repair of the damaged property, OR**
3. **An explaination why repair bill(s) or estimate(s) cannot be provided.**

6. **Was a state vehicle involved? (If Yes, please complete the following section)**

(type of state vehicle involved) (license number) (driver)

7. **Check here if this claim involves personal injury.**

All personal injury claims require a copy of your medical insurance information in place at the time of the incident.

I do not have health insurance

8. **Amount Sought:** $7,000,000.00

(Signature) 10/12/21 (Date)

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) **RESPONDENT**

COMPLAINT

COMES NOW the Claimant, Christine McAuliffe, as Special Administrator of the Estate of David Cains, by and through her attorney, Joshua D. Gillispie, and for her causes of action against the above-named Respondent, states the following:

JURISDICTION AND VENUE

1. This claim is brought pursuant to the Arkansas Claims Commission's jurisdiction over claims for monetary damages brought against an agency of the State of Arkansas, pursuant to A.C.A. § 19-10-204.

2. Venue is proper pursuant to A.C.A. § 19-10-201, et seq. The incident complained of herein occurred in Arkansas, in Logan County.

PARTIES AND SERVICE

3. Claimant hereby incorporates by reference all previous paragraphs as if fully set forth herein.

4. Claimant Christine McAuliffe (hereafter "Claimant"), Special Administrator of the estate of her brother, David Cains, brings this cause of action for survival on behalf of the

Estate of David Cains; and for the wrongful death of David Cains, on behalf of the following statutory beneficiaries: Charlene Robinson, mother of the deceased; and herself, as sister of the deceased. Claimant's Letters of Administration and the Order of Appointment are attached hereto, respectively, as ***Exhibit 5*** and ***Exhibit 6***.

5. At all times relevant to this cause of action, and at the time of the incident described further herein, Respondent, the Department of Human Services (hereafter "DHS"), was at all relevant times an Arkansas state agency. DHS, through its Division of Developmental Disability Services (hereafter "DDS"), operated five Human Development Centers throughout the state, including the Booneville Human Development Center (hereafter "BHDC"), which is where David Cains lived for 13 years and where he died. All tortious acts alleged herein occurred at the BHDC. David Cains' Death Certificate, as well as his health insurance identification cards, are attached hereto, respectively, as ***Exhibit 7*** and ***Exhibit 8***.

FACTUAL BACKGROUND

6. Claimant hereby incorporates by reference all previous paragraphs as if fully set forth herein.

7. The Booneville Human Development Center (BHDC) is a state facility established to provide care for people with developmental disabilities. It is located on the grounds of the former Arkansas Tuberculosis Sanatorium, which originally opened in 1910. The Sanatorium closed for tuberculosis patients in 1973. The BHDC can house up to approximately 150 people with disabilities, and the residents have access to limited recreation, and a cafeteria for meals.

8. The BHDC has a checkered past, and a serious history of abuse against some of the most vulnerable in our community. The facility has demonstrated indifference to improving

the training of staff to provide safe services for those with disabilities. The United States Department of Justice has twice sued the State of Arkansas regarding the failure to provide adequate services and care at its Human Development Centers; however, those cases were dismissed based on procedural grounds.

9. In 2010, a resident choked to death because staff were not providing adequate supervision to ensure the safety of a young man with known disabilities related to his ability to eat. In February of 2015, a young woman died after being regularly and improperly restrained without regard to her known seizure issues, which led to her choking to death.

10. Disability Rights Arkansas (hereafter "DRA") issued a scathing report recommending the closure of the BHDC in January of 2015, which is attached hereto as ***Exhibit 1***. The title of this report was "A New Approach to Care in Arkansas: Why the Time Has Come to Close the Booneville Human Development Center." Disability Rights Arkansas (DRA) is the designated federal Protection and Advocacy System for individuals with disabilities in Arkansas. One of DRA's core functions is to investigate the deaths of persons with developmental disabilities in facilities that provide services to them. DRA has authority under federal law to thoroughly investigate deaths occurring in any public or private entity that provides care, services, treatment, or habilitation to individuals with disabilities.

11. One year later, the DRA issued another report criticizing the lack of improvement at the BHDC titled "The Excessive Use of Restraint at Booneville Human Development Center," attached hereto as ***Exhibit 2***. DRA concluded that the restraint practices at the Booneville HDC are contrary to recognized best practices and put residents and staff at risk of physical and emotional harm. The DRA report notes that restraints should only be used on individuals who repetitively engage in dangerously aggressive behavior, and less restrictive

methods of addressing the person's behavior should first be tried and documented. Restraints should be a method of last resort. The BHDC uses a significantly higher rate of restraints on residents than the other Human Development Centers in Arkansas. Additionally, according to the DRA report, the BHDC uses restraints often as a first option to handle a "problem" resident, instead of using less restrictive methods. Restraints are used on residents for not complying with requests even when there is no danger of imminent violent behavior from the resident.

12. The Booneville HDC has not improved since the 2016 investigation and report by the DRA. Improper and abusive restraining techniques were used in 2019, which caused a disabled resident to suffer a broken arm. And, just last year the improper restraint of David Cains led to his death from choking on his own vomit. As further stated herein, the employees at BHDC did not disclose that Cains had been restrained to emergency medical services, the coroner, or any other government officials. The cover-up of the use of restraints on David Cains is troubling; it further demonstrates the lack of professionalism and proper care at the Booneville HDC.

13. David Cains, born [redacted] was admitted as a fulltime resident to BHDC on May 1, 2007. He lived there for 13 years, until his death on June 13, 2020. He liked watching the Dukes of Hazard, loved the band the Monkees, and he didn't like to be alone. Most of all, he loved being with friends and family. His mother and sister (Claimant) were very active in David's life, regularly visiting him and taking him on outings. David always spent the major holidays at home with his family.

14. David suffered from [redacted] He was 42 when he died, but testing indicated [redacted]

[redacted]

Claimant believed her brother functioned at approximately the level of a six-year-old.

15. Disability Rights Arkansas (DRA) performed an investigation into David's death and issued a written report on October 22, 2020, attached hereto as ***Exhibit 3***. DRA concluded, as further stated herein, that policy failures at BHDC – and the conduct of BHDC staff resulting from those policy failures, including the use of an excessive restraint, failure to follow David's [redacted] and failure to call 911 when David stopped breathing – caused David Cains' death, "either directly or indirectly."

16. Based on the written statements of BHDC staff, interviews conducted by DRA with BHDC staff, EMS and medical records, and various reports issued by DHS personnel, the following facts are currently known about David Cains' death:

17. David had an egg salad sandwich for lunch on the day he died. He had his lunch at the cafeteria in the BHDC Commons Building, sometime before 11:30am. After lunch David was accompanied to a nearby restroom by staff member Tyler Mattson. According to Mattson, David became irritated after exiting the restroom, began screaming, ripping paper off the wall, and attempting to hit Mattson. Mattson immediately applied physical restraints, referred to by BHDC as "personal restraints," beginning at approximately 11:30am, according to Mattson. Mattson states he grabbed David's arms, causing David to fall over and land on his face. Mattson then rolled David onto his left side where he continued to physically restrain David, who Mattson says was still resisting. Another BHDC staff member, Amy "Mandy" Jones, arrived on the scene and joined in restraining David by holding his head in place. A third BHDC staff member, Ryann Campos, then arrived and participated in the physical restraint by holding David's ankles. According to Campos, she noticed shortly after arriving that David had

defecated. At some point they saw food coming out of David's mouth, that his face was purple, and that he was not breathing. Though their participation in the physical restraint began at different times, both Mattson and Jones claim the physical restraint on the ground lasted one minute, stopping only when they realized he was no longer breathing. These conflicting statements have not been resolved or explained by Respondent.

18. None of the three staff members called 911, even though they knew David had stopped breathing. BHDC Policy IV-B-10 specifically prohibits all non-medical staff from calling 911 in response to a medical emergency. Instead, Ryann Campos called staff LPN Deborah Noah, who was present on campus at the Judge Hill Building, informing her of what was happening and that David Cains was not breathing. According to Deborah Noah, it was approximately 11:33am when Ryann Campos called her. Rather than dialing 911 right then, Noah instead relayed Ryann's message to staff LPNs Amanda Schmidt and Kelly King. Rather than dialing 911 right then, Schmidt and King instead drove by car from the Judge Hill Building to the Commons Building across campus. LPNs Schmidt and King then entered the Commons Building, located the scene, observed David, and only then did they instruct another staff member to dial 911.

19. It is of concern that all BHDC staff members, including the LPNs, claim in their written statements that Ryan Campos called medical staff at 11:33am and that 911 was called at 11:34am. In order for this to be true, it would mean LPN Noah received the call from Ryann Campos, then relayed that message to LPNs Schmidt and King, who then walked (or ran) to a parked car, drove the car across campus to the Commons Building, walked (or ran) inside, located the scene, observed David on the floor not breathing, then instructed a staff member to

call 911, which that staff member then did, all in the span of 60 seconds. That is simply not possible.

20. Furthermore, Logan County EMS records reflect the 911 call was placed, not at 11:34am, but at 11:37am, which means that a minimum of four precious minutes elapsed between the time staff realized David had stopped breathing and the time 911 was called. The Logan County Coroner's report also identifies 11:37am as the time 911 was called. At least 4 minutes, and quite possibly more, given there were no visible clocks in the area where the restraint occurred, elapsed from the time staff noticed David was not breathing to the time 911 was called.

21. All efforts by BHDC staff to resuscitate David failed. By the time Logan County EMS arrived on scene at 11:50am, it was too late; their efforts to save David were unsuccessful. David was transported to Mercy Hospital where he was pronounced dead at 12:21pm.

22. David Cains had [redacted] BHDC staff were aware of the [redacted] BHDC staff – including Mattson, Jones, and Campos – ignored these known [redacted] when they took David to the ground minutes after his lunch and pinned him there while he aspirated and choked to death – the very risk for which the [redacted] had been put in place. Subjecting an individual [redacted] to a physical restraint shortly after a meal increases the risk of death from asphyxia due to a higher probably of vomiting. They held him pinned to the ground – one held his arms, one his ankles, and the other his head – while he vomited and choked to death, only stopping when he defecated, turned purple, and stopped breathing – all of this done in response to a temper tantrum shortly after lunch.

23. At the time of David's death, BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor the facility.

24. BHDC staff misled EMS responders as to how David died. BHDC told Logan County EMS that David simply began choking on his lunch, aspirated, and stopped breathing, intentionally omitting all mention of the physical restraint. This misinformation was then relied upon by Mercy Hospital and ultimately the Logan County Deputy Coroner, who, after later learning the true circumstances of David's death, stated that an autopsy likely should have been performed.

25. The true circumstances of David's death were also kept from his family. BHDC told David's mother only that he had choked on his lunch and that they would need to contact Mercy Hospital if they wanted additional information. It was not until nine days after David's death, the Monday after his funeral, that his mother learned of the physical restraint. His mother and sister (Claimant) had requested additional details from BHDC, and on this Monday after David's funeral they received in the mail a letter from BHDC containing a "Final Synopsis" of the incident, attached hereto as ***Exhibit 4***. This final synopsis, signed by Jeff Gonyea, the Superintendent of BHDC, not only contained the first mention of the physical restraint David's family had heard, but stated there was insufficient evidence to corroborate maltreatment and that, in fact, "[a]ll staff conducted themselves in an appropriate manner." Prior to this letter nine days after David's death, his family was not even aware a maltreatment incident was being investigated. At this point, David had been buried three days and it was too late to request an autopsy.

26. The BHDC conducted an internal maltreatment investigation into David's death. That investigation, upon information and belief, was led by Sandy Evans, a DHS Residential

Services Director and Adult Maltreatment Investigator who, upon information and belief, was herself employed by the BHDC. Upon information and belief, she worked alongside the very people she was supposed to be investigating. This BHDC investigation, which, according to DRA, suppressed or omitted crucial facts, concluded that no individual involved in the incident did anything wrong. It was endorsed by Jeff Gonyea, who, as Superintendent of BHDC, was ultimately responsible for the actions of the employees being investigated.

27. The Division of Provider Services and Quality Assurance (DPSQA) also investigated the circumstances surrounding David's death. According to DRA, very little could be gleaned from this investigative report. This investigation basically concurred with the BHDC investigation, while providing no independent reasoning, no description of the events, and no statements from witnesses.

28. BHDC's policy failures, given its extensive history of problems with excessive use of physical restraints, can fairly be described as willful. BHDC was fully aware that the overuse of physical restraints greatly increased the risk of physical harm and death to its disabled patients yet did nothing to change policy or practice. As previously stated, one patient was killed during a physical restraint in 2015, another suffered a broken arm in 2019, and the problem was so bad that DRA was calling for the facility to be permanently closed. Despite all this foreknowledge, BHDC did nothing, and this failure by omission directly caused David Cains' death.

29. BHDC explicitly acknowledges, in writing, the extreme risk to disabled patients caused by physical restraints. The BHDC's "Restraint Incident Debriefing Form," which was provided to staff and used to document physical restraints *prior* to Cains' death, states the following in bold lettering: "**The Booneville Human Development Center is dedicated to the**

reduction of restraint use at the facility. The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program), when a very real risk of personal injury or severe property damage is imminent."

30. Despite knowing, and even memorializing in its internal documents, that physical restraints "dramatically" increased the risk of injury to disabled patients, BHDC did nothing to enforce a policy reflective of this dramatic risk. In fact, according to BHDC records, **staff used physical restraints on David Cains at least 16 times in the one year preceding his death**. One of these was a mechanical restraint, whereby David was bound to a chair or bed with straps on each wrist and three straps across his body. Despite knowing of safe and effective alternatives, BHDC did nothing to enforce the use of these safer alternatives. In this case, there is no evidence Mattson or any other staff member ever attempted to use any form of non-physical intervention on David Cains before taking him to the ground.

31. According to the most recent DRA report, BHDC, in April of 2012, participated in a training survey with H & W Independent Solutions to evaluate and improve the quality of care to the residents. During the evaluation, H & W found that significant improvement was needed due to, in part, the BHDC staff's reliance on emergency restraint. This is further evidence of the foreseeability of David's death on the part of BHDC.

32. Despite the fact that BHDC claims to certify its staff in the use of NCI/CPI crisis intervention (which are non-violent), BHDC also trains and allows its staff to restrain residents using methods that require no certification and are not evidence-based, such as the physical

restraint used on David Cains. The most recent DRA report states that it "is concerning that BHDC staff are then left to choose between non-violent crisis intervention and physically/emotionally traumatizing physical restraint," which in this case led to David's death.

COUNT ONE: NEGLIGENCE

33. Claimant hereby incorporates by reference all previous paragraphs as if fully set forth herein.

34. The Respondent Arkansas state agency, DHS, at all times relevant to this action controlled and operated BHDC. Respondent, at all times relevant to this action, owed David Cains a duty of ordinary care. In agreeing to accept the custody, care, and control of David, Respondent expressly assumed a duty of care for David Cains. The relationship between Respondent and Cains imposed a duty in this case. Duty can be assumed or created through actions, and "where a person undertakes to act, they must do so carefully or they will be liable for negligence." *Yanmar Co., Ltd. v. Slater*, 2012 Ark. 36, 16, 386 S.W.3d 439, 449 (2012). The moment Respondent agreed to take care, custody, and control of David, a duty was created.

35. Respondent breached its duty and proximately caused Claimant's damages in at least the following ways:

(a) By failing to set policies reflective of its knowledge that physical restraints are unreasonably dangerous to patients;

(b) By failing to train and require BHDC staff to use non-violent methods of deescalation, despite knowing the unreasonable risks of physical restraints;

(c) By using an excessive and unreasonable physical restraint on David Cains;

(d) By using this physical restraint without first even attempting to deescalate in a non-violent way;

(e) By regularly physically restraining clients in unreasonably dangerous and violent ways, such as by pinning them to the floor, which is what happened here;

(f) By allowing staff to take clients to the floor during physical restraints and engage in other means of physical restraints not based on any specific training or guidelines, but rather just the judgment of its poorly trained staff;

(g) By failing to adhere to Cains' [redacted]

(h) By ignoring known [redacted] necessary for Cains' safety;

(i) By failing to set policy allowing non-medical staff to call 911 in emergency medical situations;

(j) By failing to call 911 the moment David Cains stopped breathing, if not before;

(k) By failing to have cameras in place to monitor how residents are treated;

(l) By failing to honestly communicate the circumstances of David's death to emergency responders, law enforcement, and David's family;

(m)By failing to exercise ordinary care for David's safety;

(n) By engaging in conduct that BHDC knew or should have known would endanger the life and safety of David Cains;

(o) By failing to train, oversee, supervise and otherwise equip its staff;

(m) By failing to anticipate the danger to Cains, given the circumstances, and failing to use commensurate care to prevent the harm; and

(o) By failing to maintain and adhere to safety policies, protocols, and procedures that meet the heightened risks and vulnerabilities of the disabled residents at the BHDC.

36. All of the foregoing acts and omissions on the part of DHS (and BHDC), taken separately and/or collectively, constitute a direct and proximate cause of the injuries and damages suffered by Claimant, as set forth herein.

37. The negligence or tortious conduct of known and unknown employees and staff of DHS, DDS, and BHDC is imputed to DHS, as these staff were all acting within the scope of their employment.

DAMAGES

38. Claimant hereby incorporates by reference all previous paragraphs as if fully set forth herein.

39. As a direct and proximate result of the occurrence made the basis of this lawsuit, Claimant, on behalf of the estate of David Cains, claims the following damages:

a. Loss of life of David Cains, commencing at death and ending at life expectancy;

b. Conscious pain and suffering of David Cains prior to death;

c. Medical care and expenses incurred as a result of David Cains' death; and

d. Funeral expenses incurred as a result of David Cains' death.

40. As a direct and proximate result of the occurrence made the basis of this lawsuit, David Cains' statutory beneficiaries sustained injuries, and Claimant claims the following damages on their behalf:

a. Mental anguish and emotional distress, including grief and despair, suffered up to the present time; and

b. Mental anguish and emotional distress, including grief and despair, that will continue well into the future.

PUNITIVE DAMAGES

41. Plaintiff hereby incorporates by reference all previous paragraphs as if fully set forth herein.

42. Arkansas Supreme Court decisions permit the recovery of punitive damages in a wrongful death case. *Vickery v. Ballentine*, 293 Ark. 54, 732 S.W.2d 160 (1987); Fields v. Huff, 510 F. Supp. 238 (E.D. Ark. 1981). *See also* Comment, The Arkansas Wrongful Death Statute, 35 Ark. L. Rev. 294, 306 (1981).

43. When viewed from the standpoint of Respondent, at the time of the acts and omissions, their conduct involved an intentional and reckless disregard of the known risks and dangers to disabled individuals in their care, given the occurrence of recent similar injuries and the BHDC's known history of excessive restraints.

44. Respondent had actual subjective awareness of the risks and dangers to David Cains and other disabled individuals at BHDC. Respondent intentionally and recklessly disregarded known prior similar acts and events, placing Cains at unreasonable risk of harm.

45. DHS intentionally and recklessly failed to assess the risk of this foreseeable event, failed warn of the risk, and failed to maintain adequate safety and prevention measures.

46. Respondent's conduct displayed a conscious indifference to the rights, safety, and welfare of David Cains and other disabled people in Cains' position.

47. Claimant seeks punitive damages, in an amount deemed appropriate by the Commission, to punish Respondent, and to deter further such conduct.

RELIEF SOUGHT

48. Claimant hereby incorporates by reference all previous paragraphs as if fully set forth herein.

49. Claimant seeks damages in the amount of $7,000,000.00. Neither Claimant, nor any beneficiary, has received any prior payment on account of this claim.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, by and through her attorney, Joshua D. Gillispie, respectfully requests recovery for all damages previously pled herein, and for compensatory damages for the reasons previously pled and in an amount previously prayed for and/or allowed by common law or by statute, in an amount left to the sound discretion of this Commission, for punitive damages, for her attorney fees and all costs herein expended, and for all other relief to which Claimant is justifiably entitled.

Respectfully submitted by:

/s/ Joshua D. Gillispie
ABA # 2010131
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A New Approach to Care in Arkansas: Why the Time Has Come to Close the Booneville Human Development Center

January 2015

Prepared by:

DisabilityRights
ARKANSAS



Acknowledgements

The authors of this report would like to extend their sincere appreciation to the residents of the Booneville Human Development Center (BHDC).

DRA staff members who contributed to this report were Christian Adcock, Christy Furqueron, Cassie Howell, Tom Masseau, Susan Pierce, and Debra Poulin.

Disability Rights Arkansas, Inc. is the federally authorized and funded Protection and Advocacy System and Client Assistance Program for people with disabilities in Arkansas. DRA is authorized to protect human, civil, and legal rights of all Arkansans with disabilities consistent with federal law.

This publication was made possible by funding support from the United States Department of Health and Human Services' Administration for Community Living and Substance Abuse and Mental Health Services. The contents in this report are solely the responsibility of the grantee and do not necessarily represent the official views of the United States Department of Health and Human Services' Administration for Community Living and Substance Abuse and Mental Health Services.

Executive Summary:

In 1999, the Supreme Court ruled in *Olmstead v L.C.* that public entities are required to provide community-based services to individuals with disabilities when: a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services. Yet, in 2015, the State of Arkansas has not fully moved toward community-based services. This report highlights the physical state of the Booneville Human Development Center, the fiscal realities involved in operating the Center, and the use of restraint as a therapeutic and disciplinary tool at the Center.

From January through October of 2014, Disability Rights Arkansas conducted 22 monitoring visits to the Booneville Human Development Center (HDC) campus and we have met many wonderful residents and staff. Using the information gathered during these visits, Disability Rights Arkansas made a number of observations for areas of improvement and has formulated recommendations for the facility and the State of Arkansas.

Currently, the Arkansas Department of Human Services is in the process of seeking state funds in order to renovate and modernize the Booneville HDC. For fiscal year 2014, the Booneville HDC had an operating budget of $16,005,663. This is the second highest operating budget of all the HDCs, behind only the facility in Conway, which houses roughly four times the number of residents. Due to the age of the Booneville HDC, there are numerous physical plant issues that need to be addressed. In addition to the problems one would expect at an older facility, some of the buildings have entire floors dedicated to storage, or floors which are left vacant. Several buildings have been deemed unsafe and have been boarded up completely. These problems exist even though the State has spent $4,460,850 on capital improvements for the Booneville HDC since 2009.

In addition to the deterioration of the physical buildings and the amount of money poured into the facility for its upkeep, Disability Rights Arkansas reviewed the data provided by the Booneville HDC to the state on the number of restraints from June 2014 to September 2014. A comparison of the data on restraints reveals that the use of restraints at the Booneville HDC for disciplinary measure occurs much more often than at any of the other, similarly sized, Arkansas HDCs.

Based on the findings of this report, Disability Rights Arkansas recommends:

- The Booneville HDC should be gradually phased out over the next twelve to eighteen months.

- Admissions to Booneville HDC should be halted immediately.
- The state should begin the process of moving the majority of the residents into supported living with the community, and, if necessary, all other residents should be absorbed by the four remaining HDCs.
- The money saved by the closure of the Booneville HDC should be used to strengthen Home and Community based care throughout the state.
- All unused buildings and portions of building at the Booneville HDC that remain used should be immediately sealed off to prevent residents from accessing them.
- All HDC staff statewide should be retrained in methods to avoid the use of restraints.
- The Department of Human Services should adopt a stricter policy for tracking and monitoring the use of restraints within the HDCs in order to better recognize troubling trends.

Introduction

The Booneville Human Development Center (Booneville HDC) is an Intermediate Care Facility for individuals with developmental disabilities located in Booneville, Arkansas. The Booneville HDC provides residential care consisting of full time custodial care for individuals with physical, mental, or emotional disorders.

The Booneville HDC is one of five Human Development Centers (HDCs) established to care for those with developmental disabilities in Arkansas. The other four HDCs are located in Conway, Arkadelphia, Warren and Jonesboro. There are approximately 925 individuals with developmental disabilities living in these HDCs. The Conway HDC is the largest of the HDCs with approximately 481 residents. The other HDCs have far lower populations, ranging from approximately 90 to 120 residents at each HDC.

The Booneville HDC is located on the grounds of the former Arkansas Tuberculosis Sanatorium. The Sanatorium was originally opened in 1910 and served as a relocation center for tuberculosis patients until 1973.

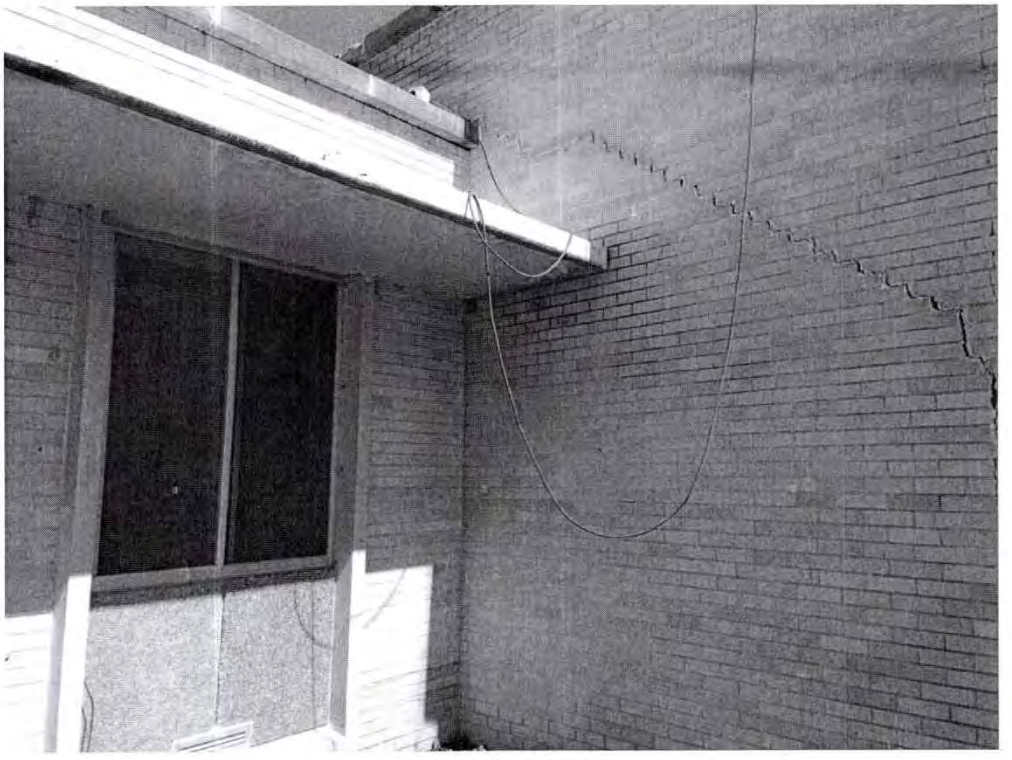
The Booneville HDC has a licensed capacity of 159 residents. However, as of September 2014, there were only 129 individuals residing there. The residents range in age from 18-68 years old, with an average age of 45. The gender breakdown of the residents is 65 percent male and 35 percent female. In addition to developmental disabilities, 92 percent of the residents have also been diagnosed with some form of mental illness. The State Department of Human Services employs 311 staff members to work at the Booneville HDC.

The living areas for residents at the Booneville HDC consist of several dormitory buildings and the Curtis Circle Apartments. There are four buildings on the campus devoted to "pre-vocational training," where the residents make rugs and participate in recycling programs in exchange for a piece-rate wage. Some residents work in the kitchen of the cafeteria as well. The cafeteria building includes a recreation room, an auditorium, and a small exercise room. A chapel and several administrative and maintenance buildings are also located on the grounds.

Physical Plant Issues

When a person visits the Booneville HDC, they first notice the beautiful old buildings on the grounds. Upon closer inspection, however, it becomes apparent that many of those buildings are falling apart. In some cases, buildings have been condemned and left to slowly crumble due to the cost of proper demolition, including asbestos abatement. The majority of the buildings on campus were constructed in either the 1930s or 1950s, and they show their age. Several buildings on campus are in such poor condition that entire floors are unsafe and not in use. The facilities at the Booneville HDC are outdated at best and dangerous at worst.

One example is the Nyberg Building which was built in 1938. The Nyberg Building houses the main administrative office for the Booneville HDC. The Nyberg Building is a massive building with six floors. The Booneville HDC staff only uses part of the first floor of the building. The rest of the building is empty.



Exterior of the Judge Hill Building Showing Need for Repairs

Another example is the Hamp Williams Building which was built in 1939. This building is used for prevocational training which consists mostly of shredding paper for recycling or separating fabric loops from bundles for use in producing rugs and place mats. There are three floors in the Hamp Williams Building. The first floor and half of the second floor are used for training. The other half of the second floor is used for storage, with one room piled full of trash bags. This half of the second floor is unlit and paint is peeling from the walls. There is no door separating the two halves of the floor.



Trash and Debris on the Second Floor of the Hamp Williams Building



Peeling Paint on the Second Floor of the Hamp Williams Building

The third floor of the Hamp Williams Building is in ruins. Walls are covered in peeling paint. There are holes in the walls, floors, and ceilings. A layer of dust covers every surface, and wires are left exposed and dangling from ceilings and walls. There are remnants of construction or demolition projects that were started and, at some point, abandoned, with fixtures removed from walls and left on the floor. In one area, a toilet has been left sitting in

the middle of a room. This area contains several safety hazards and is consistently left open to any resident who might go up the stairs. Disability Rights Arkansas has repeatedly advised the Booneville HDC staff and administrators of the safety concerns related to the conditions of the third floor and requested that the door be locked to prevent access to the third floor. These concerns and requests have been ignored.



Damaged Walls and Debris on the Third Floor of the Hamp Williams Building



Old Wiring and Debris on the Third Floor of the Hamp Williams Building



Holes in the Floor on the Third Floor of the Hamp Williams Building



Missing Walls and More Debris on the Third Floor of the Hamp Williams Building

The dormitory buildings that are in use at the Booneville HDC are generally clean and well maintained. However, there are two dormitory buildings that have been boarded up and left to collapse. They have massive holes in their roofs. After a storm, debris that has blown off the roofs of those buildings litters the surrounding area. Disability Rights Arkansas has been told that these buildings were left standing due to the high cost of safely demolishing them, specifically with regard to asbestos abatement. These buildings, one of which can be seen on the cover of this report, have been left to slowly fall apart creating a dangerous environment to residents and staff.

There also are "cottages" on the Booneville HDC grounds that are there to provide a more independent living situation for residents by allowing individuals the chance to maintain their own independent homes and develop necessary skills for independent living, such as cooking, cleaning, and doing their own laundry. Unfortunately, the cottages were all built in 1937, and as a result, they are in various states of disrepair, with some boarded up and left

empty. The ones that are still used as residences have many issues, including what looks like mold on the ceiling radiating out from ventilation ducts.



Filth from Cottage Ventilation Duct

There are numerous other physical plant issues and hazards at the Booneville HDC. One concern is a large swimming pool on the grounds that is full of stagnant water and surrounded by a chain link fence. This area is padlocked, but the fence would be easy to scale for some residents and presents a constant safety hazard.

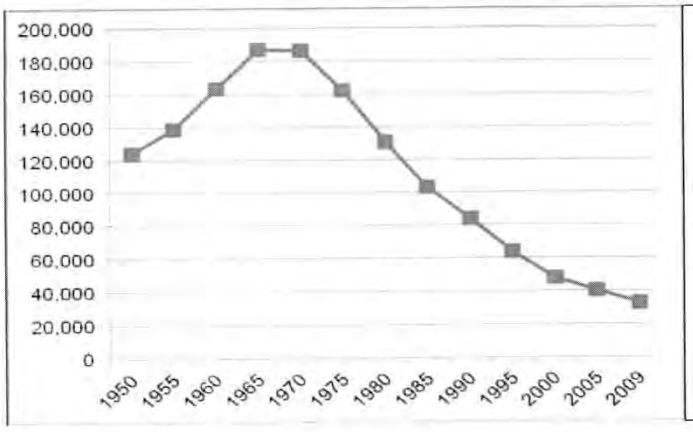
Significantly, the Booneville HDC is largely inaccessible for individuals with mobility impairments due to the hazards created by the deteriorating or condemned structures and the fact that the facility was built on a hill. The facility does not meet minimum architectural requirements that would allow for access for individuals with mobility impairments. Thus, residents who require wheelchairs or walkers or who develop a need for the use of wheelchairs or walkers cannot live at the Booneville HDC.

Fiscal Responsibility and the Booneville HDC

The United States as a whole, over the last several decades, has moved away from the idea of state owned and operated institutions and toward home and community-based services and care for individuals with disabilities. Several states have done away with their institutions entirely in favor of community-based services and care. In their 1999 decision in *Olmstead v. L.C.*, 527 U.S. 581, the United States Supreme Court upheld the integration mandate of the Americans with Disabilities Act. The integration mandate requires that individuals with disabilities be provided services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Since the Supreme Court's decision in *Olmstead*, several states have been defendants in costly litigation on behalf of residents of facilities like the Booneville HDC who seek services in appropriate integrated settings.

Arkansas operates 32.8 beds in Intermediate Care Facilities per 100,000 citizens; this is over three times the national average of 9.5 beds. Arkansas refuses to move with the times and instead continues to provide this outmoded form of care in the face of mounting evidence that it is not only less expensive for individuals with disabilities to be supported in the community, but also that the quality of life provided is better for them.

Arkansas has refused to move toward providing community based services and care despite the fact that demand for space in Intermediate Care Facilities has decreased as well, both nationally and in Arkansas. Since 1980, the population in state operated Intermediate Care Facilities has decreased 77% nationwide, and 38% in Arkansas. There are currently 48 individuals on the waiting list for a space at a Human Development Center in Arkansas. By contrast, there are almost 3,000 on the waiting list for community-based services. Half of the individuals requesting a spot at an HDC are also on the list for community-based services; only 24 individuals are exclusively interested in an institutional placement. It is clear that the majority of Arkansas families prefer community-based settings to institutions.



Average Daily Census of People with Developmental Disabilities in Large State Facilities, 1950–2009 Source: National Council on Disability

According to the Arkansas Department of Human Services, the average annual cost to the State to house one individual in a Human Development Center is $117,245. The average annual cost to the State for an individual to live in the community and receive community-based services is $59,126. Institutionalization of an individual costs the State almost twice as much as community-based services and care.

In addition to the over $16 million operating budget, during the next legislative session, the Arkansas Department of Human Services will be asking for 7.7 million dollars for capital improvements at the Booneville HDC. That seven million dollar figure is only the tip of the iceberg, as there are reportedly plans to request well over twenty million dollars throughout the next eight years. The Booneville HDC accounts for 10 percent of the State's HDC population. Yet the facility, has received 30 percent of the total HDC funding for improvement projects and maintenance over the last few years. With the disproportionate cost of maintaining and operating the Booneville HDC and declining enrollment it is not fiscally responsible for our State to put 20 million dollars - or even 7.7 million dollars - into modernizing the outdated and broken down facility.

As of September of this year, there were only 129 residents left at the Booneville HDC, with over 50 percent of them functioning in the mild and moderate categories of intellectual disabilities. These individuals could be moved into the community if they and their families chose to do so. Individuals with developmental disabilities can live and thrive in the community, having more access to their family, activities and opportunities for work. Given the strong interest in community-based services evidenced by the almost 3,000 individuals on the waiting list for those services, as well as the cost of institutional placement, the State Legislature should look into uses for the funding that the Booneville HDC is requesting that would allow individuals to stay in their communities and move Arkansas away from the outdated models of care and treatment that we have clung to for so long. Disability Rights Arkansas would like the legislature to consider shifting some of the money spent serving the relatively small population of individuals in institutional care toward more home and community-based services for the thousands of Arkansans waiting for those services.

Restraint Use

The frequent use of restraints, both mechanical and chemical, at the Booneville HDC is very concerning. A mechanical restraint is any type of device used to restrict movement. At the Booneville HDC mechanical restraints are used frequently, most commonly a restraint board. A restraint board is a device consisting of a board which an individual is laid on and secured by straps restraining the arms, chest, legs, and ankles.



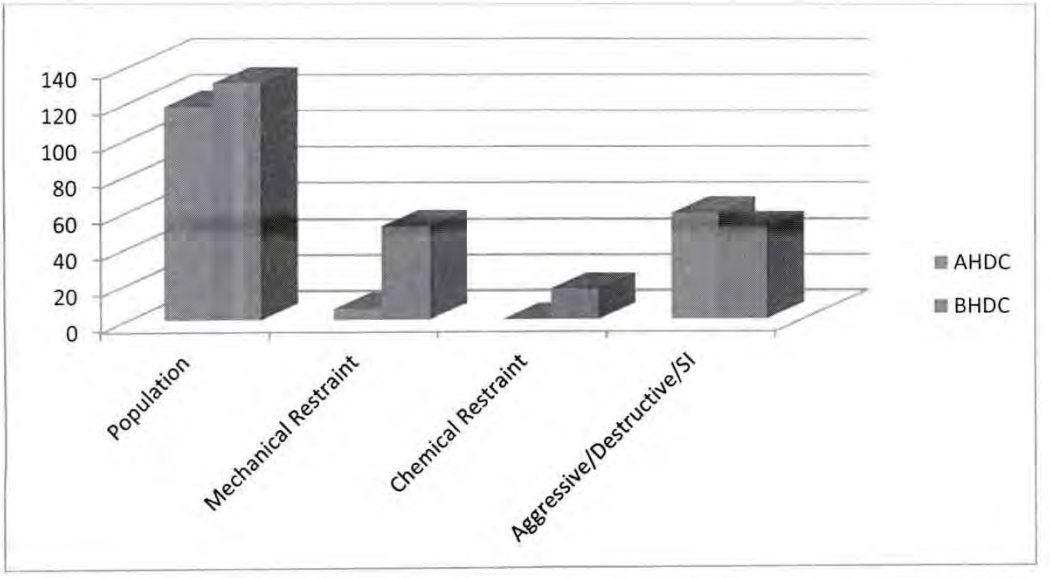
Example of a Six Point Restraint Board

Chemical restraints are pharmaceutical substances used to restrict movement or to sedate. Each type of restraint carries its own inherent dangers. According to a 2011 report published by Equip for Equality, an estimated 50 to 150 fatalities occur nationwide each year due to complications caused by restraint use. Several professional organizations have advocated for the reduction or elimination of restraint use, including the American Psychiatric Association, the National Association of State Mental Health Program Directors, the National Disability Rights Network, and the National Alliance on Mental Illness.

A comparison of the data on restraints reveals that the use of restraints at the Booneville HDC for disciplinary measure occurs much more often than at any of the other, similarly sized, Arkansas HDCs. Those other HDCs are the Arkadelphia HDC, Jonesboro HDC, and the Southeast Arkansas HDC in Warren.

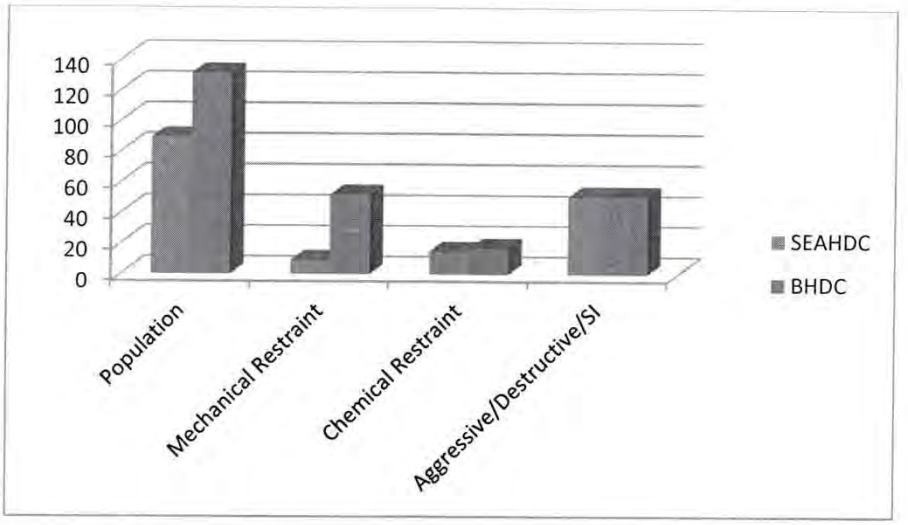
In June 2014, the Booneville HDC had 131 residents and a reported total of 51 Aggressive/Destructive/Self Injurious Behaviors. That month, mechanical restraints were used on residents 52 times and chemical restraints were used on residents 17 times.

By comparison in that same month, there were 118 residents at the Arkadelphia HDC (AHDC) and a reported total of 59 Aggressive/Destructive/Self Injurious behaviors. However, at the Arkadelphia HDC, mechanical restraint was used on residents only six times and chemical restraint was not used at all. There was less use of restraint at the Arkadelphia HDC than at the Booneville HDC in June 2014 even though there were a higher number of problem behaviors at the Arkadelphia HDC that month.



Comparison of Booneville HDC to Arkadelphia HDC Behavior and Restraint Data for June 2014

Similarly, in June 2014, there were 89 residents at the Southeast Arkansas HDC (SEAHDC) in Warren and a reported total of 51 Aggressive/Destructive/Self Injurious behaviors. At the Southeast Arkansas HDC, mechanical restraints were used on residents only 9 times and chemical restraints were used 15 times.



Comparison of Booneville HDC to Southeast Arkansas HDC Behavior and Restraint Data for June 2014

The number of restraint and behavior incidents for all HDCs stayed relatively consistent over the four month period between June and September 2014:

	June			
	AHDC	**BHDC**	**JHDC**	**SEAHDC**
Population	118	131	104	89
Mechanical Restraint	6	52	16	9
Chemical Restraint	0	17	0	15
Aggressive/Destructive/SI	59	51	66	51

	July			
	AHDC	**BHDC**	**JHDC**	**SEAHDC**
Population	119	132	105	90
Mechanical Restraint	6	66	19	7
Chemical Restraint	0	27	0	3
Aggressive/Destructive	52	78	34	28
Self-Injurious	25	17	28	29

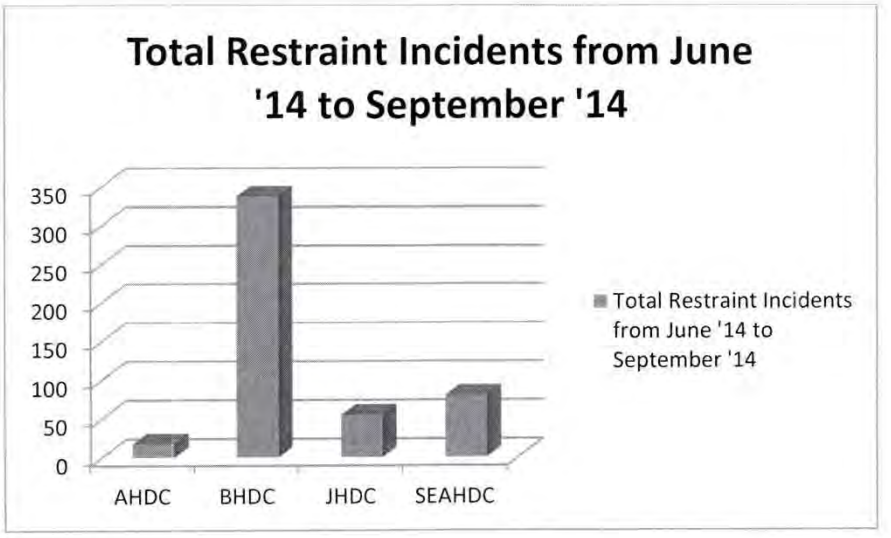
August

	AHDC	BHDC	JHDC	SEAHDC
Population	118	131	105	89
Mechanical Restraint	2	63	8	16
Chemical Restraint	0	44	0	12
Aggressive/Destructive	52	78	34	28
Self-Injurious	25	17	28	29

September

	AHDC	BHDC	JHDC	SEAHDC
Population	119	129	105	90
Mechanical Restraint	4	52	12	10
Chemical Restraint	0	17	0	8
Aggressive/Destructive	52	78	34	unknown
Self-Injurious	25	14	28	unknown

Over the four month period from June through September 2014, there were 18 restraint incidents at the Arkadelphia HDC, 55 at the Jonesboro HDC, 80 at the Southeast Arkansas HDC, and 338 at the Booneville HDC. Booneville's population averaged about 130 residents for those four months, with an average of 84.5 restraint incidents per month. The use of restraints is roughly 18 times higher than the average at the Arkadelphia HDC, six times higher than the average at the Jonesboro HDC, and four times higher than the average at Southeast Arkansas HDC.



In 2009, the Congressional Research Service issued a report on restraint in schools which stated, "[c]hemical and mechanical restraints should never be used in a school setting." If this is the case, then why are these same methods used in our state-run facilities for individuals with developmental disabilities? And why are these methods resorted to more frequently at the Booneville BHDC?

The frequency of restraint use at the Booneville HDC is too high. The Arkansas Department of Human Services, the state agency responsible for oversight of the HDCs, must take steps to determine the root causes of the excessive use of restraint at the Booneville HDC, rethink and improve the behavior plans of those residents who are frequently restrained and retrain staff on methods to avoid the use of restraint. Moreover, as part of this review, the Department of Human Services should investigate the purpose for the use of restraint. If the Department finds that restraint is being used in a punitive manner, then it should take steps to end the practice immediately.

Conclusion

The Booneville HDC has many wonderful residents and, for the most part, a dedicated and caring staff. However, there are several deeply rooted problems with no easy solution. As a result of these problems, Disability Rights Arkansas recommends the facility be gradually phased out. Admissions to the Booneville HDC should be halted as soon as possible and residents who can be moved into the community with supports from Medicaid waiver programs should be transitioned into the community. If necessary, the remainder of the residents should be absorbed by the other four Arkansas HDCs. While this may seem like a drastic step, it is the one that makes the most economic sense for Arkansas and the safety of the residents.

DRA Recommendations:

- The Booneville Human Development Center should be gradually phased out over the next 12 to 18 months and admissions to the Center should be halted immediately.
- The majority of the residents should be moved into supported living within the community and, if necessary, all other residents should be absorbed by the four remaining HDCs.
- The bulk of the money saved by the closure of the Booneville HDC should be used to strengthen home and community based care throughout the state.
- All unused buildings and portions of buildings at the Booneville HDC that remain unused should be immediately sealed off to prevent residents from accessing them.
- All HDC staff statewide should be retrained in methods to avoid the use of restraints.
- The Department of Human Services should adopt a stricter policy for tracking and monitoring the use of restraints within the HDCs in order to better recognize troubling trends.

It is our hope that the State of Arkansas will continue to strive to provide those individuals with developmental disabilities the best and most modern care possible. It is time for Arkansas to move away from the outmoded institutional model of care, as well as reduce the risk of a potentially costly *Olmstead* suit. Though a move toward community-based services would save the State a great deal of money, this is not just about the money. This is about providing Arkansans with developmental disabilities and their families both the freedom and the opportunity to live how they choose and to ensure that the State has the resources necessary to support and make available community-based living to all.

DisabilityRights
ARKANSAS



Booneville Human Development Center
Administration Building

Bound to the Past:

The Excessive Use of Restraint at Booneville Human Development Center

January 2016



Bound to the Past:

The Excessive Use of Restraint at Booneville Human Development Center

A public report by

Disability Rights Arkansas, Inc.

January 2016

Acknowledgements

Disability Rights Arkansas, Inc. (DRA) is the federally authorized and funded Protection and Advocacy System and Client Assistance Program for individuals with disabilities in Arkansas. DRA is authorized to protect the human, civil, and legal rights of all Arkansans with disabilities consistent with federal law.

This publication was made possible by funding support from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Health & Human Services Administration for Community Living. The contents of this report are solely the responsibility of the grantee and do not necessarily represent the official views of SAMHSA or the Department of Health & Human Services Administration for Community Living.

Introduction

The State of Arkansas operates five Human Development Centers (HDCs),[1] which are institutional facilities that provide 24-hour residential, medical, and habilitative services to individuals with developmental disabilities.[2] The five HDCs are located in Arkadelphia, Booneville, Conway, Jonesboro, and Warren. As of September 2015, 908 individuals with developmental disabilities reside in the State's HDCs.

Booneville HDC is the oldest property of the five HDCs. The facility is located in Logan County at the former site of the Arkansas Tuberculosis Sanatorium; it is a large facility on 900 acres with many buildings that are almost 100 years old.[3] Booneville HDC has 138 licensed beds for residents and has approximately 300 employees. The facility's annual budget was $16 million for Fiscal Year 2014; however, millions of additional dollars are needed to address the aging physical plant conditions at the facility.[4]

In January 2015, Disability Rights Arkansas (DRA) released a report expressing concerns regarding both the physical plant conditions and the high number of restraints at the facility.[5] DRA recommended closure of Booneville HDC due to the conditions and the excessive use of restraint at the facility. These concerns are in addition to DRA's general concern that Arkansas continues to rely on restrictive institutional care for individuals with disabilities in violation of the integration mandate of the Americans with Disabilities Act as articulated by the United States Supreme Court in *Olmstead v. L.C*, 527 U.S. 581 (1999),[6] while thousands of Arkansans are unable to access services that would allow them to live in their communities.[7]

There is controversy within the State about the continued existence of Booneville HDC, and there has been no movement toward closing the facility. Nevertheless, if the State continues to rely upon Booneville HDC for the care of individuals with developmental disabilities, it must take steps to ensure that the individuals who reside in the facility are free from the unnecessary use of restraint and have access to treatment that eliminates the need for restraint.

Since publication of our January 2015 report, DRA has continued to monitor and review the use of restraints at Booneville HDC. In an effort to evaluate the extent of the restraint activity, DRA reviewed all restraint reports for a sixteen month period and HDC reports, which are submitted quarterly to the Developmental Disability Services Board.[8] DRA talked with facility staff and administrators to discern not only the extent and type of restraints used in the facility but also the efforts to provide programming to reduce restraint incidents. DRA also consulted with an expert in facility practices, including reducing the use of restraint in facilities.[9]

DRA has concluded that the restraint practices at Booneville HDC are both contrary to currently recognized best practices regarding restraints and puts residents and staff at risk of physical and emotional harm. Furthermore, DRA has concluded that the restraint practices at Booneville HDC will not be eliminated without serious scrutiny and comprehensive changes within the facility.[10]

Disability Rights Arkansas, Inc.
"Bound to the Past: The Excessive Use of Restraint at Booneville Human Development Center"
January 2016

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Regulations and Policies Governing Use of Restraints

Intermediate care facilities for individuals with developmental disabilities, such as Booneville HDC, must meet certain federal standards in order to receive Medicaid reimbursement.[11] The Centers for Medicare and Medicaid Services regulations govern these types of facilities and provide requirements for compliance in order for those facilities to maintain their Medicaid funding. Within those regulations are specific criteria regarding the use of restraints at institutions such as Booneville HDC.

Facilities must "[e]nsure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints."[12] Physical restraints are only allowed as part of an individualized program intended to result in less restrictive means of managing a specific behavior, on an emergency basis if required to protect the resident or others from injury, or as prescribed by a physician to be used during specific medical or surgical procedures, or while a medical condition exists.[13]

Written policies and procedures regarding the management of any inappropriate behaviors must be developed so that these types of interventions are done on a continuum; the least restrictive means of managing a behavior must be attempted first before resorting to more intrusive methods.[14] These policies and procedures are intended to ensure that a resident's human and civil rights are protected and that restraints are not used "for disciplinary purposes, for the convenience of staff, or as a substitute for an active treatment program."[15]

The Division of Developmental Disabilities Services (DDS) within the Arkansas Department of Human Services (DHS) has developed a policy related to behavior management that the HDCs are required to follow.[16] This policy notes that the agency's philosophy is to use positive approaches to behavior management before utilizing more restrictive approaches.[17] It also recognizes that "[e]fforts at positive programming prove to be successful with the majority of maladaptive behaviors."[18]

> *"The goal is to eliminate the use of seclusion and restraint in behavioral health, as the use of seclusion and restraint creates potential physical and psychological dangers to the persons subject to the interventions, to the staff members who administer them, or those who witness the practice."* [19]

Restrictive methods, including restraints, which are used as part of an individual's behavior program, should be limited to those "individuals who repetitively engage in *dangerously aggressive* behavior and for whom other interventions have not been effective."[20]

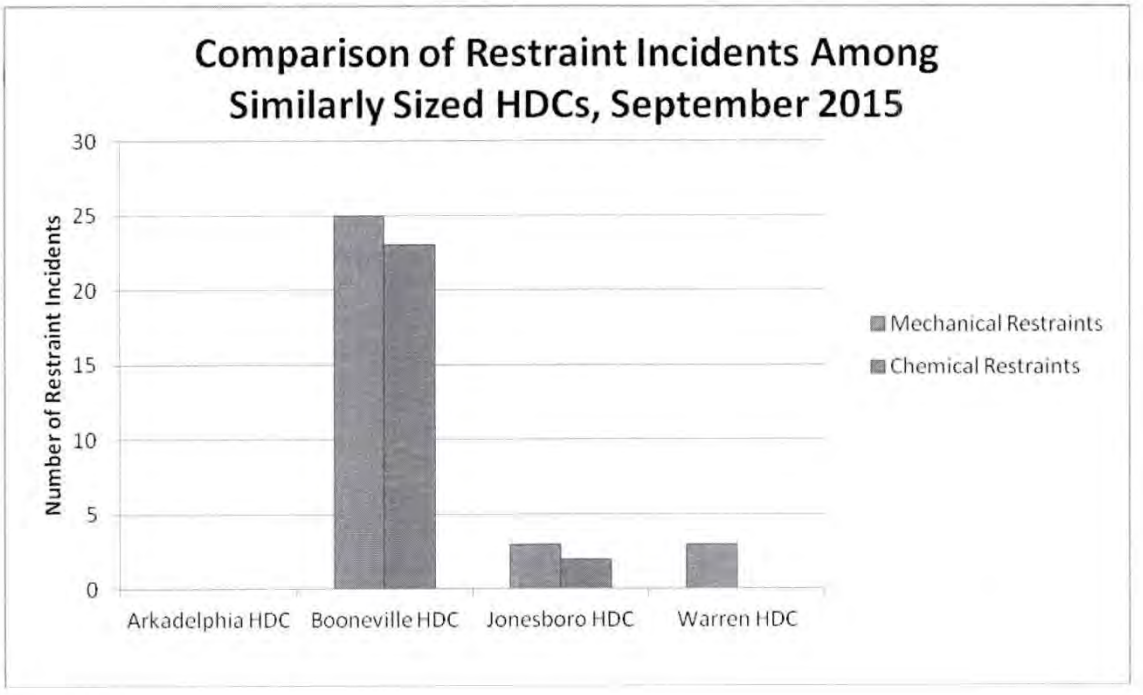
Restraints must also include documentation that other, less restrictive methods of addressing behavioral issues have previously been tried and failed. The program should be carefully reviewed and monitored by professionals and revised if the interventions are proving ineffective.[21] Regardless of how they are labeled, restraints, both personal and mechanical, should only be used to prevent personal injury or serious property damage.

Booneville HDC also has an internal policy and procedure for managing behaviors that recognizes that it is not effective to control behavior by coercion[22] and that personal or mechanical restraints for behaviors should only be used in emergency situations.[23] Emergency restraints are only to be used when a behavior is *severely aggressive* or *destructive* and never for punishment or convenience.[24] Emergency mechanical restraints are only to be used when all other means of behavior control have been exhausted and when the individual is "*so* aggressive that restraint is necessary to prevent *imminent* physical harm to themselves, others, or property."[25]

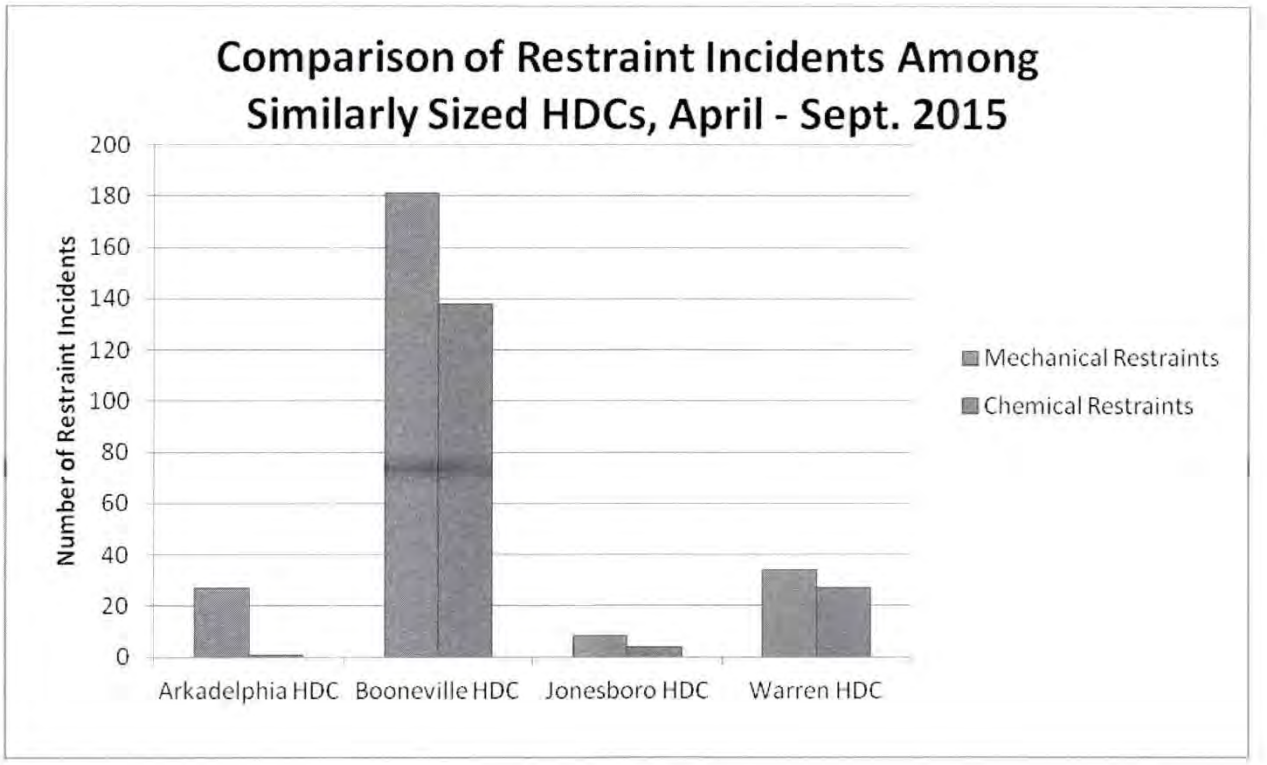
Booneville HDC Has A Significantly Higher Number of Restraints than Similar HDCs

As part of examining the use of restraint at Booneville HDC, DRA compared the frequency of restraint use at that facility with the three other similarly sized HDCs, which are in Arkadelphia, Jonesboro, and Warren.[26] Booneville HDC continues to have more restraints, in relation to population, than the other similar HDCs.[27]

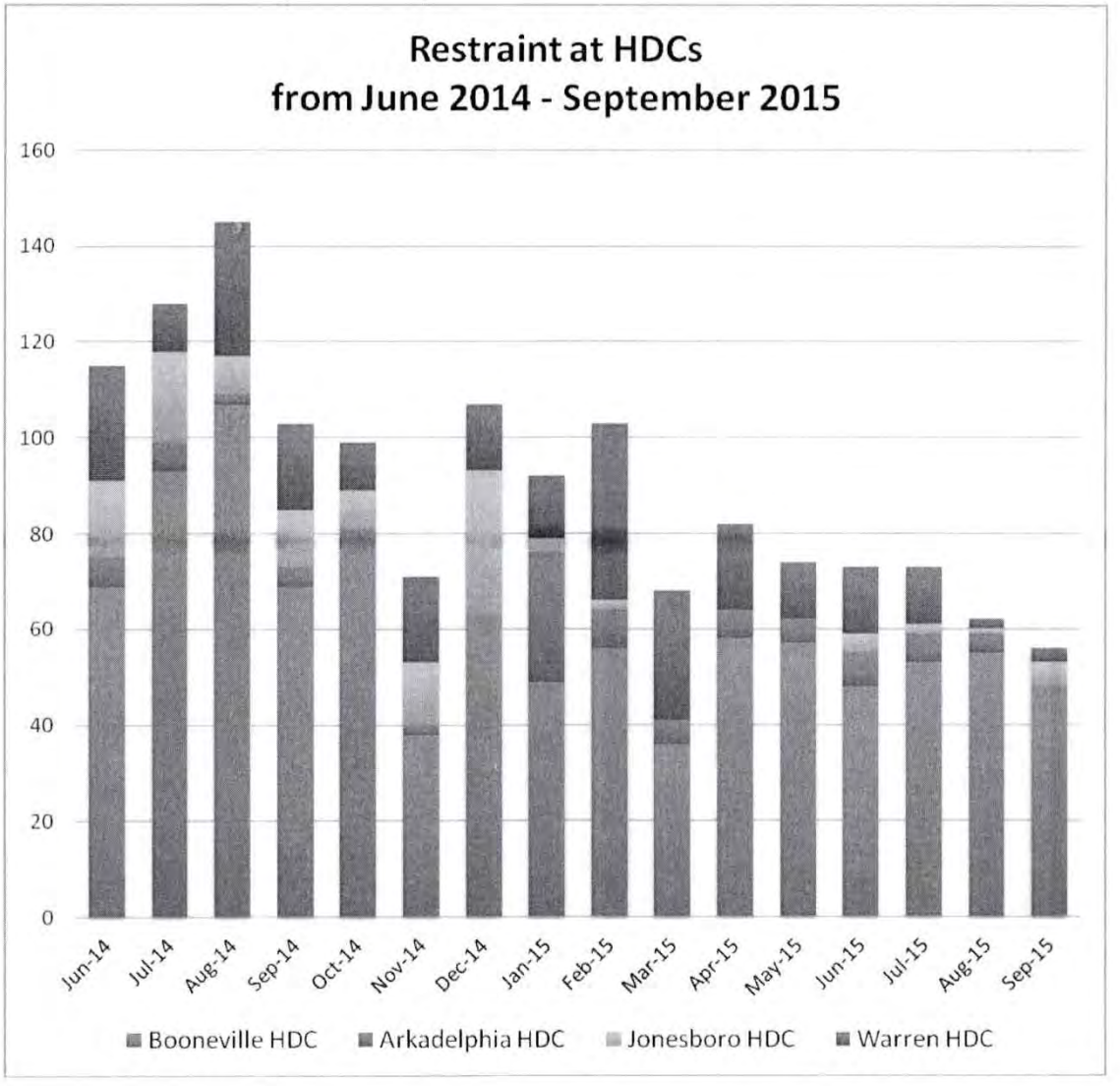
In September 2015, Booneville HDC's population was 122 residents, and it reported 25 mechanical restraints and 23 chemical restraints.[28] By comparison, Arkadelphia HDC's population was 117 residents, and it reported no restraints. For further comparison, Jonesboro HDC's population was 104 residents, and it reported 3 mechanical restraints and 2 chemical restraints. Warren HDC's population was 92 residents, and it reported only 3 mechanical restraints and 0 chemical restraints.



The September 2015 results are not an anomaly. Restraint numbers reported for the preceding six months yielded the same result—Booneville HDC has consistently higher incidents of restraint when compared with other HDCs of similar size and character. From April through September 2015, Booneville HDC reported a total of 181 mechanical restraints and 138 chemical restraints. Arkadelphia HDC reported 27 mechanical restraints and 1 chemical restraint. Jonesboro HDC reported 8 mechanical restraints and 4 chemical restraints during that same reporting period. Warren reported 34 mechanical restraints and 27 chemical restraints during that same period.



Each month over a sixteen month period from June 2014 to September 2015, Booneville HDC consistently utilized more restraints than any of the other comparable HDCs *combined*.[29] While Booneville HDC has reduced the number of restraints occurring at the facility, the average number of restraints is still approximately twenty-five times higher than the average number of restraints at other HDCs.



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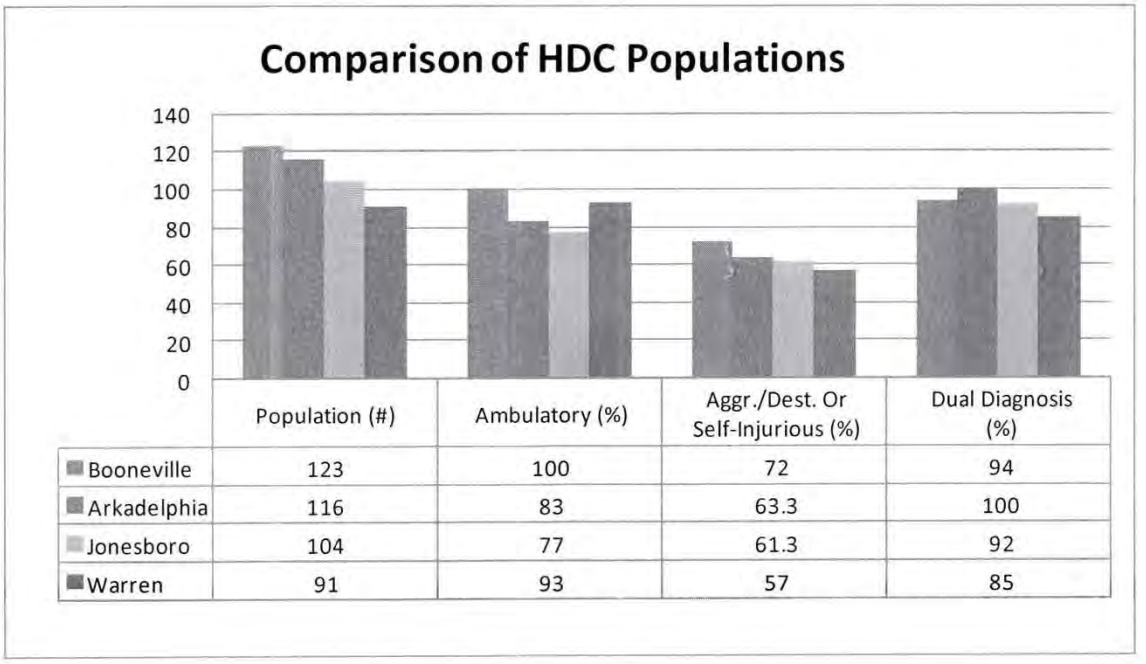
As shown in the graph below, the remaining HDCs (Arkadelphia, Jonesboro, and Warren) are comparable in not just the raw number of residents but also in the percentage of residents who (1) have a dual diagnosis, (2) have been identified as exhibiting aggressive/destructive or self-injurious behavior, and (3) are ambulatory.[30]



	Population (#)	Ambulatory (%)	Aggr./Dest. Or Self-Injurious (%)	Dual Diagnosis (%)
Booneville	123	100	72	94
Arkadelphia	116	83	63.3	100
Jonesboro	104	77	61.3	92
Warren	91	93	57	85

These particular characteristics were chosen for comparison because the Department of Human Services has explained the higher number of restraints at Booneville HDC, stating: "the number of times restraints are used at Booneville tends to trend higher than other HDCs, and we believe that relates to the fact that Booneville specializes in serving only intellectually or developmental disabled, ambulatory individuals with severe behavioral challenges [. . .]"[31] Therefore, DRA compared the number of HDC residents reported to have a dual diagnosis, which means a resident has both a developmental disability and a mental health diagnosis. The HDCs have nearly even numbers of individuals with dual diagnoses.[32] In fact, according to recent reports from the HDCs, Arkadelphia HDC has the highest number of residents with a dual diagnosis among the HDCs compared.

DRA also compared the percentage of residents who have been identified as having "aggressive/destructive" or "self-injurious" behaviors according to reports from the HDCs. While Booneville HDC has a marginally higher percentage of residents who exhibit these identified behaviors, the other HDCs have a significant number of residents with these same types of behaviors.[33] This difference in the number of residents who have been identified as having "aggressive/destructive" or "self-injurious" behaviors does not justify the uncommonly high number of restraints at Booneville HDC.

Finally, DRA compared the percentage of ambulatory residents and found some difference.[34] All of the residents at Booneville HDC are ambulatory, which is necessary due to the inaccessibility of its campus for persons with mobility impairments. However, there are significant numbers of ambulatory residents at the other HDCs as well. The small disparity in the number of ambulatory residents at Booneville HDC does not explain the large discrepancy between the number of restraints at Booneville and at the other HDCs.

Restraint is Inherently Dangerous

Concern over the high number of restraints used at Booneville HDC comes from the inherent dangers associated with these types of interventions. Published studies and articles have discussed the risks associated with restraints, which can include physical injuries, significant trauma, and death.[35] Due to these recognized risks, numerous institutions across the country providing services to individuals with mental health or developmental disabilities, or training professionals to do so, have worked to eliminate the use of restraints. They have done so due to the potential for serious physical and psychological harm, both to the individual restrained and to the staff implementing the restraint.[36] Many organizations across the country have also agreed that restraint should be a last resort and used only in instances where serious injury is imminent.[37]

Booneville HDC's Restraint Incident Debriefing Form acknowledges the danger of restraints to both staff and residents, noting that the "use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used." However, restraints routinely occur at Booneville HDC where, based on documentation of the incident, the risk of serious injury was not imminent. As a result of restraint use, residents at Booneville HDC have sustained injuries ranging from scrapes and scratches to large, multiple bruises and even broken bones.

> *"The use of physical restraints can cause harm including strangulation, loss of muscle tone, decreased bone density (with greater susceptibility for fractures), pressure ulcers, decreased mobility, depression, agitation, loss of dignity, incontinence, constipation, and in some cases, resident death."* [38]

Types of Restraints at Booneville HDC

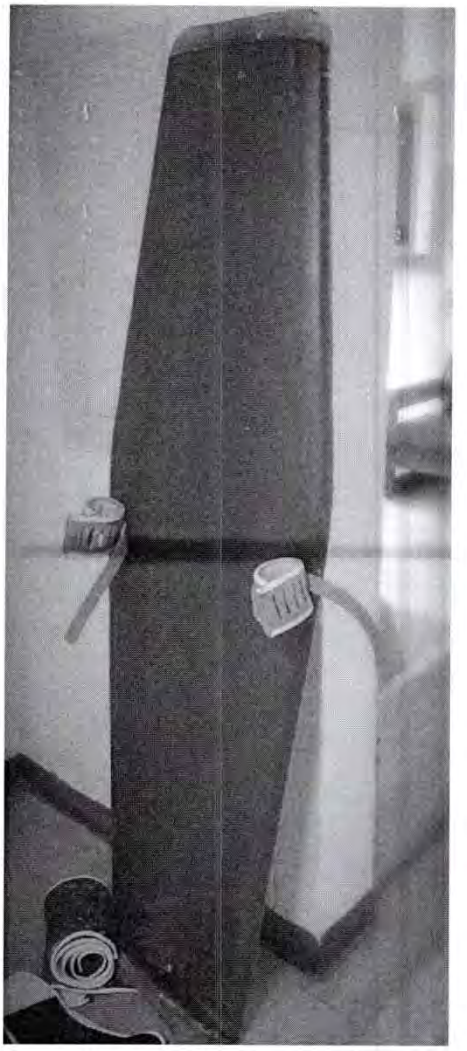
At Booneville HDC, there are five approved restraint procedures, techniques, and devices—

1. personal restraints;
2. chemical interventions;
3. protective helmets;
4. papoose board; and
5. wrist restraints.[39]

Based on our review of documents, the methods used most often are personal restraints, chemical interventions, and the papoose board. Personal restraints are procedures that limit movement by physically holding the hand or limb.[40] However, this procedure can range from a hand on the shoulder to forcing a resident to the ground and forcibly holding him or her there, sometimes with a knee in the resident's back and a forearm across the back of the resident's neck.

Chemical interventions/restraints involve the administration of a drug to restrict a resident's movement or to sedate him or her. The most commonly used chemical interventions at Booneville HDC are Ativan and Haldol.[41] Ativan is labeled as a medication to treat epileptic seizures and to sedate patients before surgery.[42] Side effects can include central nervous system depression, respiratory depression, dizziness, confusion, depression, sobbing, and delirium.[43] Meanwhile, Haldol is used to treat schizophrenia and Tourette's Disorder.[44] Its known adverse reactions or side effects include tachycardia, hypotension and hypertension, impaired liver function, anorexia, constipation, diarrhea, hypersalivation, nausea, vomiting, visual disturbances, insomnia, anxiety, agitation, depression, and "potentially irreversible, involuntary, dyskinetic movements."[45] Chemical restraints are often given in conjunction with a mechanical or personal restraint.[46]

The final method of restraint reviewed for this report is the papoose board. This "mechanical restraint" is a device that limits movement and range of motion.[47] It resembles a padded board with straps to hold a resident tightly to the board in a way that prohibits movement and completely controls a resident's body. Frequently, the term "graduated guidance" is used to describe the method of moving a resident to the papoose board and represents how a staff member must struggle with and force a resident, who does not want to be restrained, onto this restrictive device. The papoose board is used for longer periods of time than personal restraint. At least one resident has been strapped to the papoose board for six hours in a single day, while only being released for mandatory breaks every 55 minutes.



Papoose Board currently used at Booneville HDC

Use of Restraints at Booneville HDC

Booneville HDC's policies require that less restrictive measures be used before resorting to restraints. According to the documentation reviewed by DRA, restraints often occur when a lack of meaningful intervention by staff has led to an escalation in the resident's behavior.

Staff often use restraint when Booneville HDC's policy would dictate a less restrictive intervention. Staff document less restrictive interventions most often in the form of redirection, direction, or sanctions. Redirection routinely takes the form of simply telling an agitated or upset resident to "stop," "calm down," or "go back to work." Residents will also be told that they risk having a privilege taken away. None of these strategies actually address the needs of the resident, or the motives of the behavior, and frequently accomplish nothing but escalation of the resident's behavior.

This is concerning because some of the residents at Booneville HDC are in restraints for extended lengths of time.[48] In the fourteen month period between January 2014 and February 2015, the cumulative time residents were personally or mechanically restrained ranged anywhere from one minute to nearly four full days.[49] The average cumulative time a resident at Booneville HDC spent in either personal or mechanical restraints was over five hours for that period of time.[50]

A few examples from the period of January 2014 through February 2015 illustrate the lengths that residents have been restrained on a papoose board:

- Resident 1 was restrained every month and restrained a total of 59 hours and 17 minutes during this time frame.
- Resident 2, who also was restrained every month, was restrained a total of 64 hours and 51 minutes during this time frame.
- Resident 3 was restrained in all but one month and was restrained a total of 94 hours and 57 minutes during this time frame.
- Resident 4, who was also restrained in all but one month, was restrained a total of 84 hours and 22 minutes.

The restraint documentation also does not provide enough information regarding *why* a behavior escalated, or what occurred before the incident that led to the behavior. Instead, the focus is limited to the resident's actions that led to the restraint, without regard to the reason for the behavior. Resident behaviors and actions are consistently examined in a vacuum, divorced from any context or meaning, and viewed only as compliant or non-compliant. Staff involved in restraint incidents rarely document the reason for a behavior, or suggest any changes to the individual's program as a way to address the problematic behavior. This is true even in instances when a resident's behavior tends to occur in identifiable patterns, frequently taking place at the same time of day, with the same residents, or in the same location.

> *"Seclusion and restraints have no therapeutic value, cause human suffering, and frequently result in severe emotional and physical harm, and even death."* [51]

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Example: Resident was upset that another resident was telling her what to do. Staff intervened in the situation, but they stated it was too late. Staff report that Resident was then engaging in self-injurious behavior and spitting at staff. Staff also report that *Resident asked the staff to restrain her on the papoose board and give her a chemical restraint.* Resident was strapped to the papoose board for 40 minutes. There was no insight regarding program changes or the motivation for the behavior other than agitation by a co-resident.

Identifying the function that a particular behavior serves is one of the most important aspects of modifying a challenging behavior. This important step is relatively nonexistent at Booneville HDC. Instead, the same residents are subjected to repeated restraints with no attempts at providing them with needed therapy and tools for them to use to adapt their behavior.

Most human behavior has meaning. Professional staff, with training to identify that meaning, should be carefully reviewing all restraint documentation and events leading up to a restraint in order to better provide direct care staff with an understanding of what the resident is seeking to communicate with a behavior. For this to occur, staff involved in the restraint must consistently document what happened prior to the escalation of the behavior so that a true understanding of the behavior can take place.

A related issue that is apparent from review of restraint documentation at Booneville HDC is that staff routinely relies on rule enforcement instead of resident engagement. When a resident does not "comply" with a rule, a restraint often follows. This is typically due to a resident's resistance to being directed to do some action that he or she does not want to do at the time. Instead of engaging with that resident to determine why there is resistance, or to find alternate avenues that allow for resident expression, staff often will try to force the resident to comply, which only escalates the situation.

Example: Resident did not want to go to his room for shift change. When staff attempted "graduated guidance" to get him to his room, he started threatening and swinging at staff. One of the staff members fell on Resident, *breaking his collar bone.* Resident was then strapped to the papoose board for 50 minutes. There was no indication that any staff member questioned Resident to see why he did not want to go to his room. When staff asked Resident for his input to prevent future restraints, he replied that he would like to go to either the Arkansas State Hospital or jail as opposed to staying at Booneville HDC.

In fact, non-compliance is frequently used throughout the restraint documentation as justification for why a restraint was used. Non-compliance places the blame and consequences for a behavior on the resident. The focus on non-compliance reflects an outdated philosophy that exists at Booneville HDC and likely contributes to the frequency of restraints. In many similar institutional settings across the country, non-adherence has replaced non-compliance as a best practice. Non-adherence acknowledges a resident's choice in treatment and gives information to the provider that the resident needs to be better engaged in the program.

Example: Resident was asked to take a shower due to having a bowel movement in his pants during a seizure. Resident became upset with staff after they told him several times to take a shower. He swung at a staff member and was promptly strapped to the papoose board for thirty minutes until he agreed to shower. There were no recommendations to help prevent a similar event from occurring again.

Another concern is the frequency with which Booneville HDC staff routinely restrain residents based on behaviors that they classify as "attention-seeking." Restraint documentation revealed that events leading up to a resident being restrained were often due to a resident attempting to gain the attention of staff members. When those attempts were unsuccessful, due to staff either ignoring the resident or trying to redirect their actions, the resident's behavior would escalate, and restraint would result. The use of restraints in these instances is inappropriate and would be unnecessary if staff were provided with training on best practices to enable them to better understand a resident's need for attention and how to appropriately respond to that need.

The record below is an excerpt from a Restraint Incident Debriefing Form.[52] This restraint began with the resident having displayed self-injurious behavior, leading to a personal restraint. She calmed herself enough to have breakfast and take her medications, at which point a nurse announced that she was still going to administer a chemical restraint in the form of a shot. This, according to staff, escalated the resident's behavior. Upon reflection, the staff member filling out the debriefing form recommended that the nurses be more discrete when administering chemical restraints. There is no documentation that explains why staff thought a chemical restraint was necessary after the resident was already calmed.

3. Interaction with Staff: (Was the interaction with this person and the client performed in such a way as to deescalate the situation or a factor in escalating the behavior? Was this person someone whom the client likes or not? Could a different staff person have interacted with the client and avoided the emergency restraint?) Please Describe:
We calmed [redacted] to the point of taking her meds and have breakfast. The nurse [redacted] stated I'm still gonna give her that shot and [redacted] threw her water and went to bite herself and fight staff.

****

6. Recommendations: (Are there any recommendations from the Client, the Intervention Team and/or the Restraint Leader that could help prevent a similar event from occurring again?) Please List:
Have staff not say things like the Nurse said in front of clients. Need to be descreet.

Another important issue is that documentation of a restraint requires the use of multiple forms, which, though intended to capture the entire event, often miss critical pieces required to truly understand what happened. As noted earlier, staff members tend to document the resident's behavior after it has already escalated. There is little attention given to events leading up to the escalated behavior, to effective interventions prior to the use of restraint, or to an analysis of how the restraint could have been avoided.

Furthermore, the Restraint Incident Debriefing Form is often completed or reviewed at a later date, which does not aid in identifying patterns or avenues for reducing the use of restraints for that resident. DRA's review of the restraint documentation revealed that many residents experience restraints repeatedly during the same day, week, or month. Without a prompt review and thorough discussion of the restraint, the resident is subjected to repeated instances of this dangerous, dehumanizing, and coercive intervention that could have been avoided had that review taken place.

> ***Example:*** According to a *Behavior Report*, Resident was restrained for threatening to kill staff and himself, and he relentlessly continued this behavior while restrained on a papoose board for one hour and thirty-five minutes; however, a *Chemical Intervention Checklist* for the same incident states that Resident "was calm until he heard staff talking about how he needed a shot." Yet another document, the *Restraint Incident Debriefing Form,* does not mention the interaction with staff that escalated Resident's behavior.

Residents in institutional settings rely on staff members for all of their basic needs. The majority of their days are spent on the same campus, in the same rooms, with the same individuals. As such, it is simply human nature to seek out attention in a variety of ways. Instead of ignoring or punishing that behavior, staff should be working with residents to better engage them in their treatment programs and in the world outside of the Booneville HDC campus.

> ***Example:*** Resident made a homemade badge and was pretending that he worked at Booneville HDC. He began telling clients what to do. When staff tried to redirect him, he punched a staff member. He was strapped to a papoose board for 35 minutes. When asked to reflect on programmatic issues that could be made to prevent the restraint, the staff member writes, "no changes could of [sic] helped this behavior." No effort was made to transfer Resident's imagined role as a staff member to a purposeful activity before resorting to restraints.

Lack of Meaningful Follow-up

Though restraints are routinely used at Booneville HDC, there is a lack of meaningful follow-up by the facility in order to identify alternative avenues of behavior management. While other institutions across the country seek to eliminate the use of restraints, Booneville HDC has shown marginal movement towards that goal. Review of documentation revealed that the same residents are repeatedly restrained without consideration of ways to avoid the use of restraint.

Booneville HDC uses a "Restraint Incident Debriefing Form" that is to be completed by staff following an emergency restraint.[53] When an incident occurs, a restraint incident leader is to conduct a debriefing session with other staff involved, as well as the resident, to pinpoint the behavior that led to restraint, environmental factors involved, antecedents to the behavior, staff actions that could have kept the situation from escalating, the resident's reaction, and any programmatic changes or resident options that could have prevented the restraint.[54]

While staff members appear to complete the debriefing forms with regularity following a restraint, the documentation frequently does not provide the information that the questions intend to target. Many times the answer is simply "none." The area designated for resident input often does not include information from the resident to better understand the resident's point of view. There is little documentation of ways the restraint could have been avoided.

In addition, staff routinely place the blame for the use of restraints on the resident's "bad behavior," without regard to how the staff's own actions may have contributed to the escalation. Though there is an area that allows staff to put recommendations as to how to avoid restraints in the future, staff members rarely have suggestions. A review of the debriefing forms reveals that direct care staff members involved in administering the restraints do not see any other options and just accept restraint activity as a necessity. This reflects a culture at Booneville HDC where overuse of restraint is the norm.

Lack of Meaningful Oversight

Booneville HDC does have a Human Rights Committee (Committee) that is intended to protect the rights of Booneville HDC residents. The Committee, which is required and established by both the Division of Developmental Disabilities Services and Booneville HDC policies, is tasked with a number of functions, one of which is to review the restraint activity at Booneville HDC.[55] However, the Committee rarely, if ever, questions the use of restraint. The meeting minutes reflect that the Committee routinely approves the use of restraints, even for those residents who are repeatedly restrained during a review period, with no discussion documented as to ways to prevent those restraints in the future. Though the same residents often are included in the review month after month, there appears to be no effort by the Committee to question the course of action or to reduce the use of restraints. Instead, there appears to be acceptance, facility-wide and by the Committee, that the use of restraints is the status quo.

Conclusion

According to the data collected and maintained by Booneville HDC and the State, residents at Booneville live in an environment in which restraint is used excessively, far more frequently than at the Arkadelphia, Jonesboro, or Warren HDCs. Booneville HDC fails to ensure that staff utilize effective tools to de-escalate situations, leading to the use of restraints when other interventions, if implemented sooner, could eliminate the need for restraint. The Department of Human Services and its Division of Developmental Disabilities Services has failed to provide the oversight and training to ensure that residents at Booneville HDC are not subjected to unnecessary and excessive restraints. Residents and staff have already been injured due to the current restraint practice at Booneville HDC.[56]

All HDC residents are entitled to live in an environment in which restraints are used as a last resort after other interventions have failed. The residents at Booneville HDC have a right to be treated with dignity and respect, to not be subjected to unnecessary and harmful restraint, and to receive active treatment based on evidence-based best practices. DRA urges the State to take immediate action to address the culture at Booneville HDC and to instruct Booneville HDC to stop this inherently dangerous practice. The individuals with disabilities residing at Booneville HDC deserve better.

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Recommendations

DRA recommends that the State take the following steps to ensure that residents at Booneville HDC are protected from excessive and unnecessary restraint:

1. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should retain an independent expert with expertise in working with facilities to develop and implement current evidence-based best practices at Booneville HDC to significantly reduce and/or eliminate the use of restraint at the facility.

2. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should provide and require participation of Booneville HDC's senior administrative, clinical, and direct care staff in comprehensive training on person-centered and trauma-informed, recovery-oriented, evidence-based services and supports.

3. The Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and Booneville HDC's senior administrative and clinical staff should be required to develop a strategic plan to transform this institution to one that adopts current, best practice philosophy, vision, and values. This plan should be updated monthly and reviewed quarterly by the state office or an external entity.

4. The Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and Booneville HDC should ensure that all facility staff immediately receive extensive training and are intensively monitored to ensure that evidence-based best practices are used to avoid escalation of behaviors and the use of restraint. DRA recently learned that Booneville HDC has begun training some facility staff on Nonviolent Crisis Intervention Training. Nevertheless, the number of restraints a Booneville HDC are still much higher than at the other HDCs.

5. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ensure that the use of restraint at Booneville HDC is regularly monitored, including careful evaluation and scrutiny of the reasons staff utilized restraint, alternatives to restraint, and follow-up actions in response to restraint. This includes requiring that clinical and senior administrative staff be more involved in the day-to-day activities of residents to ensure that individualized treatment or behavior plans are effective and that adequate active treatment is provided.

6. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ensure that residents of Booneville HDC have access to active treatment, including the provision of mental health and other treatment that supports residents in addressing their challenging behaviors in ways that do not include coercion or punishment.

7. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ban the use of the papoose board as a form of restraint at Booneville HDC and other HDCs.

Endnotes

[1] About DDS, http://humanservices.arkansas.gov/ddds/Pages/AboutDDDS.aspx (last visited Dec. 3, 2015).

[2] Developmental disability is defined as "'an impairment of general intellectual functioning or adaptive behavior' that is a 'substantial handicap to the person's ability to function without appropriate support services, including, but not limited to, planned recreational activities, medical services such as physical therapy and speech therapy, and possibilities for sheltered employment or job training.' It is caused by mental retardation or a closely related condition; cerebral palsy; epilepsy; autism; or dyslexia (difficulty learning to read and spell) resulting from cerebral palsy, epilepsy, or autism. [. . .] The definition also includes 'a functionally retarded person who may not exhibit an intellectual deficit on standard psychological tests, but who, because of other handicaps, functions as a retarded person.'" Gloria Gordon, *DDS Children's Guide*, (2005) (citing Arkansas Code. § 20-48-101 (2015) and Arkansas Act 729 of 1993), http://humanservices.arkansas.gov/ddds/ddds_docs/dds_childrens_guide.pdf.

[3] *Booneville Human Development Center Description of Services and Programs*, Meeting of the Hosp. and Medicaid Study Subcomm. of the Ark. Legis. Council, 89th General Assemb. Exhibit D-2 (Jan. 8, 2014), http://www.arkleg.state.ar.us/assembly/2013/Meeting%20Attachments/080/I12304/Exh%20%20D-2-Booneville%20HDC.pdf.

[4] Ark. Building Authority, *Human Development Centers Condition Assessment Report for Arkansas Department of Human Services*, Developmental Disabilities Services, (2015). According to this Assessment, Booneville HDC requires an additional $79,755,937 in order to modernize the campus, which does not take into account the cost of ADA compliance, code compliance, demolition of unused buildings, or remediating hazardous material present. Therefore, it is reasonable to assume that a detailed assessment including these factors would likely be much higher.

[5] Disability Rights Arkansas, Inc., *A New Approach to Care in Arkansas: Why the Time Has Come to Close the Booneville Human Development Center*, (2015), http://disabilityrightsar.org/wp-content/uploads/2015/11/BHDC-Final-Report-January-2015.pdf.

[6] In *Olmstead*, the United States Supreme Court held that needlessly segregating individuals with disabilities is a form of discrimination that is prohibited by the Americans with Disabilities Act. The Court decision "that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life…Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Olmstead*, 527 U.S. at 600-01 (citations omitted). *Olmstead* directed states to serve individuals in the most integrated setting appropriate to meet their needs. *See e.g.*, United States Department of Justice Civil Rights Division, Olmstead: *Community Integration for Everyone*, http://www.ada.gov/olmstead/index.htm (last visited Dec. 28, 2015); United States Department of Health & Human Services Office of Civil Rights, *Serving People with Disabilities in the Most Integrated Setting: Community Living and* Olmstead, http://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html (last visited Dec. 28, 2015); Judge David L. Bazelon Center for Mental Health Law, *The* Olmstead *Decision*, http://www.bazelon.org/Where-We-Stand/Community-Integration/Olmstead-Implementing-the-Integration-Mandate/The-Olmstead-Decision-.aspx (last visited Dec. 28, 2015).

[7] *See* United Cerebral Palsy, *The Case for Inclusion 2015*, (2015), http://cfi.ucp.org/wp-content/uploads/2015/07/UCP_2015_CaseforInclusion_FINAL.pdf. According to this report, Arkansas is one of the worst states in the country for providing alternatives to institutional care, ranking number 49, and has consistently ranked as one of the worst states since United Cerebral Palsy's first report in 2007.

[8] The Developmental Disabilities Services Board (DDS Board) is charged with the oversight of the services provided to Arkansans with developmental disabilities. Arkansas Act 348 of 1985 reorganized DHS, placing the Division of Developmental Disabilities Services (DDS) under its authority, and designated control and administration of the HDCs under the management and direction of the DDS Board. The mission of DDS and the DDS Board includes a commitment to the positive management of challenging behaviors, and protection of the constitutional rights of individuals with disabilities, and their rights to personal dignity, respect and freedom from harm.

[9] DRA consulted with Dr. Kevin Ann Huckshorn, who is a licensed and certified mental health nurse and substance abuse clinician with 36 years of experience working in a variety of public and private behavioral health organizations. She has published on topics including violence, treatment adherence, trauma-informed care, and workforce development and has co-authored a book with William Anthony, PhD, titled "Principled Leadership in Mental Health Systems and Programs" (2008). Dr. Huckshorn is the President and CEO of Kevin Huckshorn & Associates, Inc., a small behavioral health consulting business. She is the former Director of the Division of Substance Abuse and Mental Health in Delaware. She led the development of the evidence-based best practice titled "The Six Core Strategies" and was involved in the successful implementation of a United States Department of Justice settlement agreement in Delaware.

[10] DRA wants to emphasize that these conclusions are not meant as any type of reflection on the community of Booneville and its residents who work at Booneville HDC. DRA's conclusions are intended to address the shortcomings in the State's provision of active treatment and safe care to HDC residents and to encourage the State to take the necessary steps to change the culture at the facility by reducing and eliminating the use of restraint.

[11] Centers for Medicare & Medicaid Services, *Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)*, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/ICFMR_Background.pdf.

[12] 42 C.F.R. § 483.420 (a)(6) (2015).

[13] 42 C.F.R. § 483.450 (d) (2015).

[14] 42 C.F.R. § 483.450 (b)(iii) (2015).

[15] 42 C.F.R. § 483.450 (b)(3) (2015).

[16] Arkansas Department of Human Services Division of Developmental Disabilities Services, Policy No. 3011-D *Behavior Management*, (2003), *available at* https://ardhs.sharepointsite.net/DDS%20Policies/Forms/By%20Policy%20Type.aspx.

[17] *Id.*

[18] *Id.*

[19] 2012 CARF Behavioral Health Standards Manual: Section 2.F. Nonviolent Practices/Nonviolent Crisis Intervention Training Program, (May 2012), https://www.crisisprevention.com/CPI/media/Media/Resources/Knowledge-Base/Carf_alignment.pdf.

[20] *See supra* note 16.

[21] *Id.*

[22] Booneville Human Development Center, Policy No. I-D-2, *Use and Documentation of Procedures to Manage Behavior*.

[23] Booneville Human Development Center, Policy No. I-D-4, *Documentation of and Response to Maladaptive Behaviors*.

[24] *Id.* at (2)(a) (emphasis added).

[25] *Id.* at (2)(f) (emphasis added).

[26] Conway HDC has over four hundred residents (more residents than the other HDCs combined) and serves a population that includes children and medically fragile residents; therefore, it will not be considered for comparison to Booneville HDC, which only has 121 residents. Conway Human Development Center, http://humanservices.

arkansas.gov/ddds/Pages/ConwayHDC.aspx (last visited Dec. 3, 2015) (explaining that Conway HDC has residents ranging from ages 7 to 74).

[27] *Human Development Center Monthly Statistical Reports* provided quarterly to the DDS Board.

[28] *Human Development Center Monthly Statistical Reports*, September 2015.

[29] *Human Development Center Monthly Statistical Reports*, June 2014-September 2015.

[30] Based upon data contained within the *Human Development Center Monthly Statistical Reports*, July 2015-September 2015.

[31] Max Brantley, *State Responds to Report on Conditions at Booneville Human Development Center*, The Arkansas Times Blog (Jan. 5, 2015, 11:40AM), http://www.arktimes.com/ArkansasBlog/archives/2015/01/05/state-responds-to-report-on-conditions-at-booneville-human-development-center.

[32] The average number of residents with dual diagnoses within Arkadelphia, Jonesboro, and Warren HDCs is 92.75%, whereas 94% of Booneville HDC's residents have a dual diagnosis.

[33] The average number of residents who have exhibited self-injurious or aggressive/destructive behaviors among Arkadelphia, Jonesboro, and Warren HDCs is 63.4%. Booneville HDC has 72% of its residents who exhibit those behaviors, which is only slightly higher than the average of the other HDCs.

[34] The average number of ambulatory residents within Arkadelphia, Jonesboro, and Warren HDCs is 88.25%. At Booneville HDC, 100% of the residents are ambulatory.

[35] *See, e.g.*, Stephan Haimowitz, Jenifer Urff, & Kevin Ann Huckshorn, *Restraint and Seclusion—A Risk Management Guide*, (2006), http://www.nasmhpd.org/sites/default/files/R-S%20RISK%20MGMT%2010-10-06%282%29.pdf; United States General Accounting Office, Report to Congressional Requesters, *Mental Health: Improper Restraint or Seclusion Use Places People at Risk*, (1999), http://www.gao.gov/archive/1999/he99176.pdf; United States General Accounting Office, Testimony Before the Committee on Finance, U.S. Senate, *Mental Health: Extent of Risk From Improper Restraint or Seclusion Is Unknown*, (1999), http://www.gao.gov/archive/2000/he00026t.pdf; Stacey A.Tovino,"*Psychiatric Restraint and Seclusion: Resisting Legislative Solution.*" 47 Santa Clara L. Rev. 511 (2007); Equip for Equality, *National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint*, (2011), http://www.equipforequality.org/wp-content/uploads/2014/04/National-Review-of-Restraint-Related-Deaths-of-Adults-and-Children-with-Disabilities-The-Lethal-Consequences-of-Restraint.pdf.

[36] *See supra* note 35.

[37] *See supra* note 35.

[38] Centers for Medicare & Medicaid Services, *Freedom from Unnecessary Physical Restraints: Two Decades of National Progress in Nursing Home Care*, (Dec. 3, 2015), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter09-11.pdf.

[39] Booneville Human Development Center, Policy No. I-D-4(6), *Documentation of and Response to Maladaptive Behaviors*.

[40] *Id.*

[41] Booneville HDC Chemical Intervention Checklists from 2014 and 2015.

[42] *Ativan (lorazepam) Injection*, (2015), http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/018140s028lbl.pdf.

[43] *Id.*

[44] *Haldol (haloperidol) Injection*, (2009), http://www.accessdata.fda.gov/drugsatfda_docs/label/2009/015923s084l-bl.pdf.

[45] *Id.*

[46] Booneville HDC Resident Behavior Reports and Chemical Intervention Checklists from 2014-2015.

[47] Booneville Human Development Center, Policy No. I-D-4(6), *Documentation of and Response to Maladaptive Behaviors*.

[48] *See* Appendix 1, which incorporates data from Human Rights Committee Reports furnished by Booneville HDC for the time period of January 2014 to February 2015. DRA compiled the aggregate times residents were in either personal or mechanical restraints per month.

[49] *Id.*

[50] This average includes residents who were not restrained at all during their time at Booneville HDC. If averaging the length of time in restraints for only persons who were actually restrained at Booneville HDC, the number of hours would be over 9 ½ hours. *See* Appendix 1.

[51] Mental Health America, *Position Statement 24: Seclusion and Restraints*, http://www.mentalhealthamerica.net/positions/seclusion-restraints (March 2011) (last visited December 2, 2015).

[52] *See* Appendix 2.

[53] *See* Appendix 2, which is an actual set of forms from a restraint incident, redacted to protect the privacy of the residents involved.

[54] Booneville Human Development Center, Policy No. I-D-4(2)(f)(v), *Documentation of and Response to Maladaptive Behaviors*.

[55] Booneville Human Development Center, Policy No. I-C-2(1)(a-d), *Human Rights Committee*.

[56] Resident injuries were previously described herein. Several employees at Booneville HDC who were placed on Worker's compensation leave from 2013-2015 were reportedly injured by "client behavior." Booneville Human Development Center, Worker's Compensation Report.

Appendix 1

MONTHLY NUMBER OF MINUTES RESTRAINED PER RESIDENT

	02/15	01/15	12/14	11/14	10/14	09/14	08/14	07/14	06/14	05/14	04/14	03/14	02/14	01/14	Total	Total (hours)
Resident		1.00										55.00		45.00	101	1h 41m
Resident	26.00						75.00		149.00						250.00	4h 10m
Resident								45.00	1.50						46.50	46.5m
Resident			1.00	18.00		323.00									342.00	5h 42m
Resident			25.50						2.00	3.00					30.50	30.5m
Resident							5.00						1.00		6.00	6m
Resident		170.00			123.00				45.00						338.00	5h 38m
Resident												3.00			3.00	3m
Resident					42.00	1.00				55.00				30.00	128.00	2h 8m
Resident		3.00	3.00	25.00				26.50	1.00					34.00	92.50	1h 32.5m
Resident		3.00	45.00	110.50	1.00		8.50	37.00	1.50	74.50		44.00	55.00	30.00	410.00	6h 50m
Resident									15.00				1.50		16.50	16.5m
Resident														30.00	30.00	30m
Resident		37.00	30.00		30.00	15.00					13.00			3.00	128.00	2h 8m
Resident					1.00										1.00	1m
Resident				2.00	145.00	43.00				56.00	5.00	60.00	1.00		312.00	5h 12m
Resident						18.00							5.00		23.00	23m
Resident									2.00						2.00	2m
Resident	35.50	72.00	34.00	104.00	11.00	51.50	112.00	87.00	341.00	110.00	11.00	126.00	87.50	140.00	1322.50	22h 2.5m
Resident							2.00		1.50				20.00		23.50	23.5m
Resident	15.00	13.00	7.00	30.00	43.00		6.00	5.50						22.00	141.50	2h 21.5m
Resident		57.00	150.00	88.00	12.00	109.00	95.00	15.00	96.00	94.00	184.00		7.00		907.00	15h 7m
Resident	23.00	80.00	129.00	111.50	335.00	190.00	214.00	694.00	45.00	215.00	80.00			93.00	2209.50	36h 49.5m
Resident			139.00		50.00			45.00	35.00	35.00	45.00			45.00	394.00	6h 34m
Resident								2.00					2.00		4.00	4m
Resident	53.00	2.00				13.00		90.00			4.00		1.00	11.00	174.00	2h 54m
Resident					15.00	13.00									28.00	28m
Resident											2.00				2.00	2m
Resident	2.00	41.00		85.00	15.00		60.00	52.00	26.00		122.00	8.00	15.00	37.50	463.50	7h 43.5m
Resident		2.00			8.00										10.00	10m
Resident							55.00	45.00	293.00	130.00	40.00	55.00	45.00	55.00	718.00	11h 58m
Resident	210.00	71.00	123.50	11.00	38.00	131.00	431.00	554.00	514.50	270.00	99.00	572.00	3.00	529.50	3557.50	59h 17.5m
Resident					27.00		38.00			30.00		45.00			140.00	2h 20m
Resident								3.00							3.00	3m
Resident		150.00							31.00					4.00	185.00	3h 5m
Resident	26.00				30.00							2.00	2.00		60.00	1h
Resident		57.00	75.00	70.00	85.00		60.00	10.00		83.00		18.00			458.00	7h 38m
Resident		85.00	58.00		365.00	190.00	34.00	3.00	173.00			57.00			965.00	16h 5m
Resident			1.00				22.00								23.00	23m
Resident			56.00									165.00		1.00	222.00	3h 42m
Resident	17.00	4.00						59.00							80.00	1h 20m
Resident								2.00							2.00	2m
Resident			158.00	3.00	119.00	213.00	483.00	231.00	79.50	55.00	628.00	71.00	1.50	365.00	2407.00	40h 7m
Resident									3.00						3.00	3m
Resident	288.00	90.00	425.00		560.00	585.00	240.00	325.00	145.00	832.00	676.00	291.50	161.50	1078.00	5697.00	94h 57m
Resident	54.00	88.00	35.00	73.00	129.00	43.00	61.00	97.00	38.00		15.00	120.00	264.00	165.00	1182.00	19h 42m
Resident	3.00	71.00			30.00	1.00	34.00			80.00					219.00	3h 39m
Resident							36.00								36.00	36m
Resident		4.00	11.00	4.00	1.00	58.00			5.00			3.50		10.50	97.00	1h 37m
Resident	203.00	298.50	475.00	298.00	450.50	169.00	235.00	270.00	319.00	83.00	353.50	424.00	208.00	105.00	3891.50	64h 51.5m
Resident			1.00												1.00	1m
Resident	50.00	86.00		55.00	165.00	314.00	161.00		82.00				65.00		978.00	16h 18m
Resident								52.00	45.00					165.00	262.00	4h 22m
Resident	75.00	120.50	229.50	2.50	166.00		888.00	730.50	213.00	700.50	128.00	857.50	115.00	836.50	5062.50	84h 22.5m
Resident	160.00	4.00	136.00	31.00	73.00	58.00	168.00	165.00	125.00	251.00	80.00	316.00	199.00	241.00	2007.00	33h 27m
Resident			17.00			29.00		46.00							92.00	1h 32m
Resident	3.00		90.00	85.00		20.50	10.00							4.00	212.50	3h 32.5m
Resident												23.00			23.00	23m
Resident				29.00		35.00				20.00	103.00	194.00	55.00		436.00	7h 16m
Resident									4.00						4.00	4m
Resident	1.00				90.00										91.00	1h 31m
Resident		1.00													1.00	1m
Resident	1.00			30.00						24.00	35.00				90.00	1h 30m
Resident			63.00	35.00	64.00	100.00	20.00		20.00	278.00	175.00	115.00	154.00		1024.00	17h 4m
Resident			5.00												5.00	5m
Resident	35.00		1.50												36.50	36.5m
Resident	45.00		223.00		164.00	130.00	195.00	77.00	132.00	49.00	125.00	55.00	157.00	150.00	1502.00	25h 2m
Resident										40.00		170.00			210.00	3h 30m
Resident			4.00		1.00	65.00	8.00		19.00	33.00	124.50		61.00		315.50	5h 15.5m
Resident									27.00			45.00			72.00	1h 12m

Appendix 2

Booneville Human Development Center
RESTRAINT INCIDENT DEBRIEFING FORM
To be completed and turned in with the Restraint Log

The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program), when a very real risk of personal injury or severe property damage is imminent.

INCIDENT:
On [redacted] [redacted] was placed in mechanical restraint
Date *Client name*
as documented on the attached Restraint Log. The reason that the use of restraint was necessary because (describe the behavior):
[redacted] was calm enough to get her meds and then have breakfast, the nurse stated she was still gonna give her the shot and [redacted] threw her water and went to hate herself and fight staff

I. The Restraint Incident Leader was [redacted]
Signature

II. The other members of the Intervention Team were:
[redacted]
Signature
[redacted]
Signature
[redacted]
Signature
[redacted]
Signature
Signature

III. Event Analysis:
The following may be contributing factors to this restraint incident:

1. Physical Environment: (Where did the incident occur, were their anything in the physical environment that may have been a factor in the incident?) Please Explain:
In med pass area

2. Interaction with Peers: (Was another person's interaction with the client a factor in the client requiring restraint?) Please Describe:

Booneville Human Development Center
RESTRAINT INCIDENT DEBRIEFING FORM
To be completed and turned in with the Restraint Log

3. Interaction with Staff: (Was the interaction with this person and the client performed in such a way as to deescalate the situation or a factor in escalating the behavior? Was this person someone whom the client likes or not? Could a different staff person have interacted with the client and avoided the emergency restraint?) Please Describe:
We calmed [redacted] to the point of taking her meds and have breakfast. The nurse [redacted] stated I'm still gonna give her that shot and [redacted] threw her water and went to bite herself. and fight staff.

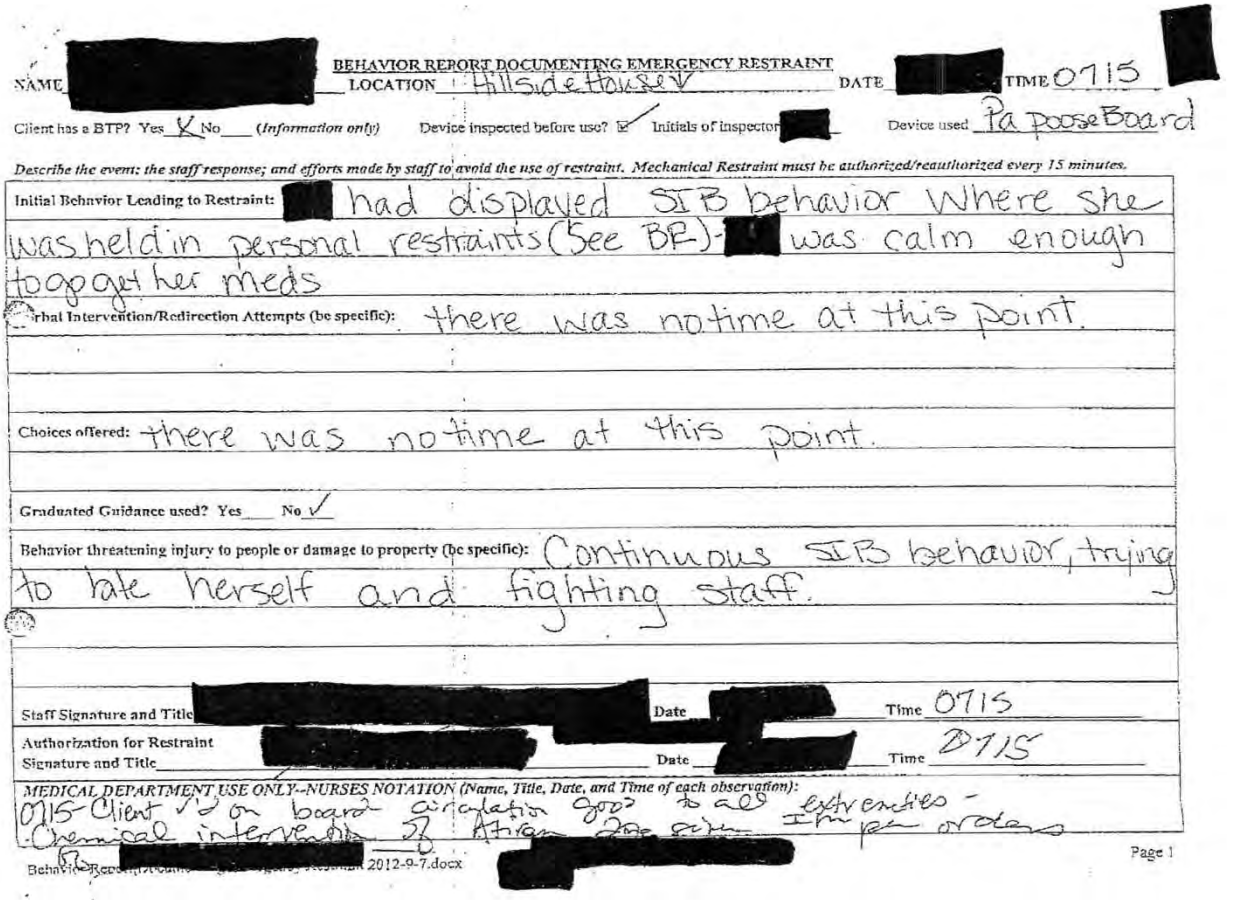
4. Programmatic Issues: (Were there any programming issues involved in the incident, such as requests to perform assigned tasks such a laundry, room maintenance, going to class, bathing, etc. involved in the incident? Could any programmatic changes be made to prevent similar incidents such as doing laundry at a different time or day, etc?) Please Describe:
none

5. Client Input: (Actively seek information from the client as to what could be done to prevent such an incident in the future. Did the client feel that staff overreacted in the incident or did they feel the restraint was justified?) Please Describe:
She ignored staff

6. Recommendations: (Are there any recommendations from the Client, the Intervention Team and/or the Restraint Leader that could help prevent a similar event from occurring again?) Please List:
Have staff not say things like the Nurse said in front of clients. Need to be descreet.

IV. Reviewed by: [redacted] Date [redacted]
Signature, Title

RECEIVED
[redacted] 2015
RECORDS ROOM
BHDC AR 72927



NAME [redacted] **BEHAVIOR REPORT DOCUMENTING EMERGENCY RESTRAINT** LOCATION Hillside House V DATE [redacted] TIME 0715 [redacted]

Client has a BTP? Yes X No ___ *(Information only)* Device inspected before use? ☑ Initials of inspector [redacted] Device used Pa poose Board

Describe the event: the staff response; and efforts made by staff to avoid the use of restraint. Mechanical Restraint must be authorized/reauthorized every 15 minutes.

Initial Behavior Leading to Restraint: [redacted] had displayed SIB behavior where she was held in personal restraints (See BR) - [redacted] was calm enough to go get her meds

Verbal Intervention/Redirection Attempts (be specific): there was no time at this point.

Choices offered: there was no time at this point.

Graduated Guidance used? Yes ___ No ✓

Behavior threatening injury to people or damage to property (be specific): Continuous SIB behavior, trying to bite herself and fighting staff.

Staff Signature and Title [redacted] Date [redacted] Time 0715

Authorization for Restraint Signature and Title [redacted] Date [redacted] Time 0715

MEDICAL DEPARTMENT USE ONLY--NURSES NOTATION (Name, Title, Date, and Time of each observation):
0715 - Client ✓'d on board circulation good to all extremities - Chemical intervention of Atiran done since Imp per orders

Behavior Report/[redacted] 2012-9-7.docx [redacted] Page 1

BEHAVIOR REPORT DOCUMENTING EMERGENCY RESTRAINT

Time started	15 minute checks	Staff Name, Title	Indicate behavior requiring restraint; whether the dangerous behavior is continuing; and what resulted in release	Authorization every 15 / minutes
0715		[redacted]	attempted SIB and fighting staff Chemical given @ 0720	[redacted]
	0723 Released		Calm	
	55 minutes Release		Was released for fluids, meals, toileting ____ Initial Ongoing Behavior:	Reauthorized every 15 minutes
	55 minutes Release		Released for fluids, meals, toileting: ____ Initial Ongoing Behavior:	Reauthorized every 15 minutes
	55 minutes Release		Released for fluids, meals, toileting: ____ Initial Ongoing Behavior:	Reauthorized every 15 minutes

RECEIVED
[redacted] 2015
RECORDS ROOM
BHDC AR 72927

JUSTIFICATION AND AUTHORIZATION FOR MECHANICAL RESTRAINTS

Client response to intervention and alternate behavioral choices: She got up put her shoes on and went and ate breakfast

Staff debriefing form completed by Restraint Incident Leader? Yes *Restraint Incident Leader Signature, Title, and Date:* [redacted]

Suggested measures to avoid restraint use: Staff needs to be more discreet.

Injury noted upon release ☒NO ☐YES Suggested *measures to insure safety:* Staff needs to be more discreet.

Regulations: Restraint is only used as an emergency procedure to prevent or minimize imminent danger of injury to people or serious damage to property. All efforts must be made to deescalate the incident prior to the use of restraint. The person in restraint must be under constant staff observation, documented every 15 minutes. The person must be released when calm. The person must be released from restraint every 55 minutes for fluids, toileting, meals, or exercise. Restraint use must be authorized; continued use must be reauthorized after 15 minutes.

Behavior Report Documenting Emergency Restraint 2012-9-7.docx Revised September 7, 2012. Page 2

Disability Rights Arkansas

Dignity. Respect. Advocacy.

Tom Masseau, Executive Director

October 22, 2020

Director
Division of Developmental Disabilities
Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72203-1437

Director :

Disability Rights Arkansas (DRA) is the designated federal Protection and Advocacy System ("P&A") for individuals with disabilities in Arkansas. One of DRA's core functions is to investigate the deaths of persons with developmental disabilities in facilities that provide services to people with developmental disabilities. DRA has authority under federal law to thoroughly investigate deaths occurring in any public or private entity that provides care, services, treatment, or habilitation to individuals with disabilities.

As you are aware, resident David Cains of Booneville Human Development Center (BHDC) died on June 13, 2020. His death occurred while three BHDC staff restrained David on the floor outside of the cafeteria. David's family contacted DRA and requested we investigate his death and the circumstances surrounding it.

DRA completed an extensive investigation into David's death. Our investigation involved reviewing the Adult Maltreatment Investigation Report, all witness statements, the DPSQA Complaint Investigation Report, the EMS report, hospital records, and the Coroner's report. Our office interviewed BHDC staff, including , , and , the individuals who restrained David; , the Adult Maltreatment Investigator; , the Superintendent; and the NCI instructor. Our office also interviewed the Emergency Medical Services provider, , who provided emergency services that day, as well as , the Deputy Coroner who was assigned to David's case.

Summary

David Cains was 42 years old, and was diagnosed as having a [redacted]

According to the BHDC Staff written statements and interviews with DRA staff:

400 West Capitol Avenue, Suite 1200 | Little Rock, AR 72201 | 501.296.1775
800.482.1174 | www.disabilityrightsar.org



On June 13, 2020, David ate his lunch in the cafeteria at the Commons Building. After finishing his meal, David put his tray away, asked to go to the restroom, and was accompanied to do so by According to , David seemed irritated, asked to sit in the lobby to calm down after exiting the restroom, and then began screaming, ripping paper off the wall, and attempting to hit

stated that he, "applied personals[1] by grabbing [David's] arms and ended up falling over."[2] David landed on his face and then rolled him to his side.[3] believes that this restraint began at 11:30 a.m., although all times are estimates as there are not any visible clocks in the area where the restraint occurred, according to all staff interviewed. arrived shortly after David was brought to the ground and assisted in the restraint. According to all written witness statements, David was resisting the restraint at that time. arrived sometime later and began holding David's legs. Within seconds of arriving noticed that David had defecated on himself and she "then looked up and [saw] food coming out of David Cains mouth"[4] and went to call medical. According to both and they noticed food coming out of David's mouth/vomiting, his face turning purple, and that he was not breathing approximately one minute after initiating the restraint, although their involvement in the restraint began at different times. They ended the restraint, tried to sit David up, and "smack[ed] his back."[5] David could not sit up, so they laid him back down, started doing abdominal thrusts, and began the Heimlich maneuver. [redacted]

From EMS Report and BHDC Staff written statements:

At 11:37 a.m. one of the nurses instructed BHDC staff to call 911.[7] At 11:50 a.m. Logan County EMS arrived.[8] The EMS personnel were told that BHDC staff found David unconscious on the floor in the hallway.[9] EMS was unsuccessful at opening his airway, so they left the facility at 12:10 p.m. and arrived at Mercy Hospital in Booneville at 12:18 p.m. EMS communicated to the ER staff what they had been told by Booneville staff: "that patient choked on food he was eating, aspirated, and stopped breathing."[10] At 12:21 p.m., David was pronounced dead.

This entire event took place on the floor while three people were holding David by his legs, torso, and head. A fact that was omitted in reports to EMS, the hospital, the Coroner, and the family.

During our investigation, we noted several unresolved discrepancies between written statements, subsequent interviews, and investigative conclusions:

1) There is not a consensus between the employees involved regarding the positioning and

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[1] during his interview, acknowledged that this is a restraint.
[2] OLTC Witness Statement, , Page 2 of 3
[3] Interview of by DRA staff on July 29th.
[4] OLTC Witness Statement Page 1 and 2
[5] OLTC Witness Statement, , Page 2 of 3
[6] OLTC Witness Statement, , LPN
[7] BHDC Policy IV-B-10 states that on-site medical should be the first call and that "medical will assess the situation and call an ambulance if appropriate." All persons interviewed, including Superintendent , interpreted the policy to prohibit non-medical staff from calling 911 in response to a medical emergency and confirmed that as the BHDC practice.
[8] Logan County EMS patient record.
[9] *Id*
[10] *Id*

actions of each employee, information pertinent to identifying not only potential wrongdoing, but also possible missteps to be avoided in the future.

a. written statement and subsequent interview by DRA staff were consistent with one another. She states that when she arrived David was on the ground on his left side, was on his knees facing David and holding his wrists, and David's hands were by his sides. "came to assist to position David's head so he wouldn't spit"[11] and then attempted to assist by holding David's ankles when he began to kick.

b. stated that when she arrived, "David was on his left side with his arms held up with his elbows bent slightly."[12] She states she assisted by holding David's hands so that he could not strike who was positioned behind David. denied ever holding David's head during the restraint.

c. According to written statement he was "squatted over him, not putting [his] weight on him during any of this, holding his shoulder and sides,"[13] assisted by "grabbing his hands," and held his legs down. During our interview, deviated from his written statement, stating "she was on his side behind him, holding his head on the side, keeping close to ground but not pushing on it"[14] because David was trying to bite. He also clarified his positioning as being behind David, who was laying on his left side and "spread out T-style"[15] with his left arm on the ground. was holding his right arm (not) and trying to get it to the ground. David's arms were never above his head.

d. Adult Maltreatment Investigation Report #5-2020, completed by , fails to resolve discrepancies regarding the placement of David's hands and whether a staff member was holding his head in place during the restraint.

e. Cameras at the facility would have been immeasurably helpful in resolving the discrepancies and ultimately understanding the circumstances surrounding David's death.

2) A timeline of events included in two separate documents we received completely omits any reference to a restraint having occurred.

a. The DHS Incident Report includes a timeline of events provided by RN/DON, who does not appear to have been at the scene of the incident at any time.

i. According to the timeline at "11:30 a.m. – Immediately after lunch, David Cains headed to common area kicking, yelling, and biting. and attempted to settle client. Suddenly started vomiting and turning cyanotic."

1. and written statements and interviews with DRA indicate that did not arrive until Mr. Cains was already on the ground and being restrained by , in conflict with the assertion here.
2. There is no evidence of either staff member attempting to "settle" David.

b. A similar statement is included in a "Timeline of Events" that appears to be a word document included in David's medical file. The statement is not attributed to anyone in this document.

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[11] OLTC Witness Statement Form, , Page 1 of 2
[12] OLTC Witness Statement Form, , Page 1 of 4.
[13] OLTC Witness Statement Form, , Page 2 of 3
[14] Interview of by DRA staff on July 29th.
[15] *Id*

When DRA interviewed Emergency Services Worker, , he stated BHDC staff never informed them that David had been in a personal restraint prior to or during this incident. stated that they were told that David was found in the hallway, unconscious, and staff attempted abdominal thrusts prior to CPR. They were told that he had choked on his lunch. EMS relayed the same information to the ER staff at Mercy Hospital in Booneville.

Mercy Hospital medical records indicate that the [redacted] The summary by Dr. , states, [redacted]

The same misinformation was passed on to the investigating coroner, Deputy Coroner leading him to list the cause of death as [redacted]. Mr. stated:

> "Logan County Coroners' office was notified by Mercy Hospital Booneville that they had a deceased male from Booneville Human Development Center and that they needed a coroner to the hospital. David Cains was eating lunch at the Booneville Human Development center where he lived, when some food became lodged in his throat. The Human Development Center tried to dislodge what was stuck but were unable. They called 911 at 11:37 A.M. when David collapsed and became unresponsive."[17]

When our office interviewed Mr. , he stated he had no knowledge that David was restrained prior to or during this incident. He confirmed that his office would have further investigated had they received that information and would likely have requested an autopsy.

When BHDC staff contacted David's mother, they told her that David choked on his lunch and that the family would need to contact the hospital for any additional information. When the family called Mercy Hospital, they were informed David was deceased. David's family did not find out about the personal restraint until June 22nd – nine days after David passed away and three days after David's funeral. By the time the family learned of the circumstances surrounding his death it was too late for them to request an autopsy.

This was a tragic event. Any time an individual passes away while in the custody and care of the state a meaningful, critical evaluation of the policies and practices that led to that incident should be required. In this case, that evaluation included: (1) an investigation by an individual who is employed by the BHDC, working alongside those who she is charged to investigate; (2) a review and endorsement of that investigation by the superintendent who hired or who is ultimately responsible for the actions of those employees investigated; (3) the suppression or omission of relevant, if not crucial facts from agencies who would further investigate the circumstances of this gentleman's death.

The BHDC review of this death, endorsed by Superintendent , concluded that no individual involved in this incident did anything wrong; therefore, nothing could have been done differently to prevent it and nothing can be learned from it. To date, we have not been informed whether BHDC has reviewed or revised their restraint policies or practices following this event.

At some time after the internal investigation concluded the Division of Provider Services and Quality

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[16] Logan County Coroner Report.
[17] *Id*

Assurance (DPSQA) investigated David's death and the circumstances surrounding it. Very little information could be gleaned from the DPSQA Complaint Investigation Report reviewed by DRA. Despite the ability to attach narratives of staff interviews, none were found or made available upon our request. Ultimately, the DPSQA investigation concluded similarly to the internal investigation conducted by BHDC with no description of the events or statements from witnesses.

Practice of Restraints at BHDC

In 2012, DDS retained H&W Independent Solutions, who are self-described "skilled trainers and workshop facilitators on a wide range of topics pertinent to organizations supporting people with disabilities." In April of 2012, BHDC participated in a training survey with H&W to evaluate and improve the quality of care to the residents. During the evaluation of BHDC, H&W found that significant improvement was needed due to, in part, the BHDC staff's reliance on emergency restraint.

Nearly four years later, in January 2016, our office issued a report regarding the use of restraint at BHDC. We warned that risks associated with restraint include physical injuries, significant trauma, and death. We pointed out that the overuse of restraint could cause physical and emotional trauma to both the residents and the staff at BHDC. We recommended that BHDC retain an independent expert to implement evidence-based alternatives aimed to reduce or eliminate the use of restraint at BHDC.

NCI/CPI trains staff to respond to crisis by intervening in non-violent ways to prevent escalation and offers programs to certify staff in this skill. At the same time BHDC certifies its staff in the use of NCI/CPI, BHDC also trains its staff to restrain residents using methods that require no certification, are not evidence-based, and, when practiced, conflict with NCI/CPI training. It is concerning that BHDC staff are then left to choose between non-violent crisis intervention and physically/emotionally traumatizing physical restraint.

Findings

- David was diagnosed [redacted]
- Instead of releasing David when he was lying down on the floor, David was restrained on the hard floor by three BHDC staff after finishing his lunch.
- Prior to the restraint, Staff failed to use other less intrusive interventions such as NCI/CPI, for which they are trained.
- Staff failed to leave him on the floor, unrestrained, until he was calm.
- Subjecting an individual [redacted] to a physical restraint shortly after a meal increases the risk of death from asphyxia due to a higher probability of vomiting.
- This restraint likely either directly or indirectly led to David's death.
- The facility failed to properly communicate the circumstances of this incident to EMS.
- We found no evidence that the facility properly communicated the circumstances of this incident to the Arkansas State Police, the Logan County Sheriff's Office, or any other law enforcement agency.

- BHDC's investigation failed to resolve discrepancies in statements from witnesses.
- It is not the policy or practice of BHDC to permit direct care staff to call 911 in an emergency.
- NCI/CPI does not endorse or instruct any maneuver that involves physically restraining an individual on the floor.
- During interviews, BHDC direct care staff reported that they, "take people to the floor often."
- BHDC could not articulate what kind of "restraint technique" is being taught to staff.
- The conclusion from Superintendent failed to find that anyone violated any policy or procedure and inexplicably failed to find that any policy or procedure might need review or modification.
- No corrective actions were made or recommended by BHDC or DHS - Division of Provider Services and Quality Assurance.
- BHDC failed to adequately inform David's family of the circumstances surrounding his death.

Recommendations

1. ***Install video cameras on campus***. Video cameras on campus would greatly assist investigators in determining whether maltreatment has occurred. Presently, we have differing statements from individuals regarding a restraint on the floor that led to an individual's death.
2. ***Retrain all staff in NCI/CPI.*** NCI/CPI does not endorse the use of restraint while an individual is lying down on the floor. The very fact that NCI/CPI is touted as the intervention strategy implemented by BHDC, and yet this individual was restrained on the floor long enough to aspirate and die means that NCI/CPI was either ignored or forgotten.
3. ***Reevaluate the use of restraint in all forms and employ evidence-based, nonviolent methods of crisis intervention.*** A greater problem that exists is the overall reliance on restraint at BHDC. It is a culture of compliance that we see often in prisons. When individuals are not compliant, they are made to comply. If DHS does not address restraint and physical, mechanical, and chemical intervention as a system-wide problem, the culture cannot be meaningfully changed. Further, the physical restraints BHDC employs are not based on any professional training or sanctioned method.
4. ***Clarify or Modify policy to permit staff to contact 911 in response to emergency medical situations.*** Staff must have permission to identify and respond in an emergency. BHDC is a large campus in a rural area of the state. While it is comforting that nursing staff is available to respond to medical issues, the current policy forces staff to ignore what many first aid/CPR certification programs insist is the first step in responding to a crisis – calling 911.
5. ***Engage qualified, independent investigators to complete thorough, meaningful investigations on ALL deaths.***

a. *Utilize investigators that are completely independent of the Human Development Centers they investigate.* While it is important that BHDC review incidents internally for quality improvement and staff oversight, there must be a truly independent investigation by a disinterested third party. At one time, DDS employed an attorney whose role was to investigate deaths at any HDC. We are unaware whether or why such a position no longer exists. Anyone DDS authorizes to investigate serious incidents should have no connection to the Human Development Centers they investigate. Investigators should be informed regarding the requesting of an autopsy and empowered to make such a request when warranted.

b. *Ensure all investigations are reflective of the gravity of the circumstances investigated.* Death investigations must be both thorough and critical. Investigations that lack specificity in their investigative processes and findings, do not include interviews of all involved parties, and by design can only substantiate maltreatment or declare nothing could have been done differently undermine confidence in the process. When a family is left to gradually learn new information regarding the death of their loved one, including that the coroner was not accurately informed of the circumstances surrounding the death, what else are they to be left with other than suspicion and anger? Instead, the trauma surrounding the death is amplified and revisited with each new fact they learn. That is not closure; that is not justice.

DRA requests a response, delivered electronically, to this letter by October 31, 2020.

Sincerely,

Kris Stewart, Advocate
Disability Rights Arkansas

Reagan Stanford, Attorney
Disability Rights Arkansas

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Booneville Human Development Center
87 Reed Road
Booneville, AR 72927
P: 479.675.2121
F: 479.675.2518
HUMANSERVICES.ARKANSAS.GOV

June 19, 2020

Charlene Robinson
P.O. Box 1543
Russellville, AR 72811

Re: David Cains

Dear Ms. Robinson,

Enclosed you will find a copy of the Final Synopsis of an incident that was reported to you earlier.

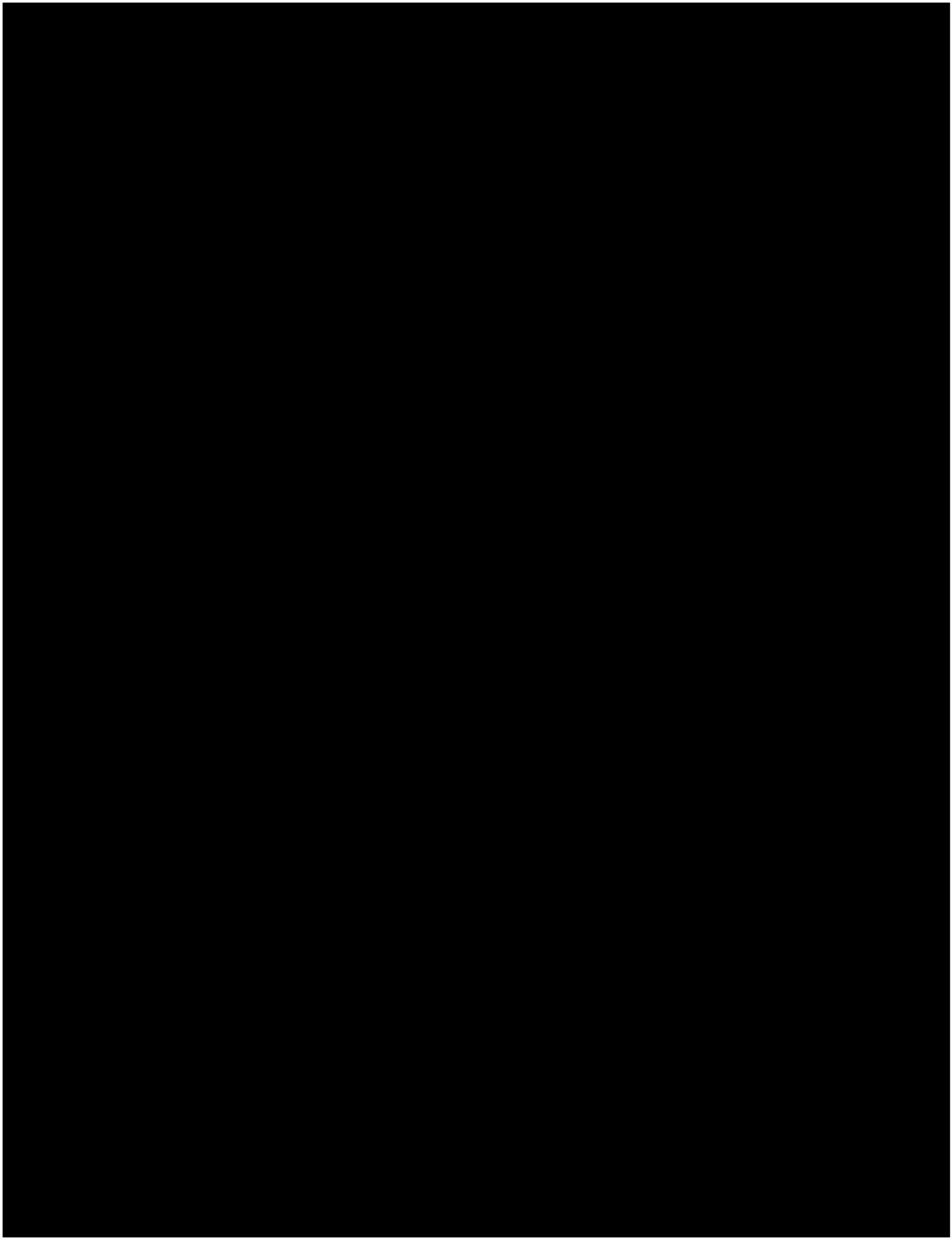
As always, I appreciate your cooperation and involvement. If you should have any questions or concerns, please do not hesitate to contact me. I can be reach by phone at 479-675-1406 or by email at Caleb.Murray@DHS.Arkansas.Gov

Sincerely,

Caleb Murray
Program Coordinator/Social Service Worker

CM/Enclosures CC: Master File

EXHIBIT
4



ELECTRONICALLY FILED
Pulaski County Circuit Court
Terri Hollingsworth, Circuit/County Clerk
2021-Sep-22 11:19:26
60PR-21-2052
C06D13 : 1 Page

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
PROBATE DIVISION

No. 60PR-21-2052

IN THE MATTER OF THE ESTATE OF DAVID CAINS, Deceased

LETTER OF SPECIAL ADMINISTRATION

CHRISTINE McAULIFFE, whose address is [redacted] having been appointed and qualified as Special Administratrix of the estate of DAVID CAINS, who died on or about June 13, 2020 is hereby authorized to act as Special Administratrix for and on behalf of the estate and to take possession of the estate's property as authorized by law. Special Administratrix of the estate for the purposes of litigation on behalf of decedent.

ISSUED this date: 22-SEP-2021

SEAL OF THE CIRCUIT COURT PULASKI COUNTY, ARKANSAS

TERRI HOLLINGSWORTH, CIRCUIT CLERK

Shamkia M. Patrick

By: Shamkia M. Patrick, Pulaski County Clerk

EXHIBIT
5

ELECTRONICALLY FILED
Pulaski County Circuit Court
Terri Hollingsworth, Circuit/County Clerk
2021-Sep-21 14:37:01
60PR-21-2052
C06D13 : 3 Pages

IN THE CIRCUIT COURT OF PULASKI COUNTY, ARKANSAS
DIVISION

IN THE MATTER OF THE ESTATE OF
DAVID CAINS, DECEASED **CASE NO.** 60PR-21-2052

ORDER APPOINTING SPECIAL ADMINISTRATORS

On this ~~17th~~ 21st day of September, 2021, is presented to the Court the Petition of Christine McAuliffe for appointment as Special Administrator of the estate of David Cains, deceased, and upon consideration of such Petition, and the facts and evidence in support thereof, the Court finds:

1. That decedent, David Cains, aged 42, who resided at [redacted], died June 13, 2020 in Logan County, Arkansas.

2. That no demand for notice of proceedings for the appointment of an administrator of the estate has been filed herein; the Petition is not opposed by any known person; and the same may be heard and decided forthwith.

3. That there is currently no court-appointed Special Administrator of the Estate of David Cains

4. That this Court has jurisdiction and venue properly lies in this County.

5. That Christine McAuliffe [redacted] has been nominated to serve as special administrator of the estate for the purposes of litigation on behalf of the decedent.

6. That the amount of property that may reasonably be expected to pass through the hands of the special administrator is unknown at this time, and that no bond is required at this



time.

7. That petitioner is authorized to employ the law firm of Green and Gillispie Attorneys at Law to assist her with litigation on the behalf of the decedent, including but not limited to litigation and settlement negotiations with Arkansas DHS and to enter into the employment contract attached to the Petition, and that said employment contract entered into between petitioner and Green and Gillispie Attorneys at Law is approved.

IT IS THEREFORE CONSIDERED, ORDERED and ADJUDGED that the Petition for the Appointment of Special Administrator of the Estate of David Cains be, and hereby is, granted; Christine McAuliffe is appointed Special Administrator of the Estate of David Cains for litigation purposes on behalf of the decedent; and that the employment contract requested in the Petition between Petitioner, Christine McAuliffe, and Green and Gillispie Attorneys at Law is hereby approved.

IT IS SO ORDERED.

CIRCUIT JUDGE

DATE: September 21, 2021

Prepared by:

/Josh Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
Green and Gillispie Attorneys at Law
1 Riverfront Pl. Suite 605
North Little Rock, AR 72114
(501) 244-0700
josh@greenandgillispie.com

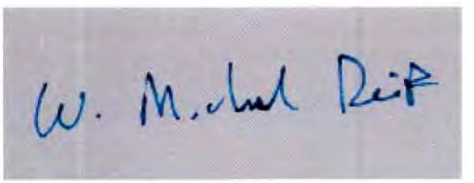
Arkansas Judiciary

Case Title: DAVID CAINS

Case Number: 60PR-21-2052

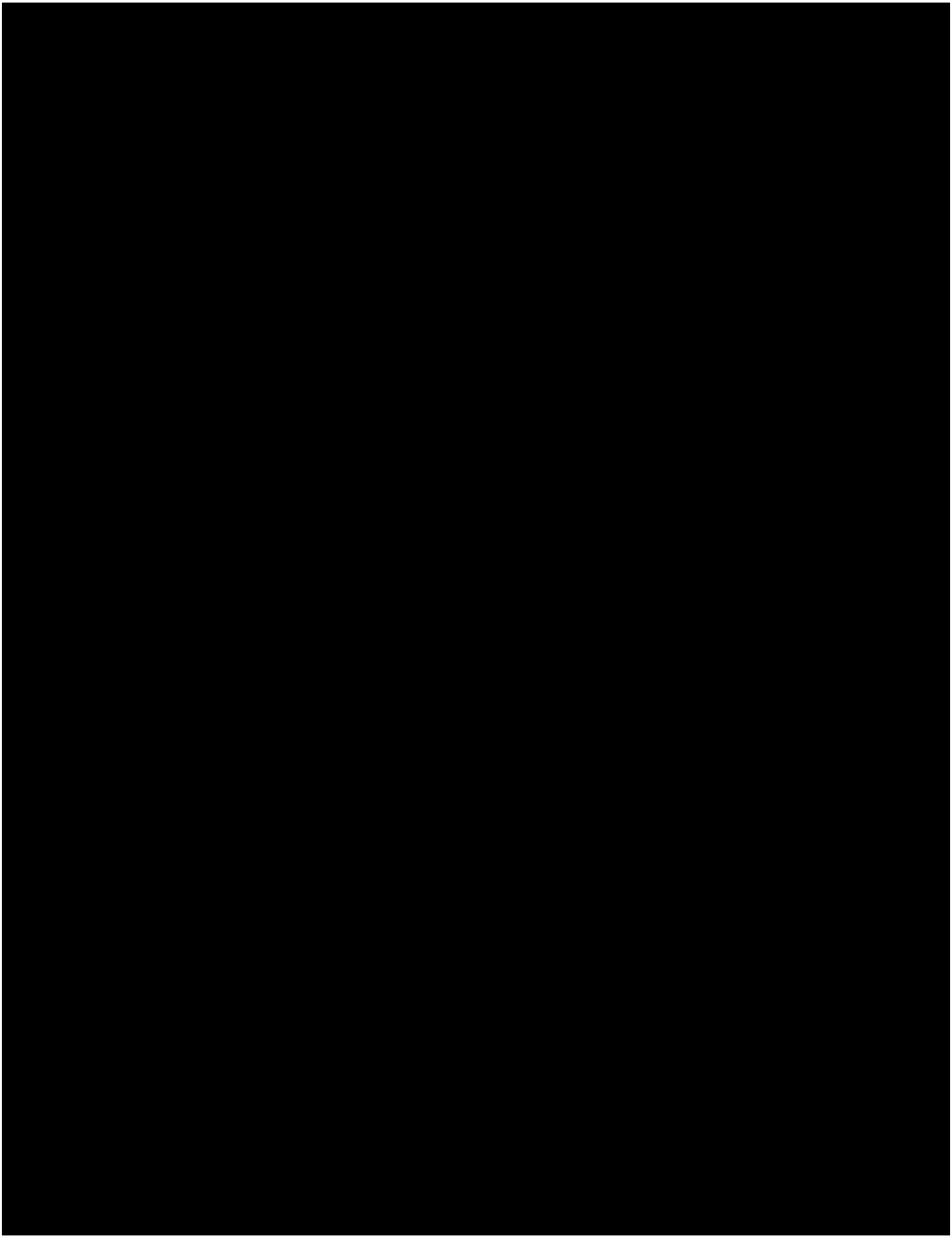
Type: ORDER APPOINT PERS REPRESENT

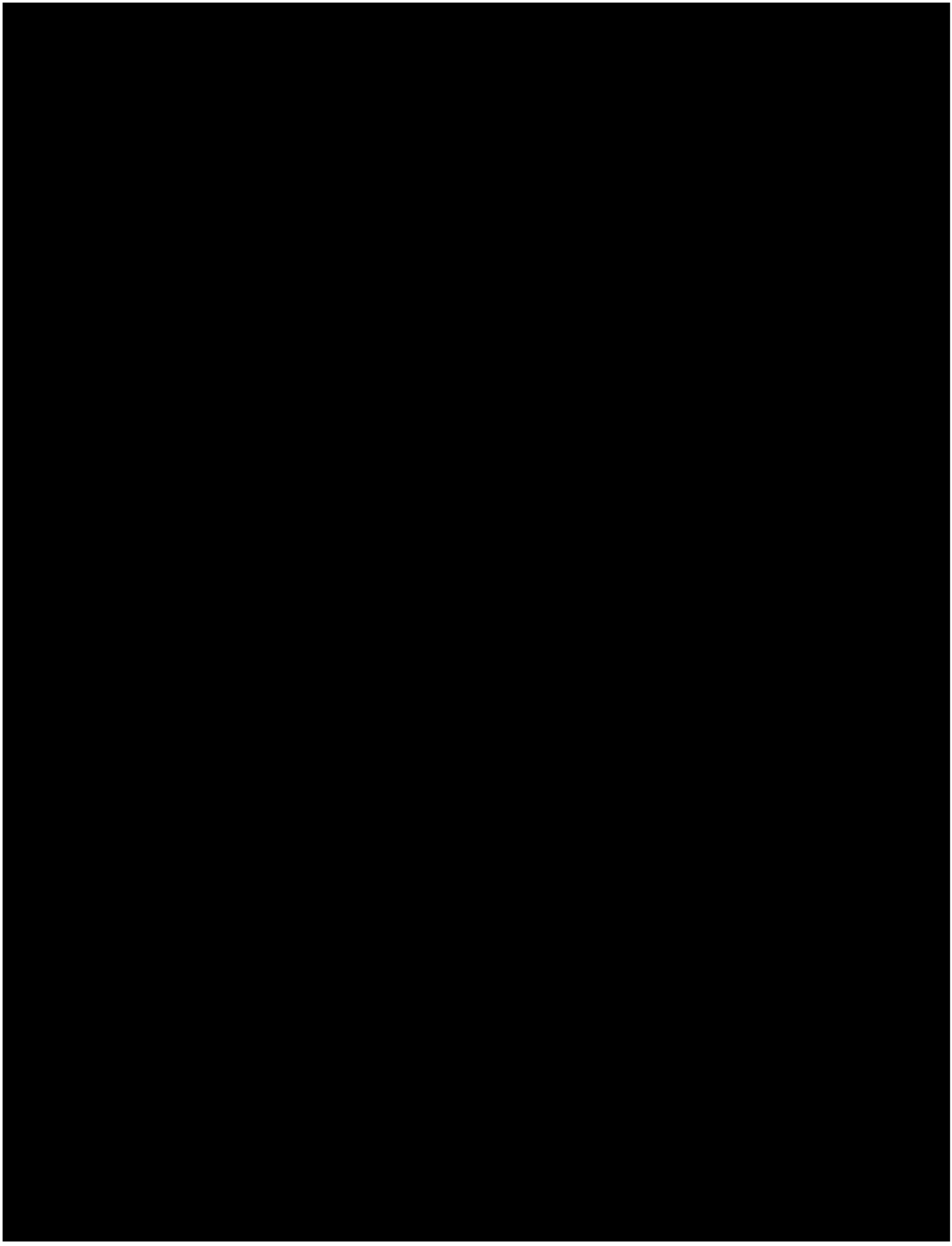
So Ordered



W. MICHAEL REIF

Electronically signed by WMREIF on 2021-09-21 14:37:04 page 3 of 3









From:	ASCC New Claims
To:	OCC Claims Commission Cases
Cc:	Kathryn Irby
Subject:	CLAIM: Christine McAuliffe v. DHS, Claim No. 220374
Date:	Wednesday, November 17, 2021 12:59:00 PM
Attachments:	christine McAuliffe vs DHS agency ltr.pdf Christine McAuliffe Claim.pdf Christine McAuliffe Sig and Supp.pdf Christine McAuliffe Supp Docs-2.pdf

---

Please see attached. Contact Kathryn Irby with any questions.

Thank you,
Caitlin

Caitlin McDaniel
Administrative Specialist II
Arkansas State Claims Commission
101 East Capitol Avenue Suite 410
Little Rock, 72201
(501) 682-1619
Caitlin.McDaniel@arkansas.gov

November 17, 2021

Ms. Sarah Linam *(via email)*
Arkansas Department of Human Services
700 Main Street, Slot S260
Little Rock, Arkansas 72203

RE: ***Christine McAuliffe v. Arkansas Department of Human Services***
Claim No. 220374

Dear Ms. Linam,

Enclosed please find a copy of the above-styled claim filed against the Arkansas Department of Human Services. Pursuant to the Arkansas Rules of Civil Procedure, as well as Claims Commission Rule 2.2, you have **thirty days from the date of service** in which to file a responsive pleading.

Your responsive pleading should include your agency number, fund code, appropriation code, and activity/section/unit/element that this claim should be charged against, if liability is admitted, or if the Claims Commission approves this claim for payment. This information is necessary even if your agency denies liability.

Sincerely,

Kathryn Irby

ES: cmcdaniel

cc: Joshua Gillispie, *representative for Claimant* (w/ encl.) *(via email)*

From: ASCC New Claims
To: "josh@greenandgillispie.com"
Bcc: "Kathryn Irby"
Subject: Christine McAuliffe v. DHS, Claim No. 220374
Date: Wednesday, November 17, 2021 1:00:00 PM
Attachments: christine McAuliffe vs DHS agency ltr.pdf

Dear Mr. Gillispie,

Attached please find a copy of the letter sent with your claim to the Arkansas Department of Human Services.

Thank you,
Caitlin

Caitlin McDaniel
Administrative Specialist II
Arkansas State Claims Commission
101 East Capitol Avenue Suite 410
Little Rock, 72201
(501) 682-1619
Caitlin.McDaniel@arkansas.gov

November 17, 2021

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Arkansas Department of Human Services
700 Main Street, Slot S260
Little Rock, Arkansas 72203

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Claim No. 220374

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Sincerely,

Kathryn Irby

ES: cmcdaniel

cc: Joshua Gillispie, *representative for Claimant* (w/ encl.) *(via email)*

From:	Daiquiri Carter
To:	ASCC Pleadings
Subject:	CC 220374
Date:	Thursday, December 16, 2021 2:53:00 PM
Attachments:	DHS Answer 220374.pdf image001.png image002.png

Please find enclosed the Answer to the above referenced Claims Commission case.

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov





NOTE - This email may contain sensitive or confidential information.

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

ANSWER

Comes now, the Respondent, The State of Arkansas, Department of Human Services ("DHS"), Office of Chief Counsel, by its attorney, Eric M. Collins, and for its Answer states:

1. Respondent denies liability for all claims arising from this present case. The account information is:

Agency Number: 0710
Cost Center: 419290
Internal Order: HMJX01XX
Fund: PWP5500
Fund Center: 896

2. DHS denies liability on this claim. DHS disputes the issues of negligence, proximate cause, liability, foreseeability and damages with regard to the death of Mr. David Cains. The Respondent reserves the right to plead further pending discovery and investigation.

3. Mr. David Arlund Cains was a 42 year old, [redacted] resident of the Booneville Human Development Center. Mr. Cains had been a resident of the BHDC since approximately 2007. Mr. Cains expressed [redacted]. According to the witness statements, Mr. Cains finished eating on the day of the incident, appeared irritated, and requested to go to the bathroom. He was escorted to the bathroom by facility staff.

Upon exiting the bathroom, Mr. Cains requested to sit in the lobby so he could calm down. Shortly after sitting down, Mr. Cains began screaming and cussing, ripping wallpaper off the wall to throw, and then jumped up after the staff member while spitting and attempting to hit the staff member. The staff member in question then attempted to hold Mr. Cain's arms and Mr. Cain ended up falling over. The staff member then proceeded to roll Mr. Cains onto his side and continued attempts to prevent Mr. Cains from striking him. Two additional staff members arrived on the scene and both stated that Mr. Cains was still hitting and spitting, both additional staff members proceeded to assist in holding Mr. Cains in order to control the behavioral outburst. During this behavioral outburst, Mr. Cains began to vomit and choke. The staff members present then called the BHDC medical team to assist.

4. There are no factual allegations contained in paragraph 1 of the complaint therefore no response is required. To the extent a response is deemed to be required, DHS denies the same.

5. There are no factual allegations contained in paragraph 2 of the complaint therefore no response is required. To the extent a response is deemed to be required, DHS denies the same.

6. There are no factual allegations contained in paragraph 3 of the complaint therefore no response is required. To the extent a response is deemed to be required, DHS denies the same.

7. DHS admits the contents of paragraph 4 to the extent that Ms. Christine McAuliffe is bringing this present action in her role as the Special Administrator of the Estate of David Cains and for certain statutory beneficiaries, Charlene Robinson and herself. To the extent that a response is required for any remaining factual allegations, DHS denies the allegations.

8. DHS admits the contents of paragraph 5 to the extent that DHS is an Arkansas State Agency, that DDS operated five Human Development Centers, including the Booneville Human Development Center. DHS denies the remaining factual allegations.

9. There are no factual allegations contained in paragraph 6 of the complaint and, therefore, no response is required.

10. DHS admits that the Booneville Human Development Center is a state facility located on the former grounds of the Arkansas Tuberculosis Sanatorium. DHS admits that the original Arkansas Tuberculosis Sanatorium opened in 1910 and closed in 1973. DHS denies the remaining factual allegations contained in paragraph 7 of the complaint.

11. DHS denies the factual allegations contained in paragraph 8 of the complaint.

12. The factual allegations contained in paragraph 9 are vague and nonspecific to location or the individuals involved. DHS is without sufficient knowledge to specifically admit or deny and, therefore, denies the same.

13. DHS denies the factual allegations contained in paragraph 10 of the complaint. DHS specifically denies the conclusions and inferences made by DRA and adopted by the Claimant.

14. DHS denies the factual allegations contained in paragraph 11 of the complaint. DHS specifically denies the conclusions and inferences made by DRA and adopted by the Claimant.

15. DHS denies the factual allegations contained in paragraph 12 of the complaint. DHS specifically denies the conclusions and inferences made by DRA and adopted by the Claimant. The use of an emergency hold is proper in situations where the safety of the client is at risk or the safety of other individuals are at risk.

16. DHS admits that Mr. Cains was born on [redacted] and that he was admitted as a resident of the Booneville Human Development Center in [redacted] DHS is without knowledge or

information to admit or deny the remaining allegations contained in paragraph 13 and, therefore, deny the same.

17. DHS admits the allegations contained within paragraph 14 to the extent they accurately describe Mr. Cains' medical diagnosis. DHS is without knowledge to admit or deny the remaining allegations and, therefore, denies the same.

18. DHS denies the factual allegations contained in paragraph 15 of the complaint. DHS specifically denies the conclusions and inferences made by DRA and adopted by the Claimant.

19. Paragraph 16 of the complaint contains no factual allegations, and no response is required. The extent a response is required, DHS denies.

20. DHS denies the factual allegations contained in paragraph 17 of the complaint. The death of Mr. Cains was not proximately caused by any claimed negligent action or inaction of the Respondent, its agents or employees. Mr. Cains expressed [redacted]. The incident at issue involved a behavioral outburst in which Mr. Cains and a staff member fell to the ground when the staff intervened to prevent Mr. Cains' physical aggression.

21. DHS denies the factual allegations and inferences contained in paragraph 18 of the complaint. Upon Mr. Cains vomiting, staff members immediately began [redacted]. The BHDC Medical Team, comprised of licensed nurses, responded within minutes and began [redacted]. Another staff member called 911 at the direction of the BHDC medical team.

22. Paragraph 19 of the complaint contains no factual allegations, merely speculation. As such no response is required. To the extent that a response is required, DHS denies the same.

23. DHS denies the factual allegations contained within paragraph 20 of the complaint. The assertions contained therein acknowledges that there were no clocks in the immediate area and therefore staff were giving approximations/estimates of the time. Furthermore, the medical team, trained nurses, arrived on the scene within minutes and began [redacted].

24. DHS admits the factual allegations in paragraph 21 pertaining to the unsuccessful efforts by the staff and BHDC medical team to clear Mr. Cains' airway. DHS denies the remaining allegations, inferences, and conclusions contained in paragraph 21 of the complaint.

25. DHS admits the allegations in paragraph 22 as to Mr. Cains' diagnosis of [redacted]. DHS denies the remaining allegations, inferences, and conclusions contained in paragraph 22. Claimant mischaracterizes Mr. Cains' Individual Program Plan which does [redacted] Mr. Cains was not "taken to the ground" as stated within this allegation, but instead fell to the ground during the behavioral outburst.

26. DHS admits the factual allegation contained in paragraph 23 of the complaint.

27. DHS denies the factual allegations contained in paragraph 24 of the complaint. Claimant mischaracterized the events surrounding the arrival of EMS to the location and DHS expressly denies that it mislead EMS.

28. DHS denies the allegations contained in paragraph 25 of the complaint. DHS specifically denies the conclusions and inferences made by the Claimant.

29. DHS cannot comment on the factual allegations contained in paragraph 26. Such reports are confidential by law. Ark. Code Ann. § 12-12-1701 *et seq.* DHS denies the remaining allegations contained in paragraph 26 of the complaint.

30. DHS admits the factual allegations contained in paragraph 27 as to the Division of Provider Services and Quality Assurances completing a survey. DHS denies the remaining allegations contained in paragraph 27 of the complaint, specifically the inferences and conclusions made by DRA and adopted by the Claimant.

31. DHS denies the factual allegations contained in paragraph 28 of the complaint. DHS specifically denies the conclusions and inferences made by DRA and adopted by the Claimant.

32. DHS denies the factual allegations contained in paragraph 29 of the complaint. Furthermore, as noted in the language put forth by the Claimant, emergency holds are permitted when there is a risk to the safety of the individual or individuals around them.

33. DHS denies the factual allegations contained in paragraph 30 of the complaint. Mr. Cains, his Mother (who also serves as his guardian), and his sister (the Claimant), all participated as members of the treatment team and approved the development of Mr. Cains' Individual Program Plan ("IPP"). Emergency holds are permitted for the protection of the individual and others around him. Due to the behavioral outburst, Mr. Cains posed a risk not only to himself but also to the staff. There are no facts to establish that Mr. Cains was ever "taken to the ground." DHS specifically denies the conclusions and inferences made by DRA and adopted by the Claimant.

34. DHS denies the factual allegations contained in paragraph 31 of the complaint. Harm that is merely possible is not necessarily reasonably foreseeable. *Robinson v. Willis*, 2018 Ark. App. 542, 8, 562 S.W.3d 265, 269, 2018 Ark. App. LEXIS 653, *10. The outcome of this

incident was not reasonably foreseeable. Negligence cannot be based on the failure to anticipate an unforeseen event. *Jackson v. Harps Food Stores, Inc*., 2020 Ark. App. 475, 5, 610 S.W.3d 173, 176, 2020 Ark. App. LEXIS 529, *6. DHS specifically denies the conclusions and inferences made by DRA and adopted by the Claimant.

35. DHS denies the factual allegations contained in paragraph 32 of the complaint. DHS specifically denies the conclusions and inferences made by DRA and adopted by the Claimant.

36. Paragraph 33 of the complaint does not contain any additional factual allegations not already addressed; therefore, no response is required. To the extent that a response is required, DHS incorporates its previous admissions or denials of all allegations contained therein.

37. DHS admits that DHS is a state agency and controlled and operated BHDC. There are no remaining factual allegations contained in paragraph 34 of the complaint. The remaining legal conclusions do not require a response; to the extent a response is deemed necessary, DHS denies.

38. DHS denies the factual allegations and legal conclusions contained in paragraph 35 of the complaint. DHS did not breach any ordinary duty of care to Mr. Cains and was not the proximate cause of Mr. Cains' death.

a. DHS denies the allegation contained in paragraph 35(a) of the complaint.

b. DHS denies the allegation contained in paragraph 35(b) of the complaint.

c. DHS denies the allegation contained in paragraph 35(c) of the complaint. All use of personal holds were reasonable in light of the risk posed by Mr. Cains not only to the staff, but also to himself.

d. DHS denies the allegation contained in paragraph 35(d) of the complaint.

e. DHS denies the allegation contained in paragraph 35(e) of the complaint. The hold was not unreasonable given the circumstances surrounding the incident.

f. DHS denies the allegation contained in paragraph 35(f). DHS has specific policy in place to permit emergency holds in situations where the clients represent a risk of harm either to themselves or others, as in the case here. Mr. Cains was not "taken to the floor" as asserted, but instead fell.

g. DHS denies the allegation contained in paragraph 35(g) of the complaint. The [redacted]

h. DHS denies the allegation contained in paragraph 35(h) of the complaint. At no times did DHS ignore the [redacted] necessary for Mr. Cains' safety. Mr. Cain was at a [redacted] and there is no allegation that Mr. Cain [redacted] during this incident.

i. DHS denies the allegation contained in paragraph 35(i) of the complaint. There is no proximate cause or relation to the time that EMS arrived at the location and Mr. Cains' death. DHS affirmatively states that BHDC's trained medical personnel were on location within minutes and began [redacted]. A different result would not have occurred even had EMS arrived sooner.

j. DHS denies the allegations contained in paragraph 35(j) of the complaint. There is no requirement to call 911 prior to an emergency occurring as asserted by Claimant. DHS restates that there is no proximate cause or relation to the time that EMS arrived at the location and Mr. Cains' death. DHS affirmatively states

that BHDC's trained medical personnel were on location within minutes and [redacted]. A different result would not have occurred even had EMS arrived sooner.

k. DHS denies the allegations contained in paragraph 35(k) of the complaint. There is no legal requirement to have cameras and the lack of cameras in any particular location does not constitute negligence.

l. DHS denies the allegations contained in paragraph 35(l) of the complaint. Such allegations do not constitute neglect.

m. DHS denies the allegations contained in paragraph 35(m) of the complaint. At all times DHS exercised ordinary care with respect to Mr. Cains.

n. DHS denies the allegations contained in paragraph 35(n) of the complaint.

o. DHS denies the allegations contained in paragraph 35(o) of the complaint.

p. DHS denies the allegations contained in paragraph 35(m)[sic] of the complaint.

q. DHS denies the allegations contained in paragraph 35(o)[sic] of the complaint.

39. DHS denies the allegations contained in paragraph 36 of the complaint. DHS is not the direct or proximate cause of the injuries or damages allegedly suffered by Claimant.

40. DHS denies the allegations contained in paragraph 37 of the complaint. DHS, nor its agents or employees, were negligent in regard to Mr. Cains. DHS did not conduct itself in a tortious manner with respect to Mr. Cains.

41. DHS denies liability for damages in paragraphs 38-47 of the complaint.

42. Any and all factual allegations contained within the complaint not expressly admitted are denied.

AFFIRMATIVE DEFENSES

1. DHS affirmatively asserts that it is not likely nor probable, and therefore not foreseeable, that in the course of a behavioral outburst and a subsequent emergency personal hold undertaken to protect the safety of the individual and others, an individual will vomit, choke, and then die. Arkansas law has recognized that there is no duty to guard against merely possible, as opposed to likely or probable, harm. *Ethyl Corp. v. Johnson*, 345 Ark. 476, 482, 49 S.W.3d 644, 648, 2001 Ark. LEXIS 432, *7. Harm that is merely possible is not necessarily reasonably foreseeable. *Robinson v. Willis*, 2018 Ark. App. 542, 8, 562 S.W.3d 265, 269, 2018 Ark. App. LEXIS 653, *10. The outcome of this incident was not reasonably foreseeable. Negligence cannot be based on the failure to anticipate an unforeseen event. *Jackson v. Harps Food Stores, Inc*., 2020 Ark. App. 475, 5, 610 S.W.3d 173, 176, 2020 Ark. App. LEXIS 529, *6.
2. DHS affirmatively asserts that there is no causal connection between the reasonable steps taken by its staff to preserve their safety and the safety of Mr. Cains and Mr. Cains' death. Proximate cause, for negligence purposes, is defined as that which in a natural and continuous sequence, unbroken by any efficient intervening cause, produces the injury, and without which the result would not have occurred. *Gilbow v. Crawford*, 2015 Ark. App. 194, 3-4, 458 S.W.3d 750, 753, 2015 Ark. App. LEXIS 246, *5.
3. Respondent asserts that any injuries were solely and proximately caused by the actions of Mr. Cains.
4. Respondent asserts the doctrines of intervening and superseding cause and denies any and all fault alleged.

5. Respondent asserts that no breach of duty occurred and that the actions of the responding staff members were proper under the circumstances. The BHDC medical team arrived within minutes and, among other interventions, began suctioning Mr. Cains airway.
6. Respondent asserts, in the alternative, to the extent that negligence is established (which it is not), that Mr. Cains bears a degree of fault for his actions preceding his death and therefore the doctrine of comparative fault is proper in this case. Ark. Code Ann. § 16-64-122.
7. Respondent asserts, in the alternative, that Mr. Cains, Ms. Robinson (his Guardian), and Ms. McAuliffe, through their involvement with the treatment team and in the development of the treatment plan, knew of the use of emergency restraints and acquiescence to its use, therefore assuming the risk.
8. Respondent is entitled to immunity from punitive damages. Ark. Code Ann. § 21-9-203. The Arkansas Claims Commission was established to enable claimants to receive payment on the "just debts" of the State of Arkansas. Acts 1955, No. 276 § 5. Punitive damages are not the "just debts" of the State of Arkansas and instead are designed to punish behavior, not compensate the Claimant.
9. Claimant has failed to state facts upon which relief can be granted and the complaint should be dismissed with prejudice.

WHEREFORE, Respondent, DHS moves that this claim be denied, and for all other just and proper relief to which it may be entitled.

Respectfully Submitted,

Arkansas Department of Human Services

Office of Chief Counsel

By: /s/ Eric Collins
Eric M. Collins
AR Bar # 2017175
Attorney Specialist
P.O. Box 1437, Slot S260
Little Rock, AR 72203
P: 501-396-6170
Eric.collins@dhs.arkansas.gov

Certificate of Service

I, undersigned, do hereby certify that on December 16, 2021, a true and correct copy of the foregoing document was served on the named individuals by way of:

U.S. Mail

Joshua Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501-244-0700
Attorney for Claimant

/s/ Eric M. Collins
Eric M. Collins
Attorney for DHS

From: Daiquiri Carter
To: ASCC Pleadings
Cc: Eric Collins
Subject: CC #220374
Date: Friday, December 17, 2021 1:51:30 PM
Attachments: DHS First Set of Discovery.pdf
image001.png
image002.png

Please find attached a copy of Respondent's First Set of Discovery to Christine McAuliffe.

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov





NOTE - This email may contain sensitive or confidential information.

CONFIDENTIALITY NOTICE: The information contained in this email message and any attachment(s) is the property of the State of Arkansas and may be protected by state and federal laws governing disclosure of private information. It is intended solely for the use of the entity to which this email is addressed. If you are not the intended recipient, you are hereby notified that reading, copying or distribution this transmission is STRICTLY PROHIBITED. The sender has not waived any applicable privilege by sending the accompanying transmission. If you have received this transmission in error, please notify the sender by return and delete the message and attachment(s) from your system.

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

Respondent's First Set of Discovery to Christine McAuliffe

Interrogatories

Comes Now the Respondent, Arkansas Department of Human Services, by and through its counsel, Eric Collins, and pursuant to Rule 8.1(b) of the Arkansas Claims Commission Rules and Regulations submits the following interrogatories to the Claimant, Christine McAuliffe, to be answered in writing and under oath within the time required under the Arkansas Rules of Civil Procedure:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

ANSWER:

INTERROGATORY NO. 2: Please identify by name, address and telephone number, each and every person who has personal knowledge of any or all of the facts, circumstances, claims and events alleged and/or damages sought in the claim filed herein including, but not limited to, all claimed acts, omissions, statements, duties, causation and damages which you assert in your claim. For each such person, please state the subject area of his or her knowledge related to the claim.

ANSWER:

INTERROGATORY NO. 3: For each and every report and/or conversation that you had with any employee of DHS prior to the death of Mr. Cains regarding Mr. Cains' treatment plans, Mr. Cains' behavioral issues, the availability of alternative care for Mr. Cains, and the management of Mr. Cains' behaviors, please:

1. Identify the name of the DHS employee involved;
2. State the date of each report and/or conversation; and
3. The facts and circumstances reported to DHS and/or reported to you.

ANSWER:

INTERROGATORY NO. 4: Please state the dates and circumstances that lead to Mr. Cains [redacted] during this time.

ANSWER:

INTERROGATORY NO. 5: Please identify, by (1) name and address, and (2) dates of residence, each and every *residential* admission of Mr. Cains to an institution, hospital, facility (medical and nonmedical), and/or school from the date of his birth until the date that he was admitted to the Booneville Human Development Center. This interrogatory includes identification of all locations where Mr. Cains received treatment, training, and/or education of any kind or nature in a *residential* setting.

ANSWER:

INTERROGATORY NO. 6: Please identify, by (1) name and address, and (2) dates present, each and every *acute* admission or stay in any institution, hospital, and treatment facility from the date of his birth until the date that he was admitted to the Booneville Human Development Center.

ANSWER:

INTERROGATORY NO. 7: Please identify, by (1) name and address, and (2) dates, each and every *unrelated caregiver* who resided with and either cared for or supervised Mr. Cains in a home type (non-institutional) setting from the date of his birth until the date that he was admitted to the Booneville Human Development Center.

ANSWER:

INTERROGATORY NO. 8: Please identify and itemize by nature, amount, and factual grounds/basis all damages sought herein, including financial damages, compensatory

damages, consequential damages, punitive damages, and all other damages which are asserted and sought in this claim.

ANSWER:

INTERROGATORY NO. 9: Please identify by name, address and relationship to Mr. Cains, all persons for whom a claim for wrongful death is made.

ANSWER:

INTERROGATORY NO. 10: Please identify by name, address and relationship to the deceased, each and every beneficiary of the Estate of David A. Cains.

ANSWER:

INTERROGATORY NO. 11: For each and every individual you have identified in Interrogatories 11 and 12 above, please state:

a. whether the beneficiary ever visited Mr. Cains while he resided at the Human Development Center facility and, if so, how often and approximately when (month and year);

ANSWER:

b. whether the beneficiary ever signed out Mr. Cains for any off campus visits and, if so, how often and approximately when (month and year); and

ANSWER:

c. whether the beneficiary ever participated in Mr. Cains' care planning and/or treatment plan while he resided at the Human Development Center facility, if so, what method (in person, by phone, etc.), how often and approximately when (month and year).

ANSWER:

INTERROGATORY NO. 12: Please identify by name, street address and relationship to the deceased, the deceased's parents and siblings.

ANSWER:

INTERROGATORY NO. 13: Please state and explain all injuries suffered as a result of the death of Mr. Cains and by whom.

ANSWER:

Request for Production of Documents

Comes Now the Respondent, Arkansas Department of Human Services, by and through its counsel, Eric Collins, and pursuant to Rule 8.1(b) of the Arkansas Claims Commission Rules and Regulations submits the following request for the production of documents to the Claimant to be answered in a manner permitted under the Arkansas Rules of Civil Procedure:

1. Copies of all exhibits that you will introduce at the trial of this matter,

including but not limited to all documents, reports, photographs, videotapes, digital recordings, records, bills, invoices, statements, accounts, receipts, x-rays, ultrasounds, and medical records.

RESPONSE:

2. Copies of all expert opinions, reports, summaries and similar types of documents by the experts that will testify on behalf of the Claimant at the trial of this matter.

RESPONSE:

3. Copies of the C.V./ resume of each and every expert that may testify at the hearing on this claim.

RESPONSE:

4. Copies of all bills, statements, and invoices itemizing the financial damages claimed herein.

RESPONSE:

By: /s/ Eric Collins
Eric M. Collins
AR Bar # 2017175
Attorney Specialist
P.O. Box 1437, Slot S260
Little Rock, AR 72203
P: 501-396-6170
Eric.collins@dhs.arkansas.gov

Certificate of Service

I, undersigned, do hereby certify that on December 17, 2021, a true and correct copy of the foregoing document was served on the named individuals by way of:

U.S. Mail

Joshua Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501-244-0700
Attorney for Claimant

/s/ Eric M. Collins
Eric M. Collins
Attorney for DHS

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF CALEB MURRY

TO: **CALEB MURRY**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on March 3, 2022 beginning at 9:00 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Caleb Murry

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, March 3, 2022 at 9:00 AM (Central Time)**

LOCATION: This matter will be held remotely, via **ZOOM**;

Link to join Zoom meeting:
https://us02web.zoom.us/j/89725577940?
pwd=T0lDZU9wZE5ueWNScW5aQzVGWGM0UT09

Meeting ID: 897 2557 7940
Passcode: 440619

COURT REPORTER: Bushman Court Reporting

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 26th day of January, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF AMY JONES

TO: **AMY JONES**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on March 3, 2022 beginning at 9:00 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Amy Jones

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, March 3, 2022 at 9:00 AM (Central Time)**

LOCATION: This matter will be held remotely, via **ZOOM**;

Link to join Zoom meeting:
https://us02web.zoom.us/j/89725577940?
pwd=T0lDZU9wZE5ueWNScW5aQzVGWGM0UT09

Meeting ID: 897 2557 7940
Passcode: 440619

COURT REPORTER: Bushman Court Reporting

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 26th day of January, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From: Kathryn Irby
To: josh@greenandgillispie.com; Eric Collins
Subject: RE: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374
Date: Monday, February 7, 2022 11:38:00 AM

Mr. Gillispie and Mr. Collins,

The Claims Commission has reviewed Mr. Gillispie's request for a hearing in the above-referenced claim and would like for the parties to conduct discovery prior to the scheduling of this claim for hearing, especially given the amount in controversy. When discovery is nearing completion, please contact me to get this claim added to the hearing docket.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Thursday, February 3, 2022 1:54 PM
To: Caitlin McDaniel <Caitlin.McDaniel@arkansas.gov>
Cc: ASCC New Claims <ASCC.New.Claims@arkansas.gov>; Dana Henderson <dana@greenandgillispie.com>; Kathryn Irby <Kathryn.Irby@arkansas.gov>; Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Christine McAuliffe; Claim No. 220374

Ms. McDaniel:

If possible, I would like to set this matter for a hearing. I would appreciate any guidance you can provide me on what my office needs to do in order to get a setting. The respondent agency, DHS, has denied liability in their answer. Their attorney, Eric Collins, has been copied on this email.

Thank you for your assistance.

Josh

Joshua D. Gillispie



1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

Arkansas
State Claims Commission
FEB 08 2022
RECEIVED

GREEN | GILLISPIE
ATTORNEYS AT LAW

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
Phone (501) 244-0700
Fax (501) 244-2020
www.greenandgillispie.com

February 7, 2022

Arkansas State Claims Commission
101 East Capitol Ave., Suite 410
Little Rock, AR 72201

SENT VIA U.S. MAIL FIRST-CLASS ONLY

Re: ***Christine McAuliffe v. Arkansas Department of Human Services***
Claim No. 220374

Dear Sir or Madam:

Please find enclosed the original and a copy of our *Notice to take Deposition of Amanda Schmidt, Notice to take Deposition of Deborah Noah,* and *Notice to take Deposition of Kelly King* regarding the above-referenced claim. Please file and return a file-marked copy of each to my office using the enclosed self-addressed, stamped envelope.

Thank you for your time and attention to this matter.

Sincerely,



Joshua D. Gillispie

JDG/deh

Enclosures

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 7th day of February, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF KELLY KING

TO: **KELLY KING**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on March 17, 2022, beginning at 9:00 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Kelly King

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, March 17, 2022 at 9:00 AM (Central Time)**

LOCATION: This matter will be held remotely, via **ZOOM**;

Link to Join Zoom Meeting:
https://us02web.zoom.us/j/88511356077?
pwd=U05SZFk4ZmZhNzVKL1dtdU51bHhQUT09

Meeting ID: 885 1135 6077
Passcode: 995988

COURT REPORTER: Bushman Court Reporting

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 7th day of February, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF DEBORAH NOAH

TO: **DEBORAH NOAH**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on March 17, 2022, beginning at 9:00 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Deborah Noah

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, March 17, 2022 at 9:00 AM (Central Time)**

LOCATION: This matter will be held remotely, via **ZOOM**;

Link to Join Zoom Meeting:
https://us02web.zoom.us/j/88511356077?
pwd=U05SZFk4ZmZhNzVKL1dtdU51bHhQUT09

Meeting ID: 885 1135 6077
Passcode: 995988

COURT REPORTER: Bushman Court Reporting

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 7th day of February, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From: Kathryn Irby
To: Joshua Gillispie
Cc: Eric Collins
Subject: RE: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374
Date: Tuesday, February 22, 2022 2:59:00 PM

Mr. Gillispie, if you'll file the discovery requests that you propound to DHS and your responses to discovery requests propounded by DHS to you, that will be sufficient. You can electronically file those by sending them to asccpleadings@arkansas.gov. DHS can do the same with its filings. No need to send us four hard copies. We are in the middle of updating our rules. Thanks.

Kathryn Irby

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Tuesday, February 22, 2022 2:54 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Re: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374

Kathryn:

With respect to the requirement that four copies of discovery responses be filed with the Commission, does that rule mean we file our responses to the state's discovery requests or do we file the state's responses to ours? I am assuming the former, but I wanted to be sure.

I see we are also to file one copy of the requests themselves. Same question there.

Thanks!

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Mon, Feb 7, 2022 at 11:39 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie and Mr. Collins,
>
> The Claims Commission has reviewed Mr. Gillispie's request for a hearing in the above-referenced

claim and would like for the parties to conduct discovery prior to the scheduling of this claim for hearing, especially given the amount in controversy. When discovery is nearing completion, please contact me to get this claim added to the hearing docket.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Thursday, February 3, 2022 1:54 PM
To: Caitlin McDaniel <Caitlin.McDaniel@arkansas.gov>
Cc: ASCC New Claims <ASCC.New.Claims@arkansas.gov>; Dana Henderson <dana@greenandgillispie.com>; Kathryn Irby <Kathryn.Irby@arkansas.gov>; Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Christine McAuliffe; Claim No. 220374

Ms. McDaniel:

If possible, I would like to set this matter for a hearing. I would appreciate any guidance you can provide me on what my office needs to do in order to get a setting. The respondent agency, DHS, has denied liability in their answer. Their attorney, Eric Collins, has been copied on this email.

Thank you for your assistance.

Josh

Joshua D. Gillispie
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From: Joshua Gillispie
To: ASCC Pleadings
Cc: Dana Henderson; Garrett Grellner; Eric Collins
Subject: Claim No. 22037
Date: Wednesday, February 23, 2022 12:37:30 PM
Attachments: P"s First Set of Discover Propounded to Defendant.pdf
P"s Rsp to D"s First Set of Discovery.pdf
P"s First Supplemental Rsp to D"s First Set of Discovery.pdf

Claims Commission:

Please find attached for filing the discovery requests propounded by Petitioner to DHS, and also Petitioner's Responses and Supplemental Responses to discovery requests propounded by DHS.

This includes a file containing the documents which Petitioner has produced to DHS, which is being shared via dropbox link, due to size. Please advise if you have any issues opening or receiving this via dropbox.

Docs Produced to D.zip_
Open link on Dropbox

Sincerely,

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BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) **RESPONDENT**

PLAINTIFF'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION PROPOUNDED TO DEFENDANT

COMES now Plaintiff, by and through her attorney, Joshua D. Gillispie, and propounds to Defendant the following Interrogatories and Requests for Production, to be answered in accordance with the Arkansas Rules of Civil Procedure and other applicable laws:

DEFINITIONS

1. "And" and "or" shall be individually interpreted in every instance as meaning "and/or" and shall not be interpreted to exclude any information within the scope of these requests.

2. "DHS" or "Defendant" or "You," as used herein, refers to all departments, offices, and facilities within the Arkansas Department of Human Services, including but not limited to the Booneville Human Development Center (referred to herein as "BHDC"), as well as all agents, employees, and officers.

3. Communication" or "Communications" refer to oral conversations, written correspondence, memoranda, telephone conversations, text messages, correspondence, notes, electronic mail, social media posts or messages, voice mails, answering machine messages, letters, notes, or cards, whether as a sender, recipient, cc, or bcc. "Communication" means any disclosure, transfer, or exchange of information or opinion, however made.

4. "Correspondence" refers to all forms of writings, electronic or otherwise, including but not limited to, letters, books, emails, text messages, computer tapes, discs, printouts, keypunch cards, memoranda, diaries, notes, reports, bulletins, printed forms, telegraphic communications, telexes, telegrams, telecopies, facsimile reproductions, minutes, microfilm, microfiche, films, videotape, and computer discs.

5. "Document" or "Documents" mean the original, or a copy when the original is not available, and each non-identical copy, including those which are non-identical by reason of notations or markings, of: papers, writings, records, notes, tapes, discs, or other substances on which communications, data, or information is recorded or stored, whether made by manual, mechanical, photographic, or electronic process. This definition includes all drafts or superseded revisions of each document. As used herein, "document(s)" includes, but is not limited to:

> Electronically Stored Information, books, pamphlets, periodicals, letters, reports, memoranda, handwritten notes, notations, messages, telegrams, cables, records, drafts, diaries, studies, analyses, summaries, magazines, circulars, bulletins, instructions, minutes, photographs, purchase orders, bills, checks, tabulations, desk or pocket calendars, charge slips, questionnaires, surveys, drawings, sketches, working papers, charts, graphs, indexes, taped correspondence, records of purchase of sale, contracts, agreements, leases, invoices, expense records, trip reports, releases, appraisals, valuations, estimates, opinions, financial statements, accounting records, income statements, electronic or other transcriptions or taping of telephone or personal conversations or conferences or any and all other written, printed, typed, punched, taped, filed or graphic matter or tangible thing, of whatever description, however produced or reproduced (including computer stores or generated data, together with instructions and programs necessary to search or retrieve such data), and shall include all attachments and enclosures to any requested item, which shall not be separated from the item to which they are attached or enclosed.

6. A document or communication "relating to," "related to," or "concerning" a given subject means any document that constitutes, contains, embodies, comprises, reflects, identifies, states, refers to, deals with, comments on, responds to, describes, or is otherwise pertinent to that subject, including without limitation documents concerning the presentation of other documents.

7. "Person" and "entity" mean the singular as well as the plural and include any natural person, partnership, corporation, association, joint venture, proprietorship, firm, agency, or other legal or business entity, and its agents and employees.

8. "Identify" and "identity":

a. When used in reference to a natural person, require his or her full name, present or last known business and home addresses, business, mobile, and home telephone numbers, and email addresses, if any;

b. When used in reference to a document, require Bates numbers and, in the alternative, the present location and the custody of the original thereof or, if unknown, the present custodian of any copy thereof, and the manner and date of disposition of any document that was, but is no longer, in your possession or subject to your control;

c. When used in reference to communications, require the substance thereof, the identity of the person who made the communication and the person to whom it was made, and the persons who participated in such communication or were present at the time same was made, the date and place thereof, whether the communication was oral, in writing, and/or exists in an electronic medium, and, if such communication has been reduced to writing, or otherwise exists in an electronic medium, includes identifying such document or ESI.

9. The singular of each word shall be construed to include its plural and vice-versa, and the root word and all derivations (i.e., "ing," "ed," etc.) shall be construed to include each other.

10. The words "and" as well as "or" shall be construed both conjunctively as well as disjunctively.

11. The word "each" shall be construed to include "every" and vice-versa.

12. The word "any" shall be construed to include "all" and vice-versa.

13. The present tense shall be construed to include the past tense and vice-versa.

14. The masculine shall be construed to include the feminine and vice-versa.

15. The words "knowledge," "information," "possession," "custody," and "control" of a person shall be construed to include such person's agents, representatives, and attorneys.

16. The word "including" shall have its ordinary meaning and shall mean "including but not limited to" and shall not indicate limitation to the examples or items mentioned.

INSTRUCTIONS

1. In answering each of these interrogatories, please furnish all information that is available to you and any to which you have access, including information in your possession, custody, or control, or in that of any agent, servant, or employee, including doctors, attorneys, investigators, examiners, testers, and evaluators contracted by you or on your behalf.

2. In the event you are unable to fully answer one or more of the following interrogatories after exercising due diligence to secure the necessary information, provide the most complete answer possible and specify the reason(s) for the inability to provide a complete response at the present time

3. Should a privilege, confidentiality agreement, protective order, or other privilege/exemption from discovery be asserted with respect to any part of any discussion, document, or other communication concerning information requested by any of the following interrogatories or requests for production, you are requested to answer the interrogatories or request in the manner indicated herein, except that the contents of the part deemed privileged need not be summarized. Instead, indicate that a privilege is claimed for such part and state the

nature of the privilege claimed and the facts upon which such claim is based in sufficient detail to permit the Court to adjudicate the validity of the privilege claim.

INTERROGATORIES AND REQUESTS FOR PRODUCTION

INTERROGATORY NO. 1: Please identify each person who may have knowledge or discoverable information relating to the claims or defenses in this lawsuit and state briefly the nature of the knowledge or discoverable information had by each such person. (For this and the below interrogatories requiring identification of individuals, please note the definition of "identify" in Definition 8.)

INTERROGATORY NO. 2: Please identify each person from whom information or documents were obtained to respond to Plaintiff's written discovery requests, or who assisted in preparing the responses and objections to said discovery requests.

INTERROGATORY NO. 3: Please identify any and all methods and devices you, your officers, agents, or employees used to exchange electronic communications referring or relating to Plaintiff or the allegations in Plaintiff's Complaint from June 13, 2020 to the present, including but not limited to: email, instant messaging, paging, text messaging, posting on social media, or faxing. "Identify" in this interrogatory means to specify: the device or devices (i.e. Blackberries, cellular phones, laptops, desktop computers, iPads, etc.); the email account(s), social media username(s), or telephone number(s) used, and the name, address, and telephone number of the person in whose name the account was held.

INTERROGATORY NO. 4: Please identify all persons with whom you have communicated concerning the allegations in the Plaintiff's Complaint or Defendant's Answer thereto (exclusive of communications with counsel in the instant action).

INTERROGATORY NO. 5: Please identify each person who was employed at BHDC on June 13, 2020. (For this and the below interrogatories requiring identification of individuals, please note the definition of "identify" in Definition 8.)

INTERROGATORY NO. 6: Please state every injury which David Cains has caused to another person at BHDC in all the years he resided there. For each such injury caused by David Cains, please provide the following:

a. the name of the person he injured;

b. how David caused the injury;

c. the nature and severity of the injury;

d. the date of the injury; and

e. identify all documents regarding the injury incident.

INTERROGATORY NO. 7: Please identify the person responsible for conducting the Adult Maltreatment Investigation into David Cains' death, and state whether that person was at the time employed at BHDC.

INTERROGATORY NO. 8: Please identify each person involved in the care, supervision, or treatment of David Cains from **January 1, 2018** until his death on or about June 13, 2020. As to each person please set forth the nature of each person's involvement and the time frame during which the person was involved in the care, supervision, evaluation, or treatment of Cains.

INTERROGATORY NO. 9: Do you contend that any person or entity (including any party to this lawsuit or Mr. Cains) negligently or intentionally committed an act or omission which caused or contributed to Cains' death, and if so, state the nature of the act or omission, and identify the person or entity in question.

INTERROGATORY NO. 10: Please identify all sets of regulations or standards you were required to comply with at the time of Cain's death, including but not limited to those required for Medicaid reimbursement.

INTERROGATORY NO. 11: Please provide the name, address, and telephone number of each expert who may be called as a witness, and for each such expert provide:

(a) the subject matter on which the witness is expected to testify;

(b) the materials reviewed by each expert;

(c) the facts known to the expert which relate to or form the basis of the mental impressions and opinions held by the expert; and

(d) the dates of all reports rendered by such experts, and the names and addresses of the persons having custody of same.

INTERROGATORY NO. 12: Please provide the name, address, and telephone number of all lay witness whom you may call at trial of this matter and for those persons identified, please state the anticipated subject matter of their testimony.

INTERROGATORY NO. 13: Please identify by title, author, editor, edition, publisher, date of publication and section, portion, page or pages of each and every book, treatise, periodical and/or pamphlet:

(a) established, or to be established, as a reliable authority by the testimony of any expert witness you have identified or will identify; and

(b) to be referred to during the trial testimony of any expert witness you have identified or will identify.

INTERROGATORY NO. 14: Do you contend there was an imminent risk of *serious* physical injury or *serious* property damage posed by David Cains on the date of his death? If so,

please describe the nature of any imminent risk of *serious* physical injury or *serious* property damage.

INTERROGATORY NO. 15: Please describe how the behavior of David Cains that led to his personal restraint on the day of his death constituted an "emergency situation."

INTERROGATORY NO. 16: Please describe with specificity what led to David Cains becoming upset just prior to the personal restraint on the date of his death (why it is DHS believes Cains' behavior escalated on this occasion or what precipitating factors or events appeared to have caused David Cains to become distressed and agitated prior to the restraint).

INTERROGATORY NO. 17: Please describe with specificity all efforts made by staff to deescalate the behavioral situation that led to the personal restraint used on David Cains on the date of his death.

INTERROGATORY NO. 18: Please state whether BHDC staff members Tyler Mattson, Ryann Campos, and Amy "Mandy" Jones were Certified Nursing Assistants (CNAs) on the date of David Cains' death.

INTERROGATORY NO. 19: Please identify David Cains' Interdisciplinary Team (IDT) for the time period of January 1, 2019 through the date of his death.

INTERROGATORY NO. 20: Please state the last known addresses and phone numbers for the following former employees of BHDC who were involved in David Cains' care:

Sue Roberson (first case manager)

Jennifer Berry (dorm supervisor in the early years)

Vickie Bradford (dorm staff and supervisor in the early years)

Ruth Freeman (case manager circa 2011)

Janet Campbell (nurse) circa 2011/12

Neil Berry (case manager)

Mary Nicholson (case manager circa 2014)

Ronnie Ledford (case manager circa 2015)

Audra Delay (David's work supervisor)

INTERROGATORY NO. 21: Please identify any rules, policies, or procedures at BHDC have changed since the death of David Cains, including but not limited to policies regarding calling 911.

REQUEST FOR PRODUCTION NO. 1: All documents you consulted in responding to these interrogatories.

REQUEST FOR PRODUCTION NO. 2: All documents written, signed, or recorded by any party or witness relating to the allegations of Plaintiff's Complaint and Defendant's Answer and defenses thereto.

REQUEST FOR PRODUCTION NO. 3: Your privilege log, in accordance with Instruction No. 3.

REQUEST FOR PRODUCTION NO. 4: All documentation regarding any injury to another person caused by David Cains.

REQUEST FOR PRODUCTION NO. 5: Please provide a copy of any organizational chart or flow sheet setting forth the departmental organization and hierarchy of the BHDC as such existed at the time of the events set forth in Plaintiff's complaint.

REQUEST FOR PRODUCTION NO. 6: All documents, including communications to or from you, related to the death of David Cains.

REQUEST FOR PRODUCTION NO. 7: All documents, including communications to or from you, related to the restraint incident involving David Cains on the day of his death.

REQUEST FOR PRODUCTION NO. 8: All communications between you and anyone else, including your employees, servants, and agents, that are related to the allegations of Plaintiff's Complaint and Defendant's Answer and defenses thereto.

REQUEST FOR PRODUCTION NO. 9: All documents BHDC provided to its employees, who were employed at the time of Cains' death, regarding the terms and conditions of their employment, including all employee manuals and rules.

REQUEST FOR PRODUCTION NO. 10: Please provide copies of any policies, rules, procedures, or guidelines in effect at BHDC at the time of David Cains' death, including but not limited to those pertaining in any way to the use of restraints, such as *Use and Documentation Procedures to Manage Behavior* and *Documentation of and Response to Maladaptive Behaviors*.

REQUEST FOR PRODUCTION NO. 11: Please provide copies of any written or recorded statements DHS or its agents or employees have obtained from the Plaintiff or any other family member of David Cains.

REQUEST FOR PRODUCTION NO. 12: Please provide copies of any audio, photographic and video footage that concerns the occurrences identified in Plaintiff's complaint, including all photographs of David Cains taken at any point over his roughly 13 years stay at BHDC.

REQUEST FOR PRODUCTION NO. 13: Please provide reports and any other documents from all investigations, including internal investigations, conducted by DHS or any DHS entity, including but not limited to maltreatment investigations, including but not limited to reports and any other documents from any review or investigation performed by the Division of Provider Services and Quality Assurance (DPSQA), the Office of Long-Term Care (OLTC), the Mortality Review Committee (MRC), or DDS.

REQUEST FOR PRODUCTION NO. 14: Please produce a copy of all training materials that were provided to BHDC staff employed at the time of Cains' death on or about June 13, 2020.

REQUEST FOR PRODUCTION NO. 15: Please provide copies of all medical articles or medical treatises which you plan to introduce into evidence, to use in any manner at the trial of this case or to use at any deposition.

REQUEST FOR PRODUCTION NO. 16: Please provide copies of any letters, documents or medical opinions which have been written by any experts, treating physicians or other physicians, or medical professionals whom you or your attorney plan on calling as expert witnesses to offer testimony at the trial of this case.

REQUEST FOR PRODUCTION NO. 17: The Defendant is requested to produce the following materials with respect to each expert witness it may call at the trial of this case:

(a) A copy of the witness's most recent curriculum vitae,

(b) A complete list of all books, texts, treatises, articles, statutes, rules, regulations, guidelines or any material which has been or may be referred to or relied upon by any expert witness in forming or explaining his or her opinions in connection with this case, together with citations to specific passages or sections relied upon,

(c) A list of any computer programs, spreadsheets, analytical programs, statistical programs of any other computer-based tool utilized by any expert witness in any manner with regard to his/her opinions in this case,

(d) Copies of each spreadsheet, program, algorithm, statistical model, macro program, or other computer-based files created by or at the direction of any expert witness which has been utilized in any manner regarding his or her opinions in this case,

(e) Copies of any and all reports, correspondence, notes, documents, writings, diagrams, charts, records, photographs, video or audio recordings of any type, computer files, e-mails or tangible items of any kind that have been supplied to any expert witness by defendant, attorneys for defendant, or any representative of the defendant or defendant's attorneys,

(f) Copies of any and all reports, correspondence, notes, documents, writings, diagrams, charts, records, photographs, video, or audio recordings of any type, computer files, e-mails, or tangible items of any kind that any expert witness has provided to the defendant, attorneys for defendant, or any representative of defendant's attorneys,

(g) Copies of any and all reports, correspondence, notes, documents, writings, diagrams, charts, records, photographs, video or audio recordings of any type, computer files, e-mails, or tangible items of any kind made or prepared by any expert witness in connection with this case regardless of whether such materials were provided to any other person,

(h) Any and all billing records, bills or invoices any expert witness has prepared or provided in connection with this case.

REQUEST FOR PRODUCTION NO. 18: Please provide copies of all documents which you plan to use at the trial of this case, including, but not limited to, documents which you plan on introducing into evidence and documents which you plan to or will use in the direct examination and cross-examination of witnesses at the trial of this case.

REQUEST FOR PRODUCTION NO. 19: Please provide your entire unredacted file on David Cains, including but not limited to all [redacted]

[redacted], and records reflecting personal, chemical, or mechanical restraints used on David Cains throughout his time at BHDC.

REQUEST FOR PRODUCTION NO. 20: Please produce all minutes of the meetings of the BHDC Human Rights Committee from the time period of January 1, 2017 through January 1, 2021, as well as any reports produced by the Human Rights Committee during this time period.

REQUEST FOR PRODUCTION NO. 21: Please produce the Human Development Center Monthly Statistical Reports provided to the DDS Board for the time period of January 1, 2017 through January 1, 2021.

REQUEST FOR PRODUCTION NO. 22: Please produce the complete personnel files of Tyler Mattson, Amy "Mandy" Jones, and Ryann Campos.

REQUEST FOR PRODUCTION NO. 23: Please produce copies of any policies, rules, procedures, or guidelines at BHDC that have been modified or altered in any way since David Cains's death, including but not limited to those pertaining to calling 911.

REQUEST FOR PRODUCTION NO. 24: Please produce copies of any recorded statements that any BHDC staff or former BHDC staff have given concerning the death of David Cains, including but not limited to recorded statements given to Disability Rights Arkansas.

INTERROGATORY NO. 22: Please treat the foregoing interrogatories as continuing and furnish to Plaintiffs, in writing, any additional information received by you subsequent to the date of your answers hereto that would modify or supplement your answers, such additional information to be furnished as soon as reasonably possible after receipt by you and within a reasonable time prior to the assigned trial date in order to permit appropriate discovery procedure. Will you do so?

VERIFICATION

Respectfully submitted,

/s/ Joshua D. Gillispie
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail on this 13th day of January, 2022.

Eric M. Collins, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

CLAIMANT'S RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

Interrogatories

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

ANSWER: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.

INTERROGATORY NO. 2: Please identify by name, address and telephone number, each and every person who has personal knowledge of any or all of the facts,

circumstances, claims and events alleged and/or damages sought in the claim filed herein including, but not limited to, all claimed acts, omissions, statements, duties, causation and damages which you assert in your claim. For each such person, please state the subject area of his or her knowledge related to the claim.

ANSWER:

Plaintiff objects to the breadth of this interrogatory as written, as Plaintiff has no way, at this early stage of the case, of knowing every single person who might have such knowledge, and Plaintiff reserves the right to supplement this response. At this time, without waiving her objection, Plaintiff can provide the following:

Charlene Robinson, [redacted]
Was the first person notified by telephone that David was in critical condition after choking on lunch and was on his way to Mercy hospital. Received the first notification from the BHDC, via a summary of incident letter, that any type of restraint had occurred.

Christine McAuliffe, [redacted]
Spoke directly with David's case manager, Caleb Murray, about details surrounding David's death, multiple times in person and on the phone during the week following David's death.

Additionally, any person identified or disclosed throughout these discovery responses and any other discovery responses; any emergency medical responders who responded to the scene; any member of law enforcement who responded to the scene or took part in any investigation; any coroner, medical examiner or coroner staff who worked the case; any medical provider, physician, or nurse who attempted to provide treatment to David Cains following the incident in question; and any employee or agent of DHS who might have such knowledge.

Logan County EMS: Samuel Scow, Jordan Wilson, [redacted] These are, upon information and belief, the EMTs who arrived at the scene of the incident.

Mercy Hospital, Booneville Attending Provider: Henry K. Upchurch DO. [redacted] Dr. Upchurch, upon information and belief, was the attending provider at Mercy Hospital in Booneville, AR on the day David Cains was transported to Mercy Hospital, Booneville and pronounced dead.

DHS Superintendent: Jeff Gonyea. [redacted]

Logan County Coroner: Michael Chrisman. [redacted]

Don Carter – former BHDC employee who knew David

Maureen Bradshaw – brother died under similar circumstances at a similar state facility

Karen Black – brother died under similar circumstances at a similar state facility

Booneville Human Development Center Staff:

Tyler Mattson - See Complaint. Initiated the physical restraint which lead to David Cains' death.

Amy "Mandy" Jones – See Complaint. Assisted Tyler Mattson and Ryann Campos in restraining David by holding David's head.

Ryann Campos – See Complaint. Assisted both Tyler Mattson and Amy Jones in restraining David by holding his ankles.

Deborah Noah – See Complaint.
The staff LPN that was notified of what happened and that David had stopped breathing by Ryann Campos.

Amanda Schmidt – See Complaint.
Staff LPN that was informed of the situation by Deborah Noah and drove to the Commons Building from the Judge Hill building.

Kelly King – See Complaint.
Staff LPN that was informed of the situation by Deborah Noah and drove to the Commons Building from the Judge Hill building.

Sandy Evans – See Complaint.
DHS Residential Services Director and Adult Maltreatment Investigator who conducted the internal maltreatment investigation into David's death.

INTERROGATORY NO. 3: For each and every report and/or conversation that you had with any employee of DHS prior to the death of Mr. Cains regarding Mr. Cains' treatment plans, Mr. Cains' behavioral issues, the availability of alternative care for Mr. Cains, and the management of Mr. Cains' behaviors, please:

1. Identify the name of the DHS employee involved;

2. State the date of each report and/or conversation; and

3. The facts and circumstances reported to DHS and/or reported to you.

ANSWER: Charlene Robinson kept in contact, sometimes in person but most commonly by telephone, with each and every case manager that was assigned to David during his 13 years at the BHDC. David's most recent case manager was Caleb Murray. Charlene Robinson spoke with Caleb Murray monthly, sometimes more often, about any medical issues, behavior events and how those behaviors were addressed. Charlene attended David's yearly meetings, in person, concerning his treatment plan. Each year the staff and family discussed David's progress, his new goals and whether or not to continue his placement at the BHDC.

Christine McAuliffe attended multiple yearly meetings for David's treatment plan, the last being in 2019. At this meeting, Christine brought up a concern of the number of behavior incidents and restraints David had received in the past year. The BHDC staff spoke about de-escalation techniques that are used during such events, to lessen the use of restraints. Christine McAuliffe kept in contact, by telephone, with multiple case managers over the years. Her last conversation with Caleb Murray, around the end of May 2020, was her concern with not being able to see David in person due to Covid protocols. Caleb explained these protocols were set by people in Little Rock but at her request he would contact his supervisors to see what the family's options were to see David in person.

Over the years, both Charlene and Christine would meet David and his staff for many of his out-of-town doctor's appointments, in Fort Smith and Fayetteville, Arkansas.

Additionally:

1.Sue Roberson (first case manager) – Ms. Robinson spoke frequently with her about David's overall care

2.Jennifer Berry (dorm supervisor in the early years) – Ms. Robinson spoke frequently with Ms Berry about David's behaviors in the dorm, eating habits, getting along with other residents

3.Vickie Bradford (dorm staff and supervisor in the early years) Ms Robinson and Ms McAuliffe kept in frequent contact with Vickie about David's behaviors at the dorm, his eating habits, getting along with other residents, any personal needs for his dorm room

4. Ruth Freeman (case manager circa 2011) - Ms Robinson spoke with frequently about David's overall care. Circa 2012, [redacted]

5. Janet Campbell (nurse) circa 2011/12 - Ms Robinson spoke with Campbell about finding a new [redacted] for David; she found one in Fort Smith, AR, which David saw multiple times

6.Neil Berry (case manager) - Ms Robinson kept in contact about David's overall care

7. Mary Nicholson (case manager circa 2014) - Ms Robinson and Ms McAuliffe kept in contact about David's overall care

8. Ronnie Ledford (case manager circa 2015) - Ms Roinson and Ms McAuliffe kept in contact about David's overall care

9. Audra Delay (David's work supervisor) - Ms Robinson and Ms McAuliffe had multiple conversations over the years staying up to date with David's progress, behaviors and attitude as it pertained to working in the shop

INTERROGATORY NO. 4: Please state the dates and circumstances that lead to Mr. Cains [redacted].

ANSWER: Plaintiff objects to this interrogatory as being irrelevant to the claims and defenses of the present case, and not designed to elicit the discovery of potentially admissible or even relevant evidence. David Cains had lived at BHDC for 13 years at the time of his death, meaning that it had been over 13 years since he had lived with the [redacted]. Without waiving the objection, Plaintiff states the following:

[redacted]

INTERROGATORY NO. 5: Please identify, by (1) name and address, and (2) dates of residence, each and every *residential* admission of Mr. Cains to an institution, hospital, facility (medical and nonmedical), and/or school from the date of his birth until the date that he was admitted to the Booneville Human Development Center. This interrogatory includes identification of all locations where Mr. Cains received treatment, training, and/or education of any kind or nature in a *residential* setting.

ANSWER: The BHDC is the only residential facility to which David was ever admitted. [redacted] David attended Center Valley Elementary, Russellville Middle, Junior and High School, graduating in the 1995/96 school year. He attended the [redacted] (Russellville, AR) for a brief period of time in the mid to late 1990s. Sometime during the late 1990s/early 2000s, David held a short job placement [redacted] in the Fayetteville, AR area.

INTERROGATORY NO. 6: Please identify, by (1) name and address, and (2) dates present, each and every *acute* admission or stay in any institution, hospital, and treatment facility from the date of his birth until the date that he was admitted to the Booneville Human Development Center.

ANSWER: Plaintiff objects to this interrogatory as being irrelevant to the claims and defenses of the present case, and not designed to elicit the discovery of potentially admissible or even relevant evidence. Without waiving her objection, Plaintiff states as follows:

To Plaintiff's knowledge, David was never admitted to any institution, hospital or treatment facility other than the BHDC. [redacted]

INTERROGATORY NO. 7: Please identify, by (1) name and address, and (2) dates, each and every *unrelated caregiver* who resided with and either cared for or supervised

Mr. Cains in a home type (non-institutional) setting from the date of his birth until the date that he was admitted to the Booneville Human Development Center.

ANSWER: Plaintiff objects to this interrogatory as being irrelevant to the claims and defenses of the present case, and not designed to elicit the discovery of potentially admissible or even relevant evidence. Without waiving her objection, Plaintiff states as follows:

[redacted]

INTERROGATORY NO. 8: Please identify and itemize by nature, amount, and factual grounds/basis all damages sought herein, including financial damages, compensatory damages, consequential damages, punitive damages, and all other damages which are asserted and sought in this claim.

ANSWER: Plaintiff objects to this request as overly broad and unduly burdensome at this early stage of the litigation, but, without waiving her objection, Plaintiff would direct Defendant to the Complaint, which provides a detailed factual basis for all damages sought, which include without limitation the following:

Damages of the Estate of David Cains

Loss of life of David Cains, commencing at death and ending at life expectancy;
Conscious pain and suffering of David Cains prior to death;
Medical care and expenses incurred as a result of David Cains' death (bills to be provided herein or upon receipt by Plaintiff's counsel); and
Funeral expenses incurred as a result of David Cains' death (bills to be provided herein or upon receipt by Plaintiff's counsel).

Damages of Cains' Statutory Beneficiaries

Mental anguish and emotional distress, including grief and despair, suffered up to the present time; and
Mental anguish and emotional distress, including grief and despair, that will continue well into the future.

INTERROGATORY NO. 9: Please identify by name, address and relationship to Mr. Cains, all persons for whom a claim for wrongful death is made.

ANSWER:

Charlene Robinson(mother) [redacted]

Christine McAuliffe (sister) [redacted]
Sarah Ashley Cains (half-sister) [redacted]

INTERROGATORY NO. 10: Please identify by name, address and relationship to the deceased, each and every beneficiary of the Estate of David A. Cains.

ANSWER:

Charlene Robinson(mother) [redacted]
Christine McAuliffe (sister) [redacted]
Sarah Ashley Cains (half-sister) [redacted]

INTERROGATORY NO. 11: For each and every individual you have identified in Interrogatories 11 and 12 above, please state:

a. whether the beneficiary ever visited Mr. Cains while he resided at the Human Development Center facility and, if so, how often and approximately when (month and year);

ANSWER: Ms Robinson and Ms McAuliffe visited David on multiple occasions throughout each year 2007-2020, and many of the visits were to pick David up and take him home to Russellville, AR to spend time with his family. Ashley Cains visited David at the BHDC campus a minimum of two times, 2011 and 2017. Ms Cains made bi-yearly visits to Russellville, AR to visit David at the family's home. She also kept in contact with David by calling the Davison dorm on occasion throughout each year he was a resident.

b. whether the beneficiary ever signed out Mr. Cains for any off campus visits and, if so, how often and approximately when (month and year); and

ANSWER: Every year from 2007 to 2020, Ms Robinson and Ms McAuliffe brought David home to Russellville, AR for every Thanksgiving and Christmas, on his birthday and on random other weekends. Along with these visits home, for every year David was a resident at the BHDC, Ms Robinson and Ms McAuliffe each took David out for day trips, for lunch or dinner, in Booneville or one of the

surrounding towns. Ashley Cains never signed David out of the BHDC, as far as Plaintiff knows.

c. whether the beneficiary ever participated in Mr. Cains' care planning and/or treatment plan while he resided at the Human Development Center facility, if so, what method (in person, by phone, etc.), how often and approximately when (month and year).

ANSWER: Ms Robinson participated, in person, in all of David's treatment plans for every year he was a resident at the BHDC. Ms McAuliffe also participated, in person, with many of David's treatment plans, the most recent being 2019. The years she could not participate in person, she followed up via telephone with his case manager. Ashley Cains never participated directly with the staff about David's treatment plan, only with the family.

INTERROGATORY NO. 12: Please identify by name, street address and relationship to the deceased, the deceased's parents and siblings.

ANSWER:
Charlene A. Robinson (mother) [redacted]
David George Cains (father) deceased
Christine E. McAuliffe (sister) [redacted]
Sarah Ashley Cains (half-sister) [redacted]

INTERROGATORY NO. 13: Please state and explain all injuries suffered as a result of the death of Mr. Cains and by whom.

ANSWER: Plaintiff objects to this request as vague, as well as overly broad and unduly burdensome at this early stage of the litigation, but, without waiving her objection, Plaintiff would direct Defendant to her response to Interrogatory 8.

Request for Production of Documents

Comes Now the Respondent, Arkansas Department of Human Services, by and through its counsel, Eric Collins, and pursuant to Rule 8.1(b) of the Arkansas Claims

Commission Rules and Regulations submits the following request for the production of documents to the Claimant to be answered in a manner permitted under the Arkansas Rules of Civil Procedure:

1. Copies of all exhibits that you will introduce at the trial of this matter, including but not limited to all documents, reports, photographs, videotapes, digital recordings, records, bills, invoices, statements, accounts, receipts, x-rays, ultrasounds, and medical records.

RESPONSE: Plaintiff reserves the right to amend this response. Plaintiff will timely supplement this response as exhibits are identified and obtained throughout discovery. At this time, Plaintiff reserves the right to use any document produced or identified by either party throughout this discovery, including but not limited to Plaintiff's medical records, medical bills, funeral bills, various photos of David Cains, coroner reports, expert reports, including those already written and produced by Arkansas Disability Rights, and any rules and regulations or policies that Defendant was required to adhere to, including those required for Medicare/Medicaid reimbursement. Many, if not most, of the exhibits Plaintiff will use are currently in Defendant's possession, not Plaintiff's, including but not limited to Individual Program Plans, Behavior Programs, Behavior Plans, Resident Behavior Reports, Restraint Incident Debriefing Forms, Restraint Logs, Emergency Restraints, and records reflecting personal, chemical, or mechanical restraints used on David Cains throughout his time at BHDC, written communications to or from you related to the restraint and death of David Cains, policies, rules, procedures, or guidelines in effect at BHDC at the time of David Cains' death, including but not limited to those pertaining in any way to the use of restraints, such as *Use and Documentation Procedures to Manage Behavior* and *Documentation of and Response to Maladaptive Behaviors*.

Plaintiff is producing with these responses the following documents currently in her possession, which have been bates stamped and mailed to Defendant's counsel on a flash drive:

- 2015 DRA Report on BHDC
- 2016 DRA Report on BHDC
- DRA Final Investigative Report on Cain's Death
- Cains' medical records from Booneville Mercy
- 11 photos of David Cains taken prior to his death.

2. Copies of all expert opinions, reports, summaries and similar types of

documents by the experts that will testify on behalf of the Claimant at the trial of this matter.

RESPONSE: Plaintiff anticipates she will be supplementing with further expert reports, but at this time is producing those currently in her possession, which include:

2015 DRA Report on BHDC
2016 DRA Report on BHDC
DRA Final Investigative Report on Cain's Death

3. Copies of the C.V./ resume of each and every expert that may testify at the hearing on this claim.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time.

4. Copies of all bills, statements, and invoices itemizing the financial damages claimed herein.

RESPONSE: Plaintiff will produce these upon receipt. However, these are not likely to be substantial, most likely consisting of funeral/burial expenses, the ambulance bill, and the hospital bill from the date of David Cains's death.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail and US Mail on this 13th day of January, 2022.

Eric M. Collins, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

FIRST SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

Interrogatories

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

ANSWER: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.

SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Janice L. LeBel, EdD/PhD, ABPP. Dr. LeBel's CV and Fee Schedule are provided herein, which contain her contact information. Dr. LeBel, as reflected in her CV, is a psychologist and an expert in field of behavioral health services and residential care for vulnerable

populations, including the disabled, mentally ill, and children. Dr. LeBel has published extensively on the use of restraints in these settings. She is expected to testify concerning the standard of care for a facility such as BHDC, and whether there were breaches of that standard that lead to Cains's death. Dr. LeBel can be made available for deposition upon request from Defendant. At this time there is no written report to share with Defendant.

Request for Production of Documents

1. Copies of all exhibits that you will introduce at the trial of this matter,

including but not limited to all documents, reports, photographs, videotapes, digital recordings, records, bills, invoices, statements, accounts, receipts, x-rays, ultrasounds, and medical records.

RESPONSE: Plaintiff reserves the right to amend this response. Plaintiff will timely supplement this response as exhibits are identified and obtained throughout discovery. At this time, Plaintiff reserves the right to use any document produced or identified by either party throughout this discovery, including but not limited to Plaintiff's medical records, medical bills, funeral bills, various photos of David Cains, coroner reports, expert reports, including those already written and produced by Arkansas Disability Rights, and any rules and regulations or policies that Defendant was required to adhere to, including those required for Medicare/Medicaid reimbursement. Many, if not most, of the exhibits Plaintiff will use are currently in Defendant's possession, not Plaintiff's, including but not limited to Individual Program Plans, Behavior Programs, Behavior Plans, Resident Behavior Reports, Restraint Incident Debriefing Forms, Restraint Logs, Emergency Restraints, and records reflecting personal, chemical, or mechanical restraints used on David Cains throughout his time at BHDC, written communications to or from you related to the restraint and death of David Cains, policies, rules, procedures, or guidelines in effect at BHDC at the time of David Cains' death, including but not limited to those pertaining in any way to the use of restraints, such as *Use and Documentation Procedures to Manage Behavior* and *Documentation of and Response to Maladaptive Behaviors*.

Plaintiff is producing with these responses the following documents currently in her possession, which have been bates stamped and mailed to Defendant's counsel on a flash drive:

- 2015 DRA Report on BHDC
- 2016 DRA Report on BHDC
- DRA Final Investigative Report on Cain's Death
- Cains' medical records from Booneville Mercy
- 11 photos of David Cains taken prior to his death.

SUPPLEMENTAL RESPONSE:

- Ambulance bill
- Ambulance records
- Headstone bill
- Funeral services bill

3. Copies of the C.V./ resume of each and every expert that may testify at the hearing on this claim.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time.

SUPPLEMENTAL RESPONSE: Provided herein, the CV of Dr. LeBel.

4. Copies of all bills, statements, and invoices itemizing the financial damages claimed herein.

RESPONSE: Plaintiff will produce these upon receipt. However, these are not likely to be substantial, most likely consisting of funeral/burial expenses, the ambulance bill, and the hospital bill from the date of David Cains's death.

SUPPLEMENTAL RESPONSE: Provided herein, ambulance bill, funeral services bill, and headstone bill.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail and US Mail on this 20th day of January 2022.

Eric M. Collins, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From: Kathryn Irby
To: Joshua Gillispie
Cc: Eric Collins
Subject: RE: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374
Date: Friday, February 25, 2022 7:57:00 AM

That should be fine, thank you.

Kathryn Irby

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Wednesday, February 23, 2022 12:38 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Re: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374

Ms. Irby:

I used a dropbox link to share the documents we have produced to DHS, due to the size. If that is not acceptable, please let me know and we can mail it on a flash drive.

Josh

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Tue, Feb 22, 2022 at 3:19 PM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Ok, thank you!
>
> Joshua D. Gillispie
> 1 Riverfront Place, Suite 605
> North Little Rock, AR 72114
> (501) 244-0700
> (501) 244-2020 fax
> www.greenandgillispie.com

On Tue, Feb 22, 2022 at 3:00 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie, if you'll file the discovery requests that you propound to DHS and your responses to discovery requests propounded by DHS to you, that will be sufficient. You can electronically file those by sending them to asccpleadings@arkansas.gov. DHS can do the same with its filings. No need to send us four hard copies. We are in the middle of updating our rules. Thanks.
>
> Kathryn Irby

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Tuesday, February 22, 2022 2:54 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Re: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374

Kathryn:

With respect to the requirement that four copies of discovery responses be filed with the Commission, does that rule mean we file our responses to the state's discovery requests or do we file the state's responses to ours? I am assuming the former, but I wanted to be sure.

I see we are also to file one copy of the requests themselves. Same question there.

Thanks!

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Mon, Feb 7, 2022 at 11:39 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie and Mr. Collins,
>
> The Claims Commission has reviewed Mr. Gillispie's request for a hearing in the above-referenced claim and would like for the parties to conduct discovery prior to the scheduling of this claim for hearing, especially given the amount in controversy. When discovery is nearing completion, please contact me to get this claim added to the hearing docket.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Thursday, February 3, 2022 1:54 PM
To: Caitlin McDaniel <Caitlin.McDaniel@arkansas.gov>
Cc: ASCC New Claims <ASCC.New.Claims@arkansas.gov>; Dana Henderson <dana@greenandgillispie.com>; Kathryn Irby <Kathryn.Irby@arkansas.gov>; Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Christine McAuliffe; Claim No. 220374

Ms. McDaniel:

If possible, I would like to set this matter for a hearing. I would appreciate any guidance you can provide me on what my office needs to do in order to get a setting. The respondent agency, DHS, has denied liability in their answer. Their attorney, Eric Collins, has been copied on this email.

Thank you for your assistance.

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Office of Chief Counsel
Eric Collins

P.O. Box 1437, Slot S-260 Little Rock, AR 72203-1437
501-396-6170 · Fax: 501-682-1390
eric.collins@dhs.arkansas.gov

February 25, 2022

Arkansas State Claims Commission
FEB 26 2022
RECEIVED

Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, AR 72201

RE: C.M. CC220374 Filings and Discovery

Dear Claims Commission,

Please find included the DHS response to the Claimant's First Set of Discovery Propounded on DHS in case 220374. As the documents are too expansive to provide via e-file, I have included the document and the disc which includes the produced discovery. On this disc is an electronic copy of the paper response included in this mailing.

Thank you,

Eric Collins
Counsel for DHS

Arkansas
State Claims Commission
FEB 26 2022
RECEIVED

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains — **CLAIMANT**

V. — **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) — **RESPONDENT**

DHS' RESPONSE TO PLAINTIFF'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION PROPOUNDED TO DEFENDANT

COMES now Respondent, by and through its attorney, Eric M. Collins, and for its responses to Claimant's First set of Interrogatories and Requests for Production, states as follows:

INTERROGATORIES AND REQUESTS FOR PRODUCTION

INTERROGATORY NO. 1: Please identify each person who may have knowledge or discoverable information relating to the claims or defenses in this lawsuit and state briefly the nature of the knowledge or discoverable information had by each such person. (For this and the below interrogatories requiring identification of individuals, please note the definition of "identify" in Definition 8.)

ANSWER: Respondent reserves the right to supplement this response as additional information becomes available. Respondent objects to the inclusion and production of personal information unrelated to the identified individual's professional capacity. Such information is an unwarranted invasion of privacy and is not reasonably calculated to lead to the discovery of admissible evidence. Without waiving objection, Respondent can provide the following: Please See Attachment: Names and Addresses Int 1-2-20, Bates Number CM001880-CM001881.

Sandra Evans

-Residential Services Director/Adult Maltreatment Investigator

-Investigated the incident

Amy Jones

-Residential Care Shift Supervisor

-Involved in the incident

Tyler Mattson

-Residential Care Technician

-Involved in the incident

Ryann Campos

- Residential Care Technician

- Involved in the incident

Deborah Noah

- LPN

-Responded to emergency call and rendered emergency aid.

Amanda Schmitt

- LPN

- Responded to emergency call and rendered emergency aid.

Lacy Fleming

- LPN

- Responded to emergency call and rendered emergency aid.

Joann Miller

- LPN

- Responded to emergency call and rendered emergency aid.

Kelly King

- LPN

- Responded to emergency call and rendered emergency aid.

Jeff Gonyea

-Superintendent

-Administrator of BHDC

Jennifer Berry

-Assistant Superintendent

-Assistant Administrator of BHDC

Danielle Jones

-Residential Care Shift Supervisor

-Involved in the incident

Stacy Weinbrenner

-RN, Nurse Manager

Angela Nelson

-RN, Assistant Nurse Manager

-Supervises the LPNs

Amanda Krigbaum

-Program Coordinator/Social Service Worker

-Communication with Mr. Cains' family over the incident.

Caleb Murray

- Program Coordinator/Social Service Worker

- Liason with BHDC and Mr. Cains and his family.

Samuel Scow

-EMS Responder

-Logan County EMS

Henry Upchurch, D.O.

-Mercy Hospital in Booneville

Tammy Benbrook

-DDS Assistant Director

INTERROGATORY NO. 2: Please identify each person from whom information or documents were obtained to respond to Plaintiff's written discovery requests, or who assisted in preparing the responses and objections to said discovery requests.

ANSWER: Respondent reserves the right to supplement this response as additional information becomes available. Respondent objects to the inclusion and production of personal information unrelated to the identified individual's professional capacity. Such information is an unwarranted invasion of privacy and is not reasonably calculated to lead to the discovery of admissible evidence. Without waiving objection, Respondent can provide the following: Please See Attachment: Names and Addresses Int 1-2-20, Bates Number CM001879.

Jeff Gonyea

Jennifer Berry

Nakita Martin

Becky Draper

Julie Street

Jennifer Bancroft

INTERROGATORY NO. 5: Please identify each person who was employed at BHDC on June 13, 2020. (For this and the below interrogatories requiring identification of individuals, please note the definition of "identify" in Definition 8.)

ANSWER: Respondent reserves the right to supplement this response as additional information becomes available. Respondent objects to the inclusion and production of personal information unrelated to the identified individual's professional capacities. Such information is an unwarranted invasion of privacy and is not reasonably calculated to lead to the discovery of admissible evidence. At this time, Respondent can provide the following: Please See Attachment: BHDC Employee 06132020 Int 5, Bates Number CM000001-CM:000007.

INTERROGATORY NO. 6: Please state every injury which David Cains has caused to another person at BHDC in all the years he resided there. For each such injury caused by David Cains, please provide the following:

a. the name of the person he injured;
    a. **ANSWER:** Respondent objects to the request to identify patients of BHDC as such information is considered confidential and protected under HIPPA.
b. how David caused the injury;
    a. **ANSWER:** Please see the attached behavior documentation. Cains David Behavior Reports for PA VA Int. 6. Bates Number: CM 000807-CM001321
c. the nature and severity of the injury;
    a. **ANSWER:** Please see the attached behavior documentation. Cains David Behavior Reports for PA VA Int. 6. Bates Number: CM 000807-CM001321
d. the date of the injury; and

a. **ANSWER:** Please see the attached behavior documentation. Cains David Behavior Reports for PA VA Int. 6. Bates Number: CM 000807-CM001321

- 04/06/2007
- 04/10/2007
- 05/21/2007
- 10/01/2008
- 11/02/2008
- 03/10/2009
- 05/12/2009
- 06/15/2009
- 11/08/2009
- 01/01/2010
- 01/12/2010
- 01/27/2010
- 02/02/2010
- 03/25/2010
- 06/07/2010
- 06/14/2010
- 06/22/2010
- 07/16/2010
- 08/04/2010
- 09/09/2010
- 09/16/2010
- 10/13/2010
- 10/18/2010
- 10/21/2010
- 10/27/2010
- 11/01/2010
- 11/02/2010
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- 12/04/2010
- 12/15/2010
- 04/06/2011
- 05/18/2011
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- 08/17/2011
- 08/29/2011
- 09/23/2011
- 11/08/2011
- 12/06/2011
- 12/29/2011
- 01/03/2012
- 01/19/2012
- 01/21/2012
- 01/25/2012
- 02/16/2012
- 03/13/2012
- 03/14/2012
- 03/18/2012
- 04/23/2012
- 05/09/2012
- 05/10/2012
- 05/11/2012
- 05/23/2012
- 05/24/2012
- 05/25/2012
- 06/15/2012

- 07/03/2012
- 07/12/2012
- 07/13/2012
- 07/19/2012
- 07/30/2012
- 07/31/2012
- 08/01/2012
- 08/07/2012
- 08/08/2012
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- 08/27/2012
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- 10/22/2012
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- 08/29/2014
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- 10/24/2014
- 01/19/2015
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- 01/29/2015
- 02/11/2015
- 03/11/2015
- 04/07/2015
- 04/17/2015
- 04/21/2015
- 05/11/2015
- 05/17/2015
- 06/03/2015
- 08/03/2015
- 08/29/2015
- 10/01/2015
- 10/05/2015
- 10/13/2015
- 10/26/2015
- 12/16/2015
- 01/25/2016
- 03/24/2016
- 04/22/2016
- 05/03/2016
- 06/07/2016
- 06/10/2016
- 06/24/2016
- 06/28/2016
- 07/03/2016
- 07/18/2016

o 07/24/2016	o 01/23/2018	o 02/21/2019
o 07/30/2016	o 03/07/2018	o 02/27/2019
o 08/24/2016	o 04/13/2018	o 02/28/2019
o 09/15/2016	o 05/12/2018	o 03/08/2019
o 10/29/2016	o 06/09/2018	o 03/19/2019
o 07/03/2017	o 06/12/2018	o 04/09/2019
o 08/17/2017	o 08/17/2018	o 10/23/2019
o 08/27/2017	o 08/22/2018	o 12/26/2019
o 09/01/2017	o 09/07/2018	o 12/30/2019
o 09/09/2017	o 12/14/2018	o 03/15/2020
o 10/23/2017	o 12/27/2018	o 04/27/2020
o 01/12/2018	o 01/26/2019	o 05/29/2020

e. identify all documents regarding the injury incident.

a. **ANSWER:** Please see the attached behavior documentation. Cains David Behavior Reports for PA VA Int. 6. Bates Number: CM 000807-CM001321.

INTERROGATORY NO. 7: Please identify the person responsible for conducting the Adult Maltreatment Investigation into David Cains' death, and state whether that person was at the time employed at BHDC.

ANSWER: Respondent reserves the right to supplement this response as additional information becomes available. Respondent objects to the inclusion and production of personal information unrelated to the identified individual's professional capacity. Such information is an unwarranted invasion of privacy and is not reasonably calculated to lead to the discovery of

admissible evidence. Without waiving objection, Respondent can provide the following: Please See Attachment: Names and Addresses Int 1-2-20, Bates Number CM001880-CM001881.

Sandra Evans

INTERROGATORY NO. 8: Please identify each person involved in the care, supervision, or treatment of David Cains from **January 1, 2018** until his death on or about June 13, 2020. As to each person please set forth the nature of each person's involvement and the time frame during which the person was involved in the care, supervision, evaluation, or treatment of Cains.

ANSWER: Respondent reserves the right to supplement this response as additional information becomes available. Respondent objects to the inclusion and production of personal information unrelated to the identified individual's professional capacity. Such information is an unwarranted invasion of privacy and is not reasonably calculated to lead to the discovery of admissible evidence. Respondent objects to the breadth of this interrogatory as written. Without waiving objection, please see the attached list of all individuals that are known to the Respondent to have been involved in the care, supervision or treatment of David Cains from January 1, 2018 through June 13, 2020. Respondent reserves the right to supplement this answer if/when new information becomes available. Attachment Name: BHDC Employees Who Provides Care Int. 8, Bates Number CM000008-CM000010.

INTERROGATORY NO. 9: Do you contend that any person or entity (including any party to this lawsuit or Mr. Cains) negligently or intentionally committed an act or omission which

caused or contributed to Cains' death, and if so, state the nature of the act or omission, and identify the person or entity in question.

ANSWER:

Mr. David Cains.

-Mr. David Cains engaged in physically aggressive behavior and property destruction during the incident. Mr. Cains advanced upon Mr. Mattson and attempted to strike Mr. Mattson. Such actions caused or contributed to the events which lead to Mr. Cains' death.

INTERROGATORY NO. 10: Please identify all sets of regulations or standards you were required to comply with at the time of Cain's death, including but not limited to those required for Medicaid reimbursement.

ANSWER:

BHDC is certified as a Medicare and/or Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFs/IID) provider through Centers for Medicaid & Medicare Services (CMS). The following link is a copy of the ICF/IID Regulations that BHDC is required to comply with: https://www.cms.gov/files/document/surveyor-guidelines

BHDC is licensed by the Arkansas Department of Human Services through the Division of Provider Services and Quality Assurance, Office of Long Term Care to maintain and operate a nursing facility on the premises located at 87 Reed Road, Hwy 116 South, Booneville, Logan County, Arkansas. BHDC is currently licensed for 138 beds with the current licensure duration of July 1, 2021 through June 20, 2022. A copy of the licensure is attached. Attachment BHDC OLTC Licensure 070121-063022 RFP 1 9, Bates Number: CM000063.

INTERROGATORY NO. 11: Please provide the name, address, and telephone number of each expert who may be called as a witness, and for each such expert provide:

(a) the subject matter on which the witness is expected to testify;

(b) the materials reviewed by each expert;

(c) the facts known to the expert which relate to or form the basis of the mental impressions and opinions held by the expert; and

(d) the dates of all reports rendered by such experts, and the names and addresses of the persons having custody of same.

ANSWER:

At this time, Respondent has not identified an expert witness. Once one or more have been retained, Respondent will supplement this response at that time.

INTERROGATORY NO. 12: Please provide the name, address, and telephone number of all lay witness whom you may call at trial of this matter and for those persons identified, please state the anticipated subject matter of their testimony.

ANSWER:

At this time, Respondent has not identified any lay witness that it will call at trial. Once one or more have been retained, Respondent will supplement this response at that time.

INTERROGATORY NO. 13: Please identify by title, author, editor, edition, publisher, date of publication and section, portion, page or pages of each and every book, treatise, periodical and/or pamphlet:

(a) established, or to be established, as a reliable authority by the testimony of any expert witness you have identified or will identify; and

(b) to be referred to during the trial testimony of any expert witness you have identified or will identify.

ANSWER:

At this time, Respondent has not identified an expert witness. Once one or more have been retained, Respondent will supplement this response at that time.

INTERROGATORY NO. 14: Do you contend there was an imminent risk of *serious* physical injury or *serious* property damage posed by David Cains on the date of his death? If so, please describe the nature of any imminent risk of *serious* physical injury or *serious* property damage.

ANSWER:

Yes, there was an imminent risk of serious physical injury posed by Mr. Cains. The incident occurred in the lobby of the Commons building with other employees and clients were nearby. The canteen, restroom, medication window, recreation room are accessed from the lobby as well as the main entrance into commons and then into the dining room. Mr. Cains exhibited dangerous behavior which posed an imminent risk to himself, other clients, employees, and property. Mr. Cains became verbally and then physically aggressive during the incident. Mr. Cains destroyed property, spit at Mr. Mattson, and advanced on and attempted to strike Mr. Mattson.

INTERROGATORY NO. 15: Please describe how the behavior of David Cains that led to his personal restraint on the day of his death constituted an "emergency situation."

ANSWER:

On June 13, 2020, Mr. Cains went to the Commons Building on BHDC's campus for his medication and lunch. Mr. Cains is visually monitored outside of his living area and any intake is supervised due to seizure precaution orders. Mr. Cains took his medication before he ate lunch. Tyler Mattson, RCT, monitored Mr. Cains during lunch. When Mr. Cains was finished with his meal, he told Mr. Mattson he needed to go to the bathroom. Mr. Mattson noted Mr. Cains seemed to be irritated and Mr. Mattson accompanied Mr. Cains to the bathroom.

Mr. Cains came out of the restroom and asked if he could sit down in the lobby to calm down. Mr. Mattson told Mr. Cains that that would be okay, and Mr. Cains sat down. Mr. Cains sat down and began screaming, cussing and ripped paper of the wall. Mr. Cains then jumped up, began spitting and attempted to hit Mr. Mattson. Mr. Mattson placed Mr. Cains in an emergency personal hold by holding Mr. Cains arms. Mr. Cains fell to the ground and Mr. Mattson fell with him. While on the floor, Mr. Cains continued to try and strike Mr. Mattson.

INTERROGATORY NO. 16: Please describe with specificity what led to David Cains becoming upset just prior to the personal restraint on the date of his death (why it is DHS believes Cains' behavior escalated on this occasion or what precipitating factors or events appeared to have caused David Cains to become distressed and agitated prior to the restraint).

ANSWER:

It is unknown at this time what exactly caused Mr. Cains to become upset just prior to the emergency personal hold being used.

INTERROGATORY NO. 17: Please describe with specificity all efforts made by staff to deescalate the behavioral situation that led to the personal restraint used on David Cains on the date of his death.

ANSWER:

The following efforts were used: Mr. Cains was noted to be irritated and allowed to leave the dining room to go to the restroom at his request, BHDC staff maintained contact with him. Mr. Cains requested and was allowed to remain in the lobby and sit in order to calm down. Mr. Cains was placed in a emergency physical hold when he charged and attempted to strike staff.

INTERROGATORY NO. 18: Please state whether BHDC staff members Tyler Mattson, Ryann Campos, and Amy "Mandy" Jones were Certified Nursing Assistants (CNAs) on the date of David Cains' death.

ANSWER:

They were not CNAs, they were RCTs.

INTERROGATORY NO. 19: Please identify David Cains' Interdisciplinary Team (IDT) for the time period of January 1, 2019 through the date of his death.

ANSWER: Respondent reserves the right to supplement this response as additional information becomes available. Respondent objects to the inclusion and production of personal information unrelated to the identified individual's professional capacity. Such information is an unwarranted invasion of privacy and is not reasonably calculated to lead to the discovery of admissible evidence. Without waiving the objections, Respondent can provide the following:

Charlene Robinson, Mother and Guardian

Chrissie McAuliffe, Sister and Advocate

Justin Jobb, Program Coordinator/QIDP

Brenda Jarrad, Team RN

Caleb Murray, Program Coordinator/Social Service Worker

Michael Alvis, Psychological Examiner

Gene Dobson, RCS

Chad Bokker, RCSS

Ashton Cobb, RCS

Nakita Martin

Chuck Hayes, RCT

Angela Yancy, RI

Audra Delay, RI

Caryn Roberts, RI

Kim Hunt, RI

John Harbison, RI

INTERROGATORY NO. 20: Please state the last known addresses and phone numbers for the following former employees of BHDC who were involved in David Cains' care:

ANSWER: Respondent reserves the right to supplement this response as additional information becomes available. Respondent objects to the inclusion and production of personal information unrelated to the identified individual's professional capacity. Such information is an unwarranted invasion of privacy and is not reasonably calculated to lead to the discovery of

admissible evidence. Without waiving the objections, Respondent can provide the following: Please See Attachment: Names and Addresses Int 1-2-20, Bates Number CM001882.

Sue Roberson (first case manager)

ANSWER: Deceased

Jennifer Berry (dorm supervisor in the early years)

ANSWER: [redacted]

Vickie Bradford (dorm staff and supervisor in the early years)

ANSWER: [redacted]

Ruth Freeman (case manager circa 2011)

ANSWER: [redacted]

Janet Campbell (nurse) circa 2011/12

ANSWER: [redacted]

Neil Berry (case manager)

ANSWER: [redacted]

Mary Nicholson (case manager circa 2014)

ANSWER: [redacted]

Ronnie Ledford (case manager circa 2015)

ANSWER: [redacted]

Audra Delay (David's work supervisor)

ANSWER: [redacted]

INTERROGATORY NO. 21: Please identify any rules, policies, or procedures at BHDC have changed since the death of David Cains, including but not limited to policies regarding calling 911.

ANSWER:

Respondent objects to the scope of this interrogatory. Such a request is not designed to elicit the discovery of potentially admissible evidence. Without waiving said objection the following policies have been changed since June 13, 2020:

- I-A-5 – Prohibition of Harmful Acts to Clients Served
- I-A-7 – Suicide Precautions
- I-A-8 – Mistreatment (Client-to-Client)
- I-B-1 – Emergency and Disaster Drills and Reporting
- I-B-3 – BHDC Library
- I-B-6 – Off Campus Trips
- I-B-11 –Transportation of Clients on Campus
- I-B-12 – State Vehicles
- I-B-15 – Inclement Weather
- I-B-17 – Buying and Selling of Items by Clients
- I-B-18 – Shift Transfers
- I-B-19 –Hepatitis Vaccine for Employees and Consultants
- I-B-22 – Cellular Phone Usage
- I-B-23 – Leave and Attendance
- I-B-24 – Use of Tobacco Products
- I-B-25 – Tuberculosis Testing

- I-B-28 – Swimming Activities and Regulations
- I-B-29 – Food/Drink Brought on Campus by Staff
- I-C-2 – Human Rights Committee
- I-C-3 – Admission Committee
- I-C-4 – Incident Review Committee
- I-C-5 – Quality Assurance Committee
- I-C-7 – Infection Control Committee
- I-D-1 – Supervision of Clients
- I-D-4 – Documentation of and Response to Maladaptive Behaviors
- I-F-1 – Personnel
- I-F-2 – On the Job Injury/Worker's Compensation
- I-F-6 – Interview Questions for the Hiring Process
- I-F-7 – Sick Leave Policy
- I-G-1 – Continuing management Audit
- I-H-1 – Comprehensive Speech/Language Pathology Services
- I-I-2 – New Employee Orientation
- I-I-3 – Training for New Employees Phase I Part 1 Orientation Training
- I-I-5 – Phase II Training for Direct Care Personnel
- I-I-6 – Supervisory/Managerial Training
- II-A-1 – Admissions and Discharges
- II-B-4 – Clients' Personal Funds Accounts
- II-E-1 – Procurement and Receipt of Goods and Services
- III-A-1 – Interdisciplinary Team

- IV-E-2 – BHDC Dental Clinic
- IV-F-1 – Physical Therapy Services
- IV-G-2 – Tuberculosis Surveillance
- IV-G-3 – Guidelines for Medical Restriction/Level of Confinement Instructions
- IV-G-4 – Infection Control Education Plan
- IV-G-5 – Infection Prevention and Control and Isolation Guidelines
- IV-H-1 – Occupational Therapy Services
- V-A-1 – Meal Times and Frequency
- V-A-4 – Modified Diets
- VI-B-2 – Rights and Responsibilities
- VI-E-1 – Interdisciplinary Team Participation
- VI-E-2 – Guardianship
- VI-F-1 – Client Leaves
- VI-G-1 – On Campus Moves
- VI-I-1 – Discharge/Referral
- VII-A-2 – Psychology Department: Animal Assisted Therapy Program
- VII-C-7 – Psychology Department: Positive Programming

• Rules, Procedures or Guideline Changes since June 13, 2020:

- Getting Medical Help
- Handling of Waste
- Leave of Absence Instructions
- Client LOA Procedure
- Weather Alert, Fire Alert, BHDC Elopement Procedures

REQUEST FOR PRODUCTION NO. 1: All documents you consulted in responding to these interrogatories.

Response: Please see the disk provided titled RFP, subfolder RFP 1.

REQUEST FOR PRODUCTION NO. 2: All documents written, signed, or recorded by any party or witness relating to the allegations of Plaintiff's Complaint and Defendant's Answer and defenses thereto.

Response: Respondent objects to this RFP to the extent it seeks the production of documents not in the possession of DHS and documents already in the possession of the Claimant. Respondent objects to the extent that it seeks documents protected by law, including the Adult Maltreatment Act (Ark. Code Ann. § 12-12-1701 et seq.) and Ark. Code Ann. § 16-46-109.

REQUEST FOR PRODUCTION NO. 3: Your privilege log, in accordance with Instruction No. 3.

Response: Please see the included privilege log located on RFP Disc.

REQUEST FOR PRODUCTION NO. 4: All documentation regarding any injury to another person caused by David Cains.

Response: Please see included behavioral reports within RFP 1. Respondent objects to further production of records on the basis of client confidentiality and HIPAA.

REQUEST FOR PRODUCTION NO. 5: Please provide a copy of any organizational chart or flow sheet setting forth the departmental organization and hierarchy of the BHDC as such existed at the time of the events set forth in Plaintiff's complaint.

Response: Please see attachment: BHDC Organizational Chart RFP 5, Bates Number CM001899-CM001908.

REQUEST FOR PRODUCTION NO. 6: All documents, including communications to or from you, related to the death of David Cains.

Response: At this time, Respondent does not have the documents ready to be produced. Respondent will be supplementing this response.

REQUEST FOR PRODUCTION NO. 7: All documents, including communications to or from you, related to the restraint incident involving David Cains on the day of his death.

Response: At this time, Respondent does not have the documents ready to be produced. Respondent will be supplementing this response.

REQUEST FOR PRODUCTION NO. 8: All communications between you and anyone else, including your employees, servants, and agents, that are related to the allegations of Plaintiff's Complaint and Defendant's Answer and defenses thereto.

Response: At this time, Respondent does not have the documents ready to be produced. Respondent will be supplementing this response.

REQUEST FOR PRODUCTION NO. 9: All documents BHDC provided to its employees, who were employed at the time of Cains' death, regarding the terms and conditions of their employment, including all employee manuals and rules.

Response: Please see Attachments:

Arkansas DHS Employee Handbook RFP 9, Bates Number CM001909-CM002138.

REQUEST FOR PRODUCTION NO. 10: Please provide copies of any policies, rules, procedures, or guidelines in effect at BHDC at the time of David Cains' death, including but not limited to those pertaining in any way to the use of restraints, such as *Use and Documentation Procedures to Manage Behavior* and *Documentation of and Response to Maladaptive Behaviors*.

Response: Please see the documents included on RFP Disc, subfolder RFP 10.

REQUEST FOR PRODUCTION NO. 11: Please provide copies of any written or recorded statements DHS or its agents or employees have obtained from the Plaintiff or any other family member of David Cains.

Response: Respondent has not identified any documents to produce at this time, if any such documents are discovered, this response will be supplemented.

REQUEST FOR PRODUCTION NO. 12: Please provide copies of any audio, photographic and video footage that concerns the occurrences identified in Plaintiff's complaint, including all photographs of David Cains taken at any point over his roughly 13 years stay at BHDC.

Response: Please see Attachment Pictures of David. Bates Number: CM002637-CM002642.

REQUEST FOR PRODUCTION NO. 13: Please provide reports and any other documents from all investigations, including internal investigations, conducted by DHS or any DHS entity, including but not limited to maltreatment investigations, including but not limited to reports and any other documents from any review or investigation performed by the Division of Provider Services and Quality Assurance (DPSQA), the Office of Long-Term Care (OLTC), the Mortality Review Committee (MRC), or DDS.

Response: Respondent objects to this request as written and will not produce the requested documents. This request for production is unduly broad and vague as to the specific information sought, seeks information concerning reports and investigations not pertinent to the current matter, including matters that are not relevant to any claim or defense of any party, and thus is irrelevant and not subject to discovery. This request is ambiguous, does not reasonably identify the information sough, and calls for information over too great a period of time. The request, as stated, would impose an unreasonable burden or expense in the course of compliance to obtain such information. The production would require the release of names, other identifying information, or other personal information with respect to non-party individuals that would expose such individuals to annoyance, embarrassment, or oppression. Additionally, many items identified in this request are confidential and not subject to disclosure or discovery under state law to include Ark. Code Ann. § 16-46-109 and Ark. Code Ann. § 12-12-1701 et seq. Without waiving objections, please see CMS-2567 063020 in RFP disc, subfolder RFP 13. Bates number CM004530-CM004531.

REQUEST FOR PRODUCTION NO. 14: Please produce a copy of all training materials that were provided to BHDC staff employed at the time of Cains' death on or about June 13, 2020.

Response: In addition to the supplied policies related to RFP 10 and RFP 23, please see the documents located in RFP Disc, subfolder RFP 14.

Annual Training
DHS Employee Handbook
HIPAA

Respondent will supplement this response as additional material is gathered.

REQUEST FOR PRODUCTION NO. 15: Please provide copies of all medical articles or medical treatises which you plan to introduce into evidence, to use in any manner at the trial of this case or to use at any deposition.

Response: Respondent has not identified an expert witness or the related documents to introduce into evidence at this time. When that occurs, Respondent will supplement this response.

REQUEST FOR PRODUCTION NO. 16: Please provide copies of any letters, documents or medical opinions which have been written by any experts, treating physicians or other physicians, or medical professionals whom you or your attorney plan on calling as expert witnesses to offer testimony at the trial of this case.

Response: Respondent has not identified an expert witness or the related documents to introduce into evidence at this time. When that occurs, Respondent will supplement this response.

REQUEST FOR PRODUCTION NO. 17: The Defendant is requested to produce the following materials with respect to each expert witness it may call at the trial of this case:

(a) A copy of the witness's most recent curriculum vitae,

(b) A complete list of all books, texts, treatises, articles, statutes, rules, regulations, guidelines or any material which has been or may be referred to or relied upon by any expert witness in forming or explaining his or her opinions in connection with this case, together with citations to specific passages or sections relied upon,

(c) A list of any computer programs, spreadsheets, analytical programs, statistical programs of any other computer-based tool utilized by any expert witness in any manner with regard to his/her opinions in this case,

(d) Copies of each spreadsheet, program, algorithm, statistical model, macro program, or other computer-based files created by or at the direction of any expert witness which has been utilized in any manner regarding his or her opinions in this case,

(e) Copies of any and all reports, correspondence, notes, documents, writings, diagrams, charts, records, photographs, video or audio recordings of any type, computer files, e-mails or tangible items of any kind that have been supplied to any expert witness by defendant, attorneys for defendant, or any representative of the defendant or defendant's attorneys,

(f) Copies of any and all reports, correspondence, notes, documents, writings, diagrams, charts, records, photographs, video, or audio recordings of any type, computer files, e-mails, or tangible items of any kind that any expert witness has provided to the defendant, attorneys for defendant, or any representative of defendant's attorneys,

(g) Copies of any and all reports, correspondence, notes, documents, writings, diagrams, charts, records, photographs, video or audio recordings of any type, computer files, e-mails, or tangible items of any kind made or prepared by any expert witness in connection with this case regardless of whether such materials were provided to any other person,

(h) Any and all billing records, bills or invoices any expert witness has prepared or provided in connection with this case.

Response: Respondent has not identified an expert witness or the related documents to introduce into evidence at this time. When that occurs, Respondent will supplement this response.

REQUEST FOR PRODUCTION NO. 18: Please provide copies of all documents which you plan to use at the trial of this case, including, but not limited to, documents which you plan on introducing into evidence and documents which you plan to or will use in the direct examination and cross-examination of witnesses at the trial of this case.

Response: Respondent has not identified any documents to introduce into evidence at this time. When that occurs, Respondent will supplement this response.

REQUEST FOR PRODUCTION NO. 19: Please provide your entire unredacted file on David Cains, including but not limited to all [redacted] and records

reflecting personal, chemical, or mechanical restraints used on David Cains throughout his time at BHDC.

Response: Many of these documents have been included throughout these Interrogatories and RFPs. Respondent will supplement this response with a complete file when such information is gathered and available.

REQUEST FOR PRODUCTION NO. 20: Please produce all minutes of the meetings of the BHDC Human Rights Committee from the time period of January 1, 2017 through January 1, 2021, as well as any reports produced by the Human Rights Committee during this time period.

Response: Respondent objects to the breadth of the information requested as such information contains confidential information. To the extent Respondent can reasonably comply, without waiving objections, please see the document entitled "Human Rights Committee" included on RFP Disc, subfolder RFP 20.

REQUEST FOR PRODUCTION NO. 21: Please produce the Human Development Center Monthly Statistical Reports provided to the DDS Board for the time period of January 1, 2017 through January 1, 2021.

Response: Please see the BHDC Statistical Reports 2017-2020 on the RFP Disc, subfolder RFP 21.

REQUEST FOR PRODUCTION NO. 22: Please produce the complete personnel files of Tyler Mattson, Amy "Mandy" Jones, and Ryann Campos.

Response: Respondent objects to the production of personal information that is not relevant to the allegations of this matter. Without waiving objection, please see the documents contained on RFP Disc, subfolder RFP 22.

REQUEST FOR PRODUCTION NO. 23: Please produce copies of any policies, rules, procedures, or guidelines at BHDC that have been modified or altered in any way since David Cains's death, including but not limited to those pertaining to calling 911.

Response: Respondent objects to the production of these documents as such requests are not reasonably calculated to lead to the discovery of admissible evidence. Without waiving said objections, please see the documents produced on RFP Disc, subfolder RFP 23.

REQUEST FOR PRODUCTION NO. 24: Please produce copies of any recorded statements that any BHDC staff or former BHDC staff have given concerning the death of David Cains, including but not limited to recorded statements given to Disability Rights Arkansas.

Response: Respondent does not currently have in its possession any recorded statements regarding the death of Mr. Cains that are subject to discovery. Respondent objects to the production of such information on the basis of confidentiality and statutory duty. Without waiving stated objections, please see the document titled "DRA Letter" in RFP Disc, subfolder RFP 24.

INTERROGATORY NO. 22: Please treat the foregoing interrogatories as continuing and furnish to Plaintiffs, in writing, any additional information received by you subsequent to the date of your answers hereto that would modify or supplement your answers, such additional information to be furnished as soon as reasonably possible after receipt by you and within a reasonable time prior to the assigned trial date in order to permit appropriate discovery procedure. Will you do so?

Response: Yes.

Respectfully submitted,

/s/ Eric Collins
Eric Collins
Ark. Bar #2017175
Ark. Dept. of Human Services
700 Main Street
P.O. Box 1437, S260
Little Rock, AR 72203
501-396-6170
eric.collins@dhs.arkansas.gov

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail on this 17th day of February, 2022.

Joshua Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501-244-0700
Attorney For Claimant

/s/ Eric Collins
Eric Collins

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Office of Chief Counsel
Eric Collins

P.O. Box 1437, Slot S-260 Little Rock, AR 72203-1437
501-396-6170 · Fax: 501-682-1390
eric.collins@dhs.arkansas.gov

March 2, 2022

Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, AR 72201

Arkansas
State Claims Commission
MAR 05 2022
RECEIVED

RE: C.M. CC220374 Filings and Discovery

Dear Claims Commission,

Please find the included discovery produced to the Claimant in the C.M. 220374 claim.

Thank you,

Eric Collins
Counsel for DHS

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains — **CLAIMANT**

Arkansas
State Claims Commission
MAR 05 2022
RECEIVED

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — **RESPONDENT**

DHS' RESPONSE TO PLAINTIFF'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION PROPOUNDED TO DEFENDANT

COMES now Respondent, by and through its attorney, Eric M. Collins, and for its supplemental responses to Claimant's First set of Interrogatories and Requests for Production, states as follows:

REQUESTS FOR PRODUCTION

REQUEST FOR PRODUCTION NO. 19: Please provide your entire unredacted file on David Cains, including but not limited to all [redacted] and records reflecting personal, chemical, or mechanical restraints used on David Cains throughout his time at BHDC.

Response: Many of these documents have been included throughout these Interrogatories and RFPs. Respondent will supplement this response with a complete file when such information is gathered and available. Please see additional documentation contained on RFP Disc 3, subfolder RFP 19.

REQUEST FOR PRODUCTION NO. 20: Please produce all minutes of the meetings of the BHDC Human Rights Committee from the time period of January 1, 2017 through January 1, 2021, as well as any reports produced by the Human Rights Committee during this time period.

Response: Respondent objects to the breadth of the information requested as such information contains confidential information. To the extent Respondent can reasonably comply, without waiving objections, please see the documents included on RFP Disc 3, subfolder RFP 20.

REQUEST FOR PRODUCTION NO. 21: Please produce the Human Development Center Monthly Statistical Reports provided to the DDS Board for the time period of January 1, 2017 through January 1, 2021.

Response: Please see the documents on the RFP Disc 3, subfolder RFP 21.

Respectfully submitted,

/s/ Eric Collins
Eric Collins
Ark. Bar #2017175
Ark. Dept. of Human Services
700 Main Street
P.O. Box 1437, S260
Little Rock, AR 72203
501-396-6170
eric.collins@dhs.arkansas.gov

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail on this 2nd day of March, 2022.

Joshua Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501-244-0700
Attorney For Claimant

/s/ Eric Collins
Eric Collins

From: Dana Henderson
To: ASCC Pleadings
Cc: Joshua Gillispie; Eric Collins; Garrett Grellner
Subject: Claim No. 22037
Date: Wednesday, March 9, 2022 5:31:44 PM
Attachments: Notice of Deposition. Tyler Mattson.pdf
Notice of Deposition. Michael Alvis.pdf

Claims Commission:

Please find attached for filing, a *Notice to take Deposition of Tyler Mattson* and a *Notice to take Deposition of Michael Alvis* regarding the above-referenced claim.

Thank you for your time and attention to this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

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This message does not create an attorney-client relationship.

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF TYLER MATTSON

TO: **TYLER MATTSON**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on March 31, 2022, beginning at 9:00 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter and videographer:

Tyler Mattson

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, March 31, 2022 at 9:00 AM (Central Time)**

LOCATION: Department of Human Services
700 Main Street
Little Rock, AR 72203

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 9th day of March, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS	**CLAIMANT**
VS. **CLAIM NO. 220374**	
THE ARKANSAS DEPT. OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)	**RESPONDENT**

NOTICE TO TAKE DEPOSITION OF MICHAEL ALVIS

TO: **Michael Alvis**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on March 31, 2022, beginning at 9:00 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter and videographer:

Michael Alvis

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, March 31, 2022 at 9:00 AM (Central Time)**

LOCATION: Department of Human Services
700 Main Street
Little Rock, AR 72203

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 9th day of March, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From:	Garrett Grellner
To:	ASCC Pleadings
Cc:	Joshua Gillispie; Eric Collins
Subject:	Claim No. 220374
Date:	Thursday, March 10, 2022 1:19:51 PM
Attachments:	Subpoena Don Carter.pdf Subpoena Samuel Scow.pdf Subpoena Sandy Evans.pdf Subpoena Ryann Campos.pdf Green-and-gillispie-attorneys-at-law-logo.png

---

Claims Commission,

Please find attached the following documents below for filing:

- Notice to take Deposition of Don Carter
- Notice to take Deposition of Samuel Scow
- Notice to take Deposition of Sandy Evans
- Notice to take Deposition of Ryann Campos

Thank you for your time and attention to this matter.

Best,

Garrett A. Grellner

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

Leave a Google Review for Green & Gillispie!

This email may contain material that is confidential and protected by attorney-client privilege. If you received this message by mistake, or are not the intended recipient of this message please destroy and notify the sender. This message does not create an attorney-client relationship.

Issued by the

CLAIMS COMMISSION

OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS

v.

THE ARKANSAS DEPT. OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)

SUBPOENA IN A CIVIL CASE

CLAIM NUMBER 220374

TO: Don Carter

[redacted]

☐ YOU ARE COMMANDED to appear in the _____ Court of _____ County, Arkansas, at the place, date, and time specified below to testify in the above case.

Place of Testimony	Courtroom
	Date and Time

☑ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Place of Deposition	Date and Time
Green & Gillispie 1 Riverfront Pl. Suite 605 North Little Rock, AR 72114	April 21, 2022 at 9 A.M.

☐ YOU ARE COMMANDED, at the time of the trial, hearing or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

☐ YOU ARE COMMANDED, no more than _____business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Arkansas Rules of Civil Procedure 30(b)(6).

Issued by the

CLAIMS COMMISSION

OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS

v.

THE ARKANSAS DEPT. OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)

SUBPOENA IN A CIVIL CASE

CLAIM NUMBER 220374

TO: Sandy Evans
[redacted]

☐ YOU ARE COMMANDED to appear in the _____ Court of _____ County, Arkansas, at the place, date, and time specified below to testify in the above case.

Place of Testimony	Courtroom
	Date and Time

☑ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Place of Deposition	Date and Time
Green & Gillispie 1 Riverfront Pl. Suite 605 North Little Rock, AR 72114	April 21, 2022 at 9 A.M.

☐ YOU ARE COMMANDED, at the time of the trial, hearing or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

☐ YOU ARE COMMANDED, no more than _____business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Arkansas Rules of Civil Procedure 30(b)(6).

Attorney for Plaintiff

Issuing Officer Signature and Title (Indicate if Attorney for Plaintiff or Defendant) Date

Issuing Officer's Name, Address, and Phone Number

PROOF OF SERVICE

SERVED Date Place

Served on (Print name) Manner of Service

Served by (Print name) Title

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
Date Signature of Server

_____
Address of Server

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the trial or hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Rule 45(d), Ark. R. Civ. P.

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Rule 45(e), Ark. R. Civ. P.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Rule 45(b), Ark. R. Civ. P. The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the court. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Rule 45(e), Ark. R. Civ. P.

When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the court may issue a warrant for arresting and bringing the witness before the court to give testimony and answer for contempt. Rule 45(g), Ark. R. Civ. P.

Issued by the

CLAIMS COMMISSION

OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS

v.

THE ARKANSAS DEPT. OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)

SUBPOENA IN A CIVIL CASE

CLAIM NUMBER 220374

TO: Samuel Scow

[redacted]

☐ YOU ARE COMMANDED to appear in the _____ Court of _____ County, Arkansas, at the place, date, and time specified below to testify in the above case.

Place of Testimony	Courtroom
	Date and Time

☑ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Place of Deposition	Date and Time
Green & Gillispie 1 Riverfront Pl. Suite 605 North Little Rock, AR 72114	April 21, 2022 at 9 A.M.

☐ YOU ARE COMMANDED, at the time of the trial, hearing or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

☐ YOU ARE COMMANDED, no more than _____business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Arkansas Rules of Civil Procedure 30(b)(6).

Attorney for Plaintiff

Issuing Officer Signature and Title (Indicate if Attorney for Plaintiff or Defendant) Date

Issuing Officer's Name, Address, and Phone Number

PROOF OF SERVICE

SERVED Date Place

Served on (Print name) Manner of Service

Served by (Print name) Title

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
Date Signature of Server

_____
Address of Server

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the trial or hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Rule 45(d), Ark. R. Civ. P.

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Rule 45(e), Ark. R. Civ. P.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Rule 45(b), Ark. R. Civ. P. The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the court. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Rule 45(e), Ark. R. Civ. P.

When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the court may issue a warrant for arresting and bringing the witness before the court to give testimony and answer for contempt. Rule 45(g), Ark. R. Civ. P.

Issued by the

CLAIMS COMMISSION

OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS

v.

THE ARKANSAS DEPT. OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)

SUBPOENA IN A CIVIL CASE

CLAIM NUMBER 220374

TO: Ryann Campos
[redacted]

☐ YOU ARE COMMANDED to appear in the _____ Court of _____ County, Arkansas, at the place, date, and time specified below to testify in the above case.

Place of Testimony	Courtroom
	Date and Time

☑ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Place of Deposition	Date and Time
Green & Gillispie 1 Riverfront Pl. Suite 605 North Little Rock, AR 72114	April 21, 2022 at 9 A.M.

☐ YOU ARE COMMANDED, at the time of the trial, hearing or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

☐ YOU ARE COMMANDED, no more than _____business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Arkansas Rules of Civil Procedure 30(b)(6).

Attorney for Plaintiff

Issuing Officer Signature and Title (Indicate if Attorney for Plaintiff or Defendant) Date

Issuing Officer's Name, Address, and Phone Number

PROOF OF SERVICE

SERVED Date Place

Served on (Print name) Manner of Service

Served by (Print name) Title

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
Date Signature of Server

_____
Address of Server

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the trial or hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Rule 45(d), Ark. R. Civ. P.

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When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the court may issue a warrant for arresting and bringing the witness before the court to give testimony and answer for contempt. Rule 45(g), Ark. R. Civ. P.

From: Garrett A. Grellner
To: ASCC Pleadings
Cc: Joshua Gillispie; Eric Collins
Subject: RE: Claim No. 220374
Date: Thursday, March 10, 2022 2:21:57 PM

Claims Commission,

I apologize on the wording of my last email. The attachments in the list I had were incorrectly named. The attachments are Subpoenas that we are submitting to the Claims Commission to be issued. Not Notices to take deposition.

Best,

Garrett A. Grellner

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

From: Garrett Grellner
Sent: Thursday, March 10, 2022 1:19 PM
To: Pleadings Ascc
Cc: Joshua Gillispie; Eric Collins
Subject: Claim No. 220374

Claims Commission,

Please find attached the following documents below for filing:

- Notice to take Deposition of Don Carter
- Notice to take Deposition of Samuel Scow
- Notice to take Deposition of Sandy Evans
- Notice to take Deposition of Ryann Campos

Thank you for your time and attention to this matter.

Best,

Arkansas
State Claims Commission

MAR 10 2022

RECEIVED

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) **RESPONDENT**

DHS' SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION PROPOUNDED TO DEFENDANT

COMES now Respondent, by and through its attorney, Eric M. Collins, and for its supplemental response to Claimant's First set of Interrogatories and Requests for Production, states as follows:

REQUEST FOR PRODUCTION NO. 19: Please provide your entire unredacted file on David Cains, including but not limited to all [redacted] nd records reflecting personal, chemical, or mechanical restraints used on David Cains throughout his time at BHDC.

Response: Please find the documents included in the disc titled RFP Disc 4.

Respectfully submitted,

/s/ Eric Collins
Eric Collins
Ark. Bar #2017175
Ark. Dept. of Human Services
700 Main Street
P.O. Box 1437, S260
Little Rock, AR 72203
501-396-6170
eric.collins@dhs.arkansas.gov

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail and certified mail on this 4th day of March, 2022.

Joshua Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501-244-0700
Attorney For Claimant

/s/ Eric Collins
Eric Collins

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Office of Chief Counsel
Eric Collins

P.O. Box 1437, Slot S-260 Little Rock, AR 72203-1437
501-396-6170 · Fax: 501-682-1390
eric.collins@dhs.arkansas.gov

March 11, 2022

Arkansas
State Claims Commission
MAR 15 2022
RECEIVED

Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, AR 72201

RE: C.M. CC220374 Filings and Discovery

Dear Claims Commission,

Please find the included discovery produced to the Claimant in the C.M. 220374 claim.

Thank you,

Eric Collins
Counsel for DHS

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) **RESPONDENT**

DHS' SUPPLEMENTAL RESPONSE TO PLAINTIFF'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION PROPOUNDED TO DEFENDANT

COMES now Respondent, by and through its attorney, Eric M. Collins, and for its supplemental response to Claimant's First set of Interrogatories and Requests for Production, states as follows:

REQUEST FOR PRODUCTION NO. 19: Please provide your entire unredacted file on David Cains, including but not limited to all [redacted] and records reflecting personal, chemical, or mechanical restraints used on David Cains throughout his time at BHDC.

Response: Please find the documents included in the disc titled RFP Disc 5.

Respectfully submitted,

/s/ Eric Collins
Eric Collins
Ark. Bar #2017175
Ark. Dept. of Human Services
700 Main Street
P.O. Box 1437, S260
Little Rock, AR 72203
501-396-6170
eric.collins@dhs.arkansas.gov

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail and certified mail on this 11th day of March, 2022.

Joshua Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501-244-0700
Attorney For Claimant

/s/ Eric Collins
Eric Collins

From:	Kathryn Irby
To:	Garrett Grellner
Cc:	Joshua Gillispie; Eric Collins
Subject:	SUBPOENAS ISSUED: Claim No. 220374
Date:	Monday, March 21, 2022 10:48:00 AM
Attachments:	McAuliffe -- 220374 -- subpoena for Carter.pdf McAuliffe -- 220374 -- subpoena for Scow.pdf McAuliffe -- 220374 -- subpoena for Evans.pdf McAuliffe -- 220374 -- subpoena for Campos.pdf image001.png

Mr. Grellner, please see attached. I apologize for the delay in issuing these.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From: Garrett Grellner <garrett@greenandgillispie.com>
Sent: Thursday, March 10, 2022 1:19 PM
To: ASCC Pleadings <asccpleadings@arkansas.gov>
Cc: Joshua Gillispie <josh@greenandgillispie.com>; Eric Collins <eric.collins@dhs.arkansas.gov>
Subject: Claim No. 220374

Claims Commission,

Please find attached the following documents below for filing:

- Notice to take Deposition of Don Carter
- Notice to take Deposition of Samuel Scow
- Notice to take Deposition of Sandy Evans
- Notice to take Deposition of Ryann Campos

Thank you for your time and attention to this matter.

Best,

Garrett A. Grellner



1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

Leave a Google Review for Green & Gillispie!

This email may contain material that is confidential and protected by attorney-client privilege. If you received this message by mistake, or are not the intended recipient of this message please destroy and notify the sender. This message does not create an attorney-client relationship.

Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Don Carter**
[redacted]

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Green & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

April 21, 2022, at 9:00 a.m.

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):

March 21, 2022

Kathryn Irby, Director
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

Date

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d), Claims Commission Rule 3.2(d).

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Ark. R. Civ. Proc. 45(e), Claims Commission Rule 3.3.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Samuel Scow**
[redacted]

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Green & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

April 21, 2022, at 9:00 a.m.

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):



March 21, 2022

_____ _____
Kathryn Irby, Director Date
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d), Claims Commission Rule 3.2(d).

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A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Sandy Evans**
[redacted]

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Green & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

April 28, 2022, at 9:00 a.m.

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):



March 21, 2022

_____ _____
Kathryn Irby, Director Date
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d), Claims Commission Rule 3.2(d).

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Ark. R. Civ. Proc. 45(e), Claims Commission Rule 3.3.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Ryann Campos**
[redacted]

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Green & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

April 28, 2022, at 9:00 a.m.

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_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):



March 21, 2022

_____ _____
Kathryn Irby, Director Date
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

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Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d), Claims Commission Rule 3.2(d).

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A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

From: Dana Henderson
To: ASCC Pleadings
Cc: Joshua Gillispie; Eric Collins; Garrett Grellner
Subject: Claim No. 22037
Date: Friday, April 8, 2022 11:59:51 AM
Attachments: Notice of Deposition. Justin Jobb.pdf

Claims Commission:

Please find attached for filing, Mr. Gillispie's *Notice to take Deposition of Justin Jobb* regarding the above-referenced claim.

Thank you for your time and attention to this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501.244.0700 (p); 501.244.2020 (f)
www.greenandgillispie.com

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF JUSTIN JOBB

TO: **JUSTIN JOBB**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on April 21, 2022, beginning at 9:00 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Justin Jobb

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, April 21, 2022 at 9:00 AM (Central Time)**

LOCATION: This matter will be held remotely, via **ZOOM**; the link to join the Zoom meeting will be emailed directly to counsel.

COURT REPORTER: Brasuell Reporting, LLC

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 8th day of April, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From: Garrett Grellner
To: ASCC Pleadings
Cc: Joshua Gillispie
Subject: Claim No. 220374
Date: Tuesday, April 12, 2022 12:01:39 PM
Attachments: Subpoena Ryann Campos.pdf
Subpoena Sandy Evans.pdf
Green-and-gillispie-attorneys-at-law-logo.png

Claims Commission,

Please find attached Subpoenas for Ryann Campos and Sandy Evans for filing and issuing back to us.

Thank you for your time and attention to this matter,

Best,

Garrett A. Grellner
Attorney

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

Leave a Google Review for Green & Gillispie!

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Issued by the

CLAIMS COMMISSION

OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS

v.

THE ARKANSAS DEPT. OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)

SUBPOENA IN A CIVIL CASE

CLAIM NUMBER 220374

TO: Ryann Campos
[redacted]

☐ YOU ARE COMMANDED to appear in the _____ Court of _____ County, Arkansas, at the place, date, and time specified below to testify in the above case.

Place of Testimony	Courtroom
	Date and Time

☑ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Place of Deposition	Date and Time
Green & Gillispie 1 Riverfront Pl. Suite 605 North Little Rock, AR 72114	April 21, 2022 at 9 A.M.

☐ YOU ARE COMMANDED, at the time of the trial, hearing or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

☐ YOU ARE COMMANDED, no more than _____business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Arkansas Rules of Civil Procedure 30(b)(6).

Attorney for Plaintiff

Issuing Officer Signature and Title (Indicate if Attorney for Plaintiff or Defendant) Date

Issuing Officer's Name, Address, and Phone Number

PROOF OF SERVICE

SERVED Date Place

Served on (Print name) Manner of Service

Served by (Print name) Title

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
Date Signature of Server

_____
Address of Server

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the trial or hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Rule 45(d), Ark. R. Civ. P.

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Rule 45(e), Ark. R. Civ. P.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Rule 45(b), Ark. R. Civ. P. The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the court. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Rule 45(e), Ark. R. Civ. P.

When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the court may issue a warrant for arresting and bringing the witness before the court to give testimony and answer for contempt. Rule 45(g), Ark. R. Civ. P.

Issued by the

CLAIMS COMMISSION

OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS

v.

THE ARKANSAS DEPT. OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)

SUBPOENA IN A CIVIL CASE

CLAIM NUMBER 220374

TO: Sandy Evans

[redacted]

☐ YOU ARE COMMANDED to appear in the _____ Court of _____ County, Arkansas, at the place, date, and time specified below to testify in the above case.

Place of Testimony	Courtroom
	Date and Time

☑ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Place of Deposition	Date and Time
Green & Gillispie 1 Riverfront Pl. Suite 605 North Little Rock, AR 72114	April 21, 2022 at 9 A.M.

☐ YOU ARE COMMANDED, at the time of the trial, hearing or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

☐ YOU ARE COMMANDED, no more than _____business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Arkansas Rules of Civil Procedure 30(b)(6).

Attorney for Plaintiff

Issuing Officer Signature and Title (Indicate if Attorney for Plaintiff or Defendant) Date

Issuing Officer's Name, Address, and Phone Number

PROOF OF SERVICE

SERVED Date Place

Served on (Print name) Manner of Service

Served by (Print name) Title

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
Date Signature of Server

_____
Address of Server

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the trial or hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Rule 45(d), Ark. R. Civ. P.

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From:	Kathryn Irby
To:	Garrett Grellner
Bcc:	Misty Scott
Subject:	SUBPOENAS: McAuliffe v. DHS, Claim No. 220374
Date:	Tuesday, April 12, 2022 3:11:00 PM
Attachments:	Green-and-gillispie-attorneys-at-law-logo.png Evans subpoena.pdf Campos subpoena.pdf

Mr. Grellner, please see attached subpoenas.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From: Garrett Grellner <garrett@greenandgillispie.com>
Sent: Tuesday, April 12, 2022 12:01 PM
To: ASCC Pleadings <asccpleadings@arkansas.gov>
Cc: Joshua Gillispie <josh@greenandgillispie.com>
Subject: Claim No. 220374

Claims Commission,

Please find attached Subpoenas for Ryann Campos and Sandy Evans for filing and issuing back to us.

Thank you for your time and attention to this matter,

Best,

Garrett A. Grellner
Attorney

1 Riverfront Place, Suite 605
North Little Rock, AR 72114

(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

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Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Sandy Evans**
[redacted]

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Green & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

May 5, 2022, at 9:00 a.m.

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):



April 12, 2022

_____ _____
Kathryn Irby, Director Date
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

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Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Ryann Campos**
[redacted]

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

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Green & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

May 12, 2022, at 9:00 a.m.

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_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):



April 12, 2022

Kathryn Irby, Director
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

Date

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

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From: Garrett Grellner
To: Kathryn Irby
Subject: Re: SUBPOENAS: McAuliffe v. DHS, Claim No. 220374
Date: Wednesday, April 13, 2022 9:58:17 AM
Attachments: Green-and-gillispie-attorneys-at-law-logo.png

Received.

Thank you.

> On Apr 12, 2022, at 3:11 PM, Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:
>
> Mr. Grellner, please see attached subpoenas.
>
> Thanks,
> Kathryn Irby
>
> **Kathryn Irby**
> **Arkansas State Claims Commission**
> 101 East Capitol Avenue, Suite 410
> Little Rock, Arkansas 72201
> (501) 682-2822
>
> ---
>
> **From:** Garrett Grellner <garrett@greenandgillispie.com>
> **Sent:** Tuesday, April 12, 2022 12:01 PM
> **To:** ASCC Pleadings <asccpleadings@arkansas.gov>
> **Cc:** Joshua Gillispie <josh@greenandgillispie.com>
> **Subject:** Claim No. 220374
>
> Claims Commission,
>
> Please find attached Subpoenas for Ryann Campos and Sandy Evans for filing and issuing back to us.
>
> Thank you for your time and attention to this matter,
>
> Best,
>
> Garrett A. Grellner
> Attorney
>
> <Green-and-gillispie-attorneys-at-law-logo.png>

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

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This message does not create an attorney-client relationship.

<Evans subpoena.pdf><Campos subpoena.pdf>

Garrett A. Grellner
Attorney



1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

Leave a Google Review for Green & Gillispie!

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This message does not create an attorney-client relationship.

From: Dana Henderson
To: ASCC Pleadings
Cc: Joshua Gillispie; Eric Collins; Garrett Grellner
Subject: Claim No. 22037
Date: Thursday, April 14, 2022 11:29:26 AM
Attachments: Notice of Deposition. Mark Hise.pdf
Notice of Deposition. Angela Nelson.pdf

Claims Commission:

Please find attached for filing, Mr. Gillispie's *Notice to take Deposition of Angela Nelson* and *Notice to take Deposition of Mark Hise* regarding the above-referenced claim.

Thank you for your time and attention to this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501.244.0700 (p); 501.244.2020 (f)
www.greenandgillispie.com

This email may contain material that is confidential and protected by attorney-client privilege. If you received this message by mistake or are not the intended recipient of this message, please destroy and notify the sender.
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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF MARK HISE

TO: **Mark Hise**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on May 12, 2022, beginning at 9:00 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Mark Hise

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, May 12, 2022 at 9:00 AM (Central Time)**

LOCATION: This matter will be held remotely, via **ZOOM**;

The link to join the Zoom Meeting will be provided directly to counsel.

COURT REPORTER: Brasuell Reporting

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 14th day of April, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF ANGELA NELSON

TO: **ANGELA NELSON**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on May 5, 2022, beginning at 9:00 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Angela Nelson

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, May 5, 2022 at 9:00 AM (Central Time)**

LOCATION: This matter will be held remotely, via **ZOOM**;

The link to join the Zoom Meeting will be provided directly to counsel.

COURT REPORTER: Brasuell Reporting

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
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josh@greenandgillispie.com

CERTIFICATE OF SERVICE

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Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From:	Garrett Grellner
To:	ASCC Pleadings
Cc:	Joshua Gillispie
Subject:	Claim No. 220374
Date:	Tuesday, April 19, 2022 10:06:22 AM
Attachments:	Proof of Service- Campos .pdf Green-and-gillispie-attorneys-at-law-logo.png

Claims Commission,

Please find attached Proof of Service of Ryann Campos for filing.

Best,

Garrett A. Grellner
Attorney

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

Leave a Google Review for Green & Gillispie!

This email may contain material that is confidential and protected by attorney-client privilege. If you received this message by mistake, or are not the intended recipient of this message please destroy and notify the sender. This message does not create an attorney-client relationship.

Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Ryann Campos**
[redacted]

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Green & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

May 12, 2022, at 9:00 a.m.

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):

April 12, 2022

Kathryn Irby, Director
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

Date

PROOF OF SERVICE

Ryan Campos
SERVED ON (Print Name)

4-16-22
DATE

[redacted]
PLACE

Personal
MANNER OF SERVICE

Cody Patton
SERVED BY (Print Name)

Process Server
TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on APR 18 2022
DATE

BPS 17-11, LS17-14
SIGNATURE OF SERVER

P.O. Box 2384
Bentonville, AR 72712
ADDRESS OF SERVER

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d). Claims Commission Rule 3.2(d).

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Ark. R. Civ. Proc. 45(e), Claims Commission Rule 3.3.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

From: Kathryn Irby
To: Joshua Gillispie
Cc: Eric Collins
Subject: RE: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374
Date: Monday, April 25, 2022 1:34:55 PM

Mr. Gillispie and Mr. Collins, how long do the parties think that the hearing will take? How many live witnesses and how many witnesses' testimony will be submitted through deposition?
Thanks,
Kathryn Irby

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Friday, April 22, 2022 11:38 AM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Re: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374
Ms. Irby:
The parties have made significant progress in conducting discovery. I conferred with Mr. Collins today and we feel that we will likely be done with discovery by September.
Would now be a good time to look at having this matter added to the hearing docket?
Best regards,
Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Mon, Feb 7, 2022 at 11:39 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie and Mr. Collins,
> The Claims Commission has reviewed Mr. Gillispie's request for a hearing in the above-referenced claim and would like for the parties to conduct discovery prior to the scheduling of this claim for hearing, especially given the amount in controversy. When discovery is nearing completion, please contact me to get this claim added to the hearing docket.
> Thanks,
> Kathryn Irby
> **Kathryn Irby**
> **Arkansas State Claims Commission**
> 101 East Capitol Avenue, Suite 410
> Little Rock, Arkansas 72201
> (501) 682-2822
>
> **From:** Joshua Gillispie <josh@greenandgillispie.com>
> **Sent:** Thursday, February 3, 2022 1:54 PM

To: Caitlin McDaniel <Caitlin.McDaniel@arkansas.gov>
Cc: ASCC New Claims <ASCC.New.Claims@arkansas.gov>; Dana Henderson <dana@greenandgillispie.com>; Kathryn Irby <Kathryn.Irby@arkansas.gov>; Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Christine McAuliffe; Claim No. 220374

Ms. McDaniel:

If possible, I would like to set this matter for a hearing. I would appreciate any guidance you can provide me on what my office needs to do in order to get a setting. The respondent agency, DHS, has denied liability in their answer. Their attorney, Eric Collins, has been copied on this email. Thank you for your assistance.

Josh

Joshua D. Gillispie

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North Little Rock, AR 72114
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(501) 244-2020 fax
www.greenandgillispie.com

From: Kathryn Irby
To: Joshua Gillispie
Cc: Eric Collins; OCC Claims Commission Cases
Subject: HEARING INFO: McAuliffe v. DHS, Claim No. 220374
Date: Tuesday, April 26, 2022 11:28:00 AM
Attachments: McAuliffe v. DHS -- 220374 -- hearing info.pdf

Mr. Collins, I spoke with Mr. Gillispie yesterday when he called with a question about submitting deposition testimony, and he and I discussed possible hearing dates. To allow for a full day of hearings, it looks like January 20, 2023, is our best bet.

Mr. Gillispie and Mr. Collins, to that end, I am attaching a hearing letter. If this date is unworkable for Mr. Collins, we can go back to the drawing board.

Thanks,
Kathryn Irby

From: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Sent: Monday, April 25, 2022 1:35 PM
To: Joshua Gillispie <josh@greenandgillispie.com>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: RE: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374

Mr. Gillispie and Mr. Collins, how long do the parties think that the hearing will take? How many live witnesses and how many witnesses' testimony will be submitted through deposition?

Thanks,
Kathryn Irby

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Sent: Friday, April 22, 2022 11:38 AM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Re: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374

Ms. Irby:

The parties have made significant progress in conducting discovery. I conferred with Mr. Collins today and we feel that we will likely be done with discovery by September.

Would now be a good time to look at having this matter added to the hearing docket?

Best regards,

Josh

Joshua D. Gillispie

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> Thanks,
> Kathryn Irby
>
> **Kathryn Irby**
> **Arkansas State Claims Commission**
> 101 East Capitol Avenue, Suite 410
> Little Rock, Arkansas 72201
> (501) 682-2822
>
> ---
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> **From:** Joshua Gillispie <josh@greenandgillispie.com>
> **Sent:** Thursday, February 3, 2022 1:54 PM
> **To:** Caitlin McDaniel <Caitlin.McDaniel@arkansas.gov>
> **Cc:** ASCC New Claims <ASCC.New.Claims@arkansas.gov>; Dana Henderson <dana@greenandgillispie.com>; Kathryn Irby <Kathryn.Irby@arkansas.gov>; Eric Collins <Eric.Collins@dhs.arkansas.gov>
> **Subject:** Christine McAuliffe; Claim No. 220374
>
> Ms. McDaniel:
>
> If possible, I would like to set this matter for a hearing. I would appreciate any guidance you can provide me on what my office needs to do in order to get a setting. The respondent agency, DHS, has denied liability in their answer. Their attorney, Eric Collins, has been copied on this email.

Thank you for your assistance.

Josh

Joshua D. Gillispie

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ARKANSAS STATE CLAIMS COMMISSION

(501) 682-1619
FAX (501) 682-2823

KATHRYN IRBY
DIRECTOR

101 EAST CAPITOL AVENUE
SUITE 410
LITTLE ROCK, ARKANSAS
72201-3823

April 26, 2022

Mr. Joshua Gillispie (*via email*)
Green & Gillispie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

Mr. Eric M. Collins (*via email*)
Arkansas Department of Human Services
Post Office Box 1437, Slot S260
Little Rock, Arkansas 72203

RE: ***Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services***
Claim No. 220374

Dear Mr. Gillispie and Mr. Collins,

The Claims Commission has scheduled this claim for hearing on **Friday, January 20, 2023**, beginning at 9:00 a.m. All parties will attend via Zoom. If either party objects to a Zoom format, a written objection must be submitted via email (kathryn.irby@arkansas.gov) or mail no later than May 2, 2022. The Zoom invitation is enclosed.

Each party's witness lists, exhibit lists, and exhibits are due by Friday, December 16, 2022. If the parties would like for the Claims Commission to review prehearing briefs, the briefs are due at the same time. If the parties will be submitting any testimony by deposition, those deposition transcripts are due at the same time.

To the extent that either party intends to file a motion of any kind, absent a showing of good cause, the motion must be submitted in sufficient time to allow the motion to be fully briefed by December 16, 2022.

Please note that a copy of any filing must be served upon the opposing party via U.S. Mail in accordance with the Arkansas Rules of Civil Procedure.

If you have any questions, please do not hesitate to contact my office.

Sincerely,

Kathryn Irby

ES: kmirby

The Claims Commission is inviting you to a scheduled Zoom meeting.

Topic: Claims Commission -- hearings
Time: Jan 20, 2023 09:00 AM Central Time (US and Canada)

Join Zoom Meeting
https://us06web.zoom.us/j/85398685548?pwd=MC9LTmwvdW5tdTJXUXp0Rk1MNTlNdz09

Meeting ID: 853 9868 5548
Passcode: 2Txirf
One tap mobile
+13017158592,,85398685548#,,,,*461703# US (Washington DC)
+13126266799,,85398685548#,,,,*461703# US (Chicago)

Dial by your location
+1 301 715 8592 US (Washington DC)
+1 312 626 6799 US (Chicago)
+1 929 436 2866 US (New York)
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 669 900 6833 US (San Jose)
Meeting ID: 853 9868 5548
Passcode: 461703
Find your local number: https://us06web.zoom.us/u/kXvGCepZL

From: Joshua Gillispie
To: Kathryn Irby
Cc: Eric Collins; OCC Claims Commission Cases
Subject: Re: HEARING INFO: McAuliffe v. DHS, Claim No. 220374
Date: Tuesday, April 26, 2022 3:43:26 PM

Ms. Irby:

Received. Thank you.

Josh

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Tue, Apr 26, 2022 at 11:29 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> **Mr. Collins**, I spoke with Mr. Gillispie yesterday when he called with a question about submitting deposition testimony, and he and I discussed possible hearing dates. To allow for a full day of hearings, it looks like January 20, 2023, is our best bet.
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> Thanks,
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> Kathryn Irby
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> **From:** Kathryn Irby <Kathryn.Irby@arkansas.gov>
> **Sent:** Monday, April 25, 2022 1:35 PM
> **To:** Joshua Gillispie <josh@greenandgillispie.com>
> **Cc:** Eric Collins <Eric.Collins@dhs.arkansas.gov>
> **Subject:** RE: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374
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Would now be a good time to look at having this matter added to the hearing docket?

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Thank you for your assistance.

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Joshua D. Gillispie

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From: Eric Collins
To: Joshua Gillispie; Kathryn Irby
Cc: OCC Claims Commission Cases
Subject: RE: HEARING INFO: McAuliffe v. DHS, Claim No. 220374
Date: Thursday, April 28, 2022 8:26:36 AM

Thank you for the update. I am out of the office on an emergency basis this week. I will review my schedule early next week and get back with everybody.

Given how far out that is, I don't imagine I will have any conflicts.

Thank you,

Eric M. Collins
Attorney
Arkansas Department of Human Services
Office of Chief Counsel
Office: (501) 396-6170
Cell: (501) 295-6356

This email may contain sensitive information.

Confidentiality Notice: The information contained in this email message and any attachment(s) is the property of the State of Arkansas and may be protected by state and federal laws governing disclosure of private information. It is intended solely for the use of the entity to whom this email is addressed. If you are not the intended recipient, you are hereby notified that reading, copying or distributing this transmission is STRICTLY PROHIBITED. The sender has not waived any applicable privilege by sending the accompanying transmission. If you have received this transmission in error, please notify the sender by return and delete the message and attachment(s) from your system.

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Tuesday, April 26, 2022 3:43 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
Subject: Re: HEARING INFO: McAuliffe v. DHS, Claim No. 220374

[EXTERNAL SENDER]
Ms. Irby:

Received. Thank you.

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Joshua D. Gillispie



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From: Dana Henderson
To: ASCC Pleadings
Cc: Joshua Gillispie; Garrett Grellner; Eric Collins
Subject: Claim No. 22037
Date: Monday, May 9, 2022 12:51:07 PM
Attachments: Notice of Deposition.Jonathon McCutcheon.pdf

Claims Commission:

Please find attached for filing, Mr. Gillispie's *Notice to take Deposition of Jonathon McCutcheon* regarding the above-referenced claim.

Thank you for your time and attention to this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501.244.0700 (p); 501.244.2020 (f)
www.greenandgillispie.com

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS	**CLAIMANT**
VS.	**CLAIM NO. 220374**
THE ARKANSAS DEPT. OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)	**RESPONDENT**

NOTICE TO TAKE DEPOSITION OF JONATHON MCCUTCHEON

TO: **JONATHON MCCUTCHEON**
[redacted]

Please take notice that on May 26, 2022, beginning at 1:00 p.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Jonathon McCutcheon

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, May 26, 2022 at 1:00 PM (Central Time)**

LOCATION: This matter will be held remotely, via **ZOOM**;

The link to join the Zoom meeting will be provided via email.

COURT REPORTER: Kristina R. Gray, CCR

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was sent for filing on this 9th day of May, 2022, and a true and correct copy was sent via certified U.S. Mail to the following:

Jonathon McCutcheon
[redacted]

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From: Kathryn Irby
To: Joshua Gillispie; Eric Collins
Cc: OCC Claims Commission Cases
Subject: RE: HEARING INFO: McAuliffe v. DHS, Claim No. 220374
Date: Monday, May 16, 2022 8:13:00 AM

Mr. Collins, I can push the prehearing material deadline to December 28, 2022.

Good luck with the military training.

Thanks,
Kathryn Irby

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Saturday, May 14, 2022 2:54 PM
To: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Cc: Kathryn Irby <Kathryn.Irby@arkansas.gov>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
Subject: Re: HEARING INFO: McAuliffe v. DHS, Claim No. 220374

Ms. Irby:

I have no objection to Mr. Collins' request. I will have Plaintiff's papers submitted by December 16th because I will be tied up with the holidays following the 16th, but I have no objection to Eric's request.

Josh

Joshua D. Gillispie

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North Little Rock, AR 72114
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> Hey Ms. Irby,
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Thank you,

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Attorney
Arkansas Department of Human Services
Office of Chief Counsel
Office: (501) 396-6170
Cell: (501) 295-6356

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Subject: Christine McAuliffe; Claim No. 220374

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From:	Kathryn Irby
To:	Joshua Gillispie; Eric Collins
Cc:	OCC Claims Commission Cases
Subject:	RESCHEDULED HEARING INFO: McAuliffe v. DHS, Claim No. 220374
Date:	Tuesday, June 28, 2022 4:00:00 PM
Attachments:	McAuliffe v. DHS -- 220374 -- rescheduled hearing ltr.pdf

Mr. Gillispie and Mr. Collins, please see attached hearing rescheduling letter.

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Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
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ARKANSAS STATE CLAIMS COMMISSION

(501) 682-1619
FAX (501) 682-2823

KATHRYN IRBY
DIRECTOR

101 EAST CAPITOL AVENUE
SUITE 410
LITTLE ROCK, ARKANSAS
72201-3823

June 28, 2022

Mr. Joshua Gillispie (*via email*)
Green & Gillispie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

Mr. Eric M. Collins (*via email*)
Arkansas Department of Human Services
Post Office Box 1437, Slot S260
Little Rock, Arkansas 72203

RE: ***Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services***
Claim No. 220374

Dear Mr. Gillispie and Mr. Collins,

Due to a scheduling conflict, the Claims Commission has rescheduled this claim for hearing on **Thursday, March 9, 2023**, beginning at 9:00 a.m. All parties will attend via Zoom. If either party objects to a Zoom format, a written objection must be submitted via email (kathryn.irby@arkansas.gov) or mail no later than July 6, 2022. The Zoom invitation is enclosed.

Each party's witness lists, exhibit lists, and exhibits are due by Thursday, February 16, 2023. If the parties would like for the Claims Commission to review prehearing briefs, the briefs are due at the same time. If the parties will be submitting any testimony by deposition, those deposition transcripts are due at the same time. If the parties will require a subpoena, subpoena requests are also due at the same time. Absent a showing of good cause, the Claims Commission will not issue subpoenas for requests received after February 16, 2023.

To the extent that either party intends to file a motion of any kind, absent a showing of good cause, the motion must be submitted in sufficient time to allow the motion to be fully briefed by February 16, 2023.

Please note that a copy of any filing must be served upon the opposing party via U.S. Mail in accordance with the Arkansas Rules of Civil Procedure.

If you have any questions, please do not hesitate to contact my office.

Sincerely,

Kathryn Irby

ES: kmirby

The Claims Commission is inviting you to a scheduled Zoom meeting.

Topic: Claims Commission -- hearings
Time: Mar 9, 2023 09:00 AM Central Time (US and Canada)

Join Zoom Meeting
https://us06web.zoom.us/j/83331127227?pwd=ZXN3RjdVZUpxUkxXakZMYm1VMk5WUT09

Meeting ID: 833 3112 7227
Passcode: YEz2R0
One tap mobile
+13017158592,,83331127227#,,,,*718080# US (Washington DC)
+13126266799,,83331127227#,,,,*718080# US (Chicago)

Dial by your location
+1 301 715 8592 US (Washington DC)
+1 312 626 6799 US (Chicago)
+1 929 436 2866 US (New York)
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 669 900 6833 US (San Jose)
Meeting ID: 833 3112 7227
Passcode: 718080
Find your local number: https://us06web.zoom.us/u/kmuitA0ZW

From: Joshua Gillispie
To: Kathryn Irby
Cc: Eric Collins; OCC Claims Commission Cases
Subject: Re: RESCHEDULED HEARING INFO: McAuliffe v. DHS, Claim No. 220374
Date: Wednesday, June 29, 2022 3:01:54 PM

Ms. Irby -

Received. I've made my clients aware of the resetting. Upon considerable reflection, I *would* prefer the opportunity to present to the Commission in-person. Please let me know if I need to file a request to that effect or if it is enough to make you aware of the request in this email.

Thanks,

Joshua D. Gillispie
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(501) 244-0700
(501) 244-2020 fax
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On Tue, Jun 28, 2022 at 4:01 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie and Mr. Collins, please see attached hearing rescheduling letter.
>
> Thanks,
>
> Kathryn Irby
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>
> **Arkansas State Claims Commission**
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or as required by law.

From: Garrett Grellner
To: ASCC Pleadings
Cc: Joshua Gillispie
Subject: Claim No. 22037
Date: Friday, July 1, 2022 2:00:15 PM
Attachments: P"s Second Supplemental Response to Respondent"s First Set of Discovery.pdf
Green-and-gillispie-attorneys-at-law-logo.png

You don't often get email from garrett@greenandgillispie.com. Learn why this is important

Claims Commission:

Please find attached for filing, Claimant's *Second Supplemental Responses to Respondent's First Set of Interrogatories and Requests for Production*.

Thank you for your time and attention to this matter.

Sincerely,

Garrett A. Grellner
Attorney

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

Leave a Google Review for Green & Gillispie!

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

SECOND SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

Interrogatories

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Second Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

ANSWER: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.

SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Janice L. LeBel, EdD/PhD, ABPP. Dr. LeBel's CV and Fee Schedule are provided herein, which contain her contact information. Dr. LeBel, as reflected in her CV, is a psychologist and an expert in field of behavioral health services and residential care for vulnerable

populations, including the disabled, mentally ill, and children. Dr. LeBel has published extensively on the use of restraints in these settings. She is expected to testify concerning the standard of care for a facility such as BHDC, and whether there were breaches of that standard that lead to Cains's death. Dr. LeBel can be made available for deposition upon request from Defendant. At this time there is no written report to share with Defendant.

SECOND SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Ricki Brown-Forestiere, MD. Dr. Brown-Forestiere's CV is provided herein. Dr. Brown-Forestiere is an Emergency Medicine Physician and an expert in her field of emergency medical services. Dr. Brown-Forestiere is board certified in Emergency Medicine. She is expected to testify concerning the cause of David Cains' death. Dr. Brown-Forestiere can be made available for deposition upon request from Defendant.

Request for Production of Documents

REQUEST FOR PRODUCTION 3. Copies of the C.V./ resume of each and every expert that may testify at the hearing on this claim.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time.

SUPPLEMENTAL RESPONSE: Provided herein, the CV of Dr. LeBel.

SECOND SUPPLEMENTAL RESPONSE: Provided herein, the CV of Dr. Brown-Forestiere.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail and US Mail on this 1st day of July, 2022.

Eric M. Collins, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

Ricki Brown-Forestiere, MD

[redacted]

EMPLOYMENT

1/2022-Present	Lakeland Regional Hospital Emergency Medicine Physician Department Chair: James Melton, MD	Lakeland, FL
8/2021-Present	HCA - Florida Brandon Hospital Emergency Medicine Physician Supervising Faculty - Emergency Medicine Residency Department Chair: Victor Sasson, MD	Brandon, FL
7/2018-6/2021	Brandon Regional Hospital Emergency Medicine Resident Program Director: Anthony Furiato, DO	Brandon, FL
1/2015-4/2017	Acute Care Solutions Providence Hospital, Emergency Department Physician Assistant, PRN Department Chair: Nicholas Steinour, MD	Waco, TX
6/2013-9/2014	Dell Seton Medical Center at The University of Texas Physician Assistant, Orthopedic Trauma Surgery Department Chair: Drake Borer, MD	Austin, TX

EDUCATION/TRAINING

7/2018-6/2021	Brandon Regional Hospital - University Southern Florida Emergency Medicine Residency	Brandon, FL
9/2014-4/2018	University of Science, Arts and Technology Doctor of Medicine	Montserrat,West Indies
7/2009-11/2011	Touro University Master of Science, Physician Assistant Studies	Henderson, NV
5/2005-12/2007	Northeastern Illinois University Bachelor of Science, Biology and Chemistry	Chicago, IL
8/2003-6/2005	Oakton Community College Major: Biology	Niles, IL
8/2001-5/2002	Michigan State University Major: Theater	East Lansing, MI

Ricki Brown-Forestiere, MD

[redacted]

HONORS

04/2018	Graduated *Magna Cum Laude* Department of Medicine, University of Science, Arts and Technology	Montserrat, West Indies
12/2007	Graduated *Summa Cum Laude*, Department of Science Northeastern Illinois University	Chicago, IL

BOARD CERTIFICATION

2021	Emergency Medicine Physician - Oral boards pending
2018	Educational Commission For Foreign Medical Graduates ID: [redacted]
2012	The National Commision on Certification of Physician Assistant ID: [redacted]

CERTIFICATIONS

ATLS, ACLS, PALS, BLS, USMLE I, USMLE 2CK, USMLE 2CS, USMLE 3

LICENSURE

4/21-Present	DEA: [redacted]
2/2021-Present	Florida Medical License ID: [redacted]
7/2018-6/2022	Florida Training Physician Medical License ID: [redacted]
10/2017-12/2018	California Physician Assistant Board ID: [redacted]
8/2012-2/2018	Texas Medical Board; Physician Assistant, ID: [redacted]

RESEARCH EXPERIENCE

2020	Brown-Forestiere R, Furiato A, Foresteire N P, et al. (May 11, 2020) Acute Appendicitis: Clinical Clues and Conundrums Related to the Greatest Misses. Cureus 12(5): e8051. DOI 10.7759/cureus.8051
2005-2007	Synthetic pathways and variations in feedstock for production of Biodiesel Ana Fraiman, PhD, Veronica Palmer, PhD, Northeastern University, Chicago, IL
2006-2007	Effects of Melatonin on rapidly dividing, HPV+ cervical cancer derived HeLa cells Terrance Puryear, PhD, Northeastern Illinois University, Chicago, IL

ABSTRACT PRESENTATION

2007	**Brown R**, Anderson M, Stoyan A, Puryear T, PhD. "Effects of Melatonin on rapidly dividing, HPV+ cervical cancer derived HeLa cells. Poster & Podium at Northeastern Illinois University Student Research Symposium, Chicago, IL. April 24, 2007

LEADERSHIP

2022	ACEP Leadership & Advocacy Conference -Lobby senators: Physician and patient centered policy -Political Affairs Focus Groups	Washington DC
2021-Present	Supervising faculty - Emergency Medicine Residency	Brandon, FL

Ricki Brown-Forestiere, MD

[redacted]

LEADERSHIP

2019-2021	Brandon Regional Hospital - Emergency Residency - Resident Mentor	Brandon, FL
2013-2018	University of Science, Arts and Technology - Student Mentor	Montserrat, West Indies
2013-2015	Central Texas Physician Assistant Society - Physician Assistant Student Preceptor	Waco, TX
2009-2011	Touro University - Student Council: Class President, Physician Assistant	Henderson, NV
2005-2007	Northeastern Illinois University - Student Council: Treasurer	Chicago, IL
2006-2007	Northeastern Illinois University - Student Council: Volunteer Event Coordinator	Chicago, IL
1999-2001	Niles West High School - Gymnastics Team Captain	Skokie, IL

TEACHING EXPERIENCE

2020	Brandon Regional Hospital EMS: Fundamentals, Fellowship, Future	Brandon,FL
2018	Brandon Regional Hospital Toxicology Lecture: Cocaine and Other Sympathomimetics	Brandon, FL
2018	EM Clerkship Podcast Episode Summary Guide	
2016	University of Science, Arts and Technology Anatomy Lab Assistant	Miami, FL
2014	University of Science, Arts and Technology Renal Lecture: Renin Angiotensin Aldosterone System Renal Lecture: Diuretic Pharmacology	Dallas, TX
2005-2007	Northeastern Illinois University Organic & Inorganic Chemistry Biweekly Review Lectures	Chicago, IL
2005-2006	Northeastern Illinois University Organic Chemistry Lab Assistant	Chicago, IL
2004-2005	Oakton Community College - Inorganic Chemistry Lab Assistant	Chicago, IL

ADMINISTRATIVE

2016	University of Science, Arts and Technology - University Web Design Team: Content	Montserrat, West Indies
2010-2011	Touro University - Student Clinical Coordinator	Henderson, NV
2009-2011	Touro University - Curriculum Develop Committee	Henderson, NV

Ricki Brown-Forestiere, MD

[redacted]

VOLUNTEER

2013	Balinese Women's Higher Education Fund - Founder	Candidasa, Bali
2012-2013	Livestrong Cancer Research Challenge	Austin, TX
2012	Gedong Gandhi Ashram Urgent Care Clinic	Candidasa, Bali
2010-2011	Multiple Sclerosis Society - Bike MS 150	San Diego, CA
2010	Justin Timberlake PGA Shriners Children Hospital	Henderson, NV
2010	Susan G. Komen Breast Cancer Walk	Las Vegas, NV
2010	Adolescent Heart & EKG Screening	Henderson, NV
2009-2010	Boys and Girl Club - Health Fair Coordinator	Henderson, NV
2009-Present	Visual Impact - Coordinator & Pediatric Vision Screening	Los Angeles, CA
2005-2007	Red Cross Blood Drive	Chicago, IL
1996-2001	March of Dimes - Finish Line Food Distributor	Chicago, IL

PROFESSIONAL ORGANIZATIONS

2018-Present	Physician's for Patient Protection
2019-Present	National Emergency Medicine Political Action Committee (NEMPAC)
2015-Present	American College of Emergency Medicine (ACEP) -Physician Member -Former Resident/Student Member
2018-Present	Emergency Medicine Residents Association (EMRA) -Former Resident Member
2013-Present	Educational Commission for Foreign Medical Graduates -Certified Physician Member - Former Resident Member
2013-Present	Central Texas Physician Assistant Society - Physician Assistant Student Preceptor - High School Student Observation Preceptor

HOBBIES: Patient advocacy, Emergency physician advocacy, Yoga, National Parks, International Travel

REFERENCES

1) Victor Sasson, MD
   Emergency Department Chair, HCA Brandon Regional Hospital, Fl
   [redacted]

2) Anthony Furiato, DO
   Residency Program Director, HCA Brandon Regional Hospital, FL
   [redacted]

3) Kelly Grabbe, DO
   Residency Assistant Program Director, HCA Brandon Regional Hospital, FL
   [redacted]

From:	Garrett Grellner
To:	ASCC Pleadings
Cc:	Eric Collins; Joshua Gillispie
Subject:	Claim No. 22037
Date:	Tuesday, July 5, 2022 10:13:17 AM
Attachments:	Subpoena Carrie Johnson-Miller.pdf Green-and-gillispie-attorneys-at-law-logo.png

Claims Commission:

Please find attached a Subpoena for Carrie Johnson-Miller for filing and to be issued back to us for service.

Thank you for your time and attention to this matter.

Best,

Garrett A. Grellner
Attorney

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

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Issued by the

CLAIMS COMMISSION

OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS

V.

THE ARKANSAS DEPT. OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)

SUBPOENA IN A CIVIL CASE

CLAIM NUMBER 220374

TO: Carrie Johnson-Miller

[redacted]

☐ YOU ARE COMMANDED to appear in the _____ Court of _____ County, Arkansas, at the place, date, and time specified below to testify in the above case.

Place of Testimony	Courtroom
	Date and Time

☑ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Place of Deposition	Date and Time
ZOOM - Link will be provided via email.	July 14, 2022 at 9AM

☐ YOU ARE COMMANDED, at the time of the trial, hearing or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

☐ YOU ARE COMMANDED, no more than _____business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Arkansas Rules of Civil Procedure 30(b)(6).

Attorney for Plaintiff

Issuing Officer Signature and Title (Indicate if Attorney for Plaintiff or Defendant) Date

Issuing Officer's Name, Address, and Phone Number

PROOF OF SERVICE

SERVED Date Place

Served on (Print name) Manner of Service

Served by (Print name) Title

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
Date Signature of Server

_____
Address of Server

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the trial or hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Rule 45(d), Ark. R. Civ. P.

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Rule 45(e), Ark. R. Civ. P.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Rule 45(b), Ark. R. Civ. P. The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the court. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Rule 45(e), Ark. R. Civ. P.

When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the court may issue a warrant for arresting and bringing the witness before the court to give testimony and answer for contempt. Rule 45(g), Ark. R. Civ. P.

From: Joshua Gillispie
To: Kathryn Irby
Cc: Eric Collins
Subject: Re: RESCHEDULED HEARING INFO: McAuliffe v. DHS, Claim No. 220374
Date: Tuesday, July 5, 2022 3:12:26 PM

Will do. Thanks, Kathryn.

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Tue, Jul 5, 2022 at 3:08 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie, I have made a note of your in-person hearing request, and I will let the commissioners know, as well. Will you please reach out to me in December to see if we can convert this hearing from Zoom to in-person?
>
> Thanks,
>
> Kathryn Irby
>
> ---
>
> **From:** Joshua Gillispie <josh@greenandgillispie.com>
> **Sent:** Wednesday, June 29, 2022 3:01 PM
> **To:** Kathryn Irby <Kathryn.Irby@arkansas.gov>
> **Cc:** Eric Collins <Eric.Collins@dhs.arkansas.gov>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
> **Subject:** Re: RESCHEDULED HEARING INFO: McAuliffe v. DHS, Claim No. 220374
>
> Ms. Irby -
>
> Received. I've made my clients aware of the resetting. Upon considerable reflection, I *would* prefer the opportunity to present to the Commission in-person. Please let me know if I need to file a request to that effect or if it is enough to make you aware of the request in this email.

Thanks,

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Tue, Jun 28, 2022 at 4:01 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie and Mr. Collins, please see attached hearing rescheduling letter.
>
> Thanks,
>
> Kathryn Irby
>
> **Kathryn Irby**
>
> **Arkansas State Claims Commission**
>
> 101 East Capitol Avenue, Suite 410
>
> Little Rock, Arkansas 72201
>
> (501) 682-2822

From: Kathryn Irby
Sent: Monday, May 16, 2022 8:14 AM
To: Joshua Gillispie <josh@greenandgillispie.com>; Eric Collins <Eric.Collins@dhs.arkansas.gov>
Cc: OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
Subject: RE: HEARING INFO: McAuliffe v. DHS, Claim No. 220374

Mr. Collins, I can push the prehearing material deadline to December 28, 2022.

Good luck with the military training.

Thanks,

Kathryn Irby

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Saturday, May 14, 2022 2:54 PM
To: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Cc: Kathryn Irby <Kathryn.Irby@arkansas.gov>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
Subject: Re: HEARING INFO: McAuliffe v. DHS, Claim No. 220374

Ms. Irby:

I have no objection to Mr. Collins' request. I will have Plaintiff's papers submitted by December 16th because I will be tied up with the holidays following the 16th, but I have no objection to Eric's request.

Josh

Joshua D. Gillispie



1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Fri, May 13, 2022 at 3:00 PM Eric Collins <Eric.Collins@dhs.arkansas.gov> wrote:

> Hey Ms. Irby,
>
> I do have a quick question related to the schedule that you have set for this case.
>
> December 16, 2022, is the current date set for the submission of witness lists, exhibit lists, exhibits, and prehearing briefs. I would like to request that the date for those submissions be extended. I am currently scheduled for extended military training in Ft. Benning during the months of October and November. I am set to return on November 22, 2022 and will be back in the office on December 1, 2022. I would greatly appreciate some additional time, perhaps another week or two, to reacquaint myself with the record, to gather the necessary materials, and to draft a prehearing brief. I understand this would push the due date to the week of Christmas, but I am hoping we can work out a solution on that timing. I have discussed this issue with Mr. Gillispie and ran the situation by him as well.
>
> Thank you,
>
> Eric M. Collins
>
> Attorney
>
> Arkansas Department of Human Services
>
> Office of Chief Counsel
>
> Office: (501) 396-6170

Cell: (501) 295-6356

This email may contain sensitive information.

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From: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Sent: Tuesday, April 26, 2022 11:29 AM
To: Joshua Gillispie <josh@greenandgillispie.com>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
Subject: HEARING INFO: McAuliffe v. DHS, Claim No. 220374

Mr. Collins, I spoke with Mr. Gillispie yesterday when he called with a question about submitting deposition testimony, and he and I discussed possible hearing dates. To allow for a full day of hearings, it looks like January 20, 2023, is our best bet.

Mr. Gillispie and Mr. Collins, to that end, I am attaching a hearing letter. If this date is unworkable for Mr. Collins, we can go back to the drawing board.

Thanks,

Kathryn Irby

From: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Sent: Monday, April 25, 2022 1:35 PM
To: Joshua Gillispie <josh@greenandgillispie.com>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: RE: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374

Mr. Gillispie and Mr. Collins, how long do the parties think that the hearing will take? How many live witnesses and how many witnesses' testimony will be submitted through deposition?

Thanks,

Kathryn Irby

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Friday, April 22, 2022 11:38 AM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Re: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374

Ms. Irby:

The parties have made significant progress in conducting discovery. I conferred with Mr. Collins today and we feel that we will likely be done with discovery by September.

Would now be a good time to look at having this matter added to the hearing docket?

Best regards,

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605

North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Mon, Feb 7, 2022 at 11:39 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie and Mr. Collins,
>
> The Claims Commission has reviewed Mr. Gillispie's request for a hearing in the above-referenced claim and would like for the parties to conduct discovery prior to the scheduling of this claim for hearing, especially given the amount in controversy. When discovery is nearing completion, please contact me to get this claim added to the hearing docket.
>
> Thanks,
>
> Kathryn Irby
>
> **Kathryn Irby**
>
> **Arkansas State Claims Commission**
>
> 101 East Capitol Avenue, Suite 410
>
> Little Rock, Arkansas 72201
>
> (501) 682-2822

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Thursday, February 3, 2022 1:54 PM
To: Caitlin McDaniel <Caitlin.McDaniel@arkansas.gov>

Cc: ASCC New Claims <ASCC.New.Claims@arkansas.gov>; Dana Henderson <dana@greenandgillispie.com>; Kathryn Irby <Kathryn.Irby@arkansas.gov>; Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Christine McAuliffe; Claim No. 220374

Ms. McDaniel:

If possible, I would like to set this matter for a hearing. I would appreciate any guidance you can provide me on what my office needs to do in order to get a setting. The respondent agency, DHS, has denied liability in their answer. Their attorney, Eric Collins, has been copied on this email.

Thank you for your assistance.

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

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https://dhs.arkansas.gov/ost/contactforms/ContactUs.aspx

or as required by law.

From: Dana Henderson
To: ASCC Pleadings
Cc: Joshua Gillispie; Eric Collins; Garrett Grellner
Subject: Claim No. 22037
Date: Thursday, July 7, 2022 11:14:13 AM
Attachments: Notice of Deposition.Stacy Weinbrenner.pdf

Claims Commission:

Please find attached for filing, Mr. Gillispie's *Notice to take Deposition of Stacy Weinbrenner* regarding the above-referenced claim.

Thank you for your time and attention to this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501.244.0700 (p); 501.244.2020 (f)
www.greenandgillispie.com

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF STACY WEINBRENNER

TO: **STACY WEINBRENNER**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on July 14, 2022, beginning at 9:00 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Stacy Weinbrenner

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, July 14, 2022 at 9:00 AM (Central Time)**

LOCATION: This matter will be held remotely, via **ZOOM**;

The link to join the Zoom meeting will be provided via email.

COURT REPORTER: Kristina R. Gray, CCR

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 7th day of July, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From: Dana Henderson
To: ASCC Pleadings
Cc: Joshua Gillispie; Eric Collins; Garrett Grellner
Subject: Claim No. 22037
Date: Thursday, July 7, 2022 10:55:55 AM
Attachments: Notice of Deposition.Randy McLemore.pdf

You don't often get email from dana@greenandgillispie.com. Learn why this is important

Claims Commission:

Please find attached for filing, Mr. Gillispie's *Notice to take Deposition of Randy McLemore* regarding the above-referenced claim.

Thank you for your time and attention to this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501.244.0700 (p); 501.244.2020 (f)
www.greenandgillispie.com

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS — **CLAIMANT**

VS. — **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) — **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF RANDY MCLEMORE

TO: **RANDY MCLEMORE**
c/o Eric Collins
Attorney for AR DHS
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on July 21, 2022, beginning at 9:30 a.m., Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Randy McLemore

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

DATE: **Thursday, July 21, 2022 at 9:30 AM (Central Time)**

LOCATION: This matter will be held remotely, via **ZOOM**;

The link to join the Zoom meeting will be provided via email.

COURT REPORTER: Kristina R. Gray, CCR

Counsel is invited to attend and cross examine.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 7th day of July, 2022 to the following:

Eric M. Collins
Attorney for DHS
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From:	Kathryn Irby
To:	Garrett Grellner
Cc:	Eric Collins; Joshua Gillispie
Subject:	SUBPOENA: Claim No. 220374
Date:	Thursday, July 7, 2022 3:47:00 PM
Attachments:	McAuliffe -- 220374 -- Johnson-Miller subpoena.pdf image001.png

Please see attached subpoena.

Kathryn Irby

From: Garrett Grellner <garrett@greenandgillispie.com>
Sent: Tuesday, July 5, 2022 10:13 AM
To: ASCC Pleadings <asccpleadings@arkansas.gov>
Cc: Eric Collins <eric.collins@dhs.arkansas.gov>; Joshua Gillispie <josh@greenandgillispie.com>
Subject: Claim No. 22037

Claims Commission:

Please find attached a Subpoena for Carrie Johnson-Miller for filing and to be issued back to us for service.

Thank you for your time and attention to this matter.

Best,

Garrett A. Grellner
Attorney

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

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Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Carrie Johnson–Miller**
[redacted]

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Deposition will take place via Zoom. (Zoom link will be provided via email.)

July 14, 2022, at 9:00 a.m.

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):



July 7, 2022

_____ _____
Kathryn Irby, Director Date
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d), Claims Commission Rule 3.2(d).

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Ark. R. Civ. Proc. 45(e), Claims Commission Rule 3.3.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

From:	Garrett Grellner
To:	ASCC Pleadings
Cc:	Eric Collins; Joshua Gillispie
Subject:	Claim No. 220374
Date:	Thursday, July 14, 2022 3:47:57 PM
Attachments:	Claimant"s Motion for Order Granting Release of Certain Documents by Respondent.pdf Proposed Order for Granting Release of Certain Documents to Claimant.pdf Green-and-gillispie-attorneys-at-law-logo.png

Arkansas Claims Commission:

Please find attached the following documents for filing by Joshua Gillispie:

- Claimant's *Motion for Order Granting Release of Certain Documents by Respondent*
- A Proposed *Order Granting Release of Certain Documents by Respondent*

Thank you for your time and attention to this matter.

Sincerely,

Garrett A. Grellner
Attorney

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244- 2020 (fax)
www.greenandgillispie.com

Leave a Google Review for Green & Gillispie!

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BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

MOTION FOR ORDER GRANTING RELEASE OF CERTAIN DOCUMENTS BY RESPONDENT

COMES NOW the Claimant, Christine McAuliffe, as Special Administrator of the Estate of David Cains, by and through her attorney, Joshua D. Gillispie, and for her *Motion for Order Granting Release of Certain Documents by Respondent*, states the following:

1. Claimant has requested certain documents concerning this claim from Respondent, who indicated that these requested documents can be released to Claimant, but only by order of the Claims Commission.
2. The documents requested are the following:
    - The entire DDS Investigative File on David Cains' death; and, to the extent the following documents are not part of that file and therefore redundant:
        - The Booneville Human Development Center "Report of Findings" submitted to the Office of Long Term Care;
        - The Adult Maltreatment Report on David Cains' death;
        - The DHS Incident Report on David Cains' death;
        - The IRIS Report(s) related to David Cains' death; and

- The Administrator's Report of Findings to the Office of Long Term Care, including but not limited to, all photos, witness statements, and medical documentation collected during the investigation of David Cains' death.

3. Claimant respectfully requests that the Claims Commission enter an order granting the release of these documents so that Respondent may provide them to Claimant.
4. Claimant reserves the right to amend this Motion.

WHEREFORE, the Claimant prays for the Arkansas Claims Commission to issue an Order directing Respondent to provide the documents requested in this Motion to Claimant, and for all other proper relief which she may be entitled.

Respectfully submitted by:

/s/ Joshua D. Gillispie
ABA # 2010131
GREEN & GILLISPIE
1 Riverfront Pl., Ste. 605
Little Rock, AR 72201
(501) 244-0700
(501) 244-2020, fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 14th day of July 2022, and service shall be accomplished via email to Eric Collins.

/s/__Joshua D. Gillispie___
Joshua D. Gillispie

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

ORDER GRANTING RELEASE OF CERTAIN DOCUMENTS BY RESPONDENT

On this ____ day of _____, 2022, the Motion for Order Granting Release of Certain Documents by Respondent was presented to the Arkansas Claims Commission. Upon consideration of such Motion and the facts in support thereof, the Arkansas Claims Commission, hearing no objection, does hereby Order the Respondent to produce the following documents to Claimant:

- The entire DDS Investigative File on David Cains' death; and, to the extent the following documents are not part of that file and therefore redundant:
    - The Booneville Human Development Center "Report of Findings" submitted to the Office of Long Term Care;
    - The Adult Maltreatment Report on David Cains' death;
    - The DHS Incident Report on David Cains' death;
    - The IRIS Report(s) related to David Cains' death; and
    - The Administrator's Report of Findings to the Office of Long Term Care, including but not limited to, all photos, witness statements, and

medical documentation collected during the investigation of David Cains' death.

IT IS SO ORDERED

_____
Arkansas Claims Commission

DATE: _____

Prepared by:

/s/ Joshua D. Gillispie_____
Joshua D. Gillispie

From: Joshua Gillispie
To: Kathryn Irby
Subject: McAuliffe v. DHS, Claim No. 220374
Date: Tuesday, August 2, 2022 2:02:01 PM
Attachments: Claimant"s Motion for Order Granting Release of Certain Documents by Respondent.pdf
Proposed Order for Granting Release of Certain Documents to Claimant.pdf

---

Kathryn-

Here is a courtesy copy of the Motion and proposed Order that we filed on July 14. Thanks!

Josh

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

V. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

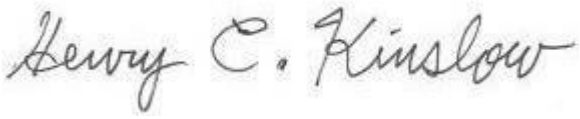
ORDER

Now before the Arkansas State Claims Commission (the "Claims Commission") is the motion filed by Christine McAuliffe, as special administrator of the Estate of David Cains (the "Claimant") seeking an order directing the Arkansas Department of Human Services (the "Respondent") to release the following documents:

> The entire DDS Investigative File on David Cains' death; and, to the extent the following documents are not part of that file and therefore redundant:
> - The Booneville Human Development Center "Report of Findings" submitted to the Office of Long Term Care;
> - The Adult Maltreatment Report on David Cains' death;
> - The DHS Incident Report on David Cains' death;
> - The IRIS Report(s) related to David Cains' death; and
> - The Administrator's Report of Findings to the Office of Long Term Care, including but not limited to, all photos, witness statements, and medical documentation collected during the investigation of David Cains' death.

Respondent did not respond to the motion. However, in Claimant's motion, Claimant noted that Respondent "indicated that these requested documents can be released to Claimant, but only by order of the Claims Commission." As such, the Claims Commission finds that Claimant's motion should be GRANTED.

IT IS SO ORDERED.



ARKANSAS STATE CLAIMS COMMISSION

Courtney Baird
Dexter Booth
Henry Kinslow, Co-Chair
Paul Morris, Co-Chair
Sylvester Smith

DATE: August 3, 2022

Notice(s) which may apply to your claim

(1) A party has forty (40) days from the date of this Order to file a Motion for Reconsideration or a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(b). If a Motion for Reconsideration is denied, that party then has twenty (20) days from the date of the denial of the Motion for Reconsideration to file a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(b)(3). A decision of the Claims Commission may only be appealed to the General Assembly. Ark. Code Ann. § 19-10-211(a).

(2) If a Claimant is awarded less than $15,000.00 by the Claims Commission at hearing, that claim is held forty (40) days from the date of disposition before payment will be processed. *See* Ark. Code Ann. § 19-10-211(b). Note: This does not apply to agency admissions of liability and negotiated settlement agreements.

(3) Awards or negotiated settlement agreements of $15,000.00 or more are referred to the General Assembly for approval and authorization to pay. Ark. Code Ann. § 19-10-215(b).

From:	Misty Scott on behalf of ASCC Pleadings
To:	Joshua Gillispie
Cc:	Eric Collins; OCC Claims Commission Cases; ASCC Pleadings; Kathryn Irby
Subject:	ORDER: Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services, Claim No. 220374
Date:	Thursday, August 4, 2022 4:31:00 PM
Attachments:	Christine McAuliffe v. DHS.pdf Christine McAuliffe-order.pdf

Mr. Gillispie and Mr. Collins:

Please see attached. Contact Kathryn Irby with any questions.

Thank you,

Misty

Misty Scott
Arkansas State Claims Commission

August 4, 2022

Mr. Joshua Gillispie *(via email)*
Green & Gillispie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

Mr. Eric M. Collins *(via email)*
Arkansas Department of Human Services
Post Office Box 1437, Slot S260
Little Rock, Arkansas 72203

Re: ***Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services***
Claim No. 220374

Dear Mr. Gillispie and Mr. Collins:

Enclosed please find an Order entered on August 3, 2022, by the Arkansas State Claims Commission. If you have any questions, please do not hesitate to contact my office.

Sincerely,

Mika Tucker

ES: msscott

From:	Rich Rosen
To:	Kathryn Irby
Cc:	Rich Rosen; Eric Collins; Joshua Gillispie
Subject:	McAuliffe v. DHS Claims Commission Case #220374 proposed order
Date:	Monday, August 8, 2022 11:53:36 AM
Attachments:	Sensitive.pdf

Ms. Irby-

Attached for submission to the Commission, please find an agreed Protective Order covering the maltreatment and incident reports which the Commission order be disclosed and released to Claimant. The Protective Order simply restricts redisclosure of these reports except as is necessary for litigation purposes. It also provides that in the event the reports are submitted to the Commission for filing, they be filed under seal. I included Mr. Gillispie on this email.

Thank you for your assistance. If you or the Commission have any questions, please let me know.

Richard Rosen
Arkansas Department of Human Services
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334 Fax: 501-682-1390

email address is: rich.rosen@dhs.arkansas.gov

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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

AGREED PROTECTIVE ORDER

THIS MATTER came on upon the stipulation of the parties that a Protective Order be entered governing the disclosure and use of certain confidential information to be provided by DHS to Claimant during the discovery process. Disclosure and discovery activity may involve production of certain confidential information or private information for which special protection from public disclosure and from use for any purpose other than in this litigation and any appeal thereof is necessary. Accordingly, the parties hereby stipulate to this protective order as follows:

1. Certain information sought by Claimant and ordered to be disclosed by Arkansas Department of Human Services (DHS) is confidential information under Ark. Code Ann. §12-12-1717 or Ark. Code Ann. §12-12-1718 and, as a result, reasonable safeguards are required to restrict disclosure or redisclosure of this information except as is otherwise necessary for purposes of litigation of this claim, including appeal.

2 Per Claimant's motion, the Arkansas State Claims Commission entered an Order requiring DHS to disclose certain reports from the DDS Investigative File on David Cains, specifically an Adult Maltreatment Report and a DHS Incident Report/IRIS Report, both of which are confidential.

Therefore, the Arkansas State Claims Commission hereby **ORDERS** that the release and disclosure of the confidential information, reports and files previously ordered be released by DHS to Claimant be subject to the following restrictions:

a. Claimant and counsel be prohibited from using, disclosing and/or redisclosing the information and files identified above except as is reasonably necessary for purposes of litigating the above-styled claim and any appeal thereof; and

b. The use of the maltreatment and incident reports as exhibits and in filings be under seal, and be unsealed only upon order of the Commission.

IT IS SO ORDERED.

_____
Arkansas State Claims Commission

Date: _____

PREPARED BY:

Eric Collins by /Rich Rosen
Eric Collins
Counsel for DHS

Agreed:

/sJoshua Gillispie
Joshua Gillispie
Counsel for Claimant

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

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2 Per Claimant's motion, the Arkansas State Claims Commission entered an Order requiring DHS to disclose certain reports from the DDS Investigative File on David Cains, specifically an Adult Maltreatment Report and a DHS Incident Report/IRIS Report, both of which are confidential.

Therefore, the Arkansas State Claims Commission hereby **ORDERS** that the release and disclosure of the confidential information, reports and files previously ordered be released by DHS to Claimant be subject to the following restrictions:

a. Claimant and counsel be prohibited from using, disclosing and/or redisclosing the information and files identified above except as is reasonably necessary for purposes of litigating the above-styled claim and any appeal thereof; and

b. The use of the maltreatment and incident reports as exbibits and in filings be under seal, and be unsealed only upon order of the Commission.

IT IS SO ORDERED.

Henry C. Kinslow

Arkansas State Claims Commission

Courtney Baird
Dexter Booth
Henry Kinslow, Co-Chair
Paul Morris, Co-Chair
Sylvester Smith

Date: August 8, 2022

PREPARED BY:

Eric Collins by Rich Rosen

Eric Collins
Counsel for DHS

Agreed:

/sJoshua Gillispie

Joshua Gillispie
Counsel for Claimant

From: Kathryn Irby
To: Rich Rosen
Cc: Eric Collins; Joshua Gillispie
Subject: ORDER: McAuliffe v. DHS, Claim No. 220374
Date: Monday, August 8, 2022 4:12:00 PM
Attachments: McAuliffe order.pdf

Mr. Rosen, Mr. Collins, and Mr. Gillispie, please see attached.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From: Rich Rosen <Rich.Rosen@dhs.arkansas.gov>
Sent: Monday, August 8, 2022 11:54 AM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Rich Rosen <Rich.Rosen@dhs.arkansas.gov>; Eric Collins <Eric.Collins@dhs.arkansas.gov>; Joshua Gillispie <josh@greenandgillispie.com>
Subject: McAuliffe v. DHS Claims Commission Case #220374 proposed order

Ms. Irby-

Attached for submission to the Commission, please find an agreed Protective Order covering the maltreatment and incident reports which the Commission order be disclosed and released to Claimant. The Protective Order simply restricts redisclosure of these reports except as is necessary for litigation purposes. It also provides that in the event the reports are submitted to the Commission for filing, they be filed under seal. I included Mr. Gillispie on this email.

Thank you for your assistance. If you or the Commission have any questions, please let me know.

Richard Rosen
Arkansas Department of Human Services
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334 Fax: 501-682-1390

email address is: rich.rosen@dhs.arkansas.gov

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From:	Daiquiri Carter
To:	ASCC Pleadings; Joshua Gillispie; Rich Rosen; Eric Collins
Cc:	Daiquiri Carter
Subject:	CC#220374
Date:	Monday, August 29, 2022 1:34:34 PM
Attachments:	RR appear(8-22).pdf image001.png image002.png

Please find attached an Entry of appearance of Counsel for the above referenced case number. I have emailed and mailed a copy to Claimant's Counsel.

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov





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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

ENTRY OF APPEARANCE OF COUNSEL FOR DHS

PLEASE TAKE NOTICE that RICHARD ROSEN of the Office of Chief Counsel hereby enters his appearance in the above-styled claim as co-counsel for Respondent, Arkansas Department of Human Services ("DHS"). Please include Richard Rosen on all further communications and notices in this matter.

Respectfully Submitted,

Arkansas Department of Human Services

By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On August 19, 2022, a copy of the above entry of appearance was served via electronic mail and mailed to:

Joshua D. Gillespie, Esquire josh@greenandgillispie.com
GREEN & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, AR 72214

Richard Rosen

From:	Joshua Gillispie
To:	ASCC Pleadings
Cc:	Kathryn Irby
Subject:	Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services, Claim No. 220374
Date:	Wednesday, September 7, 2022 11:32:49 PM
Attachments:	P"s Third Supplemental Response to Respondent"s First Set of Discovery.pdf

You don't often get email from josh@greenandgillispie.com. Learn why this is important

Dear Commission:

Please find attached for filing Claimant's Third Supplemental Responses to Discovery.

Best regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

THIRD SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

Interrogatories

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Third Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.

SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Janice L. LeBel, EdD/PhD, ABPP. Dr. LeBel's CV and Fee Schedule are provided herein, which contain her contact information. Dr. LeBel, as reflected in her CV, is a psychologist and an expert in field of behavioral health services and residential care for vulnerable populations, including the disabled, mentally ill, and children. Dr. LeBel has published extensively on the use of restraints in these settings. She is expected to testify concerning the standard of care for a facility such as BHDC, and whether there were breaches of that standard that lead to Cains's death. Dr. LeBel can be made available for deposition upon request from Defendant. At this time there is no written report to share with Defendant.

SECOND SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Ricki Brown-Forestiere, MD. Dr. Brown-Forestiere's CV is provided herein. Dr. Brown-Forestiere is an Emergency Medicine Physician and an expert in her field of emergency medical services. Dr. Brown-Forestiere is board certified in Emergency Medicine. She is expected to testify concerning the cause of David Cains' death. Dr. Brown-Forestiere can be made available for deposition upon request from Defendant.

THIRD SUPPLEMENTAL RESPONSE:

(a) Claimant will not be utilizing DRA advocates as expert witnesses in this matter. Claimant will reference the three DRA Reports in her pre-trial brief, reference them at the hearing, and likely submit copies to the Commission. Thomas Nichols, DRA's

Managing Attorney, has agreed to provide authentication and foundation, in the event DHS cannot stipulate to same and those steps are in fact necessary.

Thomas W. Nichols
Managing Attorney
Disability Rights Arkansas
400 West Capitol, Suite 1200
Little Rock AR 72201
Phone: 501.492.5776

(b)

Dr. Janice LeBel

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available and what Claimant expects. Note that Dr. LeBel has not authored or produced to Claimant a written report concerning her opinions. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Janice LeBel is a liability expert, expected to testify that the physical restraint and physical ground restraint, and the circumstances surrounding the restraint, performed by three direct care workers at BHDC, which caused David to vomit and then choke to death on his vomit, fell below the standard of care for facilities caring for the intellectually disabled and that his death was a foreseeable consequence of Respondent's negligence, as evidenced by the acknowledged violations of BHDC's own rules and regulations and those of DDS, by the fact that the death restraint was unnecessary and unjustified, that it was not the least restrictive intervention available and not used for the

least amount of time, that it was not an approved NCI method of restraint taught or authorized by DHS or BHDC, that it was medically contradicted for multiple reasons (*see* GERD for one), that it was not identified in any policies or in David's IPP as a potential form of restraint that could ever be used, that its form and repeated use by the facility was substandard, that it occurred as the result of substandard training and substandard oversight of direct care staff, that the large number of physical restraints used by BHDC staff on David Cains over the years and the facility's history of over-reliance on physical restraints in general was substandard practice and suggests a culture within the facility standing in opposition to commonly accepted norms and best practices for such facilities, that undertrained and/or underqualified direct care staff were allowed to use their own subjective discretion for when to use physical restraints with little to no oversight by supervisors and in ways often anathema to the training professed to have been provided them and the Respondent's own written rules, that the direct care staff's training and knowledge as regards first aid and basic lifesaving procedures was substandard (*see* placing him on his back after he starts vomiting), that BHDC in general failed to implement a functioning system of accountability for and oversight of staff designed to ensure staff were adhering to their training with regards de-escalation techniques and other nonviolent interventions, and that all of these ways in which BHDC fell below the standard of care directly led to and caused David Cains' untimely death – a foreseeable tragedy given the facility's historical refusal to reduce its reliance on physical restraints that are themselves inherently dangerous, particularly physical restraints performed on the ground like the one that killed David and which staff had been utilizing commonly and frequently in the months and years leading up to David's death despite the fact such

ground restraints were at all relevant times unauthorized and prohibited. Dr. LeBel's CV (previously produced) speaks for itself as to her expertise, experience, and qualifications. Her grounds for providing these opinions include the application of her expertise in this precise field to the facts and evidence of this case, including deposition transcripts, records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

Dr. Ricki Brown-Forestiere

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available. Note that Dr. Brown-Forestiere has not issued a formal written opinion or report on this matter. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Ricki Brown-Forestiere is a causation expert and <u>partial damages expert</u> (with respect only to Claimant's claim for damages based on David Cains' conscious pain and suffering prior to death), expected to testify that, but for the restraint and ground restraint in question, David Cains would not have died. David died because the physical restraint and ground restraint caused a struggle and that struggle induced vomiting upon which David choked to death. More specifically:

[redacted]

[redacted]

[redacted]

David, unfortunately, was also placed on his back after he began vomiting. [redacted]

[redacted]

Dr. Brown-Forestiere's grounds for providing these opinions include the application of her expertise in emergency medicine to the facts and evidence of this case, including deposition transcripts, medical records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

INTERROGATORY NO. 8: Please identify and itemize by nature, amount, and factual grounds/basis all damages sought herein, including financial damages, compensatory damages, consequential damages, punitive damages, and all other damages which are asserted and sought in this claim.

RESPONSE: Plaintiff objects to this request as overly broad and unduly burdensome at this early stage of the litigation, but, without waiving her objection, Plaintiff would direct Defendant to the Complaint, which provides a detailed factual basis for all damages sought, which include without limitation the following:

Damages of the Estate of David Cains

Loss of life of David Cains, commencing at death and ending at life expectancy;

Conscious pain and suffering of David Cains prior to death;

Medical care and expenses incurred as a result of David Cains' death (bills to be provided herein or upon receipt by Plaintiff's counsel); and

Funeral expenses incurred as a result of David Cains' death (bills to be provided herein or upon receipt by Plaintiff's counsel).

Damages of Cains' Statutory Beneficiaries

Mental anguish and emotional distress, including grief and despair, suffered up to the present time; and

Mental anguish and emotional distress, including grief and despair, that will continue well into the future.

SUPPLEMENTAL RESPONSE: Plaintiff reserves the right to supplement, if necessary, but identifies the below elements of damages, as found in the Arkansas Model Civil Jury Instructions.

Damages of the Estate of David Cains

- Loss of life of David Cains, commencing at death and ending at life expectancy. "Loss of life" damages are recoverable by the estate as an independent element of damage. These are the damages that would compensate a decedent for the loss of the value that a decedent would have placed on his or her own life. *Durham v. Marberry*, 356 Ark. 481, 156 S.W.3d 242 (2004). **Subject to revision as discovery continues: $2,000,000.00.**
- Conscious pain and suffering of David Cains prior to death. For cases involving conscious pain and suffering prior to death, see *New Prospect Drilling Co. v. First Commercial Trust, N.A.*, 332 Ark. 466, 966 S.W.2d 233 (1998); *Chambliss v. Brinton*, 229 Ark. 526, 317 S.W.2d 143 (1958). **Subject to revision as discovery continues: $1,000,000.00.**
- Funeral expenses incurred because of David Cains' death (bills previously provided in Claimant's First Supplemental Responses).

- Medical bills incurred, which here includes only the Ambulance bill, which has been produced in Claimant's First Supplemental Responses.

Damages of Cains' Statutory Beneficiaries (which include Claimant, David's sister, and Charlene Robinson, David's mother)

- Mental anguish and emotional distress, including grief and despair, suffered up to the present time; and
- Mental anguish and emotional distress, including grief and despair, that will continue for the remainder of each of their lives. "Future mental anguish is recoverable." *Knoles v. Salazar*, 298 Ark. 281, 766 S.W.2d 613 (1989). **Subject to revision as discovery continues: $2,000,000.00 for Claimant and $2,000,000.00 for David's mother.**

There is no amount of money that could ever fully compensate Claimant and Charlene Robinson for their mental anguish over the loss of their beloved brother and son. There is likewise no amount of money that could serve as an appropriate value on David's life and, therefore, his loss of life. Any one of these three elements of damages could by itself more than justify the current demand of $7,000,000.00. David's conscious pain and suffering that he experienced while he died choking to death while being pinned to the ground by three direct care staff is also, in and of itself, an element of damages a reasonable person would likely say is worth millions of dollars. Anyone who has ever choked for even a moment knows the intense pain and panic that comes with that. Any

funeral and medical bills are negligible and not something Claimant intends to even present.

INTERROGATORY NO. 13: Please state and explain all injuries suffered as a result of the death of Mr. Cains and by whom.

ANSWER: Plaintiff objects to this request as vague, as well as overly broad and unduly burdensome at this early stage of the litigation, but, without waiving her objection, Plaintiff would direct Defendant to her response to Interrogatory 8.

SUPPLEMENTAL RESPONSE: Claimant directs Respondent to her response and supplemental response to Interrogatory No. 8.

Request for Production of Documents

REQUEST FOR PRODUCTION 2. Copies of all expert opinions, reports, summaries and similar types of documents by the experts that will testify on behalf of the Claimant at the trial of this matter.

RESPONSE: Plaintiff anticipates she will be supplementing with further expert reports, but at this time is producing those currently in her possession, which include:

2015 DRA Report on BHDC
2016 DRA Report on BHDC
DRA Final Investigative Report on Cain's Death

SUPPLEMENTAL RESPONSE: Neither Dr. LeBel nor Dr. Brown-Forestiere have provided written opinions or expert reports at this time. Dr. Brown Forestiere has shared with Claimant an informal summary of conclusions based on what she has reviewed thus

far, which was produced in its entirety above, but will be copied below as well. Note again Claimant's reservation of her right to amend where necessary as discovery progresses:

[redacted]

[redacted]

[redacted]

David, unfortunately, was also placed on his back after he began vomiting. [redacted]

[redacted]

[redacted]

REQUEST FOR PRODUCTION 4. Copies of all bills, statements, and invoices itemizing the financial damages claimed herein.

RESPONSE: Plaintiff will produce these upon receipt. However, these are not likely to be substantial, most likely consisting of funeral/burial expenses, the ambulance bill, and the hospital bill from the date of David Cains's death.

SUPPLEMENTAL RESPONSE: Provided herein, ambulance bill, funeral services bill, and headstone bill.

SECOND SUPPLEMENTAL RESPONSE: Claimant has nothing further to produce beyond the ambulance bill, funeral services bill, and headstone bill previously produced in Claimant's First Supplemental Responses.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail 7th day of September, 2022.

Eric M. Collins, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Eric.Collins@dhs.arkansas.gov

Rich Rosen, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From:	Joshua Gillispie
To:	ASCC Pleadings
Cc:	Kathryn Irby; Eric Collins; Rich Rosen
Subject:	Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services, Claim No. 220374
Date:	Wednesday, September 14, 2022 3:42:05 PM
Attachments:	Subpoena Johnathan McCutcheon.pdf

You don't often get email from josh@greenandgillispie.com. Learn why this is important

Dear Claims Commission:

Please find attached a proposed deposition subpoena that I submit for issuance.

Best regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

Issued by the

CLAIMS COMMISSION

OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR
OF THE ESTATE OF DAVID CAINS

V.

THE ARKANSAS DEPT. OF HUMAN SERVICES
(BOONEVILLE HUMAN DEVELOPMENT CENTER)

SUBPOENA IN A CIVIL CASE

CLAIM NUMBER 220374

TO: Johnathan McCutcheon
[redacted]

☐ YOU ARE COMMANDED to appear in the _____ Court of _____ County, Arkansas, at the place, date, and time specified below to testify in the above case.

Place of Testimony	Courtroom
	Date and Time

☑ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Place of Deposition	Date and Time
Zoom link to be provided Green & Gillispie	October 21, 2022 at 2pm via ZOOM

☐ YOU ARE COMMANDED, at the time of the trial, hearing or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

☐ YOU ARE COMMANDED, no more than _____business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____

_____

Any organization not a party to this suit that is subpoenaed for the taking of a deposition shall designate one or more officers, directors, managing agents, or other persons who consent to testify on its behalf, and may set forth, for each person designated, the matters on which the person will testify. Arkansas Rules of Civil Procedure 30(b)(6).

Attorney for Plaintiff 9/14/21

Issuing Officer Signature and Title (Indicate if Attorney for Plaintiff or Defendant) Date

Joshua Gillispie 1 Riverfront Place, Suite 605, North Little Rock, AR 72114 501-244-0700

Issuing Officer's Name, Address, and Phone Number

PROOF OF SERVICE

SERVED Date Place

Served on (Print name) Manner of Service

Served by (Print name) Title

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
Date Signature of Server

_____
Address of Server

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the trial or hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Rule 45(d), Ark. R. Civ. P.

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Rule 45(e), Ark. R. Civ. P.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Rule 45(b), Ark. R. Civ. P. The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the court. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Rule 45(e), Ark. R. Civ. P.

When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the court may issue a warrant for arresting and bringing the witness before the court to give testimony and answer for contempt. Rule 45(g), Ark. R. Civ. P.

From:	Kathryn Irby
To:	Joshua Gillispie; ASCC Pleadings
Cc:	Eric Collins; Rich Rosen
Subject:	SUBPOENA: Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services, Claim No. 220374
Date:	Thursday, September 15, 2022 1:58:00 PM
Attachments:	McCutcheon subpoena.pdf

Mr. Gillispie, please see the McCutcheon subpoena attached.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Wednesday, September 14, 2022 3:41 PM
To: ASCC Pleadings <asccpleadings@arkansas.gov>
Cc: Kathryn Irby <Kathryn.Irby@arkansas.gov>; Eric Collins <Eric.Collins@dhs.arkansas.gov>; Rich Rosen <Rich.Rosen@dhs.arkansas.gov>
Subject: Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services, Claim No. 220374

Dear Claims Commission:

Please find attached a proposed deposition subpoena that I submit for issuance.

Best regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Johnathan McCutcheon**
[redacted]

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Deposition will take place via Zoom. (Zoom link will be provided via email.)

October 21, 2022, at 2:00 p.m.

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):



September 15, 2022

_____ _____
Kathryn Irby, Director Date
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d), Claims Commission Rule 3.2(d).

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Ark. R. Civ. Proc. 45(e), Claims Commission Rule 3.3.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

From: Daiquiri Carter
To: ASCC Pleadings; Joshua Gillispie; Eric Collins; Rich Rosen
Subject: CC #220374
Date: Friday, September 16, 2022 8:35:20 AM
Attachments: Notice-depo-McAuliffe.pdf
image001.png
image002.png
Notice-depo-Ashley.pdf
Notice-depo-Robinson.pdf

Please find attached 3 Notices of Deposition. I have copied Claimant's counsel on this email.

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov

NOTE - This email may contain sensitive or confidential information.

CONFIDENTIALITY NOTICE: The information contained in this email message and any attachment(s) is the property of the State of Arkansas and may be protected by state and federal laws governing disclosure of private information. It is intended solely for the use of the entity to which this email is addressed. If you are not the intended recipient, you are hereby notified that reading, copying or distribution this transmission is STRICTLY PROHIBITED. The sender has not waived any applicable privilege by sending the accompanying transmission. If you have received this transmission in error, please notify the sender by return and delete the message and attachment(s) from your system.

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS — CLAIMANT

VS. — CLAIM #220374

THE ARKANSAS DEPT. OF HUMAN SERVICES — RESPONDENT

NOTICE OF DEPOSITION

To: CHRISTINE MCAULIFFE

PLEASE TAKE NOTICE that pursuant to Rule 3.3 of the Rules and Regulations of the Arkansas State Claims Commission and the Rule 30 of the Arkansas Rules of Civil Procedure, the Respondent, the Arkansas Department of Human Services, by counsel, will take the deposition of Claimant **CHRISTINE MCAULIFFE** on the date and time and at the place identified below.

The examination shall cover all matters, issues and factual allegations raised and/or related to the matters, issues and factual allegations raised in the claim. The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date: **FRIDAY, OCTOBER 28, 2022**

Time: **9:30 a.m.**

Place: **1 Riverfront Place, Suite 605**
North Little Rock, AR 72114

ARKANSAS DEPARTMENT OF HUMAN SERVICES

By: Rich Rosen

Richard N. Rosen, Bar # 97164
Office of Chief Counsel
P.O. Box 1437, Slot S-260
Little Rock, Arkansas 72201
(501) 682-8608

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Notice was mailed, postage prepaid, and emailed this 15th 16th day of September, 2022 to:

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114

josh@greenandgillispie.com

Rich Rosen
Richard N. Rosen

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS — CLAIMANT

VS. CLAIM #220374

THE ARKANSAS DEPT. OF HUMAN SERVICES — RESPONDENT

NOTICE OF DEPOSITION

To: SARA ASHLEY

PLEASE TAKE NOTICE that pursuant to Rule 3.3 of the Rules and Regulations of the Arkansas State Claims Commission and the Rule 30 of the Arkansas Rules of Civil Procedure, the Respondent, the Arkansas Department of Human Services, by counsel, will take the deposition of **SARA ASHLEY** on the date and time and at the place identified below.

The examination shall cover all matters, issues and factual allegations raised and/or related to the matters, issues and factual allegations raised in the claim. The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date: **FRIDAY, NOVEMBER 4, 2022**

Time: **1:30 p.m.**

Place: **1 Riverfront Place, Suite 605**
North Little Rock, AR 72114

ARKANSAS DEPARTMENT OF HUMAN SERVICES

By: _____

Richard N. Rosen, Bar # 97164
Office of Chief Counsel
P.O. Box 1437, Slot S-260
Little Rock, Arkansas 72201
(501) 682-8608

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Notice was mailed, postage prepaid, and emailed this 15th day of September, 2022 to:

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114

josh@greenandgillispie.com

_____
Richard N. Rosen

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS — CLAIMANT

VS. CLAIM #220374

THE ARKANSAS DEPT. OF HUMAN SERVICES — RESPONDENT

NOTICE OF DEPOSITION

To: CHARLENE ROBINSON

PLEASE TAKE NOTICE that pursuant to Rule 3.3 of the Rules and Regulations of the Arkansas State Claims Commission and the Rule 30 of the Arkansas Rules of Civil Procedure, the Respondent, the Arkansas Department of Human Services, by counsel, will take the deposition of **CHARLENE ROBINSON** on the date and time and at the place identified below.

The examination shall cover all matters, issues and factual allegations raised and/or related to the matters, issues and factual allegations raised in the claim. The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date: **FRIDAY, NOVEMBER 4, 2022**

Time: **10:00 a.m.**

Place: **1 Riverfront Place, Suite 605**
North Little Rock, AR 72114

ARKANSAS DEPARTMENT OF HUMAN SERVICES

By: Rich Rosen

Richard N. Rosen, Bar # 97164
Office of Chief Counsel
P.O. Box 1437, Slot S-260
Little Rock, Arkansas 72201
(501) 682-8608

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Notice was mailed, postage prepaid, and emailed this 15th 16th (RR) day of September, 2022 to:

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114

josh@greenandgillispie.com

Rich Rosen
Richard N. Rosen

From: Dana Henderson
To: ASCC Pleadings
Cc: Joshua Gillispie; Eric Collins
Subject: Claim No. 22037
Date: Tuesday, October 11, 2022 1:22:13 PM
Attachments: Subpoena served. McCutcheon.pdf

Claims Commission:

Please find attached for filing, a *Subpoena Served* regarding the above-referenced claim.

Thank you for your time and attention to this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501.244.0700 (p); 501.244.2020 (f)
www.greenandgillispie.com

This email may contain material that is confidential and protected by attorney-client privilege. If you received this message by mistake or are not the intended recipient of this message, please destroy and notify the sender.
This message does not create an attorney-client relationship.

Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Johnathan McCutcheon**
[redacted]

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

Deposition will take place via Zoom. (Zoom link will be provided via email.)

October 21, 2022, at 2:00 p.m.

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):



September 15, 2022

_____ _____
Kathryn Irby, Director Date
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

PROOF OF SERVICE

Johnathan McCutcheon
SERVED ON (Print Name)

[redacted]

10/10/2022
DATE

PLACE

Personally served
MANNER OF SERVICE

Tonya Rogers
SERVED BY (Print Name)

Process Server - Sebastian County
TITLE
CV2020-893

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on 10/11/2022
DATE

Tonya Rogers
SIGNATURE OF SERVER

P.O. Box 2141 - Fort Smith, AR 72902
ADDRESS OF SERVER

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d), Claims Commission Rule 3.2(d).

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Ark. R. Civ. Proc. 45(e), Claims Commission Rule 3.3.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

From: Daiquiri Carter
To: ASCC Pleadings; Rich Rosen; Joshua Gillispie
Subject: CC# 220374
Date: Tuesday, October 11, 2022 3:31:02 PM
Attachments: DRA-notice-30b6depo1(10-22)pdf.pdf
DRA-notice-depo-Stewart2(10-22)pdf.pdf
image001.png
image002.png

Please find attached two Notices of Deposition in the above styled case.

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov





NOTE - This email may contain sensitive or confidential information.

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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

Notice of Deposition

PLEASE TAKE NOTICE that pursuant to Rules 3.3 and 8.1 of the Rules and Regulations of the Arkansas State Claims Commission and the Rule 30(b)(6) of the Arkansas Rules of Civil Procedure, the Respondent, the Arkansas Department of Human Services, Booneville Human Development Center, by counsel, will take the deposition of the Disability Rights Arkansas (a/k/a DRA), on the date and time and at the place identified below. Per these applicable rules, DRA, as the named organization or entity, shall designate one or more of its officers, directors, or managing agents, or other persons who consent to testify on its behalf. The persons so designated shall testify as to matters known or reasonably known to the organization.

The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date: **Wednesday, November 9, 2022**

Time: **9:30 a.m.**

Place: **Arkansas Department of Human Services**
700 Main Street, Second Floor Conference Room
Little Rock, Arkansas 72201

The examination shall cover all matters, issues, and factual allegations raised and/or related to the matters, issues and factual allegations identified below:

1. The **January 2015 DRA report titled: "A New Approach to Care in Arkansas: Why the Time Has Come to Close the Booneville Human Development Center",** including the basis for the observations, opinions, conclusions, positions, and recommendations articulated in the following sections of the January 2015 report:
    - Acknowledgments;
    - Executive Summary;
    - Introduction;
    - Physical Plant Issues;
    - Fiscal Responsibility and the Booneville HDC;
    - Restraint Use; Conclusion;
    - DRA Recommendations;
    - DRA observations referenced on page 2 of the report;
    - Meetings with the residents and staff referenced on page 2 of the report;
    - Meetings with the legal guardian of residents, if any;
    - Basis for position stated on page 2 of the report that "Yet, in 2015, the State of Arkansas has not fully moved toward community-based services"; and
    - Documentation of residents accessing all unused buildings and the unused portions of buildings partially used by the facility as referenced on page 3 of the report.

2. The **January 2016 DRA report titled: "Bound to the Past: The Excessive Use of Restraint at Booneville Human Development Center",** including the basis for the observations, opinions, conclusions, positions, and recommendations articulated in the following sections of the January 2016 report:
    - Acknowledgments;
    - Introduction;
    - Regulations and Policies Governing Use of Restraints;
    - Booneville HDC Has A Significantly Higher Number of Restraints than Similar HDCs;
    - Restraint is Inherently Dangerous;
    - Use of Restraints at Booneville HDC;
    - Lack of Meaningful Follow-up;
    - Lack of Meaningful Oversight;
    - Conclusion; and
    - Recommendations;

3. All prior (through date of deposition) public statements and positions taken by DRA consistent with the recommendation articulated in the 2015 Report recommending closure of the Booneville Human Development Center and closure of any and all Arkansas Human Development Centers.

Respectfully Submitted,
Arkansas Department of Human Services

By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On October 11, 2022, a copy of the above notice was served via electronic mail and mailed to:

Joshua D. Gillespie, Esquire josh@greenandgillispie.com
GREEN & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, AR 72214

Richard Rosen

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

Notice of Deposition

PLEASE TAKE NOTICE that pursuant to Rules 3.3 and 8.1 of the Rules and Regulations of the Arkansas State Claims Commission, the Respondent, the Arkansas Department of Human Services, Booneville Human Development Center, by counsel, will take the deposition of the **Kris Stewart** of the Disability Rights Arkansas (a/k/a DRA)**,** on the date and time and at the place identified below. The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date & Time: **Wednesday, November 9, 2022 at 1:30 p.m.**

Place: **Arkansas Department of Human Services**
700 Main Street, Second Floor Conference Room
Little Rock, Arkansas 72201

Respectfully Submitted,
Arkansas Department of Human Services

By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On October 11, 2022, a copy of the above notice was served via electronic mail and mailed to:

Joshua D. Gillespie, Esquire josh@greenandgillispie.com
GREEN & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, AR 72214

Richard Rosen

From:	Rich Rosen
To:	Kathryn Irby; ASCC Pleadings
Cc:	Rich Rosen; Brent Gasper; Joshua Gillispie
Subject:	McAuliffe/Canis v. DHS Claims Commission # 220374
Date:	Wednesday, October 12, 2022 9:18:18 AM
Attachments:	DRA-notice-30b6depo1(10-22)pdf.pdf

Ms. Irby-

DHS hereby requests witness subpoenas be issued and forwarded to me for service on the following:

1. **Disability Rights Arkansas (a/k/a DRA)**
   Rule 30(b)(6) designee
   400 West Capitol Ave, Suite 1200
   Little Rock, AR 72201

   Date: **Wednesday November 9, 2022**

   Time: **9:30 a.m.**

   Location: DHS Central Office
   700 Main Street, Second Floor
   Little Rock, AR 72201

   ***See* attached Notice of Deposition for the subject areas of the deposition examination upon which DRA shall designate a person to testify pursuant to Ark. Rule of Civil Procedure 30(b)(6).**

2. **Kris Stewart**
   DRA Advocate
   400 West Capitol Ave, Suite 1200
   Little Rock, AR 72201

   Date: **Wednesday November 9, 2022**

   Time: **1:30 p.m.**

   Location: DHS Central Office
   700 Main Street, Second Floor
   Little Rock, AR 72201

Please attach the Notice of Deposition to the Disability Rights Arkansas subpoena. If you have any questions, please let me know.

Thank you,
Rich

Richard Rosen
Arkansas Department of Human Services
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334 Fax: 501-682-1390

email address is: rich.rosen@dhs.arkansas.gov

SENSITIVE

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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

Notice of Deposition

PLEASE TAKE NOTICE that pursuant to Rules 3.3 and 8.1 of the Rules and Regulations of the Arkansas State Claims Commission and the Rule 30(b)(6) of the Arkansas Rules of Civil Procedure, the Respondent, the Arkansas Department of Human Services, Booneville Human Development Center, by counsel, will take the deposition of the Disability Rights Arkansas (a/k/a DRA), on the date and time and at the place identified below. Per these applicable rules, DRA, as the named organization or entity, shall designate one or more of its officers, directors, or managing agents, or other persons who consent to testify on its behalf. The persons so designated shall testify as to matters known or reasonably known to the organization.

The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date: **Wednesday, November 9, 2022**

Time: **9:30 a.m.**

Place: **Arkansas Department of Human Services**
700 Main Street, Second Floor Conference Room
Little Rock, Arkansas 72201

The examination shall cover all matters, issues, and factual allegations raised and/or related to the matters, issues and factual allegations identified below:

1. The **January 2015 DRA report titled: "A New Approach to Care in Arkansas: Why the Time Has Come to Close the Booneville Human Development Center",** including the basis for the observations, opinions, conclusions, positions, and recommendations articulated in the following sections of the January 2015 report:
    - Acknowledgments;
    - Executive Summary;
    - Introduction;
    - Physical Plant Issues;
    - Fiscal Responsibility and the Booneville HDC;
    - Restraint Use; Conclusion;
    - DRA Recommendations;
    - DRA observations referenced on page 2 of the report;
    - Meetings with the residents and staff referenced on page 2 of the report;
    - Meetings with the legal guardian of residents, if any;
    - Basis for position stated on page 2 of the report that "Yet, in 2015, the State of Arkansas has not fully moved toward community-based services"; and
    - Documentation of residents accessing all unused buildings and the unused portions of buildings partially used by the facility as referenced on page 3 of the report.

2. The **January 2016 DRA report titled: "Bound to the Past: The Excessive Use of Restraint at Booneville Human Development Center",** including the basis for the observations, opinions, conclusions, positions, and recommendations articulated in the following sections of the January 2016 report:
    - Acknowledgments;
    - Introduction;
    - Regulations and Policies Governing Use of Restraints;
    - Booneville HDC Has A Significantly Higher Number of Restraints than Similar HDCs;
    - Restraint is Inherently Dangerous;
    - Use of Restraints at Booneville HDC;
    - Lack of Meaningful Follow-up;
    - Lack of Meaningful Oversight;
    - Conclusion; and
    - Recommendations;

3. All prior (through date of deposition) public statements and positions taken by DRA consistent with the recommendation articulated in the 2015 Report recommending closure of the Booneville Human Development Center and closure of any and all Arkansas Human Development Centers.

Respectfully Submitted,
Arkansas Department of Human Services

By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On October 11, 2022, a copy of the above notice was served via electronic mail and mailed to:

Joshua D. Gillespie, Esquire josh@greenandgillispie.com
GREEN & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, AR 72214

Richard Rosen

From: Joshua Gillispie
To: ASCC Pleadings
Cc: Kathryn Irby; Rich Rosen; Brent Gasper; Dana Henderson
Subject: Claim No. 22037
Date: Thursday, October 13, 2022 4:36:12 PM
Attachments: Claimant"s Motion to Compel Release of Certain Documents.pdf

---

You don't often get email from josh@greenandgillispie.com. Learn why this is important

Dear Claims Commission:

Please find attached for filing *Claimant's Motion to Compel the Release of Certain Documents by Respondent*.

Best Regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains — **CLAIMANT**

V. — **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — **RESPONDENT**

MOTION TO COMPEL THE RELEASE OF CERTAIN DOCUMENTS BY RESPONDENT, WITH BRIEF INCORPORATED

COMES NOW the Claimant, Christine McAuliffe, as Special Administrator of the Estate of David Cains, by and through her attorney, Joshua D. Gillispie, and for her *Motion to Compel the Release of Certain Documents by Respondent*, states the following:

INTRODUCTION

Claimant, Christine McAuliffe ("Claimant") has brought this wrongful death action on behalf of her late brother, David Cains, against the Arkansas Department of Human Services, which operates the Booneville Human Development Center ("BHDC"), one of five state facilities established to provide care for people with developmental disabilities. The BHDC has long been criticized by disability rights advocates for its excessive and unnecessary use of dangerous and life-threatening physical restraints upon the developmentally disabled individuals placed there. Disability Rights Arkansas has published multiple reports in recent years critical of BHDC's overuse of physical restraints, pointing out that BHDC employs physical and mechanical restraints on its residents at a much higher rate than the state's four other human development centers. In 2016, Disability Rights Arkansas published a report finding that

BHDC's overuse of physical restraints was such a continuing danger to its residents that it recommended the facility be shut down permanently.

David Cains, born [redacted] was admitted to BHDC on May 1, 2007. He lived there until his death on June 13, 2020. David was killed during an unnecessarily violent and improperly implemented physical restraint whereby three direct care staff – Tyler Mattson, Amy Jones, and Ryann Campos – held him pinned to the ground shortly after David had finished his lunch, the violence of which caused David, who suffered [redacted] while Mattson, Jones, and Campos held him pinned to the ground.

ARGUMENT and AUTHORITY

The Arkansas Rules of Civil Procedure provide that "parties may obtain discovery regarding any matter, not privileged, which is relevant to the issues in the pending actions, whether it relates to the claim or defense of the party seeking discovery or to the claim or defense of any other party, including the existence, description, nature, custody, condition, identity and location of any books, documents, or other tangible things…." ARK. R. CIV. P. 26(b)(1).

Adult Maltreatment Reports

Claimant seeks the production of all Adult Maltreatment Reports for which Tyler Mattson was the accused offender while employed at the BHDC. Tyler Mattson is the staff member who initiated the excessive ground restraint and was the primary aggressor in the incident that killed David. Mr. Mattson, by his own admission at deposition, was previously accused and formally investigated for maltreatment against at least one other patient at the Booneville Human Development Center prior to the death of David Cains. Respondent objects to producing the additional Adult Maltreatment Reports for which Tyler Mattson was the

accused offender, citing the confidentiality provisions of A.C.A. § 12-12-1717 and A.C.A. § 12-12-1718.

However, both of these statutes relied upon by Respondent specifically provide that the documents sought by Claimant may be made available to the court "upon a finding that the information in the record is necessary for the determination of an issue before the grand jury or court." A.C.A. § 12-12-1717(a)(5); A.C.A. § 12-12-1718(c)(8). Once produced, the court may then redisclose them to Claimant under a protective order. A.C.A. § 12-12-1717(f)(1)(C); A.C.A. § 12-12-1718(g)(1)(C). Here, documentation reflecting that Mr. Mattson has a history of violence towards BHDC residents is germane to Respondent's liability. Prior similar incidents are relevant to notice, foreseeability, and duty. See *Dollar General Corporation v. Elder*, 600 S.W.3d 597, 604, 2020 Ark. 208 (2020). Foreseeability is a contested issue that will require determination by the finder of fact; therefore, the Adult Maltreatment Reports concerning prior acts of excessive force used by Tyler Mattson on BHDC residents are necessary to determine foreseeability, an important element of negligence. Claimant will agree to an additional protective order and to the redaction of information identifying the resident victim that is the subject of the report.

Furthermore, to the extent the documents sought might contain protected health information, they can still be released under a protective order and in compliance with federal regulations codified under 45 C.F.R. § 164.512(e)(1). The BHDC, upon information and belief, is a covered entity as defined under HIPPA. 45 C.F.R. §160.103. Federal regulations governing the release of protected health information state that a covered entity, such as Respondent, "may disclose protected health information in the course of any judicial or administrative proceeding"

simply in "response to an order of a court," with nothing more being needed. 45 C.F.R. § 164.512(e)(1)(i).

For these same reasons, Claimant is also seeking the production of any Adult Maltreatment Reports for which Amy Jones and Ryann Campos were accused offenders while working at the BHDC. Claimant will agree to an additional protective order and to the redaction of information identifying the resident victim that is the subject of the report.

And for related reasons, Claimant is also seeking the production of any Adult Maltreatment Reports involving allegations of staff-on-client maltreatment where Sandy Evans was the investigator and where the allegations were substantiated. Respondent previously reported to Claimant that Sandy Evans was the maltreatment investigator for 16 such substantiated staff-on-client maltreatment investigations at BHDC. The legitimacy of Sandy Evans' maltreatment investigation of the three direct care staff members involved in Cains' death, in which she chose not to substantiate maltreatment, is a significant issue in this case, and the suspect nature of that investigation has only been heightened by deposition testimony.

For instance, Tyler Mattson testified at deposition that the entirety of Sandy Evans' investigation into his personal involvement in the death included one brief interaction during which he was questioned for "barely a minute," that Evans did not ask him detailed questions about what happened, and that primarily all she did was provide him a witness statement form and then personally instruct him on how to complete the form.[1]

At her own deposition, Evans actually admitted that the death-causing restraint used by the three staff members was ***not*** the least restrictive method that could have been used on David

[1] Please see pgs. 84-87 of Tyler Mattson's deposition transcript, attached here as *Exhibit 1*.

Cains.[2] Therefore, it was not necessary to use that amount of force on David. Inexplicably, Evans still failed to substantiate maltreatment against the three staff members. Per Respondent's own policy, any physical restraint exceeding in force the least restrictive option is unnecessary and forbidden at the BHDC. *Arkansas Department of Human Services DDS Policy 3011-D.* The statutory definition of "Abuse" in long term care facilities such as the BHDC includes any "intentional and *unnecessary* physical act that inflicts pain on or causes injury" to a developmentally disabled person. A.C.A. § 12-12-1703(1). Simultaneously, "abuse" is one of the definitions of "Adult Maltreatment." A.C.A. § 12-12-1703(2). In other words, Evans, by her own admission, acknowledges that adult maltreatment, as defined in Arkansas code, occurred, yet still failed to substantiate allegations of adult maltreatment against the three staff members who engaged in the unnecessary physical act that caused David Cains' death.

Claimant needs to know what Ms. Evans would consider maltreatment, if not this death-causing restraint that she herself testified exceeded in force what was required. Unless Respondent is willing to concede that maltreatment occurred here, Claimant should be able to review the Adult Maltreatment Reports of the 16 staff-on-client investigations Respondent claims Ms. Evans has substantiated to look for inconsistencies in her methods and other evidence that would further prove that the three staff members committed adult maltreatment upon David Cains. Claimant will agree to an additional protective order and to the redaction of information identifying the resident victim that is the subject of the report.

Mortality Review Committee

Respondent also objects to producing the Mortality Review Committee documents related to David Cains' death, the subject of this suit, citing A.C.A. § 16-46-109. The documents

[2] Please see p. 50:2-7 of Sandy Evans' deposition transcript, attached here as *Exhibit 2.*

and findings produced by the Mortality Review Committee ("MRC") are potentially highly relevant to the question of liability in this case. Upon information and belief, the MRC conducts a review of each unexpected death of persons in human development centers, and that review includes, among other things, the circumstances surrounding the death, the identification of the primary risk factors involved in the death, the degree to which the death was believed to be preventable, and whether maltreatment was a factor. Respondent's position, per its Answer, is that David Cains' death was an unforeseeable incident that could not have been prevented or avoided. Upon information and belief, the findings of the MRC could belie that position, thereby further evidencing Respondent's liability for David Cains' death.

Furthermore, it is not clear to claimant from the face of the statute relied upon by Respondent that it would apply to the MRC documents sought. A.C.A. § 16-46-109 states that "proceedings, minutes, records, or reports of the quality assurance committee having the responsibility for reviewing and evaluating the quality of medical, nursing, or other care delivered in a long-term care facility" are exempt from disclosure and privileged. It is not clear to Claimant, given her understanding of the MRC's purpose and function, that it is precisely the type of quality assurance committee for which A.C.A. § 16-46-109 was meant to apply. "Mortality Review" is not synonymous with "quality assurance," in other words.

CONCLUSION

For the foregoing reasons, Claimant seeks an order compelling Respondent to release (1) all Adult Maltreatment Reports for which Tyler Mattson, Amy Jones, and Ryann Campos were an accused offender while employed at the BHDC; (2) all 16 Adult Maltreatment Reports involving substantiated staff-on-client maltreatment where Sandy Evans was the investigator; and (3) Mortality Review Committee documents related to David Cains' death.

WHEREFORE, the Claimant prays for the Arkansas Claims Commission to grant this Motion and issue an Order directing Respondent to provide the documents requested in this Motion to Claimant, and for all other proper relief which she may be entitled.

Respectfully submitted by:

/s/ Joshua D. Gillispie
ABA # 2010131
GREEN & GILLISPIE
1 Riverfront Pl., Ste. 605
Little Rock, AR 72201
(501) 244-0700
(501) 244-2020, fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 13th day of October, 2022, and service shall be accomplished via email to counsel of record.

/s/ Joshua D. Gillispie
Joshua D. Gillispie

well, spend time with him?
A. She knew him in passing but didn't work with him regularly.
Q. Okay. And did you get along with Mandy well?
A. Yes.
Q. Okay. Do you know of any issues that Mandy has had with other clients in the past? Maybe a client has complained about her? Or perhaps something like what happened to you, another staff member or somebody accused her of maltreatment?
A. Not that I know of.
Q. Okay. Did Sandy Evans -- were you questioned by Sandy Evans after David's death?
A. Yes.
Q. Okay. And do you recall -- what do you recall from that?
A. She was empathetic towards me and that she gave me the sheet, and that was pretty much it.
Q. Just she told you she was sorry that you had -- you're having to deal with this?
A. More or less.
Q. She didn't question you about how it happened or anything like that?
A. It was all explained in the sheet.
Q. What sheet?



A. The Witness Report.
Q. The Witness Report that you wrote?
A. That I wrote, yes.
Q. Okay. So she -- she -- other than your witness -- she -- she -- I understood she accepted your Witness Report.
But, as far as you recall, she didn't -- she didn't do any further interrogation or questioning of you?
A. Not that I recall. She was just being empathetic and --
Q. Okay.
A. -- as she could professionally be in the situation.
Q. Sure, sure.
And how shortly after the death was this meeting with her?
A. Immediately afterwards.
Q. Okay.
A. And after -- yeah.
Q. And you never met with her again about it?
A. No.
Q. And about how long do you think that meeting with her lasted?
A. It took me maybe 15, 20 to write the report and I left.
Q. Okay. But how long did it take her to talk with

you?
A. About the duration. She didn't talk to me afterwards or before, other than being empathetic. It was just I gave her the report and --
Q. So she had you write a report. She didn't -- she didn't ask you any questions about the event? She -- other than -- and she -- the only words you recall her speaking to you were kind of . . .?
A. She just kind of asked me what happened. But, like, as far as, like, did she interrogate me necessarily? Not that I recall.
Q. But -- so you say you do recall her as -- specifically asking questions about the event?
A. Just what happened. She didn't ask too many details that I remember.
Q. Okay. And about how long do you think the conversation part with her lasted?
A. Barely a minute. It was what happened and her being empathetic. And she handed me a sheet and she explained it me, and that's really just . . .
Q. Got it. And when you say explained it to you, meaning explained how to fill out the form?
A. Basically. I mean, like, she didn't tell me what to write down necessarily; but she was like -- she gave me a -- how do I word this? She basically just gave me

basic -- basic instructions.
Q. Okay.
A. Of what -- what to write down and how to -- all that stuff, but nothing beneficial towards me necessarily.
(Exhibit 5 marked for identification.)
Q. Gotcha.
So I'm showing you what I've marked as Exhibit 5. This is Bates stamped 2714, and this is Client's Rights or Client Rights.
And this is from your training materials, correct?
A. Yes.
Q. Okay. And you would agree that this is a list of sort of the rights of the clients that you're there to -- to care for, correct?
A. Yes.
Q. And you would agree that your -- that your primary role is to literally care for these people, correct?
A. Yes, yes.
Q. Number 8: "The right to receive medical care, nursing care, and dental care in a safe and clean environment."
Number 12: "The right to express individual preferences."
Number 14: "The right to privacy during treatment

requiring retraining, yes.
Q Okay. And, you know, I think that you'd agree with me, well, you already have agreed with me, that what happened here with these three folks was not the least restrictive thing that could have been done, given the circumstances; correct?
A Correct.
Q Okay.
MR. GILLISPIE: Let me go off the record for just a moment, please. Take five.
(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)
BY MR. GILLISPIE:
Q Ms. Evans, the 9-1-1 policy, at the time, as I understand it, was that there was a 9-1-1 policy at BHDC that dictated that nonmedical staff in emergency medical situations were to first contact medical staff.
And then, if 9-1-1 needed to be called, that had to be done by medical staff; is that correct?
A I don't recall that policy exactly, so I couldn't say with certainty.
Q Okay. Let me grab it.
MR. GILLISPIE: Eric, let me try to find it in the produced discovery. I have a



From:	Kathryn Irby
To:	Rich Rosen; ASCC Pleadings
Cc:	Brent Gasper; Joshua Gillispie
Subject:	RE: McAuliffe/Canis v. DHS Claims Commission # 220374
Date:	Friday, October 14, 2022 11:47:00 AM
Attachments:	McAuliffe -- 220374 -- subpoena 1.pdf McAuliffe -- 220374 -- subpoena 2.pdf

Please see attached subpoenas.

Thanks,
Kathryn Irby

From: Rich Rosen <Rich.Rosen@dhs.arkansas.gov>
Sent: Wednesday, October 12, 2022 9:18 AM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>; ASCC Pleadings <ASCCPleadings@arkansas.gov>
Cc: Rich Rosen <Rich.Rosen@dhs.arkansas.gov>; Brent Gasper <Brent.Gasper@dhs.arkansas.gov>; Joshua Gillispie <josh@greenandgillispie.com>
Subject: McAuliffe/Canis v. DHS Claims Commission # 220374

Ms. Irby-

DHS hereby requests witness subpoenas be issued and forwarded to me for service on the following:

1. **Disability Rights Arkansas (a/k/a DRA)**
   Rule 30(b)(6) designee
   400 West Capitol Ave, Suite 1200
   Little Rock, AR 72201

   Date: **Wednesday November 9, 2022**

   Time: **9:30 a.m.**

   Location: DHS Central Office
   700 Main Street, Second Floor
   Little Rock, AR 72201

   ***See* attached Notice of Deposition for the subject areas of the deposition examination upon which DRA shall designate a person to testify pursuant to Ark. Rule of Civil Procedure 30(b)(6).**

2. **Kris Stewart**
   DRA Advocate
   400 West Capitol Ave, Suite 1200
   Little Rock, AR 72201

   Date: **Wednesday November 9, 2022**

Time: **1:30 p.m.**

Location: DHS Central Office
700 Main Street, Second Floor
Little Rock, AR 72201

Please attach the Notice of Deposition to the Disability Rights Arkansas subpoena. If you have any questions, please let me know.

Thank you,
Rich

Richard Rosen
Arkansas Department of Human Services
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334 Fax: 501-682-1390

email address is: rich.rosen@dhs.arkansas.gov

SENSITIVE

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Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Disability Rights Arkansas (a/k/a DRA)**
Rule 30(b)(6) designee
400 West Capitol Ave, Suite 1200
Little Rock, AR 72201

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

November 9, 2022 at 9:30 a.m.

Arkansas Department of Human Services
700 Main Street, Second Floor Conference Room
Little Rock, Arkansas 72201

See attached Notice of Deposition for the subject areas of the deposition examination upon which DRA shall designate a person to testify pursuant to Ark. R. Civ. Proc. 30(b)(6).

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):



October 14, 2022

_____ _____
Kathryn Irby, Director Date
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d), Claims Commission Rule 3.2(d).

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Ark. R. Civ. Proc. 45(e), Claims Commission Rule 3.3.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Kris Stewart**
DRA Advocate
400 West Capitol Ave, Suite 1200
Little Rock, AR 72201

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

_X___ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

November 9, 2022 at 1:30 p.m.

Arkansas Department of Human Services
700 Main Street, Second Floor Conference Room
Little Rock, Arkansas 72201

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):

October 14, 2022

Kathryn Irby, Director
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

Date

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d), Claims Commission Rule 3.2(d).

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Ark. R. Civ. Proc. 45(e), Claims Commission Rule 3.3.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

From: Dana Henderson
To: ASCC Pleadings
Cc: Joshua Gillispie; Rich Rosen; Eric Collins
Subject: Claim No. 22037
Date: Friday, October 14, 2022 5:10:36 PM
Attachments: Notice of Deposition.Melissa Weatherton.pdf
Notice of Deposition.Jeff Gonyea.pdf

Claims Commission:

Please find attached for filing a *Notice to take Deposition of Jeff Gonyea* and a *Notice to take Deposition of Melissa Weatherton* regarding the above-referenced claim.

Thank you for your time and assistance with this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501.244.0700 (p); 501.244.2020 (f)
www.greenandgillispie.com

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF MELISSA WEATHERTON

TO: **MELISSA WEATHERTON**
c/o Richard Rosen
Arkansas DHS - Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on **December 2, 2022**, beginning at **9:30 a.m.**, Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Melissa Weatherton

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

Counsel is invited to attend and cross examine.

DATE: **Friday, December 2, 2022 at 9:30 AM (Central Time)**

LOCATION: Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72201

COURT REPORTER: Brasuell Reporting, LLC

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700; 501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 14th day of October, 2022 to the following:

Richard Rosen
Arkansas DHS - Office of Chief Counsel
rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

NOTICE TO TAKE DEPOSITION OF JEFF GONYEA

TO: **JEFF GONYEA**
c/o Richard Rosen
Arkansas DHS - Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on **December 8, 2022**, beginning at **11:00 a.m.**, Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Jeff Gonyea

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

Counsel is invited to attend and cross examine.

DATE: **Friday, December 2, 2022 at 9:30 AM (Central Time)**

LOCATION: Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72201

COURT REPORTER: Brasuell Reporting, LLC

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700; 501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 14th day of October, 2022 to the following:

Richard Rosen
Arkansas DHS - Office of Chief Counsel
rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From: Brent Gasper
To: Kathryn Irby
Cc: Rich Rosen
Subject: McAuliffe/Cains v. DHS, No. 230331
Date: Wednesday, October 19, 2022 10:46:10 AM

Katherine:

Per our communication last week, please consider this email a request to add me as co-counsel for Respondent DHS in McAuliffe/Cains v. DHS, No. 230331, and to remove Eric Collins as counsel for DHS due to his no longer being employed by the agency.

If you need anything else in this regard please do not hesitate to contact me.

Thanks!

Brent

Brent P. Gasper
Assistant Deputy Chief Counsel
Department of Human Services, Office of Chief Counsel
700 Main Street
Donaghey Plaza South
PO Box 1437, Slot S-260
Little Rock, AR 72203
(501) 320-8950
Brent.Gasper@dhs.arkansas.gov

CC: Rich Rosen

This email may contain sensitive or confidential information.

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From:	Daiquiri Carter
To:	ASCC Pleadings; Joshua Gillispie; Rich Rosen; Brent Gasper
Cc:	Daiquiri Carter
Subject:	CC# 220374
Date:	Friday, October 21, 2022 2:01:11 PM
Attachments:	DDS Response to Motion to Compel_001.pdf image001.png image002.png

Please find attached DHS' Response to Claimant's Motion to Compel.

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov





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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

DHS' RESPONSE TO CLAIMANT'S "MOTION TO COMPEL" RELEASE OF STATUTORILY CONFIDENTIAL INFORMATION UNRELATED TO THE PURPORTED WRONGFUL DEALTH CLAIM ASSERTED

COMES NOW Respondent, Arkansas Department of Human Services, by and through its counsel, Richard Rosen, and in response to Claimant's "Motion to Compel" release of statutorily confidential information unrelated to the actual claim, DHS submits the following points and authorities:

> **"Some misfortunes, originating in misrepresentation, frequently flow and spread before they can be dissipated by truth"**
>
> **George Washington - May 8, 1796**

Although Claimant's "motion to compel" is seemingly about the release of two types of confidential information which the Arkansas General Assembly *expressly* declared confidential as a matter of law, Claimant peppers her motion with self-serving, factually unfounded and unsupported characterizations concerning the circumstances of David Cains' unexpected death from choking, *as if* the characterizations asserted in the "motion to compel" were actually established by the facts, which they are not. Despite taking over 16 depositions of DHS staff (with two more currently scheduled), it is evident that Claimant is still searching for a *prima facie* case of liability against the state which she has yet to establish. As a result, Claimant now resorts to

"compelling" the release of statutorily confidential information of purported accusations against BHDC caregivers ***unrelated*** to any of the legal or factual claims raised in this claim. **There is no allegation here of any maltreatment or pattern of maltreatment against David Cains by BHDC staff and, consequently, any release of such confidential information (to the extent any exists) is irrelevant to the facts that Claimant must prove in order to prevail.**

David Cains, a 42 year intellectually disabled man, unfortunately choked on his on vomit during an aggressive behavioral outburst and died when neither BHDC medical staff nor the responding EMTs were able to clear his airway in time to save his life. Due to Mr. Cains prior aggression and behavioral outbursts, his [redacted] for his safety and for the safety of staff and residents around him. The IPP behavioral management plan was developed by a team whose members included both the claimant, Christine McAuliffe, and Mr. Cains mother and heir, Charlene Robinson, who **approved** and **signed** the program plan allowing such interventions during Mr. Cains aggressive behavioral episodes. The IPP included input from the BHDC medical team and David Cains' physician.

As stated by Claimant's counsel during his deposition questioning of Syed Hamid, M.D., David Cains' physician, both Mr. Cains and a staff member "toppled" to the floor after David Cains lunged at Tyler Matson during a behavioral outburst.[1] Tyler Mattson was a

---

[1] *See* 05/26/22 deposition of Syed Hamid, M.D., p. 27, lines 17 to p. 28, line 5:

Mr. Gillispie: I'll also represent to you that a behavior occurred. David and a staff member named Tyler Matson end up on the ground. How exactly David landed on the ground, whether he landed on his face, on his back, it's not crystal clear at this point, but he -- according to Mr. Matson, there was a struggle of some sort and **they sort of topple over onto the ground. And I'll represent to you that that's how he got to the ground.** Are you with me so far?

BHDC aide. Although Claimant now asserts that David Cains was somehow "taken to the ground," "pinned," and the emergency intervention was "unnecessary," none of these current statements are factually correct. Mr. Cains was not "pinned" to the floor but, instead, had his ankles and hands held to keep him from hurting himself and staff until he calmed down and could safely be released. Sadly, during this behavioral episode, Mr. Cains apparently choked on vomit which blocked his airway and the subsequent efforts to save his life were unsuccessful.

Claimant also asserts in her "motion to compel" several other characterizations and statements **unrelated** to her rationale for release of the confidential documents. For example, the motion posits that "BHDC has long been criticized" by Disability Rights Arkansas (DRA), an organization which has previously taken positions *diametrically opposed* to the expressed wishes and directions of the very family members and court appointed legal guardians of the individuals it professes to represent. DRA, however, is an organization openly critical of the availability of institutional care for the intellectually disabled and has previously sought to close down the BHDC and the other HDCs *contrary* to the interests and expressed wishes of the HDC residents, families, and the court appointed legal guardians. In context, DRA actively seeks to remove the option of institutional care from the Arkansas families and court appointed legal guardians who, along with the medical professionals, believe that institutional care is necessary for their loved ones, patients, and wards. Thus, it is no surprise that Claimant now references a 2016 DRA report critical of BHDC.[2]

---

[2] Even DRA's own legal counsel expressed to DHS that the 2016 DRA report was too remote in time to be relevant in this case. *See* DHS Ex. A – 09/26/22 email from Patrick Wilson, DRA counsel, to Rich Rosen, stating: "Those reports seem pretty removed from what happened to Mr. Cains years later, but I will look into it and discuss with DRA.

Maltreatment Reports

Per the motion, Claimant seeks release of confidential maltreatment reports, to the extent any even exist, for the three BHDC staff members attending to Mr. Cains behavioral outburst on June 13, 2020:

- Tyler Matteson
- Amy Jones
- Ryann Campos.

Significantly, none of the reports sought by Claimant, to the extent any actually exist, are asserted or alleged in the motion to be related to the June 13, 2020 incident. Claimant simply seeks any historical maltreatment reports which, she *claims*, will somehow establish liability under a *false correlation theory* that if excessive force was purportedly used against another resident at another time, it must have been used against Mr. Cains on June 13, 2020. Claimant even cites to the decision in *Dollar General Corp. v. Elder*, 2020 Ark. 208 in an effort to bolster the legitimacy of her argument. The *Elder* case, however, makes no such pronouncement supporting Claimant's argument. Instead, the decision involves real property law and addresses the property owner's duty to warn business invitees of hidden dangers existing on the property. In *Elder*, the court noted there was testimony that the plaintiff slipped and fell on smooth concrete and that others had, likewise, previously slipped and fallen on the same smooth concrete. Significantly, the Court of Appeals expressly stated that the evidence of prior falls was presented only to establish that the concrete was "unreasonably dangerous," a point relevant to the property owner's duty to warn

invitees. It did not involve issues of foreseeability as now argued by Claimant. *See Elder*, 2020 Ark at *5.[3]

In a more similar situation, the Arkansas Supreme Court held that information sought by the plaintiff about the defendant's prior traffic violations or problems with insurance were in no way relevant to the issue of whether he is was negligent. *Barker v. Clark*, 343 Ark. 8, 12 (2000). The general rule in Arkansas is that evidence of prior accidents is not admissible for the purpose of proving negligence. *Transit Homes, Inc. v. Bellamy*, 282 Ark. 453, 460 (1984) reversed on other grounds, 314 Ark. 8, 13 (1993).

In this context, the records which Claimant seeks are confidential and not relevant to any issue before the Commission. Per Ark. Code Ann. §12-12-1717(a), the availability of founded maltreatment reports by DHS "shall be confidential." Claimant, however, asserts that she is entitled to maltreatment reports, to the extent any even exist, because they are necessary for the determination of an issue before a grand jury or court. The exception, however, is not applicable because, as explained above, such prior acts are not relevant to prove negligence on the claims asserted. In other words, even if there were prior maltreatment allegations lodged against BHDC staff, it would not be admissible to prove any issue of foreseeability or proximate cause currently before the Commission. Thus, even under Claimant's theory, such reports, to the extent there are any, are not necessary for any determination before the Commission. Consequently, the exception does not apply.

---

[3] The Court of Appeals stated: "To establish that the concrete was unreasonably dangerous, Elder presented testimony from Bryant, the former assistant manager of Dollar General, who said that the area was slick and that she had seen at least four other people slip there, although not all of them fell all the way to the ground." *Elder*, 2020 Ark at *5.

The exceptions for screened out, pending, and unfounded reports under Ark. Code Ann. §12-12-1718 are even more limited. Per Ark. Code Ann. §12-12-1718(a), there are no exceptions for screened out reports. While pending reports are subject to the same exceptions as founded reports, as explained above, the exception is not applicable because the reports are not necessary for determination of any issue on the wrongful death claim presently before the Commission. Finally, unfounded reports are only subject to the release exceptions after "satisfaction of due process" and only then when, again, it is necessary for a determination of an issue before the Commission. Consequently, the exception to the confidentiality of the reports, if any exist, is not applicable.

Mortality Review Committee

Claimant further seeks release of the DDS Mortality Review Committee documents related to David Cains which, per Ark. Code Ann. §16-46-109, are expressly "confidential" and, by law, "absolutely privileged." The DDS Mortality Review Committee is a Quality Assurance Committee subject to the confidentiality provisions of Ark. Code Ann. §16-46-109. Arkansas law defines a Quality Assurance Committee as having the responsibility for reviewing and evaluating the quality of medical, nursing, or other care delivered in a long-term care facility, or of professional consultants engaged by long-term care facilities to study quality-of-care issues identified by the committee. Ark. Code Ann. § 16-46-109(a). That is exactly what the DDS Mortality Review Committee does for unexpected deaths at its HDCs. *See* DHS Ex. B ("Purpose" excerpted from DDS Mortality Review Committee Protocol for 2020).

Even Claimant, in her motion on page 6, *concedes* that the DDS Mortality Review Committee conducts a review of each unexpected death of persons in HDCs which, per Claimant, includes circumstances of death and other risk factors. *See* Motion, p. 6. As HDCs are long-term

care facilities, the DDS Mortality Review Committee meets the statutory definition of a Quality Assurance Committee whose records are confidential by law. Claimant's insinuations to the contrary defy her *own* statements about the role of the DDS Mortality Review Committee which, she admits in her motion, is to review the circumstances of unexpected deaths and other risk factors in a DDS HDC. Consequently, Claimant's arguments in favor of release are not only contrary to the Arkansas law cited but, in addition, conflict with her *own* representations to this Commission as to the duties of the committee in reviewing the circumstances of unexpected HDC deaths. Consequently, as a matter of Arkansas law, Claimant's claims are without legal merit and should be rejected.

WHEREFORE, the Arkansas Department of Human Services, by counsel, moves that the "motion to compel" release of confidential information be denied.

Respectfully Submitted,

Arkansas Department of Human Services

By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On October 21, 2022, a copy of the above response was served via electronic mail and mailed to:

Joshua D. Gillespie, Esquire josh@greenandgillispie.com
GREEN & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, AR 72214

Richard Rosen

Rich Rosen

From: Patrick D. Wilson <PWilson@wlj.com>
Sent: Monday, September 26, 2022 12:05 PM
To: Rich Rosen
Subject: David Cains Matter - Arkansas State Claims Commission

[EXTERNAL SENDER]
Rich,

Disability Rights Arkansas ("DRA") has retained us in connection with its limited involvement in the Cains matter before the Claims Commission. I don't have nearly all the information and am trying to get up to speed now, but I understand DHS is looking to take depositions of Kris Stewart and a Rule 30(b)(6) deposition of DRA on a couple of reports, from January of 2015 and January of 2016. Those reports seem pretty far removed from what happened to Mr. Cains years later, but I will look into it and discuss with DRA.

I understand you've suggested some possible dates for these depositions. Before we get too deep into that, however, we need to see a proposed notice of deposition with the topics clearly and specifically spelled out. We will then discuss with DRA.

Thank you. Look forward to working with you here.

Patrick

Patrick D. Wilson
ATTORNEY
501.212.1343 | PWilson@wlj.com

Wright, Lindsey & Jennings LLP
200 West Capitol Avenue, Suite 2300 | Little Rock, AR 72201
Main 501.371.0808 | Fax 501.376.9442 | wlj.com

EXHIBIT
A
DHS
PENGAD 800-631-6989

HDC DEATH REVIEW PROTOCOL

I. Purpose

The Human Development Center Death Review Committee is designed as an oversight committee with no enforcement authority. Its specific purposes are:

1. To review all deaths at all state-operated Human Development Centers (HDC) since January 1, 2002, and any historical deaths, as requested, to determine:

- The circumstances surrounding the death,
- The appropriateness of the medical and nursing care that was rendered by the HDC, and
- Any HDC system issues that may require review and resolution for quality improvement and quality assurance.

2. To ensure that all state programs operate in compliance with conditions and standards imposed by the Arkansas Medical Assistance Program.



From: Kathryn Irby
To: Brent Gasper
Subject: RE: quick Q
Date: Monday, October 31, 2022 10:06:00 AM
Attachments: McAuliffe hearing ltr.pdf

March 9. This hearing letter says Zoom, but one or both parties subsequently requested an in-person hearing, so that's how it's on the docket right now.

From: Brent Gasper <Brent.Gasper@dhs.arkansas.gov>
Sent: Monday, October 31, 2022 10:01 AM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Subject: quick Q

Kathryn, what day do you have the Cains matter scheduled for hearing?

Thx!

brent

Brent P. Gasper
Assistant Deputy Chief Counsel
Department of Human Services, Office of Chief Counsel
700 Main Street
Donaghey Plaza South
PO Box 1437, Slot S-260
Little Rock, AR 72203
(501) 320-8950

Brent.Gasper@dhs.arkansas.gov

This email may contain sensitive or confidential information.

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From:	Joshua Gillispie
To:	ASCC Pleadings
Cc:	Rich Rosen; Brent Gasper; Chad
Subject:	CC# 220374
Date:	Monday, October 31, 2022 3:43:31 PM
Attachments:	Claimant"s Reply for Her Motion to Compel the Release of Certain.pdf

You don't often get email from josh@greenandgillispie.com. Learn why this is important

Dear Commission:

Please find attached for filing Claimant's Reply for her Motion to Compel.

Best Regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

CLAIMANT'S REPLY FOR HER MOTION TO COMPEL THE RELEASE OF CERTAIN DOCUMENTS BY RESPONDENT

COMES NOW the Claimant, Christine McAuliffe, as Special Administrator of the Estate of David Cains, by and through her attorney, Joshua D. Gillispie, and for her *Reply*, states the following:

Tyler Mattson's history of physically abusing the developmentally disabled residents of the Booneville Human Development Center (BHDC) made his physical abuse of David Cains on the day in question foreseeable, thereby making Cains' death foreseeable. Foreseeability is pertinent to the issue of Respondent's negligence. The Arkansas Supreme Court holds that "to constitute actionable negligence, it is not necessary that the actor foresee **the particular** injury which occurred, only that the actor reasonably foresee **an** appreciable risk of harm to others." *Wallace v. Broyles*, 331 Ark. 58, 961 S.W.2d 712, 715 (1998) (emphasis added).

Jonathan McCutcheon, who worked for several years at the BHDC, recently testified in deposition that in or around 2019 he witnessed Tyler Mattson physically abuse another developmentally disabled resident; specifically, McCutcheon testified that Mattson grabbed the resident by his collar, yanked him down to the ground, and then dragged the resident along a hallway floor all the way to the resident's room. McCutcheon testified that he reported what he witnessed, that he relayed what he witnessed directly to BHDC Administrator Jeff Gonyea, that a

maltreatment investigation was conducted, and that the allegations of maltreatment against Mattson were determined to be unfounded.[1]

Meanwhile, Tyler Mattson testified at his deposition that he recalled it was Sandy Evans who most likely conducted the 2019 investigation that cleared him of wrongdoing in this prior incident of resident abuse.[2] This is significant, given that it was Sandy Evans who investigated and cleared Tyler Mattson of wrongdoing in David Cains' death. As previously stated in Claimant's *Motion*, there has been deposition evidence obtained that challenges the validity of Evans' maltreatment investigation into Cains' death.[3]

Given all this, Claimant deserves to see the documents she is requesting from Respondent. Claimant seeks an order compelling Respondent to release (1) all Adult

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[1] The transcript of McCutcheon's deposition not yet provided by the court reporter.

[2] Please see p. 20: 5-22 and p. 22: 9-20 of Tyler Mattson's deposition transcript, attached here as *Exhibit 1*.

[3] For instance, Tyler Mattson testified at deposition that the entirety of Sandy Evans' investigation into his personal involvement in the death included one brief interaction during which he was questioned for "barely a minute," that Evans did not ask him detailed questions about what happened, and that primarily all she did was provide him a witness statement form and then personally instruct him on how to complete the form.[3]
At her own deposition, Evans actually admitted that the death-causing restraint used by the three staff members was ***not*** the least restrictive method that could have been used on David Cains.[3] Therefore, it was not necessary to use that amount of force on David. Inexplicably, Evans still failed to substantiate maltreatment against the three staff members. Per Respondent's own policy, any physical restraint exceeding in force the least restrictive option is unnecessary and forbidden at the BHDC. *Arkansas Department of Human Services DDS Policy 3011-D*. The statutory definition of "Abuse" in long term care facilities such as the BHDC includes any "intentional and *unnecessary* physical act that inflicts pain on or causes injury" to a developmentally disabled person. A.C.A. § 12-12-1703(1). Simultaneously, "abuse" is one of the definitions of "Adult Maltreatment." A.C.A. § 12-12-1703(2). In other words, Evans, by her own admission, acknowledges that adult maltreatment, as defined in Arkansas code, occurred, yet still failed to substantiate allegations of adult maltreatment against the three staff members who engaged in the unnecessary physical act that caused David Cains' death.

Maltreatment Reports for which Tyler Mattson, Amy Jones, and Ryann Campos were an accused offender while employed at the BHDC; (2) all 16 Adult Maltreatment Reports involving substantiated staff-on-client maltreatment where Sandy Evans was the investigator; and (3) Mortality Review Committee documents related to David Cains' death.

WHEREFORE, the Claimant prays for the Arkansas Claims Commission to grant this Motion and issue an Order directing Respondent to provide the documents requested in this Motion to Claimant, and for all other proper relief which she may be entitled.

Respectfully submitted by;

/s/ Joshua D. Gillispie
ABA # 2010131
GREEN & GILLISPIE
1 Riverfront Pl., Ste. 605
Little Rock, AR 72201
(501) 244-0700
(501) 244-2020, fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 31st day of October, 2022, and service shall be accomplished via email to counsel of record.

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS
SPECIAL ADMINISTRATOR OF THE
ESTATE OF DAVID CAINS

CLAIMANT

VS. CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER)

RESPONDENT

VIDEOTAPED ORAL DEPOSITION

OF

TYLER ANTHONY MATTSON

March 31, 2022

Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72203

Shyloa Myers, RPR, CCR
Arkansas Lic. No. 710



Shyloa Myers, AR CRR No. 710
StenoScribe, Inc.
alldaydepo@gmail.com

time.
A. So I had the one to one, and so they sent another staff to sit with him while I just went back to the floor and did visual duties.
Q. Okay. But somebody from DHS -- or who required you to write out a statement about it?
A. I believe if I remember correctly it was the director at the time.
Q. Okay.
A. Or -- either the director or the team leader at the time; it was one of those two. It's been a few years.
Q. And is it your understanding that a -- that a maltreatment investigation was conducted but found to be unsubstantiated?
A. Yes.
Q. Is that what happened?
A. Yes.
Q. Okay. And this was in 2019?
A. As far as I remember.
Q. Okay. And do you -- do you know who the director was then?
A. Sandy Evans.
Q. Okay. And what was going on with this Johnathon McCutcheon that he -- why did he have -- why do you feel like he, you know, maybe didn't care for you?

A. Or soon after.
Q. Soon after. Okay.
A. Yeah.
Q. So he may have still been there when you --
A. Maybe.
Q. -- quit?
Okay. McCutcheon you said?
A. Yeah.
Q. Okay. Okay. And did you receive a determination letter in the mail informing you that they had investigated it and found their -- found that the allegations were not substantiated?
A. Not that I remember. I think it was just kind of a word of mouth; like, everything's okay, if I remember right. I may have gotten a letter, but I --
Q. But the main -- the person that would --
A. They let me know.
Q. The main person involved in this would have been Sandy Evans, though?
A. Yeah.
Q. Yes?
A. Yes.
Q. Okay. All right. Okay. As a residential care technician, what are your duties and responsibilities?
A. For the shift I was on, day shift, I would get them

From:	Joshua Gillispie
To:	ASCC Pleadings
Cc:	Rich Rosen; Brent Gasper; Chad
Subject:	CC# 220374
Date:	Wednesday, November 2, 2022 10:23:31 PM
Attachments:	Request for Admissions.pdf RFA Exhibit 1.pdf RFA Exhibit 2.pdf

---

Dear Claims Commission:

Please find attached for filing Requests for Admission propounded to Respondent.

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains	**CLAIMANT**
V.	**Claim No. 220374**
THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)	**RESPONDENT**

CLAIMANT'S REQUESTS FOR ADMISSION TO RESPONDENT

COMES now Plaintiff, by and through her attorney, Joshua D. Gillispie, and propounds to Defendant Arkansas Department of Human Services the following Requests for Admission, to be answered in accordance with the Arkansas Rules of Civil Procedure and other applicable laws:

INSTRUCTIONS and DEFINITIONS

"DHS" means the Respondent, the Arkansas Department of Human Services.

"DDS" means Division of Developmental Services.

"BHDC" means Booneville Human Development Center.

"Clients" means residents of BHDC, such as David Cains.

REQUEST FOR ADMISSION NO. 1: Admit that Melissa Weatherton was the director of DDS at the time of David Cains' death.

REQUEST FOR ADMISSION NO. 2: Admit that Cindy Gillespie was the director of DHS at the time of David Cains' death.

REQUEST FOR ADMISSION NO. 3: Admit that DDS had supervisory control over BHDC at the time of David Cains' death.

REQUEST FOR ADMISSION NO. 4: Admit that, at the time of David Cains' death, DHS permitted staff at BHDC to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

REQUEST FOR ADMISSION NO. 5: Admit that, at the time of David Cains' death, DDS permitted staff at BHDC to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

REQUEST FOR ADMISSION NO. 6: Admit that, at the time of David Cains' death, BHDC permitted its staff to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

REQUEST FOR ADMISSION NO. 7: Admit that, at the time of David Cains' death, DHS was aware that BHDC permitted its staff to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

REQUEST FOR ADMISSION NO. 8: Admit that, at the time of David Cains' death, DDS was aware that BHDC permitted its staff to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

REQUEST FOR ADMISSION NO. 9: Admit that, at the time of David Cains' death, the Director of DHS was aware that BHDC permitted its staff to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

REQUEST FOR ADMISSION NO. 10: Admit that, at the time of David Cains' death, the Director of DDS was aware that BHDC permitted its staff to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

REQUEST FOR ADMISSION NO. 11: Admit that, at the time of David Cains' death, BHDC did not have cameras in place to monitor common areas of the facility.

REQUEST FOR ADMISSION NO. 12: Admit that, at the time of David Cains' death, DHS was aware that BHDC did not have cameras in place to monitor common areas of the facility.

REQUEST FOR ADMISSION NO. 13: Admit that, at the time of David Cains' death, DDS was aware that BHDC did not have cameras in place to monitor common areas of the facility.

REQUEST FOR ADMISSION NO. 14: Admit that, at the time of David Cains' death, the Director of DHS was aware that BHDC did not have cameras in place to monitor common areas of the facility.

REQUEST FOR ADMISSION NO. 15: Admit that, at the time of David Cains' death, the Director of DDS was aware that BHDC did not have cameras in place to monitor common areas of the facility.

REQUEST FOR ADMISSION NO. 16: Admit that, at the time of David Cains' death, BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor common areas of the facility.

REQUEST FOR ADMISSION NO. 17: Admit that, at the time of David Cains' death, DHS was aware that BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor common areas of the facility.

REQUEST FOR ADMISSION NO. 18: Admit that, at the time of David Cains' death, DDS was aware that BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor common areas of the facility.

REQUEST FOR ADMISSION NO. 19: Admit that, at the time of David Cains' death, the Director of DHS was aware that BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor common areas of the facility.

REQUEST FOR ADMISSION NO. 20: Admit that, at the time of David Cains' death, the Director of DDS was aware that BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor common areas of the facility.

REQUEST FOR ADMISSION NO. 21: Admit that, at the time of David Cains' death, BHDC's policy was that only medical staff could determine the need to call 911.

REQUEST FOR ADMISSION NO. 22: Admit that, at the time of David Cains' death, DHS was aware that BHDC's policy was that only medical staff could determine the need to call 911.

REQUEST FOR ADMISSION NO. 23: Admit that, at the time of David Cains' death, DDS was aware that BHDC's policy was that only medical staff could determine the need to call 911.

REQUEST FOR ADMISSION NO. 24: Admit that, at the time of David Cains' death, the director of DHS was aware that BHDC's policy was that only medical staff could determine the need to call 911.

REQUEST FOR ADMISSION NO. 25: Admit that, at the time of David Cains' death, the director of DDS was aware that BHDC's policy was that only medical staff could determine the need to call 911.

REQUEST FOR ADMISSION NO. 26: Admit that, at the time of David Cains' death, BHDC's non-medical staff, including direct care staff, were not supposed to call 911.

REQUEST FOR ADMISSION NO. 27: Admit that, at the time of David Cains' death, DHS was aware that BHDC's non-medical staff, including direct care staff, were not supposed to call 911.

REQUEST FOR ADMISSION NO. 28: Admit that, at the time of David Cains' death, DDS was aware that BHDC's non-medical staff, including direct care staff, were not supposed to call 911.

REQUEST FOR ADMISSION NO. 29: Admit that, at the time of David Cains' death, the director of DHS was aware that BHDC's non-medical staff, including direct care staff, were not supposed to call 911.

REQUEST FOR ADMISSION NO. 30: Admit that, at the time of David Cains' death, the director of DDS was aware that BHDC's non-medical staff, including direct care staff, were not supposed to call 911.

REQUEST FOR ADMISSION NO. 31: Admit that, at the time of David Cains' death, BHDC's non-medical staff, including direct care staff, were required to first call BHDC medical staff, not 911, during a medical emergency.

REQUEST FOR ADMISSION NO. 32: Admit that, at the time of David Cains' death, DHS was aware that BHDC's non-medical staff, including direct care staff, were required to first call BHDC medical staff, not 911, during a medical emergency.

REQUEST FOR ADMISSION NO. 33: Admit that, at the time of David Cains' death, DDS was aware that BHDC's non-medical staff, including direct care staff, were required to first call BHDC medical staff, not 911, during a medical emergency.

REQUEST FOR ADMISSION NO. 34: Admit that, at the time of David Cains' death, the director of DHS was aware that BHDC's non-medical staff, including direct care staff, were required to first call BHDC medical staff, not 911, during a medical emergency.

REQUEST FOR ADMISSION NO. 35: Admit that, at the time of David Cains' death, the director of DDS was aware that BHDC's non-medical staff, including direct care staff, were required to first call BHDC medical staff, not 911, during a medical emergency.

REQUEST FOR ADMISSION NO. 36: Admit that Booneville HDC Policy IV-B-10, attached here as Exhibit 1, was a policy in effect at BHDC at the time of David Cains' death.

REQUEST FOR ADMISSION NO. 37: Admit that DHS was aware that Booneville HDC Policy IV-B-10, attached here as Exhibit 1, was a policy in effect at BHDC at the time of David Cains' death.

REQUEST FOR ADMISSION NO. 38: Admit that DDS was aware that Booneville HDC Policy IV-B-10, attached here as Exhibit 1, was a policy in effect at BHDC at the time of David Cains' death.

REQUEST FOR ADMISSION NO. 39: Admit that the director of DHS was aware that Booneville HDC Policy IV-B-10, attached here as Exhibit 1, was a policy in effect at BHDC at the time of David Cains' death.

REQUEST FOR ADMISSION NO. 40: Admit that the director of DDS was aware that Booneville HDC Policy IV-B-10, attached here as Exhibit 1, was a policy in effect at BHDC at the time of David Cains' death.

REQUEST FOR ADMISSION NO. 41: Admit that BHDC did not disclose to David Cains' mother the existence of a maltreatment investigation related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

REQUEST FOR ADMISSION NO. 42: Admit that DHS was aware that BHDC did not disclose to David Cains' mother the existence of a maltreatment investigation related to his death

prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

REQUEST FOR ADMISSION NO. 43: Admit that DDS was aware that BHDC did not disclose to David Cains' mother the existence of a maltreatment investigation related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

REQUEST FOR ADMISSION NO. 44: Admit that the director of DHS was aware that BHDC did not disclose to David Cains' mother the existence of a maltreatment investigation related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

REQUEST FOR ADMISSION NO. 45: Admit that the director of DDS was aware that BHDC did not disclose to David Cains' mother the existence of a maltreatment investigation related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

REQUEST FOR ADMISSION NO. 46: Admit that BHDC did not disclose to David Cains' mother that there was a restraint incident related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

REQUEST FOR ADMISSION NO. 47: Admit that DHS was aware that BHDC did not disclose to David Cains' mother that there was a restraint incident related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

REQUEST FOR ADMISSION NO. 48 Admit that DDS was aware that BHDC did not disclose to David Cains' mother that there was a restraint incident related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

REQUEST FOR ADMISSION NO. 49 Admit that the director of DHS was aware that BHDC did not disclose to David Cains' mother that there was a restraint incident related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

REQUEST FOR ADMISSION NO. 50: Admit that the director of DDS was aware that BHDC did not disclose to David Cains' mother that there was a restraint incident related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

REQUEST FOR ADMISSION NO. 51: Admit that, following the incident that led to David Cains' death, employees at Booneville Human Development Center failed to disclose to emergency medical services that David Cains had been restrained prior to choking.

REQUEST FOR ADMISSION NO. 52: Admit that BHDC failed to disclose the restraint that led to David Cains' death until *after* the funeral, meaning that the family was not offered an opportunity to have an autopsy completed.

REQUEST FOR ADMISSION NO. 53: Admit that David Cains' family was not informed about a maltreatment investigation until at least nine days after his death and the family was unable to have an autopsy completed because he had already been buried.

REQUEST FOR ADMISSION NO. 54: Admit that David Cains was under physician's ordered [redacted] at the time of his death.

REQUEST FOR ADMISSION NO. 55: Admit that Sandy Evans, the maltreatment investigator for David Cains' death, investigated the same people she worked alongside.

REQUEST FOR ADMISSION NO. 56: Admit that, due to reports made in the past by Disability Rights of Arkansas, that BHDC has been investigated in the past for overuse of physical restraints.

REQUEST FOR ADMISSION NO. 57: Admit that, in the past, physical restraints have led to patients being injured at BHDC.

REQUEST FOR ADMISSION NO. 58: Admit that BHDC's own policies stated that physical restraints dramatically increase the risk of injury to disabled patients.

REQUEST FOR ADMISSION NO. 59: Admit that Tyler Mattson had, prior to David Cains' death, been alleged to have committed maltreatment against a BHDC client.

REQUEST FOR ADMISSION NO. 60: Admit that the maltreatment investigation into Tyler Mattson stemming from Jonathan McCutcheon's allegations was conducted by Sandra (Sandy) Evans.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
Green & Gillispie Law Firm
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 facsimile
jdgillispie@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 2nd day of November, 2022, and service shall be accomplished via email to counsel of record.

/s/__Joshua D. Gillispie___
Joshua D. Gillispie

FIRST AID GUIDELINES

POLICY STATEMENT: First Aid Guidelines are available for use in each of the Aide Stations in each living area. This will permit appropriate and immediate attention to medical conditions of sudden onset, including injuries and choking.

PROCEDURES:

1. The First Aid Guidelines have been approved by the staff physician for the Booneville HDC.

2. In all cases in which a serious medical injury or illness is suspected, either to clients or staff, a call to the Medical Department should be made. This should be the first call so Medical staff can respond immediately to the situation.

   A call to Medical at 1422 should be made and the following information should be given:

   1. Caller's name and title
   2. Victim's name, location, situation and condition of the victim (alert, unconscious, etc.)
   3. Medical will assess the situation and call an ambulance if appropriate.

3. All staff members are trained in first aid, CPR, and abdominal thrust for choking so, that if necessary, emergency rescue measures can be initiated before Medical staff arrives.

4. Choking is a serious and potentially life-threatening situation and the following guidelines should be followed:

   a. Staff will supervise clients during meal times and nursing staff will be available by phone at all times;
   b. emergency equipment including oxygen and suction machine will be kept in the dining room for use as needed;
   c. All staff will receive annual training in abdominal thrust and choking precautions.

5. First Aid kits, disaster kits, and first aid guidelines will be kept in all areas. Medical will do monthly inspections on first aid kits, and every 6 month inspections on disaster kits, and refill appropriately. If living area staff notice supplies are low, Medical is to be notified and supplies will be replenished.

APPROVED: _____
Superintendent

Supersedes BHDC Policy IV-B-10, dated 03/13/15, in its entirety.



REVIEWED: 11/27/19
VERSION: 12/29/17

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Booneville Human Development Center
87 Reed Road
Booneville, AR 72927
P: 479.675.2121
F: 479.675.2518
HUMANSERVICES.ARKANSAS.GOV

June 19, 2020

Charlene Robinson
[redacted]

Re: David Cains

Dear Ms. Robinson,

Enclosed you will find a copy of the Final Synopsis of an incident that was reported to you earlier.

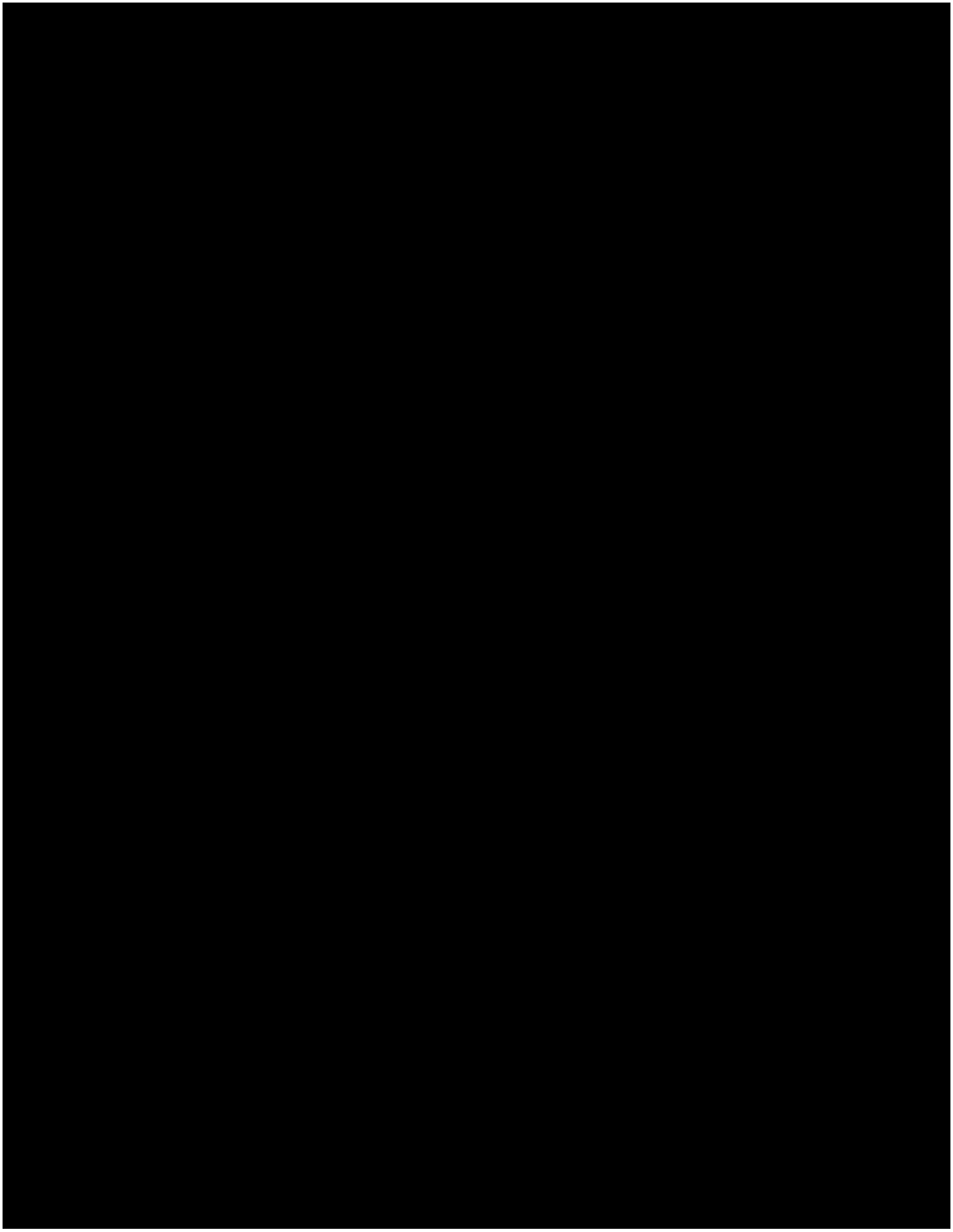
As always, I appreciate your cooperation and involvement. If you should have any questions or concerns, please do not hesitate to contact me. I can be reach by phone at 479-675-1406 or by email at Caleb.Murray@DHS.Arkansas.Gov

Sincerely,

Caleb Murray
Program Coordinator/Social Service Worker

CM/Enclosures CC: Master File

EXHIBIT
tabbies
2



From: Kathryn Irby
To: Joshua Gillispie; Rich Rosen; Brent Gasper
Cc: OCC Claims Commission Cases
Subject: HEARING CHANGES: McAuliffe v. DHS, Claim No. 220374
Date: Thursday, November 3, 2022 10:23:00 AM
Attachments: McAuliffe v. DHS -- 220374 -- hearing ltr (motion).pdf

Mr. Gillispie, Mr. Rosen, and Mr. Gasper, please see attached hearing letter regarding Mr. Gillispie's pending motion to compel.

Given this February motion hearing, I expect that we'll need to bump the claim hearing from March. I have an opening on June 16 or we can look at August/September. Please let me know your preference.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

ARKANSAS STATE CLAIMS COMMISSION

(501) 682-1619
FAX (501) 682-2823

KATHRYN IRBY
DIRECTOR

101 EAST CAPITOL AVENUE
SUITE 410
LITTLE ROCK, ARKANSAS
72201-3823

November 3, 2022

Mr. Joshua Gillispie (*via email*)
Green & Gillispie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

Mr. Rich Rosen (*via email*)
Mr. Brent Gasper
Arkansas Department of Human Services
Post Office Box 1437, Slot S260
Little Rock, Arkansas 72203

RE: ***Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services***
Claim No. 220374

Dear Mr. Gillispie, Mr. Rosen, and Mr. Gasper,

The Claims Commission has scheduled a hearing on Mr. Gillispie's pending motion to compel for on **Friday, February 10, 2023**, beginning at 9:00 a.m. All parties will attend via Zoom. The Zoom invitation is enclosed.

As this is a motions hearing, no pre-hearing submissions are requested.

If you have any questions, please do not hesitate to contact my office.

Sincerely,

Kathryn Irby

ES: kmirby

The Claims Commission is inviting you to a scheduled Zoom meeting.

Topic: Claims Commission -- hearings
Time: Feb 10, 2023 09:00 AM Central Time (US and Canada)

Join Zoom Meeting
https://us06web.zoom.us/j/87579091104?pwd=bkRDL2lFUnZUclhSUE8wS2ZLOGVpZz09

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Passcode: 6EPTmJ
One tap mobile
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+13126266799,,87579091104#,,,,*124942# US (Chicago)

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+1 646 931 3860 US
+1 929 436 2866 US (New York)
+1 301 715 8592 US (Washington DC)
+1 669 444 9171 US
+1 669 900 6833 US (San Jose)
+1 689 278 1000 US
+1 719 359 4580 US
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 360 209 5623 US
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US
Meeting ID: 875 7909 1104
Passcode: 124942
Find your local number: https://us06web.zoom.us/u/kd3oe4TIYF

From: Joshua Gillispie
To: Kathryn Irby
Cc: Rich Rosen; Brent Gasper; OCC Claims Commission Cases
Subject: Re: HEARING CHANGES: McAuliffe v. DHS, Claim No. 220374
Date: Thursday, November 3, 2022 10:35:16 AM

Thank you, all.

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Thu, Nov 3, 2022 at 10:33 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Josh, I can confirm receipt of your email, and I will remove the motion hearing from the Feb docket. This claim hearing will remain on the March docket as previously scheduled.
>
> Thanks,
>
> Kathryn
>
> ---
>
> **From:** Joshua Gillispie <josh@greenandgillispie.com>
> **Sent:** Thursday, November 3, 2022 10:29 AM
> **To:** Kathryn Irby <Kathryn.Irby@arkansas.gov>
> **Cc:** Rich Rosen <Rich.Rosen@dhs.arkansas.gov>; Brent Gasper <Brent.Gasper@dhs.arkansas.gov>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
> **Subject:** Re: HEARING CHANGES: McAuliffe v. DHS, Claim No. 220374
>
> Kathryn-
>
> Thank you for this hearing offer. However, I will voluntarily withdraw this motion, effective immediately, as my client is adamantly opposed to pushing the final hearing if that can be avoided.

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Thu, Nov 3, 2022 at 10:24 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie, Mr. Rosen, and Mr. Gasper, please see attached hearing letter regarding Mr. Gillispie's pending motion to compel.
>
> Given this February motion hearing, I expect that we'll need to bump the claim hearing from March. I have an opening on June 16 or we can look at August/September. Please let me know your preference.
>
> Thanks,
>
> Kathryn Irby
>
> **Kathryn Irby**
>
> **Arkansas State Claims Commission**
>
> 101 East Capitol Avenue, Suite 410
>
> Little Rock, Arkansas 72201
>
> (501) 682-2822

From: Rich Rosen
To: Kathryn Irby
Cc: Brent Gasper; OCC Claims Commission Cases; Rich Rosen; Joshua Gillispie
Subject: RE: HEARING CHANGES: McAuliffe v. DHS, Claim No. 220374
Date: Thursday, November 3, 2022 10:35:16 AM

Thank you for the update.

Rich

Richard Rosen
Arkansas Department of Human Services
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334 Fax: 501-682-1390

email address is: rich.rosen@dhs.arkansas.gov

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From: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Sent: Thursday, November 3, 2022 10:34 AM
To: Joshua Gillispie <josh@greenandgillispie.com>
Cc: Rich Rosen <Rich.Rosen@dhs.arkansas.gov>; Brent Gasper <Brent.Gasper@dhs.arkansas.gov>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
Subject: RE: HEARING CHANGES: McAuliffe v. DHS, Claim No. 220374

Josh, I can confirm receipt of your email, and I will remove the motion hearing from the Feb docket. This claim hearing will remain on the March docket as previously scheduled.

Thanks,
Kathryn

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Thursday, November 3, 2022 10:29 AM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Rich Rosen <Rich.Rosen@dhs.arkansas.gov>; Brent Gasper <Brent.Gasper@dhs.arkansas.gov>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>

Subject: Re: HEARING CHANGES: McAuliffe v. DHS, Claim No. 220374

Kathryn-

Thank you for this hearing offer. However, I will voluntarily withdraw this motion, effective immediately, as my client is adamantly opposed to pushing the final hearing if that can be avoided.

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

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> Mr. Gillispie, Mr. Rosen, and Mr. Gasper, please see attached hearing letter regarding Mr. Gillispie's pending motion to compel.
>
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>
> Thanks,
> Kathryn Irby
>
> **Kathryn Irby**
> **Arkansas State Claims Commission**
> 101 East Capitol Avenue, Suite 410
> Little Rock, Arkansas 72201
> (501) 682-2822

From: Dana Henderson
To: ASCC Pleadings
Cc: Joshua Gillispie; Rich Rosen; Eric Collins
Subject: Claim No. 22037
Date: Tuesday, November 15, 2022 12:29:02 PM
Attachments: Amended Notice of Deposition.Melissa Weatherton.pdf

---

Claims Commission:

Please find attached for filing, an *Amended Notice to take Deposition of Melissa Weatherton* regarding the above-referenced claim.

Thank you for your time and assistance with this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501.244.0700 (p); 501.244.2020 (f)
www.greenandgillispie.com

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This message does not create an attorney-client relationship.

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

AMENDED NOTICE TO TAKE DEPOSITION OF MELISSA WEATHERTON

TO: **MELISSA WEATHERTON**
c/o Richard Rosen
Arkansas DHS - Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203

Please take notice that on **January 10, 2023**, beginning at **9:30 a.m.**, Claimant will take the deposition upon oral examination of the following person before a duly qualified court reporter:

Melissa Weatherton

Said deposition upon oral examination is taken pursuant to Rule 26 of the Arkansas Rules of Civil Procedure governing depositions. This deposition shall begin at the time specified and shall continue thereafter until completed.

Counsel is invited to attend and cross examine.

DATE: **Tuesday, January 10, 2022 at 9:30 AM (Central Time)**

LOCATION: Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72201

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar No. 2010131
GREEN & GILLISPIE
1 Riverfront Place, Ste. 605
North Little Rock, AR 72114
501-244-0700; 501-244-2020 (fax)
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via email on this 15th day of November, 2022 to the following:

Richard Rosen
Arkansas DHS - Office of Chief Counsel
rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From:	Daiquiri Carter
To:	ASCC Pleadings; Rich Rosen; Brent Gasper; Joshua Gillispie
Cc:	Daiquiri Carter
Subject:	Claim # 220374
Date:	Tuesday, November 15, 2022 2:22:24 PM
Attachments:	depo-Berry-Notice.pdf image001.png image002.png

Please find attached a Notice of Deposition for Ms. Jennifer Berry. I have copied Claimant's counsel on this email.

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov





NOTE - This email may contain sensitive or confidential information.

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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

Notice of Deposition

PLEASE TAKE NOTICE that pursuant to Rules 3.3 and 8.1 of the Rules and Regulations of the Arkansas State Claims Commission, the Respondent, the Arkansas Department of Human Services, Booneville Human Development Center, by counsel, will take the deposition of the **Jennifer Berry,** on the date and time and at the place identified below. The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date & Time: **Tuesday, December 6, 2022, at 11:00 a.m.**

Place: **Arkansas Department of Human Services**
700 Main Street, Second Floor Conference Room
Little Rock, Arkansas 72201

Respectfully Submitted,
Arkansas Department of Human Services

By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On November 15, 2022, a copy of the above notice was served via electronic mail and mailed to:

Joshua D. Gillespie, Esquire josh@greenandgillispie.com
GREEN & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, AR 72214

Richard Rosen

From: Rich Rosen
To: ASCC Pleadings
Cc: Rich Rosen; Joshua Gillispie; Brent Gasper
Subject: McAuliffe-Cains v. DHS, Claims Commission # 220374
Date: Wednesday, November 30, 2022 4:05:19 PM
Attachments: DHS Resp Admissions Requests (11-22).pdf

Ms. Irby-

Attached for filing in the above matter, please find Respondent's Answers to Claimant's Requests for Admission. As reflected above, I included Mr. Gillispie on this email.

Thank you,
Rich Rosen

Richard Rosen
Arkansas Department of Human Services
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334 Fax: 501-682-1390

email address is: rich.rosen@dhs.arkansas.gov

SENSITIVE

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as SPECIAL Administrator OF THE ESTATE OF DAVID CAINS **CLAIMANT**

v. **CLAIM NO. 220374**

THE ARKANSAS DEPARTMET OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) **RESPONDENT**

RESPONDENT'S ANSWERS TO CLAIMANT'S REQUESTS FOR ADMISSIONS

Comes now, Arkansas Department of Human Services, by and through its attorney, Rich Rosen, and for its Answers to Claimant's Requests for Admissions.

REQUEST FOR ADMISSION NO. 1: Admit that Melissa Weatherton was the director of DDS at the time of David Cains' death.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 2: Admit that Cindy Gillespie was the director of DHS at the time of David Cains' death.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 3: Admit that DDS had supervisory control over BHDC at the time of David Cains' death.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 4: Admit that, at the time of David Cains' death, DHS permitted staff at BHDC to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

RESPONSE: Objection. The request is vague, general, and unclear in its overbroad reference to "clients" of the HDC. Restraints, including emergency safety holds, are authorized for an *individual* client by his or her physician. Because the request references "clients" in general without identifying any particular or individual client, the request is vague and overbroad. As a result, DHS is unable to broadly admit or deny the request, as worded.

REQUEST FOR ADMISSION NO. 5: Admit that, at the time of David Cains' death, DDS permitted staff at BHDC to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

RESPONSE: Objection. The request is vague, general, and unclear in its overbroad reference to "clients" of the HDC. Restraints, including emergency safety holds, are authorized for an *individual* client by his or her physician. Because the request references "clients" in general without identifying any particular or individual client, the request is vague and overbroad. As a result, DHS is unable to broadly admit or deny the request, as worded.

REQUEST FOR ADMISSION NO. 6: Admit that, at the time of David Cains' death, BHDC permitted its staff to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

RESPONSE: Objection. The request is vague, general, and unclear in its overbroad reference to "clients" of the HDC. Restraints, including emergency safety holds, are authorized for an *individual* client by his or her physician. Because the request references "clients" in general without identifying any particular or individual client, the request is vague and overbroad. As a result, DHS is unable to broadly admit or deny the request, as worded.

REQUEST FOR ADMISSION NO. 7: Admit that, at the time of David Cains' death, DHS was aware that BHDC permitted its staff to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

RESPONSE: Objection. The request is vague, general, and unclear in its overbroad reference to "clients" of the HDC. Restraints, including emergency safety holds, are authorized for an *individual* client by his or her physician. Because the request references "clients" in general without identifying any particular or individual client, the request is vague and overbroad. As a result, DHS is unable to broadly admit or deny the request, as worded.

REQUEST FOR ADMISSION NO. 8: Admit that, at the time of David Cains' death, DDS was aware that BHDC permitted its staff to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

RESPONSE: Objection. The request is vague, general, and unclear in its overbroad reference to "clients" of the HDC. Restraints, including emergency safety holds, are authorized for an *individual* client by his or her physician. Because the request references "clients" in general without identifying any particular or individual client, the request is vague and overbroad. As a result, DHS is unable to broadly admit or deny the request, as worded.

REQUEST FOR ADMISSION NO. 9: Admit that, at the time of David Cains' death, the Director of DHS was aware that BHDC permitted its staff to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

RESPONSE: Objection. The request is vague, general, and unclear in its overbroad reference to "clients" of the HDC. Restraints, including emergency safety holds, are authorized for an *individual* client by his or her physician. Because the request references

"clients" in general without identifying any particular or individual client, the request is vague and overbroad. As a result, DHS is unable to broadly admit or deny the request, as worded.

REQUEST FOR ADMISSION NO. 10: Admit that, at the time of David Cains' death, the Director of DDS was aware that BHDC permitted its staff to restrain clients on the ground for purposes other than transitioning to mechanical restraints.

RESPONSE: Objection. The request is vague, general, and unclear in its overbroad reference to "clients" of the HDC. Restraints, including emergency safety holds, are authorized for an *individual* client by his or her physician. Because the request references "clients" in general without identifying any particular or individual client, the request is vague and overbroad. As a result, DHS is unable to broadly admit or deny the request, as worded.

REQUEST FOR ADMISSION NO. 11: Admit that, at the time of David Cains' death, BHDC did not have cameras in place to monitor common areas of the facility.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 12: Admit that, at the time of David Cains' death, DHS was aware that BHDC did not have cameras in place to monitor common areas of the facility.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 13: Admit that, at the time of David Cains' death, DDS was aware that BHDC did not have cameras in place to monitor common areas of the facility.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 14: Admit that, at the time of David Cains' death, the Director of DHS was aware that BHDC did not have cameras in place to monitor common areas of the facility.

RESPONSE: DHS is unable to admit or deny the request because the Director of DHS at the time of David Cains death is no longer employed with the State of Arkansas. It is unknown whether the former Director of DHS was aware of this or not.

REQUEST FOR ADMISSION NO. 15: Admit that, at the time of David Cains' death, the Director of DDS was aware that BHDC did not have cameras in place to monitor common areas of the facility.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 16: Admit that, at the time of David Cains' death, BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor common areas of the facility.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO.17: Admit that, at the time of David Cains' death, DHS was aware that BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor common areas of the facility.

RESPONSE: Denied. See Response to Request # 16 above.

REQUEST FOR ADMISSION NO. 18: Admit that, at the time of David Cains' death, DDS was aware that BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor common areas of the facility.

RESPONSE: Denied. See Response to Request # 16 above.

REQUEST FOR ADMISSION NO. 19: Admit that, at the time of David Cains' death, the Director of DHS was aware that BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor common areas of the facility.

RESPONSE: Denied. See Response to Request # 16 above.

REQUEST FOR ADMISSION NO. 20: Admit that, at the time of David Cains' death, the Director of DDS was aware that BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor common areas of the facility.

RESPONSE: Denied. See Response to Request # 16 above.

REQUEST FOR ADMISSION NO. 21: Admit that, at the time of David Cains' death, BHDC's policy was that only medical staff could determine the need to call 911.

RESPONSE: Respondent admits that there are any number of reasons personnel, not just medical staff, would need to call 911, including instances wholly unrelated to medical issues, including fires, active shooters, or severe or damaging weather. As such, due to the lack of specificity in the Request for Admission, Respondent denies.

REQUEST FOR ADMISSION NO. 22: Admit that, at the time of David Cains' death, DHS was aware that BHDC's policy was that only medical staff could determine the need to call 911.

RESPONSE: There are any number of reasons personnel, not just medical staff, could need to call 911, including, for example, instances wholly unrelated to medical issues, including fires, active shooters, or severe or damaging weather. As such, due to the vague nature of the request and its lack of specificity, the request is denied.

REQUEST FOR ADMISSION NO. 23: Admit that, at the time of David Cains' death, DDS was aware that BHDC's policy was that only medical staff could determine the need to call 911.

RESPONSE: There are any number of reasons personnel, not just medical staff, could need to call 911, including, for example, instances wholly unrelated to medical issues, including fires, active shooters, or severe or damaging weather. As such, due to the vague nature of the request and its lack of specificity, the request is denied.

REQUEST FOR ADMISSION NO. 24: Admit that, at the time of David Cains' death, the director of DHS was aware that BHDC's policy was that only medical staff could determine the need to call 911.

RESPONSE: There are any number of reasons personnel, not just medical staff, could need to call 911, including, for example, instances wholly unrelated to medical issues, including fires, active shooters, or severe or damaging weather. As such, due to the vague nature of the request and its lack of specificity, the request is denied. See also response to request # 14.

REQUEST FOR ADMISSION NO. 25: Admit that, at the time of David Cains' death, the director of DDS was aware that BHDC's policy was that only medical staff could determine the need to call 911.

RESPONSE: There are any number of reasons personnel, not just medical staff, could need to call 911, including, for example, instances wholly unrelated to medical issues, including fires, active shooters, or severe or damaging weather. As such, due to the vague nature of the request and its lack of specificity, the request is denied.

REQUEST FOR ADMISSION NO. 26: Admit that, at the time of David Cains' death, BHDC's non-medical staff, including direct care staff, were not supposed to call 911.

RESPONSE: There are any number of reasons personnel, not just medical staff, could need to call 911, including, for example, instances wholly unrelated to medical issues, including fires, active shooters, or severe or damaging weather. As such, due to the vague nature of the request and its lack of specificity, the request is denied.

REQUEST FOR ADMISSION NO. 27: Admit that, at the time of David Cains' death, DHS was aware that BHDC's non-medical staff, including direct care staff, were not supposed to call 911.

RESPONSE: There are any number of reasons personnel, not just medical staff, could need to call 911, including, for example, instances wholly unrelated to medical issues, including fires, active shooters, or severe or damaging weather. As such, due to the vague nature of the request and its lack of specificity, the request is denied.

REQUEST FOR ADMISSION NO. 28: Admit that, at the time of David Cains' death, DDS was aware that BHDC's non-medical staff, including direct care staff, were not supposed to call 911.

RESPONSE: There are any number of reasons personnel, not just medical staff, could need to call 911, including, for example, instances wholly unrelated to medical issues, including fires, active shooters, or severe or damaging weather. As such, due to the vague nature of the request and its lack of specificity, the request is denied.

REQUEST FOR ADMISSION NO. 29: Admit that, at the time of David Cains' death, the director of DHS was aware that BHDC's non-medical staff, including direct care staff, were not supposed to call 911.

RESPONSE: There are any number of reasons personnel, not just medical staff, could need to call 911, including, for example, instances wholly unrelated to medical issues, including fires, active shooters, or severe or damaging weather. As such, due to the vague nature of the request and its lack of specificity, the request is denied. See also response to request #14.

REQUEST FOR ADMISSION NO. 30: Admit that, at the time of David Cains' death, the director of DDS was aware that BHDC's non-medical staff, including direct care staff, were not supposed to call 911.

RESPONSE: There are any number of reasons personnel, not just medical staff, could need to call 911, including, for example, instances wholly unrelated to medical issues, including fires, active shooters, or severe or damaging weather. As such, due to the vague nature of the request and its lack of specificity, the request is denied.

REQUEST FOR ADMISSION NO. 31: Admit that, at the time of David Cains' death, BHDC's non-medical staff, including direct care staff, were required to first call BHDC medical staff, not 911, during a medical emergency.

RESPONSE: Respondent notes that Claimant has not defined what would constitute a "medical emergency" under this Request for Admission nor has Claimant differentiated whether a "medical emergency" involves residents of BHDC, staff at BHDC, or members of the general public. Moreover, Respondent denies that BHDC's non-medical staff, including

direct care staff, were prohibited from calling 911. As such, Respondent contends that this Request for Admission is vague and, to the extent that it is not, Respondent denies.

REQUEST FOR ADMISSION NO. 32: Admit that, at the time of David Cains' death, DHS was aware that BHDC's non-medical staff, including direct care staff, were required to first call BHDC medical staff, not 911, during a medical emergency.

RESPONSE: Respondent notes that Claimant has not defined what would constitute a "medical emergency" under this Request for Admission nor has Claimant differentiated whether a "medical emergency" involves residents of BHDC, staff at BHDC, or members of the general public. Moreover, Respondent denies that BHDC's non-medical staff, including direct care staff, were prohibited from calling 911. As such, Respondent contends that this Request for Admission is vague and, to the extent that it is not, Respondent denies.

REQUEST FOR ADMISSION NO. 33: Admit that, at the time of David Cains' death, DDS was aware that BHDC's non-medical staff, including direct care staff, were required to first call BHDC medical staff, not 911, during a medical emergency.

RESPONSE: Respondent notes that Claimant has not defined what would constitute a "medical emergency" under this Request for Admission nor has Claimant differentiated whether a "medical emergency" involves residents of BHDC, staff at BHDC, or members of the general public. Moreover, Respondent denies that BHDC's non-medical staff, including direct care staff, were prohibited from calling 911. As such, Respondent contends that this Request for Admission is vague and, to the extent that it is not, Respondent denies.

REQUEST FOR ADMISSION NO. 34: Admit that, at the time of David Cains' death, the director of DHS was aware that BHDC's non-medical staff, including direct care staff, were required to first call BHDC medical staff, not 911, during a medical emergency.

RESPONSE: See response to request #14. Respondent notes that Claimant has not defined what would constitute a "medical emergency" under this Request for Admission nor has Claimant differentiated whether a "medical emergency" involves residents of BHDC, staff at BHDC, or members of the general public. Moreover, Respondent denies that BHDC's non-medical staff, including direct care staff, were prohibited from calling 911. As such, Respondent contends that this Request for Admission is vague and, to the extent that it is not, Respondent denies.

REQUEST FOR ADMISSION NO. 35: Admit that, at the time of David Cains' death, the director of DDS was aware that BHDC's non-medical staff, including direct care staff, were required to first call BHDC medical staff, not 911, during a medical emergency.

RESPONSE: Respondent notes that Claimant has not defined what would constitute a "medical emergency" under this Request for Admission nor has Claimant differentiated whether a "medical emergency" involves residents of BHDC, staff at BHDC, or members of the general public. Moreover, Respondent denies that BHDC's non-medical staff, including direct care staff, were prohibited from calling 911. As such, Respondent contends that this Request for Admission is vague and, to the extent that it is not, Respondent denies.

REQUEST FOR ADMISSION NO. 36: Admit that Booneville HDC Policy IV-B-10, attached here as Exhibit 1, was a policy in effect at BHDC at the time of David Cains' death.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 37: Admit that DHS was aware that Booneville HDC Policy IV-B-10, attached here as Exhibit 1, was a policy in effect at BHDC at the time of David Cains' death.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 38: Admit that DDS was aware that Booneville HDC Policy IV-B-10, attached here as Exhibit 1, was a policy in effect at BHDC at the time of David Cains' death.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 39: Admit that the director of DHS was aware that Booneville HDC Policy IV-B-10, attached here as Exhibit l, was a policy in effect at BHDC at the time of David Cains' death.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 40: Admit that the director of DDS was aware that Booneville HDC Policy IV-B-10, attached here as Exhibit 1, was a policy in effect at BHDC at the time of David Cains' death.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 41: Admit that BHDC did not disclose to David Cains' mother the existence of a maltreatment investigation related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

RESPONSE: DHS objects because the then *ongoing* maltreatment investigation was confidential under Arkansas law and could not be disclosed. *See* Ark. Code Ann. §12-12-1718 (screened-out, *pending,* and unfounded reports). At the time, David Cains' mother was not entitled to disclosure because she was not a "subject of the report," as defined by Ark. Code Ann. §12-12-1703(23). By law, a guardianship terminates upon the death of the ward. Ark. Code Ann. §28-65-401(a)(2); *White v. Palo*, 2011 Ark. 126, *8.

REQUEST FOR ADMISSION NO. 42: Admit that DHS was aware that BHDC did not disclose to David Cains' mother the existence of a maltreatment investigation related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

RESPONSE: DHS objects because the then *ongoing* maltreatment investigation was confidential under Arkansas law and could not be disclosed. *See* Ark. Code Ann. §12-12-1718 (screened-out, *pending,* and unfounded reports). At the time, David Cains' mother was not entitled to disclosure because she was not a "subject of the report," as defined by Ark. Code Ann. §12-12-1703(23). By law, a guardianship terminates upon the death of the ward. Ark. Code Ann. §28-65-401(a)(2); *White v. Palo*, 2011 Ark. 126, *8.

REQUEST FOR ADMISSION NO. 43: Admit that DDS was aware that BHDC did not disclose to David Cains' mother the existence of a maltreatment investigation related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

RESPONSE: DHS objects because the then *ongoing* maltreatment investigation was confidential under Arkansas law and could not be disclosed. *See* Ark. Code Ann. §12-12-1718 (screened-out, *pending,* and unfounded reports). At the time, David Cains' mother was not entitled to disclosure because she was not a "subject of the report," as defined by Ark. Code Ann. §12-12-1703(23). By law, a guardianship terminates upon the death of the ward. Ark. Code Ann. §28-65-401(a)(2); *White v. Palo*, 2011 Ark. 126, *8.

REQUEST FOR ADMISSION NO. 44: Admit that the director of DHS was aware that BHDC did not disclose to David Cains' mother the existence of a maltreatment

investigation related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

RESPONSE: DHS objects because the then *ongoing* maltreatment investigation was confidential under Arkansas law and could not be disclosed. *See* Ark. Code Ann. §12-12-1718 (screened-out, *pending,* and unfounded reports). At the time, David Cains' mother was not entitled to disclosure because she was not a "subject of the report," as defined by Ark. Code Ann. §12-12-1703(23). By law, a guardianship terminates upon the death of the ward. Ark. Code Ann. §28-65-401(a)(2); *White v. Palo*, 2011 Ark. 126, *8. *See also* response to request #14 above.

REQUEST FOR ADMISSION NO. 45: Admit that the director of DDS was aware that BHDC did not disclose to David Cains' mother the existence of a maltreatment investigation related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

RESPONSE: DHS objects because the then *ongoing* maltreatment investigation was confidential under Arkansas law and could not be disclosed. *See* Ark. Code Ann. §12-12-1718 (screened-out, *pending,* and unfounded reports). At the time, David Cains' mother was not entitled to disclosure because she was not a "subject of the report," as defined by Ark. Code Ann. §12-12-1703(23). By law, a guardianship terminates upon the death of the ward. Ark. Code Ann. §28-65-401(a)(2); *White v. Palo*, 2011 Ark. 126, *8.

REQUEST FOR ADMISSION NO. 46: Admit that BHDC did not disclose to David Cains' mother that there was a restraint incident related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

RESPONSE: Denied because there was no restraint incident related to David Cains' death.

REQUEST FOR ADMISSION NO. 47: Admit that DHS was aware that BHDC did not disclose to David Cains' mother that there was a restraint incident related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

RESPONSE: Denied because there was no restraint incident related to David Cains' death.

REQUEST FOR ADMISSION NO. 48: Admit that DDS was aware that BHDC did not disclose to David Cains' mother that there was a restraint incident related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final synopsis," attached here as Exhibit 2.

RESPONSE: Denied because there was no restraint incident related to David Cains' death.

REQUEST FOR ADMISSION NO. 49: Admit that the director of DHS was aware that BHDC did not disclose to David Cains' mother that there was a restraint incident related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

RESPONSE: Denied because there was no restraint incident related to David Cains' death. See also response to request # 14 above.

REQUEST FOR ADMISSION NO. 50: Admit that the director of DDS was aware that BHDC did not disclose to David Cains' mother that there was a restraint incident

related to his death prior to the letter mailed to her on June 19, 2020, containing the "Final Synopsis," attached here as Exhibit 2.

RESPONSE: Denied because there was no restraint incident related to David Cains' death.

REQUEST FOR ADMISSION NO. 51: Admit that, following the incident that led to David Cains' death, employees at Booneville Human Development Center failed to disclose to emergency medical services that David Cains had been restrained prior to choking.

RESPONSE: Denied because the EMT stated he was unaware with whom he spoke when he arrived at the scene while the nursing team and staff were attempting to save David Cains's life. The request presumes that there was a "fail[ure] to disclose" when, in actually, it appears from the EMT's testimony that he spoke with a member of the nursing team who arrived in response to the emergency and was unaware of David Cains' prior behavioral episode. The EMT did not followed-up with BHDC.

REQUEST FOR ADMISSION NO. 52: Admit that BHDC failed to disclose the restraint that led to David Cains' death until *after* the funeral, meaning that the family was not offered an opportunity to have an autopsy completed.

RESPONSE: Denied because the David Cains' mother or "next of kin," always had the opportunity to order an autopsy under Arkansas law. *See* Ark Code Ann. 20-17-302. See also Response to Request # 48 above.

REQUEST FOR ADMISSION NO. 53: Admit that David Cains' family was not informed about a maltreatment investigation until at least nine days after his death and the family was unable to have an autopsy completed because he had already been buried.

RESPONSE: DHS objects because the then *ongoing* maltreatment investigation was confidential under Arkansas law and could not be disclosed. *See* Ark. Code Ann. §12-12-1718 (screened-out, *pending,* and unfounded reports). At the time, neither David Cains' mother nor his family were entitled to disclosure because they were not "subject[s] of the report," as defined by Ark. Code Ann. §12-12-1703(23). By law, a guardianship terminates upon the death of the ward. Ark. Code Ann. §28-65-401(a)(2); *White v. Palo*, 2011 Ark. 126, *8.

REQUEST FOR ADMISSION NO. 54: Admit that David Cains was under physician's ordered [redacted] at the time of his death.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 55: Admit that Sandy Evans, the maltreatment investigator for David Cains' death, investigated the same people she worked alongside.

RESPONSE: Denied.

REQUEST FOR ADMISSION NO. 56: Admit that, due to reports made in the past by Disability Rights of Arkansas, that BHDC has been investigated in the past for overuse of physical restraints.

RESPONSE: Denied. Respondent also objects as the request asks for information outside of Respondent's knowledge and asks that Respondent speculate on the reason for any such investigation, to the extent there even was an investigation caused by or due to claims and reports made by Disability Rights of Arkansas. The Arkansas Office of Long Term Care, which is the state regulatory board for ICF-IIDs investigated BHDC over the circumstances of David Cains' death and found no failed facility practices and issued no deficiencies.

REQUEST FOR ADMISSION NO. 57: Admit that, in the past, physical restraints have led to patients being injured at BHDC.

RESPONSE: Objection. Respondent objects to the Request for Admission as being irrelevant, overly vague and fails to define the parameter of the word "injured." Restraints are for safety.

REQUEST FOR ADMISSION NO. 58: Admit that BHDC's own policies stated that physical restraints dramatically increase the risk of injury to disabled patients.

RESPONSE: Admitted.

REQUEST FOR ADMISSION NO. 59: Admit that Tyler Mattson had, prior to David Cains' death, been alleged to have committed maltreatment against a BHDC client.

RESPONSE: Objection. The request is irrelevant to the allegations asserted in the claim. *See Transit Homes, Inc. v. Bellamy*, 282 Ark. 453, 460 (1984) reversed on other grounds, 314 Ark. 8, 13 (1993) (The general rule in Arkansas is that evidence of prior accidents is not admissible for the purpose of proving negligence). BHDC states it is unaware of any actual founded or substantiated complaint of maltreatment against Tyler Matson.

REQUEST FOR ADMISSION NO. 60: Admit that the maltreatment investigation into Tyler Mattson stemming from Jonathan McCutcheon's allegations was conducted by Sandra (Sandy) Evans.

RESPONSE: Objection. The request is irrelevant to the allegations asserted in the claim. *See Transit Homes, Inc. v. Bellamy*, 282 Ark. 453, 460 (1984) reversed on other grounds, 314 Ark. 8, 13 (1993) (The general rule in Arkansas is that evidence of prior accidents is not admissible for the purpose of proving negligence). BHDC states it is unaware of any actual founded or substantiated complaint of maltreatment against Tyler Matson.

Respectfully Submitted,
Arkansas Department of Human Services

By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On November 30, 2022, a copy of the above notice was served via electronic mail to Josh Gillispie at:

josh@greenandgillispie.com

Richard Rosen

From: Daiquiri Carter
To: ASCC Pleadings
Subject: Question
Date: Thursday, December 1, 2022 1:47:10 PM
Attachments: image001.png
image002.png

Did you receive the Answer to Plaintiff's Request for Admissions from Rich Rosen yesterday? CC #220374

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov





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From:	SaBreana Hyche on behalf of ASCC Pleadings
To:	Daiquiri Carter
Subject:	RE: Question
Date:	Thursday, December 1, 2022 3:15:00 PM
Attachments:	image001.png image002.png

Responding to this email to confirm that email was received 11/30/2022.

From: Daiquiri Carter <Daiquiri.Carter@dhs.arkansas.gov>
Sent: Thursday, December 1, 2022 1:47 PM
To: ASCC Pleadings <ASCCPleadings@arkansas.gov>
Subject: Question

Did you receive the Answer to Plaintiff's Request for Admissions from Rich Rosen yesterday? CC #220374

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov

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From:	Daiquiri Carter
To:	ASCC Pleadings; Joshua Gillispie
Cc:	Rich Rosen
Subject:	CC # 220374
Date:	Thursday, December 1, 2022 2:32:18 PM
Attachments:	DHS-2nd Suppl discovery (12-22).pdf image001.png image002.png Kastner-MD-CV.pdf

Please find attached DHS' 2nd Supplemental responses and Dr. Kastners' Curriculum Vitae.

I have copied Claimant's attorney on this email.

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
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BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) **RESPONDENT**

DHS' Second Supplemental Responses Response To Plaintiff's First Set of Interrogatories and Requests for Production of Documents

COMES now Respondent, by and through its attorney, Rich Rosen, and for its Second Supplemental Responses to Claimant's First set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 11: Please provide the name, address, and telephone number of each expert who may be called as a witness, and for each such expert provide:

(a) the subject matter on which the witness is expected to testify;

(b) the materials reviewed by each expert;

(c) the facts known to the expert which relate to or form the basis of the mental impressions and opinions held by the expert; and

(d) the dates of all reports rendered by such experts, and the names and addresses of the persons having custody of same.

SUPPLEMENTAL ANSWER:

Respondent will call Theodore A. Kastner, M.D., M.S. as an expert witness. Dr. Kastner has years of medical experience working with and treating Individuals with Intellectual Disabilities, and

has authored 70 peer-reviewed original articles in medical and professional journals, the vast majority of which are related to the health, care, and treatment of individuals with developmental disabilities. Dr. Kastner has received significant grant support for over 30 years; the majority of which for work related to individuals with developmental disabilities. In addition, Dr. Kastner has authored over 40 invited articles related to developmental disabilities and has presented at over 150 conferences and meetings on health care, many of which were related to the treatment or care of individuals with developmental disabilities. Dr. Kastner has had numerous academic appointments including appointments at the Albert Einstein College of Medicine, the University of New Jersey College of Medicine and Dentistry, and Columbia University College of Medicine. Dr. Kastner has served on the boards and committees of dozens of national and regional medical and professional associations related to the care and treatment of individuals with developmental disabilities.

Dr. Kastner is familiar with the BHDC, its campus, population and, with regard to David Cains, [redacted] and review various deposition transcripts. Dr. Kastner will testify, to a reasonable degree of medical certainty, as to the cause of death of David Cains. Dr. Kastner will further testify, to reasonable degree of medical certainty and based on his extensive experience and knowledge related to the care and treatment of individuals with developmental disabilities and, including his familiarity of developmental disable individuals with aggressive behaviors, that the staff of the BHDC met the applicable standard of care when addressing David Cains' behavior on 06/13/2020 and application the emergency hold for safety, which was within the scope of the IPP, physician orders, BHDC policies, and staff training.

The facts known to Dr. Kastner and the substance of his expert opinions will be provided shortly. A copy of Dr. Kastner's Curriculum Vitae is attached.

INTERROGATORY NO. 13: Please identify by title, author, editor, edition, publisher, date of publication and section, portion, page or pages of each and every book, treatise, periodical and/or pamphlet:

(a) established, or to be established, as a reliable authority by the testimony of any expert witness you have identified or will identify; and

(b) to be referred to during the trial testimony of any expert witness you have identified or will identify.

SUPPLEMENTAL ANSWER:

See Dr. Kastner's Curriculum Vitae, a copy of which is attached.

INTERROGATORY NO. 14: Do you contend there was an imminent risk of *serious* physical injury or *serious* property damage posed by David Cains on the date of his death? If so, please describe the nature of any imminent risk of *serious* physical injury or *serious* property damage.

ANSWER:

Yes, there was an imminent risk of serious physical injury posed by Mr. Cains. The incident occurred in the lobby of the Commons building with other employees and clients were nearby. The canteen, restroom, medication window, recreation room are accessed from the lobby as well as the main entrance into commons and then into the dining room. Mr. Cains exhibited dangerous behavior which posed an imminent risk to himself, other clients, employees, and property. Mr. Cains became verbally and then physically aggressive during the incident. Mr. Cains destroyed property, spit at Mr. Mattson, and advanced on and attempted to strike Mr. Mattson.

SUPPLEMENTAL ANSWER:

In addition to above, please see the deposition testimony of Tyler Matteson, Ryann Campos, and Amy Jones for further facts and details of David Cains' aggressive behavior requiring emergency intervention of safety. See also the behavior reports previously provided which are bates numbered pages CM 00539 – CM 00806, and deposition testimony of Claimant and Ms. Robinson on David Cains' history of physical aggression behaviors.

INTERROGATORY NO. 15: Please describe how the behavior of David Cains that led to his personal restraint on the day of his death constituted an "emergency situation."

ANSWER:

On June 13, 2020, Mr. Cains went to the Commons Building on BHDC's campus for his medication and lunch. Mr. Cains is visually monitored outside of his living area and any intake is supervised due to seizure precaution orders. Mr. Cains took his medication before he ate lunch. Tyler Mattson, RCT, monitored Mr. Cains during lunch. When Mr. Cains was finished with his meal, he told Mr. Mattson he needed to go to the bathroom. Mr. Mattson noted Mr. Cains seemed to be irritated and Mr. Mattson accompanied Mr. Cains to the bathroom.

Mr. Cains came out of the restroom and asked if he could sit down in the lobby to calm down. Mr. Mattson told Mr. Cains that that would be okay, and Mr. Cains sat down. Mr. Cains sat down and began screaming, cussing and ripped paper of the wall. Mr. Cains then jumped up, began spitting and attempted to hit Mr. Mattson. Mr. Mattson placed Mr. Cains in an emergency personal hold by holding Mr. Cains arms. Mr. Cains fell to the ground and Mr. Mattson fell with him. While on the floor, Mr. Cains continued to try and strike Mr. Mattson.

SUPPLEMENTAL ANSWER:

In addition to above, please see the deposition testimony of Tyler Matteson.

INTERROGATORY NO. 19: Please identify David Cains' Interdisciplinary Team (IDT) for the time period of January 1, 2019 through the date of his death.

ANSWER:

Respondent reserves the right to supplement this response as additional information becomes available. Respondent objects to the inclusion and production of personal information unrelated to the identified individual's professional capacity. Such information is an unwarranted invasion of privacy and is not reasonably calculated to lead to the discovery of admissible evidence. Without waiving the objections, Respondent can provide the following:

Charlene Robinson, Mother and Guardian
Chrissie McAuliffe, Sister and Advocate
Justin Jobb, Program Coordinator/QIDP
Brenda Jarrad, Team RN
Caleb Murray, Program Coordinator/Social Service Worker
Michael Alvis, Psychological Examiner
Gene Dobson, RCS
Chad Bokker, RCSS
Ashton Cobb, RCS
Nakita Martin
Chuck Hayes, RCT
Angela Yancy, RI
Audra Delay, RI
Caryn Roberts, RI
Kim Hunt, RI

John Harbison, RI

SUPPLEMENTAL ANSWER: See the [redacted] which identifies all persons on the Interdisciplinary Team (IDT) and all persons who contributed to [redacted], including individuals present at the annuals reviews who were not directly on the IDT.

REQUEST FOR PRODUCTION NO. 4: All documentation regarding any injury to another person caused by David Cains.

Response: Please see included behavioral reports within RFP 1. Respondent objects to further production of records on the basis of client confidentiality and HIPAA.

Supplemental Response:

In addition to above, please see the deposition testimony of Tyler Matteson, Ryann Campos, and Amy Jones for further facts and details of David Cains' aggressive behavior requiring emergency intervention of safety. See also the behavior reports previously provided which are bates numbered pages CM 00539 – CM 00806, and deposition testimony of Claimant and Ms. Robinson on David Cains' history of aggression and violent behaviors.

REQUEST FOR PRODUCTION NO. 11: Please provide copies of any written or recorded statements DHS or its agents or employees have obtained from the Plaintiff or any other family member of David Cains.

Response: Respondent has not identified any documents to produce at this time, if any such documents are discovered, this response will be supplemented.

Supplemental Response: Please see the deposition transcripts of Claimant, Charlene

Robinson, and Sarah Ashley.

Respectfully Submitted,
Arkansas Department of Human Services

By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On December 1, 2022, a copy of the above 2nd Supplemental Response was served via electronic mail to Josh Gillispie at:

josh@greenandgillispie.com

Richard Rosen

CURRICULUM VITAE

DATE OF PREPARATION: February 1, 2022

NAME: Theodore Andrew Kastner, M.D., M.S.

PROFESSIONAL EDUCATION:

Colgate University Hamilton, NY	1973-1977	B.A.
University of Connecticut School of Medicine Farmington, CT	1977-1981	M.D.
University of Wisconsin School of Preventive Health Madison, Wisconsin	1995-1997	M.S.

POST-GRADUATE TRAINING:

Intern	Bronx Municipal Hospital Center	7/1981-6/1982
Resident	Bronx Municipal Hospital Center	7/1982-6/1984
Fellowship	Developmental Medicine	7/1984-6/1986

PROFESSIONAL EMPLOYMENT, HOSPITAL AND ACADEMIC APPOINTMENTS:

Employment:

Morristown Memorial Hospital, Medical Director, Developmental Disabilities Center	7/1986-12/1998
Morristown Memorial Hospital, Medical Director, Center for Human Development and Rehabilitation	7/1986-7/1989
Morristown Memorial Hospital, Director, Center for Human Development	7/1989-1/1998
Developmental Disabilities Health Alliance, Inc., President,	1/1998 to Present
Co-Director Rose F. Kennedy Center (Albert Einstein)	4/2015 to 1/2019
Director Children's Evaluation and Rehabilitation Center (Montefiore)	4/2015 to 1/2019
Commissioner, NYS Office for Persons with Developmental Disabilities (OPWDD)	1/2019 to 10/2021

Hospital Appointments:

2013-2019	Montefiore Medical Center, Attending Physician
2001-2018	Mountainside Hospital, Consultant

1998-2018	Robert Wood Johnson Hospital at Hamilton, Consultant
1995-1999	Mountainside Hospital, Attending Physician
1995-1999	Morristown Memorial Hospital, Attending Physician
1989-1993	Morristown Memorial Hospital, Associate Attending Physician
1986-1989	Morristown Memorial Hospital, Assistant Attending Physician
1984-1986	Bronx Municipal Hospital Center, Assistant Attending Physician

Academic Appointments:

2015-2019	Albert Einstein College of Medicine, Professor of Pediatrics, Department of Pediatrics Professor of Psychiatry, Department of Psychiatry and Behavioral Sciences
2015-2019	Ruth L. Gottesman Chair in Developmental Pediatrics
2015-2019	Chief, Division of Developmental Medicine, Department of Pediatrics
2004-2016	University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, Clinical Associate Professor of Medicine
1999-2014	University of Medicine and Dentistry of New Jersey, New Jersey Medical School Clinical Associate Professor of Pediatrics
1992-1999	University of Medicine and Dentistry of New Jersey, New Jersey Medical School Associate Professor of Pediatrics
1988-2004	Columbia University College of Physicians and Surgeons Assistant Professor of Clinical Pediatrics
1986-1988	Columbia University College of Physicians and Surgeons Instructor in Clinical Pediatrics

BOARD CERTIFICATION:

Pediatrics, American Board of Pediatrics, 1986
Medical Management, 1998, American Board of Medical Management
Certified Physician Executive, 1998, American College of Physician Executives
Developmental and Behavioral Pediatrics, 2022, American Board of Pediatrics
Neurodevelopmental Disabilities, 2024, American Board of Pediatrics

ADDITIONAL OPTIONAL INFORMATION:

Professional Society Membership:

-American Academy of Pediatrics New Jersey Chapter

Treasurer (2012-2014)
Secretary (2010-2012)

Nominating Committee (2008-2010)
Councilor (At-large) (1999 to 2003)
Councilor (District 3) (1993-1998)

-American Association on Mental Retardation (American Association on Intellectual and Developmental Disabilities) (1986-2016)

President, New Jersey Board of Directors (1996-1998)
Fellow (1996)
National Board of Directors (Term 1994-1996)
National Legislative and Social Issues Committee (1993- 1996)
National President Medicine Division (1992-1994)
New Jersey Board of Directors (Medicine) (1987-1998)
Region IX Board of Directors (Medicine) (1988- 1992)

-American College of Physician Executives (1992- present)

-American Epilepsy Society (1992-1998)

-New Jersey Medical Society (1986-1996, 2000-2006)

-New Jersey Academy of Medicine (1990-2002)

-Northwest New Jersey Pediatric Society (1986-1998)

-Pediatric Council on Research and Education (2002-2006)

Founding Board Member (2000 to 2007)

-Society for Behavioral Pediatrics (1988-2005)

-Society for Developmental Pediatrics (1991-2000)

Other Boards of Directors:

- Developmental Disabilities Health Partners

Founding Board Member (2013-2020)

Northwest New Jersey Early Intervention Collaborative

Founding Board Member (1993-1994)

-Community Health Law Project Board of Directors (1989-1992)

-Academy on Mental Retardation (1986-2005)

-American Academy of Cerebral Palsy and Developmental Medicine (1986-2012)

Committees:

-American Academy of Pediatrics (1986-Present)

-Co-Chair, New Jersey Chapter, Committee on Firearms Prevention (2001-2006)

-New Jersey Chapter Committee on Children With Disabilities (1986-2015)

-National Committee on Children With Disabilities (1997-2003)

-AAP Workgroup on Transition to Adult Health Care (September 2001)

(Member of Invitational Conference Planning Committee) Proceedings published as a supplement Pediatrics December 2002, Volume 110, Number 6 Part 2 of 2.

-AAP Medical Necessity Meeting (February 2002)

-AAP Task Force on Medication Administration (April 2000)

-AAP Representative to Planning Committee for Surgeon General's Conference on Health Disparities and Mental Retardation (December 2001); Proceedings Published as "Closing the Gap: A National Blueprint to Improve the Health of Persons With Mental Retardation." US Department of Health and Human Services. 2002

-American Association on Mental Retardation (American Association on Intellectual and Developmental Disabilities) (1986-2015)

-National Legislative and Social Issues Committee (1993- 1996)

-Association for Retarded Citizens (New Jersey) (1986-2015)

Chairperson, Mainstreaming Medical Care Advisory Committee (1988-1998)

Mainstreaming Medical Care Advisory Committee (1988-2018)

Network on Prevention of Mental Retardation (1986-1998)

Member, New Jersey State Health Care Project Advisory Committee 1987

Professional Advisory Committee (Morris Unit) (1987-1993)

-Epilepsy Foundation of New Jersey (1992-2002)

Professional Advisory Board (1993-1998)

-Other National and Regional Committees

New Jersey Division of Developmental Disabilities Advisory Committee (1998-2003)

New Jersey Department of Human Services Advisory Committee on Developmental Disabilities and Medicaid Managed Care (1995-2004)

NY United Cerebral Palsy Medicaid Managed Care Advisory Committee (1994-2000)

New Jersey Department of Human Services Advisory Committee on Medicaid Managed Care (1994-2003)

State of New Jersey Interagency Coordinating Council (1992-1998)

American Association of University Affiliated Programs Task Force on HIV and Developmental Disabilities (1988- 1998)

New Jersey Department of Health Pediatric AIDS Advisory Group (1988-1998)

Research Committee of the Governor's Council on the Prevention of Mental Retardation & Developmental Disabilities (1989-2000)
State of New Jersey Consortium on Disability (1987-1998)
Matheny School, Member, Medical Committee, Peapack, NJ (1986-1989)

-New York City Mayor's Ad Hoc Committee on Zika Virus (2015-2017)

Awards and Honors:

2008 American Medical Association Leadership Award, American Medical Association
2007 Ann Klein Advocate Award, Community Health Law Project
2007 Health Care Professional of the Year Award (Developmental Disabilities Health Alliance) Bergen Passaic (New Jersey) Arc
2006 Volunteer Excellence Award, Brain Injury Association of New Jersey
2000 Enable Incorporated, Special Recognition Award
1999 St. John's Community Services, Community Service Award
1999 Arc of Bergen and Passaic Counties, Health Care Professional of the Year Award
1998 Epilepsy Foundation of New Jersey, Distinguished Service Award
1993 Morris County Office for the Disabled, Advocate of the Year Award
1993 Union County Arc, Physician of the Year Award
1992 Special Recognition Award, New Jersey Center for Outreach and Services for the Autism Community
1991 United Cerebral Palsy Associations of New Jersey, Elizabeth M. Boggs Citizenship Award
1990 New Jersey Association for Retarded Citizens, Health Care Professional of the Year
1990 Morris County Association for Retarded Citizens, Physician of the Year Award
1984-1986 United Cerebral Palsy Fellowship Award
1980 Joseph Goldberger Scholar in Clinical Nutrition

Other Professional Activities:

Editorial Positions:

2002-2003 Consulting Editor: Archives of Pediatrics and Adolescent Medicine
2001-2002 Consulting Editor: Milbank Quarterly
2000-2003 Consulting Editor: Pediatrics
1999-2009 Associate Editor: Mental Health Aspects of Developmental Disabilities
1993-2012 Associate Editor: Mental Retardation/ Intellectual and Developmental Disabilities
1993-2012 Consulting Editor: American Journal on Mental Retardation/American

Journal on Intellectual and Developmental Disabilities

1993-2012 Consulting Editor: Mental Retardation/ Intellectual and Developmental Disabilities

National Grant Review Panels, Study Sections, Committees

1995 US Department of Health and Human Services, Administration on Developmental Disabilities, Projects of National Significance

2012 US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Chairperson Review Panel

Grant Support:

2019:

Administration on Community Living. "University Center of Excellence on Developmental Disabilities (UCEDD)." 7/1/2017-6/30/2022. $2,700,000.

New York City. "RFK CERC Early Childhood Center." (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. "Developmental Disabilities Clinic Services." 7/1/2016-6/30/2019. $555,678.

New York City. "Socialization and Recreation Services for Children with Autism." 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Developmental Behavioral Pediatric Fellowship Training Program 7/1/2018-6/30/2022. $785,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2016-6/30/2021. $3,527,225.

Heath Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Audiology Supplement." 7/1/2016-6/30/2021. $400,000.

"Statewide Community Integration and Preservation Program (SCIPP)." New Jersey Division of Developmental Disabilities; 1/1/17-12/31/17: $1,200,000

2018:
Administration on Community Living. “University Center of Excellence on Developmental Disabilities (UCEDD).” 7/1/2017-6/30/2022. $2,700,000.

New York City. “RFK CERC Early Childhood Center.” (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. “Developmental Disabilities Clinic Services.” 7/1/2016-6/30/2019. $555,678.

New York City. “Socialization and Recreation Services for Children with Autism.” 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. “Developmental Behavioral Pediatric Fellowship Training Program 7/1/2018-6/30/2022. $785,000.

Health Resources Services Administration, Maternal and Child Health Bureau. “Leadership Education in Neurodevelopmental and Related Disabilities (LEND).” 7/1/2016-6/30/2021. $3,527,225.

Heath Resources Services Administration, Maternal and Child Health Bureau. “Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Audiology Supplement.” 7/1/2016-6/30/2021. $400,000.

"Statewide Community Integration and Preservation Program (SCIPP).” New Jersey Division of Developmental Disabilities; 1/1/18-12/31/18: $1,200,000

2017:
Administration on Community Living. “University Center of Excellence on Developmental Disabilities (UCEDD).” 7/1/2017-6/30/2022. $2,700,000.

New York City Administration on Children’s Services. “GABI Replication.” (Co-PI) 7/1/2016-6/30/2019. $8,400,000.

Bronxworks. “GABI Replication.” (Co-PI) 9/1/2016-8/30/2017. $384,000.

Brooklyn Catholic Charities. “GABI Replication.” (Co-PI) 9/1/2016-8/30/2017. $384,000.

New York City. “RFK CERC Early Childhood Center.” (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. “Developmental Disabilities Clinic Services.” 7/1/2016-6/30/2019. $555,678.

New York City. “Socialization and Recreation Services for Children with Autism.” 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. “Leadership Education in Neurodevelopmental and Related Disabilities (LEND).” 7/1/2016-6/30/2021. $3,527,225.

Health Resources Services Administration, Maternal and Child Health Bureau. “Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Audiology Supplement.” 7/1/2016-6/30/2021. $400,000.

"Statewide Community Integration and Preservation Program (SCIPP).” New Jersey Division of Developmental Disabilities; 1/1/17-12/31/17: $1,200,000

2016:
New York City Administration on Children’s Services. “GABI Replication.” (Co-PI) 7/1/2016-6/30/2019. $8,400,000.

Bronxworks. “GABI Replication.” (Co-PI) 9/1/2016-8/30/2017. $384,000.

Brooklyn Catholic Charities. “GABI Replication.” (Co-PI) 9/1/2016-8/30/2017. $384,000.

New York City. “RFK CERC Early Childhood Center.” (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. “Developmental Disabilities Clinic Services.” 7/1/2016-6/30/2019. $555,678.

New York City. “Socialization and Recreation Services for Children with Autism.” 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. “Leadership Education in Neurodevelopmental and Related Disabilities (LEND).” 7/1/2016-6/30/2021. $3,527,225.

Special Hope Foundation.“Evaluation of the Developmental Disabilities Health Home.” 1/1/2016-12/31/2016: $50,000.

"Statewide Community Integration and Preservation Program (SCIPP).” New Jersey Division of Developmental Disabilities; 1/1/16-12/31/16: $1,200,000

2015:
Health Resources Services Administration, Maternal and Child Health Bureau. “Leadership Education in Neurodevelopmental and Related Disabilities (LEND).” 7/1/2015-6/30/2016. $669,789

Centers for Disease Control. “A Training Curriculum for Parents of Children with ADHD.” 9/1/2015-6/30/2015. $300,000.

Administration on Community Living. “University Center of Excellence on Developmental Disabilities (UCEDD).” 7/1/2015-6/30/2016. $545,000.

Centers for Medicare and Medicaid Services (CMS): “Health Home for Persons with Developmental Disabilities.” July 1, 2014 – December 31, 2015. $900,000.

"Integrated Service Delivery Team.” New Jersey Division of Developmental Disabilities; 1/1/15-12/31/15: $1,200,000

2014:
New York State Department of Health: “Enhancing the Developmental Disabilities Health Home: DDHA Subcontract.” Balancing Incentive Program.” 8/1/2014-3/31/2016. $850,000.

Centers for Medicare and Medicaid Services (CMS): “Health Home for Persons with Developmental Disabilities.” July 1, 2013 – June 30, 2014. $1,800,000.

“Arkansas Best Practices in Developmental Disabilities.” State of Arkansas: July 1, 2013 – June 30, 2014; $450,000

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/14-12/31/14: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14; $190,000

2013:
Centers for Medicare and Medicaid Services (CMS): "Health Home for Persons with Developmental Disabilities." July 1, 2013 – June 30, 2014. $1,000,000.

"Arkansas Best Practices in Developmental Disabilities." State of Arkansas: July 1, 2013 – June 30, 2014; $450,000

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/13-12/31/13: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13; $190,000

2012:

Care Management Demonstration Program. NJ Council on Developmental Disabilities. 10/1/12-9/30/13: $48,000.

Centers for Medicare and Medicaid Services (CMS): “Health Home for Persons with Developmental Disabilities.” July 1, 2012 – June 30, 2013. $1,700,000.

“Arkansas Best Practices in Developmental Disabilities.” State of Arkansas: 10/1/2011-6/30/2012; $450,000

“Clinical Improvements Arkansas State Hospital II.” State of Arkansas: 12/15/2011-3/15/2012; $220,000

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/12-12/31/12: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12; $190,000

2011:

“Clinical Improvements Arkansas State Hospital I.” State of Arkansas: 7/1/2011-9/30/2011; $394,668

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/11-12/31/11: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11; $190,000

2010:
"Clinical Improvements Alexander Human Development Center." State of Arkansas: 5/1/2010-6/6/2011; $2,150,000.

Care Management Contracts with Americhoice Inc. 1/1/10-12/31/10: $2,125,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10: $550,000

"Community Program of Support and Training (CPEP)," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10: $165,100

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10; $190,000

2009:
"IPP Development." State of Nebraska: 1/1/2009-8/30/2009; $750.000

Care Management Contracts with Americhoice Inc. 1/1/09-12/312/09: $2,125,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $550,000

"Family Support Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $150,000

"Community Program of Support and Training (CPEP)," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $165,100

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09; $190,000

2008: $3,565,000
Care Management Contracts with University Health Plan and Americhoice Inc. 1/1/08-12/31/08: $2,125,000.

Olmstead Plan Behavioral Services: Statewide, New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $50,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $450,000

"Family Support Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $50,000

"Community Program of Support and Training (CPST)," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $80,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08; $190,000

2007: $4,570,000
"Care Management Subcontracts: University Health Plan and Americhoice Inc." Robert Wood Johnson Health Network. 1/1/07-12/31/07: $1,567,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital: 1/1/07-12/31/07; $20,000

"Community Program of Support and Training (CPST)," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07: $240,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07: $460,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07: $350,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07; $140,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07; $190,000

2006:
"Care Management Subcontracts: University Health Plan and Americhoice Inc." Robert Wood Johnson Health Network. 1/1/06-12/31/06; $1,515,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/06-12/30/06; $255,000

"Community Program of Support and Training (CPST)," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $1,700,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $450,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06 $340,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $130,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $180,000

2005:

"Care Management Subcontracts: University Health Plan and Americhoice Inc." Robert Wood Johnson Health Network. 1/1/05-12/31/05; $1,300,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/05-12/30/05; $240,000

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/05-6/30/05; $420,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/05-12/30/05; $435,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/05-12/31/05; $340,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/05-12/31/05; $125,000

"Developmental Disabilities Center at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/05-12/31/05; $165,000

2004

“Care Management Subcontracts: University Health Plan.” Robert Wood Johnson Health Network. 1/1/04-12/312/04; $800,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/04-12/30/04; $233,793

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $700,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $421,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $325,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $118,224

"Developmental Disabilities Center at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $159,335

2003

“Care Management Subcontracts: University Health Plan.” Robert Wood Johnson Health Network. 1/1/03-12/31/03; $246,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/03-12/31/03; $241,500

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $700,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/03-12/30/03; $421,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $420,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $118,224

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $159,335

2002

“Care Management Subcontracts: University Health Plan and Horizon/Mercy Health Plan.” Robert Wood Johnson Health Network. 1/1/02-12/31/02; $158,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/02-12/31/02; $237,906

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $700,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/02-12/30/02; $413,876

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $300,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $116,568

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $157,879

2001

“Care Management Subcontracts: University Health Plan and Horizon/Mercy Health Plan.” Robert Wood Johnson Health Network. 1/1/01-12/31/01; $82,000.

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 7/1/01-6/30/04; $1,500,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $407,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $300,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $114,808

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $155,464

2000

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 7/1/00-12/31/01; $339,000

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 7/1/00-6/30/01; $400,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $400,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $131,500

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $113,000

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $152,600

1999

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 7/1/99-6/30/00; $300,000

"Care Management Demonstration Program," Robert Wood Johnson Health Network; 9/1/99-6/30/2001; $330,000

"Care Management Demonstration Program," New Jersey Division of Medical Assistance and Health Services; 9/1/99-6/30/2001; $648,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 7/1/99-12/31/00; $300,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 4/1/99-12/31/99; $26,500

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 11/1/99-12/31/00; $87,500

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities;1/1/99-12/31/99; $152,600

1998

"Mental Health Consultation Services: Northern Region," New Jersey Division of Developmental Disabilities; 11/1/98-6/30/99; $75,000

"Case Management in Managed Care for People With Developmental Disabilities," Center for Health Care Strategies; 7/1/98-12/31/98; $10,000

"A Retrospective Analysis of the Effects of Risperidone on Tardive Dyskinesia in People With Mental Retardation." Janssen Pharmaceutical Research Foundation; 1/1/98-6/30/98; $55,000

“Quality Measurement in Managed Care for People With Developmental Disabilities," Center for Health Care Strategies; 2/1/98-6/30/98; $10,000

"Technical Assistance to the New Jersey Division of Developmental Disabilities Regarding Managed Care: Case Management and Behavioral Programming," New Jersey Division of Developmental Disabilities; 2/1/98-12/31/98; $27,900

"Developmental Disabilities Center at Robert Wood Johnson University Hospital Hamilton," New Jersey Division of Developmental Disabilities; 2/1/98-12/31/98; $150,000

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities, Contract #06PX6N; 1/1/98-12/31/98; $1,672,064

1997

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities, Contract #06PX6N; 1/1/97-12/31/97; $1,672,064

"Morris County Special Child Health Services Case Management Program," New Jersey Department of Health and Senior Services Special Child Health Services, 7/196-6/30/97; $60,456.

"Service Coordination," New Jersey Department of Health and Senior Services Early Intervention Program, 7/196-6/30/97; $166,700.

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/96-12/31/96. $89,144

"Comprehensive Child Evaluation Center," New Jersey Department of Health and Senior Services Special Child Health Services, 7/1/96 - 6/30/97, $75,000.

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract;1/1/96-12/31/96: $21,219.

"Early Intervention Program", New Jersey Department of Health and Senior Services Early Intervention Program, 7/1/96 - 9/30/97; $167,820

"Parent Infant Specialist in Behavioral Issues", Northwest New Jersey Regional Early Intervention Collaborative, 10/1/96 - 6/30/97; $21,000

"Morris/Dover Expansion of Early Intervention Services", Northwest New Jersey Regional Early Intervention Collaborative, 10/1/96 - 6/30/97; $66,700

"Prevention of Cerebral Palsy With Prenatal Magnesium Sulfate," New Jersey Office of Prevention; 1/1/97-12/31/97: $10,000.

1996

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX5N; 1/1/95-12/31/95. ($1,161,071)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/95 - 6/30/96, ($75,000).

"Early Intervention Program", New Jersey Department of Health 7/1/95 - 9/30/96, Ted Kastner, Principal Investigator.

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract; 1/1/96-12/31/96. ($20,910)

1995

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX5N; 1/1/95-12/31/95. ($1,161,071)

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract; 1/1/95-12/31/95. ($20,910)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/95-12/31/95. ($162,056)

1994

"Morris County Case Management Program," New Jersey Department of Health, 7/1/94-6/31/95. ($162,056)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/94 - 6/30/95. ($75,000)

"Early Intervention Program", New Jersey Department of Health 7/1/94 - 6/30/95, ($160,800)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX4N; 1/1/94-12/31/94, ($1,127,245)

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract;1/1/95-12/31/95. ($19710)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/94-12/31/94. ($89,144)

1993

"Morris County Case Management Program," New Jersey Department of Health, 7/1/93-6/31/94. ($105,862)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/93 - 6/30/94. ($75,000)

"Early Intervention Program", New Jersey Department of Health 10/1/93 - 6/30/94, ($123,135)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX3N; 1/1/93-12/31/93. ($1,054,909)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/93-12/31/93. ($89,144)

1992

"Morris County Case Management Program," New Jersey Department of Health, 1/1/92-6/31/93. ($73,692)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/92 - 6/30/93. ($75,000)

"Early Intervention Program", New Jersey Department of Health 7/1/92 - 9/30/93, ($192,579)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX2N; 1/1/92-12/31/92. ($1,020,374)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/92 - 6/30/93. ($75,000)

1991

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX1N; 1/1/91-12/31/91. ($976,261)

"Morris County Case Management Program," New Jersey Department of Health, 1/1/92-12/31/92. ($29,700)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/93-12/31/93. ($83,610)

"Morris County Case Management Program," New Jersey Department of Health, 1/1/91-12/31/91. ($29,700)

1990

"An Educational Program to Reduce the Incidence of Fragile X Syndrome in New Jersey," New Jersey Office of Prevention, 3/1/90-2/28/91. ($15,000)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX0N; 1/1/90-12/31/90. ($914,003)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/90-12/31/90. ($81,175)

"Morris County Case Management Program," New Jersey Department of Health, 1/1/90-12/31/90. ($47,140)

1989

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PRESENTATIONS:

182: May 2021: "Overview of NYS OPWDD." Albert Einstein College of Medicine, RFK CERC Faculty. Bronx, NY.

181: October 2018: "Introduction to Disability." Albert Einstein College of Medicine, 2nd Year Medical Students. Bronx, NY.

180: October 2018: "Transformation of RFK CERC: October 15, 2018." Bronx, New York.

179: October 2018: "Introduction to RFK CERC." Bronx, New York.

178: June 2018: "The Transition from Medicaid Service Coordination to Care Coordination Organizations." Bronx Developmental Disabilities Planning Council. Bronx, NY.

177: April 2018: "Transformation of RFK CERC: April 9, 2018." Bronx, New York.

176: January 2018: "Proposal to Create a CCO/HH." Bronx, New York.

175: October 2017: "Transformation of RFK CERC: October 16, 2017." Bronx, New York.

174: July 2017: "Health Care Reform." Roundtable at Autism Care Conference. AUCD, Bethesda Md.

173: July 2017: "Integrated Primary Care/Mental Health Services." Department of Family Medicine. Montefiore Medical Center. Bronx, New York.

172: November 2016: "Health Care Reform." Roundtable at AUCD Conference. Washington DC.

171: November 2016: "The Developmental Disabilities Health Home." AUCD, Washington DC.

170: November 2015: "The Developmental Disabilities Health Home." Keynote Presentation. Bronx DD Council. Bronx, New York.

169: November 2015: “Outcomes of the Developmental Disabilities Health Home.” Association of University Centers of Excellence in Disability. Washington DC.

168: November 2015: “Integrated Primary Care/Mental Health Services for Children and Adults with Intellectual and Developmental Disabilities.” Barnett Lecture Keynote Presentation. Montefiore Medical Center. Bronx, New York.

167. September 2015 "Update on CERC Integration with Montefiore.” Rose F, Kennedy Center Children’s Evaluation and Rehabilitation Center. Bronx, NY.

166. June 2015 "An Overview of the Children’s Health Home.” Rose F, Kennedy Center Children’s Evaluation and Rehabilitation Center. Bronx, NY.

165. April 2015 "Financing Children’s Services in the New York State Developmental Disabilities System.” Rose F, Kennedy Center Children’s Evaluation and Rehabilitation Center. Bronx, NY.

164. January 2014 "Financing of the New York State Developmental Disabilities System.” Bronx DDSO Support Coordination Training. Bronx, NY.

163. January 2014 "An Overview of the Health Home for People with Intellectual and Developmental Disabilities.” Bronx DDSO Support Coordination Training. Bronx, NY.

162. November 2013 "An Overview of the Financing of the New York State Developmental Disabilities System.” Bronx DD Planning Council 2013 Health Conference. Bronx, NY.

161. May 2013 "An Overview of the Children’s System of Care.” Mainstreaming Medical Care 2013 Conference. New Brunswick, NJ.

160. May 2013 "Health Home Services for Persons with Developmental Disabilities.” HealthFirst 2013 Spring Health Home Symposium. NY, NY.

159. November 2012 "The Developmental Disabilities Health Home.” Bronx DD Planning Council 2012 Health Conference. Bronx, NY

158. October 2012 "Integrating Physical and Mental Health Services for Persons with Developmental Disabilities.” HealthFirst 2012 Fall Symposium, Managing Long-Term Services and Supports. New Brunswick, NJ.

157. August 2012 "The Developmental Disabilities Health Home." Arkansas State Providers Association, Hot Springs Arkansas.

156. June 2012 "The Developmental Disabilities Health Home." ICNY. New York, New York

155. March 2012 "Mental Health Services for Persons with Developmental Disabilities." Arkansas State Hospital. Little Rock, Arkansas

154. March 2011 "Mental Health Services for Persons with Developmental Disabilities." Open Horizons Conference. Warren, Arkansas

153. March 2010 "Adequate Insurance to Pay for Needed Services." Community Care Consortium for Children and Youth With Special Health Care Needs Summit. Freehold, New Jersey

152. January 2010 "Financing the Medical Home," Pediatric Council on Research and Education, Trenton, New Jersey

151. June 2008 "Medical Home for Persons With Developmental Disabilities," Mainstreaming Medical Care Arc of New Jersey, Princeton, New Jersey

150. April 2007 "Diagnosis and Treatment of Children with Autism," Linden, New Jersey

149. February 2005 "Medicaid Managed Care for Persons With Developmental Disabilities" US Surgeon General's National Conference on Health Disparities, Atlanta, Georgia

148. November 2004 "Diagnosis of Psychiatric Disorders in People With Developmental Disabilities," Trinitas Hospital, SCCAT, West Windsor, New Jersey

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146. September 2002 "A Comprehensive Model of Care Management and Primary Care for Persons with Developmental Disabilities in Managed Care: Developmental Disabilities Health Alliance, Inc." Healthcare Financial Management Association. Woodbridge, New Jersey.

145. June 2002 "Developmental Disabilities Health Alliance, Inc: A Business Model for Managed Care for Persons with Developmental Disabilities." Center for Health Care Strategies. Denver, Colorado.

144. May 2002 “A Model of Comprehensive Primary Care in Managed Care.” Mainstreaming Medical Care, Princeton, New Jersey.

143. May 2002 “Business Opportunities for Mental Health Providers in Medicaid Managed Care.” New Jersey Association of Mental Health Agencies. Princeton, New Jersey.

142. April 2002 “National Medical Management Forum.” Blue Cross Blue Shield Association. Chicago, Illinois.

141. April 2002 “The Child With Chronic Illness.” Childrens Health Initiative. Newark, New Jersey.

140. January 2002 “Behavioral Aspects of Epilepsy in Persons With Developmental Disabilities.” Exceptional Parent Conference. Woodcliff Lakes, New Jersey.

139. September 2001“Aging and Developmental Disabilities.” Vineland Developmental Center, Vineland, New Jersey.

138. May 2001 “Continuing Medical Education in Developmental Disabilities.” Mainstreaming Medical Care, Princeton, New Jersey.

137. December 2000 “Practice Pattern Profiling and Risk Assessment in Developmental Disabilities Community Services.” State of Illinois Department of Human Services, Chicago, Illinois.

136. May 2000 “Health Care for People With Developmental Disabilities,” American Association on Mental Retardation 2000 National Conference, New Orleans.

135. September 1999 “Integration in Managed Care for People With Developmental Disabilities,” American Academy of Cerebral Palsy and Developmental Medicine, 1999 National Conference, Washington DC.

134. May 1999 “Managed Care for People With Developmental Disabilities,” American Association on Mental Retardation 1999 National Conference, New Orleans.

133. May 1999 “Community Mental Health Services for People With Developmental Disabilities. Mainstreaming Medical Care, Princeton, New Jersey.

132. October 1998 “Health Care Outcomes for People With Developmental Disabilities,” United Cerebral Palsy Associations of New York 1998 National Conference, Albany New York.

131. October 1998 "Managed Care for Persons With Developmental Disabilities," New Jersey Family Support Awareness Day. Lawrenceville, New Jersey.

130. September 1998 “Quality Management for Children With Special Health care Needs in Medicaid Managed Care,” Society for Developmental and Behavioral Pediatrics 1998 National Conference, Cleveland, Ohio.

129. June 1998 “Disease Management for People With Developmental Disabilities,” American Association on Mental Retardation 1998 National Conference, San Diego.

128. November 1997 "Medicaid Managed Care for Persons With Developmental Disabilities," Pediatric Grand Rounds. New York Medical College, Valhalla, New York.

127. June 1997 "Disease Management and Persons With Developmental Disabilities," Making Managed Care Work for People With Disabilities New Jersey Law Center, New Brunswick, New Jersey

126. May 1997 "Strategic Planning for Managed Care and Persons With Developmental Disabilities," American Association on Mental Retardation 1997 National Conference, New York.

125. April 1997 "Managed Care and Persons With Developmental Disabilities," Laurie Lecture, Robert Wood Johnson School of Medicine, Piscataway, New Jersey

124. April 1997 "Measuring Quality of Care in Developmental Disabilities," Ohio Department of Mental Retardation and Developmental Disabilities, Columbus, Ohio
123. March 1997 "Managed Care and Persons With Developmental Disabilities," Young Adult Institute 1997 National Conference, New York, New York

122. June 1996 "Managed Care and Persons With Developmental Disabilities," American Association on Mental Retardation 1996 National Conference, San Antonio, Texas

121. June 1996 "Effects of the DRG Payment System on Hospitalization Outcomes for People With Developmental Disabilities." American Association on Mental Retardation 1996 Conference, San Antonio, Texas.

120. June 1996 "An Overview of Psychiatric Disorders in People With Developmental Disabilities," Independent Care, Milwaukee, Wisconsin

119. May 1996 "Developing Capitation Rates for People With Developmental Disabilities" Mainstreaming Medical Care, Princeton, New Jersey

118. May 1996 "An Overview of New Jersey's Managed Care Program for People With Developmental Disabilities" Mainstreaming Medical Care, Princeton, New Jersey

117. April 1996 "An Overview of Psychiatric Disorders in People With Developmental Disabilities," New Jersey AAME, Princeton, New Jersey

116. February 1996 "An Overview of Treatments in Autism," Morris/Union Jointure Commission

115. June 1995 "Health Care Reform and Persons With Developmental Disabilities," American Association on Mental Retardation 1995 National Conference, San Francisco, California.

114. June 1995 "Quality of Life Outcomes for People With Mental Retardation and Epilepsy Treated With Felbatol," American Association on Mental Retardation 1995 National Conference, San Francisco, California.

113. June 1995 "An Overview of Managed Care for People With Developmental Disabilities," Association Court Monitors and Special Masters, San Francisco, California.

112. May 1995 "Health Care Reform" Mainstreaming Medical Care, Princeton, New Jersey
111. May 1994 "The President's Committee on Mental Retardation: Health Care Reform Proposals" American Association on Mental Retardation, Boston, MA

110. May 1994 "Health Care Reform Proposals" Mainstreaming Medical Care, New Brunswick, New Jersey

109. April 1994 "Health Care Reform", President's Committee on Mental Retardation, Alexandria Virginia

108. April 1994 "Shared Responsibilities: Mental Illness and Developmental Disabilities", Morristown Memorial Hospital, Morristown, New Jersey

107. March 1994 "Standards of Care in Developmental Disabilities", Children's Evaluation and Rehabilitation Center, Bronx, NY

106. February 1994 "Primary Care for People with Down Syndrome Across the Lifespan", Hunterdon Developmental Center, Clinton, New Jersey

105. December 1993 "Managed Care for People With Developmental Disabilities," New Jersey Division of Developmental Disabilities, Budd Lake, NJ

104. December 1993 "Health Care Reform and Persons With Developmental Disabilities", National Association of Superintendents of Facilities for Persons With Mental Retardation, 1993 National Conference, Washington, D.C.

103. November 1993 "Standards of Care in Developmental Disabilities", National Physician's Conference on Developmental Disabilities Medicine, New Orleans, LA

102. November 1993 "What's New in Developmental Disabilities Medicine: The 10 Best Articles of 1991", National Physician's Conference on Developmental Disabilities Medicine, New Orleans, LA

101. November 1993 "The Relationship Between Epilepsy and Mental Illness", Epilepsy Foundation of New Jersey, Somerset, New Jersey

100. October 1993 "The Impact of Managed Care on Inpatient Utilization by Persons With Developmental Disabilities", American Association of University Affiliated Programs National Conference, Bethesda, Maryland

99. June 1993 "Health Care Reform and Persons With Developmental Disabilities", American Association on Mental Retardation 1993 National Conference, Washington, D.C.

98. June 1993 "Mortality and Advanced Directives for People With Developmental Disabilities", American Association on Mental Retardation 1993 National Conference, Washington, D.C.

97. November 1992 "Medical and Psychiatric Management for People With Developmental Disabilities", New Jersey Chapter of the American Academy of Pediatrics, Jamesburg, New Jersey

96. October 1992 "AIDS and Developmental Disabilities: Where Are We Now? Were Should We Go?" National Physician's Conference on Developmental Disabilities Medicine New Orleans, LA

95. October 1992 "What's New in Developmental Disabilities Medicine: The 10 Best Articles of 1991", National Physician's Conference on Developmental Disabilities Medicine New Orleans, LA

94. July 1992 "HIV and Developmental Disabilities: An Overview", New Jersey Association of Community Residential Providers, Trenton, New Jersey

93. June 1992 " Infectious Disease Concerns", Warren Day Training, Washington Township New Jersey

92. May 1992 "An Introduction to Managed Care for Persons With Developmental Disabilities", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

91. May 1992 "Transdisciplinary Evaluation of Behavioral Symptoms in People With Developmental Disabilities", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

90. May 1992 "Health Care Services for Children and Adults With Developmental Disabilities: The Morristown Model", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

89. May 1992 "AIDS: The Facts", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

88. March 1992 "AIDS: Myths and Reality", Tri-State Camping Conference, E. Brunswick, New Jersey

87. March 1992 "Ethical Concerns in Caring for People With Special Needs", University of Iowa, Iowa Hospital School, Iowa City, Iowa

86. February 1992 "Ethical Concerns in Caring for People With Special Needs", Phoenix Association for Retarded Citizens, Phoenix, AZ.

76-85. "Primary Care for People with Down Syndrome Across the Lifespan", A 12/1991 - 5/1992 series of lectures at 10 New Jersey Family Practice Residency Training Programs. Sponsored by the NJ Association for Retarded Citizens and the New Jersey Academy of Medicine.

75. November 1991 "HIV and Adults With Developmental Disabilities", American Association on Mental Retardation Training Institute on HIV and Developmental Disabilities, Philadelphia, PA

74. November 1991 "Recent Advances in Medication Use", Epilepsy Foundation of New Jersey, Middlesex, New Jersey

73. October 1991 "Transdisciplinary Evaluation of People With Developmental Disabilities and Behavioral Complaints", American Association of University Based Programs, Austin, Texas

72. October 1991 "A Statewide Public and Professional Education Program on Fragile X Syndrome", American Association of University Based Programs, Austin, Texas

71. October 1991 "HIV and Developmental Disabilities", N.J. Association for Retarded Citizens, New Brunswick, N.J.

70. October 1991 "Epilepsy, Mood Disorders and Anticonvulsant Medication", Region IX, American Association on Mental Retardation, Princeton, New Jersey

69. October 1991 "An Overview of Managed Care", Region IX, American Association on Mental Retardation, Princeton, New Jersey

68. August 1991 "HIV and Developmental Disabilities: A National Teleconference", In Collaboration With the ARC of the United States

67. June 1991 "Update on Immunizations" St. Joseph School for the Blind, Jersey City

66. May 1991 "Infectious Disease Concerns for Community Health Care Providers", American Association on Mental Retardation 1991 National Conference, Washington D.C.

65. May 1991 “Valproate Therapy for People With Developmental Disabilities and Mood Symptoms", 1991 American Association on Mental Retardation National Conference, Washington D.C.

64. April 1991 "Epilepsy, Mood Disorders, and Anticonvulsant Medication", Association for Retarded Citizens, New Brunswick, New Jersey

63. April 1991 "People With Developmental Disabilities and Mental Illness", Community Health Law Project Lecture Series, New Brunswick, New Jersey

62. March 1991 "Adults With Developmental Disabilities and HIV Infection", Third National HIV Infection and Developmental Disabilities Conference, Alexandria Virginia

61. March 1991 "Specialized Services", Health Care for Youth and Adults with Developmental Disabilities: Policies and Partnerships, Rockville Maryland

60. January 1991 "Down Syndrome and The Primary Care Physician", Family Practice Grand Rounds,UMDNJ-RWJ, New Brunswick, NJ

50-59. "Health Care Problems of People With Developmental Disabilities - 12/1990 - 5/1991 Epilepsy, Mood Disorders, and Anticonvulsant Medication", A series of lectures at 10 New Jersey Family Practice Residency Training Programs. Sponsored by the NJ Association for Retarded Citizens and the New Jersey Academy of Medicine.

49. November 1990 "An Overview of HIV and Developmental Disabilities", United States Association for Retarded Citizens 40th Annual Conference, Tampa Florida

48. November 1990 "Agency Preparedness in Serving People With HIV and Developmental Disabilities", United States Association for Retarded Citizens 40th Annual Conference, Tampa Florida

47. October 1990 "A Comparison of National Surveys on HIV and Developmental Disabilities 1987 vs. 1990", American Association of University Based Programs, Madison Wisconsin

46. October 1990 "The Morristown Model: A Managed Health Care Inititative For Adults With Developmental Disabilties", American Association of University Based Programs, Madison Wisconsin

45. October 1990 "Epilepsy, Mood Disorders, And Anticonvulsant Medication", N.J. Association for Retarded Citizens, New Brunswick, N.J.

44. October 1990 "HIV and Developmental Disabilities", Region IX, American Association on Mental Retardation, Wilmington, Delaware

43. October 1990 "The Ethical Function Of The Interdisciplinary Team", Region IX, American Association on Mental Retardation, Wilmington, Delaware

42. October 1990 "Obsessive Compulsive Disorder in People With Developmental Disabilities", Region IX, American Association on Mental Retardation, Wilmington, Delaware

41. September 1990 "Principles of Health Care For People With Developmental Disabilities" NJ Chapter, American Association on Mental Retardation, Piscataway, N.J.

40. June 1990 "The Relationship Between Mood Disorders And Epilepsy" Children's Evaluation And Rehabilitation Center, Bronx, N.Y

39. June 1990 "Perinatal Causes of Developmental Disabilities" The New Jersey Coalition for the Prevention Of Developmental Disabilities, Morris, N.J.

38. May 1990 "A National Survey of Developmental Disabilities and HIV: Policy and Epidemiology" American Association on Mental Retardation 1990 National Conference, Atlanta, Georgia

37. May 1990 "Exceptional Health Care: Health Care Abstracts for Physicians Serving People With Developmental Disabilities" American Association on Mental Retardation 1990 National Conference, Atlanta, Georgia

36. May 1990 "Valproate Therapy of People With Mood Symptoms And Developmental Disabilities" American Association on Mental Retardation 1990 National Conference, Atlanta, Georgia

35. May 1990 "Three Models of Health Care Delivery: The Morristown Model" New Jersey A.R.C. Mainstreaming Medical Care Conference, New Brunswick, N.J.

34. May 1990 "The Relationship Between Undiagnosed Medical Disorders and Behavioral Outbursts." New Jersey A.R.C. Mainstreaming Medical Care Conference, New Brunswick, N.J.

33. April 1990 "Psychopharmacologic Treatment of Psychiatric Illness in People With Developmental Disabilities" Hunterdon Developmental Center, Clinton N.J.

32. January 1990 "Recent Advances in Down Syndrome" Grand Rounds, Pediatric Department, Morristown Memorial Hospital, Morristown, N.J.

31. January 1990 "Psychopharmacologic Treatment of Psychiatric Illness in People With Developmental Disabilities" Woodbine Developmental Center, Woodbine N.J

30. November 1989 "HIV and Adults with Developmental Disabilities," A National Conference on Developmental Disabilities and HIV: Accessing the System, Bethesda, MD.

29. October 1989 "Mortality in Community Settings," AAMR Region IX Conference Williamsburg, VA

28. October 1989 "Planning Services for Persons with HIV and Developmental Disabilities," NJ ARC Annual Conference. Princeton, NJ.

27. October 1989 "Mental Health Issues with Developmentally Handicapped Infants and Toddlers: Medical Issues," Thirty-sixth Annual Meeting of the American Academy of Child and Adolescent Psychiatry. New York, NY.

26. September 1989 "Planning Services for Persons with HIV and Developmental Disabilities," Maryland AAMR Annual conference. Timonium, MD.

25. September 1989 "Mental Illness and Mental Retardation," NJ AAMR Annual Conference. Piscataway, NJ.

24. September 1989 "HIV and Developmental Disabilities: A New Jersey Perspective," NJ ARC Annual Leadership Conference. Princeton NJ.

23. June 1989 "Adults with Developmental Disabilities and HIV," at Children, AIDS and Developmental Disabilities: Challenge for the 1990's, sponsored by the Rose F. Kennedy Center of Albert Einstein College of Medicine, New York, NY.

22. June 1989 "AIDS and Institutions for Persons with Developmental Disabilities and Mental Illness," Twelfth Annual Conference of the National Association of Protection and Advocacy Systems, Bethesda, MD.

21. June 1989 "Pediatric AIDS: Legal and Service Issues," Twelfth Annual Conference of the National Association of Protection and Advocacy Systems, Bethesda, MD.

20. May 1989 "HIV and Developmental Services," American Association of Mental Retardation, 1989 National Conference, Chicago IL.

19. May 1989 "Mortality in Persons with Mental Retardation Living in the Community," American Association on Mental Retardation, 1989 National Conference, Chicago, IL.

18. May 1989 "Immunization of High Risk Infants with Pertussis Vaccine," American Association on Mental Retardation, 1989 National Conference, Chicago, IL.

17. May 1989 "Health Care Coordination and Its Effects on Inpatient Parameters for Persons with Mental Retardation," American Association on Mental Retardation, 1989 National Conference, Chicago, IL.

16. November 1988 "HIV and Developmental Services for Adults," First National HIV and Developmental Disabilities Conference, Administration on Developmental Disabilities, Bethesda, MD.

15. September 1988 "AIDS and Developmental Disabilities: Guidelines for Service Agencies," Association for the Advancement of the Mentally Handicapped, 1988 Board Meeting, Elizabeth, NJ.

14. July 1988 "AIDS and Developmental Disabilities: Issues for Service Providers," New Jersey Association of Community Residential Providers. Trenton, NJ.

13. May 1988 "Impact of AIDS on Mental Retardation/Developmental Disabilities Services," American Association on Mental Retardation 1988 National Conference, Washington, DC.

12. May 1988 "Ethical Considerations in Medical Decision Making: AIDS and Persons with Mental Retardation," American Association on Mental Retardation 1988 National Conference, Washington DC.

11. May 1988 "Bioethical Frontiers in Mental Retardation: The Impact of the AIDS Epidemic on Persons with Developmental Disabilities," American Association on Mental Retardation 1988 National Conference, Washington DC.

10. May 1988 "Models for Community Based Services to Persons with Developmental Disabilities and Mental Illness," American Association on Mental Retardation 1988 National Conference, Washington DC.

9. October 1987 "AIDS and Developmental Disabilities," American Association on Mental Deficiency, 1987 Region IX Annual Meeting. Martinsville, WV.

8. September 1987 "Communicable Diseases," United Cerebral Palsy Staff Training Institute. New York, NY

7. June 1987 "A System for the Provision of Comprehensive Health Care for Persons with Developmental Disabilities Living in the Community," Rose F. Kennedy Center Annual Alumni Meeting. Bronx, NY.

6. May 1987 "Managing Clients with Mental Retardation and AIDS: Medical Aspects," American Association on Mental Deficiency 1987 Annual Meeting. Los Angeles, CA.

5. April 1987 "Delivering Coordinated and Comprehensive Health Care Services to Children and Adults with Mental Retardation," Young Adult Institute 8th Annual National Conference. New York, NY.

4. April 1987 "Implications of Public Law 99-457," Keynote Speech, Tri-County Resource Symposium. Morristown, NJ.

3. November 1985 "The Relationship Between Learning Disabilities and Juvenile Delinquency," Straight Talk, WOR-TV.

2. October 1985 "Developmental Disabilities and Juvenile Delinquency," Third Annual Juvenile Health Care Conference, American Correctional Health Services Association. New York, NY.

1. September 1985 "Spina Bifida," Ithaca College School of Physical Therapy.

From: Joshua Gillispie
To: ASCC Pleadings
Cc: Rich Rosen; Daiquiri Carter
Subject: CC # 220374
Date: Monday, December 5, 2022 12:06:03 PM
Attachments: Claimant"s Responses to DHS 2nd Disco.pdf

Dear Commission:

Please find Claimant's Responses to DHS's Second Set of Discovery attached.

Counsel for DHS is copied here.

Thanks!

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

Response to DHS' Second Set of Interrogatories and Requests for the Production of Documents to Claimant

COMES NOW Claimant, and for her responses to DHS's Second Set of Interrogatories and Requests for Production of documents, states:

INTERROGATORY NO. 1: Identify by name, address, and telephone number, each and every counselor, therapist, psychiatrist, social worker, pastor, and other licensed/certified individual from whom the following persons received any form of treatment and/or counseling for grief related to this lawsuit:

a. Christine McAuliffe;

b. Charlene Robinson

Include in your response to this interrogatory the name of the clinic, group, and/or practice of the individual from whom you received such treatment, if applicable.

ANSWER:

a. [redacted]

[redacted]

b. [redacted]

INTERROGATORY NO. 2: For each and every counselor, therapist, psychiatrist, social worker, pastor, and other licensed/certified individual named in your response to Interrogatory No. 1 above, and if applicable, for each clinic, group, and/or practice identified, please state the:
(1) duration of the individual treatment (length of time in minutes each visit lasted) and (2) frequency of the treatment (number of times per week/month), and (3) the period range of the treatment (date of first treatment began and date of last treatment) for:

a. Christine McAuliffe;

b. Charlene Robinson

ANSWER:

a. See previous response.

b. See previous response.

REQUEST FOR PRODUCTION OF DOCUMENTS 1: Please produced copies of all therapy notes, counselor notes, pastor notes, physician notes, prescriptions, treatment plans, bills, invoices, and similar types of documents/records related to any and all treatment and/or counseling for grief associated with the claims made in the lawsuit.

ANSWER:

a. See previous response.

b. See previous response.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail this 5th day of December, 2022.

Rich Rosen, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From:	Joshua Gillispie
To:	ASCC Pleadings
Cc:	Rich Rosen; Chad; Daiquiri Carter
Subject:	CC # 220374
Date:	Thursday, December 22, 2022 10:18:03 AM
Attachments:	P"s SECOND Set of Discover Propounded to Defendant.pdf

Dear Commission:

Attached please find Claimant's Second Set of Discovery propounded to Respondent.

Best Regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) **RESPONDENT**

CLAIMANT'S SECOND SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION PROPOUNDED TO RESPONDENT

COMES now Plaintiff, by and through her attorney, Joshua D. Gillispie, and propounds to Respondent the following Interrogatories and Requests for Production, to be answered in accordance with the Arkansas Rules of Civil Procedure and other applicable laws:

DEFINITIONS

1. "And" and "or" shall be individually interpreted in every instance as meaning "and/or" and shall not be interpreted to exclude any information within the scope of these requests.

2. "DHS" or "Defendant" or "You," as used herein, refers to all departments, offices, and facilities within the Arkansas Department of Human Services, including but not limited to the Booneville Human Development Center (referred to herein as "BHDC"), as well as all agents, employees, and officers.

3. Communication" or "Communications" refer to oral conversations, written correspondence, memoranda, telephone conversations, text messages, correspondence, notes, electronic mail, social media posts or messages, voice mails, answering machine messages, letters, notes, or cards, whether as a sender, recipient, cc, or bcc. "Communication" means any disclosure, transfer, or exchange of information or opinion, however made.

4. "Correspondence" refers to all forms of writings, electronic or otherwise, including but not limited to, letters, books, emails, text messages, computer tapes, discs, printouts, keypunch cards, memoranda, diaries, notes, reports, bulletins, printed forms, telegraphic communications, telexes, telegrams, telecopies, facsimile reproductions, minutes, microfilm, microfiche, films, videotape, and computer discs.

5. "Document" or "Documents" mean the original, or a copy when the original is not available, and each non-identical copy, including those which are non-identical by reason of notations or markings, of: papers, writings, records, notes, tapes, discs, or other substances on which communications, data, or information is recorded or stored, whether made by manual, mechanical, photographic, or electronic process. This definition includes all drafts or superseded revisions of each document. As used herein, "document(s)" includes, but is not limited to:

> Electronically Stored Information, books, pamphlets, periodicals, letters, reports, memoranda, handwritten notes, notations, messages, telegrams, cables, records, drafts, diaries, studies, analyses, summaries, magazines, circulars, bulletins, instructions, minutes, photographs, purchase orders, bills, checks, tabulations, desk or pocket calendars, charge slips, questionnaires, surveys, drawings, sketches, working papers, charts, graphs, indexes, taped correspondence, records of purchase of sale, contracts, agreements, leases, invoices, expense records, trip reports, releases, appraisals, valuations, estimates, opinions, financial statements, accounting records, income statements, electronic or other transcriptions or taping of telephone or personal conversations or conferences or any and all other written, printed, typed, punched, taped, filed or graphic matter or tangible thing, of whatever description, however produced or reproduced (including computer stores or generated data, together with instructions and programs necessary to search or retrieve such data), and shall include all attachments and enclosures to any requested item, which shall not be separated from the item to which they are attached or enclosed.

6. A document or communication "relating to," "related to," or "concerning" a given subject means any document that constitutes, contains, embodies, comprises, reflects, identifies, states, refers to, deals with, comments on, responds to, describes, or is otherwise pertinent to that subject, including without limitation documents concerning the presentation of other documents.

7. "Person" and "entity" mean the singular as well as the plural and include any natural person, partnership, corporation, association, joint venture, proprietorship, firm, agency, or other legal or business entity, and its agents and employees.

8. "Identify" and "identity":

a. When used in reference to a natural person, require his or her full name, present or last known business and home addresses, business, mobile, and home telephone numbers, and email addresses, if any;

b. When used in reference to a document, require Bates numbers and, in the alternative, the present location and the custody of the original thereof or, if unknown, the present custodian of any copy thereof, and the manner and date of disposition of any document that was, but is no longer, in your possession or subject to your control;

c. When used in reference to communications, require the substance thereof, the identity of the person who made the communication and the person to whom it was made, and the persons who participated in such communication or were present at the time same was made, the date and place thereof, whether the communication was oral, in writing, and/or exists in an electronic medium, and, if such communication has been reduced to writing, or otherwise exists in an electronic medium, includes identifying such document or ESI.

9. The singular of each word shall be construed to include its plural and vice-versa, and the root word and all derivations (i.e., "ing," "ed," etc.) shall be construed to include each other.

10. The words "and" as well as "or" shall be construed both conjunctively as well as disjunctively.

11. The word "each" shall be construed to include "every" and vice-versa.

12. The word "any" shall be construed to include "all" and vice-versa.

13. The present tense shall be construed to include the past tense and vice-versa.

14. The masculine shall be construed to include the feminine and vice-versa.

15. The words "knowledge," "information," "possession," "custody," and "control" of a person shall be construed to include such person's agents, representatives, and attorneys.

16. The word "including" shall have its ordinary meaning and shall mean "including but not limited to" and shall not indicate limitation to the examples or items mentioned.

INSTRUCTIONS

1. In answering each of these interrogatories, please furnish all information that is available to you and any to which you have access, including information in your possession, custody, or control, or in that of any agent, servant, or employee, including doctors, attorneys, investigators, examiners, testers, and evaluators contracted by you or on your behalf.

2. In the event you are unable to fully answer one or more of the following interrogatories after exercising due diligence to secure the necessary information, provide the most complete answer possible and specify the reason(s) for the inability to provide a complete response at the present time

3. Should a privilege, confidentiality agreement, protective order, or other privilege/exemption from discovery be asserted with respect to any part of any discussion, document, or other communication concerning information requested by any of the following interrogatories or requests for production, you are requested to answer the interrogatories or request in the manner indicated herein, except that the contents of the part deemed privileged need not be summarized. Instead, indicate that a privilege is claimed for such part and state the

nature of the privilege claimed and the facts upon which such claim is based in sufficient detail to permit the Court to adjudicate the validity of the privilege claim.

INTERROGATORIES AND REQUESTS FOR PRODUCTION

INTERROGATORY NO. 1: Please state whether Dr. Theodore Kastner has ever provided testimony as an expert witness at a trial or deposition. If so, for each expert, please state:

(a) The style of the case, including the names of parties, venue and case number;

(b) Whether testimony was provided for the Plaintiff or Defendant; and

(c) A brief summary of the expert testimony provided in the particular case.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 1: Please produce for inspection and copying any and all most recent *curriculum vitaes* or written statements and reports by Dr. Theordore Kastner that you may call at the hearing of this matter and a list of any such expert's publications or other writings. *In addition, please produce a copy of the transcript for any and all testimony provided by Dr. Kastner at any previous trial, hearing and/or deposition.*

REQUEST FOR PRODUCTION OF DOCUMENT NO. 2: Please produce all documents related to Dr. Theodore Kastner's, Developmental Disabilities Health Management's, or any other Kastner entity's previous work for the Arkansas Department of Human Services since the year 2000. This includes but is not limited to Kastner's or DDHM's or any other Kastner entity's proposal when bidding on the Alexander Human Development Center, and all written findings,

recommendations, reports, opinions, and any other document related to their work, consulting work other otherwise, at AHDC.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 3: Please produce all findings, recommendations, reports, opinions, or any other document authored by Kastner (or any entity with which Kastner was involved) that in any way relate to the Arkansas Department of Human Services since the year 2000.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 4: Please produce all documents reflecting amounts paid by the state of Arkansas or by DHS or by DDS or by any other branch of state government to Dr. Theodore Kastner or to any company with which he was affiliated, including without limitation Developmental Disabilities Health Management or Disability Service Centers of Arkansas or any of Kastner's other companies. These documents should include, without limitation, contracts, invoices, proposals, bids, receipts, or any other item reflecting amounts paid to Kastner or a Kastner entity by Arkansas since the year 2000 and through the present date.

INTERROGATORY NO. 2: Please treat the foregoing interrogatories as continuing and furnish to Plaintiffs, in writing, any additional information received by you subsequent to the date of your answers hereto that would modify or supplement your answers, such additional information to be furnished as soon as reasonably possible after receipt by you and within a reasonable time prior to the assigned trial date in order to permit appropriate discovery procedure. Will you do so?

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail on this 22nd day of December, 2022.

Rich Rose, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From:	Daiquiri Carter
To:	ASCC Pleadings; Rich Rosen; Joshua Gillispie
Cc:	Daiquiri Carter
Subject:	CC 220374
Date:	Tuesday, January 3, 2023 12:09:30 PM
Attachments:	DHS-3rddiscovery(1-23).pdf image001.png image002.png

Please find attached Respondent's 3rd Set of Interrogatories and Requests for Production to Claimant. I have copied Claimant's attorney on this email.

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov

NOTE - This email may contain sensitive or confidential information.

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BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) **RESPONDENT**

Respondent's Third Set of Interrogatories And
Requests For Production Propounded to Claimant

COMES NOW DHS, by and through counsel, Rich Rosen, and propounds to Claimant its 3rd Set of Interrogatories and Requests for Production, to be answered in accordance with the Arkansas Rules of Civil Procedure and the Rules of the Arkansas State Claims Commission:

INTERROGATORY NO. 1: Please state whether Dr. Lebel has ever provided testimony as an expert witness at a trial or deposition. If so, please state:

(a) The style of the case, including the names of parties, venue and case number;

(b) Whether testimony was provided for the Plaintiff or Defendant; and

(c) A brief summary of the expert testimony provided in the particular case.

ANSWER:

INTERROGATORY NO. 2: Please state whether any state or federal court has ever denied Dr. Lebel expert witness status or otherwise not allowed her to testify as an expert witness in a case after being named as a litigant's expert witness, and if so, please identify:

(a) The name, location, and division of the court;

(b) The date;

(c) The subject-matter to which Dr. Lebel was expected to testify;

(d) The case name and case number.

ANSWER:

REQUEST FOR PRODUCTION OF DOCUMENTS NO. 1: Please produce all decisions, opinions, orders, letter opinions, and similar type of documents reflecting the court's decision referenced in your response to Interrogatory No. 2 above.

ANSWER:

Respectfully Submitted,

Arkansas Department of Human Services,

By: **Richard Rosen**
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On January 3, 2023, a copy of the above 3rd Set of Discovery was served via email to Josh Gillispie, Counsel for Claimant, at:

josh@greenandgillispie.com

Richard Rosen

From:	Joshua Gillispie
To:	ASCC Pleadings
Cc:	Chad; Daiquiri Carter; Rich Rosen
Subject:	CC 220374
Date:	Tuesday, January 3, 2023 4:44:21 PM
Attachments:	Claimant"s Fourth Supplemental Response to Respondent"s First Set of Discovery.pdf LeBel - Provisional Summary of Opinions.pdf

Dear Commission:

Please find Claimant's Fourth Supplemental Responses to DHS's First Set of Interrogatories & RFP.

Best Regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

FOURTH SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Fourth Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.

SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Janice L. LeBel, EdD/PhD, ABPP. Dr. LeBel's CV and Fee Schedule are provided herein, which contain her contact information. Dr. LeBel, as reflected in her CV, is a psychologist and an expert in field of behavioral health services and residential care for vulnerable populations, including the disabled, mentally ill, and children. Dr. LeBel has published extensively on the use of restraints in these settings. She is expected to testify concerning the standard of care for a facility such as BHDC, and whether there were breaches of that standard that lead to Cains's death. Dr. LeBel can be made available for deposition upon request from Defendant. At this time there is no written report to share with Defendant.

SECOND SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Ricki Brown-Forestiere, MD. Dr. Brown-Forestiere's CV is provided herein. Dr. Brown-Forestiere is an Emergency Medicine Physician and an expert in her field of emergency medical services. Dr. Brown-Forestiere is board certified in Emergency Medicine. She is expected to testify concerning the cause of David Cains' death. Dr. Brown-Forestiere can be made available for deposition upon request from Defendant.

THIRD SUPPLEMENTAL RESPONSE:

(a) Claimant will not be utilizing DRA advocates as expert witnesses in this matter. Claimant will reference the three DRA Reports in her pre-trial brief, reference them at the hearing, and likely submit copies to the Commission. Thomas Nichols, DRA's

Managing Attorney, has agreed to provide authentication and foundation, in the event DHS cannot stipulate to same and those steps are in fact necessary.

Thomas W. Nichols
Managing Attorney
Disability Rights Arkansas
400 West Capitol, Suite 1200
Little Rock AR 72201
Phone: 501.492.5776

(b)

Dr. Janice LeBel

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available and what Claimant expects. Note that Dr. LeBel has not authored or produced to Claimant a written report concerning her opinions. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Janice LeBel is a liability expert, expected to testify that the physical restraint and physical ground restraint, and the circumstances surrounding the restraint, performed by three direct care workers at BHDC, which caused David to vomit and then choke to death on his vomit, fell below the standard of care for facilities caring for the intellectually disabled and that his death was a foreseeable consequence of Respondent's negligence, as evidenced by the acknowledged violations of BHDC's own rules and regulations and those of DDS, by the fact that the death restraint was unnecessary and unjustified, that it was not the least restrictive intervention available and not used for the

least amount of time, that it was not an approved NCI method of restraint taught or authorized by DHS or BHDC, that it was [redacted], that its form and repeated use by the facility was substandard, that it occurred as the result of substandard training and substandard oversight of direct care staff, that the large number of physical restraints used by BHDC staff on David Cains over the years and the facility's history of over-reliance on physical restraints in general was substandard practice and suggests a culture within the facility standing in opposition to commonly accepted norms and best practices for such facilities, that undertrained and/or underqualified direct care staff were allowed to use their own subjective discretion for when to use physical restraints with little to no oversight by supervisors and in ways often anathema to the training professed to have been provided them and the Respondent's own written rules, that the direct care staff's training and knowledge as regards first aid and basic lifesaving procedures was substandard (*see* placing him on his back after he starts vomiting), that BHDC in general failed to implement a functioning system of accountability for and oversight of staff designed to ensure staff were adhering to their training with regards de-escalation techniques and other nonviolent interventions, and that all of these ways in which BHDC fell below the standard of care directly led to and caused David Cains' untimely death – a foreseeable tragedy given the facility's historical refusal to reduce its reliance on physical restraints that are themselves inherently dangerous, particularly physical restraints performed on the ground like the one that killed David and which staff had been utilizing commonly and frequently in the months and years leading up to David's death despite the fact such

ground restraints were at all relevant times unauthorized and prohibited. Dr. LeBel's CV (previously produced) speaks for itself as to her expertise, experience, and qualifications. Her grounds for providing these opinions include the application of her expertise in this precise field to the facts and evidence of this case, including deposition transcripts, records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

Dr. Ricki Brown-Forestiere

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available. Note that Dr. Brown-Forestiere has not issued a formal written opinion or report on this matter. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Ricki Brown-Forestiere is a causation expert and <u>partial damages expert</u> (with respect only to Claimant's claim for damages based on David Cains' conscious pain and suffering prior to death), expected to testify that, but for the restraint and ground restraint in question, David Cains would not have died. David died because the physical restraint and ground restraint caused a struggle and that struggle induced vomiting upon which David choked to death. More specifically:

[redacted]

[redacted]

David, unfortunately, was also placed on his back after he began vomiting. [redacted]

[redacted]

Dr. Brown-Forestiere's grounds for providing these opinions include the application of her expertise in emergency medicine to the facts and evidence of this case, including deposition transcripts, medical records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

FOURTH SUPPLEMENTAL RESPONSE:

Please find attached the *Provisional Summary of Opinions* of Dr. Janice LeBel, supplemental to previous responses concerning Dr. LeBel.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
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North Little Rock, AR 72114
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail 3rd day of January, 2023.

Rich Rosen, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

Dr. Janice L. LeBel
Board Certified, MA Licensed Psychologist-Provider
[redacted]

December 28, 2022

Joshua D. Gillispie
Green & Gillispie Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114

Re: Review and Analysis of Documents and Expert Opinion Regarding Restraint use in the Matter of the Estate of David Cains v. Arkansas Department of Human Services (AR DHS) (Booneville Human Development Center)

Dear Attorney Gillispie:

At the request of your office, I was retained as an expert who has worked nationally and internationally with publicly-funded and private service settings such as psychiatric facilities, general hospitals, developmental centers, correctional facilities, residential programs, juvenile justice programs, and schools serving people with various disabilities and different ages in reducing and preventing the use of restraint and seclusion.

I was asked to review documents regarding the death of David Cains (DC) including but not limited to: the pleadings, the witness deposition transcripts, Booneville Human Development Center (BHDC) policies and procedures, portions of DC's medical record, DC's individual treatment plan (IPP), behavior reports, restraint data, ambulance and emergency room records, the Adult Maltreatment Report, DHS Incident Report, Disability Rights Arkansas Investigative Report, OLTC Witness Statements, etc. Based upon this document review, I have rendered my professional opinion regarding the use of restraint with DC at BHDC.

My opinions, based upon my expertise and the document review process, are:

1) The physical restraint used on DC proximal to his death fell below the standard of care established by recognized standard setting entities. In addition, the physical restraint used on DC fell below the standard of care established by BHDC.

2) The BHDC emergency response policy, whereby direct care staff were prohibited from calling 911, fell below the standard of care and created a dangerous situation for DC and other clients and resulted in a delay in emergency service response and intervention.

These opinions are provisional. If additional information or documents are produced by the Respondent and submitted for review, the opinions may be modified, the report may be amended, and a revised report may be issued if necessary.

My opinions will be addressed in the order above. Deposition transcript citations/Bates Stamp numbers (where identified or applicable), standard setting citations (e.g., United Nations, World Health Organization, Centers for Medicare and Medicaid Services, AR Developmental Disability Services (DDS), other state DDS services, and BHDC Policies & Procedures) and professional literature references will be provided to support the opinion as necessary. The reference section will follow the American Psychological Association, sixth edition, formatting requirements. The facility, Booneville Human Development Center, will be referred to as BHDC. The patient may be referred to as: patient, resident, person-served, DC, he, or his. For purposes of this review, DC's history will not be restated but relevant elements of his history may be identified and cited as indicated.

<u>Opinion One</u>: The physical restraint used on DC proximal to his death fell below the standard of care, including BHDC's standard of care.

<u>Standard of Care</u>

The standard of care required the Respondent to comply with federal CMS/ICF Regulations found at 42 C.F.R. § 483.00 et seq.; Arkansas DDS policies and procedures; and BHDC's own policies and procedures. These policies establish that: a) only the least restrictive approved form of physical restraint can be used, b) for only the least amount of time necessary, c) only to prevent imminent and serious harm in emergency situations, d) only as a last resort after nonviolent techniques have been exhausted, e) the form of physical restraint used must be an authorized method clearly stated in the client's IPP, f) the form of physical restraint must be clearly identified in the facility's policies, and g) the authorized form of physical restraint must be taught to staff. The Respondent failed to meet the standard of care in this case.

Specifically, the Respondent failed in the following ways:

- The physical restraint was not necessary or justified and violated DC's right to be free from abuse and restraint;
- The physical restraint was not implemented in response to a life-threatening emergency or behavior that presented a risk of serious injury/harm;
- The physical restraint was not the least restrictive option;
- The physical restraint did not follow a reasonable effort at nonviolent de-escalation;
- The physical restraint was in violation of the attending physician's standing order for [redacted];
- The physical restraint method used by staff was not an approved, authorized or instructed technique recognized by BHDC or documented in [redacted]

Right to be Free from Abuse and Restraint

The Respondent's use of restraint in this case was a violation of patient/resident rights and a violation of the facility's obligation to uphold the patient's right to be free from abuse and restraint use. Physical restraint is defined by the federal government (Centers for Medicare & Medicaid Services [CMS]) as: *Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a*

patient to move his or her arms, legs, body, or head freely 42 C.F.R. § 482.13 and C.F.R. § 483.420. Physical restraint is a potentially lethal procedure of last resort which is used in an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or ruled out (42 C.F.R. § 483.450). Patients/residents in health care settings have a right to be free from restraint. To affirm this position and prevent the risk of serious harm associated with restraint use, standard setting organizations such as the United Nations(UN) (2006), World Health Organization (WHO) (2019), and the Centers for Medicare and Medicaid Services (CMS 483.12; CMS 483.420) mandate that **patients/residents of facilities have the right to be free** from abuse and neglect including but not limited to …**any physical** or chemical **restraint** … (emphasis added) imposed for purposes of discipline or convenience. When physical restraints are used, the facility is obligated to use the least restrictive alternative for the least amount of time and ensure that staff have and demonstrate needed competencies to effectively and appropriately interact with clients; monitor and take immediate action to address circumstances where possible abuse, neglect or mistreatment has occurred and prevent reoccurrence of abuse (CMS 483.12; Halverson et al., 2023; Huckshorn et al., 2021; AR DDS 3011-D; UN, 2006; & WHO, 2019).

Threshold for Restraint use was not Met

In health care settings, physical restraint is an emergency procedure of last resort and should only be used in the event of imminent danger to the patient/resident or others (Deposition testimony of BHDC Residential Services Director, S. Evans, 2022; Halverson et al., 2023; Huckshorn et al., 2021). BHDC staff documented and described DC's behavior as:

1. “yelling” (Jones, deposition testimony, p. 67); “screaming” (Jones OLTC Witness statement, labeled exhibit 4, p. 1)
2. “slightly agitated …became aggressive in common area” (IRIS report)
3. “irritated…screaming and cussing…ripped paper off the wall… jumped up … spitting and attempting to hit…” (Mattson, OLTC Witness statement, labeled exhibit 9, p. 1-2)

The behavior described above (# 1-3) is not lethal or life threatening, nor does it pose a risk of serious injury. The behavior described above does not require the use of force or a hands-on containment procedure. The antecedent actions described in the various documents do not meet the BHDC threshold of imminent danger requiring the implementation of physical restraint (BATES: 4348: *Booneville policy, Policy I-D-4, Documentation and Response to Maladaptive Behaviors; Booneville Behavior Management policy)* or accepted health care or restraint standards of practice (Halverson et al., 2023; Huckshorn et al., 2021; Huckshorn & LeBel, 2015; Ridley & Leitch, 2019).

In addition, **it does not appear that DC initiated physical contact with staff or physically harmed anyone** (emphasis added). Per Mattson’s OLTC Witness Statement (labeled exhibit 9, p. 2), he (Mattson) initiated physical contact with DC (“*I applied personal by grabbing his arms*”*)*. Mattson grabbed DC’s arms. Mattson activated an autonomic, defensive physical response from DC referred to as the “Withdrawal Reflex” (Clarke & Harris, 2004). Mattson initiated the physical interaction with DC; he did so without first utilizing required supported stance and blocking

techniques or any other form of nonviolent de-escalation required to be exhausted prior to physical restraint.

No Reasonable Effort at Least Restrictive Intervention and Non-violent De-escalation Intervention

The documentation provided does not identify any reasonable effort to de-escalate DC's distress. The most basic de-escalation strategies (time and physical space) were not apparent in the direct care staff OLTC witness statements (Campos & Jones). Mattson appears to be the only staff member with DC at the time the problem started. Mattson's written OLTC witness statement (p. 1-2) regarding the sequence of actions is disjointed. Mattson describes DC as: 'sitting, then screaming and cussing, then ripping paper off the wall to throw'. It is unclear how ripping paper off a wall occurs in a seated position. Mattson says DC then "jumped up … spitting and attempting to hit me." If DC was holding paper and attempting to throw it, one of DC's arms was likely elevated and rotated. It is not clear how quickly DC could rise to a standing position and attempt to hit Mattson. DC's physical actions were likely to have been slow, given his physical limitations. Mattson offers no detail about any verbal attempts he made to aid in calming DC, redirecting him, asking him to stop, offering DC any form of support, or utilizing the "supported stance" training.

Use of Restraint Violated BHDC Attending Physician's Order

[redacted]

[redacted]

Given the medical risk of restraint use with DC, BHDC could have put DC on their *Do Not Restrain List* but did not.

Use of Restraint Violated Policy Standards

The use of restraint was not consistent with BHDC policies (BATES: 4342). According to the deposition testimony of S. Evans, Residential Services Director, restraint is to be used, *"Only as an emergency measure but only if absolutely necessary* ***to protect client or others from injury****" (p.30*); per ICF/CMS regulation 483.450(d)(5) and Evans (2022, p.32), *"restraints must be designed and used* ***so as not to cause physical injury to the client"*** *(emphasis added) and implementation of behavior management policy and practices is done when an individual's actions are aggressive, disruptive, and/or present a danger to the individual or others, are* ***managed with the least restrictive method*** *(emphasis added)****."*** In this case, less restrictive interventions were not documented and the client (DC) was not protected. The client (DC) was fatally injured as a result of unwarranted restraint. No injury to staff was documented and no

threat of serious injury was documented. Furthermore, the unwarranted restraint used was not described, addressed or documented in the facility's policies or [redacted], as required by federal regulation (483.450(b)(1)(IV)); it was, in fact, unauthorized. This use of restraint was not justified per BHDC policy.

Use of Restraint Violated BHDC Staff Training and Practice Standards

DC died as a result of being physically restrained by staff on the floor/ground. According to the deposition of BHDC Staff Development Coordinator and Non-Violent Crisis Intervention Restraint Trainer (Hise, 2022):

- (p. 21, 18-20): *"The only reason that they would use the transition to the ground is putting a resident in mechanical restraint."*
- (p. 22, 8-9): *"I do not teach staff to hold a resident on the ground."*
- (p. 22,19-21): *"The training that we teach in NCI is a standing personal hold and a seated personal hold. There is no on-the-ground personal hold."*
- (p. 24, 20+): *"… use verbal strategies to de-escalate and redirection also teach blocking, stepping back..."*
- *(p. 25): "In the supported stance, if a resident was coming at you, you would put your hands up and deflect and step away."*
- (p. 28, 6) *"No, sir; do not restrain by yourself, use a supported stance to prevent falling over, if restraint on the ground, then prepare for mechanical restraint."*
- (p. 34*) So Booneville Human Development Center does not authorize the use or train staff in the use of restraining clients on the ground except when doing so for the specific purpose of transitioning to a mechanical restraint; correct? Hise's Answer: "Correct."*

BHDC Staff Development Coordinator and Restraint Trainer Mark Hise affirms that the fatal restraint used on DC was not authorized, that the facility did not adhere to relevant restraint-related policies, and BHDC direct care staff did not follow the training they were provided.

There are several steps the Respondent should have taken to prevent this situation including but not limited to:

1) Adhering to international, federal, state, and facility standards identified above,
2) Adhering to AR DDS policy 311-D,
3) Adhering to BDHC relevant policies,
4) Using only BHDC approved and taught restraint methods,
5) Adhering to DC's Attending Physician's Orders and ensuring DC remained upright for one hour after meals,
6) Not laying hands on and grabbing DC's arms,
7) Attempting non-violent de-escalation techniques, both before initiating the restraint and after DC was taken to the ground, when staff could have simply given DC space as opposed to forcefully holding him on the ground,
8) Per Hise (2022), following BHDC restraint training and NCI protocol and using supportive stance blocking and/or a pivoting technique, particularly if there was a location/position concern,
9) Adopting an organized approach to preventing the use of restraint such as the Six Core Strategies© or Ukeru which was developed with a DD population,
10) Allocating resources to train, retrain, and support/maintain staff competence in restraint prevention and establishing a culture of non-violence,

11) Teaching staff to not restrain any patient with a comorbidity that compromises digestion, respiration, cardiac functioning, etc.,

12) Obtaining external consultation to more effectively respond to DC's distress without hands-on procedures, e.g., considered safety circles, Ukeru approach (blocking pads and ensuring soft items in the environment), etc.,

13) Ensuring patients with [redacted] are put on the *Do Not Restrain List,*

14) Ensuring physician's orders are known and followed by staff,

15) Incorporating the physician's order [redacted] into a repeated medical alert protocol to remind direct care staff on a daily basis (e.g., as part of change of shift report, as part of treatment team, as part of checks procedure, as part of meal-time supervision, etc.),

16) Emphasizing restraint prevention and implementing effective alternatives to restraint use such as sensory-based approaches and other methods for staff to support clients in distress without hands-on procedures,

17) Ensuring greater medical oversight of the use of restraint including nursing presence for initiating, monitoring, and determination of earliest possible release,

18) Explicitly prohibiting ground restraint unless medically contraindicated,

19) Developing an organizational action plan of restraint prevention/reduction with a committee representing leadership, staff and families/persons-served.

In short, the Respondent should know the standard of care is rising. In an era of evidenced-based practice, accountability to the persons-served and others is owed. Exemplar programs and organizations serving a similar population have done significant work in creating low/no restraint services for people with developmental disabilities. This information should have compelled the organization to action to change their use of

restraint with persons-served creating a safer environment of care for staff and patients alike.

Opinion Two: The respondent facility's emergency response policy fell below the standard of care.

Standard of Care

The Respondent facility's policy, which prevented non-medical staff from calling 911, created an unnecessary obstacle to emergency response and life-saving intervention. The artificial layer of on-site communication created a dangerous circumstance for DC and all residents and likely contributed to DC's death. This approach to emergency intervention no longer occurs in other DDS state systems, such as Massachusetts, New Jersey, and Washington. Massachusetts DDS policies have required staff working in DDS settings to report events that they have reason to believe are harmful, including calling 911, since 1999 (#1999-4). New Jersey DDS enacted *Danielle's Law* in 2003 requiring staff working in services for people with intellectual/developmental or traumatic brain injury to call 911 when there is a life-threatening emergency to prevent delayed medical response Division of Developmental Disabilities | Danielle's Law (nj.gov). Washington state encourages staff and caretakers serving people with developmental disabilities to dial 911 and reach out online in the event of emergency circumstances (Report Concerns Involving Vulnerable Adults | DSHS (wa.gov)).

Recognizing the importance of unimpeded 911 access, broad federal legislation (Kari's Law) enacted in 2020 establishes that employers have a duty of care and a legal

responsibility to help protect anyone using their phone system. When an emergency call takes place from within an organizations' network and the caller cannot connect to 9-1-1, or if dispatchers cannot pinpoint the caller's location, the employer can be liable in the event of an unfavorable outcome due to a delayed response. New legislation has also introduced penalties for any business or organization that does not comply.

The opinions contained in this report are based on my professional opinion and are within a reasonable degree of certainty within my field of practice. In the previous 20 years I have not testified as an expert at trial or by deposition. I hope these opinions are useful to you. If a more detailed analysis is desired, I would be happy to continue to review the documents provided or other materials made available to you. In the meantime, thank you for the opportunity to provide this expert opinion regarding the use of restraint with DC.

Best regards,



Janice LeBel
Board Certified, MA Licensed Psychologist-Provider, #4950

JLL/mht

References

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Huckshorn, K. & LeBel, J. (2015). Restraint and seclusion. In A. Tasman, J. Lieberman, J. Kay, M. First & M. Riba (Eds.), Psychiatry (4th edition) (pp. 2487-2491). New York: Wiley-Blackwell.

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Jones, A. (2022, March 3). Zoom deposition transcript of Amy Jones.

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From:	Misty Scott on behalf of ASCC Pleadings
To:	Rich Rosen; ASCC Pleadings
Cc:	Kathryn Irby
Subject:	FW: RESCHEDULED HEARING INFO: McAuliffe v. DHS, Claim No. 220374
Date:	Wednesday, January 4, 2023 8:52:03 AM
Attachments:	McAuliffe v. DHS -- 220374 -- rescheduled hearing ltr.pdf

From: Kathryn Irby
Sent: Tuesday, June 28, 2022 4:01 PM
To: Joshua Gillispie <josh@greenandgillispie.com>; Eric Collins <Eric.Collins@dhs.arkansas.gov>
Cc: OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
Subject: RESCHEDULED HEARING INFO: McAuliffe v. DHS, Claim No. 220374

Mr. Gillispie and Mr. Collins, please see attached hearing rescheduling letter.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From: Kathryn Irby
Sent: Monday, May 16, 2022 8:14 AM
To: Joshua Gillispie <josh@greenandgillispie.com>; Eric Collins <Eric.Collins@dhs.arkansas.gov>
Cc: OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
Subject: RE: HEARING INFO: McAuliffe v. DHS, Claim No. 220374

Mr. Collins, I can push the prehearing material deadline to December 28, 2022.

Good luck with the military training.

Thanks,
Kathryn Irby

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Saturday, May 14, 2022 2:54 PM
To: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Cc: Kathryn Irby <Kathryn.Irby@arkansas.gov>; OCC Claims Commission Cases

<OCC.ClaimsCommCases@dhs.arkansas.gov>
Subject: Re: HEARING INFO: McAuliffe v. DHS, Claim No. 220374

Ms. Irby:

I have no objection to Mr. Collins' request. I will have Plaintiff's papers submitted by December 16th because I will be tied up with the holidays following the 16th, but I have no objection to Eric's request.

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Fri, May 13, 2022 at 3:00 PM Eric Collins <Eric.Collins@dhs.arkansas.gov> wrote:

> Hey Ms. Irby,
>
> I do have a quick question related to the schedule that you have set for this case.
>
> December 16, 2022, is the current date set for the submission of witness lists, exhibit lists, exhibits, and prehearing briefs. I would like to request that the date for those submissions be extended. I am currently scheduled for extended military training in Ft. Benning during the months of October and November. I am set to return on November 22, 2022 and will be back in the office on December 1, 2022. I would greatly appreciate some additional time, perhaps another week or two, to reacquaint myself with the record, to gather the necessary materials, and to draft a prehearing brief. I understand this would push the due date to the week of Christmas, but I am hoping we can work out a solution on that timing. I have discussed this issue with Mr. Gillispie and ran the situation by him as well.
>
> Thank you,
>
> Eric M. Collins
> Attorney
> Arkansas Department of Human Services
> Office of Chief Counsel
> Office: (501) 396-6170

Cell: (501) 295-6356

This email may contain sensitive information.

Confidentiality Notice: The information contained in this email message and any attachment(s) is the property of the State of Arkansas and may be protected by state and federal laws governing disclosure of private information. It is intended solely for the use of the entity to whom this email is addressed. If you are not the intended recipient, you are hereby notified that reading, copying or distributing this transmission is STRICTLY PROHIBITED. The sender has not waived any applicable privilege by sending the accompanying transmission. If you have received this transmission in error, please notify the sender by return and delete the message and attachment(s) from your system.

From: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Sent: Tuesday, April 26, 2022 11:29 AM
To: Joshua Gillispie <josh@greenandgillispie.com>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
Subject: HEARING INFO: McAuliffe v. DHS, Claim No. 220374

Mr. Collins, I spoke with Mr. Gillispie yesterday when he called with a question about submitting deposition testimony, and he and I discussed possible hearing dates. To allow for a full day of hearings, it looks like January 20, 2023, is our best bet.

Mr. Gillispie and Mr. Collins, to that end, I am attaching a hearing letter. If this date is unworkable for Mr. Collins, we can go back to the drawing board.

Thanks,
Kathryn Irby

From: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Sent: Monday, April 25, 2022 1:35 PM
To: Joshua Gillispie <josh@greenandgillispie.com>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: RE: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374

Mr. Gillispie and Mr. Collins, how long do the parties think that the hearing will take? How many live witnesses and how many witnesses' testimony will be submitted through deposition?

Thanks,
Kathryn Irby

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Friday, April 22, 2022 11:38 AM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Re: Request for Hearing: FW: Christine McAuliffe; Claim No. 220374

Ms. Irby:

The parties have made significant progress in conducting discovery. I conferred with Mr. Collins today and we feel that we will likely be done with discovery by September.

Would now be a good time to look at having this matter added to the hearing docket?

Best regards,

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Mon, Feb 7, 2022 at 11:39 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie and Mr. Collins,
>
> The Claims Commission has reviewed Mr. Gillispie's request for a hearing in the above-referenced claim and would like for the parties to conduct discovery prior to the scheduling of this claim for hearing, especially given the amount in controversy. When discovery is nearing completion, please contact me to get this claim added to the hearing docket.
>
> Thanks,
> Kathryn Irby
>
> **Kathryn Irby**
> **Arkansas State Claims Commission**
> 101 East Capitol Avenue, Suite 410
> Little Rock, Arkansas 72201
> (501) 682-2822
>
> ---
>
> **From:** Joshua Gillispie <josh@greenandgillispie.com>
> **Sent:** Thursday, February 3, 2022 1:54 PM

To: Caitlin McDaniel <Caitlin.McDaniel@arkansas.gov>
Cc: ASCC New Claims <ASCC.New.Claims@arkansas.gov>; Dana Henderson <dana@greenandgillispie.com>; Kathryn Irby <Kathryn.Irby@arkansas.gov>; Eric Collins <Eric.Collins@dhs.arkansas.gov>
Subject: Christine McAuliffe; Claim No. 220374

Ms. McDaniel:

If possible, I would like to set this matter for a hearing. I would appreciate any guidance you can provide me on what my office needs to do in order to get a setting. The respondent agency, DHS, has denied liability in their answer. Their attorney, Eric Collins, has been copied on this email.

Thank you for your assistance.

Josh

Joshua D. Gillispie



1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

The Arkansas Department of Human Services has determined that this message may contain confidential or otherwise protected information. We have used transport encryption to help protect this message while in transit to you. Please take all reasonable measures to protect any protected or confidential data that might be in this message, including the limitation of re-disclosure to the minimum number of recipients necessary. Please report any inappropriate disclosure to
https://dhs.arkansas.gov/ost/contactforms/ContactUs.aspx
or as required by law.

ARKANSAS STATE CLAIMS COMMISSION

(501) 682-1619
FAX (501) 682-2823

KATHRYN IRBY
DIRECTOR

101 EAST CAPITOL AVENUE
SUITE 410
LITTLE ROCK, ARKANSAS
72201-3823

June 28, 2022

Mr. Joshua Gillispie (*via email*)
Green & Gillispie
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

Mr. Eric M. Collins (*via email*)
Arkansas Department of Human Services
Post Office Box 1437, Slot S260
Little Rock, Arkansas 72203

RE: ***Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services***
Claim No. 220374

Dear Mr. Gillispie and Mr. Collins,

Due to a scheduling conflict, the Claims Commission has rescheduled this claim for hearing on **Thursday, March 9, 2023**, beginning at 9:00 a.m. All parties will attend via Zoom. If either party objects to a Zoom format, a written objection must be submitted via email (kathryn.irby@arkansas.gov) or mail no later than July 6, 2022. The Zoom invitation is enclosed.

Each party's witness lists, exhibit lists, and exhibits are due by Thursday, February 16, 2023. If the parties would like for the Claims Commission to review prehearing briefs, the briefs are due at the same time. If the parties will be submitting any testimony by deposition, those deposition transcripts are due at the same time. If the parties will require a subpoena, subpoena requests are also due at the same time. Absent a showing of good cause, the Claims Commission will not issue subpoenas for requests received after February 16, 2023.

To the extent that either party intends to file a motion of any kind, absent a showing of good cause, the motion must be submitted in sufficient time to allow the motion to be fully briefed by February 16, 2023.

Please note that a copy of any filing must be served upon the opposing party via U.S. Mail in accordance with the Arkansas Rules of Civil Procedure.

If you have any questions, please do not hesitate to contact my office.

Sincerely,

Kathryn Irby

ES: kmirby

The Claims Commission is inviting you to a scheduled Zoom meeting.

Topic: Claims Commission -- hearings
Time: Mar 9, 2023 09:00 AM Central Time (US and Canada)

Join Zoom Meeting
https://us06web.zoom.us/j/83331127227?pwd=ZXN3RjdVZUpxUkxXakZMYm1VMk5WUT09

Meeting ID: 833 3112 7227
Passcode: YEz2R0
One tap mobile
+13017158592,,83331127227#,,,,*718080# US (Washington DC)
+13126266799,,83331127227#,,,,*718080# US (Chicago)

Dial by your location
+1 301 715 8592 US (Washington DC)
+1 312 626 6799 US (Chicago)
+1 929 436 2866 US (New York)
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 669 900 6833 US (San Jose)
Meeting ID: 833 3112 7227
Passcode: 718080
Find your local number: https://us06web.zoom.us/u/kmuitA0ZW

From: Daiquiri Carter
To: ASCC Pleadings; Rich Rosen; Joshua Gillispie
Subject: Notice of Deposition CC 220374
Date: Tuesday, January 17, 2023 10:50:25 AM
Attachments: KastnerMD-notice-depo(1-23).pdf
image001.png
image002.png

Please find attached a Notice of Deposition in the above styled case. I have copied Claimant's counsel on this email.

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov





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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

Notice of Deposition

PLEASE TAKE NOTICE that pursuant to Rules 3.3 and 8.1 of the Rules and Regulations of the Arkansas State Claims Commission, the Respondent, the Arkansas Department of Human Services, Booneville Human Development Center, by counsel, will take the deposition of the **Ted Kastner, M.D.,** on the agreed date, time and manner identified below. The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date & Time: **Thursday, January 19, 2023 at 9:00 a.m. CST**

Place: **Via zoom**

Respectfully Submitted,
Arkansas Department of Human Services

By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On January 17, 2023, a copy of the above notice was served via electronic mail and mailed to:

Joshua D. Gillespie, Esquire josh@greenandgillispie.com

Richard Rosen

From:	Daiquiri Carter
To:	ASCC Pleadings
Cc:	Rich Rosen; Joshua Gillispie; Daiquiri Carter
Subject:	CC 220374
Date:	Monday, January 23, 2023 3:47:59 PM
Attachments:	DHS Resp to 2nd Discovery.pdf image001.png image002.png

Please find attached DHS' Responses to Claimant's Second Set of Interrogatories and Requests for Production.

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov





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BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains — **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — **RESPONDENT**

DHS' RESPONSES TO CLAIMANT'S SECOND SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

COMES now DHS, by counsel, and is response to Claimant's Second Set of Interrogatories and Requests for Production, States as follows:

INTERROGATORY NO. 1: Please state whether Dr. Theodore Kastner has ever provided testimony as an expert witness at a trial or deposition. If so, for each expert, please state:

(a) The style of the case, including the names of parties, venue and case number;

(b) Whether testimony was provided for the Plaintiff or Defendant; and

(c) A brief summary of the expert testimony provided in the particular case.

ANSWER: Yes. Dr. Kastner has qualified as an expert medical witness in several cases and by several courts, including the United States District Court for the Eastern District of Arkansas:

1. *United States v. Arkansas*, 794 F. Supp 2d 935 (E.D. Ark. 2011) (case No. 4:09-CV-0033);
2. *United States v. Arkansas,* #4:10-CV-00327 JLH, 2011 U.S. Dist. 7231.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 1: Please produce for inspection and copying any and all most recent *curriculum vitaes* or written statements and reports by Dr. Theodore Kastner that you may call at the hearing of this matter and a list of any such expert's

publications or other writings. *In addition, please produce a copy of the transcript for any and all testimony provided by Dr. Kastner at any previous trial, hearing and/or deposition.*

ANSWER: Dr. Kastner's C.V. has previously been provided. Dr. Kastner's publications are identified on his C.V. DHS does not have possession of Dr, Kastner's publications. In addition, two written reports have previously been provided reflecting Dr. Kastner's expert opinions and the facts in this matter, including the bases and grounds for his opinions. DHS has no transcripts of any testimony previously provided by Dr. Kastner or any of his prior publications identified on Dr. Kastner's C.V. Dr. Kastner is a medical and restraint expert with vast and extensive experience in the provision of health care and services to individuals with intellectual disabilities and developmental delays, including application of the standards of care applied to facilities and staff within the United States, restraint use in compliance with federal regulations and CMS Operations manuals and state rules/policies applicable to Intermediate care facilities for individuals with intellectual disabilities, such as the Booneville Human Development Center. Dr. Kastner is an expert witness retained by DHS. He is not a DHS employee.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 2: Please produce all documents related to Dr. Theodore Kastner's, Developmental Disabilities Health Management's, or any other Kastner entity's previous work for the Arkansas Department of Human Services since the year 2000. This includes but is not limited to Kastner's or DDHM's or any other Kastner entity's proposal when bidding on the Alexander Human Development Center, and all written findings, recommendations, reports, opinions, and any other document related to their work, consulting work other otherwise, at AHDC.

ANSWER: To the extent that any of these documents are in the possession of DHS related to the former AHDC, these documents have been provided. If additional documents are discovered in DHS possession, this response will be supplemented.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 3: Please produce all findings, recommendations, reports, opinions, or any other document authored by Kastner (or any entity with which Kastner was involved) that in any way relate to the Arkansas Department of Human Services since the year 2000.

ANSWER: Documents responsive to this request were previously provided to Claimant pursuant to its FOIA request and pursuant to discovery. *See* response to Request for Production No. 1 above.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 4: Please produce all documents reflecting amounts paid by the state of Arkansas or by DHS or by DDS or by any other branch of state government to Dr. Theodore Kastner or to any company with which he was affiliated, including without limitation Developmental Disabilities Health Management or Disability Service Centers of Arkansas or any of Kastner's other companies. These documents should include, without limitation, contracts, invoices, proposals, bids, receipts, or any other item reflecting amounts paid to Kastner or a Kastner entity by Arkansas since the year 2000 and through the present date.

ANSWER: Documents responsive to this request were previously provided to Claimant pursuant to its FOIA request. If any further documents are discovered within the possession of DHS, this response will be supplemented.

INTERROGATORY NO. 2: Please treat the foregoing interrogatories as continuing and furnish to Plaintiffs, in writing, any additional information received by you subsequent to the

date of your answers hereto that would modify or supplement your answers, such additional information to be furnished as soon as reasonably possible after receipt by you and within a reasonable time prior to the assigned trial date in order to permit appropriate discovery procedure. Will you do so?

ANSWER: Yes, to the extent required by the Arkansas Rules of Civil Procedure.

Respectfully Submitted,

Arkansas Department of Human Services,

By: /s/ **Richard Rosen**
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334

Certificate of Service

On January 23 2023, a copy of the above discovery response was served via email to

josh@greenandgillispie.com

chad@greenandgillispie.com

/s/ Richard Rosen

From: Kathryn Irby
To: Joshua Gillispie
Cc: Chad; Daiquiri Carter; Rich Rosen; Brent Gasper
Bcc: Kathryn Irby
Subject: INFO NEEDED: McAuliffe v. DHS, Claim No. 220374
Date: Friday, January 27, 2023 2:03:00 PM

Mr. Gillispie, Mr. Rosen, and Mr. Gasper,

Can you all give me an update on this hearing? Have the parties discussed the logistics for this hearing? This hearing is set for one day, which, depending on the number of witnesses, means that only a limited amount of live testimony can be presented. In some claims, parties have elected to submit all testimony through deposition and to do closing arguments and field questions from the commissioners at the hearing. In other claims, parties have submitted some testimony through deposition and presented select live testimony at the hearing. Sometimes, parties elect to waive opening statements and to rely on the prehearing briefs. If live testimony will be presented, it is helpful for the parties to discuss how the hearing day will be divided to make sure everyone is on the same page.

If the parties cannot agree on an aspect of these logistics, please let me know **by February 1**, so that I can set a status conference for February 9. If the parties agree on the logistics, please let me know the plan to ensure that this hearing can be completed in one day.

I am happy to discuss further on Monday, if need be.

Thanks,
Kathryn

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From: Joshua Gillispie
To: Kathryn Irby
Subject: Re: INFO NEEDED: McAuliffe v. DHS, Claim No. 220374
Date: Friday, January 27, 2023 3:09:25 PM

Kathryn-

Quick question. I intend to submit most testimony through deposition and present select live testimony. Given that, could you please give me a little guidance regarding an agreement between the parties on how the day will be divided? What I'm really getting at is are you wanting us to simply agree how to divide x amount of hours or are you wanting us to get into the specifics now of who are witnesses will be?

Thanks, and hope that made some sense.

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Fri, Jan 27, 2023 at 2:03 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie, Mr. Rosen, and Mr. Gasper,
>
> Can you all give me an update on this hearing? Have the parties discussed the logistics for this hearing? This hearing is set for one day, which, depending on the number of witnesses, means that only a limited amount of live testimony can be presented. In some claims, parties have elected to submit all testimony through deposition and to do closing arguments and field questions from the commissioners at the hearing. In other claims, parties have submitted some testimony through deposition and presented select live testimony at the hearing. Sometimes, parties elect to waive opening statements and to rely on the prehearing briefs. If live testimony will be presented, it is helpful for the parties to discuss how the hearing day will be divided to make sure everyone is on the same page.
>
> If the parties cannot agree on an aspect of these logistics, please let me know **by February 1**, so that I can set a status conference for February 9. If the parties agree on the logistics, please let me know the plan to ensure that this hearing can be completed in one day.
>
> I am happy to discuss further on Monday, if need be.

Thanks,

Kathryn

Kathryn Irby

Arkansas State Claims Commission

101 East Capitol Avenue, Suite 410

Little Rock, Arkansas 72201

(501) 682-2822

From: Kathryn Irby
To: Joshua Gillispie
Cc: Chad; Joanna Whittaker; Rich Rosen; SaBreana Hyche
Subject: RE: McAuliffe v. DHS, Claim No. 220374
Date: Wednesday, February 8, 2023 9:54:00 AM

Josh, the Claims Commission routinely handles claims with thousands of pages of prehearing materials. That's why the prehearing materials deadline is three weeks before the hearing. If you use binders to submit your prehearing materials, please number the binders. Also, you will need to submit four sets of binders (one for each of the three commissioners and one for the claim file).

It is also helpful when the parties do not duplicate deposition submissions. I'm copying Rich Rosen to make him aware this request, as well.

I do not know which three commissioners will be on the March panel yet, but I'm happy to share that information once I know.

If either party wants to check out the hearing room this Friday, please coordinate with SaBreana Hyche to do so. Her direct number is 682-2819.

Feel free to give me a call if this does not answer your questions.

Thanks,
Kathryn

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Friday, February 3, 2023 12:19 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Chad <chad@greenandgillispie.com>; Joanna Whittaker <joanna@greenandgillispie.com>
Subject: Re: McAuliffe v. DHS, Claim No. 220374

Kathryn:

My assistant just told me that total was wrong. It's actually approximately 14,000 pages for each of the four copies, not 26,0000.

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Fri, Feb 3, 2023 at 12:03 PM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Thanks! Would there be a time next Friday that would work?
>
> One other thing: We took over 20 depositions in this case and almost all of them contain some essential evidence. The page count for the depositions plus exhibits is going to be around 26,000 pages, of which the vast majority is depo transcripts.
>
> I am totally fine with providing four copies of all of that and that is what I intend to do, but I just wanted to make you aware in case that is a problem.
>
> I do have condensed copies for most of the depos, but I would not want to use those without explicit permission.
>
> My cell is (501) 804-5898. Call me any time.

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Fri, Feb 3, 2023 at 9:05 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Of course. Let me know when you want to come by, and we'll set it up.
>
> Kathryn
>
> Get Outlook for iOS
>
> ---
>
> **From:** Joshua Gillispie <josh@greenandgillispie.com>
> **Sent:** Thursday, February 2, 2023 5:20:05 PM
> **To:** Kathryn Irby <Kathryn.Irby@arkansas.gov>
> **Cc:** Chad <chad@greenandgillispie.com>
> **Subject:** McAuliffe v. DHS, Claim No. 220374
>
> Kathryn:

Would it be possible for me to come take a look at the hearing room so I can get a better sense of what I need to bring and just generally be better prepared?

Brandon Lacy told me there is a large tv that parties can use for showing video clips, I think.

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

FIFTH SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

Interrogatories

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Fifth Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

Request for Production of Documents

1. Copies of all exhibits that you will introduce at the trial of this matter, including but not limited to all documents, reports, photographs, videotapes, digital recordings, records, bills, invoices, statements, accounts, receipts, x-rays, ultrasounds, and medical records.

RESPONSE: Plaintiff reserves the right to amend this response. Plaintiff will timely supplement this response as exhibits are identified and obtained throughout discovery. At this time, Plaintiff reserves the right to use any document produced or identified by either party throughout this discovery, including but not limited to Plaintiff's medical records, medical bills, funeral bills, various photos of David Cains, coroner reports, expert reports, including those already written and produced by Arkansas Disability Rights, and any rules and regulations or policies that Defendant was required to adhere to, including those required for Medicare/Medicaid reimbursement. Many, if not most, of the exhibits Plaintiff will use are currently in Defendant's possession, not Plaintiff's, including but not limited to [redacted]

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AIOM WN

From: Joshua Gillispie
To: ASCC Pleadings
Cc: Rich Rosen; Chad
Subject: Re: CC 220374
Date: Monday, February 13, 2023 6:26:11 PM
Attachments: Claimant"s Sixth Supplemental Response to Respondent"s First Set of Discovery.pdf
Bob Bowen CV 2023 .pdf

Dear Commission:

Please find Claimant's Sixth Supplemental Discovery Responses, along with the CV of Bob Bowen.

Best regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Wed, Feb 8, 2023 at 1:58 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Dear Commission:
>
> Please find Claimant's Fifth Supplemental Discovery Responses, along with copies of documents being produced herewith. Certain photographs and videos shall be produced by flash drive due to size.
>
> Best regards,
>
> Joshua D. Gillispie
> 1 Riverfront Place, Suite 605
> North Little Rock, AR 72114
> (501) 244-0700
> (501) 244-2020 fax
> www.greenandgillispie.com

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

SIXTH SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Sixth Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.

SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Janice L. LeBel, EdD/PhD, ABPP. Dr. LeBel's CV and Fee Schedule are provided herein, which contain her contact information. Dr. LeBel, as reflected in her CV, is a psychologist and an expert in field of behavioral health services and residential care for vulnerable populations, including the disabled, mentally ill, and children. Dr. LeBel has published extensively on the use of restraints in these settings. She is expected to testify concerning the standard of care for a facility such as BHDC, and whether there were breaches of that standard that lead to Cains's death. Dr. LeBel can be made available for deposition upon request from Defendant. At this time there is no written report to share with Defendant.

SECOND SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Ricki Brown-Forestiere, MD. Dr. Brown-Forestiere's CV is provided herein. Dr. Brown-Forestiere is an Emergency Medicine Physician and an expert in her field of emergency medical services. Dr. Brown-Forestiere is board certified in Emergency Medicine. She is expected to testify concerning the cause of David Cains' death. Dr. Brown-Forestiere can be made available for deposition upon request from Defendant.

THIRD SUPPLEMENTAL RESPONSE:

(a) Claimant will not be utilizing DRA advocates as expert witnesses in this matter. Claimant will reference the three DRA Reports in her pre-trial brief, reference them at the hearing, and likely submit copies to the Commission. Thomas Nichols, DRA's

Managing Attorney, has agreed to provide authentication and foundation, in the event DHS cannot stipulate to same and those steps are in fact necessary.

Thomas W. Nichols
Managing Attorney
Disability Rights Arkansas
400 West Capitol, Suite 1200
Little Rock AR 72201
Phone: 501.492.5776

(b)

Dr. Janice LeBel

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available and what Claimant expects. Note that Dr. LeBel has not authored or produced to Claimant a written report concerning her opinions. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Janice LeBel is a liability expert, expected to testify that the physical restraint and physical ground restraint, and the circumstances surrounding the restraint, performed by three direct care workers at BHDC, which caused David to vomit and then choke to death on his vomit, fell below the standard of care for facilities caring for the intellectually disabled and that his death was a foreseeable consequence of Respondent's negligence, as evidenced by the acknowledged violations of BHDC's own rules and regulations and those of DDS, by the fact that the death restraint was unnecessary and unjustified, that it was not the least restrictive intervention available and not used for the

least amount of time, that it was not an approved NCI method of restraint taught or authorized by DHS or BHDC, that it was [redacted] that it was not identified in any policies or in [redacted] as a potential form of restraint that could ever be used, that its form and repeated use by the facility was substandard, that it occurred as the result of substandard training and substandard oversight of direct care staff, that the large number of physical restraints used by BHDC staff on David Cains over the years and the facility's history of over-reliance on physical restraints in general was substandard practice and suggests a culture within the facility standing in opposition to commonly accepted norms and best practices for such facilities, that undertrained and/or underqualified direct care staff were allowed to use their own subjective discretion for when to use physical restraints with little to no oversight by supervisors and in ways often anathema to the training professed to have been provided them and the Respondent's own written rules, that the direct care staff's training and knowledge as regards first aid and basic lifesaving procedures was substandard (*see* placing him on his back after he starts vomiting), that BHDC in general failed to implement a functioning system of accountability for and oversight of staff designed to ensure staff were adhering to their training with regards de-escalation techniques and other nonviolent interventions, and that all of these ways in which BHDC fell below the standard of care directly led to and caused David Cains' untimely death – a foreseeable tragedy given the facility's historical refusal to reduce its reliance on physical restraints that are themselves inherently dangerous, particularly physical restraints performed on the ground like the one that killed David and which staff had been utilizing commonly and frequently in the months and years leading up to David's death despite the fact such

ground restraints were at all relevant times unauthorized and prohibited. Dr. LeBel's CV (previously produced) speaks for itself as to her expertise, experience, and qualifications. Her grounds for providing these opinions include the application of her expertise in this precise field to the facts and evidence of this case, including deposition transcripts, records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

Dr. Ricki Brown-Forestiere

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available. Note that Dr. Brown-Forestiere has not issued a formal written opinion or report on this matter. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Ricki Brown-Forestiere is a causation expert and <u>partial damages expert</u> (with respect only to Claimant's claim for damages based on David Cains' conscious pain and suffering prior to death), expected to testify that, but for the restraint and ground restraint in question, David Cains would not have died. David died because the physical restraint and ground restraint caused a struggle and that struggle induced vomiting upon which David choked to death. More specifically:

[redacted]

[redacted]

David, unfortunately, was also placed on his back after he began vomiting. [redacted]

[redacted].

Dr. Brown-Forestiere's grounds for providing these opinions include the application of her expertise in emergency medicine to the facts and evidence of this case, including deposition transcripts, medical records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

FOURTH SUPPLEMENTAL RESPONSE:

Please find attached the *Provisional Summary of Opinions* of Dr. Janice LeBel, supplemental to previous responses concerning Dr. LeBel.

FIFTH SUPPLEMENTAL RESPONSE: Bob Bowen. CV attached. Mr. Bowen is expected to testify as a rebuttal witness to Respondent's expert Dr. Kastner. The substance of and grounds for his testimony and opinions will be dependent upon Dr. Kastner's live testimony. The subject matter of his testimony is expected to be the federal CMS regulations, also known as ICF-IID regulations, contained within Appendix J of the State Operations Manual (the federal regulations), and whether the Booneville Human Development Center violated those regulations in the case of David Cains.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail 13th day of February, 2023.

Rich Rosen, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

phone [redacted]
e-mail: [redacted]

Bob Bowen

Guiding Principles

Excellence, effectiveness, enthusiasm and ethical behavior are the guiding principles of my human services career. Having had the experience of being recruited, developed and mentored by great leaders, it is my goal to provide future leaders with the same opportunities to become their best selves professionally and personally. My experiences as an Adjunct Assistant Professor of Psychiatry at the University of Rochester for 10 years, a CEO of an international consulting firm, and experiences in the administration of residential supports for people affected by disabilities give me the ability to integrate my passion for knowledge with compassion for people to close the gap between research and practice, and most importantly improve the quality of life of all people with and for whom I work. Inviting rather than coercing behaviour change is the foundation upon which I enter relationships, seeking ways to eliminate the barriers that prevent full participation in the life of the communities in which we live, learn, work and play.

Current Employment

Prag Consulting: Disability Complex Supports, Balwyn East, VIC, Australia – Independent Contractor as a Senior Associate, Positive Behaviour Support, providing behaviour support services to people with multiple complex support needs, including mental health, inter-personal trauma, and human relations.

Current Projects

The Journal of Aggression, Conflict and Peace Research, published by Emerald Insights, has asked me to edit a Special Issue of the Journal focused on Workplace Violence and Workplace Incivility, to be published in January 2024.

Member of the Organizing Committee for the EuroNursing Conference, Zurich, Switzerland, May 4-6, 2023.

Publications (Partial Listing)

Bowen, B (2022). Autism Spectrum Differences: ASD and an Ordinary Life. *Health,* 14(12): 1267-1273. doi: 10.4236/health.2022.1412089.

Bowen, B. and Bowen, E. (2022) Moving Away from Coercion: Social Justice and Behavior Change in Disability Services. *Health*, **14**, 194-203. doi: 10.4236/health.2022.142014

Bowen, B (2021). The Matrix of Needs: A new way to understand and respond to needs. *Human Services Today,* 2(3): 34-35,

Bowen, B (2021). The myth of attention-seeking behavior: Supporting health and wellness in people with Autism Spectrum Disorders and Intellectual Disabilities. *Health*, 13(12):1452-1459. doi: 10.4236/health.2021.1312103.

Bowen, B (2021). Hope and despair: The healing power of listening. *Health*, 13(5): 591-599. doi: 10.4236/health.2021.135044

Bowen, B. (2021). The Matrix of Needs: Reframing Maslow's Hierarchy. *Health*, 13(5), 538-563. doi: 10.4236/health.2021.135041.

Bowen, B (2021). Hopelessness and hope in human services, *Human Services Today*, 2(2): 20-21.

Bowen, B (2017). The positive practice of safety: Reductions in workplace violence through increases in safety and security at organisational and interpersonal levels. Routledge International Handbook on Forensic Psychology in Secure Settings, Jane L. Ireland, Carol A. Ireland, Neil Gredecki & Martin Fisher, Ed. New York, NY: Routledge

Bowen, B (2016). Creating and sustaining cultures of care: Minimizing aggression by maximizing safety related behaviors. Ian Needham, Kevin McKenna, Odile Frank & Nico Oud (Eds) Proceedings of the Fifth International Conference on Violence in the Health Care Sector, 268-271. Dwingaloo, The Netherlands: Kavanah.

Privitera MR, Bowie V & Bowen B (2015). Translational Models of Workplace Violence in Healthcare, *Violence and Victims*, (30)2, 293-307. https://doi.org/10.1891/0886-6708.VV-D-13-00119

Bowen, B (2015). Risk, gain, liability and hope: Integrating and training family members in the treatment planning and implementation process when aggression history is present. In Patrick Callaghan, Nico Oud, Johan Hakon Bjorngaard, Henk Nijman, Tom Palmstierna & Joy Duxbury (Eds), the Proceedings of the Ninth European Congress on Violence in Clinical Psychiatry, (pp 249-251). Dwingaloo, The Netherlands: Kavanah.

Bowen, B & Kemp, S (2014). Replacing Restraint: Good Practices in North America Human Service Programmes for Persons with Intellectual Disabilities and Autism, in *A Human Rights Perspective to Reducing Restraint Practices*, Sam Karim (Ed): BILD

Privitera M, Bowie V & Bowen B (2014). Translational models of workplace violence in healthcare: Interprofessional applications. In Ian Needham, Mierelle Kingma, Kevin McKenna, Odile Frank, Carol Tuttas, Stuart Kingma & Nico Oud (Eds), Proceedings of the Fourth International Conference on Violence in the Health Care Sector (pp 145-148). Dwingaloo, The Netherlands: Kavanah.

Bowen B, Geels T & Bowie, V (2013). Creating Safety: How Risk Management Leads to Aversive Decisions. *Intellectual Disability Australiasia*, 33(3): 3-6.

Bowen, B & Risser, P (2013). Strengthening the pavement of good intentions: Ethical and legal implications of restraint and seclusion strategies. In Patrick Callaghan, Nico Oud, Johan Hakon Bjorngaard, Henk Nijman, Tom Palmstierna, Roger Almvik & Bart Thomas (Eds), the Proceedings of the Eighth European Congress on Violence in Clinical Psychiatry, (pp122-125). Dwingaloo, The Netherlands: Kavanah.

Bowen B, Privitera MR, & Bowie V. (2011). Reducing Workplace Violence by Creating Healthy Workplace Environments, *Journal of Aggression, Conflict, and Peace Research,* 3(4) 185-198, October 2011, https://doi.org/10.1108/17596591111187710

Bowen, B (2011). Moving Away From Coercion and Enhancing Patient Dignity and Respect in Workplace Violence in the Mental and General Health Care Setting, Michael R. Privitera, MD (Ed), 2011. Boston, MA: Jones & Bartlett.

Bowen, B (2010). Commonalities in Maximizing Safety in Various Human Service Sectors. In the Proceedings of the 2nd International Conference on Violence in the Health Care Sector, Ian Needham, Kevin McKenna, Mirielle Kingma & Nico Oud, editors. Pages 380-383. Dwingaloo, the Netherlands: Kavanah

Bowen, B (2009). The Dance of Aggression: Learning to Follow Instead of Lead, in the Proceedings of the 6th European Congress on Violence in Clinical Psychiatry, Ian Needham, Patrick Callaghan, Tom Palmstiera, Henk Nijman & Nico Oud, editors. Pages 218 - 222. Dwingaloo, The Netherlands: Kavanah.

Bowen, B & Mohr, WK (2009). Measuring the Presence of Coercion in Psychiatric Settings, in the Proceedings of the 6th European Congress on Violence in Clinical Psychiatry, Ian Needham, Patrick Callaghan, Tom Palmstiera, Henk Nijman & Nico Oud, editors. Pages 223-226. Dwingaloo, The Netherlands: Kavanah

Mohr, WK & Bowen, B. (2009) Decreasing Workplace Violence Means Increasing Workplace Safety Through Positive Behavior Supports**.** the Proceedings of the 6th European Congress on Violence in Clinical Psychiatry, Ian Needham, Patrick Callaghan, Tom Palmstiera, Henk Nijman & Nico Oud, editors. Pages 250-253. Dwingaloo, The Netherlands: Kavanah

Presentations (Partial Listing)

2023 – Maximising Safety, Minimising Risk – Presented to staff of Being Human Assist, Melbourne, VIC, February 7, 2023

2022 – Level III Positive Behaviour Support, Yooralla, Wonthaggi, VIC, staff training provided 25 November, 2022.

2022 – National Organization for Human Services, Symposium, "Social Justice and Behavior Change: Inviting, Not Coercing Behavioral Changes." 2022 Virtual Symposium, October 21, 2022.

2022 – Malone University Ethics Seminar, "Social Justice: the Ethics of Behavior Support vs. Behavior Management, Malone University, October 14, 2022.

2022 - Workshop presentation, "The Matrix of Needs: Supporting Students with Complex Trauma Histories," Lighthouse Ministries, Canton, OH June 2022.

2022 – Workshop presentation, "Autism Spectrum Differences: ASD in a New Light. Co-presented with Elise Muller, virtual workshop in Melbourne, Australia, September 27, 2022.

2022 - Workshop presentation, "The Matrix of Needs: Supporting Adults with Intellectual Disabilities and Trauma Histories," Sacred Ground, Berlin, OH, April 2022

2021 – Positive Childhood Experiences: Using the Matrix of Needs to Structure Resilient System. Workshop presented at the National Organization for Human Services virtual conference October 21, 2021.

2021 – Panel member, The Courage to Practice Ethically, workshop on ethical practices for social workers, Malone University, October 1, 2021.

2021 – Presented "The Matrix of Needs" virtual workshop for the Hong Kong Society for Professional Training, September 10, 2021.

2021 – Presented "The Matrix of Needs: Classroom Applications" for the California School Employees Association, online virtual conference, March 3-5, 2021

2020 – Presented "Trauma Informed Positive Behaviour Support," Easy iCare, Melbourne, Australia, April, 2020.

2019 - Presented "Maximising Safety, Minimising Risk" workshop for FBA Care, Melbourne, Australia, August, 2019

2019 – Presented "Autism Spectrum Differences: Celebrating Differences and Supporting People", Yarraville and Springvale, Victoria, Australia, May 21 and 22, 2019.

2018 – Presented "Supporting People with Complex Behavioural Needs", Bendigo, Victoria, Australia, September 2018

2018 – Presented "Supporting People with Complex Behavioural Needs", Frankston, Victoria, Australia, April, 2018

2016 – Invited Presentation, "Escalation and De-Escalation in Humans and Other Animals," International Society for Research in Aggression, Sydney, Australia, July 2016

2016 – Presented "Quality of Life: Changing Organizational Cultures from the Bottom Up," Central Okanagan Caregivers Society, Kelowna, British Columbia, Canada

2015 – Presented "Trauma Informed Teamwork: Understanding the Dynamics and Trauma Histories of Caregivers," 9th European Congress on Violence in Clinical Psychiatry, Copenhagen, Denmark, October 2015

2015 – Presented "Houses, Hope and Healing" to the Central Okanagan Caregivers Society, Kelowna, British Columbia, Canada, May 2015

2015 – Presented "The Wellness Model: Preventing Burnout of Mental Health Staff", 9th European Congress on Violence in Clinical Psychiatry, Copenhagen, Denmark, October 2015

2014 – Presented "Building Our House Together: Implementing an Indigenous Framework of Wellness to Achieve Safety and Security, 4th International Conference on Violence in Human Services, Miami, FL

2014 – Presented "Preventing the Transgenerational Transmission of Trauma" at the Inaugural Symposium on the Neurosequential Model of Therapeutics, Banff, Alberta, Canada

2013 – Co-presented "Te Whare Tapa Whā: Building Trauma Informed Systems of Care Together." Australian Society for Intellectual Disabilities, Sydney, Australia

2013 – Presented workshop, "Doing What We Know When We Know It: Translating Research to Practice," 8th European Congress on Violence in Clinical Psychiatry, Ghent, Belgium

2013 – Presented Special Workshop, "Corporate Culture Change", 8th European Congress on Violence in Clinical Psychiatry, Ghent, Belgium

2013 – Presented Special Workshop, "Supporting People with Complex Behavioural Needs," 8th European Congress on Violence in Clinical Psychiatry, Ghent, Belgium

2013 – Presented workshop, "Strengthening the Pavement of Good Intentions: Ethical and Legal Implications of Restraint and Seclusion practices, 8th European Congress on Violence in Clinical Psychiatry, Ghent, Belgium

2013 – Presented "It Was For Their Own Good: Coercion, Power, and Ethics in Positive Behaviour Support." British Institute of Learning Disabilities Research to Practice Conference, Brighton, England, May, 2013.

2012 – Presented "Conflict Resolution Strategies" as part of a retreat for the Ulster Project, bringing students from Ulster, Northern Ireland to the US to develop peacemaking and conflict resolution skills.

2012 – Presented "Enhancing Educational Outcomes: The Use of Structural Assessments to Align the goals of Students and Educators." Council for Exceptional Children National Conference, April 2012, Denver, CO

2012 – Presented "The Systemic Roots of Workplace Violence: Understanding How Funding, Regulations, Administration and Quality Assurance Create Toxic Cultures" at the 3rd International Conference on Violence in the Healthcare Sector, Vancouver, BC, Canada

2011 – Keynote presentation, "The Effect of Trauma on Neurological Development" at the Australia Society for Intellectual Disabilities, Sydney, Australia

2011 – Invited speaker, Plenary Session, "Increased Awareness About the Effect of Stress on Cognitive and Affective Behaviour" at Schizofrenidagene (Schizophrenia Days) 2011, Stavanger, Norway

2011 – Presented "Relationship of Equals, Difference of Roles: Non-Coercive Team Leadership" at the 7th International Conference on Violence in Clinical Psychiatry, Prague, Czech Republic

2011 – co-presented with Dr. Jennifer Vanderberg "The Use of Psychiatric Hospital Security Staff in the Prevention and De-escalation of Restraint" at the 7th International Conference on Violence in Clinical Psychiatry, Prague, Czech Republic

2010 – Keynote presentation – Supporting People with Complex Behavioural Needs – at the BILD International Conference on Positive Behaviour Support, Dublin, Ireland

2010 – Presented "Moving Toward the Elimination of Restraint: How Positive Behavior Supports Have Paved the Roads Ahead and One State's Experience with a Statewide Effort," Reinventing Quality, Baltimore, MD

2010 – Presented "Transforming Your Organisation from Toxic to Welcoming", University of Western Sydney, Sydney, NWS, Australia

2010 – Presented "Supporting People, Not Just Their Behaviours", Australasian Society for the Study of Intellectual Disabilities, Brisbane, QLD, Australia

2010 – Presented "Supporting People with Complex Behavioral Needs", University Hospitals Psychiatric Division, Stavanger, Norway

2009 – Presented "Traumagenic Neurodevelopmental Aspects of Positive Behavior Support, Calgary, Alberta, Canada

2009 – Presented "Working with Complex Behaviors", Texas Behavioral Health Institute, Austin, TX

2009 – Presented "Invitational Healing: Applying the Theory of Invitational Practice to Mental Health Settings", International Conference on Invitational Education, Rochester, NY

2008 – Presented "Hospitals, Hospitality, and Healing" at Bellevue Hospital, NYC, NY and five other hospitals operated by NYC Health Corporation.

2008 – Presented "Continually Moving Away From Coercion: The Use of Positive Behavior Support to Create Safe Environments,1st Annual Conference on Violence in the Health Care Sector, Amsterdam, Netherlands

2007 – Presented "Corporate Culture Change: Reducing the Use of Restraint" for organizations in Toronto and Ottawa, Ontario, CA

2006 – Presented "Supporting People, Not Just Their Behavior" at the International Association for Positive Behavior Support, Orlando, FL

2006 – Presented "A Methodology for the Reduction of Restraint and Seclusion" at the International Symposium on Restraint Reduction, Cornell University, NY

2005 – Presented "Relational Behavior Support" at the British Institute of Learning Disabilities conference, Bristol, England

2003 – Presented a Poster Session, "Establishing Best Practices Standards in Crisis Prevention and Crisis Interaction Programs," First International Symposium on Positive Behavior Support, Orlando, Florida.

2003 – wrote "A Comparison of Ohio's Behavior Support Rule and ICF/IDD Regulations", Ohio Department of Developmental Disabilities Behavior Support Advisory Committee, 2003

2003 – Presented "A Comparison of Behavior Support and Behavior Intervention Strategies" Ohio Provider Resource Association (OPRA), Columbus, Ohio

2002 – Keynote speaker, Utah State Conference on Behavior Supports, American Fork Utah

2002 – Presented "Relational Behavior Support" workshops at Exceptional Persons, Waterloo, Iowa

2000 – presented training throughout Ohio on behalf of the Ohio Department of Developmental Disabilities on proposed revisions to the Ohio Behavior Support Rule.

2000 – Presented "People First – Pushing the Paradigm" at the December TASH conference in Miami, Florida.

Expert Witness Reports

2020 – Provided expert witness report in Sioux City, Iowa. The report was pertinent to alleged severe emotional distress suffered by a 5 year old boy diagnosed with ADHD. The case was filed with the Woodbury County District Court, Case Number SCCV 181827

2018 – Provided expert witness report in Denison, Iowa. The report was pertinent to the inappropriate application of physical restraint with 10 year old boy. The case was filed with the Iowa District Court, Case Number LACV039874.

2013– Provided expert witness report to the state of Victoria Joint Conference of Experts. The report was centered on the inappropriate use of physical restraint with a 16 year old adolescent male. Proceeding No. VID844 of 2010.

Related Experience

2021 – present – Member, Malone University Social Work Department Professional Advisory Committee, Canton, Ohio

2011 – 2021, Adjunct Assistant Professor of Psychiatry, University of Rochester, Rochester, NY. In this role I worked with Michael R. Privitera, MD, MA and, until his death, Vaughn Bowie, MSW, University of Western Sydney ,in researching and writing on the subject of workplace violence in healthcare.

2018 – Present, peer reviewer for the Journal of Humanistic Psychology, the Spanish Journal of Psychiatry, the Journal of Aggression, Conflict and Peace Research.

2017 -2018 – Participated with the New Hampshire Division of Developmental Disabilities as a consultant to revise the Intensive Treatment Services model in the state.

2014 – 2015, Steering Committee member, The Oud Consultancy, Amsterdam, the Netherlands

2001 – 2010, Member, Behavior Support Advisory Committee, Ohio Department of DD, Columbus, Ohio

2002 – 2008, Chairperson, Lighthouse Committee, an after-school tutoring and drop-in center for at risk youth, Canton, Ohio

2003 – Chairperson, Committee on Developing Best Practice Training Standards, National Task Force, Child Welfare League of America

2003 – Participated in National Call to Action: Eliminating the Use of Seclusion and Restraint, sponsored by SAMHSA, Washington, DC

1999 – 2001, member of the Board of Trustees, Ohio Private Residential Association, Columbus, Ohio.
1994 – 1998, active in the Association of Developmental Disability Community Providers in New Mexico. Led efforts to improve the funding of services to community based service providers.

1992 – 1994, Chairperson, ICF/DD Program Director Committee of the Ohio Private Residential Association, Columbus, Ohio.

1986 – 1989 – Volunteer, Pegasus Farms, Equine Therapy program, Hartville, OH

1982 – Chair, Iowa Human Services Training Consortium, facilitated training conferences with Wolf Wolfensberger

Work Experience

07/01/2019 - present Prag Consulting Victoria, AU

Senior Associate, Positive Behaviour Support

- Provide training and education to family members, individuals served and staff to address behavioural concerns and understand the impact of trauma (when applicable)
- Conduct behavioural assessments and develop behaviour support plans

05/01/2016 – Present Followship Solutions, Inc. Canton, OH

Lead Consultant

- Developed The Matrix of Needs, published a comprehensive research article in the journal *Health*
- Provided organizational consulting to human services programs to improve the culture and teamwork of the organization
- Provided training on various topics including autism, trauma associated behavioral needs, organizational culture change
- Provided specific behavioral consultation as requested consistent with HCBS requirements in the United States, and appropriate state and federal regulations in Australia.
- Developed behavior support plans for specific individuals as requested
- Mentoring a person in Australia

09/2000 – April 30, 2016 The Mandt System, Inc. Richardson, TX

CEO, Senior VP for Product Development Work hours – 40+ per week

- 9/2000 to August, 2002, Faculty Member, teaching The Mandt System®
- August, 2002 – July 2014, Chief Executive Officer. Responsible for the overall administration of services provided worldwide.
- Continued responsibility to develop and/or write all materials taught by The Mandt System, Inc. including workshops on autism, complex behavioral needs, organizational culture change, management practices.
- Conducted 1-2 behavioral assessments of individuals served, completion of PBS plans, and staff training per year.
- Taught 15-25 workshops per year in all countries in which The Mandt System® operated.
- Expanded services into Canada, Australia, Hong Kong and the United Kingdom.
- New leadership structure in 2014 with Kevin Mandt as President, assumed role of Senior Vice-President for Product Development.

1999 – 2000 Walsh University North Canton, OH

Instructor, College of Education

Taught classes on the topic of "Differences and Diversity: Preparing teachers to meet the needs of students affected by disabilities who have been "mainstreamed" in elementary and secondary educational settings.

1999 – 09/2000 People Developed Systems, Inc. North Canton, OH

Executive Program Director/QIDP Work hours – 40+ per week

- Responsible for multiple site programs serving individuals affected by developmental disabilities and challenging behaviors.

- Coordinated services in a homeless shelter serving individuals who were homeless due to chronic mental illness.

1998-1999 Dungarvin Illinois, Inc. Rockford, IL

Area Director Work hours – 40+ per week

- Increased the number of individuals served by 200% over a two-year period, raised level of staff training and competencies.
- Developed innovative approach to supporting persons affected by developmental disabilities and behavioral challenges.

1996-1998 Dungarvin, Inc. St. Paul, MN

Regional Director Work hours – 40+ per week

- Responsible for all services provided by Dungarvin in New Mexico and Colorado. Established new services provided by Dungarvin in Oklahoma.
- Interacted with IDD directors in different state and county settings utilizing HCBS waiver programs.

1994-1996 Dungarvin New Mexico, Inc. Albuquerque, NM

Director, Senior Director Work hours – 40+ per week

- Provided leadership to enable to company to grow from serving seventeen individuals in 1994 to sixty-four in 1996.
- Established Supported Employment program for individuals affected by developmental disabilities

1990 – 1994 Molly Stark Hospital Louisville, OH

Program Director/QIDP Work hours – 40+ per week

- Successfully led efforts to empower individuals affected by developmental disabilities to move from this 76 person ICF/IDD to community based homes.
- Utilized Strategic Planning format to teach individuals the skills necessary to choose their service provider from a group of nine providers.

1986-1990 Hartville Meadows Hartville, OH

Program Director/QIDP Work hours – 40+ per week

- During the 4-year period had 2 surveys that were deficiency free
- Empowered one individual to live in his own Supported Living home two years before Supported Living programs were formally available.

1984-1986 Association for the Disabled of Elkhart County Elkhart, IN

Admissions Social Worker Work hours – 40 per week

- Assessed all individuals who requested services from the agency and a neo-natal ICU in South Bend, IN. Social work services provided to families in childhood programs through adulthood for entry into residential services for individuals affected by developmental disabilities.
- Established guardianship and advocacy program to serve individuals affected by developmental disabilities.

1981 – 1984 Hawkeye Community College Waterloo, Iowa

Instructor

Taught classes on Behavior Modification for nurses and psychiatric technicians, direct support and other human services professionals. Taught Level I and Level II courses.

1974 – 1983 Exceptional Persons, Inc. Waterloo, Iowa

Assistant to the Director for Residential Services (1980-1983)

- Supervised community based residential services provided to forty individuals affected by developmental disabilities.
- Wrote software program to monitor financial information for all individuals served by the organization.
- Represented over thirty individuals in appeals of denied Social Security/SSI benefits, all appeals were won.

Caseworker (1978-1980)

- Supported individuals affected by disabilities in supported living and supported employment programs, and provided counseling supports.

Houseparent (1974-1977)

Provided live-in supports at a direct support professional level to 12 women affected by developmental disabilities and co-occurring disorders.

Education

1974 – 1981 University of Northern Iowa Cedar Falls, IA

BA, Social Work, minor in English

- President, Social Work Club

1983 – 1984 Associated Mennonite Biblical Seminaries, Elkhart, IN

Thirty semester hours with a concentration in family therapy

1987 – 1988 Kent State University Kent, OH

Two courses required for QIDD certification in Ohio

2003 – 2004 University of Phoenix On-Line

16 hours towards Master of Arts in Management

References Available Upon Request

Arkansas
State Claims Commission
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BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains	**CLAIMANT**
V.	**Claim No. 220374**
THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)	**RESPONDENT**

PRE-HEARING BRIEF

COMES NOW Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Pre-hearing Brief submits the following.

FACTS

The evidence in this case tells the following story:

David "Davie" Cains, a severely developmentally disabled resident of the Booneville Human Development Center (BHDC), died on June 13, 2020, while being physically restrained on the ground by three BHDC staff members – Tyler Mattson, Amy Jones, and Ryann Campos. "This entire event took place on the floor while three people were holding David by his legs, torso, and head. A fact that was omitted in reports to EMS, the hospital, the coroner, and the family." **Exhibit 1**, "DRA - Final Report on Cains Death." **Disability Rights Arkansas (DRA), the federally mandated and funded nonprofit organization designated by the state of Arkansas to protect the rights of Arkansans with disabilities, investigated Davie's death and concluded that "this restraint likely, either directly or indirectly, led to David's death."** **Exhibit 1**, "DRA - Final Report on Cains Death."

Davie had finished lunch shortly before being restrained and pinned down to the floor by staff using a method not authorized by the facility. Staff ignored Davie's physician orders to

remain upright for one hour after eating due to [redacted]. While he was being held down on his side by three BHDC staff members trained in first aid and CPR, he began to choke and vomit. **Exhibit 18,** BHDC Shift Supervisor Amy Jones p. 74. Davie appeared to be in respiratory distress and the staff turned him over onto his back within "a couple seconds" and attempted "upward thrusts." **Exhibit 18,** BHDC Shift Supervisor Amy Jones p. 7: 13-16. [redacted]

[redacted]

Davie, as he was known to his loved ones, was 42 years old. A longtime resident of the facility, he was well-liked by staff. Davie was close with his family, particularly his sister and mother, who were very involved in his life. Davie loved his family, he loved his friends at BHDC, and he hated being alone. Davie loved to socialize, to talk, laugh, and tease, to sing and dance. Davie loved music; more specifically, Davie loved *The Monkees* – their music was a big part of Davie's life. He did not like silence. Davie did not like it when his friends were sad; he cried when they cried. **Exhibit 45,** Photos of Davie.

Davie died needlessly. The restraint staff used was unnecessary. **Exhibit 2,** BHDC Staff Development Coordinator Mark Hise, p. 35: 14-17. Staff are only allowed to physically restrain residents in emergency situations; restraint is to be used only as an emergency measure at BHDC. **Exhibit 3,** BHDC Superintendent Jeff Conyea, p. 27, p. 42, p. 44, p. 48; **Exhibit 4,** BHDC Policy I-D-4 (1); **Exhibit 2,** BHDC Staff Development Coordinator Mark Hise, p. 11. The facility may employ physical restraint "as an emergency measure, but only if *absolutely necessary* to protect client or others from injury." **Exhibit 5,** ICF-IID Reg. § 483.450(d)(1)(ii), [W296], Bates 1764; **Exhibit 3,** BHDC Superintendent Jeff Conyea, p. 32; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 30.

An emergency situation is one in which there is "imminent danger to the health or safety" of staff or clients. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 48: 12-15. Respondent defines "Imminent danger to health or safety" as a situation in which "**death or severe bodily injury could reasonably be expected to occur without intervention**." **Exhibit 7,** DDS 3004-I-Appendix A (6A), Bates 2052. This was the definition of "imminent danger" in use at BHDC at the time of Davie's death. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 62: 23-25, p. 63: 1-9. **There was no emergency, nothing that could ever have remotely posed a risk of severe bodily injury or death.** "[Davie] began screaming and cussing and ripped paper off of the wall to throw [sic] he then jumped up after me, spitting and attempting to hit me." **Exhibit 8,** Tyler Mattson OLTC Witness Statement. The evidence shows there was not even a risk of minor injury to staff.

Mattson testified at deposition to a different version of events than he gave in his OLTC Witness Statement and in his statement to DRA investigators, which were substantially the same. Almost two years after the event, he provided a very different version of the events leading up to the deadly ground restraint: in this version, Davie did ***not try to hit him***, but rather "grabbed" at him, or perhaps charged at him, but not a running charge because there wasn't enough space between them for momentum, and he added, for the very first time ever in any of his official statements, that he thought he was near a ledge, which he said made it an emergency situation for him. **Exhibit 9**. BHDC Staff Tyler Mattson, p. 100: 24-25, p. 101: 1-25, 102: 1-25, p. 105, 14-23, p. 107: 5-17.

Again, in his written OLTC Witness Statement, completed near the time of Davie's death, Mattson said that Davie tried to hit him, omitting all mention of grabbing, charging, lunging, and omitting all mention of a ledge. **Exhibit 8,** Tyler Mattson OLTC Witness

Statement. Mattson also omitted all mention of the ledge in his statement to DRA investigators, which was conducted within a few months of the event; he never mentioned a ledge, mentioned Davie charging at him, and never mentioned Davie trying to grab him or wrap him up. **Exhibit 30,** DRA Advocate Kris Stewart, p. 63; **Exhibit 1**, "DRA - Final Report on Cains Death." Dian Elliot, the Office of Long-Term Care (OLTC) Surveyor who also interviewed Mattson, approximately two weeks after the event, also reported zero mention whatsoever of a ledge during her deposition, and also zero mention of lunging or charging. See **Exhibit 21,** OLTC Surveyor Dian Elliot.

Mattson's OLTC Witness Statement says he grabbed Davie by both of his arms, causing Davie to fall to the ground. **Exhibit 8,** Tyler Mattson OLTC Witness Statement. At deposition Mattson first testified he grabbed Davie by his shoulders, then moments later said it was actually both of Davie's arms that he grabbed, and that this somehow caused them to lose their balance and fall over together. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 102, p. 103. Either way, one significant constant is that Davie never laid a finger on Mattson; Mattson *grabbed Davie* by either his shoulders or by both of his arms, a restraint violation in itself[1], and *caused* Davie to go to the ground.

Respondent will make much of Davie's size in the hopes of showing he was a threat, because he was over six-feet-tall and supposedly 250 pounds at the time of his death. However, Tyler Mattson was a very large man himself, at least average height if not tall and probably around 250 pounds or more, based on photos and based on his appearance at deposition. **Exhibit 31, Photos of Tyler Mattson. See also the Videographer Footage of Mattson at his Deposition**, which shows Mattson standing with Claimant's counsel during a demonstration.

[1] Staff are not supposed to grab both arms or both wrists of a resident simultaneously. BHDC Shift Supervisor Amy Jones, p. 34; **Exhibit 9**, BHDC Staff Tyler Mattson, p. 52

This provides a good comparison, as Claimant's counsel is 6'3 and weighs approximately 220 pounds; Mattson is clearly significantly heavier.

Davie was not dangerous. Davie never caused injury to anyone at BHDC. **Exhibit 2,** BHDC Staff Development Coordinator Mark Hise, p. 50, p. 52; **Exhibit 9**, BHDC Staff Tyler Mattson, p. 66; **Exhibit 10**, BHDC Staff Ryann Campos, p. 49; **Exhibit 11**, BHDC LPN Kelly King, p. 7, p. 10; **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 22, p. 24, p. 28; **Exhibit 13**, Former BHDC Staff Don Carter, p. 8; **Exhibit 14**, BHDC Psychological Examiner Mike Alvis, p. 59; **Exhibit 15,** BHDC Social Services Worker Caleb Murry, p. 28; **Exhibit 16**, Claimant Christine McAuliffe, p. 21, 22.

At times Davie didn't know what to do with his emotions. His IQ was 36 and his intellectual functioning was believed to be similar to that of a four-year-old. **Exhibit 14**, BHDC Psychological Examiner Mike Alvis, p. 24, p. 29: 20-25, p. 30: 1-10. He was capable of temper tantrums, like any four-year-old: throwing objects that happened to be nearby, spitting, yelling, and even swinging his arms or faux-swatting with his hands. Davie never actually hit anyone, though, at least not anyone that the approximately twenty BHDC staff members deposed could identify. This is because Davie lacked the physical capabilities, like coordination, strength, and dexterity, to do so, even if he had desired to, which he did not. **Exhibit 13**, Former BHDC Staff Don Carter, p. 15, 16 (*not physically capable of intentionally causing harm to a grown man*); **Exhibit 16**, Claimant Christine McAuliffe, p. 98: 9-16, p. 110: 7-25, p. 115: 6-25, p. 116: 1-6.

Even if this had been an emergency situation, staff were required to use only the *"least restrictive"* approved method possible. **Exhibit 17,** DDS 3011-D (3); **Exhibit 5,** Federal ICF-IID Reg. § 483.450(b)(1)(iii), [W278], Bates 1754 (*the least restrictive appropriate technique possible*); **Exhibit 5,** ICF-IID Reg. § 483.450(b)(4), [W289], Bates 1760; **Exhibit 5,**

ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753; **Exhibit 3,** BHDC Superintendent Jeff Gonyea, p. 30, p. 37: 5-9; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 26: 24-25, p. 27: 1-3, p. 34; **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 113: 3-17; **Exhibit 19,** BHDC Residential Services Manager Carrie Johnson-Miller, p. 43: 17-25, p. 44: 1-4; **Exhibit 20,** BHDC QIDP Program Manager Justin Jobb Part II, p. 49, p. 50; **Exhibit 21,** OLTC Surveyor Dian Elliot, p. 123: 5-12, p. 133: 23-25, p. 134: 1-4; **Exhibit 22**. Dr. Janice LeBel – Summary of Expert Opinions; **Exhibit 37,** Dr. Janice LeBel – CV; **Exhibit 23,** Dr. Janice LeBel Deposition Transcript. BHDC's written policy states: "*Emergency Restraint is defined as the use of* ***the least restrictive procedure*** *and for the* ***least time necessary*** *to control* ***severely aggressive or destructive behaviors***" [emphasis added]. **Exhibit 4,** BHDC Policy I-D-4 (2)(a).

The evidence revealed a certain amount of disregard within Respondent's ranks for this most primary of Respondent's written policies on restraint usage. **For example, Melissa Weatherton, Director of the Division of Developmental Services since 2016, actually testified she was *not* aware of a requirement that staff at BHDC use only the least restrictive method available when applying restraint**. **Exhibit 32,** DDS Director Melissa Weatherton, p. 14: 24-24, p. 15: 1-8. This is concerning, given this is surely the most oft repeated and foundational safety rule for restraint use within the very division she heads. **Exhibit 17,** DDS 3011-D (3); **Exhibit 5,** Federal ICF-IID Reg. § 483.450(b)(1)(iii), [W278], Bates 1754 (*the least restrictive appropriate technique possible*); **Exhibit 5,** ICF-IID Reg. § 483.450(b)(4), [W289], Bates 1760; **Exhibit 5,** ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753; **Exhibit 4**, BHDC Policy I-D-4 (2)(a).

Sandy Evans was the Residential Services Director at the time of Davie's death, in charge of all direct care staff; she was also who Superintendent Gonyea appointed to conduct the

facility's maltreatment investigation of Tyler Mattson, Amy Jones, and Ryann Campos, all three Evans' subordinates and coworkers. **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 19, p. 59, p. 60; **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 56. Gonyea, in determining the three staff members did nothing wrong, claims he relied almost entirely on Evans' investigation. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 76: 23-25, p. 77: 1-2. Gonyea confirmed that, aside from the three staff members actually involved in the restraint, Sandy Evans possesses the most direct knowledge of anyone concerning the restraint incident on the day of Davie's death. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 77: 3-8.

Sandy Evans admitted at deposition that the restraint used on Davie at the time of his death was *not* the least restrictive option available. **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 50: 1-7, p. 47: 5-25 (*they never gave Davie a chance to calm down and collect himself on the ground unrestrained*), p. 48: 1-13, p. 49: 11-25 (it was an inappropriate use in violation of policy, requiring retraining, but in her opinion did not rise to the level of maltreatment). Amy Jones and Ryann Campos, the two staff members who helped Tyler Mattson perform the restraint, made similar admissions at deposition. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 115: 5-17 (*acknowledging she probably should have made Tyler let Davie up right away*); **Exhibit 10**, BHDC Staff Ryann Campos, p. 80: 17-21, 81: 2-6 ("*there were less restrictive ways that the situation could have been handled*").

DRA's investigation also specifically concluded it was a violation of DDS 3011-D (the "least restrictive" mandate) for staff to continue to restrain Davie after he was on the ground, as opposed to giving him space and time to calm himself, which would have been a less restrictive option readily available to staff. **Exhibit 30**, DRA Advocate Kris Stewart, p. 79: 6-16; **Exhibit 1**, "DRA - Final Report on Cains Death."

Davie certainly posed no danger once Tyler got him on the ground. Amy Jones testified Davie posed no significant danger to Tyler Mattson when she arrived at the scene and joined in the restraint. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 102: 4-13. When asked why Tyler did not simply back off to give Davie some space since he was neutralized on the ground, Jones said, "I don't know." **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 66: 12-15. Tyler had Davie on his left side while he knelt behind him holding him down with his left hand on Davie's shoulder and right hand on Davie's waist; only Davie's right arm was free, but he never once hit Tyler with it. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 66: 1-15. Tyler never asked her for help, but instead of ordering Tyler to release Davie, Jones testified she knelt down, grabbed both of Davie's arms to hold them in front of him near his face[2]. Later, Ryann Campos joined the ground restraint by kneeling down and grabbing both of Davie's legs by the ankles. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 67, p. 68, p. 72.

At no point throughout the ordeal did Davie strike any of them; he never hit one of them, kicked one of them, or spit at one of them. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 77: 1-7; **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 56: 9-11, p. 98: 15-17; **Exhibit 10**, BHDC Staff Ryann Campos, p. 56: 1-3, p. 59: 14-16, p. 63: 7-18, p. 64: 14-25. DRA Advocate Kris Stewart, one of the investigators in Davie's case, illustrated well the needlessness of the ground restraint in her deposition:

> *A He said that they -- let's go back and see exactly what Tyler told me. He applied personals by grabbing his arms. So, Tyler grabs him, okay, and he says they end up falling over.* ***David lands on his face but, then, Tyler is still able to roll him onto his side. So, my point is, if you're able to get up and gain physical whatever***

[2] Ryann Campos stated in her OLTC Witness Statement that Amy Jones was holding Davie by the head, not the arms. **Exhibit 36,** Ryann Campos OLTC Witness Statement. She then repeated this to the DRA investigators. **Exhibit 30,** DRA Advocate Kris Stewart, p. 67: 16-23.

> ***over this guy and roll him on his side, you're probably just as able to be able to walk away and give him some space to see if he calms down*** [emphasis added].
> *Q What if he didn't calm down?*
> *A Well, he didn't get a chance to.*

Exhibit 30, DRA Advocate Kris Stewart, p. 99: 2-12.

Even there been a real emergency, the ground restraint used on Davie was not even an approved method of restraint at BHDC, much less the least restrictive option**.** Obviously, an unauthorized restraint technique could never be the least restrictive option. Only "authorized" forms of restraint can be used BHDC. **Exhibit 33,** BHDC Client Rights (17).

It was done in direct violation of training and facility policy. It was disallowed. Mark Hise is the Staff Development Coordinator at BHDC. Staff development is responsible for training staff in emergency procedures, which includes personal (physical) restraints[3]; staff development does "all the training" on the use of personal restraints. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 70, p. 71; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 20. Hise, who has worked at BHDC for 27 years, is NCI certified. He is responsible for showing the staff how to use personal holds or personal restraints in cases of emergencies. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 71, p. 72; **Exhibit 24**, BHDC Assistant Superintendent Jennifer Berry, p. 124. As a Staff Development Coordinator, Hise would have the most knowledge or expertise concerning the use of personal restraints and personal holds in emergency situations at the facility. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 73: 12-17. Hise is BHDC's expert in the use of personal restraints. He is the CPI/NCI expert for the BHDC

[3] BHDC employs the use of chemical restraints, mechanical restraint using a papoose board, and simple physical restraints - which they call "personal restraints" or "personal holds." **Exhibit 24**, BHDC Assistant Superintendent Jennifer Berry, p. 107. The mechanical restraint was the only approved method at BHDC that was not from the CPI/NCI curriculum. **Exhibit 2**, BHDC Staff Development Coordinator Mark Hise, p. 12: 1-22.

facility, the only training curriculum used for personal restraints at the facility. **Exhibit 24**, BHDC Assistant Superintendent Jennifer Berry, p. 127: 9-11, p. 128: 5-19.

According to Mark Hise, the ground restraint used on Davie was not allowed.

Exhibit 2, BHDC Staff Development Coordinator Mark Hise, p. 12: 1-22, p. 21: 8-25, p. 22: 1-25 ("*The training that we teach in NCI is a standing personal hold and a seated personal hold. There is no on-the-ground personal hold.*"), p. 23: 1-8, p. 27: 16-25, p. 28: 1-6, p. 32: 9-22, p. 35: 5-17, p. 42: 5-10. Other staff members, including even restraint participant Amy Jones, agreed the ground restraint used on Davie was not allowed. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 35: 14-23 (expressly prohibited from putting a client on the ground for personal restraint); p. 43: 8-18, p. 44: 9-17; **Exhibit 25**, Dr. Syed Hamid, p. 78: 12-24; **Exhibit 20,** BHDC QIDP Program Manager Justin Jobb Part II, p. 8. Staff are not authorized to hold a client on the ground even where a client puts himself on the ground during an aggressive episode. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 45: 1-9. Tyler Mattson testified he does not remember what personal restraint techniques he was taught to use in response to severe aggression prior to Davie's death. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 37: 25, p. 38: 1-3. There are good reasons ground restraints are not supposed to be used at BHDC. Ground restraints, particularly side restraints on the ground, are extremely dangerous. **Exhibit 35**, "An Investigation into the Physiological and Psychological Impact of Supine and Side Lying Physical Restraint Techniques."[4] See also **Exhibit 39**, CPI Risks of Physical Restraint - Part of BHDC Annual Training.

[4] "The SLR [side laying restraint] position was found to impose the greatest pressure to the thorax, the greatest ventilatory restriction, and was perceived to be the most anxiety inducing, the least comfortable and the most limiting to breathing when compared to the two supine positions.... In this current study SLR exerted greater pressure on the thorax (116.1 ±17.5) than did unsupported or supported prone restraint, and reduced FVC by 14.6% compared to 16% for unsupported prone, and 11% for supported prone, therefore the recommendation for

The fact that ground restraint was not described anywhere in BHDC's policies and procedures and not identified or even mentioned as an approved restraint in Davie's Individual Placement Plan (IPP) also made its use a violation of federal regulations.

Exhibit 5, ICF-IID Reg. § 483.450(b)(1)(i). [W276]. Bates 1753 (*all specific interventions for the management of inappropriate client behaviors which are approved for use in the facility are to be **clearly stated and described in its policy***). BHDC had a duty to comply with this policy. **Exhibit 3,** BHDC Superintendent Jeff Gonyea. p. 21; **Exhibit 6,** BHDC Residential Services Director Sandy Evans. p. 24. See also **Exhibit 5,** ICF-IID Reg. § 483.450(b)(1)(iv)(B). [W280]. Bates 1755 (*policies and procedures of a facility **must address the types of physical restraint allowed at the facility**, the persons who can use the restraints, **and*** **the specific training required** for staff allowed to use them), with which BHDC had a duty to comply. **Exhibit 3,** BHDC Superintendent Jeff Gonyea. p. 23. p. 24. See also **Exhibit 5**. ICF-IID Reg. § 483.450(d)(1)(i). [W295]. Bates 1764 (facility required to specify, within a client's IPP, the physical restraints that can be used, addressing "the type of physical restraint" and the "specific type of client behavior" for which the physical restraints described in the IPP can be used), with which BHDC had a duty to comply. **Exhibit 3,** BHDC Superintendent Jeff Gonyea. p. 25; **Exhibit 6,** BHDC Residential Services Director Sandy Evans. p. 29. p. 35.

There was only one definition for personal (physical) restraint at BHDC: "an emergency procedure **limiting movement by the holding of a hand or limb**." **Exhibit 4,** BHDC Policy I-D-4 (6)(a); **Exhibit 6,** BHDC Residential Services Director Sandy Evans. p. 40: 1-25; **Exhibit 3,** BHDC Superintendent Jeff Gonyea. p. 45. p. 46; **Exhibit 19,** BHDC Residential Services Manager Carrie Johnson-Miller. p. 66. It in no way encompassed ground restraints. **Exhibit 2,**

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the use of SLR as a safer alternative to both prone and supine restraint to minimize the risk of adverse restraint-related outcomes [14] should be challenged."

BHDC Staff Development Coordinator Mark Hise, p. 12: 1-22, p. 21: 8-25, p. 22: 1-25 ("*The training that we teach in NCI is a standing personal hold and a seated personal hold. There is no on-the-ground personal hold.*"), p. 23: 1-8, p. 27: 16-25, p. 28: 1-6, p. 32: 9-22, p. 35: 5-17, p. 42: 5-10.

The OLTC Survery's testimony is further confirmation that what staff did was a violation of federal regulations:

> *Q Staff can't use methods that aren't approved by the facility, can they?*
> *A No.*
> *Q They can't use methods that aren't taught to them by the facility, can they?*
> *A No.*
> ***Q Those would be violations of Appendix J, wouldn't they?***
> ***A Yes. Dian Elliot,.***

Exhibit 21, OLTC Surveyor Dian Elliot p. 110: 18-25, p. 111: 1. Mark Hise's testimony proves that staff violated Appendix J. Had Elliot interviewed Hise she would have known this:

> *Q Okay.*
> *A So, if he told me -- then at that point, if he looked at me and I would have said, "Was that theleast restrictive that they could have used," and he looked at me and said, "No," that would have been in my investigation, that's part of my evidence. So, it would have been after I did my investigation if I would have asked her that. But she is just the investigator. I would go to the CPI person.*
> ***Q And if the CPI person told you that the restraint used was something he did not teach, something that was not part of CPI, and not the least restrictive option, that would have been a big deal to you?***
> *A That would --*
> *Q That would have been a big deal to you?*
> ***A I would have considered that strongly in my investigation, yes.***

Exhibit 21, OLTC Surveyor Dian Elliot p. 140.

Tyler Mattson, who described his job caring for Davie and other developmentally disabled residents as "glorified babysitter," is the direct care staff member who initiated the restraint. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 25. **Prior to Davie's death another staff member named Jonathan McCutcheon witnessed Mattson physically abusing another resident; he reported it to administration.** **Exhibit 26**, Former Staff Jonathan McCutcheon, p. 6: 7-23, p. 7: 1-21, p. 8: 4-25, p. 9: 1-25. McCutcheon believes he reported it directly to BHDC Superintendent Jeff Gonyea. **Exhibit 26**, Former Staff Jonathan McCutcheon, p. 10: 1-25. Nothing was done. **Exhibit 26**, Former Staff Jonathan McCutcheon, p. 11: 1-11.

Just two weeks prior to Davie's death, Mattson employed unnecessary and unauthorized physical restraints on Davie twice in the same day. Had BHDC disciplined him, or even provided him additional training, Davie would very likely still be alive. The first one was in violation of policy because there was clearly no emergency to justify physical restraint, as Mattson himself acknowledged. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 71: 4-15 (*"wasn't, like, a full-blown situation"*); **Exhibit 27**, 5/29/20 Behavior Incident Report No. 1. At BHDC, staff can lay hands on residents only in full-blown situations – emergency situations likely to result in serious physical harm or death. **Exhibit 5,** ICF-IID Reg. § 483.450(d)(1)(ii), [W296], Bates 1764; **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 32; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 30. Later this same day Mattson applied physical restraints to Davie again, this time for three minutes, because Davie threatened to throw a thermometer. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 73: 4-20; **Exhibit 28**, 5/29/20 Behavior Incident Report No. 2. Mattson incurred no consequences for either violation. The administrator who reviewed and signed her approval of Mattson's use of physical restraint for this second 5/29/20 incident admitted at her deposition that the situation did not in fact meet the definition of

emergency that would justify physical force, and further, based on what is contained in the report, Mattson was not justified in his use of physical restraint and she should have flagged Tyler for this rather than approving it and moving on. **Exhibit 19**, BHDC Residential Services Manager Carrie Johnson-Miller, p. 53: 1-17, p. 54: 3-16. Davie would likely be alive if she had. This was only two weeks before he died.

Mattson also did this to Davie in March of 2020, less than three months before his death. On 3/20/20, Mattson restrained him on the ground for four minutes; he said Davie "tried to spit and swing on me," but acknowledged Davie never laid a finger on him; he only let him up once Davie apologized. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 77: 1-14; **Exhibit 29,** 3/20/20 Behavior Incident Report. This clear violation of restraint policy, notably the obvious use of an unauthorized ground restraint, was also approved by Carrie Johnson-Miller, whose testimony revealed she also required retraining on the fact that take-downs of clients to the ground for personal restraint on the ground were not allowed. **Exhibit 19**, BHDC Residential Services Manager Carrie Johnson-Miller, p. 13, p. 14, p. 22: 11-20, p. 62: 9-13. BHDC squandered this opportunity to retrain Mattson on ground restraints, which could have saved Davie's life.

By holding Davie down on the ground just after his lunch, **BHDC staff ignored Davie's know[redacted] risk and the physician orders tha[redacted]**. **Exhibit 46**, Physician Orders at Discharge 6.19.20; **Exhibit 47**, Physician Orders 6.1.20; **Exhibit 48** Physician Orders 3.1.19. [redacted] Tyler Mattson, who testified he was aware of Davie's [redacted] initiated the ground restraint right after Davie finished lunch. [redacted]. See **Exhibit 43**,

"Prevention of Choking and Aspiration" – New York Office of People with Developmental Disabilities, pgs. 3-4. This is noteworthy because Respondent's expert witness, Dr. Kastner, was recently the head of this office in New York, under former Governor Andrew Cuomo; some of Dr. Kastner's expert opinions in this case are in direct conflict with the contents of this document as it relates to [redacted]

Davie was a known [redacted]. BHDC staff knew Davie was [redacted]. See **Exhibit 49**, BHDC Prevocational Trainer Rhonda Harris p. 10, p. 11, p. 12, p. 14. He should have never been taken to the ground under any circumstances, particularly after lunch.

The ground restraint caused Davie to vomit, as explained by Claimant's expert witness, Emergency Room physician Dr. Ricki Brown-Forestiere:

> *So, when someone is struggling in this scenario that's been described by all the participants, someone who is struggling has what's called a fight or flight response, meaning they're -- have adrenaline surges and they are fight -- essentially fighting for their life. Their muscles constrict to fend off what they feel is an attack. They -- so their muscles constrict, their breathing increases, (interference) set of physiological (interference) leads to increased [intrathoracic](interference) pressure which is the pressure in your chest. And it also constricts the abdomen which increases the intra-abdominal pressure. Both of these are cavities in the body where the stomach is. The inferior or superior aspect on top of the stomach is the diaphragm in the chest above that, and just below it, the abdomen. And increased pressure on both of these does place increased pressure on the stomach and from the sides. Obviously, there's a definitive end to the body and how far it can stretch. And also his left side being on the floor is another definitive mechanical block as to where it can expand. So, if you think of the stomach as a cube, it's having pressure from all different angles for – because of the struggle and the position and the increased pressures. And it*

caused him to [redacted]

Exhibit 42, Dr. Ricki Brown-Forestiere, p. 13, p. 14; **Exhibit 44**, Dr. Ricki Brown-Forestiere CV. Dr. Brown-Forestiere further testified:

> *Q Okay. So if I'm hearing you correctly, Dr. Brown, and in my very nonmedical layman's terms, intense struggle that produces a fight or flight reflex and adrenaline can, in itself, increases the likelihood of triggering vomiting; is that correct?*
>
> *A In this scenario, it would, yes, due to gravity.*
>
> *Q And being on his left side increased the likelihood that the pressure, intrathoracic pressure and gravity, would --*
>
> *A Yeah.*
>
> *Q -- trigger vomiting?*
>
> *A Yeah. Unfortunately, the stomach -- and the stomach's on the left. So it means everything in the body and all the pressures above him were pressing down onto the stomach; which was butting up against the ground, essentially.*
>
> *Q Okay. And the fact that he had -- if I'm hearing you correctly, the fact that he* [redacted]
>
> *A Correct.*

Exhibit 42, Dr. Ricki Brown-Forestiere, p. 14, p. 15. Respondent's expert witness, Dr. Ted Kastner, similarly opines that anxiety played a role in Davie vomiting during the restraint. **Respondent's Exhibit**, Dr. Kastner Report, Pt. 1, p. 21. Intense anxiety

would certainly be an element to the "fight or flight" response described by Dr. Brown-Forestiere.

Because Davie was horizontal on the ground, gravity caused him to [redacted]:

Q And do you have any opinion as to after he began vomiting while he was on his left side, do you have any opinion or does what happened next, what staff did next, play into your opinion at all?
A Yes. So, unfortunately, [redacted]

Exhibit 42, Dr. Ricki Brown-Forestiere, p. 15, p. 16. Dr. Brown-Forestiere opined further on the role [redacted] might have played:

A So Mr. Cains was on the floor being restrained by three people in three different locations of his body. There was a struggle, fight or flight, patient just struggling, adrenaline pumping, causing a lot of constriction of muscles and things of that nature. If you think -- in simpler terms, if you think of the stomach as a water balloon, essentially, it had pressure coming from every single direction; and the water balloon, eventually the tie at the top, broke. That would be the lower esophageal I was talking about. The tie at the top broke and all the water was released and, unfortunately, the water was a solid substance and it then --
Q And his balloon tie is weaker than most because of his [redacted] *correct?*
A Correct. Yeah, so balloon, weaker tie, breaking, everything coming up. Those are solid substances. He was on his left. They then turn them [him] on his back, allowing the vomit to rest in his throat closing off his air pipe and closing off gas exchange. [redacted]

[redacted]

Exhibit 42, Dr. Ricki Brown-Forestiere, p. 27, p. 28, p. 29.

Neither Mattson nor the other two called 911, not after Davie began vomiting, not after he [redacted] **BHDC policy forbade them from doing so; at BHDC, only medical staff are authorized to call for emergency medical help, while all other staff are only allowed to alert the facility's medical department. Exhibit 34**, BHDC First Aid Guidelines – Policy IV-B-10; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 51: 7-25, p. 52: 1-25; **Exhibit 9**, BHDC Staff Tyler Mattson, p. 78: 22-25, p. 79: 1-11 *("I would have like to" been able to call 911 for David)*; p. 123: 8-17 *("We're not allowed to" call 911)*; **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 57: 9-25 (*…it don't really make sense that we couldn't call them [medical department] and then call 9-1-1 as well.*"), p. 115: 5-17 (*wishes she had violated the policy and called 911 right away for Davie*); **Exhibit 11**, BHDC CPS Kelly King, p.20: 16-19; **Exhibit 15**, BHDC Social Services Worker Caleb Murry, p. 56; **Exhibit 30**, DRA Advocate Kris Stewart, p. 54: 14-18, p. 65: 22-25, p. 66: 1-22 *(everyone she interviewed at BHDC confirmed there was a policy forbidding nonmedical staff from calling 911 in the event a resident has a medical emergency) (Gonyea told her they did not trust staff to recognize a medical emergency, feared 911 might be called unnecessarily)*, p. 67: 1-10 ; **Exhibit 13**, Former BHDC Staff Don Carter, p. 22: 16-23, p. 23: 9-22 (*There were "no exceptions" to the rule)*, p. 26: 11-25.

> *Q Do you have any idea why that was the rule?*
> *A Yes. It was to control a situation. To be blunt with you, BHDC administration wanted to present their narrative in the documentation in an event like an emergency.*
> *Q What do you mean?*

A They wanted total control of what was – would appear in the documentation. Any emergency event would have been documented. And they just presented an attitude where they wanted complete control.
Q Do you know why that was so important to them?
A It was just – they had had problems in the past where things leaked out that was not in their interest.

Exhibit 13, Former BHDC Staff Don Carter, p. 24: 18-25, p. 25: 1-6.

Among many other violations, including basic common sense, BHDC's 911 policy violated its own stated Client Rights policy, which provides residents the "right to receive medical care." **Exhibit 33,** BHDC Client Rights (8).[5] DRA Advocate Kris Stewart testified that in her 27 years of working with and on behalf of developmental disability populations, she has never seen a similar 911policy. **Exhibit 30**, DRA Advocate Kris Stewart, p. 66: 19-22. DRA also documented this glaring deficiency in its report. **Exhibit 1**, "DRA - Final Report on Cains Death." **The facility didn't believe direct care staff possessed the ability to recognize a medical emergency, yet it was these same staff in whom they entrusted the daily care of Davie and other residents, in whom they entrusted the task of performing dangerous restraints on Davie and other residents. If these staff truly were not equipped to know when to call 911, they could not possibly have been equipped to react to an emergency situation with appropriate care.**

So, they called the nursing station instead, located in another building on the BHDC campus; **they informed the three LPNs on duty Davie was not breathing**. **Exhibit 11**, BHDC

[5] This is not the first time a reckless policy instituted by BHDC deprived a resident of their right to medical care and contributed directly to that resident's death; this resident also choked to death on her own vomit. Specifically, BHDC implemented a Behavior Treatment Program for a female client that "emphasized ignoring any behavior that resembled a seizure because it was believed that Jane was deliberately engaging in the seizure-like episodes to garner attention," which is exactly what staff did – ignored her as she suffocated to death on her own vomit on the ground right in front of them. **Exhibit 38**, DRA Investigation Report - BHDC Death - 2016.

LPN Kelly King, p.16: 10-15; **Exhibit 39**, Nurses Notes – Amanda Schmitt; **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 40: 17-19. Despite being told this in no uncertain terms, these three LPNs did *not* call 911 for an ambulance; rather, two of them, Kelly King and Amanda Schmitt, got in a car and drove across campus to the Commons building where Davie wasn't breathing, because they felt they needed to see if for themselves.

> *Q Right. Because 9-1-1 -- everybody that I've talked to tells me that 9-1-1 has equipment and capabilities superior, life-saving equipment and capabilities. You know, they have EpiPens, they can do intubation, they can do deep suctioning, they can, you know, communicate. You know, they have superior life-saving skills. So I'm just asking, you know, why didn't you or Ms. Noah or Ms. Schmitt or somebody else, anybody else, call 9-1-1 the second you heard that a patient --*
> *A I don't --*
> *Q -- was literally not breathing?*
> *A Well, because, I mean, I didn't really know what was going on and a lot of --*
> *Q But you were told he wasn't breathing. Did you not believe the person?*
> *A Well --*
> ***Q Did you need to see it for yourself?***
> ***A Yes. Actually, I did.***

Exhibit 11, BHDC LPN Kelly King, p.22: 7-25 (emphasis added). King testified further that they cannot rely on direct care staff's word, that they sometimes experience false alarms:

> *A Actually, I have had a couple of phone calls where a client is not breathing within the last year; and, when we got there, they were, in fact, breathing.*
> *Q Okay. And, because of that, you guys just don't take staff's word for it? You have to see – medical needs to see for themselves that somebody's dead or not breathing before you call 9-1-1? And that seems like a safe policy to you?*
> *A I -- you know, I don't even know how to answer that, to be honest with you.*

Exhibit 11, BHDC LPN Kelly King, p. 23: 25, p. 24: 1-11.

Q So that's two questions, actually. The first question, Nurse King, is do you have to see it for yourself? That's question one. The second question is, does that seem like a good, safe policy to you? So you can go ahead and answer now.
A You know, I'm going to say no for both those questions.

Exhibit 11, BHDC LPN Kelly King, p. 25, 1-8. See also **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 48 (*they did not call 911 for emergency help after they received the initial call because they get a lot of calls from staff saying a client is choking and that most of the time the client ends up being okay*).

The three nurses' decision to "see it for themselves" squandered precious minutes for Davie. According to King and Schmitt it took them almost three minutes to reach Davie. **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 57, p. 58; **Exhibit 11**, BHDC LPN Kelly King, p. 17. According to Don Carter, whose job for four and a half years was literally to drive from building-to-building picking up recycling, says that **it would not have been possible for the nurses to make the trip in less than five minutes**. **Exhibit 13**, Former BHDC Staff Don Carter, p. 35: 6-24, p. 36: 1-3 (*"But, even on a Saturday, I would say, for me to do that in a hurry would be five minutes"*). **According to Ryann Campos, the nurses did not authorize someone to call 911 for several minutes *after*** reaching Davie. **Exhibit 10**, BHDC Staff Ryann Campos, p. 46: 1-8.

The three LPNs did this despite being well aware that paramedics have superior life-saving capabilities and superior life-saving equipment; they have deep-suctioning devices, can intubate; can do chemical codes, and were only a 911 call away. **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 54, p. 55; **Exhibit 11**, BHDC LPN Kelly King, p. 25. They knew the paramedics could have provided better life-saving care. **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 56: 7-11. These LPNs did not have the equipment, tools, or training to save Davie's

life. The paramedics who responded after nursing staff eventually authorized calling 911 had all these things. **Exhibit 40,** Paramedic Samuel Scow, p. 45: 1-9 (Scow was actually able to clear Davie's airway using a Magill forceps, one of many tools BHDC did not have available); **Exhibit 41,** Logan County EMS Report. Dr. Brown agreed with this:

> *Q Okay. And am I correct that a paramedic such as Mr.Scow, the training and the equipment that they brought to the scene, is much greater than what your typical LPN would be able to provide?*
> *A Oh, absolutely. An LPN is the -- one of the very lowest medical certifications in regards in the nursing world it -- as the lower end. And, even an RN, which is above an LPN, would not have been able to have the tools or administer the type of treatments or procedures that a paramedic can. They're very highly trained. So they -- they have quite a few tools at their disposal and knowledge to use them.*

Exhibit 42, Dr. Ricki Brown, p. 23: 6-18. Unfortunately, Scow arrived too late to save Davie's life.

The evidence strongly suggests *at least* five and maybe as many as ten minutes elapsed between the time Davie began choking and when BHDC called 911. Exhibit 9. BHDC Staff Tyler Mattson, p. 120: 1-5; **Exhibit 10**. BHDC Staff Ryann Campos, p. 46: 1-8; **Exhibit 13**. Former BHDC Staff Don Carter, p. 35: 6-24, p. 36: 1-3; **Exhibit 40,** Paramedic Samuel Scow, p. 8: 14-21, p. 10: 19-25 (*determined, based on the 911 call coming in at 11:37 am, that it was **eight minutes** from the time Davie stopped breathing and when the facility called 911*); **Exhibit 41,** Logan County EMS Report. Respondent will argue that these five to ten minutes would not have made a difference, but Paramedic Scow disagrees: "I can't give any specific like certainty. But I can say that, yeah, **time is tissue**. So it doesn't matter what the patient condition is, whether it's asphyxiation, cardiac arrest, stroke, heart attack, you know, the longer you go without oxygen circulation gas exchange, so -- and I can't say that he would have

lived. But I may or may not have been able to get ROSC. And that's just based on -- and that ROSC is return of spontaneous circulation, for those who don't know." **Exhibit 40**, Paramedic Samuel Scow, p. 13. Dr. Brown testified that "those eight minutes, honestly, in my opinion, I think that it could have had a very large impact." **Exhibit 42**, Dr. Ricki Brown, p. 21

Respondent will argue that because it took Paramedic Scow approximately nine minutes [redacted] that the paramedics arrival sooner could not have made a difference. However, there is no way for Respondent to know how long it would have taken Scow to clear the airway at an earlier time. Meaning, [redacted], was not static or fixed; Davie's condition was changing by the moment in those precious minutes wasted by BHDC, and it is entirely possible Davie's condition was more favorable for [redacted] at any time prior to Scow's arrival. Further, it is possible the ambulance could have arrived sooner if called for at an earlier time – traffic conditions might have been different, traffic lights might have been different, or the ambulance, if already mobile, might have happened to be nearer to the facility at any earlier time. All that can be said with absolute certainty is that every second counts in a medical emergency; that is inarguable. For Respondent to suggest that it would not have increased Davie's odds if the paramedics arrived five to ten minutes sooner is nonsensical. It is more likely than, by a preponderance of the evidence, Davie would have had *at least* a slightly better chance at survival.

BHDC provided false information on the cause and circumstances of Davie's death to the paramedics, to the emergency room, to the Logan County Coroner, and to Davie's family, who were not told that a restraint even occurred until ten days after Davie's death and three days after his burial; BHDC's deceit successfully prevented an autopsy,

foreclosing the possibility of criminal charges. Exhibit 52, BHDC's Timeline of Events (this was the facility's official version of events that was provided to DRA and other interested parties; it intentionally omits that there was a restraint)**; Exhibit 53,** Facility Case Notes 6.13.20 – Documents False Info Provided Davie's Mother **(**reflects BHDC gave Davie's mother false information about her son's death, telling her only that he choked on his food at lunch; all mention of the restraint was omitted). Gonyea identified this document as a case note from the day of David's death reflecting Booneville's communication with and notification to David's mother, Charlene Robinson, about Davie's death and what happened. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 92. See also **Exhibit 60** Final Synopsis Provided to Charlene Robinson (the first and only notification the family ever received notifying them there had been a restraint, received three days after Davie's funeral, and it offered no explanation beyond stating that the staff who had restrained Davie at the time of his death had been cleared of all wrong doing and the case was closed, this despite the fact that this was the very first mention of a restraint Davie's family have heard).

Paramedic Samuel Scow testified that he was never once informed there had been a restraint; rather, he was told Davie choked on his lunch and was simply found lying on the floor by himself. **Exhibit 40**, Paramedic Samuel Scow, p. 9; 1-17. This lie caused false information to be related to the emergency room and then to the coroner, Michael Chrisman, who told DRA investigators that had he known of the restraint he would have likely ordered an autopsy. **Exhibit 1**, "DRA - Final Report on Cains Death."

Davie's sister, Christine "Chrissy" McAuliffe, and his mother, Charlene Robinson, reasonably believed BHDC was the best place for Davie, who required 24-hour care. Both were heavily involved in Davie's life. Davie's mother and sister were very involved in his life; his

was one of the most involved families at BHDC, according to Caleb Murry, whose job it was to be the liaison between clients and their families. **Exhibit 15**, BHDC Social Services Worker Caleb Murry , p. 22, 23. Murry had regular contact with both his mother and sister: "It wasn't uncommon for his sister to call and say, you know, I'm going to be sending him a birthday cake for his birthday or, you know, we're going to come get him." Murry says he talked to DC's mom even more: "me and his mom talked pretty frequently." **Exhibit 15**, BHDC Social Services Worker , p. 22, 23.

> *Q And they were pretty involved?*
> *A Oh, absolutely. Yes, they were.*
> *Q More so than the average family member?*
> *A Yeah. I would say, as far as family involvement, they were probably one of the top, top ones as far as being involved with any other. They were very close to him.*

Exhibit 15, BHDC Social Services Worker , p. 23. However, they were never told that dangerous and unauthorized forms of physical restraint would be used on Davie. They were never told that nobody would call for an ambulance were Davie to suffer a medical emergency.

It was not until after Davie's death that they learned improper and excessive restraint use was pervasive at BHDC. It was not until after Davie's death that they learned BHDC administration often turned a blind eye to these violations. Following Davie's death, Chrissy and Charlene learned that in 2019 BHDC staff broke one resident's arm during a restraint and choked another resident unconscious during a restraint. **Exhibit 50**, 1.31.21 Dem-Gaz Article. They learned that Disability Rights Arkansas had issued a report in January of 2016 entitled "Bound to the Past: The Excessive Use of Restraint at the Booneville Human Development Center," which revealed, among other things, that restraint use at BHDC was "approximately twenty-five times

higher" than at the other four Human Development Centers in Arkansas. **Exhibit 51,** DRA 2016 Report - Booneville's Excessive Use of Restraints.

NEGLIGENCE

Respondent, the Arkansas Department of Human Services (DHS), and more specifically its Division of Developmental Services (DDS), which oversees operation of the Booneville Human Development Center (BHDC), is vicariously liable for the negligent acts of its agents and employees at BHDC.

The essential elements of a negligence claim are "(1) the existence of a duty on the part of the defendant to conform to a specific standard of conduct to protect the plaintiff; (2) breach of that duty by the defendant; (3) injury to the plaintiff actually and proximately caused by the defendant's breach; and (4) resulting damages to the plaintiff or his property." *Cross v. Western Waste Industries*, 2015 Ark. App. 476, 7, 469 S.W.3d 820, 825 (2015).

While negligence requires an appreciable risk of harm to others that a reasonably careful person would recognize, "it is not necessary that the actor foresee the *particular injury* which occurred, only that the actor reasonably foresee an appreciable risk of harm to others" [emphasis added]. *Wallace v. Broyles*, 331 Ark. 58, 961 S.W.2d 712, 715 (1998). Proximate cause in a negligence action may be shown from circumstantial evidence, and such evidence is sufficient to show proximate cause if the facts proved are of such a nature and are so connected and related to each other that the conclusion therefrom may be fairly inferred. *Id.*

Under the doctrine of respondeat superior, an employer may be held vicariously liable for the tortious conduct of an employee or agent if the evidence shows that such conduct was committed within the scope of the agent's employment. *St. Joseph's Reg'l Health Ctr. v. Munos*, 326 Ark. 605, 612, 934 S.W.2d 192, 195 (1996). The test for whether an employee is acting

within the scope of his employment is whether the individual is carrying out the "object and purpose of the enterprise," as opposed to acting exclusively in his own interest. *Porter v. Harshfield*, 329 Ark. 130, 137, 948 S.W.2d 83 (1997). A principal may be liable for an agent's unauthorized, and even intentional conduct if the conduct was something that might be expected in view of the agent's duties. *Life & Cas. Ins. Co. of Tenn. v. Padgett*, 241 Ark. 353, 355, 407 S.W.2d 728, 729 (1966).

RESPONDENT OWED DAVID CAINS A DUTY OF CARE.

BHDC owed David Cains a duty of care. In agreeing to accept the custody, care, and control of Davie, Respondent expressly assumed a duty of care for David Cains. The relationship between BHDC and Cains imposed a duty in this case. Duty can be assumed or created through actions, and "where a person undertakes to act, they must do so carefully or they will be liable for negligence." *Yanmar Co., Ltd. v. Slater*, 2012 Ark. 36, 16, 386 S.W.3d 439, 449 (2012). The moment Respondent agreed to take care, custody, and control of David, a duty was created.

The Arkansas enabling statute for the creation of BHDC makes this clear: "There are created and there shall be maintained institutions for the care, custody, treatment, and training of individuals with intellectual and other developmental disabilities to be known as 'human development centers.'" A.C.A. § 20-48-403. And: "For the purposes of the institutions, the Board of Developmental Disabilities Services is charged with the care and training of individuals with intellectual and other developmental disabilities." A.C.A. § 20-48-403.

More importantly, BHDC was required to comply with federal regulations governing its operation. These federal regulations are referred throughout testimony interchangeably as the CMS regulations, Appendix J, the State Operations Manual, and ICF-IID regulations – all terms referring to the same federal regulations found at 42 C.F.R. § 483.00 et seq. Additionally,

BHDC was required to adhere to state DDS policies, as well as its own policies and procedures. These federal, state, and facility policies constitute specific duties owed by BHDC to Davie Cains: **See the Policies and Regulations Summary** attached with this brief.

RESPONDENT BREACHED ITS DUTIES OF CARE

Respondent breached its duties of care to Davie as specifically described in the preceding FACTS section of this brief, as well reflected in the deposition transcripts and Deposition Summaries, attached hereto.

AN APPRECIABLE RISK OF HARM WAS A FORESEEABLE CONSEQUENCE OF RESPONDENT'S BREACHES

While negligence requires an appreciable risk of harm to others that a reasonably careful person would recognize, "it is not necessary that the actor foresee the *particular injury* which occurred, only that the actor reasonably foresee an appreciable risk of harm to others" [emphasis added]. *Wallace v. Broyles*, 331 Ark. 58, 961 S.W.2d 712, 715 (1998).

As described in the preceding FACTS section of this brief, as well reflected in the deposition transcripts and Deposition Summaries, attached hereto, not only was *an* appreciable harm to Davie foreseeable, but *this particular harm* was highly foreseeable. Respondent knew full well that restraints posed a significant risk of injury to Davie, as reflected in BHDC's own Restraint Incident Debriefing Form:

> "The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. **The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used**. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program) when ***a very real risk of personal injury or severe property damage is imminent***."

Exhibit 61, BHDC Restraint Incident Debriefing Form. This written directive was in use at BHDC at the time of Davie's death. **Exhibit 3**, BHDC Superintendent Jeff Conyers, p. 65.

RESPONDENT'S BREACHES DIRECTLY AND PROXIMATELY CAUSED DAVIE'S DEATH

Respondent caused Davie's death, as specifically described in the preceding FACTS section of this brief, as well reflected in the deposition transcripts and Deposition Summaries, attached hereto.

If Davie had been standing or seated when he vomited, he would not have [redacted], regardless of what caused the vomiting; he was on the ground when he vomited because staff were holding him on the ground, regardless of how he got to the ground. Staff were not authorized to hold clients on the ground, not trained to do so, and were in violation of policy in doing so.

THE DAMAGES ARE SIGNIFICANT

Please see the deposition transcripts of Claimant, Christine McAuliffe, Charlene Robinson, and Sarah Ashley Cains.

Damages of the Estate of David Cains

- Loss of life of David Cains, commencing at death and ending at life expectancy. "Loss of life" damages are recoverable by the estate as an independent element of damage. These are the damages that would compensate a decedent for the loss of the value that a decedent would have placed on his or her own life. *Durham v. Marberry*, 356 Ark. 481, 156 S.W.3d 242 (2004).

- Conscious pain and suffering of David Cains prior to death. For cases involving conscious pain and suffering prior to death, see *New Prospect Drilling Co. v. First Commercial Trust, N.A.*, 332 Ark. 466, 966 S.W.2d 233 (1998); *Chambliss v. Brinton*, 229 Ark. 526, 317 S.W.2d 143 (1958). Dr. Ricki Brown-Forestiere testified that Davie's death would have been particularly painful:

  A So, when someone chokes and their airway is closed off, obviously, they can no longer receive oxygen or expel CO2. This quickly induces kind of what we would call a terror fight or flight response, similar to a drowning victim. They start fighting with everything they can. Unfortunately, as the airway is blocked, CO2 which is -- turns into a toxic substance, which is an acid, builds up in their body, their muscles fighting against and are unable to expel the lactic acid they build up. So, essentially, you're not only suffocating, but it's a feeling of burning. Your lungs begin burning, your whole body, because of the acid build up. And the struggle -- and eventually you become unconscious and -- and your body continues to struggle until it no longer can.

Exhibit 42, Dr. Ricki Brown-Forestiere, p. 19.

- Funeral expenses incurred because of David Cains' death
- Medical bills incurred, which here includes only the Ambulance bill

<u>Damages of Cains' Statutory Beneficiaries (which include Claimant, David's sister, and Charlene Robinson, David's mother, and David's half-sister Sarah Ashley Cains)</u>

- Mental anguish and emotional distress, including grief and despair, suffered up to the present time; and

- Mental anguish and emotional distress, including grief and despair, that will continue for the remainder of each of their lives. "Future mental anguish is recoverable." *Knoles v. Salazar*, 298 Ark. 281, 766 S.W.2d 613 (1989).

CONCLUSION

If there are no repercussions for misconduct, likelihood that the offense will be repeated increases. If there are not consequences for this event, the roughly 900 developmentally disabled Arkansas currently residing in Arkansas HDCs will be more likely to meet the same fate as Davie.

Only significant consequences can force the change that is needed to protect this most vulnerable population of Arkansans.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 16th day of February, 2023, and service shall be accomplished via email to counsel of record.

/s/ Joshua D. Gillispie
Joshua D. Gillispie

Dr. Kastner's opinions should be given little weight, if any.

Dr. Kastner prepared two expert reports for DHS regarding this matter. One report is dated January 5, 2023 (part one), and another dated January 6, 2023 (part two). He also provided testimony via deposition. Many of Dr. Kastner's opinions are based on mistaken assumptions, incorrect representations of testimony and/or statements, his own contradictory statements, and shifting definitions and standards.

Dr. Kastner offers some of his opinions "based upon a reasonable degree of medical certainty" on matters that aren't medical. Dr. Kastner's puffery in attaching this phrase to non-medical conclusions is obvious on its face, and should be considered when judging his credibility and the weight (if any) that his opinions should carry. For example, Dr Kastner offers the following opinions "based upon a reasonable degree of medical certainty":

- "While on the floor, Mr. Cains continued to demonstrate aggressive behavior towards Mr. Mattson and, subsequently, to other staff." Kastner Part Two, p. 5.
- "While on the floor, Mr. Mattson and other staff applied personal holds for the purpose of protecting Mr. Cains, staff and other individuals." Kastner Part Two, p. 5.
- "While on the floor, staff made no effort to hold or "pin" Mr. Cains to the floor. The application of personal holds was solely for the purpose of protecting Mr. Cains, staff and other individuals from Mr. Cains's aggressive behavior." Kastner Part Two, p. 5.
- "I agree with Dr. LeBel that the CMS regulations are "centrist." Kastner Part Two, p. 3.
- "Mr. Cains, who [redacted] at the time of the event, "charged at" or "lunged" at his staff, Mr. Mattson, and thereby initiated the process which led to physical contact between the two." Kastner Part Two, p. 4.

- "Mr. Cains is entirely responsible for the fact that the medical order, [redacted] was violated." Kastner Part One, p. 9.
- "Inconsistencies in the recording of the timing of the events was so frequent that all time notations, with the exception of when EMS was notified and the team dispatched, should be considered approximate." Kastner Part One, p. 10.

These opinions aren't medical in nature, but fall more along the lines of making assertions of non-medical facts (i.e., aggressive behavior, Mr. Cains charged at and lunged); discerning the intent and purpose of staff (i.e. applied personal holds for the purpose of protecting, the application of personal holds was solely for the purpose of protecting); ideological and political opinions (the CMS regulations are centrist); assigning liability, fault and blame (Mr. Cains is "entirely" responsible); and setting his standard for how this Commission should weigh the facts and evidence in this matter (Inconsistencies in the recording of the timing of events, with one exception, should be considered approximate).

Dr. Kastner testified during his deposition that the standard of care he was applying consisted of government and facility regulations, plus what a reasonably qualified direct support professional would have done under the circumstances. Kastner Deposition, p. 70. He testified that he derives this reasonable professional standard from the fact that professionals have to comply with licensing entities who set standards for the licensure of certain professionals. Kastner Deposition, p. 186. However, he admitted that the three staff members who held Davie down did not have any such licenses, or that they were even required to have a license. Kastner Deposition, p. 221. Additionally, in both of his written reports he never references that he is applying a reasonable licensed professional standard or definition in evaluating whether staff in

this matter met the standard of care. It was during his deposition that he first made this distinction.

But Dr. Kastner contradicts himself. His report states "CMS rules and regulations, ARDDS policies and procedures, and BHDC policies and procedures represent the standard of care for the delivery of behavioral services at BHDC." Kastner Part Two, p. 3. He does explain later that "staff exercised their professional judgment in order to meet the standard of care including the use of less restrictive procedures, "time and space," and other appropriate means." Kastner Part Two, p. 5. But this brief statement that they exercised professional judgment hardly advises the reader that the licensing requirements of professionals (which didn't apply to these staff members) was part of his definition of the standard of care set out earlier in his report. Additionally, Dr. Kastner was unable to cite any federal, state, or BHDC regulation, rule or policy that applied the licensing requirements of professionals as part of the standards applied to staff members such as those in this case.

Dr. Kastner actually contradicted his licensed professional standard during his direct examination by DHS counsel. When asked "what is the standard of care for restraint use in human development centers in the State of Arkansas, who determines that, standard of care?", he testified under oath that "the standard of care is determined by the Centers for Medicaid and Medicare—Medicare and Medicaid Services, and subsequent state and facility-based documents." Kastner Deposition, p. 49. Dr. Kastner did not include his reasonable licensed professional definition in this response to the question from DHS's counsel. Dr. Kastner at one point even excluded the governmental and facility regulations from his standard of care when attacking the Claimant's expert: "the only standard of care that is applicable to the conduct of an RCT in performing their duties is the standard for what an RCT is expected to know and to do.

And that would be based upon their training, their experience and their judgment as to what was the most appropriate course of treatment." Kastner Deposition. p. 94.

In offering his opinions, Dr. Kastner ignores inconsistencies in different statements (oral or written) given by BHDC staff, and assumes every statement they made was true and accurate. Also, Dr. Kastner just simply gets some of the facts wrong. In his deposition he stated that "Mr. Mattson and Mr. Cains had been discussing how Mr. Cains felt while he was in the dining area. He had experienced and communicated some nonspecific gastrointestinal distress." Kastner Deposition. p. 65. However, Tyler Mattson testified that Davie asked to go to the bathroom immediately after finishing lunch, and that Davie was getting agitated, but he did not know what caused the agitation. Staff Tyler Mattson Deposition. p. 93. Mattson further testified that he went into the bathroom with Davie, that Davie only urinated, and took "less than a minute." Staff Tyler Mattson Deposition. p. 96. At no time during his deposition testimony, or in any other statements did Mattson say that Davie discussed how he felt regarding gastrointestinal distress.

Dr. Kastner also provides an extremely specific prediction as to Davie's life expectancy at the time of his death without any semblance of a scientific basis or methodology. He cited some figures regarding obesity in his reports; however, he admitted under oath that they only applied to individuals between the ages of twenty and twenty-nine, and that Davie was older than twenty-nine. Kastner Deposition. p. 306-308. Dr. Kastner uses inapplicable studies, statistics, and standards to support some of his opinions. He also offers opinions that defy common sense. He testified that the BHDC policy requiring direct care staff to call medical first, and prohibited them from calling 911 for an ambulance, even when a person has no pulse and isn't breathing, was a completely appropriate policy with respect to the care provided to Davie. Kastner Deposition. p. 332-333. It is shocking that any medical professional would every justify a policy

that instructs staff to disregard their CPR training by prohibiting them for immediately calling 911 or directing someone else to immediately call 911 when a person is without a pulse and not breathing. Dr. Kastner opines that Davie did not suffer severe pain when he was suffocated with his own vomit and food debris. Kastner Part One. p. 49-51. And while he attacks Dr. Brown and claims she didn't support her opinion regarding pain, he does not support his assertion other than to say the sensation of pain requires tissue damage. It is obvious the acidic contents of a person's stomach will burn and damage tissue in the airway and lungs.

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains	**CLAIMANT**
V.	**Claim No. 220374**
THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)	**RESPONDENT**

POLICIES AND REGULATIONS SUMMARY

COMES now Claimant, by and through her attorney, Joshua D. Gillispie, and for her Summary of Applicable Policies and Regulations, states the following:

Attached for the Commission's convenience is the following Summary of Applicable Policies and Regulations.

Respectfully submitted,

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Policy Summary

Federal Policy

The facility must take whatever action is necessary to protect the clients residing there. ICF-IID Reg. § 483.420(a)(5). [W127]. Bates 1658. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 16. 17.

The facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. ICF-IID Reg. § 483.420(a)(5). [W127]. Bates 1656. Identification of patterns or isolated instances of physical, verbal, sexual or psychological abuse or punishment without prompt identification and corrective action by the facility would result in a non-compliance determination for this Standard and Condition level non-compliance. *Id.* BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 15. 17.

The facility must develop and implement systems that protect clients from all forms of abuse, neglect, or mistreatment, including client to client abuse, neglect, or mistreatment. ICF-IID Reg. § 483.420(a)(5). [W127]. Bates 1657. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 15. 17.

The facility is expected to ensure that staff possess and demonstrate needed competencies to effectively and appropriately interact with clients. ICF-IID Reg. § 483.420(a)(5)(a). [W127]. Bates 1657. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 15. 17.

The facility must monitor to assure that systems are effectively implemented and the facility takes immediate actions to address circumstances where abuse, neglect, or mistreatment have occurred and prevent reoccurrence. ICF-IID Reg. § 483.420(a)(5)(b). [W127]. Bates 1657. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 15. 17.

The facility must act to prevent physical, verbal, sexual or psychological abuse. ICF-IID Reg. § 483.420(a)(5)(d). [W127]. Bates 1657. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 16. 17.

Since many clients residing in ICF/IIDs are unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, would also be viewed as abusive by the client residing in the ICF/IID, regardless of that client's perceived ability to comprehend the nature of the incident. ICF-IID Reg. § 483.420(a)(5). [W127]. Bates 1658. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 16. 17.

Regulation Section ICF-IID 483.420(a)(6). [W128]. Bates 1658 states that **a facility must ensure that clients are free from unnecessary physical restraints.** Pursuant to this regulation, **BHDC had a duty, at the time of his death, to keep Davie and other clients free from unnecessary physical restraints.** BHDC Superintendent Jeff Gonyea. p. 19: 4-18.

The long-term use of a drug/physical restraint to manage behavior combined with one or more of the following may indicate unnecessary use:
• The client's developmental and/or behavioral needs are not being met and the appropriateness of less restrictive approaches to manage inappropriate behaviors should be questioned;
• Staff behavior may be prompting behaviors in clients which result in the chronic use of physical restraints and drugs to control behavior;
• Staff may have inadequate training and/or experience to provide active treatment and employ preventive measures;
Restraints applied for behaviors when less restrictive measures have not been tried or have been tried and found to be just as effective. ICF-IID Reg. § 483.420(a)(6), [W128], Bates 1659.

The facility **must specify** all facility approved interventions to manage inappropriate client behavior. ICF-IID Reg. § 483.450(b)(1)(i), [W276], Bates 1753. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 21. Sandy Evans, p. 24.

All interventions for the management of inappropriate client behaviors which are approved for use in the facility are **clearly stated and described in its policy**. ICF-IID Reg. § 483.450(b)(1)(i), [W276], Bates 1753. BHDC had a duty to clearly state and describe in its policies all interventions for the management of inappropriate client behaviors which were approved for use. BHDC Superintendent Jeff Gonyea, p. 21. Sandy Evans, p. 24.

The facility must designate facility interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive. Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior. ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 21, 22.

Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. ***Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.*** ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 21, 22.

The facility policy for unexpected behavioral incidents must provide direction for the staff in the utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others. ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753, 1754. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 21, 22. [purpose of hierarchy is to ensure only least restrictive specific technique is used, applies equally to emergency situations]

Tags W275 and W276 fall under Section b – Management of Inappropriate Client Behaviors. As in most sections of the regulations, these separate (b) Tags are meant to be read as continuing in nature, as seen here: **"These procedures must,"** [ICF-IID Reg. § 483.450(b)(1), [W275], Bates 1752 (final line)], **"Insure" [sic]** prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; **and**
Policies must be implemented to ensure that all restrictive procedures begin at the lowest level of the hierarchy unless there is documented evidence that less intrusive interventions have been tried and have been found to be ineffective.
The facility is not required to justify discontinuing the use of a more restrictive technique before initiating a less restrictive technique, since the **intent of the regulation is to use the most positive, least intrusive technique possible.**
In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible. [ICF-IID Reg. § 483.450(b)(1)(iii), [W278], Bates 1754]. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 30. Residential Services Director Sandy Evans also testified that **BHDC had a duty to adhere to this policy, that pursuant to this regulation, in emergency situations BHDC and staff are required to choose the least restrictive technique possible.** Sandy Evans, p. 26, 27.

Q Yeah. And the last paragraph under this regulation states, that in emergency situations where an unanticipated behavior requires immediate protection of the client or others, the physical restraint technique chosen must be the least restrictive appropriate technique possible. Did I read that correctly?
A Pretty much. It says the technique chosen is the least restrictive appropriate technique possible.
Q Ah, yes. Would you agree with that statement?
A Yes.
Q And would you agree that that is a policy that Booneville was required to comply with?
A Correct. BHDC Superintendent Jeff Gonyea, p. 30.

Federal Regulation says policies and procedures of a facility must address the types of physical restraint that are allowed in the facility. ICF-IID Reg. § 483.450(b)(1)(iv)(B), [W280], Bates 1755. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 23. [Ground restraints are not addressed in BHDC's policies and procedures.]

Federal Regulation says policies and procedures of a facility must address the persons who can use the physical restraints, must address the parameters for duration of application, and **must address methods** that ensure the health and safety of the person to be restrained. ICF-IID Reg. § 483.450(b)(1)(iv)(B), [W280], Bates 1755. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 23, 24. [Persons to use, parameters, and **methods** for ground restraints are not addressed in BHDC's policies and procedures, as ground restraints are not mentioned anywhere.]

Federal Regulation says policies and procedures of a facility **must address the specific training required** for staff who are allowed to apply the physical restraints. ICF-IID Reg. § 483.450(b)(1)(iv)(B), [W280], Bates 1755. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 23, 24. [Ground restraint training is not addressed in BHDC's policies and procedures; it is not addressed because it is not an authorized method.]

Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. ICF-IID Reg. § 483.450(b)(2). [W285]. Bates 1758.

Techniques to manage inappropriate client behavior must never be used, ICF-IID Reg. § 483.450(b)(3). [285]. Bates 1758, **for the convenience of staff.** Inadequate numbers of staff, inefficient deployment of staff, and insufficient training of staff can lead to restrictive practices used for staff convenience. ICF-IID Reg. § 483.450(b)(3). [W287]. Bates 1759.

The use of behavior interventions are expected to be incorporated into the IPP and be based upon the results of the functional behavioral assessment. However, **there may be isolated and rare instances when a client exhibits unexpected behavior that requires immediate intervention on the part of the staff. In these instances, <u>the least restrictive intervention must be employed</u>** and removed as soon as the client is no longer an immediate threat to self or others. The IPP team must then discuss the need for adding a behavioral plan into the client's program. ICF-IID Reg. § 483.450(b)(4). [W289]. Bates 1760.

BHDC is required to specify, within a client's IPP, the physical restraints that can be used. ICF-IID Reg. § 483.450(d)(1)(i). [W295]. Bates 1764. The IPP must address, among other things, "**the type of physical restraint**" and the "**specific** type of client behavior" for which these physical restraints described in the plan can be used. *Id.* BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 25. Sandy Evans. p. 29. 35. [Ground restraints are not addressed or mentioned in DC's IPP.]

Q Okay. Would you agree that any physical restraint that could potentially be used on a client at Booneville needed to be clearly stated in that client's IPP?
A Yes. Superintendent Jeff Gonyea. p. 25: 8-11. Sandy Evans. p. 29. 35. [Ground restraints are not addressed or mentioned in DC's IPP.]

He waivers when I ask if this includes emergency restraints, because he realizes he's trapped.

The only physical restraint use ever at BHDC is for Emergency Situations. Therefore, if any physical restraint that could potentially be used on a client at BHDC must be clearly stated in the client's IPP, that is referring to those physical restraints used in Emergency Situations, since that is the only time physical restraint is used at BHDC.

Q I'll go back to the question that I asked that you agreed with, so one question back.
I believe I asked if you'd agreed that -- Oh, would you -- I asked if you would agree that any physical restraint potentially used on a client at Booneville needed to be clearly stated at that client's IPP.
And you responded, yes.
A Correct.
Q Is that still your answer?
A Correct. Superintendent Jeff Gonyea. p. 26.

Q I'm correct that personal restraints at Booneville can only be used in emergency situations?
A That's correct.
Q Okay.
A That's correct.
Q And I assume that there are approved forms of restraint to be used in those emergency situations?
A That's correct.
Q And am I also correct that staff can only use approved forms of restraint?

A That's --
Q Is that correct?
A That's correct. Superintendent Jeff Gonyea. p. 27.

Q Well, that's not exactly my question. My question is, has to do with this regulation, which you agreed that Booneville was required to comply with. Specifically, that approved, that the – that Booneville was required to specify within a client's IPP the use of approved physical restraints that can be used.
A Correct.
Q You still agree with that?
A Right.
Q Okay.
A Yeah.
Q Well, then -- and the only physical restraints that are ever used at Booneville are emergency restraints?
A That's correct. Superintendent Jeff Gonyea. p. 28.

The facility may employ physical restraint "as an emergency measure, but only if *absolutely necessary* to protect client or others from injury." ICF-IID Reg. § 483.450(d)(1)(ii), [W296], Bates 1764. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 32; Sandy Evans. p. 30.

Physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which the client has not exhibited before, exhibiting behaviors not identified in the functional analysis of that client's behavior, or the client **ARE** harming other people or themselves. ICF-IID Reg. § 483.450(d)(1)(ii), [W296], Bates 1764, 1765; BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 32; Sandy Evans. p. 30. [Note the present tense "are," foreclosing the appropriateness of force in *anticipation* of harm.]

The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. ICF-IID Reg. § 483.450(d)(2)(i), [W298], Bates 1766. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 33; Sandy Evans. p. 31. [Such as when the client is on the ground.]

The facility must not issue orders for restraint on a standing or as needed basis. ICF-IID Reg. § 483.450(d)(3), [W300], Bates 1767. BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 33 [Tyler was not aware that restraint could only be used for true emergency situations. He literally testified that he could use them on an "as-needed" basis.]

A client must be released from a physical restraint as quickly as possible, meaning as soon as the client is no longer a danger to self or others. ICF-IID Reg. § 483.450(d)(4), [W302], Bates 1768); BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 34; Sandy Evans. p. 32. "Yes. Anytime he was in a personal hold, they would be released as quickly as possible." BHDC Superintendent Jeff Gonyea. p. 34.

Restraints must be designed and used so as not to cause physical injury to the client. ICF-IID Reg. § 483.450(d)(5), [W304], Bates 1768); BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea. p. 35; Sandy Evans. p. 32.

Q That is a rule, that any restraint used must be designed not to cause -- specifically designed not to cause physical injury; correct?

A Correct. Sandy Evans, p. 32.

DDS Policy and other Arkansas Law

"An individual's actions that are aggressive, disruptive, and/or present a danger to the individual or others, must be managed with **the least restrictive method**." DDS 3011-D (3); Sandy Evans, p. 34; BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 37. Only the least restrictive method in any given situation can be used at BHDC. Sandy Evans, p. 34.

Q And would you agree that Booneville was required to manage an individual's actions that were aggressive, disruptive, and/or presented a danger to the individual or others with the least restrictive method?
A That's correct.
Q Okay. And you'd agree that, in fact, only the least restrictive method in any given situation would be allowed to be used at Booneville?
A That's correct. BHDC Superintendent Jeff Gonyea, p. 37.

It is *emphasized* that emergency procedures **may not be used at frequent intervals**, becoming **a routine method of intervention**. If emergency procedures are utilized **three times in a six-month period**, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. DDS 3011-D (6). BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 39.

The emergency use of restraint must conform to the federal ICF regulations, and must be reported immediately to the facility administrator or designee. DDS 3011-D (6). BHDC had a duty to comply with this policy. BHDC Superintendent Jeff Gonyea, p. 39. [They cannot just use any restraint they want because it's an "emergency."]

Personal or mechanical restraint is to be used only as an emergency measure at BHDC. BHDC Policy I-D-4 (1); Mark Hise, p. 11; BHDC Superintendent Jeff Gonyea, p. 42.

*Q And this states that emergency restraint is defined as the use of the **least restrictive procedure** and for the least time necessary to control **severely aggressive or destructive** behaviors. The use of emergency restraint will comply with all relevant standards and regulations. Did I read that correctly?*
A Yes.
Q And is what I just read, in fact, the policy at BHDC?
A Yes.
Q And was it also the policy at the time of David's death?
A Yes.
Q *And am I correct that that is Booneville's definition of emergency restraint?*
A That, what you read there?
Q Yes. Is what I read there a definition, Booneville's definition—
A Yes.
Q -- of emergency restraint?
A Yes. BHDC Superintendent Jeff Gonyea, p. 43, 44.

At BHDC, Personal (physical) restraints are only allowed in emergency situations. An emergency situation is where there is "imminent danger to the health or safety" of staff or clients. BHDC Superintendent Jeff Gonyea, p. 48.

"Imminent danger to health or safety" means a situation in which death or severe bodily injury could reasonably be expected to occur without intervention. DDS 3004-I-Appendix A (6A), Bates 2052. **This was the definition of "imminent danger" in use at BHDC at the time of Davie's death.** BHDC Superintendent Jeff Gonyea, p. 62, 63.

The burden of proof shall be upon the department to show by **clear and convincing evidence that such imminent danger exists**. DDS 3004-I-Appendix A (6B), Bates 2052.

All alleged, suspected, and witnessed maltreatment will be immediately reported by all individuals having knowledge of the alleged incident to the on-site administrator. DDS 3004-I (6)(B)(1), Bates 2047. Gonyea agrees this was the policy at BHDC and that he was in fact the on-site administrator. BHDC Superintendent Jeff Gonyea, p. 50.

All **alleged**, suspected, and **witnessed** maltreatment will be immediately reported to the appropriate abuse reporting hotlines by the on-site administrator. DDS 3004-I (6)(B)(2), Bates 2047. Gonyea agrees this was the policy at BHDC. BHDC Superintendent Jeff Gonyea, p. 54.

"The on-site administrator is responsible for ensuring that staff accused or suspected of maltreatment leave the facility grounds immediately and have no contact with clients until an investigation has been completed. Under no circumstances will the subject(s) of an investigation resume regular duties or assume new duties at the facility until an investigation is complete." DDS 3004-I (6)(C), Bates 2048.

"Abuse" means any intentional and unnecessary physical act which inflicts pain on or causes injury to an endangered or impaired adult, including sexual abuse." DDS 3004-I-Appendix A (1), Bates 2052. This was the definition of abuse in use at BHDC. BHDC Superintendent Jeff Gonyea, p. 62.

A.C.A. § 12-12-1703:
(1)(A) "**Abuse" means** with regard to any long-term care facility resident or any patient at the Arkansas State Hospital by a caregiver:
(i) Any **intentional and unnecessary physical act that inflicts pain on or causes injury** to an endangered person or an impaired person, excluding court-ordered medical care or medical care requested by the patient or long-term care facility resident or a person legally authorized to make medical decisions on behalf of the patient or long-term care facility resident;
(2) "**Adult maltreatment" means abuse**, exploitation, neglect, or sexual abuse of an adult.

BDHC Policy

BHDC defines Emergency Restraint as use of ***the least restrictive procedure*** and for the least time necessary to control ***severely aggressive*** or destructive behaviors. The use of **emergency restraint will comply with all relevant standards and regulations.** BHDC Policy I-D-4 (2)(a); Sandy Evans, p. 38; [illegible] BHDC Superintendent Jeff Gonyea, p. 43.

Restraint will not be used as punishment or **for the convenience of staff in lieu of adequate programming**. BHDC Policy I-D-4 (2). [Programming was inadequate.]

"Personal restraint of a client is used when the behavior is such that verbal control has

been lost and other less restrictive measures have failed to control the behavior." BHDC Policy I-D-4 (2)(d). [Tyler never attempted less restrictive measures.]

The use and documentation of disciplinary procedures will comply with all relevant ICF/IID regulations and DDS Policy #3011-D. BHDC Policy I-D-2.

Emergency restraint is the only form of physical restraint or personal hold allowed at BHDC. BHDC Superintendent Jeff Gonyea, p. 44.

The BHDC definition of personal (physical) restraint is "an emergency procedure limiting movement by the holding of a hand or limb." BHDC Policy I-D-4 (6); Sandy Evans, p. 40; BHDC Superintendent Jeff Gonyea, p. 45; Carrie Johnson-Miller, p. 56, 66.

[The facility's definition makes clear all personal restraint use is for emergency situations.]

Gonyea is unable to identify any other definition of personal restraint for BHDC. BHDC Superintendent Jeff Gonyea, p. 45, 46. There is no other definition or policy for approved methods of Personal (Physical) Restraint to be used at BHDC other than "an emergency procedure limiting movement by the holding of a hand or limb." Sandy Evans, p. 40, 41; Carrie Johnson-Miller, p. 66.

Q Sure. What is your understanding of why only the least restrictive method of intervention is allowed at Booneville?
A So they only use the minimum necessary to protect the client from themselves or others.
Q And would one of the reasons for that be to preserve the safety of the client?
A That's correct. BHDC Superintendent Jeff Gonyea, p. 46.

Client safety is the purpose of the "least restrictive" mandate. BHDC Superintendent Jeff Gonyea, p. 45.

"The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. **The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used**. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program) when ***a very real risk of personal injury or severe property damage is imminent***." BHDC Restraint Incident Debriefing Form. This written directive was in use at BHDC at the time of Davie's death. BHDC Superintendent Jeff Gonyea, p. 65.

BHDC Client Rights – this violated those, as one of the rights is a right to medical care, which this rule deprives. A duty of even ordinary care would encompass an obligation to provide emergency medical care, including calling 911 for an ambulance as quickly as reasonably possible (and using CPR).

DC had very little understanding of abuse and neglect, would have struggled to articulate it. "He was not able to communicate a full understanding of his rights and needs the support of his guardian and the staff here at BHDC to ensure his rights are protected." Caleb Murry, p. 35.

Staff at the HDCs are required to follow their training. They are not allowed to wing it and use techniques not taught to them. Melissa Weatherton, p. 43, 74;

"In all cases in which a serious medical injury or illness is suspected. either to clients or staff, a call to the Medical Department should be made. This should be the first call so medical staff can respond immediately to the situation. Medical will assess the situation and call an ambulance if appropriate." BHDC First Aid Guidelines – Policy IV-B-10 – Version 12/29/17

"If victim [choking victim] is unresponsive then you must call for help. ***Call 911 if the victim is a fellow staff member*** and **if the victim is an individual/client/resident** you must first phone the **BHDC Medical Only Emergency # 1422.** If there are other staff members present have them make the call – if you are alone make the call yourself and ***return to the victim's side***." BHDC Choking Protocol – Annual Training 2020

Physical Abuse: Physical contact which may include, but is not limited to such obvious physical actions as hitting, slapping, pinching, kicking, hurling, strangling, shoving, unauthorized or unnecessary use of personal intervention, or otherwise mishandling a person receiving services- Physical contact which is not necessary for the safety of a person and/or causes discomfort to the person may also be considered to be physical abuse, as may the handling of a person with more force than is reasonably necessary. Phase II Training Materials, Bates 16659

Staff training teaches that if an upset client is standing, staff should stand; if an upset client is sitting, staff should sit; purpose of this is to appear less threatening. BHDC Avoiding/Defusing Violent Behaviors

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 16th day of February, 2023, and service shall be accomplished via email to counsel of record.

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains — **CLAIMANT**

V. — **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — **RESPONDENT**

DEPOSITION SUMMARIES

COMES now Claimant, by and through her attorney, Joshua D. Gillispie, and for her Deposition Summaries, states the following:

Attached for the Commission's convenience are the following Deposition Summaries.

Respectfully submitted,

/s/ Joshua D. Gillispie
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Justin Jobb – Deposition Summary

- Jobb's job title is program coordinator/QIDP. He has been a program coordinator for BHDC for between 12 and 13 years. He has worked at BHDC for 24 years.
- Only in emergency situations can staff carry out any type of restraints
- Staff are not allowed to carry out an intervention not authorized in the IPP.

- **There are no planned restraints** or restraints that are made a planned part of a client's IPP or Behavior Treatment Plan at BHDC. "That's the only – we do not have -- in anybody's plan, we do not have any type of restraint that's not emergency." "Whether it's category one or category three. It's not part of any behavior treatment program then; it's not part of any behavior treatment program now. Only in emergency situations."
- As DC's QIDP, Justin Jobb was ultimately in charge of and responsible for DC's IPP. He wrote it.
- He is responsible for overseeing the implementation of the IPP.
- **As QIDP, he is also chair od DC's interdisciplinary team.**
- The IDT works with Jobb (as its chair) to draft the IPP.
- Chrissy attended the meeting for DC's most recent IPP, in addition to his mother; even though she wasn't his guardian and not part of his IDT (Interdisciplinary Team), she attended.

Justin Jobb II – Deposition Summary

- Jobb's job title is program coordinator/QIDP. BHDC policy states that, in that role, he monitors the implementation of training objectives and the delivery of services for clients on their assigned caseload, as determined in each client's IPP.

- Only the least restrictive method available can be used for a behavioral intervention.

- Only the least restrictive procedure and for the least time necessary to control **severely aggressive** or destructive behaviors can be used on DC.
- The definition of personal restraint at BHDC is "an emergency procedure limiting movement by the holding of a hand or limb."
- The program coordinator/QIDP also reviews monthly progress notes and other documentation relative to each client. And then they submit monthly plan reviews to summarize information from their observations and their record reviews.

- The program coordinator QIDP functions as an advocate for the client by assuring he/she receives the maximum benefit of active treatment.
- Jobb, who is primarily responsible for drafting DC's IPP and present at DC's last two IPP meetings, does not recall anyone ever explaining the types of PRs to be used on DC to his mother or sister.
- ***Q****. Do you recall anyone ever, in the 2018 and 2019 meetings for which you were the Q, do you recall anyone ever addressing with the mother and sister that David might be restrained on the ground?*
  A*. No.*
- Ground restraints were never discussed at any time with DC's mother or sister.

- **Nowhere in DC's IPP does it mention physical restraints or personal holds on the ground.**
- Jobb says he was not aware staff was using ground restraints. **He agrees with Mark Hise this is an improper restraint.**
- There is nobody, that he knows of, who is responsible for supervising how staff use PRs on clients.

- Even though, as Davie's Q, he was supposed to eventually see documentation of every restraint used on DC, he testified he'd never received a report of DC being restrained on the ground.
- It was never reported to Jobb that staff were using this restraint on DC.

- Staff are not allowed to restraint clients on the ground. That is the rule now and it was the rule at the time of DC's death.
- If Jobb had been made aware that staff had restrained DC on the ground, he would have reported it to the Superintendent.
- It is *emphasized* that emergency procedures **may not be used at frequent intervals**, becoming **a routine method of intervention**. If emergency procedures are utilized **three times in a six-month period**, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. DDS 3011-D (6). This never happened because Jobb thought it was only for mechanicals used three times in three months.

- ***Q**. Let's just, you know, for a given month, let's say David's put in personal or physical restraints three times for that particular month. Are you required to document that in your monthly progress notes?*
  ***A**. It's -- it's optional. I mean --*
  ***Q**. It's optional?*
  ***A**. Yeah.*
- Jobb says he does not think he documented the use of personal restraints on DC! He only kept up with mechanical restraints.
- Jobb was under the mistaken believe that he only had to hold IDT team meetings if DC had three mechanical restraints in a three-month period, in which case "I'd have to have a special team meeting."
- Jobb was DC's Q for several years, including 2018 through his death.
- **It was the program coordinator/QIDP's job to guide the interdisciplinary team (IDT) and assure that team decisions comply with established policies as well as ICF regulations.**
- Jobb says he was supposed to be notified every time DC was held in a PR for longer than one minute.
- There is nobody, that he knows of, who is responsible for supervising how staff use PRs on clients.

- ***Q***. *Okay. Are you able, as David's Q, as the person that drafts his plan, his IPP and is responsible for implementing his plan, are you able to articulate to me what, if any, supervisory, supervision techniques or safety mechanisms are in place to ensure that RCTs are not regularly using improper personal restraints? Or is it simply there's no system in place, it's just, if somebody sees something, they report it?*
  A. *Well, they are trained.*
  Q. *We've covered that.*
  A. *And we count on them doing the correct procedure, correct job. And, if anything is not carried out properly, we are counting on other staff to report it.*
- The persons best placed for observing and reporting abuse by RCTs are fellow RCTs.
- Jobb could not articulate or identify any formal system of staff supervision.
- ***Q***. *And are you able to articulate any formal plan or policy used for supervising the RCTs? For instance, supervisor has to be present for this many, you know, this many times a week for this long --*
  A. *No.*
- Jobb is not aware of there being a formal system in place for the supervision of RTCs in June of 2020.
- Staff at BHDC are required to report suspected maltreatment to the Superintendent, rather than to hotline it themselves. Then the Superintendent decides what happens.
- ***Q***. *And my last question, I think we basically are in agreement here, but I just want to make sure, because we kind of danced around it for a while. And it's my very last question here. So I think we definitely agreed that staff development is -- with regards to physical restraints and personal restraints, staff development is responsible for training the direct care staff in that, training the RCTs in that; correct?*
  A. *Correct.*
  Q. *And then it would mainly fall on the shoulders of the, I think you said, the direct care chain of command, all the way up to the residential services director to enforce those, that training, to ensure -- in other words, to ensure that the RCTs and other direct care staff are following the rules with regards to physical restraints; correct?*
  A. *Yes.*
- The person ultimately responsible for giving directives to RTCs and the person ultimately responsible for direct care staff is the Residential Services Director [Sandy Evans].
- ***A***. *But, a lot of times, I remember specifically with him, he'd be listening and dancing and singing to the Monkees --*

Q. *Yeah.*
A. *-- in his bedroom. So you'll probably see a lot of that in my progress notes, because that happened a lot.*
Q. *I've seen a lot of mention of the Monkees everywhere.*
A. *It was a big part of his life, yes.*

- His mother was involved in his treatment. Charlene took him to doctor appointments.

- His mother was involved in his treatment. She didn't care the facility's former psychiatrist, prior to Dr. Hudefi's arrival, and she would not allow DC to be seen by him. She'd take him to someone in Fort Smith instead, before Dr. Hudefi got there.

- Chrissy attended the meeting for DC's most recent IPP, in addition to his mother; even though she wasn't his guardian and not part of his IDT (Interdisciplinary Team), she attended.

Mike Alvis – Deposition Summary

- Mike Alvis works as the Psychological Examiner at BHDC where his job is to provide testing, psychological evaluations, individual and group counseling. He also attended meetings regarding IPP, or Individual Program Plans. Mike Alvis, p. 10.
- DC's [redacted]. Mike Alvis, p. 24.
- DC's [redacted]. Mike Alvis, p. 30.
- DC's [redacted]. Mike Alvis, p. 24.
- DC's [redacted]. Mike Alvis, p. 30.
- DC was given no therapy or counseling. Mike Alvis, p. 32, 33.
- Mike Alvis has no knowledge of DC ever harming or injuring anyone. Mike Alvis, p. 59.
- DC was Category I, not Category III, meaning he had no planned restraints, only emergency. Mike Alvis, p. 54.
- Mike Alvis, his psychological examiner and a member of his IPP team and *the author of DC's BTP*, does NOT know if emergency procedures allowed ground restraints, the same emergency procedures HIS BTP authorized. He says he does not think it "allowed for that kind of stuff" but that he is not sure. Mike Alvis, p. 56.
- **Mike Alvis, the Psychological Examiner responsible for authoring DC's Behavioral Treatment Program, does NOT know what the emergency procedures are that his own Behavioral Treatment Plan authorizes staff to use on DC.** Mike Alvis, p. 46.
- Alvis authored DC's Behavior Treatment Program. Mike Alvis, p. 43, 47.
- Alvis admits the BTP he authored provides instruction to staff on what they can and cannot do, specifically that they can use "other Center emergency procedures, if necessary," but he states he has little understanding of what those emergency procedures might be, other than that he is aware that mechanical and chemical restraints are sometimes used. He apparently has not knowledge about any personal holds that could be used in emergency situations. Mike Alvis, p. 47.
- He confirms the entirely of his knowledge with regards to emergency procedures is that mechanical and chemical restraints are used. Mike Alvis, p. 48.
- Mike Alvis testified he had little to no knowledge of what physical restraints could be used on DC, despite being author of his BTP. Mike Alvis, p. 58.

- Physician and diet orders take precedence over any possible need to employ emergency restraints – "take precedence over any possible need to employ Category I procedures or other Center Emergency Procedures." Mike Alvis, p. 49, 50 (As reflected in the Behavior Treatment Program 8.10.18 made an exhibit to his deposition).
- "Therapeutic interventions," as referenced in the Behavior Treatment Program 8.10.18 authored by Alvis, refers to Category I procedures or other Center Emergency Procedures. Mike Alvis, p. 49. [This language also contained in the Addendum to BTP 2016. Mike Alvis, p. 51.]
- Alvis believes this order for physician orders to take precedence over behavioral interventions is standard for most clients. Mike Alvis, p. 51.
- Medical issues take precedence over behavior issues. Mike Alvis, p. 52. This is so even in emergency situations, given the language of the order. Mike Alvis, p. 49, 50.
- Mike Alvis testified that [redacted] could NEVER be ignored because of need to restrain over minor physical aggression. Mike Alvis, p. 57.
- Alvis does not think counseling would have helped DC because he would not have been able to retain any of it. "Because the level of retention that people have with the -- their disability, it -- the -- I mean, they could sit there and tell you things and act like they understand it, but then they really don't understand it. Because just minutes later they go back and, you know, say I -- you know, so and so did this to me. I – you know . . ." Mike Alvis, p. 55.
- Facility was always running short-staffed. Mike Alvis, p. 60.
- Understaffing probably more of a burden for direct care staff. Mike Alvis, p. 61.

Jennifer Berry – Deposition Summary

- Jennifer Berry serves as the Assistant Superintendent at BHDC. Jennifer Berry, p. 6. She has worked in that position since March of 2020. Jennifer Berry, p. 7.
- BHDC owed a duty to keep DC reasonably safe. Jennifer Berry, p. 117.
- His IPP reflects that he seems to display aggression when [redacted]. Jennifer Berry, p. 58.
- Jennifer Berry was not personally present and did not witness any of the incidents described in the Behavior Incident Reports that Rich Rosen took her through in direct examination. Jennifer Berry, p. 129.
- She does not recall every speaking to the staff members involved in DC's incidents; she did not speak to the staff members involved in any of the incident Rich asked her about. Jennifer Berry, p. 130.
- **Exhibit 4A to Jennifer Berry's deposition, a photograph of the chairs outside of the bathroom, proves that if Tyler Mattson with within 6 or 7 feet of DC then Mattson was nowhere near the ledge.** Jennifer Berry, p. 39, 45 – Exhibit 4A.
- **If Mattson was 7 feet from those chairs, it means he was a greater distance than that from the ledge. The bathrooms are at the end of the hallway, all the way in the back, furthest from the ledge.** Jennifer Berry, p. 47 – Exhibit 4G.
- The facility cannot use any type of force that it wants on the clients. Jennifer Berry, p. 116.
- The facility must comply with ICF policies, with DDS policies, and with its own policies. Jennifer Berry, p. 116.
- Mark Hise is one of two Staff Development Coordinators at BHDC. He has been with the facility for 27 years. He worked as a program coordinator (QIPD) for thirteen years before moving to staff development in 2016. Jennifer Berry, p. 123, 124.
- Hise is responsible for training staff on the use of NCI and personal holds at BHDC. Jennifer Berry, p. 124.
- He [Hise] has done this since 2016 and he still does this now. He is NCI certified. Jennifer Berry, p. 124.
- Hise is BHDC's expert in the use of personal restraints. Jennifer Berry, p. 127.
- He [Hise] is the NCI expert for the BHDC facility. Jennifer Berry, p. 128.

- "He [Hise] has a great a sense of knowledge of what to do in terms of personal holds and NCI at our facility, based on the training he received from the experts at CPI." Jennifer Berry, p. 128.
- The portion of DC's IPP that mentions TACT procedures is supposed to say NCI. They don't use TACT; they use NCI. Jennifer Berry, p. 61.
- "A personal hold [personal restraint] is where an employee has their hands on the individual to calm them." Jennifer Berry, p. 107.
- The facility cannot use any type of force that it wants on the clients. Jennifer Berry, p. 116.
- Every single time a personal restraint is used on a client at BHDC it means there was an emergency situation; it means that they are labeling as an emergency whatever the event was the preceded the use of personal restraint. Jennifer Berry, p. 131.
- Every time hands are laid on a client it means there must have been an emergency. Jennifer Berry, p. 132.
- On **12/18/19**, they physically restrained DC for two minutes because he threw a Christmas ornament that almost hit someone. Jennifer Berry, p. 72.
- Nowhere in BHDC First Aid Guidelines – Policy IV-B-10 – Version 12/29/17 does it say that nonmedical staff have the option to call 911. Jennifer Berry, p. 133. There is no other written policy that says this either. Jennifer Berry, p. 134.
- Berry testified they preferred staff call medical because ambulances could take a while. Jennifer Berry, p. 134.
- Berry does not know why so many current and former staff members testified that they were forbidden from calling 911. She has no answer for this. Jennifer Berry, p. 136. She then concedes these staff must have interpreted the policy to be this. Jennifer Berry, p. 136.
- The version of Physician Orders with two pages is the legitimate one. Jennifer Berry, p. 145.
- Jennifer Berry testified that DC was required to remain upright for one hour after eating. Jennifer Berry, p. 151.
- Ambulances typically arrive within 15 minutes. Jennifer Berry, p. 104.
- The OLTC investigation was done before the depositions in this case. The OLTC investigator would not have had the benefit of seeing Mark Hise's or Sandy Evans' testimony or any of the other testimony from this case. Jennifer Berry, p. 119, 120.

- It [the OLTC Investigation] was conducted by a single OLTC surveyor [Dian Elliot]. Jennifer Berry, p. 121.
- Jennifer Berry, Assistant Superintendent, testified that BHDC utilizes two levels of investigation for suspected adult maltreatment: maltreatment investigations, which are full-fledged investigations and then administrative reviews, which are less than full-fledged investigations. Jennifer Berry, p. 109.
- Jennifer Berry testified that, for McCutcheon's allegation of maltreatment against Tyler Mattson, only an administrative review was done. Jennifer Berry, p. 109.
    - Then she catches herself and tries to say that administrative reviews are full-fledged investigations. Jennifer Berry, p. 110.
    - When asked to explain the difference between the two, she states that full-fledged maltreatment investigations involve reporting the allegation of maltreatment [presumably to DDS and OLTC]. Jennifer Berry, p. 110.
- **Even though she herself had served as a maltreatment investigator at BHDC and even though she is second in charge at BHDC, she could not say what the standard was for determining what gets reported for suspected maltreatment and what stays in-house as an administrative review.** Jennifer Berry, p. 110.
- She [Christine McAuliffe], along with her mother, directly participated in the development of Davie's IPP. Jennifer Berry, p. 57.
- Chrissy attended and participated even though she was not his guardian and not a member of his IDT. Jennifer Berry, p. 68.

Dr. Ricki Brown – Deposition Summary

- Dr. Ricki Brown is a board-certified emergency physician. Dr. Brown, p. 5.
- DC [redacted]. Dr. Brown, p. 12.
- *So, when someone is struggling in this scenario that's been described by all the participants, someone who is struggling has what's called a fight or flight response, meaning they're -- have adrenaline surges and they are fight -- essentially fighting for their life. Their muscles constrict to fend off what they feel is an attack. They -- so their muscles constrict, their breathing increases, (interference) set of physiological (interference) leads to increased (interference) pressure which is the pressure in your chest. And it also constricts the abdomen which increases the intra-abdominal pressure. Both of these are cavities in the body where the stomach is. The inferior or superior aspect on top of the stomach is the diaphragm in the chest above that, and just below it, the abdomen. And increased pressure on both of these does place increased pressure on the stomach and from the sides. Obviously, there's a definitive end to the body and how far it can stretch. And also his left side being on the floor is another definitive mechanical block as to where it can expand. So, if you think of the stomach as a cube, it's having pressure from all different angles for – because of the struggle and the position and the increased pressures. And it caused him to vomit. Additionally, he had an additional risk which is* [redacted]. Dr. Brown, p. 13, 14.
- ***Q**. Okay. So if I'm hearing you correctly, Dr. Brown, and in my very nonmedical layman's terms, intense struggle that produces a fight or flight reflex and adrenaline can, is itself, increases the likelihood of triggering vomiting; is that correct?*
  ***A**. In this scenario, it would, yes, due to gravity.*
  ***Q**. And being on his left side increased the likelihood that the pressure, intrathoracic pressure and gravity, would --*
  ***A**. Yeah.*
  ***Q**. -- trigger vomiting?*

A. *Yeah. Unfortunately, the stomach -- and the stomach's on the left. So it means everything in the body and all the pressures above him were pressing down onto the stomach; which was butting up against the ground, essentially.*
Q. *Okay. And the fact that he had -- if I'm hearing you correctly, the fact that he had* [redacted]
A. *Correct.* Dr. Brown, p. 14, 15.

- ***Q.*** *And do you have any opinion as to after he began vomiting while he was on his left side, do you have any opinion or does what happened next, what staff did next, play into your opinion at all?*
A. *Yes. So,* [redacted] Dr. Brown, p. 15, 16.
- Immediately placing him on his back after he began vomiting was essentially the worst thing staff could have done. Dr. Brown, p. 16.
- ***A.*** *So Mr. Cains was on the floor being restrained by three people in three different locations of his body. There was a struggle, fight or flight, patient just struggling, adrenaline pumping, causing a lot of constriction of muscles and things of that nature. If you think -- in simpler terms, if you think of the stomach as a water balloon, essentially, it had pressure coming from every single direction; and the water balloon, eventually the tie at the top, broke. That would be the lower esophageal I was talking about. The tie at the top broke and all the water was released and, unfortunately, the water was a solid substance and it then --*
Q. *And his balloon tie is weaker than most because of his* [redacted] *correct?*
A. *Correct. Yeah, so balloon, weaker tie, breaking, everything coming up. Those are solid substances. He was on his left.* [redacted] Dr. Brown, p. 27,28,29.
- *Without any intervention, someone who suffocates will likely die within five minutes. If there is a resuscitation, meaning the CPR that was immediately started for him, that leads into a resuscitation time. Our research, and it's plentiful in emergency medicine, shows that a resuscitation past 20 minutes drastically drops the possibility of a meaningful outcome; meaning not only that we can revive the body but also the brain.*

So, yes, it is very unfortunate. Those eight minutes, honestly, in my opinion, I think that it could have had a very large impact. Dr. Brown, p. 21.

- *It did take the paramedics 13 minutes to get there. And review of Samuel's deposition discusses the fact that* [redacted] *to Mr. Cains may have drastically changed his outcome.* Dr. Brown, p. 21, 22.
- *Furthermore, they were doing CPR already and getting them with a paramedic who is very well trained in what we call ACLs which is the emergency resuscitation of someone in cardiac arrest. They're very well trained. They have all of the medications and the tools needed to do so. They would have been able to do much more sophisticated resuscitation.* Dr. Brown, p. 22.
- ***A.** Many different ways that could have helped. I can't say for sure if it would have changed whether he died or not, but I can definitely tell you that there would have been a much better chance had it been done earlier.*
  ***Q.** Okay. And am I correct that a paramedic such as Mr.Scow, the training and the equipment that they brought to the scene, is much greater than what your typical LPN would be able to provide?*
  ***A.** Oh, absolutely. An LPN is the -- one of the very lowest medical certifications in regards in the nursing world it -- as the lower end. And, even an RN, which is above an LPN, would not have been able to have the tools or administer the type of treatments or procedures that a paramedic can. They're very highly trained. So they -- they have quite a few tools at their disposal and knowledge to use them.* Dr. Brown, p. 23.
- It was still wrong to put DC on his back even if he had already stopped breathing. Dr. Brown, p. 62,63.
- Back strikes, with the patient leaned over a chair if they are unable to stand or over your knee, is correct protocol. Dr. Brown, p. 62.
- Abdominal thrusts are not the correct approach to a choking patient. Dr. Brown, p. 64.
- *The teaching is quite clear that laying someone on their back occludes their airway and it is never the teaching to lay them on their back -- unless you happen to have a device that can then remove things from the airway.* Dr. Brown, p. 63.
- Make gravity work for you, not against you. "If you put them on the back, the food falls into the back of the oropharynx and blocks the trachea. If you put them over

your knees and have a space in between and strike on the back, you're trying to dislodge something and also give it space to move from the oropharynx." Abdominal thrusts would only dislodge it and cause it to fall right back into the oropharynx. Dr. Brown, p. 64, 65.

- There were multiple avenues of pressure that could have caused the stomach to erupt in vomit. Dr. Brown, p. 69.
- Regurgitation of food is a symptom [redacted] because of weakened esophageal sphincter. Dr. Brown, p. 72.
- "The only point of the [redacted] that it had a weakened sphincter and that is why he was more of a risk of vomiting." Dr. Brown, p. 73.
- A struggle often induces vomiting; being restrained is likely an intense struggle. Dr. Brown, p. 75, 76.
- However minimal Mattson's physical pressure was, if he was restraining him, there was at least some level of pressure coming from his arm. Dr. Brown, p. 105.
- ***A.*** *So, when someone chokes and their airway is closed off, obviously, they can no longer receive oxygen or expel CO2. This quickly induces kind of what we would call a terror fight or flight response, similar to a drowning victim. They start fighting with everything they can. Unfortunately, as the airway is blocked, CO2 which is -- turns into a toxic substance, which is an acid, builds up in their body, their muscles fighting against and are unable to expel the lactic acid they build up. So, essentially, you're not only suffocating, but it's a feeling of burning. Your lungs begin burning, your whole body, because of the acid build up. And the struggle -- and eventually you become unconscious and -- and your body continues to struggle until it no longer can.*
  Q. *Is it a painful death?*
  A. It's probably the -- one of the most painful deaths there could be. That and I assume burning to death. Dr. Brown, p. 19.

Ryann Campos – Deposition Summary

- Ryann Campos worked at BHDC as an RCA [Residential Care Assistant] for her first six months and was promoted to and worked as an RCT [Residential Care Technician]. Ryann Campos, p. 10. She worked there until 2020 when she resigned over bedbugs. Ryann Campos, p. 8.
- No knowledge of DC ever causing injury to another person. Ryann Campos, p. 49.
- Never seen DC cause injury to another person. Ryann Campos, p. 49.
- DC was never once aggressive or violent with Campos; Campos never once saw DC being aggressive or violent towards anyone ever; she has no knowledge of him ever injuring another person; she only ever heard good things about DC. Ryann Campos, p. 49.
- DC was a wonderful guy, a wonderful person, and fun to be around. Ryann Campos, p. 65.
- DC never struck any of the three during the incident, never made contact with hands or feet. Ryann Campos, p. 56, 59, 63, 64.
- DC did not hit or kick or spit at Campos. Ryann Campos, p. 30.
- Campos never saw DC hit Tyler, Amy, or herself, never saw him make contact with hands or feet. Ryann Campos, p. 56, 59, 63, 64.
- **The restraint used on DC was *not* the least restrictive option available.** Ryann Campos, p. 80, 81.
- **What Tyler, Amy, and Ryann did was not the least restrictive option under the circumstances.** Ryann Campos, p. 80, 81.
- DC did not hit, kick, or spit at Campos, did not make contact with her. Ryann Campos, p. 30.
- Campos says she held his legs for two minutes before realizing he was choking on his vomit. Ryann Campos, p. 30.
- Amy Jones and Ryann Campos did not witness nor does either have any knowledge of Tyler Mattson attempting nonphysical interventions prior to using physical force. Ryann Campos, p. 44.
- Mattson and Jones were holding DC pinned to the ground when Campos arrived. Ryann Campos, p. 24.

- There was no mechanical restraint present, no papoose or joey board; they were not transitioning DC to mechanicals or even considering it; not once was it mentioned. Ryann Campos, p. 29, 40.
- DC did not hit or kick or spit at Campos. Ryann Campos, p. 30.
- Campos held his legs for about TWO MINUTES before they realized he was choking; the three of them restrained him on the ground for two minutes after Campos arrived. Ryann Campos, p. 30.
- Nobody asked Campos to grab his legs. Ryann Campos, p. 36.
- Campos says they were taught to respond to a client swinging at them by calling for assistance, stepping out of the way, redirecting, backing up and giving client chance to calm down, separation; taught to do everything possible to avoid laying hands on them. Ryann Campos, p. 42, 43, 78.
- Campos has no knowledge of anything that happened prior to her arriving on scene. Ryann Campos, p. 44.
- Campos never saw DC hit Tyler, Amy, or herself, never saw him make contact with hands or feet. Ryann Campos, p. 56, 59, 63, 64.
- Campos stands by her written OLTC written statement, which states that Jones was holding DC by the head. Ryann Campos, p. 59.
- Campos agrees the following is a good question: Why not just let him up and give him some space to calm down on his own so they don't have to restrict him so severely? She cannot say that would not have worked. Ryann Campos, p. 79.
- **Campos says they could have handled the situation better: "I'm sure there is [sic] multiple ways that we could have did [sic] something better than what we did or how we did it."** Ryann Campos, p. 80. **Campos says what she means by "better ways" is in fact "less restrictive ways."** Ryann Campos, p. 81.
- They did not use the least restrictive method. Ryann Campos, p. 80, 81.
- An on-the-ground personal hold is not an approved NCI method; that should *not* be done. Ryann Campos, p. 29.
- Campos was trained in restraint use by Mark Hise. Ryann Campos, p. 25.
- Tyler Mattson testified that, for severely aggressive clients, they would put them on the ground as "a control mechanism." Used for transitioning to the papoose board but also used frequently without purpose of transitioning to mechanical restraint. Ryann Campos, p. 39.

- Mattson says he was taught to restrain clients on the floor, that he could do so for up to 15 minutes. Tyler Mattson, p. 53, 54. Campos says something very similar. Ryann Campos, p. 39.
- Campos cannot recall her training and is not sure whether she was allowed to restrain clients on the ground. Ryann Campos, p. 28. Later, Campos claims she was trained to restrain clients on the ground like they did with DC. Ryann Campos, p. 39.
- She saw other clients restrained on the ground like this, and not for purposes of transitioning to mechanicals. It was common. Ryann Campos, p. 51, 52, 53.
- Campos claims they were specifically taught them to do what they did, hold clients down for even 6-7 minutes on the ground until they calm down. Ryann Campos, p. 54, 55.
- Campos was aware DC was [redacted] DC was a wonderful guy, a wonderful person, and fun to be around. Ryann Campos, p. 66, 67.
- Campos stands by her written OLTC written statement, which states that Jones was holding DC by the head. Ryann Campos, p. 59.
- Campos testified [redacted], but that she joined the restraint and grabbed his legs anyways. Ryann Campos, p. 21, 22, 23. Campos changes her story yet again later in the deposition, saying [redacted] during the two minutes she held his legs. Ryann Campos, p. 30.
- Campos held his legs for about TWO MINUTES before they realized he was choking; the three of them restrained him on the ground for two minutes after Campos arrived. Ryann Campos, p. 30.
- DC was on his left side while they pinned him. Ryann Campos, p. 32.
- Campos' first indication that something was wrong was DC defecating. Ryann Campos, p. 36.
- **It took two to three minutes for nursing staff to get to the scene, because "Judge Hill is kind of a ways down the hill," and you would have to run to make it in two to three minutes.** Ryann Campos, p. 45.
- **They did not call 911 or for an ambulance/paramedics for 5 to 6 minutes after medical arrived at the scene.** Ryann Campos, p. 46. **The nurses waited five or six minutes after arriving on the scene to call 911**. Ryann Campos, p. 46.
- Sandy Evans was physically in the room with Mattson, Jones, and Campos while they completed their witness statements, literally looking over their shoulders and stopping

them every couple sentences in order to help them complete it correctly. Ryann Campos, p. 18.

- Campos says Sandy NEVER questioned her. Just had her fill out a witness statement and turn it in, like Mattson described as well. She never talked about the incident with Sandy. Ryann Campos, p. 18,19,20, 60.
- Staff were warned not to talk about the incident to anyone. Ryann Campos, p. 33.
- DC was a wonderful guy, a wonderful person, and fun to be around. Ryann Campos, p. 65.
- Davidson house, where DC lived, was infested with bed bugs. It was such a problem that Ryann Campos quit her job over it, after brining it home with her. Ryann Campos, p. 8, 9. Gonyea was aware, everyone was aware; facility did not do enough to get rid of the bed bugs. She saw them crawling on clients as they slept. Ryann Campos, p. 12, 13.
- Campos expelled from college for "drinking and partying too much" shortly before starting at BHDC. Ryann Campos, p. 27.
- Campos says he would have choked to death anyways even if he'd never been taken to the ground, even if he'd never been restrained and was standing perfectly upright. Ryann Campos, p. 33.
- **Campos was worried she would go to prison when it happened.** Ryann Campos, p. 62, 64.
- Nurses did CPR when they arrived. She never claims that they did it before that. Ryann Campos, p. 40

Don Carter – Deposition Summary

- Don Carter's job was literally to drive from building-to-building [at BHDC] pickup up recycling, which he did for four and a half years. Don Carter, p. 6.
- DC never injured me, never injured anyone that I know of. Don Carter, p. 8.
- Never seen DC cause injury to another person. Don Carter, p. 8.
- DC was not dangerous. DC was not capable of intentionally harming a grown man. He might kick chair or table which could potentially hurt Don Carter, p. 15.
- Otherwise, DC was not physically capable of causing actual harm to a grown man. Don Carter, p. 16.
- Don knows of no time DC ever caused harm to another person. Don Carter, p. 16.
- Don was around DC for up to 30 minutes just about every day, in the Stone Building where DC worked; Don knows him pretty well. Don Carter, p. 21.
- Don Carter helped Rhonda Harris restrain DC on the ground once in approximately 2019. DC had just come back from lunch. Rhonda Harris took DC to the ground and then Don held DC's legs to keep him from kicking while Rhonda restrained him on the ground by his shoulders until he calmed down. This was in response to DC becoming agitated and kicking at desks and maybe chairs, but he did not try to kick or hit another person, but "not to attack a person." They restrained him like this on the ground for five to ten minutes. Don Carter, p. 9, 10, 11, 12.
- Ground restraints were the common way to restrain DC in an extreme situation; Don Carter is saying the desk-kicking incident *was* an extreme situation. Don Carter, p. 12.
- Don Carter personally witnessed clients being restrained on the ground in this same way "at least" 20 to 30 times. Don Carter, p. 13.
- No staff were ever reprimanded for it; he understood it to be proper restraint procedure. Don Carter, p. 14.
- He worked there four and a half years. Ground restraints were a common occurrence. Don Carter, p. 15.
- Don Carter thinks he personally witnessed DC taken to the ground and restrained twice, including the one he participated in. Don Carter, p. 15.
- Don Carter says this was the policy: "We were told we're not – staff members were not allowed to call 911." Don Carter, p. 22, 23.

- ***Q.*** *And so you're saying the policy was, no matter what, no matter what, you were told that you cannot call 9-1-1 unless you're a member of the medical staff?*
  A. *That is correct.*
  Q. *And there were no exceptions?*
  A. *No exceptions.* Don Carter, p. 23.

- ***Q.*** *Do you have any idea why that was the rule?*
  A. *Yes. It was to control a situation. To be blunt with you, BHDC administration wanted to present their narrative in the documentation in an event like an emergency.*
  Q. *What do you mean?*
  A. *They wanted total control of what was – would appear in the documentation. Any emergency event would have been documented. And they just presented an attitude where they wanted complete control.*
  Q. *Do you know why that was so important to them?*
  A. *It was just - they had had problems in the past where things leaked out that was not in their interest.* Don Carter, p. 24, 25.

- Don Carter says deaths and injuries to clients prior to DC's death caused problems for BHDC, so it was important they control the narrative in these situations where possible. Don Carter, p. 25.

- ***A.*** *The -- from my experience, the administration were what I would call control freaks. They -- if something was out of their control, it made them uneasy. They had to -- they had to be in control.*
  Q. *Are you suggesting they would cover things up if they had to?*
  A. *I wouldn't go that far. But I would say they would paint a picture that would show them in the best light.* Don Carter, p. 26.

- He is familiar with where the nurses congregate in Judge Hill. He is familiar with the layout of the entire facility. It would NOT have been possible for the nurses to get to DC in Commons in less than five minutes. Don Carter, p. 38.

- Even on a Saturday, it would have taken the nurses at Judge Hill a minimum of five minutes to reach Davie in Commons; it would have taken him five minutes "even in a hurry." Don Carter, p. 35, 36.

- ***Q.*** *And you're saying it is simply not possible for these nurses to have taken this call in the Judge Hill building, grab their stuff, hop into a car, driven over to the Commons building, and gone inside in less than five minutes?*
  A. *That is correct.* Don Carter, p. 38.

- ***A.*** *Well, the parking areas are very cramped. By the time a person would get in their car, navigate the narrow parking area -- this is a 1940s design. And the parking areas are -- the driveways are narrow. To back out of a parking area, to navigate, and to arrive at that location, a minimum of five minutes.*
  Q. *Even on a Saturday?*
  A. *Yes.* Don Carter, p. 35.

- ***A.*** *Let me just say this. I have -- I have picked up recycle at all the offices. So, I am very familiar with the layout of all the offices.*
  Q. *Okay. So, you've driven from the Judge Hill building to the Commons building many times?*
  A. *Yes.*
  Q. *You've picked up recycling, your job was to literally pick up recycling and go from building to building?*
  A. *Yes.*
  Q. *And you're saying it is simply not possible for these nurses to have taken this call in the Judge Hill building, grab their stuff, hop into a car, driven over to the Commons building, and gone inside in less than five minutes?*
  A. *That is correct.* Don Carter, p. 38.

- ***Q.*** *Okay. Would you say it's more likely even longer than five minutes?*
  A. *Could very possibly be. But, again, under optimal conditions, it would take five minutes.*
  Q. *And, one more time, in as much detail as you can, tell me why that is.*
  A. *Several factors, as I've mentioned. Narrow driveways dating back to the '40s, possibly other cars parked along the -- those passageways which probably was not the case on a weekend. But it's just a -- it's kind of like a rat maze going from one building to another.*
  Q. *Okay. So it's not a straight shot across a flat parking lot?*
  A. *No. It's a 1940s design for smaller cars.*
  Q. *Okay.*
  A. *It's just not of modern standards.* Don Carter, p. 39.

- Don Carter estimates a distance of a quarter mile between Judge Hill and Commons, *but it would be further if you were driving.* Don Carter, p. 40.

- ***Q.*** *Do you think it would be as much of a hassle if their car was not in a parking spot, where it was instead parked on the curb?*
  A. *There are very few parking spots. Most likely, the car would have been parked on the curb.*
  Q. *Okay. Would there still have been as much of a hassle?*
  A. *Yes.*
  Q. *And why is that?*
  A. *The parking area is very small behind the Judge Hill nursing area, so it -- there's only like two parking spots. So most of the nurses park along a curb.* Don Carter, p. 41.

- The nurses would never park in front of the front door of Judge Hill on the curb. They park on the curb behind Judge Hill. Don Carter, p. 41.
- ***Q.*** *And what if they were parked in front of the front door?*
  A. *Excuse me?*
  Q. *And if they were parked in front of the front door on the curb?*
  A. *The nurses never park -- even on a weekend, the nurses -- to the best of my nurse -- the best of my knowledge, the nurses would not park in front of the front door. The front door would be in front of a living area. And the bus runs. And, because of the narrow restrictions, you do not park in front of Judge Hill. So the nurses would have parked in the back.* Don Carter, p. 41, 42.

Sandy Evans – Deposition Summary

- Sandy Evans worked at BHDC for 36 years and retired in May 2021 Sandy Evans, p. 5. She worked at BHDC as an instructor, QMRP, a team leader, a maltreatment investigator, before retiring as Residential Services Director Sandy Evans, p. 6.
- In emergency situations where an unanticipated behavior requires immediate protection of the client or others, **the physical restraint technique chosen must be the least restrictive <u>appropriate</u> technique possible**. Sandy Evans, p. 27.
- Physical restraint may be used as an emergency measure but only if *absolutely* necessary to protect client or others from injury. Sandy Evans, p. 30.
- Physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which the client has not exhibited before, exhibiting behaviors not identified in the functional analysis of that client's behavior, or the client **IS** harming other people or themselves. Sandy Evans, p. 30
- The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. Sandy Evans, p. 31.
- A client must be released from a physical restraint as quickly as possible, meaning as soon as the client is no longer a danger to self or others. Sandy Evans, p. 32.
- Restraints must be designed and used so as not to cause physical injury to the client. Sandy Evans, p. 32.
- An individual's actions that are aggressive, disruptive, and/or present a danger to the individual or others, must be managed with the least restrictive method. Sandy Evans, p. 34.
- Only the least restrictive method in any given situation can be used at BHDC. Sandy Evans, p. 34.
- BHDC defines Emergency Restraint as use of the least restrictive procedure and for the least time necessary to control ***severely aggressive*** or destructive behaviors. The use of **emergency restraint will comply with all relevant standards and regulations**. Sandy Evans, p. 38.
- **The restraint used on DC was *not* the least restrictive option available.** Sandy Evans, pgs. 47, 48, 50.
- **What Tyler, Amy, and Ryann did was not the least restrictive option under the circumstances**. Sandy Evans, p. 50.

- Tyler and the other two could have used a less restrictive method. Sandy Evans, pgs. 47, 48.
- They never gave DC a chance to calm down and collect himself on the ground, which would have been a less restrictive method. Sandy Evans, pgs. 47, 48.
- Personal restraint policy comes from Staff Development. Sandy Evans, Residential Services Director, testified that Staff Development was responsible for teaching direct care staff the rules regarding physical restraints, not her (Hise is the expert, meaning anything Mark Hise says is going to be accurate). Sandy Evans, p. 20.
- Federal Regulation states that all interventions for the management of inappropriate client behaviors which are approved for use in the facility **must be clearly stated and described in its policy**. Any type of intervention that is to be used to manage client behavior must be clearly explained and stated in the facility's policy. Sandy Evans, p. 24.
- **BHDC is required to specify, within a client's IPP, the use of approved physical restraints that can be used.** Any physical restraint that could potentially be used on a client must be clearly stated in the client's IPP. Sandy Evans, p. 29, 35.
- Approved Personal (Physical) Restraint use at BHDC includes only "an emergency procedure limiting movement by the holding of a hand or limb." Sandy Evans, p. 40.
- There is no other definition or policy for approved methods of Personal (Physical) Restraint to be used at BHDC other than "an emergency procedure limiting movement by the holding of a hand or limb." Sandy Evans, p. 40, 41.
- There is no policy or document that allows for ground restraint or the restraint used on DC. Sandy Evans, p. 41,42.
- The facility must not issue orders for restraint on a standing or as-needed basis. This is forbidden. Sandy Evans, p. 31.
- Sandy Evans testified that every personal restraint can be different. Sandy Evans, p. 42
- Sandy Evans believes that NCI teaches the ground restraint used on DC. Sandy Evans, p. 47.
- Sandy Evans believes that it is okay for staff to ignore physician orders when a client is being aggressive. Sandy Evans, p. 56.
- Sandy Evans acknowledges the policy was that only medical staff could call 911. She assumes medical came up with it. Staff *may* have complained to her about it. Sandy Evans, p. 52, 53.
- DC was [redacted]. Sandy Evans, p. 54.

- The staff who restrained DC were required to take this into consideration. Sandy Evans, p. 54.
- These three staff did not keep him upright; they held him on the ground. Sandy Evans, p. 55.
- Physician orders are to take precedence over behavioral interventions. Sandy Evans, p. 58.
- The three staff *could* have given the [redacted] consideration. Sandy Evans, p. 58.
- Sandy Evans' job, as Residential Services Director, was to oversee the direct care of the clients and oversee the direct care staff. Sandy Evans, p. 19.
- Sandy Evans reported directly to Superintendent Gonyea. Sandy Evans, p. 19.
- Sandy Evans had the power to control how staff treated clients. Sandy Evans, p. 20.
- Sandy's testimony reveals that she is not even aware that unnecessary restraint is a form of physical abuse, i.e., maltreatment. Sandy Evans, p. 49.
- Sandy Evans believes that using a more restrictive method than necessary is only a violation of policy, not maltreatment. Sandy Evans, p. 49.
- Jeff Gonyea personally asked her to investigate her subordinates, assigned her the job at 12:13pm the day DC died. Sandy Evans, p. 59, 60.
- Gonyea reviewed her findings; he did not question them. Sandy Evans, p. 61, 62.
- Sandy Evans completed the Maltreatment Investigation June 17, 2020, four days after DC died, and submitted it to Gonyea. Sandy Evans, p. 62.
- Gonyea used Evans' Maltreatment Investigation to create his own report (the DHS Incident Report presumably), then sent his report, Sandy's report, and the witness statements to DDS. Sandy Evans, p. 63.
- Sandy's Maltreatment Investigation consisted of interviews with nine staff members, all of them conducted on the day of DC's death. Nine interviews in a single afternoon – that was pretty much the investigation. Sandy Evans, p. 63.
- Sandy says Tyler's version of her investigation is a lie. Sandy Evans, p. 73.
- Sandy's interview method is laughable. Strongly suggests she's coaching witnesses. Sandy Evans, p. 74.
- Sandy admits that she essentially helped them write their witness statements. Sandy Evans, p. 74, 75.
- Sandy Evans was physically in the room with Mattson, Jones, and Campos while they completed their witness statements, literally looking over their shoulders and stopping

them every couple sentences in order to help them complete it correctly. Sandy Evans, p. 74,75, 80, 81.

- Sandy Evans then used these same witness statements to find there was no maltreatment. Sandy Evans, p. 81.
- Sandy Evans investigated her subordinates who were under her supervision in the department she was in charge of. Sandy Evans, p. 87.
- The three staff would have been terminated on the spot had Sandy substantiated maltreatment. Sandy Evans, p. 88.
- Sandy Evans testified she doesn't recall if she'd investigated him [Tyler Mattson] for maltreatment before. Sandy Evans, p. 15.
- Later, Sandy still says she doesn't recall investigating Tyler previously, but now she says it *may be* in her files. Sandy Evans, p. 66.
- She *might* have been the one who investigated Tyler previously for the McCutcheon allegations, but she "cannot say with certainty" that she recalls. Sandy Evans, p. 67.
- Sandy Evans **does not have a favorable opinion** of Tyler Mattson; she will only say she has a "neutral" opinion. Sandy Evans, p. 68.
- Sandy Evans testified the Superintendent's office keeps records that would show if Evans investigated Tyler before. Sandy Evans, p. 18.

Dr. Syed Hamid – Deposition Summary

- Dr. Hamid is the medical physician at BHDC and has worked there since 2007. Dr Hamid, p. 6.
- Dr. Hamid, facility physician, did not approve the use of ground restraints for DC. Dr. Hamid, p. 77.
- Dr. Hamid agrees that ground restraints, for any purpose other than transitioning to mechanicals, is not allowed. Dr. Hamid, p. 78.
- More likely to choke on vomit if on the ground. Dr. Hamid, p. 44.
- The kind of "extreme agitation" that DC was under while being restrained on the ground can trigger a heart attack, can trigger a stroke, can trigger a lot of things, **including vomiting**. Dr. Hamid, p. 42, 62.
- Vomiting can be brought on by extreme agitation. Dr. Hamid, p. 62.
- Dr. Hamid acknowledges the possibility that the physical restraint or taking him to ground caused the vomiting. Dr. Hamid, p. 61.

Rhonda Harris – Deposition Summary

- Rhonda Harris worked there [at BDHC] ten years and had DC every afternoon for 5 or 6 years for his vocation. Rhonda Harris, p. 6. She was a prevocational trainer in the Stone building. She oversaw the clients tearing books for recycling morning and afternoon; DC came to her in the afternoon every day for his vocation. Rhonda Harris, p. 5, 19.
- Rhonda Harris was around DC every afternoon for 5 or 6 years. Rhonda Harris, p. 6.
- Rhonda Harris and Don Carter took DC to the ground and restrained him for about 5 minutes after he threw a chair that did not hit anyone. Rhonda Harris, p. 7, 8.
- Rhonda Harris says DC was at risk for sudden vomiting, so she was always careful to put him facedown when restraining him on the ground. Rhonda Harris, p. 9.
- They would take him to the ground for restraints, whether he initiated it or not. Rhonda Harris, p. 11.
- Ground restraint worked best for DC, particularly face down. Rhonda Harris, p. 12.
- Everyone that worked there knew DC had medical issues that caused him to vomit suddenly at times and knew to keep him facedown when restraining him on the ground. Rhonda Harris, p. 10.
- ***Q.*** *And that's specifically because he was a* [redacted]*?*
  A. *Yes. He had medical issues going on. I still to this day don't know if the nurses ever found out what exactly was wrong with him, but everybody that worked around him knew that, you know, so you always – we always -- where I worked, you know, we had the understanding, you know,* [redacted] Rhonda Harris, p. 10.
- DC was not vomiting intentionally. Rhonda Harris, p. 10, 11.
- ***Q.*** *So everybody that was accustomed to David or had been around David and knew David was aware that there was a risk of him vomiting?*
  A. *Yes.*
  Q. *I think you said at first, you know, you couldn't tell if he was doing this on purpose.*
  A. *Yeah, purposefully or not, but, you know, as time went on, you know, and it*

continued -- and I'm telling you it was months, you know, of this, that he was doing this. [redacted]

Q. [redacted]

A. [redacted] Rhonda Harris, p. 10, 11.

- DC w[redacted] and the nurses were not helping when they'd call. **It happened right after lunch.** It was not on purpose. The nurses didn't take it seriously. Rhonda Harris, p. 13.
- Cafeteria crowds upset DC; this was known. Rhonda Harris tried for a long time to get them to let him eat lunch in his dorm instead so he wouldn't be so upset when he gets to afternoon vocation. Rhonda Harris, p. 13.
- [redacted]t. Rhonda Harris, p. 14.
- All the direct care staff would have been aware of his [redacted]. Rhonda Harris, p. 14.
- Nurses did not take health concerns seriously – "not at all" seriously; they were quick to accuse patients of faking things. [see DRA Death Report on 2016 Victim.]. Rhonda Harris, p. 15.
- King, Noah, Schmidt, and Nelson were four nurses who possibly didn't take client's medical needs seriously. Rhonda Harris, p. 16.
- Rhonda Harris specifically recalls discussing the [redacted] with Schmidt, King, and Noah, Weinbrenner, and Nelson. Rhonda Harris, p. 16.
- [redacted]e. Rhonda Harris, p. 18.
- "We didn't know he was [redacted] at the time. We originally first thought like maybe he was just doing it purposely, but, I mean, when you go like, you know, several months of this for, you know, almost every day during the week, like no human -- to me, no any human is going to be able to do that, you know. And then we started figuring maybe there was, you know, a little in-depth, you know, situation going on, so we would just, you know -- and his behaviors, you know, got to where they escalated, you know what I mean, where it was more frequent, you know, with him because [redacted]

[redacted] so we just got to where we would, you know, contact the nurses. And they would say it was a behavior." Rhonda Harris, p. 18, 19.

- Eventually they found out DC was [redacted] Rhonda Harris, p. 16.
- The vomiting mainly always happened just after lunch. Rhonda Harris, p. 22.
- Harris recalls the vomiting got [redacted]. Rhonda Harris, p. 22.
- She thinks that's when they figured out [redacted]. Rhonda Harris, p. 23.
- ***Q.*** *Do you feel like there was something that the medical team, the nurses, could have done more to help him with his* [redacted]*? Just based on your --*
  A. *Yeah, they -- yeah, they -- yeah.*
  Q. *What else do you think they could have done?*
  A. [redacted] *You know, we're around him all the time.* Rhonda Harris, p. 23.
- Written warnings were sent out to staff about DC's [redacted]. Rhonda Harris, p. 23, 24.
- She thinks Weinbrenner sent out a memo on DC[redacted] to all staff. Rhonda Harris, p. 24.

Mark Hise – Deposition Summary

- Mark Hise, Staff Development Coordinator who's been with BHDC 27 years, was a program supervisor over direct care staff for 13 years before moving to Staff Development in 2016; he is responsible for training staff on BHDC policies and procedures, including how to use NCI. Mark Hise, p. 8.
- Mark Hise is responsible for teaching staff NCI, **responsible for teaching the use of emergency restraint procedures.** Mark Hise, p. 9.
- I never knew DC to be physically aggressive. I supervised his unit under a previous role at BHDC. He was happy-go-lucky. He would get sad and cry sometimes. Never violent with me, that I can recall. Mark Hise, p. 50, 52.
- No knowledge of DC ever causing injury to another person. Mark Hise, p. 50.
- DC was NOT considered one of the dangerous clients. Mark Hise, p. 52.
- Staff are given specific training on what to do when a client tries to hit them: de-escalation techniques including verbal commands, redirection techniques, removal from situation and several other procedures. Mark Hise, p. 23, 24.
- Staff are specifically taught not to lay hands on the client unless all other measures have been exhausted. Mark Hise, p. 24.
- **If a client swings at a staff member the staff member must attempt verbal control and to redirect client before laying hands on them.** Mark Hise, p. 24.
- Staff are specifically trained to use a **supportive stance and blocking technique** in situations when a client tries to hit. Mark Hise, p. 24, 25. Put your hands up in supportive stance, deflect, step away.
- Staff *absolutely* have to at least try the blocking technique or some other form of de-escalation before laying hands on a client with personal restraint. Mark Hise, p. 25.
- Tyler Mattson must have failed to use the supportive stance in which he was trained; otherwise, he should not have fallen. The supportive stance is designed to communicate respect to the upset client, to show you mean them no harm. The supportive stance, properly used, should have prevented Tyler and DC from ever going to the ground. Mark Hise, p. 28, 29.
- "Supported stance" is the first order of action whenever intervening during a crisis. Mark Hise, p. 29.

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- If they do end up on the ground, staff should get up and get off the ground. Let the client stay on the ground if client wants without touching client. Staff should get up and give the upset client some space in which the client can de-escalate. Mark Hise, p. 29.
- Client attempting to hit staff is not necessarily an emergency. Mark Hise, p. 31.
- The contact Tyler Mattson made with DC after he was already on the ground was unnecessary. Mark Hise, p. 35.
- Restraints are dangerous; ground restraints are dangerous; staff is taught restraints are dangerous to clients. Mark Hise, p. 36.
- Staff are also taught to use a pivot movement when using the blocking technique in supported stance, to use if they cannot move backward. Mark Hise, p. 43.
- Tyler should have been capable of taking a hit from DC's body if DC were charging at him. Mark Hise, p. 45.
- Tyler should have been able to pivot, assuming he's telling the truth about being near the ledge. There was room to sidestep or pivot and maintain his supportive stance and blocking technique. Even if he couldn't pivot or sidestep, Tyler was trained to maintain his supportive stance which should have prevented the need to restrain DC. Mark Hise, p. 54, 55.
- Mark Hise is a certified NCI instructor; he personally teaches staff how to use PR in emergency situations. Mark Hise, p. 12.
- **All personal restraints taught at BHDC are NCI; staff are not allowed to use anything but NCI methods he teaches**. Mark Hise, p. 12, 20.
- The three staff involved would have received the same training Mark Hise teaches, which is only NCI approved methods. Mark Hise, p. 16.
- The *only* time you transition a client to the ground or hold a client on the ground is for the sole purpose of transitioning to a mechanical restraint. Mark Hise, p. 21, 42.
- Staff are NOT taught to hold a client on the ground or restrain a client on the ground. Mark Hise, p. 21, 42.
- "The training that we teach in NCI is a **standing** personal hold and a seated personal hold. There is no on-the-ground personal hold." Mark Hise, p. 22, 42.
- An on-the-ground personal hold is not an approved NCI method; that should *not* be done. Mark Hise, p. 23.
- What the three staff did to DC is definitely not something taught at BHDC; it was in fact against NCI policy. Mark Hise, p. 28, 31, 32, 42.

- It would be "dangerous" to attempt to restrain a client on the ground by yourself. Mark Hise, p. 32.
- Staff has no business holding a client on the ground unless they are transitioning the client to the papoose board. Mark Hise, p. 35, 42.
- Personal or mechanical restraint is to be used only as an emergency measure. Mark Hise, p. 11.
- Staff are given refresher training in NCI only every two years. Mark Hise, p. 20.
- Training files on Mattson and Campos containing their competency ratings were deleted. Mark Hise, p. 18.
- Staff are taught clients' medical conditions can make personal restraints particularly dangerous; this is "covered pretty intensely" in phase training. Mark Hise, p. 40.
- Mattson and the others were specifically trained to be aware that things lik[redacted] can make personal restraints deadly; choking, in particular, is a big risk at BHDC; choking is a high priority. Mark Hise, p. 40.
- Mark Hise was not questioned or consulted in Sandy's investigation. Mark Hise, p. 33.
- He was a happy-go-lucky guy. Mark Hise, p. 50.

Carrie Johnson-Miller – Deposition Summary

- Carrie Johnson-Miller was hired at BDHC in 2011. She was originally hired to work as a Q before being promoted to Residential Services Manager in 2014. Carrie Johnson-Miller, p. 5. She retired December 1, 2021. Carrie Johnson-Miller, p. 6.
- Carrie Johnson-Miller claims she saw DC hit a staff member in the head with his fist while walking down a hallway. Carrie Johnson-Miller, p. 17. [There is no report of this that I know of.]
- She cannot say who the staff member was or when this happened. She cannot say when this happened, other than she doesn't think she'd been at BHDC very long. Carrie Johnson-Miller, p. 21.
- She cannot say whether the staff member was injured. She doesn't know if he was hurt. She does not know if he needed medical attention or if he just shook if off and went about his day. Carrie Johnson-Miller, p. 18, 21.
- She has no other recollection of DC harming anyone else. Carrie Johnson-Miller, p. 19.
- She never witnessed DC harm anyone else, in the approximately ten years she worked there. She never heard of any other situations in the approximately ten years she worked there suggesting DC caused harm, aside from hearing about the MacDonald's thing off campus with his uncle. Carrie Johnson-Miller, p. 20.
- Johnson-Miller cannot identify a single incident in which DC caused injury to someone necessitating medical attention. Carrie Johnson-Miller, p. 21.
- **If a client swings at a staff member the staff member must attempt verbal control and to redirect client before laying hands on them.** Carrie Johnson-Miller, p. 70, 71.
- Johnson-Miller says they were taught to respond to a client swinging at them by calling for assistance, stepping out of the way, redirecting, backing up and giving client chance to calm down, separation; taught to do everything possible to avoid laying hands on them. Carrie Johnson-Miller, p. 70, 71.
- Carrie Johnson-Miller testified that staff should take a step backwards if a client swings at them. If the client moves forward staff should keep moving back. Carrie Johnson-Miller, p. 28.
- When asked what if staff cannot keep moving back, she said staff should watch their body posture and try to move out the client's way. She added that by then, hopefully, other staff are there to help or you have been able to contact the nurse. Carrie Johnson-Miller, p. 28.

- **In a one-on-one situation where a client swings at the staff member, that staff member is supposed to step back, be careful with his posture because the client takes cues from that, attempt to redirect, and call for assistance or for a nurse – all of these things should be tried before staff lays hands on a client who swung on them.** Carrie Johnson-Miller, p. 70, 71.
- Personal restraint should never be used unless there is an emergency. Carrie Johnson-Miller, p. 41.
- Laying hands on a client should only occur in an emergency situation as a last resort. Carrie Johnson-Miller, p. 42.
- "**A personal hold is dangerous if you are the client period wherever you're at.** That's why you use the least restrictive method you can that's available to you at the time." Carrie Johnson-Miller, p. 43.
- Staff are only allowed to use the least restrictive intervention for the least amount of time possible in any situation. Carrie Johnson-Miller, p. 44.
- Carrie Johnson-Miller, the Residential Services Manager who supervised Tyler Mattson and who often reviewed and approved his use of physical restraint on DC, when asked how she was supposed to know what form of personal restraint staff used on a client when the Behavior Incident Reports typically never say, responded that "Well, there is a definition of personal restraint." Carrie Johnson-Miller, p. 55.
- She is referring to the BHDC Policy I-D-4 (6); she testified that "personal restraint" is "an emergency procedure limiting movement by the **holding of a hand or limb**." Carrie Johnson-Miller, p. 56.
- This is the only definition of "personal restraint" of which she is aware; she knows of no definition that includes taking clients to the ground or holding clients on the ground. Carrie Johnson-Miller, p. 66.
- **She knows of no policy that authorizes personal restraints on the ground.** Carrie Johnson-Miller, p. 66.
- She also agreed that BHDC defines "Emergency Restraint" as the use of the least restrictive procedure and for the least time necessary to control *severely aggressive* or destructive behaviors [as found at BHDC Policy I-D-4 (2)]. Carrie Johnson-Miller, p. 56.
- Johnson-Miller refused to admit that Tyler's written description of the **3/20/20 restraint** clearly implies they were on the ground [*Tyler himself testified that this four-minute restraint DID occur on the ground,* Tyler Mattson, p. 77], but she did testify that if Tyler did in fact restraint DC on the ground for four minutes [as he admits he did] that she would have flagged it as a bad act [she did not]. Carrie Johnson-Miller, p. 64. [Presumably, this means she'd have flagged Tyler for the death restraint.].

- Carrie Johnson-Miller, the Residential Services Manager who reviewed and signed off on this restraint after it happened, at first testified that the **second 5/29/20** incident "could be deemed as an emergency, you know." Carrie Johnson-Miller, p. 52. **[An emergency is anything they choose to label as an emergency. There are no rules. They routinely label minor events as emergencies in order to justify use of physical restraint, because physical restraint is convenient for staff.]**
- She repeatedly mentions "he may have been escalating," further evidence that staff would physically restrain clients in *anticipation* of their actions, as Tyler admitted to doing. Carrie Johnson-Miller, p. 53.
- When pressed, Johnson-Miller admits that screaming and threatening to throw something [as was the case in the **second 5/29/20** incident] could NOT meet the definition of emergency that would necessitate physical force. Carrie Johnson-Miller, p. 53.
- ***Q.*** *Screaming and threatening to throw something could meet the definition of an emergency necessitating physical force, yes or no?*
  A. *No.*
  Q. *Okay. So did you report Tyler for improperly using a physical restraint for this incident?*
  A. *At that time, it was not deemed improper.*
  Q. *What does that mean?*
  A. *At that time, it was an acceptable -- evidently an acceptable thing that we did. What date was that anyway?*
  Q. *It was May 29th of 2020, two weeks before David was killed.* Carrie Johnson-Miller, p. 53.
- Johnson-Miller admits that, based on what is contained in Behavior Incident Report for the **second 5/29/20** restraint, Mattson was not justified in his use of physical force/restraint and she should have flagged this as a bad act by Tyler rather than approving it and moving on. Carrie Johnson-Miller, p. 54. [Johnson-Miller suggests that perhaps there was more to the story than what was contained in the written account; however, Mattson himself confirmed in his deposition that this was all it was. Tyler Mattson, p. 72, 73].
- Johnson-Miller, regarding the **3/20/20 restraint** that she reviewed and approved:
- ***Q.*** *And that biting [DC biting himself] combined with him trying to spit at Tyler calling him a bitch and swinging on Tyler, that, to you, justifies <u>taking him down</u> and holding him down there for four minutes in personals?*
  A. *It could.* Carrie Johnson-Miller, p. 62. [Takedowns would never be justified]
- Carrie Johnson-Miller, a Residential Services Manager at the time of DC's death, **at first** testified staff was taught that they could take clients to the ground. Carrie Johnson-Miller, p. 11, 13.

- She understood that I was *not* asking about taking to the ground for purposes of transitioning to mechanicals, but purely for purposes of personal restraints on the ground. Carrie Johnson-Miller, p. 13. [Takedowns were used for personal restraints.]
- Carrie Johnson-Miller, Residential Services Manager over Mattson at the time of DC's death, wrongly believed that they were allowed to take clients to the ground for purposes of personal restraint. Carrie Johnson-Miller, p. 13, 14, 15, 16, 17, 22.
- *Q Were you taught that for any other reason, meaning you weren't taught to restrain them on the ground as a form of a personal hold that does not intend to transition to a mechanical restraint, did you?*
  A As far as on the ground or on the floor, it depends on what the situation is at the time. It depends on the severity of their violence at the time and keeping them safe and other clients safe and yourself safe. Carrie Johnson-Miller, p. 11.
- *Q Right. So when were you taught or what were you taught about when you can take them to the ground?*
  A If they're out of control, if they're going to hurt themselves, if, you know, other clients -- you've got to get the safety of the other clients. Carrie Johnson-Miller, p. 13.
  [Acknowledges takedowns]
- ***Q.** And, again, we're not talking about – you understand that I'm not asking about mechanical restraints or transitioning to mechanical restraints, right?*
  ***A.** Right.*
  ***Q.** I'm just asking about personal holds on the ground separate and apart from taking them to the ground for purposes of transition. I'm not interested in the latter. You understand that?*
  ***A.** Yes. When they're out of control, sometimes their head is going back and forth. Their arms will be going back and forth. They're kicking you. They're kicking walls. They're hitting walls. And it's very difficult at times to provide safety for someone like that.*
  ***Q.** Okay. And so describe for me then -- I guess in that situation, you might have to -- or you might need to take the client to the ground in that situation if there's no other option?*
  ***A.** If you can't get them to stop, yes. I mean, if you can't get a hold of their arms and just get them calm, you may have to.*
  ***Q.** And if you had to, how would you do it?*
  ***A.** Well, there's different holds that people are -- the staff were taught that they could do to just keep their limbs from moving.* Carrie Johnson-Miller, p. 13, 14.
- ***Q.** Ms. Johnson-Miller, I'm asking can you -- if you can't tell say that, that's fine. I'm just asking you, you were a residential services manager for roughly seven years and these staff members who had to do these things were under your supervision as well as under Ms. Evans' supervision and I just want to know, **do you know specifically the way that these staff members took clients to the ground?** Physically how did they do it and how were they supposed to do it?*

A. Well, like I say, there's different holds were taught and I don't know all of the holds *and I don't remember all the different holds that they use.*
Q. *Well, is there a hold you were taught specifically for taking clients to the ground?*
A. *You can hold them on each shoulder. You can hold their arm. You can take them down. If their legs are flailing, you would need other staff probably to help assist with the legs. And then you just lower them to the ground as gingerly as you can.* Carrie Johnson-Miller, p. 15. [She doesn't know that takedowns are not allowed.]

- She recalls seeing these takedowns (for personal restraint purposes) occur seven or eight times. Carrie Johnson-Miller, p. 16. She did not see it but she heard of this happening to DC at some point before his death. Carrie Johnson-Miller, p. 17.

- ***Q.*** *But it is your testimony as you sit here today that* ***staff were authorized to take clients to the ground in emergency situations in order to restrain them there on the ground****, correct?*
A. Yes, *for their safety of the clients and the other clients.* Carrie Johnson-Miller, p. 22.

- After she hears about Hise's testimony, Johnson-Miller tries to change her testimony, basically saying she misspoke: "Maybe not while on the ground...." "you do the best you can to keep off the ground...." "Okay. What I meant was you may not be intentionally taking them to the ground. That may be where the -- where it winds up." Carrie Johnson-Miller, p. 23, 24.

- ***Q.*** *You specifically said you were taught to take them to the ground and that you had to do that sometimes. Are you saying that's not the case now?*
A. *Well, that's some of it, yes, but initially you're not going to just slam somebody on the ground.* Carrie Johnson-Miller, p. 25.

- ***Q.*** *Ms. Johnson-Miller, are you now saying that initiating taking a client to the ground was not allowed, that it was only something that could be done if going to the ground sort of occurred naturally in a struggle?*
A. *Yes. And sometimes that -- most of the time that helps.* Carrie Johnson-Miller, p. 26.

- ***Q.*** *Before you said that sometimes you could initiate taking the client to the ground to restrain them if the situation required it, in a situation where you said where they might be flailing or kicking. You can take them to the ground purposefully to restrain them on the ground.*
A. *Yes.*
Q. *Are you now saying that that is not the case?*
A. *No, and I never intended for that to sound like that either. I mean, you might -- you're going to do least restrictive. You're going to get help. You're going to do everything you can, and if it takes you there, then you're going.*
Q. *So now your testimony is that you can only restrain a client on the ground if you accidentally end up on the ground with your client?*

A. But yes, you're not going to slam somebody to the ground. Carrie Johnson-Miller, p. 26, 27.

- Finally, when asked one final time whether staff were authorized to "take a client to the ground" if the situation called for it, she testified: "Authorized is questionable." Carrie Johnson-Miller, p. 43.
- Carrie Johnson-Miller, Residential Services Manager and BHDC staff member for approximately ten years, cannot describe specifically which personal holds were allowed and which were not. Carrie Johnson-Miller, p. 42 [More top-down ignorance/failure]
- Johnson-Miller claims DC could vomit at will, but then admits that she never once witnessed this herself. Carrie Johnson-Miller, p. 45, 46.
- Carrie Johnson-Miller was one of three Residential Services Managers at the time of DC's death. Carrie Johnson-Miller, p. 7.
- This position was under the Residential Services Director (Sandy Evans). Carrie Johnson-Miller, p. 5.
- She supervised Team White (one of three teams), which included Tyler Mattson. Carrie Johnson-Miller, p. 6, 7.
- There were also direct floor supervisors between Johnson-Miller and Mattson [like Amy Jones at the time of DC's death]. Carrie Johnson-Miller, p. 6.
- Carrie Johnson-Miller testified there was a bed bug infestation at Davidson House, on both the first and second floors, and that it was so bad that multiple staff members quit over it. Carrie Johnson-Miller, p. 29, 30.
- Johnson-Miller testimony indicates that direct care staff might have been short staffed on the day of death. She thinks there was supposed to be two staff for every 8 clients. Carrie Johnson-Miller, p. 39, 40.

Amy Jones – Deposition Summary

- Amy Jones had worked at BDHC briefly in the 2000s as a Life Skills Trainer and again in 2016 as a Cook before returning in 2017. She worked as a Residential Care Technician She was promoted to Residential Care Supervisor a few weeks before DC's death. She currently works as a Residential Operations Manager.
- Never seen DC cause injury to another person.
- DC never caused harm or injury to Amy Jones.
- DC never made contact with Tyler, never struck him, was only swinging his one free arm behind his back at Tyler.
- An individual's actions that are aggressive, disruptive, and/or present a danger to the individual or others, must be managed with the least restrictive method.
- BHDC defines Emergency Restraint as use of the least restrictive procedure and for the least time necessary to control ***severely aggressive*** or destructive behaviors. The use of **emergency restraint will comply with all relevant standards and regulations**
- **The restraint used on DC was *not* the least restrictive option available.**
- **What Tyler, Amy, and Ryann did was not the least restrictive option under the circumstances.**
- Staff are given specific training on what to do when a client tries to hit them: de-escalation techniques including verbal commands, redirection techniques, removal from situation and several other procedures.
- Staff are specifically taught not to lay hands on the client unless all other measures have been exhausted.
- Staff are also taught to use a pivot movement when using the blocking technique in supported stance, to use if they cannot move backward.
- Jones and Campos never attempted any non-physical de-escalation before joining Tyler in the personal restraint on the ground.
- Jones admits DC was not a danger to them or Tyler while on the ground.

- **Amy Jones admits she should have made Tyler let go of DC so she could try to calm him down.**
- Amy Jones was the Residential Care "Shift Supervisor" on duty at the time of DC's death. She was the supervisor over Tyler Mattson and Ryann Campos; she'd recently been promoted from Residential Care Supervisor. Her direct supervisor was Sandy Evans. Says normally there would be a Program Supervisor that was below Sandy but above Shift Supervisor, but there was not one assigned at this time.
- Amy Jones says staff were trained to respond to a client swinging at them by grabbing the client's wrist [singular] and maneuvering it to where they cannot hit staff or hurt themselves, by pushing client's arm away from their body.
- A staff member is *not* supposed to grab a client by both wrists or by both arms.
- Staff are trained not to grab clients by both arms; rather, staff are specifically taught a sidestep maneuver for when they are by themselves and a client attempts to hit them, which involves pushing the client's hand away [blocking technique] and moving around the side of the client in a sidestepping [pivot] motion, which allows staff to avoid grabbing the client by both arms – which is something that could lead to injury.
- **Staff are not authorized to hold a client on the ground *even where* a client puts himself on the ground during an aggressive episode.**
- Amy did not witness how Tyler got DC to the ground.
- DC was struggling while on this left side, trying to hit Tyler who was behind him with his right arm, according to Amy Jones. However, DC did *not* make contact with Tyler, only tried to. "He wasn't hitting him. He was hitting at him."
- "I don't know" why Tyler did not just back up and give DC space to calm himself since he was already on the ground.
- Amy Jones, instead of ordering Tyler to release DC, kneels down, grabs both DC's arms and holds them in front of him near his face.
- Ryann Campos joins the ground restraint by kneeling down and grabbling both of DC's legs by the ankles.
- Amy Jones and Ryann Campos did not witness nor does either have any knowledge of Tyler Mattson attempting nonphysical interventions prior to using physical force.

- Jones and Campos attempted no nonphysical techniques before helping pin DC to the ground by force. Jones verbally asked DC to calm down, but only after she'd already taken hold of his arms.
- Jones admits DC posed no significant danger to Tyler Mattson when she arrived at the scene and joined in the restraint.
- The *only* time you transition a client to the ground or hold a client on the ground is for the sole purpose of transitioning to a mechanical restraint.
- Staff are NOT taught to hold a client on the ground or restrain a client on the ground.
- An on-the-ground personal hold is not an approved NCI method; that should *not* be done.
- Staff has no business holding a client on the ground unless they are transitioning the client to the papoose board.
- No ground restraints were taught or allowed. Staff expressly prohibited from putting client on the ground. NCI does not teach restraining clients while on the ground.
- **Staff are not authorized to hold a client on the ground *even where* a client puts himself on the ground during an aggressive episode.**
- Amy Jones says this was the policy.
- Amy Jones thinks it **still** is the policy, as does Tyler.
- Amy Jones wishes she had called 911 right away, despite the policy.
- **Only medical staff were authorized to call 911.**
- **Amy Jones says they could not even call 911 after first calling medical, which she says does not make much sense.**
- Jones was not aware of DC's [redacted] at the time of the restraint; she admits she should have been.
- Jones says all the clients are supposed to remain upright after meals, [redacted]; she also says she was aware DC had just eaten at time of restraint.
- **They rolled him onto his back as soon as they saw he was vomiting.**

- DC [redacted] according to Jones.
- They knew [redacted] when they called medical.
- They did not do CPR because there was no mouthpiece/barrier, and they were taught only to do it when a mouth barrier was available. No CPR until nurses arrived.
- Amy Jones saw DC on his left side with Tyler behind him. DC was struggling; Tyler was trying to control DC on the ground and Tyler had one hand on DC's shoulder and **ONE HAND ON DC's WAIST**.
- DC's face was red and he was "very agitated" at the point during which Amy Jones joined in the restraint. Tyler has his right hand on DC's waist and his left on DC's shoulder trying to keep DC from moving.
- After all three staff are restraining him together, Amy Jones remembers DC moving his head to look back at Tyler; then vomit started coming out of his mouth, while all three staff have him restrained – Jones has his arms, Campos his legs, and Mattson his midsection (Jones thinks about 20 seconds after Campos started holding his legs).
- 11:33am is pretty close as to when staff called medical.
- Sandy Evans was physically in the room with Mattson, Jones, and Campos while they completed their witness statements, literally looking over their shoulders and stopping them every couple sentences in order to help them complete it correctly.
- Amy Jones' OLTC Witness Statement contains a significant inaccuracy; it says that she saw DC hitting Tyler when she arrived at the scene, but the truth, as she explained in her deposition, is that she saw DC hitting *AT* Tyler after he was already restrained on the ground on his side and Tyler was behind him; all she saw was DC swing his one free arm behind himself *AT* Tyler, but never made contact, didn't hit him.
- Staff training teaches that if an upset client is standing, staff should stand; if an upset client is sitting, staff should sit; purpose of this is to appear less threatening.
- DC enjoyed music, particularly the Monkees.

Kelly King – Deposition Summary

- Kelly King has worked at BDHC as an LPN [Licensed Practical Nurse] since 2008. Kelly King, p. 5.
- Kelly King worked with DC for 12 years. She described him as funny and playful. Kelly King, p. 6.
- No knowledge of DC ever causing injury to another person. Kelly King, p. 7.
- DC was NOT considered one of the dangerous clients. Kelly King, p. 10.
- Kelly King was slapped once by DC during 12 years of working with him; this was the only time he ever touched her. She was not injured; it only hurt briefly. She admits that she was not in danger when he slapped her, that it was "like a child acting out." Kelly King, p. 7, 11.
- Kelly King witnessed staff restrain patients on the ground regularly, estimated once every two or three months. Staff holds them down on the ground so she can administer chemicals sometimes. Kelly King, p. 14, 15.
- Kelly King says this was the policy. Kelly King, p. 20.
- **Only medical staff were authorized to call 911.** Kelly King, p. 20.
- BHDC wants medical staff making the decision. Kelly King, p. 21.
- Nurse Deborah Noah was told in the initial call from direct care staff that DC was not breathing. Kelly King, p. 16.
- The drive itself from Judge Hill to Commons took about a minute. Kelly King, p. 17. Kelly King claims it took 20 second to grab their gear run to Schmidt's car and 30 seconds to exit the car and haul the gear to the scene in Commons. Schmitt says it all took a bit longer. Kelly King, p. 17.
- The nurses did not ask for 911 to be called until after they physically arrived at the scene themselves, despite being told on the phone DC wasn't breathing. Even by King's shorter timeline, nursing staff still squandered anywhere from two to five minutes (depending on who you are asking) between learning DC was not breathing and calling 911. Kelly King, p. 18.
- Kelly King wasn't willing to take staff's word that it was an emergency, even though she was told he wasn't breathing. She says she needed to see if for herself. Kelly King, p. 22.
- They cannot rely on direct care staff's word. Get a lot of false alarms. Kelly King, p. 23, 24.

- **King later agrees that this is <u>not a safe policy</u>.** Kelly King, p. 25.
- Paramedics have superior life-saving capabilities and superior life-saving equipment; they have deep-suctioning devices, can intubate; can do chemical codes. Kelly King, p. 25.
- DC [redacted]d. Kelly King, p. 26.

Tyler Mattson – Deposition Summary

- Tyler Mattson was hired at BDHC in February 2017 as an RCA [Residential Care Assistant]. Tyler Mattson, p. 11. He was promoted to RCT [Residential Care Technician] six months after he was hired. Tyler Mattson, p. 12. He worked at BDHC for 4 and a half years. Tyler Mattson, p. 13.
- No knowledge of DC ever causing injury to another person. Tyler Mattson, p. 66.
- DC was NOT considered one of the dangerous clients. Tyler Mattson, p. 66.
- DC always told Tyler Mattson that he loved him: "I love you, Tyler." Tyler Mattson, p. 61.
- DC never injured me, never injured anyone that I know of. Tyler Mattson, p. 66.
- DC craved reassurance. Tyler Mattson, p. 61.
- DC got along with everyone. Tyler Mattson, p. 62.
- DC never once harmed Mattson, never once even made contact when swinging towards Mattson. Tyler Mattson, p. 77.
- Mattson testified at deposition to a different version of events than he gave in his OLTC written statement and in his statement to DRA. Says DC "grabbed" *at* him, but did not swing at him or try to hit him; charged at him, but not a running charge because there was only 6 or 7 feet between them. Tyler Mattson, p. 101, 102.
- Admits his memory was fresher two years before when he gave his OLTC and DRA statements than it is now; note he made ZERO mention of a ledge in either statement. Tyler Mattson, p. 107.
- Mattson's justification for holding DC on the ground was that DC was resisting (while lying face down) after he was taken down; Mattson described this resistance as "squirming," and testified that this squirming constituted DC being "violent." Mattson is conflating resistance with violence to justify his actions. Tyler Mattson, p. 108, 109.
- Mattson chose not to give him space to deescalate while on the ground or use any de-escalation techniques as required. Mattson pinned him on his left side and intended to hold him there until DC complied with his orders to calm down, until he stopped calling Tyler names. Tyler Mattson, p. 109, 110.
- Staff are also taught to use a pivot movement when using the blocking technique in supported stance, to use if they cannot move backward. Tyler Mattson, p. 50, 51, 52.
- Tyler was taught the blocking technique and says he was taught to pivot away by stepping in a half circle if a client swings at you or attacks. Tyler Mattson, p. 50, 51, 52.

- Not supposed to grab clients by both wrists at the same time. Tyler Mattson, p. 52.
- DC was sitting in chair outside of bathroom before he allegedly charged Mattson; Mattson was standing 6 or 7 feet away when DC got out of the chair and supposedly charged. Tyler Mattson, p. 101.
- **Mattson made physical contact with DC before DC ever made contact with him**; Mattson testified that he grabbed DC by both of his upper arms/biceps before DC ever could touch him. Tyler Mattson, p. 102, 103.
- Mattson OLTC statement says DC fell over and he went with him after grabbing DC by his arms. Mattson OLTC Witness Statement. But at deposition Mattson says they tripped each other up after he grabbed DC by both of his arms. Tyler Mattson, p. 104.
- DC landed face down, but according to Mattson did not hit his face on the ground. Tyler Mattson, p. 106.
- Mattson held DC on the ground for around two minutes before Jones arrived. Tyler Mattson, p. 113.
- Mattson and Jones held him down on the ground together for two or three minutes more before Campos arrives. Tyler Mattson, p. 114.
- They continued to hold him down simply because he was still resisting and screaming. Tyler Mattson, p. 114.
- Mattson admits they were going to keep him pinned on the ground until he stopped screaming and "said that he was calm," even though DC had not harmed any of them and had not even made contact with any of them with his hands or feet. Tyler Mattson, p. 115, 116.
- All three held him down together after Campos joins in for another one to two minutes. Tyler Mattson, p. 116.
- They continued to keep him pinned to the ground *even after they knew he'd* defecated because he was still "being aggressive". Tyler Mattson, p. 117.
- Tyler agreed that once DC was on the ground, he could no longer charge at him. Tyler Mattson, p. 130.
- Mattson could have tried to give DC space on the ground, but he didn't because DC was still squirming, screaming, and appeared agitated, and because Mattson *speculated* DC *could* get back up and attack him. Tyler Mattson, p. 133.
- **If he could do it over Tyler Mattson would try to let DC up off the ground sooner.** Tyler Mattson, p. 137.

- Tyler testified he does not remember what personal restraint techniques he was taught to use in response to severe aggression before DC's death. Tyler Mattson, p. 38.
- Tyler Mattson's practice was to use personal restraints, including the basket hold and hip-to-hip maneuver, in response to non-emergencies – verbal aggression and slight physical aggression or resistance to guidance. Tyler Mattson, p. 34, 35, 36.
- Tyler Mattson testified that, for severely aggressive clients, they would put them on the ground as "a control mechanism." Used for transitioning to the papoose board but also used frequently without purpose of transitioning to mechanical restraint. Tyler Mattson, p. 38, 39.
- Mattson says he was taught to restrain clients on the floor, that he could do so for up to 15 minutes. Tyler Mattson, p. 53, 54.
- Mattson believes he could use personal restraints on an as-needed basis, based on his own discretion. Tyler Mattson, p. 55.
- Mattson believed he was allowed to operate based on his own subjective discretion: "the job was very much pick your battles kind of job," as he says. Tyler Mattson, p. 60.
- Mattson doesn't know the difference between graduated guidance and personal restraint. Tyler Mattson, p. 70
- Mattson claims that holding a client by the wrist is not an approved method or method that is taught. Tyler Mattson, p. 72.
- Mattson put DC in physical restraints on **5/29/20 twice**, the **first time** because he says DC "was screaming and attempted to smack me." This was not an emergency, yet Mattson physically restrained him anyways. **Mattson admits this was not an emergency** situation, stating that "it wasn't like a full-blown situation." Mattson attempted no nonviolent methods of de-escalation prior to putting him in physical restraints. Tyler Mattson, p. 70, 71.
- On **5/29/20** Mattson put DC in physical restraints for a **second time**, this time for three minutes *even though he was not attacking anyone* or trying to hit anyone or attempting to go after anyone; all DC did was threaten to throw a thermometer. Tyler Mattson, p. 72, 73.
    - Mattson put DC in personal restraint *before* DC became physically aggressive; Mattson said he put him in the hold because he *anticipated* DC might become aggressive; Mattson attempted zero de-escalation techniques prior to using personal restraint, even though DC had not yet made a move towards anyone. Tyler Mattson, p. 74, 75.

- The method of personal restraint used is never described in the behavior incident reports. Tyler claims he cannot remember what hold he used each time on 5/29/20. Tyler Mattson, p. 73.

- Mattson put DC in personal restraints on **3/20/20**; restrained him **on the ground for four minutes** while they were alone and **only let him up once DC apologized** and appeared calm; Tyler again lies that they "fell over," when in reality he took him to the ground because he regularly took people to the ground; claims DC had tried to spit and swing on him, but did not make contact because he never once made contact. So Tyler restrained DC on the ground for four minutes even though DC never laid a finger on him. Tyler Mattson, p. 77.
- Tyler Mattson says this was the policy. **He wishes he could have called 911 as soon as he knew DC was in trouble.** Tyler Mattson, p. 78, 79, 123.
- Mattson says he is not even aware that the policy has since changed. Tyler Mattson, p. 79.
- Tyler had his cell phone on him during the time of the death restraint. Tyler Mattson, p. 91.
- Mattson knew that DC had just eaten less than 10 minutes before the restraint. Tyler Mattson, p. 106, 125.
- Mattson was aware of the [redacted] Tyler Mattson, p. 125.
- Tyler had his cell phone on him during the time of the death restraint. Tyler Mattson, p. 91.
- Mattson was holding DC down with one hand on DC's side. Tyler Mattson, p. 112.
- **They rolled him onto his back as soon as they saw he was vomiting.** Tyler Mattson, p. 118.
- Two or three minutes passed between when DC started vomiting and when they called medical. Tyler Mattson, p. 120.
- They knew he had stopped breathing when they called medical. Tyler Mattson, p. 120.
- They did not attempt mouth to mouth because there was no mouthpiece and they didn't want to make direct contact with his mouth. Tyler Mattson, p. 122.
- **DC was screaming right up until the moment vomit started coming out of this mouth.** Tyler Mattson, p. 119.
- Sandy Evans was physically in the room with Mattson, Jones, and Campos while they completed their witness statements, literally looking over their shoulders and stopping

them every couple sentences in order to help them complete it correctly. Tyler Mattson, p. 84, 85, 86, 87.

- Tyler Mattson recalls that it was probably Sandy Evans who investigated and cleared him in the 2019 maltreatment incident. Tyler Mattson, p. 20, 22.
- Tyler Mattson testified that the entirety of Sandy Evans' investigation into his personal involvement in the death included one brief interaction during which he was questioned about the incident for "barely a minute," that Evans did not ask him detailed questions about what happened, that primarily all she did was provide him a witness statement form and then personally instructed him on how to complete the witness statement, that she was very empathetic towards him, and that the whole process took only 15 to 20 minutes. Tyler Mattson, p. 84, 85, 86, 87.
- Mattson attempted to get CNA certification twice before DC's death, but both times he was unable to successfully complete the test requirement. He did not get certification until after DC's death. Tyler Mattson, p. 14, 15.
- Tyler Mattson was accused of physically abusing a client by another staff member in 2019 and was investigated. Tyler Mattson, p. 18, 19.
- Tyler Mattson recalls that it was *probably Sandy Evans* who investigated and cleared him in the 2019 maltreatment incident. Tyler Mattson, p. 20, 22.
- Lied under oath by saying he never participated in other physical restraints on DC before his death, other than one time using hip-to-hip. Tyler Mattson, p. 67.
- When called on this contradiction at deposition, Mattson said he could not remember, that maybe what he put in his OLTC statement was the right version, it had been a long time. Tyler Mattson, p. 104.
- DC landed face down, but according to Mattson did not hit his face on ground, only admitting this after being confronted with his prior DRA statement; then finally admits that his memory was fresher when he spoke to DRA and told them DC did hit his face. Admits it's possible DC's face struck the ground. Tyler Mattson, p. 106, 108.
- Tyler *was standing*, ready for confrontation, while *DC was sitting* in the chair outside of the bathroom in the moments before Tyler says DC got aggressive. Tyler Mattson, p. 99.
- DC was very friendly, very social with staff. Fun to be around. Tyler liked him a lot. They had a good bond. Tyler Mattson, p. 64, 65.
- Describes as job as "glorified babysitter." Tyler Mattson, p. 25.

Christine McAuliffe – Deposition Summary

- Christine McAuliffe is DC's younger sister. Christine McAuliffe, p. 10.
- McAuliffe felt like nobody with the state was taking Davie's death seriously. Christine McAuliffe, p. 144.
- DC never hurt Chrissy, never threatened her, never hurt any of her friends. Christine McAuliffe, p. 21,22.
- ***Q.*** *Okay. And when you would pick him up and bring him back to Russellville, was there ever any incidents or behavioral problems that you encountered?*
  A. *I mean, he dealt with, you know, behaviors.*
  Q. *Tell me about them.*
  A. *Like he would get anxious, sometimes he would cry, he would get upset. Yeah, you know, he dealt with those types of things.*
  Q. *Did he ever become violent?*
  A. *No.*
  Q. *Aggressive?*
  A. *I mean, he would get agitated.*
  Q. *Tell me what that means.*
  A. *Like he might raise his voice, he might start cussing or crying.*
  Q. *Did he ever threaten violence?*
  A. *No.*
  Q. *Did he ever spit or scream?*
  A. *He was known to spit sometimes when he was upset and he would yell, yes.* Christine McAuliffe, p. 29.
- "And his behaviors generally lasted a short period of time. And immediately after, he would always start crying and apologize." Christine McAuliffe, p. 42.
- McAuliffe has a good understanding of her brother's behavioral issues at BHDC: "My understanding is that they were -- he would get upset, he would yell, he might cuss, he would spit sometimes, he was known to pick something up that was near him and throw it, he was known to, you know, swing his arms out, he would get - you know, you didn't always know why, you know, but he would get upset. And he was known to do those types of things." Christine McAuliffe, p. 59, 60.
- ***Q.*** *Okay. Tell me what evidence you have it was a temper tantrum and not an aggressive or violent behavioral outburst.*
  A. *Because I had 40 years of experience with my brother, because I had been with him when he has had behavioral incidents when he -- when he, you know, swung his arm out, because of my own experience and my own knowledge.* Christine McAuliffe, p. 95.

- *Q. Oh. Trying to strike at another human being is not violence?*
  A. I don't think, with my brother's capabilities and my knowledge of my entire life, my brother didn't have the capability, because he never had done it, he had never severely injured someone, he had never hurt someone. I've been hit by my brother, I've been spit on by him. I've dealt with his behaviors, my brother has never injured me. Christine McAuliffe, p. 97.

- ***Q. And did he ever lunge at you?***
  A. No. My brother -- absolutely not, my brother didn't attack people. If you were in his general area when he was having a behavior event, he would swing his arms, he would pick something up and throw it. He didn't have the physical capability or strength to fight another person, to take on another person, and he never did that, to my knowledge. Christine McAuliffe, p. 98.

- It would be misleading to say Davie was physically a grown man simply because of his height or weight. He lacked the strength of a man. He wasn't physically strong. He didn't have the strength or dexterity or physical capabilities of a grown man. Christine McAuliffe, p. 110.

- He couldn't open a jar of pickles. Christine McAuliffe, p. 116.

- *A. I mean, like my brother, he couldn't -- you know,* ***he couldn't ball up his fist and aim it and land it on you and hit you. Anytime I witnessed my brother, it was just, you know, swinging his arms. And when he did hit you -- like I've been hit by my brother, it never even left a bruise. He just -- he didn't physically have that capability.*** *Like even little tasks, picking things up and moving them, opening jars, those types of things, he didn't have the strength to do a lot of that. I would have to do it or my mom, somebody would have to do it for him, those types of tasks, you know.*
  Q. *Like opening a pickle jar?*
  A. *Like a pickle jar, because he loved pickles, actually. So, we would have these big, huge jars that we would have to open because he couldn't do it.*
  Q. *Claussen or Vlasic?*
  A. *I think he liked the Kroger brand, actually.*
  Q. *I had a roommate in college, and that was a debate, sometimes a fight.* ***He couldn't open a pickle jar?***
  A. Not on his own, no.
  Q. *Okay. Well, did he have any athletic skills?*
  A. *No. Actually, it was -- I mean, we would joke about that. I mean, when we were little kids, we would play in the yard and stuff. But he was always -- he was terrible at sports. I mean, I played sports, I loved it. And we would play ball in the back yard with our dad, but he couldn't -- he would wear my dad's baseball glove on the wrong hand, he couldn't catch a ball, and he couldn't throw it and actually, you know, get it to a person.* Christine McAuliffe, p. 115, 116.

- "So, it was explained to me that they -- there was never -- this is what was explained to me. They were allowed, which we authorized personal restraint. Caleb Murray explained to me because I asked, a personal restraint was holding one or both arms to the side of the body." Christine McAuliffe, p. 88.
- **I was never told that they are allowed to take him physically to the ground just for the sake of holding them on the ground.** Christine McAuliffe, p. 88.
- ***Q.** Okay. And so, was he -- in the lawsuit, you say he was pinned. Tell me what evidence you have that he was pinned to the ground. You used that term "pinned".*
  ***A.** Because the -- the three staff members said I have read their witness statements, and by their statements they all say my brother was on his side, and one -- Tyler was in the middle, another girl had his legs, another girl was at his head, and either holding his arms, his wrists, or his head. That's pinned to the ground. If you're holding someone at all three points of their body on the ground and they can't move, that's pinned to the ground.* Christine McAuliffe, p. 100.
- McAuliffe specifically asked BHDC, around the time of Davie's 2019 IPP, to clarify personal restraints. She was told that it meant holding one or both of Davie's arms by his side. That was the entire definition she was provided; that's what she thought it meant. She was never told and she had no idea they would ever use personal restraints on the ground. Nor was her mother ever told this, so far as she is aware. Christine McAuliffe, p. 129, 130. Had she been informed this was happening, she would not have approved. Christine McAuliffe, p. 131.
- ***Q.** Okay. Were you ever told of the policy that was in place at the time whereby -- at Booneville whereby only medical staff could call 911?*
  ***A.** I was never aware of that prior to my brother's death.*
  ***Q.** Okay. Had you been made aware of that, would that have caused you concern?*
  ***A.** Yes, absolutely.* Christine McAuliffe, p. 130.
- "I feel like my brother shouldn't have died that day, first of all. I feel like I went through the proper chain of command, I went to get answers of, I feel like, we were purposely misled and just flat out lied to about how he died. It was withheld from us that there was even a restraint, and the behaviors." Didn't learn the truth until it was too late for an autopsy. Christine McAuliffe, p. 132, 133.
- She and her family were told Davie died after choking on his lunch. Christine McAuliffe, p. 135.
- She was immediately suspicious because she knew her brother wasn't a choking risk. It didn't make sense that he would have choked on his lunch and died. That he was found in some hall. Christine McAuliffe, p. 135.
- She asked Caleb Murry at the funeral home that Monday what happened and all he would tell her is that he didn't know, that he wasn't there. Christine McAuliffe, p. 135.

- Then throughout that week she had phone conversations with Caleb Murry, pleading with him to walk her through what happened, and all he kept saying was that he wasn't there and he didn't know. He wouldn't answer her. Christine McAuliffe, p. 136.

- ***A.*** *He [Caleb Murry] actually showed up to the funeral [six days after the death] with a few other staff members, Audra, the one Davie was really close to, and a few other people my mother knew but I didn't really remember. And I asked him that Friday, since it was during COVID, they had brought a lot of Davie's stuff, because we weren't allowed to go to the facility. I asked him again, I said, "Listen, I don't – I mean, we need someone to tell us what happened." He told me there was an investigation and it was concluded and we would get a paper in the mail so that--* Christine McAuliffe, p. 136.

- Then the following Monday or Tuesday her mom got the letter and called Christine to read it to her. This was the very first time they learned there had been a restraint incident. This was the very first time they ever heard the word "restraint" or "behavior" used related to Davie's death, and this was nine to ten days after his death. Christine McAuliffe, p. 137.

- Davie had been buried for three days by this point; it was too late for an autopsy. Christine McAuliffe, p. 137.

- ***Q.*** *What did you do then?*
  A. *I immediately called Caleb Murray, and I wasn't very nice. I said, you know, "This is ridiculous. Why did nobody tell us this?" I said, "Why is this the first we're learning of this?" All he said was, "I don't know, I wasn't" -- he just keep repeating the same thing, "I don't know, I wasn't there. I don't know." I said, "Well, somebody needs to give me some answers." He said, you know, "I can't answer anything for you." I said, "Well, then, who do I need to talk to? He gave me the number of Jeff Gonyea. I left multiple messages with him, he never returned my call. I finally, I think on the third try, he picked up the phone, I had a conversation with –*
  Q. *Was this over a period of days that you tried to get ahold of Mr. Gonyea?*
  A. *This was over a period of a few days. Jeff Gonyea.*
  Q. *G-0-N-Y-E-A.*
  A. *I mean, I finally spoke with Jeff Gonyea. I said all those same things. I said, "You know, this is the first we have heard about a restraint, a behavior." I said, "Why is this, why has nobody told us this?" I said, "I need to see, you know, reports, investigation, whatever you have. I want someone to explain this to me." He said, "I can't help you or give you any of that information." I said, "Well, then, who can?" He directed me to Tammy Bimbrook, he gave me her number.* Christine McAuliffe, p. 138, 139.

- Gonyea refused to answer any questions about Davie's death or to provide any information about what happened. He ignored her phone calls for days, in fact. She had left two messages that went unreturned. She only got to speak with him because he

happened to pick up on one of her attempts at calling. He was very short with her, she recalls. Christine McAuliffe, p. 139.

- "I had been lied to." Christine McAuliffe, p. 140.
- The synopsis, which was redacted and only contained five or six sentences, was the only information BHDC or DHS every voluntarily provided the family about Davie's death. Christine McAuliffe, p. 141.
- It is Chrissy's understanding that DC was still dealing with some [redacted] at the time of this death. Christine McAuliffe, p. 72.
- *Q. Okay. What symptoms was he dealing with?*
  [redacted]
  Q. What does that mean?
  [redacted]
  Q. Okay.
  A. So, I know he was still dealing with symptoms. Christine McAuliffe, p. 72.
- *Q. Okay. Are you aware -- so, you're attributing vomiting to the* [redacted]*?*
  A. I don't know, because I'm not a doctor. I know in my experience that we -- my mother and I paid attention, especially when he was home, with what he ate. Specifically like we cut out spicy foods and stuff like that, stuff with too much sugar. He would get snacks and stuff, and I know if he ate - ***if he did happen to eat, you know, too many Doritos or eat something that may have been a little spicy or had too much sugar, he would still -- he would say, "Oh, I don't feel good," you know, "My stomach hurts."***
  Q. And you witnessed all that?
  A. Yes. Christine McAuliffe, p. 72, 73.
- *Q. But as the claimant here, you're saying that his* [redacted] *that you saw was this vomiting from eating?*
  A. I'm saying what I witnessed, and they said, when we talked about him having [redacted] *at IDT meeting], that we needed to pay particular attention after he ate.* Christine McAuliffe, p. 73.
- When he got anxious his stomach would get upset. Christine McAuliffe, p. 30.
- Chrissy is who actually asked OLTC for an investigation. About a week later she got an email simply saying there was no grounds for maltreatment. That is all they would give her. Christine McAuliffe, p. 143, 144.

- OLTC refused to share their findings, claiming Charlene's guardianship no longer applied now that Davie was dead and that they did not have to let Charlene and Christine have any information about the investigation. Christine McAuliffe, p. 161.
- She did not feel with OLTC was impartial. She wanted someone not employed by the state to look at what happened. Christine McAuliffe, p. 165.
- DC enjoyed socializing. She wouldn't say that he necessarily enjoyed tearing the books, but he really loved Audra DeLay and the social aspects of his vocation. Christine McAuliffe, p. 51.
- ***Q.*** *Did he always order the Big Mac meal at McDonald's?*
  A. *He always. He was very much a creature of habit, and but he was just very, you know, sweet. When he first came to the HDC, we would get him sugar-free snacks, sugar-free sodas. And they would let him keep them in his room. But he would give them away to everybody. So, he had to start -- they would put it in the hall closet and ration it out to him. He was just -- he was just funny and he was a happy guy.*
  Q. *Did he love food?*
  A. *Yeah, he loved food. That was -- when we were eating lunch, he would say, "Hey, what are we having for dinner," I mean, while we were eating lunch. That was probably -- eating was one of his favorite things.* Christine McAuliffe, p. 119.
- ***Q.*** *Okay. And what are some other things that Davie loved besides -- aside from his sister and food?*
  A. He just -- he loved music. Everybody that has been around him for five minutes knows he loved the Monkees, because he would listen to it 24/7 every day. That's not even an exaggeration. I'm sure the people at Booneville would tell you that. But, you know, ever since he was a little kid--
  Q. *And how did he come to love the Monkees? Being, you know, born in the late '70s, he was -- the Monkees were around in the '60s. How did he discover the Monkees?*
  A. *Me and my brother, when we were kids, we watched Nick At Nite all the time. We didn't-- you know, that's about all we watched. So, I remember me and him, we watched things like I Love Lucy, The Monkees, Leave It To Beaver, those types of shows. And for whatever reason, he just -- he just latched onto the Monkees and the rest is -- you know, he never stopped.* Christine McAuliffe, p. 122, 123.
- *He had Monkees CDs, tapes, vinyl records, DVDs. His two favorite tracks were "*Not Your Stepping Stone" *and* "Last Train to Clarksville." Christine McAuliffe, p. 123.
- "And actually, thankfully, I have a few videos of him, he would play tambourine, and he had some maracas I had gotten him from Central America, and I actually have a few videos of him playing those, and one of my friends playing them with him, which he did all the time, you know." Christine McAuliffe, p. 123.

- He loved the Dukes of Hazzard. He had the DVDs and he would watch on repeat, except for the one season when Bo and Luke were replaced by Coy and Vance. He really didn't like that. Christine McAuliffe, p. 124.
- "Yeah. So, I mean, he loved music, he loved, you know, DVDs, watching TV, he loved food, he loved --really, he loved -- he was very social. He loved making people laugh and being around people. He didn't like being alone, he didn't like silence. He just -- I don't know. He just -- he loved those things, he loved being a part of something, you know. I feel like, you know, being part of - - he had friends. I don't know how to explain it." Christine McAuliffe, p. 124, 125.
- Photo of Chrissy and Davie at the Xmas tree in downtown Russellville in 2018. Christine McAuliffe, p. 151.
- Davie loved Christmas. It made him very happy. Christine McAuliffe, p. 152.
- McAuliffe has worked for a labor union since 2008, primarily at nuclear power plants. She moved to Vermont in 2016 doing the same work for the same union. Christine McAuliffe, p. 8.
- She works long hours. "So, I worked at Arkansas Nuclear One, but I also traveled to other nuclear plants. So, normally when they're shut down for maintenance, they're shut down anywhere from two weeks to four to six weeks. So, you're working seven days a week, six or seven, 12 hours a day. Christine McAuliffe, p. 9.
- When not working on power plants in Arkansas the union would send her to other states to this same work. Between 2008 and 2016, her job required her to travel to other states two to three times per year to work on their nuclear power plants. Christine McAuliffe, p. 9. These trips would be for several weeks at a time. Christine McAuliffe, p. 10.
- She was three years younger than Davie. Christine McAuliffe, p. 11.
- She and Davie grew up together in the same home. Their parents divorced in around 1982; she and Davie always lived in the same house growing up. Christine McAuliffe, p. 14.
- She and Davie lived primarily with their mother until Chrissy was about eight. Then they lived together with their dad for two or three years. Christine McAuliffe, p. 16
- Chrissy wasn't separated from Davie until their father was murdered in front of them when she was eleven. Christine McAuliffe, p. 17.
- They were each sent to different places for their own protection, as they were witnesses to their father's murder. Christine McAuliffe, p. 18. 4

- Chrissy testified against the man who killed their father in front of them and he was convicted in 1992. Christine McAuliffe, p. 19.
- Neither child was allowed to live with their mother because of the danger as witnesses. Davie went into care placement. Chrissy lived in Germany with an uncle for a year. Christine McAuliffe, p. 20.
- Davie was placed with the Green family in Pope County, where he lived for approximately four to five years. Chrissy spent a lot of time with her brother during this time period. "Yes. Actually, I spent a lot of time with the Greens. I would spend the night with them. They – you know, so Davie would come home on the weekends. I actually hung out with them a lot to spend time with my brother." Christine McAuliffe, p. 22.
- ***Q.*** *Okay. And did you ever spend the night over at the Greens' house?*
  A. *Yes.*
  Q. *Okay. Tell me about their house.*
  A. *I mean, they lived in different places through those years. They had a house, they had an apartment. At some point, my brother transitioned from living with the mother, Marie Green, to her daughter, I believe, Julie Green.* Christine McAuliffe, p. 23.
- After the Greens, DC was placed with the Roberts, also in Pope County. Christine McAuliffe, p. 24.
- They [the Roberts] had a house in Russellville. DC was with them until 2007. She visited her brother there as well. Christine McAuliffe, p. 25.
- She would go over to the Roberts' house to hang out with Davie; they spent time in his bedroom listening to music. Christine McAuliffe, p. 26.
- The Roberts moved to Fayetteville in around 1998-1999, around the time she graduated high school. Christine McAuliffe, p. 26.
- She visited her brother in Fayetteville a lot. Christine McAuliffe, p. 27.
- ***Q.*** *Okay. Now, tell me about the Roberts' home in northwest Arkansas. Did you ever go there, first of all?*
  A. *Yes, we went there a lot.*
  Q. *Okay. How often?*
  A. *We would go up there to pick Davie up to bring him back to Russellville for his birthday, holidays, for just random visits, and then we would also go up there just to visit him.* Christine McAuliffe, p. 27.
- She visited DC during his last several months with the Roberts and they still brought him home to Russellville regularly during these last several months with the Roberts. Christine McAuliffe, p. 31.

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- She would have liked to have been able to care for him herself, but she believed that the HDC was what was best for him at the time. "I felt like once he came to the HDC and he started living there, they -- from the way it was set up, you know, I felt at that time that was good for him, because my brother was very social and outgoing, and it was like a little college campus. And I felt like that place had everything that, you know, that he deserved, you know, his own -- his independence and a job and his own friends." Christine McAuliffe, p. 38.
- When pressed by counsel for Respondent about why she didn't volunteer to take in DC in 2007: "That for me, that was always a conversation. But what it came down to was, you know, I worked two, three jobs. **My brother needed 24-hour care. I would have loved to have done that. I mean, ideally, I love my brother, we had a good relationship, and I felt like, you know, in theory, I could have provided him a safe home.** I mean, I could have provided him a safe home. **But** I worked multiple jobs, and since my mom -- and my brother needed 24-hour care, **I wasn't capable of giving him 24-hour care.**" Christine McAuliffe, p. 39.
- She and her mom were of the believe that BHDC was a good placement for DC. Christine McAuliffe, p. 43.

- ***Q.*** *Okay. Now hold on one second, okay? Now, there came a point in time when David passed away.*
  A. *Yes.*
  Q. *What day was that?*
  A. *June 13th, 2020.*
  Q. *And where did you live at that time?*
  A. *I lived in Vermont.*
  Q. *Okay. And someone told you that this happened?*
  A. *My uncle called me the day that it happened.*
  Q. *And your uncle, what's his name?*
  A. *My Uncle Patrick Riley.*
  Q. *And where does he live?*
  A. *He lives in London, Arkansas.*
  Q. *Where is that?*
  A. *Right next to it's right next to Russellville.*
  Q. *Okay. And he was your mom's brother?*
  A. *Correct.*
  Q. *And I'm sorry. What was his name again?*
  A. *Patrick Riley.*
  Q. *Okay. And did you come back to Arkansas?*
  A. *In general, or-*
  Q. *I mean, right after -- after you heard the news, did you return?*
  Oh, yes. I flew in as soon as I could get a flight. Christine McAuliffe, p. 43, 44.
- She visited DC at BHDC "all the time." Christine McAuliffe, p. 48.
- In response to Rich's testing, her testimony revealed she knows all about how Davie spent his days at BHDC. She knows which staff members were his favorites. She knows what he did in prevocational training. She knows what he liked and didn't like at the facility. She got to know Caleb Murry and talked to him frequently about DC. She knew he lived in Davidson house and all about the living arrangements at BHDC. She knew he lived on the second floor of Davidson and then moved to the first floor around 2012. Christine McAuliffe, p. 48-53.
- Christine is very familiar with her brother's IPPs. "It's a plan that they would do at that facility yearly that included all kinds of things about his living situation, about his -- how to respond to behaviors, his medical needs, his things that work -- just like the class, things that they wanted him to work on. It encompassed a large amount of things." Christine McAuliffe, p. 54, 55.
- She directly participated in-person with his IDT in the development of more than one of his IPPs, including the last one. Christine McAuliffe, p. 55.
- My mother was not able to handle DC alone after our father was killed. Davie needed 24-hour supervision and she could not provide that. Christine McAuliffe, p. 58, 59.

- McAuliffe has a good understanding of her brother's behavioral issues at BHDC: "My understanding is that they were -- he would get upset, he would yell, he might cuss, he would spit sometimes, he was known to pick something up that was near him and throw it, he was known to, you know, swing his arms out, he would get - you know, you didn't always know why, you know, but he would get upset. And he was known to do those types of things." Christine McAuliffe, p. 59, 60.
- A typical visit to BHDC: "Normally I would pick him up around lunchtime and I would take him out to lunch somewhere in town, in Booneville. Sometimes I might drive - - you know, we might go to Fort Smith or the next town. But generally it was in Booneville. And after we ate lunch, which was always a - - you know, he had very - - he had a routine, and the KFC or McDonald's, we would go to Wal-Mart after that where he would pick something out, a hat, a DVD, a t-shirt. Sometimes we would go to Dollar General, and we would always go to Sonic and get a shake. And then, we would usually drive around and just talk and listen usually to the Monkees." Christine McAuliffe, p. 62, 63.
- Her visits would last between two and five hours, usually two or three hours. Christine McAuliffe, p. 63.
- She visited him at least every two to three months even after moving to Vermont. Christine McAuliffe, p. 64.
- Emergency restraint use on her brother was explained to her as in a case where they thought David was going to "severely harm himself or someone else, that they would, per the physician, I understood it was a nurse or physician that had to authorize it." Christine McAuliffe, p. 66, 67.
- Chrissy did not become aware of BHDC's checkered past and the DRA investigations and complaints of excessive restraints until after her brother's death. Christine McAuliffe, p. 75.
- She did voice concern over the number of restraints being used on DC in the last IPP meeting. She spoke with Caleb Murry about it as well at other times. Christine McAuliffe, p. 76.
- They discussed the restraint use at the IPP meeting and she and her mother agreed to its continued use as written in the IPP and as explained to her by Caleb Murry. Christine McAuliffe, p. 77.
- "I'm saying that I had a discussion with Caleb Murray about it was my concern for my brother that we needed to figure out, you know, why we thought he was having so many behaviors, **because as his sister and being protective over him, of course, I didn't like the idea of him being physically restrained.**" Christine McAuliffe, p. 78. She was told how they were working on de-escalation techniques and redirection and techniques for him to calm himself. Christine McAuliffe, p. 78.

- "So, it was explained to me that they -- there was never -- this is what was explained to me. They were allowed, which we authorized personal restraint. Caleb Murray explained to me because I asked, a personal restraint was holding one or both arms to the side of the body." Christine McAuliffe, p. 88.

- **"I was never told that they are allowed to take him physically to the ground just for the sake of holding them on the ground."** Christine McAuliffe, p. 88.

- *Q. Tell me exactly, as the claimant in this lawsuit, what you are alleging here that the Booneville HDC staff did wrong for which there is liability.*
  ***MR. GILLISPIE**: Object to the form.*
  BY MR. ROSEN:
  ***Q.** And I'm going to write it all down so I can just understand it. So, go ahead.*
  ***A.** Would you ask that one more time?*
  ***Q.** Yes. Tell me exactly what you're alleging in this lawsuit that Booneville Human Development staff did wrong for which they should be held liable.*
  ***MR. GILLISPIE:** Object to the form. Are you asking her to read the lawsuit to you?*
  ***MR. ROSEN:** No.*
  BY MR. ROSEN:
  ***Q.** I'm asking you what did they do wrong? Do you have an opinion as to what they did wrong?*
  ***A.** Yes, I do.*
  ***Q.** Tell me what that is.*
  A. I believe that they used excessive unnecessary physical force to restrain my brother and for a behavior incident that didn't call for that. I believe that they used improper techniques once he was on the ground to continually hold him on the ground, which wasn't necessary. I believe they caused him to -- to choke and to die because of the decisions they made. Christine McAuliffe, p. 99, 100.

- She did weekly zoom sessions with a counselor for a couple of months after her brother's death as a result of her brother's death. Christine McAuliffe, p. 104, 105.

- ***A.** I mean, my whole life has changed since my brother is not here.*
  ***Q.** Okay. Tell me how that changed.*
  ***A.** I mean, my brother was three years older than me and, you know, we -- so he was literally there my whole life, and he was like my best friend. He was kind of like a kid to me. I had step-kids. I don't have my own kids. But my brother, because he was so child-like, he was like my best friend, he was like, you know, a child, I was protective of him. But for our whole life, I mean, we were always -- we had a special bond, and he was probably the person, you know, that I was closest to in my family. Like, we just -- we have always been that close. And the months after his death, it was just -- it was hard to deal with, like losing that connection.*
  ***Q.** Okay. So, I know, and I think I have seen elsewhere maybe, in somewhere that your -- intellectually, your brother was -- had a very low IQ; right?*

A. *Right.* Christine McAuliffe, p. 109.

- A favorite memory: *"Throughout his life he always participated in Special Olympics, and actually one of the last years that he was there, it's one of my favorite memories of him, I didn't tell him I was coming, it was at the Booneville High School. And because if I couldn't make it, I didn't want him to be upset. So, I get there and I'm in the stands, and I don't know how he saw me, but in the middle of the field, somehow he saw me and yelled, '"Yeehaw,"' like he was taking a hat off, which he didn't have on. And he said, '"There's my sister, there's my sister."' He yelled it. But so, it was just really funny."* Christine McAuliffe, p. 116.

- A favorite memory*: "But that particular year is the only time I remember he actually won a race. And I have a picture of that. It's one of my favorite ones, because he came up to me afterwards and he was so proud. And he said, "Look, did you see me, Chrissie, I ran fast as hell." And I mean, he was just -- but like I said, his whole life, he was in his 30s and he – you know, he participated, but he never -- you know, he wasn't really good at it."* Christine McAuliffe, p. 117. *"That's probably one of my favorite memories, just because he was so happy and so proud of himself. Because he literally never, I don't think ever, won anything."* Christine McAuliffe, p. 117.

- "Oh. And he was really funny and outgoing. He didn't like [s]violence. He never - - anybody that was around him would tell you he never stopped talking. I mean, even when he went to the bathroom, he never stopped talking. So, he -- I guess one of my favorite stories is, you know, me and mom were probably the two closest people to him, but we still had different relationships. My mom was his mother, you know, I was his sister. So, he could always get, you know, extra stuff out of my mom. And he knew that I wouldn't do that. Like we would buy him dinner, and he would be at the HDC and we would take him out for the day, we would always get him dinner for later, and he would get a Big Mac meal and a Diet Coke. Well, he would always talk her into getting him an extra cheeseburger, too. But I wouldn't do that when he was with me, but he knew he could get my mom to buy him, you know, an extra cheeseburger." Christine McAuliffe, p. 118.

- ***Q.*** *Did he always order the Big Mac meal at McDonald's?*
  A. *He always. He was very much a creature of habit, and but he was just very, you know, sweet. When he first came to the HDC, we would get him sugar-free snacks, sugar-free sodas. And they would let him keep them in his room. But he would give them away to everybody. So, he had to start -- they would put it in the hall closet and ration it out to him. He was just -- he was just funny and he was a happy guy.*
  Q. *Did he love food?*
  A. *Yeah, he loved food. That was -- when we were eating lunch, he would say, "Hey, what are we having for dinner," I mean, while we were eating lunch. That was probably -- eating was one of his favorite things.* Christine McAuliffe, p. 119.

- She enjoyed taking him to Walmart to buy him little gifts during their visits. Christine McAuliffe, p. 119.
- "I mean, I feel like me and him had a really special relationship that he didn't have with anybody else. And I feel like, of our childhood and, you know, we went through some pretty traumatic things together [father's death], and nobody else experienced that. I feel like that definitely bonded us, and I just -- it's hard to explain, but his disability as far as our relationship, you know, it didn't factor in as far as personality. You know, we still had that connection. And that's, you know, what I miss the most." Christine McAuliffe, p. 120.
- He was always "Davie" to her and other close family. Christine McAuliffe, p. 122.
- ***Q.*** *Okay. And what are some other things that Davie loved besides -- aside from his sister and food?*
  A. He just -- he loved music. Everybody that has been around him for five minutes knows he loved the Monkees, because he would listen to it 24/7 every day. That's not even an exaggeration. I'm sure the people at Booneville would tell you that. But, you know, ever since he was a little kid--
  Q. *And how did he come to love the Monkees? Being, you know, born in the late '70s, he was -- the Monkees were around in the '60s. How did he discover the Monkees?*
  A. *Me and my brother, when we were kids, we watched Nick At Nite all the time. We didn't-- you know, that's about all we watched. So, I remember me and him, we watched things like I Love Lucy, The Monkees, Leave It To Beaver, those types of shows. And for whatever reason, he just -- he just latched onto the Monkees and the rest is -- you know, he never stopped.* Christine McAuliffe, p. 122, 123.
- *He had Monkees CDs, tapes, vinyl records, DVDs. His two favorite tracks were "Not Your* Stepping Stone" and "Last Train to Clarksville." Christine McAuliffe, p. 123.
- "And actually, thankfully, I have a few videos of him, he would play tambourine, and he had some maracas I had gotten him from Central America, and I actually have a few videos of him playing those, and one of my friends playing them with him, which he did all the time, you know." Christine McAuliffe, p. 123.
- He loved the Dukes of Hazzard. He had the DVDs and he would watch on repeat, except for the one season when Bo and Luke were replaced by Coy and Vance. He really didn't like that. Christine McAuliffe, p. 124.
- "Yeah. So, I mean, he loved music, he loved, you know, DVDs, watching TV, he loved food, he loved --really, he loved -- he was very social. He loved making people laugh and being around people. He didn't like being alone, he didn't like silence. He just -- I don't know. He just -- he loved those things, he loved being a part of something, you know. I feel like, you know, being part of - - he had friends. I don't know how to explain it." Christine McAuliffe, p. 124, 125.

- Davie had friends at BHDC. He had a job he was proud of. He seemed happy there. He would sometimes talk about getting back to his friends when he was home with them. She thought it gave him an opportunity to have a little bit of independence and something like a normal life. He seemed to excel there. Christine McAuliffe, p. 125, 126.
- "I feel like he had two homes. He called Russellville his home, where me and, you know, where my mom was, and he called Booneville his home. So, I feel like he actually -- he enjoyed it there." Christine McAuliffe, p. 126.
- Davie came home for the major holidays every year and for his birthday. Christine McAuliffe, p. 127.
- ***Q.*** *Did you still, after moving to Vermont, make a point to see your brother in person?* ***A.*** *Yeah. I mean, that was something that was like nonnegotiable. I mean, at the time, he was my boyfriend, he's my husband now, but that was a discussion, and just for me personally, like, "Listen," I said, you know, "Financially, whatever I've got to do, I have to make sure that I can see my brother, you know, every couple months, and fly home, drive home, you know, make it work around working." That's what I did. To me, it was important, but I know it was important to Davie, too.* Christine McAuliffe, p. 127.
- After moving to Vermont in 2016 she travelled back to Arkansas just to visit Davie every two to three months. There may have been random gaps that were a little longer, but for the most part it was every two to three months. No matter the cost, no matter the trouble. Christine McAuliffe, p. 128.
- When she drove, it was a 24-hour drive, which took two days getting her and two days getting back. When she flew, it was expensive. She and her husband had to budget for the plane tickets. Christine McAuliffe, p. 128.
- She saved money specifically for traveling home to visit Davie. Christine McAuliffe, p. 129.
- They called him on the phone every week. They regularly sent him mail. Christine McAuliffe, p. 128.
- "I think about my brother every day, and I wouldn't say at this point, a few years later, I think about how he died every day, but I mean, especially the month, you know, the year after, I mean, it's still something -- I try not to let myself go there now, because, you know, just thinking that my brother's last moments were on the ground choking to death, I just can't imagine that there's a worse death than that, gasping for air and choking. And then to add to it that there was three people that he presumably knew and trusted, I just can't imagine how scared he was and what that was like for him. And so, that has been a really hard part of -- I mean, it would have been hard, obviously, losing him, but knowing, it upsets me just because, you know, he's a human being, just to know

that that's how his story ended, it – I mean, it breaks my heart." Christine McAuliffe, p. 132.

- ***A.*** *That Saturday, June 13th, 2020, I had gone to town to go grocery shopping. I was a couple miles from my home. My uncle called me, and I answered and he just said, "Davie died." I said, "What are you talking about?" He said, "Davie died." I said, "Davie who?" I was confused, and he just kept saying, "Davie."*
He was obviously hysterical. I said, "What do you mean, my brother, Davie?" He said, "Yeah, he's dead. " I said, "What are you talking about?" He said, "Your mom" -- you know, "Your mom was called today, they told her that he choked while eating his lunch, they tried to do the Heimlich, they couldn't get his throat clear, they took him, you know, to the hospital, but he was dead.
And it was -- I mean, it was pretty you know, wasn't the best way -- I mean, there's no best way to get that information, but, you know, my uncle was hysterical, too. So, I said, "Where's my mom?" He said, "She's hysterical right now. She can't talk on the phone. She asked me to call you." So, I hung up the phone, I was a few miles from home, I wanted to get home as fast as I could to my husband.
And, I mean, I was -- you know, I was sick to my stomach, I couldn't make any phone calls, I was crying. My husband actually talked to my uncle. I had reached out to a friend to make it to Russellville to go sit with my mom. My husband booked a ticket for me to come home. I came into town, flew to Little Rock that Monday. Christine McAuliffe, p. 133, 134.

Jonathan McCutcheon – Deposition Summary

- Jonathan McCutcheon worked at BHDC as direct care staff, an RTC, for over eight years.
- Jonathan McCutcheon, who worked for several years at the BHDC, testified at deposition that in or around 2019 he witnessed Tyler Mattson physically abuse another developmentally disabled resident; specifically, McCutcheon testified that Mattson grabbed the resident by his collar, yanked him down to the ground, and then dragged the resident along a hallway floor all the way to the resident's room. McCutcheon testified that he reported what he witnessed, that he relayed what he witnessed directly to BHDC Administrator Jeff Gonyea, that a maltreatment investigation was conducted, and that the allegations of maltreatment against Mattson were nevertheless determined to be unfounded.
- He witnessed Tyler Mattson commit an act of adult maltreatment upon another male client. He saw Mattson "grab him by the back of his shirt, jerk him down, and drag him to his room."
- This took place in the upstairs hallway of Davidson House, which is also where DC lived.
- ***Q.*** *Okay. And, when you say drag the client, you mean he grabbed him by like the back of his shirt collar and kind of caused him to go to the ground and then dragged him along the ground back to his room?*
  MR. ROSEN: *Objection.*
  A. *Yes.*
- ***Q.*** *Mr. McCutcheon, are you testifying that he grabbed the client by the back of the shirt collar?*
  A. *Yes.*
  Q. *Okay. Did the client then go to the floor or end up on the floor?*
  A. *Yes.*
  Q. *Okay. Are you saying that Tyler Mattson pulled the client down onto the floor?*
  A. *Yes.*
- ***Q.*** *We can keep going, Mr. McCutcheon. Mr. McCutcheon, after, as you just said, Tyler Mattson grabbed the client by the back of the shirt, pulled him to the ground, what happened next?*
  A. *He drug him to his room.*
  Q. *Okay. Did he drag him along the ground to his room?*
  A. *Yes.*

- ***Q.*** *Okay. Who did you report this to?*
  A. *I think it was Jeff Gonyea. And then I was told to write a statement on it.*
  Q. *Okay. Do you remember who told you to write the statement?*
  A. *If I'm remembering correctly, it was Jeff Gonyea.*
- McCutcheon recalls speaking to Gonyea about the incident over the phone. He was asked by Gonyea to write a statement and turn it in to the program supervisor.
- McCutcheon does not know the details of how his allegation was investigated or what the specific outcome might have been, but he knows that Tyler Mattson remained an employee. He knows of no disciplinary action being taken against Mattson.
- McCutcheon says there was no bad blood between he and Mattson preceding this incident; they were just coworkers.
- ***Q.*** *Okay. And did you and Tyler, did you have any sort of relationship with him before this incident that you witnessed? And what I mean by that is were you friends? Were you enemies? Or were you just coworkers and you didn't know him that well?*
  A. *Mainly just coworkers. I mean, yeah, we talked a little bit here and there; but, I mean, I don't know that we'd consider it friends. But we wasn't enemies, by no means.*
- McCutcheon believes this incident occurred sometime around 2019.
- McCutcheon quit BHDC, he thinks in 2021. Left by his own choice.
- McCutcheon is not 100% sure, but he believes Sandy Evans was the Residential Services Director at the time of the incident.
- McCutcheon says that BHDC staff were "not always" terminated after allegations of maltreatment were substantiated against them.
- ***Q.*** *Okay. And so I think you mentioned it earlier. So, if the determination is founded or substantiated as being likely correct, the person would be terminated, would they not?*
  A. *Not always.*
  Q. *Okay. Well, there could be some due process hearings, appeals that they -- and so on. Are you familiar with that?*
  A. *Well, I have noticed, on some of them, they do an investigation and all they'll do is just move them away from that one client.*
  Q. *Okay.*
  A. *They won't put them back in that area.*

- McCutcheon was at the other end of the hallway when he saw it happen.
- McCutcheon thinks Mattson dragged the client 50 to 75 feet.

Caleb Murray – Deposition Summary

- Caleb Murry, DC's Social Services Worker, who is also part of the team that develops his IPP, testified that he does not believe that DC's IPP contains the types of restraints authorized to be used on him. Caleb Murry, p. 76.
- DC had very little understanding of abuse and neglect, would have struggled to articulate it. "He was not able to communicate a full understanding of his rights and needs the support of his guardian and the staff here at BHDC to ensure his rights are protected." Caleb Murry, p. 35.
- DC was placed on enhanced supervision in or around September 2018 because of [redacted] Caleb Murry, p. 16, 17.
- Caleb Murry interacted with DC regularly for approximately three years as his Social Services Worker. DC was never once physically aggressive towards him Caleb Murry, p. 18, 19.
- Caleb Murry never once witnessed DC be physically aggressive towards anyone. Caleb Murry, p. 21.
- Murry stated that when another client would become upset DC would start crying out of sympathy for the other client. Caleb Murry, p. 20.
- DC was very friendly, but he sometimes required reassurance that things would be okay. Caleb Murry, p. 22.
- Murry has no knowledge of DC causing injury to any staff or other client ever. Caleb Murry, p. 28.
- DC was physically restrained frequently. Caleb Murry, p. 38.
- Caleb Murry testified that if he or any other staff member who is not medical personnel sees an emergency, they are required to call medical, not 911. That policy has not changed, so far as he is aware. He still is required to call medical, not 911. Caleb Murry, p. 56.
- According to Caleb Murry's case note dated 6/24/20, DC's mom reported to him that she'd received the summary mentioning the behavior and restraint [the letter she received three days after DC was buried]; that she'd not previously been told about DC having "a behavior" [or the restraint] at the time of his death; and that this was different than what she'd originally been told, which was that DC had gone to use the restroom and then was simply found on the ground. Caleb Murry, p. 61. This was the last time Murry spoke with DC's mom. Caleb Murry, p. 65.

- Murry claims he cannot remember if he was aware of the restraint incident when he and Susan met with the family at the funeral home on the Monday following DC's death. Caleb Murry, p. 62.
- Christine McCauliffe also called Caleb Murry on 6/24/20, according to this case note. She told him the summary provided by BHDC was not good enough. She told him there were things in the summary that did not make sense, such as DC vomiting and them doing the Heimlich in response. She noted the discrepancies between the EMS report [which contained no mention of the restraint] and the summary. "She seemed upset about the information that David was in a behavior" and was upset to learn about the restraint. Murry's note states he contacted Gonyea, who told him to document the calls with sister and mother and to make Jennifer Berry aware. Caleb Murry, p. 67.
- Caleb Murry was DC's Social Services Worker from 2017 until his death. Caleb Murry, p. 13.
- He was main point of contact between BHDC and DC's family. Caleb Murry, p. 7.
- DC's mother and sister were very involved in DC's life; DC's was one of the most involved families at BHDC, according to Caleb Murry, whose job it was to be the liaison between clients and their families. Caleb Murry, p. 22, 23.
- Murry had regular contact with both his [DC's] mother and sister. Caleb Murry, p. 22, 23.
- "It wasn't uncommon for his sister to call and say, you know, I'm going to be sending him a birthday cake for his birthday or, you know, we're going to come get him." Murry says he talked to DC's mom even more: "me and his mom talked pretty frequently." Caleb Murry, p. 23.
- ***Q.*** *And they were pretty involved?*
  A. *Oh, absolutely. Yes, they were.*
  Q. *More so than the average family member?*
  A. Yeah. I would say, as far as family involvement, they were probably one of the top, top ones as far as being involved with any other. They were very close to him. Caleb Murry, p. 23.
- The campus had been closed for a few months due to covid and they'd not been able to visit DC prior to his death. Caleb Murry, p. 60. This was hard for DC, because "he was used to having regular family contact," **"he was used to having so much contact" with his family.** Caleb Murry, p. 60.
- DC talked to his mom once per week on the phone, in Caleb Murry's office. After he was placed on advanced supervision in September of 2018, he would talk to his mom once a week from his dorm. Caleb Murry, p. 14. [Enhanced supervision was due to his diabetes.]

- Sometime in 2018, his mom requested that she be notified of DC's behavior incidents. Caleb Murry, p. 40.
- Caleb Murry testified that Alvis was the best person to know about anxiety triggers for DC. Caleb Murry, p. 22.

Amanda Schmitt – Deposition Summary

- Amanda Schmitt worked at BHDC as an LPN for 5 years. Amanda Schmitt, p. 9.
- No knowledge of DC ever causing injury to another person. Amanda Schmitt, p. 24.
- DC was NOT considered one of the dangerous clients. Amanda Schmitt, p. 22, 28.
- Never seen DC cause injury to another person. Amanda Schmitt, p. 24.
- DC was a "really fun guy." "He was such a fun guy." "He played the tambourine and loved the Monkees. "And he had a Mr. Potato Head. That was kind of mine and his thing, is he had this Mr. Potato Head and I'd always tell him I was going to take the eyes from his Mr. Potato Head and put it where the nose goes and the nose where the eyes go; and he would just get like all kinds of excited about it. And he moved it on a top shelf to show me that I couldn't reach it to move his eyes. And he was -- he was a really cool guy." Amanda Schmitt, p. 22.
- He couldn't control his behaviors. He would become overwhelmed and kind of lash out, but he didn't mean to. He never had behaviors in order to get his way. Amanda Schmitt, p. 22.
- DC might get overwhelmed and lash out, usually by throwing something, but he was never trying to hurt anybody; "he just didn't know what to do with his feelings." It was similar to toddler behavior; he would come down to the med window when he was upset and just cry. His behaviors were quickly followed with apologies; he never meant it. Amanda Schmitt, p. 23.
- According to Schmitt, the only thing DC ever did that could have caused harm was that he threw a fire extinguisher in the direction of her head once, but she says he was ***not*** aiming for her. Amanda Schmitt, p. 23.
- Schmitt never saw or heard of DC harming anyone; she cannot even think of a time he left a mark on another person. Amanda Schmitt, p. 25.
- Schmitt never saw or heard of DC swinging at or hitting anybody; she saw him pull his hand back like he was going to, but he never swung; it was more like what an upset child would do. Amanda Schmitt, p. 26.
- There are dangerous clients; DC was NOT one of them. Amanda Schmitt, p. 28.
- "I would never be afraid to be alone anywhere with David." Amanda Schmitt, p. 29.
- Schmitt believes it is correct to restraint clients on the ground if they are having a behavior, even if they are on [redacted] and have just eaten. Amanda Schmitt, p. 62.

- Amanda Schmitt, upon arriving at scene, told staff she needed to know exactly what happened. Direct care staff told her he was choking, omitted that it began during a restraint. Amanda Schmitt, p. 41.
- Schmitt specifically remembers paramedics asking direct care staff what had happened. Amanda Schmitt, p. 71.
- Direct care staff told paramedics how DC choked. It was one of the three direct care staff involved in the restraint who told paramedics what happened. Amanda Schmitt, p. 75.
- It was known that DC sometimes vomited during times of stress. Schmitt believes "very strongly that that's what happened," that he vomited due to the stress of the restraint - "he had a behavior, he was being restrained, and he -- he vomited." Amanda Schmitt, p. 61.
- Commons was up the road from Judge Hill. It took 45 seconds for Schmitt and King to get to Schmitt's car after Noah took the call. It took right about 1 minute to drive from Judge Hill to Commons. It then took another 45 seconds to 1 minute to get out of the car and arrive at the scene. Amanda Schmitt, p. 57, 58.
- Paramedics have superior life-saving capabilities and superior life-saving equipment; they have deep-suctioning devices, can intubate; can do chemical codes. Amanda Schmitt, p. 54, 55.
- The paramedics could have provided better life-saving care. Amanda Schmitt, p. 56.
- DC had no pulse when nurses arrived. Amanda Schmitt, p. 45.
- Deborah Noah took the emergency call from Campos; Schmitt and King were present with her in the Judge Hill break room when the call came in. Noah was told that a client was not breathing. Noah relayed this to Schmitt and King, who ran to Schmitt's car; by the time they got to the car Campos was calling Schmitt on her personal cell phone telling her to bring an AED, that the client isn't breathing. Amanda Schmitt, p. 37, 38, 40, 41.
- Schmitt says they did not call 911 for emergency help after they received the initial call because they get a lot of calls from staff saying a client is choking and that most of the time the client ends up being okay. Amanda Schmitt, p. 48.
- Schmitt was told DC choked on vomit. Amanda Schmitt, p. 67.
- [redacted]

- Staff should not have put DC on his back after he began vomiting and choking. Amanda Schmitt, p. 76.
- DC was fun to play with; he would tease them and they would tease him. Amanda Schmitt and Kelly King enjoyed playing with him; he was one they were close with. "He -- he'd always say Kelly's a big fat witch; and she's like this little bitty, tiny, skinny thing. And so I taught him to say that Kelly's a big fat witch and Amanda's a pretty, pretty princess." Amanda Schmitt, p. 59.
- Amanda Schmitt testified she quit because they don't care for the residents well enough, pointed to conflict between medical and residential departments. Amanda Schmitt, p. 7.
- Schmitt thinks DC was overwhelmed at times and needed to be allowed to recharge in his dorm rather than have to eat in commons or go to work. Amanda Schmitt, p. 8.
- Schmitt testified that chemical interventions were becoming more frequent with DC towards the end; she participated in them at least once every couple of months. Amanda Schmitt, p. 30.
- The facility was constantly understaffed. Often not enough staff to care for clients properly; staff frustrated and exhausted. Amanda Schmitt, p. 35, 36.

Kris Stewart – Deposition Summary

- Kris Stewart, who investigated DC's death for DRA and co-authored the report, has a bachelor's degree in social work (graduated 1995). She previously worked as a case manager for 12 years in two HDCs, one in Missouri and one in Tennessee. (Bellefontaine Habilitation Center is in St. Louis and Clover Bottom Developmental Center in Nashville). Part of her role in those jobs was to investigate abuse and neglect at those HDCs; also to write IPPs and work on client behavior plans. These HDCs were largely identical to Arkansas' HDCs, though Missouri has since abolished HDCs. The clients at these places were dual diagnosis (DD and mental health issues) clients who typically had behavioral and aggression issues, just like at BHDC. Kris Stewart, p. 56, 57, 58, 101.
- Mattson wrote in his OLTC statement that DC jumped up out of the chair and tried to hit him, omitting all mention of charging, lunging, and **omitting all mention of a ledge**. Mattson OLTC Witness Statement. Same with this DRA statement. Kris Stewart, p. 63.
- Admits his memory was fresher two years before when he gave his OLTC and DRA statements than it is now; note he made ZERO mention of a ledge in either statement. Kris Stewart, p. 63.
- Campos also told DRA Jones was holding DC's head, so that he wouldn't spit. Kris Stewart, p. 68.
- **DRA investigation concluded it was a violation of DDS 3011-D for staff to continue to restrain DC after he fell to the floor [or was taken to the floor] as opposed to giving him space and time to calm himself, which would have been a less restrictive option available to staff.** Kris Stewart, p. 77,78,79.
- ***A.*** *Just back away. He wasn't a danger to you anymore if he's on the floor."*
  Q. *How do you know that?*
  A. *If he's on the floor and you're -- how is he a danger to you?*
  Q. *If I fell on the floor right now -- if I was threatening you and I fell on the floor, and hitting you and fell on the floor, could I not get up and hit you again?*
  A. *Couldn't you just get up and get away from him?*
  Q. *Well --*
  A. *That would be the least restrictive measure to take.* Kris Stewart, p. 98.
- ***A.*** *He said that they -- let's go back and see exactly what Tyler told me. He applied personals by grabbing his arms. So, Tyler grabs him, okay, and he says they end up falling over. David lands on his face but, then, Tyler is still able to roll him onto his side. So, my point is, if you're able to get up and gain physical whatever over this guy and*

roll him on his side, you're probably just as able to be able to walk away and give him some space to see if he calms down.
***Q.** What if he didn't calm down?*
***A.** Well, he didn't get a chance to.*
***Q.** So, was Tyler, when they were on the ground, still attacking -- excuse me, was David Cains --*
***A.** No. He was on his face.*
***Q.** Well, let me ask you that. That's --*
***A.** That's what he says.*
***Q.** Did he hit his head?*
***A.** He told us that he landed on his face.*
***Q.** And during the course of your investigation, did David Cains have any injuries to his face?*
***A.** I don't know. There were no photos taken of him [by BHDC].*
***Q.** So, you don't know --*
A. There were no photos taken of him. There were no photos taken of where it happened. Kris Stewart, p. 99.

- Mark Hise told DRA investigators that the ground restraint used on DC was not taught, approved, or authorized for use at BHDC. Kris Stewart, p. 73.
- DRA investigation concluded that NCI/CPI does not endorse or instruct any maneuver that involves physically restraining an individual on the floor. Kris Stewart, p. 80.
- They don't take people to the floor in NCI. He's [Mattson's] restraining someone on the floor, so the staff still had to get down there to restrain him. NCI does not do restraints like that. Kris Stewart, p. 88.
- DRA learned that, while BHDC formally trains staff in NCI, that staff are also regularly using methods of restraint that conflict with NCI training. Direct care staff told DRA investigators that they take clients to the floor often in restraints. Mattson is one of the staff members who told this to DRA. Kris Stewart, p. 74.
- Staff told DRA that they take clients to the floor in restraints, but staff could not articulate what this technique was called or where it came from. Kris Stewart, p. 80.
- Staff could not clarify what techniques they were commonly using physically restrain clients. Kris Stewart, p. 87.
- Staff could not state who was trained in taking clients to the ground or who was teaching the technique. Kris Stewart, p. 95.
- Staff told DRA that they take clients to the ground a lot for restraints. Kris Stewart, p. 88.

- DRA investigation determined all staff at Booneville needed to be retrained because NCI/CPI does not endorse the use of restraint while an individual is lying on the floor, and that the very fact that NCI is touted as the intervention strategy implemented by Booneville, and yet this individual was restrained on the floor long enough to aspirate and die means that NCI was either ignored or forgotten. Kris Stewart, p. 81, 82, 83.
- **Only medical staff were authorized to call 911.** Kris Stewart, p. 54, 66.
- Direct care staff are not allowed to call 911; they have to go through the nurses. Kris Stewart, p. 54.
- **Every single BHDC employee that DRA interviewed told them that BHDC had a policy that forbade non-medical staff from calling 9-1-1 during a medical emergency.** Kris Stewart, p. 66.
- Superintendent Jeff Gonyea himself admitted there was a policy that forbade non-medical staff from calling 9-1-1 during a medical emergency. Kris Stewart, p. 66.
- Gonyea told DRA they were "worried that people would call 9-1-1 kind of haphazardly, that didn't have training, you know, maybe for things that weren't a 9-1-1 emergency." Kris Stewart, p. 66, 67.
- In her 27 years of working with and on behalf of DD populations, Kris Stewart has never seen a similar 911 policy. Kris Stewart, p. 66.
- Samuel Scow told DRA that BHDC reported to him on the scene that "patient choked on food he was eating, aspirated, and stopped breathing" and that patient was found on unconscious on the floor in the hallway; that DC simply choked on his lunch; and that he **was never once told of the restraint incident.** Kris Stewart, p. 64, 65.
- BHDC provided DRA with a written timeline of events concerning DC's death that completely omitted that a restraint even occurred. Kris Stewart, p. 71.
- DRA interviewed the coroner, Chrisman, who stated that he would have likely requested an autopsy done had he been made aware of the restraint. Kris Stewart, p. 71.
- DRA investigation revealed that DC's family was also given false information that DC choked on his lunch with no mention of the restraint. Kris Stewart, p. 72.
- DC's family did not find out that the personal restraint had occurred until June 22nd, which was nine days after David had died and three days after he was buried. Kris Stewart, p. 72.
- DRA concluded BHDC failed to adequately inform David's family of the circumstances surrounding his death. Kris Stewart, p. 81.

- DRA investigation concluded that the facility failed to properly communicate the circumstances of this incident to emergency responders; that there was no evidence the facility properly communicated the circumstances of this incident to the Arkansas State Police, the Logan County Sheriff's Office, or any other law enforcement agency. Kris Stewart, p. 79, 80.
- DRA concluded DC's [redacted]
- Campos also told DRA Jones was holding DC by the head, so that he wouldn't spit. Kris Steward, p. 68.
- While omitted from his OLTC statement, Mattson told DRA that Jones was holding DC's head during the restraint so that he could not bite. Kris Stewart, p. 70.
- **The DRA investigation concluded that "this restraint likely, either directly or indirectly, led to David's death."** Kris Stewart, p. 79.
- *Q. So, if there was a delay in a few minutes in calling 9-1-1, how would that impact the result, or the outcome here?*
  A. Well, I think that if you are not allowed to call 9-1-1 when someone is on the ground and obviously in dire straits -- you know, they're out in Booneville in the middle of nowhere, ***so I think every minute counts****. It takes them a long time to get there, and that was part of our argument.* Kris Stewart, p. 107.
- The only start time for the restraint given to Kris Stewart was 1-1-3-0; she specifically remembers being told 1-1-3-0; she does not recall anyone telling her it was an estimate. Kris Stewart, p. 55.
- Kris Stewart then spent six years working for Missouri's Department of Mental Health as a case manager for DD individuals living in the community. Kris Stewart, p. 57.
- Stewart then moved to New Mexico to work for Easter Seals, where she worked for five years with the same DD population as in an HDC except these were in smaller group homes of around 15 individuals. Kris Stewart, p. 58.
- Kris Stewart spent 23 years working with DD populations prior to joining DRA in 2016 as an Advocate. Kris Stewart, p. 58.
- The DRA investigation involved reviewing the maltreatment investigation report, all witness statements, the DPSQA complaint investigation report, EMS report, hospital records, and the coroner's report. DRA interviewed BHDC staff, including Tyler Mattson, Amy (Mandy) Jones, and Ryann Campos, the individuals who restrained David; as well as Sandy Evans, the adult maltreatment investigator and director of residential services; Jeff Gonyea, the superintendent; Mark Hise, the staff

development coordinator and NCI instructor; paramedic Samuel Scow; and the coroner. Kris Stewart, p. 62.

- **Tyler Mattson NEVER mentioned a ledge, mentioned DC charging at him, never mentioned DC trying to wrap him up.** Kris Stewart, p. 63. Mattson gave DRA the same version of events as in his OLTC statement. Kris Stewart, p. 63.
- Mattson told DRA that he grabbed DC by both arms, they fell over, and that DC landed on his face. Kris Stewart, p. 64.
- **Every single BHDC employee that DRA interviewed told them that BHDC had a policy that forbade non-medical staff from calling 9-1-1 during a medical emergency.** Kris Stewart, p. 66.
- Superintendent Jeff Gonyea himself admitted there was a policy that forbade non-medical staff from calling 9-1-1 during a medical emergency. Kris Stewart, p. 66. Gonyea told DRA they were "worried that people would call 9-1-1 kind of haphazardly, that didn't have training, you know, maybe for things that weren't a 9-1-1 emergency." Kris Stewart, p. 66, 67.
- In her 27 years of working with and on behalf of DD populations, Kris Stewart has never seen a similar 911 policy. Kris Stewart, p. 66.
- DRA investigation concluded Superintendent Gonyea failed to find that anyone violated any policy or procedure and *inexplicably* failed to find that any policy or procedure might need review and modification. Kris Stewart, p. 77.
- DRA investigator Kris Stewart authenticated the DRA Death Report she co-authored. Kris Stewart, p. 84.
- DRA's investigation and interviews of staff occurred within two to three months of DC's death. Kris Stewart, p. 93.
- BHDC provided DRA with a written timeline of events concerning DC's death that completely omitted that a restraint even occurred. Kris Stewart, p. 71.
- DRA interviewed the coroner, Chrisman, who stated that he would have likely requested an autopsy done had he been made aware of the restraint. Kris Stewart, p. 71.
- Tyler Mattson's statement to DRA deviated from his written OLTC statement. Kris Stewart, p. 70.
- While omitted from his OLTC statement, Mattson told DRA that Jones was holding DC's head (discrepancy) so that he could not bite (also a discrepancy, as biting is not mentioned anywhere else in the case). Kris Stewart, p. 70.

- DRA questioned Mattson's credibility; DRA found it "hard to believe" they fell over and more likely Mattson took DC to the ground, given the inconsistencies in his statements. Kris Stewart, p. 89.
- Mattson also reported to DRA it was common practice to take clients to the ground for restraint. Kris Stewart, p. 74.
- "I feel like my -- so, in investigations you have hunches. You kind of -- right? It's -- it's odd to me. I've been doing investigations about abuse and neglect. It's odd to me that he talks all about taking people to the floor and he -- it's just like he would not ever say that he restrained him -- that they fell and, so, it was -- it was odd. The whole thing seemed odd but -- he says he fell, so he did, but my -- you know, we stick with, if he fell, he was already on the floor. Just back away. He wasn't a danger to you anymore if he's on the floor." Kris Stewart, p. 98.
- One of the female staff members involved in the restraint did not seem bothered at all by the DC death incident. Kris Stewart, p. 92.

Melissa Weatherton – Deposition Summary

- **Melissa Weatherton, Director of the Division of Developmental Services since 2016, testified she was NOT aware of any requirement that staff at BHDC use only the least restrictive method available when applying restraint.** She is not aware of any rules or regulations to that effect. Melissa Weatherton, p. 14, 15.
- Weatherton is the boss over the HDCs. Melissa Weatherton, p. 42.
- Weatherton does not know that staff can only use "least restrictive" in all scenarios; she erroneously believes it can vary from client to client based on what is in their Behavior Management Plans. Melissa Weatherton, p. 14.
- Weatherton chose not to review a single document concerning David Cains' case prior to her deposition. Melissa Weatherton, p. 15.
- ***Q.*** *Okay. All right. What is your understanding of what happened with Mr. Cains that day?*
  A. *My understanding is Mr. Cains was having lunch and that he went to the restroom and came out agitated and there was a fall and he started to aspirate. Again, I read the case probably two years ago.*
  Q. *I understand. You have access to all of those reports and reports; correct?*
  A. *I do. Uh-huh.*
  Q. *Okay. Is this any particular reason you didn't take a look at that before today?*
  A. I did not have time. Melissa Weatherton, p. 16.
- **Weatherton testified that she was not aware Cains was restrained around the time of this death.** Melissa Weatherton, p. 16.
- Weatherton was not aware of the protocols in place with regards to DC's care, nor did she take the time to educate herself on this. Melissa Weatherton, p. 10.
- She only has "some understanding" of the restraint methods used at BHDC and the other four HDCS. Melissa Weatherton, p. 11.
- Weatherton agrees that federal CMS guidelines regulate how restraints are used at HDCs. Melissa Weatherton, p. 12.
- Weatherton claimed to **know** that BDHC's and DDD's policies on restraint usage are "in compliance with federal and state law." Melissa Weatherton, p. 13. It is unclear how she could know this if she doesn't know about "least restrictive."
- Weatherton testified that staff at HDCs are trained to attempt de-escalation techniques prior to using restraint. Melissa Weatherton, p. 13.

- She claims it is a goal of DDS to reduce restraints as much as possible; **she agrees that is because restraints increase the risk of danger to both clients and staff**. Melissa Weatherton, p. 30.
- There was a problem, at the time of DC's death, with HDCs not keeping up with personal restraint data, not collecting data on their usage of personal restraints, and not reporting their usage to the HDC Board. Melissa Weatherton, p. 38, 39.
- Shortly following DC's death, the HDCs began keeping up with personal restraint data and reporting it to the HDC board. Melissa Weatherton, p. 41.
- Weatherton acknowledged authoring her responsive letter to Tom Masseau in which she wrote "I am committed with your help and other members of the behavioral consultation committee to change the culture and significantly reduce the restraint usage." Melissa Weatherton, p. 46.
- BHDC was the only HDC that did not have cameras. Melissa Weatherton, p. 65, 66.
- ***Q.*** *Would you agree that using a restraint should be an option of last resort if the other deescalation and other things that your staff have been trained have not been successful?* ***A.*** *I think we already talked about this. I didn't answer that because* ***I really don't.*** *It's so case specific and it's based on that person's behavior plan and I'm just not comfortable answering.* Melissa Weatherton, p. 66.
- Restraint incidents are routed to the HDC's Human Rights Committee, who is supposed to review it to make sure it was appropriate, etc. However, Weatherton is not able to even say whether the HRCs have a standardized protocol or process they go by in doing so, or what any of those protocols might be. Melissa Weatherton, p. 67, 68.
- Weatherton has no recollection of the 2019 BHDC incident in which a staff member broke a client's arm during a restraint. She also has no recollection of a 2019 BHDC incident in which a staff member choked a client unconscious during a restraint. Melissa Weatherton, p. 67, 68
- ***Q.*** *Do you have an opinion as to whether or not a choke hold around someone's neck that rendered them unconscious would be appropriate?*
  A. *I'm not going to give an opinion on something I don't know about it.* Melissa Weatherton, p. 69.
- Weatherton acknowledges that CPI/NCI is the training curriculum used at HDCs to train staff on de-escalation techniques and proper use of restraints. Melissa Weatherton, p. 42.
- CPI/NCI is the training that has been authorized for use by staff at HDCs. Melissa Weatherton, p. 43.

- **Staff at the HDCs are required to follow their training.** They are not allowed to wing it and use techniques not taught to them. Melissa Weatherton, p. 43.
- Weatherton trusts Gonyea and Berry to provide accurate information. She would assume their statements concerning Hise to be true (same would go for statements they made about Evans). Melissa Weatherton, p. 45.
- Weatherton was quoted in a news piece stating that staff who broke client's arm in 2019 committed abuse and what he did was "not in compliance with our training," so he was terminated. Melissa Weatherton, p. 73, 74.
- **Staff must follow the training they have been given when restraining clients.** Melissa Weatherton, p. 74.
- **Failure to follow proper training can cause abuse.** Melissa Weatherton, p. 74
- Weatherton believes BHDC policy needs to be clarified or modified "to permit staff to contact 911 in response to emergency medical situations. Staff must have permission to identify and respond in an emergency." This was a recommendation made by DRA to the Committee she formed, and she agrees with this specific recommendation, which she included in her responsive letter to Tom. Melissa Weatherton, p. 58.
- According to Weatherton, retraining only occurs when OLTC finds something that needs further addressing after an event occurs, or when something is wrong. Melissa Weatherton, p. 51, 61, 62, 85.
- DDS formed a Behavioral Consultation Committee within a couple months of DC's death to work on reducing restraint usage within the HDCs. Melissa Weatherton, p. 35.
- Weatherton acknowledges she said this to the Dem-Gaz: "It's very clear that a personal restraint did occur leading up to him passing away-- but I've looked at every document, I've looked at [Disability Rights Arkansas]'s report, I've looked at hospital reports. I've not been given any kind of documentation that says the personal restraint did, or did not, lead to the passing of that client." Melissa Weatherton, p. 81.
- Weatherton's position is *still* that she does not know whether the restraint did or did not cause DC's death. Melissa Weatherton, p. 83.
- "Federally, we're required in Arkansas, when you have a developmental disabilities division, you're required to have a three-pronged organizational structure in your state. So Disability Rights fills one of those three prongs along with my division and the University of Arkansas at Fayetteville. They are a federal advocacy organization that's been designated by the state to be the advocacy organization here in Arkansas." Melissa Weatherton, p. 17.
- The DD Act mandates DRA's involvement. Melissa Weatherton, p. 18.

- DRA's involvement is required by law. Melissa Weatherton, p. 19.
- She thinks it [the Behavioral Consultation Committee] was formed around the "end of summer" of 2020. Melissa Weatherton, p. 36.
- Weatherton appointed two representatives of DRA to this Committee, including its director Tom Masseau and one of its advocate attorneys, Regan Sanford (who co-authored the DRA Death Report on DC). Melissa Weatherton, p. 35, 37, 64.
- She wants their [the behavioral consultation committee] involvement on the Committee and to hear their [the behavioral consultation committee] ideas. Melissa Weatherton, p. 46, 47
- Weatherton told the Democrat Gazette that cameras would have helped make the [David Cains] situation "black and white" to her.
  ***Q**. I think, in the article, you're quoted as saying that cameras -- if there had been cameras at the facility in Booneville, which had none, it would have helped to make the situation, quote, black and white to you. Does that sound like something you would have said or believed at the time?*
  ***A**. I am a big believer that we need to have high quality cameras across our facilities.* Melissa Weatherton, p. 81.
- DC is not responsible for his own death, "**of course not**!" Melissa Weatherton, p. 85. This runs counter to the opinion of her expert witness.

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 16th day of February, 2023, and service shall be accomplished via email to counsel of record.

/s/ Joshua D. Gillispie
Joshua D. Gillispie

Deposition Summary – Dian Elliott

The OLTC surveyor, Dian Elliot, is employed by the Arkansas Department of Human Services. Dian Elliot, p. 29 She works for the same state agency as DDS staff and as BHDC staff. She lives in the Booneville area, in Paris, which is about 20 to 25 miles from Booneville, according to Ms. Elliot. Dian Elliot, p. 30 She conducted the OLTC investigation in one day, 6.30.20. She began at approximately 8:40am and was finished by approximately 3:07pm. Dian Elliot, p. 31 On this same day, during these same hours, she conducted at least two other investigations into complaints unrelated to David Cains. Dian Elliot, p. 48

She conducted only four interviews; those were the three staff members who restrained Davie and one LPN who responded. Dian Elliot, p. 20 She does not recall the identity of the one LPN she interviewed. Dian Elliot, p. 55 She did not interview anyone else at BHDC during her investigation. Dian Elliot, p. 56 She did not interview or speak with Davie's mother or sister. Dian Elliot, p. 36 Elliot testified that all the documents she reviewed for her survey were: Ambulance Records, Clinical Record, Facility In-Service Records, Facility Investigative Reports, Hospital Records, Incident Records or Critical Incident Reports, Nurses Notes, Personnel Records/Background Check, et cetera, Physician Orders, Physician Progress Notes, Roster Matrix/Resident, Client Census, Staff Training, and the IPP and Speech/Language Evaluation. Dian Elliot, p. 50, 51

Ms. Elliot's testimony revealed she conducted her investigation under the mistaken belief that the paramedics were not able to clear Davie's airway. Dian Elliot, p. 58

The federal regulations (Appendix J) are the only set of policies that she uses to determine facility compliance. Dian Elliot, p. 71 It contains policies regarding restraint use. Dian Elliot, p. 72 Elliot testified that, in her investigation into whether the facility complied with ICF-IID federal regulations (aka CMS regulations, aka Appendix J, aka State Operations Manual), she utilized only certain parts of the regulations, those found under Tags 127, 128, 153, 154, 285, 286, and 331. Dian Elliot, p. 56, 57

Elliot testified that, if a BHDC staff member were to violate the federal regulations, it would be a violation on the facility. Dian Elliot, p. 64 The facility is responsible for its staff's actions. Dian Elliot, p. 64 If a staff member does something in violation of the federal regulations, that violation is attributed to the facility. She would cite the facility. Dian Elliot, p. 65 If a staff member were to subject a client to abuse, the facility would be in violation. Dian Elliot, p. 66 **She looks at staff actions to determine whether the facility is in compliance with the federal ICF-IID regulations.** Dian Elliot, p. 69, 70 **Appendix J (the federal regulations, CMS regulations) pertains to how staff treat clients, including staff's use of restraints on clients.** Dian Elliot, p. 70, 71

Q Right? And for a facility to be either in compliance or not in compliance, that would have to be based on what the people working there do or do not do?
A Yes. Dian Elliot, p. 64

Elliot testified that unnecessary physical restraint would be abuse. Dian Elliot, p. 88, 89.

She did not speak to Sandy Evans about how she went her interviews of staff during the maltreatment investigation. Dian Elliot, p. 94.

Elliot did not look to determine compliance with Tag 276 during her investigation. Dian Elliot, p. 94, 56, 57, 20. The facility **must <u>specify</u>** all facility approved interventions to manage inappropriate client behavior. ICF-IID Reg. § 483.450(b)(1)(i), [W276], Bates 1753. All interventions for the management of inappropriate client behaviors which are approved for use in the facility are **clearly stated and described** in its policy. ICF-IID Reg. § 483.450(b)(1)(i), [W276], Bates 1753.

Elliot agrees that the policies and procedures of a facility like BHDC must specify all facility-approved interventions to manage inappropriate client behavior. Dian Elliot, p. 98, 99. She agrees that all interventions for the management of inappropriate client behaviors which are approved for use in a facility like BHDC must be stated and described in its policy.

Elliot did not look to determine compliance with Tag 277 during her investigation. Dian Elliot, p. 101, 56, 57, 20. The facility must designate facility interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive. Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior. ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753. Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. ***Individual plans should <u>specify the specific techniques</u> that have been determined through assessment to be least restrictive for each client.*** ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753.

Elliot's testimony reveals that she does not possess a full understanding of at least some of the federal regulations. She testified that the potential physical restraints that might be used on a client do NOT have to be stated or described in that client's IPP. Dian Elliot, p. 105. Counsel gave her an opportunity to correct herself, but Elliot doubled down, testifying that the types of restraints that could potentially be used on a client are NOT required to be described in the client's IPP. Dian Elliot, p. 106: 19-22. Her testimony directly contradicts the federal regulation found at Tag 295, which Elliot did not look at to determine compliance with during her investigation. Dian Elliot, p. 108, 56, 57. **BHDC is required to specify, within a client's IPP, the physical restraints that can be used.** ICF-IID Reg. § 483.450(d)(1)(i), [W295], Bates 1764. The IPP must address, among other things, "**the type of physical restraint**" and the "**specific** type of client behavior" for which these physical restraints described in the plan can be used. *Id.*

After counsel pointed this contradiction out to Elliot, she explained she had misunderstood counsel's question: "It does say type of physical restraint. But you asked me, does it not have to describe the types, or how you -- I took it as how you do them, no. Because that -- and it will

say -- the IPP will give you it gives you less restrictive measures, such as talking to them -- trying to talk them down, trying to -- they might say, you can put in a physical hold. Now, if there is something in a physical hold that will trigger them worse, that may be included in the IPP. Like they are not -- you are not allowed to maybe take them to the floor. (Indicating.)" Dian Elliot p. 109. Elliot eventually changes her answer, testifying that a client's IPP must address the "type of physical restraint" that could be used on that client. Dian Elliot, p. 112

Staff cannot use any form of physical restraint they deem appropriate. "Absolutely not." Dian Elliot, p. 110. Staff cannot use any form of physical restraint they choose in an emergency either. "Absolutely not." Staff must follow their training and instruction. Dian Elliot, p. 112, 24-25, p. 113, 1-5. Staff can only use the restraint methods they are taught. Dian Elliot, p. 116.

Q Staff can't use methods that aren't approved by the facility, can they?
A No.
Q They can't use methods that aren't taught to them by the facility, can they?
A No.
Q Those would be violations of Appendix J, wouldn't they?
A Yes. Dian Elliot, p. 110, 18-25, p. 111, 1. [Mark Hise's testimony proves that staff violated Appendix J. Had Elliot interviewed Hise she would have known this.]

Elliot did not look to determine compliance with Tag 280 during her investigation. Dian Elliot, p. 111, 16, 17, 20. Federal Regulation says policies and procedures of a facility must address the **"types of physical restraint"** that are allowed in the facility. ICF-IID Reg. § 483.450(b)(1)(iv)(B), [W280], Bates 1755. Federal Regulation says policies and procedures of a facility must address the persons who can use the physical restraints, must address the parameters for duration of application, and **must address methods** that ensure the health and safety of the person to be restrained. ICF-IID Reg. § 483.450(b)(1)(iv)(B), [W280], Bates 1755. Federal Regulation says policies and procedures of a facility **must address the specific training required** for staff who are allowed to apply the physical restraints. ICF-IID Reg. § 483.450(b)(1)(iv)(B), [W280], Bates 1755.

She testified she agreed that a facility's policies and procedures must address the types of physical restraint that are allowed in the facility. Dian Elliot, p. 118. **Elliot admits that she does not recall seeing the ground restraint used on David Cains mentioned anywhere in BHDC's policies and procedures.** Dian Elliot, p. 119, 12-14.

Elliot never spoke to Mark Hise, Staff Development Coordinator and BHDC's restraint instructor. Dian Elliot, p. 120.

Q Hypothetically, if you had learned in your investigation that this was an unauthorized restraint that was used on David on the ground, could that have changed the outcome of your survey?

A It's possible that it could have as far as the use of an unauthorized restraint, yes. Dian Elliot, p. 122, ll. 4-9

Elliot, to explain why she might not have deemed the facility responsible for his death even had she been aware the restraint was unauthorized, then goes on to offer the following opinion as to David's cause of death: "As far as the facility being responsible for his death, probably not. **Because he had diagnosis of GERD**, he had a seizure disorder. **It was directly after he had eaten**. The facility -- he got upset, the facility responded as soon as he vomited. **And aspiration of food is a big possibility whenever you vomit.** You know, I mean, for him, for us, you know, we could -- (Indicating.) **The GERD might have contributed to it**, he may have had a seizure. I do not know. According to the documentation that I looked at, food could have even gotten into the airway, you know." Dian Elliot, p. 122 [Elliot opines correctly that GERD likely contributed to David vomiting. However, Elliot neglected to learn or consider that staff, by restraining Davie on the ground right after lunch, violated his physician's order requiring that he remain upright for one hour after eating. Elliot neglected to learn that the ground restraint used was not an authorized form of restraint in which staff are trained. It was unauthorized and staff were not trained to do it.]

Elliot did not look to determine compliance with Tag 278 during her investigation. Dian Elliot, p. 123, ll. 5-6, 17-20 **In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.** [ICF-IID Reg. § 483.450(b)(1)(iii), [W278], Bates 1754].

Elliot testified she is aware that only the least restrictive form of physical restraint that is available can be used in any situation. Dian Elliot, p. 123 **In an emergency situation, the staff are required to use the least restrictive technique available that might be effective in the situation.** Dian Elliot, p. 123, ll. 13-14, 1-4

Q Okay. And the least restrictive -- and so, if I'm hearing you right, what you are saying is or how you interpret the regulation is that they would be required to use the least restrictive technique that could work for any given situation? Does that make sense?
A They have to use the least restrictive technique that would be appropriate for that behavior or situation that is happening at that time, yes. Dian Elliot, p. 146, ll. 17-25

Elliot did not speak with Sandy Evans, the facility's maltreatment investigator for the incident. Dian Elliot, p. 90, l. 138 Elliot says that it might not have made a difference in the outcome of her survey had Sandy Evans admitted (as she did during deposition) to her that the restraint used on Davie was not the least restrictive, because Sandy is "just the investigator." **It would be CPI instructor (Mark Hise) whose opinion would have really mattered to her.** Dian Elliot, p. 139, 140

A I do my own investigation. So, if she – even if she told me something like that, I would have to investigate and see what I found out, because I do my independent investigation. I do not go by what their facility has investigated.
Q Okay. Would that have been useful information to you?
A Not until after -- that might have been something -- if I had decided in my investigation that that was an inappropriate restraint and it was not the least restrictive or whatever, then what we would do is, then I would go to the CPI person, trainer, and I would ask -- I would ask him questions. Dian Elliot, p. 139

Q Okay.
A So, if he told me -- then at that point, if he looked at me and I would have said, "Was that the least restrictive that they could have used," and he looked at me and said, "No," that would have been in my investigation, that's part of my evidence. So, it would have been after I did my investigation if I would have asked her that. But she is just the investigator. ***I would go to the CPI person.***
Q And if the CPI person told you that the restraint used was something he did not teach, something that was not part of CPI, and not the least restrictive option, that would have been a big deal to you?
A That would --
Q That would have been a big deal to you?
A I would have considered that strongly in my investigation, yes. Dian Elliot, p. 140

Q Ms. Elliott, is it your testimony, as you sit here today, that in response to an emergency situation staff are allowed to use any technique that they want? they want?
A Oh, no.
Q Is it your testimony, as you sit here today, that in an emergency situation anything that staff does in response is, by definition, the least restrictive possible?
A Anything they do in response would be the least restrictive? No. Dian Elliot, p. 141: 23-25; p. 142: 1-8. [Elliot interprets Tag 278 the same way Claimant does. She does not agree with her lawyer's interpretation, which is insane.]

Elliot also did not look to determine compliance with Tag 289 during her investigation. Dian Elliot, p. 20: 56: 57. The use of behavior interventions are expected to be incorporated into the IPP and be based upon the results of the functional behavioral assessment. However, **there may be isolated and rare instances when a client exhibits unexpected behavior that requires immediate intervention on the part of the staff. In these instances, <u>the least restrictive intervention must be employed</u>** and removed as soon as the client is no longer an immediate threat to self or others. The IPP team must then discuss the need for adding a behavioral plan into the client's program. ICF-IID Reg. § 483.450(b)(4), [W289], Bates 1760.

Elliot also did not look to determine compliance with Tag 296 during her investigation. Dian Elliot, p. 20: 56: 57. **The facility may employ physical restraint "as an emergency measure, but only if *absolutely necessary* to protect client or others from injury."** ICF-IID Reg. § 483.450(d)(1)(ii), [W296], Bates 1764.

Elliot also did not look to determine compliance with Tag 298 during her investigation. Dep. Elliot, p. 20: 56: 57. The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. ICF-IID Reg. § 483.450(d)(2)(i), [W298], Bates 1766.

Arkansas
State Claims Commission
FEB 16 2023
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BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains	**CLAIMANT**
V.	**Claim No. 220374**
THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)	**RESPONDENT**

WITNESS LIST

COMES now Claimant, by and through her attorney, Joshua D. Gillispie, and for her Witness List, states the following:

Live Witnesses:

1. Kris Stewart – Disability Rights Advocate
2. Christine McAuliffe – Claimant – Davie's sister
3. Charlene Robinson – Davie's mother
4. Dr. Ricki Brown – Causation Expert – ER Physician – via ZOOM
5. Bob Bowen – via ZOOM

Witnesses Appearing by Deposition:

1. Amanda Schmitt – BHDC LPN
2. Amy Jones – BHDC Shift Supervisor – participated in death restraint
3. Caleb Murry – BHDC Social Services Worker
4. Carrie Johnson-Miller – BHDC Residential Services Manager
5. Dian Elliott – OLTC Surveyor
6. Don Carter – Form BHDC Staff Member
7. Dr. Janice Lebel – Liability Expert – Restraint Reduction Specialist

8. Jeff Gonyea – BHDC Superintendent
9. Jennifer Berry – BHDC Assistant Superintendent
10. Justin Jobb – BHDC QIDP/Program Director
11. Kelly King – BHDC LPN
12. Mark Hise – BHDC Staff Development Coordinator
13. Jonathan McCutcheon – Former BHDC Staff Member
14. Mike Alvis – BHDC Psychological Examiner
15. Rhonda Harris – BHDC Prevocational Trainer
16. Dr. Ricki Brown – Causation Expert – ER Physician
17. Ryann Campos – BHDC Staff Member – participated in death restraint
18. Samuel Scow – Logan County Paramedic
19. Sandy Evans – BHDC Residential Services Director
20. Sarah Cains – Davie's half-sister
21. Dr. Syed Hamid – BHDC Staff Physician
22. Tyler Mattson – BHDC Staff Member – initiated death restraint
23. Melissa Weatherton – DDS Director

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 16th day of February, 2023, and service shall be accomplished via email to counsel of record.

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains	**CLAIMANT**
V.	**Claim No. 220374**
THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)	**RESPONDENT**

EXHIBIT LIST

COMES now Claimant, by and through her attorney, Joshua D. Gillispie, and for her Exhibit List, states the following:

Exhibits:

1. DRA – Final Report on Cains Death
2. BHDC Staff Development Coordinator Mark Hise Deposition Transcript
3. BHDC Superintendent Jeff Gonyea Deposition Transcript
4. BHDC Policy I-D-4
5. ICF-IID Reg. § 483.450
6. BHDC Residential Services Director Sandy Evans Deposition Transcript
7. DDS 3004-I-Appendix A (6A)
8. Tyler Mattson OLTC Witness Statement
9. BHDC Staff Tyler Mattson Deposition Transcript
10. BHDC Staff Ryann Campos Deposition Transcript
11. BHDC LPN Kelly King Deposition Transcript
12. BHDC LPN Amanda Schmitt Deposition Transcript
13. Former BHDC Staff Don Carter Deposition Transcript

14. BHDC Psychological Examiner Mike Alvis Deposition Transcript
15. BHDC Social Services Worker Caleb Murry Deposition Transcript
16. Claimant Christine McAuliffe Deposition Transcript
17. DDS 3011-D
18. BHDC Shift Supervisor Amy Jones Deposition Transcript
19. BHDC Residential Services Manager Carrie Johnson-Miller Deposition Transcript
20. BHDC QIDP/Program Manager Justin Jobb Part II Deposition Transcript
21. OLTC Surveyor Dian Elliott Deposition Transcript
22. Dr. Janice LeBel - Summary of Expert Opinions
23. Dr. Janice LeBel Deposition Transcript
24. BHDC Assistant Superintendent Jennifer Berry Deposition Transcript
25. Dr. Syed Hamid Deposition Transcript
26. Former Staff Jonathan McCutcheon Deposition Transcript
27. 5/29/20 Behavior Incident Report No. 1
28. 5/29/20 Behavior Incident Report No. 2
29. 3/20/20 Behavior Incident Report
30. DRA Advocate Kris Stewart Deposition Transcript
31. Photos of Tyler Mattson
32. DDS Director Melissa Weatherton Deposition Transcript
33. BHDC Client Rights
34. BHDC First Aid Guidelines – Policy IV-B-10
35. "An Investigation into the Physiological and Psychological Impact of Supine and Side Lying Physical Restrain Techniques"

36. Ryan Campos OLTC Witness Statement
37. Dr. Janice LeBel – CV
38. DRA Investigation Report – BHDC Death – 2016
39. Nurses Notes – Amanda Schmitt
40. Paramedic Samuel Scow Deposition Transcript
41. Logan County EMS Report
42. Dr. Ricki Brown Deposition Transcript
43. NY OPDD – Prevention of Choking and Aspiration – NY State Training
44. Dr. Ricki Brown-Forestiere CV
45. Photos of Davie
46. Physician Orders at Discharge 6-19-20
47. Physician Orders 6-1-20
48. Physician Orders 3-1-19
49. BHDC Prevocational Trainer Rhonda Harris Deposition Transcript
50. 1.31.21 Dem-Gaz Article
51. DRA 2016 Report – Booneville's Excessive Use of Restraints
52. BHDC's Timeline
53. Facility Case Notes 6.13.20 – False Info Provided Mother
54. Charlene Robinson Deposition Transcript
55. Ashley Cains Deposition Transcript
56. Justin Jobb Deposition Transcript—Part One
57. BHDC Annual Training—Avoiding /Defusing Violent Behaviors
58. David Cains Behavior Treatment Program—2018

59. BHDC Annual Training—Choking Protocol

60. Behavior Treatment Program Addendum—David Cains 2016

61. Logan County EMS Bill

62. BHDC Policy I-D-2

63. David Cains Psychological Evaluation 2020

64. Consultant Report—September 2022

65. David Cains IPP 2019

66. BHDC Policy I-A-1

67. BHDC Residential Tracking Sheet—Incident Reporting—6/15/20

68. BHDC Policy I-A-5

69. BHDC Policy III-A-8

70. Bob Bowen CV

71. Logon County Coroner's Report

72. *Roland v. Cellucci*, 198 F.Supp2d 25 (U.S.D.C.—Mass. District, 2002)

73. David Cains Dysphagia Disorder Survey 2018

74. Letter to Tom Masseau from Melissa Stone

75. David Cains Death Certificate

76. DHS emails—Masseau and Stone

77. DHS Policy No. 3011-D

78. Deposition Videos

Respectfully submitted,

/s/ Joshua D. Gillispie
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 16th day of February, 2023, and service shall be accomplished via email to counsel of record.

/s/ Joshua D. Gillispie
Joshua D. Gillispie

Disability Rights Arkansas

Dignity. Respect. Advocacy.

Tom Masseau, Executive Director

October 22, 2020

Arkansas
State Claims Commission
FEB 16 2023
RECEIVED

Director Melissa Stone
Division of Developmental Disabilities
Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72203-1437

Director Stone:

Disability Rights Arkansas (DRA) is the designated federal Protection and Advocacy System ("P&A") for individuals with disabilities in Arkansas. One of DRA's core functions is to investigate the deaths of persons with developmental disabilities in facilities that provide services to people with developmental disabilities. DRA has authority under federal law to thoroughly investigate deaths occurring in any public or private entity that provides care, services, treatment, or habilitation to individuals with disabilities.

As you are aware, resident David Cains of Booneville Human Development Center (BHDC) died on June 13, 2020. His death occurred while three BHDC staff restrained David on the floor outside of the cafeteria. David's family contacted DRA and requested we investigate his death and the circumstances surrounding it.

DRA completed an extensive investigation into David's death. Our investigation involved reviewing the Adult Maltreatment Investigation Report, all witness statements, the DPSQA Complaint Investigation Report, the EMS report, hospital records, and the Coroner's report. Our office interviewed BHDC staff, including Tyler Mattson, Amy (Mandy) Jones, and Ryann Campos, the individuals who restrained David; Sandy Evans, the Adult Maltreatment Investigator; Jeff Gonyea, the Superintendent; and Mark Hines the NCI instructor. Our office also interviewed the Emergency Medical Services provider, Samuel Scow, who provided emergency services that day, as well as Michael Chrisman, the Deputy Coroner who was assigned to David's case.

Summary

David Cains was 42 years old, [redacted]

According to the BHDC Staff written statements and interviews with DRA staff:



On June 13, 2020, David ate his lunch in the cafeteria at the Commons Building. After finishing his meal, David put his tray away, asked to go to the restroom, and was accompanied to do so by Tyler. According to Tyler, David seemed irritated, asked to sit in the lobby to calm down after exiting the restroom, and then began screaming, ripping paper off the wall, and attempting to hit Tyler.

Tyler stated that he, "applied personals[1] by grabbing [David's] arms and ended up falling over."[2] David landed on his face and Tyler then rolled him to his side.[3] Tyler believes that this restraint began at 11:30 a.m., although all times are estimates as there are not any visible clocks in the area where the restraint occurred, according to all staff interviewed. Mandy Jones arrived shortly after David was brought to the ground and assisted in the restraint. According to all written witness statements, David was resisting the restraint at that time. Ryann Campos arrived sometime later and began holding David's legs.

[redacted]

From EMS Report and BHDC Staff written statements:

At 11:37 a.m. one of the nurses instructed BHDC staff to call 911.[7] At 11:50 a.m. Logan County EMS arrived.[8]

[redacted]

This entire event took place on the floor while three people were holding David by his legs, torso, and head. A fact that was omitted in reports to EMS, the hospital, the Coroner, and the family.

During our investigation, we noted several unresolved discrepancies between written statements, subsequent interviews, and investigative conclusions:

1) There is not a consensus between the employees involved regarding the positioning and

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[1] Tyler, during his interview, acknowledged that this is a restraint.
[2] OLTC Witness Statement, Tyler Matteson, Page 2 of 3
[3] Interview of Tyler Mattson by DRA staff on July 29th.
[4] OLTC Witness Statement, Ryann Campos Page 1 and 2
[5] OLTC Witness Statement, Tyler Matteson, Page 2 of 3
[6] OLTC Witness Statement, Amanda Schmidt, LPN
[7] BHDC Policy IV-B-10 states that on-site medical should be the first call and that "medical will assess the situation and call an ambulance if appropriate." All persons interviewed, including Superintendent Gonyea, interpreted the policy to prohibit non-medical staff from calling 911 in response to a medical emergency and confirmed that as the BHDC practice.
[8] Logan County EMS patient record.
[9] *Id*
[10] *Id*

actions of each employee, information pertinent to identifying not only potential wrongdoing, but also possible missteps to be avoided in the future.

a. Ryann's written statement and subsequent interview by DRA staff were consistent with one another. She states that when she arrived David was on the ground on his left side, Tyler was on his knees facing David and holding his wrists, and David's hands were by his sides. Mandy "came to assist to position David's head so he wouldn't spit"[11] and then Ryann attempted to assist by holding David's ankles when he began to kick.

b. Mandy stated that when she arrived, "David was on his left side with his arms held up with his elbows bent slightly."[12] She states she assisted by holding David's hands so that he could not strike Tyler, who was positioned behind David. Mandy denied ever holding David's head during the restraint.

c. According to Tyler's written statement he was "squatted over him, not putting [his] weight on him during any of this, holding his shoulder and sides,"[13] Mandy assisted by "grabbing his hands," and Ryann held his legs down. During our interview, Tyler deviated from his written statement, stating "she [Mandy] was on his side behind him, holding his head on the side, keeping close to ground but not pushing on it"[14] because David was trying to bite. He also clarified his positioning as being behind David, who was laying on his left side and "spread out T-style"[15] with his left arm on the ground. Tyler was holding his right arm (not Mandy) and trying to get it to the ground. David's arms were never above his head.

d. Adult Maltreatment Investigation Report #5-2020, completed by Sandy Evans, fails to resolve discrepancies regarding the placement of David's hands and whether a staff member was holding his head in place during the restraint.

e. Cameras at the facility would have been immeasurably helpful in resolving the discrepancies and ultimately understanding the circumstances surrounding David's death.

2) A timeline of events included in two separate documents we received completely omits any reference to a restraint having occurred.

a. The DHS Incident Report includes a timeline of events provided by Stacy Weinbrenner, RN/DON, who does not appear to have been at the scene of the incident at any time.

i. According to the timeline at "11:30 a.m. – Immediately after lunch, David Cains headed to common area kicking, yelling, and biting. Tyler and Mandy attempted to settle client. Suddenly started vomiting and turning cyanotic."

1. Tyler and Mandy's written statements and interviews with DRA indicate that Mandy did not arrive until Mr. Cains was already on the ground and being restrained by Tyler, in conflict with the assertion here.
2. There is no evidence of either staff member attempting to "settle" David.

b. A similar statement is included in a "Timeline of Events" that appears to be a word document included in David's medical file. The statement is not attributed to anyone in this document.

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[11] OLTC Witness Statement Form, Ryann Maria Campos, Page 1 of 2
[12] OLTC Witness Statement Form, Amy Amanda Jones, Page 1 of 4.
[13] OLTC Witness Statement Form, Tyler Mattson, Page 2 of 3
[14] Interview of Tyler Mattson by DRA staff on July 29th.
[15] *Id*

When DRA interviewed Emergency Services Worker, Samuel Scow, he stated BHDC staff never informed them that David had been in a personal restraint prior to or during this incident. Samuel stated that they were told that David was found in the hallway, unconscious, and staff attempted abdominal thrusts prior to CPR. They were told that he had choked on his lunch. EMS relayed the same information to the ER staff at Mercy Hospital in Booneville.

[redacted]

The same misinformation was passed on to the investigating coroner, Deputy Coroner Michael Chrisman, [redacted] Mr. Chrisman stated:

[redacted]

When our office interviewed Mr. Chrisman, he stated he had no knowledge that David was restrained prior to or during this incident. He confirmed that his office would have further investigated had they received that information and would likely have requested an autopsy.

When BHDC staff contacted David's mother, they told her that David choked on his lunch and that the family would need to contact the hospital for any additional information. When the family called Mercy Hospital, they were informed David was deceased. David's family did not find out about the personal restraint until June 22nd – nine days after David passed away and three days after David's funeral. By the time the family learned of the circumstances surrounding his death it was too late for them to request an autopsy.

This was a tragic event. Any time an individual passes away while in the custody and care of the state a meaningful, critical evaluation of the policies and practices that led to that incident should be required. In this case, that evaluation included: (1) an investigation by an individual who is employed by the BHDC, working alongside those who she is charged to investigate; (2) a review and endorsement of that investigation by the superintendent who hired or who is ultimately responsible for the actions of those employees investigated; (3) the suppression or omission of relevant, if not crucial facts from agencies who would further investigate the circumstances of this gentleman's death.

The BHDC review of this death, endorsed by Superintendent Gonyea, concluded that no individual involved in this incident did anything wrong; therefore, nothing could have been done differently to prevent it and nothing can be learned from it. To date, we have not been informed whether BHDC has reviewed or revised their restraint policies or practices following this event.

At some time after the internal investigation concluded the Division of Provider Services and Quality

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[16] Logan County Coroner Report.
[17] *Id*

Assurance (DPSQA) investigated David's death and the circumstances surrounding it. Very little information could be gleaned from the DPSQA Complaint Investigation Report reviewed by DRA. Despite the ability to attach narratives of staff interviews, none were found or made available upon our request. Ultimately, the DPSQA investigation concluded similarly to the internal investigation conducted by BHDC with no description of the events or statements from witnesses.

Practice of Restraints at BHDC

In 2012, DDS retained H&W Independent Solutions, who are self-described "skilled trainers and workshop facilitators on a wide range of topics pertinent to organizations supporting people with disabilities." In April of 2012, BHDC participated in a training survey with H&W to evaluate and improve the quality of care to the residents. During the evaluation of BHDC, H&W found that significant improvement was needed due to, in part, the BHDC staff's reliance on emergency restraint.

Nearly four years later, in January 2016, our office issued a report regarding the use of restraint at BHDC. We warned that risks associated with restraint include physical injuries, significant trauma, and death. We pointed out that the overuse of restraint could cause physical and emotional trauma to both the residents and the staff at BHDC. We recommended that BHDC retain an independent expert to implement evidence-based alternatives aimed to reduce or eliminate the use of restraint at BHDC.

NCI/CPI trains staff to respond to crisis by intervening in non-violent ways to prevent escalation and offers programs to certify staff in this skill. At the same time BHDC certifies its staff in the use of NCI/CPI, BHDC also trains its staff to restrain residents using methods that require no certification, are not evidence-based, and, when practiced, conflict with NCI/CPI training. It is concerning that BHDC staff are then left to choose between non-violent crisis intervention and physically/emotionally traumatizing physical restraint.

Findings

- David was diagnosed [redacted]
- Instead of releasing David when he was lying down on the floor, David was restrained on the hard floor by three BHDC staff after finishing his lunch.
- Prior to the restraint, Staff failed to use other less intrusive interventions such as NCI/CPI, for which they are trained.
- Staff failed to leave him on the floor, unrestrained, until he was calm.
- [redacted]
- This restraint likely either directly or indirectly led to David's death.
- The facility failed to properly communicate the circumstances of this incident to EMS.
- We found no evidence that the facility properly communicated the circumstances of this incident to the Arkansas State Police, the Logan County Sheriff's Office, or any other law enforcement agency.

- BHDC's investigation failed to resolve discrepancies in statements from witnesses.
- It is not the policy or practice of BHDC to permit direct care staff to call 911 in an emergency.
- NCI/CPI does not endorse or instruct any maneuver that involves physically restraining an individual on the floor.
- During interviews, BHDC direct care staff reported that they, "take people to the floor often."
- BHDC could not articulate what kind of "restraint technique" is being taught to staff.
- The conclusion from Superintendent Gonyea failed to find that anyone violated any policy or procedure and inexplicably failed to find that any policy or procedure might need review or modification.
- No corrective actions were made or recommended by BHDC or DHS - Division of Provider Services and Quality Assurance.
- BHDC failed to adequately inform David's family of the circumstances surrounding his death.

Recommendations

1. ***Install video cameras on campus***. Video cameras on campus would greatly assist investigators in determining whether maltreatment has occurred. Presently, we have differing statements from individuals regarding a restraint on the floor that led to an individual's death.
2. ***Retrain all staff in NCI/CPI.*** NCI/CPI does not endorse the use of restraint while an individual is lying down on the floor. The very fact that NCI/CPI is touted as the intervention strategy implemented by BHDC, and yet this individual was restrained on the floor long enough to aspirate and die means that NCI/CPI was either ignored or forgotten.
3. ***Reevaluate the use of restraint in all forms and employ evidence-based, nonviolent methods of crisis intervention.*** A greater problem that exists is the overall reliance on restraint at BHDC. It is a culture of compliance that we see often in prisons. When individuals are not compliant, they are made to comply. If DHS does not address restraint and physical, mechanical, and chemical intervention as a system-wide problem, the culture cannot be meaningfully changed. Further, the physical restraints BHDC employs are not based on any professional training or sanctioned method.
4. ***Clarify or Modify policy to permit staff to contact 911 in response to emergency medical situations.*** Staff must have permission to identify and respond in an emergency. BHDC is a large campus in a rural area of the state. While it is comforting that nursing staff is available to respond to medical issues, the current policy forces staff to ignore what many first aid/CPR certification programs insist is the first step in responding to a crisis – calling 911.
5. ***Engage qualified, independent investigators to complete thorough, meaningful investigations on ALL deaths.***

a. *Utilize investigators that are completely independent of the Human Development Centers they investigate.* While it is important that BHDC review incidents internally for quality improvement and staff oversight, there must be a truly independent investigation by a disinterested third party. At one time, DDS employed an attorney whose role was to investigate deaths at any HDC. We are unaware whether or why such a position no longer exists. Anyone DDS authorizes to investigate serious incidents should have no connection to the Human Development Centers they investigate. Investigators should be informed regarding the requesting of an autopsy and empowered to make such a request when warranted.

b. *Ensure all investigations are reflective of the gravity of the circumstances investigated.* Death investigations must be both thorough and critical. Investigations that lack specificity in their investigative processes and findings, do not include interviews of all involved parties, and by design can only substantiate maltreatment or declare nothing could have been done differently undermine confidence in the process. When a family is left to gradually learn new information regarding the death of their loved one, including that the coroner was not accurately informed of the circumstances surrounding the death, what else are they to be left with other than suspicion and anger? Instead, the trauma surrounding the death is amplified and revisited with each new fact they learn. That is not closure; that is not justice.

DRA requests a response, delivered electronically, to this letter by October 31, 2020.

Sincerely,

Kris Stewart, Advocate
Disability Rights Arkansas

Reagan Stanford, Attorney
Disability Rights Arkansas

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF

MARK HISE

May 12, 2022, at 12:40 p.m.

CRIS M. BRASUELL, CCR
BREPORTING@GMAIL.COM



A P P E A R A N C E S

ON BEHALF OF THE CLAIMANT:

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I N D E X

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EXHIBITS IDENTIFIED

(None Marked)

S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Mark Hise, produced, sworn, and examined via Zoom, commencing on May 12, 2022, at 12:40 p.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

PROCEEDINGS

WHEREUPON, Mark Hise was duly sworn to tell the truth, the whole truth, and nothing but the truth, and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Hi, Mr. Hise. Your name's Mark Hise; correct?

A Yes.

Q I'm Josh Gillispie. I'm an attorney and I'm just going to be asking you a few questions here.

Have you ever been deposed before?

A Maybe. (Inaudible.)

Q Mr. Hise --

A Not that I remember.

Q Okay. I got it.

You were speaking and we weren't able to hear you for a moment. I think you were cutting out for a second.

But can you hear me?

A Yes. I can hear you fine.

Q Okay. I can hear you fine now. All right. Good.

So a couple of ground rules here. The court reporter is taking down everything we're saying and she has to make a clean record so that we can have a good transcript. So, to that effect, it's important to

verbalize yeses and nos as opposed to head movements so she can hear it clearly and avoid hu-uh, uh-huhs and stuff. You know, try to say yes or no, if possible.

If you need to take a break, at any point, that's fine. Just let us know. And, other than that, you know, like I said -- did she swear you in already?

A Yes.

Q Okay.

So, you know, a deposition is you're giving testimony at a deposition just like if you were in court. You know, you're under oath, subject to perjury, all that. And so that's what a deposition is. And I'm just going to talk to you for a little bit today and you'll be done.

If you don't understand any of my questions, please let me know right away. Okay?

A Okay.

Q And I'll rephrase them or help you understand them, as best I can.

Mr. Hise, my understanding is you work in the staff development department at Booneville Human Development Center?

A Yes.

Q Okay. What is your job title there?

A Staff development coordinator.

Q Okay. You also work with a woman who is also a staff development coordinator?
A Yes.
Q And remind me of her name.
A Vanessa Wyrick.
Q Vanessa Wyrick. Okay.
Is there a Ms. Shipley?
A There was a former employee in staff development named Shigley, Sandra Shigley.
Q Okay. Sandra Shigley. And she's no longer there?
A Correct.
Q How long have you been at Booneville?
A I started in June of 1990, so almost 27 years.
Q Okay. And, when I say Booneville, I mean, of course, the Human Development Center.
A Sure. Almost 27 years.
Q Wow. And have you been in staff development that entire time?
A No, sir. I've been in staff development since 2016. I think around May 2016.
Q Okay. What did you do before staff development?
A I've had several different titles at BHDC. I started out as what's called a life skills trainer. I was working directly with the residents.
And I kind of worked my way up through the

supervisory ranks. I worked down at resident training and our recycling project for three years.

I've been a program supervisor on the 4-12 shift for ten years. And I was program supervisor on dayshift for about three years before I transferred to staff development.

Q So you've kind of done a little bit of everything?

A Everything. I started at the ground level and worked my way up.

Q Okay. And did you say that you've worked in direct care, at one point, as well?

A Yes, sir. For about two years when I first started.

Q About how many years?

A Two years.

Q Ten or two?

A Two.

Q Two? I'm sorry. I just couldn't hear you.

And, since 2016, you've been the staff development coordinator; is that right?

A Yes.

Q Okay. And what does that job entail?

A Basically, we train our new employees on policies and procedures. You know, certified in CPR and nonviolent crisis intervention training.

A lot of policy and procedure.

Q Okay. And, when you say policies and procedures, do you mean all BHDC policies and procedures? That's up to you to train them in?
A It's not up to me. We have different instructors that do certain parts of the training.
Q Okay. What parts of the Booneville policy are you responsible for training them on?
A Okay. I'm responsible for teaching our residential service staff and our nursing staff CPR, first aid, and AED operations.
Q What's that? ADD?
A Yes.
Q What's that?
A Automated external defibrillator.
Q Oh, okay. I cut you off. Sorry. Go ahead.
A Okay. And I teach our nursing staff BLS, which is basic life support.

I also teach all new-hire staff the nonviolent crisis intervention techniques. I teach emergency procedures.

There's -- they go through a two-week classroom training and we have different instructors coming in at different times and do certain trainings.
Q And is that what y'all refer to as Phase One?
A Yes, sir.

Q And is Phase I Booneville's term or is Phase I a term of some external policy or external training program y'all have adopted?
A No, it's a BDS policy, that we do the trainings.
Q Okay. So where does the term phase come from? Whose term is that?
A It's been phase every since I started 27 years ago. It's just called phase training.
Q Okay.
A I think we might have called it preservice before we send our employees out to work directly with clients. They have to be trained on how to properly handle situations and work with our residents.
Q Okay. And do you think that -- so it's not just Booneville but it's your understanding that it's all the human development centers across the state --
A Yes, sir.
Q -- are utilizing this same phase terminology and phase training?
A Yes, sir.
Q Okay. So it's your understanding it comes from DDS? It's DDS's terminology, their program?
A Yes, sir.
Q Do you know who at DDS would be most knowledgeable about this particular topic?

A No, sir.
Q And you said there are multiple people -- so Phase I lasts for how long?
A Two weeks. It's 40 hours of classroom training.
Q Okay. And that also includes training on personal restraints?
A Yes.
Q And does it also --
A Personal holds is a terminology that we use.
Q Okay. And does it also include training on personal holds or personal restraints in emergency situations?
A Yes. That's the only time that we use personal holds here, in an emergency situation.
Q Fair enough.
And you said there are multiple people throughout that first two weeks phase that come in and provide training; correct?
A Correct.
Q Are they all under you? Are you the boss of all those people?
A No, sir. I do not hold a management title.
Q Okay.
A I'm not a supervisor in any way. I just coordinating the training.
Q I see.

Who provides the actual training for the personal holds?

A Okay. That would be myself. I'm a certified nonviolent crisis intervention instructor.

Q Okay. That was my next question.

A That's what we touch on mostly.

Q Okay. So you are NCI certified?

A Yes.

Q Okay. I've been looking through their materials. A lot of it is available online and I've been studying up on that the last couple days, so I was going to ask you for that.

And the personal holds that you teach, are those all based on NCI?

A Yes.

Q Okay. So, as far as you know, there are no personal holds authorized at Booneville, authorized use at Booneville, that would not be authorized by NCI?

A No. We only use the nonviolent crisis intervention techniques that's been instructed to teach.

Q Okay.

A That's what I train our staff.

Q Okay. And has it always been that way? Or has it changed over the years?

A Changed over the years. When I first started in

1995, we used what was called -- it was -- let me try and think of the name of it. It's been awhile.

Gosh. Okay. It was AMT. And I can't remember what it was --

Q That's okay. How long has it been NCI?

A We had to switch from NCI or what was called -- gosh. I'm drawing a blank here. I'm sorry.

Q That's okay. Take your time.

A Okay. When I first started up here, it was called AMT. And it was called aggression management training.

And then, probably five years later, we switched to another aggression type training. And it was called Tact, T-a-c-t.

Q Uh-huh.

A And, to the best of my knowledge, we switched to the NCI training around 2010, possibly. Somewhere in there.

Q At the time of David Cains' death, y'all were using NCI?

A Yes.

Q And David passed away in June of 2020.

Has the personal restraint training changed in any way since David's death? Or personal hold training, however you want to call it.

A No.

Q Okay. So, since June of 2020, there's been no

changes in what's allowed, what's not allowed, et cetera, as it relates to personal holds?
A No.
Q Okay. So is Phase One broken down into part one and part two?
A Yes. Uh-huh. We do Phase One, 40 hours on the first week. Then they go out for OJT for one full week. And then come back for the Phase One, Part Two, for another 40 hours.
So it's actually three weeks of training, including the on-the-job.
Q Okay. OJT, on the job.
And which part of it is the personal hold -- is it Part One or Part Two where the personal holds are taught?
A Part One. And then we do a refresher on it before we actually send them out on the floor.
Q Gotcha.
A So it's covered two times during the training.
Q Okay. And my understanding is there are written tests that new hires have to pass in order graduate from Phase One, part one and two.
A Correct.
Q And is there also a written test, a separate written test that relates solely to the personal holds?
A Yes. It's through the NCI, Nonviolent Crisis

Institute. They had their own test that we give them with their book and their workbook whenever we're doing the class.

Q Okay. I think I have that here. I don't know if it's the same one, but y'all use the NCI test?

A Yes.

Q And my understanding is, in order to pass, each person has to get 70 percent or better, at least 70 percent of the answers correct; is that right?

A Correct.

Q And that's both for the restraint portion of the test but then also just the overall score of their test as well?

A Correct.

Q And these tests, these written test scores, are they kept by your office? Are they kept in personnel files?

A They're kept in staff development, in the employee's personal training file.

Q I think my understanding is not all of phase is NCI. Just the personal hold, personal restraint portion, is NCI based?

A Correct.

Q Okay. Sorry to ask repeat questions. All of this stuff is new to me and I'm just trying to wrap my head around it.

A I understand.
Q Do you recall if you conducted the training for the three direct care staff that were involved in the death incident of Mr. Cains?
A Not right off. I can't say that I was the one that conducted the initial training.
But it's our policy and procedure that they get recertified every two years; so I would have been in the recertification process.
Q And I'm sorry. I didn't even tell you who they were. Tyler Mattson, Ryann Campos, and Mandy Jones, Amy Jones. I think she goes by Mandy.
Do you recall anything specifically about their phase training?
A No. That was -- we train a lot of staff the initial training. No, I can't say for certain that they -- that I was in staff development when they went through Phase One training. I would have to look at the dates.
Q Well, I'm pretty certain that all three of them came to work at Booneville around 2017 or later, I want to say.
So, assuming that's true, despite whether you were the one that gave the training, would they have received the same training that we're talking about here today?
A Yes, sir.

Q Okay.
And then have you looked, have you gone back and looked at their test scores in preparation for today?
A No, I have not.
Q Okay. So you couldn't tell me what their test scores were off the top of your head?
A Not off the top of my head. But I have access to their file right here.
Q Okay. Well, yeah. If you've got it right there, I'd be curious to know. I'm going to ask Mr. Collins to give me copies of it. But, just for the purposes of today, that'd be helpful, if you don't mind taking a quick look.
A Okay.
Q Do you need a minute? Do you want us to go off the record for a minute while you find those?
A Sure.
Q Okay.

MR. GILLISPIE: Come back in like five minutes.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:
Q Mr. Hise, what did you find?

A Okay. Let me explain this to you.

Last year, we got relocated out of the HR building and moved to a different area. And so I do not have the deleted files on Campos and Mattson whenever they worked here the time before. Okay? I would have to do some digging and find those.

But, since Mandy Jones has been a current employee, I do have her file.

Q Okay. And what does hers reflect?

A Okay. It reflects that she successfully passed the NCI training.

Q Okay. Does it --

A I can show you the letter. Can you see it or. . .

Q I mean, does it say how she did on the test?

A It's just pass or fail.

Q Okay. So you don't keep a record of somebody if they got a 70 percent, 71 percent, or a 99 percent?

A Just on the final exam, all the things that were covered.

But, on the NCI training itself, it -- she passed.

Q Okay. Well, I'm going to, at some point, ask Eric to produce a copy of those things. You'll probably have to at least try to find some of those at some point. But you don't have to worry about it right now.

A Okay.

Q Okay.

Is everyone who would be teaching this NCI training in NCI certified as well?

A **Correct. Yes.**

Q Okay.

A **The Crisis Prevention Institute's policy is that we have to be recertified every two years.**

Q Okay. And I know you are. I just was asking, you know, you said there's other people that do training.

Who else is NCI certified at Booneville right now?

A **Vanessa Wyrick.**

Q Was Ms. Shigley?

A **She was.**

Q There was a video produced to me with you and a lady demonstrating transitioning to the ground.

Was that Ms. Wyrick or Ms. Shigley?

A **No, that was Ms. Wyrick.**

Q That was Ms. Wyrick? Okay.

And, real quick, Phase Two, does Phase Two involve personal holds or restraints at all? Phase Two training.

A **We do like a refresher type training.**

Q Okay. And then there's another test at the end of Phase Two?

A **Correct.**

Q And phase Two is only available to folks who have

maintained their employment for six months?
A **Correct.**
Q And then decent employees, I believe?
A **Sure.**
Q Okay.
And then, after this initial phase training, Phase One and Phase Two -- and I apologize if you already told me this. In fact, I think you might have but I can't recall what you said.
How often are the direct care staff given refresher courses or retraining in the use of personal holds?
A **Our procedure is that they get retrained every two years.**
Q Okay. And is that procedure consistently complied with?
A **Oh, yes.**
Q Okay. Other than what we've already talked about -- and I'm assuming the answer's no.
But, other than what we've talked about, is there any other form of training provided to staff related to personal holds?
A **No.**
Q Okay.
Mr. Hise, I saw that video for transitioning to the ground. Am I correct that video is demonstrating how to

safely -- and, again, this is the video with you and Ms. Wyrick and there's a volunteer and then there's a long-haired young man standing behind you acting as a spotter. You know what I'm talking about?

A Correct.

Q You know the video I'm talking about?

A Yes.

Q And I correct that what you're demonstrating in that video is how to safely transition a client to the ground for purposes of putting them in a mechanical restraint?

A Yes.

Q Okay. Is there any other purpose that you teach for transitioning a client to the ground?

A No.

Q Are staff members taught to restrain clients while the client is on the ground for purposes unrelated to transitioning to a mechanical restraint?

A No. The only reason that they would use the transition to the ground is putting a resident in mechanical restraint.

Q Okay.

So if a staff member, if a direct care staff member, were to hold a client on the ground because that client is having a behavior episode and that staff member were to hold that client on the ground, restrain that client

while they're on the ground for several minutes, hoping the client will calm down, would that be an improper restraint?

A I really don't have enough information to speculate on that. That's -- you know, I don't know the details of the situation. Could you be a little bit more specific?

Q Sure.

A I do not teach that, no. I do not teach staff to hold a resident on the ground.

Q Right. And that's my understanding as well. My understanding has been, from what I'm reading in the NCI and what I've gathered from witnesses such as Ms. Jones is that clients are only to be taken to the ground in emergency situations where they're needing to be transitioned to a papoose board or a mechanical restraint; is that correct?

A Correct.

Q Okay.

A The training that we teach in NCI is a standing personal hold and a seated personal hold. There is no on-the-ground personal hold.

Q Okay. Therefore, if a staff member were to be using a on-the-ground personal hold, that would not -- that would be outside of what is allowed by NCI?

A Unless it was during a restraint procedure, an

emergency mechanical restraint procedure.
Q Unless it was what?
A During an emergency mechanical restraint procedure. A resident had to be placed in a mechanical restraint.
Q Okay. But, in a situation where there is no mechanical restraint involved at all, that should not be done?
A Correct.
Q All right.
My understanding is you teach -- and I assume this is in Phase One. You teach staff techniques for responding to situations, different situations, where a client is behaving aggressively.
My question is, is there something specific that you teach for staff to use in response to a client who is slapping at them or acting like they're going to hit them or even swinging at them?
A Absolutely. De-escalation techniques. Trying to --
Q Okay.
A Verbal control of the situation. You know, first, you ask the resident that's being aggressive or in a crisis situation, to stop the act.
Q Okay.
A And then, you know, we teach our staff to, you know, redirect the resident, remove them from the situation.

So, yes, there's several different procedures that we use before we ask staff to put hands on. We teach our staff to only put hands on when all other measures have been exhausted.

Q Okay. And, in the situation where a client swings at a staff member, does that one act of swinging at the staff member, does that allow the staff to deem that an emergency situation and immediately use physical force?

A If they can't gain verbal control of the situation or redirect the resident.

Q Okay. But, if they're being swung on, how do they try to use verbal control or other de-escalations without using force when a client, you know, slaps at them?

Do they, you know, try to back away? Get out of the way? I'm asking --

A What we do, we go into -- the staff are trained to go into a supported stance to where you're ready in case the resident does swing at you.

Q Uh-huh.

A We try to de-escalate the situation, ask the resident, hey, what's wrong, can we go outside and talk about this, can you tell me what's bothering you.

Redirection. You know, try to get the resident's mind off what's bothering them and open up to staff and talk to them.

Q How about staff preventing themselves from getting hit though?
A Okay. If a resident is coming at you, we teach a blocking technique.
Q Yeah. Please tell me about that.
A Okay. In the supported stance, if a resident was coming at you, you would put your hands up and deflect and step away.
Q Okay.
A Stand back. Not step toward the resident. Step back.
Q Okay.
And what you teach, in that situation, a staff member absolutely has to at least try that or some other de-escalation technique before taking physical hold of the client?
A That is correct.
Q Okay.
Now, what about in a situation where a client is coming at a staff member and that staff member loses control of the situation and they both fall to the ground together?
In that situation, what would you recommend or train for that particular situation?
And if I need to reword that I can.

A Could you be a little bit more specific?
Q Yeah. So let me just tell you what mister -- first of all, let me ask you this, Mr. Hise.
Did you look at any documents to prepare for today?
A No, sir. I have limited knowledge of this incident.
Q Okay. Did you speak --
A The only document that I'd seen was my deposition order and I talked to Eric for a bit.
Q Okay. Other than Eric, have you talked to anyone else --
A No.
Q -- about what happened to David?
A No.
Q Do you have any knowledge about the incident that led to his death?
A No, I do not.
Q Okay. You're not aware of the restraints used by Mr. Mattson, Ms. Jones, and Ms. Campos?
A No.
Q Okay.
So what I'm going to do is, as best I can, I'm going to tell you what they said happened. When I deposed Mr. Mattson, Mr. Mattson says that Mr. Cains became upset and charged at him. And, originally, he said he swung at him. And then, when I deposed him, Mr. Mattson said that

he thought that maybe David was trying to wrap his arms around him.

But what was consistent in his story was that he and Mr. Cains both ended up falling over onto the ground in the lobby of the Commons building outside of the cafeteria. Are you familiar with that area?

A Yes. That's the building that I work in.

Q Yeah. You've been there since 1995; obviously, you're familiar with it.

And so Mr. Mattson, in his written statement that he gave to Ms. Evans and the statement that he gave to Disability Rights and in the deposition statement he gave to me, says they ended up on the ground together and that David -- I'm not show how he landed. He may have landed on his face. I'm not sure.

But, for purposes of my question, just know that David ended up on his left side and Tyler then knelt behind him and placed his arms on various parts of his body to kind of hold him there.

A couple of minutes later, Ms. Jones hears the commotion, she comes in and she kneels down and either holds David by the hands or by the head, depending on who you're asking. If you ask her, she says by the hands; if you ask Ms. Campos, she'll say by the head.

And then, a couple minutes later, Ms. Campos arrived

and joins in on the restraint and holds David by the legs because he's -- they're saying he's kicking and flailing and spitting.

And they do that for several minutes. I'm assuming that is definitely not something that you teach.

A No, sir.

Q Okay.

So my question would be, in that situation where Tyler or any other staff member and David Cains or any other client were to fall over together, would NCI say that the staff members should immediately get up and give the client some space?

A No. But that's the main reason why we use a supported stance.

You know, we teach the supported stance as, you know -- of course, when you're doing it, you're getting prepared so you don't go off balance.

It's not only for the safety of the resident, it's for -- you know, it communicates respect to where you're not like, you know, being forceful towards the resident.

You take a step back.

Q Yeah. So if the training had been properly utilized, you shouldn't fall over to begin with; is that what you're saying?

A I'm saying that the supported stance should not

allow anybody to fall to the ground.
Q And that supported stance, they're trained in that supported stance? They should know how to use that; right?
A Correct. That's the first order of actions whenever you are intervening during a crisis situation.
Q Okay. Aside from that, let's say, for whatever reason, they both do end up on the ground.
What would be the proper thing for the staff to then do if he, you know, tumbles over with a client?
A Staff members should get up and get off the ground. And, you know, if the resident is still in crisis situation, you know, there's no policy saying that you have to intervene with a resident that's in crisis mode that's on the ground.
Q Right.
A Unless they were being put into a mechanical restraint.
Q But, in that situation, you'd at least get up, give them some space, and see if the separation, at least, can de-escalate the client's behavior?
A Sure.
Q Okay.
A Correct.
Q Okay.

MR. GILLISPIE: I'm going to take five minutes to confer with Garrett and then we can hopefully wrap up pretty soon.

THE WITNESS: Okay.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Mr. Hise, I've just got a couple more questions for you.

A Okay.

Q I wanted to ask you about what constitutes an emergency situation.

And I think I have understanding of what it is; and I'll tell you what my understanding of it is and you tell me if I'm right.

Is an emergency situation a situation where severe injury is imminent or likely to occur to a client or staff member?

A We like to use the terminology crisis situation.

Q Okay. Well, flesh that out for me. And define with the bare minimum, the minimum -- well, what would count as an emergency situation?

A Okay. One, you would have to put hands on them.

Q Okay. But what kind of -- any time a client tries

to hit a staff member, is that an emergency situation?
A Not necessarily. It could be an escalation.
Q Okay. What I just descried to you as having happened to Mr. Cains there where those three staff members restrained him on the ground, do you recall my description of that?
A Yes.
Q Okay. I know you weren't there. But assuming that my description of that is accurate, would you agree with me that that was unnecessary physical contact they were making with him?
A You know, I can't really speculate. I don't know the -- it's hard to say without being in that situation.
Q Well, we've already said that it's definitely against NCI policy.
A Correct.
Can I ask, the staff members, when they were restraining the resident on the ground, were they preparing to do the mechanical restraint procedure?
Q No.
A Okay.
Q No. And, assuming everything I'm telling you about it is accurate, assuming that's -- you know, you've said that's definitely not something they're trained in and that would mean it's something they're not supposed to

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do?
A Correct.
Q All right.
A Unless they were applying the mechanical restraint.
Q Right. And, when a mechanical restraint is to be applied, that's to be done in the way shown in that video; right?
A Correct.
Q There's no other way that they're allowed to get a client to the ground or keep a client on the ground for that purpose, is there?
A No. Definitely not by yourself.
Q Okay.
A Never try to restrain a client by, you know -- in that situation, on the ground, by yourself.
Q Okay.
A You know, that's dangerous.
Q And, when you're transitioning a client to the ground for an emergency mechanical restraint, I would assume that the client, you want to keep the client on the ground for as little time as possible; right?
A Correct.
Q So you'd want to have -- you know, you wouldn't do it unless you had that papoose board or mechanical restraint device nearby to complete the transition;

right?
A Correct.
Q Okay.
Did you ever serve as a maltreatment investigator at Booneville?
A Could you be more specific? I mean, I've done administrative reviews, but I've never had any formal training on maltreatment investigating.
Q Okay. Yeah. You would have received some sort of training from Little Rock on --
A No.
Q -- the certification process.
I know Sandy Evans investigated this particular incident or investigated the three staff involved to determine whether or not there was any maltreatment.
Were you questioned at all during that investigation?
A No.
Q Okay. Have you ever been questioned for any type of maltreatment investigation?
A Yes. Several times.
Q Have you yourself ever been the subject of a maltreatment investigation?
A Yes.
Q Okay. And it's not particularly relevant, but when

was that?
A Oh, probably around 2006. Maybe 2007, somewhere in there. I was put on administrative leave for a maltreatment investigation. But it was cleared.
Q Okay. Do you recall what the basic allegation was? Did it have anything to do with restraints?
A No.
Q No? Okay. That's fine.
So Booneville Human Development Center does not authorize the use or train staff in the use of restraining clients on the ground except when doing so for the specific purpose of transitioning to a mechanical restraint; correct?
A Correct.
But, also, keep in mind too, you know, a lot of times, whenever your staff transition a resident to the ground, they may calm down. And, if they're calm and not fighting no more, we don't carry on with the restraint procedure.
Q Sure. Sure.
A I just wanted to make that clear.
Q Yeah.
Meaning that, if three staff members or two staff members were to properly transition someone to the ground for that purpose and then the client calmed down before

they got them on the board, you wouldn't put them on the board?
A That is correct.
Q Good. That makes a lot of sense.
But, when there's no board present, there's no mechanical restraint present, not even contemplated, the staff has no business just holding the client on the ground in the way that I described?
A I'd say not.
Q Okay. Because there's so many other de-escalation options that not only could but have to be tried first; right?
A Correct.
Q And so it would be just unnecessary for a staff member to make that physical contact with the client on the ground in the way I described?
A I would say that's fair.
Q I saw in the NCI nonviolent crisis intervention workbook or training materials that it specifically talks about how certain types of restraints, particularly ground restraints, are very dangerous because they can lead to things like asphyxiation.
Are you familiar with what I'm talking about?
A Sure. I have the definition.
If you don't restraint -- restraint related position

asphyxial.
Q Right.
A You know, that's one of the -- when we begin the training, you know, during our introduction, we tell people about the dangers of using restraints.
Q Do you tell them specifically about the dangers of using ground restraints?
A Any restraint. It don't --
Q Any restraint.
But you know the -- you just said it. You know the section I'm talking about. And then it has these -- I ought to just pull it up here. And then we're going to be done. Give me just a second.
Okay. I should now be sharing a screen with you. Do you see that?
A Yes. That doesn't look familiar to me. I don't know that I've ever -- could you tell me a -- is there a page number?
Q Well, yeah. And I got this document -- it's the Nonviolent Crisis Intervention, understand the risks of restraint.
A Right.
Q Dangers of restraints.
And it talks about these -- the restraint related positional asphyxia. That's what you said earlier;

right?
A Correct.
Q But you --
A I've never seen that particular page in my instructor manual.
Q Okay.
A It doesn't look familiar.
And it's saying that it looked like it was revised in 2012?
Q Yeah. I got that one off line. It may not be -- I'll need to use the one that you were given. And if it's been produced to me, I just haven't found it yet.
Regardless, what is your understanding of these? What did you call it?
A Could you be more specific about -- restraint related positional asphyxia? Is that --
Q Right. Right.
A Okay.
Q So the workbook that you have or the manual that you have, what does it say about examples of restraints that are particularly risky for that? Asphyxia.
A Can I read you the definition?
Q Yeah.
A Okay. It says a fatal condition that occurs when the position of a person's body interferes with

respiration and results in asphyxia or suffocation.
Q But your materials don't specifically address how on the ground scenarios are most likely to lead to this?
A I've never seen that page that you showed me there.
Q Okay.
A That's not in my manual.

MR. GILLISPIE: Eric, do you know if his manual was produced?

MR. COLLINS: I don't know off the top of my head.

MR. GILLISPIE: Okay. Give me just a moment. I think I know where it might be if it was.

THE WITNESS: My instructor manual was updated May of 2018.

MR. GILLISPIE: Okay. May of 2018?

THE WITNESS: Yes.

MR. GILLISPIE: All right. Just a moment. If I have it, it's here, and I'll find it.

THE WITNESS: I mean, my manual, where it talks about understanding the risk of physical restraints, it starts on Page 155. And it says understanding the risk of physical restraints, theories of related -- restraint related deaths, positional asphyxia, and restraint

position, prolonged physical restraint. It's in the very back of my instructor manual.

MR. GILLISPIE: All right. Yeah, I just have a very small part of NC -- it doesn't look like I have the same thing. That's okay.

MR. COLLINS: Josh, the small part you said, how long is it? How many pages?

MR. GILLISPIE: What I have from, it looks like it's NCI, is -- it looks like it's only about ten pages or so. It's Bates Stamped 2784. It's called CPI's top ten de-escalation tips.

MR. COLLINS: Okay. Thank you.

MR. GILLISPIE: And then there's a part called risk of physical restraints.

But it doesn't sound like it's the same as what Mark was reading from. But it's fine, I think. It's fine. I can do without it for now.

BY MR. GILLISPIE:

Q Okay.

Mark, are you also involved or do you also train staff to be conscious of clients, any medical conditions a client might have that could be compromised by a personal hold?

A Absolutely. That's covered pretty intensely throughout the phase training.
Q Okay.
Now, Mr. Cains, David Cains, was on [redacted]
This incident occurred just after lunch. That's something that's taught heavily though, that staff need to be aware of things like that in making decisions about interventions?
A Sure. Yes.
Q Okay.
A Choking is a major thing at our facility. You know, we have a lot of residents that, you know, have a lot of different healthcare needs.
Q Uh-huh.
A Choking -- you know, choking is a really high priority.
Q Would you say that choking is the most likely bad outcome from a personal hold?
A No, I couldn't say that. That's not what I'm saying.
I mean, I'm just saying that we've had client deaths in the past due to choking. But, usually, that was, you know, choking on food or accidental choking incidents.

Q Uh-huh. Okay.
A I personally never heard of a death due to a restraint incident and choking together.
Q I'm sorry. Say that again.
A In my career, I haven't experienced a choking death with a resident during a restraint procedure.
Q What kind of injuries to clients have you heard of during restraints?
A There's, you know, bumps and bruises, cuts and scrapes.
Q Okay. And have you ever heard of a client aspirating and choking on their own vomit at Booneville?
A Let's see. It seems like in 2010, we had a client-related death to where he had choked on some lunch meat and they -- they had trouble clearing the airway.
Q I don't mean just deaths. It's my understanding that a lot of clients there [redacted]

And I'm asking if you just -- not necessarily incidents that resulted in death but incidents where a client aspirates and chokes on their own vomit. Which I'll represent to you is what happened to Mr. Cains while he was being restrained on the ground by those three staff members.
A I did not know that.

Q Well, I don't think I have anymore questions for you, Mr. Hise.

Have you understood all of my questions?

A Yes.

Q Is there anything you feel like you need to clarify for me?

A No. I just want to reiterate that, you know, we don't train our staff to restrain residents on the ground unless it's for the purpose of placing them in emergency mechanical restraints.

And if, any time during that process, if the resident calms down, we don't follow -- we stop the restraint procedure once they're calm.

Q Uh-huh.

All right. Well, I appreciate your honest testimony.

A Okay.

Q Thank you very much.

A Thank you.

THE WITNESS: Eric, do you have any?

MR. COLLINS: Yeah. I have a few follow-up questions for you.

CROSS EXAMINATION

BY MR. COLLINS:

Q I guess we're going to start with your testimony

earlier about the blocking.

So, when they're doing this blocking, are they standing rigid or are they expected -- I believe Tyler said it's a blocking plus a moving backwards type operation.

Which of those is the accurate assumption?

A In the supported stance.

Q Supported stance.

A Yes.

Q Okay.

A Block and would move backwards.

Q Say that again.

A You would block and remove or move backwards like in a retreating type.

Q Okay. And, if there was something blocking their movement, what steps should they take at that time?

A Pivot. We teach a -- pivot away.

Q If they're being blocked from pivoting or moving backwards, what steps should they take?

A Could you be a little bit more specific?

Q Okay. I believe Tyler testified to a ledge that was behind him that, had he backed away or moved behind, he would have fell over anyways; so that's why he chose not to back away. So, in that instance, what would he have done if he assessed the situation and decided not to back

away?
A It would be hard for me to speculate on that.
Q They don't teach them what to do in that situation?
A Like whenever you're backed up against a ledge?
Q Uh-huh.
A I personally have never, you know, been put in that type of situation.
Q Okay.
When you're in the supported stance -- have you ever seen Mr. Cains or met Mr. Cains?
A Oh, yes. I've worked with David for -- ever since he was enrolled at our facility.
Q Okay. So are you aware of his size?
A I am.
Q How tall would you say he is? If you had to guess.
A He's probably about my height, 5'10".
Q Okay. And how much do you think he weighs? How much do you think he would have weighed?
A Maybe 160, 160 pounds; 170, maybe.
Q What if I told you that the medical records show he's around 6'2", 250 pounds?
A Wow. Okay.
Q I understand he was there for a while, so his weight may have fluctuated. But that was approximately his weight at the time of --

A He had put on some pandemic pounds, to me.
Q Okay.
So in the supported stance, if you had a resident charging you that was approximately that size, do you think that you'd be able to, you know, take a hit from that?
A Sure. Possibly. Uh-huh.
Q Would it possibly force you backwards?
A Yes, possibly.
Q Okay. And, if you had a ledge behind you and were contemplating the fact that you were going to get knocked over, would that possibly change how you would react to that situation?
A Possibly.
Q Okay.
Mr. Gillispie kind of gave you a rundown of the situation. And while it's largely accurate, I do disagree with some of the facts in there, so I'm going to add some additional facts and see how that maybe changes your opinion on it.
A Okay.
Q So, as Mr. Gillispie said, Tyler Mattson's testimony was that David had stood up, charged at him.
There was some discrepancy as to whether or not he was swinging at him or attempted to wrap him up.

Mr. Mattson, I believe, said that he attempted to hold his wrist or hold his arms; they fell down together.

At this point, I believe Mr. Mattson and the other two, Ms. Campos and Mandy's testimony, kind of all covers the same things, that Tyler was simultaneously attempting to kick, attempting to punch. He was spitting on them.

I believe Mandy said, if I can get her actual quote here, that David was yelling that he wanted to kill Tyler.

So that's the situation that's going as they're maintaining a physical hold on the ground.

When confronted with that situation, is it your belief that they should have released him and stepped away? Or do you believe that maybe that risk was too great at that time?

A It sounds like, to me, you know, that was at the heightened stage of a crisis situation.

You know, if the resident is threatening to kill you and spitting at you and charging you and hitting you, I would say that it would possibly be necessary for the resident to be put in mechanical restraints.

Now, I say that from my point of view. But I wasn't there. I don't know the specifics.

Q Yeah, it's all speculation for you. I understand that.

A That would be at the high end of a crisis situation.
Q Okay.
And NCI, does it cover every situation that you guys might face?
A Knowing this field, Eric, it's a -- you know, it changes all the time.
Q Okay. But is it kind of a high-level overview of the most common situations you guys might face?
A Yes. But a lot of things -- this is kind of irrelevant. But we're seeing a lot of trauma-informed care.
Q Uh-huh.
A That's the new terminology, that we're kind of having to adjust, adapt and adjust our training methods to deal with more trauma-informed care type residents.
Q I'm just going to go out there to the more far out thing. Let's say a resident had a gun and was pointing it at someone.
Does NCI teach you how to handle that situation?
A No. We don't -- no weapons.
Q So the NCI teaches you specific holds. Are you always able to perform that hold a hundred percent accurate or is it expected that you're going to have somebody weigh one way or the other?
A You know, it all depends on the situation.

You know, if it's a hot summertime and you're trying to physically hold somebody and they're sweaty, and -- you know, it would be possible for you to, you know, lose your grip and slip and maybe get busted in the nose or, you know, fall backwards. Or -- I mean, it could happen.

Q Okay.

A No intervention is foolproof.

Q Gotcha.

So what I'm kind of getting at, the NCI, that's a set of guidelines on how to handle these situations then?

A Correct.

Q Best case scenario is the scenarios that are found in --

A Sure.

Q Okay.

A The (inaudible) values of the nonviolent crisis intervention is, you know, the care, welfare, and safety and security of all persons involved.

Q Okay. When you're approaching a crisis or you're evaluating a crisis, do you teach your students that it's not a crisis unless someone is actually physically hit?

A No.

Q No? So they can intervene to prevent that hit from happening in the first place?

A Well, you know, if you had a resident that was being

verbally aggressive, you're going to try to use a de-escalation technique to, you know, find out what's wrong with the resident.

Q Okay. I'll rephrase it a little bit. I was being too broad there.

I'm talking about physical intervention.

A Okay. Because --

Q I understand you're going to have the verbal interventions, you're going to have the removing them, de-escalading.

But, a physical intervention, are they allowed to physically intervene even if they've not been literally hit?

So for instance, in this case, someone's been kicking at them, swinging at them, are they allowed to intervene, even though they haven't physically been hit?

A Sure. I mean, say, if you had two residents that was involved in a fist fight, you know, staff have to intervene and break that up.

Q Okay.

A You might get hit in the process.

Q Okay.

MR. COLLINS: I have nothing further.

REDIRECT EXAMINATION

BY MR. GILLISPIE:

Q Mark, did you know David Cains to be particularly violent or aggressive?
A I knew David. You know, he was pretty happy-go-lucky. He -- sometimes, you know, I supervised the unit he lived in whenever we first got him. And, sometimes, he would get sad over certain things and he would, you know, cry a little bit.
Q Uh-huh.
A But I'd never really known him to, you know, be physically aggressive.
I want to say that's -- that's a possibility with any resident that we have at BHDC, you know.
Q Did you ever witness or do you know of David causing a physical injury to another person?
A I would have to think about that.
It's, you know. . .
Q That you can specifically recall as you sit here today.
A No.
I remember one time, whenever I was a program supervisor, that I got a call from the sheriff's department and had to go or send some staff to go get David from his hometown because he had become aggressive toward his mother.
Q Uh-huh.

A And we had to go --
Q But as far as staff or other clients at Booneville, you don't know of any situations where he caused an injury?
A No.
Q I'm sorry, no?
A No.
Q And, as far as the situation at his mother's house, do you have any knowledge of whether he caused an injury there?
A I can't speculate on that. I don't remember the details. That's been a long time ago.
Q No, I'm not asking you to speculate. I'm actually asking the opposite.
I'm asking, do you know what he did or didn't do at his mother's house on that occasion?
A I know that it was serious enough to where I got a call from the sheriff's department to send staff to get him, so. . .
Q Okay. Do you have any personal knowledge to whether any injuries occurred in that incident?
A No.
Q Okay.
And I assume David was never violent with you, personally.

A Not that I remember.
Q Okay.
Are there certain clients over the years who, if I asked you the same question, you'd say, yes, certainly, that person is dangerous and violent?
A Sure.
Q Okay.
A You know, for 27 years, I've had black eyes and bloody noses. You know, I was stabbed with a piece of glass one time. You know, it's -- it's the nature of the profession.
Q Right. I don't doubt it. I don't doubt it.
But David was not one of those clients where you felt the need to, you know, have your guard up more than normal?
A I didn't; because, you know, I never worked directly with David.
Q Okay.
A You know, I supervised the unit that he lived in for a while.
Q But he didn't have that kind of reputation, as far as you know? He didn't have that reputation for being a particularly -- you know, a dangerous client?
A Not dangerous. I mean, he would have his, you know, typical bad days to where --

Q Uh-huh.
A -- he'd throw things and break things.
Q Uh-huh.
A That's just typical.
Q Yeah.
This area that we're talking about outside of the cafeteria in the Commons building, I've not been up there. I've not seen the room or -- it's been described as a lobby to me in which this incident took place. My understanding is there's a bathroom in the room.
Tell me, do you know exactly the room that I'm describing?
A I do. It's right outside my door.
Q Okay. Is there a ledge in that room?
A There is.
Q And, when you say a ledge, what do you mean? What is it --
A It's a retaining wall that goes along the top of a stairwell.
Q Uh-huh.
A So there's a stairwell that goes down to go outside the exit doors; and there's that ledge to keep, you know, somebody from, you know, walking --
Q Okay.
A -- walking off the ledge.

Q Okay. So there's a ledge; and then, below it -- and then, next to the ledge, there's a stairwell that goes down?
A Correct.
Q Okay.
Let's say that David and Tyler are the only two people in that room, which they were when this incident started, and you had this ledge. And let's assume, for argument's sake, that Tyler is telling the truth about being close to that ledge. I say argument's sake because he didn't mention the ledge in any statement up until the time of his deposition.
But, assuming he's telling the truth about being close to that ledge, couldn't he still have sidestepped away? Couldn't he have sidestepped away to avoid the client and the ledge?
A It's kind of hard to say, I mean, unless you're in that situation yourself.
I mean, I can't -- I don't want to say that he did the wrong thing or did the right thing. I can't really say.
I mean, I would think that there would have been room, I mean, because that goes into the cafeteria doors there. And there's two doors that lead into the cafeteria.

Q I mean, unless it's a crowded room where he doesn't have room to go left to right, I don't see how he could not have room to sidestep.
A Yeah.
Q I mean, is that -- am I --
A I would think that there would be room.
Q Okay.
And, even if there wasn't, he was taught a positioning technique to support himself anyhow, as you previously said.
A Supported stance. Correct.
Q Supported stance. All right.
MR. GILLISPIE: That's all I have. Thank you.
MR. COLLINS: I have nothing further.
(WHEREUPON, the proceedings were concluded in the matter at 2:15 p.m.)
* * * * * * * * *
(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Mark Hise, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 25th day of May, 2022.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

VIDEO DEPOSITION OF

JEFF GONYEA

December 8, 2022, at 11:33 a.m.

CRIS M. BRASUELL, CCR
ARKANSASCOURTREPORTER.COM



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I N D E X

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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Jeff Gonyea, produced, sworn, and examined at the Office of Arkansas Department of Human Services, 700 Main Street, Little Rock, Arkansas, commencing on December 8, 2022, at 11:33 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

Arkansas
State Claims Commission
FEB 16 2023
RECEIVED

PROCEEDINGS

VIDEOGRAPHER: We are on the audio and video record. Today's date is December the 9th, 2022. I'm sorry. December the 8th, 2022. The time is approximately 11:33 a.m.

This is the videotaped deposition of Jeff Gonyea. This is the case of Cains versus Arkansas Department of Human Services.

My name is John Sims; I'm a videographer out of Little Rock, Arkansas.

Will Counsel please make a record of your appearance.

MR. GILLISPIE: Josh Gillespie for the claimant, Christine McAuliffe.

MR. ROSEN: Rich Rosen for DHS.

VIDEOGRAPHER: Madam Court Reporter, will you please swear in the witness.

(WHEREUPON, Jeff Gonyea was duly sworn to tell the truth, the whole truth, and nothing but the truth and gave the following testimony to wit.)

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Mr. Gonyea, thank you for being here today.

My name is Josh Gillespie. I'm the attorney for the

Estate of Mr. David Cains and his sister, Christine McAuliffe, who is the Special Administrator of that Estate and the claimant in this matter.

Have you ever been deposed before, Mr. Gonyea?

A I don't believe so.

Q Okay. Well, not a lot of rules to it.

Because she has to make a record, it's important that -- to verbalize yeses and nos as opposed to nodding or shaking your head is we're -- want to do.

A Okay.

Q Although we are filming it, if you don't understand a question, let me know.

A Okay.

Q I'll rephrase it.

Oftentimes, you're going to hear your attorney make an objection. And, typically, you're still going to need to answer the question unless he tells you, you know, specifically tells you not to answer.

The purpose of these objections is sort of the attorneys talking to each other; it's to make a record for the trial or the hearing in this case.

A Okay.

Q But you are going to hear that. And we may talk back and forth a little bit; but, when we're done, you're still expected to answer unless your attorney tells you

not to answer.
A Okay.
Q Okay?
If you need to take a break, we can do that. Let me know. I'd only ask that you wait until there's not a pending question on the table.
A Okay.
Q So, with that said, tell me a little bit about your background and how you ended up becoming the superintendent of the Booneville Human Development Center.
A I started with DHS in 1998.
Q Okay.
A And I started Behavioral Health. I worked with the State Hospital and Arkansas Health Center.
And deployed to Iraq in 2003. When I came back, I came back to DDS, worked in the Community Waiver Program for about five years. And then, in January of 2010, became the superintendent up at Booneville Human Development Center.
Q Okay. Oh, and for purposes of today, when I say Booneville, I'm talking about the facility.
A Right.
Q I might say, BHDC, also talking about this facility.
A That's fine.

Q But, more than likely, I'm going to say Booneville.
A **Okay.**
Q So you were in the military?
A **Correct.**
Q Okay. Thank you for your service.
A **Thank you.**
Q What branch of military were you in?
A **Ten years Air Force, 12 years Army.**
Q Okay. And you served overseas in Iraq for a period of time?
A **Correct.**
Q And, prior to that, you began at DHS 1998, you said?
A **That's correct.**
Q All right. What was your -- what's your educational background?
A **I have a Bachelor of Science.**
Q Okay.
And skipping ahead somewhat, prior to being appointed the superintendent of Booneville in 2010, what was your job title?
A **Before Booneville, Director of Waiver Services, Home Community Based Waiver Services.**
Q Okay. Is that at a -- would you have worked at a particular facility doing that job or is that a job that you would --

A No, it was here in the central office.
Q Okay.
A I was responsible for the state, so --
Q Okay. Prior to becoming the superintendent at Booneville, had you served in any administrative role at any other similar type facility?
A Yes.
Q Okay. Tell me about that.
A I got my license as a long-term care administrator in 1991.
Q Okay.
A Started with Beverly Enterprise for a few years. Worked with some other --
Q Is that a private nursing home company?
A Nursing home. Uh-huh.
Q Okay.
A Worked for another private nursing home. Well, actually two others. Opened a facility in '95 out in Chenal.
Q What was the name of the facility in Chenal that you worked --
A Chenal Rehab.
Q Chenal Rehab?
A Uh-huh. And then --
Q What was your job at Chenal Rehab?

A I was the administrator. Of all these facilities, I was the administrator.
Q Administrator?
A Uh-huh.
Q And does that mean the --
A It's the same position I have now, superintendent.
Q So the top level --
A Yes.
Q -- person at the facility?
A Correct.
Q Okay. And, before Chenal Rehab, what nursing home did you work at?
A Before Chenal was the Lakewood Plaza, North Little Rock.
Q Lakewood Plaza, North Little Rock. I grew up near there.
A Okay. The Catletts own that home.
Q I'm sorry?
A Leon Catlett and his family, I believe, still owns that facility.
THE COURT REPORTER: Please speak up.
THE WITNESS: Oh, sorry.
THE COURT REPORTER: That's not my mic.
THE WITNESS: Oh, sorry.
BY MR. GILLISPIE:

Q All right. So you were an administrator at Lakewood Plaza, Chenal Rehab. Where else?
A Oh, let's see. At -- it's not -- it's no longer in existence. It was Lakeland Lodge in Heber Springs.
Q Lakeville Lodge?
A Lakeland --
Q Lakeland Lodge?
A -- Lodge in Heber Springs.
Q Okay.
A And, before that, I was assistant administrator at another facility in Jacksonville that's no longer there either, Jacksonville Rehab or nursing home.
I don't even remember what it was called.
Q Okay. And is that, those four, is that -- are those all the places that you were a nursing home administrator?
A Yes.
Q Okay.
A Well, Arkansas Health Center.
Q Is that private or state?
A State. It was -- it was called Benton Service Center and then they changed their name to Arkansas Health Center.
Q And what did -- what services does it provide?
A Nursing home, skilled nursing facility.

Q Okay. But a state run --
A Yes.
Q -- nursing home essentially?
A Uh-huh.
Q Were you ever -- I apologize to have to ask this, but were you ever terminated from any of these jobs?
A No.
Q Okay. Did you leave all of these jobs voluntarily?
A Yeah. I mean, promotions and I went -- like when I went to Iraq, I -- it was a change of pace, you know, coming back to more facility-based services at DDS.
Q Okay. But, as far as you recall, there were -- you weren't, you know, asked to leave or left or resigned for any disciplinary reasons or anything like that?
A I -- no. No disciplinary.
Q Okay.
And so your first and only job at Booneville has been a superintendent?
A That's correct.
Q Okay. Do you recall who the superintendent was prior to you?
A I think it was Judy Story.
Q Okay.
And am I correct that there are certain policies and procedures that Booneville is required to comply with

such as the ICF Federal Regulations?
A That's correct.
Q Okay. I'm going to start with -- I'm sorry.
MR. GILLISPIE: My phone's on silent, but --
MR. ROSEN: Do you have a copy for me, Counsel?
MR. GILLISPIE: Yes, I do.
(WHEREUPON, the document was marked for identification as Exhibit No. 1 and is attached hereto.)
BY MR. GILLISPIE:
Q Mr. Gonyea --
A Uh-huh.
Q -- do you recognize this document that I've handed you and what I've marked as Plaintiff's Exhibit 1 and what is also Bates stamped 1607 --
A Yes.
Q -- as those ICF federal regulations? Or portions of them anyways.
A Yeah. I said yes.
Q Okay. I'm sorry. I didn't hear you.
MR. ROSEN: Jeff, you're going to have to keep your voice up --
THE WITNESS: Okay.

MR. ROSEN: -- so that -- and it's a big room and --

THE WITNESS: Sorry.

MR. GILLISPIE: That's okay.

THE WITNESS: I'm not usually a loud talker.

MR. GILLISPIE: That's okay.

BY MR. GILLISPIE:

Q And like I said, this is -- I didn't print off the entire document but only portions of it that are relevant to this case.

What I'd like to do first is draw your attention to Regulation Section 4803.420(a), which --

MR. ROSEN: Which page?

MR. GILLISPIE: That's going to be Bates stamped 1656.

BY MR. GILLISPIE:

Q Do you see this regulation that I'm referencing, Mr. Gonyea?

A The W140 or 127?

Q Yes. Under that, you see the Section 483.420 --

A Okay.

Q -- (a)(5)?

A Yes.

Q Okay.

And you'd agree with me that that says that -- well, that the title of that regulation is -- well, the subject of that regulation maybe is ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment?

A Yes.

Q Okay. And then, under that, you have guidance.

And, if you turn to the next page, you see at the top where the guidance for this regulation states, that the facility must develop and implement systems to protect clients from all forms of abuse, neglect, or mistreatment, including client-to-client abuse, neglect, or mistreatment.

Did I read that correctly?

A Yes.

Q Okay. And, under that, it further states that the facility is expected to ensure that staff possess and demonstrate needed competencies to effectively and appropriately interact with clients.

Did I read that correctly?

A Yes.

Q Okay. And, under that, it states that the facility must monitor to ensure that systems are effectively implemented and the facility takes immediate actions to address circumstances where abuse, neglect, or

mistreatment have occurred and prevent occurrence.

Do you see that?

A Yes.

Q Did I read that correctly?

A Yes.

Q And skipping down to D, the facility must act to prevent physical verbal, sexual, or psychological abuse. Do you see that?

A Yes.

Q All right. Next, on the next page but still further guidance on this regulation, which again is 4803.420(a)(5), you see the top, the first sentence, since many clients residing in ICF/IIDs are unable to communicate feelings of fear, humiliation, et cetera associated with abusive episodes, the assumption is made that any action that would usually be viewed as psychologically or verbally abusive by a member of the general public would also be viewed as abusive by the client residing in the ICF/IID regardless of that client's perceived ability to comprehend the nature of the incident.

Did I read that correctly?

A Yes.

Q And, finally, fourth paragraph down, the first sentence, the facility must take whatever action is

necessary to protect the clients residing there.

Did I read that correctly?

A That's correct.

Q And would you agree with me, Mr. Gonyea, that all of these, all of this guidance that I've read from here for this regulation is a federal regulation that the facility, your facility, Booneville, must comply with?

A This is the state operations manual, so it wouldn't be a federal guide. But what you read is correct.

Q Okay. Yeah. And it says state operations manual. And I believe that the state operations manual contains these regulations which are the federal regulations, I believe, found at 42 CFR, Section 483.

But, regardless, are the statements that I just read from, would you agree that all of those are policy that Booneville was required to comply with?

A Yes.

Q Okay. And, specifically, you'd agree that Booneville had a duty to ensure that rather -- scratch that.

You'd agree that Booneville had a duty to take whatever action is necessary to protect the clients residing there?

A That's correct.

Q And generally owed the clients a duty of care to

keep them reasonably safe?
A That's correct.
Q Moving to Regulation 4803.420(a)(6) on this same page, Bates stamped 1658, the subject of this regulation is ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.
Did I read that correctly?
A Yes.
Q And would you agree with me, that pursuant to this regulation, Booneville was -- and when I say was, I'm talking about at the time of David Cains' death, which was in June of 2020. Is that understood?
A I -- rephrase that again.
Q When I say was --
A Okay.
Q -- I'm referring to the time of my client's death.
A Okay. Okay.
Q Does that make sense to you?
A Okay. Yeah.
Q Because, likely, these policies presently are still your policies. And I understand --
A That's correct.
Q -- that, so -- but, for purposes of our case, we're concerned with what the policies were in June of 2020,

even though they may still be the policies now.
A Okay.
Q That's all.
So my question is, Mr. Gonyea, would you agree with me, that pursuant to this Regulation 4803.420(a)(6), that Booneville was required to ensure that clients are free from unnecessary physical restraints?
A That's correct.
Q Booneville is a Human Development Center; is that correct?
A That's correct.
Q Okay.
And I did not print this off, but I found in Arkansas statute about the creation of Human Development Centers. And what I found, it states that the human development centers are created and there shall be maintained institutions for the care, custody, treatment and training of individuals with intellectual and other developmental disabilities to be known as human development centers.
Does that sound accurate?
A I -- I've never seen that statement, so --
Q Okay.
A -- I'm not --
Q Would you agree that at least one of the purposes of

the Booneville Human Development Center is to provide care, custody, treatment, and training of individuals with developmental disabilities?

A For -- for Booneville, that would be the case. I mean, not all centers are the same, so --

Q But for Booneville it would be the case?

A Yeah.

Q And I'm pretty certain I'm only going to be asking about Booneville today. I don't think I'm going to ask you about any other --

A Okay.

Q -- human development centers. But I appreciate the clarification.

All right. I'll next turn to the same exhibit, Page 1753 is the Bates stamp number, sir. Let me know when you get there.

The top, this is Regulation Section 4803.450, little b, one, Arabic one, little i.

And would you agree with me that the subject of this regulation is the specification of approved interventions?

A Yes.

Q Okay. And the first sentence of the paragraph here under guidance states that all interventions for the management of inappropriate client behaviors, which are

approved for use in the facility, are clearly stated and described in its policy.

Did I read that correctly?

A Yes.

Q And would you agree with me, that at Booneville, all interventions for the management of inappropriate client behaviors, which are approved for use at Booneville, must be clearly stated and described in its policy?

A Yes.

Q All right.

Next Regulation, Section 4803.450, little b, Arabic one, Roman numeral two, this regulation states that the facility is to designate interventions on a hierarchy to be implemented and ranging from the most positive or least intrusive to the least positive or most intrusive.

Did I read that correctly?

A Yes.

Q And then, under guidance, it states that policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior. Did I read that correctly?

A Yes.

Q And then it goes on to say that facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally

appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment.

Did I read that correctly?

A Yes.

Q The plan must still begin at the least restrict, least intrusive technique shown effective for that client. Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.

Did I read that correctly?

A Yes.

Q Okay. The facility policy for unexpected behavioral incidents must provide direction for the staff in the utilization of the hierarchy.

Did I read that correctly?

A Yes.

Q And would you agree that those are all -- those are all things that Booneville was required to comply with?

A Yes.

Q Moving to 483.450, little b, Arabic one, Roman numeral four, big B, which is Page -- Bates stamped 1755.

And this regulation -- the subject of this regulation is the use of physical restraints; correct?

A Correct.
Q And this states that physical restraint is defined as any manual hold or mechanical device that the client cannot remove easily and which restricts the free movement of normal functioning of or normal access to a portion or portions of a client's body.
Did I read that correctly?
A Yes.
Q And, skipping to the next paragraph, it states that policies and procedures of a facility must address the types of physical restraint that are allowed in the facility.
Did I read that correctly?
A Yes.
Q And would you agree with me that that is something that Booneville was required to do?
A Yes.
Q Policies and procedures must address the persons who apply such restraints, the parameters for duration of application, the methods that assure the health and safety of clients while in restraints, and the specific training required for staff allowed to apply such restraints.
And would you agree with me that all those things, in addition to the types of physical restraint allowed,

must be addressed in Booneville's policies and procedures?
A Yes.
Q Okay.
Moving to the next page, which is Bates stamped 1763, you see that?
A Yes.
Q All right. Do you see at the bottom, Regulation No. 4803.450, little d, Arabic one?
A Yes.
Q Okay. This states that the facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating behavior for which the restraint is applied.
Did I read that correctly?
A Yes.
Q Okay. And the regulation we're discussing here is, again, 4803.450, little d, Arabic one, Roman numeral -- well, little i, is what I'll call that.
But this states that the use of physical restraint is to be specified within the IPP; and that that plan must address the specific type of client behavior to be managed by this plan and must address the type of physical restraint.

Did I read that correct -- that's not all of it, but would you agree what I read is part of, part of it, and that I read that correctly?

A So you went from one then four?

Q I did.

A Those are two, two parts of that plan. That's correct.

Q Okay. Would you agree that any physical restraint that could potentially be used on a client at Booneville needed to be clearly stated in that client's IPP?

A Yes.

Q Including the types of emergency procedures or personal restraints that could be used in emergency procedures?

A Say that again.

Q And would that include also restraints that could be used in emergencies?

MR. ROSEN: I'm going to object. I'm not sure -- can you reword your question? Because it --

MR. GILLISPIE: Yeah.

MR. ROSEN: I think you're changing a little bit of the statute. And I just want to make clear as to whether it -- or not the statute, the regulation.

MR. GILLISPIE: I'll go back to the question that I asked.

BY MR. GILLISPIE:

Q I'll go back to the question that I asked that you agreed with, so one question back.

I believe I asked if you'd agreed that -- Oh, would you -- I asked if you would agree that any physical restraint potentially used on a client at Booneville needed to be clearly stated at that client's IPP.

And you responded, yes.

A Correct.

Q Is that still your answer?

A Correct.

Q And so my follow-up question to that was, would that also include restraints that would be used and could be used in an emergency situation?

A Well, it -- it -- it would -- that's kind of hard to answer specifically just because you can't plan for all emergencies. And you can't always say, if an emergency arises, if it's not in their plan, how you would address it.

Because, first, our first priority is to protect the client.

Q Uh-huh.

A So -- so that's -- my answer is going to be we're

going to do everything we can to protect the client first.

Now, if there's a plan for it, I can't say every client we have up there is going to have something in their IPP to address every situation that they are put in.

Q I'm correct that personal restraints at Booneville can only be used in emergency situations?

A That's correct.

Q Okay.

A That's correct.

Q And I assume that there are approved forms of restraint to be used in those emergency situations?

A That's correct.

Q And am I also correct that staff can only use approved forms of restraint?

A That's --

Q Is that correct?

A That's correct.

Q Okay.

And so, my -- I guess, my question is, would the IPP not be required to contain or rather specify what those approved forms of restraint are?

A Honestly, I -- I can't answer without really looking at every IPP to see if it's addressed in there.

Q Well, that's not exactly my question.
My question is, has to do with this regulation, which you agreed that Booneville was required to comply with. Specifically, that approved, that the -- that Booneville was required to specify within a client's IPP the use of approved physical restraints that can be used.
A Correct.
Q You still agree with that?
A Right.
Q Okay.
A Yeah.
Q Well, then -- and the only physical restraints that are ever used at Booneville are emergency restraints?
A That's correct.
Q Okay.
MR. GILLISPIE: Take just a couple of minutes here.
MR. ROSEN: You want to say five?
MR. GILLISPIE: Yeah.
MR. ROSEN: We've been going about a half an hour or so --
MR. GILLISPIE: Sure.
MR. ROSEN: Okay.
VIDEOGRAPHER: Going off the record. The time was roughly 12:08 p.m.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

VIDEOGRAPHER: We are back on the record. The time is approximately 12:21 p.m.

BY MR. GILLISPIE:

Q All right. Mr. Gonyea, we're going to -- we're still on this same exhibit. What we're going to turn to page -- Bates -- what's the Bates stamped, 1754. You there?

A Fifty-four?

Q 1754.

A Yep.

Q Okay. And the regulations we're going to talk about now is for 483.450, little b, Arabic one, and then the three little i's.

A Okay. I'm sorry. Three -- I got it.

Q Yeah. And the last paragraph under this regulation states, that in emergency situations where an unanticipated behavior requires immediate protection of the client or others, the physical restraint technique chosen must be the least restrictive appropriate technique possible.

Did I read that correctly?

A Pretty much. It says the technique chosen is the

least restrictive appropriate technique possible.
Q Ah, yes. Would you agree with that statement?
A Yes.
Q And would you agree that that is a policy that Booneville was required to comply with?
A Correct.
Q Okay.
Skipping to Section D, so 483.450, little d, one, ii, which is going to be on Page 1764.
MR. ROSEN: 483.450, what did you say?
MR. GILLISPIE: Little d, Arabic one, and two little i's. Let me know when you guys are there.
THE WITNESS: Okay.
BY MR. GILLISPIE:
Q So this states that physical restraint may be used as an emergency measure but only if absolutely necessary to protect client or others from injury.
Do you see where it says that there --
A Well, you kind of --
Q -- in bold right there?
A Well, you just kind of paraphrased a little bit.
Q I'll withdraw my question and I'll restate it.
So I'm looking at section 483.450, little d, Arabic one, two little i's.

A Okay.
Q And it states right there as an emergency measure -- well, scratch that as well. Because what it is, this is a continuation of 450(d)(1).
So if you'll turn one page back, 1763, the bottom, you see where it says 483.450, little d, Arabic one?
A Yes.
Q Okay. The facility may employ physical restraint only. And then it continues that regulation statement here on the next page at 483.450, little d, Arabic one, two little i's, as an emergency measure, but only if absolutely necessary to protect client or others from the injury.
You follow me?
A Yes.
Q Okay.
MR. ROSEN: Wait. I see it.
MR. GILLISPIE: Okay.
BY MR. GILLISPIE:
Q And so on. But my question would be, would you agree, Mr. Gonyea, with that statement, that physical restraint at Booneville may be used as an emergency intervention only in situations where -- I'm sorry. Scratch that. Withdraw that.
Would you agree rather, Mr. Gonyea, that at

Booneville, physical restraint may be used as an emergency measure but only if absolutely necessary to protect client or others from injury?

A That's correct.

Q Okay. And would you further agree, that at Booneville, physical restraint may be used as an emergency intervention? Well, withdraw that.

Let me address the actual regulation first. And, again, this is going to be -- actually, this is guidance here at the bottom of 1764. So it's guidance for 483.450, little d, Arabic one, two little i's.

And it states here that physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which, one, the client has not exhibited before; two, were not identified in the functional analysis of that client's behavior; or, three, are harming other people or themselves.

Did I read that correctly?

A Yes.

Q Okay. And would you agree with me that that applies to Booneville, meaning that's something Booneville must comply with?

A Yes.

Q Okay.

All right. Turning to the next page, Bates Stamp

1766, middle of the page, see the Regulation Section 483.450, little d, Arabic two, little i.

You see that?

A Yes.

Q Okay. And under that the second sentence under -- in that paragraph, under guidance, the client must be released from the physical restraint as soon as the client is no longer a risk to self or others.

Did I read that correctly?

A Yes.

Q And you would agree that is also a policy that Booneville was required to comply with?

A That's correct.

Q Next page, Bates stamp 1767, regulation found in the middle of the page there, Section 483.450, little d, Arabic three, the facility must not issue orders for restraint on a standing or as-needed basis.

Did I read that correctly?

A Yes.

Q Would you agree that that applies to Booneville? That Booneville must not order issue -- well, that that applied to Booneville and that Booneville was not allowed to issue orders for restraint on a standing or as-needed basis?

A That's correct.

Q Okay.

Next page. Well, the regulation I intended to address is 483.450, little d, Arabic four. However, I think that this regulation most likely pertains more so to mechanical restraints than personal restraints. And I'm not concerned with mechanical restraints.

But the guidance here talks about just the need to release the client from restrain as quickly as possible. Would you agree that that's kind of the subject of this?

A Yes.

Q Okay. And even though this particular regulation may be more relevant to mechanical restraints, would it also be true, that in a personal restraint scenario, the facility or staff at the facility would want to or need to release the client from that restraint as quickly as safely possible?

A Yes. Anytime he was in a personal hold, they would be released as quickly as possible.

Q Okay. Thank you.

Same page here, Bates No. 1768, Regulation Section 483.450, little d, Arabic five, you see that? They're kind of hard to --

A Yes.

Q Okay. And that says restraints must be designed and used; and then it skips down, so as not to cause physical

injury to the client.

Did I read that correctly?

A Yes.

Q And would you agree, that at Booneville, restraints must be designed and used so as not to cause physical injury to the client?

A That's correct.

Q And that was the case at the time of David Cains' death as well?

A Was that the --

Q That was also the -- that restraints were required to be designed and used so as not to cause physical injury to the client --

A That's correct.

Q -- in 2020 as well?

A That's correct.

Q Okay. I'm just correcting my own error because I didn't use the past tense in the question.

All right. I believe we are done with this Exhibit. Mr. Gonyea, did you understand all my questions concerning this --

A Yes.

Q -- document? Okay. I'll make that Exhibit 1.

MR. GILLISPIE: Actually, I'm going to relabel that so that it doesn't say Plaintiff's

Exhibit because we are claimant, not plaintiff. I don't believe they make a Claimant's Exhibit. We'll just call this Exhibit 1. Exhibit.

BY MR. GILLISPIE:

Q Mr. Gonyea, we're going to now look at DDS Policy 3011-D. And, Mr. Gonyea, do you --

MR. GILLISPIE: You want one?

MR. ROSEN: Yeah.

BY MR. GILLISPIE:

Q Mr. Gonyea, do you recognize the document that I've handed you to be a DHS, Division of Developmental Disability Services, policy? Specifically, Policy No. 3011-D?

A Yes.

Q Okay. And, if you go down to -- on the first page, under Section 3, the first paragraph states that behavior management as covered by this policy. And I guess the subject of this policy is behavior management; correct?

A Right.

Q All right. And so, back to this first paragraph under Section 3, behavior management, as covered by this policy, serves as a guide to ensure that an individual's actions that are aggressive, disruptive, and/or present a danger to the individual or to others are managed with the least restrictive method.

Did I read that correctly?
A Yes, you did.
Q And would you agree with that statement?
A Yes.
Q And would you agree that Booneville was required to manage an individual's actions that were aggressive, disruptive, and/or presented a danger to the individual or others with the least restrictive method?
A That's correct.
Q Okay. And you'd agree that, in fact, only the least restrictive method in any given situation would be allowed to be used at Booneville?
A That's correct.
MR. GILLISPIE: Give me just a moment, please.
MR. ROSEN: Sure.
BY MR. GILLISPIE:
Q Okay.
If you would, please turn to Page 8 of this document. It'll be Section 6 but Page 8. Let me know when you're there.
A Okay.
Q And would you agree with me that this section pertains to emergency procedures?
A Are you talking about Item No. 6?

Q Yes, sir.
A **Yes.**
Q All right. And I'm going to read it.

Nothing in this policy prohibits the use of emergency restraint, mechanical or personal, confiscation, confiscation of any item used in a threatening manner or removal from the environment for the purpose of protecting the individual or others around him or her.

This includes the use of restraint procedures in the course of an established program when the individual becomes a danger to himself or herself or others, prior to staff being able to implement a lesser restrictive hierarchy.

Did I read that correctly?
A **Yes.**
Q Okay. It goes on to say that, however, it is emphasized that emergency procedures may not be used at frequent intervals becoming a routine method of intervention.

If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action.

Did I read that correctly?

A Yes.
Q And then, finally, it says the emergency use of restraint must conform to ICF/MR Regulations and must be reported immediately to the facility administrator or designee.
Did I also read that correctly?
A Yes.
Q And would you agree that everything that I just read, which was, in fact, this Section 6, was policy applicable to Booneville at the time of David Cains' death?
A Yes.
Q What does IDT stand for?
A Interdisciplinary Team.
Q Okay. And who typically would be part of a given client's IDT?
A There'll be a psychologist, a nurse. Typically, the, the QMRP. Like a case manager.
Q The Q?
A Yeah, the Q. And probably some direct care staff.
Q Okay. As superintendent, are you ever part of an IDT?
A Not typically.
Q Were you ever part of an IDT for David Cains?
A No.

Q Okay. Do you happen to know if Jennifer Berry ever was?
A I would not know.
Q Okay. The last sentence where it says the emergency use of restraint must conform to ICF regulations, that's referring to the federal regulations that we -- contained in Exhibit 1; correct?
A Correct. Correct.
Q Okay.
All right. Did you understand my questions regarding this is Exhibit 2, sir?
A Yes.
Q Okay.
MR. GILLISPIE: If you will -- thank you. I'll mark this as 2.
(WHEREUPON, the document was marked for identification as Exhibit No. 2 and is attached hereto.)
(WHEREUPON, the document was marked for identification as Exhibit No. 3 and is attached hereto.)
BY MR. GILLISPIE:
Q I'm now -- excuse me. I'm now showing you, Mr. Gonyea, what I intend to be Exhibit 3.
Do you recognize this to be a BHDC policy?

A Yes.
Q Okay. And it's -- specifically, it's BHDC Policy, Roman numeral, I don't know if that's a Roman numeral one or an I. But I'm going to call that an I. Do you know?
A I'd say one-D-four.
Q One-D-Four. All right. One-D-Four.
Possibly I-D-4, but we'll call it 1-D-4. And Policy 1-D-4, is -- the title of this is documentation of response to maladaptive behaviors; correct?
A Correct.
Q All right.
First paragraph, second sentence, personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure.
Did I read that correctly?
A Where are you at again?
Q At first paragraph, second sentence.
MR. ROSEN: Can you read it again?
MR. GILLISPIE: Yes.
BY MR. GILLISPIE:
Q Personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure at Booneville?
MR. ROSEN: For clarification, it's up in the policy statement, at the top.

THE WITNESS: Up here.
MR. GILLISPIE: I'm sorry. Yeah.
THE WITNESS: Okay. Okay.
MR. ROSEN: Can you read it again now?
THE WITNESS: Yes.
MR. GILLISPIE: Yeah.
THE WITNESS: I'm with you now.

BY MR. GILLISPIE:

Q Yeah. Yeah. I'll read it again. Give me just a second. Just a moment. Right.

So I'll -- I'm going to read this statement one more time here now that we're looking at the same thing.

Personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure.

Do you see that?

A Yes.

Q Did I read that correctly?

A Yes.

Q And was that the policy at Booneville at the time of David's death?

A That's correct.

Q Okay. And then it goes on to state that maladaptive behaviors include but are not limited to behaviors that result in or have the potential to result in injury to self or others or the destruction of property.

Did I read that correctly?
A Yes.
Q And then, at the bottom, under -- or at the bottom of this page, Section 2, which is titled emergencies of restraint, do you see that?
A Yes.
Q And this states that emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors. The use of emergency restraint will comply with all relevant standards and regulations.
Did I read that correctly?
A Yes.
Q And is what I just read, in fact, the policy at BHDC?
A Yes.
Q And was it also the policy at the time of David's death?
A Yes.
Q And am I correct that that is Booneville's definition of emergency restraint?
A That, what you read there?
Q Yes. Is what I read there a definition, Booneville's definition --
A Yes.

Q -- of emergency restraint?
A **Yes.**
Q Okay. And, again, emergency restraint is, in fact, the only form of physical or, I'm sorry, of personal restraint or personal hold allowed at Booneville; right?
A **Say that one more time.**
Q Emergency restraint --
A **Uh-huh.**
Q -- is the only form of physical --
A **That's correct.**
Q -- restraint allowed?
A **That's correct.**
Q Okay. Okay.
Turn to Page 4 of this document, please, which the Bates stamp number for that will be 4351. You see Section 6 there at the bottom --
A **Correct.**
Q -- titled approved restraint procedures, techniques and devices?
And the first item listed there is personal restraint; correct?
A **That's correct.**
Q And this defines personal restraint as an emergency procedure limiting movement by the holding of a hand or limb?

A That's correct.
Q Did I read that correctly?
A Yes.
Q And that is, in fact, the definition of personal restraint for Booneville?
A Correct.
Q Is there -- as far as you know, is there any other written definition of personal restraint found anywhere else in Booneville's --
A I --
Q -- documents or policies?
A I couldn't answer that. I'd have to do some research on that.
Q But, as you sit here today, you cannot point to any other definition of personal restraints specifically?
A Not without doing some research on it. What you've read is correct. But I -- I don't know if there's any other documentation to define that.
Q Do you think there could be an additional or supplementary definition of personal restraint in y'all's policy somewhere?
A I -- I'd have to ask my QA director who's over all the policies. That --
Q But --
A That'd be a better person to know that specifically.

Q Okay. But for today's -- or as you, you know, as of now, you can't --
A But that's --
Q -- specifically identify anything else right now at least?
A No. Correct.
Q Okay. This -- did you understand my questions concerning this Exhibit 3?
A Yes.
MR. GILLISPIE: I lost my microphone. Give me just a moment here.
BY MR. GILLISPIE:
Q Mr. Gonyea, what is your understanding of why only the least restrictive method of intervention is allowed at Booneville?
A Say that one more time.
Q Sure. What is your understanding of why only the least restrictive method of intervention is allowed at Booneville?
A So they only use the minimum necessary to protect the client from themselves or others.
Q And would one of the reasons for that be to preserve the safety of the client?
A That's correct.
(WHEREUPON, the document was marked for

identification as Exhibit No. 4 and is attached hereto.)

BY MR. GILLISPIE:

Q The next exhibit here is another DDS policy. This is DDS Policy 3004-I.

Mr. Gonyea, do you recognize this as a -- as being that DDS Policy number?

A Yes.

Q Okay. And you recognized that the subject of this policy is maltreatment prohibition, prevention, reporting, and investigation?

A Correct.

Q And Section 2 on the first page, Purpose -- oh, I'm sorry. Section 1, philosophy. You see that?

A Yes.

Q And I'm going to read that.

Every individual served by the Division of Developmental Disability Services, a/k/a DDS, has the right to be free from maltreatment. DDS strictly prohibits maltreatment, which includes but is not limited to, physical, verbal, psychological, or sexual abuse, neglect, exploitation, misappropriation of property, and violation of rights of individuals receiving services.

Did I read that correctly?

A Yes.

Q Do you agree with that statement?
A **Yes.**
Q And that statement was, in fact, policy applicable to Booneville in 2020?
A **That's correct.**
Q And I feel certain I've already asked this, so apologies for being repetitive.
But, at Booneville, personal restraints or personal holds, as I understand y'all call them, are only allowed in emergency scenarios?
A **That's correct.**
Q All right. And would an emergency be a situation where there is imminent danger to the health or safety of staff or the client?
A **That's correct.**
Q Okay. Just a moment.
Turn to Page 3 under Section 3, where it says prevention. And I'm going to read this and I'm going to paraphrase slightly at the beginning.
Rather, let me ask it this way. Take a moment and read that to yourself, Mr. Gonyea. Just that first sentence there under Section 3, under prevention.
A **Okay.**
Q Okay. And I guess, first, I just want to know, you understand that or you would agree that this is, this is

-- or that the -- this policy statements here would apply to Booneville?

A **Correct.**

Q Okay.

And so the second sentence there then would say that Booneville would be required to identify, correct, and intervene in situations in which maltreatment are more likely to occur.

Is that a fair statement?

A **Correct.**

Q Okay. And this would include an analysis of features of the physical environment that may make maltreatment and/or neglect more likely to occur; failure to recognize and respect clients rights.

Then, below that, the deployment of staff on each shift in sufficient numbers to meet the needs of the clients and assure that the staff assigned have knowledge of the individual client's care needs.

And then, below that, it states that this policy would include an analysis, or require rather, an analysis of inappropriate staff behaviors such as derogatory language, rough handling, ignoring clients while giving care, directing clients, any toileting assistance to urinate or defecate in their beds, and use items and staff for convenience.

Did I essentially read that correctly, even though I paraphrased a little bit?

A Yes.

Q Okay. And I guess, really, my only question is, would you -- you would agree, that at Booneville, rough handling, derogatory language, use of items for staff convenience would be considered inappropriate staff behaviors?

A That's correct.

Q Okay.

And Section B, reporting, number one, all alleged, suspected, and witnessed maltreatment will be immediately reported by all individuals having knowledge of the alleged incident to the on-site administrator.

Did I read that correctly?

A That's correct.

Q And that's a policy that would have applied to Booneville; correct?

A That's correct.

Q What does -- who does on-site administrator refer to?

A Probably --

Q At Booneville.

A Well, it would be myself. And, if I'm not there, it'd be my assistant superintendent or a designee, if

both of us are absent.
Q Assistant Superintendent, meaning Jennifer Berry?
A That's correct.
Q Who are the folks that would be -- that -- present day, who are some of the -- are there particular staff members that you would designate?
A Our QA director or Residential Service Director.
Q Okay. And was that also the case in 2020?
A Yes.
Q And, at the time of David's death, who was the Q? Well, what did say, Q what?
A Q -- QA Director.
Q Who was a QA Director in 2000 -- in June of 2020?
A I'm not exactly sure. I don't know the timeline. Our -- the one prior to the one we have now retired. So I don't know if she retired --
Q Who's the one now?
A Right now, it's Nikita Martin.
Q Okay. And who was the one before Nikita?
A Jane. I can't recall her last name right now --
Q But it would have been --
A Jane --
Q It's okay.
A Yeah.
Q But it would have been one of them though?

A Yes. Yes.
Q Okay.
A Yes. Yeah.
Q And then Sandy Evans was the residential services director --
A That --
Q -- in 2020?
A That's correct.
Q Okay. Who is RSD now?
A That's Jennifer Bancroft.
Q Jennifer Bancroft. And I've seen her name. Was Ms. Bancroft sort of like a deputy to Ms. Evans in 2020?
A She was -- we have -- the hierarchy of that is the residential services director and then there's three team leaders.
Q Uh-huh.
A So she was probably a team leader at that time.
Q Okay. And then are team leaders the same as program supervisors?
A No.
Q Are program supervisors a different department than --
A It's --
Q -- direct care?
A -- still under residential services. It's just not

-- they don't have the same -- our -- our program supervisors there's usually -- we have three different shifts.

Q Uh-huh.

A And a program supervisor is -- was responsible for running the operations of that shift. So that's the day -- daily, you know, the --

Q Yeah.

A -- movement of clients, appointments, different things like that.

Q And --

A Possibility of staffing changes if they had to move somebody from an area to another area.

Q Okay. But you said program supervisors are part of residential care?

A Yes.

Q And those supervisors would have -- are answerable or they -- rather, they answer to the residential services director?

A Ultimately.

Q Ultimately.

A Yeah. I mean, there's resident service director, then you have your team leaders, and your program supervisors. Then you have other supervision below them.

Q Is it possible -- are -- and you may have already

answered this.
But are program supervisors above team leaders or --
A No.
Q -- below?
A Below.
Q Below.
A Below.
Q Got it.
All right. Same section but here under report, No. 2, all alleged, suspected, and witnessed maltreatment will be immediately reported to the appropriate abuse reporting hotlines by the on-site administrator.
Did I read that correctly?
A Yes.
Q And do you agree with that?
A Yes.
Q And that was a policy at Booneville in 2020?
A Yes.
Q Okay. And then skipping to the next page, number five --
A Under which letter?
Q Same -- the same --
A Under B?
Q -- B reporting, yeah. Just next page number --
A Okay.

Q B-5. This states that reports of allegations shall also be made by telephone or fax by the on-site administrator/designee to local law enforcement where the facility is located and to the individuals parent, guardian, or advocate.

Did I read that correctly?

A Yes.

Q And do you agree with that statement?

A Yes.

Q And was that the policy at Booneville at the time of David's death?

A Yes.

Q Okay.

Under D, investigations -- actually, rather than read through this, I just have a couple more general questions about this investigative process.

Am I correct, that when it's determined that a maltreatment investigation needs to occur, well, such as in David's case, an investigator or a licensed investigator or --

A Trained --

Q -- somebody who's received the training, right --

A Yes.

Q -- is appointed to do so; right?

A That's correct.

Q And, in David's case, my understanding is you appointed Sandy Evans?
A **Correct.**
Q Okay. She's one of your trained or qualified investigators?
A **Correct.**
Q And then she does an investigation.

And my question is, am I correct that she does an investigation that would include interviewing witnesses and participants, reviewing records where necessary, reviewing the IPP and other documents necessary to review, and then she would generate a document that y'all refer to as the maltreatment investigation?
A **Correct.**
Q Okay. And then the next thing she does is give that to you; is that right?
A **Yes. After she's completed her investigation.**
Q And so my question is, does the investigator, in this case Sandy herself, make a -- substantiate -- what am I -- you know what I'm trying to say.

Does the investigator make a determination as to whether or not maltreatment has been substantiated or does she simply give you the results of her investigation for you to make that determination?
A **She'll -- she'll come up with a conclusion --**

Q Okay.
A -- as to what her investigate -- what she's found in her investigation.
And then I'll review that information and supporting documents and either concur or not concur.
Q Okay. I think that makes sense. So, if I hear you right, she will say in her investigation, you know, my conclusion after conducting this investigation is that there was -- is that maltreatment is not substantiated or maltreatment was substantiated --
A That's correct.
Q -- but it's not official, it's not the official determination until you approve it?
A That's correct.
Q Okay. And then do you then produce your own written document?
A I -- I do a summary document of the investigation that was conducted by the investigator. And we put that on a what's called an IRIS report, which is what we report through DHS.
Q And is that what you refer to as the DHS incident report?
A I -- I don't know if they call it that or not. I -- It's called an IRIS --
Q IRIS report?

A -- I don't know what the acronym -- I don't know what that stands for. But it's just -- is an IRIS report. It's throughout DHS for any kind of report.
Q And then that's what you send to -- where do you send that?
A It goes to -- I -- I don't even know what office actually gets it.
But, once it goes in there, it gets farmed out like also long-term care would, would get a copy of that. And then that triggers them for an investigation.
And so they would come out, do their thing. I think it goes maybe today to the A -- IG's office. I'm not sure. There's -- there's a list on there of who all it goes to.
Q Okay.
A So --
Q Do you also send them a copy of the investigator's maltreatment investigation? Or is it contained -- or is it all --
A I -- I --
Q -- one document?
A I believe they -- everything's one document. I don't do IRIS reporting. I have an individual that actually fills that out on the computer.
My best recollection is they put everything from the

investigator's report, plus my summary in there, and that's what goes in. And then --

Q And then sometimes OLTC will follow up with its own investigation?

A Right. They'll -- they would come in and they get a copy of the entire investigation and -- you know, to include all the statements made by staff and any of the investigations or any documents that went into that. And then they would conclude their own investigation from that.

Q Does OLTC do that in every situation or just in cases of deaths and other, certain other --

A I --

Q -- more serious cases?

A It probably depends on the severity. It would probably be -- I don't know how long-term care quantifies --

Q Yeah.

A -- their investigations. But that, nine times out of ten though, a maltreatment investigation would probably trigger at least a -- what in -- on their side they call a complaint --

Q Uh-huh.

A -- which would trigger an investigator or a surveyor to come out to, to look at it.

Q Okay.
A So --
Q Turn to Page 5 of this same document, Section E, titled investigative reports, please.
Number one there, it says that when a reported incident has been determined to warrant an investigation, the on-site administrator must submit a report of findings to the Office of Long-term Care within five working days of the facility's knowledge of the incident to comply with OLTC Regulation, LTC 300, et. seq.
What is that referring to?
A That -- that's the IRIS.
Q That's the IRIS?
A Uh-huh.
Q Okay. That's not necessarily -- does that -- that's not necessarily your final summary?
A By -- yeah. By the fifth day, I have to submit my final summary to them.
Q Oh, okay. So the investigation is supposed to be -- the maltreatment investigation itself then is supposed to be concluded within that five-day window?
A That's correct.
Q Okay.
A That's the next paragraph.
Q Yeah. Okay. But, in David's case, you didn't have

to submit any sort of status report? It was -- you were able to submit the --
A There's -- there's an initial report --
Q Uh-huh.
A -- that goes in to just -- and you have until, I don't know, 10 or 11 o'clock the following business day to get it, the initial report in, so --
Q Uh-huh.
A -- if there was a death, they would re -- at least started the IRIS. So that starts the process. Then you have five days to complete it.
Q And, in this case, you were able to get the final report to OLTC within the five days?
A Correct.
Q And then, under Paragraph 3, it says a full report in the format of a DDS investigative file must be completed and submitted to the DDS director and to OLTC within 14 calendar days of notification that an incident is being investigated.
Now, what is that referring to? The DDS investigative file.
A I -- IRIS report. They get that, that same report goes to them.
Q Okay. So that -- that's referring --
A It goes to multiple agencies.

Q Okay. So it -- that's also referring to the document that you generate and produce to Central Arkansas within that five-day window?
A **Correct.**
Q Okay. Almost done with this here.
Skipping to Page 8, which are some -- which is a -- do you recognize this to be Appendix A, statutory definitions that go along with this policy number 3004-I or Roman numeral one?
A **Yes.**
Q Okay. And this -- the first definition defines abuse. And one of the definitions of abuse, there at the big A, states that abuse means any intentional and unnecessary physical act which inflicts pain on or causes injury to an endangered or impaired adult, including sex abuse.
Did -- would you agree I read that correctly?
A **That's correct.**
Q And would you agree that that definition of abuse is what was in use at Booneville at the time of David Cains' death?
A **Yes.**
Q And skip down to No. 6, big A, imminent danger to health or safety means a situation in which death or severe bodily injury could reasonably be expected to

occur without intervention.

Did I read that correctly?

A Yes.

Q Okay. And is that also a definition that was in use at Booneville at the time of David's death?

A Yes.

Q Okay. Did you understand my questions related to this document, sir?

A Yes.

Q Thank you.

(WHEREUPON, the document was marked for identification as Exhibit No. 5 and is attached hereto.)

BY MR. GILLISPIE:

Q Okay. I'm showing you here what I intend to mark as Exhibit 5.

Do you recognize this to be a Booneville restraint incident debriefing form? And take your time to take a look at it and make sure it's what I think it is.

A Looks like part of one.

Q It looks like the first page of one?

A Yes.

Q Okay. And it is, it's just the first page of one because I -- I only have one. I only -- short question here about it.

A I've seen it. This is not our current one. And I don't know when it changed to the new debriefing form, but --
Q Okay.
A -- this is as of October of '19, so --
Q Okay. About eight months, approximately, before David's death; correct?
A Correct.
Q All right.
This paragraph at the top, that's what I want to ask you about. And I'm going to read it.
The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. Has that -- you said it's changed.
Has that dedication to the reduction of restraint use at the facility changed since this date?
A No. That's always -- always -- we always strive for --
Q Okay.
A -- restraint free.
Q Okay. The use of restraints has proven to be dangerous for both staff and clients with the occurrence of injuries dramatically increasing when restraint is used. Did I read that correctly?
A Yes.

Q And is that still a true statement for -- is that still a true statement today?
A **Probably so.**
Q Okay. All efforts must be made to de-escalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only, parentheses, even when part of a behavior treatment program, end of parentheses, when a very real risk of personal injury or severe property damage is imminent.
Did I read that correctly?
A **Yes.**
Q And do you feel like that is a statement that is still applicable at Booneville today?
A **Yes.**
Q Okay. And it would have been applicable at what I've -- this paragraph I've read would have also been applicable at the time of David's death?
A **Correct.**
Q Okay.
Any questions about this? Did you understand my questions about this document?
A **Yes.**
Q Okay. We're about done with policies here. I'm just make -- give me a second here to make sure I didn't

miss anything. I'm trying to save us some time here.

There was a couple other policies I was going to ask you about that I don't think I'm going to have to.

A Okay.

Q If you'll just give me a moment to go through them.

MR. ROSEN: You -- it might be a good time to take like a ten-minute break, 15 maybe.

MR. GILLISPIE: Well, if you want to -- let's see. We've been going about two hours.

MR. ROSEN: Or do you want to take a lunch break? Whatever you want. I'm -- we're --

MR. GILLISPIE: I need to run -- I need -- I don't -- I don't know if you heard me saying my pharmacy has been out of my blood pressure medicine for two days.

MR. ROSEN: So you need to go get it?

MR. GILLISPIE: Yeah. My mom -- my wife -- my mom. Tell you I need it --

MR. ROSEN: Yeah.

MR. GILLISPIE: My wife has it, so I'm going to go get it.

MR. ROSEN: You don't have to explain anything. You need something --

MR. GILLISPIE: Can I please go, Rich? Please?

MR. ROSEN: Yes.
MR. GILLISPIE: Thank you.
MR. ROSEN: Of course.
MR. GILLISPIE: Thank you.
MR. ROSEN: We can take lunch.
MR. GILLISPIE: Yeah, we'll take lunch.
MR. ROSEN: That's fine.
MR. GREEN: Okay. It's 1:25, do you want to come back at 2:30?
MR. GILLISPIE: You guys tell me. I'll do whatever.
MR. GREEN: How long do you want --
MR. GILLISPIE: It'll take me 30 minutes to go and come back, but -- 45 minutes? You want to come back at 2:30?
MR. ROSEN: Whenever you get back here.
MR. GREEN: Let's ask the court reporter.
MR. ROSEN: You'll probably -- it'll take -- where are you driving -- this is not on the record.
VIDEOGRAPHER: Okay. We're going off the record. The time is approximately 1:25 p.m.
(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

VIDEOGRAPHER: We are back on the record. The time is approximately 2:42 p.m.

BY MR. GILLISPIE:

Q Just a second. I'm trying to find my place here. Okay. All right.

Mr. Gonyea, we've talked about some policies. I have one more policy here to show you. Well, there's going to be a couple more, but one of the last ones here. I only have one copy of it here.

So I'm about to hand it to you, but I'll represent to you that it's Booneville policy, I believe that says either Roman numeral 1-1-1 or big I, big I, big I. But it's staff develop -- it has to do with staff development department.

And number one on that says the staff development department shall develop and implement training programs to meet the requirements of DDS Policy ICF/IID regulations and applicable accreditation council standards.

Did I -- do you recognize that policy to be what I represented that it is?

A Yes.

Q Okay. And did I read number one correctly?

A Yes.

Q Okay. Number two states that staff development

depart, staff development department staff will work closely with the directors of residential services and superintendent and assistant superintendent for assistance.

Did I read number two correctly?

A Yes.

Q Okay. Number three, staff development department staff will work with the executive staff members to assist in the determination of training needs of each department.

Did I read that correctly?

A Yes.

Q Then, number four, the staff development department will maintain training records for each employee.

Did I read that correctly?

A Yes.

Q And then there's a fifth sentence. I'm not going to read that, but I assume you recognize this document and you agree with --

A Yes.

Q -- the statements contained therein; is that right?

A Yes.

Q Okay. Go ahead, Rich.

MR. ROSEN: Just as a matter of clarification, there's highlight on there

though?

MR. GILLISPIE: Yes. Those are my --

MR. ROSEN: You did that?

MR. GILLISPIE: Those are my highlights, yeah. And that's -- I apologize. I didn't --

MR. ROSEN: No, no problem.

MR. GILLISPIE: Didn't get extra copies made of it.

Let's see. Make this Exhibit 6.

(WHEREUPON, the document was marked for identification as Exhibit No. 6 and is attached hereto.)

BY MR. GILLISPIE:

Q And so piggybacking off of this staff development regulation, am I correct that staff development at Booneville is responsible for training staff in the use of emergency procedures?

A There's probably multiple things that they actually train on. That would probably be one of them.

Q Okay. Is there any other department at Bonneville that handles training staff in emergency procedures? Or is that staff development's responsibility?

A Primarily staff development.

Q Okay. And the emergency procedures, the staff development, train staff and would obviously include

personal restraints or personal holds?
A Right. We -- we use CPI, which both of our staff development instructors are both trained in, certified.
Q Okay.
A And they do all the training with our staff.
Q Okay. And those -- and one of those staff develop -- what did you call them?
A Staff development.
Q Staff development --
A Instructor.
Q Instructors. And one of those staff development instructors is Mark Hice?
A That's correct.
Q Okay. And the staff development instructor, the staff development instructors, are NCI certified?
A That's correct.
Q Okay. And they're the folks at Booneville who are responsible for showing the staff how to use personal holds or personal restraints in cases of emergencies?
A That's correct.
Q And Mark Hice is a -- is one of those staff development coordinators; correct?
A Correct.
Q And you may not be aware, but am I correct that he's been with Booneville for approximately 27 years?

A Probably pretty close to that.
Q Okay. And I understand that he was a -- he's been a program supervisor. He did that for maybe 13 years before moving to staff development. Does that sound correct to you?
A I -- he worked at direct care. I couldn't tell you exactly how long in each position, but --
Q Okay.
A -- he did come out of residential services.
Q Okay.
A So he has a very good understanding of how that works.
Q Okay. And would you agree he also has a very good understanding of how personal restraints and personal holds are to be applied?
A Yes.
Q Okay. And he's been in, I believe he told me, he's been a staff development coordinator since 2016. Does that sound --
A I -- if that's what he told you.
Q Okay. And so Mark Hice is one of the staff development coordinators.
Is he -- would you agree that he's the person or one of the two people at Booneville with the most knowledge concerning the use of personal restraints and what to

apply and how to apply it in emergency situations?
A Well, we have two instructors up there. Vanessa Wyrick is the other instructor. I -- I'm not sure which one's been there longer as an instructor, but --
Q And I -- you may --
A -- probably pretty close.
Q I may have mumbled it, but I actually said would you agree that he's one of two people --
A Right. Right.
Q -- up there. Because I knew there was another one.
A Right?
Q He's -- I guess another way to rephrase this question would be, are the staff development coordinators the folks at Booneville with the most knowledge or expertise concerning the use of personal restraints and personal holds in emergency situations?
A Yes. Yes.
Q And moving back briefly to the maltreatment investigation that occurred following David Cains' death, excuse me, Sandy Evans, who was director of residential services at the time, conducted that maltreatment investigation?
A Correct.
Q Was there anybody other than Sandy who took part in conducting that investigation in a direct way?

And I can --
A Not -- not -- not that I'm aware of.
Q Probably a poorly worded question.
Did you yourself, you know, conduct interviews with any of the witnesses or participants?
A No.
Q Okay. And my understanding of the way it works is -- and you tell me if I'm right or wrong.
But my understanding of the way it probably works would be that -- well, first of all, Sandy Evans received all the appropriate training in order to become an investigator; right?
A Correct. Correct.
Q You can't just say, Sandy, you're going to be an investigator now --
A That's correct. They go --
Q -- she has to --
A -- go through some training performed by an outside agency and they get certified.
Q They get certified?
A Yes.
Q And, at the time of David's death, do you have any, any idea how many certified maltreatment investigators you had at Booneville?
A I -- I would be guessing. Maybe five, six.

Q Oh, okay. I didn't realize it was that many.
Okay. And my understanding is Sandy -- you almost immediately got her working on this investigation after you --
A Correct.
Q Right. And my understanding is that she conducted at least, I think, 11 or so interviews with staff, including, you know, witnesses and participants that very day; right?
A I -- I -- I wouldn't know exactly how many she did that day, but I'm sure there were several.
Q And my understanding is she reviewed portions of, if not all of David's IPP, and reviewed EMT records, emergency room records, in addition to conducting the interviews with staff, is -- is that --
A I would --
Q -- also your understanding?
A I would -- I would say everything that was available to her, she probably looked at.
Q Okay. And did you, when she brought you -- when she finished her investigation, she came to you with a document? Is that kind of how it worked?
A Normally, when the investigator's done, they bring the complete report with all the supporting statements and --

Q Uh-huh.
A -- any evidence they have. They'll bring me a packet and then I review it.
Q Includes the OLTC witness statements?
A Yes. Yes.
Q All that. And that's what occurred in this case?
A Yes.
Q Okay. And I don't believe you had any criticisms or issues or any reason to question her findings at the time, did you?
A No, I did not.
Q Okay. And would it be fair to say that you relied upon, heavily relied upon, the results of her investigation in making the determination that you did make?
A That's correct.
Q Okay. And I don't know if we've ask -- if we've addressed this specifically, but the determination that was made in this case was that maltreatment was unsubstantiated for the three direct care staff involved in the restraint; correct?
A That's correct.
Q Okay. And, again, it was -- and I assume this is, you know, how it's supposed to work.
But you relied very heavily or almost entirely on

Sandy's investigation in making your determination?
A Yes.
Q All right. Is there anybody at Booneville, aside from the staff members that were actually involved in the incident, that would have more direct knowledge of the restraint incident on the day of Davey's death than Sandy?
A I -- I don't believe so.
Q Okay. When the Office of Long-term Care comes in and sort of does their -- does a follow-up investigation, are they investigating for the purpose of substantiating or not substantiating maltreatment, or rather are they simply coming in to review to make sure that everything -- that policy seemed to have been followed?
A I would --
Q If that makes sense.
A I would -- I'm not a surveyor. But I would think they would look at both those things.
One -- one, they want to see that the facility followed their practice and did everything according to the --
Q Uh-huh.
A -- what our policies state. But they also look at it in regards of, you know, did -- did they do what they were supposed to do.

Q Yeah. And I guess a better way to ask what -- the question I was trying to ask would be, does OLTC have the ability to reverse --

A Yes.

Q -- a maltreatment finding?

A They sure do.

Q So they can come in and say, no, we think this was maltreatment and --

A Yes, most definitely.

Q Oh, okay. All right.

MR. ROSEN: Wait -- wait until he --

THE WITNESS: Okay.

MR. ROSEN: -- finishes the question.

THE WITNESS: Okay. Yes.

BY MR. GILLISPIE:

Q That's one -- it's something I've been curious about. But that certainly answers that for me.

MR. GILLISPIE: I've got another exhibit here. And these are the first aid guidelines.

(WHEREUPON, the document was marked for identification as Exhibit No. 7 and is attached hereto.)

BY MR. GILLISPIE:

Q Well, let me do it the right way here.

Do you recognize these, Mr. Gonyea, as being the

Booneville HDC first aid guidelines that were in effect at the time of David Cains' death?

A Yes.

Q Okay. Specifically, this is policy Roman numeral four, big B, Arabic 10; is that right?

A Yes.

Q Okay. And this is Bates stamped 4423.

And, Mr. Gonyea, would you agree that this is Booneville's written policy concerning -- or withdraw that.

Would you agree that one of the things that this policy covers or covered, I understand it's -- the policy was in place at the time. But one of the things that it covered was who can call 9-1-1 in cases of medical emergency?

Would you agree that's one of the things that this policy covers?

A I don't believe so.

Q Okay.

A This -- this is first aid guidelines and --

Q Okay.

A -- you know, the kind of first blush with things.

Q Sure. Well, let me just kind of take it and let's kind of go through it step by step.

Under Procedures, number two, you see number two

under procedures?
A Yes.
Q I'm going to read.
In all cases in which a serious medical injury or illness is suspected, either to clients or staff, a call to the medical department should be made. This should be the first call, so medical staff can respond immediately to the situation.
A call to medical at 1422 should be made and the following information should be given; one, caller's name and title; two, victim's name, location, situation, and condition of the victim, in parentheses, alert, unconscious, et cetera; number three, medical asset -- will assess the situation and call an ambulance, if appropriate.
Did I read that section two correctly or accurately, Mr. Gonyea?
A Yes.
Q Okay.
And would you agree that this was, in fact, Booneville's 9-1-1 policy, at least at the time of David's death?
A No.
Q Okay. Why would -- and why would you not agree with that?

A If it was 9-1-1, it would state that it would be an emergency.

So anybody can call for an emergency, whether it's medical, could be a weather-related incident, it could be a fire, could be -- so anybody could call 9-1-1 at any time. As this states, it's a first aid guide, so --

Q Uh-huh.

A -- you know --

Q So this has to --

A -- depending on the situation, I guess, you know, if it's an emergency, they can call 9-1-1.

If it's a first aid or something, assessment, you know, could be a -- various things, it could be, they would assess it.

Q Would you -- okay.

Well, for the purposes of medical emergencies, would you agree that this policy, this is a Booneville policy pertaining to calling for emergency services in the event of a medical emergency?

A I think this -- this policy is in place to assess anybody, regardless of severity of their medical need.

This is just any time that there's -- there's something a nurse needs to look at, that's what they would call.

Q Is there another written policy at Booneville that

covers calling 9-1-1?
A I -- I would probably have to check with my QA Director.
Q As you sit here today --
A And I -- I mean --
Q -- do you know of one, specifically?
A I mean, not off the top of my head.
Q Do you know of -- off the top of your head or as you sit here today, do you know of any other document, memorandum, anything that pertains to calling for an ambulance at Booneville, besides this document?
A Probably in some of the orientation training, there's going to be a reference into, you know, if there's an emergency call 9-1-1.
But I -- I don't have that document in front of me. So I couldn't reference anything, per se.
Q And you also don't know for sure if it's there or not?
A Not off the top of my head.
Q Okay. Would you agree with me that the first sentence of this document in section two states, that in all cases in which a serious medical injury or illness is suspected, either to clients or staff, a call to the medical department should be made?
Did I read that correctly?

A Yes.
Q And you agree that that sentence represents a policy that was in place at Booneville in -- at the time of David's death?
A I mean, that was the procedure in place at the time, yes.
Q And then the next sentence says this should be the first call so medical staff can respond immediately to the situation.
Did I read that correctly?
A Yes.
Q And would you also agree that that sentence represents a policy that was in place at Booneville at the time of David's death?
A Yes.
Q And then the -- still section two but number three in that subcategory or subparagraph there, medical will assess the situation and call an ambulance if appropriate.
Did I read that correctly?
A Yes.
Q And you'd agree that that sentence represents a policy that was in place at Booneville at the time of David's death?
A Yes.

Q And would you agree with me that nowhere in this document does it say that someone other than medical can call an ambulance?
A **Say that again.**
Q Would you agree with me that nowhere in this document in front of you does it say that anyone else, other than medical, can call an ambulance?
A **This -- this document doesn't say they can or cannot call 9-1-1. Anybody can call 9-1-1.**
Q Well, I guess what I'm -- you'd agree that this document specifically says that medical will assess the situation and call an ambulance, if appropriate; right?
A **Right.**
Q So it's -- it --
A **But -- but it doesn't say in an emergency situation. This is just first aid guideline.**
Q Okay. Is there another document that would pertain to some other situation, an emergency situation? Or is there some other document?
A **Off the top of my head, I couldn't tell you that.**
Q Okay. And you don't think that this document is meant to apply to emergencies?
A **I do not.**
Q You don't think a serious medical injury would be an emergency?

A It -- it could be. That's why, after the nurses get there, they would assess the situation. And, if it turns out to be an emergency, they would do the appropriate thing.

But this -- if somebody fell and got a scratch, they're going to call 1422 and the nurse is going to come over and assess them for an abrasion, a cut, the -- the need to maybe have it x-rayed. There's just a multiple reasons they would call that. I mean --

Q As -- as you sit here today, sir, is there a -- is there a document that you can identify for me today or point to today that specifically says that anybody can call 9-1-1 in an emergency situation?

A No. I -- I -- I think I've answered a couple times the same question. I -- I don't recall anything off the top my head to -- we may have one. I just couldn't tell you what it is.

Q Okay.

Well, if you do have one, would you agree to, with all possible speed, please get that to your attorneys?

A Sure.

Q Just a moment.

MR. GILLISPIE: Let me see that.

BY MR. GILLISPIE:

Q Same document here where it says policy statement at

the very top, the second sentence, I'm going to read that. Again, this is under policy statement for these first aid guidelines. Well, I'll just read both sentences. Policy Statement.

First Aid Guidelines are available for use in each of the aid stations in each living area. This will permit appropriate and immediate attention to medical conditions of sudden onset, including injuries and choking.

Did I read that correctly?

A Yes.

Q And, again, these, those sentences I just read, those represent policies that were in place at Booneville at the time of David's death?

A Correct.

Q I've been -- my questions have used the term 9-1-1 mainly.

How about calling for an ambulance? Would your responses be any different if I used that term instead of calling 9-1-1?

A I mean, that -- that's how we would get an ambulance there, would be 9-1-1.

Q Okay. So, when I say 9-1-1, I -- I would -- I say -- I would use calling 9-1-1 or calling an ambulance interchangeably myself, but --

A Right.
Q -- are you saying that you kind of feel the same way?
A Some -- sometimes. Sometimes we call an ambulance just for transport. Depending on the nature of the client, if there's an injury or it could be a health condition that they -- they -- they have to be transported to a medical facility, so that -- we'll call for an ambulance up there.
Q Okay.
A We live in a rural area and the availability sometimes of getting an ambulance up there may be five or ten minutes or it could be up to 45, depending on where they are coming.
Q You typically would call 9-1-1 to get the ambulance though?
A Yes.
Q Okay. Okay. Oh, yeah, thank you.
A Yeah.
MR. GILLISPIE: Let's take a couple of minutes.
MR. ROSEN: Before -- can you mark that as Exhibit 7 --
MR. GILLISPIE: Yeah.
MR. ROSEN: -- just before we forget?

MR. GILLISPIE: Yeah.

VIDEOGRAPHER: Going off the record. The time is approximately 3:14 p.m.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

VIDEOGRAPHER: We're back on the record. The time is approximately 3:26 p.m.

BY MR. GILLISPIE:

Q So I'm finished with Exhibit 7. I did want to -- and I did mark it as Exhibit 7 and put it in here.

I did want to very quickly -- we're very close to being done, at least my part --

A Okay.

Q -- draw -- go back to 3011-D. I'm going to hand it to you. I'm just finding it.

MR. ROSEN: Which exhibit, Counsel, is that?

MR. GILLISPIE: It's two.

MR. ROSEN: Two.

BY MR. GILLISPIE:

Q This is more just my curiosity than anything.

VIDEOGRAPHER: Excuse me. You're on your mic, Josh.

MR. GILLISPIE: Oh.

MR. GREEN: You're stepping on it.
MR. GILLISPIE: I got it.
BY MR. GILLISPIE:
Q And, Mr. Gonyea, my question is about these categories. Are you familiar with these Category I, Category II, Category III, that are described in this policy?
A Just -- just in reading it, I'm not the expert on their, you know, behavior management programs.
Q Yeah. And I don't have any particularly detailed questions about this. My questions were more general and it's this.
Am I correct that what all -- considering that -- well, as we've gone over ad nauseam, personal holds and/or personal restraints are only used in emergencies at Booneville? That, meaning that they're not made part of a treatment plan as described here in Category III; is that correct?
A That's correct.
Q Okay. But there are -- so everybody at Booneville is either going to be Category I or Category II
A I'd even have to look at the definitions in the categories.
Q Go ahead. Yeah.
A I -- I --

Q Take your time. Take your time. Just let me know when you're ready to continue.
A So what was your question again?
Q Are all of the clients at Booneville -- I know -- okay. I know David was Category I, but are all of the clients at Booneville Category I?
A I believe there'll be -- there'll be clients in each category all the way up to a III.
Q So you could have -- so you might have a Category III client and just -- but you still have the option of not including restraint in their behavior plan then?
A I'm not the psychologist to really make that determination.

But, to be a Category III, you have to -- you have to have a licensed psychologist sign off on it. So that'd really be a question for them.

Q But you believe that Booneville does have Category III clients?
A I -- I -- I think we have a few threes.
Q Would Category III clients, would that mean that they're more prone to violence or dangerous or in some other way kind of more severe cases?
A Again, I think that would be a psychologist question.
Q Okay. You're not --

A Because -- because they have to sign off on it, so --
Q Okay.
A -- that -- I'm not sure how they make all their determinations. That's what they're licensed --
Q Okay.
A -- for, so --
Q That's fine. That's fine. You can have that.
I have what I think is going to be our last exhibit here.

(WHEREUPON, the document was marked for identification as Exhibit No. 8 and is attached hereto.)

BY MR. GILLISPIE:
Q I showed you what is Bates stamped Page 9019 and 9020 and 9021, so 9019 through 9021. And it's titled Arkansas Department of Human Services Developmental Disability Services Case Notes. Do you see that?
A Yes.
Q And dated the date of David's death, 6/13/2020. Do you see that?
A Yes.
Q Okay. And take a moment to scan through this, if you like or even, you know, read it, if you want to. I just have a couple of quick questions about it.

And just let me know when you're ready. Take your time.

A Okay.

Q All right.

Okay. Now that you've had a chance to review this document, what would you -- how do you describe what -- how would you describe what this document is? What is this document?

A To me, it looks like a case note of the conversation and notification from the social worker to the mom as to what happened. Or at least initially what happened.

Q You'd agree this, these -- this is a case note from the day of David's death reflecting Booneville's communication with and notification to David's mother, Charlene Robinson?

A That's what it looks like.

Q Okay. The second paragraph, it says -- and I'm sorry. And this was drafted by and signed by Amanda Krigbaum; is that correct?

A That's correct.

Q And she -- the date of the top says 6/13/20, but looks like she signed it, maybe completed it and signed it on 6/15/2020.

Who is Amanda Krigbaum?

A She's a social service worker.

Q Okay. So the second paragraph, I'm going to read what Amanda wrote here.

This is Amanda. I asked what happened -- and I'm sorry. Let me strike that. And let me preface by saying, that in this second paragraph, this would appear to be Ms. Krigbaum describing the initial notification she got from Amanda. I assume Amanda Schmitt in medical; correct?

A That's what it looks like.

Q Okay. And Ms. Krigbaum writes, I asked what happened; she, she being Nurse Amanda Schmitt, she said she did not know exactly what happened except he started having a behavior while he was eating, he started to choke.

Did I read that correctly?

A That's what it says.

Q Okay.

And down, the last paragraph, where it starts at 12:24 p.m., I, I being Ms. Krigbaum, made a call to Ms. Charlene Robinson, David's mother and guardian.

She answered the phone. I introduced myself; I could hear her clearly. I thought she could hear me. I gave the notifications.

During the call, the phone started having static sound and the call ended. I immediately called back at

12:25. She answered in a panic; again, I could hear her clearly, she could not hear me. She kept saying hello, then would hang up. I checked the on-call phone. It had full service bars. I continued to call, it went to her voicemail twice. I tried calling on a personal cell phone, it would not go through.

I called Jennifer Berry on my personal cell phone at 12:27. She said to try to call again with the on-call phone. I called while Jennifer was still on my personal cell. Ms. Robinson picked up, I made sure she could hear me, she said yes.

Did I read all that correctly?

A **Yes.**

Q It sounds like there was some mishaps with the phone.

I, again being Ms. Krigbaum, asked if she, meaning David's mother Ms. Robinson, heard anything from my initial call. She, being Ms. Robinson, said no. All she heard was that I didn't have any further information.

I, meaning Ms. Krigbaum, then started to give the notification again. I stated that I received a call from medical that David choked on his food. Before I could say anything else Ms. Robinson went into a panic mode and began crying and sobbing.

Did I read that accurately?

A Yes.
Q Okay. I tried to say that staff did rescue procedures until EMS arrived but unable to say that statement due to her continuing to cry and be in a panic state. She, meaning Ms. Robinson, then started asking if he was okay.
I, Ms. Krigbaum, stated that EMS got involved. He

[redacted]

During this statement, Ms. Robinson continued to cry, very upset, and in a panic state. Did I read that correctly?
A Yes.
Q She, meaning Ms. Robinson, then asked what kind of food did he choke on. I, meaning Ms. Krigbaum, stated I did not know that information but just that he choked on his food.
Ms. Robinson continued to say that she just talked to him the other night and he was doing good.
Did I read that correctly?
A Yes.
Q Okay. And you'd agree with me that this is -- this reflects, that at least at this time, Ms. Krigbaum told Ms. Robinson that David had choked on his food?

A Was that a question?
Q Yes.
A Okay. Yes.
Q Okay. Last sentence of that same paragraph, she, meaning Ms. Robinson, continued to cry and sob and then she hung up the phone.
Jennifer Barry was still on my personal call and could hear the conversation.
All right. Read that correctly as well?
A Yes.
Q All right. And, at 12:58 p.m., Ms. Krigbaum notes here that she got a call from Angie, I presume Angie Nelson in medical, stating that the hospital had called time of death at 12:21. Is that correct?
A That's correct.
Q Okay.
Go down to the short little paragraph that starts at 3:14 p.m. Ms. Krigbaum writes that Angie from medical called stating the mother called them and asked to speak to us.
I explained I was getting information from the hospital to share with mom. Under that, 3:17 p.m., I, being Krigbaum, called Ms. Robinson, informed her that the hospital said that he was being taken care of and being sent to Roberts Funeral Home, the County Morgue.

She, meaning Ms. Robinson, was relieved when she heard this news and said, good, thank you. She was mixing up her words; and, after a couple of tries, stated that David's sister is coming from Vermont and will be in town Monday. But then she said that she was sorry, that she could not think clearly. She asked that I please notify her brother, Mr. Patrick Riley, because she was not able to. And then if -- on the last page --

MR. ROSEN: Was there a question there? Just for clarification.

MR. GILLISPIE: Oh, yes.

BY MR. GILLISPIE:

Q My -- I'm sorry. My question is, did I read that correctly?

A Yes.

Q Okay. And I assume you have no reason to think this is not an accurate accounting of Ms. Krigbaum's interactions with Ms. Robinson on this day?

A I -- I wouldn't have anything to -- I guess, best of her knowledge, at the point that --

Q I --

A -- spoke to her, that was -- that was the information she had.

Q Okay. And I just really was just asking if you -- you know, I assume you don't have any reason to think

that what Ms. Krigbaum is writing here -- I'll withdraw that. Unnecessary.

Okay. The last page, at 1623 p.m., I, again Ms. Krigbaum, received a call on the on-call phone from Ms. Robinson. She asked if we were going to put this in the paper. I explained I do not believe so but I could double check. She said please do and she did not want this in the newspaper at all.

She, meaning Ms. Robinson, also asked if she would be able to come to BHDC to go through his things. She said that she wanted to get his favorite Monkees hoodie sweatshirt. I assume that means Monkees, the band, hoodie sweatshirt, and a nice pair of jeans to bury him in.

Did I read or at least paraphrase that accurately, Mr. Gonyea?

A **Yes.**

Q Okay. I assume you probably know, knew, David well enough to know that he loved the Monkees?

A **I did not know that.**

Q Oh, you didn't?

A **No.**

Q The band? Okay.

So my question is, are you aware of whether anyone, you yourself or anyone that works for you, are you aware

if anyone ever got back in touch with Ms. Robinson and clarified the circumstances surrounding his death? Specifically that, you know, he had not choked on his food during lunch?

A I'm pretty sure at least -- I mean, I -- I couldn't answer interimly between the investigation, but I -- I think she was made aware of the end result of the Sandy Evans investigation, but --

Q She got a letter, that's correct. But I'm asking --

A I --

Q Let me just --

A I --

Q -- ask it in a sim --

A I don't have personal knowledge --

Q Okay.

A -- of that.

Q You never made a phone -- you yourself never reached out to her to tell her what -- the more accurate circumstances of his death?

A No. I -- I've never spoken with her.

Q Are you aware of anybody that works for you having done that, reached out to her to clarify the circumstances of his death?

A I -- not -- I don't know if they have or have not.

Q Okay.

A I don't -- I don't have personal knowledge of that.
Q Okay.
I'll represent to you that Ms. Robinson testified in her deposition that she was not informed of the restraint or that it wasn't his lunch that he choked on until she got that letter roughly nine days, I think, after his death.
Do you have any personal knowledge that would suggest she's wrong about that?
A I -- I do not have any knowledge of that.
Q Okay.
MR. GILLISPIE: I'm done with this. This is 8.
BY MR. GILLISPIE:
Q We discussed this policy contained within -- one of the policies contained within 3011-D, DDS 3011-D, that we already discussed. And I can hand it back to you, if we need. It's Exhibit 2. But you may be able to answer this without having to look at it.
But one of those policies stated, that if emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action.
Do you recall that?
A Yes.

Q Okay. Do you have any -- do you have your -- do you have any personal knowledge of David Cains' IDT meeting and conducting a functional analysis at any point in 2020?

A I wouldn't know that.

Q Okay. So you don't have any personal knowledge of that?

A No.

Q Do you have any personal knowledge of David Cains' IDT meeting to conduct a functional analysis and develop an appropriate plan of action at any point in 2019?

A I wouldn't know that either.

Q So you have no personal knowledge of that?

A No.

Q How about for 2018 or 2017?

A I --

Q Same answer?

A That's -- yes. I don't -- I don't track each client in their -- that's why they have case managers, to track that and follow up on.

Q Okay. Do you have any personal knowledge or memory of ever discussing David Cains' -- let me rephrase that.

Do you have any personal knowledge of ever discussing David Cains with his case managers at any point?

A No.
Q You said case managers is who you said would --
A Or -- or their Q --
Q -- keep with this; right? Okay.
A Yeah, their --
Q Well, do you have any personal recollection or knowledge of discussing David Cains with his Q or his case manager?
A No.
Q Did you ever attempt to reach out to the ambulance service or the hospital or the coroner to clarify the circumstances of David's death?
A I -- I have not.
Q Do you know if anybody that works for you ever did?
A I'm not sure.
Q You didn't ask anybody to though?
A It -- that wouldn't be something that I'd normally -- I'm -- I'm not sure what I would reach out to them for.

I mean, normally, social services handles any kind of like (inaudible) case or if there was a medical issue, it would be my director of nursing that might reach out for something.

But there wouldn't be anything for me to reach out, unless there was a problem with something.

Q Were you aware that the paramedic who responded to, that arrived on the day of Davey's death, claims that he was similarly told something similar to what Ms. Krigbaum told Ms. Robinson? Meaning that David had choked on his lunch? Were you aware of that?
A I -- I was not aware of that.
Q Okay. Nobody's ever talked to you about that?
A I -- I -- at the time, nobody ever brought it up. Probably when all this started, somebody mentioned something about that, but I don't, don't have any knowledge of it.

Nobody's presented me anything. Nobody's asked me any questions about it or said there was an issue.
Q Well, did you -- what about the -- did you personally review the Disability Rights Arkansas investigation that was -- the investigative report that was done concerning David's death?
A DRA, Disability Rights, never came to my facility to review that case.

Whatever they reviewed, I don't -- I don't know what they looked at. So they didn't -- they didn't present me with anything. I think there might have been some kind of something they wrote up, but there was never anything presented to me.
Q You weren't aware that they spoke to members of your

staff during an investigation into David Cains' death?
A It might -- maybe afterwards. After everything had transpired.
But they -- they come up on my campus all the time to ask my staff or anybody all kinds of stuff. So that wouldn't be anything out of the ordinary.
Q But are you saying you never personally read the report produced by Disability Rights Arkansas regarding David's death?
A I -- I may have, but it's -- if -- if -- when it came out two years ago or more, I couldn't recall what it said.
Q Okay.
A They've put out a lot of disinformation over the years and I take everything they have with a grain of salt.
Q Okay.
Do you recall having a telephone conversation with David's sister, Christine McAuliffe?
A Not that I recall.
Q Do you -- is there something you're remembering that --
A I -- I -- honestly, I don't remember speaking with her.
Q Okay.

A I don't -- I don't know if I've ever met the lady.
Q You don't remember her ever calling you at your office shortly after they got the report and found out that there had been a restraint?
A I -- I couldn't recall that. I mean, it -- they could have talked to my assistant, Jennifer.
Q Okay.
A They come into the same office though. I don't personally recollect that, but --
Q Did you ever ask -- I understand that you didn't yourself, but did you ever ask anybody on your staff to reach out to David's sister or David's mother to -- after the -- after that, the determination was mailed to them?
A I -- I didn't specifically tell anybody to.
Normally, our social service department, Susan Bruce, would do that.
Jennifer Berry used to be over social services. She might have done it -- that herself as well. Those would be the two people that would have reached out to the family.
Q But you didn't personally yourself?
A No, I did not.
Q And you didn't personally order anybody to either?
A No.
Q How did you know -- how well did you know David?

Or it's vague question, but if you can answer it, go ahead.

A I mean, I knew who David was.

Q Uh-huh.

A And, I mean, the ones -- the ones I know the best are the ones we usually have the problems with, just because there -- there's more involvement with them, you know.

Q But you didn't know David particularly well?

A Not -- not -- not -- not really.

Q Okay.

Mr. Gonyea, is it your testimony or your opinion that -- well, testimony.

Is it your opinion that the restraint used on David on the day of his death was not a contributing factor to his death?

MR. ROSEN: Well, I'm going to object. I'm not sure that the administrator of that facility can determine cause of death. That would be more of a medical opinion.

MR. GILLISPIE: I agree. I recognize that. If, I guess, basically, if he has an opinion on it that he's going to give, I just want to hear it. And if --

MR. ROSEN: Well --

MR. GILLISPIE: -- if not, then that can be the answer.

MR. ROSEN: -- I'm going to also object to relevance. But -- but, I mean --

BY MR. GILLISPIE:

Q He makes a good point. I get that you're not a medical expert. So I'll try to -- I'll withdraw that question and I'll try to break it down and rephrase it.

And it'll sound a little silly because you're not a medical doctor, but I'm going to ask this anyway.

Do you intend to give any sort of opinion yourself on David's cause of death at the hearing?

MR. ROSEN: Same objections. At the hearing?

MR. GILLISPIE: Or at any point in this case.

BY MR. GILLISPIE:

Q Now, anytime between the hearing or at the hearing, do you yourself -- I understand that you have an -- that there's an expert, you know, that there'll be expert testimony.

I just mean, do you, Mr. Jeff Gonyea, intend to give any, you know, testify as to David's cause of death?

A I -- I don't -- I don't believe so. I mean, I'm just going to go with what the evidence showed and the

investigation and what transpired there. That's all I can go by.
Q Okay. What do you mean by that?
A Well, the outcome of Sandy Evans' investigation and that staff followed protocols. And so, I mean, I -- I -- I can't really give you an opinion on that.
Q I understand that. I'd certainly agree that Sandy Evans' investigation determined that the determination was that there was no maltreatment.
But I don't believe Ms. Evans' investigation touched on cause of death, did it?
A No. And I -- I -- I don't -- again, she's not a medical person either. So I don't --
Q Right.
A I don't -- none of my staff would have really made a determination on cause of death. That would be a medical --
Q And I don't disagree. Just, you know, if you have some burning opinion, you know, some burning desire to give an opinion on this or you intend to at a later time, I just wanted to hear it now so I can be prepared.
A No.
Q That's all.
A I mean, I don't.
Q Okay.

MR. GILLISPIE: I'm going to take a take quick break. I think I'm done.

MR. ROSEN: Okay.

MR. GILLISPIE: I'm just going to consult with Chad.

MR. ROSEN: So five minutes or so?

MR. GILLISPIE: Sure.

MR. ROSEN: All right. We'll step out.

MR. GILLISPIE: It's probably 25.

MR. ROSEN: Okay.

VIDEOGRAPHER: We are going off the record. The time is approximately 4:06 p.m.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

VIDEOGRAPHER: We are back on the record. The time is approximately 4:10 p.m.

BY MR. GILLISPIE:

Q All right. Mr. Gonyea, I don't believe I have anymore, don't believe I have any more questions for you. Thank you.

MR. ROSEN: I have no questions. Thanks you.

VIDEOGRAPHER: This concludes the deposition. We're going off the record. The

time is approximately 4:11 p.m.

(WHEREUPON, the proceedings were concluded in the matter at 4:11 p.m.)

* * * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Jeff Gonyea, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 19th day of December, 2022.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

State Operations Manual

Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities

Releases
State Forms Commission
FEB 16 2023
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(Rev. 178, 04-13-18)

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EXHIBIT
tabbies
1

CONDITION OF PARTICIPATION	Key Standard(s) Regulatory Reference within the CoP	W-tag associated with the key standard regulation	Corresponding standard(s) under the key standard W-tag reference
	employ physical restraint only— (i) As integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. 42 CFR 483.450(e)(1) The facility must not use drugs in doses that interfere with the individual client's daily living activities	W310	W302, W303, W304 W305, W306, W307 W308, W309 W311, W312, W313, W314, W315, W316, W317
42 CFR 483.460 Health Care Services (W318)	42 CFR 483.460(a)(3) The facility must provide or obtain preventive and general care 42 CFR 483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including, licensed dentists and dental hygienists either through organized dental services in-house or	W322 W348	W319, W320, W321 W323, W324, W325 W326, 327, W328, W329 W330, W331, W332, W333, W334, W335 W336, W337, W338, W339, W340, W341 W342, W343, W344 W345, W346, W347 W393, W394 W349, W350, W351 W352, W353, W354 W355, W356, W357 W358, W359, W360

2. The ability to make choices;
3. The ability to identify preferences; and
4. Cognitive abilities including tracking, attention span, communication, and the client's ability to understand the cause and effect. (The client understands of cause and effect is significant in the determination.)

Money management includes a broad spectrum of programs with varying levels of participation by the client ranging from the use of choice in money expenditures, to an understanding of the concept of money, and ultimately to actual money handling and budgeting. The IDT must not conclude that a money management program is inappropriate based solely upon the level of intellectual or physical disability of the client.

The CFA must be reviewed at least annually per 42 C.F.R.483.440(f)(2). As a part of this annual review, a client's ability to participate in money management will also be reviewed. The annual review should always include an update to the CFA and take into consideration any changes in the client's circumstances since the last IPP. The need for a formal money management program must be addressed in every client's IPP by the IDT on an annual basis.

The determination of the appropriateness of a formal money management program is made by the IDT and must be based upon a CFA. The IDT discussions resulting in that determination must be established through documentation in the client's IPP.

W127

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

Guidance §483.420(a)(5)

Identification of patterns or isolated instances of physical, verbal, sexual or psychological abuse or punishment without prompt identification and corrective action by the facility would result in a non-compliance determination for this Standard and Condition level non-compliance.

The facility must develop and implement systems that protect clients from all forms of abuse, neglect, or mistreatment, including client to client abuse, neglect, or mistreatment.

a. The facility is expected to ensure that staff possess and demonstrate needed competencies to effectively and appropriately interact with clients.

b. The facility must monitor to assure that systems are effectively implemented and the facility takes immediate actions to address circumstances where abuse, neglect, or mistreatment have occurred and prevent reoccurrence.

c. The facility must be organized in such a manner as to proactively assure clients are free from any threat to their physical and psychological health and safety.

d. The facility must act to prevent physical, verbal, sexual or psychological abuse.

If the facility fails to implement appropriate corrective action, the potential of additional threats to the clients remain at the facility.

"Threat", for the purposes of this guideline, is considered any condition/situation which could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of clients, or in their death.

"Abuse", for the purposes of this guideline, is the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or personal anguish.

Physical abuse refers to any action intended to cause physical harm or pain, trauma or bodily harm (e.g., hitting, slapping, punching, kicking, pinching, etc.). It includes the use of corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment.

Verbal abuse refers to any use of insulting, demeaning, disrespectful, oral, written or gestured language directed towards and in the presence of the client. Psychological abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation, sexual

coercion and intimidation (e.g. living in fear in one's own home). Since many clients residing in ICF/IIDs are unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, would also be viewed as abusive by the client residing in the ICF/IID, regardless of that client's perceived ability to comprehend the nature of the incident.

Sexual abuse includes any incident where a client is coerced or manipulated to participate in any form of sexual activity for which the client did not give affirmative permission (or gave affirmative permission without the attendant understanding required to give permission) or sexual assault against a client who is unable to defend him/herself.

The facility must implement, through policies, oversight and training, safeguards to ensure that clients are not subjected to abuse by anyone including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the client, family members or legal guardians, friends, other clients, or the general public.

The facility must take whatever action is necessary to protect the clients residing there. For example, if a facility is forced by court order or arbitration rulings to retain or reinstate an employee found to be abusive, the facility must take measures to protect the clients of the facility (such as assigning the employee to an area where there is no contact with clients).

W128

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

Guidance §483.420(a)(6)

The facility must implement an aggressive active treatment program, which includes appropriate replacement behaviors, to address the reduction/elimination of physical restraints and drugs to manage behaviors.

For purposes of this Guideline drugs to manage behavior are "unnecessary" if there is evidence the drugs are being used:

- In excessive dose (duplicate therapy);
- For excessive duration;
- Not monitored adequately;
- Without adequate indications for its use;
- With adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combination of the reasons listed above.

The long term use of a drug/physical restraint to manage behavior combined with one or more of the following may indicate unnecessary use:

- The client's developmental and/or behavioral needs are not being met and the appropriateness of less restrictive approaches to manage inappropriate behaviors should be questioned;
- Staff behavior may be prompting behaviors in clients which result in the chronic use of physical restraints and drugs to control behavior;
- Staff may have inadequate training and/or experience to provide active treatment and employ preventive measures;

Restraints applied for behaviors when less restrictive measures have not been tried or have been tried and found to be just as effective.

W129

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.420(a)(7) Provide each client with the opportunity for personal privacy and

Guidance §483.420(a)(7)

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.430(e)(2) developmental,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- developmental programming principles and techniques (e.g. techniques to involve clients in their programs to their highest capability, use of positive reinforcement, use of assistive technology, use of appropriate materials and providing informal opportunities to practice skills);
- use of adaptive equipment and augmentative communication devices and systems; and
- effective recordkeeping procedures.

W191

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) behavioral,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- use of behavioral principles during interactions between staff and clients;
- use of accurate procedures regarding abuse detection and prevention, restraints, drugs to manage behaviors, client safety, emergencies, etc.;
- use of least restrictive interventions;

- use of positive behavior intervention programming; and
- training clients in appropriate replacement behaviors.

W192

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) and health needs

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- signs and symptoms of the client's changing health (e.g. constipation, urinary tract infections, adverse drug reactions, as indicated);
- exercise and diet;
- first aid;
- infection control;
- reporting to appropriate healthcare professionals; and
- for those staff who can administer medications, how to include clients in their medication administration by recognizing and encouraging the use of applicable skills.

W193

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

Guidance §483.430(e)(3)

Staff correctly and consistently implement the interventions specified in the behavior plans of clients with whom they are working.

§483.440(f)(3)(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

Guidance §483.440(f)(3)(i)

Any program that utilizes restrictive or intrusive techniques must be reviewed and approved by the specially constituted committee prior to implementation. This includes, but is not limited to:

- restraints;
- drugs to manage behavior;
- restrictions on community access;
- contingent denial of any right; or
- restrictions of materials or locations in the home.

The committee should ensure that consequences within a written behavior management program do not violate the client's rights.

There is no requirement for the committee to evaluate whether the proposed program is consistent with current practices in the field. Documentation should verify that the specially constituted committee considered factors, such as whether less intrusive methods have been attempted, whether the severity of behavior outweighs the risks of the proposed program and whether replacement behaviors are included within the plan.

Any revision to a behavior plan that increases the level of intrusiveness must be re-reviewed by the specially constituted committee. The committee need not reapprove a program when revisions are made in accordance with the approved plan. For example, if the physician changes the dosage of a medication in accordance with the drug treatment component of the active treatment plan to which the legally authorized person has given consent and which has already been approved by the committee, then there is no need for the committee or the legally authorized person to reapprove the plan. Generally, this would also apply if the medication was changed to another within the same therapeutic class or family.

W276

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(i) Specify all facility approved interventions to manage inappropriate client behavior;

Guidance §483.450(b)(1)(i)

All interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy. Examples of positive interventions include, but are not limited to, verbal praise reward systems, and prompting. Examples of negative interventions include, but are not limited to, removal of a privilege, implementation of restraint, and/or the use of exclusionary time out.

W277

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;

Guidance §483.450(b)(1)(ii)

Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior.

Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.

The facility policy for unexpected behavioral incidents must provide direction for the staff in the

utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others.

W278

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iii) Insure prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and

Guidance §483.450(b)(1)(iii)

Policies must be implemented to ensure that all restrictive procedures begin at the lowest level of the hierarchy unless there is documented evidence that less intrusive interventions have been tried and have been found to be ineffective.

The facility is not required to justify discontinuing the use of a more restrictive technique before initiating a less restrictive technique, since the intent of the regulation is to use the most positive, least intrusive technique possible.

In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.

§483.450(b)(1)(iv) Address the following:

W279

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(A) The use of time-out rooms;

Guidance §483.450(b)(1)(iv)(A)

"Time-out room" is defined as a separate room that is used to remove a client from stimulation that may be triggering and reinforcing maladaptive behavior. The facility must have written

policies and procedures for the use of time out rooms which address all the requirements of 483.450 (c) (1-4) standard: time out room.

W280

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(B) The use of physical restraints;

Guidance §483.450(b)(1)(iv)(B)

"Physical restraint" is defined as any manual hold or mechanical device that the client cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of a client's body. Examples of mechanical devices may include arm splints and mittens.

Policies and Procedures must address:

- the types of physical restraint that are allowed in the facility;
- the persons who apply such restraints;
- the parameters for duration of application;
- the methods that assure the health and safety of clients while in restraints; and
- the specific training required for staff allowed to apply such restraints.

W281

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(C) The use of drugs to manage inappropriate behavior;

Guidance §483.450(b)(1)(iv)(C)

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

Guidance §483.450(c)(3)

Because placement in the time out room is typically secondary to extreme behaviors, it is acceptable that there be no furniture in this room.

A door that opens inward can potentially be held closed, either intentionally or inadvertently, by the client in the room, thereby denying staff immediate access to the room.

W294

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(4) A record of time-out activities must be kept.

Guidance §483.450(c)(4)

The documentation in the client's record accurately reflects planned (e.g. part of the IPP) usage and presents a picture of events prior to, during, and following the use of time-out. The IPP should include direction as to how often data must be collected during each use of time out for each individual client.

(d) Standard: Physical restraints

§483.450(d)(1) The facility may employ physical restraint only- -

W295

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;

Guidance §483.450(d)(1)(i)

The use of physical restraint is specified within the IPP. The plan must address:

1) The specific type of client behavior to be managed by this plan;
2) The less restrictive behavioral approaches which were previously used, but were unsuccessful;
3) The hierarchy of measures that must be utilized prior to the application of physical restraint;
4) The type of physical restraint;
5) The type of client behavior that would indicate that the patient is calm and can be released from the restraint; and
6) The replacement behavior being taught to the client to reduce the need for future restraints.

W296

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(ii) As an emergency measure, but only if absolutely necessary to protect client or others from injury; or

Guidance §483.450(d)(1)(ii)

Physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which:

1) the client has not exhibited before;
2) were not identified in the functional analysis of behavior; or
3) are harming other people or themselves.

When there are repeated episodes of the use of physical restraint as an emergency safety measure, these episodes should be assessed for their predictability by the IDT, and revisions to the IPP considered addressing the behaviors through a formal behavior plan in order to reduce/eliminate the use of physical restraint.

W297

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

Guidance §483.450(d)(1)(iii)

Physical restraint during medical procedures must be utilized only when absolutely necessary and be used as a last resort in order for the facility or practitioners to deliver needed medical care to the client. The restraint must be released as soon as the medical procedure is completed unless it is necessary to continue restraint for a longer period of time to continue to deliver care or to prevent the client from displacing tubes or dressings. These restraints may only be used as long as the physician indicates them to be necessary.

For instances where physical restraint are used by the facility or a practitioner during a medical procedure, the client record and interviews should verify that less restrictive measures were attempted before using physical restraint and verify whether any injuries occurred during the use of the physical restraint. Written orders by medical personnel for the application of a physical restraint should include the reason that the restraint is necessary, the type of restraint to be used and the length of time the restraint will be applied.

A restraint device used to prevent a client engaging in self-injurious behavior is not considered a restraint for medical condition.

§483.450(d)(2) Authorizations to use or extend restraints as an emergency measure must be:

Guidance §483.450(d)(2)

Facility policies should list who in the facility is allowed to authorize the emergency use of restraints or to extend the use of an emergency restraint, and the training that is required for those persons who may authorize. Documentation in the client record in those instances should confirm that the facility follows that policy.

W298

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(2)(i) In effect no longer than 12 consecutive hours; and

Guidance §483.450(d)(2)(i)

This regulation does not mean that restraints may be authorized to be applied for up to a 12 hour period. The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. Once the behavior has ceased, the emergency has ended, and the client has been released, another authorization would be required for any new emergency situation.

The 12 consecutive hour period is the absolute maximum period of time that emergency physical restraint may be utilized for a client during an individual behavioral incident. It is reasonable to expect that the facility will reassess the emergency situation for any client who remains in physical restraint for longer than one hour and reassess the situation at least every 30 minutes thereafter up to 12 hours when the physical restraint must be removed.

W299

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(2)(ii) Obtained as soon as the client is restrained or stable.

Guidance §483.450(d)(2)(ii)

There may be instances where the maladaptive behaviors of a client or clients escalate into a serious and immediate event that must be de-escalated quickly in order to prevent harm to clients, staff, other clients, or by standers when incidents occur in the community. In these instances, the staff should contact the appropriate person to obtain authorization for the use of physical restraint as soon as the situation is stable. Retrospective documentation of the incident should confirm the need for authorization after application.

W300

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(3) The facility must not issue orders for restraint on a standing or as needed basis.

Guidance §483.450(d)(3)

All instances of physical restraint must be ordered on a case by case basis with individual assessment of the situation and authorization based upon the individual client. Authorizations should include the rationale for the use of the physical restraint versus other less restrictive measures.

W301

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints,

Guidance §483.450(d)(4)

The frequency of monitoring will vary according to the type and design of the device and the

psychological and physical well-being of the client. The facility should be checking the client often enough to adequately assess the physical status of the client (e.g., circulation, respiration and vital signs) of the client and the need to continued restraint. The more restrictive the intervention, the greater the risk to the client and the more often the client must be assessed. Frequent assessment will assure that the client will be released as soon as possible, however, in no instance may the staff go longer than 30 minutes without checking the client.

W302

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) released from the restraint as quickly as possible, and

Guidance §483.450(d)(4)

"As quickly as possible" means as soon as the client is no longer a danger to self or others. Documentation should support that the client was released from restraint as soon as they became calm.

W303

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) a record of these checks and usage must be kept.

§483.450(d)(5) Restraints must be designed and used

W304

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(5) so as not to cause physical injury to the client

Guidance §483.450(d)(5)

Physical restraints to include mechanical devices must be the correct size for the client and be applied with the correct amount of pressure according to manufacturer's directions. In addition to observation of any physical mechanical restraint in use at the time of the survey, review incident reports for any injuries as a result of restraint use.

W305

§483.450(d)(5) and so as to cause the least possible discomfort.

§483.450(d)(6) Opportunity for motion and exercise must be provided

W306

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(6) for a period of not less than 10 minutes during each two hour period in which restraint is employed,

Guidance §483.450(d)(6)

This requirement does not apply to cases of medical restraints that are specifically ordered for the immobilization of bones and joints during the physical healing process involved with fractures, sprains, etc. (e.g. a broken bone immobilized by a cast or splint). See 331 483.460(c) regarding surveillance of skin integrity during the use of medical restraints.

However, if a mechanical physical restraint is applied to an extremity to prevent a client from removing post-operative sutures, the restraint must be released every two (2) hours for a period of not less than ten (10) minutes in order to maintain adequate circulation.

Mechanical restraints placed on the client during sleeping hours must be medically based and specifically ordered by a physician. There should be evidence in the client's record why the mechanical physical restraint is necessary during sleeping hours. While it is not necessary to wake the client every two (2) hours to release the restraint and provide opportunity for exercise, the staff must check the restraint frequently during the night to ensure that the

restraint is still properly applied and the client appears comfortable.

W307

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(6) and a record of such activity must be kept.

§483.450(d)(7) Barred enclosures

Guidance §483.450(d)(7)

A bed or play equipment with bars that prevent the client from leaving the bed or voluntarily climbing out of the bed are barred enclosures. The use of such enclosures must be a part of the written IPP and behavioral assessments must clearly state why such an enclosure is necessary, the risks of using the enclosure versus not using it and what less restrictive measures have been tried prior to the implementation of the barred enclosures.

Such devices may not be used in lieu of adequate staffing.

W308

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(7) must not be more than three feet in height and

W309

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(7) must not have tops.

(e) Standard: Drug usage

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

1. **Purpose**. This policy is intended to provide guidelines for managing challenging behaviors of individuals residing in DDS operated programs (Human Development Centers).

2. **Scope**. This policy applies to all DDS operated programs (Human Development Centers) and their employees/volunteers. All such programs will include a review of this policy as part of the employee orientation process.

3. **Definition of Terms**

Behavior management, as covered by this policy, serves as a guide to ensure that an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others are managed with the least restrictive method. Behavior management is not a substitute for other forms of active treatment and is incorporated into program plans, based on individual needs.

Qualified Mental Retardation Professional (QMRP) or QMRP designee is used in this policy as a person designated to monitor, supervise, and make decisions regarding specific behavioral situations. QMRP/designee will be assigned by the administrator of the DDS program in which he/she works. Criteria for selection will involve prior training, experience, and demonstrated ability in the area of behavioral management. The QMRP/designee must be in a position that is on a level involving supervisory or decision-making responsibilities. The QMRP designee is authorized to perform any of the duties of the QMRP as outlined by regulations or policy.

Interdisciplinary Team (IDT) is defined as a group of persons (professionals, paraprofessionals and non-professionals) who develop an individual's program plan and whose participation is required in order to identify the needs of the individual and to devise ways to meet those needs. The IDT includes the individual and may also include those persons who have worked or will work most closely with the individual, those persons who provide needed assessments or services, and the individual's family, guardian, or advocate. In general, the IDT includes persons professionally qualified in such fields as health care, education, psychology, and social work.

Licensed nurse is defined as a registered nurse or licensed practical nurse. The agency may use a physician, in lieu of a licensed nurse, but this is not required.

Replacement: This policy replaces DDS Commissioner's Policy 3011-D, dated January 28, 1981, March 13, 1981, and DDS Director's Policy dated October 1, 1991; December 1, 1993; and January 30, 1998.

Reviewed: Arkansas Legislative Council Rules and Regulations Subcommittee _____, 2003



Effective date February 1, 2003

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Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

4. Policy

NOTE: It is the philosophy of the agency to utilize all positive approaches to behavior management prior to and in conjunction with more restrictive programmatic techniques. Positive approaches may include, but are not limited to: positive reinforcement, gentle teaching, redirection, graduated guidance, and modeling of appropriate behaviors. Measures to address positive behavior should be incorporated into formal program efforts to the extent feasible.

Efforts at positive programming prove to be successful with the majority of maladaptive behaviors. All Human Development Centers will maintain policies and procedures for positive programming. The use of behavioral programming other than positive is designed for the individuals who repetitively engage in dangerously aggressive behavior and for whom other interventions have not been effective. All behavior programs developed in accordance with this policy will be designed to reduce or eliminate the target behavior(s) within a specified time frame, will be supported by documentation that positive, less restrictive methods have been systematically attempted and failed, will be monitored regularly by the individual's QMRP and Interdisciplinary Team (IDT), and will be revised if proved to be ineffective. The potential harmful effects of each procedure will be weighed carefully against the harmful effects of the targeted behavior and the IDT will determine if the harmful effects of the behavior outweigh the potentially harmful effects of the procedure.

Category I:

Category I procedures are those which may be used without prior approval of the Human Rights Committee or psychology staff. To ensure consistency, they should be addressed by the IDT. Frequent use (as determined by IDT) of these procedures with an individual indicates the need for consideration of the development of a behavior plan by the individual's IDT.

The individual must be supervised during these procedures. With the exception of verbal intervention, any use of Category I procedures, whether part of a formal behavior program or not, requires documentation on a Behavior Incident Report, Data Sheet, or other locally used behavior documentation system.

A. Verbal Intervention: Verbal intervention is utilized to stop an inappropriate behavior in progress and involves telling the individual "no" or "stop", identifying the behavior, and redirecting to an appropriate activity. The command is given in a firm but normal tone of voice. Threats, screaming, yelling or issuing repetitive or multiple sets of commands are not considered verbal correction and are inappropriate.

B. Separation From Activity Up to 30 Minutes: The individual is prevented from engaging in a reinforcing activity in which he/she has displayed inappropriate behavior. Separation is maintained within the same room or outdoor area where the activity is conducted. This is considered a Category I procedure if compliance by the individual can be

accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

C. Separation From Setting Up to 30 Minutes: The individual is removed from the area where the reinforcing activity is taking place. Separation must occur under observation either outdoors or in a living or training area (bathrooms, storage rooms and closets do not constitute living/training area). This is considered a Category I procedure if compliance by the individual can be accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

Note: Separation to Allow Calming (STAC) – Also available is the positive procedure of STAC whereby the person is encouraged to move to an area away from the person or situation that upset them. At the same time, they are assisted in directing their attention to talking about the problem, listening to music, talking about family, relaxing quietly, going for a walk, etc. The activity should be chosen by the person in need of calming. When sufficiently calm, staff will assist the person in resuming normal activities.

D. Assignment of Additional Chores: The individual is assigned additional chores as a consequence for inappropriate behavior. Additional chores may be assigned only if such chores are already a part of the Individual Program Plan (IPP) and are not designed to replace work assignments of housekeeping personnel.

E. Restitution: The individual is cued to restore any property damaged, stolen or defaced. If appropriate to the individual's level of functioning, he/she may be cued to offer a verbal apology to the offended person. If appropriate to the individual's ability to comprehend, monetary reimbursement for the value of the damaged or stolen property may be required if this is a part of the IPP. In lieu of full value, a symbolic portion of the value may be required. Monetary reimbursement requires Human Rights Committee approval and Guardian consent.

Note: The individual is not degraded nor put on display while restoring damage. The individual is given the same equipment and protection to complete the restitution as would normally be given to a person not responsible for the damage.

F. Withholding Privileges: The individual loses a particular privilege following the occurrence of an inappropriate behavior. Privileges include such things as special planned community activities. However, trips off grounds are special and should only be curtailed if problem behavior is anticipated during that trip. Examples of situations where problem behaviors may be anticipated include a problem behavior having already occurred and the person is not fully calm, or, a problem behavior has not yet occurred, but there are indications that a problem behavior is likely. The curtailing of trips off grounds should be done after consultation with psychology staff, or with supervisory staff if psychology staff is not available. Privileges do not include basic living activities, such as meals, habilitation activities, or basic rights afforded all individuals.

G. Personal Property Removal (less than one hour): Removal of an individual's personal item that is being used in an inappropriate or unsafe manner or location. For example, if an individual disturbs others in a common TV room by playing his radio too loudly and will not reduce the volume when instructed, the radio may be removed from that individual for a time not to exceed one hour. The item will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate (See Section 6, *Page 8 of 9*).

Category II:

Category II procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian.

A. Response Cost: The individual loses reinforcers previously earned in a behavior management system, (i.e., Token Economy Program)

B. Overcorrection - includes the following procedures:
   1) Restitutional Overcorrection: Requires the individual to restore the environment to a state that is better than it was before the occurrence of the inappropriate behavior.

   2) Positive Practice Overcorrection: Requires the individual to engage in an intensive practice period in which the alternative appropriate behavior is practiced.

C. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or individual directly, as appropriate. This procedure is considered Category II if the individual voluntarily (without duress or coercion) surrenders the property upon request.

Category III:

Category III procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, other professionals, as indicated by the nature of the program, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian. The individual's record documents the IDT's conclusion that the potential harmful effects of each restrictive procedure (restraint, etc.) are clearly outweighed by the harmful effects of the targeted behavior.

A. Separation Time Out (Activity or Setting): Placement of an individual in a quiet area away from reinforcing activities or persons as a result of an inappropriate behavior occurring. The individual will be visually monitored during the time out. Further conditions include ***either:***

1) Separation lasting for over 30 minutes to one (1) hour maximum.

2) Separation (any length of time) requiring physical intervention/personal restraint to ensure compliance.

B. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate. This procedure is considered Category III if the individual does not voluntarily surrender the property upon request, and it must be physically removed.

C. Sensory Deprivation: Involves the temporary impeding of one of the individual's senses for a period of time, contingent upon the occurrence of the target behavior. Most often, this procedure includes only the use of a blindfold or cloth placed over the individual's eyes when it has been shown to facilitate calming. The individual must be visually supervised during the use of this procedure, which may be used in combination with other Category III procedures, as designated in the individual program. It could also include lessening auditory input by covering the individual's ears, or covering a body part (usually the hands) to limit tactile stimulation, hand in mouth, or biting.

D. Restraint: When utilizing restraint as a programmatic option, a hierarchy of lesser restrictive procedures will be attempted prior to restraint, except in limited cases where this is clearly clinically contraindicated. IDT consideration will be given to parent/guardian notification of the use of restraint and address it in the behavior program.

1) Personal Restraint: **In order to prevent personal injury or serious property damage**, the individual or a portion of an individual's body is immobilized by another person or persons in order to prevent personal injury or serious property damage. Approved methods of intervention must be in the individual's behavior program. This is planned personal restraint, contingent upon occurrence of a target behavior. When available, a licensed nurse should monitor the personal restraint and/or check the individual's physical condition as soon as possible following restraint.

Excluded as personal restraint are: physical assistance, prompting of graduated physical guidance to assist individuals during such procedures as toothbrushing and feeding, or to control random head or arm movements during such procedures

as haircutting, or the use of physical assistance in escorting, redirecting, or in manual guidance techniques are not considered personal restraint and do not require documentation as personal restraint. Also excluded as programmed personal restraint is the use of personal restraint in an emergency situation (Section 6, ***Page** 8 of 9*) or during a necessary medical or dental procedure.

In the event of personal restraint, the QMRP/designee of the area must be notified as soon as possible. Programmed personal restraint will occur until the individual is calm and will not exceed fifteen (15) minutes. The IDT will define what constitutes calm behavior for this individual when used in a behavior program.

2) Mechanical Restraint: **In order to prevent personal injury or serious property damage,** the individual or a portion of the individual's body is immobilized until calm by an approved device or devices which may also prevent normal functioning, as described in section C, above. Restraints must be checked for safety and integrity prior to use. The device's use will not exceed 15 minutes without an extension of time approved and documented by the QMRP/designee, preferably, after face-to-face attention. Unless otherwise determined by the IDT, QMRP/designee extensions will be obtained every 15 minutes until the individual is calm. The IDT should define what constitutes calm behavior for this individual when used in a behavior program. Unless determined clinically contraindicated by the QMRP/designee, should the time in restraint reach 55 minutes, the individual must be released for five minutes for motion, liquid intake, or toileting.

Should time in restraint reach 1 hour and 50 minutes, the individual must be released for at least 10 minutes–for motion, liquid intake, or toileting. If this 10-minute release is judged to be a danger to the individual and/others, additional staff should be called to ensure safety for all concerned. In addition, the individual will be checked, face to face, at least every 15 minutes for safety, well being, and integrity of the restraint. Constant observation is required.

Note: On-site monitoring by the QMRP/designee is recommended. When available, a licensed nurse should monitor the mechanical restraint. If unavailable to monitor, a licensed nurse shall check the individual's physical condition as soon as possible following restraint, but in no case later than thirty minutes after the initiation of the restraint.

Excluded as programmed mechanical restraint is the use of restraints in an emergency situation (Section 6, *Page 8 of 9*), during a necessary medical or dental procedure, or to promote healing following a medical procedure or injury. Devices such as a helmet which are not prescribed for the purpose of restricting an individual's movement and/or normal functioning, but rather for their safety and protection are not considered a mechanical restraint.

Note: For medical management, please refer to local site Policy on drugs to manage behavior (Behavior Management/Psychiatric Interventions).

5. **Conditions for Use of Behavior Programs.**

A. A formal behavior program will be developed by the IDT, written by a licensed psychological professional, and approved by a psychologist. It will include the following elements:

1) Description of the behavior to be modified;
2) Functional Analysis;
3) Thorough description of each step of the program to include duration and intensity of specific procedures, the methods of monitoring and analyzing the process, and special precautions that will be taken;
4) Description of any alternatives to the specific procedures;

B. The Individual Program Plan or behavior program will include:
1) Description of all procedures already attempted;
2) Side effects and risks, if any, of the intervention, in comparison with those of allowing the maladaptive behavior to continue; and
3) Behavioral objectives.

C. Behavior Management Procedures should be used in order of least restrictive, unless clinically contraindicated. Exceptions to this order must be fully documented and substantiated as to why more restrictive procedures are advisable before less restrictive ones.

D. All persons administering Category II and III procedures must have been trained in the administration of those specific procedures and have personally experienced those particular procedures, unless medically contraindicated for that person.

E. The Human Rights Committee will review all Category II and III programs at least every 6 months.

F. IDT consideration will be given to seeking consultation from outside expertise when IDT staff resources have been exhausted, as evidenced by the use of Category III procedures for over one (1) year without significant progress. If an outside consultant has been used without success, the agency should continue to access this or other outside expertise until an effective strategy is realized.

An outside consultant is defined as a professional of any discipline and who is not a member of the IDT. For instance, the outside consultant may be a member of the HDC

staff not on the identified IDT, the agency staff, or a professional not affiliated with the agency.

6. **Emergency Procedures**. Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. This includes the use of restraint procedures in the course of an established program, when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy. However, it is emphasized that emergency procedures may not be used at frequent intervals, becoming a routine method of intervention. If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. The emergency use of restraint must conform to ICF/MR regulations and must be reported immediately to the facility administrator or designee.

7. **Prohibitions**: These activities are expressly prohibited.

   A. Corporal punishment - refers to the application of painful stimuli to the body as a penalty for certain behavior, and includes, but is not limited to, hitting, pinching, the use of electrical shock or other infliction of pain, whether or not applied as part of a systematic behavior intervention program.

   B. Individuals who receive services from the agency disciplining other individuals unless involved in an organized and approved self-governing program. Individuals will not participate in the actual administration of discipline.

   C. Seclusion of an individual alone in a room or other area from which entry/exit is prevented. This does not include placement in a time-out area for brief, programmed time segments, as part of a behavior program that meets all applicable standards.

   D. ***Unless specifically requested by family/guardian,*** any procedure that denies visitation or communication with family members.

   E. Any procedure that denies sleep, shelter, bedding, food, drink, or use of bathroom facilities.

   F. Inappropriate vocalizations, maltreatment, neglect, or forced exercise.

8. **Informed Consent**. The individual served and/or guardian, as appropriate, will be provided a copy of the behavior program which utilizes Category II and III procedures. Informed consent will be obtained PRIOR to the implementation of the program, with the following procedures:

A. Persons 18 years of age or older who have no legally appointed guardian may give informed consent for their behavior program. If there is a question about the individual's ability to give informed consent and no guardian can be located, appropriate legal action must be pursued to have someone appointed who can give consent.

B. Consent by the legal guardian(s) is required if guardianship has been established.

C. The legally adequate consent will:
1) Specify, in terms that are easily understood, the restrictive or intrusive procedure(s) involved;
2) Inform the person(s) giving consent of any potentially harmful effects of the procedure(s);
3) Be time-limited, not to exceed one year; and
4) State that consent may be withdrawn at any time.

9. **Uncategorized Procedures**. In the event a proposed procedure does not readily fit in one of the prescribed categories, it may be utilized on an emergency basis, if necessary, at the discretion of the administrator or designee until the appropriate category is determined.

NOTE: Behavior Management Policy 3011-D does not preclude the use of other restrictive/intrusive procedures that would prevent serious bodily harm and/or destruction of property or death. These procedures can only be considered when lesser restrictive procedures have been proven ineffective or their implementation are determined to be clinically contraindicated. Approvals required are the same as those for Category III procedures. Additional approvals may be required as deemed necessary by the facility administrator.

DOCUMENTATION OF AND RESPONSE TO MALADAPTIVE BEHAVIORS

POLICY STATEMENT: Maladaptive behaviors must be documented on a **Behavior Report (BR)**, a **Behavior Report Documenting Emergency Restraint** (also called the Restraint Log), or other authorized data keeping device. Personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure. Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, or the destruction of property. Nothing in this policy removes or alters requirements as stated in other policies of verbal notification of incidents to the Superintendent and/or other staff.

PROCEDURES:

1. REQUIRED DOCUMENTATION

   a. When indicated, a **BR** must be completed following the maladaptive behavior. Incidents that are to be documented on the **BR** are the following:

      i. Behaviors that pose a threat to the physical or mental well being of the client or others.
      ii. Behaviors that have a direct negative impact on the client's programming.
      iii. Behaviors that directly contribute to the client remaining in a setting requiring a greater degree of supervision rather than a less restrictive one.
      iv. Target Behaviors identified by the Psychology Department and the Interdisciplinary Team.
      v. An incident requiring personal restraint (also requires notification of a QIDP). See Attachment #1.

   b. If the incident requires emergency mechanical restraint, a **Behavior Report Documenting Emergency Restraint** must be completed. Such behaviors are defined as those emergency situations in which behaviors may result in, or have the potential to result in, injury to self or others, or the destruction of property and cannot be controlled through the use of less restrictive measures.

   c. The rules of confidentiality will be followed when documenting these incidents. Any reference to a client other than the identified client in an incident report must be by initial only. Reference to other staff members involved will include their full name and title. All corrections must be made by a single line through the incorrect entry and the writer's initials. The **Behavior Report Documenting Emergency Restraint** must include the signature of the QIDP or other staff member authorizing the restraint.

2. EMERGENCY USE OF RESTRAINT

   a. Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors. The use of emergency restraint will comply with all relevant standards and regulations. Restraint



will not be used as punishment or for the convenience of staff in lieu of adequate programming.

b. Seclusion will not be used as either an emergency or programmatic procedure.

c. A QIDP must be notified when personal restraint is used and it must be documented on a **Behavior Report.**

d. Personal restraint of a client is used when the behavior is such that verbal control has been lost and other less restrictive measures have failed to control the behavior.

e. Personal restraint will be implemented by staff who have been trained in the use of approved methods. **Personal restraint must not exceed 10 minutes.** During the period of personal restraint if the client becomes calm no further restraint procedures are to be implemented. If the client shows no indication of calming and becomes violent, staff will proceed as indicated in Paragraph f. below.

f. The request for the emergency use of mechanical restraint will be based on need as exhibited by the client who is so aggressive that restraint is necessary to prevent imminent physical harm to themselves, others, or property. Mechanical restraint may be used only when all other means of controlling the behavior have been exhausted. Staff will proceed in the following manner:

   i. A Restraint Incident Leader will be identified. The attending staff will immediately implement emergency mechanical restraint. As soon as possible staff will notify the on duty Program Supervisor who will contact a QIDP or other authorized staff for authorization for the use of emergency mechanical restraint.
   ii. The authorization for the mechanical restraints must not exceed 15 minutes. Continued use of mechanical restraint must be re-authorized every 15 minutes.
   iii. Immediately after emergency mechanical restraint has been applied, staff must contact the nurse on duty. The nurse will examine the client to ensure the restraint is applied in a pain free and harmless manner and present no physical danger to the client. The nurse will make a notation of the examination on the **Behavior Report Documenting Emergency Restraint.**
   iv. A client in emergency mechanical restraint must be:

      1. Kept under constant visual observation. This observation will be for the client's physical condition (e.g., distressed breathing, bleeding, adequate blood flow to the head and extremities) as well as for signs of calming.
      2. Checked for security of restraint, current behavior and general status. A synopsis will be documented every 15 minutes.
      3. Released for 5 minutes every hour for motion and exercise.
      4. Given the opportunity for fluid intake, meals, baths and toileting. These needs will be addressed and documented as the need arises.

5. Released from emergency mechanical restraint as soon as possible. This is defined to mean as soon as the client is calm and no longer a danger to self or others. Verbal outbursts do not necessarily mean a person is still out of control or that restraint should continue.

v. After release from emergency mechanical restraint, using the **Restraint Incident Debriefing Form**, the Restraint Incident Leader will conduct and document a debriefing discussion with the other staff members involved in the restraint and the client that must include the following:

1. The behavior which resulted in the use of the personal or emergency mechanical restraint.
2. Any environmental factors involved in the incident.
3. The antecedents to the behavior including interactions with peers or staff
4. Any action by staff that might have kept the incident from escalating to restraint.
5. The client's reaction to the use of restraint.
6. Any changes to the client's programming which might have prevented the incident.
7. Options that the client could have used to avoid the use of restraint.

3. COMPLETION OF DOCUMENTATION

a. The person authorizing the use of emergency mechanical restraint must sign the authorization. During deviant hours authorization may be obtained by telephone. Attending staff will note on the **Behavior Report Documenting Emergency Restraint** that such authorization was obtained by telephone.

b. The on duty Program Supervisor will be responsible for ensuring that the appropriate reports are completed in a timely and accurate manner.

c. Completed **Behavior Report Documenting Emergency Restraint** and **Restraint Incident Debriefing Form** will be filed in the client's Master File "Behavior Incident File".

4. REVIEW AND DISTRIBUTION OF THE COMPLETED DOCUMENTS

a. Upon completion of the report it will be sent to the appropriate Team Office.

b. The Team Leader will review all reports for content, accuracy and appropriateness and sign in the appropriate place. If corrections are required the Team Leader will contact the writer of the report and ensure corrections are made. As soon as possible the report will be given to Quality Assurance to be scanned, copied, and distributed to appropriate staff. The original report will be sent to the Record Center Operator and filed in each client's file within five days.

c. The Record Center Operator will review **Behavior Report, Behavior Report Documenting Emergency Restraint**, and **Restraint Incident Debriefing Form** for completeness and errors. The originator will be notified to correct errors found by the Record Center Operator.

d. The QIDP and Psychology staff member will review copies of all reports for programmatic issues, patterns of use, and the appropriate follow-up.

e. The authorized data keeping device (i.e., **Behavior Report, Behavior Report Documenting Emergency Restraint**, and **Restraint Incident Debriefing Form**) will be forwarded to the Psychology Department depending on the program requirement.

5. FUNCTIONAL AND ENVIRONMENTAL ANALYSES OF BEHAVIORS

a. The purposes of conducting functional and environmental analyses are to determine:

1. The pragmatic utility of a behavior for a client, i.e., what the behavior "does" for the client.
2. What role the environment may have played in the causation of the behavior.

These analyses assume aberrant behavior does serve a functional purpose, but that a functionally equivalent (appropriate) communicative response can be taught, and will serve to substitute for the aberrant behavior. Further, the aberrant behavior will reduce in frequency as the more appropriate response becomes systematically reinforced.

b. These analyses will provide the data needed to formulate programmatic responses to teach and reinforce appropriate behaviors to replace aberrant behaviors and inappropriate behaviors.

6. APPROVED RESTRAINT PROCEDURES, TECHNIQUES, AND DEVICES

a. **Personal Restraint,** an emergency procedure limiting movement by the holding of a hand or limb.

b. **Chemical Intervention** ordered by the Physician.

c. **Protective Helmet**.

d. **Papoose Board**, a Mechanical Restraint device limiting movement and range of motion.

f. **Wrist Restraint**, a Mechanical Restraint device limiting movement and range of motion.

7. AT BHDC ONLY ICF/IID QUALIFIED QIDP's SHALL BE APPROVED TO AUTHORIZE THE USE OF RESTRAINT

The Program Coordinator/QIDP is the first choice person to authorize restraint for clients on their caseload. After hours and on weekends the Team Leaders or other qualified QIDPs may be notified.

The following positions are recognized as being qualified QIDPs:

Program Coordinators/QIDPS, Team Leaders, Director of Residential Services, Superintendent, Assistant Superintendent, Director of Quality Assurance; Chief Psychologist, Psychological Examiners, Registered Nurses, and Staff Physician.

Current work telephone numbers for these persons can be obtained from DHS/BHDC Share.

THE STAFF PHYSICIAN MUST REVIEW, BY SIGNATURE, THE USE OF ALL EMERGENCY MECHANICAL RESTRAINT.

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-D-4, dated 01/07/16, in its entirety.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Maltreatment Prohibition, Prevention, Reporting, and Investigation	3004-I

1. **Philosophy** Every individual served by the Division of Developmental Disabilities Services (DDS) has the right to be free from maltreatment. DDS strictly prohibits maltreatment (which includes but is not limited to physical, verbal, psychological, or sexual abuse, neglect, exploitation, misappropriation of property, and violation of rights) of individuals receiving services.

2. **Purpose** Each facility shall do all that is within its control to prevent occurrences of maltreatment and to report and investigate maltreatment when it occurs. This policy establishes a maltreatment prohibition protocol and defines responsibilities for reporting and investigating alleged, suspected, and witnessed maltreatment of individuals served by DDS.

   This Policy does not replace or remove the mandated legal responsibility of any entity to report maltreatment or of any external entity to conduct investigations as required by law.

3. **Scope** Compliance with this policy is the responsibility of all facility staff, clients, consultants, volunteers, staff of other agencies serving the client, family members, legal guardians, friends, or other individuals. It is the responsibility of the on-site administrator to ensure overall compliance with this policy and to take all necessary precautions to prevent maltreatment.

4. **Definitions**

1. Maltreatment – Actions which include, but are not limited to, physical, verbal, psychological, or sexual abuse, neglect, exploitation, misappropriation of property, and violation of rights of individuals receiving services

2. Founded charge of maltreatment - Credible evidence exists that supports the charge of maltreatment of an individual by a DDS employee.

3. On-site administrator – The administrator or his or her designee.

See other terms as defined by statutes in Appendix A and B.

Replacement: This Policy replaces: DDS Commissioner's Office Policy 3004-I (January 28, 1981, June 4, 1982, and May 25, 1983); DDS Deputy Director's Office Policy 3004-I (January 8, 1987); DDS Director's Office Policy 3004-I (May 1, 1993, December 1, 1993, and *May 22, 1995*).

References: *Act 1208 of 1991; Arkansas Code Annotated (ACA) § 5-28-101; 12-12-507 (d) (e); 12-12-509 (a) (1); 12-12-509 (2) (A) (B); 12-12-503 (10); DHS Policy 1090; DDS Director's Office Policies 1027, 3010-I, 3011-D, and DDS Procedural Guidelines for Investigations*

Reviewed: *Administrative Rules & Regulations Subcommittee of Arkansas Legislative Council:* (New date)

CM 002045

EXHIBIT 4 tabbies

Policy Type	Subject of Policy	Policy No.
Service	Maltreatment Prohibition, Prevention, Reporting, and Investigation	3004-I

5. **Policy** DDS Programs (hereafter referred to as facilities) will implement this policy and develop and implement consistent procedures for the prevention, identification, reporting, and investigation of maltreatment.

6. **Procedures**

A. Prohibition of Maltreatment

The on-site administrator is responsible for implementing this policy and consistent procedures that prohibit maltreatment through screening, training, prevention, and identification. Below are ways in which facilities should implement each component.

1. Screening:
   Screen potential employees for a history of maltreatment, as defined by applicable requirements. This includes:
   - attempting to obtain information from previous employers and/or current employers,
   - checking with the appropriate licensing boards, registries, and DHS personnel offices, and
   - performing criminal record checks.

2. Training:
   Train employees, through orientation and through on-going sessions, on issues related to maltreatment prohibition practices such as:
   - Rights of clients
   - Recognition of events that may precede or trigger certain behaviors
   - Early intervention techniques for positive behavioral support
   - Approved interventions to deal with aggressive and/or catastrophic reactions
   - Recognizing signs of staff burnout, frustration and stress that may lead to maltreatment;
   - Definition of maltreatment, and
   - Reporting suspected maltreatment.

3. Prevention:
Provide clients, families, and staff information on how and to whom they may report concerns, incidents and grievances; and how they may receive feedback regarding the concerns that have been expressed.
Identify, correct and intervene in situations in which maltreatment are more likely to occur. This includes an analysis of:
   - Features of the physical environment that may make maltreatment and/or neglect more likely to occur, such as secluded areas of the facility;
   - Failure to recognize and respect client rights.
   - The deployment of staff on each shift in sufficient numbers to meet the needs of the clients, and assure that the staff assigned have knowledge of the individual clients' care needs;
   - Inappropriate staff behaviors, such as:
     - derogatory language,
     - rough handling,
     - ignoring clients while giving care,
     - directing clients who need toileting assistance to urinate or defecate in their beds; and
     - use of items for staff convenience (i.e., disposable briefs, restraints)
   - The assessment, care planning, and monitoring of clients with needs and behaviors which might lead to conflict or neglect. This would include clients with a history of aggressive behaviors, clients who have behaviors such as entering other clients' rooms, clients with self-injurious behaviors, clients with communication disorders, and clients that require extensive care.

4. Identification:
Identify events, occurrences, patterns, and trends, such as bruising of clients, or a change in behavior that may suggest maltreatment.

B. Reporting.

1. All alleged, suspected, and witnessed maltreatment will be immediately reported by all individuals having knowledge of the alleged incident to the on-site administrator.

2. All alleged, suspected, and witnessed maltreatment will be immediately reported to the appropriate abuse reporting hotlines by the on-site administrator.

NOTE: Nothing in this policy removes the right and obligation of a mandated reporter (see Appendix B) to immediately report an incident directly to the appropriate abuse reporting hotline, as well as to the on-site administrator.

3. Reporting shall not be delayed for any type of investigation.

4. Incidents shall be reported in accordance with DHS Policy 1090, Incident Reporting, and the DHS Incident Reporting and Information System (IRIS).

5. Reports of allegations shall also be made by telephone or fax by the on-site administrator/designee to local law enforcement where the facility is located and to the individual's parent/guardian/advocate.

6. Incidents which are not specifically defined in statute as abuse but which have or may have a negative impact on clients shall be reported as noted in item 4 above. An example would be one or more acts of discourteous treatment by an employee, as defined in DHS Policies 1084 and 1085, Minimum Conduct Standards.

C. Protection of Individuals During Investigations

The on-site administrator is responsible for ensuring that staff accused or suspected of maltreatment leave the facility grounds immediately and have no contact with clients until an investigation has been completed. Under no circumstances will the subject(s) of an investigation resume regular duties or assume new duties at the facility until an investigation is complete.

D. Investigations

1. Investigations will begin promptly after an incident is reported. When applicable, the on-site administrator may delegate this task to a trained investigator on staff.

2. Allegations of maltreatment will be investigated according to DDS Procedural Guidelines for Investigations. Physical evidence (i.e., bruises, marks, etc.) shall be photographed when an incident is reported and again no more than three days later.

3. The on-site administrator may request that the Human Rights Committee review and make recommendations on current investigations and shall notify the Committee of all founded cases of maltreatment.

4. As mandated by statute, the on-site administrator will defer investigations to the proper entity (law enforcement, protective service agencies, Office of Attorney General, etc.).

5. Officials outside DDS who are authorized to conduct investigations shall request and obtain a copy of relevant documents from the on-site administrator.

E. Investigation Reports

1. When a reported incident has been determined to warrant an investigation, the on-site administrator must submit a report of findings to the Office of Long Term Care (OLTC) within five (5) working days of the facility's knowledge of the incident, to comply with OLTC regulation LTC 300 *et.seq.*

2. If the administrator is unable to submit a final report to OLTC within five days, he or she must submit a status report to OLTC within the five-day timeframe. This status report must detail the findings that have been determined to that point and what areas need further investigation.

3. A full report, in the format of a DDS Investigative File, must be completed and submitted to the DDS Director and to OLTC within 14 calendar days of notification that an incident is being investigated.

4. An extension of the 14-day timeframe must be requested of and granted by the Director's Office. Documentation of the extension approval shall be part of the file.

5. The DDS Director's Office shall send a copy of all investigative files to the appropriate Protective Services Agency, the Office of Chief Counsel, and the Office of the Attorney General.

F. Discipline.

1. Founded charge of maltreatment
   The employee is immediately terminated and his/her personnel file is designated as "not eligible for rehire" by DHS.

2. Failure to report alleged, suspected, or witnessed maltreatment
   The employee is subject to termination, as in item F-1. If not terminated, the on-site administrator will utilize progressive discipline as noted in DHS Policy 1084 Employee Discipline, unless the documented circumstances clearly warrant a deviation from the guidelines, due to aggravating or mitigating facts.

3. Delay in reporting alleged, suspected, or witnessed maltreatment
   The employee is subject to termination, as in item F-1. If not terminated, the on-site administrator will utilize progressive discipline as noted in DHS Policy 1084 Employee Discipline, unless the documented circumstances clearly warrant a deviation from the guidelines, due to aggravating or mitigating facts.

4. Other Involvement
   Any employee who is involved in any way with any aspect of a case of maltreatment and who is not terminated will be required to attend training relative to maltreatment prevention, reporting, and investigation. The on-site administrator shall specify the training course(s) and ensure that documentation of training is maintained.

G. Record Keeping.

1. Each facility shall maintain a copy of all files related to cases of alleged, suspected, or witnessed maltreatment in a secure location. This record will include the original incident report (IRIS) and all follow-up reports; the on-site administrator's investigation report; any correspondence; any documentation of supporting evidence (photos, etc.), and documentation of the actions taken by the on-site administrator. These internal records shall be maintained for no less than ten (10) years. Original investigative files will be maintained in the DDS Director's office and retained indefinitely, in either paper format or other medium.

2. A summary report of investigations of all alleged, suspected, and witnessed maltreatment conducted at the HDCs and subsequent outcomes shall be submitted to the DDS Director by January 15 of each year for the previous calendar year. Individual identifier information shall not be used. Victims shall be identified by case number and staff shall be identified by Job Title.

3. DDS Systems Development Section will also submit a summary report of the same information, as reported by DDS Community Programs, to the DDS Director by January 15 each year for the previous calendar year. Requests for the summary reports noted in G.2 and G.3 shall be made in writing to the DDS Director.

H. Release of Investigative Files.

It is the intent of this policy to protect the anonymity of all clients noted in investigative reports and the names of those who report abuse. For specific guidance for the release of information under the Freedom of Information Act (FOIA), see DHS Policy 1053. All client and reporter identifiers must be deleted (redacted) prior to release.

NOTE: When an investigation results in disciplinary action that is grieved, a copy of pertinent information from the investigation report will be provided to the grievant with client and reporter identifiers deleted. This may not apply to the grievance process at the state level.

I. Confidentiality.

All aspects of allegations, reports, and investigations of child and adult maltreatment are confidential. Verified violations will be subject to discipline under DHS Policy 1084, Employee Discipline and DHS Policy 1085, Minimum Conduct Standards.

J. Appeals.

Employees who have been disciplined based on provisions set forth in this policy retain the right of appeal according to established grievance procedures outlined in DHS Policy 1086, Employee Grievance Procedure.

Appendix A

Statutory definitions

Adult abuse (5-28-101)

(1) **"Abuse"** means:
(A) Any intentional and unnecessary physical act which inflicts pain on or causes injury to an endangered or impaired adult, including sexual abuse; or
(B) Any intentional or demeaning act which subjects an endangered or impaired adult to ridicule or psychological injury in a manner likely to provoke fear or alarm;
(2) **"Caregiver"** means a related or unrelated person, owner, agent, high managerial agent of a public or private organization, or a public or private organization that has the responsibility for the protection, care, or custody of an endangered or impaired adult as a result of assuming the responsibility voluntarily, by contract, through employment, or by order of the court;
(3)(A) **"Department"** means the Department of Human Services.
(B) The Director of the Department of Human Services may assign responsibilities for administering the various duties imposed upon the department under this chapter to respective divisions of the department which, in his or her opinion, are best able to render service or administer the provisions of this chapter;
(4) **"Endangered adult"** means:
(A) An adult eighteen (18) years of age or older who is found to be in a situation or condition which poses an imminent risk of death or serious bodily harm to that person and who demonstrates a lack of capacity to comprehend the nature and consequences of remaining in that situation or condition; or
(B) A resident eighteen (18) years of age or older of a long-term care facility, which is required to be licensed under § 20-10-224, who is found to be in a situation or condition which poses an imminent risk of death or serious bodily harm to the person and who demonstrates the lack of capacity to comprehend the nature and consequences of remaining in that situation or condition;
(5) **"Exploitation"** means the illegal use or management of an endangered or impaired adult's funds, assets, or property, or the use of an endangered or impaired adult's person, power of attorney, or guardianship for the profit or advantage of himself, herself, or another;
(6)(A) **"Imminent danger to health or safety"** means a situation in which death or severe bodily injury could reasonably be expected to occur without intervention.
(B) The burden of proof shall be upon the department to show by clear and convincing evidence that such imminent danger exists.

(7)(A) **"Impaired adult"** means a person eighteen (18) years or older who, as a result of mental or physical impairment, is unable to protect himself or herself from abuse, sexual abuse, neglect, or exploitation, and as a consequence thereof is endangered.
(B) For purposes of this chapter, adult clients of a long-term care facility are presumed to be impaired adults;
(8) **"Neglect"** means acts or omissions by an endangered adult; for example, self-neglect or intentional acts or omissions by a caregiver responsible for the care and supervision of an endangered or impaired adult constituting:
(A) Negligently failing to provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision, or medical services to an endangered or impaired adult;
(B) Negligently failing to report health problems or changes in health problems or changes in the health condition of an endangered or impaired adult to the appropriate medical personnel; or
(C) Negligently failing to carry out a prescribed treatment plan;
(9)(A) **"Physical injury"** means the impairment of a physical condition or the infliction of substantial pain.
(B) Where the person is an endangered or impaired adult, there shall be a presumption that any physical abuse resulted in the infliction of substantial pain;
(10)(A) **"Protective services"** means services to protect the endangered or impaired adult from:
(i) Self-neglect or self-abuse; and
(ii) Abuse or neglect by others.
(B) Protective services shall include, but not be limited to:
(i) Evaluation of the need for services;
(ii) Arrangements for appropriate services;
(iii) Assistance in obtaining financial benefits to which the person is entitled, or
(iv) Securing medical and legal services.
(C)(i) Protective services may include:
(a) Referrals for services available in the community;
(b) Seeking protective custody or court-ordered services for endangered adults; or
(c) In appropriate cases, assistance in locating an appropriate person or entity interested in and able to assume guardianship over an endangered adult.
(ii) In situations involving exploitation of an endangered or impaired adult not resulting in any imminent danger to health or safety or involving protection of the property of such an impaired adult, protective services may include one (1) or more of the following:
(a) Referrals for legal assistance;
(b) Referrals, as appropriate, to law enforcement or prosecutors; or
(c) Assistance in locating an appropriate person or entity interested in and able to assume guardianship;
(11) **"Serious bodily harm"** means physical abuse, sexual abuse, physical injury, or serious physical injury as defined in this chapter;

(12) **"Serious physical injury"** means physical injury to an endangered or impaired adult that creates a substantial risk of death or that causes protracted disfigurement, protracted impairment of health, or loss or protracted impairment of the function of any bodily member or organ;

(13) **"Sexual abuse"** means deviate sexual activity, sexual contact, or sexual intercourse, as those terms are defined in § 5-14-101, with another person who is not the actor's spouse and who is incapable of consent because he or she is mentally defective, mentally incapacitated, or physically helpless, as those terms are defined in § 5-14-101; and

(14) **"Subject of the report"** means the endangered or impaired adult, the adult's guardian, and the offender.

Child abuse (12-12-503)

(1) **"Abandonment"** means:

(A) Failure of the parent to provide reasonable support and to maintain regular contact with the juvenile through statement or contact when the failure is accompanied by an intention on the part of the parent to permit the condition to continue for an indefinite period in the future;

(B) Failure to support or maintain regular contact with the juvenile without just cause; or

(C) An articulated intent to forego parental responsibility;

(2)(A) **"Abuse"** means any of the following acts or omissions by a parent, guardian, custodian, foster parent, or any person who is entrusted with the juvenile's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the juvenile's welfare:

(i) Extreme or repeated cruelty to a juvenile;

(ii) Engaging in conduct creating a realistic and serious threat of death, permanent or temporary disfigurement, or impairment of any bodily organ;

(iii) Injury to a juvenile's intellectual, emotional, or psychological development as evidenced by observable and substantial impairment of the juvenile's ability to function within the juvenile's normal range of performance and behavior;

(iv) Any injury that is at variance with the history given;

(v) Any nonaccidental physical injury;

(vi) Any of the following intentional or knowing acts, with physical injury and without justifiable cause:

(a) Throwing, kicking, burning, biting, or cutting a child;
(b) Striking a child with a closed fist;
(c) Shaking a child; or
(d) Striking a child on the face;

(vii) Any of the following intentional or knowing acts, with or without physical injury:
(a) Striking a child age six (6) or younger on the face;
(b) Shaking a child age three (3) or younger; or
(c) Interfering with a child's breathing.

(B)(i) The list in subdivision (2)(A) of this section is illustrative of unreasonable action and is not intended to be exclusive.

(ii) No unreasonable action shall be construed to permit a finding of abuse without having established the elements of abuse.

(C)(i) **"Abuse"** shall not include physical discipline of a child when it is reasonable and moderate and is inflicted by a parent or guardian for purposes of restraining or correcting the child.

(ii) **"Abuse"** shall not include when a child suffers transient pain or minor temporary marks as the result of an appropriate restraint if:

(a) The person exercising the restraint is an employee of an agency licensed or exempted from licensure under the Child Welfare Agency Licensing Act, § 9-28-401 et seq.;

(b) The agency has policy and procedures regarding restraints;

(c) No other alternative exists to control the child except for a restraint;

(d) The child is in danger or hurting himself or herself or others;

(e) The person exercising the restraint has been trained in properly restraining children, de-escalation, and conflict resolution techniques; and

(f) The restraint is for a reasonable period of time.

(iii) Reasonable and moderate physical discipline inflicted by a parent or guardian shall not include any act that is likely to cause and which does cause injury more serious than transient pain or minor temporary marks.

(iv) The age, size, and condition of the child and the location of the injury and the frequency or recurrence of injuries shall be considered when determining whether the physical discipline is reasonable or moderate;

(3) **"Caretaker"** means a parent, guardian, custodian, foster parent, or any person ten (10) years of age or older who is entrusted with a child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person responsible for a child's welfare;

(4)(A) **"Central intake"**, otherwise referred to as the **"child abuse hotline"**, refers to a unit that shall be established by the Department of Human Services for the purpose of receiving and recording notification made pursuant to this subchapter.

(B) Central intake shall be staffed twenty-four (24) hours per day and shall have statewide accessibility through a toll-free telephone number;

(5) **"Child"** or **"juvenile"** means an individual who:
(A) Is from birth to the age of eighteen (18);
(B) Is under the age of twenty-one (21) years, whether married or single, who was adjudicated delinquent under the Arkansas Juvenile Code of 1989, § 9-27-301 et seq., for an act committed prior to the age of eighteen (18) years, and for whom the court retains jurisdiction; or
(C) Was adjudicated dependent-neglected under the Arkansas Juvenile Code of 1989, § 9-27-301 et seq., before reaching the age of eighteen (18) years, and who, while engaged in a course of instruction or treatments, requests the court to retain jurisdiction until the course has been completed;
(6) **"Child maltreatment"** means abuse, sexual abuse, neglect, sexual exploitation, or abandonment;
(7) **"Department"** means the Department of Human Services;
(8) **"Deviate sexual activity"** means any act of sexual gratification involving:
(A) Penetration, however slight, of the anus or mouth of one person by the penis of another person; or
(B) Penetration, however slight, of the labia majora or anus of one person by any body member or foreign instrument manipulated by another person;
(9)(A)(i) **"Forcible compulsion"** means physical force, intimidation, or a threat, express or implied, of physical injury to or death, rape, sexual abuse, or kidnapping of any person.
(ii) If the act was committed against the will of the juvenile, then forcible compulsion has been used.
(B) The age, developmental state, and stature of the victim, and the relationship of the victim to the assailant, as well as the threat of deprivation of affection, rights, and privileges from the victim by the assailant, shall be considered in weighing the sufficiency of the evidence to prove compulsion;
(10) "Indecent exposure" means the exposure by a person of the person's sexual organs for the purpose of arousing or gratifying the sexual desire of the person or of any other person under circumstances in which the person knows the conduct is likely to cause affront or alarm;
(11) **"Near fatality"** means an act that, as certified by a physician, places the child in serious or critical condition;
(12) **"Neglect"** means those acts or omissions of a parent, guardian, custodian, foster parent, or any person who is entrusted with the juvenile's care by a parent, custodian, guardian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible under state law for the juvenile's welfare, which constitute:
(A) Failure or refusal to prevent the abuse of the juvenile when the person knows or has reasonable cause to know the juvenile is or has been abused;

(B) Failure or refusal to provide necessary food, clothing, shelter, and education required by law, excluding the failure to follow an individualized educational program, or medical treatment necessary for the juvenile's well-being, except when the failure or refusal is caused primarily by the financial inability of the person legally responsible and no services for relief have been offered or rejected;
(C) Failure to take reasonable action to protect the juvenile from abandonment, abuse, sexual abuse, sexual exploitation, neglect, or parental unfitness where the existence of such condition was known or should have been known;
(D) Failure or irremediable inability to provide for the essential and necessary physical, mental, or emotional needs of the juvenile;
(E) Failure to provide for the juvenile's care and maintenance, proper or necessary support, or medical, surgical, or other necessary care;
(F) Failure, although able, to assume responsibility for the care and custody of the juvenile or participate in a plan to assume such responsibility; or
(G) Failure to appropriately supervise the juvenile that results in the juvenile's being left alone at an inappropriate age or in inappropriate circumstances that put the juvenile in danger;
(13) **"Parent"** means a biological mother, an adoptive parent, or a man to whom the biological mother was married at the time of conception or birth or who has been found by a court of competent jurisdiction to be the biological father of the juvenile;
(14) **"Pornography"** means:
(A) Obscene or licentious material, including pictures, movies, and videos, lacking serious literary, artistic, political, or scientific value, which, when taken as a whole and applying contemporary community standards would appear to the average person to appeal to the prurient interest; or
(B) Material that depicts sexual conduct in a patently offensive manner lacking serious literary, artistic, political, or scientific value;
(15) **"Serious bodily injury"** means bodily injury that involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty;
(16) **"Severe maltreatment"** means sexual abuse, sexual exploitation, acts or omissions which may or do result in death, abuse involving the use of a deadly weapon as defined by the Arkansas Criminal Code, § 5-1-101 et seq., bone fracture, internal injuries, burns, immersions, suffocation, abandonment, medical diagnosis of failure to thrive, or causing a substantial and observable change in the behavior or demeanor of the child;

(17) **"Sexual abuse"** means:
(A) By a person ten (10) years of age or older to a person younger than eighteen (18) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion;
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact;
(iii) Indecent exposure; or
(iv) Forcing, permitting, or encouraging the watching of pornography or live sexual activity;
(B) Between a person eighteen (18) years of age or older and a person not his or her spouse who is younger than sixteen (16) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact or solicitation; or
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact; or
(C) Between a person younger than eighteen (18) years of age and a sibling or caretaker:
(i) Sexual intercourse, deviate sexual activity, or sexual contact or solicitation; or
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact;
(18)(A) **"Sexual contact"** means any act of sexual gratification involving the touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female.
(B) Provided, that nothing in this section shall permit normal affectionate hugging to be construed as sexual contact;
(19) **"Sexual exploitation"** means allowing, permitting, or encouraging participation or depiction of the juvenile in prostitution, obscene photographing, filming, or obscenely depicting a juvenile for any use or purpose; and
(20) **"Subject of the report"** means:
(A) The offender;
(B) The parents, guardians, and legal custodians of the child who is subject to suspected maltreatment; and
(C) The child who is the subject of suspected maltreatment.

Appendix B

(5-28-203) Mandated Reporters (adult)

Persons required to report abuse:

(a)(1) Whenever any of the following has observed or has reasonable cause to suspect that an endangered or impaired adult has been subjected to conditions or circumstances which would reasonably result in abuse, sexual abuse, neglect, or exploitation, as defined in this chapter, he or she shall immediately report or cause a report to be made in accordance with the provisions of this section:

(A) A physician;
(B) A surgeon;
(C) A coroner;
(D) A dentist;
(E) An osteopath;
(F) A resident intern;
(G) A registered nurse;
(H) Hospital personnel who are engaged in the administration, examination, care, or treatment of persons;
(I) Any social worker;
(J) A case manager;
(K) A case worker;
(L) A mental health professional;
(M) A peace officer;
(N) A law enforcement officer;
(O) A facility administrator;
(P) An employee in a facility;
(Q) An employee of the Department of Human Services;
(R) A firefighter; or
(S) An emergency medical technician.

(2) Whenever a person is required to report under this chapter in his or her capacity as a member of the staff, an employee in a facility, or an employee of the department, he or she shall immediately notify the person in charge of the institution, facility, or agency, or that person's designated agent, who shall then become responsible for making a report or cause a report to be made.

(3) In addition to those persons and officials required to report suspected adult abuse, sexual abuse, or neglect, any other person may make a report if the person has reasonable cause to suspect that an adult has been abused, neglected, or exploited, as defined in this chapter.

(b)(1) A report required under this chapter shall be made to the central registry by the receiving agency for abused or neglected adults not residing in long-term care facilities. (2) A report for abused or neglected adults residing in a long-term care facility shall be made immediately to the local law enforcement agency for the jurisdiction in which the facility is located and to the Office of Long Term Care of the Division of Medical Services of the Department of Human Services, pursuant to regulations of that office. (3) The office shall notify the central registry and the office of the Attorney General. No privilege or contract shall relieve anyone required by this subchapter to make notification of the requirement of making notification.

12-12-507. Reports of suspected abuse or neglect (child)

(a) Any person with reasonable cause to suspect child maltreatment or that a child has died as a result of child maltreatment, or who observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, may immediately notify the child abuse hotline.

(b) When any of the following has reasonable cause to suspect that a child has been subjected to child maltreatment or has died as a result of child maltreatment, or who observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, he or she shall immediately notify the child abuse hotline:

(1) Any child or foster care worker;
(2) A coroner;
(3) A day care center worker;
(4) A dentist;
(5) A domestic abuse advocate;
(6) A domestic violence shelter employee;
(7) A domestic violence shelter volunteer;
(8) An employee of the Division of Youth Services of the Department of Human Services;
(9) An employee working under contract for the Division of Youth Services of the Department of Human Services;
(10) A family service worker;
(11) A judge;
(12) A law enforcement official;
(13) A licensed nurse;
(14) Any medical personnel who may be engaged in the admission, examination, care, or treatment of persons;
(15) A mental health professional;
(16) An osteopath;
(17) A physician;

(18) A peace officer;
(19) A prosecuting attorney;
(20) A resident intern;
(21) A school counselor;
(22) A school official;
(23) A social worker;
(24) A surgeon; or
(25) A teacher.

Booneville Human Development Center
RESTRAINT INCIDENT DEBRIEFING FORM
To be completed and turned in with the Restraint Log

The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program), when a very real risk of personal injury or severe property damage is imminent.

INCIDENT:
On 10/23/19 (*Date*), David Cains (*Client name*) was placed in mechanical restraint as documented on the attached Restraint Log. The reason that the use of restraint was necessary because (describe the behavior):
He became upset and began throwing items at staff. When asked to stop ~~PA~~ he became physically aggressive.

I. The Restraint Incident Leader was: Paula Angel, RT (*Signature*)

II. The other members of the Intervention Team were:
Lynnett Lee, RT (*Signature*)
Rhonda Harris TA (*Signature*)
[illegible] TA (*Signature*)
Vicki Sharpe, RT (*Signature*)
Brenda Richardson TA (*Signature*)
[illegible] RT

III. Event Analysis:
The following may be contributing factors to this restraint incident:

1. Physical Environment: (Where did the incident occur, were their anything in the physical environment that may have been a factor in the incident?) Please Explain:
He was sitting quietly then out of the blue he became upset and physically aggressive

2. Interaction with Peers: (Was another person's interaction with the client a factor in the client requiring restraint?) Please Describe:

EXHIBIT 5

STAFF DEVELOPMENT DEPARTMENT

POLICY STATEMENT: A Staff Development Department shall exist at Booneville HDC.

1. The Staff Development Department shall develop and implement training programs to meet the requirements of DDS Policy, ICF/IID Regulations and applicable accreditation council standards.

2. Staff Development Department staff will work closely with the Directors of Residential Services and Superintendent and Assistant Superintendent for assistance.

3. Staff Development Department staff will work with the Executive Staff members to assist in the determination of training needs of each department.

4. The Staff Development Department will maintain training records for each employee.

5. The Staff Development Department shall prepare a training report at the end of each month.

APPROVED: _____
Superintendent

Supersedes BHDC Policy 1-I-1. dated 05/14/15, in its entirety.



REVIEWED: 12/02/21
VERSION: 11/15/17

FIRST AID GUIDELINES

POLICY STATEMENT: First Aid Guidelines are available for use in each of the Aide Stations in each living area. This will permit appropriate and immediate attention to medical conditions of sudden onset, including injuries and choking.

PROCEDURES:

1. The First Aid Guidelines have been approved by the staff physician for the Booneville HDC.

2. In all cases in which a serious medical injury or illness is suspected, either to clients or staff, a call to the Medical Department should be made. This should be the first call so Medical staff can respond immediately to the situation.

   A call to Medical at 1422 should be made and the following information should be given:

   1. Caller's name and title
   2. Victim's name, location, situation and condition of the victim (alert, unconscious, etc.)
   3. Medical will assess the situation and call an ambulance if appropriate.

3. All staff members are trained in first aid, CPR, and abdominal thrust for choking so, that if necessary, emergency rescue measures can be initiated before Medical staff arrives.

4. Choking is a serious and potentially life-threatening situation and the following guidelines should be followed:

   a. Staff will supervise clients during meal times and nursing staff will be available by phone at all times;
   b. emergency equipment including oxygen and suction machine will be kept in the dining room for use as needed;
   c. All staff will receive annual training in abdominal thrust and choking precautions.

5. First Aid kits, disaster kits, and first aid guidelines will be kept in all areas. Medical will do monthly inspections on first aid kits, and every 6 month inspections on disaster kits, and refill appropriately. If living area staff notice supplies are low, Medical is to be notified and supplies will be replenished.

APPROVED: _____ Superintendent

Supersedes BHDC Policy IV-B-10, dated 03/13/15, in its entirety.



: 11/27/19
: 12/29/17

Arkansas Department of Human Services
Developmental Disabilities Services

CASE NOTES

Name: David Cains Date: 06/13/2020 Residence: DH Blue

On 06/13/2020 @1158, I received a call from Amanda, LPN in medical. She stated that she had some bad news and that they have been working on David Cains and have not been able to get a heartbeat.

I asked what happened. She said she did not know exactly what happened, except he started having a behavior while he was eating. He started to [redacted]

@1203, I contacted Jennifer Berry, asking what the procedures are on how to handle this. She said get as much information as possible to give mom a heads up. She provided me with Stacy's cell phone number (I already had Angie's), she stated contact Stacy or Angie and get information as what is going on from them.

[redacted]

@ 1214 I relayed the information to Jennifer, she stated to go ahead and call the mother and let her know, also provide the hospital phone number so that she could call her herself and also let her know she is able to go to the hospital as well.

@1224, I made a call to Ms. Charlene Robinson, David's mother and Guardian. She answered the phone, I introduced myself. I could hear her clearly, I thought she could hear me. I gave the notifications. During the call the phone stated having static sound, then the call ended. I immediately called back @ 1225. She answered in a panic, again I could hear her clearly, she could not hear me. She kept yelling Hello…then would hang up. I checked the on-call phone, it had full-service bars. I continued to call; it went to her voicemail twice. I tried calling on my personal cell phone, it would not go through. I called Jennifer Berry on my personal cell phone @ 1227. She said to try to call again with the on-call phone. I called while Jennifer was still on my personal cell. Ms. Robinson picked up, I made she sure could hear me, she said yes. I asked if she heard anything from my initial call. She said no, all she heard was that I didn't have any further information. I then started to give the notification again. I stated that I received a call from medical, that David choked on his food; before I could say anything else, Ms. Robinson went into a panic mode and began crying and sobbing. I tried to say that Staff did rescue procedures until EMS arrived, but unable to say that statement due to her continuing to cry and be in a panic state. She then started [redacted] stated that [redacted] also stated [redacted] during this statement, Ms. Robinson continued to cry, very upset and in panic state. She then asked what kind of food did he choke

CM 009019

EXHIBIT 8

PENGAD 800-631-6989

Arkansas Department of Human Services
Developmental Disabilities Services

CASE NOTES

Name: David Cains Date: 06/13/2020 Residence: DH Blue

on? I stated I did not know that information, but just that he choked on his food. Ms. Robinson continued to say that she just talked to him the other night and he was doing good; she hasn't seen him in three months. She continued to cry, I Stated I could provide the hospital phone number and the she could call the hospital herself if she wanted it, she said yes and asked for the number. I provided the following number to her, 479-675-2800, and directed her to speak to the Emergency Room. I also let her know that she was able to go to the hospital if she wanted. She continued to cry and sob and then she hung up the phone. Call ended around 1233.

Jennifer Berry was still on my personal phone call and hear the conversation.

@1258, Angie from Medical called stating that the Hospital called and said that they had called the code at 1221.

@1258, I then called Jennifer to let her know.

@ 1301 Debbie, LPN from Medical called stating that the hospital called and needed to know if David's family had any idea what they wanted to do, any burial policy in place. She said that Dustin from the Hospital tried talking to the mother, but she was to distraught to answer any questions and asked that I call her.

@ 1304 I called Caleb Murry, Social Service Worker, for David, to see if they had a burial policy in place. Caleb said no, there was not one in place, they had just stated in their consents that they wanted to get one started.

@ 1310 I called Booneville Mercy ER to see exactly what they needed from us. I talked to Dustin, he stated that he just needed us to relay to the mother that he has called the County Coroner and that they are going to send David to the County Morgue. Which is Robert's Funeral Home in Booneville AR.

@ 1314, Angie from Medical called stating the mother called them and asked to speak to us. I explained I was getting information from the Hospital to share with mom.

@ 1317 I called Ms. Robinson, informed her that the hospital said that he was being taken care of and being sent to Roberts Funeral Home, the County Morgue. She was relieved when she heard this news and said good, thank you. She was mixing up her words and after a couple of tries stated that David's sister is coming form Vermont and will be in town Monday and then she said she was sorry that she could not think clearly. She asked that I please notify her Brother, Mr. Patrick Riley because she was not able to. I asked if she had given permission to talk to him and she said yes, he is on the contact list. I said I would notify him.

@ 1329 I contact Mr. Riley. Introduced myself. He said that he just got off the phone with David's sister and knew what was going on. He was very calm. He explained that he and his niece, Ms. Robinson's daughter, were going to help Ms. Robinson with all the details. He

Arkansas Department of Human Services
Developmental Disabilities Services

CASE NOTES

Name: David Cains Date: 06/13/2020 Residence: DH Blue

asked where David was being taken. I shared the information about Roberts Funeral Home. He then stated that he did not want to be rude, but that he didn't know me, and he would feel more comfortable with David's original social worker, Caleb. He asked if I could have Caleb call him. I stated that was fine and I would have Caleb call him.

@1336 I called Caleb Murry, Social Service worker, and explained Mr. Riley's request. I provided Caleb with the information about Roberts funeral home and provided Mr. Riley's cell phone number.

@ 1623, I received a call on the On-Call phone from Ms. Robinson. She asked if we (BHDC) were going to put this in the paper? I explained I did not believe so, but I could double check. She said please do and that she did not want this in the news paper at all. She also asked if she would be able to come to BHDC to go through his things? She said that she wanted to get his favorite Monkey Hoodie/Sweatshirt. And a nice pair of jeans to bury him in. I stated I would let Caleb know and that he or I look for the Hoodie on Monday morning and get it to her. I stated that due to Covid-19 our campus is still closed but I would get with Jennifer and see if there was something that could be done to let her come up. She said yes just let her know when we can, she would like for her daughter to be able to come up as well so that she could help carry everything

@ 1624 I called Jennifer Berry, Asst. Superintendent, and asked if this would be released in the paper, and that mom did not want it in the paper at all. Jennifer stated that no she had signed a consent not letting us release his name and image. And that is something the funeral home would do and that she would just need to decline that at the funeral home. She also stated that she would check and see about letting Ms. Robinson on campus and would let Caleb or myself know when she got an answer.

@1627, I called Ms. Robinson back, shared the information that Jennifer stated to me. She thanked me for checking. Currently Ms. Robinson was in a calmer state.

Amanda Krigbaum 112/5510 6/15/2020
Amanda Krigbaum Program Coordinator/Social Service Worker

Original: Master File

CM 009021

DOCUMENTATION OF AND RESPONSE TO MALADAPTIVE BEHAVIORS

POLICY STATEMENT: Maladaptive behaviors must be documented on a **Behavior Report (BR)**, a **Behavior Report Documenting Emergency Restraint** (also called the Restraint Log), or other authorized data keeping device. Personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure. Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, or the destruction of property. Nothing in this policy removes or alters requirements as stated in other policies of verbal notification of incidents to the Superintendent and/or other staff.

PROCEDURES:

1. REQUIRED DOCUMENTATION

   a. When indicated, a **BR** must be completed following the maladaptive behavior. Incidents that are to be documented on the **BR** are the following:

      i. Behaviors that pose a threat to the physical or mental well being of the client or others.
      ii. Behaviors that have a direct negative impact on the client's programming.
      iii. Behaviors that directly contribute to the client remaining in a setting requiring a greater degree of supervision rather than a less restrictive one.
      iv. Target Behaviors identified by the Psychology Department and the Interdisciplinary Team.
      v. An incident requiring personal restraint (also requires notification of a QIDP). See Attachment #1.

   b. If the incident requires emergency mechanical restraint, a **Behavior Report Documenting Emergency Restraint** must be completed. Such behaviors are defined as those emergency situations in which behaviors may result in, or have the potential to result in, injury to self or others, or the destruction of property and cannot be controlled through the use of less restrictive measures.

   c. The rules of confidentiality will be followed when documenting these incidents. Any reference to a client other than the identified client in an incident report must be by initial only. Reference to other staff members involved will include their full name and title. All corrections must be made by a single line through the incorrect entry and the writer's initials. The **Behavior Report Documenting Emergency Restraint** must include the signature of the QIDP or other staff member authorizing the restraint.

2. EMERGENCY USE OF RESTRAINT

   a. Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors. The use of emergency restraint will comply with all relevant standards and regulations. Restraint



will not be used as punishment or for the convenience of staff in lieu of adequate programming.

b. Seclusion will not be used as either an emergency or programmatic procedure.

c. A QIDP must be notified when personal restraint is used and it must be documented on a **Behavior Report**.

d. Personal restraint of a client is used when the behavior is such that verbal control has been lost and other less restrictive measures have failed to control the behavior.

e. Personal restraint will be implemented by staff who have been trained in the use of approved methods. **Personal restraint must not exceed 10 minutes**. During the period of personal restraint if the client becomes calm no further restraint procedures are to be implemented. If the client shows no indication of calming and becomes violent, staff will proceed as indicated in Paragraph f. below.

f. The request for the emergency use of mechanical restraint will be based on need as exhibited by the client who is so aggressive that restraint is necessary to prevent imminent physical harm to themselves, others, or property. Mechanical restraint may be used only when all other means of controlling the behavior have been exhausted. Staff will proceed in the following manner:

   i. A Restraint Incident Leader will be identified. The attending staff will immediately implement emergency mechanical restraint. As soon as possible staff will notify the on duty Program Supervisor who will contact a QIDP or other authorized staff for authorization for the use of emergency mechanical restraint.
   ii. The authorization for the mechanical restraints must not exceed 15 minutes. Continued use of mechanical restraint must be re-authorized every 15 minutes.
   iii. Immediately after emergency mechanical restraint has been applied, staff must contact the nurse on duty. The nurse will examine the client to ensure the restraint is applied in a pain free and harmless manner and present no physical danger to the client. The nurse will make a notation of the examination on the **Behavior Report Documenting Emergency Restraint**.
   iv. A client in emergency mechanical restraint must be:

      1. Kept under constant visual observation. This observation will be for the client's physical condition (e.g., distressed breathing, bleeding, adequate blood flow to the head and extremities) as well as for signs of calming.
      2. Checked for security of restraint, current behavior and general status. A synopsis will be documented every 15 minutes.
      3. Released for 5 minutes every hour for motion and exercise.
      4. Given the opportunity for fluid intake, meals, baths and toileting. These needs will be addressed and documented as the need arises.

5. Released from emergency mechanical restraint as soon as possible. This is defined to mean as soon as the client is calm and no longer a danger to self or others. Verbal outbursts do not necessarily mean a person is still out of control or that restraint should continue.

v. After release from emergency mechanical restraint, using the **Restraint Incident Debriefing Form**, the Restraint Incident Leader will conduct and document a debriefing discussion with the other staff members involved in the restraint and the client that must include the following:

1. The behavior which resulted in the use of the personal or emergency mechanical restraint.
2. Any environmental factors involved in the incident.
3. The antecedents to the behavior including interactions with peers or staff
4. Any action by staff that might have kept the incident from escalating to restraint.
5. The client's reaction to the use of restraint.
6. Any changes to the client's programming which might have prevented the incident.
7. Options that the client could have used to avoid the use of restraint.

3. COMPLETION OF DOCUMENTATION

a. The person authorizing the use of emergency mechanical restraint must sign the authorization. During deviant hours authorization may be obtained by telephone. Attending staff will note on the **Behavior Report Documenting Emergency Restraint** that such authorization was obtained by telephone.

b. The on duty Program Supervisor will be responsible for ensuring that the appropriate reports are completed in a timely and accurate manner.

c. Completed **Behavior Report Documenting Emergency Restraint** and **Restraint Incident Debriefing Form** will be filed in the client's Master File "Behavior Incident File".

4. REVIEW AND DISTRIBUTION OF THE COMPLETED DOCUMENTS

a. Upon completion of the report it will be sent to the appropriate Team Office.

b. The Team Leader will review all reports for content, accuracy and appropriateness and sign in the appropriate place. If corrections are required the Team Leader will contact the writer of the report and ensure corrections are made. As soon as possible the report will be given to Quality Assurance to be scanned, copied, and distributed to appropriate staff. The original report will be sent to the Record Center Operator and filed in each client's file within five days.

c. The Record Center Operator will review **Behavior Report, Behavior Report Documenting Emergency Restraint**, and **Restraint Incident Debriefing Form** for completeness and errors. The originator will be notified to correct errors found by the Record Center Operator.

d. The QIDP and Psychology staff member will review copies of all reports for programmatic issues, patterns of use, and the appropriate follow-up.

e. The authorized data keeping device (i.e., **Behavior Report, Behavior Report Documenting Emergency Restraint**, and **Restraint Incident Debriefing Form**) will be forwarded to the Psychology Department depending on the program requirement.

5. FUNCTIONAL AND ENVIRONMENTAL ANALYSES OF BEHAVIORS

a. The purposes of conducting functional and environmental analyses are to determine:

1. The pragmatic utility of a behavior for a client, i.e., what the behavior "does" for the client.
2. What role the environment may have played in the causation of the behavior.

These analyses assume aberrant behavior does serve a functional purpose, but that a functionally equivalent (appropriate) communicative response can be taught, and will serve to substitute for the aberrant behavior. Further, the aberrant behavior will reduce in frequency as the more appropriate response becomes systematically reinforced.

b. These analyses will provide the data needed to formulate programmatic responses to teach and reinforce appropriate behaviors to replace aberrant behaviors and inappropriate behaviors.

6. APPROVED RESTRAINT PROCEDURES, TECHNIQUES, AND DEVICES

a. **Personal Restraint,** an emergency procedure limiting movement by the holding of a hand or limb.

b. **Chemical Intervention** ordered by the Physician.

c. **Protective Helmet**.

d. **Papoose Board**, a Mechanical Restraint device limiting movement and range of motion.

f. **Wrist Restraint**, a Mechanical Restraint device limiting movement and range of motion.

7. AT BHDC ONLY ICF/IID QUALIFIED QIDP's SHALL BE APPROVED TO AUTHORIZE THE USE OF RESTRAINT

The Program Coordinator/QIDP is the first choice person to authorize restraint for clients on their caseload. After hours and on weekends the Team Leaders or other qualified QIDPs may be notified.

The following positions are recognized as being qualified QIDPs:

Program Coordinators/QIDPS, Team Leaders, Director of Residential Services, Superintendent, Assistant Superintendent, Director of Quality Assurance; Chief Psychologist, Psychological Examiners, Registered Nurses, and Staff Physician.

Current work telephone numbers for these persons can be obtained from DHS/BHDC Share.

THE STAFF PHYSICIAN MUST REVIEW, BY SIGNATURE, THE USE OF ALL EMERGENCY MECHANICAL RESTRAINT.

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-D-4, dated 01/07/16, in its entirety.

State Operations Manual

Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities

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(Rev. 178, 04-13-18)

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for Individuals with Intellectual Disabilities

§440.150 Intermediate Care Facility Services, Other Than in Institutions for Mental Diseases
§483.410 Condition of Participation: Governing Body and Management
§483.410(a) Standard: Governing Body
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§483.410(d) Standard: Services Provided Under Agreements With Outside Sources
§483.410(e) Standard: Licensure
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§483.420(a) Standard: Protection of Clients' Rights
§483.420(b) Standard: Client Finances
§483.420(c) Standard: Communication With Clients, Parents, and Guardians
§483.420(d) Standard: Staff Treatment of Clients
§483.430 Condition of Participation: Facility Staffing
§483.430(a) Standard: Qualified Intellectual Disabilities Professional
§483.430(b) Standard: Professional Program Services
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§483.440(a) Standard: Active Treatment
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§483.440(c) Standard: Individual Program Plan
§483.440(d) Standard: Program Implementation
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§483.450 Condition of Participation: Client Behavior and Facility Practices
§483.450(a) Standard: Facility Practices - Conduct Toward Clients
§483.450(b)Standard: Management of Inappropriate Client Behavior
§483.450(c) Standard: Time-Out Rooms
§483.450(d)Standard: Physical Restraints
§483.450(e) Standard: Drug Usage
§483.460 Condition of Participation: Health Care Services
§483.460(a) Standard: Physician Services
§483.460(b) Standard: Physician Participation in the Individual Program Plan
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§483.460(d) Standard: Nursing Staff
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§483.460(f) Standard: Comprehensive Dental Diagnostic Services
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§483.460(h) Standard: Documentation of Dental Services
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§483.460(m) Standard: Drug Labeling
§483.460(n) Standard: Laboratory Services

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§483.470(a) Standard: Client Living Environment
§483.470(b)Standard: Client Bedrooms
§483.470(c) Standard: Storage Space in Bedrooms
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§483.470(e) Standard: Heating and Ventilation
§483.470(f) Standard: Floors
§483.470(g) Standard: Space and Equipment
§483.470(h) Standard: Emergency Plan and Procedures
§483.470(i) Standard: Evacuation Drills
§483.470 (j) Standard: Fire Protection
§483.470(k) Standard: Paint
§483.470(l) Standard: Infection Control
§483.480 Condition of Participation: Dietetic Services
§483.480(a) Standard: Food and Nutrition Services
§483.480(b) Standard: Meal Services
§483.480(c) Standard: Menus
§483.480(d) Standard: Dining Areas and Service
§483.480(d) Standard: Dining Areas and Service
The facility must ---

Part 1 - *Survey Protocol* for Intermediate Care Facilities for Individuals with Intellectual Disabilities

I - Introduction

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

The principal focus of the ICF/IID survey process is on the "outcome" of the facility's provision of active treatment as defined by 42 CFR 483.440(a). Direct your principal attention to what actually happens to clients: whether the facility provides needed services and interventions; whether the facility insures clients are free from abuse, mistreatment, or neglect; whether clients, families and guardians participate in identifying and selecting services; whether the facility promotes greater independence, choice, integration and productivity; how competently and effectively the staff interact with clients; and whether all health needs are being met.

Use observation as the primary method of information gathering.
Conduct interviews and record reviews after completion of observations to confirm specific issues. Verify that the facility develops interventions and supports that address the clients' needs, and provides required client protections and health services. Do not conduct in-depth reviews of assessments, progress notes or historical data unless outcomes fail to occur for clients.

The provision of active treatment includes:

Comprehensive Functional Assessment (42 CFR 483.440(c)(3)).--Each individual client's interdisciplinary team must perform accurate, comprehensive functional assessments and reassessments within 30 days after admission that identifies all of the client's:

Specific developmental strengths, including client preferences;
Specific functional and adaptive social skills the client needs toacquire; Any presenting disabilities, and when possible their causes; and
The need for services without regard to their availability.
(W196, W197, W200, W210, W211, W212, W213, W214, W215, W216, W217, W218, W219, W220, W221, W222, W223, W224, W225, W259)

Individual Program Plan (IPP) (42 CFR 483.440(c)).--The interdisciplinary team must prepare an IPP which:

- *Includes opportunities for individual choice and self-management;*
- *Identifies the discrete, measurable, criteria-based objectives the client is to achieve;*
- *Identifies the specific individualized program of specialized and generic strategies, supports, and techniques to be employed; and*
- *Must be directed toward the acquisition of the skills necessary for the client to function with as much self-determination and independence as possible and the Prevention or egression or loss of current optimal functional status.*

(W196, W209, W227, W240, W242, W247, W159)

Program Implementation (42 CFR 483.440(d)).--Each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient intensity and frequency to support the achievement of IPP objectives.

(W196, W249, W104, W120, W159, W164, W186, 189, W190, W194, W436, W474, W488)

Program Documentation (42 CFR 483.440(e)).--Accurate, systematic, behaviorally-stated data about the client's performance toward meeting the IPP objectives serves as the basis for necessary change and revision to the program.

(W196, W252, W253, W254, W111)

Program Monitoring and Change (42 CFR 483.440(f)).--At least annually, the comprehensive functional assessment of each client is reviewed by the interdisciplinary team for its relevancy and updated, as needed. The IPP is revised, as appropriate.

(W196, W255, W256, W257, W262, W263, W258, W259, W260, W264, W104, W159, W448, W449)

II - *Survey Levels*

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

There are three levels of ICF/IID surveys. They are the focused fundamental survey, the extended survey, and the full survey. Initial certifications and annual re-certification of ICF/IIDs also requires a Life Safety Code survey (see instructions in Appendix I), which is separate from these three health surveys). A full survey must be conducted for initial certification surveys and do not require a focused fundamental survey. A focused fundamental survey should be conducted for recertification surveys, unless, the State Survey Agency determines that a full survey is warranted based on the survey agency's identification of concerns related to the provider's capacity to furnish adequate services. A recertification survey can be expanded at any time to an extended survey or to a full survey based on surveyor findings.

A. Focused Fundamental Survey

The focused fundamental survey may be utilized for all ICF/IID recertification surveys. ***In addition to the entrance and exit, the focused fundamental survey follows the procedures outlined in tasks one through three.*** *Initial surveys will still require a full survey. The focused fundamental survey process focuses the predominance of the survey time on the basic elements of the active treatment process. This is accomplished through the concept of regulatory standards; an emphasis on increased client observation time; and more effective use of interviews and client record reviews. During the focused fundamental survey, the primary method of information gathering is observation. Interviews and record reviews are conducted to confirm and/or provide additional information on any concerns identified during observations. Beyond the IPP and the comprehensive functional assessment (CFA), in-depth review of progress notes or historical data is not performed unless there is suspected non-compliance of a key standard. As a result, this focused fundamental survey requires less on- site survey time than the full survey while still providing sufficient information regarding the*

delivery of services by the facility to enable the State Survey Agency (SA) and/or CMS Regional Office (RO) to determine compliance or non- compliance with the Conditions of Participation (CoPs).

The focused fundamental survey involves the identification of key standards within the ICF/IID CoPs from which all other standards correspond When the facility is determined to be in substantial compliance with the identified key standard, the standards corresponding from that key standard are automatically determined as being met since the key standard could not be compliant otherwise. However, if any key standard is found to be out of compliance, all regulations corresponding to the key standard (s) must be reviewed to determine compliance or non-compliance of each corresponding standard. The SA or CMS RO must, at this point, make a decision as to whether it would be more appropriate to continue the focused fundamental survey by simply adding review of the regulations under the non-compliant key standard(s) or to convert the survey to an extended survey. The SA or CMS RO must convert the focused fundamental survey to an extended survey if standard-level deficiencies are found during survey and the survey team has determined or suspects that one or more CoPs examined during the survey may be out of compliance.

The focused fundamental survey process is focused on the key standards. However, the surveyors are not precluded from reviewing or citing any of the corresponding standards if indicated during the review of the key standards.

The key standard list and the corresponding regulations associated with each key standard is provided below in Table 1. The CoP is highlighted in bold and the key standard(s) under each CoP is shaded in gray. The specified W tags under each shaded key standard are the corresponding regulations associated with that key standard.

Table 1: Key standards and corresponding standards within the CoPs for the focused fundamental survey:

CONDITION OF PARTICIPATION	*Key Standard(s) Regulatory Reference within the CoP*	*W-tag associated with the key standard regulation*	*Corresponding standard(s) under the key standard (W-tag reference)*
42 CFR 483.410 Governing Body and Management	**This Condition is reviewed only during a full survey.*		

CONDITION OF PARTICIPATION	*Key Standard(s) Regulatory Reference within the CoP*	*W-tag associated with the key standard regulation*	*Corresponding standard(s) under the key standard (W-tag reference)*
(W102)			
42 CFR 483.420 Client Protections (W122)	*42 CFR 483.420(a)(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment*	*W127*	*W149, W150, W151, W152, W153, W154, W155, W156, W157*
	42 CFR 483.420(a)(7) Provide each client with the opportunity for personal privacy	*W129*	*W130, W133, W134, W135, W145, W146*
	42 CFR 483.420(a)(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing	*W137*	*W126, W138, W140, W141, W142*
			**The corresponding standards below are reviewed when any key standard (W127, W129 or W137) under the CoP at 42 CFR 483.420 is out of compliance and is reviewed in conjunction with the corresponding standards under that key standard. W123, W124, W125, W128, W131, W132, W136, W139, W143, W144, W147, W148*
42 CFR 483.430 Facility Staffing (W158)	*42 CFR 483.430(a) Each client's active treatment program must*	*W159*	*W160, W161, W162, W163*

CONDITION OF PARTICIPATION	*Key Standard(s) Regulatory Reference within the CoP*	*W-tag associated with the key standard regulation*	*Corresponding standard(s) under the key standard (W-tag reference)*
	be integrated, coordinated and monitored by a qualified intellectual disability professional		
	42 CFR 483.430(d)(1) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans	*W186*	*W164, W165, W166, W167, W168, W169, W170, W171, W172, W173, W174, W175, W176, W177, W178, W179, W180, W181, W182, W183, W184, W185, W186, W187, W188, W189, W190, W191, W192, W193, W194*
42 CFR 483.440 Active Treatment Services (W195)	*42 CFR 483.440(a)(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan*	*W226*	*W200, W206, W207, W208, W209, W210, W211, W212, W213, W214, W215, W216, W217, W218, W219, W220, W221, W222, W223, W224, W225, W227, W228, W229, W230, W231, W232, W233, W234, W235, W236, W237, W238, W239, W240*
	42 CFR 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed	*W249*	*W196, W197, W198, W199, W250, W251, W252, W253, W254*

CONDITION OF PARTICIPATION	Key Standard(s) Regulatory Reference within the CoP	W-tag associated with the key standard regulation	Corresponding standard(s) under the key standard (W-tag reference)
	interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan		
	42 CFR 483.440(f)(1)(i) (1) The individual program plan must be reviewed at least by a qualified intellectual disabilities professional and revised as necessary, including, but not limited to situations in which the client— (i) Has successfully completed an objective or objectives identified in the individual program plan	W255	W256, W257, W258, W259, W260, W261, W262, W263, W264, W265 *The corresponding standards below are reviewed when any key standard (W226, W249, W255) under the CoP at 42 CFR 483.440 is out of compliance and is reviewed in conjunction with the corresponding standards under that key standard. W201, W202, W203, W204, W205, W241, W242, W243, W244, W245, W246, W247,

CONDITION OF PARTICIPATION	*Key Standard(s) Regulatory Reference within the CoP*	*W-tag associated with the key standard regulation*	*Corresponding standard(s) under the key standard (W-tag reference)*
			W248
42 CFR 483.450 Client Behavior and Facility Practices (W266)	*42 CFR 483.450(a)(1)(i) The facility policies and procedures must— Promote the growth, development and independence of the client*	*W268*	*W267, W269, W270, W271, W272, W273*
	42 CFR 483.450(b)(1)(iii) Facility procedures must— Insure prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective	*W278*	*W274, W275, W276, W277, W279, W280, W281, W282, W283, W284*
	42 CFR 483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.	*W285*	*W286, W287, W288, W289, W290, W291, W292, W293, W294*
	42 CFR 483.450(d)(1)(i) (1) The facility may	*W295*	*W296, W297, W298, W299, W300, W301,*

CONDITION OF PARTICIPATION	*Key Standard(s) Regulatory Reference within the CoP*	*W-tag associated with the key standard regulation*	*Corresponding standard(s) under the key standard (W-tag reference)*
	employ physical restraint only— *(i) As integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.*		*W302, W303, W304, W305, W306, W307, W308, W309*
	42 CFR 483.450(e)(1) *The facility must not use drugs in doses that interfere with the individual client's daily living activities*	*W310*	*W311, W312, W313, W314, W315, W316, W317*
42 CFR 483.460 Health Care Services (W318)	*42 CFR 483.460(a)(3)* *The facility must provide or obtain preventive and general care*	*W322*	*W319, W320, W321, W323, W324, W325, W326, 327, W328, W329, W330, W331, W332, W333, W334, W335, W336, W337, W338, W339, W340, W341, W342, W343, W344, W345, W346, W347, W393, W394*
	42 CFR 483.460(e)(1) *The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including, licensed dentists and dental hygienists either through organized dental services in-house or*	*W348*	*W349, W350, W351, W352, W353, W354, W355, W356, W357, W358, W359, W360*

CONDITION OF PARTICIPATION	*Key Standard(s) Regulatory Reference within the CoP*	*W-tag associated with the key standard regulation*	*Corresponding standard(s) under the key standard (W-tag reference)*
	through arrangement		
	42 CFR 483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly	*W362*	*W361, W363, W364, W365, W366, W367, W368, W369, W370, W371, W372, W373, W374, W375, W376*
	42 CFR 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration	*W382*	*W377, W378, W379, W380, W381, W383, W384, W385, W386, W387, W388, W389, W390, W391, W392*
42 CFR 483.470 Physical Environment (W406)	*42 CFR 483.470(a)(1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together*	*W407*	*W408*
	42 CFR 483.470(b)(4)(i) (4) The facility must provide each client with— (i) A separate bed of proper size and height for the convenience of the client	*W417*	*W409, W410, W411, W412, W413, W414, W415, W416, W418, W419, W420, W421, W422, W423, W427, W428*

CONDITION OF PARTICIPATION	*Key Standard(s) Regulatory Reference within the CoP*	*W-tag associated with the key standard regulation*	*Corresponding standard(s) under the key standard (W-tag reference)*
	42 CFR 483.470(d)(1) The facility must— Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients	*W424*	*W425, W426*
	42 CFR 483.470(g)(1) The facility must— Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services, as required by this subpart and as identified in each client's individual program plan	*W435*	*W429, W430, W431, W432, W433, W434, W436, W437*
	42 CFR 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases	*W455*	*W454, W456, W457, W458*
			**The corresponding standards below are reviewed when any key standard (W407, W417,*

CONDITION OF PARTICIPATION	*Key Standard(s) Regulatory Reference within the CoP*	*W-tag associated with the key standard regulation*	*Corresponding standard(s) under the key standard (W-tag reference)*
			W424, W435 or W455) under the CoP at 42 CFR 483.470 is out of compliance and is reviewed in conjunction with the corresponding standards under that key standard. W438, W439, W440, W441, W442, W443, W444, W445, W446, W447, W448, W449, W450, W451, W452, W453
42 CFR 483.480 Dietetic Services (W459)	*42 CFR 483.480(a)(1) Each client must receive a nourishing, well balanced, diet including modified and specially prescribed diets*	*W460*	*W461, W462, W463, W464, W465, W466, W467, W468, W469, W470, W471*
	(2) Food must be served-- 42 CFR 483.480(b)(2)(i) In appropriate quantity;	*W472*	*W476, W477, W478, W479, W480, W481, W482, W483, W484, W485, W486, W487, W488, W489*
	42 CFR 483.480(b)(2)(ii) At appropriate temperature;	*W473*	
	42 CFR 483.480(b)(2)(iii) In a form consistent with the developmental level of the client; and	*W474*	
	42 CFR 483.480(b)(2)(iv) With appropriate utensils	*W475*	

B. Extended Survey

During a focused fundamental survey, if a key standard of a CoP is found to be out of compliance, then the surveyor will review all corresponding standards under that key standard to determine compliance with that condition (i.e., to determine condition-level compliance). If the review of the key standard and corresponding standards could result in a condition-level non-compliance finding, then the SA can decide to survey all the standards within that CoP. This review of all the standards within an ICF/IID CoP is known as an extended survey.

However, if the review of the key standard and corresponding standards results in a CoP non-compliance finding at 42 CFR 483.420, 42 CFR 483.450 or 42 CFR 483.460, then the team must convert the extended survey to a full survey and follow the procedures for a full survey as indicated below.

***NOTE:** Neither the focused fundamental nor the extended survey processes preclude the survey agency from review of any standard, if evidence of non-compliant facility practice is suspected during any survey.*

C. Full Survey

A full survey is a review of all of the standards within all eight ICF/IID CoPs. In addition to the entrance and exit, a full survey follows the procedures outlined in all seven tasks.

A full survey is conducted when any one or more of the following criteria are met:

- *The survey team is conducting an initial survey;*
- *An immediate jeopardy is called;*
- *The survey team determines from the extended survey that Condition-level deficiencies exist at one or more of the specific CoPs at 42 CFR 483.420, 42 CFR 483.450 or CFR 483.460; or*
- *At the discretion of the SA*

III - *Entrance*

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

In addition to standard entrance procedures, the surveyor will complete the Form CMS-3070G "Intermediate Care Facilities for Individuals with Intellectual Disabilities Survey Report," to capture characteristics of the facility and the facility's population. Furthermore, the surveyor will establish the client sample selection by requesting a complete and accurate list of all the

clients that currently reside in the facility. After the core number of clients are selected (see Task 1 below), the surveyor will request a copy of each selected client's Individual Program Plan (IPP). Each IPP will be utilized during observations to determine:

1. *If the client's skills matches the IPP;*
2. *If the IPP is being followed;*
3. *If staff understand the IPP;*
4. *Staff and client interactions during the programs; and*
5. *Health concerns interfering with the IPP.*

IV - *Task One - Sample Selection*

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

The complete sample for the facility will include a core number of clients selected at the beginning of the survey and additional clients are added during the process of the survey as needed based on observations and/or interviews. Do not permit the facility staff to select the sample.

A full review (observation, record review and interview) will be conducted on all clients in the core sample to include:

1. *Comparison of the Comprehensive Functional Assessment to the Individualized Program Plan (IPP);*
2. *Comparison of the IPP to actual activity observed;*
3. *Review of documentation of client participation and progress compared to observations;*
4. *Timely and appropriate behavior program plan development and implementation as indicated; and*
5. *Medical assessments conducted as indicated and indicated medical care or interventions.*

The core sample of clients is selected from a list of the facility's current client list without regard to client developmental levels or locations in the facility. At minimum, the core sample should include clients that meet any one or more of the following criteria:

- ☐ *Admission within the last six (6) months;*
- ☐ *Participation in a day program;*
- ☐ *On a self-administration program; and/or*
- ☐ *Frequent hospitalizations or ER visits.*

Table 2: Guidance to Calculate Core Sample Size:

Number of Clients Residing in the Facility	Minimum Number in Core Sample
4	2
5-16	3
17-50	4
51-100	6
101-150	8
Over 150	10

During observations, additional clients should be added to the core sample if areas of concern are identified. Examples may include, but are not limited to:

1. *Clients with significant medical involvement which may be impacting the implementation of their IPP;*
2. *Clients with significant behaviors with lack of or inappropriate staff intervention;*
3. *Clients that are idle for extended periods oftime;*
4. *Clients that appear to have strengths but are not encouraged to use those skills or are performing activities below their skill levels; and*
5. *Clients who are not provided appropriate medical care.*

Additional Sample Clients:

A client added to the core sample, during observations, does not require a full review of his/her program record. There is no minimum or maximum number of additional clients that must be added to the core sample. The program records for clients added to the core sample (additional clients), should only be reviewed for the observed areas of concern. For instance, in the case of a client observed to be doing work that appears to be for the benefit of the facility, the record should be reviewed to determine whether the work is included in the client's IPP; whether fair compensation is provided; and whether the client's needs are being addressed by the facility. The client and the staff should be interviewed and the information compared to the program records.

Another client may be added to the sample based solely on the fact that he/she is on a self - administration program for medication. In this case, the surveyor would focus the record review on:

- *Whether the comprehensive assessment supported the indication for such a program;*
- *What the current objectives of the program are and whether the client is following those objectives; and*
- *What documentation is maintained of oversight of the objectives and whether the objectives are revised as indicated.*

Observations and interviews with the client and staff would focus on the medication administration.

V - *Task Two - Review of Facility Systems to Prevent Abuse, Neglectand Mistreatment and to Resolve Complaints*

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

When determining whether or not facility systems are in place to prevent abuse, neglect, and mistreatment and to resolve complaints, surveyors will use Task Two.

Task Two consists of two phases. *In the absence of pre-existing characteristics as described below, only Phase One should be completed. If there are pre-existing criteria or if in the course of the survey concerns with client protections are identified, the surveyor should extend to the Phase Two review. Any one or more of the following are pre-existing criteria that would initiate a Phase Two review.*

- *Substantiated complaints or facility reported events in Client Protections since the last recertification survey;*
- *A survey history of citations at W127, W153-W157; or*
- *Concerns identified by the SA that warrant a Phase Two review.*

A. Task Two Phase One

The critical components of this Phase are client observations including staff-to-client and client-to-client interactions, and staff/client/family interviews. These observations and interviews identify the reporting records or investigation records that will be reviewed by the surveyor.
These records/reports are requested after the observations and interviews have been completed.

If the surveyor determines during Phase One that there is evidence of possible abuse, neglect and mistreatment, then the surveyor should follow-up with associated interviews and record reviews. The surveyor should contact his or her SA for a possible Immediate Jeopardy (IJ) call. If the CoP for Client Protections at 42 CFR 483.420 is cited, then this concludes Task Two.
Additional review of Task Two is completed at the discretion of the SA or CMS RO.

If during Phase One, the surveyor does not observe any instances of possible abuse, neglect and mistreatment, then Task Two may be ended.

1. Phase One Observations:

- *Any signs of client injury (e.g., bruising, splints, bandages, scratches, limping or favoring a limb, etc.);*
- *Client-to-client aggression;*
- *Inappropriate staff-to-client interactions (e.g., physical, verbal);*

- *Signs of fear in the presence of specific clients or staff;*
- *Signs of mistreatment or punishment by staff such as rudeness, rough handling, restriction of rights, etc.; or*
- *Any clients currently in the hospital or experiencing recent hospitalizations or emergency room visits*

2. *Phase One Interviews:*

If Phase One observations identify any concerns with possible abuse, neglect and mistreatment, as well as failure to resolve complaints, then specifically associated interviews must be conducted.

The client is interviewed first. Do not exclude clients who use alternate means of communication, such as communication boards or gestures. Most clients are able to communicate in some manner. Questions to the client may include, but are not be limited to:

a. *Are the staff nice to you?*
b. *Do the staff yell, swear, or hit? Who?*
c. *Has anyone ever hurt you? Who? When?*
d. *Are you ever punished for anything? What was yourpunishment?*
e. *How did you get injured? (If the client has an obviousinjury)*

Interview the family, legal guardian, advocates (if applicable) and close friends (if identified) of each client for whom a concern was identified either during observations or client interviews. Family members, legal guardians, advocates and close friends may be interviewed at the facility or by telephone. Questions to the families, legal guardians, advocates and close friends may include, but are not be limited to:

a. *Have you noticed any bruises or injuries of an unknown source on (client'sname)?*
b. *If so, did you speak with thestaff?*
c. *What did they say?*
d. *How does the staff interact with (client'sname)?*
e. *Does (client name) complain of any mistreatment duringvisits?*

Facility staff should be interviewed as indicated. This includes direct care staff from more than one shift, the applicable Qualified Intellectual Disability Professional (QIDP) and medical personnel. The goals of the interviews are to determine how often injuries/mistreatment are occurring, what process the facility is using for reporting such instances, the timeliness of notifications, whether clients are protected from harm during investigations and whether process changes are implemented by the facility to prevent future injuries and/or mistreatment. The questions during each interview should be tailored according to the observations made.

3. Phase One Record Reviews:

For any specific injury noted during observations (regardless of whether the client is in the sample or not), the surveyor requests the documentation associated with the injury (reporting/investigation/disposition). The goal of this documentation review is to verify the information provided by the staff and to ensure the prompt reporting, investigation and protection of clients with injuries and allegations of mistreatment.

If the observations, interviews or record reviews during Phase One confirm that the facility is identifying injuries and mistreatment promptly, notifying the appropriate persons, doing appropriate investigations, and doing appropriate interventions, then Task Two is concluded. Deficiencies may be written at Phase One without proceeding to Phase Two.

B. Task Two Phase Two:

If the surveyor determines during Phase One that there is insufficient evidence to find that the facility is in compliance with the Condition of Participation for client protections at 42 CFR 483.420, a more global review is indicated. Request the facility log of client incidents and reports and select a sample of 5 percent of the incidents from the total client incidents occurring during the last three (3) months (a minimum of 10 if available). Request the investigative reports for these incidents. Look for any evidence that suggests that clients are being abused, neglected or mistreated. Determine whether in each case the incident was reported promptly and investigated thoroughly and that safeguards were put into place during the investigation and corrective measures taken in order to prevent recurrences.

If the facility has a system in place to prevent abuse, neglect and mistreatment and to resolve complaints and takes the appropriate corrective measures, then, Task Two is complete.
If the 5 percent sample review is not determinative as to the compliance with the CoP for client protections, or the surveyor identifies any patterns of possible abuse, mistreatment or neglect, or the incident report logs for the past three (3) months indicate an extremely high incident rate, the surveyor should proceed to a full review of the total number of incidents and reports for the past three (3) months to identify any deficient practice by the facility.

If the surveyor believes that issues exist that rise to the level of an Immediate Jeopardy, investigate and procedures in Appendix Q should be followed.

VI - Task Three – Focused Observation

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

The majority of the time on an ICF/IID focused fundamental survey is spent doing observation, associated interviews and associated targeted record review. It is critical that observations of sufficient duration occur across the entire survey (i.e. early morning, afternoon, and evening) and occur across the client's various environments (home, recreation and day program). A minimum of two meals must be observed and two medication pass observations must be conducted.

Once the client core sample is selected and copies of the Individual Program Plan for each selected client have been obtained, the observations should begin. Do not delay beginning

observations awaiting the IPPs. Begin general observations until the IPPs are provided by the facility.

Initially note and record the first general impressions of each area where the clients are observed (i.e., the milieu). Conduct these observations, without intruding (unless it is necessary to alert a staff member to a possible risk to a client) for at least an hour in each initial location. Note things on the general milieu such as:

a. *Are all the clients in the area dressed appropriately but individually according to what appears to be their preferences?*

b. *What activities are taking place? Note the time of day. Are these activities appropriate for the time of day?*

c. *How many staff are present?*

d. *Does the environment appear calm and purposeful?*

e. *What is the staff doing? How is the staff interacting with the clients? How are clients interacting with each other?*

f. *Are clients being encouraged by the staff to participate in activities or are things done for them?*

g. *What types of adaptive equipment or assistive devices are used?*

h. *Do the staff use teachable moments with the clients?*

i. *How are behavioral episodes addressed?*

j. *Do clients appear well nourished? Do they appear sleepy (not early in the morning)?*

k. *Do any clients have signs of injury? (Note for subsequent staff interview and Task 2 review.)*

The results of these initial observations are critical to the focused fundamental survey process on two levels. The surveyor(s) may observe specific issues which would indicate further investigation or additional clients may need to be added to the core sample. The SA may determine that, based upon the overall initial observation findings, the facility will require an extended or full survey rather than a focused fundamental.

Focused Observation Areas:

1. Active Treatment-
Each IPP must be appropriate for the client based upon a comprehensive assessment and revised with changes in client program needs. The IPP must correspond to what treatments, programs or services the client is actually receiving. Programs should be appropriate for the client (i.e., is the client able to accomplish/complete the program too easily; have they already accomplished the components of the program; or does the client have program needs that have not been addressed by the IPP (e.g., ADL, behavioral, socialization))? If there are discrepancies with the IPP

programs after observing the client in several environments, the surveyor should speak with the client and/or appropriate staff (QIDP, direct care staff, psychology staff) for additional information on the identified concerns. Interviews with staff are not done routinely. If during observations the surveyor(s) determine that the current objectives of the IPP match the strengths and needs of the client, the staff is familiar with the methodology of accomplishing these programs, and they are being carried out as written in the IPP, there is no need to conduct formal staff interviews. The surveyor should ask the staff (direct care staff carrying out the program(s)) for records documenting program(s). Generally, the client should be making steady progress and this should be reflected in the program data. However, if there is no progress made or if there has been a regression, there should be evidence that the QIDP/ID team is aware of the issue and is addressing it. In this case or in the case where actual programs do not match IPP programs or do not seem appropriate for the client based upon the client's identified skills, it will be necessary for the surveyors to interview appropriate staff.

2. Staff

Generally, an inadequate number of staff will result in concerns with client programming and client protection. During observations, note how the on duty staffing ratios either promote or prevent a safe and productive active treatment environment. In some instances surveyors will see the effects of inadequate staffing early (during the first impression observation). These effects may include chaotic environment, client-to-client abuse, self-abuse by clients, clients sitting unengaged for long periods of time with little or no staff presence, clients not given the opportunity to assist in ADLs or participate in the rhythms of life due to the need to "get things done" (such as assisting with mal preparation), or programs not being carried out due to inadequate on-duty staffing.

3. Qualified Intellectual Disabilities Professional (QIDP)

The increased time devoted to observations during the survey provides more of an opportunity to also observe the QIDP in action. Observe interactions between the QIDP and the staff and the QIDP and the clients. Is the QIDP familiar with client programs and client progress? How much direct interaction is occurring among the QIDP, the staff and the clients? Is the QIDP intervening when necessary and facilitating revisions to IPP as indicated? If the surveyor has unresolved discrepancies, any concerns should be discussed with the QIDP.

4. Health Care Services

The surveyor should determine from observations whether or not the sampled clients are receiving medical care as indicated. NOTE:

- *a. Do any of the clients have acute or chronic medical issues? How are these issues being addressed by the medical staff at the facility?*
- *b. Do the clients seem alert and energetic?*
- *c. Are clients at a healthy weight?*
- *d. Do the clients have good oral health? Have any dental problems been dealt with promptly and appropriately?*
- *e. Are the staff trained on first aid and reporting of medical issues?*

If during observation there is concern about the health of a client, the nurse surveyor should talk with the client and/or the nurse about the issues observed. In the event that there is not a nurse surveyor, the non-clinical surveyor will need to consult with a clinician at the SA. Determine what interaction is occurring between the client and the medical staff and whether the situation is improving or deteriorating? Review the pertinent portions of the client record and discuss with the medical staff as necessary.

If there are clients on a self-administration of medications program, the evaluation of the program should be part of the active treatment observations.

5. Physical Environment
During observations, the surveyor should observe the facility for cleanliness, comfortable temperature and any safety hazards (i.e. obstructed walkways, resilient, nonabrasive, and slip-resistant floors).

Client Record Review:

Review of the client record during the focused fundamental survey is kept to a minimum. No routine record review is done. All record reviews are focused on obtaining additional information to clarify or completely document areas of question or concern identified during observation.

VII - *Task Four - Required Interviews with Individuals and/or Family/Advocate Direct Care Staff*

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

A – Purpose

Individuals living in the facility, their families/guardians and advocates, and direct care staff are important sources of information about the receipt of active treatment on a daily basis. Interviews are conducted for two purposes: to determine how the individual perceives the services delivered by the facility, and to clarify information gathered during observations.

B - Interview Procedure

Start with the individual in the sample and the people most closely associated with the individual's daily program implementation. Use the following hierarchy of sources, to the maximum extent possible, in the order shown:

- Individual;
- Families, legal guardian, or advocate;
- Direct care staff;

- Qualified intellectual disabilities professional (QIDP) and/or professional staff; and
- Managers, administrators, or department heads.

Determine from your observations and from the staff how the individual communicates with others. Also determine from the staff the extent of involvement of family members, guardians or advocates with the individuals in the sample. Based on this information, select the individuals from the sample with whom you will conduct more in-depth interviews. Select those individuals who will be able to communicate at least some basic information or those who have actively involved family members, guardians or advocates. Do not exclude from interviews individuals who use alternate means of communication, such as communication boards, sign language, and gestures. Most individuals are able to communicate in some manner.

Attempt to obtain the required number of interviews first from individuals and then from family members, guardians or advocates. In the absence of individuals who are able to communicate and active significant others, interview the direct care staff person who works most closely with the individual in order to obtain the required number of in-depth interviews.
The questions and communication method will vary from person to person. For individuals who use a specialized communication method, attempt to begin the interview on a one to one basis. If you find you are unable to communicate with the individual, ask someone familiar with the person to assist you (e.g., a family member or a staff person.) For this individual, pay close attention to how the staff communicates with him or her. If the person uses sign language or a communication board, does staff understand and interact with the individual using the same method? If the person uses gestures, does staff take time to determine his or her needs?
Family members, guardians or advocates may be interviewed at the facility, at a location convenient to both the surveyor and the interviewee, or by telephone. All interviews should be conducted in private locations and scheduled at mutually agreed upon times in order to minimize disruptions to individual, family, or staff activities.

C - Content of In-depth Interviews
Determine what the facility does to provide individualized services and supports; and how individuals and families participate in service planning and in making choices about matters important to them.

- Are individuals treated with respect and dignity?
- Does the facility attempt to help the person set and attain individual goals?
- Are there consistent opportunities for making choices?
- When a choice is not an option, how is the individual assisted to understand?
- For example, if a planned activity is to go to a restaurant for dinner, who chooses the restaurant?
- Is it staff or the individuals living in the facility?
- If one group of people does not want to go, how is this choice accommodated?

- Is the accommodation based on individual choice, staff convenience, or a reasonable justification if a choice is not an option?

See section D for suggested interview questions. Unless designated that certain questions be directed to a certain person, questions are relevant to whoever is being interviewed (individual, family member, advocate or staff person.) Modify the wording of the questions based on the person being interviewed (individual, family member, or staff) and on the communication skills of that individual. For example, you may discover that the person responds better to questions that can be answered "yes" or "no" than to open-ended questions. Be sensitive to signs that the individual is tiring or becoming uncomfortable and either end the interview or continue it at a later time if this occurs. It is not necessary to ask every question in the guide, but do try to ask at least one question from each topic area.

D - Suggested Interview Questions

If you have not met the person before, begin the interview by explaining who you are and what your role is. To put the person at ease you may want to begin with some general conversation, e.g., about the weather or a special event coming up. At the end of the interview, if you think you may need to discuss or confirm personal information with staff or family, ask the person if it is OK to share that information.

Questions Related to Choice and Community Participation (W136, W147, W247):

- What sorts of things do you like to do for fun?
- Do you go out to activities or events in the community (like shopping, movies or church)?
- How often do you do this?
- How do you get there?
- Who chooses where you go?
- Do you go to visit family members or take vacations?
- Is there something you would like to do more often?

Questions Related to Personal Finances and Possessions (W126, W137):

- Do you earn money on your job (at your day program)?
- What do you like to buy with your money?
- Do you have enough money to buy the things you want or need?
- Does someone help you with spending or saving your money?

- When you go to the store, do you pay for items or does a staff person pay for them?
- Do you have enough clothes and shoes?
- Do you always have enough deodorant and toothpaste, etc.?
- What do you do if you need to buy something?

Questions Related to Personal Relationships and Privacy (W129-W130, W133, W143 - W148):

- Do you have family or friends who visit you?
- Does your family write to you or telephone you?
- Does someone help you read their letters/ call them on the phone?
- If you feel like being alone or spending private time with a friend or family where do you go?
- Does staff knock on your door before they come into the room?

For family member/advocate:

- How do you learn about things like the services your family member receives, an illness or a change in medication?
- Are there any restrictions on when you visit your family member or where you can go within the home?

Questions Related to Individual's and Family's Participation in the IPP Process (W209, W247):

- Do you go to (team) meetings with the staff where they talk about the services you get?
- Does your family/advocate come to these meetings?
- Were you asked if the date and time of the meeting were OK with you?
- What would you like to learn to do for yourself?
- Does the staff ask you what you want?
- Who chooses what you do?
- Does the staff listen to you and make changes based on what you want?

For staff:

- How do you communicate with this individual?
- What does (s) he like and dislike? How do you know that?

Questions Related to Service Delivery (W242, W249, W436):

- What help do you need from staff to dress, eat, bathe, etc?
- Do you get any special therapy (e.g., speech or physical therapy)?
- What new things are you learning to do?
- What chores do you help with around the house?
- Who helps you when you do not know how to do something?
- What special equipment do you use?

Questions Related to Individual's Rights and Protections: W124-W125, W127, W153 - W157, W127-W128, W263:

- Who do you tell if you do not like something, or something is wrong?
- Are there rules that everyone who lives here must follow?
- What sorts of things are you allowed to do or not do?
- How does the staff treat you?
- Are staff loud?
- Does staff yell, swear or hit?
- Do you ever do things you are not supposed to do? What happens then?
- Were you ever asked to give consent for any treatments or services?
- Were you told the benefits, risks and alternatives?

Questions Related to Health Status (W322, W356):

- How often do you see a doctor? A dentist?
- Do you have any health problems?
- Do you take any medicines? Do you know what they are for?

Wrap-up Questions:

- Is there anything you especially like about living here? Anything you especially dislike?
- Is there anything else you think I should know about what it is like to live here?

E - Interviews to Clarify Observations

In the absence of finding appropriate interaction between staff and individuals during observations, it may be necessary to judge whether or not staff is knowledgeable about individual objectives and techniques for implementation of programs. If possible, interview staff following the interval in which the individual was observed with the particular staff member. (For example, if you have just observed Individual A engaging in stereotypical behaviors, ask: "Can you tell me what, if anything, you do when he rocks back and forth?") Ask questions that elicit information about how staff learns what to do with individuals across the spectrum of support and programming activities they are expected to perform. Ask professional staff questions to see if they know how to implement programs for an individual other than their professional discipline (e.g., how to carry through with a behavior program in the midst of communications training).

Ascertain whether the staff is competent to carry out the individual's choices and skill development activity. Is there evidence that programs are in fact being carried out throughout the individual's waking hours? Are interventions revised based on changes in the individual's progress toward goals? If staff cannot demonstrate the skills necessary to implement the individual's programs and choices, if interventions are not being carried out consistently, or if revisions to interventions do not occur, you have findings that active treatment is not being delivered.

F - Documentation

Record each interview you conduct with individuals, staff, consultants, off-site day program staff, legal guardians, etc., in your personal notes or on the optional observation worksheet(Form CMS-3070I). Include the following information in your notes for eachinterview:

- Date and time of interview;
- Job title and assignment at the ICF/IID;
- Relationship to the individual or reason for the interview; and
- Summary of the information obtained.

VIII - *Task Five - Drug Pass Observation*

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

Observe the preparation and administration of medications to individuals. With this approach, there is no doubt that the errors detected, if any, are errors in drug administration, not documentation.

Follow the procedure in the interpretive guidelines at W369 for conducting the drug pass observation. Notes on observations of the drug pass may be recorded on Form CMS- 677 (LTC Medication Pass Worksheet) or in the surveyor's personal notes. The purpose of the review is to direct the facility's attention to assuring an error free drug distribution system and away from the paper processes that often do not represent actual errors in medication administration. For the purposes of this task, a "small" facility is one that houses 16 or fewer residents.

IX - *Task Six - Visit to Each Area of Facility Serving Certified Individuals*

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

A - Purpose

By the end of the survey, visit each area of the facility serving certified individuals in order to:

- Ensure that all areas of the facility (including those that are not represented by individuals in the sample) are providing services in the manner required by the regulations.
- Assess generally the physical safety of the environment.
- Assess that individual rights are proactively asserted and protected.

B – Protocol

After individuals in the sample have been assigned to team members, review the facility's map or building layout. Assign members to visit each remaining residential and on-campus day program site prior to completing the survey. Insure that each area of the facility that is utilized by individuals has been visited. This visit may be done with or without facility staff accompanying you, as you prefer, and subject to their availability. Record your observations in your notes.

Converse with individuals, family members/significant others (if present), and staff. Ask open-ended questions in order to confirm observations, obtain additional information, or corroborate information, e.g., accidents, odors, apparent inappropriate dress, adequacy and appropriateness of training activities. Observe staff interactions with other staff members as well as with individuals for insight into matters such as individual rights and staff responsibilities.

X - *Task Seven - Record Review of Individuals in the Sample*

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

A - Introduction

Do not spend an excessive amount of time looking at fine details in the record review of the selected sample. The purposes are to:

- Verify the applicable information obtained from your observations and interviews;
- Review revisions that have been made to the objectives; and
- Verify that needed health and safety supports are in place.

Do not review in detail the written training programs that are developed for each individual unless you discover serious differences between the record and your observations and interviews. Review those parts of the record most relevant to your purposes as described below.

B - The Individual Program Plan (IPP)

Identify the developmental, behavioral, and health objectives the facility has committed itself to accomplish during the current IPP period. Identify what, if any, behavioral strategies (e.g., behavior modification programs, use of psychotropics) are being used with individuals in your sample. Determine what, if any, health or other problems might interfere with participation in program services.

C - Program Monitoring and Change

Skim the most recent interdisciplinary team review notes to identify what revisions were made to the IPP. Determine whether revisions were based on objective measures of the individual's progress, regression, or lack of progress toward his/her objectives.

D - Health and Safety Supports

Verify, either through the interdisciplinary team review notes or through the most recent nursing notes, that the individual has received follow-up services for any health or dental needs identified in the IPP and check the person's current drug regimen. For individuals with whom restrictive or intrusive techniques are used, verify that the necessary consents and approvals have been obtained.

If this information is consistent with your observations and interviews, conclude the record review. If discrepancies are found, conduct further observations or interviews as needed to verify your findings.

XI - *Exit Conference*

(Rev. 178; Issued: 04-13-18; Effective: 04-13-18; Implementation: 04-13-18)

During the pre-exit conference, the survey team records on the Form CMS-3070H ("Intermediate Care Facilities for Individuals with Intellectual Disabilities Deficiencies Report") those requirements that are determined to be deficient and the findings that support that determination. Write the deficiency statement in terms specific enough to allow a reasonably knowledgeable person to understand the aspect(s) of the requirement(s) that is (are) not met. Indicate on the Form CMS-3070H the data prefix tag, followed by a summary of the deficient facility practice(s). Briefly identify the supporting findings for each deficiency (i.e., transfer to the Form CMS-3070H the identifier numbers of all clients to whom the deficient practice applies.) It is not necessary to write a full description of the findings on the Form CMS- 3070H since they will be described in more detail on the completed Statement of Deficiencies (Form CMS-2567). It is necessary to complete the Form CMS-3070H for each survey because the Form CMS-3070H is the only document in which the survey team's recommendations for deficiencies are recorded (which may be changed later on the final Form CMS-2567 as a result of supervisory review) and because not all client examples may be used on the Form CMS-2567. During the exit conference, provide the facility administrator with all regulations determined to not be met during the survey. Provide examples as necessary, allow the facility to provide additional information if it chooses, inform the facility that the findings are preliminary and final compliance determinations will be made by the survey office.

Part II- Interpretive Guidelines-Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities

§440.150 Intermediate Care Facility Services, Other Than in Institutions for Mental Diseases

W101

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

W101 is reassigned to §483.410(e). Section 442.251, the standard which requires that facilities meet the requirement for a State license, is redesignated to §483.410(e) and W101 is reassigned as well to afford a sense of continuity.

W102

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410 Condition of participation: Governing body and management

(a) Standard: Governing body

W103

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(a) The facility must identify an individual or individuals to constitute the governing body of the facility.

Guidance §483.410(a)

If concerns are noted regarding the governing body, written documentation verifies that the facility has designated the individual or individuals to constitute the governing body and their titles.

W104

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility.

Guidance §483.410(a)(1)

The governing body develops, monitors, and revises, as necessary, policies and operating directions which ensure the necessary staffing, training resources, equipment and environment to provide clients with active treatment and to provide for their health and safety.

Direction by the Governing Body includes areas such as health, safety, sanitation, maintenance and repair, and utilization and management of staff.

Condition level operational deficiencies may be associated with a failure by the Governing Body to exercise general direction of the facility.

W105

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(a)(2) The governing body must set the qualifications (in addition to those already set by State law, if any) for the administrator of the facility.

Guidance §483.410(a)(2)

The policies of the facility must include the qualifications of the administrator, and the qualifications are stated in the job description of the administrator.

W106

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(a)(3) The governing body must appoint the administrator of the facility.

Guidance §483.410(a)(3)

This appointment must be in writing.

(b) Standard: Compliance with Federal, State and local laws

§483.410(b) The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to:

Guidance §483.410(b)

The facility has no final adverse action by a Federal, State, or local authority. Such adverse actions include, but are not limited to fines, limitation on services that may be provided, or loss of licensure.

The facility must be able to provide for review, current licenses and permits as well as applicable reports of inspections by State or local health authorities.

If a situation is identified indicating the provider may not be in compliance with Federal, State, or local law, refer that information to the authority having jurisdiction (AHJ) for follow-up actions. See W107, W108, or W109.

W107

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(b) health,

Guidance §483.410(b)

Reference the specific law, regulation, or code not met.

W108

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(b) safety, and

Guidance §483.410(b)

Reference the specific law, regulation, or code not met.

W109

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(b) sanitation.

Guidance §483.410(b)

Reference the specific law, regulation, or code not met.

(c) Standard: Client Records

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

W110

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(c)(1) The facility must develop and maintain a record keeping system that includes a separate record for each client and;

W111

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(c)(1) that documents the client's health care, active treatment, social information, and protection of the client's rights.

Guidance §483.410(c)(1)

The structure and content of a client's record must be an accurate, functional representation of the actual experience of the client in the facility.

The record should contain an accurate account of all information relevant to the client's health care, active treatment, social information and protection of the client's rights, such as communications, correspondence, program plans (to include both in-house and outside service programs), progress summaries, activity plans and activity participation, incidents, consent forms and all medical information.

If the records are maintained electronically, the facility staff should be able to access various parts of the record without difficulty. If they are unable to access components of the record upon request, then this may indicate a lack of training by the facility.

W112

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(c)(2) The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.

Guidance §483.410(c)(2)

"Keep confidential" means safeguarding the content of information including video, audio, and/or computer stored information from unauthorized disclosure without the specific informed consent of the client, parent of a minor child, or legal guardian, and consistent with the advocate's right of access. Facility staff and consultants, hired to provide services to the client, sign confidentiality agreements before having access to client records and should have access to only that portion of information that is necessary to provide effective responsive services to the client.

These agreements should be renewed according to the policies of the facility. The agreement may stipulate that the agreements are in place until either the facility or member terminates the agreement.

The facility has in place safeguards to ensure that access to all information regarding clients is limited to those clients designated by Health Insurance Portability and Accountability Act (HIPAA) requirements, the Developmental Disabilities Act, State law and facility policy.

The facility should prevent any instances of unauthorized access or dissemination. For example, the staff is observed to leave the client record (hard copy or electronic version) in the living room of the house when visitors or persons not authorized to access client records are present. Client records must be secured when staff is not present.

The facility must develop and follow procedures for maintaining the confidentiality of client information during transport to medical appointments or to other locations outside the facility.

Confidentiality applies to both central records and information kept at dispersed locations. If there is information considered too confidential to place in the record used by all staff (e.g., identification of the family's financial assets, sensitive medical data), it may be retained in a companion record located in a secure location in the facility with a notation made in the primary record as to the location of confidential information. The facility must ensure that any client information provided to day services programs is maintained confidential.

The sharing of client specific information with members of the "specially constituted committee" required by §483.440(f)(3), who are not affiliated with the agency, does not violate

a client's right to have information about him or her kept confidential. The committee must have relevant information to function properly.

Facility confidentiality safeguards include the development and implementation of written policies to assure that members of the specially constituted team maintain confidentiality. Such processes may include signed confidentiality agreements.

These agreements should be renewed according to the policies of the facility. The agreement may stipulate that the agreements are in place until either the facility or member terminates the agreement.

W113

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(c)(3) The facility must develop and implement policies and procedures governing the release of any client information, including consents necessary from the client, or parents (if the client is a minor) or legal guardian.

Guidance §483.410(c)(3)

The facility develops and follows written policies governing the release of client information.

Release of any personally identifiable information does not occur unless consent(s) is obtained prior to the release.

These policies must address at a minimum who must give consent for the release of information from records. The policy and procedures should account for other situations involving the release of client information, such as:

who should be notified when records have been released;

procedures to be followed with subpoenas;

time frames for providing requested information; and

information regarding a client's HIV status may not be released without specific consent and may not be in the record if that consent has not been given.

W114

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(c)(4) Any individual who makes an entry in a client's record must make it legibly, date it, and sign it.

Guidance §483.410(c)(4)

Illegible writing in hard copy records can contribute to communication deficits among staff. Illegible writing which cannot be easily interpreted by facility staff upon surveyor request may constitute a safety issue.

Electronic signatures are acceptable in the electronic record system.

W115

§483.410(c)(5) The facility must provide a legend to explain any symbol or abbreviation used in a client's record.

W116

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(c)(6) The facility must provide each identified residential living unit with appropriate aspects of each client's record.

Guidance §483.410(c)(6)

"Appropriate" means those parts of each client's record are most likely (or known) to be needed by the residential staff to carry out the client's active treatment program in the unit; to alert staff to health risks and other aspects of medical treatment; to support the psychosocial needs of the client; to contact family or emergency contacts, and to provide anything else necessary to the staff's ability to work on behalf of the client.

The staff of the residential living unit has, and can access, all information which is relevant to implementing client program plans, appropriate care of, interaction with, and provision of services for the client.

(d) Standard: Services provided under agreements with outside sources

W117

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(d)(1) If a service required under this subpart is not provided directly, the facility must have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

Guidance §483.410(d)(1)

If a service is not provided directly, there must be a written agreement for such services.

Written agreements are required for emergency services such as dentists and pharmacies. For those services that require a visit to a hospital, the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) typically utilizes services from an emergency department of the hospital, thus no written contract is required.

Federal statute (P.L. 94-142) requires all school-aged children to receive a free and appropriate school education. Therefore, a written agreement between ICF/IIDs and public schools is not necessary.

W118

(d)(2)(i) Contain the responsibilities, functions, objectives, and other terms agreed to by both parties; and

W119

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(d)(2)(ii) Provide that the facility is responsible for assuring that the outside services meet the standards for quality of services contained in this subpart.

W120

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(d)(3) The facility must assure that outside services meet the needs of each client.

Guidance §483.410(d)(3)

Outside services are any services needed by the clients and not provided directly by the facility (hospital visits, dental visits, day program services, etc.).

Programs and services must be coordinated between the facility and the outside service, and foster consistency of implementation across settings of teaching strategies and behavior management.

The facility monitors outside services on an ongoing basis to ensure that services provided are consistent with the needs of each client as identified in the Individual Program Plan (IPP). For example, if the facility is implementing a behavior management or a communication program for the client, it is shared with the outside program and implemented by the outside program (workshop, day program, etc.) and the outside program agrees to incorporate it into their day program. At periodic intervals, the facility staff visit or communicate with the outside program to verify consistency across the two settings.

With outside resources, it is the responsibility of the facility to assure that the services are provided in a safe clean environment, by appropriately qualified professions, and any untoward outcome of services are promptly addressed. If, in spite of attempts by the facility to assure compliance, the outside program does not implement the program for the client, then the facility remains responsible for the lack of active treatment.

W121

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(d)(4) If living quarters are not provided in a facility owned by the ICF/IID, the ICF/IID remains directly responsible for the standards relating to physical environment that are specified in §483.470(a) through (g), (j) and (k).

Guidance §483.410(d)(4)

Even though the facility's premises may be rented from a landlord, the facility must ensure that the requirements for physical environment are met, either through arrangement with the landlord or through the facility's own services.

(e) Standard: Licensure

§483.420(a) Standard: Protection of Clients' Rights

The facility must ensure the rights of all clients. Therefore, the facility must

Guidelines §483.420(a)

"Ensure" means that the facility actively asserts the individual's rights and does not wait for him or her to claim a right. This obligation exists even when the individual is less than fully competent and requires that the facility is actively engaged in activities which result in the pro-active assertion of the individual's rights, e.g., guardianship, advocacy, training programs, use of

specially constituted committee, etc.

§483.410(e) Standard: Licensure

W101

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.410(e) The facility must be licensed under applicable State and local law.

Guidance §483.410(e)

The facility has a current, valid State license when required under State law.

W122

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420 Condition of participation: Client protections

(a) Standard: Protection of clients' rights

§483.420(a) The facility must ensure the rights of all clients. Therefore the facility must

Guidance §483.420(a)

The facility must ensure the client's rights and does not wait for him or her to claim a right. This obligation exists even when the client is less than fully competent and requires that the facility is actively engaged in activities which result in the protection of the client's rights, advocacy for individual clients who have no family or an inactive family, and training programs for clients and staff on the understanding and protection of client rights.

W123

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(1) Inform each client, parent (if the client is a minor), or legal guardian, of the client's rights and the rules of the facility;

Guidance §483.420(a)(1)

The obligation to inform requires that the facility presents information on rights to the client, his or her family or his or her legal guardian in a manner and form which they can understand. In most instances, family means parent. However, in those instances where parents are deceased or choose not to be active in the client's life and there is another family member who does wish to be active, but is not the legal guardian, this family member should be informed of the client's rights. Printed materials should be provided in understandable terms and provided in the language necessary to ensure understanding. Specialized methods, as indicated, should be provided for communication with clients, families or legal guardians with hearing or vision impairment.

Pro-active assertion of client rights includes, but is not limited to:

- Signed evidence that the client, his or her family and/or his or her legal guardian have been informed of the client's rights, and

- Evidence that the communication of these rights were provided at the client's level of comprehension, and in the language understandable to the client.

The obligation to inform also requires that the facility make some determination of whether the client and his or her family, or legal guardian understood the rights presented and made additional efforts to communicate the rights if the rights were not understood.

If the facility has written "rules of the facility", these rules must be communicated to the client, their family and or legal guardians at the time of admission and must not be in conflict with any of the rights listed in 42 CFR 483.420 (a) (1-13).

W124

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(2) Inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment;

Guidance §483.420(a)(2)

Clients, their families or legal guardians are promptly informed of any change in the client's medical or behavioral needs that requires immediate alteration to programmatic or medical intervention. Promptly is defined by the level of severity of the alteration. In each case, they must also be informed of the attendant risks of any recommended treatments or interventions and of their right to refuse treatment, training or services.

If parents or legal guardians wish for other members of the client's family to be informed of such changes, they must put this permission in writing.

The communication of this information must be provided in the manner and language understood by the client or their family or legal guardian (language boards, sign language, etc.).

The term "attendant risks of treatment" describes the risk vs. risk and risk vs. benefit associated with the treatment. These risks include possible side effects, other complications from treatments including medical and drug therapy, unintended consequences of treatment, other behavioral or psychological ramifications arising from treatment, etc.

The facility actively attempts to engage clients who refuse to participate in active treatment. While the regulation recognizes the client's right to refuse treatment, persistent refusal that impacts the health and safety of the client and/or others, or the ability to provide overall active treatment, may result in facility's consideration of alternative placements for the client. It is expected, however, that the facility has assessed the reason for refusal, and developed and implemented all possible interventions to engage the client in active treatment programs prior to referring the client to another therapeutic setting.

A client, his or her family member, or legal guardian who refuses a particular treatment (e.g., a behavior control, seizure control medication or a particular intervention strategy) must be offered information about acceptable alternatives to the treatment, if acceptable alternatives are available. The client's preference about alternatives should be elicited and considered in deciding on the course of treatment. If the client, family member, or legal guardian also refuses the alternative treatment, or if no alternative exists to the treatment refused, the facility must consider the effect this refusal may have on other clients, the client himself or herself, and if they can continue to provide services to the client consistent with these regulations.

If the facility is unable to provide services to a client due to consistent refusal to participate, they must weigh all options including an involuntary discharge. Involuntary discharge must be for good cause (see 483.440(b)(4)(i)).

When a client is considered for participation in experimental research the client, his/her family and/or legal guardian must be fully informed of the nature of the experiment (e.g., what medications or physical interventions will be utilized, the length of the research, any possible side effects and how the information from the research will be utilized). Information regarding the possible consequences of participating or not participating must be provided to the client, family member or legal guardian. The written consent of the client, his/her family or legal guardian must be received prior to participation. For a client who is a minor or who has been adjudicated as incompetent, the written informed consent of the parents of the minor or the legal guardian is required. The signed, informed consent documentation must be in compliance with HHS Guidelines for Research Involving Human Subjects. The signed consent must also include a clear discussion of what treatments will be included in the research, the time limits for the research and should clearly inform the client, family member or legal guardian that the client may end participation at any time without fear of recrimination. If the research protocol indicates that clients receive compensation, then clients are compensated per the protocol.

Any research must be reviewed and approved by the Specially Constituted Committee. See W263.

W125

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process;

Guidance §483.420(a)(3)

To the extent that a client is able, choices are made on his/her own. Each client has autonomy of decision making and choice.

They are free to move about without limitations imposed due to staff preferences or staff convenience.

Clients are not restricted without due cause or due process.

To the extent that the client is able to make decisions for him or herself, it is inappropriate to delegate the person's right to others (e.g. parents, family members, etc.).

The facility has an obligation to assure client health and safety and must balance that obligation with the rights of clients.

If the facility has implemented a restriction, the following should be in place:

- An assessment supporting the need for the restriction;
- An individualized behavior plan to reduce the need for the restriction has been developed and implemented;
- A written informed consent for the behavior plan which includes the restriction;
- Approval of the Specially Constituted Committee; and
- Monitoring by the Committee of the progress of the training program, designed to reduce and eventually eliminate the restriction.

Clients, families, and legal guardians have the right to register a complaint with the facility and the State Survey Agency. If so, the facility must respond promptly and appropriately. The facility must ensure protection of the client from any form of reprisal or intimidation as a result of a complaint or grievance reported by the client, family, or legal guardian.

Issues involving the exercise of constitutional rights such as voting should be addressed as a component of the IPP when the Interdisciplinary Team (IDT) determines a need for training. Clients who have been adjudged to need guardianship or have been assessed as needing assistance to advocate for themselves should receive assistance or support so they may exercise their rights as citizens of the United States.

W126

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities;

Guidance §483.420(a)(4)

The regulation is clear that in those cases where a client already possesses the skills necessary to independently manage their own financial affairs, the facility will allow the client to continue to do so. Formal training in financial management must be provided for all other clients in the facility to the extent of their capabilities. The regulation places the responsibility for determining the extent of the client's capabilities in this matter upon an assessment and interdisciplinary process within the facility.

To reach a determination as to whether a money management program is appropriate, the facility IDT uses the comprehensive functional assessment (CFA) to evaluate the ability of each client to participate in such a program. Under 42 C.F.R. 483.440(c)(3), the team evaluation must establish, through documentation, that the IDT considers all of the objective data within the assessment in reaching their determination, especially the identification of client skills which can be used across training programs. Examples of assessment findings that may be considered by the IDT include skills that can be cross-utilized in training programs such as:

1. Fine motor coordination;

2. The ability to make choices;
3. The ability to identify preferences; and
4. Cognitive abilities including tracking, attention span, communication, and the client's ability to understand the cause and effect. (The client understands of cause and effect is significant in the determination.)

Money management includes a broad spectrum of programs with varying levels of participation by the client ranging from the use of choice in money expenditures, to an understanding of the concept of money, and ultimately to actual money handling and budgeting. The IDT must not conclude that a money management program is inappropriate based solely upon the level of intellectual or physical disability of the client.

The CFA must be reviewed at least annually per 42 C.F.R.483.440(f)(2). As a part of this annual review, a client's ability to participate in money management will also be reviewed. The annual review should always include an update to the CFA and take into consideration any changes in the client's circumstances since the last IPP. The need for a formal money management program must be addressed in every client's IPP by the IDT on an annual basis.

The determination of the appropriateness of a formal money management program is made by the IDT and must be based upon a CFA. The IDT discussions resulting in that determination must be established through documentation in the client's IPP.

W127

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

Guidance §483.420(a)(5)

Identification of patterns or isolated instances of physical, verbal, sexual or psychological abuse or punishment without prompt identification and corrective action by the facility would result in a non-compliance determination for this Standard and Condition level non-compliance.

The facility must develop and implement systems that protect clients from all forms of abuse, neglect, or mistreatment, including client to client abuse, neglect, or mistreatment.

a. The facility is expected to ensure that staff possess and demonstrate needed competencies to effectively and appropriately interact with clients.

b. The facility must monitor to assure that systems are effectively implemented and the facility takes immediate actions to address circumstances where abuse, neglect, or mistreatment have occurred and prevent reoccurrence.

c. The facility must be organized in such a manner as to proactively assure clients are free from any threat to their physical and psychological health and safety.

d. The facility must act to prevent physical, verbal, sexual or psychological abuse.

If the facility fails to implement appropriate corrective action, the potential of additional threats to the clients remain at the facility.

"Threat", for the purposes of this guideline, is considered any condition/situation which could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of clients, or in their death.

"Abuse", for the purposes of this guideline, is the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or personal anguish.

Physical abuse refers to any action intended to cause physical harm or pain, trauma or bodily harm (e.g., hitting, slapping, punching, kicking, pinching, etc.). It includes the use of corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment.

Verbal abuse refers to any use of insulting, demeaning, disrespectful, oral, written or gestured language directed towards and in the presence of the client. Psychological abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation, sexual

coercion and intimidation (e.g. living in fear in one's own home). Since many clients residing in ICF/IIDs are unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, would also be viewed as abusive by the client residing in the ICF/IID, regardless of that client's perceived ability to comprehend the nature of the incident.

Sexual abuse includes any incident where a client is coerced or manipulated to participate in any form of sexual activity for which the client did not give affirmative permission (or gave affirmative permission without the attendant understanding required to give permission) or sexual assault against a client who is unable to defend him/herself.

The facility must implement, through policies, oversight and training, safeguards to ensure that clients are not subjected to abuse by anyone including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the client, family members or legal guardians, friends, other clients, or the general public.

The facility must take whatever action is necessary to protect the clients residing there. For example, if a facility is forced by court order or arbitration rulings to retain or reinstate an employee found to be abusive, the facility must take measures to protect the clients of the facility (such as assigning the employee to an area where there is no contact with clients).

W128

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

Guidance §483.420(a)(6)

The facility must implement an aggressive active treatment program, which includes appropriate replacement behaviors, to address the reduction/elimination of physical restraints and drugs to manage behaviors.

For purposes of this Guideline drugs to manage behavior are "unnecessary" if there is evidence the drugs are being used:

- In excessive dose (duplicate therapy);
- For excessive duration;
- Not monitored adequately;
- Without adequate indications for its use;
- With adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combination of the reasons listed above.

The long term use of a drug/physical restraint to manage behavior combined with one or more of the following may indicate unnecessary use:

- The client's developmental and/or behavioral needs are not being met and the appropriateness of less restrictive approaches to manage inappropriate behaviors should be questioned;
- Staff behavior may be prompting behaviors in clients which result in the chronic use of physical restraints and drugs to control behavior;
- Staff may have inadequate training and/or experience to provide active treatment and employ preventive measures;

Restraints applied for behaviors when less restrictive measures have not been tried or have been tried and found to be just as effective.

W129

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.420(a)(7) Provide each client with the opportunity for personal privacy and

Guidance §483.420(a)(7)

The facility must provide areas within the living area in which the client can have time to be alone, when appropriate, and to have privacy (their conversations cannot be overheard) for personal interactions/activities. There should be a location where the client can meet privately with family and/or friends and a telephone available where he/she can hold private telephone conversations.

Personal privacy for clients also includes the right to have certain personal information about them kept confidential. Staff should not discuss one client in front of others (clients, parents, legal guardians, visitors, etc.) and should not post personal information about clients in areas where other clients, families and the public can read the information.

Video/audio taping or live feed must not be used in place of or for the convenience of staff. The facility may install video/audio equipment for purposes of observing client/staff interactions. Video/audio equipment may only be installed in common areas (in no case may videotaping or live feed be done in bathrooms or areas where private visits are conducted). The clients, families and/or legal guardians of the clients residing in the areas where videotaping or live feed will occur must give informed consent for the installation and must be assured that no personal privacy will be jeopardized. The use of the equipment must be presented at and approved by the specially constituted committee for the facility prior to the installation of video or audio devices.

Motion sensors should not be considered cameras.

W130

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(7) ensure privacy during treatment and care of personal needs;

Guidance §483.420(a)(7)

Clients must be provided privacy during personal hygiene activities (e.g., toileting, bathing, dressing) and during medical/nursing treatments that require exposure of one's body.

People not involved in the care of the client should not be present without their consent while they are being examined or treated.

Whenever possible, the facility should be sensitive to clients' preferences for same sex care in private situations.

W131

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(8) Ensure that clients are not compelled to perform services for the facility and

Guidance §483.420(a)(8)

Clients are not required or expected to be a source of labor for a facility. The client must not be required or expected to do productive work for the facility, other than appropriate care of one's own personal space or shared responsibilities for common areas.

W132

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(8) ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities;

Guidance §483.420(a)(8)

"Work", as used in the regulation, means any directed activity, or series of related activities which results in a benefit to the economy of the facility or in a contribution to its maintenance, or in the production of a salable product. In deciding whether a particular activity constitutes "work" as defined above, the key determinant is whether the facility would be required to hire additional full or part-time staff (or pay overtime to existing staff) to perform the service the client is asked to perform.

Clients volunteering to do real work that benefits the facility should give informed consent for such practices and understand that by providing employable services they are able to be

compensated. This does not preclude a client from helping out a friend or being kind to others. Self-care activities related to the care of one's own person or property are not considered "work" for purposes of compensation.

In general, participation in any household task which promotes greater independent functioning and assists the client to prepare for less restrictive setting (and which the client has not yet learned) is permitted as long as tasks are included in the IPP in written behavioral and measurable terms. This participation must be supervised, and indices of performance should be available. No task may be performed for the convenience of staff (e.g., supervising clients, running personal errands).

"Compensated" means the client is provided with money or other forms of negotiable compensation for work (including work performed in an occupational training program) and such compensation is to be used at the client's discretion.

Prevailing wage refers to the wage paid to non-disabled workers in nearby industry or the surrounding community for essentially the same type, quality and quantity of work or work requiring comparable skills. A client who works in the facility must be paid at least the prevailing minimum wage, unless an appropriate certificate has been obtained by the facility in accordance with current regulations and guidelines issued under the Fair Labor Standards Act, as amended.

Any client performing "work", as defined above, must be compensated in direct proportion to his or her output. The facility should utilize Department of Labor and/or Department of Vocational Rehabilitation formulas and techniques for determining rate of pay. A client's pay is not dependent on the production of other clients when he or she works in a group.

When the client's active treatment program includes assignment to occupational or vocational training or work, specific work objectives of anticipated progress should be included in the IPP along with reasons for the assignments. If the training of clients on particular occupational activities or functions involves "real work" to be accomplished for the facility, the clients must be compensated based on ability. For example, if in the process of work training activities which involve learning to clean a floor, the floor for a particular building is cleaned and does not require further janitorial cleanup, then the client must be compensated for this activity at the prevailing wage.

W133

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice,

Guidance §483.420(a)(9)

Privacy must be provided for both face-to-face interactions and electronic interactions.

The facility must provide opportunities for the client to communicate, through regular mail, telephone and/or electronic mail and meet in private with persons of their choice (e.g., friends from the community, family members, and advocates). There may be instances where legal guardians override the wishes of the client. In these instances, the facility should be actively working with the legal guardian and the client to reach the maximum agreeable level of interaction for the client.

Space must be provided for clients to receive visitors in reasonable comfort and privacy.

W134

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(9) and to send and receive unopened mail;

Guidance §483.420(a)(9)

Clients must be provided the opportunity to send/receive all types of mail unopened and read the contents themselves if able. If the staff has to open and read mail to the client, this should be done in a private place allowing the client as much participation as possible.

Clients who have their own electronic equipment must be provided the opportunity to send, receive, and read electronic mail with privacy.

W135

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans;

Guidance §483.420(a)(10)

Any restriction of telephone access must be explained in the IPP with a plan to advance the client's access. For persons with hearing loss who could benefit, Text Telephone (TTY) services or other accommodations should be provided.

As with any other rights restriction, the restriction must be addressed in the IPP, written informed consent obtained, and the plan must be reviewed and approved by the specially constituted committee.

W136

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(11) Ensure clients the opportunity to participate in social, religious, and community group activities;

Guidance §483.420(a)(11)

Clients should be offered the opportunity to participate in various types of activities in the community (e.g., going to grocery stores, hair salons, restaurants, places of worship, pharmacies, community meetings and events) based on their interests and choices. The facility must make accommodations for physical issues such as hearing impairment and mobility limitations. In addition, clients should be taught the applicable skills to participate in their choice of activities to the fullest extent of their abilities.

It is not acceptable for all client activities to be provided in the facility.

When a client is identified to be on restriction from community integration opportunities, interview clients, families, legal guardians and staff to determine if due process was afforded for this restriction and whether the restriction is included in the IPP.

In the event of a court placement that restricts community access, due process does not apply.

There should be evidence that the facility assists and encourages all clients, regardless of functioning levels, to have input into the decisions on community integration activities. It is not acceptable to require clients to attend unwanted activities due to staffing considerations.

W137

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and

Guidance §483.420(a)(12)

Clients should have personal possessions and clothing which meet their needs, interests and choices.

Clients should have free access to their own possessions and clothing. When considering whether a client has free access to their personal possessions and clothing, ensure that physical limitations have been addressed.

Clients who are unable to access and use personal possessions and clothing appropriately are involved in programs to learn the necessary skills to do so.

In situations where the behavior of one or more clients in a living area prevents free access to personal possessions for each client, the facility must develop IPPs for the client with disruptive behavior. The facility must also ensure that during the implementation of this program plan

that none of the other clients have their rights infringed upon. Clients should not be without personal possessions because of the behavior of others with whom they live.

All client possessions, regardless of their apparent value to others are treated with respect for what they may represent to the client. Where those choices include socially stigmatizing materials, the facility should provide learning opportunities to make more socially appropriate choices. The facility should encourage clients to use or display possessions of his or her choice in a culturally normative manner.

If a method for identifying personal effects is used, it should be inconspicuous and in a manner that will assist the client to identify them.

"Appropriate" clothing means a supply of clothing that is sufficient, in good repair, accounts for a variety of occasions and seasons, and appropriate to age, size, gender, and level of activity. Modification or adaptation of clothing fasteners should be considered based on the needs of a client with a physical disability to become more independent.

As appropriate, each client's active treatment program maximizes opportunities for choice and self-direction with regard to choosing and shopping for clothing which enhances his or her appearance, and selecting daily clothing in accordance with age, sex and cultural norms.

Clients are permitted to keep personal clothing and possessions for their use while in the facility. Determine how the facility both ensures the safety of personal possessions while at the same time providing client access to them when the client chooses.

Clients are provided the opportunity, encouraged, and trained to use age-appropriate materials. The term "age-appropriate" refers to anything that reinforces recognition of the client as a person of a certain chronological age. Clients who choose to keep items traditionally used by children such as dolls or model cars are not an automatic citation. There must be evidence the facility is encouraging the client to use these possessions in a socially appropriate, non-stigmatizing manner. The facility's environment must be furnished with materials and activities that will enhance opportunities for growth.

W138

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(12) ensure that each client is dressed in his or her own clothing each day; and

Guidance §483.420(a)(12)

Clothing such as pajamas, underwear, socks, hats, mittens/gloves, and coats should be the personal property of the client and not considered "stock" items. There should be no communal clothes. If clients are unable to do their own personal laundry the facility must ensure that clothing is properly laundered and returned to the appropriate client.

The staff of the facility should ensure that clients dress appropriately for the season and the occasion by implementing training programs or guidance for the client as indicated.

W139

§483.420(a)(13) Permit a husband and wife who both reside in the facility to share a room.

§483.420(b) Standard: Client Finances

(b)(1) The facility must establish and maintain a system that

W140

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(b)(1)(i) Assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients; and

Guidance §483.420(b)(1)(i)

All purchases made using client personal funds must be itemized in the accounting record with the exception of pocket money. Pocket money given to the client does not need to be itemized. Pocket money should be considered a nominal amount of five dollars or less at a time. Funds provided by the facility and dispensed to a client as part of a program to train the client in money management, and funds that are not entrusted to the facility (e.g., funds paid directly to the client's representative payee) do not require accounting.

In those instances where a legal guardian or the individual client is in control of their personal funds, no accounting is necessary by the facility.

W141

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(b)(1)(ii) Precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

Guidance §483.420(b)(1)(ii)

If the facility elects to pool clients' funds in an interest-bearing account, including common trust accounts, it is expected to know the interest separately accrued by each client, as part of its required accounting of funds. Interest accumulated to a client's account belongs to the client, not the facility.

W142

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(b)(2) The client's financial record must be available on request to the client, parents (if the client is a minor) or legal guardian.

Guidance §483.420(b)(2)

Those persons having legal authority to access the accounting records for personal funds such as the client, parent, or legal guardians should be afforded access upon request unless there is documented rationale for withholding the information.

It is not necessary that a facility furnish an annual financial statement to the client, or the client's parent or legal guardian, since the facility is already required to make the financial record available at any time upon request. The client, parent, and/or legal guardian, in turn, is free to choose to make the financial record available to anyone else.

(c) Standard: Communication with clients, parents, and guardians.

§483.420(c)

The Facility must –

W143

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(c)(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate;

Guidance §483.420(c)(1)

The facility must maintain an on-going effort to communicate with parents, family members and/or legal guardians regarding the implementation of active treatment programs for the client. The facility encourages and engages parents, family members and legal guardians in the continued implementation of active treatment programs even while spending time outside of the facility setting.

"Unobtainable", for the purposes of this guideline, means that the facility has made a good faith effort to seek parental or legal guardian participation in the process, even though the effort may ultimately be unsuccessful (for example, the parent may be impossible to locate or may prove unwilling or unable to participate).

"Inappropriate", for the purposes of this guideline, means that behavior of the parent or legal guardian could be disruptive or detrimental to the client's program outcome. In this case, determine what the facility has done to bring effective resolution to the problem.

W144

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(c)(2) Answer communications from clients' families and friends promptly and appropriately;

Guidance §483.420(c)(2)

It is reasonable to expect that the facility will provide at least an interim response to inquiries from the client's families and friends within 48 hours.

W145

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(c)(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate;

Guidance §483.420(c)(3)

Any limitations on visitors must be implemented as a result of IDT evaluation and discussion and be documented. This documentation should include evidence of approval from the specially constituted committee. Decisions to restrict a visitor for an individual client must be reviewed and re-evaluated each time the IPP is reviewed or at the client's request. Broad restrictions on visitors such as times of the day or certain days of the week are a violation of this requirement.

W146

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(c)(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy;

W147

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(c)(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations; and

Guidance §483.420(c)(5)

The facility should assist and encourage the client to communicate with their families or legal guardians concerning possible outside visits and vacations as frequently as possible. When the client does schedule a trip or vacation, the facility must ensure that all necessary preparation is completed to facilitate the departure.

The facility should not sponsor or allow clients to take a particular type of trip that would jeopardize their safety or health without consultation with parents/legal guardians and/or the IDT.

W148

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(c)(6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

Guidance §483.420(c)(6)

"Significant" incidents or changes in the client's condition include serious injury, unusual seizure activity, hospitalization, serious illness, accident, death, allegations of abuse, neglect, or mistreatment, unauthorized absence, or any notifications the parent or legal guardian's requests.

It is reasonable to expect the facility to contact the family or legal guardian of a client as soon as possible after an incident occurs, but no later than 24 hours after the incident. If notification is done via electronic mail, the facility must request a response from the e-mail recipient to confirm notification. Telephone notification must be accomplished by talking to the person directly. If a message is left, the facility must request a call back to confirm receipt of the notification.

Contact by letter may be utilized as follow up confirmation, but not be the initial, primary or sole mode of communication with the family or legal guardian.

If unable to contact the family or legal guardian, there should be evidence that the facility attempted to reach alternate emergency contacts.

Requests from clients who are their own guardian to limit notifications to their families must be honored.

(d) Standard: Staff treatment of clients.

W149

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

Guidance §483.420(d)(1)

The facility, through implementation of its policies, must set up a structure that screens and trains employees, protects clients and prevents, identifies, investigates and reports abuse, neglect and mistreatment of clients.

The policies must designate who (either by name or title) has the authority to act in the Administrator's absence and take any immediate corrective actions necessary to assure a client's safety such as removing a staff person from direct client contact.

"Mistreatment", for the purposes of this guideline, includes behavior or facility practices that result in any type of client exploitation such as financial, physical, sexual, or criminal. Mistreatment also refers to the use of behavioral management techniques outside of their use as approved by the specially constituted committee and facility policies and procedures.

"Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Staff failure to intervene appropriately to prevent self-injurious behavior may constitute neglect. Staff failure to implement facility safeguards, once client to client aggression is identified, may also constitute neglect.

Refer to W127 for definitions of abuse.

W150

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(d)(1)(i) Staff of the facility must not use physical, verbal, sexual or psychological abuse or punishment.

W151

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(d)(1)(ii) Staff must not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

W152

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(d)(1)(iii) The facility must prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

Guidance §483.420(d)(1)(iii)

The facility is required to screen potential employees for a prior employment history of child or client abuse, neglect or mistreatment, as well as for any conviction based on those offenses. The abuse, neglect or mistreatment must have been directed toward a child or a client/resident/patient of a health care facility in order for the prohibition of employment to apply.

No one with a conviction or substantiated allegation of child or client abuse, neglect or mistreatment regardless of employment date, is employed by the facility. This requirement also applies to acts of abuse, neglect or mistreatment committed by a current ICF/IID employee outside the jurisdiction of the ICF/IID (e.g., in the community or in another health care facility). The facility must follow state guidelines or requirements for background checks to assure that they make every effort to check new employee's background.

Where the facility has terminated an employee based upon confirmation that abuse, neglect or mistreatment occurred during the employee's performance, and the termination decision was overturned by either arbitration finding or a court finding, the employee must be returned to a position which does not involve direct contact between that employee and clients of the facility.

A person who abused a resident in a nursing facility, and as a result, is barred from employment in the nursing home setting would also be prohibited from employment in the ICF/IID. While facilities are not required to periodically screen existing employees, if the facility becomes aware that such action has been taken against an employee, the facility is required to prohibit continued employment. This is also true of any conviction in a court of law for child, elder, or client (resident, patient) abuse, neglect or mistreatment. Therefore, conviction for abusing one's own child is also a reason employment would be prohibited.

W153

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

Guidance §483.420(d)(2)

Injuries of unknown source that give rise to a suspicion that they may be the result of abuse or neglect, should be reported immediately.

An injury should be reported as an "injury of unknown source" when:

- The source of the injury was not witnessed by any person and the source of the injury could not be explained by the client; and

- The injury raises suspicions of possible abuse or neglect because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

It is important to note that members of the ICF/IID population are a mobile population and lead active lives. Therefore, they experience normal day-to-day bumps and minor abrasions as they go about their lives. These minor occurrences which are not of serious consequence to the individual and do not present as a suspicious or repetitive injury (as discussed above) should be recorded by the facility staff once they are aware of them and follow-up should be conducted as indicated. For injuries that do not rise to the level of reportable "injuries of unknown source", the facility should follow its policies and procedures for incident recording, investigation, and tracking.

The facility must immediately report any suspicious injuries of unknown source and all allegations of mistreatment, neglect or abuse to a client residing in the facility regardless of who is the alleged perpetrator (e.g., facility staff, parents, legal guardians, volunteer staff from outside agencies serving the client, neighbors, or other clients, etc.).

If state law requires reporting to an agency or entity other than the administrator, the Centers for Medicare & Medicaid Services (CMS) expects the administrator to be notified as well, in order to ensure facility response to promptly safeguard the client(s).

For the purposes of this regulation "immediately" means there should be no delay between staff awareness of the occurrence and reporting to the administrator or other officials in accordance with State law unless the situation is unstable in which case reporting should occur as soon as the safety of all clients is assured.

W154

(Rev. 162, Issued: 10-14-16, Effective: 10-14-16, Implementation: 10-14-16)

§483.430(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated; and

Guidance §483.430(d)(3)

In the absence of any pre-survey information that would indicate the need for a more thorough review, the surveyors review 5 percent of the total client incidents and associated investigative reports of all alleged violations of abuse, neglect or mistreatment, as well as injuries of unknown source for the last three (3) months (but no less than 10).

Investigative reports are completed as indicated for all allegations.

A thorough investigation includes at a minimum:

- The collection of all interviews, statements, physical evidence and any pertinent maps, pictures or diagrams;
- Review of all information related to the allegation;
- Resolution of any discrepancies;
- Summary of conclusions; and
- Recommendations for action both to safeguard all the clients during the investigation and after the completion of the report.

If patterns of possible abuse, neglect, mistreatment or injuries of unknown source are identified during the review, or the facility incident report logs for the past three (3) months indicate an

extremely high incident rate, then a full review of all alleged violations of abuse, neglect or mistreatment, as well as injuries of unknown source for the past three (3) months should be completed.

W155

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(d)(3) must prevent further potential abuse while the investigation is in progress.

Guidance §483.420(d)(3)

The facility must take all measures necessary to protect the client, including removal of the staff from working with the client if indicated. See W154.

W156

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident and,

Guidance §483.420(d)(4)

Some states require that allegations of abuse must be reported to the police. A police investigation may take longer than five (5) working days. Their investigation does not change the requirement that the facility must complete an internal investigation report of findings within the five day timeframe. When outside authorities are involved, the facility will still be required to complete their investigation within five days to the extent authorized by such entities. "Working days" means Monday through Friday, excluding state and Federal holidays.

W157

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(d)(4) if the alleged violation is verified, appropriate corrective action must be taken.

Guidance §483.420(d)(4)

The facility is required to ensure that clients residing in the facility are not subjected to physical, verbal, sexual or psychological abuse or punishment.

Appropriate corrective action is required for findings of abuse, neglect or mistreatment by other clients residing in the facility, staff of outside agencies, parents or any other person, and for injuries to clients resulting from controllable environmental factors.

If the facility receives allegations of abuse, neglect, or mistreatment of a client during out of facility visits with their family, they must report these allegations to the appropriate state authority for investigation. The facility does not have to conduct an internal investigation regarding the alleged violation.

Appropriate corrective action is defined as that action which is reasonably likely to prevent the abuse, neglect, mistreatment or injury from recurring.

This regulation does not require staff termination as the only appropriate corrective action.

The corrective action imposed by the facility is commensurate with the violation.

When a facility is forced to re-hire a staff person, determined by the facility investigation to have been responsible for abuse, neglect, or mistreatment, the facility continues to be responsible for ensuring the health and safety of the clients, and ensures that those staff members do not work directly with clients.

W158

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430 Condition of participation: Facility staffing.

(a) Standard: Qualified intellectual disability professional

W159

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who –

Guidance §483.430(a)

The position of qualified intellectual disability professional (QIDP) is unique to the ICF/IID program. This position can be central to the overall responsiveness and effectiveness of an active treatment program. Whether a supervisory or non-supervisory position, the QIDP is responsible to:

- Orchestrate all facets of the active treatment effort, including the IDT creation of relevant IPPs tailored to meet individual client needs;
- Effectively coordinate internal and external program services and supports to facilitate the acquisition of client skills and adaptive behaviors; and
- Promote competent interactions of residential staff with clients in program implementation and behavior management.

Breakdowns in the provision of needed services does not automatically equate with deficient practice with QIDP regulations. Non-compliance with QIDP regulations exist where the facility has failed to provide a QIDP or sufficient numbers of QIDPs to effectively perform these required functions or the QIDP(s) has failed to assertively attempt to integrate, coordinate and/or monitor each client's active treatment program.

Elements of integrating, coordinating and monitoring active treatment programs include:

- Routinely observing clients across settings in program areas to assess effectiveness of program implementation and consistency of training effort to determine effectiveness of IPPs and making timely modifications to facilitate achieving desired skills or goals.

- Routinely interacting with program staff across settings to assist in determining the effectiveness and continued relevance of program plans in meeting identified client needs.

- Determining the need for program revision based on client performance.

- Identifying inconsistencies in training approaches or programs not being implemented as written and facilitating the resolution of these inconsistencies.

- Assures follow-up occurs for any recommendation for services, equipment or programs so that needed services and supplies are provided in a timely manner to meet the client's needs.

The number of QIDPs will vary depending on such factors as the number of clients the facility serves, the complexity of needs manifested by these clients, the number, qualifications and competencies of additional professional staff members, and whether or not other duties are assigned to the QIDP function.

The QIDP function may not be delegated to other employees even though the QIDP co-signs their work.

W160

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(a)(1) Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and

Guidance §483.430(a)(1)

"Experience" means providing professional or direct services, either paid or volunteer, in a setting that serves persons with intellectual disabilities. The experience working directly with persons with intellectual or other developmental disabilities can be obtained prior to or after obtaining the qualifying degree or credentials.

§483.430(a)(2) Is one of the following:

W161

(a)(2)(i) A doctor of medicine osteopathy.

W162

(a)(2)(ii) A registered nurse.

W163

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(a)(2)(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)(5) of this section

Guidance §483.430(a)(2)(iii)

The individual must have at least a bachelor's degree in one of the professions listed in §483.430 (b)(5)(i-xi).

(b) Standard: Professional program services

W164

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430 (b)(1) Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.

Guidance §483.430 (b)(1)

The effectiveness of the active treatment effort is dependent on a facility's assembly of a competent team of professional program staff, with knowledge of contemporary care practices in intellectual disabilities specific to their field of expertise, that work cooperatively as members of an IDT. The facility is responsible for the acquisition of professional staff necessary to provide direct and indirect professional services to meet client needs.

Professional program services are those services that meet the needs identified by a client's CFA that must be provided by a member of a vocation founded upon specialized education/training.

Professional staff services also include on-going monitoring of the effectiveness of programs and plans developed by professional staff but implemented by non -professional staff.

Indirect professional staff services also include on-going, technical support to staff implementing these programs as well as timely assessment of the need for modification of the program with appropriate communication to the QIDP and IDT.

The needs identified in the initial CFA, as required in §483.440(c)(3)(v), should guide the team in deciding if a particular professional's involvement is necessary and, if so, to what extent professional involvement must continue on a direct or indirect basis.

Since such needed professional expertise may fall within the purview of multiple professional disciplines, based on overlapping training and experience, determine if the facility's delivery of professional services is adequate by the extent to which clients' needs are aggressively and competently addressed. Some examples in which professional expertise may overlap include, but are not limited to:

- Physical development and health: nurse, dietitian, pharmacist.

- Nutritional status: nurse, nutritionist or dietitian.

- Sensorimotor development: educators, recreation therapists, and occupational therapist, physical therapist.

- Affective (emotional) development: special educators, social workers, psychologists, psychiatrists, mental health counselors, rehabilitation counselors, behavior therapists, behavior management specialists, behavior analyst, and medical staff.

- Speech and language (communication) development: speech-language pathologists, special educators for people who are deaf or hearing impaired, and medical staff.

- Auditory functioning: audiologists (basic or comprehensive audiologic assessment and use of amplification equipment); speech-language pathologists (like audiologists, may perform aural rehabilitation); special educators for clients who are hearing impaired and medical staff.

- Cognitive development: teachers (if required by law, e.g., school aged children, or if pursuit of GED is indicated), behavior analysts, psychologists, speech-language pathologists.

- Vocational development: occupational therapists, vocational rehabilitation counselors, or other work specialists (if development of specific vocational skills or work placement is indicated).

- Social Development: teachers, professional recreation staff, social workers, behavior analysts, psychologists (specialized training needs for social skill development).

Adaptive behaviors or independent living skills: special educators, occupational therapists, behavior analysts, and medical staff.

W165

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(1) Professional program staff must work directly with clients

Guidance §483.430(b)(1)

Examples of professional staff working directly with clients include: performing professional assessments of clients, provision of direct support and services and periodic monitoring by the professional of the client working on the program. The amount and degree of direct care that professionals must provide will depend on the needs of the client and the ability of other staff to effectively work with clients on a day-to-day basis.

For those services that must be provided by a professional due to either law, licensure or registration, the client receives the services directly from the professional. Professionals may deliver services through the supervision and direction of subordinates where provided by law.

W166

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(1) and with paraprofessional, nonprofessional and other professional program staff who work with clients.

Guidance §483.430(b)(1)

Paraprofessionals are persons in various occupational fields who are trained to assist professionals but are themselves not licensed at the professional level.

Examples of "working with" these other staff may include, but not be limited to:

- Modeling the correct technique for interacting with clients or implementing a specific program objective.

- Designing residential activity programs and teaching staff how to implement them.
- Conducting classes on discipline specific topics.
- Answering questions of staff related to program implementation or specific behavioral management issues.
- Monitoring active treatment areas to identify program implementation or staff-client interaction issues.

W167

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(2) The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

Guidance §483.430(b)(2)

There should be sufficient professional staff in the facility to ensure that:

- needed assessments by professionals are completed timely;
- direct professional services are provided when indicated;
- clients are receiving interventions as specified in the IPP;
- client outcomes are being monitored by the professional;
- assessments and outcomes are being communicated to the IDT; and
- professional staff are available to consult with team members when needed.

W168

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(3) Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

Guidance §483.430(b)(3)

When a professional does an assessment and determines there are client needs which become incorporated into the IPP, with a current prioritized objective, the professional should actively participate on the IDT. This participation may be through written reports or verbally while attending the IPP meeting or participating via telephone or other electronic means, to provide team members with the opportunity to review and discuss information and recommendations relevant to the client's needs, and to reach decisions as a team, rather than individually, on how best to address those needs.

W169

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(4) Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

Guidance §483.430(b)(4)

Professional program staff provides various types of training to staff as indicated by the IPP and IDT.

Formal training: a specific training done at the time a program is implemented or updated by the professional, with all staff who works with the client.

Informal training: when the professional observes the staff not correctly implementing a program, the professional provides informal guidance on correct implementation.

Training on programs that apply to multiple clients: when a particular program applies to several clients in a facility, a professional may provide training to several staff on a particular topic that applies to multiple clients (such as safe transfer techniques).

Professional staff of the facility should participate in ongoing training such as conferences and workshops to maintain current standards of practice in the field of intellectual and developmental disabilities as required by their professional licensure or certification.

W170

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5) Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. Those professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements, specified in §483.410(b), must meet the following qualifications:

W171

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(i) To be designated as an occupational therapist, an individual must be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

Guidance §483.430(b)(5)(i)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

The American Occupational Therapy Association is now known as the National Board for Certified Occupational Therapists (NBCOT). There is no "other comparable body."

Eligibility means the professional must have completed a degree in their designated field,

completed all field work required for a license, must meet licensure requirements in the state they are practicing in, and are registered or certified nationally as applicable.

W172

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(ii) To be designated as an occupational therapy assistant, an individual must be eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

Guidance §483.430(b)(5)(ii)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

The American Occupational Therapy Association is now known as the National Board for Certified Occupational Therapists (NBCOT). There is no "other comparable body."

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in state they are practicing in, and are registered or certified nationally as applicable.

W173

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(iii) To be designated as a physical therapist, an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

Guidance §483.430(b)(5)(iii)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated filed and are eligible to sit for the national exam.

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in state they are practicing in, and are registered or certified nationally as applicable.

W174

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(iv) To be designated as a physical therapy assistant, an individual must be eligible for registration by the American Physical Therapy Association or be a graduate of a two year college-level program approved by the American Physical Therapy Association or another comparable body.

Guidance §483.430(b)(5)(iv)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated filed and are eligible to sit for the national exam.

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in State they are practicing in, and are registered or certified nationally as applicable.

W175

§483.430(b)(5)(v) To be designated as a psychologist, an individual must have at least a master's degree in psychology from an accredited school.

§483.430(b)(5)(vi) To be designated as a social worker, an individual must--

W176

§483.430(b)(5)(vi)(A) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or

§483.430(b)(5)(vi)(B) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

§483.430(b)(5)(vii) To be designated as a speech-language pathologist or audiologist, an individual must--

W177

§483.430(b)(5)(vii)(A) Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body; or

§483.430(b)(5)(vii)(B) Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

W178

§483.430(b)(5)(viii) To be designated as a professional recreation staff member an individual must have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

W179

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(ix) To be designated as a professional dietitian, an individual must be eligible for registration by the American Dietetics Association.

Guidance §483.430(b)(5)(ix)

If a professional is not nationally registered as a dietician, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

W180

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(x) To be designated as a human services professional an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

Guidance §483.430(b)(5)(x)

Human Services is a diverse field focused on improving the quality of life of clients in communities in which the professional serves. A human services professional works directly with the population being served. Surveyors should see evidence that a human service professional has a bachelor's degree at a minimum.

W181

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(xi) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of paragraph (b)(5)(i) through (x) of this section are not required-

(A) Except for qualified intellectual disability professionals;

(B) Except for the requirements of paragraph (b)(2) of this section concerning the facility's provision of enough qualified professional program staff; and

(C) Unless otherwise specified by State licensure and certification requirements.

Guidance §483.430(b)(5)(xi)

An individual client program may not require that professional staff perform all of the services as outlined by the IPP (e.g. the direct support staff may be trained by the professional to safely and effectively carry out the designed program), however, any specialized therapy must involve evaluation, program development, and re-assessment by the appropriate professional at periodic intervals.

(c) Standard: Facility staffing

W182

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(c)(1) The facility must not depend upon clients or volunteers to perform direct care services for the facility.

Guidance §483.430(c)(1)

The facility must have sufficient staff to provide needed care and services without the use of volunteers or enlisting the help of clients residing in the facility to perform the duties normally performed by facility staff.

The facility may not rely on volunteers in lieu of paid staff to fill required staff positions and perform direct care services. Volunteers are permissible, but must be in addition to the number of paid staff required to carry out a function. Volunteers should have an orientation to the policies and procedures of the facility and oversight is required by facility staff.

W183

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(c)(2) There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing- -

(i) Clients for whom a physician has ordered a medical care plan;

(ii) Clients who are aggressive, assaultive or security risks;

(iii) More than 16 clients; or

(iv) Fewer than 16 clients within a multi-unit building.

Guidance §483.430(c)(2)

Indicators of staff not being awake in relation to the occurrence of incidents, accidents, and injuries may include, but are not limited to:

- incidents of unplanned client absences;
- untimely reaction to a medical emergency;
- injuries from client to client aggression; or
- a pattern of injuries of unknown origin.

If even one client meets 483.430(c)(2)(i-ii) then staff must be awake on a 24-hour basis.

A client has a medical care plan when an acute or chronic occurrence requires clinical assessment and monitoring on a scheduled basis.

W184

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(c)(3) There must be a responsible direct care staff person on duty on a 24 hour basis (when clients are present) to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing- -

(i) Clients for whom a physician has not ordered a medical care plan;

(ii) Clients who are not aggressive, assaultive or security risks; and

(iii) Sixteen or fewer clients.

Guidance §483.430(c)(3)

At all times, there must be at least one staff person on-duty in the facility if even one client is present. For purposes of this provision, "on duty" staff need not be awake during normal sleeping hours, but do need to respond to injuries, illness, and emergencies promptly.

W185

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(c)(4) The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

Guidance §483.430(c)(4)

Direct care staff should not be performing support services (e.g., making beds, cooking, cleaning, etc.) independently which takes them away from client interaction and teaching. If support services in the house cannot be done jointly as chores between clients, as part of their training program, and the support staff, additional staff should be added to perform the chores. This does not include any staff chores done during client's sleeping hours.

"Support staff" include all personnel hired by the facility that are not either direct care staff or

professional staff. For example, support staff includes, but are not limited to, secretaries, clerks, housekeepers, maintenance and laundry personnel.

(d) Standard: Direct care residential living unit staff

W186

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(d)(1) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

Guidance §483.430(d)(1)

"Sufficient" means enough direct care staff to effectively implement the active treatment programs as defined in the IPP, to meet client needs, and to respond to emergencies, illness, or injuries.

Even though minimum ratios are defined at §483.430(d)(3), active treatment may require more staff than the minimums required ratios, therefore compliance should not be based on staffing ratios alone.

§483.430(d)(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

Guidance §483.430(d)(2)

"Direct care staff" are those personnel who are assigned to work directly with the clients providing support during activities of daily living and active treatment programs.

Professional staff who work with clients in a living unit on a periodic basis are not included in direct care staff ratios.

Supervisors of direct care staff can be counted only if they share in the actual work of the direct care of clients on a continuous basis (e.g. take client assignment).

Direct care supervisors whose principle assigned function is to supervise direct care staff may not be included in direct care staff ratios although they may occasionally provide direct services to clients.

Non-direct care staff supervisors whose principle assigned function is to supervise non-direct care staff may not be included in direct care staff ratios.

W187

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.430(d)(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients:

(i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2.

(ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4.

(iii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4.

Guidance §483.430(d)(3)

The minimum ratios in this standard indicate the **minimum** number of direct-care staff that must be present and on duty, 24 hours a day, 365 days a year, for each discrete living unit. For example, to calculate the minimum number of living unit staff that must be present and on duty in a discrete living unit serving 16 individuals with multiple disabilities: divide the number of individuals "16," by the number corresponding to the regulation "3.2," the result equals "5." Therefore, the facility must determine how many staff it must hire to ensure that at least 5 staff will be able to be present and on duty during the 24 hour period in which those individuals are present.

Using the living unit described above, "calculated over all shifts in a 24-hour period" means that there are present and on duty every day of the year: one direct care staff for each eight individuals on the first shift (1:8), one direct care staff for each eight individuals on the second shift (1:8), and one direct care staff for each 16 individuals on the third shift (1:16). Therefore, there are five (5) direct care staff present and on duty for each twenty-four hour day, for 16 individuals. The same calculations are made for the other ratios, whichever applies. Determine

if absences of staff for breaks and meals results in a pattern of prolonged periods in which present and on-duty staff do not meet the ratios.

W188

§483.420(d)(4) When there are no clients present in the living unit, a responsible staff member must be available by telephone.

§483.430(e) Standard: Staff Training Program

W189

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

Guidance §483.430(e)(1)

Newly employed staff receive a supported orientation program (mentor or ongoing supervision) during their early employment. All staff receive continuing education on such issues as abuse and neglect, handling emergency situations, behavior management, and treating people with respect and dignity, etc.

The primary evidence of an effective staff training program is the observed competent interaction between staff and clients.

§483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients'

W190

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.430(e)(2) developmental,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- developmental programming principles and techniques (e.g. techniques to involve clients in their programs to their highest capability, use of positive reinforcement, use of assistive technology, use of appropriate materials and providing informal opportunities to practice skills);
- use of adaptive equipment and augmentative communication devices and systems; and
- effective recordkeeping procedures.

W191

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) behavioral,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- use of behavioral principles during interactions between staff and clients;
- use of accurate procedures regarding abuse detection and prevention, restraints, drugs to manage behaviors, client safety, emergencies, etc.;
- use of least restrictive interventions;

- use of positive behavior intervention programming; and
- training clients in appropriate replacement behaviors.

W192

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) and health needs

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- signs and symptoms of the client's changing health (e.g. constipation, urinary tract infections, adverse drug reactions, as indicated);
- exercise and diet;
- first aid;
- infection control;
- reporting to appropriate healthcare professionals; and
- for those staff who can administer medications, how to include clients in their medication administration by recognizing and encouraging the use of applicable skills.

W193

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

Guidance §483.430(e)(3)

Staff correctly and consistently implement the interventions specified in the behavior plans of clients with whom they are working.

Inadequate training is evident when staff do not correctly implement behavioral programs, use inappropriate management techniques, cannot explain what intervention is to be used and how it is to be implemented.

W194

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

Guidance §483.430(e)(4)

Staff are observed in various settings during the day correctly and consistently implementing the specific IPPs of the clients with whom they are working.

W195

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440 Condition of participation: Active treatment services

(a) Standard: Active treatment

W196

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward-

(i) The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

Active treatment embodies an individually- tailored series of daily life and living experiences that serve as the primary opportunity for the acquisition, development and expression of functional skills and adaptive behaviors necessary for the client to experience optimal independence and promote purposeful "self-expression".

The uniqueness of each client is a core consideration in the design of active treatment programs. It is expected that individual clients are given the opportunity to provide input into the content of their day-to-day living experiences.

An active treatment program includes the following elements as substantiated through observation, interview and record review:

a) Each client's needs and strengths have been accurately assessed and relevant input has been obtained from team members; (Observations and interviews with the client by the surveyor should be consistent with the current assessment information. Interview the QIDP regarding any needs observed but not addressed through assessment/programming by the facility).

b) Each client's IPP is based on assessed needs and strengths, and addresses major life areas such as personal skills, home living skills, community living skills, employment skills, etc., essential to increasing independence and ensuring rights;

c) Needs identified as a priority are addressed formally and through activities which are relevant and responsive to client need, interest and choice;

d) Active treatment is consistently implemented in all relevant settings both formally and informally as the need arises or opportunities present themselves. It should not be limited to specific periods of time during the day or environments. Each client should receive aggressive and consistent training, treatments and supports in accordance with

their needs and IPP. New skills and appropriate behaviors are encouraged and reinforced across environments and times of day. Each client has the adaptive equipment and environmental adaptations necessary for him/her to progress toward heightened independence as recommended and contained in their IPP. Active treatment means taking advantage of opportunities for the practice of new skills and the use of other skills during the normal rhythm of each client's day.

e) Each client's performance related to IPP objectives is accurately and consistently measured and documented and programs are modified on an ongoing basis based on data and major life changes; and

i. Clients with degenerative conditions receive training, treatment and services designed to retain skills and functioning and to prevent further regression to the extent possible.

ii. Clients may need adjustments to their active treatment programs as functional or endurance limitations are identified associated with the aging process. In such cases, there may be more of an emphasis on the retention of skills already attained and reducing the rate of loss of skills, than on the acquisition of new skills.

In large part, it is this pervasive and continuous reinforcement of "formal" training through "informal" routine daily living experiences and interactions with staff and others that makes active treatment programs effective. Formal settings are those that are planned and specifically structured for training on objectives and interventions. Informal settings are times that are not anticipated or planned but that offer the opportunity for training.

Active treatment programs mirror normal living experiences such as leisure activities and social conversation at the dinner table. It must be clear that active treatment programs are far more than implementation of discreet formal training sessions or programs that are conducted at prescribed times by defined personnel. Learning occurs in the process of the normal rhythm of life and life experiences.

W197

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(a)(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

Guidance §483.440(a)(2)

All active treatment programs must be based upon assessed developmental needs which are prohibiting the client from living in a more independent setting.

Active treatment moves clients to a more independent setting.

- When a client is in the facility simply for protective oversight and is not in need of training for developmental deficits, this does not constitute active treatment (e.g. a court placement to protect the community or the client from the client's behavior).

- Programs that are simply being provided to maintain a client's independence would not be considered active treatment since the client is not actively being trained to live in a more independent setting. If a client already possesses the skills that enables them to live in a less restrictive environment, and does not require the structure, support and resources that services that only an ICF/IID can provide, they can be considered generally independent.

For example, a client is admitted to the ICF/IID for the primary purpose of competency determination for a court hearing. This client lived independently prior to admission. The active treatment programs they are receiving are focused on maintaining that independence and do not address specific developmental deficits that inhibit independent living. This would not be considered active treatment.

(b) Standard: Admissions, transfers, and discharge

W198

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(b)(1) Clients who are admitted by the facility must be in need of and receiving active treatment services.

Guidance §483.440(b)(1)

All client admissions must be based upon assessed developmental deficits which are prohibiting the client from living in a more independent setting and which require those intensive specialized supports, services, and supervision that only an ICF/IID can provide.

The individual components of the provision of active treatment include CFA, IPP, program implementation, program documentation, and program monitoring and change. When any of these individual components of active treatment are not in place, resulting in the clients not receiving active treatment, this regulation this not met.

W199

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(b)(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

Guidance §483.440(b)(2)

Preliminary evaluations should support the need for an admission to an ICF/IID (e.g., deficits in functional skills or adaptive behaviors). The information from the preliminary evaluation must be used by the facility to make an admission decision.

Occasionally, emergency admissions of clients may occur without benefit of a preliminary evaluation having been conducted prior to admission. When situational emergencies necessitate admission before a preliminary evaluation can be conducted, or when pre-admission information is incomplete, the completion of the preliminary admission evaluation within seven (7) calendar days after admission will satisfy compliance with this requirement.

W200

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(b)(3) A preliminary evaluation must contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

Guidance §483.440(b)(3)

The preliminary evaluation contains specific information useful to determine if the facility can meet the client's needs and if the client can benefit from placement.

The facility makes every reasonable effort to gather all available data to assist in their determination.

Background information would include information that gives insight into the clients' previous living environments and programming efforts.

The assessment must include a consideration as to whether reasonable accommodation as required by the Americans with Disabilities Act would enable the client to benefit from placement in facility.

§483.440(b)(4) If a client is to be either transferred or discharged, the facility must- -

W201

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(b)(4)(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and

Guidance §483.440(b)(4)(i)

Transfer or discharge occurs only when the facility cannot meet the client's needs, the client no longer requires an active treatment program in an ICF/IID setting; the individual/guardian chooses to reside elsewhere, or when a determination is made that another level of service or living situation would be more beneficial to the client.

"Transfer" means the temporary movement of a client to another facility (e.g. another ICF/IID, psychiatric hospital, medical hospital) with the intention of return to the original site.

"Discharge" means the permanent movement of a client to another facility or setting which operates independently from the ICF/IID (e.g. the facility is not under the jurisdiction of the facility's governing body).

Documentation includes evidence of an assessment that evaluated the pros and cons of the transfer or discharge and the rationale for the final decision.

W202

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(b)(4)(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

Guidance §483.440(b)(4)(ii)

The client and their family or the client and their legal guardian are involved in planning for any transfer or discharge and receive the services necessary to assist in preparing for movement, unless an emergency (medical) situation prevents that involvement. If the client has an advocate, the advocate should participate in the decision-making process.

Orderly, planned transfers and discharges usually take place over an extended period of time. The IPP should reflect objectives or interventions which prepare the client for transfer or discharge. Transfers or discharges executed on short timeframes (e.g. less than 30 days) without "good cause" would not comply with the "reasonable" intent of the regulations.

"Reasonable" time is the time required to provide clients and their families with planned steps and established timeframes to facilitate the successful transition. Time frames are modified based on client needs and emergent situations.

Preparation of the client for transfer may include orientation or trial visits to the new location. Staff should take steps to minimize potential anxiety or any behavioral reactions which could result from the client's transfer.

§483.440(b)(5) At the time of the discharge, the facility must-

W203

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(b)(5)(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status

Guidance §483.440(b)(5)(i)

The final summary should be useful for continued services in the client's new setting. The final discharge summary should be entered into the client's record, provide a summary of the client's course of stay in the ICF/IID, provide a final summary of the client's developmental, behavioral, social, health and nutritional status, and include the current status of the objectives listed in the client's IPP.

The status should address whether or not a clients' skills have been maintained, deteriorated, or improved during their stay.

W204

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(b)(5)(i) and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies; and

Guidance §483.440(b)(5)(i)

When the client is discharged, the receiving entity (another ICF/IID, waiver home, family home, nursing home, etc.) is provided a copy of the discharge summary. The ICF/IID should obtain written consent to share this information with the persons who will be providing services to the client in the future and their parents/or legal guardians. Sharing the discharge summary with State Agencies as applicable is determined by state requirements.

W205

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(b)(5)(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

Guidance §483.440(b)(5)(ii)

The post discharge plan of care is a component of the discharge summary.

The facility utilizes the information from the discharge summary to prepare the discharge plan of care. The post-discharge plan of care identifies the essential supports and services necessary for the client to successfully adjust to the new living environment and describe necessary coordination of services. It should incorporate the client's preferences. It should identify specific client needs after discharge such as personal care, physical therapy, client/caregiver education needs, and the ability of the client or caregiver to meet those needs after discharge.

(c) Standard: Individual program plan

W206

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to- -

i) **Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and**

ii) **Designing programs that meet the client's needs.**

Guidance §483.440(c)(1)

If a need is identified in the CFA, the professional associated with that need will conduct an initial evaluation for the development of the IPP.

The needs identified in the CFA determine the professional, paraprofessional, direct support staff, disciplines or service areas that must participate in the development of the IPP.

W207

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(2) Appropriate facility staff must participate in interdisciplinary team meetings.

Guidance §483.440(c)(2)

While there is no correct number of individuals that comprise the IDT, the team should include appropriate facility staff (professional and paraprofessional staff), that are responsible for designing, developing, and/or implementing the client's IPP and direct support staff who work closely with the clients.

For any prioritized objective, the paraprofessional or professional personnel responsible for the development and monitoring of that program should participate on the team, either through actual attendance or written or verbal input.

Members of the IDT may change as the assessed needs of the client change (e.g. medical issues, nutritional issues, communication needs, fine motor skill needs, gross motor skill needs, social issues or behavioral concerns).

W208

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(2) Participation by other agencies serving the client is encouraged.

Guidance §483.440(c)(2)

The facility must make every effort to coordinate the Individual Education Plan (IEP) from the school or the client's program plan from outside program, work site or workshop with the IPP. This may result in a single document, but there is no requirement for a single combined document. There must be evidence that all applicable plans were coordinated (evidence of discussion across the plans and observation would confirm integration of the IPP across the various settings). The QIDP is responsible for the coordination of the plans.

The facility should communicate changes in the IPP or in the clients' life situation with teachers and workplace representatives either directly or through written communication.

W209

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(2) Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate.

Guidance §483.440(c)(2)

The facility should make every effort to schedule team meetings at a time that enables the client parent or legal guardian, to attend without having to forfeit work time or pay.

The facility should make every effort to schedule team meetings at a time that enables the client parent or legal guardian, to attend without having to forfeit work time or pay.

It is expected that the client will routinely attend team meetings unless their participation is unobtainable. Examples of when client participation is not available include, but are not limited to: 1) the client is away from the facility for medical reasons or hospitalization; or 2) although the facility has documented repeated attempts to engage the client, the client refuses to participate.

If families/legal guardians are unable to attend a program planning meeting, the facility provides them information regarding the meeting outcome and gives them an opportunity to discuss the plan with the facility staff.

"Unobtainable", for the purposes of this guideline, means that the facility has made a good faith effort to seek parental or legal guardian participation in the process, even though the effort may ultimately be unsuccessful (for example, the parent may be impossible to locate or may prove unwilling or unable to participate).

"Inappropriate", for the purposes of this guideline, means that the parent or legal guardian's behavior is so disruptive or uncooperative that others cannot effectively participate; the client does not wish his or her parent to participate, and the client is competent to make this decision; or there is strong and documented evidence that the parent or legal guardian is not acting on the client's behalf or in the client's best interest. In the case of the latter, determine what the facility has done to bring effective resolution to the problem.

Instances when it is not appropriate for the client, parent or legal guardian, to attend the team discussion are rare. If the client does not attend the meeting, the facility must document the reason for his/her non-participation.

There may also be instances where a parent or legal guardian is considered unobtainable for a team meeting, such as being out of the country. In these instances, the parent or legal guardian should still be notified of the meeting, provided with information concerning the outcome of the

meeting and documentation in the client record should describe why the parent or legal guardian could not attend and what information was provided to them.

If the client is an adult who is competent to make decisions and who is not adjudicated, parents may not participate in the process if their participation is opposed by the client.

In the event that a non-adjudicated adult chooses not to have their family involved in the active treatment process, the surveyor should see evidence in the record of efforts made by the facility to understand why the client has declined family participation. If the client continues to decline family involvement after the facility has held discussions with him/her about the importance of this issue, the facility should honor the wishes of the client.

In general, the more involvement and communication among the team members, the client and the parent or legal guardian the more likely the plan will be successful. The facility goal should be to routinely include these parties unless rare circumstances exist.

W210

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.

Guidance §483.440(c)(3)

For new admissions, the CFA is completed within 30 days after admission and is utilized as the basis for the IPP.

New, revised or updated assessments completed within the first 30 days of admission, accurately identify the functional abilities of the client.

"Accurate" assessments refer to assessment data that are current, relevant and valid, and the skills, abilities, and training needs identified by the assessment correspond to the client's actual, observed status. Assessments must be administered with appropriate adaptations such as

specialized equipment, use of an interpreter, use of manual communication and tests designed to measure performance in the presence of visual disability.

The content of or format of the assessments or the particular assessment tools which are to be used for the CFA are not specified. Assessments must include identification of those functional life skills in which the client needs to be more independent and those services needed for the client to become more community integrated.

W211

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3) The comprehensive functional assessment must take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must -

Guidance §483.440(c)(3)

During assessment, the client is given opportunities to participate in age-appropriate activities to assess the person's functioning in those activities or settings. For example, the use of baby toys during the assessment of an adult would not be appropriate.

W212

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(i) Identify the presenting problems and disabilities and where possible, their causes;

Guidance §483.440(c)(3)(i)

The CFA includes:

- all diagnoses and developmental deficits for the client;

- the supporting information for each; and
- each evaluation should include conclusions and recommendations which go into the development of an active treatment program for the client.

W213

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(ii) Identify the client's specific developmental strengths;

Guidance §483.440(c)(3)(ii)

The client's identified developmental strengths, preferences, methods of coping/compensation, community use and awareness, friendships and positive attributes and capabilities are clearly described in functional terms in the assessments.

Identified strengths are consistent with the client's observed functional status.

W214

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(iii) Identify the client's specific developmental and behavioral management needs;

Guidance §483.440(c)(3)(iii)

The CFA must address and identify those skill deficits/needed supports that may be amenable to training, those that must be treated by therapy and/or provision of assistive technology, and those that require adapting the environment and/or providing personal support. Assessment of needed supports should be done within the context of the client's age, gender, and culture.

"Behavioral management needs" include those behaviors that interfere with progress, prevent assimilation into the community, decrease freedom or increase the need for restriction of activities (e.g. spitting, pica, self-injurious behavior, aggressive behavior toward others or self-injurious behavior).

A functional behavioral assessment is a problem-solving process for evaluating client inappropriate behavior. It relies on a variety of techniques and strategies to identify the purpose of the specific behavior(s) and to help the IDT select interventions to directly address the behavior(s). A functional behavior assessment looks beyond the behavior itself. The focus when conducting a functional behavioral assessment is on identifying significant client-specific social, affective, cognitive, and/or environmental factors associated with the occurrence (and non-occurrence) of specific behaviors.

The CFA must identify the specific accommodations that address the client's needs to ensure better opportunity for the client's success. The identified accommodations may be assistive technology which can help a person learn, play, complete tasks, get around, communicate, hear or see better, control their own environment and take care of their personal needs (e.g. door levers instead of knobs, plate switches, audio books, etc.).

W215

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(iv) Identify the client's needs for services without regard to the actual availability of the services needed; and

Guidance §483.440(c)(3)(iv)

Identification of needed services is based on the CFA.

In the presence of significant developmental deficits, it is not acceptable for the facility to say that a particular professional therapy or treatment is not needed or not available if the CFA identifies a deficit. The assessment must identify the course of specific interventions recommended to meet the client's needs, both through direct professional services and non-professional services. For example, a client's communication skill development may not require the intensive services of a speech-language pathologist however, the direct care staff will need to work with the client and use a pre-determined communication system.

§483.440(c)(3)(v) Include

Guidance §483.440(c)(3)(v)

The CFA should include an assessment of each of the areas listed below. Assessments should include specific information about the person's ability to function in different environments, specific skills or lack of skills, and how function can be improved, either through training, environmental adaptations, or provision of adaptive, assistive, supportive, orthotic, or prosthetic equipment.

If assessments are done separately by professional disciplines, there should be evidence that the assessments are brought together in an interdisciplinary approach to address the client's various developmental areas.

The CFA must be completed upon admission and annually as indicated. While the assessment may not have the specific titles of the areas listed below, the surveyor must be able to identify information within assessments from each of the areas below.

W216

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(v) physical development and health,

Guidance §483.440(c)(3)(v)

Physical development and health: This portion of the CFA includes the client's developmental history, results of the physical examination conducted by a licensed physician, physician assistant, or nurse practitioner, health assessment data (including a medication and immunization history); a review and summary of all laboratory reports since the last comprehensive evaluation, a summary of all required medical interventions since the last CFA; skills of the client normally associated with the monitoring and supervision of one's own health status, and administration and/or scheduling of one's own medical treatments. Reports of all

specialist consultations should be included in the assessment as indicated by physical examination results.

IDT reviews any current advanced directives that the client may have in place as part of the CFA.

W217

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(v) nutritional status,

Guidance §483.440(c)(3)(v)

Nutritional status: Nutritional status includes height and weight, the client's eating habits and preferences, favorite foods, determination of appropriateness of diet, adequacy of total food intake, bowel habits, means through which the client receives nutrition (e.g. feeding tube) and the skills associated with eating (including chewing, sucking and swallowing disorders).

W218

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(v) sensorimotor development,

Guidance §483.440(c)(3)(v)

Sensorimotor development: Sensorimotor development includes the development of perceptual skills that are involved in observing the environment and making sense of it. Identified sensory deficits should be evaluated in conjunction with the impact they will have on the client's life. A sensory deficit in eye contact may not have a detrimental effect on the client's life if it will not hold the client back from further accomplishments or skill acquisitions. Motor development includes those behaviors that primarily involve: muscular, neuromuscular, or physical skills and varying degrees of physical dexterity. Because sensory and motor development are intimately related and because activities in these areas are functionally inseparable, attention to these two aspects of bodily activity is often combined in the concept of

sensorimotor development. For those motor areas that are identified by the assessment as limited, the assessment should specify the extent to which corrective, orthotic, prosthetic, or support devices would impact on functional status and the extent of time the device is to be used throughout the day.

W219

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(v) affective development,

Guidance §483.440(c)(3)(v)

Affective (Emotional) development: Affective or emotional development includes the development of behaviors that relate to one's interests, attitudes, values, morals, emotional feelings and emotional expressions.

W220

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(v) speech and language development

Guidance §483.440(c)(3)(v)

Speech and language (communication) development: One of the most contributable causes of behaviors, frustration by the clients, etc. is lack of effective communication. It is imperative that the CFA identifies how the client communicates, what barriers are present, what services are available and what programs and services will be provided to assist the client to go out into and participate fully in the world. Observed client communication skills match the evaluation results and that training programs are in place to address needs.

Communication development refers to the development of both verbal and nonverbal and receptive and expressive communication skills. Assessment data identify the appropriate intervention strategy to be applied, and which, if any, augmentative or assistive devices will

improve communication and functional status. These intervention strategies should provide the client with a viable means of communication which is appropriate to their sensory, cognitive and physical abilities.

W221

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(v) and auditory functioning,

Guidance §483.440(c)(3)(v)

Auditory functioning: Auditory functioning refers to the extent to which a person can hear, to the maximum use of residual hearing if a hearing loss exists, and whether or not the client will benefit from the use of amplification, including a hearing aid or a program of amplification.

W222

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(v) cognitive development,

Guidance §483.440(c)(3)(v)

Cognitive development: Cognitive development refers to the development of those processes by which information received by the senses is stored, recovered, and used. It includes the development of the processes and abilities involved in memory, reasoning and problem solving. It is also the identification of different learning styles the client has and those best used by the trainers. It is critical that the CFA address the individual learning style of the client in order to best direct the way the trainers will teach formal and informal programs.

W223

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(v) social development,

Guidance §483.440(c)(3)(v)

Social Development: Social development refers to the formation of those self-help, recreation and leisure, and interpersonal skills that enable a client to establish and maintain appropriate roles and fulfilling relationships with others. Assessments may address family supports and relationships, sexual awareness and sexuality, friendships, social awareness, social skills and social interests.

W224

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(v) adaptive behaviors or independent living skills necessary for the client to be able to function in the community,

Guidance §483.440(c)(3)(v)

Adaptive behaviors or independent living skills: Adaptive behavior refers to the effectiveness or degree with which clients meet the standards of personal independence and social responsibility and community orientation and integration expected of their age and cultural group. Adaptive behaviors are those behaviors that are developed to cope with deficits in order to be able to perform every day skills as independently as possible. Independent living skills include, but are not limited to, such things as food shopping, meal preparation, housekeeping and kitchen chores, laundry, bed making, and budgeting. Assessment may be performed by anyone trained to do so. Standardized tests are not required. Standardized adaptive behavior scales which identify all or predominantly all "developmental needs" are not sufficient to meet this requirement, but can serve as a basis for screening.

W225

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(3)(v) and as applicable, vocational skills.

Guidance §483.440(c)(3)(v)

Vocational development, "as applicable": Vocational development refers to work interests, work skills, work attitudes, work-related behaviors, and present and future employment options. The determination of whether or not a vocational assessment is "applicable" is typically based on age (adolescents or adults more than likely require this type of assessment). The vocational assessment for each client may address job sampling, job development, on-site job training and long term follow-up, as appropriate to the client and determined by the IDT.

Vocational assessments should describe, for all domains, what clients can and cannot do in terms of skills needed within the context of their daily lives and jobs.

Assessments should be individualized and based on:

- Actual performance of the client against objective criteria;
- Reports by staff/parents/legal guardians; and

Observed performance in a variety of settings.

W226

§483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan

W227

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(4) that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section,

Guidance §483.440(c)(4)

Objectives are developed for those needs that are identified by the CFA and which are considered to be most likely to improve the client's ability to independently function in his/her daily life, as determined by the IDT.

There is a clear link between the specific objectives and the functional assessment data and recommendations.

Objectives are developed for those needs that are observed to most likely impact the client's ability to function in daily life. Training objectives should be developed to address client needs rather than staff oriented objectives.

Clients are expected to have training objectives in the areas of activities of daily living, based on the client's assessed needs and as prioritized by the IDT. If clients have eyeglasses, dentures and/or other assistive devices it is expected that the team considers objectives, based upon the assessment of client needs, addressing the care and use of such devices. However, in the area of programs to teach the clients' money management it is not expected that every client will automatically have a formal training objective to participate in such a program. The decision to prioritize such a program and to what level the program is developed is decided by the IDT based upon the results of the CFA and in consideration of such factors as, transferable skills, the ability to make choices, the ability to identify preferences and cognitive abilities such as attention span and an understanding of the principle of cause and effect.

Similarly, the decision to prioritize and develop a training objective for a client to participate in a self-administration program for medications must be made by the IDT and be based upon information from the CFA. Formal self administration programs should not be confused with informal efforts to include the client in the administration process such as allowing them to hold a glass of water, identify the box where his/her medications are stored or put a pill into their own mouth themselves under the supervision of a person who is qualified to administer medications.

W228

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(4) and the planned sequence for dealing with those objectives.

Guidance §483.440(c)(4)

The objectives identified in W227 are organized in a logical sequence, determined by the team that will assist the client toward the attainment of skills resulting in greater self-choice, independence, and community integration. The logical sequencing of objectives means there is a completion of one objective that serves as the building block for the next with relevance to the client's functional status. Where objectives are logically ordered but do not have relevance to the client's functional status, refer to 483.440(c)(4).

If the IPP is organized in a logical sequence, this requirement is met. For example, if the long term goal is to travel independently in the community, the objective sequencing may involve training the client to recognize traffic signs, cross the street safely, and to obtain help when needed if lost or an emergency arises.

These objectives must –

W229

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(4)(i) Be stated separately, in terms of a single behavioral outcome;

Guidance §483.440(c)(4)(i)

Each objective clearly states one expected learning result.

"Single" behavioral outcome means that there is a separate objective assigned for each discrete behavior that the team intends the client to learn. For example, "Mary will bake a cake and clean the oven" are two separate behaviors and, therefore, should be stated in two separate objectives. Completion of the morning hygiene routine includes programs for performance of face washing, tooth brushing and hair combing which are three separate objectives; however, the behavioral outcome for each would be the same (e.g. completion of the morning hygiene routine).

W230

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(4)(ii) Be assigned projected completion dates;

Guidance §483.440(c)(4)(ii)

Completion dates are based on the client's rate of learning.

Completion dates are assigned to each objective on which the client is currently working.

Completion dates are individualized (e.g. not all the same for all clients and all objectives).

The "projected date of completion" for an IPP objective is not the same as a "review" date. For each objective assigned a priority, the team should assign a projected date (month and year) by which it believes the client will have learned the new skill, based on all of the assessment data. This date triggers the team to evaluate continuously whether or not the client's progress or learning curve is sufficient to warrant a revision to the training program.

W231

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(4)(iii) Be expressed in behavioral terms that provide measurable indices of performance;

Guidance §483.440(c)(4)(iii)

The desired learning outcome is stated in a manner which enables all staff working with the client to consistently identify the target behavior and to clearly identify when it is being displayed.

The objective is stated in a manner which permits it to be measured with quantifiable data.

"Behavioral" terms include only those behaviors which are "client" rather than staff oriented and those that any person would agree can be seen or heard. Determine if all staff who work with the client can define the exact same outcome on which to measure the client's performance.

"Measurable indices of performance" are the quantifiable criteria to use in determining successful achievement of the objective. Quantifiable criteria include various measurements of intensity and duration. For example, "Client X will walk ten feet, with the use of her tripod walker, on each of five (5) consecutive days."

W232

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(4)(iv) Be organized to reflect a developmental progression appropriate to the individual; and

Guidance §483.440(c)(4)(iv)

Objectives must be relevant to the client's current skill sets and abilities as identified in the CFA.

The ICF/IID must consider the person's current functional abilities and project what steps, methods, and strategies are likely to be effective in achieving the objective.

W233

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(4)(v) Be assigned priorities.

Guidance §483.440(c)(4)(v)

Priorities are established based on the needs and in consideration of the desires of the client and emphasize the development of greater independence, self-choice, and community integration.

The team determines which objectives are the highest priority to be addressed, either because the client has an immediate need or the priority objectives must be accomplished before other priorities are addressed.

§483.440(c)(5) Each written training program designed to implement the objectives in the individual program plan must specify:

Guidance §483.440(c)(5)

The following regulations (5) (i-iv) apply to formal training programs developed for current implementation.

W234

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(5)(i) The methods to be used;

Guidance §483.440(c)(5)(i)

The training program provides clear directions to any staff person working with the client on how to implement the teaching strategies. To comply with this requirement the methodologies must be written in a clear enough manner that a substitute staff person will be able to read the methodologies and implement them without substantial differences from a regularly assigned staff person. Methodologies should be consistent across settings, such as when the client is in the day program.

W235

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(5)(ii) The schedule for use of the method;

Guidance §483.440(c)(5)(ii)

Active treatment (the implementation of training programs pursuant to objectives) should be provided in formal and informal settings throughout the rhythm of the client's day. While there may be structured episodes when the client works intensively and singularly on one or more objectives (schedule), the provision of active treatment is not adequate when confined solely to these types of formal settings but should be incorporated into all activities when appropriate (client's routine). For example, objectives on grasping may be as effectively carried out during the client's use of a toothbrush and a spoon as in an isolated session.

W236

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(5)(iii) The person responsible for the program;

Guidance §483.440(c)(4)(v)

The IPP should include the actual name of the staff person who is responsible for the ongoing monitoring of the client's program to ensure it is being implemented appropriately, as well as the designated position which will implement the program.

The QIDP should be familiar with the assessment and recording requirements for each client for each formal objective, including who is responsible for making these observations and completing the recording, and demonstrate a familiarity with the current data recorded for each client.

W237

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(5)(iv) The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;

Guidance §483.440(c)(5)(iv)

The IDT must determine the type of data necessary to judge a client's progress on an objective, and describe the data collection method in the written training program. The facility determines what data to collect, but whatever system is chosen for collection must yield accurate measurement of the criteria stated in the client's IPP objectives. For example, if the criteria in the client's IPP objective specified a behavior to be measured by "accuracy," or "successes out of opportunities," then it would not be acceptable for the prescribed data collection method to record "level of prompt".

Examples of a few data collection systems include, but are not limited to:

- level of prompt;
- successful trials completed out of opportunities given;
- frequency counts; and
- frequency sampling.

The IDT must consider and select the type and frequency of data collection for each objective based upon the need to measure appropriately the client's performance toward the targeted IPP skill development. The facility should collect data with enough frequency and content to be able to appropriately measure the client's performance toward the targeted IPP skill development. The frequency of data collection may vary with the objective but must be made at sufficient intervals to allow analysis of the progress of the client.

W238

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(5)(v) The inappropriate client behavior(s), if applicable; and The inappropriate client behavior(s), if applicable; and

Guidance §483.440(c)(5)(v)

Any specific behaviors which would interfere with the client's ability to function in, or benefit from the training program are identified (e.g. a fear of water could interfere with the client's bathing program).

W239

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(5)(vi) Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

Guidance §483.440(c)(5)(vi)

The training program provides specific information as to how to elicit or strengthen appropriate behavior and what behaviors to teach reinforce or encourage which would reduce or replace the inappropriate behavior.

If a client is exhibiting an inappropriate behavior, the CFA should discover why the behavior is occurring and the team should develop associated training objectives to help the client develop more appropriate behaviors. The objective for decelerating targeted inappropriate behaviors is not solely the reduction of these behaviors. The objective should also include the positive functional replacement behavior (adaptive behavior).

A replacement behavior allows a client to substitute an unconstructive or disruptive behavior with something more constructive and functionally equivalent. For example, instead of throwing work materials as a way to get a break from vocational task demands, teach the client to say or sign for 'break'.

§483.440(c)(6) The individual program plan must also:

W240

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(6)(i) Describe relevant interventions to support the individual toward independence.

Guidance §483.440(c)(6)(i)

Appropriate materials, adaptations and modifications to equipment and the environment are available in order to promote and support individual training programs. Examples may include, but are not limited, to built-up toilet seats, adaptive eating utensils, extended reach devices, and modification to the facility van to accommodate a wheelchair.

The IPP describes supports and services, in addition to the individual goals and objectives that will be provided by the facility to assist the client to function with greater independence.

W241

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(6)(ii) Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found.

Guidance §483.440(c)(6)(ii)

This requirement refers to the training program plans, objectives, descriptions of staff interventions and data collection tools which must be readily accessible to any staff in order for the programs to be consistently and effectively carried out and data collected.

W242

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(6)(iii) Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

Guidance §483.440(c)(6)(iii)

All clients who lack the skills listed within this standard have associated training programs developed to meet their needs according to prioritization. These programs are consistently implemented in both formal and informal settings.

"Developmentally incapable" is a decision made by the IDT that means a client does not have the capacity to acquire certain skill sets. The decision must be based on an assessment of the client's strengths, needs, and functional limitations.

The determination of developmental incapability must be accompanied by written evidence supporting this determination.

Such evidence may include training programs which failed after many different strategies were tried, or physical limitations that preclude the acquisition of the skill. Examples are:

1) Eye contact program was attempted using seven different methods over a two year period;

2) An client has two frozen elbow joints which do not allow her to get her hands to her mouth and consequently she will not be trained on any hand to mouth skills; and

3) Some clients may have insufficient neuromuscular and sensory control to ever be totally independent in toileting skills.

Toilet scheduling alone without any plan to progress would not be considered a toilet training program.

The components of functional skills "training" as used in this regulation means aggressive implementation of a systematic program of formal and informal techniques, which are:

- targeted toward assisting the client achieving the measurable behavioral level of skill competency specified in IPP objectives;

- implemented at natural occurrences of activity and training programs; (e.g.: an objective for a client to increase grasping may be implemented as easily in the workshop with a built up tool as in the bathroom with a toothbrush);

- conducted by all personnel involved with the client including those outside the home such as in day programs; and

- carried out in conversation and interaction with the client appropriate to the situation.

§483.440(c)(6)(iv) Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify

Guidance §483.440(c)(6)(iv)

The use of mechanical supports are based upon an individual assessment and fitting. Mechanical devices are used to support a client's proper body position or alignment and may be essential to prevent contractures or deformities. However, mechanical supports restrict movement and the client should be released from the support periodically for exercise and free movement. Mechanical supports may not be used as a substitute for programs or therapy. For example, the use of a bolster to position a client upright in a sitting position without any indication there has been an assessment for the need for muscle re-training may be an indication of a mechanical device in lieu of programming. Some supports allow movement and provide opportunity for more increased functioning. Some examples of devices used as mechanical supports include splints, wedges, bolsters, lap trays, etc.

Wheelchairs are not generally used to position or align the body and would not alone constitute a mechanical support. However, adaptations to a wheelchair which facilitate correct body alignment by inhibiting reflexive, involuntary motor activity are mechanical supports and should be included in the plan for the client.

W243

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(6)(iv) the reason for each support,

W244

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(6)(iv) the situations in which each is to be applied,

W245

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(6)(iv) and a schedule for the use of each support.

W246

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(6)(v) Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

Guidance §483.440(c)(6)(v)

Clients with sensory or physical difficulties should be given the same opportunities to move around in their environments as clients who do not have those difficulties. Even clients who use specialized wheelchairs should be given the opportunity to utilize other devices such as walkers, wagons and scooters to move about and/or change their positions.

With the exception of those clients who are acutely ill (such as those who are hospitalized or incapacitated by a "short term" illness), all clients should be out of bed and outside their bedroom area as long as possible each day, and in proper body alignment at all times. This is a necessity in order to prevent regression, contractures, and deformities and to provide sensory stimulation.

Bed rest is a temporary situation associated most usually with a medical condition and must be ordered by the medical staff of the facility. The term implies that the client will remain in his/her bed for most of any 24-hour period. Although active treatment programs may be carried out to some extent while the client is on bed rest, the client's program cannot be completed in its entirety. While there may be situations where continuous bed rest may be necessary, these situations are rare.

For those rare instances where out-of-bed activity is a threat to a client's health and safety (e.g., blood clot in the leg), active treatment adapted to the medical capacity of the client must be continued.

W247

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(6)(vi) Include opportunities for client choice and self-management.

Guidance §483.440(c)(6)(vi)

Choice and self-management are integral components of becoming independent. Clients should be given opportunities for choice and self-management in both formal and informal settings through the IPP process, leisure activities, and other life choices.

The ICF/IID must incorporate opportunities into daily life experiences that promote choice making and decision making by clients. Examples of some activities leading toward responsibility for one's own self-management include, but are not limited to:

1) choosing housing or roommates;
2) choosing clothing to purchase or wear;
3) choosing what, where, and how to eat (e.g., the use of family style dining, access to condiments and second helpings).

Choices can be made by all clients. The type of choices the person makes may vary from simple to complex, dependent upon client abilities.

Clients are provided opportunities for choice and self-management and the facility does not limit choices by making decisions for the people being served without their input. Clients are provided the opportunity to demonstrate skills to the degree they are capable and only assisted by staff as indicated in their IPP. A lack of facility staffing or staff convenience must not result in a limitation of choices of self-management for the clients.

W248

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(c)(7) A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

Guidance §483.440(c)(7)

The client or legal representative, as well as the facility staff, and staff from outside agencies, with appropriate consent, have, or can access, a copy of the IPP.

(d) Standard: Program implementation

W249

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

Guidance §483.440(d)(1)

There should be no delay in the development and implementation of the IPP. To promote a team process and meaningful discussion, IPP development should take place during IDT meetings. Any IPP objective or modification that is critical to the health and safety of any client should be implemented immediately following IDT discussion."

Each individual receives training and services consistent with the current IPP.

The time period between admission and the 30 day IDT meeting is primarily to assist the client to become adjusted and acclimated to his or her new living environment and to enable the facility to complete the CFA. During this time period the facility should also be providing those services and activities determined during the pre-admission assessment as essential to the client's daily functioning.

The active treatment program for the client is consistently implemented in all relevant settings both formally and informally as opportunities present themselves. It should not be limited to specific periods of time during the day or specific environments.

Each client should receive aggressive and continuous training, treatments and supports in accordance with their needs and IPP. New skills and appropriate behaviors are encouraged and reinforced across environments and times of day.

- During observations confirm that the client activities relate directly to the strengths, needs and objectives in the IPP for each client and are not "busy work," generalized or non-developmental time fillers. For example, screwing nuts on bolts and then unscrewing them repeatedly with no goal or transferable skills is "busy work." Screwing nuts on bolts that will be part of a product is functional reinforcement of skill acquisition.

- Clients use adaptive equipment, assistive devices, environmental supports, materials, supplies, etc., as specified in each client's IPP to assist the client to accomplish stated objectives.

There is no specific number or frequency of interventions that meets this requirement. The surveyors should see that the facility capitalizes on all opportunities throughout the course of the day that promote progress toward the achievement of goals and objectives.

Informal opportunities ("teachable moments") should be utilized to reinforce learning or appropriate skill development and needs are addressed as they present.

Although a client may not be able to reach complete independence in a functional skill, it is crucial that retention of their current skills be supported.

Clients may have defined periods of time where they may engage in leisure activities of their choice which are not necessarily directly associated with their IPP goals and objectives.

W250

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

Guidance §483.440(d)(2)

The schedule is individualized, consistent with the client's objectives, and reflects normal daily routines.

The staff working with individual clients are familiar with their daily schedules and can produce the schedule upon request.

The active treatment schedule allows flexibility and is adjusted to the needs and preferences of the client, as necessary. It's a schedule of the client's general daily plans, but can be changed.

The active treatment schedule is a functional schedule which enables client and staff to be in the right location in order to participate in the training as scheduled by the IPP.

W251

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(d)(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

Guidance §483.440(d)(3)

All disciplines, including direct care staff, interacting with the client work together to provide a uniform, consistent approach to implementation of the IPP.

(e) Standard: Program documentation

W252

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.

Guidance §483.440(e)(1)

"Data" are defined to be performance information collected and reported in numerical or quantifiable form for each training objective assigned priority in the IPP.

Data are those performance measurements collected at the time the treatment, procedure, intervention or interaction occurs with the client and recorded as soon as possible. The data should be located in a place accessible to staff who conduct training.

Data should be collected in a form and frequency as required by the plan to enable quantitative (frequency or numbers) analysis of the client's progress.

Data are accurate (e.g., reflective of actual client performance.)

§483.440(e)(2) The facility must document significant events that

W253

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(e)(2) are related to the client's individual program plan and assessments and

Guidance §483.440(e)(2)

Significant events are those events which would cause a reasonable person to be affected and which impact a normal routine. Such events include changes in the client's functional status, emotional health, physical health, accomplishments, activities or needs which impact the CFA and IPP, as well as instances of abuse, neglect or mistreatment.

The client record should contain documentation that such events are evaluated and monitored.

W254

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(e)(2) that contribute to an overall understanding of the client's ongoing level and quality of functioning.

(f) Standard: Program monitoring and change

§483.440(f)(1) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client- -

Guidance §483.440(f)(1)

Program implementation is a critical piece of each client's active treatment program. The QIDP must review or revise client programs according to 483.440(f)(1)(i-iv) and at such an interval that any of the requirements are promptly identified and addressed.

W255

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(1)(i) Has successfully completed an objective or objectives identified in the individual program plan;

Guidance §483.440(f)(1)(i)

The QIDP ensures the program has been modified or changed in response to the client's specific accomplishments or need for new program.

W256

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(1)(ii) Is regressing or losing skills already gained;

W257

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(1)(iii) Is failing to progress toward identified objectives after reasonable efforts have been made; or

Guidance §483.440(f)(1)(iii)

There should be evidence that the QIDP has reviewed and revised the IPP in those situations when the client's IPP has been consistently implemented yet the client fails to achieve their objectives.

W258

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(1)(iv) Is being considered for training towards new objectives.

§483.440(f)(2) At least annually,

Guidance §483.440(f)(2)

For the "annual" review to meet this requirement, it must be completed by at least the 365th day following the previous review, unless in an isolated or rare instance a client or the client's family is not available for a projected period of time and the subsequent delay is a minimal number of days.

W259

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(2) the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed;

Guidance §483.440(f)(2)

The CFA is reviewed at least annually.

The review of the CFA occurs sooner than annually if:

- indicated by the needs of the client;
- reflects any changes in the client since their last evaluation; and
- incorporates information about the client's progress or regression with objectives.

The review of the CFA applies to all evaluations conducted for a client. It is not required that each assessment be completely redone each year, except the physical examination. It is required that at least annually the assessment(s) be updated when changes occur so as to accurately reflect the client's current status.

W260

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(2) and the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.

Guidance §483.440(f)(2)

The IPP reflects the functional changes for the client which occurred since the last IPP. It is unlikely that an active treatment program will have no changes from year to year without documentation to support not changing the plan. Question an IPP that is a duplication of the prior year's plan without explanation.

W261

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.440(f)(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to- -

Guidance §483.440(f)(3)

The facility must have a specially constituted committee whose primary function is to proactively protect client rights by monitoring facility practices and programs. The purpose of the committee is to assure that each client's rights are protected utilizing a group of both internal staff and external participants who have no vested interest in the facility as well as clients as appropriate. There should be evidence that the committee members have been trained annually on the rights of the clients, what constitutes a restriction of a right and the difference between punishment and training.

Depending on size, complexity and available resources, the ICF/IID may establish more than one specially constituted committee. However, each committee must contain the required membership and participate regularly and perform the functions of the committee according to the requirements. Participation on the specially constituted committee(s) must be in real time allowing all membership to speak and discuss in an interactive mode.

The regulation does not specify the professional credentials of the "qualified persons" (who have either experience or training in contemporary practices to change inappropriate client behavior). There is no requirement that any specific discipline, such as nurse, physician or pharmacist be a member of the committee.

The intent of including "persons with no ownership or controlling interest" on the committee is to assure that, in addition to having no financial interest in the facility, at least one member of each constituted committee is an impartial outsider in that he/she would not have an "interest" represented by any other of the required members or the facility itself. Staff and consultants employed by the facility or at another facility under the same governing body, cannot fulfill the role of person with no ownership or controlling interest.

Although occasional absences from committee meetings are understandable, patterns of absence by the required membership of the committee is not acceptable. At least a quorum of committee members (as defined by the facility) must review, approve and monitor the programs which involve risk to client rights and protections and that quorum must include one person from each of the required categories.

W262

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(3)(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

Guidance §483.440(f)(3)(i)

Any program that utilizes restrictive or intrusive techniques must be reviewed and approved by the specially constituted committee prior to implementation. This includes, but is not limited to:

- restraints;
- drugs to manage behavior;
- restrictions on community access;
- contingent denial of any right; or
- restrictions of materials or locations in the home.

The committee should ensure that consequences within a written behavior management program do not violate the client's rights.

There is no requirement for the committee to evaluate whether the proposed program is consistent with current practices in the field. Documentation should verify that the specially constituted committee considered factors, such as whether less intrusive methods have been attempted, whether the severity of behavior outweighs the risks of the proposed program and whether replacement behaviors are included within the plan.

Any revision to a behavior plan that increases the level of intrusiveness must be re-reviewed by the specially constituted committee. The committee need not reapprove a program when revisions are made in accordance with the approved plan. For example, if the physician changes the dosage of a medication in accordance with the drug treatment component of the active treatment plan to which the legally authorized person has given consent and which has already been approved by the committee, then there is no need for the committee or the legally authorized person to reapprove the plan. Generally, this would also apply if the medication was changed to another within the same therapeutic class or family.

W263

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(3)(ii) Insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian; and

Guidance §483.440(f)(3)(ii)

The committee must ensure that written informed consent must be obtained prior to implementation of any restrictive or intrusive program. In the event of an emergency, the facility may obtain a verbal consent, which must be authenticated in writing as soon as possible and subsequently submitted to the committee as verification.

The consent is required for the entire behavior management program not just the specific restrictive technique.

Consent is informed when the person giving consent is fully aware of the:

- specific treatment;
- reason for treatment or procedure;;
- the attendant risks vs. benefits;
- alternatives;
- right to refuse; and
- the consequences associated with consent or refusal of the program.

Informed consent must be in writing and must be specific to the program and restrictive practice and reflect a specific time frame. Blanket consents are not allowed. In the case of unplanned events such as assault and property destruction requiring immediate action, verbal consent may be obtained. However, it should be authenticated in writing as soon as reasonably possible (within 30 days).

For clients up to the age of 18, their parent or legally appointed guardian must give consent for him or her. At the age of 18, however, clients become adults and are assumed to be competent unless otherwise determined by a court.

For clients who are adults and have not been adjudicated incompetent and have not been assigned a legal guardian who may not fully understand the consequences of the program, informed consent for use of restrictive programs, practices or procedures should be obtained from a person or an entity in accordance with state law, to act as the representative or advocate of the client's interests.

The specially constituted committee must ensure that the informed and voluntary consent of the client, parent of a minor, legal guardian, or the person or organization designated by the state is obtained prior to each of the following circumstances:

- The involvement of the client in research activities; or
- Implementation of programs or practices that could abridge or involve risks to client protections or rights.

W264

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(f)(3)(iii) Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.

Guidance §483.440(f)(3)(iii)

The committee has been made aware of and reviewed:

- facility policies and procedures;
- facility services;
- programs; and

- practices which may restrict or violate the rights of client.

The committee has established and uses a mechanism for monitoring clients' rights issues and informs the governing body of any issues of concern in a timely manner. This process is at the discretion of the committee. There is no requirement for periodic review of the policies by the committee.

The function of the committee is not limited to the review, approval and monitoring of restrictive behavior management practices. Examples of issues involving client rights that might be reviewed by the committee, in addition to behavior management, include, but are not limited to:

1) Research proposals involving clients;
2) Abuse, neglect and mistreatment of clients;
3) Allegations dealing with theft of a client's personal property or funds;
4) Damage to a client's goods or denial of other client rights;
5) Client grievances;
6) Visitation procedures;
7) Guardianship/advocacy issues;
8) Rights training programs;
9) Confidentiality issues;
10) Advance directives/DNR orders;
11) Practices which restrict clients (e.g., locked doors, fenced in yards); and
12) Video monitoring.

W265

§483.440(f)(4) The provisions of paragraph (f)(3) of this section may be modified only if, in the judgment of the State survey agency, Court decrees, State law or regulations provide for equivalent client protection and consultation.

W266

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450 Condition of participation: Client behavior and facility practices

(a) Standard: Facility practices-- Conduct toward clients

W267

(Rev.135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(a)(1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients.

Guidance §483.450(a)(1)

The primary survey emphasis is on the implementation of the policies and procedures developed by the facility.

Conduct between staff and clients refers to language, actions, discipline, rules, order and other types of interactions exchanged between staff and clients or imposed upon clients by the staff during a client's daily experiences that affect the quality of a client's life.

§483.450(a)(1) These policies and procedures must –

W268

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(a)(1)(i) Promote the growth, development and independence of the client;

Guidance §483.450(a)(1)(i)

Consistent with facility policies, staff is observed to be engaged in activities which promote the client's growth, development and independence.

1) IPPs and data support the fact that from the time of admission, clients are learning new adaptive and functional skills while becoming more independent.

2) Interactions between clients and staff are consistent and positive.

3) Staff teach and encourage clients to interact with each other in a manner that promotes social integration both in the facility and out in the community.

4) All opportunities to teach and reinforce skill acquisition are utilized.

5) Staff identify and remove impediments in the learning environment (e.g. client is unable to concentrate in a room with a television because when they see the television, they want to watch their favorite show. Staff must identify this learning impediment and train in an environment without a television).

6) Staff encourage clients to complete tasks with as much independence as possible.

7) Staff encourage clients to take risks while providing reasonable safeguards to prevent injury.

8) Encourage clients to make choices during their daily activities.

W269

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(a)(1)(ii) Address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible;

Guidance §483.450(a)(1)(ii)

Written facility policies describe how the facility will offer choice to the clients during the course of their day.

Written policies describe how self-determination, as defined by free choice of one's own acts and decisions without external coercion or direction, to the extent possible and self-management, as defined by control of one's own routine and daily responsibilities, to the extent possible, are incorporated into the development of program plans and daily routines.

W270

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(a)(1)(iii) Specify client conduct to be allowed or not allowed; and

Guidance §483.450(a)(1)(iii)

"Client conduct" refers to any behavior, choice, action, or activity in which a client may choose to engage alone or with others.

Written policies and procedures which may be in the form of "house rules", must not impinge on individual client rights and must not be used as a substitute for the development of individualized programs and plans.

W271

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(a)(1)(iv) Be available to all staff, clients, parents of minor children, and legal guardians.

Guidance §483.450(a)(1)(iv)

Policies and procedures for management of conduct between staff and clients (483.450(a)(1)) should be provided to clients, parents of minor children, and legal guardians at admission and upon request. Policies and procedures are available on the residential and program areas if these are in separate buildings.

W272

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(a)(2) To the extent possible, clients must participate in the formulation of these policies and procedures.

Guidance §483.450(a)(2)

"To the extent possible" does not mean that the clients are excluded due to the clients' schedule or intellectual or developmental level. Facilities should be able to provide documentation that substantiates that clients were offered the opportunity and participated in the development of the policies. This could be accomplished through client committees or in house meetings. There should be documentation of these discussions between the client representatives and the facility.

W273

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(a)(3) Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.

Guidance §483.450(a)(3)

Staff will promptly intervene when any clients tries to independently impose discipline upon another client. For example, a client who is serving dessert to the group withholds dessert from another client based upon their own evaluation of that client's behavior.

(b) Standard: Management of inappropriate client behavior

W274

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1) The facility must develop and implement written policies and procedures that govern the management of inappropriate client behavior

Guidance §483.450(b)(1)

At a minimum, the facility must have written policies and procedures regarding the management of maladaptive behaviors addressing the following:

483.450(b)(1) (W 275 – W284).

- the use of a functional behavior assessment in the development of behavior management programs;
- a hierarchy of least to most intrusive measures; and
- incorporation of behavior management programs into the IPP.

§483.450(b)(1) These policies and procedures must be

W275

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1) consistent with the provisions of paragraph (a) of this section.

§483.450(b)(1) These procedures must

W276

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(i) Specify all facility approved interventions to manage inappropriate client behavior;

Guidance §483.450(b)(1)(i)

All interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy. Examples of positive interventions include, but are not limited to, verbal praise reward systems, and prompting. Examples of negative interventions include, but are not limited to, removal of a privilege, implementation of restraint, and/or the use of exclusionary time out.

W277

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;

Guidance §483.450(b)(1)(ii)

Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior.

Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.

The facility policy for unexpected behavioral incidents must provide direction for the staff in the

utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others.

W278

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iii) Insure prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and

Guidance §483.450(b)(1)(iii)

Policies must be implemented to ensure that all restrictive procedures begin at the lowest level of the hierarchy unless there is documented evidence that less intrusive interventions have been tried and have been found to be ineffective.

The facility is not required to justify discontinuing the use of a more restrictive technique before initiating a less restrictive technique, since the intent of the regulation is to use the most positive, least intrusive technique possible.

In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.

§483.450(b)(1)(iv) Address the following:

W279

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(A) The use of time-out rooms;

Guidance §483.450(b)(1)(iv)(A)

"Time-out room" is defined as a separate room that is used to remove a client from stimulation that may be triggering and reinforcing maladaptive behavior. The facility must have written

policies and procedures for the use of time out rooms which address all the requirements of 483.450 (c) (1-4) standard: time out room.

W280

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(B) The use of physical restraints;

Guidance §483.450(b)(1)(iv)(B)

"Physical restraint" is defined as any manual hold or mechanical device that the client cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of a client's body. Examples of mechanical devices may include arm splints and mittens.

Policies and Procedures must address:

- the types of physical restraint that are allowed in the facility;
- the persons who apply such restraints;
- the parameters for duration of application;
- the methods that assure the health and safety of clients while in restraints; and
- the specific training required for staff allowed to apply such restraints.

W281

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(C) The use of drugs to manage inappropriate behavior;

Guidance §483.450(b)(1)(iv)(C)

Applicable policies may include a discussion of:

When a drug can be used to manage inappropriate behavior;

Consistency with diagnosis;

Alternatives tried before a drug is used;

Precautions that must be followed prior to and during the use (lab values, monitoring of side effects);

Implementation of a plan to address the behaviors for which the drug was prescribed; and

Plan to reduce the medication as appropriate.

Drugs to manage inappropriate behavior are defined as any medication prescribed and administered for purposes of modifying the maladaptive behavior of a client.

W282

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(D) The application of painful or noxious stimuli;

Guidance §483.450(b)(1)(iv)(D)

"Application of painful or noxious stimuli" is defined as any procedure by which staff apply, contingent upon the exhibition of maladaptive behavior, startling, unpleasant, or painful stimuli, or stimuli that have a potentially noxious effect.

While the regulation permits the use of painful or noxious stimuli these techniques are the last resort and can only be utilized for behaviors that are causing significant harm and have not responded to competently administered interventions of less intrusive nature.

Facility policies must state that:

- The use of noxious stimuli is only permitted when the client exhibits behaviors so severe that they present a potential risk for significant or even life-threatening circumstances;

- the IDT and facility must weigh the potential risk of the behavior against the risk involved in the use of the painful or noxious techniques to manage behavior;
- that safeguards and strict oversight must be in place for consideration to use techniques that may be painful or even unpleasant;

- techniques that may be painful or noxious must be time limited;

- the proposed use of these techniques requires scrutiny of clinical effectiveness and specially constituted committee review; and

  on-going monitoring and safeguards must be in place during implementation of the technique.

W283

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(E) The staff members who may authorize the use of specified interventions;

Guidance §483.450(b)(1)(iv)(E)

W284

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(F) A mechanism for monitoring and controlling the use of interventions.

Guidance §483.450(b)(1)(iv)(F)

Facility policies must address what supervisory oversight is provided during the application of the intervention in order to ensure that procedures were followed correctly. Procedures should also address what retrospective analysis is done on each intervention to ensure that procedures are being consistently followed.

W285

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(2) Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.

§483.450(b)(3) Techniques to manage inappropriate client behavior must never be used

W286

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(3) for disciplinary purposes,

Guidance §483.450(b)(3)

No intervention, whether as a part of a formal program or in emergency situations (see W289) may be used as punishment, retaliation or retribution. A staff member cannot employ a behavior management technique simply because a client refuses to follow a staff request.

The implementation of all interventions, except in emergency situations, must be administered consistent with the IPP and the specific behaviors identified in the IPP requiring the intervention. Instances where an intervention is done as a punishment because the client did not comply with staff instructions and not associated with the IPP include:

- Personal property confiscated for behavior at staff discretion;
- Rights restricted without approved plans; and
- Punitive house rules, such as prohibiting reentry into the kitchen for snacks if a meal is not eaten completely.

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W287

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(3) for the convenience of staff

Guidance §483.450(b)(3)

Inadequate numbers of staff, inefficient deployment of staff, and insufficient training of staff can lead to restrictive practices used for staff convenience.

Examples of techniques used to manage client behavior for staff convenience including, but are not limited to:

- Clients allowed to discipline other clients;
- Clients restricted to one area of the home; and
- Unauthorized use of restraints (e.g., lap trays, bean bags, gait belt, and merry walkers for the purpose of restricting movement)

W288

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(3) or as a substitute for an active treatment program.

Guidance §483.450(b)(3)

Substitutions for active treatment programming occur when the staff utilizes interventions and restrictive techniques on their own, either because there is not a formal behavioral program to address the client's behaviors or because the staff do not follow the plan as written.

W289

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(4) The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.

Guidance §483.450(b)(4)

The use of behavior interventions are expected to be incorporated into the IPP and be based upon the results of the functional behavioral assessment.

However, there may be isolated and rare instances when a client exhibits unexpected behavior that requires immediate intervention on the part of the staff. In these instances, the least restrictive intervention must be employed and removed as soon as the client is no longer an immediate threat to self or others. The IPP team must then discuss the need for adding a behavioral plan into the clients program.

W290

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(5) Standing or as needed programs to control inappropriate behavior are not permitted.

Guidance §483.450(b)(5)

The staff of the facility may not maintain or use, outside of the IPPs, any list of "as needed" interventions that can be used with any client at any time. With the exception of isolated and rare emergency situations, all restrictive behavior interventions must be incorporated into the formal IPP and individualized for the client.

(c) Standard: Time-out rooms

W291

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(1) A client may be placed in a room from which egress is prevented only if the following conditions are met:

(i) The placement is a part of an approved systematic time-out program as required by paragraph (b) of this section. (Thus, emergency placement of a client into a time-out room is not allowed.)

(ii) The client is under the direct constant visual supervision of designated staff.

(iii) The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

Guidance §483.450(c)(1)

Seclusion, defined as the placement of a client alone in a locked room, is never allowed.

Time out procedures allows a client to be alone in a room, but do not allow that room to be locked. During a time out procedure, egress can only be prevented by a person standing in the

door way, or holding the door closed, but as soon as the staff move from the door way or let go of the door the client can come out.

Use of the timeout room or procedure must be part of an approved behavioral plan and may involve the separation of a client from a group or a particular situation, in a non-locked setting for the purpose of calming or removing the client from the reinforcing stimuli that are sustaining an identified maladaptive behavior.

Designated time out rooms must be set up so that the staff has continuous, direct observation of the client at all times. Because of the danger that staff can get distracted by other events or duties, this cannot be accomplished by a camera in lieu of the staff having direct visual of the client.

Key locks, latch locks, and doors that open inward without an inside doorknob are not permitted by the regulations for use in time out rooms as they do not require constant physical pressure from a staff member to keep the door shut. In each instance where a time out room is used, the client's IPP must include:

- The functional behavioral assessment which resulted in a recommendation for the use of time out procedures; and

- Instructions on how often data is to be collected during the time out period and the criteria for release from time out.

The use of a time out room must be approved by the Specially constituted committee as part of an approved program.

W292

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(2) Placement of a client in a time-out room must not exceed one hour.

W293

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

Guidance §483.450(c)(3)

Because placement in the time out room is typically secondary to extreme behaviors, it is acceptable that there be no furniture in this room.

A door that opens inward can potentially be held closed, either intentionally or inadvertently, by the client in the room, thereby denying staff immediate access to the room.

W294

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(4) A record of time-out activities must be kept.

Guidance §483.450(c)(4)

The documentation in the client's record accurately reflects planned (e.g. part of the IPP) usage and presents a picture of events prior to, during, and following the use of time-out. The IPP should include direction as to how often data must be collected during each use of time out for each individual client.

(d) Standard: Physical restraints

§483.450(d)(1) The facility may employ physical restraint only- -

W295

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;

Guidance §483.450(d)(1)(i)

The use of physical restraint is specified within the IPP. The plan must address:

1) The specific type of client behavior to be managed by this plan;
2) The less restrictive behavioral approaches which were previously used, but were unsuccessful;
3) The hierarchy of measures that must be utilized prior to the application of physical restraint;
4) The type of physical restraint;
5) The type of client behavior that would indicate that the patient is calm and can be released from the restraint; and
6) The replacement behavior being taught to the client to reduce the need for future restraints.

W296

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(ii) As an emergency measure, but only if absolutely necessary to protect client or others from injury; or

Guidance §483.450(d)(1)(ii)

Physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which:

1) the client has not exhibited before;
2) were not identified in the functional analysis of behavior; or
3) are harming other people or themselves.

When there are repeated episodes of the use of physical restraint as an emergency safety measure, these episodes should be assessed for their predictability by the IDT, and revisions to the IPP considered addressing the behaviors through a formal behavior plan in order to reduce/eliminate the use of physical restraint.

W297

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

Guidance §483.450(d)(1)(iii)

Physical restraint during medical procedures must be utilized only when absolutely necessary and be used as a last resort in order for the facility or practitioners to deliver needed medical care to the client. The restraint must be released as soon as the medical procedure is completed unless it is necessary to continue restraint for a longer period of time to continue to deliver care or to prevent the client from displacing tubes or dressings. These restraints may only be used as long as the physician indicates them to be necessary.

For instances where physical restraint are used by the facility or a practitioner during a medical procedure, the client record and interviews should verify that less restrictive measures were attempted before using physical restraint and verify whether any injuries occurred during the use of the physical restraint. Written orders by medical personnel for the application of a physical restraint should include the reason that the restraint is necessary, the type of restraint to be used and the length of time the restraint will be applied.

A restraint device used to prevent a client engaging in self-injurious behavior is not considered a restraint for medical condition.

§483.450(d)(2) Authorizations to use or extend restraints as an emergency measure must be:

Guidance §483.450(d)(2)

Facility policies should list who in the facility is allowed to authorize the emergency use of restraints or to extend the use of an emergency restraint, and the training that is required for those persons who may authorize. Documentation in the client record in those instances should confirm that the facility follows that policy.

W298

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(2)(i) In effect no longer than 12 consecutive hours; and

Guidance §483.450(d)(2)(i)

This regulation does not mean that restraints may be authorized to be applied for up to a 12 hour period. The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. Once the behavior has ceased, the emergency has ended, and the client has been released, another authorization would be required for any new emergency situation.

The 12 consecutive hour period is the absolute maximum period of time that emergency physical restraint may be utilized for a client during an individual behavioral incident. It is reasonable to expect that the facility will reassess the emergency situation for any client who remains in physical restraint for longer than one hour and reassess the situation at least every 30 minutes thereafter up to 12 hours when the physical restraint must be removed.

W299

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(2)(ii) Obtained as soon as the client is restrained or stable.

Guidance §483.450(d)(2)(ii)

There may be instances where the maladaptive behaviors of a client or clients escalate into a serious and immediate event that must be de-escalated quickly in order to prevent harm to clients, staff, other clients, or by standers when incidents occur in the community. In these instances, the staff should contact the appropriate person to obtain authorization for the use of physical restraint as soon as the situation is stable. Retrospective documentation of the incident should confirm the need for authorization after application.

W300

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(3) The facility must not issue orders for restraint on a standing or as needed basis.

Guidance §483.450(d)(3)

All instances of physical restraint must be ordered on a case by case basis with individual assessment of the situation and authorization based upon the individual client. Authorizations should include the rationale for the use of the physical restraint versus other less restrictive measures.

W301

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints,

Guidance §483.450(d)(4)

The frequency of monitoring will vary according to the type and design of the device and the

psychological and physical well-being of the client. The facility should be checking the client often enough to adequately assess the physical status of the client (e.g., circulation, respiration and vital signs) of the client and the need to continued restraint. The more restrictive the intervention, the greater the risk to the client and the more often the client must be assessed. Frequent assessment will assure that the client will be released as soon as possible, however, in no instance may the staff go longer than 30 minutes without checking the client.

W302

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) released from the restraint as quickly as possible, and

Guidance §483.450(d)(4)

"As quickly as possible" means as soon as the client is no longer a danger to self or others. Documentation should support that the client was released from restraint as soon as they became calm.

W303

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) a record of these checks and usage must be kept.

§483.450(d)(5) Restraints must be designed and used

W304

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(5) so as not to cause physical injury to the client

Guidance §483.450(d)(5)

Physical restraints to include mechanical devices must be the correct size for the client and be applied with the correct amount of pressure according to manufacturer's directions. In addition to observation of any physical mechanical restraint in use at the time of the survey, review incident reports for any injuries as a result of restraint use.

W305

§483.450(d)(5) and so as to cause the least possible discomfort.

§483.450(d)(6) Opportunity for motion and exercise must be provided

W306

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(6) for a period of not less than 10 minutes during each two hour period in which restraint is employed,

Guidance §483.450(d)(6)

This requirement does not apply to cases of medical restraints that are specifically ordered for the immobilization of bones and joints during the physical healing process involved with fractures, sprains, etc. (e.g. a broken bone immobilized by a cast or splint). See 331 483.460(c) regarding surveillance of skin integrity during the use of medical restraints.

However, if a mechanical physical restraint is applied to an extremity to prevent a client from removing post-operative sutures, the restraint must be released every two (2) hours for a period of not less than ten (10) minutes in order to maintain adequate circulation.

Mechanical restraints placed on the client during sleeping hours must be medically based and specifically ordered by a physician. There should be evidence in the client's record why the mechanical physical restraint is necessary during sleeping hours. While it is not necessary to wake the client every two (2) hours to release the restraint and provide opportunity for exercise, the staff must check the restraint frequently during the night to ensure that the

restraint is still properly applied and the client appears comfortable.

W307

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(6) and a record of such activity must be kept.

§483.450(d)(7) Barred enclosures

Guidance §483.450(d)(7)

A bed or play equipment with bars that prevent the client from leaving the bed or voluntarily climbing out of the bed are barred enclosures. The use of such enclosures must be a part of the written IPP and behavioral assessments must clearly state why such an enclosure is necessary, the risks of using the enclosure versus not using it and what less restrictive measures have been tried prior to the implementation of the barred enclosures.

Such devices may not be used in lieu of adequate staffing.

W308

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(7) must not be more than three feet in height and

W309

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(7) must not have tops.

(e) Standard: Drug usage

§483.450(e) Standard: Drug Usage

W310

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(e)(1) The facility must not use drugs in doses that interfere with the individual client's daily living activities.

Guidance §483.450(e)(1)

Clients are alert and available for participation in daily living activities.

Some medications administered for medical reasons or to manage behavior may cause drowsiness as a side effect or due to an accumulation of the drug in the client's system. For clients who are observed to be sleeping in chairs during their work day, their programs or recreational times, there should be evidence that the facility staff notified the medical staff and an assessment was performed of the client including their medication regimen. Medical staff should make adjustments to address the issue if indicated.

§483.450(e)(2) Drugs used for control of inappropriate behavior must

W311

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(e)(2) be approved by the interdisciplinary team and

Guidance §483.450(e)(2)

The physician and other team members discuss the risks and benefits of the medication to address the target behavior/symptoms, and approve the use of the drug as being consistent

with the active treatment program. Decisions about the necessity of the use of drugs to manage inappropriate behavior should be made by the IDT. It is the responsibility of the IDT members to provide the physician with sufficient information regarding the need for a client to receive a drug for inappropriate behavior. The physician will make the ultimate decision to order the use of the drug. The IDT should document any disagreement with the physician's order.

In those instances where a client returns from a physician's visit with an order for an unsolicited drug to manage client's inappropriate behaviors, there must be evidence (e.g. IDT meeting notes or clients record) that the team concurred with the necessity for the order without trying less restrictive measures first and discussed any concerns with the physician.

W312

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.

Guidance §483.450(e)(2)

All medications to manage behavior must be integrated into the IPP and the IPP must specify how the specific target behavior for which the medication is prescribed will be reduced or eliminated. This includes medications which are typically used for medical conditions that may be used to manage behavior (e.g. 1. propranolol (Inderal), an antihypertensive used for self-injurious behavior, and 2. carbamazepine (Tegretol), an anticonvulsant, used for aggression).

Drugs for behavior management must not be ordered on a PRN basis for a client. The facility staff must contact the physician to obtain a one-time order if the situation necessities the use of medication. The facility policy must address the maximum number of times a medication can be used as an emergency prior to being incorporated in the IPP, side effects of such medications, and the frequency of re-evaluation of ongoing behavior and its treatment.

Clients or their legal guardian have the right to choose sedation for medical and dental procedures. However, the facility cannot do routine administration of medication for sedation for medical and dental procedures without the agreement/consent of the client or their parent/legal guardian and they must follow the specific orders of the healthcare practitioner

who will be providing services to the client. Decisions to order medications prior to medical and dental procedures must be made on an individual basis. Clients who demonstrate severe anxiety around these procedures should be considered for desensitization programs.

W313

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(e)(3) Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

Guidance §483.450(e)(3)

The risk(s) associated with the drug being used is consistent with the type and severity of the behavior/symptoms it is intended to affect.

At the time the drug was started and incorporated into the IPP, the behaviors were discussed and presented to team members. It was the documented decision of the team that the behaviors were of such a severity that pharmacological intervention was required and the physician was provided with the team information to assist him in his decision to prescribe the medication.

§483.450(e)(4) Drugs used for control of inappropriate behavior must be- -

§483.450(e)(4)(i) Monitored closely,

W314

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(e)(4) in conjunction with the physician and the drug regimen review requirement at §483.460(j),

Guidance §483.450(e)(4)

The physician and pharmacist must regularly review use of drugs for control of inappropriate behavior for their effectiveness in changing the targeted behavior/symptoms, untoward side effects, contraindications for continued use, and communicate this information to relevant staff.

W315

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(e)(4) for desired responses and adverse consequences by facility staff; and

Guidance §483.450(e)(4)

Direct support staff members are the people who most closely and most frequently observe and record client behaviors. There should be evidence that the direct support staff receive information via the IPP as to the behaviors to be observed, the side effects associated with the medication, the amount and types of documentation required and the communication with clinical staff which is indicated. See 483.430 (e)(1) for training on observations, documentation and communication related to behavior management.

§483.450(e)(4)(ii) Gradually withdrawn

W316

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(e)(4) at least annually

Guidance §483.450(e)(4)

Clients receiving medications to control behavior must be evaluated at least annually for a possible reduction of the medication progressing the client toward final elimination of the drug or lowest possible therapeutic level of the drug. However, evaluation should be done earlier than annually if observations indicate that the client's behavior has improved to the point that

reduction may be considered as determined by the IPP, unless otherwise ordered by the client's physician.

W317

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(e)(4) in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

Guidance §483.450(e)(4)

The IDT is aware of and involved in planning the drug reduction program and participates in its implementation and monitoring.

Progress or regression of the client is monitored and taken into consideration in determining the rate of withdrawal and whether to continue withdrawal.

In determining whether there is clinical contraindication to the annual drug withdrawal, the physician and IDT should consider the client's clinical history, diagnostic/behavioral status, previous reduction/discontinuation attempts, and current regimen effectiveness.

If a client also has a diagnosis of a psychiatric condition that requires a stable level of a psychiatric medication in order to control the symptoms associated with the psychiatric diagnosis, the annual evaluation for reduction of that particular medication for the symptoms of the psychiatric diagnosis would not apply. Documentation in the client's record from their psychiatrist or physician that medication reduction would be contraindicated or that the current level of medications is therapeutic meets the intent of this regulation.

W318

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460 Condition of participation: Health care services

(a) Standard: Physician services

W319

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(a)(1) The facility must ensure the availability of physician services 24 hours a day.

Guidance §483.460(a)(1)

A designated physician must be available via telephone, pager, e-mail or on-site in the facility on a 24 hour per day basis for consultation regarding both emergency and non-emergency medical issues. If the facility employs a fulltime physician, there must be procedures in place for coverage in the absence of the physician from the facility.

If the facility contracts with a community-based physician for 24 hour per day coverage, there must be written arrangements in place to detail the responsibilities of the contract physician regarding direct services to the clients, interactions with the direct support staff and the interactions between the nursing staff of the facility and the contract physician. The contract with the contract physician must delineate the process for coverage when he/she is not available.

Upon interview, the staff should be aware of the procedures they are to follow to contact a physician in the event of an illness or injury. Routinely sending clients to emergent care or the emergency room of a hospital because there are no facility physicians available for consultation is not consistent with the regulations.

Interview and record review verify that the physician is available and responsive 24 hours a day.

W320

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(a)(2) The physician must develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care.

Guidance §483.460(a)(2)

A medical care plan of treatment is developed for those clients who are either acutely ill and require licensed nursing care and monitoring temporarily on a 24 hour basis or clients whose chronic medical conditions require or indicate 24 hour licensed nursing care and monitoring. The physician determines when 24 hour nursing care is required.

The medical care plan is based upon the orders from the physician for treatments and care and nursing standards of practice. There is evidence in the client's record that the physician and the nursing staff at the facility work together to ensure that the medical care plan is current and appropriate (e.g. changes in physician written orders for care pursuant to observations from the nursing staff and/or direct observations and interactions with the client, and nursing documentation of care).

The fact that a client has a medical care plan in place should not preclude him/her from an active treatment program, except in instances of acute illness where the active treatment program is temporarily suspended. For clients with chronic medical conditions, it may be necessary for their active treatment program to be modified due to the tolerance level of the client or adapted to accommodate medical limitations. However, active treatment must be provided on a continuous basis.

W321

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(a)(2) This plan must be integrated in the individual program plan.

Guidance §483.460(a)(2)

Although the medical care plan can be a separate document, it is always an integral part of the IPP process. There should be evidence that the plans are shared and discussed at the time of all

interdisciplinary discussions and the information from the medical care plan is utilized in the development of the IPP objectives.

§483.460(a)(3) The facility must provide or obtain

W322

(Rev. 158, Issued: 09-09-16, Effective: 09-09-16, Implementation: 09-09-16)

§483.460(a)(3) The facility must provide or obtain preventive and general care

Guidance §483.460(a)(3)

The facility has procedures in place to ensure that the clients receive general health care services to assure optimal levels of wellness. General health care services include assessment and treatment of acute and chronic complaints or situations; teaching relevant heath care principles to staff and clients; and periodic surveillance of the health status of the clients.

As a result of clinical assessment, referrals are made for specialized assessment and tests. Facility health care staff follow-up to ensure the assessments are done and the findings incorporated into the medical care plan and/or the IPP.

The facility must have arrangements in place to provide routine or episodic laboratory, and radiology services for the clients if not provided in-house or through the clients physician. There must be a written agreement that specifies the responsibilities of the facility and outside provider. (See §483.410(a)).

Preventive health care services include screening procedures designed to identify health concerns and initiate treatment as early as possible. The facility should have a health prevention program in place and follow the plan to address those screenings that the facility will perform periodically that are relevant to all clients, and those screenings associated with a particular gender or age or vulnerability.

Physician refusal to perform a test, such as a pap smear, must be consistent with guidelines for clients, per the local standard in the community.

If the facility has a physician that refuses to provide preventative healthcare based on the client's level of functioning, medical staff at the facility should meet with and consult with this physician in order to ensure that clients receive the same health services as persons living in the local community.

Current recommended screenings for men and women can be accessed at the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Disease Control (CDC).

§483.460(a)(3) as well as annual physical examinations of each client that at a minimum include the following:

W323

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(a)(3)(i) Evaluation of vision and hearing;

Guidance §483.460(a)(3)(i)

Information relevant to the client's ability to see and hear is a critical component in the development of appropriate active treatment strategies.

All clients, including clients who are non-verbal, should have evidence in his/her record that they receive an annual evaluation of their vision and hearing which includes a screening as a minimum, follow-up examination as indicated by the screen and timely referrals as indicated by the examination. Screening is a gross assessment of the client's vision and hearing and usually does not include a measurement of acuity. Examinations are conducted to follow-up on issues noted in the screening and are conducted by qualified professionals.

Clients who appear to have vision or hearing problems or the staff indicate that they have vision or hearing problems and no accommodations have been made. The annual vision and hearing evaluation verifies that clients appearing to have vision/hearing issues or if staff indicate that a client has vision/hearing issues that these issues have been/are being addressed.

If a client's vision or hearing can only be assessed through examinations conducted by specialists

(e.g., comprehensive ophthalmological examinations and evoked response audiometry (ERA)), these tests need not be conducted yearly, but rather upon the specialist's expressed recommendations. During discussions at the annual IPP review the team reviews information from the health professional, speech and hearing professional, and direct support staff and makes referrals back to the specialist if indicated.

W324

(Rev. 158, Issued: 09-09-16, Effective: 09-09-16, Implementation: 09-09-16)

§483.460(a)(3)(ii) Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics;

Guidance §483.460(a)(3)(ii)

These immunization guides may be obtained from the American Academy of Pediatrics and/or the Centers for Disease Control (CDC).

W325

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(a)(3)(iii) Routine screening laboratory examinations as determined necessary by the physician,

Guidance §483.460(a)(3)(iii)

The facility may have a set of routine laboratory tests which are to be done on every client annually which is developed and approved by the facility physician. However, such a list is not required. The physician may write orders individually for the clients based upon their medical history, age, gender or medical vulnerabilities.

W326

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(a)(3)(iii) and special studies when needed;

W327

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(a)(3)(iv) Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.

Guidance §483.460(a)(3)(iv)

The facility should have in place a system for the identification, reporting, investigation, and control of Tuberculosis (TB) in order to prevent its transmission within the facility. This system should include:

1) Policies and procedures for screening new employees, new clients, and other people who interact on a consistent basis with clients residing in the facility when those persons are volunteers or professional staff hired or utilized directly by the facility (such as volunteers and contract professional staff);

2) Policies and procedures for subsequent screening for clients and for employees, and other people (such as volunteers and contract professional staff) who interact on a consistent basis with clients residing in the facility when those persons are volunteers or professional staff hired or utilized directly by the facility per State Health Department requirements;

3) Policies and procedures for reporting positive TB test results to the appropriate State authorities;

4) Policies for the investigative procedures, per the local health department, that would be put in place should a client or staff person test positive for TB;

5) Policies and procedures for treatment and precautions to be used with clients who display TB symptoms, as substantiated by positive skin testing or x-ray results; and

6) Policies and procedures for the evaluation of the effectiveness of the surveillance system.

When one or more clients or staff display TB symptoms, as substantiated by positive skin testing or x-ray results, they do not return to work until a physician has cleared them to return to work.

W328

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(a)(4) To the extent permitted by State law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this section.

Guidance §483.460(a)(4)

Refer to the applicable State Nurse Practice Act or applicable Board of Medicine Practice Act to determine the extent that the nurse practitioner or physician assistant may provide physician services.

(b) Standard: Physician participation in the individual program plan

§483.460(b) A physician must participate in-

W329

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(b)(1) The establishment of each newly admitted client's initial individual program plan as required by §456.380 of this chapter that specifies plan of care requirements for ICFs; and

Guidance §483.460(b)(1)

During the admission process, which takes place from the time the client is admitted to the facility to the time the initial IPP is completed, a physician is required to ensure that an assessment of the client's medical status is thoroughly considered and incorporated into the IPP planning process by the team as it develops the IPP. The physician's input may be by means of written reports, evaluations, and recommendations.

The physician (consistent with Medicaid Utilization Control regulations at §456.380) must evaluate the client at the time of admission to identify all diagnoses and complaints, provide orders for all medications and treatments and provide recommendations for restorative and rehabilitative services.

§456.380 requires that a physician conduct this initial assessment therefore, it may not be done by a physician extender (e.g., Physician assistant or Advanced Practice Registered Nurse).

W330

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(b)(2) If appropriate, physicians must participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

Guidance §483.460(b)(2)

The need for physician participation on an individual client's IPP team is determined by the medical needs of the client. How the physician participates (whether through written report, telephone consultation, attendance at the meeting, etc.) is to be left to the discretion of the facility. In instances where a client has no overriding medical issues, the nurse of the facility can represent the medical component on the IDT process or consult with the appropriate physician and share the information with the team. However, in situations where a client's medical condition is unstable/fragile to the extent that it impacts the training/work that may be planned, the physician must participate in providing guidance on the types and extent of programs that would be appropriate considering the client's physical/medical limitations.

If a client is noted to be having difficulty participating in the objectives set forth in his/her IPP due to serious medical concerns, review the input that was provided by the physician into the development of the plan and whether the IPP team requested such input.

(c) Standard: Nursing services

W331

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c) The facility must provide clients with nursing services in accordance with their needs.

Guidance §483.460(c)

The nurse responds in a timely manner to all medical concerns reported, conducts assessments as indicated, effects timely and appropriate interventions, communicates with the client's physicians and other health care professionals as indicated, provides treatments as ordered, monitors client progress following illness or injury and provides training to clients and/or staff as indicated.

§483.460(c) These services must include

W332

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process;

Guidance §483.460(c)(1)

For those clients who have had an uneventful year medically and have no medical/health concerns at the time of the IPP meeting the facility nurse may submit a summary report to the IDT unless the IDT determines that his/her attendance is necessary. An eventful year medically would include a year which required unplanned hospital admissions or in which medical issues necessitated treatment for a prolonged or continuing period. However when a client has had an eventful year medically or current medical/health concerns, this could have an impact on their objectives and accordingly the nurse should participate in the IDT discussion directly.

W333

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan;

Guidance §483.460(c)(2)

A medical care plan addresses those clinical treatments and observations that are to be done for the client by the medical staff and other staff of the facility in order to either improve an acute medical condition or to maintain a medically fragile client as clinically stable as possible. The medical care plan is an adjunct to the IPP and is not considered a substitution for the IPP.

§483.460(c)(3) For those clients certified as not needing a medical care plan, a review of their health status which must-

W334

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(3)(i) Be by a direct physical examination;

Guidance §483.460(c)(3)(i)

A direct physical examination means a visual review of the body as well as examination/assessment of body systems. This includes observations made through non-verbal

communication (including visual, tactile, nonverbal gestures, grimaces, etc.) which may be an indication that there is a potential for further assessment and/or monitoring. A paper review of the client's medical record and health statistics does not meet the intent of the regulation for a direct physical examination.

W335

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(3)(ii) Be by a licensed nurse;

Guidance §483.460(c)(3)(ii)

The term "licensed nurse", for purposes of these guidelines, means a registered nurse, a licensed practical nurse or a licensed vocational nurse currently licensed by the State in which the facility is located. The nurse must operate consistent with the requirements of the applicable Nurse Practice Act. If this direct physical examination is done by a physician, it is not necessary for the nurse to repeat the exam.

W336

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(3)(iii) Be on a quarterly or more frequent basis depending on client need;

Guidance §483.460(c)(3)(iii)

"On a quarterly basis" means that the examinations are conducted approximately 90 days apart (e.g. scheduled to be conducted approximately once every 90 days). If during the course of a calendar year, there were three quarterly examinations conducted by a licensed nurse and in the fourth quarter the annual physical examination was performed by a physician, the intent of this requirement is met without the nurse performing an additional examination.

W337

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(3)(iv) Be recorded in the client's record; and

Guidance §483.460(c)(3)(iv)

The actual findings of each examination and the date conducted must be incorporated into the client's record.

W338

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(3)(v) Result in any necessary action (including referral to a physician to address client health problems).

Guidance §483.460(c)(3)(v)

The nursing staff document that referrals are made in a timely manner, if indicated, for any concerns identified. Nurses must ensure all concerns they identify are communicated and addressed appropriately, including:

- Need is fully identified in assessment;
- Appropriate referrals are made;
- Revisions are made to IPP/Medical care plan; and
- Follow-up occurs to the new plan.

W339

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(4) Other nursing care as prescribed by the physician or as identified by client needs; and

Guidance §483.460(c)(4)

Nursing interventions are implemented as indicated by the needs of the client and consistent with either standard nursing practice principles or orders from the attending physician. Health and wellness are actively promoted, problems are attended to before they negatively impact the client's health and wellness, and steps are taken to prevent the recurrence of such problems while responding promptly to client's needs.

Client health care complaints that are reported either directly by the client or by the direct care staff are addressed promptly by the nursing staff. Client health care complaints and response by nursing staff are documented in the client's record.

§483.460(c)(5) Implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to- -

W340

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(5)(i) Training clients and staff as needed in appropriate health and hygiene methods;

Guidance §483.460(c)(5)(i)

Nursing staff periodically provides training to clients and staff on how to care for health needs or conditions, personal hygiene, health maintenance, and disease prevention. Nursing staff actively participates in periodic discussions with client and staff to promote health habits in the areas of diet, exercise and non-smoking.

Based upon individual training needs, the nursing staff provides training to individuals in areas such as medications, family planning, prevention of sexually transmitted diseases, control of other infectious diseases, self-monitoring of health status and self-prevention of health

problems, etc. The nurses may train clients directly on their objectives or train other staff to do this training as appropriate.

W341

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(5)(ii) Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control; and

Guidance §483.460(c)(5)(ii)

Nursing staff should actively participate in surveillance and reporting of communicable diseases per the Centers for Disease Control (CDC) guidelines and applicable state laws. They should teach and promote infection control techniques such as hand washing by clients and staff and should be making periodic observations to ensure that such good infection control techniques are consistently utilized.

W342

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(c)(5)(iii) Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

Guidance §483.460(c)(5)(iii)

Nursing staff must train and ensure direct support staff demonstrate competency in detecting signs and symptoms of illness, injury, or change in the client's health baseline (e.g. responsiveness, fatigue, irritability, constipation, diarrhea, dehydration, confusion, unexplained weight loss, changes in endurance and changes in respiratory function).

Staff is responsive to health care needs or injuries of clients and receives instruction and support during temporary illness of clients.

If not, review staff training records to determine whether training was provided periodically to the involved employee. Interview direct care staff to determine their level of understanding regarding the signs and symptoms of illness that are to be reported to the medical staff. The records of clients with recent hospitalizations verify that staff detected and reported relevant symptoms promptly.

(d) Standard: Nursing staff

W343

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(d)(1) Nurses providing services in the facility must have a current license to practice in the State.

Guidance §483.460(d)(1)

The facility should have a procedure in place to ensure that any contract nursing staff members are currently licensed prior to the provision of services. Include any contract nurses used by the facility in the sample of nurses reviewed for licensure.

W344

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(d)(2) The facility must employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

Guidance §483.460(d)(2)

The facility provides for nursing services based on the health needs and conditions of clients residing there. Examples include:

1) physician ordered treatments that require the skills of a licensed nurse;
2) preventive screenings ;
3) assessment and intervention;
4) direct physical examination and examination of body systems;
5) teaching; and
6) advocacy for the medical services needed by the client.

Client health care needs are met in a timely manner (within 24 hours) by the available nursing staff.

If nurses who do not have experience in the care of persons with intellectual disabilities are employed by the facility, they should be provided with a formal orientation period and on-going educational opportunities to increase their understanding of the client population.

When one or more clients in the facility has an active medical care plan, there must be 24 hour nursing services available to come to the facility as needed to make skilled assessments and interventions.

W345

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(d)(3) The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.

Guidance §483.460(d)(3)

Refer to the applicable State Nurse Practice Act.

W346

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(d)(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.

Guidance §483.460(d)(4)

The facility must have written arrangements with a registered nurse (RN) to provide consultation in those instances where LPNs/LVNs provide all the direct nursing care for the clients. Verify that the agreement requires the RN to respond promptly to all calls from the LPN/LVN and to come on-site to the facility if necessary. The facility must also ensure registered nurse back-up when the primary registered nurse consultant is unavailable (vacations, etc.). Review documentation in the client records to confirm that the LPNs/LVNs of the facility are consulting the registered nurse consultant when indicated and that she/he responds promptly to such calls.

W347

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(d)(5) Non- licensed nursing personnel who work with clients under a medical care plan must do so under the supervision of licensed persons.

The work of any direct support staff (caring for clients with a medical care plan) is directed by an onsite licensed nurse). The nurse evaluates the care provided by the staff as needed, but at least each shift. If observations of care indicate that direct care staff are not providing care as directed by the medical care plan, then review the supervision provided by the nursing staff.

(e) Standard: Dental services

W348

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.

Guidance §483.460(e)(1)

It is expected that the clients will obtain dental services (both diagnostic and treatment) from community dentists whenever possible. In some instances, there may be clients residing in the facility who are physically unable to travel to the community for services. The facility must secure dental services (both diagnostic and treatment) for these clients either through an in-house program, which is part of the organizational and administrative structure of the facility, or through a written agreement with an outside dental service to come into the facility to provide such services.

W349

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(e)(2) If appropriate, dental professionals must participate, in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

Guidance §483.460(e)(2)

Reports of dental care may be submitted to the IDT for inclusion in their discussions surrounding either development of the plan or update to the plan. This includes procedures a client may have had or be having during the plan development period, such as root canal or singular extractions. Actual attendance at the IDT meeting by the dentist may be left to the request of the IDT.

W350

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(e)(3) The facility must provide education and training in the maintenance of oral health.

Guidance §483.460(e)(3)

Formal or informal training in the maintenance of oral hygiene is provided to clients who require it, and to those staff who are responsible for carrying out such activities. The IPP should include an assessment of the client's ability to perform oral hygiene independently and an associated program if the client is not independent.

(f) Standard: Comprehensive dental diagnostic services

§483.460(f) Comprehensive dental diagnostic services include

W351

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(f)(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission);

Guidance §483.460(f)(1)

A "month" is defined as the interval between the date of admission and close of business of the corresponding day in the following month.

A complete intraoral examination includes an oral cancer screen.

§483.460(f)(2) Periodic examination and diagnosis performed

W352

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(f)(2) at least annually,

Guidance §483.460(f)(2)

Dental examinations occur no less frequently than annually. Clients without teeth must receive an annual oral cancer screening examination by a dental professional.

W353

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(f)(2) including radiographs when indicated and detection of manifestations of systemic disease; and

Guidance §483.460(f)(2)

There should be evidence in dental reports that dentists follow current standards of practice for the performance of x-rays in order to assist in the diagnosis and treatment of the client.

W354

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(f)(3) A review of the results of examination and entry of the results in the client's dental record.

Guidance §483.460(f)(3)

The entry referenced at this regulation is the dental entry into the dental record. See W359 for requirement of copying this dental record into the facility record.

(g) Standard: Comprehensive dental treatment

§483.460(g) The facility must ensure comprehensive dental treatment services that include- -

W355

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(g)(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist; and

Guidance §483.460(g)(1)

The facility should be able to produce upon request, a written contract/agreement between the facility and a licensed dentist for 24/7 guidance/provision of emergency services for the clients. The agreement should also indicate what back-up coverage will be provided when the dentist is not available.

W356

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(g)(2) Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health.

(h) Standard: Documentation of dental services

§483.460(h)(1) If the facility maintains an in-house dental service, the facility must

W357

keep a permanent dental record for each client,

W358

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(h)(1) with a dental summary maintained in the client's living-unit.

Guidance §483.460(h)(1)

The "dental summary" refers to the summary of each visit entered by the dental professional. The note includes any care instructions to be followed up by facility staff as a result of treatment.

§483.460(h)(2) If the facility does not maintain an in-house dental service, the facility must

W359

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(h)(2) obtain a dental summary of the results of dental visits

Guidance §483.460(h)(2)

The facility should receive a written report of each dentist visit for inclusion in the client's record at the facility and for reference by the medical and direct support staff.

W360

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(h)(2) and maintain the summary in the client's living unit.

See guideline above at W359.

(i) Standard: Pharmacy services

W361

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(i) The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

Guidance §483.460(i)

The facility either has an onsite pharmacy or has formal arrangements in place for the provision of routine, unanticipated, or emergency drugs. There are no instances where a client does not receive needed medications due to the unavailability of drugs.

(j) Standard: Drug regimen review

W362

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.

Guidance §483.460(j)(1)

The primary function of the pharmacist during the quarterly drug review is to identify possible

drug interactions, check for evidence of any side effects associated with the drug usage, determine if laboratory results associated with the drug are within normal limits and verify that the facility is administering the medication appropriately and to comment upon the efficacy of the drug use (e.g. blood sugar controlled, blood pressure within normal limits). In the case of drugs used to manage behavior, the pharmacist may need information from the IDT to determine efficacy. See Appendix PP, Indicators for Surveyor Assessment of the Performance of Drug Regimen Reviews, to the State Operations Manual (Pharmaceutical Service Requirements in Long Term Care Facilities).

W363

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(j)(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

Guidance §483.460(j)(2)

The physician and IDT members must discuss, document and take necessary follow-up action for any irregularities noted.

W364

§483.460(j)(3) The pharmacist must prepare a record of each client's drug regimen reviews and the facility must maintain that record.

W365

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(j)(4) An individual medication administration record must be maintained for each client.

W366

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(j)(5) As appropriate the pharmacist must participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

Guidance §483.460(j)(5)

Pharmacist participation on the IDT is at the request of the team. It would not be necessary for the pharmacist to routinely attend all team meetings when the client is on a stable drug regimen that does not appear to be influencing his/her active treatment programs. Pharmacist participation may be appropriate, in situations such as assisting the IDT develop the most effective training programs for when the client is in an evolving situation with their medication.

For example:

- A client begins a new or more complex drug regimen;
- The physician orders off-label use of a medication;
- Frequent changes in the drug regimen are affecting IPP implementation.

(k) Standard: Drug administration

W367

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k) The facility must have an organized system for drug administration that identifies each drug up to the point of administration.

§483.460(k) The system must assure that

W368

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(1) All drugs are administered in compliance with the physician's orders;

Guidance §483.460(k)(1)

Administration errors identified in previous medication administration records qualify as non-compliance with physician's orders.

W369

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(2) All drugs, including those that are self-administered, are administered without error;

Guidance §483.460(k)(2)

A medication error is an observed discrepancy during the medication pass between what is ordered and what is administered.

This also applies to self-administered medications.

For small facilities (16 beds or less), the medication administration pass will encompass a total of eight (8) drug doses. The observations should be split between two separate drug passes 4/4 (one in the morning and one in the late afternoon or early evening). The medications observed during the observations may or may not be for clients in the survey sample. Any concerns regarding a medication that is about to be administered should be brought to the attention of the person administering the medication. The record of observation should be reconciled with the most current signed physician's orders.

For large facilities (17 or more beds) with either single or multiple buildings, the medication administration pass will encompass a total of 12 doses. The observations should be split

between two separate passes 6/6 (one in the morning and one in late afternoon or early evening). Any concerns regarding a medication that is about to be administered should be brought to the attention of the person administering the medication. The record of observation should be reconciled with the most current signed physician's orders.

W370

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(3) Unlicensed personnel are allowed to administer drugs only if State law permits;

Guidance §483.460(k)(3)

Unlicensed personnel administer only those forms of medication which state law permits. Licensed nurse(s) in the facility oversee any administration of medications by unlicensed persons and periodically evaluate their performance.

W371

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(4) Clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise;

Guidance §483.460(k)(4)

The IDT decision that a self-administration program is appropriate, as is the case for all formal training objectives, must be based upon accurate, current, valid assessment of the client's skills and potential. The determination as to the appropriateness of a self-administration program must never be made singularly on the client's diagnosis or current functional abilities.

For clients assessed to be inappropriate for a self-administration program, but determined by the IDT to possess the capacity to functionally, cognitively, emotionally or developmentally benefit from participation in the drug administration process, it is expected that the facility will

provide opportunities for the client to participate in the medication administration process under direct supervision. This participation can include but is not limited to, identifying the medication taken, reaching/grasping a cup of water during the process and placing oral medications in the mouth, etc.

W372

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client;

Guidance §483.460(k)(5)

While the IDT may set an objective of self administration of medication for a client, they are required to notify the client's physician of this proposed objective. If the client's physician objects on medical grounds, the team must not proceed with the objective until such time as a discussion is held with the physician and he/she agrees to proceed after receiving additional information.

W373

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(6) No client self-administers medication until he or she demonstrates the competency to do so;

Guidance §483.460(k)(6)

The written self-administration program for a client must detail the criteria that will be employed by the facility staff to verify that the client successfully completes all phases of the program and continues to comply with all necessary requirements for self administration. Clients who self-administer medications must secure all medications in such a manner as to protect access by other clients or visitors.

W374

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law;

Guidance §483.460(k)(7)

When clients go out of the facility for home visits, or to attend work or school, drugs they are taking must be packaged and labeled in accordance with state law by a person authorized by state law to package and label.

§483.460(k)(8) Drug administration errors and adverse drug reactions are

Guidance §483.460(k)(8)

Documentation of any medication error should be entered into the client's record and should include what error was made, who was notified of the error, the response of the medical person notified, the physical condition of the client at the time of the notification and subsequent observations of the clients physical condition related to the error.

W375

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(8) recorded

Guidance §483.460(k)(8)

Documentation of adverse drug reactions must be entered into the client's record and should include all complaints made by the client or observations made by the staff following the drug administration, the notification of medical personnel, and the response of the medical personnel, any emergency actions that were required and all subsequent observations of the client's condition related to the reaction.

W376

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(k)(8) and reported immediately to a physician.

Guidance §483.460(k)(8)

"Immediately" means at the time the error or reaction is identified.

(l) Standard: Drug storage and recordkeeping

§483.460(l)(1) The facility must store drugs under proper conditions of

Guidance §483.460(l)(1)

Drugs are stored according to manufacturer's recommendations.

W377

sanitation,

W378

temperature,

W379

light,

W380

humidity,

W381

and security.

W382

§483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration.

W383

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area.

Guidance §483.460(l)(2)

"Authorized persons" is restricted to those who administer the drugs (as allowed by state law) and nursing supervisors (if any). No other personnel should have access to these keys.

W384

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(l)(2) Clients who have been trained to self-administer drugs in accordance with §483.460(k)(4) may have access to keys to their individual drug supply.

Guidance §483.460(l)(2)

Drugs that are self-administered do not have to be double locked. The purpose for the double locking is to limit access to scheduled drugs. Since the client is generally the only one who has access to his/her drug supply (with perhaps the exception of a licensed nurse or whoever has overall responsibility for medication administration at the facility and a facility's Director of Nursing Services, who may have access to all of the facility's drug supplies), there is no need to further limit access.

W385

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(l)(3) The facility must maintain records of the receipt and disposition of all controlled drugs.

Guidance §483.460(l)(3)

The facility must follow state requirements for the control and disposition of controlled drugs.

W386

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(l)(4) The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308).

Guidance §483.460(l)(4)

The facility should follow state requirements for the reconciliation of controlled drugs.

W387

§483.460(l)(5) If the facility maintains a licensed pharmacy, the facility must comply with the regulations for controlled drugs

§483.460(m) Standard: Drug Labeling

§483.460(m)(1) Labeling of drugs and biologicals must

W388

§483.460(m)(1)(i) Be based on currently accepted professional principles and practices; and

W389

§483.460(m)(1)(ii) Include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

§483.460(m)(2) The facility must remove from use--

W390

§483.460(m)(2)(i) Outdated drugs; and

W391

§483.460(m)(2)(ii) Drug containers with worn, illegible, or missing labels.

W392

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(m)(3) Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician.

(n) Standard: Laboratory services

W393

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.460(n)(1) If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter.

Guidance §483.460(n)(1)

If the facility performs laboratory services, it must have a current, valid Clinical Laboratory Improvement Amendment (CLIA) certificate for the types of tests it is performing.

For the purposes of this regulation, a "laboratory service or test" is defined as any examination or analysis of materials derived from the human body for purposes of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings.

W394

(Rev. 158, Issued: 09-09-16, Effective: 09-09-16, Implementation: 09-09-16)

§483.460(n)(2) If the laboratory chooses to refer specimens for testing to another laboratory,

the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.

Guidance §483.460(n)(2)

A facility performing any laboratory service or test must have applied to CMS, and received a Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation. An application for a Certificate of Waiver may be made if the facility performs only those tests on the waived list. A complete list of waived tests can be accessed at the Food and Drug Administration (FDA).

If the facility performs any test, not appearing on the waived list, a Certificate of Compliance or Certificate of Accreditation is required. An appropriate CLIA certificate is required regardless of the frequency with which the laboratory services or tests are conducted. When no tests are performed, a CLIA certificate is not needed. Facilities only collecting specimens and not performing testing do not need a certificate.

A not-for-profit, a state, or local government organization may have one certificate covering all the facilities it operates (e.g., all the separately certified residences which fall under its governing body), if no more than a total of 15 types of waived or moderately complex laboratory tests are used. This exception applies only to laboratories performing limited public health testing. See State Operations Manual (SOM) 6008. Each location where a laboratory tests are performed must file a separate application to be separately certified unless the laboratory meets one if the exceptions outlined at 42CFR493.35(b), 493.443(b), or 493.55(b).

Any laboratory located in a state that has a CMS-approved laboratory program is exempt from CLIA certification. Currently there are two states with approved programs: Washington and New York. New York has a partial exemption; therefore, if the laboratory is located in New York, contact the New York State Agency to determine if the exemption applies.

W406

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.470 Condition of participation: Physical environment.

(a) Standard: Client living environment.

W407

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

Guidance §§483.470(a)(1)

Clients of grossly different ages, functional levels, and/or social needs should not be housed together unless all of the following documentation supports the placement:

- Assessment;
- Client program plan;
- Staff documentation of client response to training programs; and
- QIDP notes.

W408

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) The facility must not segregate clients solely on the basis of their physical disabilities. It must integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders, etc., with others of comparable social and intellectual development.

(b)Standard: Client bedrooms.

(1) Bedrooms must- -

W409

§483.470(b)(1)(i)Be rooms that have at least one outside wall

W410

§483.470(b)(1)(ii)Be equipped with or located near toilet and bathing facilities;

W411

§483.470(b)(1)(iii) Accommodate no more than four clients unless granted a variance under paragraph (b)(3) of this section;

§483.470(b)(1)(iv) measure

W412

At least 60 square feet per client in multiple client bedrooms

W413

And at least 80 square feet in single client bedrooms; and

W414

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(v) In all facilities initially certified, or in buildings constructed or with major renovations or conversions on or after October 3, 1988, have walls that extend from floor to ceiling.

Guidance §483.470(b)(l)(v)

If a facility was initially certified on or after October 3, 1988 and/or is under renovations or conversions, they must have walls that extend floor to ceiling.

W415

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) If a bedroom is below grade level, it must have a window that--

(i) Is usable as a second means of escape by client(s) occupying the room; and

(ii) Is no more than 44 inches (measured to the window sill) above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches (measured to the window sill) above the floor.

Guidance §483.470(b)(2)

The intent of the regulation is to prohibit the housing of clients in basements that are entirely below grade. Clients may be housed on the lower level of housing (e.g. a bi-level house), provided the window height requirements are met and the window is of sufficient size to be used as a means of escape.

W416

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(3) The survey agency may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified intellectual disabilities professional--

(i) Certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and

(ii) Documents the reason why housing in a room of only four or fewer persons would not be medically feasible.

Guidance §483.470(b)(3)

The medical care plan for each client housed in a room with more than four clients should indicate the need for continuous monitoring. The medical care plan will include:

- the physician certification that the client is severely medically impaired and requires direct and continuous monitoring during sleeping hours; and

  the reason why this housing arrangement for fewer than four people would not be medically feasible.

(4) The facility must provide each client with—

W417

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(i) A separate bed of proper size and height for the convenience of the client;

Guidance §483.470(b)(4)(i)

The client's preference, chronological age, and physical and medical needs are the determining factors in bed size and height.

W418

§483.470(b)(4)(ii) A clean, comfortable, mattress;

W419

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(iii) Bedding appropriate to the weather and climate; and

W420

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(iv) Functional furniture, appropriate to the client's needs,

Guidance §483.470(b)(4)(iv)

Client preferences and program needs should be considered in furniture selection. For clients with physical disabilities, furniture is adapted to accommodate the client's physical challenges and enable the client to use the furniture with minimal support.

W421

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.

Guidance §483.470(b)(4)(iv)

Closets should have enough space for a reasonable amount of the current season's clothing.

Clients who use wheelchairs or have other physical challenges can reach the racks and shelves in their closets.

The facility is permitted either to provide the client with an individualized closet or with a designated area in a shared closet. The use of central clothing bins in a facility clothing room, in the absence of required client closet space in the bedroom, is not an acceptable practice.

(c) Standard: Storage space in bedrooms.

The facility must provide—

W422

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) Space for equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety; and

Guidance §483.470(c)(1)

Sufficient space that permits the use of wheelchairs, walkers and other adaptive equipment should be provided within the bedroom.

W423

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) Suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.

Guidance §483.470(c)(2)

Each client should have storage in their bedroom for their personal belongings. Clients should have free access to this storage without the assistance of staff. If it is necessary for clients' personal belongings to be locked due to the behavior of other clients, the client must still be provided free access to his own possessions (See W137 for requirements for locked areas).

(d) Standard: Client bathrooms

The facility must—

W424

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients;

Guidance §483.470(d)(1)

In a home setting, the toilet facilities need to be of sufficient number to meet the needs of the client without prolonged delay. There must be enough toilets in the living units to meet the program needs of the clients at any given time, as well as provide for intermediate toileting needs of the clients living in the unit.

In a home setting, it may be unrealistic to say a client would never have to wait for a shower or bath or to brush his/her teeth.

Bathrooms and fixtures must be adapted to accommodate clients with physical disabilities.

W425

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) Provide for individual privacy in toilets, bathtubs, and showers; and

Guidance §483.470(d)(2)

A bathroom containing multiple toilets, showers or bathtubs, must have doors, curtains, or some other means of protecting the client from view when fully or partially unclothed.

Clients should not be able to be seen through the door or window by passersby when they are using the bathrooms.

Client privacy does not preclude the assistance provided by facility staff when necessitated by the client's condition.

W426

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110□Fahrenheit.

(e) Standard: Heating and ventilation.

(1) Each client bedroom in the facility must have--

W427

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(i) At least one window to the outside; and

Guidance §483.470(e)(1)(i)

(See also W415)

W428

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(ii) Direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.

(2) The facility must—

W429

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(i) Maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means; and

Guidance §483.470(e)(2)(i)

A "normal comfort range" in most instances is defined as not going below a temperature of 68 degrees Fahrenheit or exceeding a temperature of 80 degrees Fahrenheit in facilities in most geographic areas of the country.

In extremely hot or extremely cold weather, precautions are taken by the facility to protect the clients, particularly those who are medically compromised, from ill effects of the temperature.

W430

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(ii) Ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.

Guidance §483.470(e)(2)(ii)

Refer to Life Safety Code Chapters 32 and 33

Unvented fuel fired heaters are prohibited. NFPA 101 2000 Edition.

32/33.2.5.23

(f) Standard: Floors.

The facility must have—

W431

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) Floors that have a resilient, nonabrasive, and slip-resistant surface.

W432

§483.470(f)(2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor; and

§483.470(f)(3) Exposed floor surfaces and floor coverings that

W433

promote mobility in areas used by clients,

W434

and promote maintenance of sanitary conditions.

§483.470(g) Standard: Space and Equipment

The facility must--

W435

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services, as required by this subpart and as identified in each client's individual program plan.

Guidance§483.470(g)(1)

Staff and clients must have the space, materials and equipment needed to implement formal and informal active treatment programs.

There must be sufficient space to accommodate group activities, including groups with clients who use wheelchairs.

Recreational supplies, equipment, and materials are available and reflect the interests, physical abilities and chronological age of the clients.

W436

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

Guidance §483.470(g)(2)

The term "furnish" means that the facility is responsible for obtaining or purchasing these items once an assessment has identified the need and is responsible for making any necessary arrangements for the client to receive them. Clients' personal funds should not be used for these items since this is a covered service under the ICF/IID benefit.

The term "maintain in good repair" means that the facility is responsible for ensuring that these items are kept in good working order, and is responsible for any resulting expense that may be incurred.

Programs must be in place, when identified by assessment and determined by the ID team, to teach clients about the use and care for their equipment to the extent of their capabilities.

W437

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(3) Provide adequate clean linen and dirty linen storage areas.

Guidance §483.470(g)(3)

Clean linen must be is separated from dirty linen and stored in a manner which prevents contamination.

Linen soiled with bodily fluids must be stored separately and in a manner which protects clients from exposure to possible infectious sources.

A bedroom hamper can be an acceptable dirty linen storage "area" if kept odor free and consistent with the infection control requirements at §483.470(1).

(h) Standard: Emergency plan and procedures.

W438

(Rev., 175, Issued: 12-22-17, Effective: 12-22-17, Implementation: 12-22-17)

(1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

Guidance §483.470(h)(1)

See State Operations Manual, Appendix Z – Emergency Preparedness for All Provider and Certified Supplier Types, Interpretive Guidance at §483.475(a)(1).

W439

(Rev., 175, Issued: 12-22-17, Effective: 12-22-17, Implementation: 12-22-17)

(2) The facility must communicate, periodically review, make the plan available, and provide training to the staff.

Guidance §483.470(h)(2)

See State Operations Manual, Appendix Z – Emergency Preparedness for All Provider and Certified Supplier Types, Interpretive Guidance §483.475(d).

(i) Standard: Evacuation drills.

(1) The facility must hold evacuation drills

W440

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

at least quarterly for each shift of personnel

Guidance §483.470(i)(1)

Life Safety Code NFPA 101, 2000 Edition (LSC):

Chapter 32/33 code: Clients have to participate in an evacuation drill each shift at least quarterly.

Chapter 18/19 code: There must be an evacuation drill on each shift at least quarterly. This drill is designed to train staff on evacuation procedures.

Review facility records to verify that evacuations drills are held each shift at least once in each 3-month period.

Refer to (S&C 10-26-LSC)

W441

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

and under varied conditions to—

Guidance §483.470(i)(1)

Life Safety Code NFPA 101, 2000 Edition (LSC):

Chapter 32/33: Expects that all clients living in that unit are capable of self-evacuation during an emergency. This self evacuation should be practiced under varying conditions including various times of the day or night and in various weather conditions.

Chapter 18/19: Requires drills which simulate emergency situations which familiarize facility staff with emergency actions they may be required to perform. The general emphasis of these sections of the code is upon training of the staff and not upon providing practice for the client. Drills should be practiced under varying conditions including various times of the day or night and in various weather conditions.

W442

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;

Guidance §483.470(i)(1)(i)

For facilities under Chapter 18/19 of the LSC

Staff should be able to verbalize the proper procedures to be followed during emergency drills. Staff training records should document that all staff have received training on emergency drills and evacuations.

W443

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and

Guidance §483.470(i)(1)(ii)

Staff on all shifts are able to express familiarity with the use of fire extinguisher, alarms, and any other safety features in the facility.

W444

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(iii) Evaluate the effectiveness of emergency and disaster plans and procedures.

Guidance §483.470(i)(1)(iii)

See also W448. The plan(s) must be revised as needed and must be based upon analysis completed under W448.

(2) The facility must--

W445

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(i) Actually evacuate clients during at least one drill each year on each shift;

Guidance §483.470(i)(2)(i)

All clients totally evacuate the building at least once per year per shift, regardless of the occupancy chapter under which the building falls.

All facilities, regardless of their size require actual evacuation. "Actually evacuate", as used in this standard, applies to all clients. The drills are conducted not only to rehearse the clients and staff for a fire emergency (see §483.470(i)(2)(v)), but for other disasters such as hurricanes, tornadoes, floods, etc. Such disasters would require the entire occupancy to be evacuated, and, therefore, the actual evacuation must be practiced, as required.

W446

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(ii) Make special provisions for the evacuation of clients with physical disabilities;

Guidance §483.470(i)(2)(ii)

Clients with physical or medical disabilities may require special procedures for evacuation, taking into account equipment or staff that must be maintained for the client's care at all times. The facility's evacuation plan should:

- identify such clients;
- clearly delineate any special evacuation procedures for those clients.

Staff should be familiar with the facility's special evacuation procedures when working with clients who are in need of unique provisions.

W447

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(iii) File a report and evaluation on each evacuation drill;

Guidance §483.470(i)(2)(iii)

There is a written report of each evacuation drill held.

W448

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(iv) Investigate all problems with evacuation drills, including accidents,

Guidance §483.470(i)(2)(iv)

The documentation for each evacuation drill includes an analysis of:

- The timeliness of the evacuation;
- Any difficulties observed during the drill;
- Investigates the cause of the difficulties; and
- Develops a plan to ensure the difficulties will not reoccur.

W449

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

and take corrective action; and

Guidance §483.470(i)(2)(iv)

When a problem is identified during the evacuation drill and the facility develops a plan to prevent reoccurrence, there is evidence the facility implemented corrective action and follow-up completed to ensure corrective action was successful.

W450

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

Guidance §483.470(i)(2)(v)

The Life Safety Code NFPA 101, 2000 Edition at 3.3.167 defines safe location as "a location remote or separated from the effects of a fire so that such effects no longer pose a threat."

W451

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(3) Facilities must meet the requirements of paragraph (i)(1) and (2) of this section for any live-in and relief staff they utilize.

Guidance §483.470(i)(3)

In the case of live-in staff, drills must occur quarterly. Typically, live-in staff can be found in facilities that fall under Chapter 32/33 of the LSC code. Drills should be held at varying times of the day and night for clients to practice evacuation including morning, afternoon, evening and the middle of the night.

(j) Standard: Fire protection.

Guidance §483.470(j)

These standards are covered by the Life Safety Code (LSC) survey. The facility must meet the appropriate chapter of the Life Safety Code, 2000 edition.

When surveying an ICF/IID for compliance with the LSC, it is first necessary to determine whether the facility will be surveyed under Health Care (HC) or Board and Care (BC) occupancy.

- If clients receive nursing services, or if the provider elects to use Health Care, the facility should be surveyed as a Health Care Facility under Chapter 18 or 19 of the LSC, as appropriate.

- If clients receive personal care and protective oversight but not continuing nursing services, the facility is to be surveyed under Board and Care and the following three steps should be followed:

  1) Determine the size (16 or less = small; 17 or more = large);

2) Determine the Evacuation Difficulty (PROMPT, SLOW, or IMPRACTICAL) using Appendix F of the fire safety evaluation system for board and care facilities (FSES/BC); and

3) Survey the building using one of two methods:

a. The prescriptive requirements of Chapters 32 or 33; or

b. The FSES/BC, Appendix G.

(1) General. Except as otherwise provided in this section—

(i) The facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.

(ii) Chapter 19.3.6.3.2, exception number 2 of the adopted LSC does not apply to a facility.

Guidance §483.470(j)(1)(ii)

Roller latches are prohibited on corridor doors as a latching device.

(2) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

(3) A facility that meets the LSC definition of a residential board and care occupancy must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the Fire Safety Evaluation System for Board and Care facilities (FSES/BC).

Guidance §483.470(j)(3)

The evacuation capability of residents is determined using Chapter 6 of NFPA 101A, 2001 edition.

4) If CMS finds that the State has a fire and safety code imposed by State law that adequately protects a facility's clients, CMS may allow the State survey agency to apply the State's fire and safety code instead of the LSC.

5) Beginning March 13, 2006, a facility must be in compliance with Chapter 19.2.9, Emergency Lighting.

Guidance §483.470(j)(5)

Battery powered emergency lighting must last at least 90 minutes.

6) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to a facility.

Guidance §483.470(j)(6)

Roller latches are prohibited on corridor doors as a latching device.

(7) Facilities that meet the LSC definition of a health care occupancy.

(i) After consideration of State survey agency recommendations, CMS may waive, for appropriate periods, specific provisions of the Life Safety Code if the following requirements are met:

Guidance §483.470(j)(7)(i)

Waivers may be granted only to facilities that meet the Life Safety Code definition of a Health Care Occupancy. Waivers are not granted to facilities that met the requirements of a Residential Board and Care Occupancy.

Waivers are recommended by the State Survey Agency and approved by the Regional Office.

(A) The waiver would not adversely affect the health and safety of the clients.

B) Rigid application of specific provisions would result in an unreasonable hardship for the facility.

ii) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a facility may install alcohol-based hand rub dispensers if—

(A) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;

(B) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls;

(C) The dispensers are installed in a manner that adequately protects against inappropriate access;

D) The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD and at the Office of the

Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269; and

(E) The dispensers are maintained in accordance with dispenser manufacturer guidelines

(k) Standard: Paint.

The facility must—

W452

§483.470(k)(1) Use lead-free paint inside the facility; and

W453

§483.470(k)(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

§483.470(l) Standard: Infection Control

W454

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(1) The facility must provide a sanitary environment to avoid sources and transmission of infections.

Guidance §483.470(l)(1)

The facility is clean and staff have eliminated opportunities for cross-contamination of infections. Food is stored, prepared, distributed, and served in a sanitary manner to prevent food borne illness.

W455

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

Guidance §483.470(l)(1)

Facilities maintain an ongoing surveillance program of communicable disease control and investigation of infections and an active training program that ensures the clients served receive adequate prevention of transmission information and skills, according to needs.

The facility's infection control program should include procedures for:

- identification of the extent of infestation or infection;
- protection of clients;
- treatment of clients;
- notification of family or legal guardian;
- reporting to the health department as indicated; and
- continued follow-up to resolution.

Both the Occupational Safety and Health Administration (OSHA) and the CDC have specific requirements regarding human immuno-deficiency virus (HIV), TB, and hepatitis precautions. These requirements should be incorporated into the facility's practices when relevant to the clients residing in the facility. Concerns about OSHA violations should be referred to OSHA.

W456

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(2) The facility must implement successful corrective action in affected problem areas.

W457

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(3) The facility must maintain a record of incidents and corrective actions related to infections.

W458

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

(4) The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

Guidance §483.470(l)(4)

The facility should have and implement a policy that clearly delineates those signs and symptoms for which they will restrict staff access to clients or to clients' food.

W459

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480 Condition of participation: Dietetic services

(a) Standard: Food and nutrition services

W460

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(1) Each client must receive a nourishing, well balanced, diet including modified and specially prescribed diets.

Guidance §483.480(a)(1)

"Well balanced diets" are defined as diets that contain a variety of foods from the food groups currently recommended by the Academy of Nutrition and Dietetics (AND).

"Modified and specially-prescribed" diets are defined as diets that are altered in any way to enable the client to eat (e.g. food that is chopped, pureed) or diets that are intended to correct or prevent a nutritional deficiency or health problem.

Refer to W463 and W474 regarding modified and specially prescribed diets.

The following may be indicators of or may lead to compromised nutritional status:

- Unplanned significant weight gain or loss;
- Fever/infection;
- Diarrhea;
- Chronic disease;
- Chewing and Swallowing problems;
- Teeth and gum diseases;
- Excessive use of laxatives;
- Abnormal laboratory values;
- Brittle, dry hair;
- Ridged or spoon shaped nails;
- Dry flaky skin; and

- Unexplained changed in mood such as general fatigue, apathy, irritability, lack of concentration.

If one or more of these indicators are present, determine the facility's response through observation, interview, and record review.

Surveyors should assure the facility is responsive to client food allergies and the potential for adverse food/drug interactions. If surveyors suspects these may exist, investigate further.

Examples of facility responsiveness to allergies and food/drug interactions include, but are not limited to:

- Clients on long term anticonvulsant drug regimens (e.g., phenobarbital, phenytoin, primidone) are periodically monitored per facility policy for decreased serum levels of folic acid and vitamin D;

- Therapeutic doses of nutrients are provided to decrease the likelihood of anemia and prevent decreased bone density, etc.; and

- Fiber and fluids are increased in the diet of clients to decrease the likelihood of constipation.

Guidance §483.470(a)(1)

Clients of grossly different ages, functional levels, and/or social needs should not be housed together unless all of the following documentation support the placement:

- Assessment;
- Client program plan;
- Staff documentation of client response to training programs; and
- QIDP notes.

W461

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(2) A qualified dietitian must be employed either full-time, part-time, or on a consultant basis at the facility's discretion.

Guidance §483.480(a)(2)

The facility employs a registered dietitian either on a part-time, full-time or on a consultant basis.

W462

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(3) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services.

Guidance §483.480(a)(3)

Where the facility does not have a full-time qualified dietitian, verify that the director of food services coordinates with a dietitian to assure the nutritional adequacy of meals and snacks.

The food service director coordinates with the part-time or consultant dietitian to develop client meal plans and monitor client nutritional status.

The qualifications of the food service director may be dictated by facility policy or by state law, if applicable.

In small group home settings where the staff and clients plan and prepare meals cooperatively, there may not be a designated food services director. In these cases, the consultant or part-time dietitian would meet with the available home staff to ensure adequacy of menus and diets.

§483.480(a)(4) The client's interdisciplinary team, including a qualified dietitian and physician must prescribe

W463

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(4) all modified and special diets

W464

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(4) including those used as a part of a program to manage inappropriate client behavior.

Guidance §483.480(a)(4)

Modifying a clients' diet must never be used as punishment.

W465

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(a)(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

Guidance §483.480(a)(5)

This regulation addresses the use of food in shaping positive adaptive behavior. Where clients have specialized nutritional needs, these needs must be taken into consideration.

When food is used as a primary reinforcement of behavior for a client who has a dietary restriction, these foods should be consistent with the foods allowed by the prescribed diet.

Food used as a reinforcement must be part of a behavior plan approved by the IDT and consistent with nutritional parameters for that client. For example, a client with diabetes does not receive concentrated sweets as a reinforcement.

W466

(Rev. 158, Issued: 09-09-16, Effective: 09-09-16, Implementation: 09-09-16)

§483.480(a)(6) Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

Guidance §483.480(a)(6)

The suggested guidelines can be accessed at the United States Department of Agriculture (USDA).

(b) Standard: Meal services

W467

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(1) Each client must receive at least three meals daily,

Guidance §483.480(b)(1)

Meal times may be flexible and accommodate a variety of activities (e.g. holiday and weekend activities). Clients should be offered the opportunity of three meals every day, but may be given the choice of not participating in a meal due to their schedule or preference.

For example, a client wakes up late on a Saturday morning and decides to have brunch.

W468

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(1) at regular times comparable to normal mealtimes in the community

Guidance §483.480(b)(1)

Generally, meal times conform to the norms of the community, however the clients' schedules and preferences may result in slight variations. Slight variations are acceptable, but gross variations such as breakfast at 3 am would not be acceptable.

§483.480(b)(1) with –

W469

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(1)(i) Not more than 14 hours between a substantial evening meal and breakfast of the following day,

Guidance §483.480(b)(1)(i)

A "substantial evening meal" is defined as an offering of three or more items at one time, one of which includes a high quality protein such as meat, fish, eggs, or cheese. The meal should represent no less than 20 percent of the day's total nutritional requirements.

W470

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(1)(i) except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may lapse between a substantial evening meal and breakfast; and

Guidance §483.480(b)(1)(i)

A "nourishing snack" is an offering of items, single or in combination, from the basic food groups. Snack supplies are available in the facility and are accessible to clients. Interview staff and clients about their access to snacks.

W471

§483.480(b)(1)(ii) Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under paragraph (b)(1)(i).

§483.480(b)(2) Food must be served--

Facility Practices §483.480(b)(2)(i)

Portions served, either by staff or by the individuals themselves, closely match designated serving sizes on menus. Slight variations are not significant enough or frequent enough to affect individual's health.

W472

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(2)(i) In appropriate quantity;

Guidance §483.480(b)(2)(i)

Meal observations verify that portions served, either by staff or by the clients, match the designated serving sizes on menus.

W473

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(2)(ii) At appropriate temperature;

Guidance §483.480(b)(2)(ii)

Hot foods are served hot and cold foods are served cold, according to facility policy specific to the type of food or as desired by the client. The facility follows current state requirements for safe food temperatures.

W474

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(2)(iii) In a form consistent with the developmental level of the client; and

Guidance §483.480(b)(2)(iii)

The term "form", as used in this requirement, refers to food consistency (e.g., pureed, chopped, ground, etc.). Food that is ground, chopped or pureed is based on assessed client need, and only to the extent required.

Food consistency modifications due to an acute medical or dental condition are temporary and; client's food consistency is upgraded at the soonest possible time. Clients with chronic medical or dental conditions are periodically reviewed and at least annually for the possibility of an upgrade in food consistency.

Client assessments must document the justification for modified texture of the client's diet.

W475

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(2)(iv) With appropriate utensils.

Guidance §483.480(b)(2)(iv)

"Appropriate utensils" refers to eating utensils and adaptive eating equipment that enable clients to eat as independently as possible in accordance with their highest functional level.

Commonly used utensils (fork, knife, and spoon) appropriate to the food being consumed are provided to all clients except those using adaptive equipment instead. Clients should be afforded the opportunity to use forks, spoons, and knives as indicated by the food served.

Utensils must be in good condition, clean, allow portion sizes appropriate to the client's prescribed diet and meet the client's needs.

W476

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(b)(3) Food served to clients individually and uneaten must be discarded.

Guidance §483.480(b)(3)

This standard does not apply to food served in family-style dishes, unless the length of time the food is on the table or other considerations (such as clients fingering or drooling in the food) compromise the safety and nutritive value for later consumption of the food.

(c) Standard: Menus

W477

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(c)(1)(i) Be prepared in advance;

Guidance §483.480(c)(1)(i)

The facility should be able to produce a copy of client menus prospectively to verify that meal planning is done in advance.

W478

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(c)(1)(ii) Provide a variety of foods at each meal;

Guidance §483.480(c)(1)(ii)

A "variety" of food at each meal includes offerings from each of the food groups.

W479

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(c)(1)(iii) Be different for the same days of each week and adjusted for seasonal changes; and

Guidance §483.480(c)(1)(iii)

Menus should make use of seasonal foods in order to capitalize on the availability of fresher more vitamin enriched foods.

In certain portions of the country, there may be cultural preferences that influence the frequency with which a food appears on the menu. This is acceptable in the facility if it is acceptable in the community.

W480

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(c)(1)(iv) Include the average portion sizes for menu items.

Guidance §483.480(c)(1)(iv)

Verify the menu lists client portion sizes and observe that the portions served correspond to the clients prescribed diet.

W481

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(c)(2) Menus for food actually served must be kept on file for 30 days.

(d) Standard: Dining areas and service

§483.480(d) The facility must –

W482

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician;

Guidance §483.480(d)(1)

For purposes of this standard, "dining areas" mean discrete eating areas located outside of bedrooms, established, furnished, and equipped for the purpose of eating meals.

When a client is not eating in a designated dining area, there must be either a medical rationale or this must be an isolated instance when the client has a personal reason to eat in another area, such as a television area to watch his or her favorite program.

Interview with the client should confirm that this is not routine, but is for a particular isolated reason.

W483

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs;

Guidance §483.480(d)(2)

Clients must have the opportunity to participate in the normal dining experience with their companions in the dining room.

Clients in wheelchairs are included in dining groupings of their peers without physical disabilities.

Clients in wheelchairs eat at the table and not with lap trays/hospital trays unless medically contraindicated.

W484

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client;

Guidance §483.480(d)(3)

Clients use adaptive equipment or are being trained to use such equipment when the need is identified in the IPP.

Examples of adaptive equipment that may be needed are:

- Double suction cups or other devices to anchor dishes on a table or tray for clients with major coordination problems;
- Rocking one-handed knife-fork or knife-spoon for a client with the use of only one hand;
- Built-up or extended handles or silverware for those with problems of grasp or range of motion;
- Plate guards or plates with raised rims to provide a surface against which the client with a physical disability can push food onto a fork or a spoon;
- Flexible drinking straws;
- Spoon bent to a 90 degree angle at the bowl or a swivel spoon to assist a client without normal wrist motions; and
- Any other adaptive device deemed by the team as needed by the client to eat more independently.

W485

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(4) Supervise and staff dining rooms adequately

Guidance §483.480(d)(4)

There should be sufficient staff to implement eating programs for clients who require them and to provide necessary intervention and supervision for normalization including normal meal time behavior.

Client mealtime should not be inadequately delayed due to insufficient staff assistance.

W486

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(4) to direct self-help dining procedures,

Guidance §483.480(d)(4)

Staff is present during meal times to monitor clients who are able to eat independently, promoting, supporting, reinforcing and encouraging them to eat in an appropriate and normalized manner (e.g., manners, social behaviors, etc.)

W487

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(4) to assure that each client receives enough food and

Guidance §483.480(d)(4)

Clients can request and receive second helpings unless contraindicated by a prescribed diet.

For clients on restrictive diets that prefer not to be on these diets or seek seconds, the facility resolves the personal choice issues vs. health risks.

W488

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(4) to assure that each client eats in a manner consistent with his or her developmental level; and

Guidance §483.480(d)(4)

The intent of this regulation is to promote the acquisition of skills that lead to greater independence in eating.

Clients should be actively encouraged to eat independently to the extent possible and in accordance with their assessed abilities.

Clients should receive training to develop independent eating skills consistent with their developmental potential as identified through the CFA.

Clients learn skills in accordance with their functional levels. Skills may include:

- Use of utensils;
- Meal preparation;
- Socialization during meals;
- Family style dining; and
- Ordering food in restaurants.

Clients' eating programs are implemented in accordance with their training objectives.

To the maximum extent possible, staff model appropriate mealtime behavior and conversation by sitting at the table with clients, and when possible, eating meals with clients.

W489

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.480(d)(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.

Guidance §483.480(d)(5)

If a client eats in any position other than an upright position, the physician should document the medical necessity for the position, and/or the IPP should include the program plan to teach the client the physical skill necessary for eating upright.

This applies to all clients, including those fed by nasogastric tube or gastrostomy tube. The IPP should identify the most appropriate position for the client to be positioned during mealtime, in relation to the placement of the food contents.

Transmittals Issued for this Appendix

Rev #	Issue Date	Subject	Impl Date	CR#
R178SOMA.pdf	04/13/2018	Revisions to State Operations Manual (SOM) Appendix J, Part I – Survey Protocol for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	04/13/2018	N/A
R175SOMA	12/22/2017	Revisions to State Operations Manual (SOM) Appendix J, Part II – Interpretive Guidelines – Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	12/22/2017	N/A
R162SOM	10/14/2016	Revisions to State Operations Manual (SOM) Appendix J, Part II – Interpretive Guidelines – Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities	10/14/2016	N/A
R158SOM	09/09/2016	Revisions to State Operations Manual (SOM) Appendix J, Part II – Interpretive Guidelines – Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities and Exhibit 355, Probes and Procedures for Appendix J	09/09/2016	N/A
R144SOM	08/14/2015	Revisions to State Operations Manual (SOM) Appendix J, Part II – Interpretive Guidelines – Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities	08/14/2015	N/A
R135SOM	02/27/2015	Revisions to State Operations Manual (SOM) Appendix J, Part II	04/27/2015	N/A

		– Interpretive Guidelines – Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities revisions. An addition of a New Exhibit to the State Operations Manual (SOM) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Probes and Procedures for Appendix J, Part II – Interpretive Guidelines- Responsibilities of Intermediate Care Facilities for Individuals with Intellectual Disabilities		
R94SOM	12/06/2013	State Operations Manual (SOM) Appendix J, Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities, nomenclature revisions	12/06/2013	N/A
R10SOM	08/12/2005	Revisions to Appendix J	08/12/2005	N/A

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF

SANDY EVANS

May 5, 2022, at 11:13 a.m.

CRIS M. BRASUELL, CCR
BREPORTING@GMAIL.COM



A P P E A R A N C E S

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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Sandy Evans, produced, sworn, and examined via Zoom, commencing on May 5, 2022, at 11:13 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

PROCEEDINGS

WHEREUPON, Sandy Evans was duly sworn to tell the truth, the whole truth, and nothing but the truth, and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Hi, Ms. Evans. Thanks for being here today. You doing all right today?

A I'm good. How are you?

Q Good.

Could you state your full name for us, for the record.

A Sandra Beth Evans.

Q Okay.

And, as I understand it, you no longer work for the facility?

A That's correct. I retired in May of 2021.

Q I'm sorry, ma'am. Let me turn my volume up.

You retired when?

A May of 2021.

Q Okay. And retired after how many years there?

A Thirty-six years.

Q Okay. All at the BHDC?

A Yes. That's right.

Q All right. And, over the years, what positions did you hold at BHDC?
A When I started, in 1995, I was an instructor. I trained clients.
Then I became a -- they call it a QMRP, so you led team meetings for your clients. Then I became a team leader. And then my final job was residential services director.
Q Okay. And from what years did you serve as residential services director?
A I can't be exactly sure on the years. I would say I was in that possibly three years. I'm unclear on it.
Q Three or more years prior to your retirement?
A Yes.
Q And that was the position that you held at the time of David's Cains' death?
A Yes. That's correct.
Q Which was June 13th of 2020?
A Yes.
Q Okay.
Did you hold any other -- did you perform any other functions at the facility other than as residential services director at that time?
A Yes. I was a maltreatment investigator.
Q Okay. And how long had you been a maltreatment

investigator?
A I don't remember the exact date from when I took the course and qualified. Perhaps ten years, but I can't say for certainty.
Q Perhaps ten year prior to David's death?
A Yes.
Q Were you the only licensed maltreatment investigator at the BHDC?
A No.
Q Okay. How many others were there?
A I'm not a hundred percent certain. Possibly six or seven. But I don't -- I'm not a hundred percent sure.
Q And, in your time as a licensed maltreatment investigator, approximately how many investigations did you conduct?
A Investigations, again, because I've been retired for a year, I'm a little sketchy on some of these details.
Ten, possibly 15; and that's strictly a guess.
Q Okay. Would all of those have been investigations whereby you're investigating whether a fellow employee of the BHDC committed maltreatment?
A Yes.
Q Okay. None of them would have been investigations into maltreatment, client-on-client maltreatment, for instance?

A No. No, I did do -- I apologize. I did do one investigation that involved client-on-client.
Q Okay. But the rest of them were staff-on-client investigations?
A Yes.
Q And you estimate between ten to 14 of those?
A That's an approximate guess, yes.
Q Okay. Over a period of approximately ten years?
A Approximately. Approximately, yes.
Q Sure.
A I'm sorry, I -- I haven't had access to my files in the last year. So I can't give you very specific information.
Q I understand that.
Were you able to review anything prior to -- in preparation for this deposition?
A I came in early this morning to read through my report and the report that was sent to Little Rock at that time.
Q Okay. And what reports are those? When you say your report, what is that report called, officially?
A It's called an adult maltreatment investigation report.
Q Okay.
A And then that includes statements from the staff.

And then I also reviewed the report that our superintendent sends to Little Rock summarizing the incident.

Q And what is --

A An IRIS report.

Q I'm sorry?

A It's called an IRIS report.

Q Irish?

A IRIS, I-R-I-S. Uh-huh.

Q Okay. So your report is called -- I'm sorry. Say that one more time.

A Adult maltreatment investigation report.

Q Okay. And then the report that Mr. Gonyea sends to Little Rock -- and by Little Rock, you mean the director of DDS?

A Yes.

Q And that report is called an IRIS report?

A I believe they -- his report may be -- we report it as an IRIS, an incident reporting system that all incidents have to be reported on.

I'm looking for the copy of his report to give you an exact title. I can't find it in here. But he does send -- he reviews my report and then sends another report to DHS. It's called a DHS incident report.

Q DHS incident report?

A Yes.
Q So it's not called an IRIS report?
A No. I'm sorry.
Q What would an IRIS report be?
A An IRIS report is any incident on campus of any type of serious nature, is a report that one of the admin assistants completes and sends to central office, DDS.
Q Would there have been an IRIS report for this incident with Mr. Cains?
A Yes.
Q Who would have done the IRIS report?
A Lynn Spain. She is an administrative assistant at BHDC. She completes those and then sends it while we're working on the investigation.
Q Okay. And, again, she sends that to Little Rock?
A Yes. I believe that's correct.
Q And do you have all three of those reports in front of you right now?
A I'm looking through here. I -- yes. She has BHDC IRIS alert and report.
Q Okay.

MR. GILLISPIE: Eric, do you have these documents?

MR. COLLINS: Not in front of me right now, no.

MR. GILLISPIE: Do you know if these, all three of these, were produced, Eric?

MR. COLLINS: I'm not sure about the IRIS report. I thought I had seen it in the production. The maltreatment wouldn't be produced. What was the third one?

MR. GILLISPIE: So there's the adult maltreatment report, that's Ms. Evans's report.

There's the DHS incident report, that's Mr. Gonyea's report. And the IRIS report which was done by Ms. Lynn Spain.

MR. COLLINS: I'll check into the DHS incident report. I'm pretty sure I've seen the IRIS report and the incident report in there. I'll double check it.

The maltreatment report is protected by statute, so there's, you know, manners for you to request that. But we can't give that without you (inaudible).

MR. GILLISPIE: So she has that in front of her right now. She's using it for this deposition. I really would need to be able to see what she's looking at to question her about it.

Is there a way I can get a copy of it for

today's purposes under an agreed, you know -- we can -- I'll agree on the record to some sort of basic protective order preventing it from being used outside of this litigation or made public.

MR. COLLINS: One second. Let me read the statute.

I don't think we can. But, if you want to seek a leave from the Claims Commission, which I'm not going to oppose, but I'm not going to put (inaudible) --

MR. GILLISPIE: I know that, for child maltreatment reports, the victim, even in cases where it's unsubstantiated, I believe the victim can get a copy of -- in fact, I know they can. I've gotten them.

You can request a copy of child maltreatment investigative reports. Even when they're unsubstantiated.

MR. COLLINS: You're client's not the victim; nor is your client victim's guardian, since the victim has died.

MR. GILLISPIE: But, since she has the -- you think that since she has letters of guardianship, she stands in the shoes and could

request that on his behalf.

It's kind of like it's always the parents that request it anyways. The child can't request anything.

MR. COLLINS: In that instance, the parents are the guardian. She's not the guardian of anybody at the moment.

Again, if you request it from the Claims Commission, request that authority, I'm not going to object to it. I'm not going to fight it.

MR. GILLISPIE: Okay.

MR. COLLINS: I'm not going to put myself out there and say, hey, it's fine.

MR. GILLISPIE: Well, can we just agree that, if I get that document and that document leads to additional questions for Ms. Evans, that we can reopen her deposition?

It may not. But --

MR. COLLINS: I'm completely fine with that.

I'll just reiterate I'm not Mrs. Evans' attorney.

MR. GILLISPIE: Sure.

But you won't object to --

MR. COLLINS: No, I will not.

MR. GILLISPIE: And you won't object to me subpoena -- and, Ms. Evans, I probably won't have to do that. I probably won't have to do that; but, just in case. Okay.

BY MR. GILLISPIE:

Q Tell me about the training that you had to go through to become a licensed maltreatment investigator, Ms. Evans.

A I attended a -- I believe it was a five-day training program at the Conway HDC.

They had contracted out with trainers. It was five days of lecture and reading; and then you were tested at the end. And you had to pass the test in order to get licensed.

Q Okay.

A And you received a certificate, yes.

Q All right.

As soon as you got that certificate, approximately ten years ago, you started serving in that role in addition to whatever your full-time job title was?

A Yes.

Q And, again, at the time of Mr. Cains' death, that was residential services director?

A Yes.

Q And of those approximately ten to 15 -- or ten to 14, I think you said one was client-on-client.

On those approximately ten to 14 maltreatment investigations that you conducted involving allegations of the staff-on-client maltreatment, have you ever substantiated maltreatment in any of those?

A Yes.

Q Yes?

A Yes.

Q Okay. Approximately how many of them? Do you know?

A I can't say with any accuracy.

Q Well, how many can you specifically remember substantiating?

A I remember probably five. And that -- again, that's a guess. Because I don't have access to my files.

Q Okay. But five is, you think it's around that number?

A Yes.

Q Okay. And I'm not going to get into confidential information about who was involved.

Well, I will ask this. Other than this, the investigation that you did in this case for this incident, did you ever conduct a maltreatment investigation involving Tyler Mattson other than this?

A I do not recall. I'm sorry.

Q Okay.
How about Ms. Jones, Mandy Amy Jones?
A I don't recall whether I did or not. It -- it doesn't spring to mind.
Q Okay. How would you, if you wanted to determine how many of your investigations led to substantiated maltreatment, how would you determine that?
A I would have to -- I kept files in office, as the services director, with all of my investigations.
I would have to go through all of those to look and see how many.
Q Okay. So there exists a file that --
A Yes.
Q -- is still there at the facility that would answer that question?
A It should still be there.
Q Okay.
A They may have moved it to a different location. I don't know.
MR. GILLISPIE: Eric, would it be possible for me to get a redacted copy of that just so I can -- redacted copy of those that provides specific information to me, mainly substantiated or unsubstantiated, and whether Ms. Campos, Ms. Jones, or Mr. Mattson were

involved?

MR. COLLINS: I'll have to confer with my supervisors on that one. I don't see an issue with giving you information pertaining to that. I'm not sure if I can give the documents up.

MR. GILLISPIE: So that would maybe need to be something that the claims -- I would need to ask the Claims Commission for?

MR. COLLINS: For the actual documents, even if redacted, yes.

MR. GILLISPIE: Even if redacted?

MR. COLLINS: Yeah. I don't necessarily see an issue with saying, hey, we had x amount of investigations.

MR. GILLISPIE: Uh-huh.

MR. COLLINS: This --

MR. GILLISPIE: Yeah.

MR. COLLINS: -- (inaudible) ten of them, five of --

MR. GILLISPIE: Right.

So all I want to know is how many investigations Ms. Evans conducted involving staff-on-client, how many of those were substantiated, and finally how many of those involved one of these three staff members.

MR. COLLINS: Okay.
Can you send it to me as an interrogatory?
MR. GILLISPIE: Yes, I can.
MR. COLLINS: Okay.
THE WITNESS: I will say, Mr. Collins, the superintendent's office would also have those records.
MR. COLLINS: Yeah. I imagine we can find them.
THE WITNESS: Yes, sir.
MR. GILLISPIE: Okay.
If we can go off the record just a moment, please. I'm going to write that down real quick, Eric.
Go off the record for just a moment, please.
(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)
BY MR. GILLISPIE:
Q Ms. Evans, tell me about your job as residential services director.
A That job involved overseeing all client living areas and all client training areas.
Q Did it not also involve overseeing all direct care

staff?
A Yes. Yes.
Q So you would have been the immediate supervisor for Ms. Amy Jones at the time of this incident?
A No. Under my position, there would have been team leaders and then direct care supervisors.
And they would directly supervise the direct care staff.
Q Okay. But, basically, the residential services director oversees the direct care of the clients that is administered by these shift leaders, team leaders, and RTCs, direct care staff, such as Mr. Mattson, Ms. Jones, and Ms. Campos?
A Yes.
Q Okay.
And then who would you have reported to directly in that position?
A The superintendent.
Q Mr. Gonyea?
A Yes.
Q Okay.
In serving in that role, you would have been very familiar with the policies and procedures that the facility and the staff at the facility were required to follow regarding physical restraints of the clients;

correct?
A Yes.
Q And is it fair to say that these policies and procedures, these rules regarding physical restraints of the clients, are things that the director of residential services would have been responsible for imparting to the people under you, the direct care staff, making sure they know what the rules are?
A It would actually come from our staff development people and from those direct line supervisors in the areas and the program supervisors who are the highest level of direct care supervisors.
Q Okay. Hypothetically, take a situation where you learn that a direct care staff member is reasonably restraining a client. What would your role be as the director of residential services?
Would you have any obligation to do anything in that event?
A Yes. I would look into the incidents, gather data on it, analyze it. Talk to the supervisors, perhaps talk to that staff person, and possibly (inaudible) a recommendation for that person.
Q Okay. And did you have the authority to control how direct care staff interact with the clients?
A Yes; although, understanding that I would not be in

every living area all the time.
Q Right.
A A lot of the information went from me to their supervisors to impart down to the actual direct care staff.
Q All right.
Are you familiar with the, what's been produced to us, the state operations manual? Bates Stamp 1607.
This is a guidance or these are the regulations that have to be met in order to be compliant with Medicaid.
A Yes.
Q Are you familiar with those?
A Yes. It's been awhile since I've seen them; but, yes.
Q Sure. I'm not going to quiz you on --
A Yeah.
Q I'm not going to make you, you know, quote anything.
But I just want to go though a few of these that are relevant to what happened to Mr. Cains and secure your agreement that these are, in fact, policies and regulations that the facility has to abide by.
You are familiar with what these are? You would agree with me, just in general, that these regulations are applicable to BHDC and that these are policies and procedures that the facility is required to comply with?

A Yes. I assume those are like Office of Long-Term Care and federal regulations.
Q I believe they are federal regulations.
For the format they were produced to me in, it's called a State Operations Manual; but, yes.
MR. GILLISPIE: Eric, this is Bates Stamp 1658.
BY MR. GILLISPIE:
Q And I'm going to show it to you as best I can, Ms. Evans.
Regulation Section 483.420(A)(6) states that a facility must ensure that clients are free from unnecessary physical restraints.
Do you see that? I highlighted that. There's other parts of the sentence, but that's -- for our purposes, that's what's relevant. Do you see that?
A Yes.
Q Okay. You would agree that that's a regulation that BHDC must comply with; right?
A Yes.
Q Next page, Bates Stamp 1698, and this is Regulation Section 483.430(E)(2).
States that staff is to receive training in the following areas. And those areas include use of accurate procedures regarding restraints and use of least

restrictive interventions.

Use of least restrictive interventions. Do you see that?

A Yes.

Q And you would agree that those, that is also a regulation that BHDC must comply with?

A Yes.

Q All right. Same exhibit. This page is Bates Stamped 1753. This is Regulation Section 483.450(b)(1)(l). And this states that all interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy. You see that?

MR. COLLINS: I'm going to object to the form of that question. I think it's misstating the document as presented.

MR. GILLISPIE: What part of this am I misstating? I'll try to --

MR. COLLINS: I believe, the way you worded the question, you're stating that that is what the regulation, using your terminology, says. That's what the guidance says below the regulation. The regulation is above it.

So, if you look up and down, Guidance Section 483.450(e)(l) --

MR. GILLISPIE: Right.

MR. COLLINS: -- I just want to specify that what you're reading is, in fact, the guidance. It's not the regulation itself.

MR. GILLISPIE: Okay. I see what you mean.

BY MR. GILLISPIE:

Q The regulation says specify all facility-approved interventions to manage inappropriate client behavior.

Do you see that one in bold, ma'am?

A Yes.

Q Okay. And we're all in agreement that is the regulation; correct?

A Yes.

Q Okay.

And what I take that to mean is that any type of intervention that is to be used to manage client behavior must be clearly explained and stated in the facility's policy.

Would you agree with my interpretation?

A Yes.

Q Okay.

And the part that I highlighted that Mr. Collins correctly pointed out is the guidance paragraph.

It says that all interventions for the management of

inappropriate client behaviors which are approved for use in facility are clearly stated and described in its policy.

You agree that I'm reading that correctly?

A Yes.

Q Okay.

Move to page Bates Stamp 1754, this is Regulation Section 483.450(b)(1), Roman numeral -- well, three I's. So 483.450(b)(1)(III).

This regulation states that a facility must ensure, prior to the use of more restrictive techniques, that the clients' record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.

And that's the part in bold. Can you -- and I'm sorry, ma'am, if you --

A You can go up just a little bit. Oh, in bold. Okay. Yes, I see what you're saying.

Q Okay. And you'd agree that that's a regulation that BHDS must follow?

A Yes.

Q Okay.

COURT REPORTER: Josh, feel free to share your screen, if you need to, if you have these

documents in PDF form.

MR. GILLISPIE: Well, I do have these documents in PDF form.

(Brief discussion off the record.)

MR. GILLISPIE: Why don't we go off the record for just a second.

MR. COLLINS: Okay.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Ms. Evans, you should be able to see the document I'm referring to now on the screen. Can you?

A Yes.

Q Okay.

So we already went over this regulation here, 483.450(b)(1)(III). But, under guidance, do you see this part that I've highlighted that says, in emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible? Do you see that?

A Yes.

Q Okay. And would you agree with that, with that guidance? That, in those situations, BHDC and staff are

required to choose the least restrictive technique possible?

A Yes.

Q All right.

Bates Stamp 1755, this is Regulation 483.450(b)(1)(IV)(b). The use of physical restraints.

The guidance here states that physical restraint is defined as any manual hold or mechanical device that the client can not remove easily and which restricts the free movement of normal functioning of or normal access to a portion or portions of the clients' body.

Examples of mechanical devices may include arm splints and mittens. Policies and procedures of a facility must address the types of physical restraint that are allowed in the facility.

Would you agree with that?

A Yes.

Q Policies and procedures must address the persons who apply such restraints. Would you agree with that?

A Yes.

Q They must address the parameters for duration of application. Would you agree with that?

A Yes.

Q And they must address the methods that ensure the health and safety of clients while in restraints. Would

you agree with that?

A I can't quite see that bottom line.

Q I'm sorry.

A That's okay. Yes.

Q Okay.

And then, finally, the specific training required for staff allowed to apply such restraints.

Would you agree that, that this guidance, is a regulation that the facility must comply with?

A Yes.

Q Okay.

Moving on to Bates Stamp 1763, this is Regulation 483.450(d)(1).

The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.

Do you agree that I'm reading that correctly?

A Yes.

Q Okay.

And the guidance here, same regulation, states that the use of physical restraint is specified within the IPP.

So would you agree with me that BHDC is required to

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specify the use of physical restraint within a client's IPP?

A Yes. That would likely also be included as part of a behavior treatment program which is part of the IPP.

Q But you would agree that any physical restraint that is potentially to be used upon a client should be clearly stated in policies and in the client's IPP?

A Yes.

Q Okay.

The guidance on this regulation also says that the plan must address the specific type of behavior to be managed by this plan. Do you see that?

And then, under four, the plan; and, again, this is referring to IPPs. But it's saying that the plan, and for our purposes, the IPP must address the type of physical restraint. Do you see that?

A Yes.

Q And would you agree that is a regulation that the BHDC must comply with?

A Yes.

Q Okay.

Same regulation down at the bottom here. This is a continuation of the same regulation.

The beginning of the regulation says the facility may employ physical restraint only; and so this is the

continuation of that.

Only as an emergency measure but only if absolutely necessary to protect client or others from injury.

So I'll repeat that. Only as an emergency measure but only if absolutely necessary to protect client or others from injury.

Would you agree I'm reading that accurately?

A Yes.

Q And would you agree that is a regulation BHDC must comply with?

A Yes.

Q Okay.

And the guidance there goes on to say that physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which the client has not exhibiting before or not identified in the functional analysis of that client's behavior or are harming other people or themselves.

A Yes.

Q Would you agree that is a rule that BHDC must abide by?

A Yes.

Q Okay.

Moving on to page, in this same exhibit, Bates Stamp 1766, this is Regulation Section 483.450(d)(2)(I). And

this has to do with how long a physical restraint can be used.

The guidance here, moving down, that I'm concerned with is this part. The client must be released from the physical restraint as soon as the client is no longer a risk to self or others.

Would you agree with that?

A Yes.

Q Okay.

Moving on to Regulation 483.450(d)(3), the facility must not issue orders for restraint on a stating or as-needed basis.

A Correct.

Q You see that?

A Yes.

Q And do you understand that is a rule that BHDC was required to comply with?

A Right. All restraint is considered an emergency use. We don't have standing order for mechanical restraint.

Q And I'm just asking if you agree that this is the rule.

A Yes.

Q Okay. You agree that standing orders or -- I'm sorry.

You agree that restraint on a standing or as-needed basis is forbidden?

A Yes.

Q Okay.

Moving on to 483.450(d)(4), would you agree that this regulation states that a client must be released from a physical restraint as quickly as possible?

A Yes.

Q Okay. And you'd agree that is a regulation BHDC must comply with?

A Yes.

Q Okay.

This is the last one for this exhibit. 483.450(d)(5), restraints must be designed and used so as not to cause physical injury to the client.

A Yes.

Q And you would agree that is a regulation that BHDC and its staff are required to follow?

A Yes.

Q That is a rule, that any restraint used must be designed not to cause -- specifically designed not to cause physical injury; correct?

A Correct.

MR. GILLISPIE: This is Exhibit 1. And we'll e-mail that to you, Cris.

(WHEREUPON, the document was marked for identification as Exhibit No. 1 and is attached hereto.)

MR. GILLISPIE: I'm going to pull up Exhibit 2 now that we have this nifty share screen option.

Is everybody seeing DHS policy 3011-D?

THE WITNESS: Yes.

MR. GILLISPIE: Okay.

Eric, you can see it? Y'all can't see all my files, can you?

MR. COLLINS: No.

MR. GILLISPIE: Okay. All right.

BY MR. GILLISPIE:

Q Are you familiar with this policy, Ms. Evans?

A Yes.

Q Okay. And you'd agree with me that this is the DHS Division of Developmental Disability Services Policy No. 3011-D Behavior Management; correct?

A Yes.

Q And you would agree that this policy is also something that BHDC is required to comply with; correct?

A Yes.

Q Okay. Behavior management, this section states that behavior management -- this is Paragraph Three.

Behavior management, as covered by this policy, behavior management, as covered by this policy, serves as a guide to ensure that an individual's actions that are aggressive, disruptive, and/or present a danger to the individual or others, are managed with the least restrictive method. Do you see that?

A Yes.

Q And, again, you would agree that, at BHDC, only the least restrictive method can be used on a client?

A Yes.

Q Least restrictive for the situation; correct?

A Yes.

Q Okay.

Moving to Page Five of this document, this is D, Restraint, you see where it says that IDT consideration will be given to parent/guardian, notification of use of restraint, and address it in the behavior program?

A Yes.

Q Okay. And then, under that, in Section One where I've highlighted here, it says approved methods of intervention must be in the individual's behavior program.

Do you see that?

A Yes.

Q And would you agree with that?

A I don't know that -- it could have been. I can't -- I can't recall.
Q Well, I'm just asking do you --
A Yeah.
Q -- agree that approved methods of physical restraint or personal restraint to be used on a client must be in the individual's program, in their IPP?
I think we've already gone over that.
A Yeah. Yeah. Yes.
Q Okay. So you would agree with that?
A Yes.
Q Okay.
Page Seven, conditions for use of behavior programs. So this regulation requires that, for a behavior program or an intervention can be used, a former behavior program will be developed by the IDT written by a licensed psychological professor and approved by a phycologist.
It will include the following elements; number three being a thorough description of each step of the program to include duration and intensity of specific procedures, the methods of monitoring and analyzing the process, and special precautions that will be taken.
Do you see that?
A Yes.
Q You would say that that is a policy that BHDC must

follow?
A Yes.
Q And then, in B, the IPP or behavior program will include a description of all procedures already attempted. And then the side effects and risks, if any, of the intervention in comparison with those of allowing the maladaptive behavior to continue.
A Yes.
Q Do you see that?
A Yes.
Q And you agree that, according to this policy, an IPP is required to include that information?
A Yes. They would do a risk-versus-risk analysis.
Q Okay.
That's all the questions I have for this exhibit.
MR. GILLISPIE: It will be Exhibit 2.
(WHEREUPON, the document was marked for identification as Exhibit No. 2 and is attached hereto.)
BY MR. GILLISPIE:
Q Moving on to Exhibit 3, Ms. Evans, do you recognize this? This is a Booneville policy, Policy I-D-4 Documentation and Response to Maladaptive Behaviors.
A Yes.
Q Do you recognize this?

A Yes.
Q In this first paragraph, you see it says personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure.
Maladaptive behaviors include but are not limited to behaviors that result in or have the potential to result in injury to self or others or the destruction of property.
Am I reading that correctly?
A Yes.
Q Okay.

MR. COLLINS: Josh, what is the Bates stamp on that document?

MR. GILLISPIE: 4348.

MR. COLLINS: Was that produced in the procedures that were in place at the time of the incident?

MR. GILLISPIE: Yeah. This one, the version is from 2018.

MR. COLLINS: Okay. I was just looking at the wrong version. I wanted to make sure on that one. Thank you.

MR. GILLISPIE: Yeah. The other one was after the incident, so I'm only using this one.

MR. COLLINS: Gotcha. Thank you.

MR. GILLISPIE: Okay.
BY MR. GILLISPIE:
Q Emergency use of restraint. Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors.
The use of emergency restraint will comply with all relevant standards and regulations.
Did I read that correctly?
A Yes.
Q And you'd agree that is a policy, a BHDC policy?
A Yes.
Q That the least restrictive procedure, that only the least restrictive procedure for the least amount of time necessary to control severely aggressive or destructive behavior can be used; correct?
A Correct.
Q Page Four of this document, Section Six, you would agree -- will you take a look at Section Six just for a second? Let me know when you've had a chance to look at it.
A Yes.
Q Okay. Would you agree that this is a list of approved restraint procedures for emergencies, for emergency situations?

A Yes. But I don't believe wrist restraints have been used up here in years.
Q Okay. And I'm actually not even going to ask you about that.
A Okay.
Q I'm concerned with a --
A Uh-huh.
Q -- personal restraint; which is defined as an emergency procedure limiting movement by the holding of a hand or limb.
A Yes.
Q Did I read that correctly?
A Yes.
Q Yes?
A Yes.
Q I'm sorry. It's --
A That's okay.
Q No, no.
Okay. So this is the list of approved procedures to be utilized for emergency restraint; correct?
A Yes. With the approval or notification of a (inaudible) RP.
Q So this defines a personal restraint as an emergency procedure limiting the movement by the holding of a hand or limb.

You would agree that's how the BHDC policy defines personal restraint; correct?

A Yes.

Q Okay.

And are you aware of any other BHDC written policy where personal restraint is defined in a different way?

A I don't member. I couldn't say with certainty.

Q Well, as you sit here today, can you point to any other policy or any other approved list of personal or any other approved list of restraints that can be used in emergency situations or -- well, let me break that down into two questions.

Ms. Evans, as you sit here today --

A Yes.

Q -- can you point to any other policy, whether it be a BHDC policy or a DDS policy or whatever, any other policy or document that lists the types of restraints that can be used in an emergency situation?

A No.

Q Okay.

The second part of the question is, as you sit here today, can you tell me about or point to or identify any other definition of personal restraint other than what you see here?

A No.

Q Okay. And nowhere in any of the policies or documents, that you know of, is personal restraint defined in any other way but by limiting movement by the holding of a hand or limb?
A No. Not that I recall.
Q Okay.

MR. GILLISPIE: I'm done with this document. That will be Exhibit 3.

(WHEREUPON, the document was marked for identification as Exhibit No. 3 and is attached hereto.)

BY MR. GILLISPIE:
Q Okay.

Ms. Evans, can you point to any policy or any document that allows for clients to be held down on the ground during an emergency incident?
A I don't believe anything specifically says that. But, often times, the client will go down to the ground on their own during restraint.
Q Uh-huh. And, in this case, the case of Mr. Cains, Tyler Mattson, who we deposed a couple of weeks ago, he testified under oath that, during this restraint, he by himself, held Mr. Cains on the ground by force with both hands for two minutes.

Then Mandy Jones joined in the restraint and that it

lasted another two or three minutes where the two of them held him down on the ground, holding different parts of his body against his will, for two or three more minutes.

And, finally, Mr. Mattson testified that Ms. Ryann Campos then joined in causing all three of them to be holding him on the ground against his -- holding him, pinned to the ground, for another one to two minutes.

And that's prior to him -- according to Mr. Mattson, that's up to seven minutes where they were holding him down on the ground prior to him going into cardiac arrest and choking or aspirating.

Please tell me where, BHDC policy, would it describe that type of a personal restraint as an allowed use of restraint.

Where would that be authorized?

A I don't know that it would be in a policy; because every personal restraint can be different, depending on what the client is doing.

Q Well, Mr. Mattson also said that that was a type of -- in fact, everybody I've talked to, just about, has said that's a type of restraint that was common.

That holding clients on the ground, while they're on the ground, holding them down there on the ground until they calm down, was a common thing.

Do you disagree with that?

MR. COLLINS: I'm going to object to this line of questioning.

I don't remember everything Mr. Mattson said. I doubt you remember. You're obviously paraphrasing.

We have his deposition. I feel, if you're going to ask her a question about his testimony, you can show her his testimony so she has verbatim what he said, and then ask her a question about what he said.

MR. GILLISPIE: Well, I, you know, appreciate the speaking objection, Eric.

BY MR. GILLISPIE:

Q But I want to know if -- assuming that I'm -- Ms. Evans, assuming that I'm accurately stating Mr. Mattson's testimony, is it your position that what he described, which is approximately seven minutes of holding Mr. Cains down on the ground, is it your position that is an appropriate personal restraint? A personal restraint that is allowed under the rules?

A It is. But I would disagree with the time, based on my investigation report.

My investigation said that Tyler held him for approximately one minute. Mandy Jones came in and helped for another one minute. So, according to my report, the

time was much less than seven minutes.
Q Okay. Even if it was less than seven minutes, where is that allowed in the policies?
We've already established and you've already agreed with me that the types of physical restraints to be used are to be clearly indicated, clearly stated.
And we talked about the definition of personal restraints, can be used in emergency situations as holding a hand or limb.

MR. COLLINS: I'm going to object to the form of the question.

I feel you're misstating earlier testimony. It was clear from the procedure, she said those were treatment plan policies; and that's differentiated from emergency policies.

BY MR. GILLISPIE:
Q Go ahead and answer the question, Ms. Evans.
A Okay. Could you repeat it, please?
Q Yes.
Now, I can show you the pages from Mr. Mattson's deposition where he gives me these times. And, you know two minutes for him, two to three minutes for him and Mandy, one to two minutes for all three of them.
And those are his words. I didn't -- I'm not making

that up. But I can show you those pages. But --
A I (inaudible) --
Q -- even if --
A I'm basing my information on the information they gave me directly after the incident.
Q Okay.
A I have statements from them directly after the incident.
Q And so, based on the form you were given directly after the incident, how long did the three of them have him pinned to the ground prior to him going into cardiac arrest?
A I don't know that he did actually go into cardiac arrest. I was not made aware of that fact. However --
Q Prior to him vomiting and choking.
A Tyler said he held him in restraint for one minute. Amy, when Amy cane in, she assisted for about one minute. Ryann Campos, she did not give a timeframe.

But Tyler had also stated in his statement directly after the incident that David fell over onto the floor.
Q Uh-huh.
A That's why they were on the floor.
Q Okay. And it's your position that -- even though he said something completely different to me, let's go with the numbers you're saying he gave you.

A Uh-huh.
Q It's your position that, again, the amount of time you're saying was reported to you after the incident, it's your position that doing that, what they did, holding him there on the ground --
A Uh-huh.
Q -- one with his hands on him, the other holding his legs, somebody holding either his arm or his head, depending on who you ask, your position is that is allowed? That's an allowed restraint? That's an appropriate restraint?
A Yes. If the client is fighting him.
Q And where can I find that? Where does it say that that is allowed if the client is fighting?
A Well, that's the only reason you would be using restraint, is if the client is aggressive. You wouldn't use it if the client was not aggressive.
Q I'm asking, have you been given any document, any training, do you know of any document, any training manual or anything provided by the state or by BHDC itself that specifically says, yeah, you can hold a client to the ground if they're having a behavior incident?
A Yes. We receive nonviolent crisis intervention training when you first begin work. And then you get

periodic retrainings on that process.
Q Okay.
A And both -- all three of those people were up to date on their retraining.
Q And you're saying that the NCI training teaches what they did here in this case with Mr. Cains?
A If that's what the situation calls for.
If the client falls to the ground fighting you, then you would go to the ground with them.
Q You would go to the ground with him? Why would you not back up and give the client some space to try to calm down?
A You can do that.
Q If the client's on the ground --
A Yes, you can do that.
Q I'm sorry?
A You can do that if you need -- if you feel it's necessary.
Q Well, wouldn't you say that would be a less restrictive option?
A Yes.
Q Okay. And they didn't do that here though. Tyler went to the ground with him immediately and held him there and then two others joined in; correct?
A Yes.

Q And at no point did anybody, you know, get up and kind of leave him there on the ground to collect himself and calm down, did they?
A **Did not appear to.**
Q And wouldn't you agree with me then that that would have been a less restrictive option that could have been attempted here; correct?
A **Possibly.**
Q Okay.
So why, specifically, did you find no fault on the part of any of these folks?
A **I felt that their handling of the situation did not rise to the level of maltreatment or abuse.**
Q Just in a vacuum, hypothetically, would an unreasonable personal restraint used on a client at BHDC rise to the level of maltreatment?
A **I don't understand the term unreasonable.**
Q Well, let me ask it this way.
When I say unreasonable, I mean a restraint that was not the least restrictive option available.
A **I would say, if a client is being aggressive and attempting to hit the staff, then the use of personal restraint would be appropriate.**
Q That's not what I asked. That's not what I asked.
A Okay.

MR. GILLISPIE: Cris, could you repeat my question to her, please? My last question?

COURT REPORTER: I believe you said, when I say unreasonable, is it the least restrictive option available.

MR. GILLISPIE: Okay. I needed a reminder.

BY MR. GILLISPIE:

Q So I'll ask the question again, ma'am.

A Okay.

Q If a staff member uses as physical personal restraint such as holding the client on the ground when there was a less restrictive option, does that rise to the level of maltreatment, in your opinion?

A I would not qualify it as maltreatment. I would qualify it as inappropriate use.

Q Because we've, ad nauseam, established that only the least restrictive option possible is allowed to be used; right?

A Yes.

Q So you'd agree that, if a restraint is used that is more than the least restrictive possible in the situation is used, that would, at the very least, be a violation of policy, if not maltreatment; right?

A It could be considered a violation of policy

requiring retraining, yes.
Q Okay. And, you know, I think that you'd agree with me, well, you already have agreed with me, that what happened here with these three folks was not the least restrictive thing that could have been done, given the circumstances; correct?
A Correct.
Q Okay.
MR. GILLISPIE: Let me go off the record for just a moment, please. Take five.
(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)
BY MR. GILLISPIE:
Q Ms. Evans, the 9-1-1 policy, at the time, as I understand it, was that there was a 9-1-1 policy at BHDC that dictated that nonmedical staff in emergency medical situations were to first contact medical staff.
And then, if 9-1-1 needed to be called, that had to be done by medical staff; is that correct?
A I don't recall that policy exactly, so I couldn't say with certainty.
Q Okay. Let me grab it.
MR. GILLISPIE: Eric, let me try to find it in the produced discovery. I have a

physical copy of it here but I think I know where it is.

MR. COLLINS: Okay.

MR. GILLISPIE: All right. Y'all see that?

THE WITNESS: Yes.

MR. GILLISPIE: This is First Aid Guidelines. So this is BHDC Policy IV-B-10, First Aid Guidelines. I'm sorry. I apologize. Just a second. This is the current policy.

I'm just going to hold it up here. This is First Aid Guidelines, Version 12-29-19, Bates Stamped 4423.

BY MR. GILLISPIE:

Q I'm going to read from it to you, Ms. Evans.

A Okay.

Q Paragraph Two. In all cases in which a serious medical injury or illness is suspected either to clients or staff, a call to the medical department should be made.

This should be the first call so medical staff can respond immediately to the situation. A call to medical at 1422 should be made and the following information should be given; callers name and title, victim information.

And then it says medical will assess the situation and call an ambulance if appropriate.

Are you saying you're not familiar, you don't recall that policy?

A I do -- I do now that you're reading it to me, yes. Yes.

Q And I know that you don't make these policies. I get that. It's not your fault.

But do you happen to know, do you have any information as to why this policy was in place? This policy that only medical staff can call 9-1-1?

A I do not.

Q Do you know who came up with the policy? Was it Mr. Gonyea? Was it someone else?

A I would assume, possibly, the medical department. But I don't know for sure.

Q Have you ever had a discussion with anybody about this policy other than Mr. Collins?

Have you ever had a discussion with anybody about this policy before?

A No. Not that I recall.

Q You don't recall ever having staff come and complain to you about not being able to call 9-1-1 in emergency situations?

A I can't say with certainty.

Q Okay.
A They may have. I can't say for sure.
Q All right. That's fine. That's kind of all I wanted to know about this. You know, it's not your policy. I get it. I just wanted to -- if you happen to have some additional information about it, I just wanted to know.
A No.
Q So moving on to the investigation itself -- I'm sorry.
Do you see the document here that I'm showing you that says physicians orders?
A Yes.
MR. GILLISPIE: This is going to be our next exhibit.
Will this be six, Cris?
MR. GRELLNER: Five.
MR. GILLISPIE: Five? It's either five or six.
COURT REPORTER: I would say five; but I'm honestly not clear on what four is.
MR. GILLISPIE: I think four is going to be the First Aid Guidelines.
And then this will be five. These are the physicians orders.

COURT REPORTER: Okay.

(WHEREUPON, the document was marked for identification as Exhibit No. 4 and is attached hereto.)

BY MR. GILLISPIE:

Q Ms. Evans, were you aware yourself that Mr. Cains was on [redacted]

A Yes.

Q And, at the time of his death, there was a [redacted]

A Yes.

Q Okay. And would you agree with me that this is something that the staff who restrained him needed to know about and were required to take into consideration?

A Yes.

Q And would you agree with me that -- well, you investigated it, so you know that this whole thing happened right after lunch; right?

A Yes.

Q Yes?

A Yes. Yes.

Q And so you'd agree with me then that the fact that they used this restraint which we've already established was not the least restrictive available, you would agree

with me that the fact that he was on these [redacted] makes that even a greater violation of policy; correct?

A My understanding is, when they held him in restraint, they held him on his side rather than putting pressure on his stomach area.

It's also why they followed him into the bathroom after he finished lunch, to make sure he did not vomit up his food.

Q I appreciate that, ma'am. But, you know, this -- that's not what I'm asking.

And, also, this physician's order, if you see right here --

A Yes.

[redacted]

[redacted]

Q Well, we've already established that they used means that were more restrictive than they needed to.

So I'm just asking, would you not agree that the fact that the [redacted] was also not taken into account, wouldn't you agree that makes it even more of a policy violation, even more of a mistake?

A No, I'm not sure I would agree with that.

Q Okay.

[redacted]

Q Okay. And you would agree that a physicians order regarding a client's health trumps any sort of behavioral intervention, wouldn't you?

A No. This is -- this order is intended for when the client is behaving appropriately.

If he becomes aggressive and staff have to

intervene, I'm not sure they would be able to strictly follow that order.

Q Okay.

MR. GILLISPIE: So we'll make that physicians order Exhibit 5.

(WHEREUPON, the document was marked for identification as Exhibit No. 5 and is attached hereto.)

BY MR. GILLISPIE:

Q And you see what I'm showing you here, Exhibit 6, Behavior Treatment Program?

A Yes.

[redacted]

A Right.

Q I'm reading that correctly; right?

A Yes.

Q So wouldn't you agree with me that what this is saying is that medical orders are to take precedence over

behavioral interventions? Isn't that literally what that's saying?

A It is what it's saying. But I'm not sure personal restraint is listed as a therapeutic intervention in the behavioral treatment program, as personal restraint as an emergency procedure, it's not a PPP procedure.



Q Okay.

MR. GILLISPIE: We'll make this Exhibit 6.

(WHEREUPON, the document was marked for identification as Exhibit No. 6 and is attached hereto.)

BY MR. GILLISPIE:

Q All right.

I'm going to show you portions of Mr. Mattson's deposition rather than make the whole thing an exhibit.

When did you get assigned to conduct the

maltreatment investigation of -- well, first of all, which staff members were you technically investigating?
A Tyler Mattson, Amy Jones, and Ryann Campos.
Q Okay.
And when were you assigned to that investigation?
A I received a call from Jeff Gonyea on 6/13 at 12:13 p.m. And then I headed straight up to BHDC from my home.
Q Okay. And, when you got to the scene, who all did you speak with at the scene?
A Well, at that point, the ambulance had already taken David to the hospital.
Q Uh-huh.
A Those three staff had been taken to the Kelly building, which is where the program supervisor is, to hold them so that I could interview them separately.
Q Okay. So those three staff members were immediately sequestered over in the Kelly building for you to come and speak with; is that right?
A Yes. That's correct.
Q Did you personally speak with the paramedics or EMTs?
A No. They were already gone by the time I arrived.
Q Okay. They were already gone?
A Yes.
Q Okay.

Who did you see at the scene and speak with at the scene before you went over to the Kelly building?
A There was no one up at the scene, by the time I arrived.
Medical staff had left, David had left in the ambulance, and the three staff members had been sent to Kelly building by the time I got there.
Q Okay. So you just went straight to the Kelly --
A Yes. There was really nothing at the scene at Commons.
Q Okay. So you went straight to the Kelly building?
A Yes.
Q Is that right?
A Yes. That's correct.
Q Okay. And who called you and had you come up there to do the investigation?
A The superintendent, Jeff Gonyea.
Q And what all do you recall Mr. Gonyea saying to you, telling you, about the matter?
A I don't recall his specific words. Just that -- I believe he told me that David had passed away and there was an incident at Commons and for me to start the maltreatment investigation immediately.
Q Okay. And is a maltreatment investigation automatically began in the case of a client death or was

there an allegation of maltreatment?
A No, it was automatic because a client had passed away.
Q Okay.
And what all did Mr. Gonyea tell you about the incident at that time?
A I don't recall specifics. Just that the incident had occurred and that I needed to get up there.
He may have said more. I just don't recall.
Q Okay. I assume you've spoken with him since then about the Cains incident, the Cains death; correct?
A You mean recently?
Q I mean any time.
A Okay.
I spoke to him after I completed the investigation. I gave it to him to look over and review.
Q Uh-huh.
A And then, you know, we have a five-day window to get them done, and I spoke to him about that.
Q Uh-huh.
A I don't recall further conversations. There may have been some though.
Q Did he or anybody else question your findings or ask for edits or changes?
A Not that I recall.

Q Is that something that occasionally happens in these investigations?
A You know, if I, you know, typed it quickly and made misspellings or things like that, he may point that out. Or he may ask, you know, why didn't I interview a certain person. Something along those lines.
But, generally, we just do it and he reviews it.
Q Okay. And you don't recall any specifics of criticisms or suggestions from Mr. Gonyea on this particular investigation?
A No.
Q Okay.
So you began your investigation on his death, of David Cains' death, June 13th, 2020; right?
A Yes.
Q Okay. And when did you finish the investigation? When was it completed?
A I completed it on June the 17th.
Q Okay. And, on that date, you completed the document I don't have, the adult maltreatment investigation, which is a written document; correct?
A Yes.
Q And so, by June 17th, that document was complete and had been submitted?
A Yes.

Q And you submitted it directly to Mr. Gonyea?
A Yes. And then he uses some of that information to complete a report of his own.
And then my investigation and all the witness statements are sent to Little Rock.
Q Okay.
And who are all the witnesses that you spoke to, that you've interviewed or spoke to, for this investigation?
A I interviewed Tyler Mattson, Amy Jones, Ryann Campos, Danniel Jones. I'm not sure if I directly interviewed the -- yes. I think I did interview the medical staff. Deborah Noah, LPN; Amanda Schmitt, LPN; Kelly King, LPN; Joann Miller, LPN; and, Lacey Fleming, LPN.
Q Okay. Anyone else?
A No, not that I have listed.
Q And were all of those interviews done on the 20th?
A I believe -- let me look at the date. They were all done on the 13th --
Q I'm sorry, the 13th? They were all done on the 13th?
A Yes. They were done on the 13th.
Q Okay. And so all the interviews were done on the 13th, and then does that just leave drafting the report

then?
A I also secured pertinent written documents regarding David. I got a copy of the EMS patient record, nurses notes regarding David, that were dated the 14th.
I had looked at a choking risk assessment completed by an RN. These are done annually for clients.
And the (inaudible) risk assessment by an RN and a dysphagia disorder survey completed by the speech pathologist.
Q What you just said -- well, you started by saying you looked at various documents relating to David.
A Yes.
Q Did you just name all of those documents?
A Yes.
Q Okay. And so everything you just named there, those are all the documents that you reviewed for the investigation?
A Yes.
Q Okay.
A Now, I did not list it, but I felt quite certain I reviewed his individual program plan, IPP.
Q Okay.
Did you take written statements or did you -- did you obtain written statements from everybody you interviewed?

A Let me look through here to make sure I've got them. Yes. Yes. From the direct care staff and the nursing staff.
Q Would those statements be the same statements -- for instance, I have statements, written statements, from the three direct care staff that were provided to Office of Long-Term Care. Do you know if those are the same written statements?
A I'm not sure what statements OLTC had. I would assume they're the same, but I couldn't say for sure.
Q Who would provide OLTC with whatever it is they needed as a result of his death?
A I believe it would be Lynn Spain, the administrative assistant, who also does the IRIS reports.
Q Uh-huh.
A She generally takes care of getting the paperwork together and sending it to the appropriate people.
Q Okay.
Do you deal directly with OLTC?
A Just when they come for our annual surveys or if they --
Q No, no. I mean in maltreatment investigations. Or, specifically, in this maltreatment investigation, did you deal directly with OLTC?
A I don't recall. Sometimes, if there is a client

death, they will come to do their own investigation.
I may have spoken with them.
Q Okay. So do you happen to recall if OLTC did its own investigation for this case?
A I do not.
Q Okay.
I'm going to show you here, so this is Tyler Mattson's deposition, Page 84. And I'm asking him kind of about the -- well, your investigation.
First of all, that reminded me of something.
Had Tyler Mattson ever had any disciplinary issues that you know of as an employee there prior to David's death?
A I don't recall. I don't know.
Q At least you never -- you were one of his bosses. And you don't recall ever reprimanding him or substantiating any maltreatment against him; correct?
A Right.
Q Do you recall ever having investigated him for maltreatment for a prior incident?
A As I said, I don't recall. It may be in my files on investigations.
Q Do you recall a former employee named Jonathan McCutchen?
A Yes.

[redacted]

Q Are you saying that you sort of recall that Tyler might have been investigated for that or something like that?

A No. I'm saying, if he was, I don't remember doing that investigation. Someone perhaps looked into it.

Q But you don't remember that incident or those allegations at all?

A It's not ringing any bells. I can't say that I do and be confident in that answer.

Q Okay. I appreciate you being thoughtful about it. And I'm certainly not trying to get you to guess.

I'm just reading between the lines of what you're saying, it kind of sounds like there's something you're remembering but you're just not certain it's an accurate memory. Is that right?

Or are you saying you have no memory?

A I'm saying I dealt with a lot of staff issues over those years.
Q Right.
A And I could be recalling something that had nothing to do with the incident you're mentioning.
Q Okay.
A But, you know, I worked with Jonathan, I worked with Tyler.
Q What you are recalling about -- what is it that you are recalling that may involve Tyler?
And, if you're wrong, we can go back in the records and no harm done. But I just need to know what you think you might be recalling about Tyler.
A I really have no specifics to give you. I don't.
Q Okay.
A I mean, I've spoken to Tyler over the years but --
Q You what?
A Spoken with him. Just, you know, in the dorms and in passing, like I do with all the staff.
Q And you've never had any issues with him?
A Not that I can recall.
Q Do you have a favorable opinion of him as a staff member?
A I have a neutral opinion.
Q Okay.

What about Ryann Campos? What's your opinion of her as one of your former employees?

A I didn't know her that well. Again, probably a neutral opinion. Neither a good nor bad.

[redacted]

Q And what is the incident that you are referring to? What do you recall about it?

A I don't recall specifics. And you know it -- I could have her mixed up with someone else. I'm sorry.

I wish my memory were a little better on all these things.

Q So I take it you never investigated Ms. Campos for a maltreatment investigation prior to David Cains' death?

A Not that I recall. No.

Q And you have no knowledge of anybody else investigating her for maltreatment prior to David Cains' death?

A I may not know if Jeff assigned an investigation to someone else.

Q I'm just asking what you know and what you recall.
A No, I don't.
Q Okay.
Same line of questioning except with -- well, you know her as Mandy Jones. But Amy Jones, same line of questioning.
Anything you can tell me about her along these lines of whether, you know, you've had issues with her, whether she's been reprimanded, whether you've heard of allegations made against her, if she's been investigated prior to David's death?
A I do not recall any investigations.
My impression of Amy, who I knew a little bit better, was positive.
Q Okay.
A She was willing to take responsibility and step up and do what was needed, so I had a good favorable impression of her.
Q Okay. I guess would you have been the one that -- I understand she had been promoted prior to David's death. Was that you that would have promoted her?
A I believe it would have been her team leader.
Q Okay.
A But I worked with her more regularly than the other two.

Q Okay. Fair enough.

So this document in front of you, this is Page 84 of Tyler Mattson's deposition transcript. And I'm going to Line 12.

A **Uh-huh.**

Q And I'm just going to take you through some of these portions, let you take a look at it, and then I'll have some questions.

Line 12, I ask Tyler, did Sandy Evans -- were you questioned by Sandy Evans after David's death; Tyler, yes.

He says that he was empathetic towards me and she gave me the sheet and that was pretty much it. I said -- well, how about this.

Why don't you read this starting at Line 12 all the way down to the bottom of this page and tell me when you're done reading it.

A **Yeah, I've already read it.**

Q You've already read it?

A **Yeah.**

Q Okay.

I ask, she didn't question you about how it happened or anything like that; he said it was all explained in the sheet. So I said what sheet; he said the witness report.

I said the witness report you wrote; he said, that I wrote, yes. I said, okay, so I understand she accepted your witness report; but, as far as you recall, she didn't do any further interrogation or questioning of you; no, not that I recall; she was just being empathetic and -- as she could professionally be in the situation.

I asked him, how shortly after the death was this meeting with her; he said, immediately afterward.

I said, and you never met with her again about it; he said no. And I asked, about how long do you think that meeting with her lasted; and he said it took me maybe 15, 20, he means minutes, 15, 20 minutes, to write the report and I left.

And I said, okay, but how long did it take her to talk with you. He said, about the duration, she didn't talk to me afterwards or before other than being empathetic; it was just I gave her the report and -- and I said, so she had you write a report, she didn't ask you any questions about the event, and the only words you recall her speaking to you were kind of -- and then he cuts me off and he says, she just kind of asked me what happened; but like as far as like did she interrogate me necessarily, not that I recall.

And I ask, so you do recall specifically, ask -- her specifically asking questions about the event. He says,

just what happened, she didn't ask too many details, that I remember.

And I said, okay, how about -- about how long do you think the conversation part with her lasted; he says barely a minute; it was what happened and her being empathetic. She handed me a sheet and she explained it to me.

And I said, and when you say explained it to you, meaning she explained how to fill out the form; he said, basically, I mean, like she didn't tell me what to write down, necessarily, but she was like, how do I word this, she basically gave me basic instructions. And I said okay.

And said of what to write down and how to, all that stuff, but nothing beneficial towards me, necessarily.

Is that how you remember --

A **No.**

Q -- this?

A **No. That's not how I remember it at all.**

Q Okay.

A **When I -- go ahead.**

Q Are you surprised by Tyler's version of events here?

A **Yes. But I've done this long enough to know everybody sees everything completely differently.**

Q All right.

A When I interview someone, we start at the beginning and I ask them a question, they write down their response.

I look at the response, I ask them another question. It's a very detailed, step-by-step, process.

Q Okay. Well, what parts of his version of events do you take issue with?

A That I didn't ask him any questions.

Q Okay.

A That's all the -- that's what the interview entails.

Q So did you give him instructions on how to write the report? Well, did you give him a sheet or a form and tell him to write a statement?

A What I did is I gave him a sheet, the witness report sheet.

And then -- first, we talked about it before he wrote anything down. We went through the incident with me asking him questions about what happened then and what happened then.

Then you have the witness write it down. And I will stop them every sentence or two to look at what they've written.

Because, sometimes, what they told you initially, they will write down something different. So then I would ask him, okay, but earlier you said this. And so

we went through it step by step.

I didn't instruct him on what to say. I looked at what he was saying to make sure he got all the information in there that I was going to need, that he didn't leaving anything out.

So, yes, I'm a little surprised by his take on it. Yes.

Q Okay. Do you agree that the whole thing took 15 to 20 minutes?

A No. I would say probably an hour.

Q Okay. And this sheet you gave him, it's called a witness report sheet?

A Yes.

Q And you would have given one of these to all of the witnesses?

A Yes. It's called an OLTC Witness Statement Form.

Q I'm sorry. Say that again.

A OLTC, Witness Statement Form.

Q All right. Well, that is the -- okay.

And, when you said you got a written statement from these witnesses, that's what you're referring to?

A Yes. Yes.

Q Actually, I think I have some of those. Okay. OLTC Witness Statements.

And are those part of one of the documents you have

in front of you?
A Yes.
Q Which document are they made apart of?
A They're included in the maltreatment report.
Q Okay. Got it. I just want to make sure I get those. That's part of the maltreatment report.
A Right.
Q All right.
Did you have any other interaction with Tyler during this investigation other than this interaction that he describes as 15 to 20 minutes and you described as more like an hour? Was there any other interaction that you had with him during the investigation?
A I don't believe so. I'm trying to -- sometimes, if I have extra questions, I will call a witness back in.
Q Yeah.
A I'm looking to see and I don't believe I did that with him after the interview was completed.
He was sent home on administrative leave.
Q Okay. And was that automatic policy or did somebody make a specific decision to send him home on administrative leave?
A No, that's our policy. If you're, you know, named in maltreatment, after we get your statement, you're sent home on administrative leave until the -- it's completed.

Q So he says that you didn't ask too many details. You're saying that's not true? You feel like you did ask detailed questions?
A I did a lot of detailed questions.
Q Okay.
A Where were you at, where was he lying down, what side was he on, what side were you on. Those are all details you have to have.
Q Did you get answers, did you obtain any answers from him that are not in his written report?
A Not that I recall. No.
Q Please take some time to look through that and then -- before you answer that question, please take some time to look through his witness report sheet.
A I'm finding page three of three but not the other pages.
His report was a three-page report, obviously.
Q Yeah, I think you're right.
A But I don't see the other pages in here.
Q I can try to find it.
A Here we go. Found it.
Q Yeah, just take a second and read through that. My only question is, did you ask him any questions or, rather, did you obtain any other information from him in questioning him that is not contained in that written

statement? Does that make sense?
A Yeah.
Q Okay.
A I will notice, in this report, his hand-written report, he also said David was held in personal for one minute, in response to the previous question.
Q Okay.
A I'm not recalling asking him any other questions. I know he was very upset at the time of the interview and I was being empathetic because it is difficult to lose a client. But, also, it helps put the interviewee at ease when you're questioning them.

I don't recall asking anything else, but that's all I -- I don't recall.
Q And was it this -- so is it fair to say that you made your -- your determination that Mr. Mattson had not committed maltreatment was based on this interview with him and this witness statement, this interview that he says talked -- well, he said the talking part lasted one minute and the part of him writing it down lasted 15, 20 minutes.

And, of course, I understand you say it lasted more like an hour.

But is it fair to say that this interaction, whether it was 15 minutes or an hour, that is everything you used

to base your determination, your maltreatment determination with regard to Mr. Mattson?
A No. I interviewed the other three staff involved and all the other witnesses to reach my conclusion.
Q Fair enough. Okay.
But, as far as the direct questioning statement taken of Mr. Mattson, that was everything; right?
A Yes. As I recall, yes.
Q All right.

MR. GILLISPIE: I'm going to make, as the next exhibit, Pages 84 through 87 of Mr. Mattson's deposition which we will e-mail to you, Cris.

(WHEREUPON, the document was marked for identification as Exhibit No. 7 and is attached hereto.)

MR. GILLISPIE: Almost done, Ms. Evans. I appreciate your patience with me.

THE WITNESS: No problem.

BY MR. GILLISPIE:
Q Okay. There's two pages. This is the transcript from Ms. Amy Jones's deposition. This part, I've already asked you about, Page 105 of her deposition. Let me grab my physical copy.
So I questioned her a little bit about how you

investigated her. And you'll see, Line 10 there, she says Sandy came and took my statement after it happened very shortly after the incident.

And then she says that she instructed -- I guess she means you instructed her to go back to the Kelly building and start your statement. And then she says you came in while she was doing her statement along with Jennifer Bancroft.

A Uh-huh.

Q Does that sound right?

A I think she was filling out the top portion of the statement where you have to put your name, address, phone number, all of that good stuff. And then we get into the details.

Q So you were physically in the room with both Ms. Jones and Mr. Mattson while they're completing these witness report sheets? These statements that --

A They were in the Kelly building.

Q Yes, I understand that separately. But for each of them. I understand they're in different rooms and this didn't happen at the same time.

A Right.

Q I'm with you there.

But I'm just asking, you were physically in the room with them while they're writing their statements;

correct?
A Yes. That's correct.
Q And, at this point, these are statements that you're going to use to help determine whether or not there was maltreatment; correct?
A Yes.
Q And you're in the room with them while they're writing them?
A Yes.
Q And Jennifer Bancroft is also in the room during Ms. Jones's?
A No. Jennifer Bancroft, she was a team leader. We had -- Amy Jones was serving as acting program supervisor that day because the original program supervisor had to leave. So (inaudible) to Amy.

Then this incident occurred and Amy was going to be sent home, so I called in Jennifer Bancroft to come in and take over as program supervisor.

So she came in the Kelly building which is where the program supervisor is.
Q All right. That's fine. Thank you.
A Yeah.

MR. GILLISPIE: Just a moment. I'm going through my notes here. We may be done. Just a second.

THE WITNESS: Okay.
BY MR. GILLISPIE:
Q Is there anything else that you think I need to know about regarding your investigation that I have not asked about?
A I cannot think of anything.
Q Substantiated maltreatment, would they have been placed on just the general adult maltreatment registry or would it have been a different registry specifically for Long-Term care facilities?
A I believe it's just the regular --
Q Okay.
A Just regular registry.
Q Okay. And I'm not going to be able to pull it up on my computer, but I'm looking at Policy I-A-5. This is the Prohibition of Harmful Acts to Clients Served.
MR. GILLISPIE: Eric, Bates Stamp 4274.
BY MR. GILLISPIE:
Q And this first page, it says that all allegations of harmful acts to clients served at the facility must be reported immediately as possible maltreatment and reviewed as such. Y'all did that.
Upon completion of the review, investigative findings will be forwarded to the Office of Long-Term Care for a determination regarding whether employee

actions rise to the level of violating the Arkansas Adult Long-Term Care Facility Resident Maltreatment Act and Child Maltreatment Act. Boy, that's a mouthful.

I guess my only question is, can you help me understand the reporting requirements here?

So is this -- when you say Mr. Gonyea had to send your findings or he took your findings and then, apparently, did his own report, and sent that to Little Rock, is that the same thing as forwarding it to the office of Long-Term Care?

A I don't know. I don't know.

Q You don't know? Okay.

A Pretty much, once I've completed my report and given it to the appropriate people, my part is done.

Q Okay.

A And then Mr. Gonyea and the administrative assistant, they take care of the rest.

Q This goes on to say that an OLTC finding is in addition to the facility determination regarding a violation of DHS Policy 1084, which are the employee conduct standards, so a maltreatment violation.

So an OLTC finding is in addition to, I suppose, your determination; and then the OLTC determination is apart and separate from the facility findings.

Is that your understanding as well?

A Yes. Yes.
Q Do you have any knowledge as to whether there was a separate report done by OLTC?
A I may have seen it at that time, but I don't recall. My understanding is that they upheld our determination.
Q Uh-huh. Okay. But you've not seen any written document to that effect?
A Not that I recall. No.
Q Who would be the best person to ask about that?
A I would say, probably, Jennifer Barry, our assistant superintendent. She keeps up with a lot of the OLTC things.
Also, Nakita Martin is our quality assurance person and she is in charge of OLTC issues.
Q Okay.

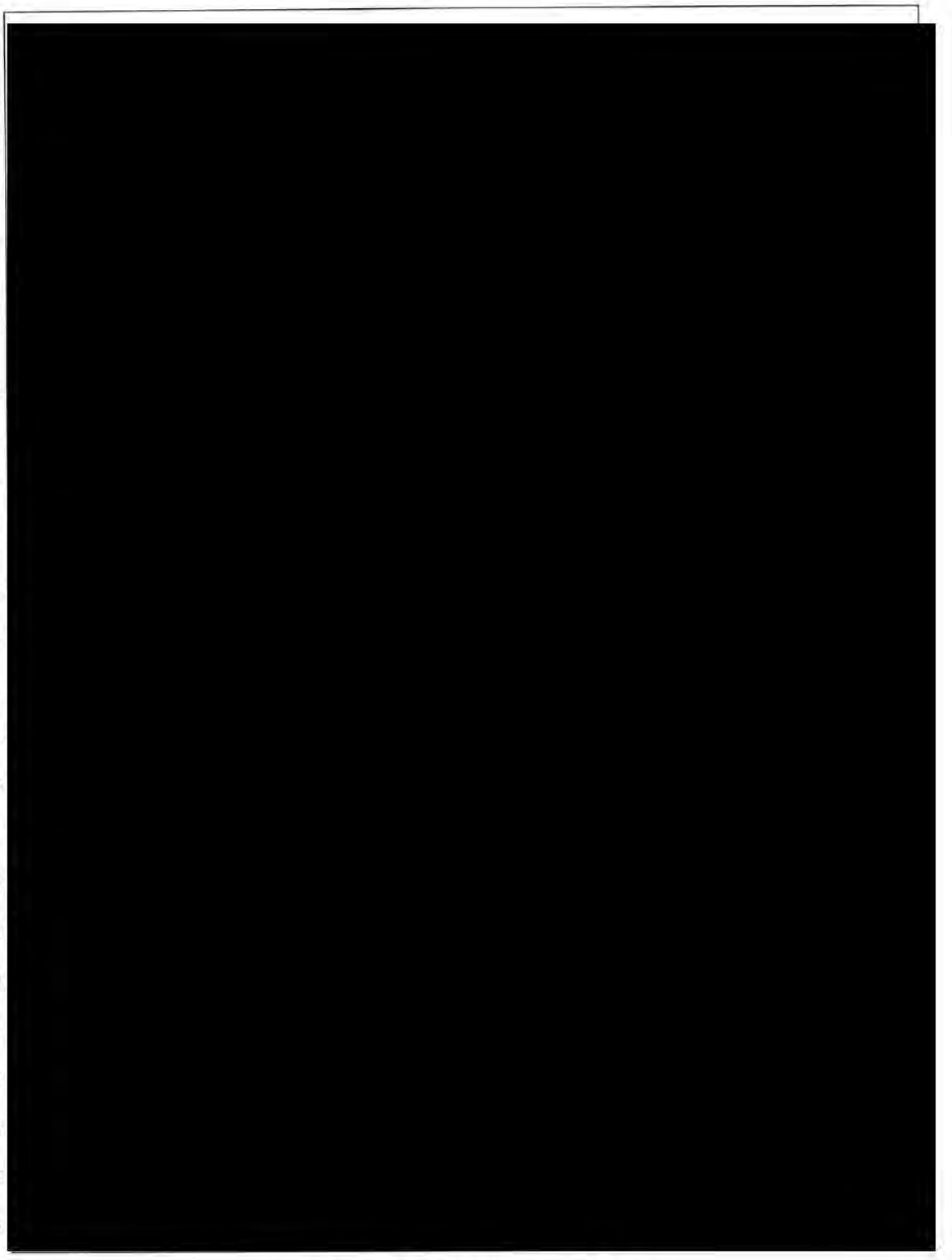
MR. GILLISPIE: Just to be thorough, I'm going to make this policy an exhibit here as well.

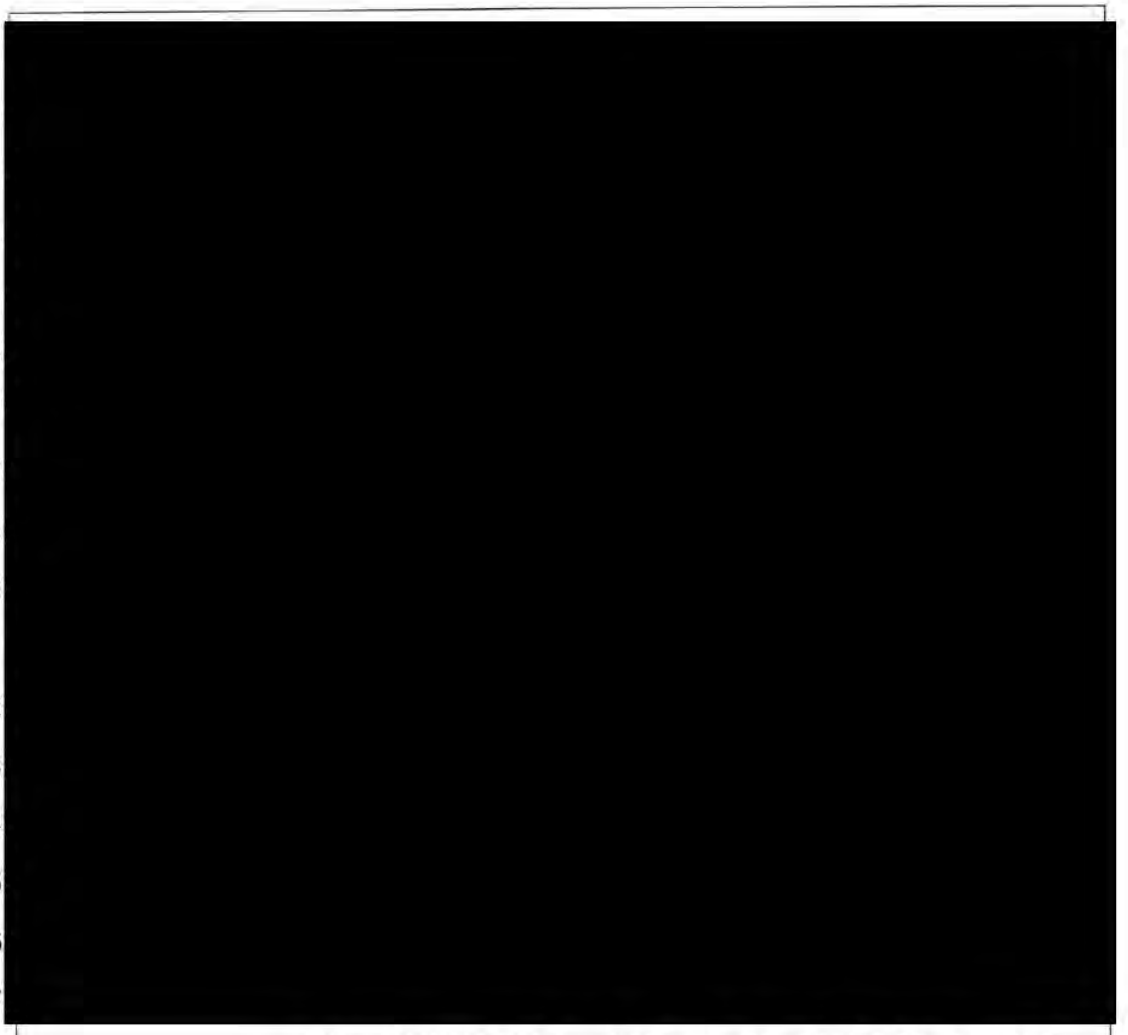
(WHEREUPON, the document was marked for identification as Exhibit No. 8 and is attached hereto.)

BY MR. GILLISPIE:

[redacted]

[redacted]





MR. GILLISPIE: Can we go off the record for just two minutes here?

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Ms. Evans, am I correct that, if you had substantiated maltreatment against Mr. Mattson, Ms.

Jones, or Ms. Campos, they would have been immediately terminated and designated not eligible for rehire by DHS?

A Yes, that's correct.

Q Okay.

MR. GILLISPIE: I'll pass the witness.

MR. COLLINS: I have no questions.

(WHEREUPON, the proceedings were concluded in the matter at 1:54 p.m.)

* * * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Sandy Evans, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 19th day of May, 2022.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

State Operations Manual

Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities

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(Rev. 178, 04-13-18)

Transmittals for Appendix J

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PLAINTIFF'S EXHIBIT 1

CONDITION OF PARTICIPATION	Key Standard(s) Regulatory Reference within the CoP	W-tag associated with the key standard regulation	Corresponding standard(s) under the key standard (W-tag reference)
	employ physical restraint only— (i) As integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. 42 CFR 483.450(e)(1) The facility must not use drugs in doses that interfere with the individual client's daily living activities	W310	W302, W303, W304, W305, W306, W307 W308, W309 W311, W312, W313, W314, W315, W316, W317
42 CFR 483.460 Health Care Services (W318)	42 CFR 483.460(a)(3) The facility must provide or obtain preventive and general care 42 CFR 483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including, licensed dentists and dental hygienists either through organized dental services in-house or	W322 W348	W319, W320, W321, W323, W324, W325, W326, 327, W328, W329, W330, W331, W332, W333, W334, W335, W336, W337, W338, W339, W340, W341 W342, W343, W344, W345, W346, W347, W393, W394 W349, W350, W351, W352, W353, W354, W355, W356, W357, W358, W359, W360

coercion and intimidation (e.g. living in fear in one's own home). Since many clients residing in ICF/IIDs are unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, would also be viewed as abusive by the client residing in the ICF/IID, regardless of that client's perceived ability to comprehend the nature of the incident.

Sexual abuse includes any incident where a client is coerced or manipulated to participate in any form of sexual activity for which the client did not give affirmative permission (or gave affirmative permission without the attendant understanding required to give permission) or sexual assault against a client who is unable to defend him/herself.

The facility must implement, through policies, oversight and training, safeguards to ensure that clients are not subjected to abuse by anyone including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the client, family members or legal guardians, friends, other clients, or the general public.

The facility must take whatever action is necessary to protect the clients residing there. For example, if a facility is forced by court order or arbitration rulings to retain or reinstate an employee found to be abusive, the facility must take measures to protect the clients of the facility (such as assigning the employee to an area where there is no contact with clients).

W128

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

Guidance §483.420(a)(6)

The facility must implement an aggressive active treatment program, which includes appropriate replacement behaviors, to address the reduction/elimination of physical restraints and drugs to manage behaviors.

For purposes of this Guideline drugs to manage behavior are "unnecessary" if there is evidence the drugs are being used:

- In excessive dose (duplicate therapy);
- For excessive duration;
- Not monitored adequately;
- Without adequate indications for its use;
- With adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combination of the reasons listed above.

The long term use of a drug/physical restraint to manage behavior combined with one or more of the following may indicate unnecessary use:

- The client's developmental and/or behavioral needs are not being met and the appropriateness of less restrictive approaches to manage inappropriate behaviors should be questioned;
- Staff behavior may be prompting behaviors in clients which result in the chronic use of physical restraints and drugs to control behavior;
- Staff may have inadequate training and/or experience to provide active treatment and employ preventive measures;

Restraints applied for behaviors when less restrictive measures have not been tried or have been tried and found to be just as effective.

W129

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.420(a)(7) Provide each client with the opportunity for personal privacy and

Guidance §483.420(a)(7)

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.430(e)(2) developmental,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- developmental programming principles and techniques (e.g. techniques to involve clients in their programs to their highest capability, use of positive reinforcement, use of assistive technology, use of appropriate materials and providing informal opportunities to practice skills);
- use of adaptive equipment and augmentative communication devices and systems; and
- effective recordkeeping procedures.

W191

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) behavioral,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- use of behavioral principles during interactions between staff and clients;
- use of accurate procedures regarding abuse detection and prevention, restraints, drugs to manage behaviors, client safety, emergencies, etc.;
- use of least restrictive interventions;

- use of positive behavior intervention programming; and
- training clients in appropriate replacement behaviors.

W192

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) and health needs

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- signs and symptoms of the client's changing health (e.g. constipation, urinary tract infections, adverse drug reactions, as indicated);
- exercise and diet;
- first aid;
- infection control;
- reporting to appropriate healthcare professionals; and
- for those staff who can administer medications, how to include clients in their medication administration by recognizing and encouraging the use of applicable skills.

W193

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

Guidance §483.430(e)(3)

Staff correctly and consistently implement the interventions specified in the behavior plans of clients with whom they are working.

§483.440(f)(3)(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

Guidance §483.440(f)(3)(i)

Any program that utilizes restrictive or intrusive techniques must be reviewed and approved by the specially constituted committee prior to implementation. This includes, but is not limited to:

- restraints;
- drugs to manage behavior;
- restrictions on community access;
- contingent denial of any right; or
- restrictions of materials or locations in the home.

The committee should ensure that consequences within a written behavior management program do not violate the client's rights.

There is no requirement for the committee to evaluate whether the proposed program is consistent with current practices in the field. Documentation should verify that the specially constituted committee considered factors, such as whether less intrusive methods have been attempted, whether the severity of behavior outweighs the risks of the proposed program and whether replacement behaviors are included within the plan.

Any revision to a behavior plan that increases the level of intrusiveness must be re-reviewed by the specially constituted committee. The committee need not reapprove a program when revisions are made in accordance with the approved plan. For example, if the physician changes the dosage of a medication in accordance with the drug treatment component of the active treatment plan to which the legally authorized person has given consent and which has already been approved by the committee, then there is no need for the committee or the legally authorized person to reapprove the plan. Generally, this would also apply if the medication was changed to another within the same therapeutic class or family.

W276

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(i) Specify all facility approved interventions to manage inappropriate client behavior;

Guidance §483.450(b)(1)(i)

All interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy. Examples of positive interventions include, but are not limited to, verbal praise reward systems, and prompting. Examples of negative interventions include, but are not limited to, removal of a privilege, implementation of restraint, and/or the use of exclusionary time out.

W277

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;

Guidance §483.450(b)(1)(ii)

Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior.

Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.

The facility policy for unexpected behavioral incidents must provide direction for the staff in the

utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others.

W278

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iii) Insure prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and

Guidance §483.450(b)(1)(iii)

Policies must be implemented to ensure that all restrictive procedures begin at the lowest level of the hierarchy unless there is documented evidence that less intrusive interventions have been tried and have been found to be ineffective.

The facility is not required to justify discontinuing the use of a more restrictive technique before initiating a less restrictive technique, since the intent of the regulation is to use the most positive, least intrusive technique possible.

In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.

§483.450(b)(1)(iv) Address the following:

W279

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(A) The use of time-out rooms;

Guidance §483.450(b)(1)(iv)(A)

"Time-out room" is defined as a separate room that is used to remove a client from stimulation that may be triggering and reinforcing maladaptive behavior. The facility must have written

policies and procedures for the use of time out rooms which address all the requirements of 483.450 (c) (1-4) standard: time out room.

W280

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(B) The use of physical restraints;

Guidance §483.450(b)(1)(iv)(B)

"Physical restraint" is defined as any manual hold or mechanical device that the client cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of a client's body. Examples of mechanical devices may include arm splints and mittens.

Policies and Procedures must address:

- the types of physical restraint that are allowed in the facility;
- the persons who apply such restraints;
- the parameters for duration of application;
- the methods that assure the health and safety of clients while in restraints; and
- the specific training required for staff allowed to apply such restraints.

W281

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(C) The use of drugs to manage inappropriate behavior;

Guidance §483.450(b)(1)(iv)(C)

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

Guidance §483.450(c)(3)

Because placement in the time out room is typically secondary to extreme behaviors, it is acceptable that there be no furniture in this room.

A door that opens inward can potentially be held closed, either intentionally or inadvertently, by the client in the room, thereby denying staff immediate access to the room.

W294

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(4) A record of time-out activities must be kept.

Guidance §483.450(c)(4)

The documentation in the client's record accurately reflects planned (e.g. part of the IPP) usage and presents a picture of events prior to, during, and following the use of time-out. The IPP should include direction as to how often data must be collected during each use of time out for each individual client.

(d) Standard: Physical restraints

§483.450(d)(1) The facility may employ physical restraint only- -

W295

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;

Guidance §483.450(d)(1)(i)

The use of physical restraint is specified within the IPP. The plan must address:

1) The specific type of client behavior to be managed by this plan;
2) The less restrictive behavioral approaches which were previously used, but were unsuccessful;
3) The hierarchy of measures that must be utilized prior to the application of physical restraint;
4) The type of physical restraint;
5) The type of client behavior that would indicate that the patient is calm and can be released from the restraint; and
6) The replacement behavior being taught to the client to reduce the need for future restraints.

W296

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(ii) As an emergency measure, but only if absolutely necessary to protect client or others from injury; or

Guidance §483.450(d)(1)(ii)

Physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which:

1) the client has not exhibited before;
2) were not identified in the functional analysis of behavior; or
3) are harming other people or themselves.

When there are repeated episodes of the use of physical restraint as an emergency safety measure, these episodes should be assessed for their predictability by the IDT, and revisions to the IPP considered addressing the behaviors through a formal behavior plan in order to reduce/eliminate the use of physical restraint.

W297

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

Guidance §483.450(d)(1)(iii)

Physical restraint during medical procedures must be utilized only when absolutely necessary and be used as a last resort in order for the facility or practitioners to deliver needed medical care to the client. The restraint must be released as soon as the medical procedure is completed unless it is necessary to continue restraint for a longer period of time to continue to deliver care or to prevent the client from displacing tubes or dressings. These restraints may only be used as long as the physician indicates them to be necessary.

For instances where physical restraint are used by the facility or a practitioner during a medical procedure, the client record and interviews should verify that less restrictive measures were attempted before using physical restraint and verify whether any injuries occurred during the use of the physical restraint. Written orders by medical personnel for the application of a physical restraint should include the reason that the restraint is necessary, the type of restraint to be used and the length of time the restraint will be applied.

A restraint device used to prevent a client engaging in self-injurious behavior is not considered a restraint for medical condition.

§483.450(d)(2) Authorizations to use or extend restraints as an emergency measure must be:

Guidance §483.450(d)(2)

Facility policies should list who in the facility is allowed to authorize the emergency use of restraints or to extend the use of an emergency restraint, and the training that is required for those persons who may authorize. Documentation in the client record in those instances should confirm that the facility follows that policy.

W298

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(2)(i) In effect no longer than 12 consecutive hours; and

Guidance §483.450(d)(2)(i)

This regulation does not mean that restraints may be authorized to be applied for up to a 12 hour period. The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. Once the behavior has ceased, the emergency has ended, and the client has been released, another authorization would be required for any new emergency situation.

The 12 consecutive hour period is the absolute maximum period of time that emergency physical restraint may be utilized for a client during an individual behavioral incident. It is reasonable to expect that the facility will reassess the emergency situation for any client who remains in physical restraint for longer than one hour and reassess the situation at least every 30 minutes thereafter up to 12 hours when the physical restraint must be removed.

W299

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(2)(ii) Obtained as soon as the client is restrained or stable.

Guidance §483.450(d)(2)(ii)

There may be instances where the maladaptive behaviors of a client or clients escalate into a serious and immediate event that must be de-escalated quickly in order to prevent harm to clients, staff, other clients, or by standers when incidents occur in the community. In these instances, the staff should contact the appropriate person to obtain authorization for the use of physical restraint as soon as the situation is stable. Retrospective documentation of the incident should confirm the need for authorization after application.

W300

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(3) The facility must not issue orders for restraint on a standing or as needed basis.

Guidance §483.450(d)(3)

All instances of physical restraint must be ordered on a case by case basis with individual assessment of the situation and authorization based upon the individual client. Authorizations should include the rationale for the use of the physical restraint versus other less restrictive measures.

W301

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints,

Guidance §483.450(d)(4)

The frequency of monitoring will vary according to the type and design of the device and the

psychological and physical well-being of the client. The facility should be checking the client often enough to adequately assess the physical status of the client (e.g., circulation, respiration and vital signs) of the client and the need to continued restraint. The more restrictive the intervention, the greater the risk to the client and the more often the client must be assessed. Frequent assessment will assure that the client will be released as soon as possible, however, in no instance may the staff go longer than 30 minutes without checking the client.

W302

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) released from the restraint as quickly as possible, and

Guidance §483.450(d)(4)

"As quickly as possible" means as soon as the client is no longer a danger to self or others. Documentation should support that the client was released from restraint as soon as they became calm.

W303

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) a record of these checks and usage must be kept.

§483.450(d)(5) Restraints must be designed and used

W304

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(5) so as not to cause physical injury to the client

Guidance §483.450(d)(5)

Physical restraints to include mechanical devices must be the correct size for the client and be applied with the correct amount of pressure according to manufacturer's directions. In addition to observation of any physical mechanical restraint in use at the time of the survey, review incident reports for any injuries as a result of restraint use.

W305

§483.450(d)(5) and so as to cause the least possible discomfort.

§483.450(d)(6) Opportunity for motion and exercise must be provided

W306

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(6) for a period of not less than 10 minutes during each two hour period in which restraint is employed,

Guidance §483.450(d)(6)

This requirement does not apply to cases of medical restraints that are specifically ordered for the immobilization of bones and joints during the physical healing process involved with fractures, sprains, etc. (e.g. a broken bone immobilized by a cast or splint). See 331 483.460(c) regarding surveillance of skin integrity during the use of medical restraints.

However, if a mechanical physical restraint is applied to an extremity to prevent a client from removing post-operative sutures, the restraint must be released every two (2) hours for a period of not less than ten (10) minutes in order to maintain adequate circulation.

Mechanical restraints placed on the client during sleeping hours must be medically based and specifically ordered by a physician. There should be evidence in the client's record why the mechanical physical restraint is necessary during sleeping hours. While it is not necessary to wake the client every two (2) hours to release the restraint and provide opportunity for exercise, the staff must check the restraint frequently during the night to ensure that the

restraint is still properly applied and the client appears comfortable.

W307

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(6) and a record of such activity must be kept.

§483.450(d)(7) Barred enclosures

Guidance §483.450(d)(7)

A bed or play equipment with bars that prevent the client from leaving the bed or voluntarily climbing out of the bed are barred enclosures. The use of such enclosures must be a part of the written IPP and behavioral assessments must clearly state why such an enclosure is necessary, the risks of using the enclosure versus not using it and what less restrictive measures have been tried prior to the implementation of the barred enclosures.

Such devices may not be used in lieu of adequate staffing.

W308

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(7) must not be more than three feet in height and

W309

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(7) must not have tops.

(e) Standard: Drug usage

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

1. **Purpose**. This policy is intended to provide guidelines for managing challenging behaviors of individuals residing in DDS operated programs (Human Development Centers).

2. **Scope**. This policy applies to all DDS operated programs (Human Development Centers) and their employees/volunteers. All such programs will include a review of this policy as part of the employee orientation process.

3. **Definition of Terms**

Behavior management, as covered by this policy, serves as a guide to ensure that an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others are managed with the least restrictive method. Behavior management is not a substitute for other forms of active treatment and is incorporated into program plans, based on individual needs.

Qualified Mental Retardation Professional (QMRP) or QMRP designee is used in this policy as a person designated to monitor, supervise, and make decisions regarding specific behavioral situations. QMRP/designee will be assigned by the administrator of the DDS program in which he/she works. Criteria for selection will involve prior training, experience, and demonstrated ability in the area of behavioral management. The QMRP/designee must be in a position that is on a level involving supervisory or decision-making responsibilities. The QMRP designee is authorized to perform any of the duties of the QMRP as outlined by regulations or policy.

Interdisciplinary Team (IDT) is defined as a group of persons (professionals, paraprofessionals and non-professionals) who develop an individual's program plan and whose participation is required in order to identify the needs of the individual and to devise ways to meet those needs. The IDT includes the individual and may also include those persons who have worked or will work most closely with the individual, those persons who provide needed assessments or services, and the individual's family, guardian, or advocate. In general, the IDT includes persons professionally qualified in such fields as health care, education, psychology, and social work.

Licensed nurse is defined as a registered nurse or licensed practical nurse. The agency may use a physician, in lieu of a licensed nurse, but this is not required.

Replacement: This policy replaces DDS Commissioner's Policy 3011-D, dated January 28, 1981, March 13, 1981, and DDS Director's Policy dated October 1, 1991; December 1, 1993; and January 30, 1998.

Reviewed: Arkansas Legislative Council Rules and Regulations Subcommittee _____, 2003



Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

4. Policy

NOTE: It is the philosophy of the agency to utilize all positive approaches to behavior management prior to and in conjunction with more restrictive programmatic techniques. Positive approaches may include, but are not limited to: positive reinforcement, gentle teaching, redirection, graduated guidance, and modeling of appropriate behaviors. Measures to address positive behavior should be incorporated into formal program efforts to the extent feasible.

Efforts at positive programming prove to be successful with the majority of maladaptive behaviors. All Human Development Centers will maintain policies and procedures for positive programming. The use of behavioral programming other than positive is designed for the individuals who repetitively engage in dangerously aggressive behavior and for whom other interventions have not been effective. All behavior programs developed in accordance with this policy will be designed to reduce or eliminate the target behavior(s) within a specified time frame, will be supported by documentation that positive, less restrictive methods have been systematically attempted and failed, will be monitored regularly by the individual's QMRP and Interdisciplinary Team (IDT), and will be revised if proved to be ineffective. The potential harmful effects of each procedure will be weighed carefully against the harmful effects of the targeted behavior and the IDT will determine if the harmful effects of the behavior outweigh the potentially harmful effects of the procedure.

Category I:

Category I procedures are those which may be used without prior approval of the Human Rights Committee or psychology staff. To ensure consistency, they should be addressed by the IDT. Frequent use (as determined by IDT) of these procedures with an individual indicates the need for consideration of the development of a behavior plan by the individual's IDT.

The individual must be supervised during these procedures. With the exception of verbal intervention, any use of Category I procedures, whether part of a formal behavior program or not, requires documentation on a Behavior Incident Report, Data Sheet, or other locally used behavior documentation system.

A. Verbal Intervention: Verbal intervention is utilized to stop an inappropriate behavior in progress and involves telling the individual "no" or "stop", identifying the behavior, and redirecting to an appropriate activity. The command is given in a firm but normal tone of voice. Threats, screaming, yelling or issuing repetitive or multiple sets of commands are not considered verbal correction and are inappropriate.

B. Separation From Activity Up to 30 Minutes: The individual is prevented from engaging in a reinforcing activity in which he/she has displayed inappropriate behavior. Separation is maintained within the same room or outdoor area where the activity is conducted. This is considered a Category I procedure if compliance by the individual can be

accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

C. Separation From Setting Up to 30 Minutes: The individual is removed from the area where the reinforcing activity is taking place. Separation must occur under observation either outdoors or in a living or training area (bathrooms, storage rooms and closets do not constitute living/training area). This is considered a Category I procedure if compliance by the individual can be accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

Note: Separation to Allow Calming (STAC) – Also available is the positive procedure of STAC whereby the person is encouraged to move to an area away from the person or situation that upset them. At the same time, they are assisted in directing their attention to talking about the problem, listening to music, talking about family, relaxing quietly, going for a walk, etc. The activity should be chosen by the person in need of calming. When sufficiently calm, staff will assist the person in resuming normal activities.

D. Assignment of Additional Chores: The individual is assigned additional chores as a consequence for inappropriate behavior. Additional chores may be assigned only if such chores are already a part of the Individual Program Plan (IPP) and are not designed to replace work assignments of housekeeping personnel.

E. Restitution: The individual is cued to restore any property damaged, stolen or defaced. If appropriate to the individual's level of functioning, he/she may be cued to offer a verbal apology to the offended person. If appropriate to the individual's ability to comprehend, monetary reimbursement for the value of the damaged or stolen property may be required if this is a part of the IPP. In lieu of full value, a symbolic portion of the value may be required. Monetary reimbursement requires Human Rights Committee approval and Guardian consent.

Note: The individual is not degraded nor put on display while restoring damage. The individual is given the same equipment and protection to complete the restitution as would normally be given to a person not responsible for the damage.

F. Withholding Privileges: The individual loses a particular privilege following the occurrence of an inappropriate behavior. Privileges include such things as special planned community activities. However, trips off grounds are special and should only be curtailed if problem behavior is anticipated during that trip. Examples of situations where problem behaviors may be anticipated include a problem behavior having already occurred and the person is not fully calm, or, a problem behavior has not yet occurred, but there are indications that a problem behavior is likely. The curtailing of trips off grounds should be done after consultation with psychology staff, or with supervisory staff if psychology staff is not available. Privileges do not include basic living activities, such as meals, habilitation activities, or basic rights afforded all individuals.

G. Personal Property Removal (less than one hour): Removal of an individual's personal item that is being used in an inappropriate or unsafe manner or location. For example, if an individual disturbs others in a common TV room by playing his radio too loudly and will not reduce the volume when instructed, the radio may be removed from that individual for a time not to exceed one hour. The item will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate (See Section 6, *Page 8 of 9*).

Category II:

Category II procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian.

A. Response Cost: The individual loses reinforcers previously earned in a behavior management system, (i.e., Token Economy Program)

B. Overcorrection - includes the following procedures:
   1) Restitutional Overcorrection: Requires the individual to restore the environment to a state that is better than it was before the occurrence of the inappropriate behavior.

   2) Positive Practice Overcorrection: Requires the individual to engage in an intensive practice period in which the alternative appropriate behavior is practiced.

C. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or individual directly, as appropriate. This procedure is considered Category II if the individual voluntarily (without duress or coercion) surrenders the property upon request.

Category III:

Category III procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, other professionals, as indicated by the nature of the program, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian. The individual's record documents the IDT's conclusion that the potential harmful effects of each restrictive procedure (restraint, etc.) are clearly outweighed by the harmful effects of the targeted behavior.

A. Separation Time Out (Activity or Setting): Placement of an individual in a quiet area away from reinforcing activities or persons as a result of an inappropriate behavior occurring. The individual will be visually monitored during the time out. Further conditions include ***either:***

1) Separation lasting for over 30 minutes to one (1) hour maximum.

2) Separation (any length of time) requiring physical intervention/personal restraint to ensure compliance.

B. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate. This procedure is considered Category III if the individual does not voluntarily surrender the property upon request, and it must be physically removed.

C. Sensory Deprivation: Involves the temporary impeding of one of the individual's senses for a period of time, contingent upon the occurrence of the target behavior. Most often, this procedure includes only the use of a blindfold or cloth placed over the individual's eyes when it has been shown to facilitate calming. The individual must be visually supervised during the use of this procedure, which may be used in combination with other Category III procedures, as designated in the individual program. It could also include lessening auditory input by covering the individual's ears, or covering a body part (usually the hands) to limit tactile stimulation, hand in mouth, or biting.

D. Restraint: When utilizing restraint as a programmatic option, a hierarchy of lesser restrictive procedures will be attempted prior to restraint, except in limited cases where this is clearly clinically contraindicated. IDT consideration will be given to parent/guardian notification of the use of restraint and address it in the behavior program.

1) Personal Restraint: **In order to prevent personal injury or serious property damage**, the individual or a portion of an individual's body is immobilized by another person or persons in order to prevent personal injury or serious property damage. Approved methods of intervention must be in the individual's behavior program. This is planned personal restraint, contingent upon occurrence of a target behavior. When available, a licensed nurse should monitor the personal restraint and/or check the individual's physical condition as soon as possible following restraint.

Excluded as <u>personal restraint</u> are: physical assistance, prompting of graduated physical guidance to assist individuals during such procedures as toothbrushing and feeding, or to control random head or arm movements during such procedures

as haircutting, or the use of physical assistance in escorting, redirecting, or in manual guidance techniques are not considered personal restraint and do not require documentation as personal restraint. Also excluded as programmed personal restraint is the use of personal restraint in an emergency situation (Section 6, ***Page** 8 of 9*) or during a necessary medical or dental procedure.

In the event of personal restraint, the QMRP/designee of the area must be notified as soon as possible. Programmed personal restraint will occur until the individual is calm and will not exceed fifteen (15) minutes. The IDT will define what constitutes calm behavior for this individual when used in a behavior program.

2) Mechanical Restraint: **In order to prevent personal injury or serious property damage,** the individual or a portion of the individual's body is immobilized until calm by an approved device or devices which may also prevent normal functioning, as described in section C, above. Restraints must be checked for safety and integrity prior to use. The device's use will not exceed 15 minutes without an extension of time approved and documented by the QMRP/designee, preferably, after face-to-face attention. Unless otherwise determined by the IDT, QMRP/designee extensions will be obtained every 15 minutes until the individual is calm. The IDT should define what constitutes calm behavior for this individual when used in a behavior program. Unless determined clinically contraindicated by the QMRP/designee, should the time in restraint reach 55 minutes, the individual must be released for five minutes for motion, liquid intake, or toileting.

Should time in restraint reach 1 hour and 50 minutes, the individual must be released for at least 10 minutes–for motion, liquid intake, or toileting. If this 10-minute release is judged to be a danger to the individual and/others, additional staff should be called to ensure safety for all concerned. In addition, the individual will be checked, face to face, at least every 15 minutes for safety, well being, and integrity of the restraint. Constant observation is required.

Note: On-site monitoring by the QMRP/designee is recommended. When available, a licensed nurse should monitor the mechanical restraint. If unavailable to monitor, a licensed nurse shall check the individual's physical condition as soon as possible following restraint, but in no case later than thirty minutes after the initiation of the restraint.

Excluded as programmed mechanical restraint is the use of restraints in an emergency situation (Section 6, *Page 8 of 9*), during a necessary medical or dental procedure, or to promote healing following a medical procedure or injury. Devices such as a helmet which are not prescribed for the purpose of restricting an individual's movement and/or normal functioning, but rather for their safety and protection are not considered a mechanical restraint.

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

Note: For medical management, please refer to local site Policy on drugs to manage behavior (Behavior Management/Psychiatric Interventions).

5. **Conditions for Use of Behavior Programs.**

A. A formal behavior program will be developed by the IDT, written by a licensed psychological professional, and approved by a psychologist. It will include the following elements:

1) Description of the behavior to be modified;
2) Functional Analysis;
3) Thorough description of each step of the program to include duration and intensity of specific procedures, the methods of monitoring and analyzing the process, and special precautions that will be taken;
4) Description of any alternatives to the specific procedures;

B. The Individual Program Plan or behavior program will include:
1) Description of all procedures already attempted;
2) Side effects and risks, if any, of the intervention, in comparison with those of allowing the maladaptive behavior to continue; and
3) Behavioral objectives.

C. Behavior Management Procedures should be used in order of least restrictive, unless clinically contraindicated. Exceptions to this order must be fully documented and substantiated as to why more restrictive procedures are advisable before less restrictive ones.

D. All persons administering Category II and III procedures must have been trained in the administration of those specific procedures and have personally experienced those particular procedures, unless medically contraindicated for that person.

E. The Human Rights Committee will review all Category II and III programs at least every 6 months.

F. IDT consideration will be given to seeking consultation from outside expertise when IDT staff resources have been exhausted, as evidenced by the use of Category III procedures for over one (1) year without significant progress. If an outside consultant has been used without success, the agency should continue to access this or other outside expertise until an effective strategy is realized.

An outside consultant is defined as a professional of any discipline and who is not a member of the IDT. For instance, the outside consultant may be a member of the HDC

staff not on the identified IDT, the agency staff, or a professional not affiliated with the agency.

6. **Emergency Procedures**. Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. This includes the use of restraint procedures in the course of an established program, when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy. However, it is emphasized that emergency procedures may not be used at frequent intervals, becoming a routine method of intervention. If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. The emergency use of restraint must conform to ICF/MR regulations and must be reported immediately to the facility administrator or designee.

7. **Prohibitions**: These activities are expressly prohibited.

   A. Corporal punishment - refers to the application of painful stimuli to the body as a penalty for certain behavior, and includes, but is not limited to, hitting, pinching, the use of electrical shock or other infliction of pain, whether or not applied as part of a systematic behavior intervention program.

   B. Individuals who receive services from the agency disciplining other individuals unless involved in an organized and approved self-governing program. Individuals will not participate in the actual administration of discipline.

   C. Seclusion of an individual alone in a room or other area from which entry/exit is prevented. This does not include placement in a time-out area for brief, programmed time segments, as part of a behavior program that meets all applicable standards.

   D. ***Unless specifically requested by family/guardian,*** any procedure that denies visitation or communication with family members.

   E. Any procedure that denies sleep, shelter, bedding, food, drink, or use of bathroom facilities.

   F. Inappropriate vocalizations, maltreatment, neglect, or forced exercise.

8. **Informed Consent**. The individual served and/or guardian, as appropriate, will be provided a copy of the behavior program which utilizes Category II and III procedures. Informed consent will be obtained PRIOR to the implementation of the program, with the following procedures:

A. Persons 18 years of age or older who have no legally appointed guardian may give informed consent for their behavior program. If there is a question about the individual's ability to give informed consent and no guardian can be located, appropriate legal action must be pursued to have someone appointed who can give consent.

B. Consent by the legal guardian(s) is required if guardianship has been established.

C. The legally adequate consent will:
1) Specify, in terms that are easily understood, the restrictive or intrusive procedure(s) involved;
2) Inform the person(s) giving consent of any potentially harmful effects of the procedure(s);
3) Be time-limited, not to exceed one year; and
4) State that consent may be withdrawn at any time.

9. **Uncategorized Procedures**. In the event a proposed procedure does not readily fit in one of the prescribed categories, it may be utilized on an emergency basis, if necessary, at the discretion of the administrator or designee until the appropriate category is determined.

NOTE: Behavior Management Policy 3011-D does not preclude the use of other restrictive/intrusive procedures that would prevent serious bodily harm and/or destruction of property or death. These procedures can only be considered when lesser restrictive procedures have been proven ineffective or their implementation are determined to be clinically contraindicated. Approvals required are the same as those for Category III procedures. Additional approvals may be required as deemed necessary by the facility administrator.

DOCUMENTATION OF AND RESPONSE TO MALADAPTIVE BEHAVIORS

POLICY STATEMENT: Maladaptive behaviors must be documented on a **Behavior Report (BR)**, a **Behavior Report Documenting Emergency Restraint** (also called the Restraint Log), or other authorized data keeping device. Personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure. Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, or the destruction of property. Nothing in this policy removes or alters requirements as stated in other policies of verbal notification of incidents to the Superintendent and/or other staff.

PROCEDURES:

1. REQUIRED DOCUMENTATION

   a. When indicated, a **BR** must be completed following the maladaptive behavior. Incidents that are to be documented on the **BR** are the following:

      i. Behaviors that pose a threat to the physical or mental well being of the client or others.
      ii. Behaviors that have a direct negative impact on the client's programming.
      iii. Behaviors that directly contribute to the client remaining in a setting requiring a greater degree of supervision rather than a less restrictive one.
      iv. Target Behaviors identified by the Psychology Department and the Interdisciplinary Team.
      v. An incident requiring personal restraint (also requires notification of a QIDP). See Attachment #1.

   b. If the incident requires emergency mechanical restraint, a **Behavior Report Documenting Emergency Restraint** must be completed. Such behaviors are defined as those emergency situations in which behaviors may result in, or have the potential to result in, injury to self or others, or the destruction of property and cannot be controlled through the use of less restrictive measures.

   c. The rules of confidentiality will be followed when documenting these incidents. Any reference to a client other than the identified client in an incident report must be by initial only. Reference to other staff members involved will include their full name and title. All corrections must be made by a single line through the incorrect entry and the writer's initials. The **Behavior Report Documenting Emergency Restraint** must include the signature of the QIDP or other staff member authorizing the restraint.

2. EMERGENCY USE OF RESTRAINT

   a. Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors. The use of emergency restraint will comply with all relevant standards and regulations. Restraint

PLAINTIFF'S EXHIBIT 3

will not be used as punishment or for the convenience of staff in lieu of adequate programming.

b. Seclusion will not be used as either an emergency or programmatic procedure.

c. A QIDP must be notified when personal restraint is used and it must be documented on a **Behavior Report**.

d. Personal restraint of a client is used when the behavior is such that verbal control has been lost and other less restrictive measures have failed to control the behavior.

e. Personal restraint will be implemented by staff who have been trained in the use of approved methods. **Personal restraint must not exceed 10 minutes.** During the period of personal restraint if the client becomes calm no further restraint procedures are to be implemented. If the client shows no indication of calming and becomes violent, staff will proceed as indicated in Paragraph f. below.

f. The request for the emergency use of mechanical restraint will be based on need as exhibited by the client who is so aggressive that restraint is necessary to prevent imminent physical harm to themselves, others, or property. Mechanical restraint may be used only when all other means of controlling the behavior have been exhausted. Staff will proceed in the following manner:

   i. A Restraint Incident Leader will be identified. The attending staff will immediately implement emergency mechanical restraint. As soon as possible staff will notify the on duty Program Supervisor who will contact a QIDP or other authorized staff for authorization for the use of emergency mechanical restraint.
   ii. The authorization for the mechanical restraints must not exceed 15 minutes. Continued use of mechanical restraint must be re-authorized every 15 minutes.
   iii. Immediately after emergency mechanical restraint has been applied, staff must contact the nurse on duty. The nurse will examine the client to ensure the restraint is applied in a pain free and harmless manner and present no physical danger to the client. The nurse will make a notation of the examination on the **Behavior Report Documenting Emergency Restraint**.
   iv. A client in emergency mechanical restraint must be:

      1. Kept under constant visual observation. This observation will be for the client's physical condition (e.g., distressed breathing, bleeding, adequate blood flow to the head and extremities) as well as for signs of calming.
      2. Checked for security of restraint, current behavior and general status. A synopsis will be documented every 15 minutes.
      3. Released for 5 minutes every hour for motion and exercise.
      4. Given the opportunity for fluid intake, meals, baths and toileting. These needs will be addressed and documented as the need arises.

5. Released from emergency mechanical restraint as soon as possible. This is defined to mean as soon as the client is calm and no longer a danger to self or others. Verbal outbursts do not necessarily mean a person is still out of control or that restraint should continue.

v. After release from emergency mechanical restraint, using the **Restraint Incident Debriefing Form**, the Restraint Incident Leader will conduct and document a debriefing discussion with the other staff members involved in the restraint and the client that must include the following:

1. The behavior which resulted in the use of the personal or emergency mechanical restraint.
2. Any environmental factors involved in the incident.
3. The antecedents to the behavior including interactions with peers or staff
4. Any action by staff that might have kept the incident from escalating to restraint.
5. The client's reaction to the use of restraint.
6. Any changes to the client's programming which might have prevented the incident.
7. Options that the client could have used to avoid the use of restraint.

3. COMPLETION OF DOCUMENTATION

a. The person authorizing the use of emergency mechanical restraint must sign the authorization. During deviant hours authorization may be obtained by telephone. Attending staff will note on the **Behavior Report Documenting Emergency Restraint** that such authorization was obtained by telephone.

b. The on duty Program Supervisor will be responsible for ensuring that the appropriate reports are completed in a timely and accurate manner.

c. Completed **Behavior Report Documenting Emergency Restraint** and **Restraint Incident Debriefing Form** will be filed in the client's Master File "Behavior Incident File".

4. REVIEW AND DISTRIBUTION OF THE COMPLETED DOCUMENTS

a. Upon completion of the report it will be sent to the appropriate Team Office.

b. The Team Leader will review all reports for content, accuracy and appropriateness and sign in the appropriate place. If corrections are required the Team Leader will contact the writer of the report and ensure corrections are made. As soon as possible the report will be given to Quality Assurance to be scanned, copied, and distributed to appropriate staff. The original report will be sent to the Record Center Operator and filed in each client's file within five days.

c. The Record Center Operator will review **Behavior Report, Behavior Report Documenting Emergency Restraint,** and **Restraint Incident Debriefing Form** for completeness and errors. The originator will be notified to correct errors found by the Record Center Operator.

d. The QIDP and Psychology staff member will review copies of all reports for programmatic issues, patterns of use, and the appropriate follow-up.

e. The authorized data keeping device (i.e., **Behavior Report, Behavior Report Documenting Emergency Restraint,** and **Restraint Incident Debriefing Form**) will be forwarded to the Psychology Department depending on the program requirement.

5. FUNCTIONAL AND ENVIRONMENTAL ANALYSES OF BEHAVIORS

a. The purposes of conducting functional and environmental analyses are to determine:

1. The pragmatic utility of a behavior for a client, i.e., what the behavior "does" for the client.
2. What role the environment may have played in the causation of the behavior.

These analyses assume aberrant behavior does serve a functional purpose, but that a functionally equivalent (appropriate) communicative response can be taught, and will serve to substitute for the aberrant behavior. Further, the aberrant behavior will reduce in frequency as the more appropriate response becomes systematically reinforced.

b. These analyses will provide the data needed to formulate programmatic responses to teach and reinforce appropriate behaviors to replace aberrant behaviors and inappropriate behaviors.

6. APPROVED RESTRAINT PROCEDURES, TECHNIQUES, AND DEVICES

a. **Personal Restraint,** an emergency procedure limiting movement by the holding of a hand or limb.

b. **Chemical Intervention** ordered by the Physician.

c. **Protective Helmet**.

d. **Papoose Board**, a Mechanical Restraint device limiting movement and range of motion.

f. **Wrist Restraint**, a Mechanical Restraint device limiting movement and range of motion.

7. AT BHDC ONLY ICF/IID QUALIFIED QIDP's SHALL BE APPROVED TO AUTHORIZE THE USE OF RESTRAINT

The Program Coordinator/QIDP is the first choice person to authorize restraint for clients on their caseload. After hours and on weekends the Team Leaders or other qualified QIDPs may be notified.

The following positions are recognized as being qualified QIDPs:

Program Coordinators/QIDPS, Team Leaders, Director of Residential Services, Superintendent, Assistant Superintendent, Director of Quality Assurance; Chief Psychologist, Psychological Examiners, Registered Nurses, and Staff Physician.

Current work telephone numbers for these persons can be obtained from DHS/BHDC Share.

THE STAFF PHYSICIAN MUST REVIEW, BY SIGNATURE, THE USE OF ALL EMERGENCY MECHANICAL RESTRAINT.

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-D-4, dated 01/07/16, in its entirety.

FIRST AID GUIDELINES

POLICY STATEMENT: First Aid Guidelines are available for use in each of the Aide Stations in each living area. This will permit appropriate and immediate attention to medical conditions of sudden onset, including injuries and choking.

PROCEDURES:

1. The First Aid Guidelines have been approved by the staff physician for the Booneville HDC.

2. In all cases in which a serious medical injury or illness is suspected, either to clients or staff, a call to the Medical Department should be made. This should be the first call so Medical staff can respond immediately to the situation.

   A call to Medical at 1422 should be made and the following information should be given:

   1. Caller's name and title
   2. Victim's name, location, situation and condition of the victim (alert, unconscious, etc.)
   3. Medical will assess the situation and call an ambulance if appropriate.

3. All staff members are trained in first aid, CPR, and abdominal thrust for choking so, that if necessary, emergency rescue measures can be initiated before Medical staff arrives.

4. Choking is a serious and potentially life-threatening situation and the following guidelines should be followed:

   a. Staff will supervise clients during meal times and nursing staff will be available by phone at all times;
   b. emergency equipment including oxygen and suction machine will be kept in the dining room for use as needed;
   c. All staff will receive annual training in abdominal thrust and choking precautions.

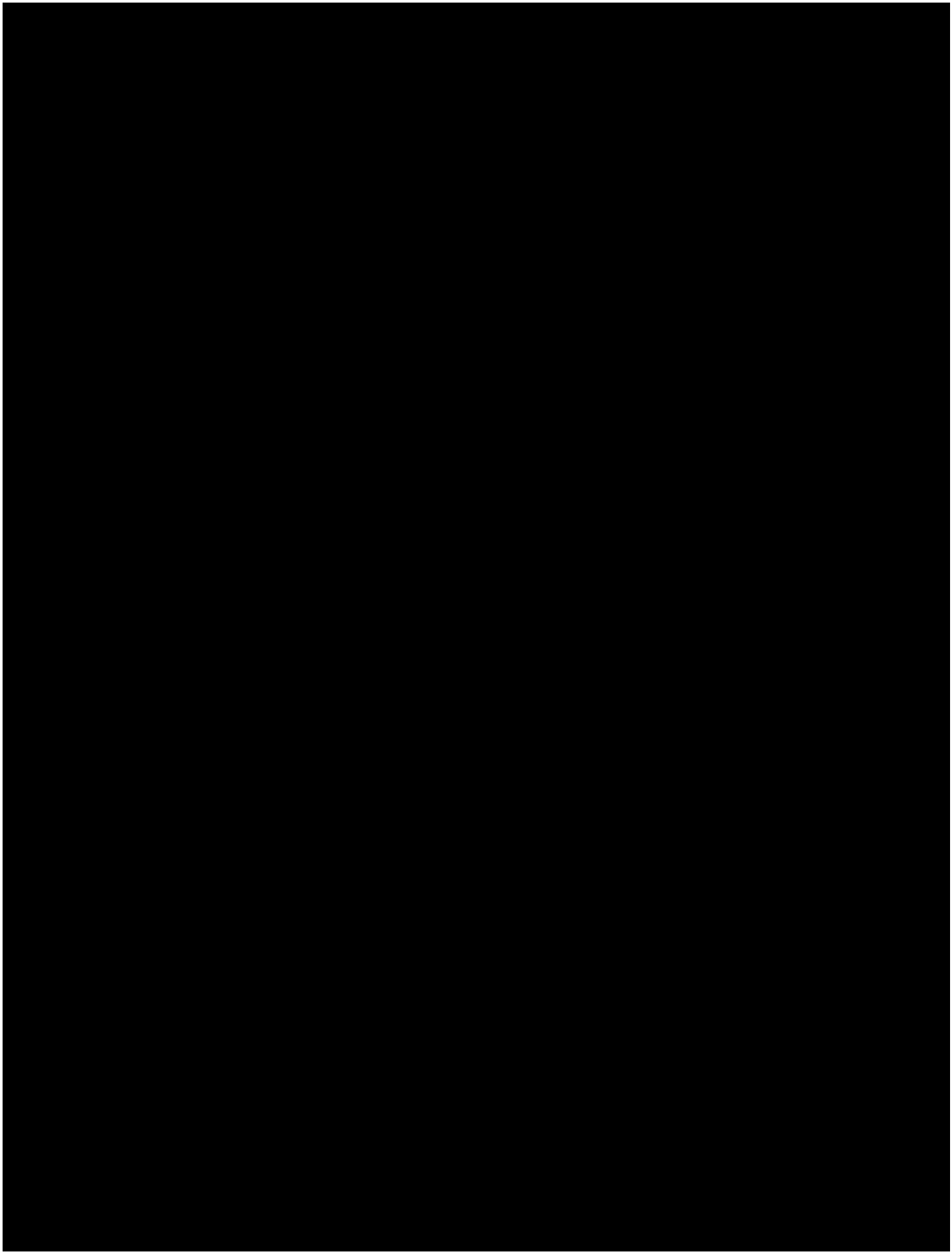
5. First Aid kits, disaster kits, and first aid guidelines will be kept in all areas. Medical will do monthly inspections on first aid kits, and every 6 month inspections on disaster kits, and refill appropriately. If living area staff notice supplies are low, Medical is to be notified and supplies will be replenished.

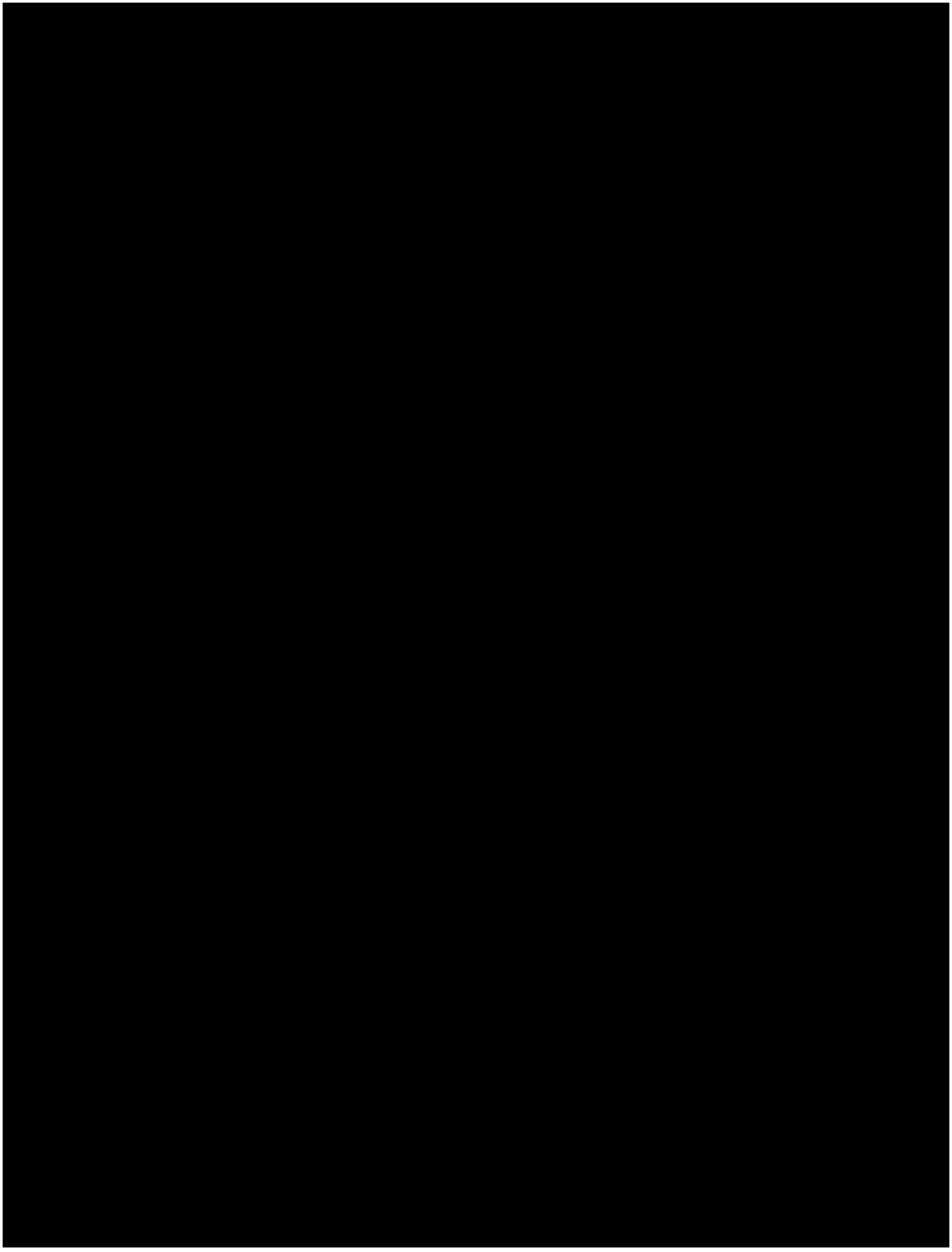
APPROVED: _____ Superintendent

Supersedes BHDC Policy IV-B-10, dated 03/13/15, in its entirety.

: 11/27/19
: 12/29/17







well, spend time with him?
A. She knew him in passing but didn't work with him regularly.
Q. Okay. And did you get along with Mandy well?
A. Yes.
Q. Okay. Do you know of any issues that Mandy has had with other clients in the past? Maybe a client has complained about her? Or perhaps something like what happened to you, another staff member or somebody accused her of maltreatment?
A. Not that I know of.
Q. Okay. Did Sandy Evans -- were you questioned by Sandy Evans after David's death?
A. Yes.
Q. Okay. And do you recall -- what do you recall from that?
A. She was empathetic towards me and that she gave me the sheet, and that was pretty much it.
Q. Just she told you she was sorry that you had -- you're having to deal with this?
A. More or less.
Q. She didn't question you about how it happened or anything like that?
A. It was all explained in the sheet.
Q. What sheet?



A. The Witness Report.
Q. The Witness Report that you wrote?
A. That I wrote, yes.
Q. Okay. So she -- she -- other than your witness -- she -- she -- I understood she accepted your Witness Report.
But, as far as you recall, she didn't -- she didn't do any further interrogation or questioning of you?
A. Not that I recall. She was just being empathetic and --
Q. Okay.
A. -- as she could professionally be in the situation.
Q. Sure, sure.
And how shortly after the death was this meeting with her?
A. Immediately afterwards.
Q. Okay.
A. And after -- yeah.
Q. And you never met with her again about it?
A. No.
Q. And about how long do you think that meeting with her lasted?
A. It took me maybe 15, 20 to write the report and I left.
Q. Okay. But how long did it take her to talk with

Exh 7

you?
A. About the duration. She didn't talk to me afterwards or before, other than being empathetic. It was just I gave her the report and --
Q. So she had you write a report. She didn't -- she didn't ask you any questions about the event? She -- other than -- and she -- the only words you recall her speaking to you were kind of . . .?
A. She just kind of asked me what happened. But, like, as far as, like, did she interrogate me necessarily? Not that I recall.
Q. But -- so you say you do recall her as -- specifically asking questions about the event?
A. Just what happened. She didn't ask too many details that I remember.
Q. Okay. And about how long do you think the conversation part with her lasted?
A. Barely a minute. It was what happened and her being empathetic. And she handed me a sheet and she explained it me, and that's really just . . .
Q. Got it. And when you say explained it to you, meaning explained how to fill out the form?
A. Basically. I mean, like, she didn't tell me what to write down necessarily; but she was like -- she gave me a -- how do I word this? She basically just gave me

basic -- basic instructions.
Q. Okay.
A. Of what -- what to write down and how to -- all that stuff, but nothing beneficial towards me necessarily.
(Exhibit 5 marked for identification.)
Q. Gotcha.
So I'm showing you what I've marked as Exhibit 5. This is Bates stamped 2714, and this is Client's Rights or Client Rights.
And this is from your training materials, correct?
A. Yes.
Q. Okay. And you would agree that this is a list of sort of the rights of the clients that you're there to -- to care for, correct?
A. Yes.
Q. And you would agree that your -- that your primary role is to literally care for these people, correct?
A. Yes, yes.
Q. Number 8: "The right to receive medical care, nursing care, and dental care in a safe and clean environment."
Number 12: "The right to express individual preferences."
Number 14: "The right to privacy during treatment

well, spend time with him?
A. She knew him in passing but didn't work with him regularly.
Q. Okay. And did you get along with Mandy well?
A. Yes.
Q. Okay. Do you know of any issues that Mandy has had with other clients in the past? Maybe a client has complained about her? Or perhaps something like what happened to you, another staff member or somebody accused her of maltreatment?
A. Not that I know of.
Q. Okay. Did Sandy Evans -- were you questioned by Sandy Evans after David's death?
A. Yes.
Q. Okay. And do you recall -- what do you recall from that?
A. She was empathetic towards me and that she gave me the sheet, and that was pretty much it.
Q. Just she told you she was sorry that you had -- you're having to deal with this?
A. More or less.
Q. She didn't question you about how it happened or anything like that?
A. It was all explained in the sheet.
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Q. The Witness Report that you wrote?
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But, as far as you recall, she didn't -- she didn't do any further interrogation or questioning of you?
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Q. Okay.
A. -- as she could professionally be in the situation.
Q. Sure, sure.

And how shortly after the death was this meeting with her?
A. Immediately afterwards.
Q. Okay.
A. And after -- yeah.
Q. And you never met with her again about it?
A. No.
Q. And about how long do you think that meeting with her lasted?
A. It took me maybe 15, 20 to write the report and I left.
Q. Okay. But how long did it take her to talk with

you?
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Q. So she had you write a report. She didn't -- she didn't ask you any questions about the event? She -- other than -- and she -- the only words you recall her speaking to you were kind of . . .?
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A. Yes.
Q. And you would agree that your -- that your primary role is to literally care for these people, correct?
A. Yes, yes.
Q. Number 8: "The right to receive medical care, nursing care, and dental care in a safe and clean environment."
Number 12: "The right to express individual preferences."
Number 14: "The right to privacy during treatment

Need policy 3004-1

PROHIBITION OF HARMFUL ACTS TO CLIENTS SERVED

POLICY STATEMENT (Philosophy): Each person served by the Booneville Human Development Center (BHDC) has the right to be free from treatment or conduct that is harmful to them physically or psychologically. BHDC strictly prohibits inappropriate treatment in any form or of any nature to individuals receiving services.

REFERENCES: **DDS Policy #3004-1**
Maltreatment Prohibition, Prevention, Reporting and Investigation
DHS Policy #1090
Incident Reporting

1. **Purpose:** BHDC will do everything in its control to prevent inappropriate treatment of those served at the facility and to report, investigate, and address instances of such activity. This policy establishes a protocol and defines responsibilities for reporting and investigating instances where a person served by BHDC is potentially subjected to improper treatment.

   This policy does not replace or remove the legal responsibility of any person or organization to report maltreatment or of any external organization to conduct investigations as required by law. Because of the nature of acts which constitute a violation of this policy, all allegations of harmful acts to clients served at a facility must be reported immediately as possible maltreatment and reviewed as such. Upon completion of the review, investigative findings will be forwarded to the Office of Long Term Care (OLTC) for a determination regarding whether employee actions rise to the level of violating the Arkansas Adult Long Term Care Facility Resident Maltreatment Act and Child Maltreatment Act. A facility review may determine inappropriate conduct or acts that do not rise to the level of maltreatment. Such conduct or acts shall be addressed through a personnel action up to and including termination.

   An OLTC finding is in addition to the facility determination regarding a violation of Department of Human Services (DHS) Policy 1084, Employee Conduct Standards. The OLTC determination is apart and separate from the facility findings, and relates to the question of whether the infraction of policy also constituted a violation of state law. The OLTC finding is not indicative of employee innocence regarding DHS policy and does not impact the facility determination that an action violated policies of the Department of Human Services.

2. **Scope:** Compliance with this policy is the responsibility of all staff, consultants and volunteers at the facility or any other person as determined by the facility administrator. It is the responsibility of the facility administrator to ensure overall compliance with this policy and to take all necessary precautions to prevent the occurrence of harmful acts against residents of a facility. (Persons outside the scope of this policy suspected of harmful acts against a person served at the facility will be reported to the appropriate state protective agencies according to OLTC guidelines.)



WED: 12/04/19
ION: 12/29/17

3. **Definitions:**

Harmful Acts - Actions which include, but are not limited to, inappropriate/harmful physical, verbal, psychological, sexual, or neglectful acts, exploitation, misappropriation of property, and violation of the rights or dignity of individuals receiving services.

Founded charge – A preponderance of credible evidence exists that supports the allegation that a harmful act to an individual by a BHDC employee has occurred.

Facility administrator – The licensed administrator or designee.

A. Prohibition of harmful acts to clients served

The facility administrator is responsible for implementing this policy in a manner to lessen the potential that harmful acts to clients served by the BHDC occur. Implementation measures will include, but are not be limited to, the areas of employee screening/training/prevention.

1. Screening:
Pre-employment screening of potential employees for a history of committing harmful acts to others. Screening includes:
   - Attempting to obtain information from previous employers and/or current employers,
   - Checking with the appropriate licensing boards, registries, and DHS personnel offices, and
   - Performing criminal record background checks.

2. Training:
Training employees, through orientation and on-going educational sessions, on issues related to the prohibition of harmful acts against people served at the facility. Areas of training may include:
   - Rights of clients
   - Recognition of events that may precede or trigger certain behaviors
   - Early intervention techniques for positive behavioral support
   - Approved interventions to deal with aggressive and/or catastrophic reactions
   - Recognizing signs of staff burnout, frustration and stress that may lead to maltreatment
   - Definition of harmful acts and maltreatment, and
   - Reporting suspected harmful acts.

3. Prevention:
Providing the people served at the facility, their families, and staff information on how and to whom they must report concerns, incidents and grievances; and how they may receive feedback regarding the concerns expressed.

Staff should immediately intervene when suspected maltreatment is witnessed to ensure client protection.

Identify, correct and intervene in situations in which harmful acts are more likely to occur. This includes an ongoing analysis of:

- Physical environments
- Supports in place to encourage recognizing and respecting client dignity and rights
- Deployment of staff
- Reports of inappropriate staff behaviors related to harmful acts
- Care planning and monitoring of people served at the facility who have challenges that might lead to conflict or neglect.

4. Identification:
Identify and respond to events, occurrences, patterns, and trends that may suggest harmful acts are being committed against a person or persons served at the facility.

B. Reporting

1. All alleged, suspected, and witnessed harmful or inappropriate acts will be **immediately** reported by **all** persons having knowledge of the alleged incident to the facility administrator.

2. All alleged, suspected, and witnessed harmful acts will be reported as required by policy to the appropriate abuse reporting hotlines by the facility administrator.

   NOTE: Nothing in this policy removes the right and obligation of a person reporting a harmful act to immediately report an incident directly to the appropriate abuse reporting hotline, as well as to the facility administrator.

3. Reporting shall not be delayed for any type of investigation.

4. Incidents shall be reported in accordance with DHS Policy 1090, Incident Reporting.

5. Reports of allegations shall also be made by the facility administrator/designee to local law enforcement and to the individual's parent/guardian/advocate. Documentation of these notifications should be maintained as part of the IRIS/investigative report.

C. Protection of Individuals During Investigations

The facility administrator will ensure staff accused or suspected of committing harmful acts as defined in this policy leave the center campus and have no contact with any

persons served at the facility until an investigation has been completed. Under no circumstances will the subject(s) of an investigation resume regular duties or assume new duties at the facility until investigative results are final. The facility administrator or designee may allow employees who are alleged to have committed harmful acts to be on the facility campus under the supervision of management staff when being interviewed as part of an investigation.

D. Investigations

1. Investigations will begin promptly after an incident is reported and be conducted by a person trained in the area of performing investigations and reviews.

2. The facility administrator shall notify the facility Human Rights Committee of all founded cases of harmful acts and may also request the committee to make recommendations on current investigations.

3. As mandated by statute, the facility administrator will defer investigations to the proper entity (law enforcement, protective service agencies, Office of Attorney General, etc.) when requested. In such cases, however, a completed review of the matter by the facility is still required.

4. Officials outside BHDC who are authorized to conduct/review investigations may request and obtain a copy of relevant documents from the facility administrator.

E. Investigation Reports

1. The facility administrator must submit a report of findings to the Office of Long Term Care (OLTC) within five (5) working days of the facility's knowledge of the incident to comply with OLTC regulations. The submitted report should contain all information collected (photos, witness statements, medical documentation, etc.) during the investigation.

2. If circumstances prevent a findings report from being completed within five (5) working days, a status report must be submitted to OLTC at the conclusion of that five-day period.

F. Discipline

1. Founded charge of harmful acts
The employee is immediately terminated as outlined in DHS Policy 1084, Employee Discipline, and is designated as "not eligible for rehire" by DHS.

2. Failure to report or delay in reporting alleged, suspected, or witnessed harmful acts
The facility administrator will utilize discipline as noted in DHS Policy 1084, Employee Discipline, unless the documented circumstances call for a deviation from the guidelines, due to aggravating or mitigating facts.

The facility administrator will utilize discipline as noted in DHS Policy 1084, Employee Discipline, unless the documented circumstances call for a deviation from the guidelines, due to aggravating or mitigating facts.

3. Other Involvement
An employee alleged to have committed a harmful act and who is not terminated will be required to attend training that at a minimum covers prevention of harmful acts and reporting requirements. The facility administrator will identify, based on factors identified in a harmful act investigation, other staff required to attend retraining. The facility administrator shall specify the training course(s) and ensure that documentation of training is maintained.

G. Record Keeping

BHDC shall maintain in a secure location a copy of all files related to cases of alleged, suspected, or witnessed harmful acts. The following items will be maintained in this file:

- The original incident report and all follow-up reports
- The facility investigation report and findings
- Any correspondence regarding the allegation
- Any documentation of supporting evidence (photos, etc.)
- Documentation of corrective actions taken by the facility administrator

A summary report of investigations of all alleged, suspected, and witnessed harmful acts conducted at the HDCs and subsequent outcomes shall be submitted to the DDS Director by January 15 of each year for the previous calendar year. Individual identifier information shall not be used. Victims shall be identified by case number and staff shall be identified by job title. Investigative files will be maintained at the facility for a minimum of 10 years.

H. Release of Maltreatment Investigative Files

Maltreatment investigative files will not be released without prior consultation with the DHS Office of Chief Counsel.*

*NOTE: When an investigation results in a disciplinary action that is grieved, relevant portions of a maltreatment investigation report will be provided to the grievant through the DHS Office of Equal Opportunity. The names of people served at the facility must be deleted from the record before it is released. Aspects of the report that are prohibited from release by law will not be included in the information submitted.

I. Confidentiality

All aspects of allegations, reports, and investigations of harmful acts to people living at an HDC are confidential. Verified violations of confidentiality will be subject to discipline under DHS Policy 1084, Employee Discipline.

J. Appeals

Employees who have been disciplined as a result of violations of this policy may appeal utilizing DHS Policy 1086, Employee Grievance Procedure.

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-A-5, dated 11/05/15, in its entirety.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Maltreatment Prohibition, Prevention, Reporting, and Investigation	3004-I

1. **Philosophy** Every individual served by the Division of Developmental Disabilities Services (DDS) has the right to be free from maltreatment. DDS strictly prohibits maltreatment (which includes but is not limited to physical, verbal, psychological, or sexual abuse, neglect, exploitation, misappropriation of property, and violation of rights) of individuals receiving services.

2. **Purpose** Each facility shall do all that is within its control to prevent occurrences of maltreatment and to report and investigate maltreatment when it occurs. This policy establishes a maltreatment prohibition protocol and defines responsibilities for reporting and investigating alleged, suspected, and witnessed maltreatment of individuals served by DDS.

   This Policy does not replace or remove the mandated legal responsibility of any entity to report maltreatment or of any external entity to conduct investigations as required by law.

3. **Scope** Compliance with this policy is the responsibility of all facility staff, clients, consultants, volunteers, staff of other agencies serving the client, family members, legal guardians, friends, or other individuals. It is the responsibility of the on-site administrator to ensure overall compliance with this policy and to take all necessary precautions to prevent maltreatment.

4. **Definitions**

1. Maltreatment – Actions which include, but are not limited to, physical, verbal, psychological, or sexual abuse, neglect, exploitation, misappropriation of property, and violation of rights of individuals receiving services

2. Founded charge of maltreatment - Credible evidence exists that supports the charge of maltreatment of an individual by a DDS employee.

3. On-site administrator – The administrator or his or her designee.

See other terms as defined by statutes in Appendix A and B.

Replacement: This Policy replaces: DDS Commissioner's Office Policy 3004-I (January 28, 1981, June 4, 1982, and May 25, 1983); DDS Deputy Director's Office Policy 3004-I (January 8, 1987); DDS Director's Office Policy 3004-I (May 1, 1993, December 1, 1993, and *May 22, 1995*).

References: *Act 1208 of 1991; Arkansas Code Annotated (ACA) § 5-28-101; 12-12-507 (d) (e); 12-12-509 (a) (1); 12-12-509 (2) (A) (B); 12-12-503 (10); DHS Policy 1090; DDS Director's Office Policies 1027, 3010-I, 3011-D, and DDS Procedural Guidelines for Investigations*

Reviewed: *Administrative Rules & Regulations Subcommittee of Arkansas Legislative Council:* (New date)



5. **Policy** DDS Programs (hereafter referred to as facilities) will implement this policy and develop and implement consistent procedures for the prevention, identification, reporting, and investigation of maltreatment.

6. **Procedures**

A. Prohibition of Maltreatment

The on-site administrator is responsible for implementing this policy and consistent procedures that prohibit maltreatment through screening, training, prevention, and identification. Below are ways in which facilities should implement each component.

1. Screening:
   Screen potential employees for a history of maltreatment, as defined by applicable requirements. This includes:
   - attempting to obtain information from previous employers and/or current employers,
   - checking with the appropriate licensing boards, registries, and DHS personnel offices, and
   - performing criminal record checks.

2. Training:
   Train employees, through orientation and through on-going sessions, on issues related to maltreatment prohibition practices such as:
   - Rights of clients
   - Recognition of events that may precede or trigger certain behaviors
   - Early intervention techniques for positive behavioral support
   - Approved interventions to deal with aggressive and/or catastrophic reactions
   - Recognizing signs of staff burnout, frustration and stress that may lead to maltreatment;
   - Definition of maltreatment, and
   - Reporting suspected maltreatment.

3. Prevention:
Provide clients, families, and staff information on how and to whom they may report concerns, incidents and grievances; and how they may receive feedback regarding the concerns that have been expressed.
Identify, correct and intervene in situations in which maltreatment are more likely to occur. This includes an analysis of:
   - Features of the physical environment that may make maltreatment and/or neglect more likely to occur, such as secluded areas of the facility;
   - Failure to recognize and respect client rights.
   - The deployment of staff on each shift in sufficient numbers to meet the needs of the clients, and assure that the staff assigned have knowledge of the individual clients' care needs;
   - Inappropriate staff behaviors, such as:
     - derogatory language,
     - rough handling,
     - ignoring clients while giving care,
     - directing clients who need toileting assistance to urinate or defecate in their beds; and
     - use of items for staff convenience (i.e., disposable briefs, restraints)
   - The assessment, care planning, and monitoring of clients with needs and behaviors which might lead to conflict or neglect. This would include clients with a history of aggressive behaviors, clients who have behaviors such as entering other clients' rooms, clients with self-injurious behaviors, clients with communication disorders, and clients that require extensive care.

4. Identification:
Identify events, occurrences, patterns, and trends, such as bruising of clients, or a change in behavior that may suggest maltreatment.

B. Reporting.

1. All alleged, suspected, and witnessed maltreatment will be immediately reported by all individuals having knowledge of the alleged incident to the on-site administrator.

2. All alleged, suspected, and witnessed maltreatment will be immediately reported to the appropriate abuse reporting hotlines by the on-site administrator.

NOTE: Nothing in this policy removes the right and obligation of a mandated reporter (see Appendix B) to immediately report an incident directly to the appropriate abuse reporting hotline, as well as to the on-site administrator.

3. Reporting shall not be delayed for any type of investigation.

4. Incidents shall be reported in accordance with DHS Policy 1090, Incident Reporting, and the DHS Incident Reporting and Information System (IRIS).

5. Reports of allegations shall also be made by telephone or fax by the on-site administrator/designee to local law enforcement where the facility is located and to the individual's parent/guardian/advocate.

6. Incidents which are not specifically defined in statute as abuse but which have or may have a negative impact on clients shall be reported as noted in item 4 above. An example would be one or more acts of discourteous treatment by an employee, as defined in DHS Policies 1084 and 1085, Minimum Conduct Standards.

C. Protection of Individuals During Investigations

The on-site administrator is responsible for ensuring that staff accused or suspected of maltreatment leave the facility grounds immediately and have no contact with clients until an investigation has been completed. Under no circumstances will the subject(s) of an investigation resume regular duties or assume new duties at the facility until an investigation is complete.

D. Investigations

1. Investigations will begin promptly after an incident is reported. When applicable, the on-site administrator may delegate this task to a trained investigator on staff.

2. Allegations of maltreatment will be investigated according to DDS Procedural Guidelines for Investigations. Physical evidence (i.e., bruises, marks, etc.) shall be photographed when an incident is reported and again no more than three days later.

3. The on-site administrator may request that the Human Rights Committee review and make recommendations on current investigations and shall notify the Committee of all founded cases of maltreatment.

4. As mandated by statute, the on-site administrator will defer investigations to the proper entity (law enforcement, protective service agencies, Office of Attorney General, etc.).

5. Officials outside DDS who are authorized to conduct investigations shall request and obtain a copy of relevant documents from the on-site administrator.

E. Investigation Reports

1. When a reported incident has been determined to warrant an investigation, the on-site administrator must submit a report of findings to the Office of Long Term Care (OLTC) within five (5) working days of the facility's knowledge of the incident, to comply with OLTC regulation LTC 300 *et.seq.*

2. If the administrator is unable to submit a final report to OLTC within five days, he or she must submit a status report to OLTC within the five-day timeframe. This status report must detail the findings that have been determined to that point and what areas need further investigation.

3. A full report, in the format of a DDS Investigative File, must be completed and submitted to the DDS Director and to OLTC within 14 calendar days of notification that an incident is being investigated.

4. An extension of the 14-day timeframe must be requested of and granted by the Director's Office. Documentation of the extension approval shall be part of the file.

5. The DDS Director's Office shall send a copy of all investigative files to the appropriate Protective Services Agency, the Office of Chief Counsel, and the Office of the Attorney General.

F. Discipline.

1. Founded charge of maltreatment
   The employee is immediately terminated and his/her personnel file is designated as "not eligible for rehire" by DHS.

2. Failure to report alleged, suspected, or witnessed maltreatment
   The employee is subject to termination, as in item F-1. If not terminated, the on-site administrator will utilize progressive discipline as noted in DHS Policy 1084 Employee Discipline, unless the documented circumstances clearly warrant a deviation from the guidelines, due to aggravating or mitigating facts.

3. Delay in reporting alleged, suspected, or witnessed maltreatment
   The employee is subject to termination, as in item F-1. If not terminated, the on-site administrator will utilize progressive discipline as noted in DHS Policy 1084 Employee Discipline, unless the documented circumstances clearly warrant a deviation from the guidelines, due to aggravating or mitigating facts.

4. Other Involvement
Any employee who is involved in any way with any aspect of a case of maltreatment and who is not terminated will be required to attend training relative to maltreatment prevention, reporting, and investigation. The on-site administrator shall specify the training course(s) and ensure that documentation of training is maintained.

G. Record Keeping.

1. Each facility shall maintain a copy of all files related to cases of alleged, suspected, or witnessed maltreatment in a secure location. This record will include the original incident report (IRIS) and all follow-up reports; the on-site administrator's investigation report; any correspondence; any documentation of supporting evidence (photos, etc.), and documentation of the actions taken by the on-site administrator. These internal records shall be maintained for no less than ten (10) years. Original investigative files will be maintained in the DDS Director's office and retained indefinitely, in either paper format or other medium.

2. A summary report of investigations of all alleged, suspected, and witnessed maltreatment conducted at the HDCs and subsequent outcomes shall be submitted to the DDS Director by January 15 of each year for the previous calendar year. Individual identifier information shall not be used. Victims shall be identified by case number and staff shall be identified by Job Title.

3. DDS Systems Development Section will also submit a summary report of the same information, as reported by DDS Community Programs, to the DDS Director by January 15 each year for the previous calendar year. Requests for the summary reports noted in G.2 and G.3 shall be made in writing to the DDS Director.

H. Release of Investigative Files.

It is the intent of this policy to protect the anonymity of all clients noted in investigative reports and the names of those who report abuse. For specific guidance for the release of information under the Freedom of Information Act (FOIA), see DHS Policy 1053. All client and reporter identifiers must be deleted (redacted) prior to release.

NOTE: When an investigation results in disciplinary action that is grieved, a copy of pertinent information from the investigation report will be provided to the grievant with client and reporter identifiers deleted. This may not apply to the grievance process at the state level.

I. Confidentiality.

All aspects of allegations, reports, and investigations of child and adult maltreatment are confidential. Verified violations will be subject to discipline under DHS Policy 1084, Employee Discipline and DHS Policy 1085, Minimum Conduct Standards.

J. Appeals.

Employees who have been disciplined based on provisions set forth in this policy retain the right of appeal according to established grievance procedures outlined in DHS Policy 1086, Employee Grievance Procedure.

Appendix A

Statutory definitions

Adult abuse (5-28-101)

(1) **"Abuse"** means:

(A) Any intentional and unnecessary physical act which inflicts pain on or causes injury to an endangered or impaired adult, including sexual abuse; or

(B) Any intentional or demeaning act which subjects an endangered or impaired adult to ridicule or psychological injury in a manner likely to provoke fear or alarm;

(2) **"Caregiver"** means a related or unrelated person, owner, agent, high managerial agent of a public or private organization, or a public or private organization that has the responsibility for the protection, care, or custody of an endangered or impaired adult as a result of assuming the responsibility voluntarily, by contract, through employment, or by order of the court;

(3)(A) **"Department"** means the Department of Human Services.

(B) The Director of the Department of Human Services may assign responsibilities for administering the various duties imposed upon the department under this chapter to respective divisions of the department which, in his or her opinion, are best able to render service or administer the provisions of this chapter;

(4) **"Endangered adult"** means:

(A) An adult eighteen (18) years of age or older who is found to be in a situation or condition which poses an imminent risk of death or serious bodily harm to that person and who demonstrates a lack of capacity to comprehend the nature and consequences of remaining in that situation or condition; or

(B) A resident eighteen (18) years of age or older of a long-term care facility, which is required to be licensed under § 20-10-224, who is found to be in a situation or condition which poses an imminent risk of death or serious bodily harm to the person and who demonstrates the lack of capacity to comprehend the nature and consequences of remaining in that situation or condition;

(5) **"Exploitation"** means the illegal use or management of an endangered or impaired adult's funds, assets, or property, or the use of an endangered or impaired adult's person, power of attorney, or guardianship for the profit or advantage of himself, herself, or another;

(6)(A) **"Imminent danger to health or safety"** means a situation in which death or severe bodily injury could reasonably be expected to occur without intervention.

(B) The burden of proof shall be upon the department to show by clear and convincing evidence that such imminent danger exists.

(7)(A) **"Impaired adult"** means a person eighteen (18) years or older who, as a result of mental or physical impairment, is unable to protect himself or herself from abuse, sexual abuse, neglect, or exploitation, and as a consequence thereof is endangered.
(B) For purposes of this chapter, adult clients of a long-term care facility are presumed to be impaired adults;
(8) **"Neglect"** means acts or omissions by an endangered adult; for example, self-neglect or intentional acts or omissions by a caregiver responsible for the care and supervision of an endangered or impaired adult constituting:
(A) Negligently failing to provide necessary treatment, rehabilitation, care, food, clothing, shelter, supervision, or medical services to an endangered or impaired adult;
(B) Negligently failing to report health problems or changes in health problems or changes in the health condition of an endangered or impaired adult to the appropriate medical personnel; or
(C) Negligently failing to carry out a prescribed treatment plan;
(9)(A) **"Physical injury"** means the impairment of a physical condition or the infliction of substantial pain.
(B) Where the person is an endangered or impaired adult, there shall be a presumption that any physical abuse resulted in the infliction of substantial pain;
(10)(A) **"Protective services"** means services to protect the endangered or impaired adult from:
(i) Self-neglect or self-abuse; and
(ii) Abuse or neglect by others.
(B) Protective services shall include, but not be limited to:
(i) Evaluation of the need for services;
(ii) Arrangements for appropriate services;
(iii) Assistance in obtaining financial benefits to which the person is entitled; or
(iv) Securing medical and legal services.
(C)(i) Protective services may include:
(a) Referrals for services available in the community;
(b) Seeking protective custody or court-ordered services for endangered adults; or
(c) In appropriate cases, assistance in locating an appropriate person or entity interested in and able to assume guardianship over an endangered adult.
(ii) In situations involving exploitation of an endangered or impaired adult not resulting in any imminent danger to health or safety or involving protection of the property of such an impaired adult, protective services may include one (1) or more of the following:
(a) Referrals for legal assistance;
(b) Referrals, as appropriate, to law enforcement or prosecutors; or
(c) Assistance in locating an appropriate person or entity interested in and able to assume guardianship;
(11) **"Serious bodily harm"** means physical abuse, sexual abuse, physical injury, or serious physical injury as defined in this chapter;

(12) **"Serious physical injury"** means physical injury to an endangered or impaired adult that creates a substantial risk of death or that causes protracted disfigurement, protracted impairment of health, or loss or protracted impairment of the function of any bodily member or organ;

(13) **"Sexual abuse"** means deviate sexual activity, sexual contact, or sexual intercourse, as those terms are defined in § 5-14-101, with another person who is not the actor's spouse and who is incapable of consent because he or she is mentally defective, mentally incapacitated, or physically helpless, as those terms are defined in § 5-14-101; and

(14) **"Subject of the report"** means the endangered or impaired adult, the adult's guardian, and the offender.

Child abuse (12-12-503)

(1) **"Abandonment"** means:

(A) Failure of the parent to provide reasonable support and to maintain regular contact with the juvenile through statement or contact when the failure is accompanied by an intention on the part of the parent to permit the condition to continue for an indefinite period in the future;

(B) Failure to support or maintain regular contact with the juvenile without just cause; or

(C) An articulated intent to forego parental responsibility;

(2)(A) **"Abuse"** means any of the following acts or omissions by a parent, guardian, custodian, foster parent, or any person who is entrusted with the juvenile's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible for the juvenile's welfare:

(i) Extreme or repeated cruelty to a juvenile;

(ii) Engaging in conduct creating a realistic and serious threat of death, permanent or temporary disfigurement, or impairment of any bodily organ;

(iii) Injury to a juvenile's intellectual, emotional, or psychological development as evidenced by observable and substantial impairment of the juvenile's ability to function within the juvenile's normal range of performance and behavior;

(iv) Any injury that is at variance with the history given;

(v) Any nonaccidental physical injury;

(vi) Any of the following intentional or knowing acts, with physical injury and without justifiable cause:

(a) Throwing, kicking, burning, biting, or cutting a child;

(b) Striking a child with a closed fist;

(c) Shaking a child; or

(d) Striking a child on the face;

(vii) Any of the following intentional or knowing acts, with or without physical injury:
(a) Striking a child age six (6) or younger on the face;
(b) Shaking a child age three (3) or younger; or
(c) Interfering with a child's breathing.

(B)(i) The list in subdivision (2)(A) of this section is illustrative of unreasonable action and is not intended to be exclusive.

(ii) No unreasonable action shall be construed to permit a finding of abuse without having established the elements of abuse.

(C)(i) **"Abuse"** shall not include physical discipline of a child when it is reasonable and moderate and is inflicted by a parent or guardian for purposes of restraining or correcting the child.

(ii) **"Abuse"** shall not include when a child suffers transient pain or minor temporary marks as the result of an appropriate restraint if:

(a) The person exercising the restraint is an employee of an agency licensed or exempted from licensure under the Child Welfare Agency Licensing Act, § 9-28-401 et seq.;

(b) The agency has policy and procedures regarding restraints;

(c) No other alternative exists to control the child except for a restraint;

(d) The child is in danger or hurting himself or herself or others;

(e) The person exercising the restraint has been trained in properly restraining children, de-escalation, and conflict resolution techniques; and

(f) The restraint is for a reasonable period of time.

(iii) Reasonable and moderate physical discipline inflicted by a parent or guardian shall not include any act that is likely to cause and which does cause injury more serious than transient pain or minor temporary marks.

(iv) The age, size, and condition of the child and the location of the injury and the frequency or recurrence of injuries shall be considered when determining whether the physical discipline is reasonable or moderate;

(3) **"Caretaker"** means a parent, guardian, custodian, foster parent, or any person ten (10) years of age or older who is entrusted with a child's care by a parent, guardian, custodian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person responsible for a child's welfare;

(4)(A) **"Central intake"**, otherwise referred to as the **"child abuse hotline"**, refers to a unit that shall be established by the Department of Human Services for the purpose of receiving and recording notification made pursuant to this subchapter.

(B) Central intake shall be staffed twenty-four (24) hours per day and shall have statewide accessibility through a toll-free telephone number;

(5) **"Child"** or **"juvenile"** means an individual who:
(A) Is from birth to the age of eighteen (18);
(B) Is under the age of twenty-one (21) years, whether married or single, who was adjudicated delinquent under the Arkansas Juvenile Code of 1989, § 9-27-301 et seq., for an act committed prior to the age of eighteen (18) years, and for whom the court retains jurisdiction; or
(C) Was adjudicated dependent-neglected under the Arkansas Juvenile Code of 1989, § 9-27-301 et seq., before reaching the age of eighteen (18) years, and who, while engaged in a course of instruction or treatments, requests the court to retain jurisdiction until the course has been completed;
(6) **"Child maltreatment"** means abuse, sexual abuse, neglect, sexual exploitation, or abandonment;
(7) **"Department"** means the Department of Human Services;
(8) **"Deviate sexual activity"** means any act of sexual gratification involving:
(A) Penetration, however slight, of the anus or mouth of one person by the penis of another person; or
(B) Penetration, however slight, of the labia majora or anus of one person by any body member or foreign instrument manipulated by another person;
(9)(A)(i) **"Forcible compulsion"** means physical force, intimidation, or a threat, express or implied, of physical injury to or death, rape, sexual abuse, or kidnapping of any person.
(ii) If the act was committed against the will of the juvenile, then forcible compulsion has been used.
(B) The age, developmental state, and stature of the victim, and the relationship of the victim to the assailant, as well as the threat of deprivation of affection, rights, and privileges from the victim by the assailant, shall be considered in weighing the sufficiency of the evidence to prove compulsion;
(10) "Indecent exposure" means the exposure by a person of the person's sexual organs for the purpose of arousing or gratifying the sexual desire of the person or of any other person under circumstances in which the person knows the conduct is likely to cause affront or alarm;
(11) **"Near fatality"** means an act that, as certified by a physician, places the child in serious or critical condition;
(12) **"Neglect"** means those acts or omissions of a parent, guardian, custodian, foster parent, or any person who is entrusted with the juvenile's care by a parent, custodian, guardian, or foster parent, including, but not limited to, an agent or employee of a public or private residential home, child care facility, public or private school, or any person legally responsible under state law for the juvenile's welfare, which constitute:
(A) Failure or refusal to prevent the abuse of the juvenile when the person knows or has reasonable cause to know the juvenile is or has been abused;

(B) Failure or refusal to provide necessary food, clothing, shelter, and education required by law, excluding the failure to follow an individualized educational program, or medical treatment necessary for the juvenile's well-being, except when the failure or refusal is caused primarily by the financial inability of the person legally responsible and no services for relief have been offered or rejected;
(C) Failure to take reasonable action to protect the juvenile from abandonment, abuse, sexual abuse, sexual exploitation, neglect, or parental unfitness where the existence of such condition was known or should have been known;
(D) Failure or irremediable inability to provide for the essential and necessary physical, mental, or emotional needs of the juvenile;
(E) Failure to provide for the juvenile's care and maintenance, proper or necessary support, or medical, surgical, or other necessary care;
(F) Failure, although able, to assume responsibility for the care and custody of the juvenile or participate in a plan to assume such responsibility; or
(G) Failure to appropriately supervise the juvenile that results in the juvenile's being left alone at an inappropriate age or in inappropriate circumstances that put the juvenile in danger;
(13) **"Parent"** means a biological mother, an adoptive parent, or a man to whom the biological mother was married at the time of conception or birth or who has been found by a court of competent jurisdiction to be the biological father of the juvenile;
(14) **"Pornography"** means:
(A) Obscene or licentious material, including pictures, movies, and videos, lacking serious literary, artistic, political, or scientific value, which, when taken as a whole and applying contemporary community standards would appear to the average person to appeal to the prurient interest; or
(B) Material that depicts sexual conduct in a patently offensive manner lacking serious literary, artistic, political, or scientific value;
(15) **"Serious bodily injury"** means bodily injury that involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty;
(16) **"Severe maltreatment"** means sexual abuse, sexual exploitation, acts or omissions which may or do result in death, abuse involving the use of a deadly weapon as defined by the Arkansas Criminal Code, § 5-1-101 et seq., bone fracture, internal injuries, burns, immersions, suffocation, abandonment, medical diagnosis of failure to thrive, or causing a substantial and observable change in the behavior or demeanor of the child;

(17) **"Sexual abuse"** means:
(A) By a person ten (10) years of age or older to a person younger than eighteen (18) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact by forcible compulsion;
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact;
(iii) Indecent exposure; or
(iv) Forcing, permitting, or encouraging the watching of pornography or live sexual activity;
(B) Between a person eighteen (18) years of age or older and a person not his or her spouse who is younger than sixteen (16) years of age:
(i) Sexual intercourse, deviate sexual activity, or sexual contact or solicitation; or
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact; or
(C) Between a person younger than eighteen (18) years of age and a sibling or caretaker:
(i) Sexual intercourse, deviate sexual activity, or sexual contact or solicitation; or
(ii) Attempted sexual intercourse, deviate sexual activity, or sexual contact;
(18)(A) **"Sexual contact"** means any act of sexual gratification involving the touching, directly or through clothing, of the sex organs, buttocks, or anus of a person or the breast of a female.
(B) Provided, that nothing in this section shall permit normal affectionate hugging to be construed as sexual contact;
(19) **"Sexual exploitation"** means allowing, permitting, or encouraging participation or depiction of the juvenile in prostitution, obscene photographing, filming, or obscenely depicting a juvenile for any use or purpose; and
(20) **"Subject of the report"** means:
(A) The offender;
(B) The parents, guardians, and legal custodians of the child who is subject to suspected maltreatment; and
(C) The child who is the subject of suspected maltreatment.

Appendix B

(5-28-203) Mandated Reporters (adult)

Persons required to report abuse:

(a)(1) Whenever any of the following has observed or has reasonable cause to suspect that an endangered or impaired adult has been subjected to conditions or circumstances which would reasonably result in abuse, sexual abuse, neglect, or exploitation, as defined in this chapter, he or she shall immediately report or cause a report to be made in accordance with the provisions of this section:

(A) A physician;
(B) A surgeon;
(C) A coroner;
(D) A dentist;
(E) An osteopath;
(F) A resident intern;
(G) A registered nurse;
(H) Hospital personnel who are engaged in the administration, examination, care, or treatment of persons;
(I) Any social worker;
(J) A case manager;
(K) A case worker;
(L) A mental health professional;
(M) A peace officer;
(N) A law enforcement officer;
(O) A facility administrator;
(P) An employee in a facility;
(Q) An employee of the Department of Human Services;
(R) A firefighter; or
(S) An emergency medical technician.

(2) Whenever a person is required to report under this chapter in his or her capacity as a member of the staff, an employee in a facility, or an employee of the department, he or she shall immediately notify the person in charge of the institution, facility, or agency, or that person's designated agent, who shall then become responsible for making a report or cause a report to be made.

(3) In addition to those persons and officials required to report suspected adult abuse, sexual abuse, or neglect, any other person may make a report if the person has reasonable cause to suspect that an adult has been abused, neglected, or exploited, as defined in this chapter.

(b)(1) A report required under this chapter shall be made to the central registry by the receiving agency for abused or neglected adults not residing in long-term care facilities.
(2) A report for abused or neglected adults residing in a long-term care facility shall be made immediately to the local law enforcement agency for the jurisdiction in which the facility is located and to the Office of Long Term Care of the Division of Medical Services of the Department of Human Services, pursuant to regulations of that office.
(3) The office shall notify the central registry and the office of the Attorney General.
No privilege or contract shall relieve anyone required by this subchapter to make notification of the requirement of making notification.

12-12-507. Reports of suspected abuse or neglect (child)

(a) Any person with reasonable cause to suspect child maltreatment or that a child has died as a result of child maltreatment, or who observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, may immediately notify the child abuse hotline.
(b) When any of the following has reasonable cause to suspect that a child has been subjected to child maltreatment or has died as a result of child maltreatment, or who observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, he or she shall immediately notify the child abuse hotline:
(1) Any child or foster care worker;
(2) A coroner;
(3) A day care center worker;
(4) A dentist;
(5) A domestic abuse advocate;
(6) A domestic violence shelter employee;
(7) A domestic violence shelter volunteer;
(8) An employee of the Division of Youth Services of the Department of Human Services;
(9) An employee working under contract for the Division of Youth Services of the Department of Human Services;
(10) A family service worker;
(11) A judge;
(12) A law enforcement official;
(13) A licensed nurse;
(14) Any medical personnel who may be engaged in the admission, examination, care, or treatment of persons;
(15) A mental health professional;
(16) An osteopath;
(17) A physician;

(18) A peace officer;
(19) A prosecuting attorney;
(20) A resident intern;
(21) A school counselor;
(22) A school official;
(23) A social worker;
(24) A surgeon; or
(25) A teacher.

Ex. 1
Pg. 1 of 3

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities

OLTC Witness Statement Form

Date: 6-13-20 Time: 1454 ☐ AM ☒ PM

Witness Full Name: Tyler Matteson

Job Title: RCA Shift: 9-4

Home Address: [redacted]

Home Phone #: [redacted]

Relation To Resident (If Any?)

State in your own words what you witnessed (be very descriptive) and sign below.

I was at lunch with David, he had finished eating his sandwich and cucumber and put his tray up. he sat down and seemed fine, shortly after he asked if he could go to the restroom I followed him inside the bathroom because he seemed irritated before hand, while in there I heard no abnormal sounds such as vomiting due to his history of intentionally vomiting when he is upset we walked out and he asked if he could sit in the lobby to calm down, I said that's fine, shortly after he began screaming and cussing and ripped paper off of the wall to throw he then jumped

(Continue on Back as Necessary)

The information provided above is true to the best of my knowledge.

Signature of Witness: Tyler Matteson Date: 6-13-20

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Page 9 of 9

EXHIBIT 8

Ex. 1
Pg. 2 of 3

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities

OLTC Witness Statement Form
(Continued from front)

Up after me, spitting and attempting to hit me, I applied personals by grabbing his arms he ended up falling over, I did not land on him, he continued fighting and I called him on his left side so as to not put any pressure on his stomach because he had just ate, At that he was still fighting and mandy arms joined to assist me, grabbing his hands, all while I was squatted over him, not putting my weight on him during any of this, holding his shoulder and sides, he was still continuously fighting and Ryan campos showed up and held his legs down still fighting. We had him in personal for appox 1min and noticed he had

[redacted]

The information provided above is true to the best of my knowledge.

Signature of Witness: _____ Date: _____

DMS-762

Ex. 1
Pg. 3 of 3

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities

OLTC Witness Statement Form

Date: 6-13-20 Time: 1454 ☐ AM ☑ PM

Witness Full Name: Tyler Mattson

Job Title: RN Shift: 8-4

Home Address [redacted]

Home Phone #: [redacted]

Relation To Resident (If Any?)

State in your own words what you witnessed (be very descriptive) [redacted]

(Continue on Back as Necessary)

The information provided above is true to the best of my knowledge.

Signature of Witness: Tyler Mattson Date: 6-13-20

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS
SPECIAL ADMINISTRATOR OF THE
ESTATE OF DAVID CAINS

CLAIMANT

VS. CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER)

RESPONDENT

VIDEOTAPED ORAL DEPOSITION

OF

TYLER ANTHONY MATTSON

March 31, 2022

Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72203

Shyloa Myers, RPR, CCR
Arkansas Lic. No. 710

Shyloa Myers, AR CRR No. 710
StenoScribe, Inc.
alldaydepo@gmail.com



A P P E A R A N C E S

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ALSO PRESENT:

GARRETT GRELLNER

JOHN SIMS, Videographer

I N D E X

STYLE AND NUMBER 2

APPEARANCES 3

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C A P T I O N

ANSWERS AND ORAL DEPOSITION OF TYLER ANTHONY MATTSON, a witness produced at the request of the CLAIMANT, taken in the above-styled and numbered cause on the 31st of March, 2022 before Shyloa Myers, CCR, RPR, and Notary Public, at 12:44 p.m. at the offices of Arkansas Department of Human Services, 700 Main Street, Little Rock, Arkansas 72203.

S T I P U L A T I O N S

NO STIPULATIONS ON THE RECORD

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(Deposition commences at 12:44 p.m.)

PROCEEDINGS

THE VIDEOGRAPHER: We are on the audio and video record. Today's date is March 31, 2022. The time is approximately 12:44 p.m.

This is the videotaped deposition of Tyler Mattson. This is the case of *McAuliffe V. Arkansas Department of Human Services Booneville Human Development Center.*

My name is John Sims. I'm a videographer out of Little Rock, Arkansas.

Will counsel please make a record of your appearance.

MR. GILLISPIE: Josh Gillispie on behalf of Ms. McAuliffe.

MR. COLLINS: Eric Collins on behalf of DHS.

TYLER ANTHONY MATTSON,

Called as a witness, having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. GILLISPIE:

Q. Mr. Mattson, your name's Tyler Mattson; right?

A. Uh-huh.

Q. Have you ever taken a -- have you ever had your deposition taken before, Tyler?
A. No.
Q. It's important that you verbalize yeses and nos so that the court reporter can make a clean record. I know it's our habit to nod and say "uh-huh."
A. Yeah.
Q. I do that too.
A. Yeah.
Q. But in depositions we have to verbalize yeses and nos clearly.

I'm going to ask you some questions here today. If you don't understand a question, I can repeat it. If you can't hear me, tell me and I'll speak up.

If you need to take a break, that's fine. Just let us know.

Other than that, I don't have any preliminary directions for you. We'll try to get through this as quickly as we can.

I know you don't want to be here any longer than you have to, right?
A. Right.
Q. Okay. All right. So state your full name for us.
A. Tyler Anthony Mattson.
Q. Okay. And, how old are you, Mr. Mattson?

A. 27.
Q. 27.
Okay. What's your date of birth?
A. [redacted]
Q. All right. And did -- where -- where did you grow up and go to high school?
A. I went to Magazine until seventh grade. Then I switched to Booneville High School and graduated from there.
Q. Okay. And what year did you graduate?
A. 2013.
Q. 2013. Okay.
And did you go to college after that?
A. I started some college but I dropped out.
Q. Okay. How much college did you -- did you do, about?
A. A year, about a year.
Q. Okay. Where did you go?
A. Ozark ATU, a smaller college campus.
Q. Okay. And, before coming to Booneville, where all did you work?
A. Rockline and Walmart.
Q. What's Rockline?
A. They make baby wipes. It's just a factory. They make baby wipes and coffee fil- -- and I think they used

to do coffee filters.
Q. Okay. And what did you do for Rockline?
A. I was a packer and palletizer. I just would stand on the conveyor belt line, put packages into boxes, send them down to be palletized; and we would swap off.
Q. Okay. And why did you leave that job?
A. To get a job at BHDC.
Q. Okay. And why did you want to work at BHDC?
A. I had grown up around disabled people all my life --
Q. Okay.
A. -- beforehand. My mom worked there for years, and my dad worked there. And it just kind of down -- down the tree.
Q. I see.
What did your -- when you say -- did you have relatives that are disabled?
A. I had an aunt that was one; I had never met her.
Q. Okay.
A. But back then my dad -- or my dad's ex-wife now used to work for BOST, with a live-in person; so I was about -- around that as well.
Q. What did your mom do at Booneville?
A. She was the same as me. Back then she was called an RCA or something like that.

Q. How long did she work there, if you know?
A. About maybe 15 years.
Q. Okay. Does she still work there now?
A. No.
Q. No.
Do you know when she -- when her employment ended there?
A. 2001.
Q. Okay. And what about your dad? When did he work there?
A. I don't know. He wasn't there for very long. Maybe -- maybe a year or two.
Q. Okay. Did you have brothers or sisters?
A. None biological.
Q. Okay. Are your parents still together?
A. No.
Q. No.
Who do you -- who do you -- do you live -- do you live alone now?
A. I live with my girlfriend.
Q. Okay. And do y'all live in Booneville?
A. Yeah.
Q. Okay. And you've never been married?
A. No.
Q. And you don't have any children?

A. None biological.
Q. Do you have a stepchild or a -- well, I guess --
A. Yes, technically.
Q. Your girlfriend has children?
A. Yeah, yeah.
Q. Okay. And do those children live with y'all?
A. Yeah.
Q. How old are they?
A. Five.
Q. One child that's five?
A. Uh-huh. Yes, yes. Sorry.
Q. It's okay. It's habit. I do it too.
A. Yeah.
Q. It's just . . .
So you -- when did you first start working at Booneville?
A. 2017. February was my hire date. I don't know the exact number.
Q. Okay. And what were you -- were you hired as a -- as a res- -- you tell me what you were hired as?
A. RCA was the title.
Q. Okay. And that stands for residential care --
A. Assistant.
Q. -- assistant.
And was that also your title at the time of David's

death?
A. RCT.
Q. Okay. What's RCT stand for?
A. Residential care technician.
Q. Okay. And so does that mean you got a promotion?
A. No.
After six months of being there everybody goes from an R -- back then it was from an RCA to a RCT.
Q. Okay. So there's kind of, like, a six-month probationary period?
A. Yeah, yeah.
Q. So -- and you were an RCT at the time of David's death?
A. Yes.
Q. When did you -- I understand you left Booneville and have since come back.
When did you leave Booneville?
A. About -- at this point 6 1/2 months ago. I don't know exact dates, but it was about 6 1/2 months ago.
Q. Okay. And did you leave on our own accord or by your own choice? Or were you asked to leave?
A. No. By my own choice.
Q. Okay. Why did -- where did you -- what is -- what was your reason for leaving?
A. Trauma was an issue. And just --

Q. What do you mean?
A. After that, after a while it just kind of I guess ate at me necess- -- sort of.
Q. What did?
A. The David situation.
Q. Okay.
A. And just after a -- 4 1/2 years of doing it, I was kind of burnt out for a little bit. I needed a break I think is really what it boiled down to.
Q. Okay. I don't blame you. I have no doubt it's a difficult job.
A. It can be.
Q. So what did you do in between -- what did you do while you were -- during the time you were --
A. I -- I worked at BOST, which is similar to that but just on a smaller scale.
Q. Is it a lo- -- is it a residential facility?
A. They have facilities where they live in, like, group homes.
Q. Uh-huh.
A. But I went to this person's apartment and watched them on the weekends.
Q. Okay. And what -- so what prompted you to leave that and come back to Booneville?
A. Well, in between that after I left there, I went to

Walmart for a short time; and it just wasn't for me. Like, I -- I just didn't enjoy it again.
Q. Right.
A. I just really missed the clients, is what it really just boiled down to.
Q. Okay.
A. Like, I just missed the -- missed them a lot, so . . .
Q. You missed the clients that you -- I take it you enjoy the work?
A. Yeah. Yeah, absolutely.
Q. Okay.
A. Yeah.
Q. What kind of -- and I'm not -- I'll get to training you received from Booneville in a little bit.
A. Uh-huh.
Q. But what sort of -- did you have any kind of specialized training, nursing classes, CNA training, anything like that before coming to Booneville?
A. I went for a CNA before I got at the BHDC, but I never finished my test because I got -- honestly, I just got really nervous in tests, and so I just couldn't -- I did it a couple times, and I couldn't get through it.
Q. Okay. And at that time residential care techs weren't required to be CNAs?

A. No.
That was long before -- it was before I even worked there that I got a CNA or that I went for a CNA rather.
Q. Oh, okay. Am I correct that residential care techs now are required to have CNA training?
A. Yes.
Q. When did that come up, that requirement?
A. Maybe a year and a half ago.
Q. Okay. It was after David's death, though?
A. Yes. Yes.
Q. Okay. So I assume now you do have the -- that CNA training?
A. Yes.
Q. And, briefly, what did that entail? How long did it take and --
A. It took three weeks: One week of book learning, another week of skills training, and then third week of alter- -- alterations [sic] between book and skills.
They would just tell us general basic medical -- like, measuring urine; bedpan changing; changing beds, just things of that sort.
Q. Is it -- there's no basic lifesaving training?
A. I did CPR in my Phase class whenever I first came there 4 1/2 years ago.
Q. But that is not taught in -- at -- in the CNA

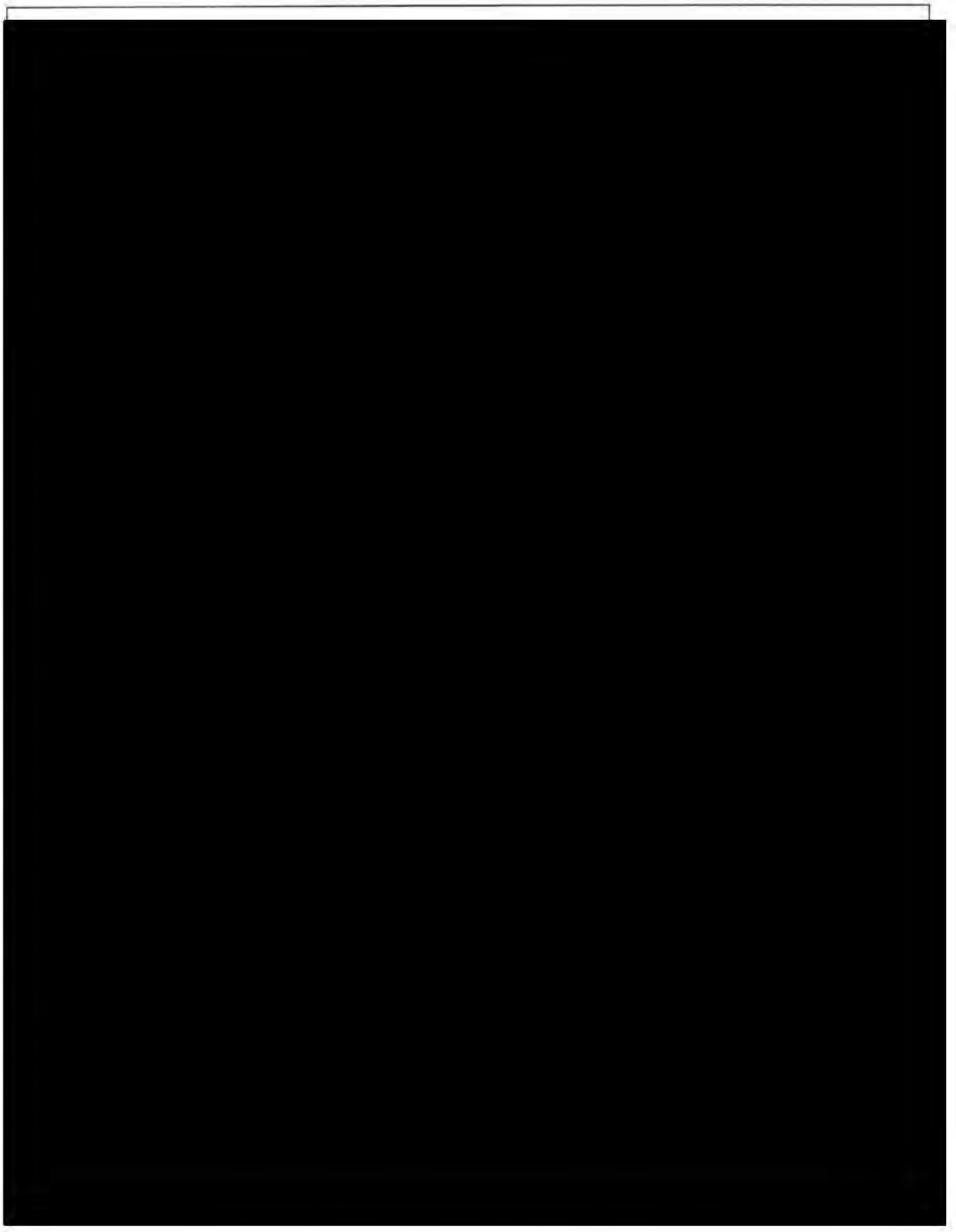
training?
A. Not that I remember.
Q. Okay. So as far as you recall -- and I have no idea myself.
A. Right.
Q. But, as far as you know, the CNA training does not encompass or include, you know, basic lifesaving techniques like CPR and that sort of thing?
A. Not that I remembered.
Q. Okay. And we'll get to your training here in -- at Booneville in just a minute.
But have you ever been terminated from a job?
A. No.
Q. Okay. You paused for a second there.
A. I had to think. But no.



Q. Okay. Have you ever had any other job that would have involved having to intervene in behavioral incidents with a client other than at Booneville?
A. No.

Q. Okay. So the BOOST job --
A. BOST.
Q. BOST job, that's -- that's more you're going to somebody's home that needs assistance with --
A. They -- the BOST clients, as far as I understood, they weren't behavioral risks. They were living in an apartment for a reason; because they could be trusted I guess to live out in the -- in the community.
Q. Okay. Have you ever -- have you ever been arrested?
A. No.
Q. So you have -- you've no misdemeanor or felony convictions on your record?
A. No.

[redacted]



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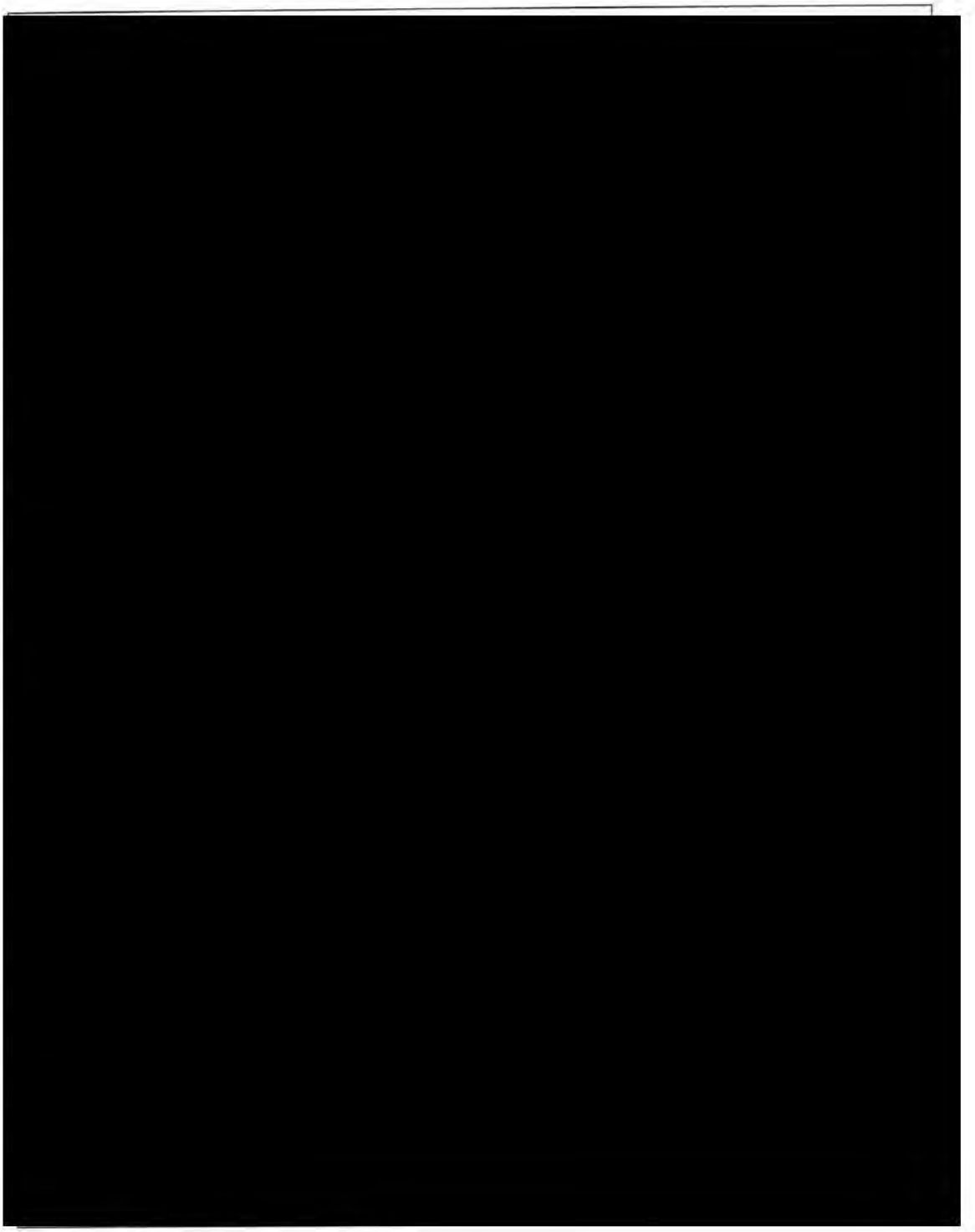

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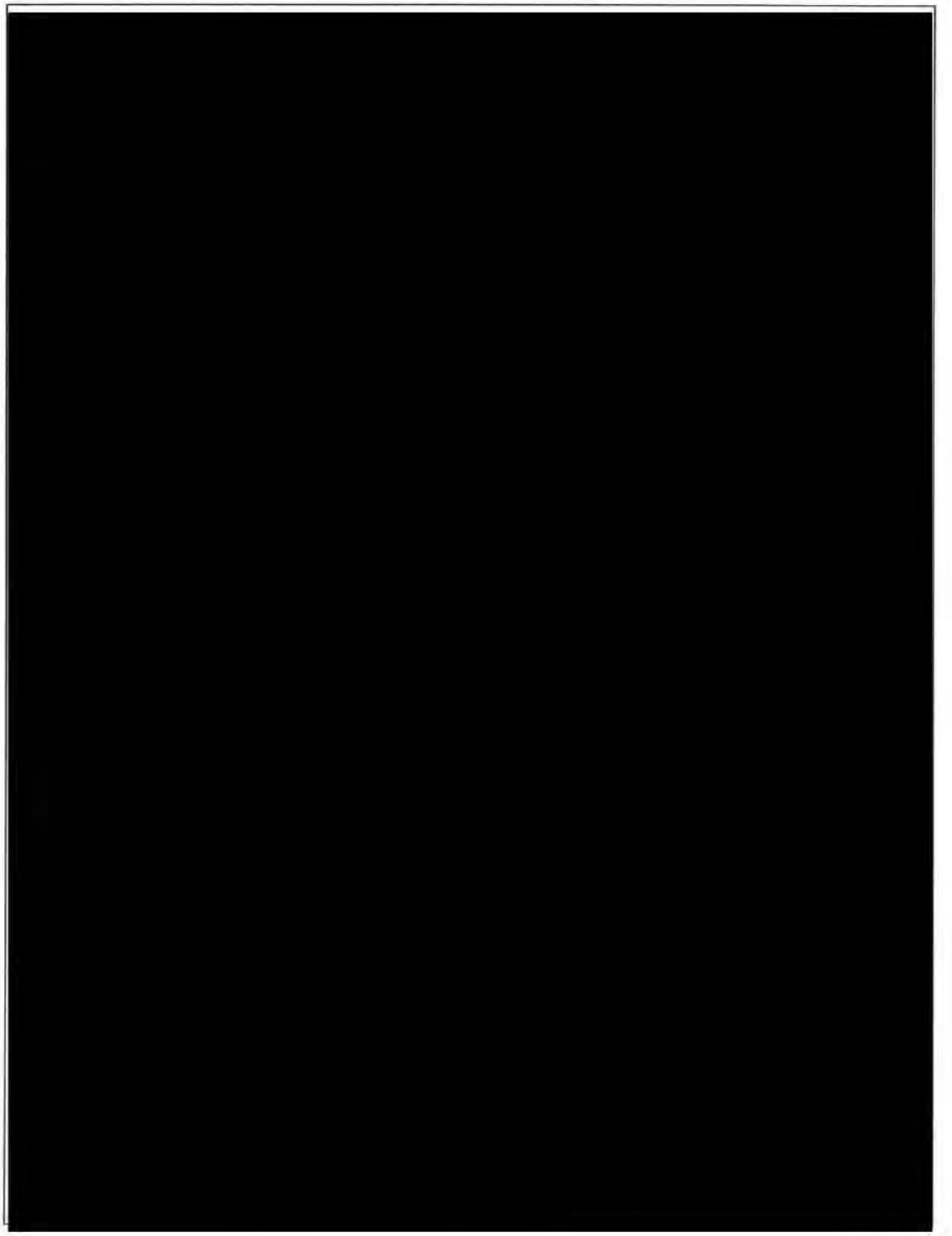

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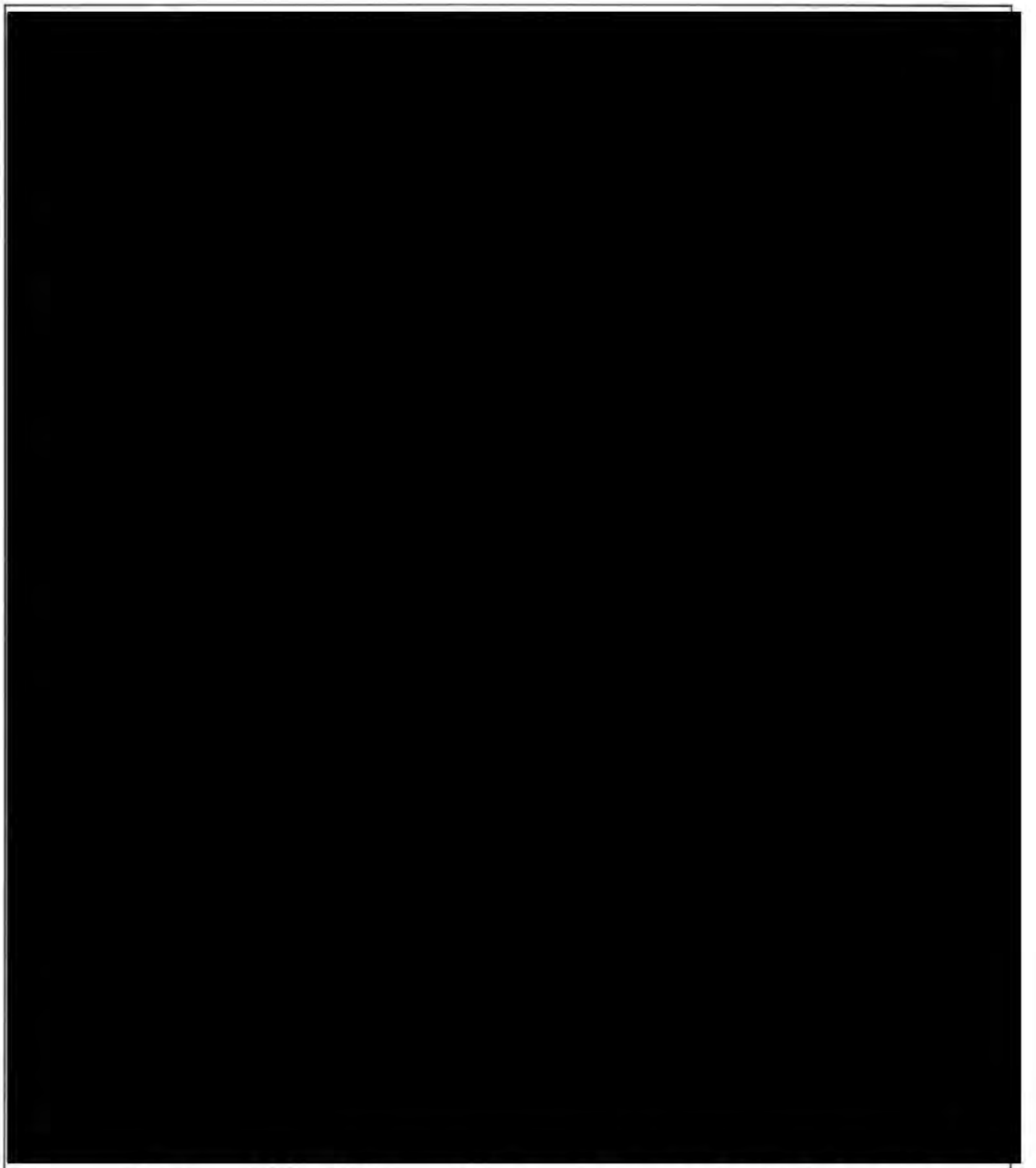


Q. Okay. All right. Okay. As a residential care technician, what are your duties and responsibilities?

A. For the shift I was on, day shift, I would get them

ready if they hadn't been ready from the previous shift.
Q. Okay.
A. To get them shipped out to work.
Whenever they were all out to work, I would go in, clean their rooms, bathrooms. And typically when they got back from work, just because it's easier on us and easier on them, we would do their showers or prompt them to do their showers.
Q. Okay. And did you typically work the same shift?
A. Yes.
I worked 12 to eight when I first started.
Q. Uh-huh.
A. For about six months and then went to --
Q. 12 p.m. to 8 p.m?
A. 8 a.m. -- 12 -- 12 a.m. to 8 a.m., rather. I'm sorry.
Q. Okay.
A. And then I did 8 a.m. to 4 p.m. after about six months.
Q. So at the time of David's death, you were -- you were on the 8 a.m. to 4 p.m. shift?
A. Yes.
Q. Okay. How many days a week did you work?
A. Five.
Q. And I've never -- I've -- I've neglected to ask

anybody this, but when you're -- do you have, like, a certain number of patients? Or when you go in for your shift at -- I'm sorry, eight in the morning?
A. Uh-huh.
Q. Are you informed, okay, Patient X or Patient A, Patient B, Patient C are your responsibility today? Is that kind of how it works?
A. It's a one-to-eight ratio for every area.
Q. Okay.
A. So --
Q. One RCT to eight patients?
A. Yes.
Q. Okay.
A. It's -- so at the -- where I was working at the time, it would be two people there. So -- but we have a visual list of who was there, and so we would know every -- there wouldn't be different people there every day necessarily.
Q. On the day in question -- I believe it was a Saturday, right?
A. Yes.
Q. Okay. Was it a -- were you -- were you tasked with -- is it fair to say your job was to supervise them?
A. I don't like that word; but I guess, yeah.
Q. Well, and I -- and I don't know -- you know, tell

me; educate me. What is --
A. In an outsider's point of view, yeah. I -- I suppose so, yes.
Q. How would you describe it? Because I really want to -- I mean, I want to know --
A. The way I put it -- I've always kind of put in jokingly in ways and --
Q. Right.
A. -- like, this doesn't -- I don't mean this unprofessionally.
Q. Yes.
A. But it's like kind of a glorified babysitter sometimes.
Q. Okay.
A. Within -- but extra steps, you know.
Q. Right.
A. So -- as in shower, cleaning them up if accidents happen, things of that sort; but . . .
Q. But your responsibility would be eight individual clients?
A. Yes.
But if there's two people -- which there always needs to be two people -- it's everybody on that area.
So, for instance, I think back then we had 10. So we would be responsible -- me and whoever else was there

would be responsible for them.
Q. For 10?
A. At the area I was working at, the Blue.
I -- I don't know if that's the exact number of clients that was there; but, like, that's just the example I was using.
Q. So one to eight --
A. If there was eight individuals on the -- I'm sorry for interrupting.
Q. Go ahead.
A. If there was eight individuals on the floor, I could be there alone.
Q. Okay.
A. Yeah.
Q. If there was more than eight --
A. But if one more stepped in, I would need another person.
Q. So on the day in question on June '20 -- June 13, 2020, how many RCTs were -- well, how many -- how many clients were you responsible for on that day?
A. Me and one other were responsible for the -- our regular 10.
Q. 10?
A. If -- if it was 10. But I don't remember exact numbers because people have come and gone since then

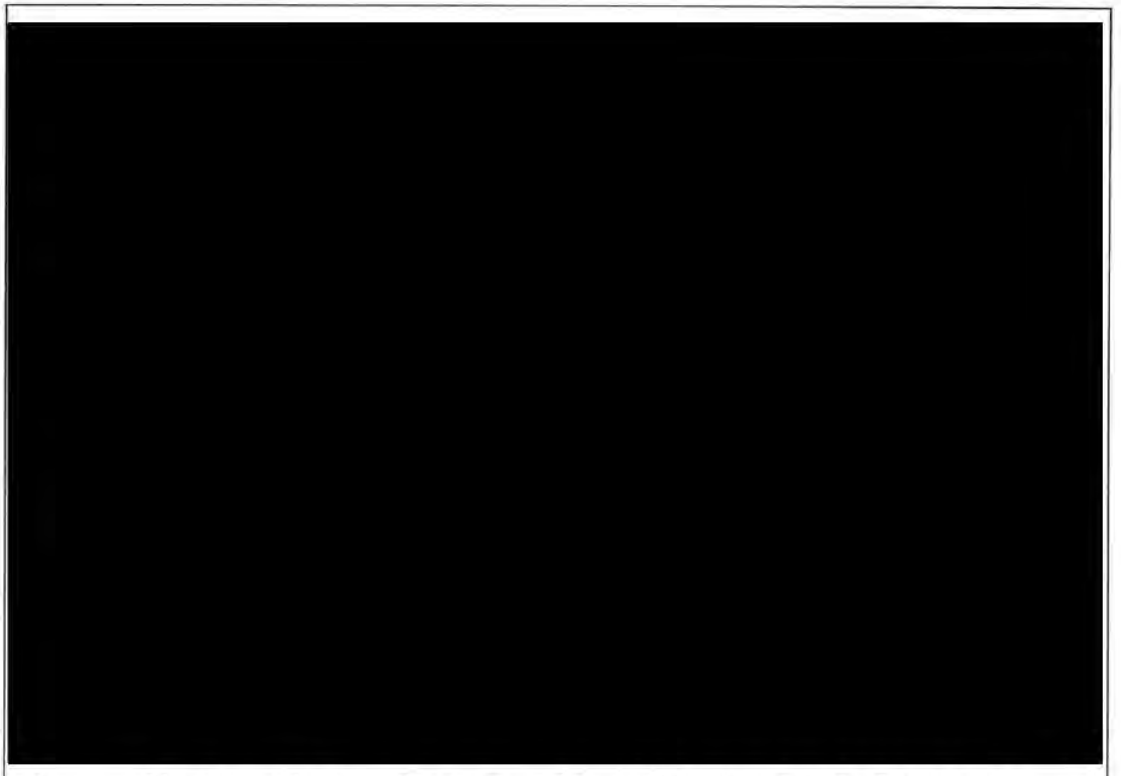
and --
Q. But there were two of -- two RCTs?
A. Yes, there were two RCTs.
Q. Who was the other one?
A. Eileen Helms.
Q. Eileen Helms?
A. Yeah.
Q. Okay. Was she present -- I've never heard that name. Was she present?
A. She was in the lunchroom, so she wasn't actually outside with me during --
Q. Okay.
A. -- the event.
Q. Did she ever -- do you know if she ever came to the scene of the event or?
A. No. No, she couldn't because she was --
Q. Okay.
A. She had to deal with other clients.
Q. Okay. I guess that's why I've never --
A. Yeah.
Q. And is she somebody that you were typically paired with?
A. Yeah. She was a regular staff then as well at the time.
Q. Is she still there?

A. She works in a different area; but she is still there, yes.

Q. Where does she work now?

A. The Green. So, she's like, on the same hall but on a different end.

[redacted]



Q. Okay. Okay. Tyler, I'd like you to tell me as best you can about the training you received when you -- when you first got hired there, which was again 2017?
A. Yes.
Q. And, to clarify and speed things up, I'm only concerned with training you received on how to respond to behavior incidents, meaning acceptable forms of intervention during -- you know, you know what I'm talking about?
A. Yes.
Q. I don't need to know about --
A. Okay.

Q. -- you know, irrelevant things. So you seem like a bright guy; I think you can parse through it.

So tell me as much as -- tell me -- tell me about your initial training that you received as -- training that would in any way pertain to intervening in behavioral issues with clients?

A. From what I remember on the training that I had in 2017, we had different levels per se --

Q. Uh-huh.

A. -- of training. So it kind of just depended on the severity of the case.

Q. Uh-huh.

A. It would just be basically walking hip to hip and walking them to sit down per se.

Q. Uh-huh.

A. Or elevate up.

And they would call it the "basket technique." And it's basically underhanding, holding the elbow and holding the arm and then walking.

But typically you would want another person with that if they were going -- if they were being a lot more aggressive in the case.

Q. Did you go through something called Phase 1 --

A. Yes. That was the -- that was the title of the initial training.

Q. The what?
A. The title of the initial training, the first training.
Q. Okay. And so just broadly speaking what are the kind of things they teach you in Phase 1?
A. As far as, like, everything?
Q. As far as -- as far as how to -- as far as how to manage -- I guess as far as how to manage the clients?
A. They taught us a lot of basic psychology and understanding of the different disabilities and how we could possibly respond to them.
Q. Okay.
A. Techniques we could use to deescalate the situation.
Q. And what are -- tell me about those.
A. It's kind of a person-to-person basis.
Q. Uh-huh.
A. Distractions work wonders.
Q. Okay.
A. Reinforcements.
Q. Pos- -- kind of like positive reinforcement type --
A. Yeah, yes.
Q. -- verbal cues?
A. Yes.
Just things of that nature, really. Just

distractions and -- changing the subject is the same.

But positive reinforcements, removing them from what could be agitating them if there is a physical thing agitating them is a big one if you can get it to happen.

Q. Uh-huh.

A. That's really all I can think of offhand.

Q. And was it also in Phase 1 where you were taught the different pers- -- maneu- -- personal restraint maneuvers that you --

A. Yes.

Q. -- started to describe?

A. Yes.

Q. Okay. And tell me about those as much as you can recall.

A. Well, like I said earlier, we had the basket as a -- that was like I guess the proper term they used.

And the one I was like -- I said "hip to hip" where I'm just behind them, and if they're not full-blown necessarily --

Q. Uh-huh.

A. -- like, I can just walk them out. But if they're being sort of aggressive I guess like -- because, again, it was based on different levels of aggression. Like I said, the medium one, typically you would want another person with that because that's whenever they're starting

to get actual physical.
Q. The what you would want?
A. The -- the basket one. I just call it the medium one. I'm sorry.
Q. The what?
A. The basket where, like I said, when you hook under and --
Q. What else did you call it?
A. -- wrap their -- medium tier. Like, I --
Q. Medium tier?
A. Yeah. I -- I've just kind of made up my own little . . .
Q. But the basket ma- -- the basket -- you call it the basket what?
A. Just really that was what it was called, was the basket. It's kind of like you're holding a basket.
Q. And you -- and you under- -- and you consider that to have been for kind of medium-level aggression?
A. Yeah, yeah.
Q. And -- okay. And how is the basket move performed?
A. I --
Q. You can stand up.
A. Okay.
Q. Please do, actually.
A. Basically -- let me just use you for an example

maybe.
So it would be this sort and this sort.
Q. Okay.
A. And, as you can see a basket, you know, I'm holding his -- holding his arm like a basket.
Q. Yeah.
A. So and then it would be guiding them to a seat or whatever to get them in a grounded position or else a sitting position so it's not -- they're not as, you know, able.
Q. Okay. And you kind of -- you kind of bend the wrist like this?
A. No, no. No, no. I wasn't trying to bend this wrist. It's just holding it like this.
Q. Okay.
A. How -- I didn't mean to bend his wrist; I wasn't trying to.
Q. And that's something you would -- is that also -- is that also how you would move them hip to hip?
A. Yes.
But that's with, like, another person. There's no way you could do that easily with just yourself I feel like.
Q. So that's more for getting them to lay down.
A. No, no. No, no. Seated.

Q. Seated.
A. Yeah, seated.
Q. And, again, that -- that's something that you said would be used for middle-level type aggression?
A. Yes.
Q. What -- what would you consider to be middle-level aggression?
A. More verbal threats. And you can see -- or, well, I could see just them getting more clearly aggravated.
Q. Uh-huh.
A. Because it kind of just -- like I said earlier, it kind of goes in tiers. You know, they're kind of just irritated; then it begins more --
Q. So --
A. -- apparent aggravation.
Q. So that's a personal restraint you might use for a -- for a client who's not being physically aggressive but just is being verbally aggressive, appears agitated, and might get physically aggressive but hasn't yet?
A. There's a little physical aggression. Like, I probably -- I should have reiterated that. I'm sorry.
There's a little physical aggression; but, like, there's not enough to -- to me to really, like, apply anything else necessarily I guess.
Q. Well, okay. What do you mean? Like, what would be

a little -- what would you consider a little physical aggression?
A. Well, like -- ah, just kind of -- well, basically from the first restraint that I told you about, it's whenever they're --
Q. The basket?
A. -- being -- no. The first one is the hip to hip.
Q. But you need two people for that?
A. No. No, the basket is two people.
Q. Okay. What's hip to hip then?
A. As it is -- oh, yeah.

THE WITNESS: Sorry. Oh, my goodness.

THE VIDEOGRAPHER: That's okay.

THE WITNESS: Okay.

A. So it's quite literally just this.
Q. Oh.
A. And you're just walking. Like, there's no, like, hardcore physical restraints. You know, it's just --
Q. You're guiding them?
A. Yeah, more or less. It's just guidance and that's it.

But if they were being --

Q. And you would use --
A. -- resistive --
Q. And you would use that --

A. As the beginner or the start of it.
Q. The -- and so give me an idea of the types of client behaviors that would necessitate using that hip to hip?
A. Seeing them going after another client per se. It's mostly, like I said, a removal mechanism.
Q. So if they were physically attacking another client?
A. Or even another staffer exam- --
Q. Okay.
A. -- in that case.
But just attacking something or someone.
Q. That's when you would use this --
A. Yeah. It's a removal technique to get them away from whatever the issue is and separation.
Q. And that's the -- that's for the lowest level of aggression?
A. Yes, yes.
Q. Okay.
A. But whenever -- the basket for example is whenever they're kind of resisting during that. So you -- it's a step process.
Q. Okay. And the basket you need two people?
A. It makes it a lot easier.
Q. Okay. And what about the high -- a higher level of

physical aggression?
A. I don't remember what they taught us then because they've changed it.
Q. Okay. What is it now?
A. A spotter -- if I remember correctly, it's a spotter technique. And that's whenever it becomes transitioning to the ground.
Q. What's a spotter technique?
A. Two people, along with the basket, like I said.
Q. Uh-huh.
A. And then one person's behind the pers- -- behind who you're transitioning.
Q. So that you can lower them onto the ground?
A. Safely.
Q. Safely.
And for the purposes of -- for what purpose would you put them on the ground?
A. When they're full blown out of control, basically.
Q. Okay. And how does -- and getting them on the ground does what? Again, I'm just asking you to you educate me. I --
A. Yeah, no. You're fine.
It's just -- it's more of a control mechanism I think.
Q. Okay.

A. It -- that's the easiest way to proceed to mechanical if you need it, mechanical restraints if you needed them.
Q. But they're -- there are I'm sure lots of times where it's necessary to get them on the ground --
A. Oh, absolutely.
Q. -- and you -- but you don't have to graduate to the papoose board, right?
A. No. Yeah, exactly.
There's been several times where it's more of like -- to me it's, like, okay, why are you here now, you know.
Q. Okay.
A. So I would talk to them -- I feel like this is a silly way to put it; but, like, it's more of a personal level at that point, you know.
Q. Yeah.
A. Because there -- there's a reason you're here, you know.
Q. I understand. I understand. I understand and I -- and I get it's a difficult job. I'm just trying to understand as best I can what --
A. I'm trying to explain it to, like, someone who doesn't understand the best I can too; so . . .
Q. You're doing good, actually.

A. Okay. Good.
Q. And those -- those three maneuvers that we just went over --
A. Uh-huh.
Q. -- those were -- do you think those were all taught in Phase 1?
A. The first two I know for sure. I don't know about the third one; because, like I said, it -- it's recently changed.
Q. Okay. Was there a Phase 2 of training?
A. Yes.
Q. Well, put a pin in that.
A. Okay.
Q. Was there anything else from Phase 1 that you were taught that's relevant to -- that you think is relevant to this that we haven't discussed?
A. I guess it would be kind of relevant. They would go over their BTPs and their LURs, which is basically sort of like --
Q. Behavioral Treatment Plans?
A. Program.
Q. Programs?
A. And LUR is, like, Living Unit Record.
Q. Okay.
A. So it was a very general summary.

Q. Uh-huh.
A. And I say that very lightly. But it's a very general summary of what they were -- or what their day consisted of. Like, they would have their 24-hour schedule; positive reinforcers; what they could get, what they could not get.
Q. Uh-huh.
A. Rights restrictions, things of that sort.
Q. Okay. Okay. Any -- anything else that you -- that you recall from Phase 1 training?
A. Honestly, after the LUR you could really just go from there as far as, like, knowing a client.
Q. Tell me about LUR again. What is that? Living?
A. Living Unit Record.
Q. And what does that contain?
A. It -- like I said, the 24-hour schedule, their reinforcers, their rights restrictions.
Q. Okay.
A. Things of that sort. Just, like I said, a very general summary of them.
Q. So at this first training session, this Phase 1, you were given -- you were introduced to the people that are going to be your clients and given this basic information about them, their --
A. Not necessarily. Phase 1 was all bookwork also; so

it was a lot of examples, per se.
Q. So an example of what a 24 hour --
A. Exactly, yeah.
Q. -- looks like? I've got you.
A. But the second week of Phase 1 was OJT training, on-the-job training. And that's when they would give you an assignment of a particular client, not necessarily the one you're going to be assigned to permanently.
Q. I see.
A. But they would be -- it would be, for example, go into that person's LUR and see their rights restrictions or their positive reinforcers or their schedule; and we write it down on a little quiz sheet.
Q. Okay.
A. And we would be -- be assigned two people from the same area, and we would work on the floor -- with some restrictions, but we would work on the floor as OJTs.
Q. Okay.
A. For the week.
Q. And Phase 1 lasted a week, and then there's a week of on-the-job training after that?
A. Phase 1 lasted three weeks total, but it was --
Q. Three weeks.
A. -- books, OGT [sic]. Books with some OGT [sic] mixed in.

Q. And then also some -- some physical techniques that you're learning as well?
A. On the first week.
Q. On the first week, during the first week.
And is there a Phase 2?
A. Yes, six months after your initial Phase 1.
Q. Did you -- and I assume all of these are done on the Booneville campus?
A. Yes.
Q. And did you complete Phase 2 as well?
A. Yes. That's how I got my RCT.
Q. Makes sense.
And what is -- what is -- what's different about Phase 2? What are you -- what additionally are you taught in Phase 2?
A. Honestly, I don't remember much of Phase 2.
Q. Okay.
A. Like, it was -- if -- if I remember correctly, it was really just a big summary week.
Q. Maybe reinforcing things you learned and --
A. Yeah, just -- just a refresher period. And, like, I think they added a few things. They added telemetry, system hunt.
Q. What's telemetry?
A. It's a watch device that they have on certain

clients who are on -- who are known to be elopers.
Q. Like mind reading? No, I'm just kidding.
A. Yes -- no.
Q. Okay.
A. But it's -- it's a watch device on certain clients who would be elopers.
Q. Okay.
A. And basically there's -- they look like satellite boxes, honestly.
Q. Yeah.
A. But it can -- if they run off within a mile radius, they can track them on a beeping system.
Q. Okay.
A. So what they would do for the training is they would hide it out in a general area, off campus usually just to not be in the way of clients or whatever because they'd would be walking around, you know.

And we would get the little device box and hunt around for it.

Q. Okay. Okay. Were there any other phases after that that you had to do?
A. Just CPR refreshers, but it wasn't necessarily a Phase.
Q. Okay. CPR refreshers, I believe that was once a year?

A. I think it was then, yeah.

They -- they've added and changed so much since I've came back, like, it's kind of hard to remember everything from then.

Q. And do you recall who provided the -- which staff members provided that, the Phase training to you?

A. At that time it was Mark Hise and Sandra Shipley.

Q. Okay. What about NCI training? Noncrisis -- nonviolent crisis intervention? Did you have to go through that as well?

A. That was the -- the basket and the hip to hip. That was the title of it.

Q. Oh, okay. So the NCI was incorporated into the Phase 1?

A. Yes.

Q. There wasn't a separate -- you didn't have to, you know, come to Little Rock and do a week of NCI?

A. No. No, no, no. It was all incorporated. And it was, like, a full day, full day or two-day event that, like, they really kind of drilled into us.

Q. Okay. And tell me what you were taught specifically on when you were allowed to make physical contact with the clients, lay hands on the client in a -- well, let me -- let me edit that question a little bit.

I'm not talking about, you know, incidental contact

when you're helping them brush their teeth or something like that.
A. Right.
Q. I mean what were you taught specifically about when you were authorized to apply any form of physical or personal restraint? When were you --
A. When --
Q. -- allowed to do that?
A. When they are being a threat to objects, to themselves, or to other clients or staff.
Q. Okay.
A. So any time there was, like, a actual -- like, verbal, it was kind of just, like, okay; you know, we'll let them get it out and rant per se.
But, like, once they -- whenever they started getting real physical and actually trying to actually harm themselves or other people --
Q. Uh-huh.
A. -- that's when we stepped in per se.
Q. And you weren't required to first exhaust nonviolent or nonphysical contacts, techniques?
A. Oh, yeah, absolutely. I would do my best to try to just deescalate as best I can. Like, I did not want to put hands on anyone --
Q. Sure.

A. -- unless I absolutely had to.
Q. So what are some things that you would do to avoid having to put hands on them? What would you try first?
A. If I had --
Q. Or what were you taught to try first, rather?
A. Well --
Q. Or what you actually tried first? Either way.
A. Yeah, it's -- it's kind of a person-by-person thing. If I had a good rapport with them, I could -- I could just talk to them.
Q. Okay.
A. Because most of the people I worked with were kind of high functioning so they understood, and they understood what was -- they were doing wrong.
Q. Uh-huh.
A. But generally if I didn't have, like, necessarily bad or good rapport and they just knew me as the staff, I could kind of remove them. You know, just, Hey, let's go over here. Let's, you know, do this. Let's color or let's hang out or let's listen to your iPod.
Q. Uh-huh.
A. Just things of that sort. Just coping mechanisms, distracting mechanisms that I knew would work for that individual person. Because I worked so long with those people, I kind of knew what made them tick in that sort.

Q. Uh-huh.
A. So . . .
Q. What about just getting up, walking away, and giving them some space?
A. Some of them that would be good. But generally whenever there was -- whenever they were aggravated, they were in a crowded area.
Q. Uh-huh.
A. So I didn't want to it to escalate further and other clients get involved, so I would try my best to kind of remove them and maybe then walk away. Like, move -- take them to their room --
Q. Uh-huh.
A. -- for them to calm down alone and then walk away, if that makes sense.
Q. So I think you said it was kind of -- kind of based on your -- as opposed to there being a set requirement or a list of noncon- -- nonphysical contact interventions you had to exhaust first, it was more just kind of up to you based on your personal experience and knowledge with an individual client?
A. They gave us examples. And that was kind of me using them but in a casual way because --
Q. What examples did they give you?
A. Just as I said: Distracting mechanisms,

reinforcers, removing them from the situation, whatever.
Q. And what are some things that you would use to distract?
A. Change the subject was a big one.
Q. Okay.
A. Joke with them.
Q. Okay.
A. That was a big one. If you can get them to be in a better mood immediately and go --
Q. Snacks, treats?
A. Me personally, I wasn't a fan of that because it reinforced bad behavior. If I had to I would, but I wanted to exhaust all my other possibilities or options before that.
Q. And what specifically had to happen before you would lay a hand on a client? What -- what did you need to see before you would consider --
A. Physical aggression to another person was a big flag for me.
Q. Okay.
A. Whether it be to myself or to another client or to another staff.
Q. Okay. Were you not taught techniques for sort of sidestepping a physically-aggressive client?
A. Like defensive techniques?

Q. Yes, defensive techniques that -- that would prevent you from having to lay hands on them but instead just allow you to sort of get out of the way kind of.
A. Like, I'm trying to understand how you're asking that.
Q. Well, okay. Mandy Jones or Amy Mandy Jones --
A. Uh-huh.
Q. -- when I -- when I deposed her, she told me that -- that she was taught in NCI to maneuver away from a client to not --
A. Oh, yes, yes. Like, we have blocking techniques. And, like, if they've got you in a hold per se --
Q. Yeah.
A. -- we had options or we had --
Q. Tell me about blocking techniques.
A. What I remember, it was just two hands and swiping away. So like --
Q. Two hands swiping away?
A. Like, if they swung at you and step back.
Q. Okay.
A. Step back in, like, a half circle.
Q. And -- yeah. And I remember telling her -- I remember thinking it kind of sounded like a matador. You know, get out of the way.
A. Yeah, exactly.

Q. What you're saying makes more sense. Blocking and just kind of --
A. Uh-huh, block and deflect and --
Q. Yeah.
And you were taught that --
A. Yes.
Q. -- in Phase 1?
A. Yes.
Q. Okay. Anything else like that that you were taught in Phase 1?
A. Like I said, just techniques if they got ahold of you.
Q. Okay. Like, got ahold of you? Got ahold of you like how?
A. Like, got ahold of me. Like bear hug, chokehold. Anything they could do, really.
Q. Okay.
A. But they just used the most common things that they've experienced and they were told to -- taught.
Q. And I assume that this blocking and sidestepping you were -- that's an NCI maneuver, right?
A. Yes.
Q. And I assume that's -- that's what you were taught to do if a client is going to -- is --
A. Yes.

Q. -- slapping at you or swinging at you, right? Yes?
A. Yes.
Q. Do you receive any certification from NCI?
A. No.
Q. Paper --
A. The only certification we got was for CPR.
Q. Okay.
A. And we just get a card and . . .
Q. Were there any NCI representatives present at this training?
A. Not that I remembered.
Q. Okay. So it was more -- it was Booneville's own staff just teaching portions of the NCI program to y'all?
A. Teaching what they were required to teach.
Q. Required by --
A. I don't know.
Q. -- their bosses?
A. I guess.
Q. Okay.
A. But what they taught us was what was -- what they had to teach us for the little bit they could teach us.
Q. And Amy -- or Ms. Jones also testified that y'all were taught not to grab a client by both wrists at the same time; is that correct?
A. Yes.

Q. I can't remember what she said about one wrist. I think she said you can -- if you have to, you can grab a client by one wrist?
A. If I remember correctly, like -- I -- yeah.
Q. Okay. And so we've already talked about -- and you were taught to -- you were taught to physically restrain clients on the floor if --
A. If needed be.
Q. -- if need be, right?
A. Yes.
Q. And were you taught how long you could hold them there on the floor?
A. There were -- if I remember correctly -- this is just kind of a vague memory, know-how -- we had a 15-minute check-in period --
Q. Okay. If it's --
A. -- if I remember right.
Q. So -- okay. So potentially you could -- you could -- if you had to, you could hold a -- you know, keep a client --
A. Then you could call back. Then you would have to call back and get reauthorization by a Q. That's what they were called.
Q. But for -- oh, here's another. I forgot this one. I have to -- it's hard for me; I'm going to try to never

talk over you so she can make a clean record. If you can -- if at all possible, just let me get the -- I know -- let me get my lawyer words out before you --

A. All right.

Q. -- respond.

A. That's fine.

Q. I know you're guessing what I'm going to ask.

A. Sorry.

Q. And you're probably guessing right most of the time.

A. Yeah.

Q. That's okay.

A. It's a habit. I'm sorry.

Q. I have the same habit. Just ask my wife.

MR. GILLISPIE: What was my -- Madam Court Reporter, what was my last question?

(Record read as requested.)

Q. (Mr. Gillispie) So my question was: Presumably if -- if the client is just really out of control and you had to, you could -- you could restrain them on -- on the ground for up to 15 minutes?

A. Yes.

But in my experience it's not going to last that 15 minutes --

Q. Right.

A. -- because if you're still fighting, it needs to be mechanical intervention at that point.
Q. Okay.
A. That's just my personal experience that I've had in -- over the four years that I worked there.
Q. So it -- I guess it would be fair to say then you as an RCT are tasked with using your best judgment?
A. It's very much a pick your own battle situation.
Q. Okay. And you're authorized -- your understanding is you were authorized by Booneville to use these different physical restraints we've been talking about on kind of an as-needed basis if the circumstances required, correct?
A. Yes.
Q. Okay.
A. They were -- to me personally they were a last-ditch effort kind of thing, any of them, honestly. Like I said earlier, I don't -- I didn't like doing them --
Q. Sure.
A. -- unless I just absolutely had to. Like, I would honestly feel bad if I ever have to.
Q. Right.
Were you also taught to, you know, recognize behavior patterns in individual clients that you got to

know that might signal that they're about to have a behavior event or recognize triggers that you think -- that you know would likely lead to a client having a behavior event? Were you taught to recognize those and try to anticipate?

A. Yes, we were taught; but it really -- in that specific scenario, it was really just a time learned. This -- it was a situational thing. You would -- you would learn your clients and learn what would trigger them and learn what they would do whenever they were about to have a behavior.

Q. I hear you.

A. So it was -- again, it was very much a individual basis, so . . .

Q. And an as-needed basis?

A. Yes. You -- you would pick up on those things real quick.

Q. I'm showing you here what I'm going to mark as Exhibit 1 to your deposition.

THE COURT REPORTER: Are we staring over? Okay.

MR. GILLISPIE: Yeah, let's start over.

(Exhibit 1 marked for identification.)

Q. (Mr. Gillispie) This is titled "Avoiding/Defusing Violent Behaviors."

MR. GILLISPIE: And, Eric, I'll give you this just as soon as I'm done with it here.

MR. COLLINS: Okay.

Q. (Mr. Gillispie) Bates number 002716.

Do you recognize this from your annual training?

A. Yes.

Q. Okay. And are these, some of these things that you're taught to help defuse or avoid violent behaviors?

A. Yes.

Q. So "Know the individual."

"Listen," correct?

A. Yes.

Q. Okay. Were you -- do you recall ever being instructed that it's -- that -- to "Keep your hands at your sides with your palms open in a reassuring stance"?

A. Yes.

Q. And it -- and I'm assuming that's a form of deescalating or --

A. Yes, it --

Q. -- preventing -- or preventing the need to deescalate, right?

A. Yes.

It just basically means I'm not here to be a threat or I'm not trying to --

Q. Uh-huh.

A. You know what I mean.
Q. And I assume you were taught to pay attention to the distance between yourself and the client?
A. Yes.
Q. So that the client doesn't feel I guess kind of like a cornered animal, right?
A. Yes.
Q. And were you taught if the client -- you know, if the client is upset, you're taught it looks like to stand if they stand, sit if they sit?
A. Yes.
Q. Yes? Okay.
And you're taught "not to argue, threaten, or raise your voice or become judgmental," correct?
A. Yes.
Q. And to "keep your face passive and neutral" as opposed to frowning and scowling or laughing?
A. Yes.
Q. Okay. And to stay relaxed and "reassure the individual that you're there to help," and basically just be calm -- as calm and nonthreatening as possible; that's what this is all about, right?
A. Yes.
Q. Okay. And you were taught those things and -- and would that have been those first three weeks of training?

A. Yes.
Q. Okay. And did you find that these techniques were helpful?
A. Yes.
The sitting and standing one actually goes a long way, more than what people would think. Because me personally, if, like, if I'm sitting down and someone is standing over me, I'm just like --
Q. Yeah.
A. -- it's stressing me out, so . . .
Q. I get it. Yeah, I get it. Okay.
Are these -- is this a pretty exhaustive list of the -- the sort of deescalating or --
A. It's a very --
Q. -- or techniques that you were taught?
A. -- it's a very -- what's the word? Perfect situation list.
Q. Meaning -- are you trying to say in a perfect world, it would be nice if this worked every time?
A. Yes, yes.
Obviously not all of this is going to be a hundred percent; but this is a good, like, basic guideline and to branch out from that.
Q. Okay. And, really, all I'm asking is: Is there anything else important you were taught like this that --

that we haven't talked about?
A. Like I said earlier, it's very much -- the whole job in general is very much a pick your own battles kind of -- kind of job.
Q. Okay. Tell me one more time what you mean by that.
A. Don't overreact to things.
Q. Okay.
A. Like -- like I said earlier for the verbal, just -- just let them get it out if they -- if that's really all it is. You know, don't -- don't get upset over it, you know.
Q. Sure.
A. Acknowledge it but don't -- "planned ignoring" is the word.
Q. Sure.
A. Is the proper term.

But, again, it's a -- very much a pick your own battles, and you make the most out of the job.

So there's some clients that -- I hate to use this word, but had the wherewithal to know whether or not they like you or not.
Q. Uh-huh.
A. And, if they don't like you, they're gonna let you know, you know; so -- but if they like you, they'll also let you know; so . . .

Q. Was -- did David Cains have that wherewithal?
A. Most of the time.
Q. Okay. And did he ever let you know one way or another whether he liked you?
A. He always told me, "I love you." You know, he always said, "I love you. I love you, Tyler." You know, just --
Q. Okay.
A. -- but sometimes, you know, David has -- had his demons, and so it's something he couldn't help sometimes. It just -- it would just explode.
Q. And when you say "demons" you're talking about a tendency to get upset and -- and be noncompliant or physically aggressive?
A. Yes.
I hate to use that word; but, like, that's -- you know, I don't like the word "issues."
Q. But, as far as you know, he never expressed a displeasure specifically with you?
A. No. No, he never said once, "I hate you," or "I don't like you," or anything like that. It was -- he was -- whenever he was in a good mood, like, he would always want reassurance.
Q. Were there staff members that he did have noticeable issues with?

A. Not that I noticed.

The shift I worked, the people that I worked with, he all got along with.

Q. Okay.

A. Other people, I don't know. He never verbalized it.

Q. To the extent a guy like David could have enemies, did -- does he have any -- I know it's silly to even ask, but did he -- did he have any known enemies there, whether it be staff or other clients? Did he?

A. There -- there was one client, it was kind of wishy-washy with him. Some days he liked him and some days he didn't. But there was one client, individual he was kind of iffy about more than others. But, other than that, no.

Q. Had something gone on with him?

A. I'm not sure. There's -- it had been going on before I even got to his work area.

Q. How -- were you -- was David one of your assigned clients every time you worked?

A. Yes.

Q. So you were around him a lot?

A. I was familiar, yes.

Q. In a -- you know, in a given -- so you'd get there at eight. You leave at four.

At the time -- at least that was your schedule at the end there, right?
A. Yes.
Q. When you get there at eight, do you -- do you immediately begin interacting with him and the other clients?
A. Immediately when I get that -- get there I fill out my paperwork. And then I branch out and say, "Hey, let's get ready." You know, "Let's do this. Let's do this."
Q. So you -- you'd meet -- when you first meet them each day, they're -- they're -- it's before breakfast and you --
A. It's after breakfast.
Q. It's after breakfast.
A. Yes.
Q. Okay. Night shift does breakfast, and then it's --
A. Yes.
Q. Okay. So what's kind of the first thing that you would do with David?
A. Just --
Q. On a -- on an average day?
A. Generally I really didn't have to mess with him too much, because he was pretty good about just getting up and around.
Q. So what would he be doing? Let's say it's 9:00 in

the morning. What's David doing on an average day?
A. Waiting for mobile.
Q. What's -- okay. And mobile to take him somewhere?
A. To work.
Q. Okay. And that's, like, a shuttle?
A. Yes. It's a van.
Q. A van.
And it takes him to another building where he -- remind me; I can never remember.
What did he do? What was his job?
A. If I remember right, in the morning times he went to the Stone building and he did recycling.
Q. So, but before that bus got there, he'd kind of just be hanging out in his room?
A. Hanging out talking to us, hanging out in his room.
Q. Okay.
A. Just in the TV room.
Q. Okay.
A. He was kind of -- he wasn't hyper but he just kind of -- he'd just kind of float around.
Q. He was social?
A. Yeah. Yeah, especially with staff.
Q. Okay. And, from what I understand, he was a pretty friendly guy?
A. Oh, yeah. Yeah.

Q. So, I mean, do you -- did you have positive feelings towards him? Do you, you know --
A. I cared really deeply about him. Yeah, I mean, I didn't -- like, just in general I didn't have, like, any negative stuff.
Q. Sure.
A. Just I -- I don't know. I -- I liked him a lot.
Q. Yeah.
And I imagine there were clients that -- well, at least I've been told that there were clients there that were truly dangerous individuals that, you know, you maybe wouldn't want to be alone with?
A. Yes.
Q. So I -- I imagine that you didn't, you know, feel deeply -- you know, have a bond with every client; did you?
A. No, no.
There was some who I gravitated to more than others. But that will be any staff up there; that's not just me, you know.
Q. Of course.
But he was one that you -- that you had a particularly -- you felt like you had a particularly good bond with?
A. I felt like I did, yeah. I liked him.

Q. Okay. Okay.
MR. GILLISPIE: Can we take a -- take, like, a quick five-minute break, if you y'all don't mind.
THE VIDEOGRAPHER: We're going off the record. The time is approximately 1:48 p.m.
(Recess taken.)
THE VIDEOGRAPHER: We are back on the record. The time is approximately 2 p.m.
Q. (Mr. Gillispie) Okay. Tyler, were you ever part of David's Individual Program Plan or part of his IDP team?
A. No.
Q. No. Okay.
So I -- I assume you had no hand in the contents of that?
A. No.
Q. Do you -- are you aware of -- of David Cains having caused injury to a staff member or other client ever?
A. No.
Q. He never caused injury to you?
A. No.
Q. So I assume you didn't consider him to be a particularly dangerous or violent client?
A. No.
Q. And here in a minute we'll jump into the actual

incident; but I want to know what you know, if anything, about other physical restraints used on David in the past.

So let me start by asking: Have you -- you, Tyler Mattson, ever participated in any other physical restraints of -- or personal restraints of David?

A. No.

Q. Okay. This was the only -- you think this, this one incident was the only time that you ever --

A. No.

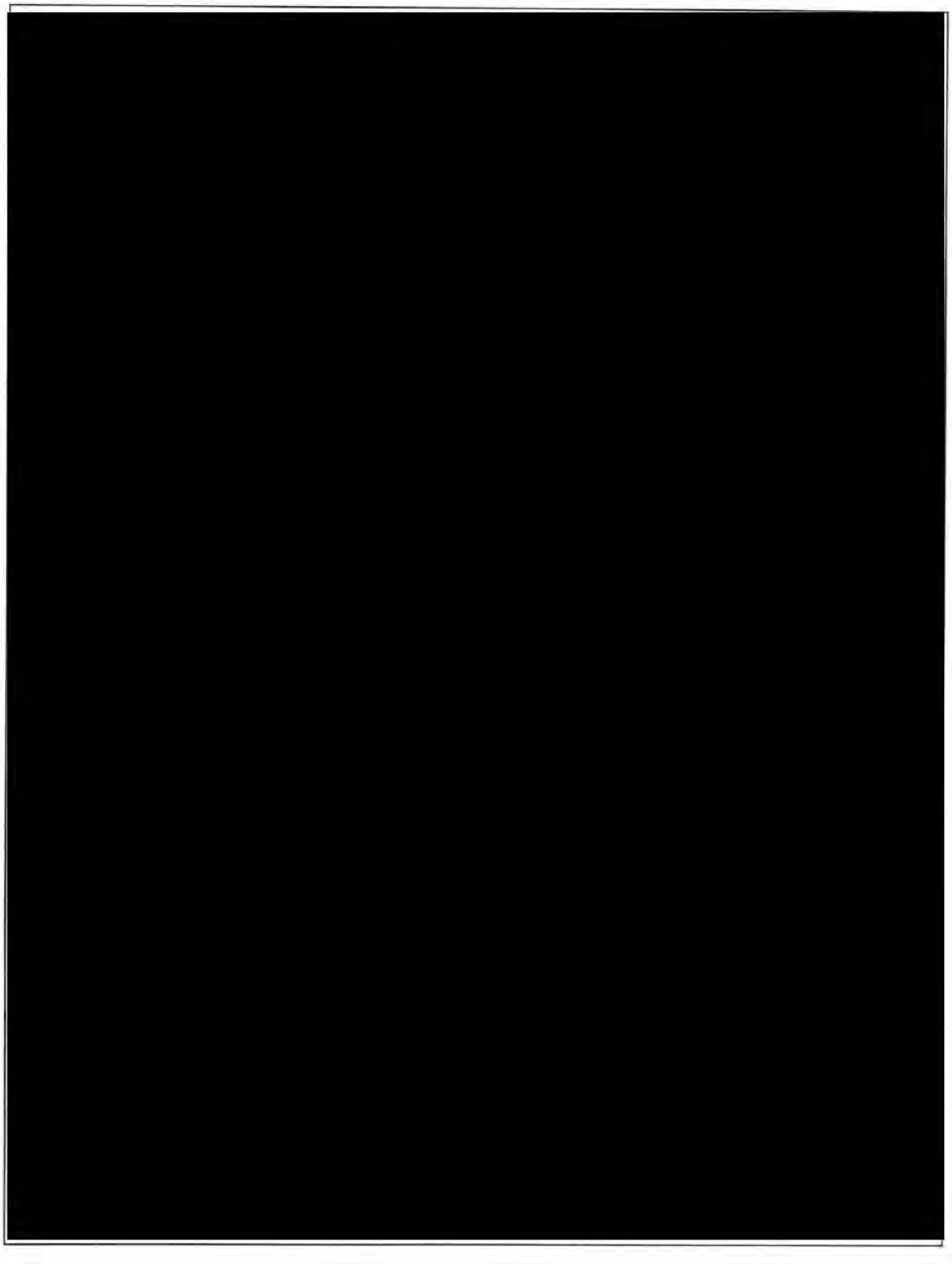
He had went after a nurse; but I didn't, like -- it -- it was basically the hip to hip. I just kind of remember the situation, didn't escalate much further than that.

MR. GILLISPIE: Okay. I apologize. I don't have -- I think I do have copies. Are these the same thing?

MR. GRELLNER: The time, check that just to make sure.

MR. GILLISPIE: Yeah, you're right. You're right.

[redacted]



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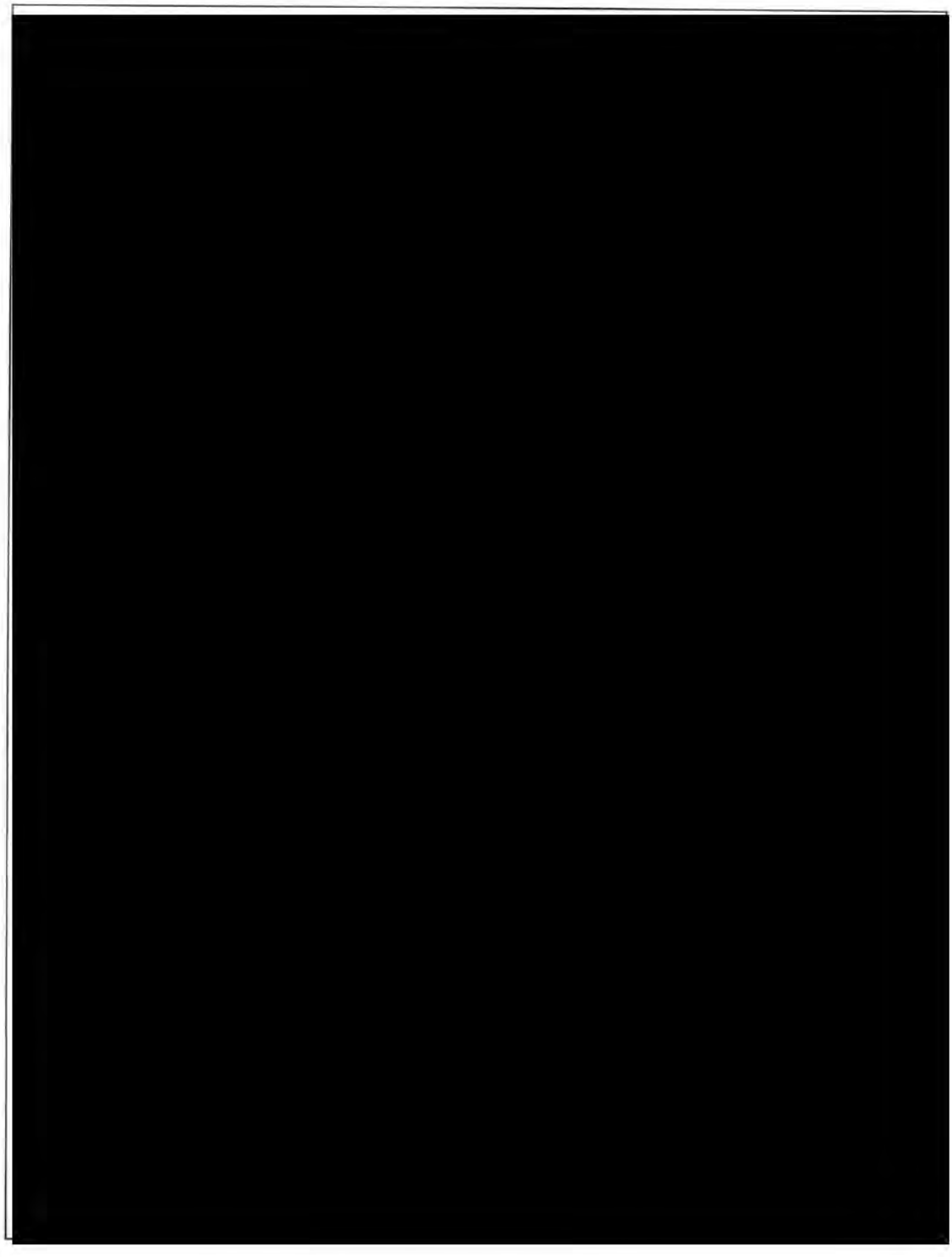

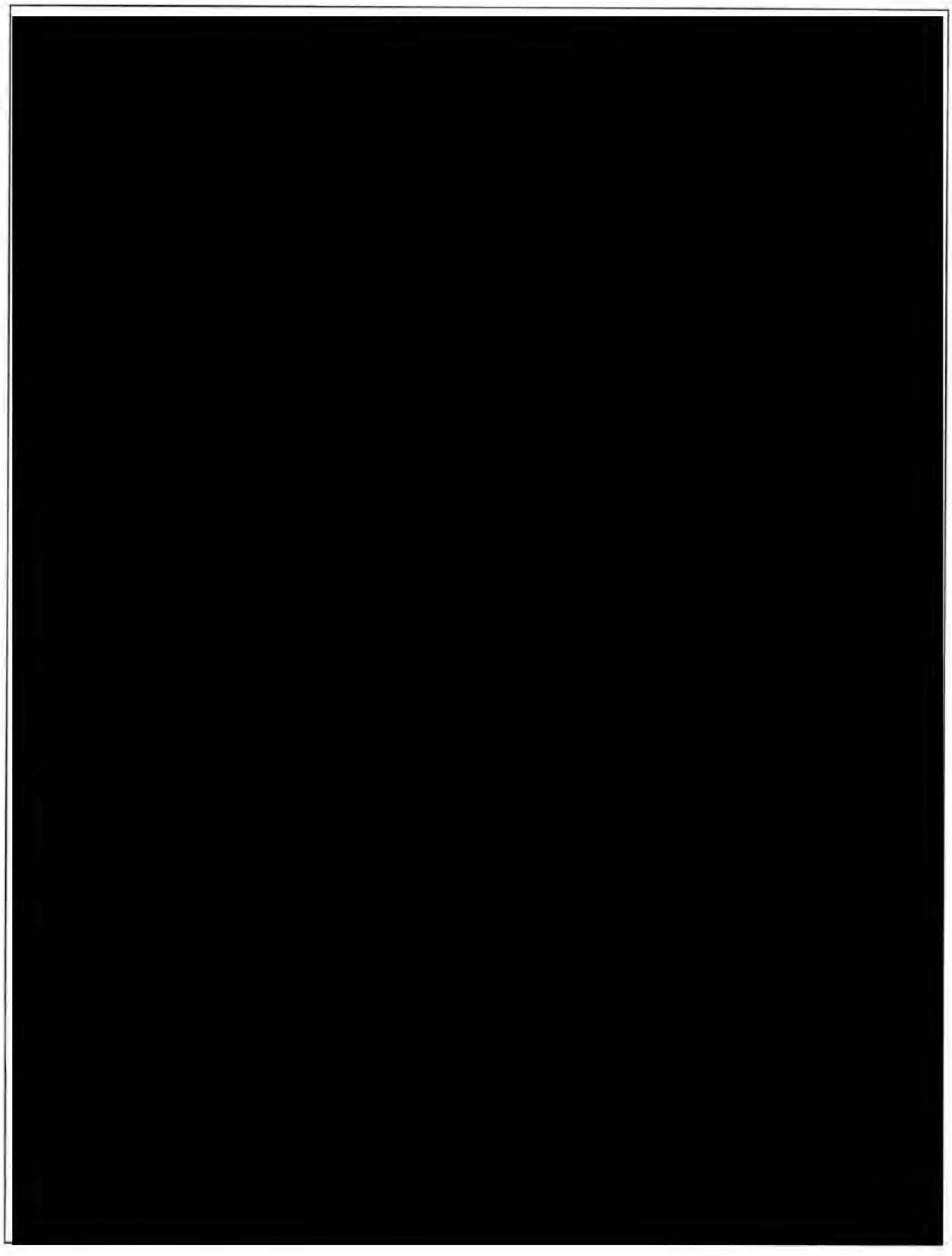

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Q. Okay. What would have been the next step in personal -- or the -- a step up in personal restraint for the --

A. Basket.

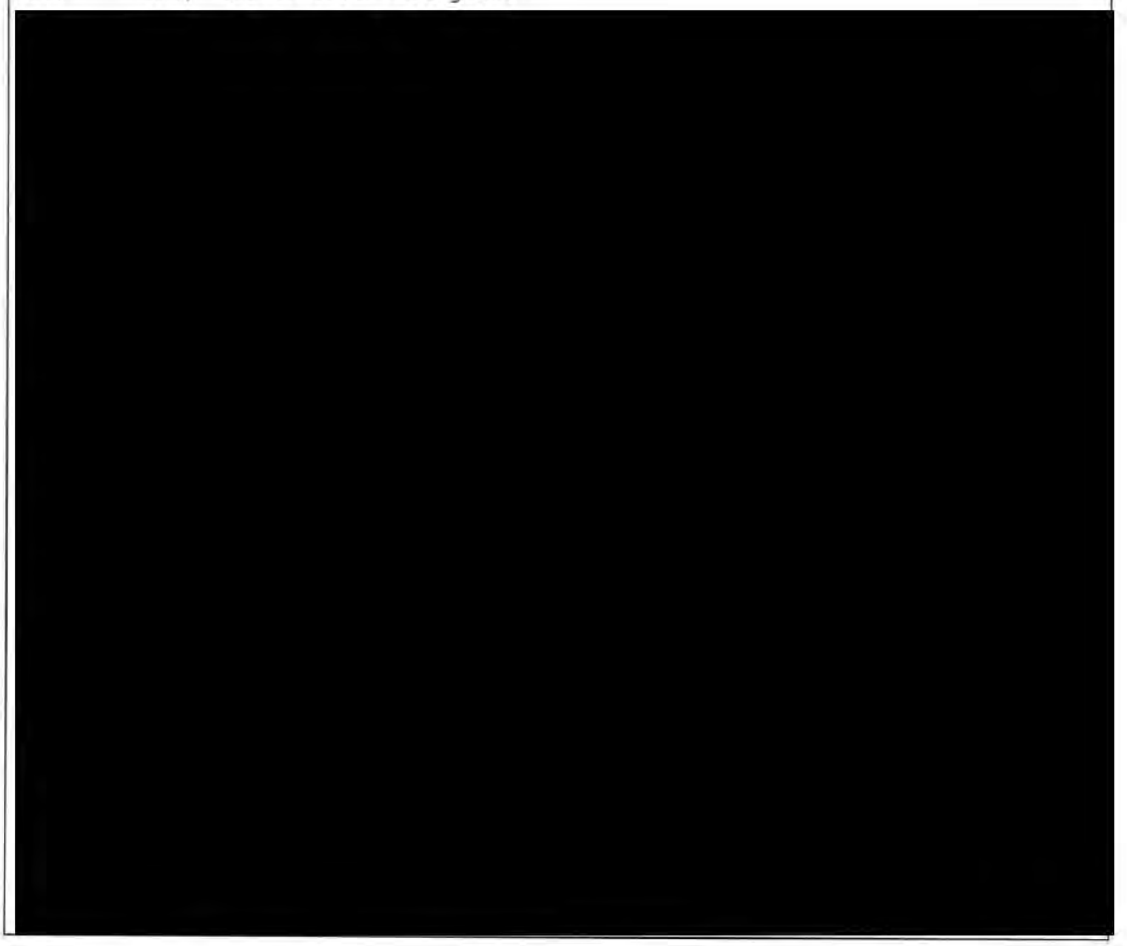
Q. The basket. Okay.

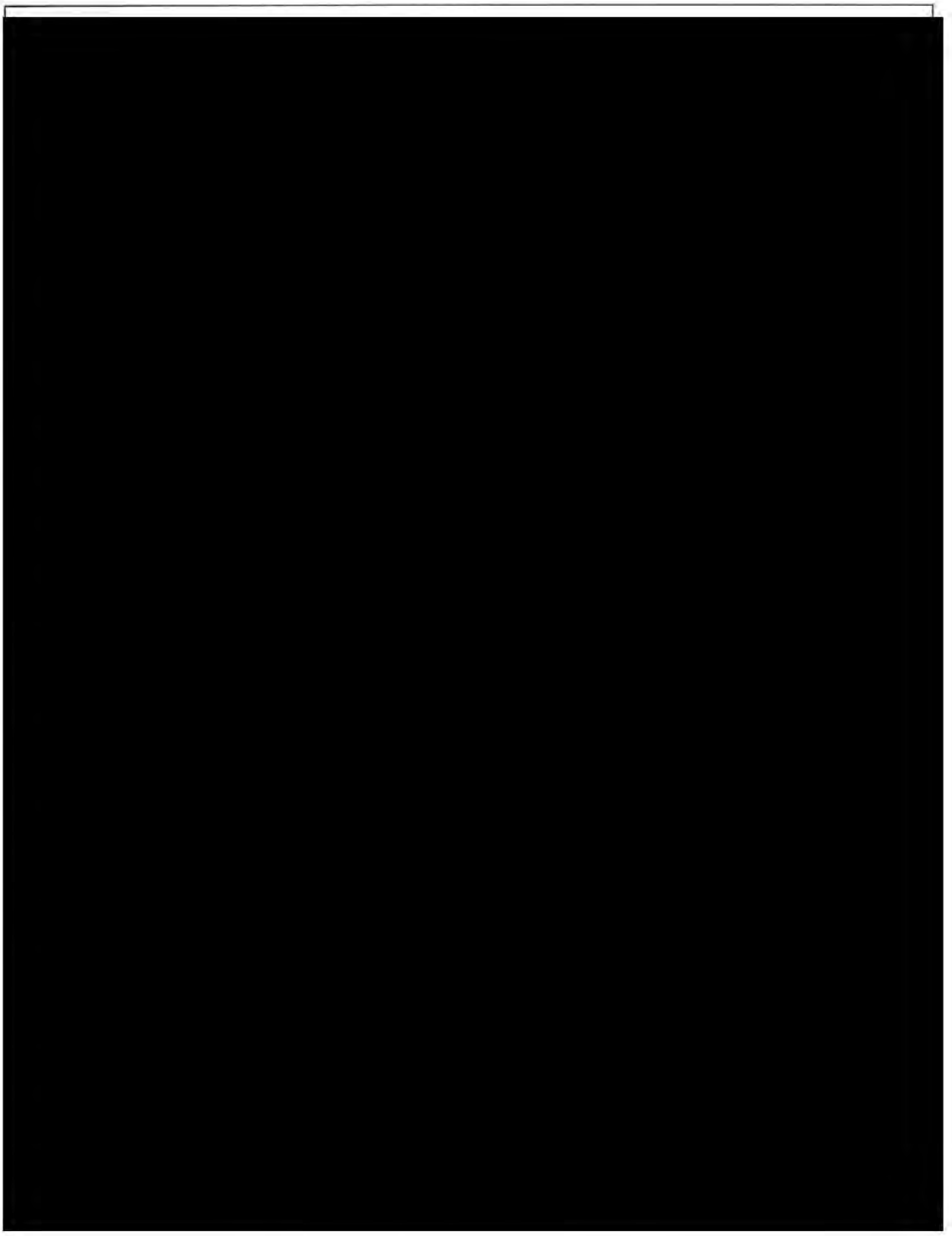
You wouldn't grab his -- you wouldn't hold him by the wrist?

A. No.

Q. Okay. Is that not taught as far as your know -- you know?

A. Not that I know, especially not both wrists. Like Amy had stated, you don't grab both wrists.
Q. Right.
But you're not even -- you're not really even aware that grabbing by the one wrist is taught?
A. I don't like doing it, so no.
Q. Well, I'm not asking that; I'm asking if it's taught?
A. No, it's not taught.





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MR. GILLISPIE: What exhibit are we on for this one?

THE COURT REPORTER: 2.

(Exhibit 2 marked for identification.)

(Discussion off the record.)

MR. GILLISPIE: I'll mark that as Exhibit 2.

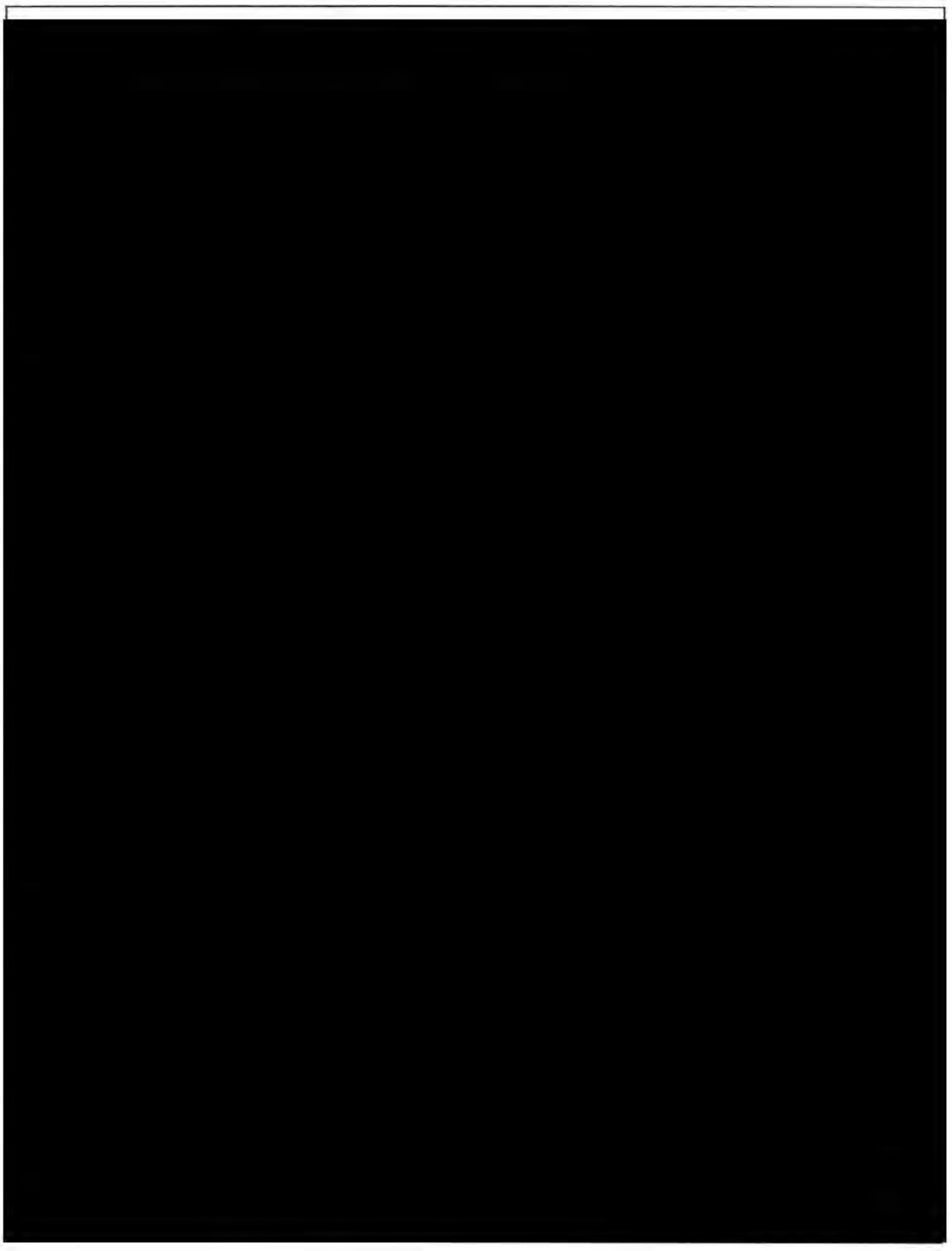
Q. (Mr. Gillispie) And then, Tyler, do you want to take a look at it and make sure I didn't misrepresent something.

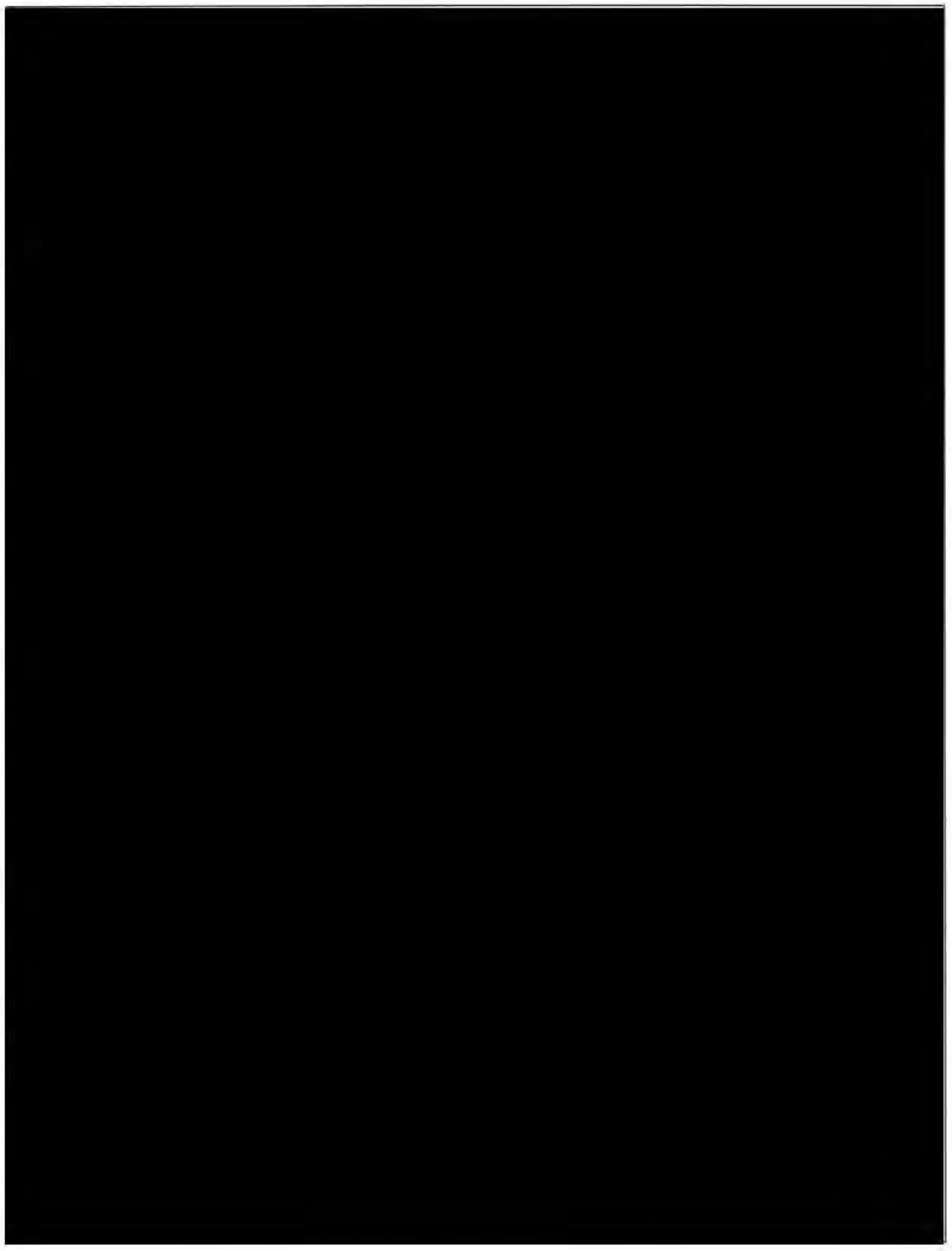
A. That looks good.

MR. GILLISPIE: Okay. We'll make this Exhibit 2.

Q. (Mr. Gillispie) Okay. And then one more of these.

[redacted]





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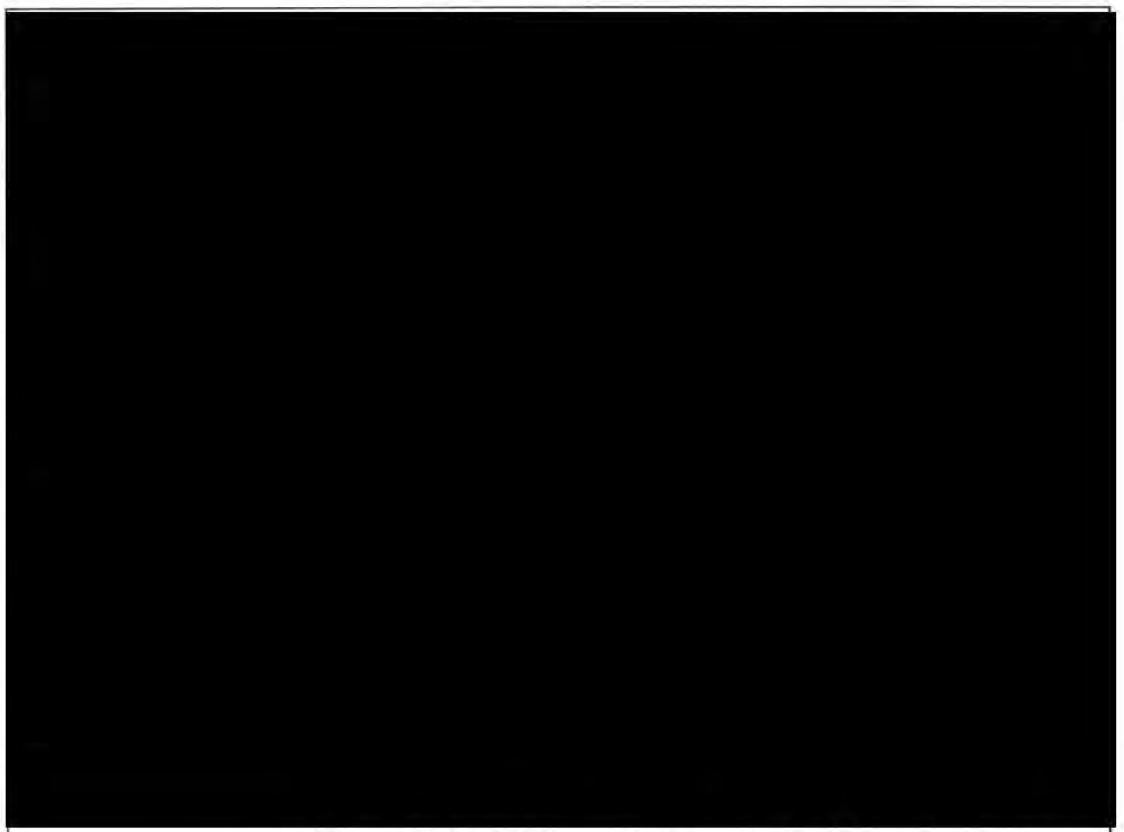


MR. GILLISPIE: Okay. And this is Bates numbered 747. It will be Exhibit 3 for this deposition.

(Exhibit 3 marked for identification.)

MR. GILLISPIE: Give me just a moment. For what it's worth, I'm actually doing the opposite of wasting y'all's time here. I'm going through here and X'ing out things I don't -- I think I can skip.

Q. (Mr. Gillispie) Okay. Other than those, the ones we've gone over, can you specifically recall any other

personal restraints that you've ever been involved in with David Cains?
A. No.
Q. Okay. Do you have any idea around the time of his death in -- or in 2020 are you able to ballpark about how many restraints were required for David maybe by other staff other than you?
A. No.
Q. Okay. Did you personally ever notify David's family about any personal restraints used on David?
A. No.
Q. Did you ever -- I'm assuming you never spoke to them after his death either?
A. No.
Q. Okay. Do you have any knowledge about whether anybody else ever notified his family about these in- -- these, these behavior incidents?
A. I don't know.
Q. Okay. Were you ever present for any mechanical restraints used on David?
A. Not that I can recall.
Q. Okay. And I assume you'd agree with me -- or I assume that you would acknowledge that at the time of David's death, the policy at Booneville was that only medical staff could call for an ambulance?

A. Yes.
Q. Okay. That's changed since then?
A. I --
Q. You're not sure?
A. I don't know. I don't know if it's changed.
Q. If it has, you haven't been told about it?
A. No. I haven't been told, no.
Q. Would you have liked to have been able to call 911 yourself at the -- as soon as you realized he was in serious trouble?
A. I would have liked to, yes.
Q. At the time of his death, was the facility short staffed?
A. I believe it was just before COVID, but not -- not too terribly short staffed that I recall.
Q. That you recall. You -- nothing -- it doesn't stand out --
A. Nothing, like, extreme.
Q. Yeah.
A. So not that I recall.
Q. It doesn't stick out in your memory as -- as short staffing being any factor in his death?
A. No.
Q. Okay. Are you familiar with the terms Category I, Category II, Category III, as it pertains to behavioral

management of the clients?
A. I've heard the term but I'm not a hundred percent familiar with what it means.
Q. Okay. So if I were to tell you that -- that you're -- and you're also familiar with the term IPP, that every client has an IPP?
A. (Witness nods head.)
Q. If I were to -- yes?
A. Yes, I'm sorry. Yes.
Q. If I were to tell you that David's IPP allowed for Category I interventions as well as -- as well as -- if I -- okay.

So if I were to tell you that his IPP specifically only allows for Category I procedures or other Center emergency procedures that would be necessary to protect folks from injury, would you -- I'm sorry -- would you know specifically what I was talking about?
A. No.
Q. Okay. Do you recall ever -- having ever been provided this document, which I'm labeling as Exhibit 4? It's Pol- -- it's referred to as Policy 3011-D.

Do you recall having ever seen that in your training or in your class work?

(Exhibit 4 marked for identification.)

A. Not that I remember. But maybe in my early

Phase 1.
Q. Okay.
A. But, again, that was four years ago.
Q. Okay. Could you read the part there that I have highlighted.
A. "Behavior management as covered by this policy serves as a guide to ensure that individual's actions that are aggressive, disruptive -- disruptive and/or present a danger to the individual or to others are managed with the least restrictive method."
Q. Go ahead. Keep going.
A. Oh. "Behavior management is not a substitute for other forms of active treatment and is incorporated into program plans based on individual needs."
Q. Okay. So, according to this Policy 3011-D, which again is -- I've come to understand is a kind of an overarching policy produced by DHS, DDS Director's Office that applies to all the behavioral -- behavioral development centers throughout the state, this policy says -- you would agree this policy says -- or dictates, rather, that when dealing with -- with trying to manage the behavior of a client, you're required to use the least restrictive method possible; correct?
A. Yes.
Q. Okay. And if you'll turn to -- to Page 2, do you

see where it says "Category I"?
A. Yes.
Q. Okay. And under Category I it lists the types of interventions contained within Category I, and those include: "Verbal intervention, separation from activity up to 30 minutes, separation from setting up to 30 minutes, assignment of additional chores, restitution, withholding privileges" and finally, "personal property removal" for not more than an hour.
Would you agree that I described Category I accurately?
A. As it's stated, yes.
Q. Okay. And do you see where it says Category III? On Page 4 at the bottom where it says Category III?
A. Yes.
Q. Okay. Now let's turn to page -- Section D of Category III, within Category III is included personal restraints, physical restraints; correct?
A. Yes.
Q. So according to this document -- at least according to this document -- and I understand you're not familiar with this document.
But, according to this document and assuming what I'm telling you is correct, physical restraints are acceptable for clients under Category III precautions but

not for clients under Category I precautions; correct?
A. That's what it -- yes.
Q. Yes?
A. Yes.
Q. Okay.
MR. GILLISPIE: Do you want to see?
MR. COLLINS: No, thank you.
MR. GILLISPIE: You can give that to her, Exhibit 4.
Q. (Mr. Gillispie) And so my question to you is: As far you can recall, it was never conveyed to you -- it was never told to you by -- by a supervisor or anyone else that David's IPP provided for only Category I?
A. Not that I can recall.
Q. Okay. And, at the time of his death, your direct supervisor was Amy Mandy Jones?
A. She was the PS -- if I recall right, she was the PS running The Hill, yes.
Q. Okay. And then above her would have been?
A. I believe it would be Sandy Evans or the director.
Q. Okay. Who did you consider to be your boss when you -- at the time of --
A. The person running The Hill would have been Mandy.
Q. Okay. And did Mandy have a -- any kind of -- did Mandy have a relationship with David? Did she know him

well, spend time with him?
A. She knew him in passing but didn't work with him regularly.
Q. Okay. And did you get along with Mandy well?
A. Yes.
Q. Okay. Do you know of any issues that Mandy has had with other clients in the past? Maybe a client has complained about her? Or perhaps something like what happened to you, another staff member or somebody accused her of maltreatment?
A. Not that I know of.
Q. Okay. Did Sandy Evans -- were you questioned by Sandy Evans after David's death?
A. Yes.
Q. Okay. And do you recall -- what do you recall from that?
A. She was empathetic towards me and that she gave me the sheet, and that was pretty much it.
Q. Just she told you she was sorry that you had -- you're having to deal with this?
A. More or less.
Q. She didn't question you about how it happened or anything like that?
A. It was all explained in the sheet.
Q. What sheet?

A. The Witness Report.
Q. The Witness Report that you wrote?
A. That I wrote, yes.
Q. Okay. So she -- she -- other than your witness -- she -- she -- I understood she accepted your Witness Report.

But, as far as you recall, she didn't -- she didn't do any further interrogation or questioning of you?
A. Not that I recall. She was just being empathetic and --
Q. Okay.
A. -- as she could professionally be in the situation.
Q. Sure, sure.

And how shortly after the death was this meeting with her?
A. Immediately afterwards.
Q. Okay.
A. And after -- yeah.
Q. And you never met with her again about it?
A. No.
Q. And about how long do you think that meeting with her lasted?
A. It took me maybe 15, 20 to write the report and I left.
Q. Okay. But how long did it take her to talk with

you?
A. About the duration. She didn't talk to me afterwards or before, other than being empathetic. It was just I gave her the report and --
Q. So she had you write a report. She didn't -- she didn't ask you any questions about the event? She -- other than -- and she -- the only words you recall her speaking to you were kind of . . .?
A. She just kind of asked me what happened. But, like, as far as, like, did she interrogate me necessarily? Not that I recall.
Q. But -- so you say you do recall her as -- specifically asking questions about the event?
A. Just what happened. She didn't ask too many details that I remember.
Q. Okay. And about how long do you think the conversation part with her lasted?
A. Barely a minute. It was what happened and her being empathetic. And she handed me a sheet and she explained it me, and that's really just . . .
Q. Got it. And when you say explained it to you, meaning explained how to fill out the form?
A. Basically. I mean, like, she didn't tell me what to write down necessarily; but she was like -- she gave me a -- how do I word this? She basically just gave me

basic -- basic instructions.
Q. Okay.
A. Of what -- what to write down and how to -- all that stuff, but nothing beneficial towards me necessarily.
(Exhibit 5 marked for identification.)
Q. Gotcha.
So I'm showing you what I've marked as Exhibit 5. This is Bates stamped 2714, and this is Client's Rights or Client Rights.
And this is from your training materials, correct?
A. Yes.
Q. Okay. And you would agree that this is a list of sort of the rights of the clients that you're there to -- to care for, correct?
A. Yes.
Q. And you would agree that your -- that your primary role is to literally care for these people, correct?
A. Yes, yes.
Q. Number 8: "The right to receive medical care, nursing care, and dental care in a safe and clean environment."
Number 12: "The right to express individual preferences."
Number 14: "The right to privacy during treatment

and care of personal needs."

Number 16: "The right to be free from mental and physical abuse and threats of punishment or deprivation."

Do you recall having -- having these, these rights taught to you?

A. Yes.

Q. Okay. Number 17: "The right to be free from chemical and physical restraints except when properly authorized for specific behavior and limited period of time or to protect them from injury to themselves or others."

18: "The right to the protection of a qualified guardian if needed for their personally well-being and interest."

And 19: "The right to considerate and respectful treatment."

Do you agree with me that all of those are listed here as the rights of the clients that you were tasked with caring for?

A. Yes.

Q. Okay. Do you agree with all of these?

A. Yes.

Q. Is there anything here that you -- anything that I read off that you disagree with or think shouldn't be a right?

A. No.
Q. Okay. Do you agree that the -- that the clients have a right to be free from physical restraint, restraints except when specifically provided for a specific behavior or to protect them from injury or causing injury; correct?
A. Yes.
MR. GILLISPIE: Okay. That is Exhibit 5. And then let's take one more break, and then we'll come back and wrap up.
THE VIDEOGRAPHER: We're going off the record. The time is approximately 2:39 p.m.
(Recess taken.)
THE VIDEOGRAPHER: We are back on the record. The time is approximately 2:47 p.m.
Q. (Mr. Gillispie) Okay. Mr. Mattson, tell me about the day in question.
Specifically what do you recall -- do you recall interacting with David prior to the incident that day?
A. He was in a good mood all day.
Q. Did you -- did you first see him when you got there early in the morning?
A. Yeah. He would usually be there to greet us.
Q. Okay. Kind of take me through what you remember all the way through lunch.

A. I just -- it was a normal weekend. Weekends are pretty lax. We -- we just kind of hang out more than anything. I got there; I did my normal paperwork of signing in and all the things I would sign.

He was just, like, "Hey, Tyler. Hey, Tyler. Hey, Tyler," you know --

Q. Yeah.

A. -- just how he does.

I was like, "Hey, David." You know, just kind of talking to him and just talking to everybody else that I can. Because usually whenever you get in there, you just kind of get swarmed by everybody. It's like, Oh, so and so's here. You know, it happens with every area.

Q. Uh-huh.

A. But that was really pretty much it. We just kind of hung out, just watched TV if he went in the TV room or . . .

Q. Uh-huh.

A. But he -- most of the time he stayed in his room.

Q. Okay. And did you escort him to lunch?

A. He -- we rode mobile together, me and the rest of the guys.

Q. Okay.

A. And the other staff.

Q. And about how many of y'all rode mobile to lunch

together and had lunch together?
A. I don't know the exact numbers back then. Because, like I said earlier, it's fluctuated.
Q. It wasn't 10?
A. If I had to do a ballpark guess, it would be 10.
Q. Okay. And what time is -- is lunch served the same time every day?
A. Generally in, like, an hour window between, like, 11 to 12-ish.
Q. Okay.
A. If I remember right.
Q. And on this date do you recall what time you arrived at the cafeteria?
A. No, I don't know. I don't remember the exact time.
Q. Okay. Do you wear a watch?
A. (Witness indicates.)
Q. No.
A. I have my phone but I don't take my phone out at lunch.
Q. Okay. And do you -- do you recall what David had for lunch?
A. Egg sandwich.
Q. Okay. Egg salad sandwich?
A. Just an -- like, I -- I guess it was an egg sandwich of some sort.

Q. Okay. Did you eat as well?
A. No.
Q. Okay. And did he sit alone?
A. No.
Q. Was his --
A. We sat in a group.
Q. Okay. I'm picturing, like, a -- like, a school lunchroom table; is that --
A. Yeah, sort of. Well, just a regular wooden table.
Q. Okay. What did he have -- do you recall what he -- do you recall what else he ate other than the egg sandwich?
A. No, I don't know the sides or anything. That's what -- I just know the main thing was an egg sandwich.
Q. Okay. You don't recall what he had to drink or anything like that?
A. Maybe Kool-Aid or tea is what they usually had, so it had to have been one of those two.
Q. Did anything happen on the way to lunch or during lunch that upset him?
A. No.
Q. Okay. How long after arriving to -- at the cafeteria would you say it took him to get his lunch and finish it?
A. 10 minutes maybe.

He wasn't super slow eating but not too quick. He was pretty normal.
Q. Okay.
A. I mean, that --
Q. Maybe 10 minutes to eat his sandwich?
A. Yeah. 10, 15.
Q. And then he immediately after finishing the sandwich asked you to take him to the bathroom?
A. He was getting agitated by -- I don't -- I don't know what. No one had spoken to him that I'd seen. I could just see he was getting agitated.
That's why I was, like, "Hey, let's go to the bathroom and get away."
Q. What was he doing to let you know he was agitated?
A. His facial expressions.
Q. Okay.
A. He had very dignified facial expressions whenever he was ag- -- agitated.
Q. Say that one more time. That was --
A. He had very, like, dignified -- he had very, like, evident facial expressions whenever he was ag- -- agitated.
Q. You used the term "dignified"?
A. Well, I -- I think I used it poorly.
He was very apparent with his facial expressions.

I think I just used the wrong word.
Q. Okay. Did it -- did he suddenly have a very serious look on his face? Is that what you mean?
A. He would just look agitated, like, just -- I mean --
Q. Was he saying anything?
A. -- he wasn't scowling or anything, no. He was just --
Q. Okay.
A. Not that I recall.
Q. He wasn't slamming his fist or --
A. No.
Q. -- throwing Kool-Aid?
A. No.
Q. So you could just tell just from the look on his face that he was agitated, so you initiated -- you initiated removing him to the hallway?
A. To the bathroom.
Q. To the bathroom?
A. Yes.
Q. Don't you have to walk out of the cafeteria?
A. Well, yes. Yes, but . . .
Q. And then is that -- when you walk out of the cafeteria, are you in a hallway or more, like, a lobby?
A. More like a lobby.

Q. And then the bathroom is off of that lobby?
A. Yeah. It's just -- yeah.
Q. Okay. Well, did he go with -- was he happy to go out there with you? Did he --
A. I mean, he wasn't happy but he didn't argue.
Q. Okay.
A. He stood up and just -- he took a clients's hat and kind of smacked him on the head -- not hard but like --
Q. Uh-huh.
A. -- he wasn't doing it jokingly, necessarily.
Q. Uh-huh.
A. And then I was like, "Okay, well, let's go," you know.
Q. Uh-huh.
A. Like, I didn't -- I didn't put hands on him necessarily.
Q. Okay. And you -- so you sort of escort him to the bathroom.
Did you go into the bathroom with him?
A. Yes.
Q. Okay. And was he -- did he go into the bathroom willingly?
A. Yes.
Q. Okay. Do you think it's possible he didn't want to leave the cafeteria?

A. No.
Because if he didn't he would have said, "I don't want to go."
Q. He would have?
A. Yeah.
Q. Okay. Do you think it's possible he didn't want to go in the bathroom?
A. No. Because he asked that as well.
Q. He asked what?
A. He asked, "Can we go to the bathroom?" just -- well, it was more of, like, do you -- a suggestion, "Do you want to go to the bathroom?"
He was willing for it. He was, like, "Yeah, let's go," you know.
Q. Okay. All right.
And you guys -- was it just the two of y'all in there?
A. Yes.
Q. Did he use the bathroom?
A. Yes.
Q. Okay. About how long did that take?
A. Less than a minute.
Q. Okay. So he urinated?
A. Yes.
Q. In a urinal or a stall?

A. Urinal.
Q. A urinal.
And he is able to do that without any assistance?
A. Yes.
Q. Is he also able to wipe himself without any assistance?
A. Yes.
Q. Okay. And, after he's done using the bathroom, I assume you -- did you ask him to wash his hands? Or does he know to do that on his own?
A. He knew to do it on his own. He was pretty -- for the most part pretty hygienic.
Q. Good. All right. So he washes his hands.
Are y'all talking at this point?
A. Yes.
Like, I was trying to just kind of BS with him, you know, just kind of shoot the breeze.
Q. Okay.
A. Just trying to bring him down as much as I could in the moment. Just joking, is what I usually would do with him.
Q. And, as he's using the bathroom and washing his hands and you're joking around with him, does -- is he -- seem okay at that point?
A. He just has a neutral expression.

Q. Okay. Not necessarily agitated but not necessarily happy?
A. Yeah.
Q. All right. And do you remember specifically anything you might have said to him in the bathroom?
A. No.
Q. Just sort of --
A. I wasn't hounding him or anything of that sort.
Q. Right.
A. No. I was just -- just talking, you know.
Q. Yeah, I assumed not. I just -- I'm just --
A. Right.
Q. I'm just trying to figure out what -- what the trigger might have been to upset him?
A. Uh-huh.
Q. Do you -- and, if you know, save me the time and tell me.
A. I have no idea.
Q. Okay.
A. I honestly have zero clue.
Q. Okay. All right. So washes his hands.
Then what happens?
A. He was like: "Can we stay out here in the lobby?"
I was like, "Yeah, sure. That's fine."
Q. Is he sitting down or standing up?

A. Sitting down in a chair.
Q. A chair. Okay.
What are you doing?
A. I'm standing near him but not like -- not towering over him. I'm at a good distance, you know.
Q. Okay.
A. I'm not just, like, trying to be imposing necessarily. I'm being ready I guess.
Q. Was there another chair you could have sat in?
A. Not that I saw.
Q. Okay. So you would have had to sit on the ground if you were going to --
A. Yeah.
Q. -- sit with him?
A. Yeah.
Q. Okay. So he's sitting there.
Do y'all -- what happens next? Do you talk? Does -- what happens?
A. I tried to talk to him, but he's just kind of just sitting there.
Q. Okay. About how long?
A. A minute, if that. Not -- not a long time at all.
Q. And at this point can you -- does he have that agitated look on his face again?
A. Not quite.

Q. Okay. What's he doing as he's sitting there?
A. Just sitting. He was just sitting look- -- staring out.
Q. All right. And then what happens?
A. He grabs a paper and goes after me.
Q. Where does he grab paper from?
A. There was a flyer on the wall.
Q. Does he stand up to grab it?
A. He grabbed it and then went after me. He was sitting down and then went after me to attack me.
Q. What -- what kind of paper was it? Just --
A. It was just -- it was just a printout paper, just a flyer.
Q. What did he do with it after grabs it?
A. He was throwing it and then went after me. He threw it down and then went after me.
Q. He threw it down and then went after you.
Did he say anything?
A. No. He just screamed "bitch."
Q. He screamed "bitch"?
A. Yes. That I recall.
Q. Anything else that you recall him saying?
A. No.
Q. And then you said he -- he came after you?
A. Yes. He charged me.

Q. Charged you.
A. Yes.
Q. Okay. Does -- describe that for me as best you can.
A. He just went to grab me. I mean . . .
Q. How far away from him were you?
A. Maybe from here to that pole. Maybe a little bit shorter.
Q. This pole?
A. Yeah, about there. Maybe to the chair.
Q. My chair?
A. Between there.
Q. Okay.
A. Yeah.
Q. So about 6, 7 feet?
A. Maybe.
Q. Okay. And when you say "charge," was he running at you?
A. Lunging, running. Yeah, just -- he went after me. He didn't really have room to necessarily run.
Q. Can you -- do you mind standing up and showing me?
A. I -- as best as I can. Like, he just -- it was, like, just a classic -- like, went to grab at me.
Q. Okay. Went to grab at you?
A. Yes.

Q. So not swing at you but grab at you?
A. Grab at me.
But, like, he had -- like -- like I said, that distressed face.
Q. Okay.
A. Like he was agitated and -- yeah.
Q. All right. And -- okay. And then what -- what did you do?
A. I tried to hold him and we kind of just fell.
Q. How did you try to hold him? Stand up and show us, please.
A. Like, I was -- like, I just kind of grabbed him by the shoulders the best as I could, you know, with him -- momentum --
Q. Yeah.
A. -- and we just kind of stumbled over, you know.
Q. Okay. So he's coming at you arms raised like this?
A. It -- yeah.
Q. Like this?
A. Outwards, yeah.
And I just kind of grabbed, like, here and here. I didn't, like, grab by the wrist. You know, but, like, we kind of just awkwardly fell.
Q. Did he get a -- did he get a grip around you?
A. No, he didn't get a grip around me.

Q. Okay. Sorry.
A. No, that's all right.
Q. This won't take long.
So he's coming at you. Show me and slowly so -- so I can really see it: What -- what do -- show me what you do as he's coming at -- he's lunging at you.
What do you do? What do your hands do? Where do they go?
A. I'm just like -- biceps, like, arms.
Q. Okay. So you would have your -- your right hand on his left bicep and your left hand on his right bicep?
A. Yeah.
Q. Pretty much?
A. Pretty much, yeah.
Q. Okay. And -- and do you stay there locked like --
A. No.
Like, we tripped. Like -- like, we just kind of fumbled around. Because it was, like, all in one big momentum, you know.
Q. Uh-huh. And you fall to the ground, and he hits his face on the ground?
A. No, he didn't hit his face on the ground.
It wasn't a fast fall. It was a controlled fall as much as I could control it.
Q. Okay. Give me just a moment, Tyler.

And he wasn't spitting at you?
A. I -- I don't remember.
Q. Okay. So -- and I'm going to -- I'm going to show you this in a minute. This is -- what I'm looking at here is the Witness Statement Form, the Office of Long-Term Care Witness Statement Form that you completed on the day of.
I assume it's the -- does that look familiar?
A. Yes, sir.
Q. Is that the form Sandy Evans gave you?
A. Yes.
Q. Okay. So in this statement you don't say that he tried to put his arms around you, lunge at you. You just told me that he tried to lunge at you and put his arms around you.
In this -- in this statement you said he attempted to hit you.
A. He -- that's -- he may have. I don't remember. Like, it was two years ago; and so I don't remember every intricate detail about it. That's just what I remember, and it could be different.
Q. And it says I -- and it says that you "Applied personals by grabbing his arms. He ended up falling over. I did not land on him."
So that's a little different than what you're

describing now. What you're kind of describing now is that he lunged at you, and you grabbed him by the biceps; and then the force caused you guys to tumble over.

That's what you're describing now, but that's different than what you wrote here. So how -- I mean, how can you . . .?

A. He fell and I just kind of went with him, as far as I can recall.

Q. How did he fall? What caused him --

A. We --

Q. -- to fall?

A. We just kind of tripped up on each other. It was all one big motion, like I had said.

Q. Okay. And why did you not attempt to do the blocking technique where you block and kind of get out of his way?

A. I wouldn't have had room. I was against a ledge.

Q. You were against a ledge?

A. Yes.

Q. Why would a ledge prevent you from being able to do like this?

A. Because I would have fell over be- -- if he had put enough momentum into me.

Q. Okay. So you guys fall over.

And what happens -- and where did -- how did he

land? If he didn't land on his head, how did he land?
A. Like I said, I kind of controlled it so he just kind of landed relatively safely. Like, I tried to not let him land on his stomach because I knew that he just aten [sic].
Q. So what did he land on?
A. Just kind of his -- the side of his arms. Like, we just kind of landed funny; but . . .
Q. Do you recall giving a statement to Disability Rights Arkansas on July 29, 2020?
A. Vaguely.
Q. Okay. Well, they -- they issued a report concerning the incident.
Have you ever seen that report?
A. No.
Q. And according to their report -- and this -- this report dated October 22, 2020, Bates marked 4523, this report claims that -- that you, specifically you gave a statement to them stating that David landed on his face.
A. Face down. But he didn't hit his face, no.
Q. Well, this says "landed on his face."
A. Okay. I . . . no.
Q. Are you saying that -- that their -- what they -- that they're misquoting you?
A. Possibly.

Q. What would the other alternative be?
A. He -- landing face down, they misconstrued it. They made it sound like he, like, smacked his face; and he didn't --
Q. Well, did he land face down?
A. He landed towards his face, but he did not hit his face.
Q. How do you know?
A. I would have seen it.
Q. Well, like you said, it's been over two years; and, you know, you didn't -- you couldn't remember if he spit or if it was a hit or a grab.

So wouldn't you have -- whatever you told them July 29, that would be fresher in your memory than what you're saying now; wouldn't it?
A. I suppose.
Q. And, you know, I mean, it's possible they -- they're misconstruing your statement, but it's pretty clear what it says is that -- that David landed on his face, and then you rolled him onto his side.

You're absolutely 100 percent positive that -- particularly considering that you're now saying that he did land face down, you're saying you're also a hundred percent positive he did not land on his face?
A. I don't recall him, like, smacking his face, no.

Q. But it doesn't mean it didn't happen; because you were also tumbling yourself, right?
A. Yes, that's possible.
Q. Okay. So you fall over.
What -- where is he positioned?
A. On his side.
Q. Did you try --
A. And I tried to put him on his side as fast as I could.
Q. All right. So he lands face down and then you -- where do you land?
A. Like -- I don't remember exactly. Just around him. I didn't land on him, necessarily.
Q. Okay. Necessarily.
Do you think, like, some of your weight landed on him?
A. Not that I recall.
Q. Okay. And you just, like, instantly turned him onto his side?
A. As fast as I could, yeah.
Q. Which side did you turn him onto?
A. His left if I remember right.
Q. Okay. Well, before you turned him onto his side, what was he doing? Just laying there kind of face down?
A. Resisting me.

Q. He was both laying face down and resisting you?
A. He was trying to squirm around, yes.
Q. And you didn't want him squirming?
A. Because he was still being violent.
Q. He was still being violent by squirming around face down on the ground?
A. Yes, he -- he wouldn't --
Q. How is that violent?
A. He was trying to resist and fight me.
Q. Why didn't you just get up and give him some space, since he's already on the ground?
A. Because he was still very agitated.
Q. Well, so. Let him calm down. Why didn't you do that?
A. That's not how it works immediately.
Q. How does it work?
A. He would still be agitated afterwards, very agitated.
Q. So you thought it was best to turn him on his side and pin him on the ground?
A. I was wanting him to calm down. I was trying to get him to calm down.
Q. And in order to get --
A. And I was talking -- I was talking to him.
Q. And, in order to get what you wanted, you turned

him over, held him down?
A. I -- I guess.
Q. Well, you guess. You were there.
Did you -- is that what happened or isn't it?
A. Yes.
Q. Okay. And is he talking to you at that point?
A. No. He was just still insulting me, calling me names and screaming.
Q. Okay.
A. That was another semblance that I knew he was still agitated.
Q. Yep, still agitated. Still needed to be controlled. I understand.
About how long -- and where are your hands on him?
A. On, like, his upper body. Not, like, on his head but, like, controlling his arms. Like, not on his wrists but just -- generally his arms, upper area.
Q. Okay. And you didn't have one hand on his -- on his -- kind of his waist, one on his shoulder area?
A. No.
I just had, like, his arms controlled. Because that's -- he was infamous for, like, kind of winging back and swinging at you.
Q. Well, you said he's never hit you before. He's never made contact with you before.

So how can you tell me he's infamous for that?
A. Because I have seen him do it. I have -- and just from hearsay.
Q. We're talking about a four year old, the mind of a -- somebody with the mind of a four year old. You're telling me he's never hurt you, never hurt anybody else that you know of; he's never even made contact with you.
But you're also telling me he's infamous for some sort of on-the-ground boxing move?
A. Winging his arm back isn't a boxing move.
Q. Well, is it infamous?
A. I -- I -- like I said --
Q. Infamous?
A. I've had -- I've heard hearsay.
Q. Okay. You know, are you familiar with what the word means, "infamy"? Might --
MR. COLLINS: Objection. At this point you're starting to harass. Like, you've had this phrase back and forth. I don't know why you're getting to this point that you're harassing him.
Q. Well, I'm not trying to harass you. I just want to make sure that we're talking about the same thing. But I'll withdraw the question.
Okay. And when you say you were holding the upper

part of his body, would you say you had both hands -- he's laying -- he's laying on his left side like this, right?

A. He -- he's completely on his left side, like, legs and everything. He is parallel to the ground.

Q. Okay. And so both of your -- as far as you remember, both of your hands would have been up, like, on his --

A. Yes.

Q. -- up on this part of his right --

A. Yes.

Q. Like, the upper right part of his body and shoulder?

A. I was -- I was more or less just kind of holding the left side.

Q. Okay.

A. I wasn't really necessarily restraining. I was more holding. But I -- there was -- like, I was actively restraining the right arm because he was like --

Q. Okay.

A. -- that's whenever he was, like, most flailing.

Q. Okay. And I know you weren't holding his head. That's not what I'm -- what I'm suggesting. I just want to make sure I understand where your hands were.

A. Right.

Q. How long did this go on before Mandy Jones arrived on the scene?
A. That I can remember a couple of minutes. It wasn't -- shortly after because her area --
Q. Okay.
A. -- or she was coming up to monitor lunch.
Q. Okay. So about -- about a couple minutes later Mandy arrives, correct?
A. To the best of my knowledge.
Q. Okay. And what does -- does she say anything? Or do you say anything to her?
A. No. She just immediately jumps in and starts helping.
Q. Okay.
A. Starts holding one side because I was getting worn out.
Q. And is that when she was holding his head?
A. She -- I don't remember her holding his head.
Q. Okay. And that's another -- that's another one of those statements that I -- in your OLTC statement you didn't mention her holding her [sic] head. Ryann Campos mentioned maybe holding her [sic] head.
But then according to DRA, you said Mandy was holding his head. But we can -- we don't necessarily have to get into that, unless you have some way to

clarify that for me now.
A. Not that I remember.
Q. Okay. So where do you remember Mandy holding him?
A. I think she just took the other arm. Because I was just kind of . . .
Q. Okay.
A. Kind of -- he was doing more like a full body --
Q. Yeah.
A. -- flail at this point, but he was still --
Q. I --
A. He was still there.
Q. And I assume you're on your knees?
A. Yes.
Q. Okay. All right. And so you guys are holding him. And then I know at some point Ryann Campos shows up.
How long is it that you and Mandy are holding him there before Ryann arrives, about?
A. About maybe the same time, two or three minutes. It wasn't very long.
Q. Okay.
A. That I remember.
Q. Okay. And you're saying this whole time all these minutes he's -- he's just violently out of control on the ground there?
A. Yes. He's still resisting. Resisting, screaming,

everything.
Q. Okay. Okay. And then Ryann arrives and what does she do?
A. She grabs his legs.
Q. Okay. And is David saying anything at this point?
A. Still screaming for a moment.
Q. For a moment?
A. Yeah.
Q. What is he screaming?
A. Just insults, "Bitch. I hate you." Just -- he -- he would scream, "I hate you" and those, those two words seemed to be his popular ones.
Q. Okay. And what were you waiting for? What did you want to see? What -- when were you guys going to let him up?
A. Whenever he was saying he was calm and he wasn't screaming anymore.
Q. Okay. So until he stopped screaming and said what -- you know, you guys weren't going to let him up?
A. Yes, until he -- we knew for sure that he wasn't going to be agitated still and aggressive, we were going to -- we would leave him there.
Q. Even though he'd not caused any injury to any of you, not even made physical contact with any of you with his -- with his hands?

A. He was so spontaneous we had to be careful.
Q. Even though he has no history of injuring anybody ever?
A. Full-on injury, no; but I have seen him get aggressive.
Q. Okay.
A. That I know of, injuring.
Q. Well, I mean, you know, I have two-year-old twin toddlers. They get aggressive sometimes. I tell you what I don't do. I don't pin them to the ground until they --
MR. COLLINS: Are you testifying now?
Q. -- until they say what I want to them to say.
Okay. So how long are you three pinning him to the ground now that Ryann's arrived before he starts changing colors and defecating on himself and throwing up and dying?
A. As best I remember, maybe a minute or two. But it wasn't very -- it wasn't a long time.
Q. Okay.
A. And, as soon as we noticed the color change and all that, we immediately got up.
Q. Okay. And what's the very first thing that you noticed that alerted you that he was having a health crisis?

A. He was throwing up. There was food coming out of his mouth.
Q. And he --
A. And, as soon as we noticed that, we stopped.
Q. And he's still on his side at this point?
A. Yes.
We didn't put him on his stomach; we didn't put him face -- like, we didn't roll him face down or anything. We were using what I thought was our best judgment. Whether or not that was -- I don't know.
Q. And what -- okay. So he starts throwing up; that's the very first thing you noticed.
Before you -- before you smell defecation --
A. He had --
Q. -- or before you --
A. He had --
Q. -- notice a color change, you -- he's throwing up? That's the first thing?
A. He had messed himself, but that was another thing he would do whenever he was angry. He would mess himself, pee, you know.
Q. Okay. So he messed himself.
Y'all kept holding him down there after he messed himself?
A. Because he was still being aggressive.

Q. Okay. And he -- and it's only when he -- when you notice that he's vomiting that you guys let up and roll him onto his side -- or onto his back?

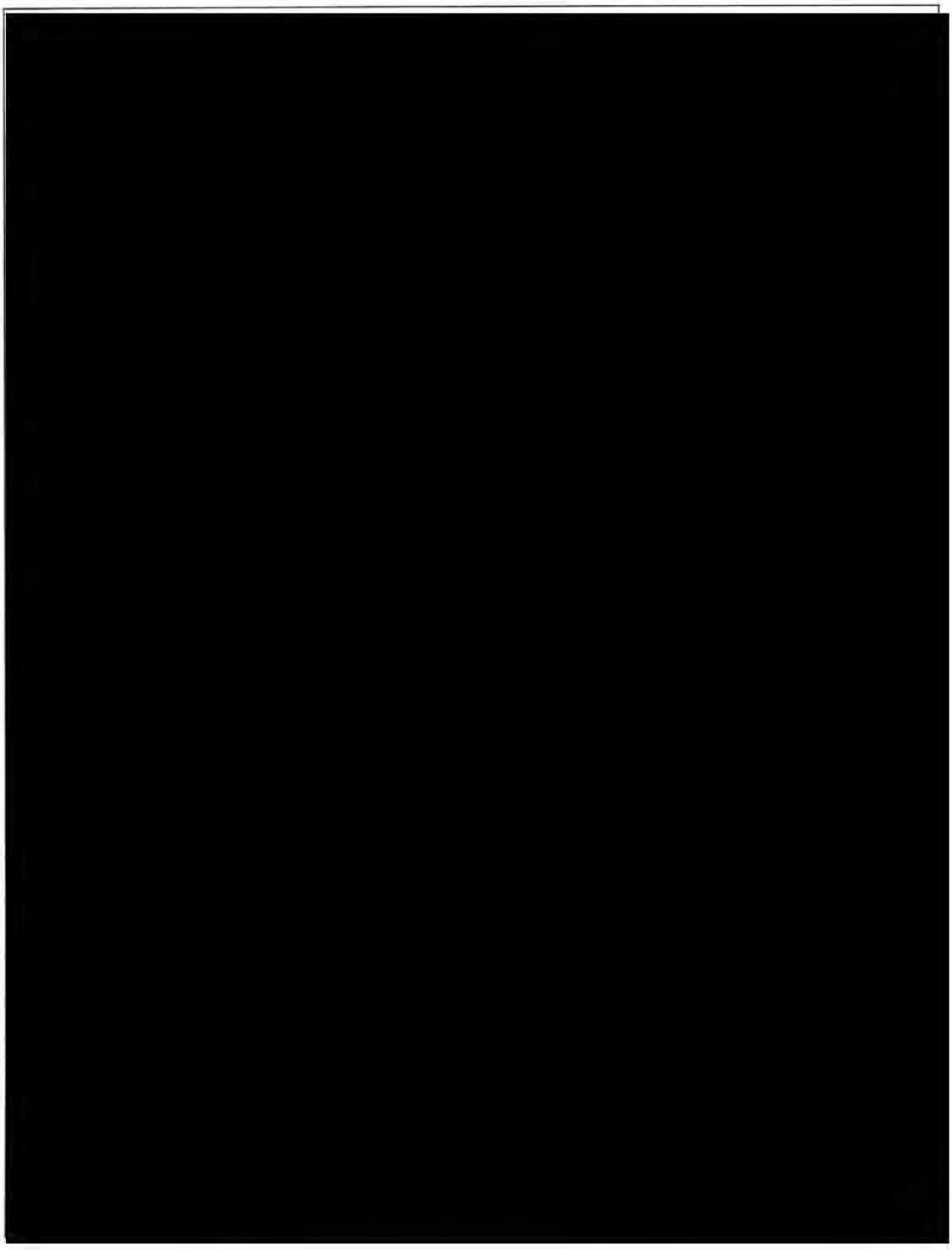
A. Yes.

That's what we thought would be the best course of action at the time.

Q. So you rolled him onto his back.

And what happens then?

[redacted]



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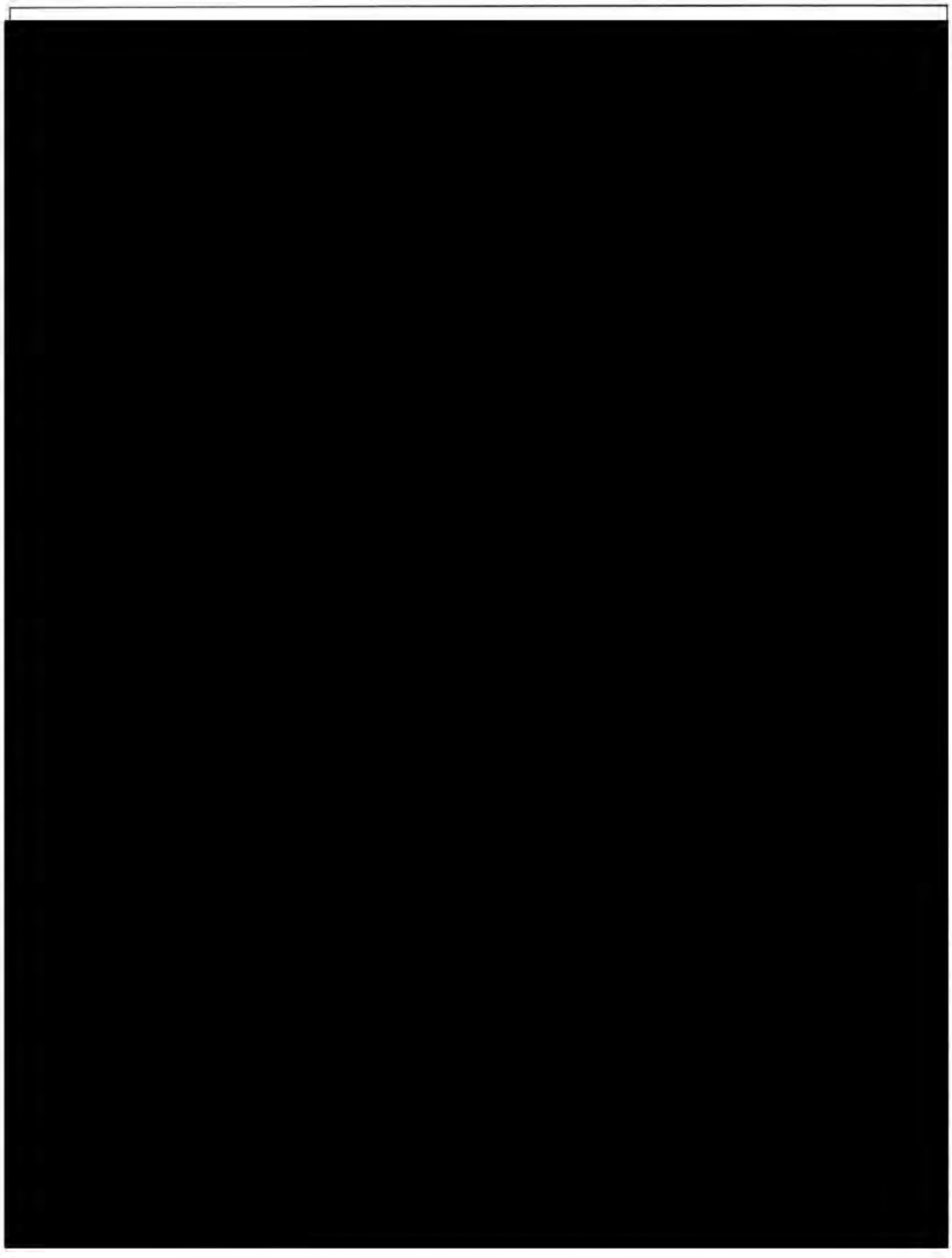
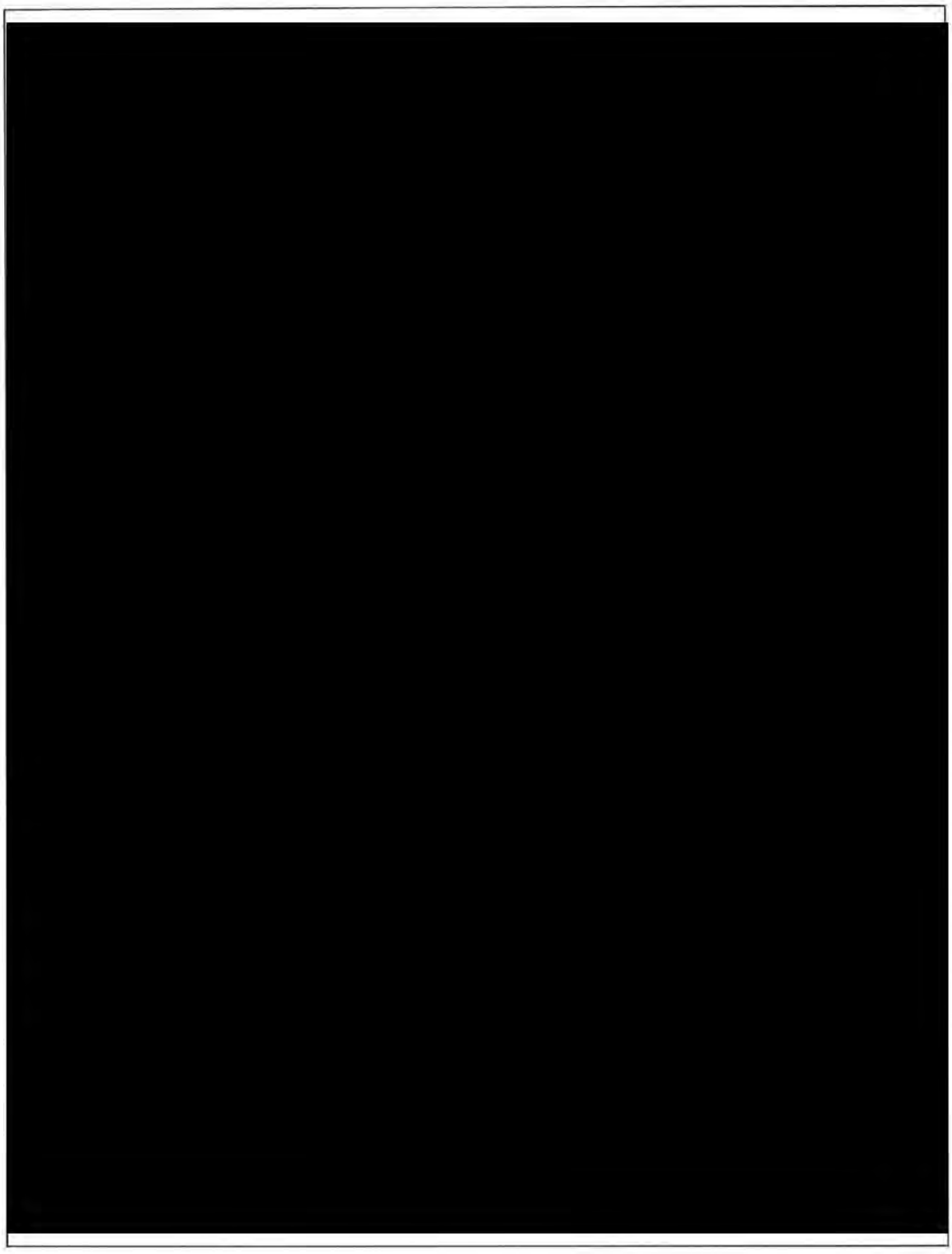
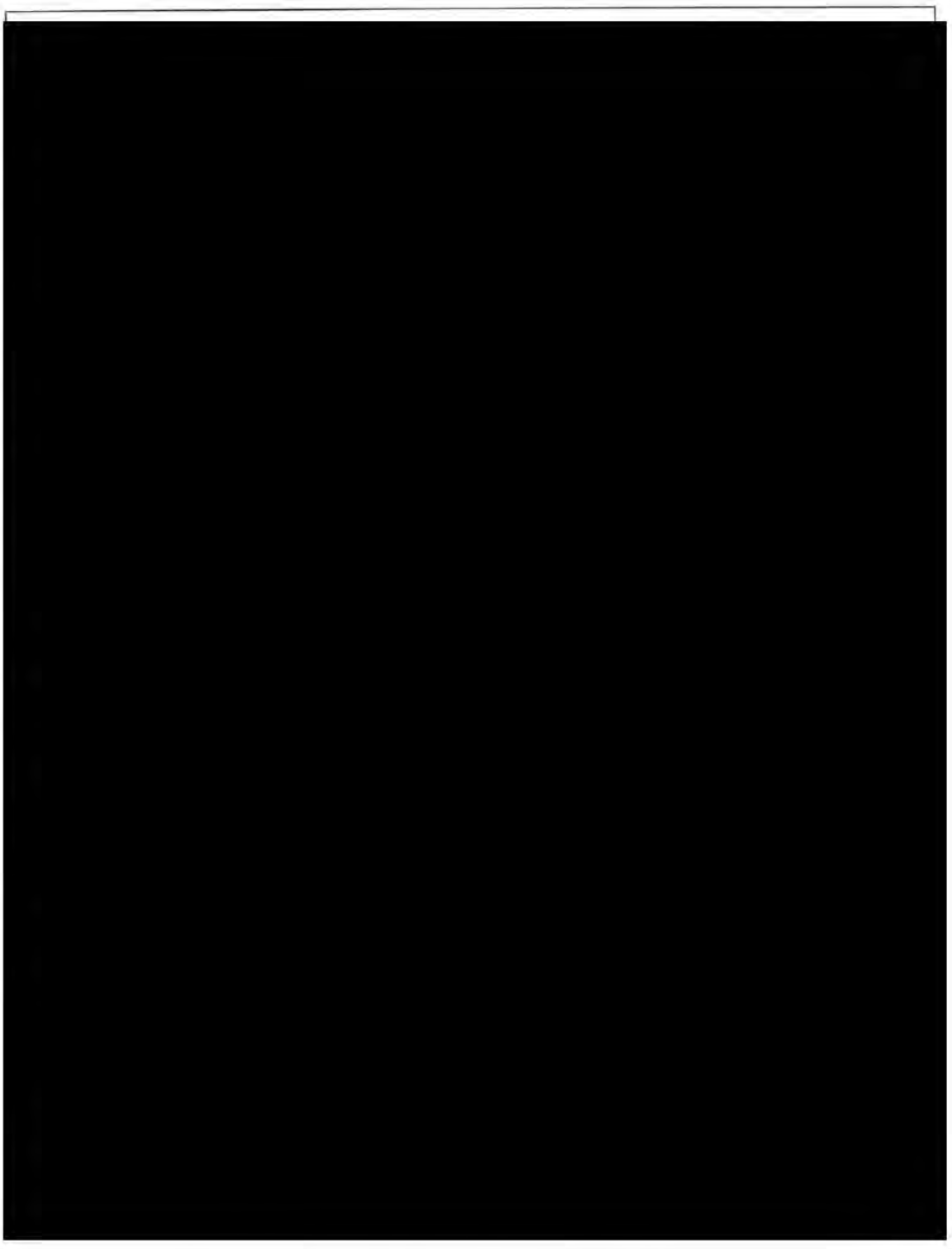






[redacted]

Q. But you know 911 wasn't called until medical actually got there and laid eyes on the scene, right?
A. That's -- as far as I know.
Q. Okay. Again because --
A. We're not allowed to.
Q. You and Mandy and Ryann we're not allowed to call 911?
A. Right.
Q. Because you're not medical staff, right?
A. Yes.

MR. GILLISPIE: Could you hear his yes?

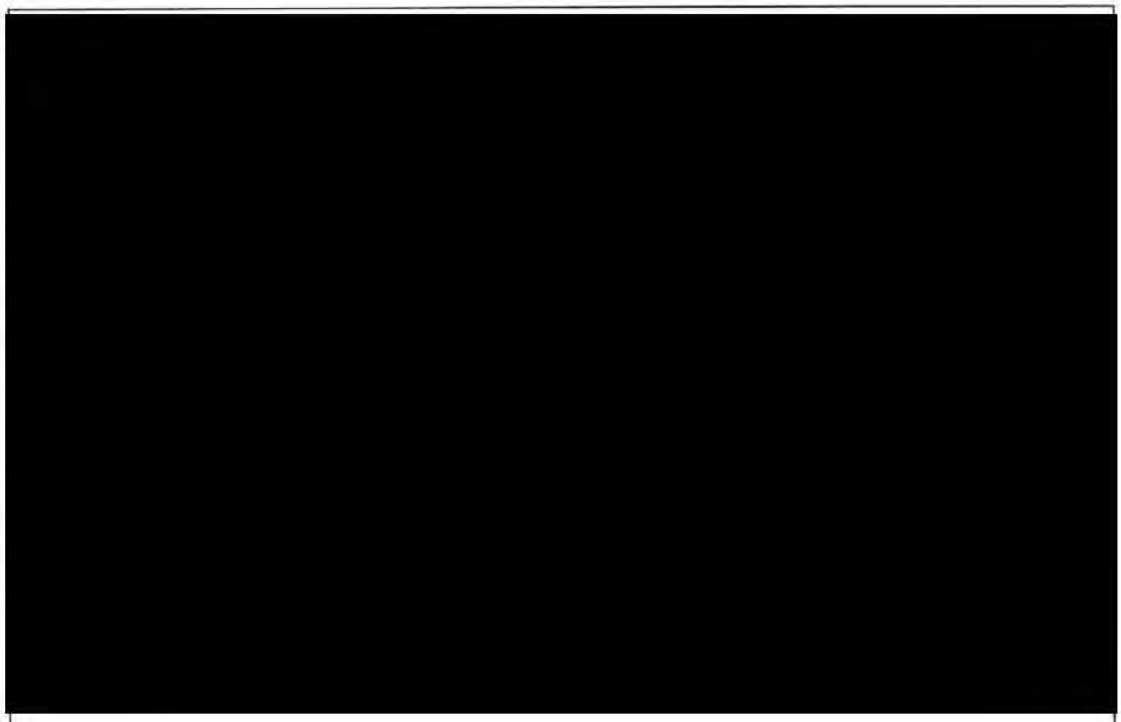
THE COURT REPORTER: I did. Thank you.

Q. (Mr. Gillispie) I -- I understand that at the time you had not been given CNA training but you since have and maybe some other training.

Since his death have you learned any lifesaving techniques that would have been useful had you been trained in them --

A. Not --
Q. -- at the time?
A. Nothing different.
Q. Nothing different. Okay.
Did you personally speak to paramedics or the police?
A. No.
Q. Do you know who did personally speak to paramedics or the police?
A. No. Just I know it was a nurse. I don't know which one.
Q. Okay.
A. It was the medical team.
Q. You -- and you know it was a nurse just because you -- I'm assuming just happened to glance around and see it?
A. Whenever I glanced around whenever I got a chance to, I had seen it, as far as I remember.
Q. But you weren't -- you don't know what she might have said or didn't say?
A. I have no idea.
Q. It was a female nurse too, right?
A. We only have female nurses so I assume.
Q. Okay. Who all do you remember being at the scene other than that female nurse, the three of y'all, Nurse

King, Nurse Schmidt?
A. The only person that I recall is Nurse Angie and Nurse Amanda.
Q. Amanda Schmidt and Angie Nelson?
A. Yes. Yes, that's all I remember because they all just kind of blurred together.
Q. Okay. And I assume you were aware of David's [redacted]
[redacted]
Q. Do you see that?
A. Yes.
[redacted]



Q. Okay.
A. I don't know exact -- my details, what all he finished. But, like, I know that was a big thing that he had; and that was -- yeah.
MR. GILLISPIE: Okay. Are we on 6?
THE COURT REPORTER: Yes, sir.
(Exhibit 6 marked for identification.)
(Exhibit 7 marked for identification.)
Q. Okay. Tyler, I'm showing you what's been marked as Exhibit 7 to your deposition. This is a BHDC Restraint Incident Debriefing Form.
Do you see the paragraph at the very top in bold?
A. Yes.

Q. Do you see what I'm talking about?
A. Yes.
Q. Okay. I'm going to read that. "The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used. All efforts must be made to deescalate behavioral situations so that they do not result in restraint.

"All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program) when a very real risk -- very real risk of personal injury or severe property damage is imminent."

Do you agree that I -- that's a correct reading of what that says?
A. Yes.
Q. And have you -- are you familiar with that, that policy language?
A. Yes.

MR. GILLISPIE: Okay. All right. If you'll hand that to her, please.

THE WITNESS: (Witness complies.)

(Exhibit 8 marked for identification.)

Q. And then the last exhibit here is what I've marked as Exhibit 8.

Do you recognize this, this Booneville HDC Policy, Policy Roman Numeral I-D-4?

A. Yes.

Q. Okay. Have you been instructed on this policy? Provided this document in training?

A. Yes, in Phase class.

Q. Okay. In what?

THE COURT REPORTER: I'm sorry. In what class?

THE WITNESS: Phase class.

Q. Phase class, okay.

Do you see at the bottom where it -- Emergency Use of Restraint?

A. Yes.

Q. Would you read the -- just the first two sentences there, please.

A. "Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors."

Q. And then the next sentence.

A. "The use of emergency restraint will comply with all relevant standards and regulations."

Q. Okay. So, as you sit here today, is it -- is it your testimony that what -- what you and Mandy and Ryann did complies with this policy?
A. As best as we could in the situation.
Q. You feel like that -- that holding him, pinning him there to the ground, all three of you, for as you said two, three, up to seven minutes possibly before he starts choking or vomiting and choking, that was the least restrictive thing you could have done at the time?
A. With how aggressive he was being, I feel like yes.
Q. And you would describe what he did as severely aggressive --
A. Yes.
Q. -- or destructive?
A. Yes.
Q. And specifically what -- what -- specifically what did he do that you would call severely aggressive?
A. He had intents of attacking me. He had intents of causing harm to me. And --
Q. And you -- and you know that how?
A. He went straight for me.
Q. And he'd never once hurt you in the past, so why -- you know, how -- why could you not have dealt with this just as you would any other situation where he's swung? Or, you know, why did it have to get this --

A. Because it was escalated as it was, and I was the only one there for the time being. There wasn't a -- a whole lot of build-up time.

Q. Well, let's say that what you're saying is -- hypothetically let's saying -- let's say what you're saying about him charging at you and you having no other choice but to grab him by the arms and roll to the ground with him is true.

How was holding him there on the ground when he's already on the ground, face down on the ground at the beginning, how is what you guys then did the least restrictive thing you could have done?

At that point he's on the ground. He's not charging at you anymore.

A. Right.

Q. I mean, why on -- I just -- just why? Why not get up, give him a chance to calm down, get 10 feet away from him? Get in a spot that if he does charge you again, you can use your blocking techniques; you can -- you know, he's a little boy. He can't hurt you; you know that.

Why? Why not do that?

A. Because he wasn't a little boy, necessarily. Mentally, yes; but physically he was a big guy. And he was very explosive; he was very -- from what -- my understanding of it and in my direct work with him -- I

wasn't there for, like, two years like I had been with other people. I'd only known him for six months.

But, from my understanding and my experience, he was very explosive and, frankly, kind of unpredictable at times.

Q. But, Tyler, you said many times he's never even made physical contact with you, and you're around him hours every time you work there. You know him well; you have a deep bond with him. He's never even -- he's never even landed a slap on you. I mean --

MR. COLLINS: Is there a question here?

Q. That is the question: How can you say -- how can both things be true?

A. As I said, he's unpredictable. It wouldn't have mattered if it was his best friend at the time. He could have just attacked him just because he was mad about something. It didn't matter if it was me; it didn't matter if it was Eileen; it didn't matter if it was anyone. He could have just gotten wildly aggressive.

Q. And you do not think that -- as you sit here today, you do not think that the safer option after he's on the ground, particularly for 15 seconds, much less six, seven minutes, you don't agree that the safer option would have been to ease up on him, just -- just give him a little bit of space?

A. Like I said, he was still flailing and being aggressive. He would -- he was being violent.
Q. On the ground --
A. He was --
Q. -- how?
A. Like I said, he was flailing; he was whipping around. I was doing the best I could for my -- only person.
Q. Okay. Well, then give him some space.
Why couldn't you give him some space? You don't think that would have been a better thing to do? You don't --
A. No, I don't --
Q. You don't think that if you had done that he would be alive today?
A. No, I don't think so.
Because with how I knew him, he -- like I said several times, he was severely unpredictable. He could have gotten up and just went right after me. He could have got up and went and attacked another client in the -- in there, in the --
MR. COLLINS: Can we put pause on this real quick and clarify which question he's answering? Because you asked two there. You asked did you think there'd be a better thing

to do or do you think he would be alive today.
Which question are you answering?
Q. I'm ask -- do you think there's anything you could have done differently that would cause him to not have died in this horrific way on this day?
A. I don't know. I don't know. I . . .
Q. You wouldn't -- if you could go back in a time machine, there's not a single thing you would do differently?
A. If I could I wouldn't even put hands on him if I could have -- didn't have to. I didn't want to. But he was being violent towards me specifically at that time, so letting up the -- while he's still squirming around -- he's still agitated, clearly; and he was still screaming at me.

I asked him: "Are you calmed down? Are you calmed down?" And he was still screaming at me. He was still very agitated.

If I let him up -- with what knowledge I had of him, he could have easily and more than likely would have attacked me again.
Q. But he would be alive, wouldn't he?
A. I don't know.
Q. I do.
MR. GILLISPIE: That's -- that's -- I just

want to enter his OTLC statement into the -- as an exhibit. Let me find it.

(Discussion off the record.)

(Exhibit 9 marked for identification.)

MR. GILLISPIE: Do you want to see that? It's just his -- I'm not even going to question him about it. I just want to -- other than what I already have.

MR. COLLINS: This doesn't have any Bates numbers on it. Where did you get this document from?

MR. GILLISPIE: It was -- it was what was produced to the family by DHS before I got involved.

MR. COLLINS: Okay.

MR. GILLISPIE: We can -- we can go back and check if it's the same.

MR. COLLINS: I was just --

MR. GILLISPIE: Yeah. She -- they gave her, like -- I don't know, like, 300, 400 pages of documents before she ever . . .

(Exhibit 10 marked for identification.)

MR. GILLISPIE: And then this is Exhibit 10. Eric's seen this many times. This is the Disability Rights Final Report,

Exhibit 10, Bates stamp 4523.

I am going to take this back for a second.

THE COURT REPORTER: No problem.

Q. (Mr. Gillispie) I just to want to show you this real quick, Tyler. This is -- actually, this is Exhibit 2 from Mike Alvis's deposition; but it's a Behavior Treatment Program that Mike -- Mike Alvis generated on August 20, 2018.

[redacted]

Shyloa Myers, AR CRR No. 710
StenoScribe, Inc.
alldaydepo@gmail.com



Q. And, yet even knowing that, you guys still held him there for that long on the ground?

A. That's why we attempted to just at least put him at some sort of an angle. We didn't just lay him completely flat. Maybe the angle was wrong, but we were just -- we were using our best judgment in the moment.



[redacted]

Q. And so I'll ask you again for the last time: You wouldn't -- knowing all that, you wouldn't have let him up -- you would -- if you could do it again, you wouldn't let him up off the ground quicker, sooner?
A. I would try to, yes.
Q. All right.

MR. GILLISPIE: I'll pass the witness.

MR. COLLINS: No questions for you.

THE COURT REPORTER: Did you say you have no questions, sir?

MR. COLLINS: No questions.

THE COURT REPORTER: Okay. We're ready to close this record out.

THE VIDEOGRAPHER: This concludes the deposition. We are going off the record. The time is approximately 3:42 p.m.

(Discussion off the record.)

MR. COLLINS: We would like transcript copies for both Mr. Alvis and Mr. Mattson so they can review and correct anything he feels

was misstated.

THE VIDEOGRAPHER: Would you like the video as well?

MR. COLLINS: Yes, please.

(Deposition concluded at 3:44 p.m.)

Shyloa Myers, AR CRR No. 710
StenoScribe, Inc.
alldaydepo@gmail.com

CHANGES AND SIGNATURE

WITNESS: TYLER ANTHONY MATTSON
DATE TAKEN: March 31, 2022

PAGE/LINE CORRECTION AND REASON FOR CORRECTION

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Witness Signature:_____ Date:_____

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My Commission Expires_____ (Notary Seal)'s

Shyloa Myers, AR CRR No. 710
StenoScribe, Inc.
alldaydepo@gmail.com

CERTIFICATE

STATE OF ARKANSAS)
)ss
COUNTY OF SALINE)

I, Shyloa Myers, CCR, RPR, and Notary Public, do hereby certify that the foregoing testimony of the witness, TYLER ANTHONY MATTSON, was reported verbatim through the use of the stenographic method and thereafter transcribed by me or under my direct supervision to the best of my ability, taken at the time and place set out on the caption hereto.

I FURTHER CERTIFY that in accordance with Rule 30(e) of the Rules of Civil Procedure, review of the transcript WAS requested.

I FURTHER CERTIFY that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise in the outcome of this action, and that I have no contract with the parties, attorneys, or persons with an interest in the action that affects impartiality or that requires me to provide any service not made available to all parties to the action.

WITNESS MY HAND AND SEAL this 18th day of April, 2022.

SHYLOA MYERS
MY COMMISSION # 12359002
EXPIRES: February 3, 2027
Saline County

SHYLOA MYERS CERTIFIED COURT REPORTER LICENSE # 710 ARKANSAS SUPREME COURT

Shyloa Myers, RPR, Notary Public
Arkansas CCR Lic. No. 710

Shyloa Myers, AR CRR No. 710
StenoScribe, Inc.
alldaydepo@gmail.com

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AVOIDING / DEFUSING VIOLENT BEHAVIORS

Employees are reminded that we must continue to strive to calm upset individuals without injury or damage. The following steps may help defuse or avoid violent behaviors:

1. Know the individual.
2. Breathe slowly and deeply to relax
3. Try to appear calm and relaxed before intervening- even if you are not.
4. Speak slowly and softly, keeping voice low at all times.
5. **Listen.**
6. Keep hands at sides with palms open in a reassuring stance. Do not trap or corner the angry person. Do not double your fist, point your finger, cross your arms, put your hands on your hips, in your pockets, or behind your back.
7. Judge the distance you keep by your knowledge of the individual and your rapport with him/her; allow both of you space and room to escape.
8. Stand if he/she stands; sit if he/she sits. Squat or sit down if the individual is in a wheelchair.
9. Do not ask "Why." Do not argue, threaten, raise your voice, or become judgmental.
10. **Listen.**
11. Let the individual know you are there to help in any way you can, but do not make promises you cannot keep.
12. Keep your face passive and neutral – do not frown, scowl, or laugh.
13. Reassure the individual that you are there to help and you will wait with him/her until he/she works through whatever is bothering them. Let them express his/her fears, frustrations, and accusations without censor.
14. Stay relaxed, keep a monitor on your voice tone, body stance, muscle tension, and breathing so that you present yourself as a source of stability and model of how to remain calm.
15. **Listen.**

NONVIOLENT CRISIS INTERVENTION TRAINING PROGRAM OBJECTIVES (NCI)

Identify behavior levels that contribute to the development of a crisis and choose appropriate staff intervention for each level. This program is used to provide guidance to the acting out individual and the employees that are dealing with de-escalating the behavior.

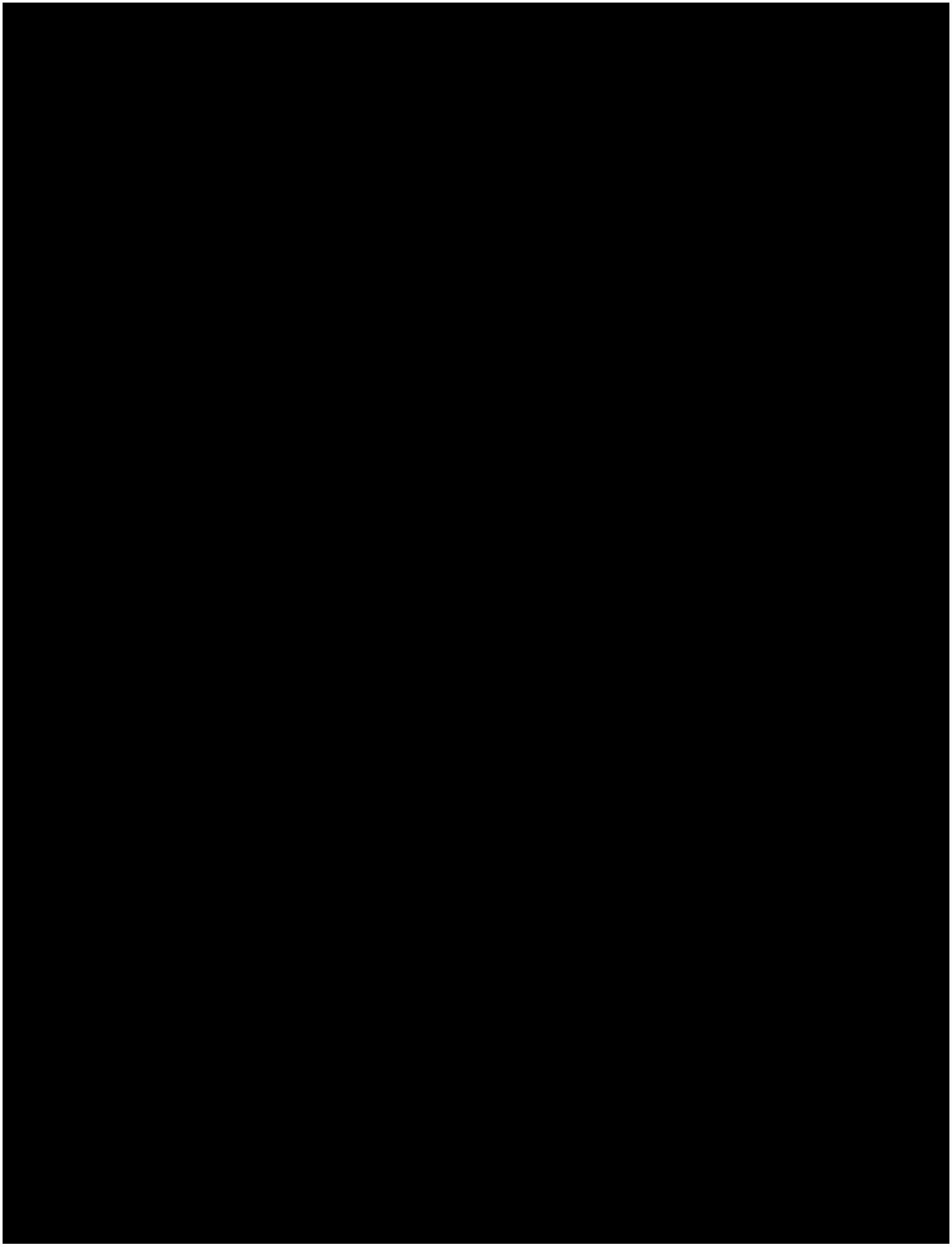
When writing a Behavior Report, be careful not to include any of your personal feelings (opinions) about the incident or behavior. Instead, always rely on the Five 'Ws'- *Who, What, Where, When, and Why.*

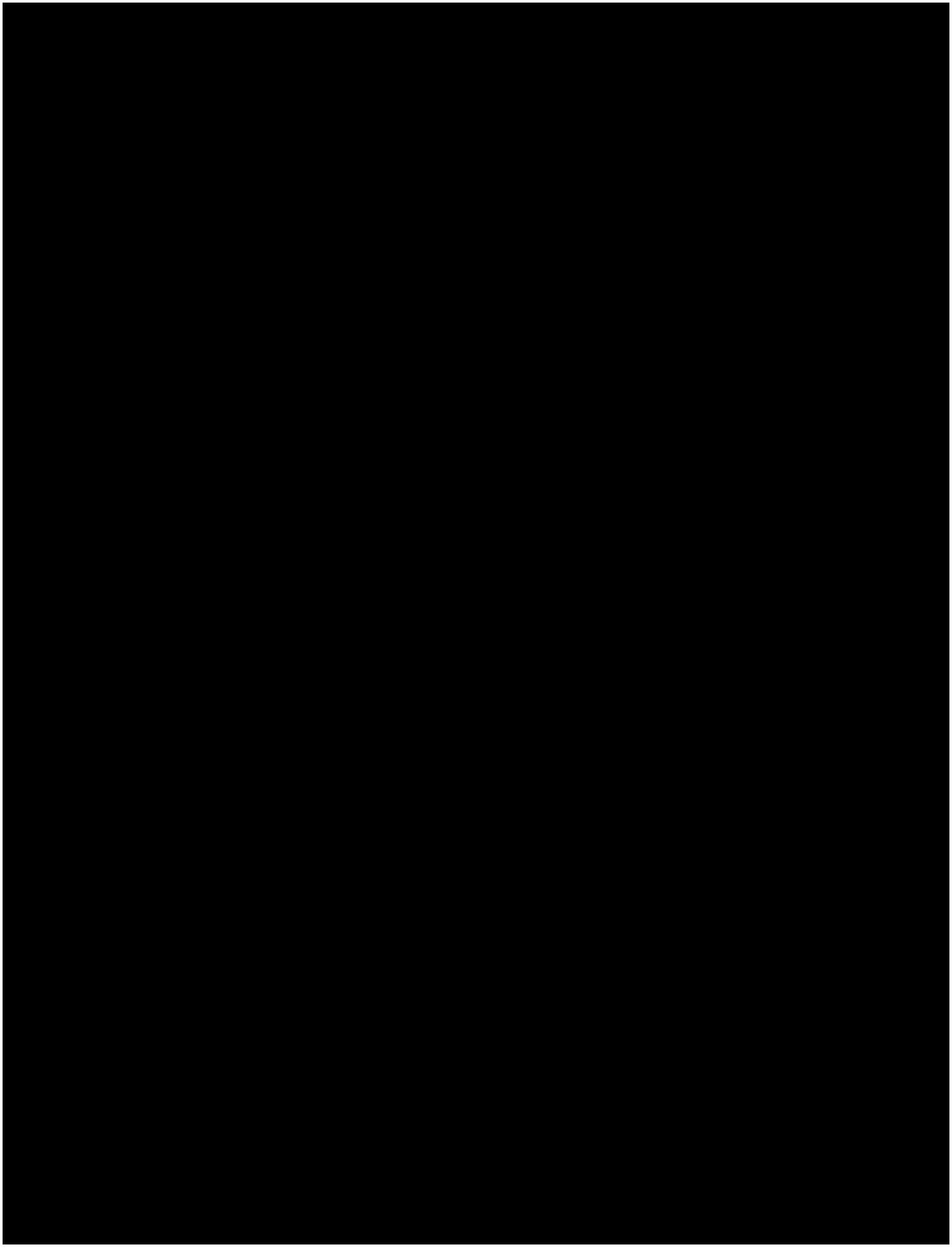
PREVENTION / REPORTING OF MALTREATMENT

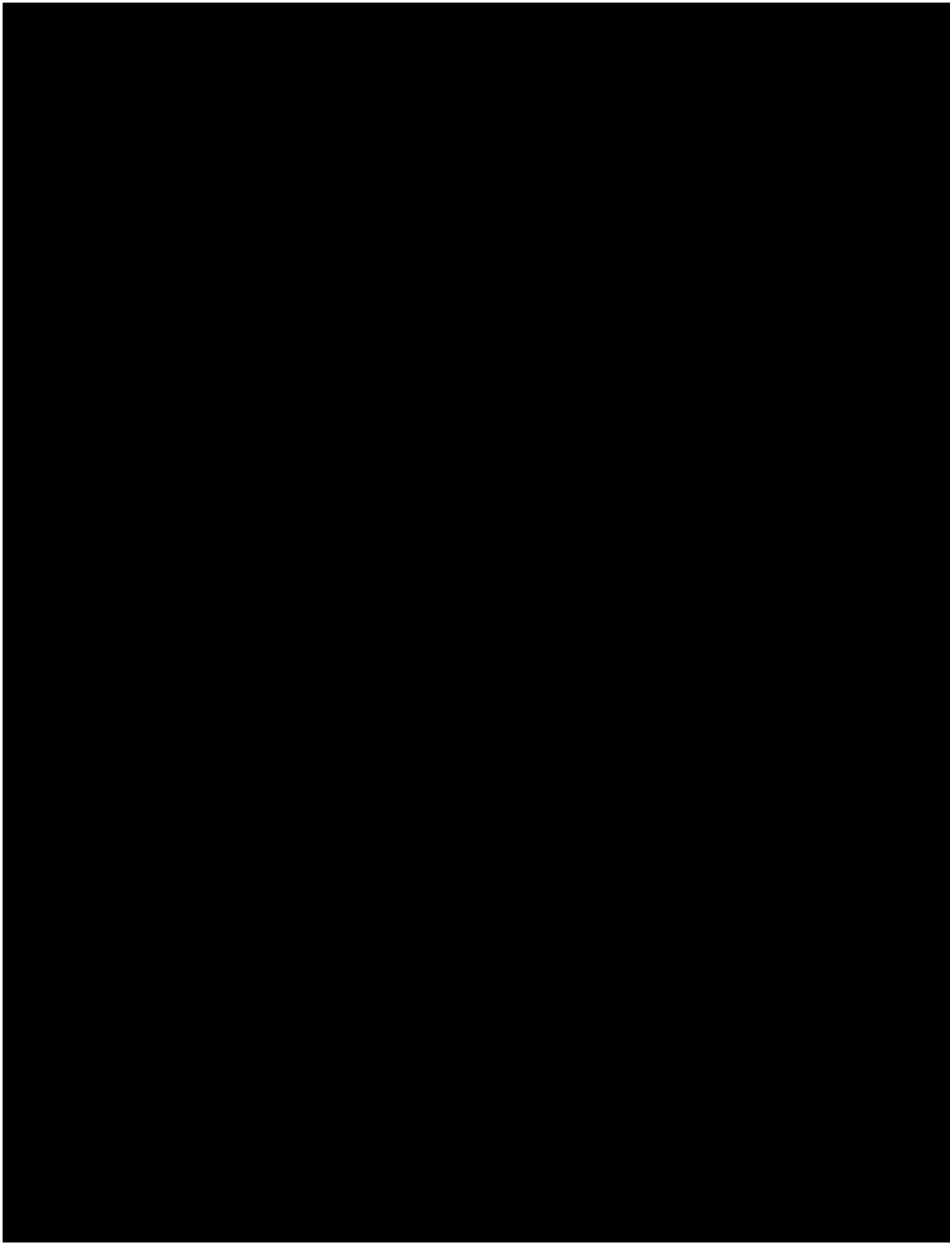
BHDC strictly prohibits the maltreatment of clients residing at this facility. Maltreatment is defined as:

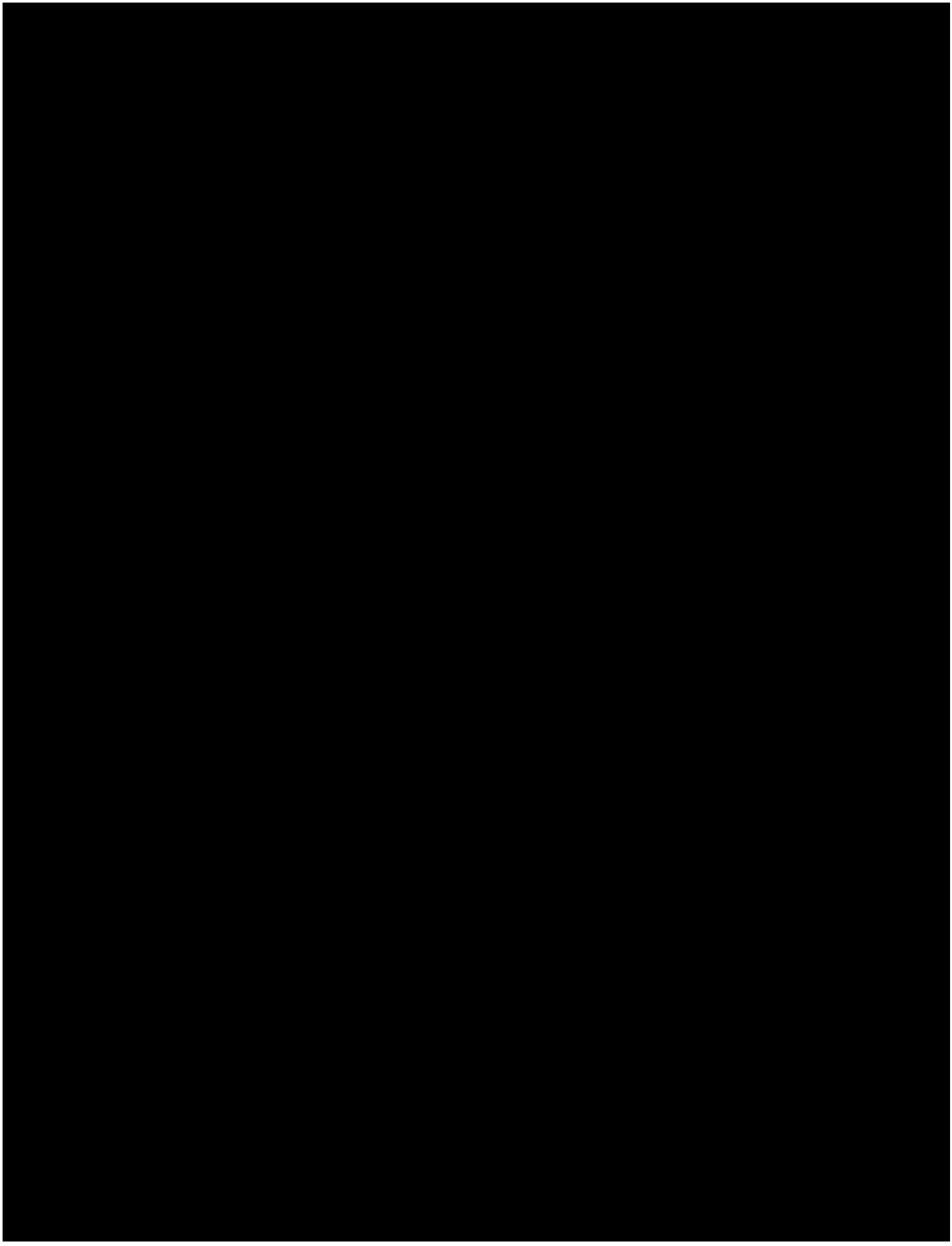
- Physical abuse or assault.
- Psychological abuse.
- Verbal abuse.
- Negligence.
- Failure to provide necessary care.
- Exploitation or sexual abuse.
- Misappropriation of personal property or moving furniture or belongings without permission.











ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

1. **Purpose**. This policy is intended to provide guidelines for managing challenging behaviors of individuals residing in DDS operated programs (Human Development Centers).

2. **Scope**. This policy applies to all DDS operated programs (Human Development Centers) and their employees/volunteers. All such programs will include a review of this policy as part of the employee orientation process.

3. **Definition of Terms**

Behavior management, as covered by this policy, serves as a guide to ensure that an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others are managed with the least restrictive method. Behavior management is not a substitute for other forms of active treatment and is incorporated into program plans, based on individual needs.

Qualified Mental Retardation Professional (QMRP) or QMRP designee is used in this policy as a person designated to monitor, supervise, and make decisions regarding specific behavioral situations. QMRP/designee will be assigned by the administrator of the DDS program in which he/she works. Criteria for selection will involve prior training, experience, and demonstrated ability in the area of behavioral management. The QMRP/designee must be in a position that is on a level involving supervisory or decision-making responsibilities. The QMRP designee is authorized to perform any of the duties of the QMRP as outlined by regulations or policy.

Interdisciplinary Team (IDT) is defined as a group of persons (professionals, paraprofessionals and non-professionals) who develop an individual's program plan and whose participation is required in order to identify the needs of the individual and to devise ways to meet those needs. The IDT includes the individual and may also include those persons who have worked or will work most closely with the individual, those persons who provide needed assessments or services, and the individual's family, guardian, or advocate. In general, the IDT includes persons professionally qualified in such fields as health care, education, psychology, and social work.

Licensed nurse is defined as a registered nurse or licensed practical nurse. The agency may use a physician, in lieu of a licensed nurse, but this is not required.

Replacement: This policy replaces DDS Commissioner's Policy 3011-D, dated January 28, 1981, March 13, 1981, and DDS Director's Policy dated October 1, 1991; December 1, 1993; and January 30, 1998.

Reviewed: Arkansas Legislative Council Rules and Regulations Subcommittee _____, 2003



ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

4. Policy

NOTE: It is the philosophy of the agency to utilize all positive approaches to behavior management prior to and in conjunction with more restrictive programmatic techniques. Positive approaches may include, but are not limited to: positive reinforcement, gentle teaching, redirection, graduated guidance, and modeling of appropriate behaviors. Measures to address positive behavior should be incorporated into formal program efforts to the extent feasible.

Efforts at positive programming prove to be successful with the majority of maladaptive behaviors. All Human Development Centers will maintain policies and procedures for positive programming. The use of behavioral programming other than positive is designed for the individuals who repetitively engage in dangerously aggressive behavior and for whom other interventions have not been effective. All behavior programs developed in accordance with this policy will be designed to reduce or eliminate the target behavior(s) within a specified time frame, will be supported by documentation that positive, less restrictive methods have been systematically attempted and failed, will be monitored regularly by the individual's QMRP and Interdisciplinary Team (IDT), and will be revised if proved to be ineffective. The potential harmful effects of each procedure will be weighed carefully against the harmful effects of the targeted behavior and the IDT will determine if the harmful effects of the behavior outweigh the potentially harmful effects of the procedure.

Category I:

Category I procedures are those which may be used without prior approval of the Human Rights Committee or psychology staff. To ensure consistency, they should be addressed by the IDT. Frequent use (as determined by IDT) of these procedures with an individual indicates the need for consideration of the development of a behavior plan by the individual's IDT.

The individual must be supervised during these procedures. With the exception of verbal intervention, any use of Category I procedures, whether part of a formal behavior program or not, requires documentation on a Behavior Incident Report, Data Sheet, or other locally used behavior documentation system.

A. Verbal Intervention: Verbal intervention is utilized to stop an inappropriate behavior in progress and involves telling the individual "no" or "stop", identifying the behavior, and redirecting to an appropriate activity. The command is given in a firm but normal tone of voice. Threats, screaming, yelling or issuing repetitive or multiple sets of commands are not considered verbal correction and are inappropriate.

B. Separation From Activity Up to 30 Minutes: The individual is prevented from engaging in a reinforcing activity in which he/she has displayed inappropriate behavior. Separation is maintained within the same room or outdoor area where the activity is conducted. This is considered a Category I procedure if compliance by the individual can be

accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

C. Separation From Setting Up to 30 Minutes: The individual is removed from the area where the reinforcing activity is taking place. Separation must occur under observation either outdoors or in a living or training area (bathrooms, storage rooms and closets do not constitute living/training area). This is considered a Category I procedure if compliance by the individual can be accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

Note: Separation to Allow Calming (STAC) – Also available is the positive procedure of STAC whereby the person is encouraged to move to an area away from the person or situation that upset them. At the same time, they are assisted in directing their attention to talking about the problem, listening to music, talking about family, relaxing quietly, going for a walk, etc. The activity should be chosen by the person in need of calming. When sufficiently calm, staff will assist the person in resuming normal activities.

D. Assignment of Additional Chores: The individual is assigned additional chores as a consequence for inappropriate behavior. Additional chores may be assigned only if such chores are already a part of the Individual Program Plan (IPP) and are not designed to replace work assignments of housekeeping personnel.

E. Restitution: The individual is cued to restore any property damaged, stolen or defaced. If appropriate to the individual's level of functioning, he/she may be cued to offer a verbal apology to the offended person. If appropriate to the individual's ability to comprehend, monetary reimbursement for the value of the damaged or stolen property may be required if this is a part of the IPP. In lieu of full value, a symbolic portion of the value may be required. Monetary reimbursement requires Human Rights Committee approval and Guardian consent.

Note: The individual is not degraded nor put on display while restoring damage. The individual is given the same equipment and protection to complete the restitution as would normally be given to a person not responsible for the damage.

F. Withholding Privileges: The individual loses a particular privilege following the occurrence of an inappropriate behavior. Privileges include such things as special planned community activities. However, trips off grounds are special and should only be curtailed if problem behavior is anticipated during that trip. Examples of situations where problem behaviors may be anticipated include a problem behavior having already occurred and the person is not fully calm, or, a problem behavior has not yet occurred, but there are indications that a problem behavior is likely. The curtailing of trips off grounds should be done after consultation with psychology staff, or with supervisory staff if psychology staff is not available. Privileges do not include basic living activities, such as meals, habilitation activities, or basic rights afforded all individuals.

G. Personal Property Removal (less than one hour): Removal of an individual's personal item that is being used in an inappropriate or unsafe manner or location. For example, if an individual disturbs others in a common TV room by playing his radio too loudly and will not reduce the volume when instructed, the radio may be removed from that individual for a time not to exceed one hour. The item will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate (See Section 6, *Page 8 of 9*).

Category II:

Category II procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian.

A. Response Cost: The individual loses reinforcers previously earned in a behavior management system, (i.e., Token Economy Program)

B. Overcorrection - includes the following procedures:
   1) Restitutional Overcorrection: Requires the individual to restore the environment to a state that is better than it was before the occurrence of the inappropriate behavior.

   2) Positive Practice Overcorrection: Requires the individual to engage in an intensive practice period in which the alternative appropriate behavior is practiced.

C. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or individual directly, as appropriate. This procedure is considered Category II if the individual voluntarily (without duress or coercion) surrenders the property upon request.

Category III:

Category III procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, other professionals, as indicated by the nature of the program, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian. The individual's record documents the IDT's conclusion that the potential harmful effects of each restrictive procedure (restraint, etc.) are clearly outweighed by the harmful effects of the targeted behavior.

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Service	Behavior Management	3011-D

A. Separation Time Out (Activity or Setting): Placement of an individual in a quiet area away from reinforcing activities or persons as a result of an inappropriate behavior occurring. The individual will be visually monitored during the time out. Further conditions include ***either:***

1) Separation lasting for over 30 minutes to one (1) hour maximum.

2) Separation (any length of time) requiring physical intervention/personal restraint to ensure compliance.

B. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate. This procedure is considered Category III if the individual does not voluntarily surrender the property upon request, and it must be physically removed.

C. Sensory Deprivation: Involves the temporary impeding of one of the individual's senses for a period of time, contingent upon the occurrence of the target behavior. Most often, this procedure includes only the use of a blindfold or cloth placed over the individual's eyes when it has been shown to facilitate calming. The individual must be visually supervised during the use of this procedure, which may be used in combination with other Category III procedures, as designated in the individual program. It could also include lessening auditory input by covering the individual's ears, or covering a body part (usually the hands) to limit tactile stimulation, hand in mouth, or biting.

D. Restraint: When utilizing restraint as a programmatic option, a hierarchy of lesser restrictive procedures will be attempted prior to restraint, except in limited cases where this is clearly clinically contraindicated. IDT consideration will be given to parent/guardian notification of the use of restraint and address it in the behavior program.

1) Personal Restraint: **In order to prevent personal injury or serious property damage**, the individual or a portion of an individual's body is immobilized by another person or persons in order to prevent personal injury or serious property damage. Approved methods of intervention must be in the individual's behavior program. This is planned personal restraint, contingent upon occurrence of a target behavior. When available, a licensed nurse should monitor the personal restraint and/or check the individual's physical condition as soon as possible following restraint.

Excluded as <u>personal restraint</u> are: physical assistance, prompting of graduated physical guidance to assist individuals during such procedures as toothbrushing and feeding, or to control random head or arm movements during such procedures

as haircutting, or the use of physical assistance in escorting, redirecting, or in manual guidance techniques are not considered personal restraint and do not require documentation as personal restraint. Also excluded as programmed personal restraint is the use of personal restraint in an emergency situation (Section 6, ***Page** 8 of 9*) or during a necessary medical or dental procedure.

In the event of personal restraint, the QMRP/designee of the area must be notified as soon as possible. Programmed personal restraint will occur until the individual is calm and will not exceed fifteen (15) minutes. The IDT will define what constitutes calm behavior for this individual when used in a behavior program.

2) Mechanical Restraint: **In order to prevent personal injury or serious property damage,** the individual or a portion of the individual's body is immobilized until calm by an approved device or devices which may also prevent normal functioning, as described in section C, above. Restraints must be checked for safety and integrity prior to use. The device's use will not exceed 15 minutes without an extension of time approved and documented by the QMRP/designee, preferably, after face-to-face attention. Unless otherwise determined by the IDT, QMRP/designee extensions will be obtained every 15 minutes until the individual is calm. The IDT should define what constitutes calm behavior for this individual when used in a behavior program. Unless determined clinically contraindicated by the QMRP/designee, should the time in restraint reach 55 minutes, the individual must be released for five minutes for motion, liquid intake, or toileting.

Should time in restraint reach 1 hour and 50 minutes, the individual must be released for at least 10 minutes–for motion, liquid intake, or toileting. If this 10-minute release is judged to be a danger to the individual and/others, additional staff should be called to ensure safety for all concerned. In addition, the individual will be checked, face to face, at least every 15 minutes for safety, well being, and integrity of the restraint. Constant observation is required.

Note: On-site monitoring by the QMRP/designee is recommended. When available, a licensed nurse should monitor the mechanical restraint. If unavailable to monitor, a licensed nurse shall check the individual's physical condition as soon as possible following restraint, but in no case later than thirty minutes after the initiation of the restraint.

Excluded as programmed mechanical restraint is the use of restraints in an emergency situation (Section 6, *Page 8 of 9*), during a necessary medical or dental procedure, or to promote healing following a medical procedure or injury. Devices such as a helmet which are not prescribed for the purpose of restricting an individual's movement and/or normal functioning, but rather for their safety and protection are not considered a mechanical restraint.

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

Note: For medical management, please refer to local site Policy on drugs to manage behavior (Behavior Management/Psychiatric Interventions).

5. **Conditions for Use of Behavior Programs.**

A. A formal behavior program will be developed by the IDT, written by a licensed psychological professional, and approved by a psychologist. It will include the following elements:

1) Description of the behavior to be modified;
2) Functional Analysis;
3) Thorough description of each step of the program to include duration and intensity of specific procedures, the methods of monitoring and analyzing the process, and special precautions that will be taken;
4) Description of any alternatives to the specific procedures;

B. The Individual Program Plan or behavior program will include:
1) Description of all procedures already attempted;
2) Side effects and risks, if any, of the intervention, in comparison with those of allowing the maladaptive behavior to continue; and
3) Behavioral objectives.

C. Behavior Management Procedures should be used in order of least restrictive, unless clinically contraindicated. Exceptions to this order must be fully documented and substantiated as to why more restrictive procedures are advisable before less restrictive ones.

D. All persons administering Category II and III procedures must have been trained in the administration of those specific procedures and have personally experienced those particular procedures, unless medically contraindicated for that person.

E. The Human Rights Committee will review all Category II and III programs at least every 6 months.

F. IDT consideration will be given to seeking consultation from outside expertise when IDT staff resources have been exhausted, as evidenced by the use of Category III procedures for over one (1) year without significant progress. If an outside consultant has been used without success, the agency should continue to access this or other outside expertise until an effective strategy is realized.

An outside consultant is defined as a professional of any discipline and who is not a member of the IDT. For instance, the outside consultant may be a member of the HDC

staff not on the identified IDT, the agency staff, or a professional not affiliated with the agency.

6. **Emergency Procedures**. Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. This includes the use of restraint procedures in the course of an established program, when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy. However, it is emphasized that emergency procedures may not be used at frequent intervals, becoming a routine method of intervention. If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. The emergency use of restraint must conform to ICF/MR regulations and must be reported immediately to the facility administrator or designee.

7. **Prohibitions**: These activities are expressly prohibited.

   A. Corporal punishment - refers to the application of painful stimuli to the body as a penalty for certain behavior, and includes, but is not limited to, hitting, pinching, the use of electrical shock or other infliction of pain, whether or not applied as part of a systematic behavior intervention program.

   B. Individuals who receive services from the agency disciplining other individuals unless involved in an organized and approved self-governing program. Individuals will not participate in the actual administration of discipline.

   C. Seclusion of an individual alone in a room or other area from which entry/exit is prevented. This does not include placement in a time-out area for brief, programmed time segments, as part of a behavior program that meets all applicable standards.

   D. ***Unless specifically requested by family/guardian,*** any procedure that denies visitation or communication with family members.

   E. Any procedure that denies sleep, shelter, bedding, food, drink, or use of bathroom facilities.

   F. Inappropriate vocalizations, maltreatment, neglect, or forced exercise.

8. **Informed Consent**. The individual served and/or guardian, as appropriate, will be provided a copy of the behavior program which utilizes Category II and III procedures. Informed consent will be obtained PRIOR to the implementation of the program, with the following procedures:

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

A. Persons 18 years of age or older who have no legally appointed guardian may give informed consent for their behavior program. If there is a question about the individual's ability to give informed consent and no guardian can be located, appropriate legal action must be pursued to have someone appointed who can give consent.

B. Consent by the legal guardian(s) is required if guardianship has been established.

C. The legally adequate consent will:
1) Specify, in terms that are easily understood, the restrictive or intrusive procedure(s) involved;
2) Inform the person(s) giving consent of any potentially harmful effects of the procedure(s);
3) Be time-limited, not to exceed one year; and
4) State that consent may be withdrawn at any time.

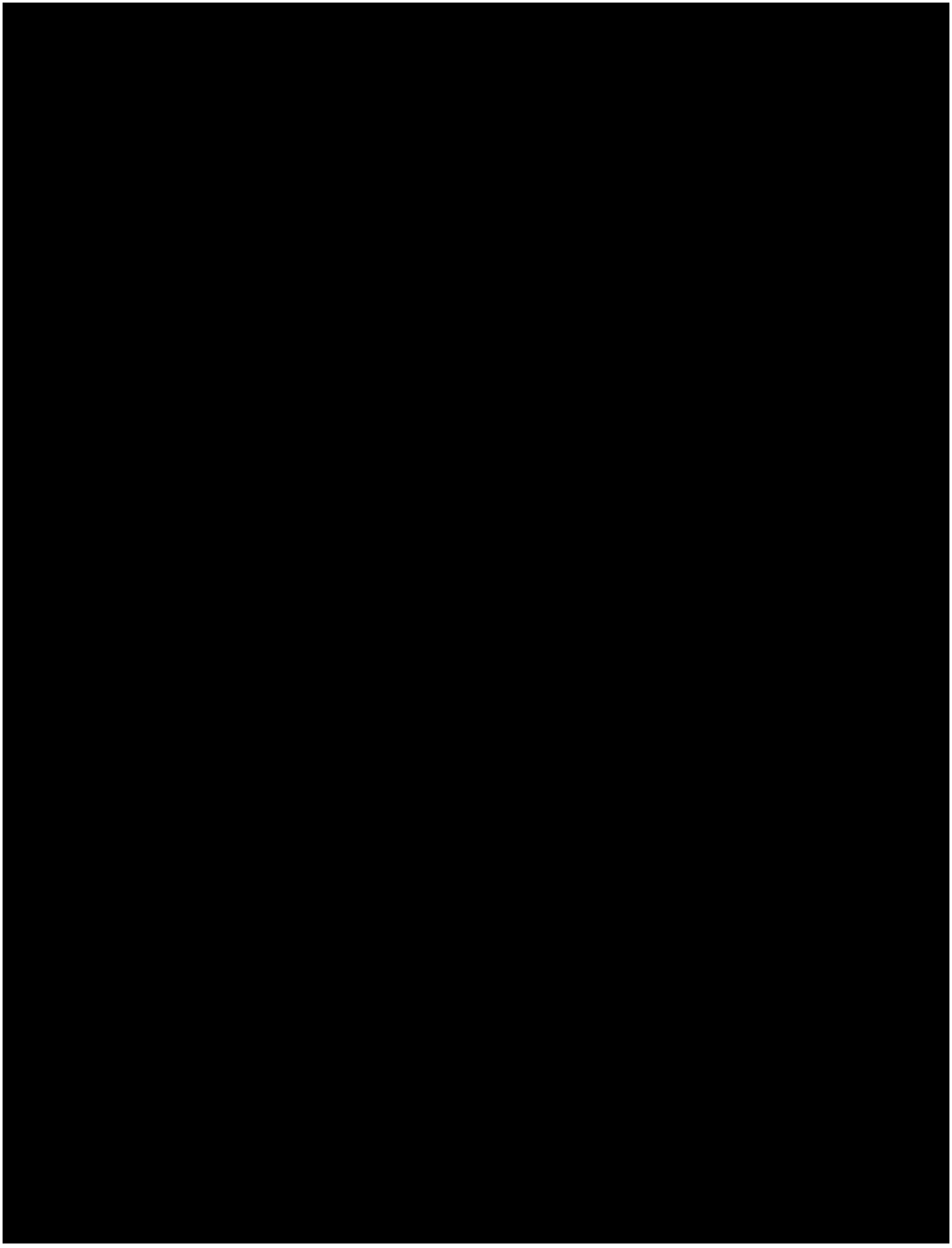
9. **Uncategorized Procedures**. In the event a proposed procedure does not readily fit in one of the prescribed categories, it may be utilized on an emergency basis, if necessary, at the discretion of the administrator or designee until the appropriate category is determined.

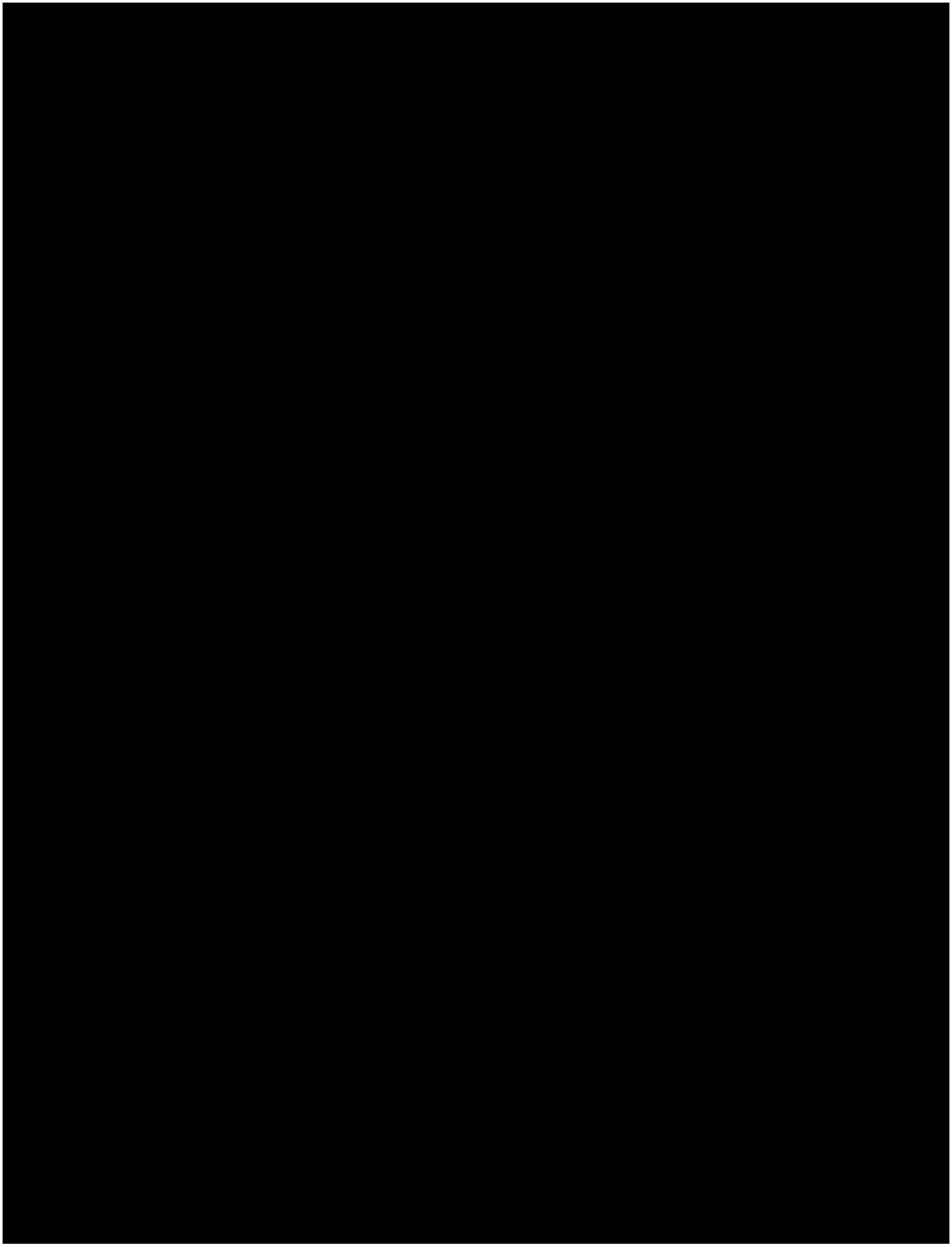
NOTE: Behavior Management Policy 3011-D does not preclude the use of other restrictive/intrusive procedures that would prevent serious bodily harm and/or destruction of property or death. These procedures can only be considered when lesser restrictive procedures have been proven ineffective or their implementation are determined to be clinically contraindicated. Approvals required are the same as those for Category III procedures. Additional approvals may be required as deemed necessary by the facility administrator.

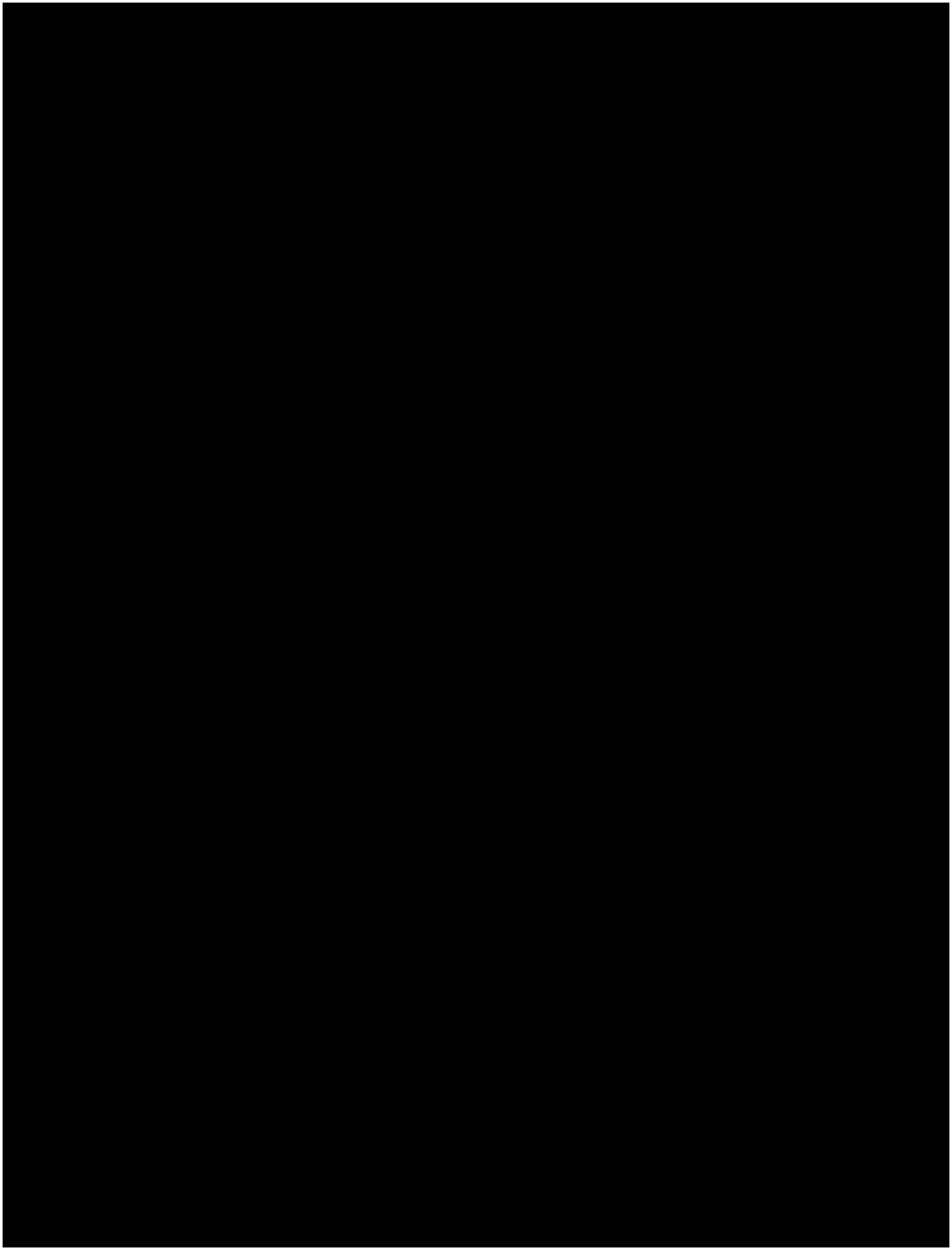
CLIENT RIGHTS

1. The right to due process
2. The right to be fully informed of their rights, responsibilities, and any rules they are expected to follow.
3. The right to be fully informed of services available in the facility and of related charges for those services.
4. The right to be fully informed by a physician of their health and medical condition unless the physician documents in their medical record that such information is contraindicated.
5. The right to receive rehabilitative and restorative therapies when needed.
6. The right to refuse treatment.
7. The right to refuse to participate in experimental research.
8. The right to receive medical care, nursing care, and dental care in a safe and clean environment.
9. The right to participate in planning their total care and treatment to the level of their capabilities.
10. The Right to exercise all constitutional and legal rights, including the right to vote and to marry.
11. The right to voice grievances and recommend changes in policies and services.
12. The right to express individual preferences.
13. The right to confidentiality
14. The right to privacy during treatment and care of personal needs.
15. The right to associate, communicate, and meet privately with persons of their choice in an appropriate place and manner
16. The right to be free from mental and physical abuse, and threats of punishment or deprivation.
17. The right to be free from chemical and physical restraints, except when properly authorized for a specific behavior and limited period of time or to protect them from injury to themselves or others.
18. The right to the protection of a qualified guardian if needed for their personal well-being and interest.
19. The right to considerate and respectful treatment.
20. The rights to obtain, retain, and have access to their personal clothing, possessions, and toilet items as space permits.
21. The right to have access to their personal money and to direct the management of their financial resources.
22. The right to productive work or other meaningful activities.
23. The right to a pattern of daily living which follows a normal rhythm of life and which reflects personal choice.
24. The right to participate in activities of social, religious, and community groups of their choice.
25. The right to refuse to participate in activities.
26. The right to be free from retaliation for making a complaint, turning in abuse or maltreatment for investigation, or for filing an appeal.









DOCUMENTATION OF AND RESPONSE TO MALADAPTIVE BEHAVIORS

POLICY STATEMENT: Maladaptive behaviors must be documented on a **Behavior Report (BR)**, a **Behavior Report Documenting Emergency Restraint** (also called the Restraint Log), or other authorized data keeping device. Personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure. Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, or the destruction of property. Nothing in this policy removes or alters requirements as stated in other policies of verbal notification of incidents to the Superintendent and/or other staff.

PROCEDURES:

1. REQUIRED DOCUMENTATION

   a. When indicated, a **BR** must be completed following the maladaptive behavior. Incidents that are to be documented on the **BR** are the following:

      i. Behaviors that pose a threat to the physical or mental well being of the client or others.
      ii. Behaviors that have a direct negative impact on the client's programming.
      iii. Behaviors that directly contribute to the client remaining in a setting requiring a greater degree of supervision rather than a less restrictive one.
      iv. Target Behaviors identified by the Psychology Department and the Interdisciplinary Team.
      v. An incident requiring personal restraint (also requires notification of a QIDP). See Attachment #1.

   b. If the incident requires emergency mechanical restraint, a **Behavior Report Documenting Emergency Restraint** must be completed. Such behaviors are defined as those emergency situations in which behaviors may result in, or have the potential to result in, injury to self or others, or the destruction of property and cannot be controlled through the use of less restrictive measures.

   c. The rules of confidentiality will be followed when documenting these incidents. Any reference to a client other than the identified client in an incident report must be by initial only. Reference to other staff members involved will include their full name and title. All corrections must be made by a single line through the incorrect entry and the writer's initials. The **Behavior Report Documenting Emergency Restraint** must include the signature of the QIDP or other staff member authorizing the restraint.

2. EMERGENCY USE OF RESTRAINT

   a. Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors. The use of emergency restraint will comply with all relevant standards and regulations. Restraint



will not be used as punishment or for the convenience of staff in lieu of adequate programming.

b. Seclusion will not be used as either an emergency or programmatic procedure.

c. A QIDP must be notified when personal restraint is used and it must be documented on a **Behavior Report.**

d. Personal restraint of a client is used when the behavior is such that verbal control has been lost and other less restrictive measures have failed to control the behavior.

e. Personal restraint will be implemented by staff who have been trained in the use of approved methods. **Personal restraint must not exceed 10 minutes.** During the period of personal restraint if the client becomes calm no further restraint procedures are to be implemented. If the client shows no indication of calming and becomes violent, staff will proceed as indicated in Paragraph f. below.

f. The request for the emergency use of mechanical restraint will be based on need as exhibited by the client who is so aggressive that restraint is necessary to prevent imminent physical harm to themselves, others, or property. Mechanical restraint may be used only when all other means of controlling the behavior have been exhausted. Staff will proceed in the following manner:

   i. A Restraint Incident Leader will be identified. The attending staff will immediately implement emergency mechanical restraint. As soon as possible staff will notify the on duty Program Supervisor who will contact a QIDP or other authorized staff for authorization for the use of emergency mechanical restraint.
   ii. The authorization for the mechanical restraints must not exceed 15 minutes. Continued use of mechanical restraint must be re-authorized every 15 minutes.
   iii. Immediately after emergency mechanical restraint has been applied, staff must contact the nurse on duty. The nurse will examine the client to ensure the restraint is applied in a pain free and harmless manner and present no physical danger to the client. The nurse will make a notation of the examination on the **Behavior Report Documenting Emergency Restraint.**
   iv. A client in emergency mechanical restraint must be:

      1. Kept under constant visual observation. This observation will be for the client's physical condition (e.g., distressed breathing, bleeding, adequate blood flow to the head and extremities) as well as for signs of calming.
      2. Checked for security of restraint, current behavior and general status. A synopsis will be documented every 15 minutes.
      3. Released for 5 minutes every hour for motion and exercise.
      4. Given the opportunity for fluid intake, meals, baths and toileting. These needs will be addressed and documented as the need arises.

5. Released from emergency mechanical restraint as soon as possible. This is defined to mean as soon as the client is calm and no longer a danger to self or others. Verbal outbursts do not necessarily mean a person is still out of control or that restraint should continue.

v. After release from emergency mechanical restraint, using the **Restraint Incident Debriefing Form**, the Restraint Incident Leader will conduct and document a debriefing discussion with the other staff members involved in the restraint and the client that must include the following:

1. The behavior which resulted in the use of the personal or emergency mechanical restraint.
2. Any environmental factors involved in the incident.
3. The antecedents to the behavior including interactions with peers or staff
4. Any action by staff that might have kept the incident from escalating to restraint.
5. The client's reaction to the use of restraint.
6. Any changes to the client's programming which might have prevented the incident.
7. Options that the client could have used to avoid the use of restraint.

3. COMPLETION OF DOCUMENTATION

a. The person authorizing the use of emergency mechanical restraint must sign the authorization. During deviant hours authorization may be obtained by telephone. Attending staff will note on the **Behavior Report Documenting Emergency Restraint** that such authorization was obtained by telephone.

b. The on duty Program Supervisor will be responsible for ensuring that the appropriate reports are completed in a timely and accurate manner.

c. Completed **Behavior Report Documenting Emergency Restraint** and **Restraint Incident Debriefing Form** will be filed in the client's Master File "Behavior Incident File".

4. REVIEW AND DISTRIBUTION OF THE COMPLETED DOCUMENTS

a. Upon completion of the report it will be sent to the appropriate Team Office.

b. The Team Leader will review all reports for content, accuracy and appropriateness and sign in the appropriate place. If corrections are required the Team Leader will contact the writer of the report and ensure corrections are made. As soon as possible the report will be given to Quality Assurance to be scanned, copied, and distributed to appropriate staff. The original report will be sent to the Record Center Operator and filed in each client's file within five days.

c. The Record Center Operator will review **Behavior Report, Behavior Report Documenting Emergency Restraint,** and **Restraint Incident Debriefing Form** for completeness and errors. The originator will be notified to correct errors found by the Record Center Operator.

d. The QIDP and Psychology staff member will review copies of all reports for programmatic issues, patterns of use, and the appropriate follow-up.

e. The authorized data keeping device (i.e., **Behavior Report, Behavior Report Documenting Emergency Restraint,** and **Restraint Incident Debriefing Form**) will be forwarded to the Psychology Department depending on the program requirement.

5. FUNCTIONAL AND ENVIRONMENTAL ANALYSES OF BEHAVIORS

a. The purposes of conducting functional and environmental analyses are to determine:

1. The pragmatic utility of a behavior for a client, i.e., what the behavior "does" for the client.
2. What role the environment may have played in the causation of the behavior.

These analyses assume aberrant behavior does serve a functional purpose, but that a functionally equivalent (appropriate) communicative response can be taught, and will serve to substitute for the aberrant behavior. Further, the aberrant behavior will reduce in frequency as the more appropriate response becomes systematically reinforced.

b. These analyses will provide the data needed to formulate programmatic responses to teach and reinforce appropriate behaviors to replace aberrant behaviors and inappropriate behaviors.

6. APPROVED RESTRAINT PROCEDURES, TECHNIQUES, AND DEVICES

a. **Personal Restraint,** an emergency procedure limiting movement by the holding of a hand or limb.

b. **Chemical Intervention** ordered by the Physician.

c. **Protective Helmet**.

d. **Papoose Board,** a Mechanical Restraint device limiting movement and range of motion.

f. **Wrist Restraint**, a Mechanical Restraint device limiting movement and range of motion.

7. AT BHDC ONLY ICF/IID QUALIFIED QIDP's SHALL BE APPROVED TO AUTHORIZE THE USE OF RESTRAINT

The Program Coordinator/QIDP is the first choice person to authorize restraint for clients on their caseload. After hours and on weekends the Team Leaders or other qualified QIDPs may be notified.

The following positions are recognized as being qualified QIDPs:

Program Coordinators/QIDPS, Team Leaders, Director of Residential Services, Superintendent, Assistant Superintendent, Director of Quality Assurance; Chief Psychologist, Psychological Examiners, Registered Nurses, and Staff Physician.

Current work telephone numbers for these persons can be obtained from DHS/BHDC Share.

THE STAFF PHYSICIAN MUST REVIEW, BY SIGNATURE, THE USE OF ALL EMERGENCY MECHANICAL RESTRAINT.

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-D-4, dated 01/07/16, in its entirety.

Ex. 1
Pg. 1 of 3

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities

LTC Witness Statement Form

Date: 6-13-20 Time: 1451 ☐ AM ☒ PM

Witness Full Name: Tyler Mattson

Job Title: RCA Shift: 8-4

Home Address: [redacted] City/Zip [redacted]

Home Phone #: [redacted] Work Phone #:

Relation To Resident (If Any?)

State in your own words what you witnessed (be very descriptive) and sign below.

I was at lunch with Derek, he had finished eating his sandwich and cucumber and put his tray up. he sat down and seemed fine, shortly after he asked if he could go to the restroom I followed him inside the bathroom because he seemed irritated before hand, while in there I heard no abnormal sounds such as vomiting due to his history of intentionally vomiting when he is upset we walked out and he asked if he could sit in the lobby to calm down. I said that's fine, shortly after he began screaming and cussing and ripped paper off of the wall to throw he then jumped

(Continue on Back as Necessary)

The information provided above is true to the best of my knowledge.

Signature of Witness: Tyler Mattson Date: 6-13-20

EXHIBIT
tabbies
9
Mattson

DMS-762
Page 9 of 9

Ex. 1
Pg. 2 of 3

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities

OLTC Witness Statement Form
(Continued from front)

Up after me, spitting and attempting to hit me, I applied personals by grabbing his arms, he ended up falling over, I did not land on him, he continued fighting and I rolled him on his left side so as to not put any pressure on his stomach because he had just ate. At that he was still fighting and needs joined to assist me, grabbing his hands, all while I was squatted over him, not putting my weight on him during any of this, holding his shoulder and sides, he was still continuously fighting, and Ryan Campos showed up and held his legs down still fighting. We had him in restraint for appox 1min and noticed he had

[redacted]

The information provided above is true to the best of my knowledge.

Signature of Witness: _____ Date: _____

DMS-762

Ex. 1
Pg. 3 of 3

Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities

OLTC Witness Statement Form

Date: 6-13-20 Time: 1454 ☐ AM ☑ PM

Witness Full Name: Tyler Matthes

Job Title: RCA Shift: 8-4

Home Address: [redacted] City/Zip [redacted]

Home Phone #: [redacted] Work Phone #:

Relation To Resident (If Any?)

State in your own words what you witnessed (be very descriptive) and sign below:

[redacted]

(Continue on Back as Necessary)

The information provided above is true to the best of my knowledge.

Signature of Witness: Tyler Matthes Date: 6-13-20

DMS-762
Page 9 of 9

Disability Rights Arkansas

Dignity. Respect. Advocacy.

Tom Masseau, Executive Director

October 22, 2020

Director Melissa Stone
Division of Developmental Disabilities
Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72203-1437

Director Stone:

Disability Rights Arkansas (DRA) is the designated federal Protection and Advocacy System ("P&A") for individuals with disabilities in Arkansas. One of DRA's core functions is to investigate the deaths of persons with developmental disabilities in facilities that provide services to people with developmental disabilities. DRA has authority under federal law to thoroughly investigate deaths occurring in any public or private entity that provides care, services, treatment, or habilitation to individuals with disabilities.

As you are aware, resident David Cains of Booneville Human Development Center (BHDC) died on June 13, 2020. His death occurred while three BHDC staff restrained David on the floor outside of the cafeteria. David's family contacted DRA and requested we investigate his death and the circumstances surrounding it.

DRA completed an extensive investigation into David's death. Our investigation involved reviewing the Adult Maltreatment Investigation Report, all witness statements, the DPSQA Complaint Investigation Report, the EMS report, hospital records, and the Coroner's report. Our office interviewed BHDC staff, including Tyler Mattson, Amy (Mandy) Jones, and Ryann Campos, the individuals who restrained David; Sandy Evans, the Adult Maltreatment Investigator; Jeff Gonyea, the Superintendent; and Mark Hines the NCI instructor. Our office also interviewed the Emergency Medical Services provider, Samuel Scow, who provided emergency services that day, as well as Michael Chrisman, the Deputy Coroner who was assigned to David's case.

Summary

David Cains was 42 years old, [redacted]

According to the BHDC Staff written statements and interviews with DRA staff:



On June 13, 2020, David ate his lunch in the cafeteria at the Commons Building. After finishing his meal, David put his tray away, asked to go to the restroom, and was accompanied to do so by Tyler. According to Tyler, David seemed irritated, asked to sit in the lobby to calm down after exiting the restroom, and then began screaming, ripping paper off the wall, and attempting to hit Tyler.

Tyler stated that he, "applied personals[1] by grabbing [David's] arms and ended up falling over."[2] David landed on his face and Tyler then rolled him to his side.[3] Tyler believes that this restraint began at 11:30 a.m., although all times are estimates as there are not any visible clocks in the area where the restraint occurred, according to all staff interviewed. Mandy Jones arrived shortly after David was brought to the ground and assisted in the restraint. According to all written witness statements, David was resisting the restraint at that time. Ryann Campos arrived sometime later and began holding David's legs. Within seconds of arriving Ryann noticed that David had defecated on himself and she

[redacted]

From EMS Report and BHDC Staff written statements:

[redacted]

This entire event took place on the floor while three people were holding David by his legs, torso, and head. A fact that was omitted in reports to EMS, the hospital, the Coroner, and the family.

During our investigation, we noted several unresolved discrepancies between written statements, subsequent interviews, and investigative conclusions:

1) There is not a consensus between the employees involved regarding the positioning and

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[1] Tyler, during his interview, acknowledged that this is a restraint.
[2] OLTC Witness Statement, Tyler Matteson, Page 2 of 3
[3] Interview of Tyler Mattson by DRA staff on July 29th.
[4] OLTC Witness Statement, Ryann Campos Page 1 and 2
[5] OLTC Witness Statement, Tyler Matteson, Page 2 of 3
[6] OLTC Witness Statement, Amanda Schmidt, LPN
[7] BHDC Policy IV-B-10 states that on-site medical should be the first call and that "medical will assess the situation and call an ambulance if appropriate." All persons interviewed, including Superintendent Gonyea, interpreted the policy to prohibit non-medical staff from calling 911 in response to a medical emergency and confirmed that as the BHDC practice.
[8] Logan County EMS patient record.
[9] *Id*
[10] *Id*

actions of each employee, information pertinent to identifying not only potential wrongdoing, but also possible missteps to be avoided in the future.

a. Ryann's written statement and subsequent interview by DRA staff were consistent with one another. She states that when she arrived David was on the ground on his left side, Tyler was on his knees facing David and holding his wrists, and David's hands were by his sides. Mandy "came to assist to position David's head so he wouldn't spit"[11] and then Ryann attempted to assist by holding David's ankles when he began to kick.

b. Mandy stated that when she arrived, "David was on his left side with his arms held up with his elbows bent slightly."[12] She states she assisted by holding David's hands so that he could not strike Tyler, who was positioned behind David. Mandy denied ever holding David's head during the restraint.

c. According to Tyler's written statement he was "squatted over him, not putting [his] weight on him during any of this, holding his shoulder and sides,"[13] Mandy assisted by "grabbing his hands," and Ryann held his legs down. During our interview, Tyler deviated from his written statement, stating "she [Mandy] was on his side behind him, holding his head on the side, keeping close to ground but not pushing on it"[14] because David was trying to bite. He also clarified his positioning as being behind David, who was laying on his left side and "spread out T-style"[15] with his left arm on the ground. Tyler was holding his right arm (not Mandy) and trying to get it to the ground. David's arms were never above his head.

d. Adult Maltreatment Investigation Report #5-2020, completed by Sandy Evans, fails to resolve discrepancies regarding the placement of David's hands and whether a staff member was holding his head in place during the restraint.

e. Cameras at the facility would have been immeasurably helpful in resolving the discrepancies and ultimately understanding the circumstances surrounding David's death.

2) A timeline of events included in two separate documents we received completely omits any reference to a restraint having occurred.

a. The DHS Incident Report includes a timeline of events provided by Stacy Weinbrenner, RN/DON, who does not appear to have been at the scene of the incident at any time.

i. [redacted]

1. Tyler and Mandy's written statements and interviews with DRA indicate that Mandy did not arrive until Mr. Cains was already on the ground and being restrained by Tyler, in conflict with the assertion here.
2. There is no evidence of either staff member attempting to "settle" David.

b. A similar statement is included in a "Timeline of Events" that appears to be a word document included in David's medical file. The statement is not attributed to anyone in this document.

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[11] OLTC Witness Statement Form, Ryann Maria Campos, Page 1 of 2
[12] OLTC Witness Statement Form, Amy Amanda Jones, Page 1 of 4.
[13] OLTC Witness Statement Form, Tyler Mattson, Page 2 of 3
[14] Interview of Tyler Mattson by DRA staff on July 29th.
[15] *Id*

[redacted]

The same misinformation was passed on to the investigating coroner, Deputy Coroner Michael Chrisman, leading him to list the cause of death as respiratory arrest, due to food aspiration, and cardiac arrest. Mr. Chrisman stated:

[redacted]

When our office interviewed Mr. Chrisman, he stated he had no knowledge that David was restrained prior to or during this incident. He confirmed that his office would have further investigated had they received that information and would likely have requested an autopsy.

When BHDC staff contacted David's mother, they told her that David choked on his lunch and that the family would need to contact the hospital for any additional information. When the family called Mercy Hospital, they were informed David was deceased. David's family did not find out about the personal restraint until June 22nd – nine days after David passed away and three days after David's funeral. By the time the family learned of the circumstances surrounding his death it was too late for them to request an autopsy.

This was a tragic event. Any time an individual passes away while in the custody and care of the state a meaningful, critical evaluation of the policies and practices that led to that incident should be required. In this case, that evaluation included: (1) an investigation by an individual who is employed by the BHDC, working alongside those who she is charged to investigate; (2) a review and endorsement of that investigation by the superintendent who hired or who is ultimately responsible for the actions of those employees investigated; (3) the suppression or omission of relevant, if not crucial facts from agencies who would further investigate the circumstances of this gentleman's death.

The BHDC review of this death, endorsed by Superintendent Gonyea, concluded that no individual involved in this incident did anything wrong; therefore, nothing could have been done differently to prevent it and nothing can be learned from it. To date, we have not been informed whether BHDC has reviewed or revised their restraint policies or practices following this event.

At some time after the internal investigation concluded the Division of Provider Services and Quality

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[16] Logan County Coroner Report.
[17] *Id*

Assurance (DPSQA) investigated David's death and the circumstances surrounding it. Very little information could be gleaned from the DPSQA Complaint Investigation Report reviewed by DRA. Despite the ability to attach narratives of staff interviews, none were found or made available upon our request. Ultimately, the DPSQA investigation concluded similarly to the internal investigation conducted by BHDC with no description of the events or statements from witnesses.

Practice of Restraints at BHDC

In 2012, DDS retained H&W Independent Solutions, who are self-described "skilled trainers and workshop facilitators on a wide range of topics pertinent to organizations supporting people with disabilities." In April of 2012, BHDC participated in a training survey with H&W to evaluate and improve the quality of care to the residents. During the evaluation of BHDC, H&W found that significant improvement was needed due to, in part, the BHDC staff's reliance on emergency restraint.

Nearly four years later, in January 2016, our office issued a report regarding the use of restraint at BHDC. We warned that risks associated with restraint include physical injuries, significant trauma, and death. We pointed out that the overuse of restraint could cause physical and emotional trauma to both the residents and the staff at BHDC. We recommended that BHDC retain an independent expert to implement evidence-based alternatives aimed to reduce or eliminate the use of restraint at BHDC.

NCI/CPI trains staff to respond to crisis by intervening in non-violent ways to prevent escalation and offers programs to certify staff in this skill. At the same time BHDC certifies its staff in the use of NCI/CPI, BHDC also trains its staff to restrain residents using methods that require no certification, are not evidence-based, and, when practiced, conflict with NCI/CPI training. It is concerning that BHDC staff are then left to choose between non-violent crisis intervention and physically/emotionally traumatizing physical restraint.

Findings

- [redacted]
- Instead of releasing David when he was lying down on the floor, David was restrained on the hard floor by three BHDC staff after finishing his lunch.
- Prior to the restraint, Staff failed to use other less intrusive interventions such as NCI/CPI, for which they are trained.
- Staff failed to leave him on the floor, unrestrained, until he was calm.
- [redacted]
- This restraint likely either directly or indirectly led to David's death.
- The facility failed to properly communicate the circumstances of this incident to EMS.
- We found no evidence that the facility properly communicated the circumstances of this incident to the Arkansas State Police, the Logan County Sheriff's Office, or any other law enforcement agency.

- BHDC's investigation failed to resolve discrepancies in statements from witnesses.
- It is not the policy or practice of BHDC to permit direct care staff to call 911 in an emergency.
- NCI/CPI does not endorse or instruct any maneuver that involves physically restraining an individual on the floor.
- During interviews, BHDC direct care staff reported that they, "take people to the floor often."
- BHDC could not articulate what kind of "restraint technique" is being taught to staff.
- The conclusion from Superintendent Gonyea failed to find that anyone violated any policy or procedure and inexplicably failed to find that any policy or procedure might need review or modification.
- No corrective actions were made or recommended by BHDC or DHS - Division of Provider Services and Quality Assurance.
- BHDC failed to adequately inform David's family of the circumstances surrounding his death.

Recommendations

1. ***Install video cameras on campus***. Video cameras on campus would greatly assist investigators in determining whether maltreatment has occurred. Presently, we have differing statements from individuals regarding a restraint on the floor that led to an individual's death.
2. ***Retrain all staff in NCI/CPI.*** NCI/CPI does not endorse the use of restraint while an individual is lying down on the floor. The very fact that NCI/CPI is touted as the intervention strategy implemented by BHDC, and yet this individual was restrained on the floor long enough to aspirate and die means that NCI/CPI was either ignored or forgotten.
3. ***Reevaluate the use of restraint in all forms and employ evidence-based, nonviolent methods of crisis intervention.*** A greater problem that exists is the overall reliance on restraint at BHDC. It is a culture of compliance that we see often in prisons. When individuals are not compliant, they are made to comply. If DHS does not address restraint and physical, mechanical, and chemical intervention as a system-wide problem, the culture cannot be meaningfully changed. Further, the physical restraints BHDC employs are not based on any professional training or sanctioned method.
4. ***Clarify or Modify policy to permit staff to contact 911 in response to emergency medical situations.*** Staff must have permission to identify and respond in an emergency. BHDC is a large campus in a rural area of the state. While it is comforting that nursing staff is available to respond to medical issues, the current policy forces staff to ignore what many first aid/CPR certification programs insist is the first step in responding to a crisis – calling 911.
5. ***Engage qualified, independent investigators to complete thorough, meaningful investigations on ALL deaths.***

a. *Utilize investigators that are completely independent of the Human Development Centers they investigate.* While it is important that BHDC review incidents internally for quality improvement and staff oversight, there must be a truly independent investigation by a disinterested third party. At one time, DDS employed an attorney whose role was to investigate deaths at any HDC. We are unaware whether or why such a position no longer exists. Anyone DDS authorizes to investigate serious incidents should have no connection to the Human Development Centers they investigate. Investigators should be informed regarding the requesting of an autopsy and empowered to make such a request when warranted.

b. *Ensure all investigations are reflective of the gravity of the circumstances investigated.* Death investigations must be both thorough and critical. Investigations that lack specificity in their investigative processes and findings, do not include interviews of all involved parties, and by design can only substantiate maltreatment or declare nothing could have been done differently undermine confidence in the process. When a family is left to gradually learn new information regarding the death of their loved one, including that the coroner was not accurately informed of the circumstances surrounding the death, what else are they to be left with other than suspicion and anger? Instead, the trauma surrounding the death is amplified and revisited with each new fact they learn. That is not closure; that is not justice.

DRA requests a response, delivered electronically, to this letter by October 31, 2020.

Sincerely,

Kris Stewart, Advocate
Disability Rights Arkansas

Reagan Stanford, Attorney
Disability Rights Arkansas

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF

RYANN CAMPOS

May 12, 2022, at 9:10 a.m.

CRIS M. BRASUELL, CCR
BREPORTING@GMAIL.COM



A P P E A R A N C E S

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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Ryann Campos, produced, sworn, and examined via Zoom, commencing on May 12, 2022, at 9:10 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

PROCEEDINGS

WHEREUPON, Ryann Campos was duly sworn to tell the truth, the whole truth, and nothing but the truth, and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Hi, Ms. Campos. How are you?

A Hello. Good morning. I'm doing good.

Q Good. Thanks for being here.

I know you got served with a subpoena. But, for some reason, they didn't serve you with your witness fee check at the same time.

A Right.

Q So our office mailed you a check for -- it's $35 for your appearance here today; which is the statutory amount that witnesses get when they're subpoenaed to a deposition.

So you should be receiving that today or tomorrow. I think it was mailed --

A I have to pay that or --

Q No, you get it.

A Oh.

Q It's for you.

A Okay. Well, thank you.

Q Yeah. It's for you.
Now, if you had come to Little Rock, I would have had to pay you a lot more --
A **Uh-huh.**
Q -- because I would have to pay for your mileage as well.
A **Yeah.**
Q And I think 35 is low. If it was up to me, it would be -- they need to bump that up. But --
A **Ha.**
Q Anyway, so you're in Fayetteville; is that right? Or Rogers?
A **Fayetteville.**
Q Fayetteville. Okay.
A **Uh-huh.**
Q Well, thank you for being here. And your name --
A **You're welcome.**
Q And your name is Ryann Campos?
A **Ryann.**
Q Ryann, I'm sorry.
A **Yes. No, you're good.**
Q All right. How old are you, Ryann?
A **I just turned** [redacted]
Q Okay. All right. I wanted to start by asking you, what all you -- what documents did you look at today to

prepare?
A Well, documents wise, I haven't seen a document in three years or two, so --
Q And you don't have anything in front of you there? You don't have any documents with you that you're using --
A No.
Q -- or notes?
A No.
Q Okay.
A This is all off the top of my head.
Q That's fine. I know it's been a couple years.
Have you spoken with anybody in preparation for this today?
A No.
Q Have you ever spoken with Mr. Collins?
A No.
Q Okay. This other attorney right here, you've never spoken with him?
A And might have in the past, like when I was working for BHDC, but my memory -- I don't. . .
Q Okay --
A I --
Q But not in preparation for today's deposition?
A Correct.

Q Okay. And you've not seen any deposition transcripts from this case?
A The only paperwork I've received was the date and time that I had to be in Little Rock.
Q Okay. Okay. Good deal. Good deal.
When did you leave BHDC?
A Oh, goodness. It was 2019 or 2020.
Q Okay. Well --
A Because --
Q -- this incident happened in June of 2020. So I --
A Okay. Then yeah.
Q Do you know about when in -- I think your personnel file says that you left because of bedbugs.
A Yes. That place was infested.
Q Okay. So it was bedbugs at BHDC?
A Yeah.
Q Tell me --
A I can't believe they showed y'all that.
Q Tell me about that.
A It should -- I -- I haven't been there since then, so it could be better. I know they were remodeling and rebuilding.
But I was currently working at Davidson house.
Q Uh-huh.
A And we had -- multiple times, me and my other

co-workers had to go in and just pack everything up, throw it through the washer and dryer. Keep it all together until, you know, everything was gone.

But, obviously, not all of the bedbugs were gone. We were finding them in the aid stations, in the TV room. Like it was so bad that I brought them home to my home. And I'm a clean freak, like everything is spotless. And --

Q Yeah.

A I was devastated. I mean, I felt the nastiest I've ever felt when that happened.

And, after that happened, I was like, nope, I'm leaving.

Q Oh, my gosh. Wow.

A Because I had to spend over $1,000 just to heat treat my unit, my apartment, so --

Q Because you brought -- they were so bad at Davidson house. That you brought them home with you?

A Yes. Yeah.

Q I think David Cains lived in Davidson house, didn't he?

A Correct.

Q And did his room have bedbugs?

A He was downstairs and I worked upstairs. So --

Q So he --

A I didn't really work with him much.

The only time I seen David was in the interaction of going to lunch or vice versa.

Q Okay. And did you become a -- you started there as a --

A Residential technician.

Q Residential tech? And then would that be an RTA? And then, after six months, you became a residential tech, whatever the next level is?

A Yeah.

Q RCT?

A Yes.

Q Okay. Started as an RCA and then you became you a -- you made it through Phase Two and got your RCT?

A Correct.

Q Okay. And did I see that you have multiple family members that worked there as well or that do work there still?

A No. I only had -- my cousin's wife was the only one that worked there.

Q Okay. I saw, not in your personnel file, but just in other -- well, no, I guess it was in your personnel file. But Bernice Campos and a Carly Campos.

A Oh, no, they never worked there. That's my sister and my mom.

Q Oh, so were those like letters of recommendation?
A Yeah.
Q Okay. Obviously, I didn't read that very closely, did I?
A It's okay.
Q That's all right.
A No, I would never let them work there.
Q Okay.
A Crazy.
Q Well, why wouldn't you let them work there?
A I don't know. At one -- it just wasn't their type of field history.

Like my mom's a dental hygienist. My sister's a CNA. And she has a heart. She's real soft spoken and that would just probably intimidate her --

Q Yeah.
A -- working there.
Q Other than the bedbugs, were there other things about that job that kind of got to you after a while?
A No. I mean, everything was good. It was just the bugs. Like --
Q It was just the bugs.
A -- nobody wants to bring home bedbugs.

And they did -- even if you did catch them, there was no helping you get through that situation. And I've

never had them in my life and it was just gross --
Q Did you --
A -- so I was like --
Q Did you complain to your supervisors or a supervisor?
A Oh, yeah. Everybody knew about it. Everybody on that hill knew. Jeff Gonyea knew. I mean, everybody knew.
Q Did you ever talk to him about it?
A I mean, there's been multiple, multiple people that has brought it up to his -- his attention.
But I've never personally spoke -- spoke to him about it. I just quit and moved on. Got my house -- moved --
Q Well --
A -- out of my apartment, started from scratch. I threw everything away.
Q Wow. I'm sorry.
A It's okay.
Q Did they ever try to fix the problem?
A I mean, they'd have pest control come in and spray. But that was like it. They wouldn't do anything else besides call pest control.
Q And, if it had been your house, what would you have done? Or, if it have been out to you, what would you

have done?
A I probably would have burned the building down. No.
Q Other than that.
A No. I mean, I'd try and do everything I could to get rid of them.
I mean, I had to spend over $1,000 just for a little studio to get rid of what I had.
Q And so I assume then that you'd say they did not do everything they could have to get rid of the bedbugs in Davidson house?
A No, they didn't.
Q Did clients ever -- did you ever notice the, you know, clients being attacked by bedbugs or --
A Yeah. All the time. I mean, they were up in their bed frames.
Q And so would the bedbugs be attached to the clients and they're walking around with these beds?
A We've seen them crawling on them while they were sleeping. Because we'd go in every two -- we'd do our rounds every, you know, every two hours, checking on them.
And we would go in there with a flashlight and we would see them crawling on them.
Q Crawling on the clients?
A Yes. And then we would have to wake that client up.

And then we would have to strip their whole room. We'd have to bag up all their clothes. They would have only just a mattress to sleep on because we would have to take out everything. I mean, it was sad.

Q You didn't work on David's floor, but do you have any idea whether this problem was on David's floor as well?

A I think it was mainly Davidson up. It wasn't -- I don't know how -- I don't know. I don't know how downstairs was as much as I did upstairs.

Q Can you recall what other staff member might have been working down on the downstairs part of Davidson that would know the answer to that?

A Tyler Mattson.

Q Okay. All right. And what did you think of Tyler Mattson?

A He was a good worker.

Q Good worker?

A He was a hard worker. He came to work all the time. He did his job. He did everything that he could for those residents. I mean. . .

Q Did you ever hear about allegations of him mistreating a resident?

A No. Not at the time I was working.

Q What about other times?

A No.
Q Okay. You never heard stories about other incidents? Not the one involving David, but other incidents?
A No.
Q Okay.
What about Amy Jones or Mandy Jones?
A Amy was our PS. She was amazing.
Q Okay.
A She -- she loved them residents like they were her kids.
Q Yeah. And did you feel the same way?
A Yeah, I did.
I mean -- no, just leave them in there. I'm sorry. My dogs are barking.
Q Okay.
You loved the residents though?
A Yeah, we treated -- they were like kids to us. Like we took them out, we played basketball. We did activities. We took them fishing.
I mean, everybody has bad days and everybody has good days. And we tried to treat them like they were part of our family.
Q Uh-huh. Yeah. And when you say everybody has bad days and everybody has good days, do you mean the

residents or the staff or both?
A Both.
Q Kind of like a parent has bad days where maybe they're not the best parent on certain days?
A Correct. Correct.
Q Okay.
I can tell by looking at you the answer's no, but you ever been convicted of a crime?
A No.
Q You ever been --
A I've never been to jail.
Q Okay. Have you ever been accused of any sort of maltreatment or been investigated for maltreatment?
A No.
Q Okay.
While you were at Booneville, other than for the David Cains incident, were you ever investigated for maltreatment at any other point?
A No.
Q Okay. And I understand that you were, that you were cleared by Sandy Evans for the David Cains incident.
But could you tell me about that investigation and what you recall from it following David's death?
A When I -- okay. So we were on our way to lunch. And it was a pretty day.

We normally walk the residents down to Commons area, I mean, just to get them out of the dorm. Because, at that time, it was all -- I believe COVID was happening. So we tried to keep everyone separated. So we'd walk down --

Q Ms. Campos --

A Yes?

Q I don't mean to interrupt you, but I think -- I don't think you maybe understood my question.

A Oh.

Q I was just asking about, after David Cains' death, do you recall --

A Oh, sorry.

Q No, yeah. I'm just asking about the investigation that Sandy Evans conducted.

A Uh-huh.

Q Can you tell me what you recall about that specifically?

A I just remember we had to be interviewed on Skype with a few people. I don't remember their names though.

Q Do you recall being brought over to, I think it's, the Kelly building right after David was -- right after David died and put in a room to fill out a form and talk to Sandy?

A Yes. Yes.

Q Okay. And was that a witness -- did she hand you a witness statement form?
A Correct.
Q And did she --
A That's -- sorry.
Q You go ahead, please.
A All I did was fill out a witness statement and turned it in to her.

We physically didn't talk about the situation. I just filled it out and turned it in.
Q Okay. So you never talked, you never had a conversation with Sandy about the incident?
A No.
Q She never questioned you about it?
A She -- I don't remember. I'm sure she probably had to, so. . .
Q Do you recall her ever, you know, taking you into a room and sitting you down and questioning you similarly to how I'm questioning you here today?
A No. She just -- I just remember filling out a witness statement. And then --
Q So you don't specifically recall being sort of questioned by Sandy?
A Yeah. Yeah, I don't recall that.
Q Okay.

Was there another time, not that day but another time down the road, that you may have been brought in for questioning by Sandy?

A The only time I was questioned is when we did our Zoom there at BHDC.

Q But that wasn't with Sandy, was it?

A I -- I believe she was there; because she was the one that was on camera first introducing herself.

Q Who else was on the Zoom?

A That, I can't tell you.

Q How many --

A I don't know.

Q -- people were on the Zoom?

A Three or four.

I know it was go -- it was going by so quickly. There was like multiple coming at me.

Q And do you recall who was questioning you on the Zoom call?

A I know -- I don't mean to be -- sound rude, but remember, there was a colored lady. I don't remember her name.

And there was two or three after her. I don't --

Q Okay. And I'm assuming this wasn't the day of his death or even the day after his death. This would've been --

A No. This was after, I guess, the sister started her whole process of trying to figure things out.
Q Okay. So that would be several weeks after his death or more?
A Yep.
Q Okay.
And what is your understanding of what the sister was trying to do at that time?
A All I know is that she's trying to sue the state because of his death saying that we were the ones that killed David.
Q Okay. And do you understand why she might feel that way?
A Yes and no. I mean, if it was my family, I'd be concerned as well.
Q And I appreciate your honesty. And, look, for the record, I'm not here to make you feel like a bad person or --
A I mean, for my opinion --
Q -- I'm not here to do that.
A -- I did everything I could to save him.
Q Sure.
A I mean, so did everyone else behind me.
Q And I believe that. The problem is that the restraint itself on the ground is what caused him to die

though, isn't it?
A No.
Q No? Okay. How would you --
A What restraint?
Q The restraint that you participated in.
A No. That did not cause his death.
Q Okay. Tell me what you mean.



A Yes. And there was -- I was on the phone with the nurse. There was -- I don't remember who all was calling nurses at that time.
Q So you're saying you never participated in the

restraint then?
A I -- I don't -- it's been a while. I wish I had my notes. I wish I had --
Q You never held his legs?
A I do -- he was kicking.
So, I mean, from us trying to get the nurses over there and trying to relax him, I didn't want someone else ending up getting hurt, so, I mean. . .
Q Is it your -- have you ever been deposed before --
A No.
Q -- like this? Okay.
A No.
Q A deposition, first thing you need to understand is that you're testifying under oath.
She administered an oath to you. Do you recall?
A What's an oath?
Q At the very beginning, she had you raise your hand.
A Oh, yes.
Q Okay. What that means is that you're under oath and that, if you testify in a way that's not truthful, you're committing the crime of perjury.
A Right.
Q Which is a felony. And I do not expect you're going to commit perjury. But I just need -- I try to remind everybody of that, just so they --

A Right.
Q -- understand the seriousness of what this is. The gravity of this situation.
A Absolutely.
Q So what I'm asking -- and if you don't -- you know, it's not a memory test.
But I do need to know what you recall. And I need to know if what you're saying is that, when you first arrived on the scene, David was already having an emergency health situation? Is that what you're saying?
A He was -- yes.
Q And then -- but you also held his legs?
A He -- I didn't want him hurting him or anyone else. And he was -- he -- I guess he was having a behavior before I got there.
Q Okay.
A So at -- I wish I had my paper. Because I -- I don't remember everything.
Q Sure.
Well, let me start this way. What do you remember seeing? What's the first thing you remember seeing when you walked into the Commons building and saw David on the ground? Who was there and what did you see them doing?
A They were -- he was -- I don't remember. I just know that he was punching and kicking.

Q Okay. How do you -- and who was he punching and kicking?
A Tyler Mattson.
Q But, at the same time, he was also, you said --
A That -- that was --
Q -- choking and --
A That was after his behavior.
Like I -- I came in -- I came into the situation kind of like at the end of everything, of his behavior. Like I -- it was --
Q But he was on the ground, wasn't he?
A Yes.
Q Okay. And Tyler and Amy were holding him on the ground; right?
A Correct.
Q And do you recall how they were holding him on the ground?
A No, I do not.
Q Okay. Let's put a pin in that and come back to it.
Okay. And you underwent Phase One training and Phase Two training; correct?
A Correct.
Q Okay. And in, Phase One training, do you remember having to pass a test?
A For?

Q Do you remember having to get 70 percent or better as an assessment score in order to complete Phase One and to complete Phase One before two?
A Yes. Yes.
Q You do? And was that a written test?
A Yes.
Q Okay. And do you recall, I guess you passed those tests?
A Yeah. I don't remember what was -- I mean, I know we went through CPR training.
Q Uh-huh.
A I mean, that was one of the tests.
Q I believe one of the tests also had to do with restraints and responding to behavior incidents.
Do you recall that test?
A Okay. Yeah.
Q Okay. And I assume you passed that test?
A Correct.
Q Okay. And was that test administered to you by staff development?
A Yes.
Q Would that have been Mark Hise?
A Correct.
Q All right. And, prior to taking that test, what are the things that you were taught about restraining

clients?
A Oh, goodness. It's been awhile.
Q Were you ever taught that you were authorized to hold a client down on the ground while the client's having a behavior incident?
A I do -- I mean, we were taught a lot. It's just been a while. I mean --
Q What do you do now?
A I'm a CNA.
Q Okay. Where do you work?
A I work at Greenhurst --
Q In Charleston?
A I mean, Butterfield. Butterfield. Sorry. Butterfield.
Q Okay. And Butterfield is a nursing home?
A Correct.
Q Okay. And how long have you worked there?
A Since August of last year.
Q Okay. And do you work there full time?
A Correct.
Q All right.
And did you have any other jobs between Booneville HDC and Butterfield?
A I worked at Greenhurst in Charleston.
Q Okay. The nursing home there in Charleston?

A Correct.
Q All right. And are you from Booneville originally?
A Yes.
Q Okay. And I believe I saw that you -- did you finish high school at Booneville High School?
A Correct.
Q What year did you graduate high school?
A 2016.
Q 2016?
A Uh-huh.
Q All right. And did you do any college?
A I went to Ozark Tech for a couple -- or a semester and then I got kicked out. And I had to learn how to grow up real quick, so. . .
Q How did you get kicked out?
A Drinking and partying too much.
Q Okay. And then it would have -- and then, shortly after that, you started working at BHDC?
A Correct.
Q Okay.
Do you recall being taught to transition clients to the ground in phase training?
A Yes.
Q Okay. And am I correct that the purpose of that was to transition them to the ground so that they can be

placed on the papoose board for mechanical restraint?
A Correct. Or the Joey board.
Q What's the Joey board?
A It's the same thing. It's just smaller.
Q Okay. And were you taught any other reason for transitioning a client to the ground or taking a client to the ground that you recall?
A Just to be -- for them to not harm themselves or others. I mean, we --
Q So what I'm getting at is, were you specifically authorized to take a client to the ground in an emergency behavior situation?

Were you specifically authorized to take a client to the ground for the purpose of holding them there on the ground until they calmed down?

Not for purposes of the papoose board or mechanical strength but simply to hold them there on the ground until they calmed down, were you taught to do that?

And were you told that that was -- were you authorized to do that?
A I don't re -- I don't remember everything through the training.

I mean, I've had things happen to me. I've had a wreck. I mean, I don't remember everything, so. . .
Q In other words, the thing that was happening to

David Cains when you arrived on the scene, holding him on the ground there, but not for the purpose of a papoose board?

A Correct.

Q You don't recall whether that was authorized --

A The --

Q -- or not?

A There was no board, papoose board or Joey board, there.

Q I know.

A I mean --

Q I know. They were just holding him there for him to calm down.

What I'm asking is, were you authorized to do that? Or were you only authorized --

A No, I mean --

Q -- which is my understanding -- let me finish.

Or were you only authorized to take a client to the ground for purposes of transitioning them to a mechanical restraint?

A I can't -- I don't -- I believe we -- it was for the next step to be.

I know we were -- they were in the process of calming him down.

Q Right.

A I mean, he was -- he was hitting, he was swinging. He was kicking. He was spitting.
Q Did he hit or kick or spit at you?
A No.
Q Did you see him hit anybody?
A Yeah, Tyler.
Q Okay. Where did he hit Tyler?
A I don't remember.
Q But he was on the ground, David was on the ground, the whole time you saw him; right?
A Yes. For like not even two minutes.
Q Okay. So two minutes is about the time that you held his legs while they held him at other parts of his body?
A And then that's when I realized, hey, we need to get a nurse. I mean, something's happening. And this isn't --
Q But you'd agree that -- but two minutes is about the time that you would have held his legs; is that correct?
A Correct.
Q Okay. And was he vomiting and was he choking or was he struggling to breathe during those two minutes that you were holding his legs?
A No.
Q He wasn't?

A No.
Q Because the first thing you said was that, when you first got there, he was struggling to breathe already.
A Well, I jumped ahead. I jumped in. I'm nervous. I mean --
Q That's okay. That's okay. That's all right.
But I just want -- because this is important. I just want to make sure that we're clear on this.
So it would have been -- when you first arrived on the scene, he was not yet struggling to breathe; correct?
A Correct.
Q Okay. And Tyler and Amy were already holding him down on the ground, trying to get him to calm down; right?
A Correct.
Q Okay. And you recall David sort of -- was he flailing?
A What does that mean?
Q Sort of waving his arms and legs, kicking. You know, maybe moving --
A Trying to hit --
Q -- his arms and legs.
A -- and kick.
Q Sorry?
A Trying to hit and kick or --

Q Sure. Was he making movements like that?
A Yes.
Q Okay. And you said he was spitting?
A Yes.
Q Okay. Did he seem to spit on anybody?
A He did spit on someone. I can't -- I don't recall who it was.
Q Uh-huh. And he was on his left side, wasn't he?
A Correct.
Q Okay. And Tyler was holding him, was holding -- was kind of over -- was on top of him?
A I don't -- I don't remember all the -- what all they did. I mean --
Q Okay.
A -- I don't --
Q They were each holding him down on parts of his body and you grabbed his legs; right?
A Yeah. They -- it -- in no harm's way were they holding him in any way that he would not be able to, you know, be -- breathe or anything.

I mean, they were nowhere near his neck.

Q So you don't feel like what happened eventually, which is that he aspirated and choked on his own vomit, you don't feel like that was related to being held down on the ground?

A No.
I mean, David was a fast eater. He ate -- he ate pretty quick. That's why he has -- had to have someone sit with him --
Q Uh-huh.
A -- at lunch or at breakfast or at dinner. I mean --
Q I just want to be really clear here.
You're saying that that you don't think -- you're saying that you don't think that the ground restraint, whereby the three of y'all were holding him on the ground, you don't think that was in any way related to how he died?
A No.
Q You think he would have aspirated and choked to death anyways?
A Yeah.
Q Even if he was just standing perfectly upright?
A Correct.
Q Okay. And have you shared that opinion with anybody else before?
A No.
Q Have you ever talked --
A We were told to not talk about the situation. I mean, I kept --
Q Who told you that?

A I mean, it would have been HIPAA if we did.
Q Okay. But who --
A And then I would --
Q Who told you not to talk about it?
A I mean, it was under investigation, so. . .
Q Again, but who told you not to talk about it?
A Upper people. I don't rem -- I don't fully remember who. I mean, I just -- bits and pieces, you know.
Q Okay.
Did you ever talk with Sandy Evans about what you just told me? Did you ever say that to her?
A What? That --
Q That you think that he would have died even if there hadn't been a restraint?
A Yeah.
Q And did she agree with you?
A Absolutely.
Q Sandy agreed with you that he was going -- he would have aspirated and died, even if he had been --
A I mean, nobody knew that he was going to die. I mean. . .
Q Well, I'm just trying to make sure I understand what's your beliefs are here about this.
A I don't be -- I believe that everything we did, did not escort (ph) to his death.

Q So your position is that absolutely nothing that y'all did in any way contributed to his death?
A Correct.
Q All right. And did Sandy Evans ever tell you that was her opinion as well?
A Me and Sandy, we never really talked like that. I mean, I turned in my witness statement and that was done.
We went a few weeks and then we got interviewed with some other people. And then three years or two years went by and here I am.
Q Okay. And -- just a moment.
Did Tyler or Mandy ever tell you or do you know, from some other source, how long they had been holding David on the ground before you got there?
A I don't -- I don't know how long. Like I said, I came after all that.
Q Did anybody speak to you when you arrived on the scene? Did Tyler or Amy say anything to you?
A No. I was more worried about David getting -- you know, hurting himself or someone getting hurt from him kicking.
Q Okay. But he wouldn't have been able to kick anybody on his left side, while he's on his left side, would he have?
A I mean, yeah. I can kick on my sides. I mean --

Q Okay. So nobody asked you to grab his legs? You just did that on your own?
A Right.
Q All right. And you don't remember speaking to -- prior to him vomiting and choking to death, you don't remember exchanging any words with either Tyler or Amy?
A The only thing I remember is calling a nurse and getting the nurses there as quick as I could.
Q Okay.
And, after he started, what was the very first indication that he was choking to death?
A Well, I didn't -- I didn't -- I don't know it. I just know he had a bowel movement.
Q Uh-huh.
A And I was like something's wrong. I mean, we need to get a nurse.
So, immediately, I called the nurse; and they all came running.
Q Okay. And that was the only thing that you -- there wasn't any other signs that he was in trouble other than that he defecated?
A Not that I can recall. As soon as the nurses came, they took over and then the EMTs showed up.
Q Okay.
A And then, once the nurses came, I remember them

asking me to run and go get the medicals.

We have a medical bag full of, you know, for people that aspirate and that. I ran and grabbed that, dropped it off to the nurse, and I had to go back to my people.

Q Okay.

So you've testified here that you held his legs while Amy and Tyler held other parts of his body. Y'all held him on the ground, all three of you, for two minutes before --

A I mean, I don't know exactly the time. I mean, I'm just estimating. I don't know if it -- it wasn't that long.

Q Okay.

It's important in depositions, Ms. Campos, if you could, just let me finish the question before you start speaking just so the court reporter doesn't get confused and can make a clear record. Does that make sense?

A Okay. Yeah.

Q And I know you can guess what I'm saying because you're a bright person; but, just so this can go smoother, just, if you could, try to let me finish my question. Okay?

A Okay.

Q And I'll try to do the same for you with your answers. And you've already been good about verbalizing

yeses or nos. But that's another instruction that I should have given you. Rather than using uh-huh or hu-uh or shaking your head or nodding your head, try to say yes or no. Again, it's just so the court reporter can accurately record our conversation.

A **All right.**

Q Make sense?

A **Yep.**

Q Great.

Okay. So approximately -- you know what the word approximately means? About?

A **Yeah.**

Q Okay.

A **Yes.**

Q Right around?

Okay. So you testified that you held his legs and Amy and Tyler held other parts of his body while he's on the ground for approximately, about, two minutes before he defecates and starts choking; correct?

A **Yes.**

Q Okay.

And can you recall specifically whether you were ever taught to do that? Were you ever taught to do that to a client while they're on the ground?

Was that something you were taught? Was that

something you were told you can do?
A To refrain them from hurting themselves and others.
Q Even on the ground?
A Correct.
Q Okay. So do you recall who would have taught you to do that?
A Uh.
Q Would that have been staff development, Mark Hise?
A Correct. Yes.
Q Okay. So your testimony here is that that Mark Hise taught you that, in addition to transitioning clients to the ground for purposes of putting them on the papoose board or the Joey board, you can also transition clients to the ground and just hold them there to prevent them from harming themselves or others?
A Correct.
Q Okay.
A Until -- you know, it probably would have led up to a Joey board. But then he started -- you know, he had a bowel movement. And that was when I was like something's wrong. So we called the nurse and they came running.
Q You say it probably would have led to a Joey board. But you said there was no --
A Right.
Q -- Joey board anywhere near there; right?

A No. There wasn't. No. Absolutely --
Q And nobody --
A -- no boards were --
Q And nobody -- Tyler -- nobody said, hey, let's call for a Joey board --
A Correct.
Q -- correct?
A No.
Q Nobody said anything about a Joey board or papoose board --
A No.
Q -- did they?
A No.
Q You know, Tyler -- I've deposed Tyler.

Tyler testified that, prior to your arrival, they'd been holding him on the ground between four and -- I'm sorry. Between four and five minutes prior to your arrival.

And you get there and another two minutes passes with y'all holding him on the ground. But not once did anybody say anything about a papoose board or a Joey board, did they?

A No.
Q And so there wasn't one mentioned and there wasn't one nearby?

A Correct.
Q And nobody did anything to call for one did they?
A We -- I don't re -- I think somebody was in the process. But I don't remember their name.
I mean, I don't know what all happened before I got there.
Q So you have no specific knowledge that anybody was in the process of ordering a Joey board?
A Not to my knowledge.
Q Okay. And a Joey board is the same thing as a papoose board?
A Correct.
Q Okay. Did you know David well?
A No.
Q (Inaudible) --
A No.
Q Okay.
A I didn't work with him that much as I did upstairs.
Q Okay.
I assume you recall that the policy at Booneville and at all of these types of facilities in the state is that, when personal restraints are used, it must be the least restrictive form of personal restraints possible; correct?
A Correct.

Q Okay. And you'd also agree that staff are required to do everything they possibly can to avoid having to use physical or personal restraints --

A Correct.

Q -- correct?

A Correct.

Q And you're taught de-escalation techniques; correct?

A Yes, we were.

Q And you're taught these things to -- signs to look for to determine whether a particular client is getting agitated so that you can de-escalate before it has to get physical; right?

A Correct.

Q And do you recall being taught methods for -- well, let me just ask you.

What do you recall being taught about handling a situation where a client swings at you or tries to slap you?

A I would call for assistance.

Q Okay. Do you recall specifically any techniques you were taught to deal with that?

And when I say that, I mean, a situation where a client is agitated and becomes aggressive and tries to hit you.

A We try to redirect them.

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Q How?
A As in trying to calm them down, taking a walk. I mean, going to get a snack, try to go play basketball. I mean, we try --
Q But how do you address not being hit or being hit? I mean, what do you -- like a client takes a swing at you, what are you taught to do?
A I would call for assistance.
Q Are you not taught any sort of methods for stepping out of the way --
A Of course.
Q -- or -- okay.
A Yeah. We would step out of the way. We wouldn't want to get hit.
Q And are you taught -- Amy Jones was talking about a particular sidestepping maneuver that she was taught. Do you recall that?
A Yeah. We would, I mean, step out of the way. I mean --
Q And then would you then try to give them -- back up and just give them some space --
A Yeah.
Q -- and try to let them calm down?
A Correct. Correct.
Q Okay.

And you have no knowledge whether, in this instance, Tyler Mattson did any of that prior to the restraining him on the ground, do you?

A I don't -- I don't recall anything that happened. Everything that happened before I showed up, I did not see.

Q Okay. And you have no knowledge about what happened prior to when you showed up; correct?

A Correct. Correct.

Q Tyler's never told you about it?

A No.

Q Mandy's never told you --

A No.

Q -- about it?

A No.

Q Okay. Do you call Ms. Jones Amy or Mandy?

A Mandy.

Q Mandy. Okay. And you never talked with either of them about what happened prior to your arrival on the scene?

A No. I just wrote everything that I -- what I did as in calling the nurse and getting them there.

Q Okay. And you are the one that called medical; correct?

A Correct.

Q Okay. And did Amy tell you to do that? I'm sorry. Did Mandy tell you to do that or did you do that on your own accord?
A It was kind of -- I did it. I was -- I was getting up to do it. And then everything happened. I was in the process of doing it myself. I mean. . .
Q Okay. And how long did it take medical to arrive after you called?
A Not that long.
Q Best guess. I know you can't say for certain, but just best guess.
A I would say two, three minutes. I mean, they had to come from Judge Hill and Judge Hill is kind of a ways down the hill.
Q If you had been at Judge Hill and gotten this call, how long would it have taken you to grab your equipment and get to the scene?
A Two to three minutes.
Q Okay.
A If you were on the run.
Q If you were running?
A If you were on the run, like jumping in your car and going.
Q Yeah.
Okay. And how long after the nurses arrived was

9-1-1 called? Do you know?
A Well, they did what they had to do. And then once they -- the EMT showed up. Oh, goodness.
Oh, the nurses did all they could do and then they called the EMTs. I want to say maybe six, five to six minutes.
Q After they arrived?
A Right.
Q Okay. Do you recall --
A It's been awhile.
Q I understand. Did you specific -- I understand. But it had to have been a -- I can't imagine --
A I mean, it happens, boom, boom, boom. I mean. . .
Q Have you ever been involved in a situation where a person died other than this?
A Nope.
Q I've never been involved --
A I was -- I mean, now that work at a nursing home, yes, people -- I mean, they're not checking in to check out.
Q Understood. Understood.
A I mean, people come and go. I've seen multiple dead bodies now that I work in a nursing home.
Q Uh-huh.
A So kind of like, when that happened, it kind of --

it scared me. It -- I mean, I didn't know what to do. All I knew is I need a nurse, I need a nurse.

Q Okay. Do you recall specifically --

A And as far -- sorry.

Q Do you recall specifically what the nurses did to try to help David prior to calling 9-1-1?

[redacted]

Q Okay. And what were you doing while they were doing that?

A I had to go back and refrain to my group for lunch.

Q Okay. Were you there when the paramedics arrived?

A I seen them leaving. I seen them taking David out.

Q Okay. Did you ever speak to a paramedic?

A No.

Q Did you ever see anybody speaking to the paramedics?

A I mean, the nurses.

Q Which nurses did you see talking to the ambulance? The paramedics.

A I want to say Trish, Amanda. I don't know everybody's last name.

Q Trish --

A There was -- Trish, I believe, is the top of all the nurses.

Q Is she an RN?
A Correct.
Q Okay.
A Amanda Schmidt, Kelly King --
Q Okay.
A -- Fleming. I don't remember her first name.
Q Lacey Fleming?
A Lacey, yes. Correct.
Q Okay.
A There was a couple others I don't remember.
Q Okay.
So you said you didn't know David well. Had you ever participated in a physical restraint with David prior to this?
A No.
Q Had you ever seen David physically restrained prior to this?
A No.
Q Had you ever participated in -- so you've never participated in any chemical, mechanical, or personal restraint on David Cains prior to this day?
A No, sir.
Q And you never witnessed David being restrained, chemically and mechanically or personally, prior to this date?

A No, sir.
Q All right.
So I assume David Cains had never been aggressive or violent towards you before?
A No.
Q Okay. And I assume you never witnessed David be violent or aggressive towards anyone else before?
A As long as I worked there, no, I did not.
Q Okay. Are you saying that you've heard of him being aggressive?
A I really never -- no. I never really spoke about him.
Q Okay.
A I --
Q So you --
A All I heard was good things. I mean, he's a -- I know, I mean, he's in there for a reason, and he's a good person. I heard nothing but good about him.
Q Okay. That's good enough.
So you never heard of David causing injury to anyone else then?
A No.
Q All right.
MR. GILLISPIE: Eric, I think this may end quicker than I anticipated, but I want to take

ten minutes, ten minute break here, to go through my notes and make sure that I haven't missed anything important.

And then, Ms. Campos, we'll get back on here in about ten minutes and I'll try to wrap this up for you. Okay?

THE WITNESS: Okay. Thank you.

MR. GILLISPIE: Thank you.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q All right. Ms. Campos, almost done here.

A Okay.

Q So far, have you understood every question that I've asked you?

A Correct.

Q Okay. You've heard my questions and understood my questions and then answered those questions to the best of your knowledge and recollection; correct?

A Correct.

Q All right.

Aside from this, this ground restraint, that occurred on the day of David's death, had you ever seen any other clients be pinned to the ground in this same

way during a behavior incident?
A Yes.
Q Okay. And not for the purpose of transition to a papoose board but just for these same purposes of controlling a client's behaviors?
A Correct. And then sometimes other residents, you know, everybody has different -- I -- I can't speak for the other behaviors. But I know some did lead to the boards, so. . .
Q Have you ever personally participated in a similar type of ground restraint?
And, again, I'm not talking about for transitioning to a papoose board, but I'm talking about like what happened with David where the restraint is in response to a behavioral incident and the purpose of it would appear to be to hold the client there on the ground until he or she calms down.
Have you ever yourself participated in another one of these other than the one on David's date of death?
A No.
Q But you've seen or heard of them occurring?
A Correct.
Q About how many?
A I mean, I couldn't tell you. They're -- I can't tell you what's true and what's not true.

I mean, there's stories that were just being told.
Q Okay. Give me an example.
A Like I said, as we were refraining him from trying to hurt himself or anybody else, I mean, there has been situations like that.
Q Can you think of a specific situation?
A Not off the top of my head, no.
Q You've heard -- how do you know it's happened? I guess.
A I -- like I said, I don't know what's true and what's not true. They were just stories.
Q And you're saying that these, you've heard stories about other clients being restrained on --
A In the past.
Q Let me finish.
You've heard other stories about clients being restrained on the ground in a similar way?
A Correct.
Q In the past? But you've not participated in it, have you witnessed it?
A I've not -- no.
Q Okay. You just know it's happened before because of things you've heard?
A Correct.
Q And do you know where you heard them? Who told

these stories to you?
A No.
Q Okay. Would you say that it's a fairly common way to restrain a client who's having a behavior problem?
A Yeah.
Q Okay. And why would you say that?
A I mean, that's what we were taught.
Q You were taught to do this even when it's not for purposes of transitioning to a papoose board?
You were taught that --
A Correct.
Q -- you can take clients to the ground and hold them there on the ground?
A I mean, from -- if they were trying to harm themselves or others.
Q Right. And, in those situations, as you sit here today, you're testifying that you were specifically taught that, in those situations, you can do what the three of y'all did to David on the day of his death?
A Correct.
Q And was that authorization ever provided to you in writing?
A No. We went through class.
Q Okay.
A I mean, that was one of our. . .

Q And, again, that would have been Mark Hise that trained you in that?
A Correct.
Q Do you know if there's a document that exists or a policy that exists that specifically addresses this issue?
A I'm not for sure.
Q Okay. Nothing that you can recall though?
A I'm sure somewhere along the lines. I mean, I -- I -- that's something for Mark to answer.
Q Okay.

But, to be clear one last time, if going by your estimate of how long he was held on the ground, which actually matches up with -- Mr. Mattson estimated that the restraint lasted about two minutes after you got there as well.

And he said that, before you got there, it had lasted between four and five minutes, so for a total of either six or seven minutes of ground restraint prior to David defecating and having trouble breathing and vomiting and all that.

You're saying, just one last time because I want to be clear, you're saying that, that six to seven minutes of holding a client on the ground, was in order for them to try to get them to calm down was specifically taught

and authorized by Mark Hise?
A Correct.
Q Okay.
Describe for me, if you can, to the very best of your memory, what you saw when you first walked into this Commons area.
When you first got to the scene, did you hear things first? Did you hear commotion and then see David on the ground? Just try to -- try to --
A I mean, that --
Q -- take me through it.
A -- that particular area is always loud. I mean, it -- I mean, we have an activities room where everybody plays pool in, loud music was playing.
We had the cafeteria -- cafeteria full of people eating. I mean, it was pretty loud. So I can't -- I can't tell you at -- I mean, what all -- all I was trying to do was refrain anyone from getting hurt.
Q I want you to tell me what you saw, what you remember seeing, the moment that you turn the corner and laid eyes on David on the ground. What do you recall --
A Him kicking.
Q -- as best as you can recall. Okay. Him kicking. Where were his hands?
A I can't tell you that. I don't remember.

Q Okay. So you never saw him hit anybody, actually make contact with anybody, did you?
A **Not from when I walked in, no.**
Q Okay. And you never saw him --
A **That's --**
Q -- make contact with his feet either with anybody; correct?
A **I mean, he was trying to kick Tyler at that time.**
Q But he was laying on his -- but David was also laying on his left side and Tyler was now behind him; correct?
A **I can't -- I don't remember where everybody was positioned. I can -- I remember what -- what all I did and what I did to get the nurses there.**
Q Do you recall -- you said you did recall filling out a witness statement form for this; correct.
A **Correct.**
Q And you also recall giving a statement to some folks over Zoom; correct?
A **Correct.**
Q And I am speculating that that Zoom call would have been your interview with Disability Rights. Does that --
A **Yes.**
Q -- ring a bell?
A **Yes.**

Q Okay. Because I know that disability rights took, interviewed you as well. And I have what -- I have their report that talks about your interview.

So would that Zoom interview, that would have been the Disability Rights interview?

A **Probably, yeah.**

Q Okay.

A **Be like -- because, like I said, all I remember was turning in a witness statement. Then a couple -- few weeks later, I got interviewed. And then here I am two years later.**

Q I hear ya.

So your written witness statement, I'll represent to you, says that, when you got to the Commons room, you noticed David Cains on his left side fighting Tyler; is that --

A **Uh-huh.**

Q -- correct?

A **Yes.**

Q Okay. David was on his left side; correct?

A **Correct.**

Q Okay.

A **Like I said, I haven't seen that piece of paper since two years ago.**

Q And it says that Tyler was on David's left side

holding both wrists. Does that ring any bells for you?
A I mean, if it's on that paper, then -- like I said, I don't remember what all I --
Q Okay.
A -- put on there.
Q And it says that you saw David Cains look up at Tyler and spit?
A Yes.
Q Okay. Do you recall that?
A I recall him spitting.
Q Okay. And then it says that Mandy Jones then held David's head so that he couldn't spit.
A I -- it's been -- it's been a while. I don't know everything, what all they did. I just remember what all happened when I --
Q Well, it's in your report that she --
A Yes.
Q -- held his head --
A Okay.
Q -- so --
A Well, I don't have that report in front of me. I don't know -- I haven't seen that report in two years. They wouldn't send me a copy of it. So, whatever you're reading from my report, then that's what I wrote.
Q Okay. Assuming that what I'm reading is accurate,

assuming that I'm reading it to you accurately, Ms. Campos, that would mean that what you wrote is true; right?

A Right.

Q And, if you did in fact write in your report that Mandy Jones was holding David's head, then Mandy Jones was holding David's head; right?

A Right.

Q Okay. And then it says that you saw David Cains' legs start to kick and you stepped in to assist by holding both ankles.

A Correct.

Q Okay.

So nowhere in that statement do you say that you saw David kick anybody or hit anybody; correct?

A Correct.

Q All right.

A I mean, we were all shooken up because we all -- I mean, obviously, we all knew he had pass -- or we didn't know he passed. But something was wrong and I mean --

Q Are you saying --

A -- like all of our nerves were up.

Q And they made you do this statement --

A Like right after everything happened.

So, I mean, we didn't have no time to sit down and

rethink, you know. . .
Q And then they never gave you an opportunity to be interviewed again by Sandy and more thoroughly; correct?
A No.
Q And, as far as you recall, Sandy never questioned you at all; correct?
A Correct.
Q So my point, again, you just assuming that what -- I know you don't have it. But assuming that what I'm looking at or assuming that I'm accurately describing to you what your statement says, you have no reason to think that something you put in here isn't true, do you?
A No. All -- everything I put in there is true.
Q Okay.
A I mean, I wouldn't lie. That someone's life, you know?
Q Right. And I'm just pointing out that, you know, you didn't put -- you did mention that he spit.

But you make no mention of him actually striking anybody with his hands or his feet, nor do you make any mention of it in your DRA statement, according to their report.

So would you agree with me then that you have no specific memory of him landing a punch or a hit with either his feet or his hands?

A All I remember was he was trying to kick. And I was trying to help him from hurting himself or others.
Q I understand that. And I do understand that --
A And --
Q I understand that. I believe you. And I promise you, I'm not trying to make you out to be a bad person.
I'm, honestly -- I just have to -- I wasn't there, there's no video of it. I just have to get a very detailed and very accurate understanding of what happened.
A Right.
Q So these little, little details are very, very important. And, again, I promise you, this is not about making you look bad. That's not my intention at all.
And, after today, you know, you probably won't ever have to think about this again.
But -- and I just want you to listen to when I ask that --
A What do you mean by that? Am I -- I mean, that I'll never have to worry about this again. I mean, this is -- it's serious.
And I'm scared for my life, you know, because all we were trying to do was refrain from -- I mean, we didn't expect this to happen. It was -- it all hap -- it was crazy. I mean --

Q I can tell you that, you know, I do not foresee any possible way that you would suffer any personal consequences at this point. Okay?
A Okay.
Q You know, you're not being sued.
A No. Am I --
Q You know, I didn't sue you.
A Am I -- prison, that's what I'm worried about. Like --
Q No.
A I mean, I've never been to freaking jail. I don't want to --
Q I can promise you, I promise you, we're not -- nobody's going to sue you.
A Okay.
Q At least over this case.
A Yeah.
Q I don't know what you're getting up to in other parts of your life.
A No. No. Hopefully not that.
Q I can promise you, nobody's going sue you. And it's not possible, it's not legally possible, for you to get in any trouble at this point.
A Okay.
Q Okay?

Well, all I'm asking is what -- let me repeat it.

Your written statement that you did right after and the statement that you gave to DRA, they do mention you saw David spit, but neither of them mentioned that you saw him strike with his hand, strike anyone with his hands or his feet.

I'm just confirming that. You did not see him strike anyone, make contact, strike anyone --

A Yeah. I didn't --

Q -- with his hands or his feet?

A He didn't fully kick. He was kicking at. And that's when I stepped in to -- or try not let that escalate, you know, him hurting himself or someone else.

Q So you're saying that -- but you did not see him strike anyone --

A No.

Q -- actually make contact; correct?

A From the time I was there, no.

Q Okay. You don't know what happened --

A And I know at the time -- at the time, my nerves were completely up.

And, I mean, you -- I know I left out -- I mean, obviously, you can tell too and the interviewers before y'all. I mean, there's lots of things being left out.

But at the time, our -- everything was just -- we

were scared. I mean, I was only 20 years old thinking that, oh, no, I'm going to prison because someone passed away. But I mean --

Q I understand.

A And when they interviewed us, they were pretty -- I mean, that was the first time I've ever been interviewed like that. So I was pretty intimidated.

Q When --

A I mean, I was sweating bullets, I mean --

Q On that Zoom?

A Yes.

Q I understand that you don't know what happened before you got there.

But, after you got there, did you or did you not see David land a blow with his hands or his legs?

A No.

Q You did not see that?

A No.

Q Okay. You didn't see him destroy any property, did you?

A No. He didn't destroy anything.

Q All right. And so, since you didn't see him land any blows, obviously, you didn't see him causing injury to staff either; correct?

A Not that I'm aware of. No.

Q Okay.
A Like I said we -- as soon as I called the nurses, I mean, everybody was pretty, boom, boom, boom.
Q Uh-huh.
A I mean, they -- as all -- everything that I heard, David was a wonderful person. He was a wonderful guy. He was fun to be around. I mean, nobody was there to harm him.
Q No. I do not think at all that you intended to harm him.
A No.
Q I know that you did not intend to harm him. Everybody understands that.
This is more about policy failures. But that's not for -- it's not your responsibility to understand my case at this point. So --
A Right.
Q -- were you aware that David -- you are aware David had just eaten lunch at the time of this incident?
A He just -- he just got done or he was in the middle of eating.
Q Well, is there any reason he would have been eating his lunch in the lobby? Wouldn't he have done that in the cafeteria?
A It could have been -- I don't -- I don't know. I

was not there.
Q But you knew he'd eaten --
A He ate breakfast --
Q -- short --
A -- he ate breakfast. He ate -- he -- they have snacks through a certain period.
Some of them get snacks, so I don't know what all he had ate'n or when -- when he did eat.
Q But you --
A I don't -- I do not know if he was eating lunch at that time.
Q Okay.
A I should -- that's what I meant to say. I was just trying to think around everything.
Q Did you know if he had recently eaten lunch before this incident?
A I don't know.

[redacted]



Q Are you talking about the quick look sheet?
A Oh, I don't remember --
Q Let me pull it -- let me show you something and --
A Okay.
Q -- tell me if this is what you're talking about.
Just a moment.
MR. COLLINS: Hey, Josh, if you'd wait one second please.
MR. GILLISPIE: Yeah.
MR. COLLINS: I think Mark is joining a little bit too soon, unless he just disconnected. Okay. I think he disconnected. You're good.
BY MR. GILLISPIE:

Q Can you see this?
A Yes.
Q Is this what you would have been able to --
A Every -- everything was printed out and in a binder. We had no computers.
MR. COLLINS: Hey, Josh, if I can interrupt real quick. All I see right now is your master exhibit list. I'm not seeing --
THE WITNESS: Yeah.
MR. GILLISPIE: Okay.
BY MR. GILLISPIE:
Q You don't see something that says Quick Look Sheet?
A No.
MR. COLLINS: I saw the document titled that, but the document is not pulled up. It's just in the list.
MR. GILLISPIE: Okay. Do you see it now?
THE WITNESS: Yes.
MR. COLLINS: Yes.
BY MR. GILLISPIE:
Q So all you should be seeing is a two-page document. At the top, it says Quick Look sheet.
A Yes. And underneath special precautions, it should say that he is GERD -- GERD. Yep, there it is.
Q Okay. And I'm just asking, is this quick look sheet

what would have been in that physical file so that staff could look --

A Read, yes.

Q Okay. Okay. And is there any other document that would've -- you said it's a nurse's station where this is kept?

A I mean, that should be at the nurse's station. It should be at each aid station.

Q Aid station.

A Yes. The nurses should have a copy of this also.

Q I didn't mean to say nurse's station. So, yeah --

A No, you're good.

[redacted]

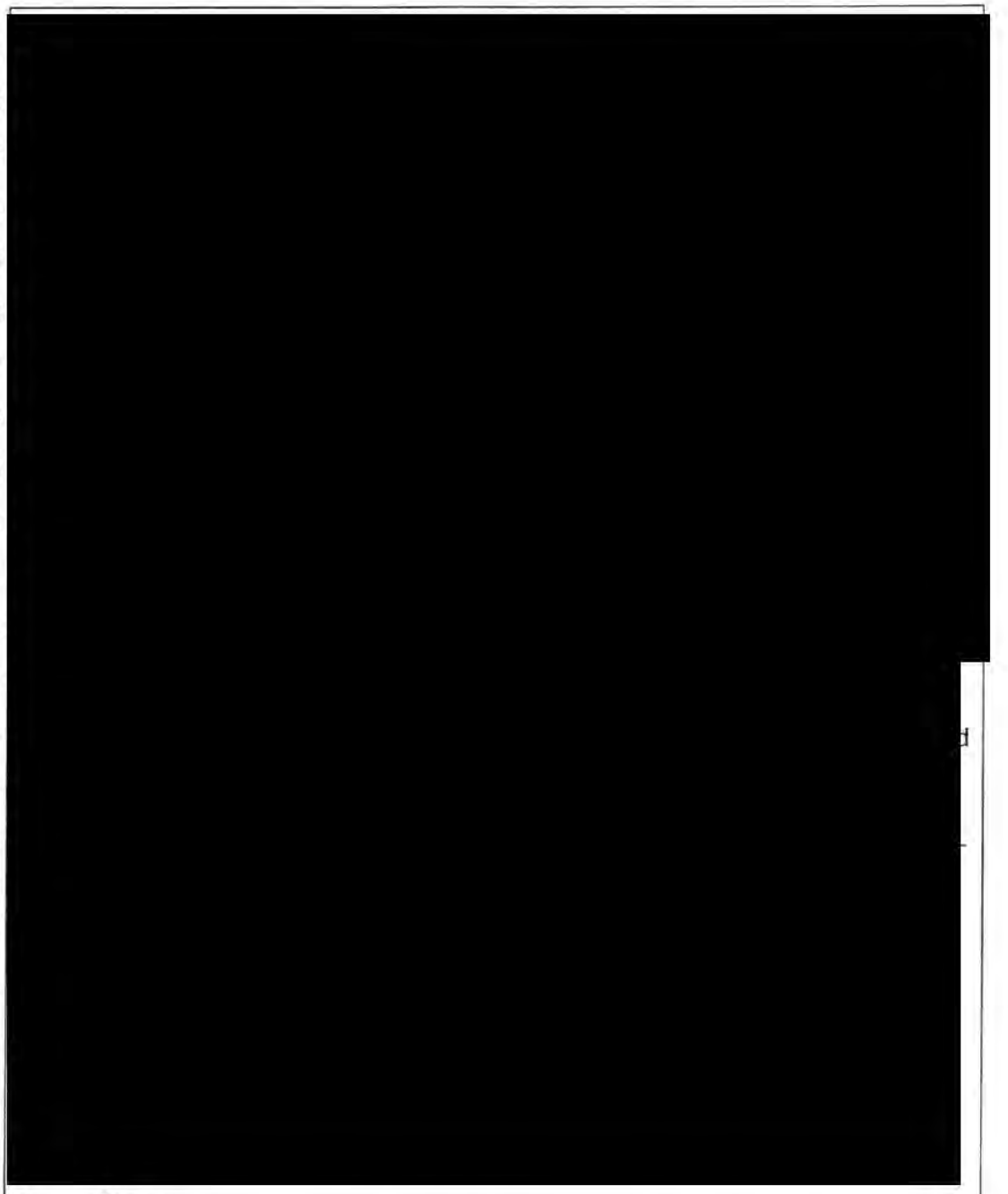
A Like I said, I was at work one day and I was just -- because we get -- they send these papers out like no other.

So we have to go through -- like at the bottom of this paper, it should have a date. And things get updated. So they'll send us a new one. And we have to pull the old one and put the new one in because we --

Q I see.

A -- have new people coming in and out all the time.

[redacted]



Q Okay.

A Unless they sent out before -- after that. I mean --

Q Okay.

MR. GILLISPIE: We'll make this Exhibit 1, Cris. And then how do I stop share? There we go.

(WHEREUPON, the document was marked for identification as Exhibit No. 1 and is attached hereto.)

BY MR. GILLISPIE:

Q All right. Y'all can't see my stuff now; right?

A No, we cannot.

Q Okay. Good. I got lots of secret stuff on there.

A Okay.

Q Not really. Not really.

A Probably a bunch of mess that you would really not have to worry about.

Q According to the DR, the Disability Rights Report, according to -- there's a portion of the DR, Disability Rights Report, where it describes the statement that you gave them in that Zoom interview.

And it says it was consistent with your written statement, which is good. It says that Ms. Campo states that, when she arrived, David was on the ground on his left side. Tyler was on his knees facing David and holding his wrists and David's hands were by his sides.

A Uh-huh.

Q So is that correct? I suppose that's consistent with your written statement --

A **Yeah.**

Q -- as well.

A **Uh-huh.**

Q Does that jog your memory a little bit?

A **Yeah.**

Q And, as you sit here day, is that your best recollection of what Tyler was doing at the time you arrived?

A **Correct.**

Q Okay. And that would have been, you know, in your best recollection of what David was doing at the time, which was laying on his left side; right?

A **Correct.**

Q And Tyler was on his knees behind David, holding David's wrists, both of his wrists down by David's side; right?

A **Correct.**

Q Okay.

So, at that point, did anybody ever consider, you know, at that point, David is not -- at that point, was David able to -- let me scratch that line of questioning for now.

I'm going to show you one more document.

A Go. She's scratching at the door.

(WHEREUPON, the document was marked for identification as Exhibit No. 2 and is attached hereto.)

MR. GILLISPIE: Okay. You all should be seeing a document. This will be Exhibit 2. Booneville HDC Policy.

Is that supposed to be a one or an I, Eric?

THE WITNESS: I think an I.

MR. COLLINS: I believe it's I.

MR. GILLISPIE: I mean, it looks like an I. It's just in some of -- I've seen other places where it's referred to as a one, so -- okay.

BY MR. GILLISPIE:

Q Policy I-D-4, documentation of response to maladapted behaviors.

You're seeing that, Ms. Campos?

A Yes, sir.

Q Okay. I'm going to go down to -- ignore that Plaintiff's Exhibit 3 sticker.

But, this part here, do you see where it says that emergent restraint is defined as the use of the least restrictive procedure and for the least time necessary to

control severely aggressive or destructive behaviors?
The use of emergency restraint will comply with all relative standards, relevant standards, and regulations. Did I read that correctly?
A Yes.
Q Okay. And you understand what you participated in with David to be an emergency restraint; correct?
A Correct.
Q And you would agree that this policy, this is a rule, what I just read, this is a rule that defines and mandates how to handle emergency restraints situations; correct?
A Correct.
Q And you would agree that, in an emergency restraint situation, that staff must only use the least restrictive procedure possible; correct?
A Correct.
Q Do you know what least restrictive -- how do you understand least restrictive? What do you understand that to mean?
A As in using the Joey board or the other board, the papoose board.
Q Okay. Could you explain what you mean?
A Like we tried to not have to go as far as using the papoose board or Joey board.

Q Okay. So that's your understanding of what the least restrictive procedure means? It means doing whatever you can to not have to use a mechanical restraint?

A Correct.

Q Would it not also mean the least restrictive type of personal restraint --

A Correct.

Q -- as well? It would?

A Correct.

Q Okay. And, by least restrictive, you'd agree that refers to the least restrictive or least restrictive for the client, meaning the least -- something that is the -- now I've got my -- I'm struggling to come up with the word I'm looking for here.

But you would agree that least restrictive means the thing that restricts the client's freedom of movement in the least possible way; correct?

A Correct.

Q Okay. And, for the least amount of time necessary; correct?

A Correct.

Q And that it's only to be used to control severely aggressive or destructive behaviors; correct?

A Correct.

Q And, at the time that you arrived on this scene, you said that -- you've already testified that you didn't see David hit anybody, you didn't see him kick anybody.

And Tyler was holding his wrists, in fact, and Mandy was holding his head, so --

A As from -- from the time --

Q So let me finish my question.

A Okay.

Q So how, at that point, how could -- would you agree that, at that point, would you agree that what you were witnessing there, when you got there, I know, you don't know what happened before. But what you witnessed when you got there could not possibly be described as severely aggressive behavior by David, could it?

A I don't know. I -- I just know that as -- I was just trying to refrain anyone from getting hurt.

Q I get that. I get that. But you can't -- do you think it's fair to describe what David was doing there laying on his side with Tyler holding his hands and Mandy holding some other part of him as severely aggressive by David?

A I mean, from what he did before I showed up, they -- their nerves -- I can't speak for them.

Q You don't know -- we already established you don't know what happened before you shut up.

I'm only talking about what you saw with your eyes --

A Uh-huh.

Q -- Ms. Campos.

And what I'm asking is, do you think it's fair to describe what you personally witnessed by David as severely aggressive, given that he was restrained on his left side, his wrists held by Tyler, Mandy hold another part of him?

A I mean, I -- I don't -- I don't know how to answer that.

Q I just want your opinion. Is that what you would -- would you call what David was doing in that moment when you walked in there, was David being severely aggressive --

A Yes.

Q -- and destructive?

A Yes.

Q Okay. How? How so?

A I mean, he -- he was trying to kick. I mean, he spit in someone's face. I mean, he could have hurt someone or himself.

Q Okay.

And you would agree that you are taught before laying hands on these clients, you are taught that,

before you can lay hands on them, you guys are to do absolutely everything you can to de-escalate the situation, use other methods; right?

A Correct.

Q And one of those methods is defined in the policies as separation?

A Uh-huh.

Q Are you familiar with that?

A Correct.

Q Okay. Well, did it ever occur to you, particularly given that you were aware of his GERD restrictions and that he may have eaten recently and is supposed to have remained upright as opposed to on the ground, given all that, did it ever occur to you to attempt to just separate from him or to -- or for everybody just to kind of get away from him --

A After --

Q -- and let him calm down?

A After -- I mean, everything happened so quickly.

I -- I know as soon as I felt like a nurse needed to be there, that's when I stepped back.

Q But rather than join in, in grabbing his legs when they're already holding him down, why did y'all -- why not just suggest to Tyler and Amy that, hey, let's -- you know, this guy isn't even supposed to be on the ground

for one thing, let's just back up, give him some space, separate, and see if he can just kind of calm down on his own so that we don't have to restrict him so severely?

A Oh, I mean, that's a good question.

Q Would you agree that that might have worked, if it had been tried?

A I -- I -- I don't know. I cannot -- I can't answer that.

Q Well, don't the policies require that you try that though?

A And I'm not saying they didn't try that before all this happened. They could have very well did.

I mean -- and then it could have been him -- I can't -- like I said, I can't speak for them and what happened before I got there. But. . .

Q But nobody attempted that after you got there.

A No. Because after -- after that happened, I called the nurse (inaudible) and then that's when everybody stepped back.

Q Well, when you first got there, you joined in on the ground restraint and grabbed his legs. And that lasted for approximately two minutes. So it wasn't that quick.

But, in that two minutes that you were there, nobody suggested or nobody attempted --

A I mean, nobody --

Q Let me finish.

Nobody suggested or nobody attempted to get up and separate, give him some space, since he's already on the ground and mobilized, get up, give him some space and see if he can gather himself? Nobody did that; right?

A Oh, I was -- I don't know. I --

Q You don't know if, after you got there, there was an attempt made to de-escalate the situation without --

A I mean, we were --

Q -- without grabbing him?

A All I seen when I got there was him kicking, him on his side and still trying to kick.

I mean -- and I tried to refrain anybody get hurt or him hurting himself. And I know I keep repeating myself and repeating myself. But I don't know -- I -- I can't talk for them. And I don't know how else to word it.

Q And I know you can't talk for them. But you can talk for yourself and for the time that you --

A And, yes, I'm sure there is multiple ways that we could have did something better than what we did or how we did it.

I mean, there's always better ways of doing something. But, at that time and how everything escalated and how it ended, I mean, everybody's nerves were up. I mean, it -- it's something I've never been

in.

Q I understand that. But there were -- you said there were better ways and -- meaning, you know, there were less restrictive ways that that situation could have been handled at that point; correct?

A Correct.

Q Okay.

MR. GILLISPIE: I'll pass the witness.

MR. COLLINS: I have nothing for Ms. Campos.

MR. GILLISPIE: Thank you, Ms. Campos.

THE WITNESS: Thank you.

(WHEREUPON, the proceedings were concluded in the matter at 11:17 a.m.)

* * * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Ryann Campos, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

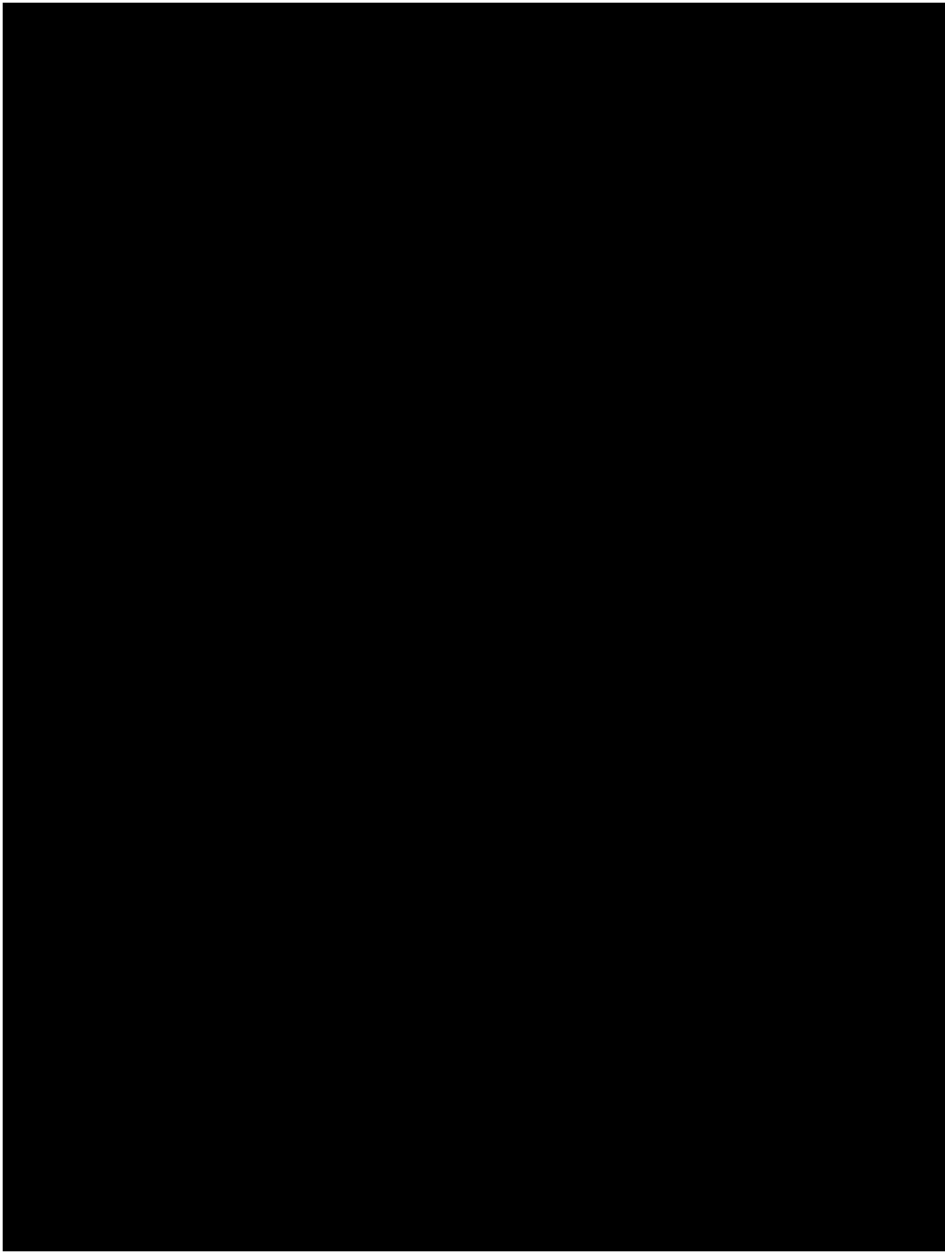
I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

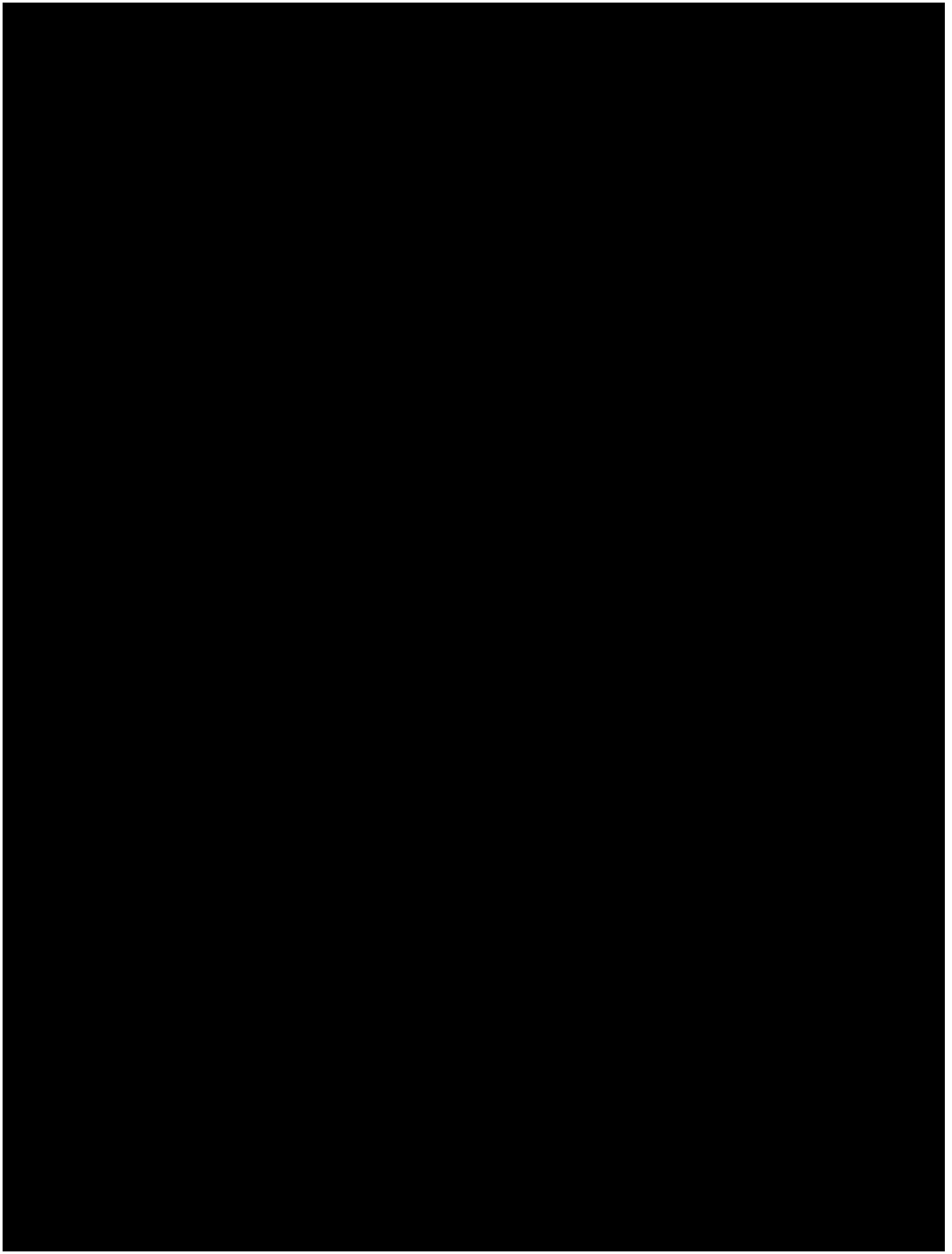
WITNESS MY HAND AND SEAL this 25th day of May, 2022.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031





DOCUMENTATION OF AND RESPONSE TO MALADAPTIVE BEHAVIORS

POLICY STATEMENT: Maladaptive behaviors must be documented on a **Behavior Report (BR)**, a **Behavior Report Documenting Emergency Restraint** (also called the Restraint Log), or other authorized data keeping device. Personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure. Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, or the destruction of property. Nothing in this policy removes or alters requirements as stated in other policies of verbal notification of incidents to the Superintendent and/or other staff.

PROCEDURES:

1. REQUIRED DOCUMENTATION

   a. When indicated, a **BR** must be completed following the maladaptive behavior. Incidents that are to be documented on the **BR** are the following:

      i. Behaviors that pose a threat to the physical or mental well being of the client or others.
      ii. Behaviors that have a direct negative impact on the client's programming.
      iii. Behaviors that directly contribute to the client remaining in a setting requiring a greater degree of supervision rather than a less restrictive one.
      iv. Target Behaviors identified by the Psychology Department and the Interdisciplinary Team.
      v. An incident requiring personal restraint (also requires notification of a QIDP). See Attachment #1.

   b. If the incident requires emergency mechanical restraint, a **Behavior Report Documenting Emergency Restraint** must be completed. Such behaviors are defined as those emergency situations in which behaviors may result in, or have the potential to result in, injury to self or others, or the destruction of property and cannot be controlled through the use of less restrictive measures.

   c. The rules of confidentiality will be followed when documenting these incidents. Any reference to a client other than the identified client in an incident report must be by initial only. Reference to other staff members involved will include their full name and title. All corrections must be made by a single line through the incorrect entry and the writer's initials. The **Behavior Report Documenting Emergency Restraint** must include the signature of the QIDP or other staff member authorizing the restraint.

2. EMERGENCY USE OF RESTRAINT

   a. Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors. The use of emergency restraint will comply with all relevant standards and regulations. Restraint

PLAINTIFF'S EXHIBIT 3

will not be used as punishment or for the convenience of staff in lieu of adequate programming.

b. Seclusion will not be used as either an emergency or programmatic procedure.

c. A QIDP must be notified when personal restraint is used and it must be documented on a **Behavior Report**.

d. Personal restraint of a client is used when the behavior is such that verbal control has been lost and other less restrictive measures have failed to control the behavior.

e. Personal restraint will be implemented by staff who have been trained in the use of approved methods. **Personal restraint must not exceed 10 minutes**. During the period of personal restraint if the client becomes calm no further restraint procedures are to be implemented. If the client shows no indication of calming and becomes violent, staff will proceed as indicated in Paragraph f. below.

f. The request for the emergency use of mechanical restraint will be based on need as exhibited by the client who is so aggressive that restraint is necessary to prevent imminent physical harm to themselves, others, or property. Mechanical restraint may be used only when all other means of controlling the behavior have been exhausted. Staff will proceed in the following manner:

   i. A Restraint Incident Leader will be identified. The attending staff will immediately implement emergency mechanical restraint. As soon as possible staff will notify the on duty Program Supervisor who will contact a QIDP or other authorized staff for authorization for the use of emergency mechanical restraint.
   ii. The authorization for the mechanical restraints must not exceed 15 minutes. Continued use of mechanical restraint must be re-authorized every 15 minutes.
   iii. Immediately after emergency mechanical restraint has been applied, staff must contact the nurse on duty. The nurse will examine the client to ensure the restraint is applied in a pain free and harmless manner and present no physical danger to the client. The nurse will make a notation of the examination on the **Behavior Report Documenting Emergency Restraint**.
   iv. A client in emergency mechanical restraint must be:

      1. Kept under constant visual observation. This observation will be for the client's physical condition (e.g., distressed breathing, bleeding, adequate blood flow to the head and extremities) as well as for signs of calming.
      2. Checked for security of restraint, current behavior and general status. A synopsis will be documented every 15 minutes.
      3. Released for 5 minutes every hour for motion and exercise.
      4. Given the opportunity for fluid intake, meals, baths and toileting. These needs will be addressed and documented as the need arises.

5. Released from emergency mechanical restraint as soon as possible. This is defined to mean as soon as the client is calm and no longer a danger to self or others. Verbal outbursts do not necessarily mean a person is still out of control or that restraint should continue.

v. After release from emergency mechanical restraint, using the **Restraint Incident Debriefing Form**, the Restraint Incident Leader will conduct and document a debriefing discussion with the other staff members involved in the restraint and the client that must include the following:

1. The behavior which resulted in the use of the personal or emergency mechanical restraint.
2. Any environmental factors involved in the incident.
3. The antecedents to the behavior including interactions with peers or staff
4. Any action by staff that might have kept the incident from escalating to restraint.
5. The client's reaction to the use of restraint.
6. Any changes to the client's programming which might have prevented the incident.
7. Options that the client could have used to avoid the use of restraint.

3. COMPLETION OF DOCUMENTATION

a. The person authorizing the use of emergency mechanical restraint must sign the authorization. During deviant hours authorization may be obtained by telephone. Attending staff will note on the **Behavior Report Documenting Emergency Restraint** that such authorization was obtained by telephone.

b. The on duty Program Supervisor will be responsible for ensuring that the appropriate reports are completed in a timely and accurate manner.

c. Completed **Behavior Report Documenting Emergency Restraint** and **Restraint Incident Debriefing Form** will be filed in the client's Master File "Behavior Incident File".

4. REVIEW AND DISTRIBUTION OF THE COMPLETED DOCUMENTS

a. Upon completion of the report it will be sent to the appropriate Team Office.

b. The Team Leader will review all reports for content, accuracy and appropriateness and sign in the appropriate place. If corrections are required the Team Leader will contact the writer of the report and ensure corrections are made. As soon as possible the report will be given to Quality Assurance to be scanned, copied, and distributed to appropriate staff. The original report will be sent to the Record Center Operator and filed in each client's file within five days.

c. The Record Center Operator will review **Behavior Report, Behavior Report Documenting Emergency Restraint,** and **Restraint Incident Debriefing Form** for completeness and errors. The originator will be notified to correct errors found by the Record Center Operator.

d. The QIDP and Psychology staff member will review copies of all reports for programmatic issues, patterns of use, and the appropriate follow-up.

e. The authorized data keeping device (i.e., **Behavior Report, Behavior Report Documenting Emergency Restraint**, and **Restraint Incident Debriefing Form**) will be forwarded to the Psychology Department depending on the program requirement.

5. FUNCTIONAL AND ENVIRONMENTAL ANALYSES OF BEHAVIORS

a. The purposes of conducting functional and environmental analyses are to determine:

1. The pragmatic utility of a behavior for a client, i.e., what the behavior "does" for the client.
2. What role the environment may have played in the causation of the behavior.

These analyses assume aberrant behavior does serve a functional purpose, but that a functionally equivalent (appropriate) communicative response can be taught, and will serve to substitute for the aberrant behavior. Further, the aberrant behavior will reduce in frequency as the more appropriate response becomes systematically reinforced.

b. These analyses will provide the data needed to formulate programmatic responses to teach and reinforce appropriate behaviors to replace aberrant behaviors and inappropriate behaviors.

6. APPROVED RESTRAINT PROCEDURES, TECHNIQUES, AND DEVICES

a. **Personal Restraint,** an emergency procedure limiting movement by the holding of a hand or limb.

b. **Chemical Intervention** ordered by the Physician.

c. **Protective Helmet**.

d. **Papoose Board**, a Mechanical Restraint device limiting movement and range of motion.

f. **Wrist Restraint**, a Mechanical Restraint device limiting movement and range of motion.

7. AT BHDC ONLY ICF/IID QUALIFIED QIDP's SHALL BE APPROVED TO AUTHORIZE THE USE OF RESTRAINT

The Program Coordinator/QIDP is the first choice person to authorize restraint for clients on their caseload. After hours and on weekends the Team Leaders or other qualified QIDPs may be notified.

The following positions are recognized as being qualified QIDPs:

Program Coordinators/QIDPS, Team Leaders, Director of Residential Services, Superintendent, Assistant Superintendent, Director of Quality Assurance; Chief Psychologist, Psychological Examiners, Registered Nurses, and Staff Physician.

Current work telephone numbers for these persons can be obtained from DHS/BHDC Share.

THE STAFF PHYSICIAN MUST REVIEW, BY SIGNATURE, THE USE OF ALL EMERGENCY MECHANICAL RESTRAINT.

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-D-4, dated 01/07/16, in its entirety.

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF

KELLY KING

March 17, 2022, at 1:20 p.m.

CRIS M. BRASUELL, CCR
BREPORTING@GMAIL.COM



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I N D E X

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EXHIBITS IDENTIFIED

(None Marked)

S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Kelly King, produced, sworn, and examined via Zoom, commencing on March 17, 2022, at 1:20 p.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

P R O C E E D I N G S

THEREUPON, Kelly King was duly sworn to tell the truth, the whole truth, and nothing but the truth and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Hey, Ms. King. Could you state your full name for me, please?

A Kelly Sue Gruber King.

Q Okay. Ms. King, I appreciate you being here today.

How long have you been -- you're an LPN at Booneville Human Development Center; correct?

A Correct. Yes.

Q And how long have you worked there in that role?

A Since 2008.

Q Oh, okay. A long time. And you work there still; correct?

A Correct. Yes.

Q All right. Where did you work before there?

A Saint Claire Hospital in Baraboo, Wisconsin.

Q Okay.

And, other than at LPN, do you have any other nursing certificates or degrees or anything like that that I need to know about?

A No.
Q Okay. All right.
Did you know David Cains before he died?
A Well, I worked with him for many years.
Q You did? Okay. You had regular contact with him for many years?
A Yes.
Q Okay. What were your thoughts on him? Did you have a good relationship with him? Did you get along well with him? Was he a troublemaker?
A Yeah. He's a funny -- he was funny. He liked to tease the staff. Yeah.
Q Did he ever cause you any physical harm?
A He slapped me once.
Q He did?
A Yes.
Q He slapped you in the face?
A Correct. Yes.
Q Okay. How did that happen? Or what led to that?
A We were at med pass and he came up for his meds; grabbed his meds and took his meds and then just slapped me across the face.
Q Was it very hard? I mean, did it hurt? Or was it --
A Briefly. It just hurt briefly.

Q Yeah. Is that something that would happen often or just happened that one time?
A To me, just once.
Q Did you require any kind of medical attention for that?
A No. Hu-uh.
Q Okay. Do you know of him slapping, hitting, or in any other way, hurting any other staff?
A Yes. Yes, he did.
Q Tell me about that.
A Well, he -- I remember one time, maybe more than once, he was spinning and trying to slap when the staff was trying to calm him down.

I can tell you twice I walked into the dorm and he had the fire extinguisher above his head; but, the minute he saw me, he gave it to me.

Q So, Ms. King, Nurse King, I appreciate you going into great detail. But I mean just injuries.

Do you know of any injury he ever caused to a staff member that required medical attention?
A No. Not that I can think of offhand.
Q Okay. Do you know of any specific incidents where he slapped another and made contact, like he did with you, slapped another staff member?
A Specific? No.

Q Okay. What about kicking or punching?
A Well, I know he punched a female staff in the stomach. I didn't actually witness it, but I was called to see him after that.
Q Okay. Who was the staff member?
A Her name is Christina.
Q Christina?
A Yeah.
Q Do you know the last name?
A I don't. I'm not good with their first names, so getting that's pretty good for me.
Q When about did that happen?
A I'd say two or three years ago.
Q Do you know the circumstances?
A I don't.
Q And so Christina then came -- he punched her in the stomach is your understanding?
A Correct. Yeah.
Q You didn't see it though?
A Correct.
Q But this staff member came to you afterwards?
A No. Hu-uh.
Q They didn't come to you for treatment?
A No.
Q And they didn't --

A We're not allowed to treat the staff.
Q Oh, okay. Do you know if this staff member required medical treatment?
A She did not.
Q Okay. How did you know it happened?
A I was called over to assess him for a chemical.
Q Okay. And do you where -- do you know if there's documentation? We didn't find -- when going through his behavioral incident reports, we didn't see this.
Do you know if there's documentation on this somewhere?
A I don't know. The staff would have to write a behavior report and I don't think --
Q Okay.
A Okay.
Q Thank you. I didn't mean to cut you off. I just don't want to waste more of your time than I have to.
MR. GILLISPIE: Eric, would you please check and see if there's a -- that's not in what we were given. Would you see if that exists for that?
MR. COLLINS: Yeah, I will.
MR. GILLISPIE: And also the one that I think Amy or Caleb mentioned but didn't know any details on as well, if there's any

documentation on that that exists.

MR. COLLINS: Gotcha.

BY MR. GILLISPIE:

Q Okay.

Nurse King, I apologize if I already asked this question, but it's been a long day.

Are you aware of any -- are you aware of David harming anybody to the extent they needed medical treatment at any point? Are you specifically aware of that ever happening?

A No.

Q Okay. Did you consider David to be among the more dangerous and violent of the clients there?

A No.

Q A couple of the other nurses have told me that there were -- okay. There are, at times, patients who are sexual assault risks or, you know, can truly be dangerous men. Is that your -- would you agree with that?

That there are clients that are, you know, you would actually be fearful of being caught alone with?

A Yes.

Q David was not one of those though; right?

A No.

Q Okay.

And, the time that he slapped you, did you feel like

you were in any serious danger of any kind of significant physical injury or was it more like a, you know, a child who is acting out?
A Probably more like a child that was acting out.
Q Okay. Did you ever personally witness anything that David did that would be considered something that could cause severe physical injury to someone?
A Yes. Like I said, he held the fire extinguishers over his head like he was getting ready to throw them at staff.
Q Uh-huh. Did he throw it?
A No. He did not.
Q Okay. Other than that, anything else? Is that it?
A Nothing that I can recall.
Q Okay. Very good.
Did you ever participate in any physical -- okay. Let me preface this by saying I don't mean chemical restraints; meaning, I know that you would probably, at times, be called to administer Ativan or something. I'm not talking about that.
Did you ever participate in any personal, physical restraints, like holding him on the ground or helping him get put in a mechanical restraint? Anything like that?
A No.
Q Okay. Did you ever witness that happen?

A I remember him being on the board, but I don't recall seeing his actually being put on a board.
Q Okay. Do you know the circumstances for why he was on that board at that time?
A The only time they're in that circumstance is when they're just out of control. Physically out of control.
Q And is it your understanding that David, on the day of his death, was that physically out of control? Or do you not know?
A I don't know. Actually, I don't know.
Q Have you since talked to anybody about what was going on before you guys arrived on the scene?
A Not -- not beforehand. No.
Q Since he died, have you talked to anybody, whether it be one of the direct care staff or anybody else, have you learned anything about what was going on prior to when he went into cardiac arrest?
A No. We didn't discuss it.
Q Okay. You've not discussed it with anybody?
A Correct.
Q Other that your -- other than Mr. Collins, which I don't get to know about. But, anybody else, I do get to know about.
A No.
Q Okay.

So you have zero knowledge about what his behavior was like prior to medical getting the emergency call that day?

A Well, afterwards, a group of people -- right afterwards, a group of people got together and our boss asked what happened.

And I don't -- there was a young girl. I remember a young girl being there and I remember she said that he was thrashing about. I don't think she used that term. And that he was waving his arms, quote, like he was trying to hit us.

That's all I can tell you that I know about that.

Q And you don't know which young girl was saying that?

A No, I don't.

Q Would it have been Amy Mandy Jones or Ryann Campos?

A I know it wasn't Mandy. I don't think it was Mandy and I don't think it was Ryann. I don't know who Amy is.

Q Amy is Mandy's first name. She just goes by Mandy.

A Oh. I don't know who it was. She was young. That's about all I know.

Q Okay.

So you never participated in a personal restraint. Did you ever witness David be restrained by direct care staff?

A Yes. I mean, kind of.

Q Okay. Did you ever witness David be restrained by direct care staff on the ground?
A I don't think on the ground.
Q Did you ever witness direct care staff restrain anybody on the ground?
A Yes.
Q Okay. How often?
A I'd say probably once every two or three months.
Q Okay. And is it your understanding that, like Ms. Schmitt told me, is it your understanding that direct care staff received some kind of training on how to take clients to the ground when necessary?
A Yes. They get training.
Q In specifically that?
A Yes.
Q And do you have any idea what that training is? I know you don't receive that training, do you?
A No. The only -- no.
Q Do you know what it is?
A I don't know. I don't know. I've never seen it. I've never seen it by an instructor anyway.
Q You've never seen it, you've never seen the training? You've seen it done, you've just never seen the training, you mean?
A Right. Yes.

Q Okay.
And, when you've seen direct care staff take a client to the ground, can you describe an example of that, of what you've seen?
A Well, usually, they -- they're just down on the ground and the staff is kind of like in a half hold. Not like a full-body hold but just holding them down.
And the only time they do that is when we have to give them a chemical so that nobody else is getting hurt from the needle and that the needle just goes into the client.
Q And you'd say you've seen that, with them kind of holding them on the ground like that, what did you say, once every couple months?
A Yeah. Two, three months.
Q And you've been working there for over a decade?
A Yeah.
Q Okay. Do you know who trains them in that by chance?
A Mark Hise.
Q Okay. That's what I thought.
Was there a staffing issue with direct care staff in this time period around June of 2020? Were they short staffed? Do you have any knowledge of that?
A I think we were full staffed back then. I think

there was about, I could be wrong, maybe 300 employees at the time.

Q Okay.

So my understanding of your involvement -- and you can just correct -- I'm going to save us all some time here and tell you what my understanding is. And you just tell me if I get it wrong and then you can correct me.

But my understanding of your involvement is that you and Nurse Schmitt and Nurse Noah were in the Judge Hill building on this day. Nurse Noah received a call from Ryann Campos stating that, I think they got the name of the client wrong, but stating that a client was not breathing over in the commons area.

So far, is that correct?

A Yes.

Q Okay. And then Nurse Noah, I guess, kind of tells you and Nurse Schmitt to get on over there pretty quickly; right?

A Correct.

Q Okay. And Nurse Schmitt tells me that you guys then immediately got up, walked out to her car, grabbed the AED.

She estimated that probably took about, I think she said, 40, 45 seconds to get to her car. Is that about right?

A I would probably say 30 seconds. It wasn't -- it wasn't long.
Q Okay. And then her estimate was I think it was another --
MR. GILLISPIE: Eric, correct me if I'm wrong, if you remember better than me.
BY MR. GILLISPIE:
Q I think she said it was another, maybe a minute, to get to -- to drive over to the building itself.
A Yes.
Q Is that about right?
A That's correct. Yes.
MR. COLLINS: Uh-huh.
BY MR. GILLISPIE:
Q And then maybe, what, another --
A Thirty --
Q -- 40, 45 seconds to get out, walk in, and get to the scene?
A Yeah. About 30 seconds.
Q Okay.
And then what do you see immediately? What do you recall seeing immediately?
A David Cains was laying on his right side.
Q Okay. And was anybody doing anything to --
A No. I didn't see him at first because we had to

come up the stairs. But I believe it was Ryann in front of him clearing his mouth.

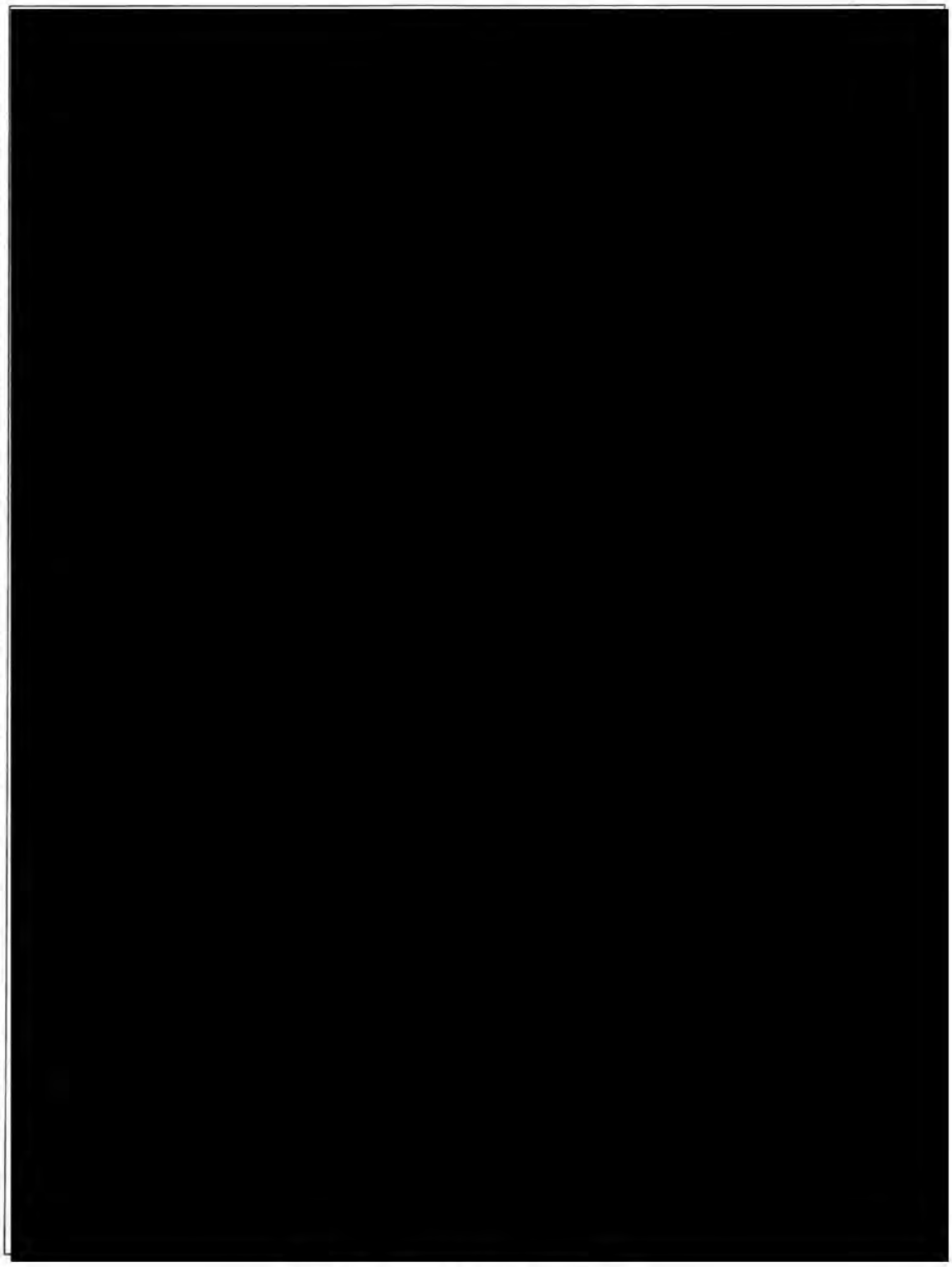
Q Uh-huh. Okay. And, in as much detail as you can recall, tell me what happened next.

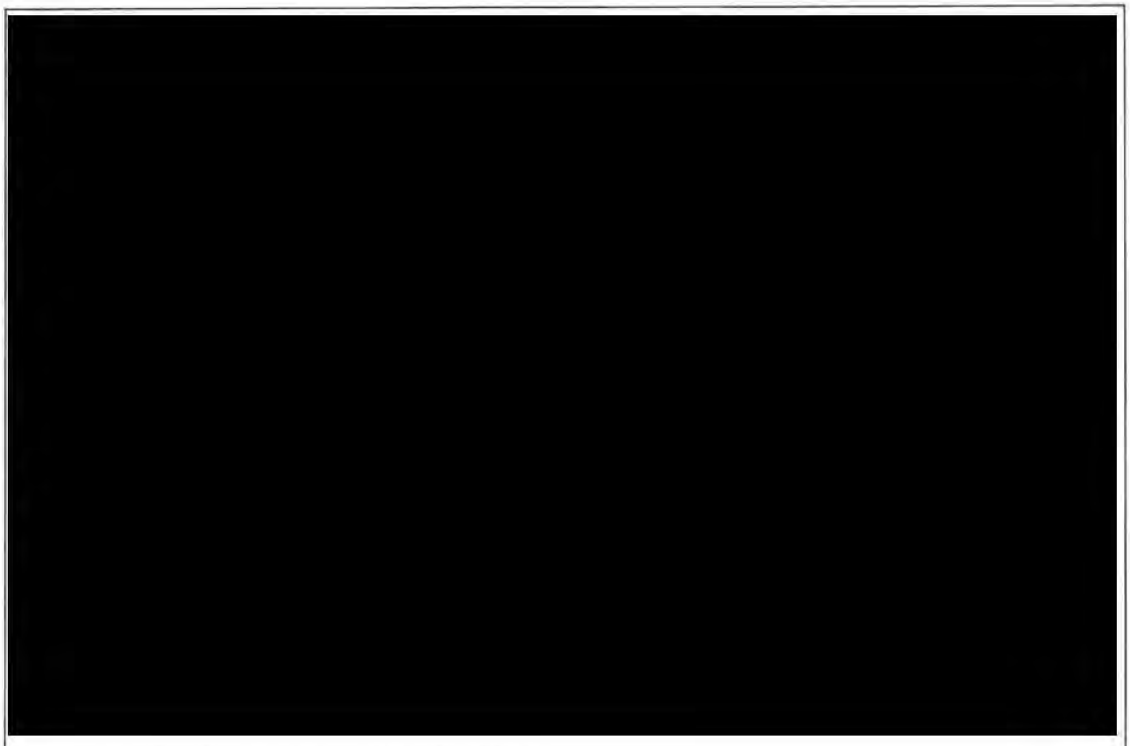
A Actually --

Q Starting with you arriving at the scene.

A Okay. Actually, I'm not sure, but I think there was somebody at the double doors by the kitchen when we first came on; because I think that's when we asked if -- or -- I can't remember if we said call 9-1-1 or -- I don't remember the exact conversation. But I think that's when it was called.

[redacted]





Q And who had called EMS?
A You know, I'm not real sure, to tell you the truth. I -- I'm not real sure.
Q Okay. And I am correct that only you, medical staff, at this time, were authorized to call 9-1-1; right?
A Yes.
Q Do you know why that was a policy?
A I'm actually -- I think it's because we can respond faster than EMS.
Q Well, but --
A Initially.
Q -- what would have been the harm to allow staff to

call you and 9-1-1 at the same time?
A Oh, well, they can.
Q Their understanding was they weren't allowed to. And that's been my understanding throughout this. That there was a policy that only medical staff, meaning you and other nurses and what other doctors maybe were authorized, to ever call 9-1-1 at this time.
A Well, BHDC wants medical staff to make that decision.

But American Red Cross does tell you that you can call 9-1-1 and that is a part of the American Red Cross teaching that everybody gets.
Q So what if the American Red Cross teaching contradicts or -- I'll tell you what. Scratch that. Withdraw that line of questioning.

Debbie Noah got a call that a client was not breathing. Can I ask why 9-1-1 wasn't just called right at that moment?

Like I know that you guys needed to get over there right away, but why couldn't Debbie or somebody else at Judge Hill or one of you, while you were driving over there, also not call 9-1-1- like, right away, when you hear somebody's not breathing?

I mean, that's what I would do. I'm just trying to figure out why, you know, y'all didn't do that.

A I don't know who called or when. I mean, they could have called. I don't know.
Q Well, that's not what I'm asking. I'm asking why you personally, why didn't you call 9-1-1 when you are riding over there in the car with Amanda?
A Why didn't I call?
Q Right. Because 9-1-1 -- everybody that I've talked to tells me that 9-1-1 has equipment and capabilities superior, life-saving equipment and capabilities.

You know, they have EpiPens, they can do intubation, they can do deep suctioning, they can, you know, communicate. You know, they have superior life-saving skills.

So I'm just asking, you know, why didn't you or Ms. Noah or Ms. Schmitt or somebody else, anybody else, call 9-1-1 the second you heard that a patient --
A I don't --
Q -- was literally not breathing?
A Well, because, I mean, I didn't really know what was going on and a lot of --
Q But you were told he wasn't breathing. Did you not believe the person?
A Well --
Q Did you need to see it for yourself?
A Yes. Actually, I did.

Q Why?
A Well, because, a lot of times, we get calls and they say things that aren't quite -- like, for example, recently, we've had two phone calls that clients were nonresponsive.
Well, when we hear nonresponsive, we're thinking that they're passed out and they're not responding to physical stimuli.
So we get calls like that and they're actually awake and alert, they're just not -- they're ignoring their staff. So, we actually --
Q Right.
A -- need to see what's --
Q Nonresponsive is different than not breathing. This call was specific. It was somebody's not breathing.
Do you get calls from your -- do you guys regularly get calls from staff telling you somebody's not breathing when they actually are, in fact, breathing?
You get a lot of cry-wolf, not breathing calls at --
MR. COLLINS: I'm going to object to this. She's answering your question. She's given her reasoning as to why she didn't call.
BY MR. GILLISPIE:
Q You still have to go ahead and answer.
A Actually, I have had a couple of phone calls where a

client is not breathing within the last year; and, when we got there, they were, in fact, breathing.
Q Okay. And, because of that, you guys just don't take staff's word for it? You have to see -- medical needs to see for themselves that somebody's dead or not breathing before you call 9-1-1? And that seems like a safe policy to you?
A I -- you know, I don't even know how to answer that, to be honest with you.
Q Well, yes or no?
A Yes or no what?
MR. GILLISPIE: Cris, could you read her the question again that I just asked?
COURT REPORTER: The very last part of the questions was seems like -- does that seem like a safe policy to you? Meaning --
MR. GILLISPIE: Actually, back it up. Back it up. Read the whole passage of what I said to her.
COURT REPORTER: Okay. You have to see for yourself if somebody is breathing before your -- you will call 9-1-1. Does that seem like a safe policy to you.
A Well --
BY MR. GILLISPIE:

Q So that's two questions, actually.
The first question, Nurse King, is do you have to see it for yourself? That's question one.
The second question is, does that seem like a good, safe policy to you?
So you can go ahead and answer now.
A You know, I'm going to say no for both those questions.
Q Okay. You don't have to see it for yourself?
A Correct.
Q And, had that been the policy, you would agree that's not a safe policy then? Or no for both questions is fine. You answered it.
And you would agree with me though about the part about paramedics having the superior capabilities, superior life-saving capabilities?
A Yes.
Q Okay. They have equipment that y'all don't have; right?
A Yeah. They can intubate and we can't.
Q And they can -- they can administer --
A IV medications. They can -- they have an automatic compression machine where ours is all by hand.
Q And they have a, I believe, deep suctioning device?
A Yes.

Q Okay. And those are all things that y'all don't have that they do have; right?
A Yes.
Q And that's not your fault. This isn't an attack on you. It's not your fault. I'm just, you know -- of course that's not your -- you don't set this policy. You don't make those decisions. I just, you know, just want to know the facts.
Okay. Last bit of questioning. Do you have any knowledge as to specifically what caused David to -- well, actually, back up.



[redacted]

Q Okay.

MR. GILLISPIE: I'm going to take a couple of minutes and see if there's anything else.

MR. COLLINS: Okay.

MR. GILLISPIE: Thanks.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Ms. King, you said you were there when the paramedics arrived? Yes?

A Yes.

Q Okay. Did police or firemen arrive as well or do you just recall ambulance?

A No, I just remember two EMS people.

[redacted]

Q Do you recall who would have spoken to -- do you

recall anybody telling the paramedics about how it all happened?
A I don't. No.
Q Okay.
Do you have any information about, relevant information, about any of these direct care staff, meaning Campos, Mattson, and Jones, that you thinking is important to this case or you might talk about at a trial of this matter?
A No. In fact, the only one that I even know is Tyler Mattson.
Q Okay. And what's your impression of him?
A He's a -- seems like a good kid. He doesn't work here anymore. But I don't think he worked here very long.
Q You don't have any knowledge of him having issues of going overboard in physical restraints with clients?
A I've never seen it.
Q Have of heard of that?
A And I've never heard of anything either.
Q Okay.
Do you know if David Cains, if there were any staff members that had an issue with David Cains or that David Cains had an issue with or was afraid of or would tend to get upset around?

A No, actually, I don't.
Q Okay.
A I -- he never showed me around anybody.
Q Is there anything else that you have to say about this matter?

And let me clarify. What I mean is, you know, we may have to have a trial in this case in which you're going to testify.

You know, is there anything that I haven't asked you about that you feel like is important information that you have and that you're going to want to share at trial?
A I don't think so. And, really, I think you know more about it than me. I don't know what else to say.
Q And you've not had conversations with anybody at the facility about --
A I wanted to. But I'm trying to remember everything on my own, to be honest with you.
Q Okay.

All right. Well, I appreciate you being here today. Thank you.

MR. COLLINS: Thank you.

(WHEREUPON, the proceedings were concluded in the matter at 1:55 p.m.)

* * * * * * * * *

(**WITNESS EXCUSED**)

CERTIFICATE

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Kelly King, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 29th day of March, 2022.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

SIGNATURE OF DEPONENT CERTIFICATE

I, Kelly King, do hereby certify that I have read the foregoing deposition and that, to the best of my knowledge and belief, said deposition is true and accurate with the exception of the following corrections listed below:

PAGE	LINE	CORRECTION
8	6	Christine was there but not the one
		hit in the Stomach. She
		Couldn't remember anything
		about it but Said David would
		~~targeting~~ target Jessica Vinez
		& Brittany Engell, I spoke
		with both girls & they
		Said it wasn't them
		who got hit in the Stomach.

3-31-22
Date

Signature of Witness

STATE OF ARKANSAS
ss
COUNTY OF Logan

SUBSCRIBED AND SWORN TO before me this 31st day of March, 2022.

My commission expires:
May 12, 2028

Kimberly Thomas
NOTARY PUBLIC

STATE OF ARKANSAS NOTARY PUBLIC
KIMBERLY THOMAS
MY COMMISSION # 12704379
EXPIRES: May 12, 2028
Logan County

Kastner

The evidence in this case tells the following story:

If he had been standing or seated when he vomited, he would not have drowned in his vomit/aspirated death, regardless of what caused the vomiting; he was on the ground when he vomited because staff were holding him on the ground, regardless of how he got to the ground. Staff were not authorized to hold clients on the ground, not trained to do so, and were in violation of policy in doing so.

At the end of the day there were three staff members supposedly trained in CPR and first aid right next to DC with their hands on him, yet they somehow let him drowned in his own vomit right in front of them.

DRA warnings ignored. Gonyea acknowledged that he ignores DRA.

BHDC's NEGLIGENCE CAUSED DC'S DEATH

Kastner

DUTY

To adhere to state and federal regulations concerning restraint usage, as well as the Booneville facility's own policies and procedures.

Rules

FORESEEABILITY

She claims it is a goal of DDS to reduce restraints as much as possible; **she agrees that is because restraints increase the risk of danger to both clients and staff**. Melissa Weatherton, p. 30.

"The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. **The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used**. All efforts

must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program) when ***a very real risk of personal injury or severe property damage is imminent***." BHDC Restraint Incident Debriefing Form. This written directive was in use at BHDC at the time of Davie's death. BHDC Superintendent Jeff Gonyea, p. 65.

"**A personal hold is dangerous if you are the client period wherever you're at**. That's why you use the least restrictive method you can that's available to you at the time." Carrie Johnson-Miller, p. 43.

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF

AMANDA SCHMITT

March 17, 2022, at 9:15 a.m.

CRIS M. BRASUELL, CCR
BREPORTING@GMAIL.COM



A P P E A R A N C E S

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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Amanda Schmitt, produced, sworn, and examined via Zoom, commencing on March 17, 2022, at 9:15 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

PROCEEDINGS

THEREUPON, Amanda Schmitt was duly sworn to tell the truth, the whole truth, and nothing but the truth and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Ms. Schmitt, could you please state your full name for us?

A My name is Amanda Schmitt. My married name is McClure but I still go by, legally, Schmitt.

Q Okay. And my name is Josh Gillispie. I'm an attorney for David Cains and his family and I'm going to be asking you some questions here today.

Have you ever been deposed before?

A No. Not -- not anything like this. I've spoken like to office of long-term care and stuff but never like -- it's never went past there.

Q Okay. Let's just jump right in.

Are you still employed at Booneville Human Development Center?

A No.

Q Okay. Where do you work now?

A I work at Legacy Health and Rehab.

Q Okay. When did you stop working at Booneville?

A About a month ago.
Q All right. Why did you switch jobs?
A I -- I needed to explore other opportunities. I -- it's not a very good work environment for me, on the Hill.
Q Okay. Why is that?
A I -- I don't agree with a lot of issues there between the DEON, the ADON, myself, and just all of medical, in general.
Q I'm sorry, Ms. Schmitt. You cut out partially there. Would you mind repeating that last sentence starting with I don't agree with?
A I don't -- I just don't agree with a lot of viewpoints of the DON, the ADON, and just how medical -- the medical department is there.
Q What is D --
A It just wasn't a good fit for me anymore.
Q What does DON stand for? Is that department of nursing?
A Director of nursing, yeah.
Q And who's the director of nursing there?
A Stacy Weinbernner.
Q Okay. And what was the other? AD --
A The ADON is Angie Nelson.
Q Okay. And I assume that's the assistant director of

nursing.
A ADON, it's assistant director of nursing.
Q Okay.
Could you tell me, please, what the things are that you disagreed with? It may not be relevant but I just need to know just in case it is relevant to this case.
A Well, the medical department and the living area departments are very separate there.
If I have a concern about something, I'm told that that's not my lane and to stay out of it. I have a hard time with that.
I feel like the care of the residents should be a little bit more and medical should have a little bit more say in it.
Got in a lot of arguments with everybody there over things, simple things, just where the two departments can't agree to make a decision for the residents.
And then there are some personal issues between the -- between Angie Nelson and I.
Q Okay. I don't need to know, I won't get into your personal business. But, as far as the other stuff you were telling me about, what of that would, if any, would relate to what happened with Mr. Cains? Do you think that played a role?
A I don't believe that it necessarily played a role in

what happened with him.

But like, from a medical perspective, I had pulled him from schedule full times because I felt like he was too overwhelmed to go to class that day or to his work area or to go to Commons to eat and had placed him, you know, back at the dorm for those instead of going to those activities.

And, ultimately, I'm not allowed to make that decision. It has to be made by his team.

Q So you feel like there were a lot of times where, emotionally, it was better for him, safer for him to just go back to his dorm; and you wish you would have been able to make that call for him?

A Yeah. I'd made that call several times, to send him back to his dorm from class because he just became overwhelmed sometimes.

Q Do you know if that was happening on the day he died? Was he overwhelmed? Do you know?

A I did not see him, unfortunately, until he was already down that day.

Q Okay. So you don't know what his mood was like previous, prior to when he started choking that day?

A No. I wasn't his nurse that morning, I don't believe. I believe that Kelly King was his nurse that morning and I was working the upstairs dorm.

Q Okay. How long did you work at Booneville?
A Five years.
Q And you're an LPN; correct?
A Yes.
Q Do you have any other licenses or specialized training that I should know about?
A No. I don't have any like specialized training other than [redacted] So I've got a couple of years of like hands-on experience with special needs. But nothing that -- like school wise.

[redacted]

[redacted]

A Yeah.

Q Did you grow up in the Booneville area?

A Yes.
Q Okay. Where did you go to school?
A Booneville.
Q Booneville High?
Any college?
A Yes. I went to the nursing program at ATU at Ozark.
Q And how long is that program?
A That was a long time ago. I think it's about a year.
I've went back since then and gotten a degree, taken some classes. I was going to go back for my RN but then I had kids that started college and decided that I didn't need to be trying to pay for my college and theirs at the same time, so. . .
Q Sacrifices.
A Yeah.
Q What was your degree in?
A I don't want to tell you wrong, but I think it is -- it's the associates degree with Allied Health, I believe.
Q Okay. The LPN, that was a one-year program at Arkansas Tech Ozark?
A Yes. It wasn't a degree program, at that point. It was just like the diploma nursing.
Q Okay. And, just broadly, tell me about your work history prior to -- where did you work prior to

Booneville?
A Well, I worked four or five years in a nursing home in Booneville. And then I worked at Mercy Fort Smith in the ER Department.
Q Okay.
A And then in the in-patient hospice department before coming to Booneville.
Q Okay.
I'm sorry, but I have to ask this. Have you ever been terminated from any nursing position?
A No, I haven't.
Q Okay. I assume you don't have any criminal history.
A No.
Q Okay.
And so you had worked at Booneville for roughly five years before recently leaving, so you started in maybe, what, 2016, '17?
A I -- yeah. If that was five years ago, then yeah.
Q Yeah. Five years ago from now --
A Yeah.
Q -- (inaudible) 2017.
A Yeah, that sounds right.
Q Was your title the same the whole time?
A Yes.
Q And what was that title?

A LPN.
Q LPN? And not to belabor the obvious but what were your duties and responsibilities as an LPN there at Booneville?
A I did medication, chemical interventions, treatments; just monitored for change in condition.
Q And you did not provide direct care to the clients; correct?
A Like showering, things like that, no.
Q Well, for instance, I've spoken with Amy Jones and I'm going to talk to Ryann Campos and Tyler Mattson.
And my understanding is, you know, they were residential care workers, they provide direct care. Your duties were --
A Yeah.
Q -- really nothing like their duties?
A No, no. I didn't have any of the same things they did.
Q Okay.
What was your interaction -- how much daily interaction did you have with the clients in general?
A That kind of changes day to day. I spend -- I like to spend a little bit more time at the door kind of building those relationships.
But med passes are very quick. We -- we don't get

to spend a lot of time with them during med pass. They -- they line them up in the hall and bring them to the med window, just one right after the other.

The ones I have a little bit more behaviors I spent more time with because, you know, they would call us to do like a check to see if they needed a chemical. And a lot of times, you know, just change in person being with them and talking to them can kind of calm that down.

So, ones with behaviors, I spent a little bit more time with.

Q I'm going to ask you a little bit more about that later.

But, if you could, just take me through a normal day for you there. You get there, what shift did you typically work?

A I worked 6 a.m. until 7:15 p.m.

Q And, if you can, tell me, again, broadly, I don't need you to go minute by minute, but what an average day would be like.

You know, you get there, what building you're in, what do you do, what do you do the next hour. You catch my drift?

A Okay. Pre-COVID and during COVID are kind of different. But --

Q I'm concerned about the time David --

A About --
Q -- (inaudible) his death and --
A -- when this happened?
Q Let's say -- yeah. So COVID started in March of --
A Okay.
Q -- 2020. This happened in June of 2020. So just, you know, spring of 2020, around this time, what was a typical day for you.
A We get to work and clock in at Judge Hill.
Q Okay.
A And we'll count, decide who's going to what area, get our narcotics for that area, and then we go to that dorm.

On the days that I had up and down, I would usually go upstairs and set up a couple of my medications for the ones that don't like to wait for you and then I would go back downstairs and do med pass downstairs and then go back upstairs and do med pass and then come back downstairs to get the couple that had refused to come to the med window. There's always somebody who doesn't want to get up.

And then go back to Judge Hill for our morning meeting. And then the clients would go to their various schedules. And, unless we were called to an area for there being a problem, then I usually wouldn't see them

again until lunchtime. And they were still eating lunch still at Commons, at that point.

Q Where would you be --

A They would get their meds -- where would I what?

Q Where would you physically be when they're at lunch?

A I'm trying to remember if we were already giving meds at the dorm during the incident with David.

Because we had changed some things. Before, they all came up to Commons and got their medication at the med room that's at Commons for lunch. And so we would kind of be in the building while they were, most of them, were eating. Or a nurse would be kind of in the building while they were giving -- while they were eating lunch.

But I believe, when this happened, we were already giving lunch meds at the dorm because some of the work areas weren't going all the time.

It's -- I'm -- it's been awhile and things have been so different.

Q Let me ask it a different way.

When there's downtime, when you're not needed for a chemical intervention, when you're not needed for handing out meds, kind of in that time period that you were alluding to, do you have an office that you go to or somewhere in Judge Hill that you --

A Yeah. We have an office, slash, break room that

we're in for most of the time.
Q Okay.
A If we're not in our dorms.
Q And that's in the Judge Hill building?
A Yes.
Q But you would also be assigned to a specific dorm?
A Yes. Well, when we come in, in the mornings, there's -- the nurses that are working decide where they're going.
Q Okay.
MR. COLLINS: Hey, Josh --
A And Davidson House was --
MR. COLLINS: Go ahead, Amanda.
THE WITNESS: I'm sorry, what?
MR. COLLINS: You go ahead. Finish your --
A Okay. Davidson House was my normal dorm. It's usually where I worked if there were two nurses upstairs. If there were not, then I would work the whole dorm most of the time that I worked.
BY MR. GILLISPIE:
Q Okay.
MR. COLLINS: Josh, before we move on, real quick, I know we kind of skipped past it at the beginning since we were trying to get

into this real quick.

The usual stipulations and reserve any objections, I want to make sure we have that on the record, that we're doing that, and not waiving them; right?

MR. GILLISPIE: Yes. Yes, sir.

MR. COLLINS: Okay. Thank you.

MR. GILLISPIE: Okay.

BY MR. GILLISPIE:

Q Okay.

So we talked about how your role is obviously different than that of the direct care providers.

A Correct.

Q And, by direct care providers, I mean the residential --

A Yeah.

Q I'm sorry. I forgot the term.

A Yeah.

Q Help me out here. For what Tyler and --

A Residential staff.

Q Yeah, residential staff. Direct care staff.

I'm going to refer to them interchangeably as residential staff, direct care staff. Does that make sense to you?

A Yes.

Q Okay. And what you did was different?
You were there for medical purposes and for emergencies when needed? Is that fair to say?
A Yes.
Q Okay. And I'm assuming you did not have to go through the same training as them either as it relates to --
A No.
Q Specifically, you did not have to go through the same training as them as it relates to restraining, physical restraints on clients, that sort of thing?
A Yeah. We don't -- we don't have any of that training.
Q Okay. None of the NCI non-violent crisis intervention? None of the de-escalation stuff? You don't go through that training?
A We had a very short training. Our -- the nursing isn't anything like residential. We have a very short -- like how to -- how to get loose if they get ahold of us training.
Q Okay. Briefly --
A But we don't learn (inaudible) --
Q Briefly, tell me how you would get loose.
A They told us things like, if they came up and grabbed you like around your chest, you know, from

behind, you know, to wiggle, to scoot down to get your arms underneath them to get loose.

Or, if they grab your wrist to, you know, pull your arms towards their thumb side to get your arm loose.

Q Okay.

A But we didn't learn any takedown holds or anything like that.

Q Okay.

Just to be crystal clear, because if I'm correct in what I hear you saying, we can move on and this is going to go a lot quicker.

But I think what you're saying, and I just need you to verify it for me, is that, as an LPN, you didn't have to get any of that -- you weren't trained in NCI or how to apply personal restraints to clients; correct?

A No. We were never shown how to do restraints.

Q Okay.

Do you have any knowledge of what kind of training the residential staff would have had in those things?

A No.

Q Okay.

A I know that they're shown what they can do. They practice in a class how to take somebody down to the ground or how to like just restrain their hands for personal holds.

Q Okay.
A But I --
Q And you know they have a class, they're taught how to take clients to the ground in a class?
A Yeah. Or how to like just restrain their hands, how to remove them from harm efficiently.
Q Okay.
A But I don't know what they're taught in those classes.
Q Okay. Do you know where those classes are given or who teaches them?
A No.
Q Okay. But it's your understanding, at least, that those classes include techniques for getting clients to the ground?
A Yes.
Q And you don't know what those techniques are though; right?
A No.
Q And tell me about your relationship with David Cains. I think you said you worked in Davidson and I think that's where he lived.
A Yeah.
Q Did you know him, see him regularly?
A Yeah. I had David quite frequently. He -- it

was -- he was really a fun guy.

I mean, he did have behaviors and he would get overwhelmed and kind of lash out, but he -- he didn't mean to. He wasn't like -- he wouldn't have a behavior because he wanted to get his way.

It was -- you know, he would just kind of lose control sometimes. But he was -- he was such a fun guy. He played the tambourine and loved the Monkees.

And he had a Mr. Potato Head. That was kind of mine and his thing, is he had this Mr. Potato Head and I'd always tell him I was going to take the eyes from his Mr. Potato Head and put it where the nose goes and the nose where the eyes go; and he would just get like all kinds of excited about it. And he moved it on a top shelf to show me that I couldn't reach it to move his eyes.

And he was -- he was a really cool guy. We had a pretty good relationship.

Q That's great. That's great to hear.

A Yeah.

Q So you didn't consider him to be a particularly violent or aggressive patient?

A No. I mean, he -- he lashed out a lot when he got overwhelmed. But it was usually like a really quick just throw a fire extinguisher or throw a stack of cups or whatever, you know, but I don't think that he was ever

trying to hurt anybody. He just didn't know what to do with his feelings.

Q It kind of sounds like almost like toddler stuff. Is that fair to say?

A Yeah. Yeah. Several times that he was very upset and going to have a behavior like at the dorm, he would come down to the med window and just -- he'd cry.

You know, he'd just come down there and start crying. And usually he'd -- you know, me and him would just kind of joke around about the Mr. Potato Head or whatever and he would calm down.

But it's just -- I don't know. Sometimes he would come down there too and grab a stack of cups off my med cart and throw them across the room.

But it was always followed with, I'm sorry, I'm sorry, are you mad at me, am I in trouble. You know, he -- he didn't mean it.

Q And you never felt like he was -- did you ever feel like he was capable of causing real violence to you or anybody else? You know, physical harm, that sort of thing?

A He threw a fire extinguisher at my head one time.

Q Okay.

A That was -- but I don't think he was actually aiming for my head. I think he was just mad and found a -- you

know, saw the fire extinguisher and threw it that direction, you know?
Q Do you know --
A But, yeah, he -- he could have hurt somebody very easily though.
Q Did he ever hurt you?
A No.
Q Okay. Did you see him hurt anyone else?
A No, not hurt anybody else.
Q Okay. Did you ever hear about or do you know of him ever causing actual injury to anybody else?
A Actual injury, no.
We have a lot of client to clients that result in like a red mark or a scratch. And I can't tell you that David never did any of that.
Q Uh-huh.
A That's just such a frequent occurrence, I can't say that he never did. But never serious injury, no.
Q Do you know of any specific instance or a specific person that he ever left a scratch or mark on?
A There -- there's no way for me to be able to answer that. There's a lot of behaviors in that facility and there are a lot to client to clients. And if I told you --
Q Well, let me --

A -- for sure that --
Q Let me stop you --
A -- (inaudible) know.
Q Let me make that easier for you.
I'm not asking you to guess. Obviously, you can't possibly know everything that goes on. I get that. I just mean do you have any specific knowledge, as we sit here today, of the name of a person or the specifics of any incident where he left a mark on somebody?
A There is nothing that sticks out in my mind.
Q Okay. And I understand that, you know, it may have -- I'm just asking, do you know of any -- I just need to know if there's any specific --
A Yeah, I don't -- I don't. I just don't want to tell you that for sure, that he didn't any time that I was a nurse because I --
Q That's not what I'm asking.
A -- don't want --
Q That's not what I'm asking.
A -- (inaudible) --
Q I only want to know what you know, what you truly know. Does that make sense?
A Okay. Yes.
Q And that's going to --
A I do not recall --

Q -- make this whole thing go faster for you and easier.
A Right. Okay. I do not recall a certain person that he has left marks on; no, I do not.
Q Okay.
Did you ever witness David trying to hit anybody?
A Yeah. I witnessed him throw a fire extinguisher. I've witnessed him throw things at people.
Q I mean with his hand, like a slap or a punch.
A Yeah. He pulls his hand back. I've seen him pull his hand back several times but not actually hit somebody.
Q And, when he does it, is it like, you know, a grown man about to slug somebody like this or is it more like what a kid would do?
A Usually more like a kid to, you know, like preaching.
Q Okay. But you've never seen him make a fist and swing at anybody with his fist?
A I don't believe so.
Q And you never heard of him doing that?
A I don't believe so.
Q Okay. And, again, you don't have any personal or specific knowledge of David causing an injury to anybody; correct?

A Correct.
Q Okay.
A I have seen him hit himself --
Q Uh-huh.
A -- when he's been upset and pull his hand up like he's going to bite himself.
Q Uh-huh.
Are there other residents that -- and I'm not asking for their personal information or their names. But are there other residents that you know of that have caused real injury to somebody that's the kind of injury that's required medical attention? Has that happened?
A Yes, it has. But they are usually more self injuries for -- the major injuries that we've had are usually more self inflicted.
Q To your knowledge --
A But we do get --
Q To your knowledge, has any staff member ever had to go to the hospital or get any kind of medical treatment because of something a client has done to them?
A Yes.
Q Okay. Who was the staff member?
A There have been several that have had to come like to the nurse for deep scratches, for bite marks.
Q Okay.

A We've had some sexual assaults on campus --
Q Okay.
A -- from residents.
Q Okay. Never from David though; right?
A No. Not that I'm aware of.
Q Okay. And you never had to treat any bite marks or scratch marks that David has caused, as far as you specifically know; right?
A Not as far as I recall.
Q Okay. David certainly never sexually assaulted anybody; right?
A No. No.
Q Okay. But there are -- I guess there are clients there that are capable of serious stuff like that?
A Yes, there are.
Q Okay. Are there clients there that, you know, you really wouldn't want to be alone in a room with?
A Most definitely.
Q Are there a lot? I mean, is that a rare thing? Are there several men, male clients, like that there?
A There are several there that you definitely should not want to be alone with. I -- downstairs --
Q And David's not one of them; right?
A No. David's not, no.
Q Okay.

A I would never be afraid to be alone anywhere with David.
Q David, you know, plays with Mr. Potato Head and listens to the Monkees. You know, don't give him a fire extinguisher; but, other than that --
A Right.
Q -- he's nothing to be afraid of?
A They're all -- you should be afraid of all of them. You should really be concerned that any of them, at any point, could hurt you.
Q Okay.
A But -- you know what I mean? You know that going in though.
Q Okay.
Have you ever participated in any restraints of David other than chemical restraints?
A No. No physical restraints.
Q I assume you've had to administer chemical restraints at times.
A Yes.
[redacted]
Q Okay. Approximately how often would you have to do that, administer the chemical intervention with David?

A I'm sorry. I can't really answer that. I don't know; and it's been quite a while since I've had David and I -- there are so many clients there.
Q Uh-huh.
A It seems like it was getting more frequently.
Q If you had to put a number on it -- and, again, I know it's been a long time and I'm asking you to estimate to the best of your memory.

If you had to put a number on how many chemical interventions you would have been involved in with David Cains during your time there, about how many would you say?
A I don't feel comfortable making a guess on that. There's too many clients and it's been too long. And we respond to all chemicals, not just the ones for our clients. And I -- I don't feel comfortable putting a number on that.
Q Okay. And I get that. I'm just trying to -- I have no idea whether it was once a year or once a week. Could you at least help me out there?
A At least once every couple of months.
Q Okay. Thank you. Thank you. That gives me something.

MR. COLLINS: John, do you mind if I take two minutes?

MR. GILLISPIE: No. Let's do it.
MR. COLLINS: Okay.
(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)
BY MR. GILLISPIE:
Q I think the last thing I'd asked you, you said you never participated in any personal restraint.
Aside from chemical restraints, you never participated in any other type of physical restraint of David; right?
A Right.
Q How about mechanical restraints? Did you ever have to participate in that with David?
A We don't -- nurses don't normally put somebody in mechanical restraints. We do check them after they've been in the mechanical restraints; but I don't recall ever -- I don't recall David being in mechanical restraints.
Q Okay. And, when I say mechanical restraints -- rather, when you say mechanical restraints, are you referring to the papoose board?
A Yes.
Q Anything else that would be considered mechanical restraints that you're aware of at Booneville?

A Not -- no. That's what -- that's what they use. But I don't recall David being in that.

Q Okay.

Did you ever witness David being restrained, put in a personal restraint, taken to the ground, anything like that? Did you ever witness that prior to the date of his death?

A I believe that I've seen like somebody holding his hands, like when he's reaching through to grab something. I've seen people like pull his hands back down.

But I've never seen him be like held. Usually, when they have called me for a chemical on him, he's crying when I get there and not in any type of restraint.

And I could ask him, you know, David, do you need something to help you calm down; and he would very happily, yes, and he'd take his coat off, he'd pull his sleeve up. Like they didn't have to hold him for that.

Q Yeah. [redacted]

A He didn't like being out of control.

[redacted]

Did you ever -- was he ever being restrained on the ground? Do you ever recall him being restrained on the ground when you've got to give him that chemical restraint?

A I don't recall ever seeing that, no.
Q Okay.
Did you know Tyler Mattson?
A Yes.
Q Y'all worked together for several years?
A Yes.
Q How close were you?
A He wasn't always one of staff at my dorm. He worked at other dorms also.
We talked at work but not outside of work unless I just bumped into him at Walmart or something.
Q Okay. Do you recall him ever having any issues with David Cains? Or David Cains having any issues with Tyler?
A Oh, like personal issues? No.
Q Okay. Or any issues? Do you have any memory of --
A No.
Q -- those two interacting?
A No. I really don't.
Q Were there any staff members that David Cains was afraid of or would have bad reactions to or have any issues with whatsoever that you know of?
A Not -- not that I recall. Not a particular staff member. It was more situations that he had problems with than people.

Q And what were those situations?
A Well, like if he was somewhere where things were very loud or if there was a lot going on or somebody was having an outburst around him, that would really affect him.

And he didn't like to go to class. He didn't like to go to schedule frequently.
Q When would class be during the day?
A They go, usually, after breakfast until three o'clock. But different ones have different schedules. I don't know David's particular schedule.
Q Do you know what he --
A I just know that he --
Q Do you know what he would typically do --
A He went to the Hemp building and -- or Hamp. I'm not for sure exactly how they say it.

But that's where -- I know he was -- at least one of his training areas. Because I've went there several times because he was upset and needed to go back to the dorm or needed a chemical.
Q Do you know --
A I'm not really for sure what he did though. I think he did (inaudible) but I'm not positive.
Q Do you know what David would typically do after lunch?

A No. I don't remember his schedule.
Q Okay.
Amy Jones testified that Booneville was short staffed at the time of his death, in June of 2020. Do you also recall that being the case?
A I don't recall when they weren't short staffed.
Q Okay. Tell me more about that.
A We have a lot of people that have to stay when their shift is over and work another shift without notice. We have -- you know, sometimes night shift can't go home. They stay and have to work during the day.
There's been a lot of times that they have taken somebody that's supposed to be a one-to-one staff and had to drop their supervision level to just where you can visually see them instead of one-to-one. That's a very frequent occurrence.
Q And would it be fair to say that there were times when the facility was running with less than the necessary amount of staff needed to care for the patients properly?
A There were a lot of times that they had a lot less staff than I felt was what they needed, yes.
Q Okay. And, in your opinion or based on your observations or how you feel about it, do you feel like that understaffing issue led to frustration on the part

of staff and direct care staff?
A Most definitely. They were exhausted.
Q Made their days more difficult and stressful than it needed to be, I assume.
A Yes. They were -- they were absolutely exhausted.
Q And this was the case in June of 2020 as well; correct?
A Right after COVID first started, we had -- a lot of people quit.
Q Uh-huh.
A And it's very hard, like in my mind, to think about when that was in relation to David.
This past couple of years has been one very, very, long day, is what it's felt like; because it's -- and everything like time wise is kind of like thrown off.
Q Well, let me help you --
A But they -- they've been short since I started.
Q You -- okay. So, even in normal times, staffing was an issue.
But I'm assuming that, after COVID started, when people started quitting, staffing was even more of an issue; correct?
A Yes. Yes.
Q Okay. And --
A It was a huge issue.

Q Okay. And, in my mind, the pandemic started in March of -- you know, pandemic for us started in March of 2020. I think of it that way because it's when the NBA shut down, it's when Tom Hanks announced he had it, and it was just like, oh, my God, this is real. My kids were in the NICU at the time, so I'll always remember that.

So it was roughly four months after that, in June, that David died. So fair to say that's in the middle of the pandemic; right?

A Yes.

Q Okay.

All right. Let's just get to the date of his death.

Were you the nurse that received the emergency medical call from the direct care staff that day?

A I did not receive -- they called the emergency number. And I'm not the nurse who answered that number. But we were all in the break room and --

Q At Judge Hill?

A -- Debbie had answered that phone call.

Yes. And she said that we had a patient choking.

Q Uh-huh.

A And she said I'll grab the emergency bag. I grabbed the AED and when I -- I ran to my car. And, by the time I got to my car, they were calling my personal phone.

Q Okay. Back up just a little bit. Put a pin in

that, back up just a little bit.

You said Debbie Noah is who received the call?

A I'm -- yes. Yes. Debbie Noah received the emergency call.

Q Okay. And you were with Debbie Noah in the Judge Hill building when she got that call?

A Yes.

Q And who else was there? Ms. King?

A Kelly King. Uh-huh.

Q Okay. And do you know -- I believe it was Ryann Campos that made this call. Do you know if that's true or not?

A She's the one that called my personal.

Q And she told you that --

A But I don't -- I don't know who called the number.

[redacted]



Q That's okay. You don't need to. I just wanted to know so my associate could write it down for me.

All right. Do you know -- I believe that what I've seen in the record was that that call came to Debbie Noah at 11:33 a.m. Do you know if that's true or do you not know?

A I have not reviewed my nurses note since the day of the incident, so I don't know time.

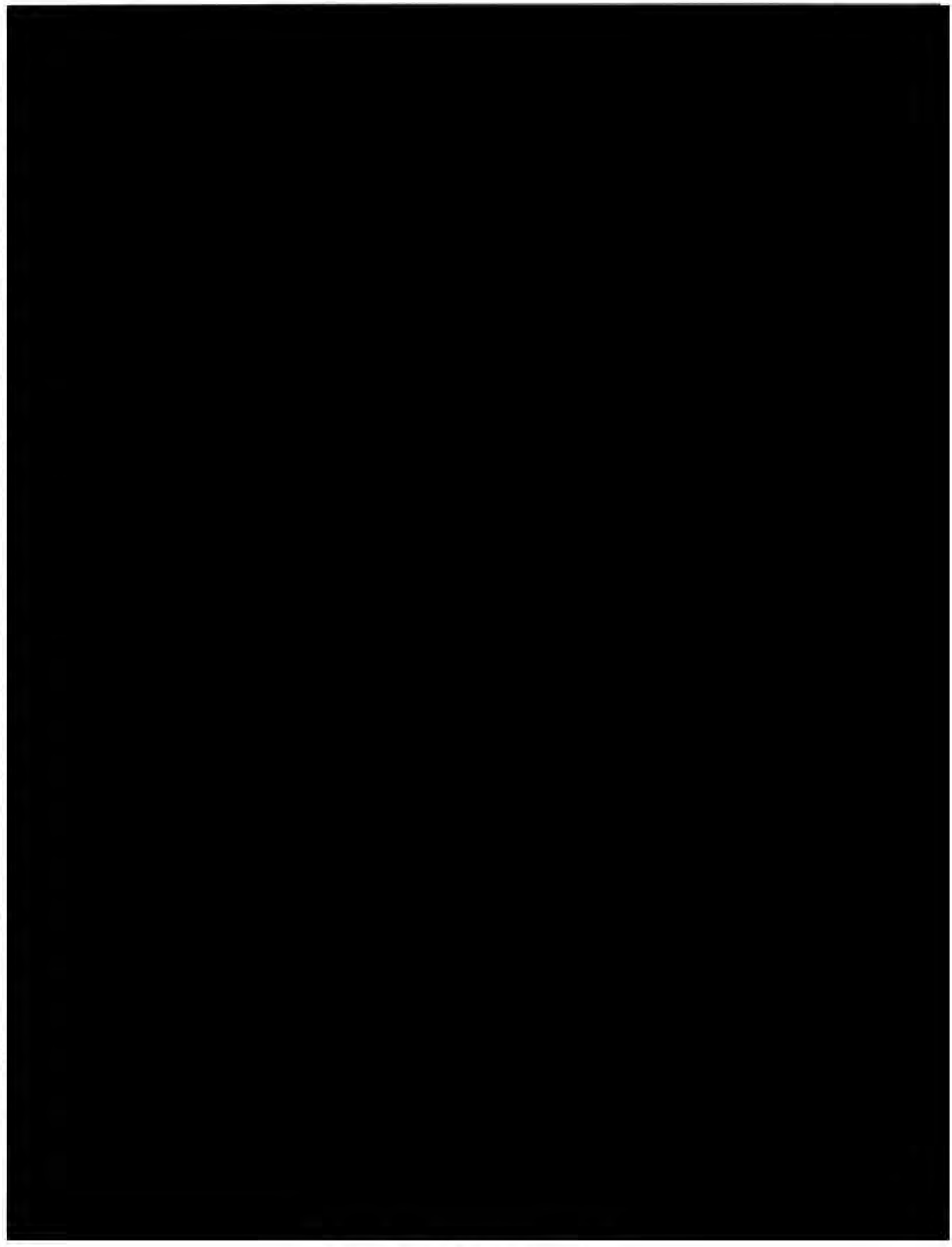
Q Okay.

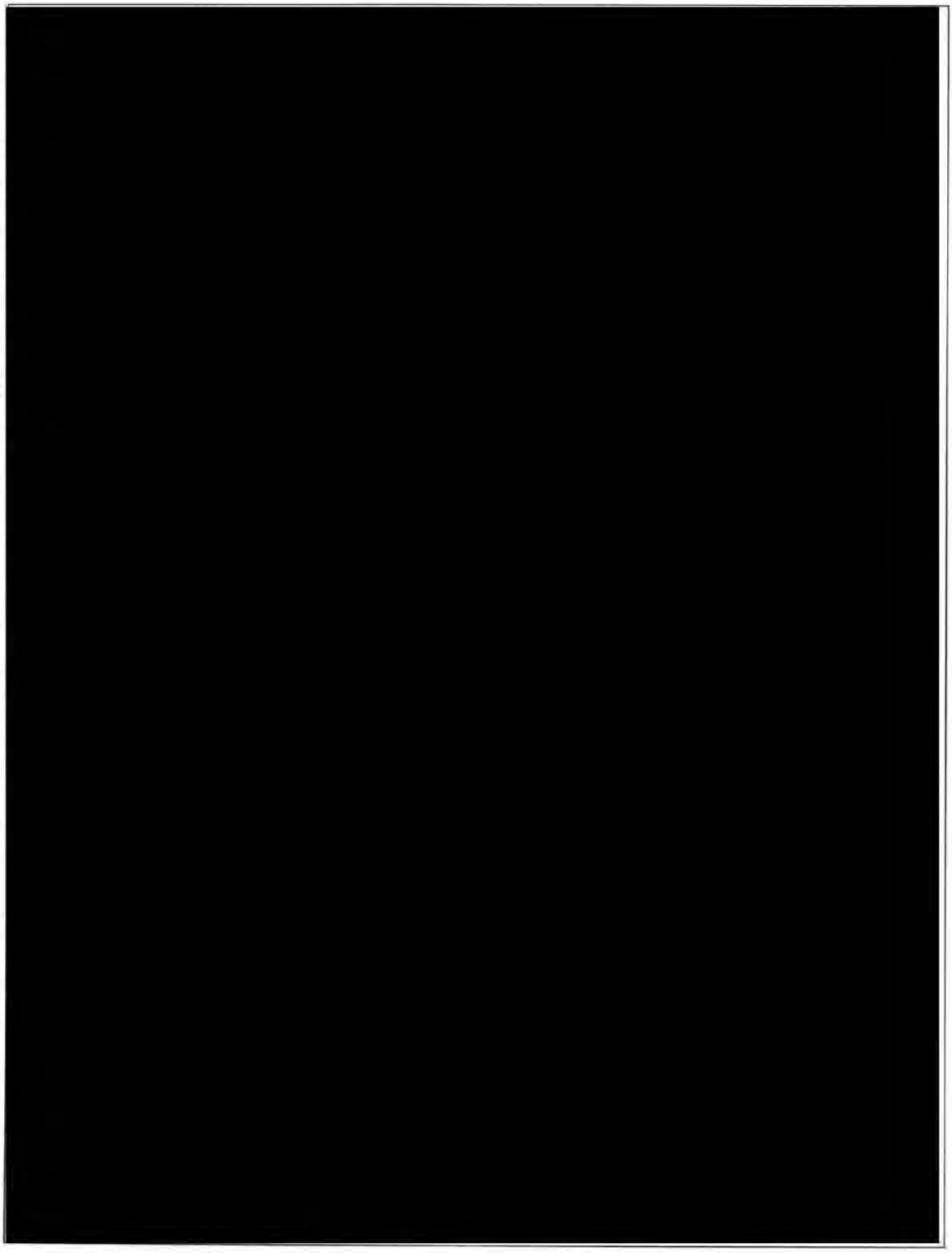
(Brief discussion off the record.)
A Now, I did speak with the office of long-term care after the incident.
BY MR. GILLISPIE:
Q Okay. And I have that statement and I know I've seen it. And I was going to refer to it just to help you out, but I'm not sure I have it in front of me. That's okay though.
All right. So Debbie Noah gets that call. Take me through step by step what happens after Debbie gets that call. And in as much detail as you can recall. This is kind of the important part of your deposition.
So as much detail --
A Right.
Q -- second, minute by minute, go.
A Okay.
Debbie got the call; she hung up and said that a client was not breathing. She gave us the name of a different client.
I don't know if we're supposed to say somebody else's name, but she said that they had said that a different client was choking and not breathing. They had given the wrong name.
And she said -- she was getting the emergent -- they were at Commons. She was getting the emergency bag.

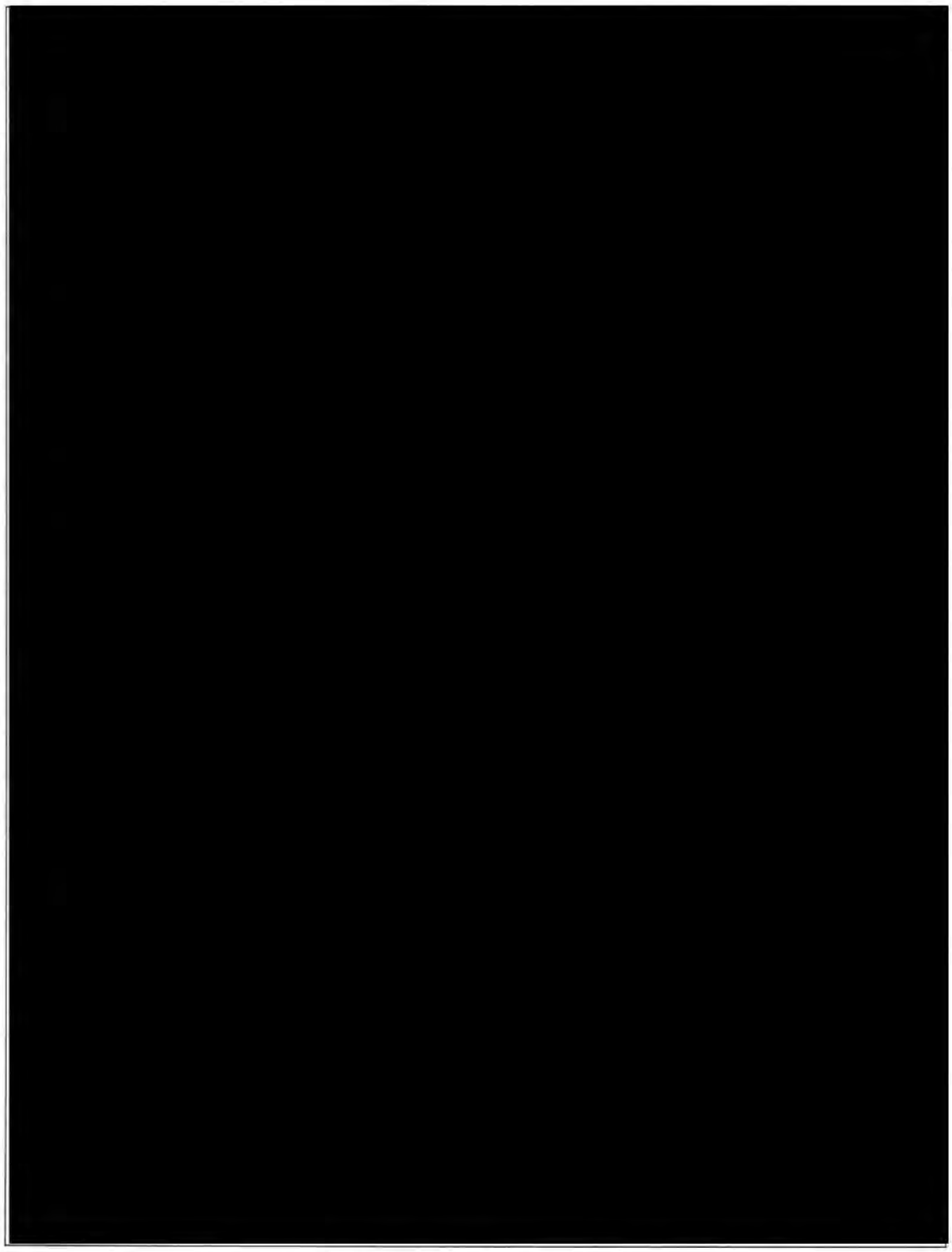
Kelly King and I ran out the front door, I grabbed the AED that is at Judge Hill by the front door to take with me.

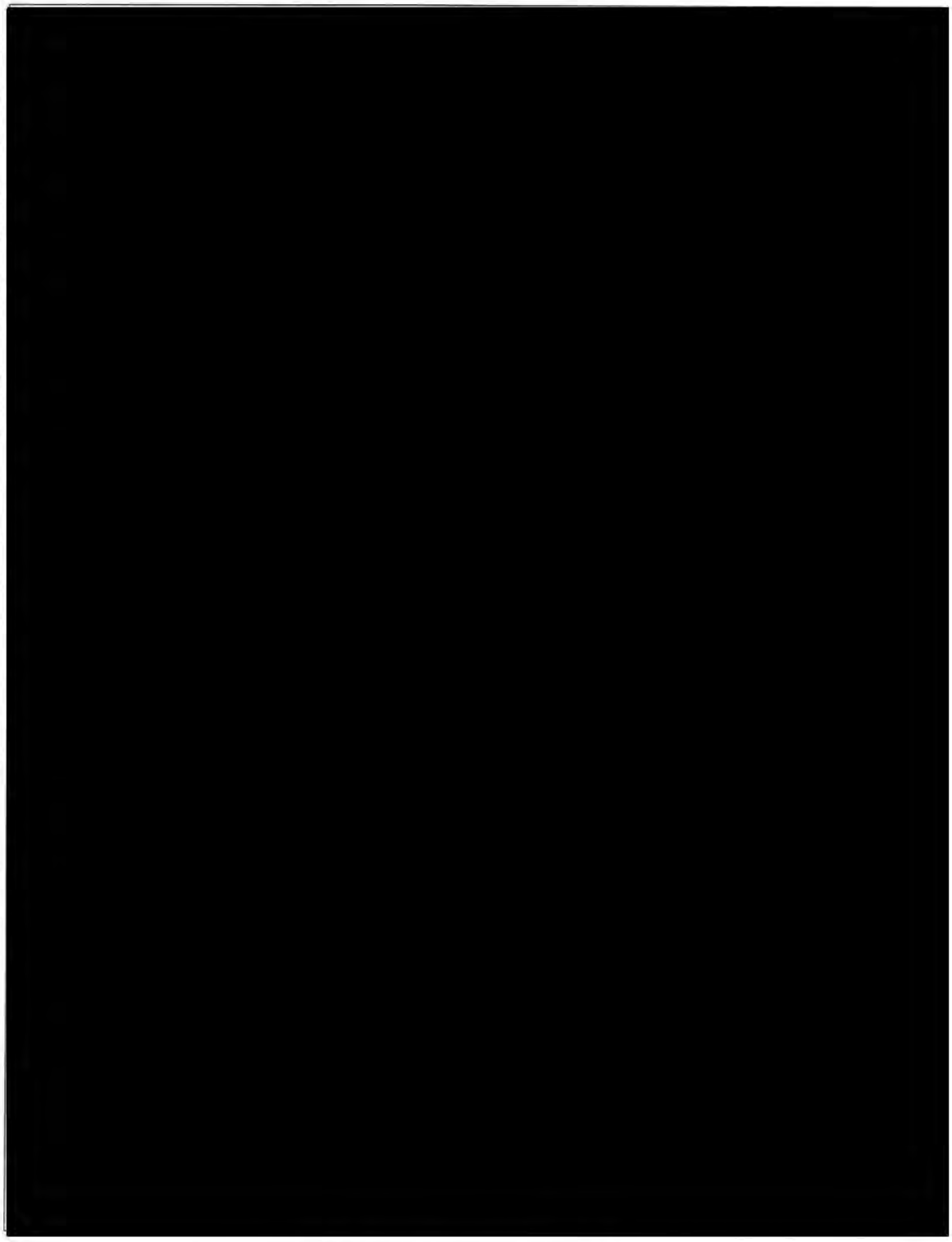
There is one at Commons. But, if I'm in an area that has one, in responding to an emergency, I'm always going to grab that one too, just in case a battery is dead or there's a problem with it, whatever.

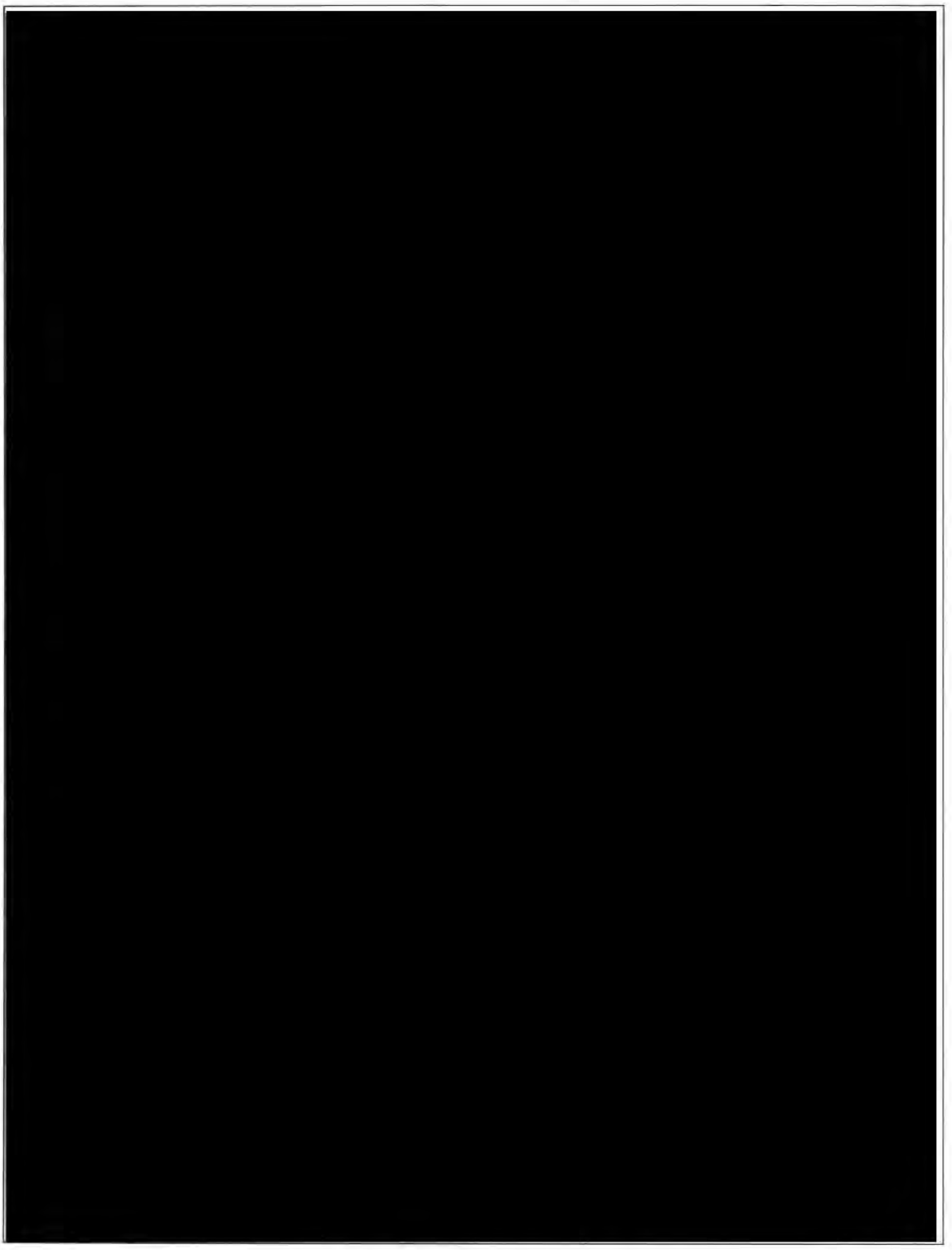
[redacted]

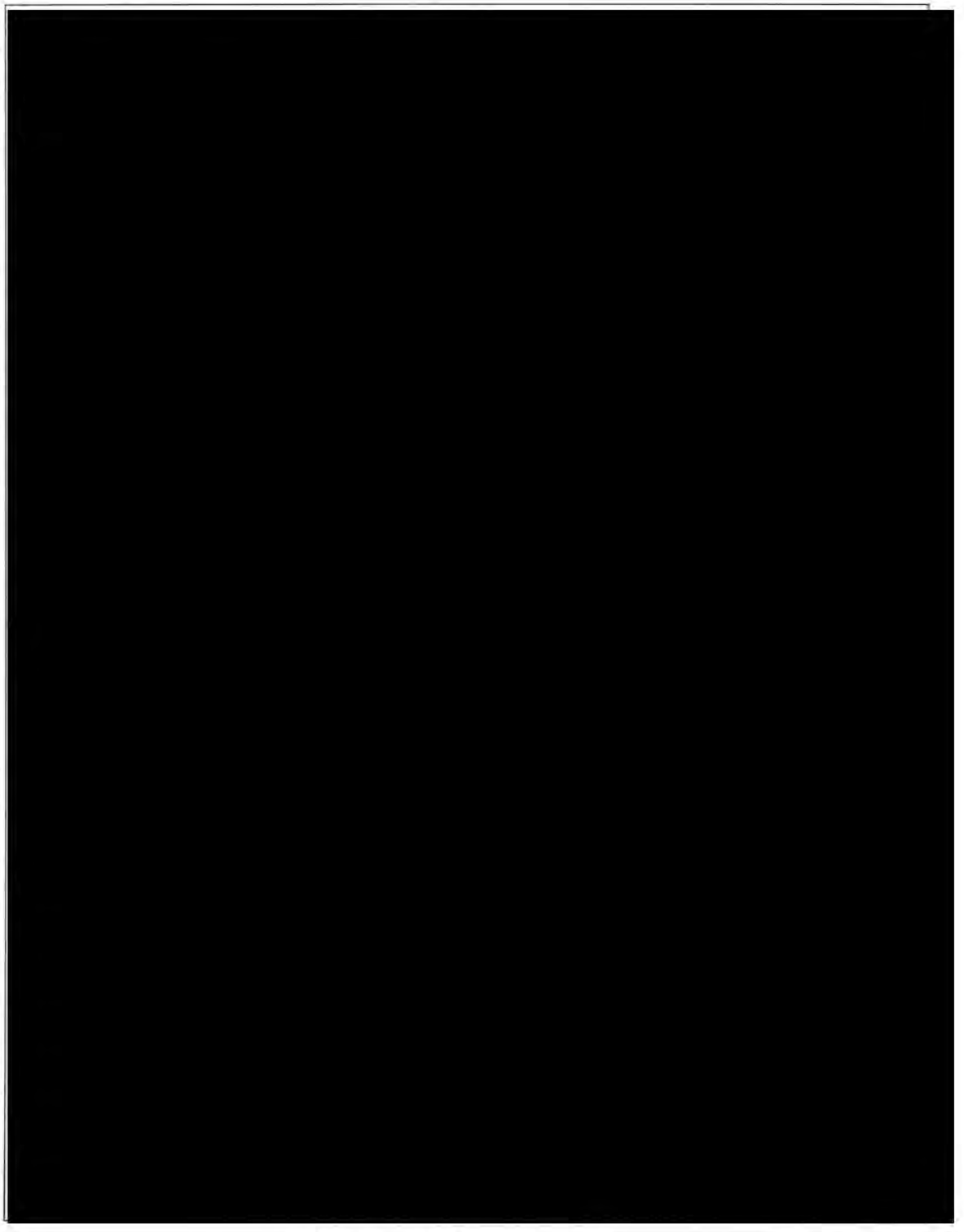














As soon as we got on scene, 9-1-1 was -- we made sure that 9-1-1 was notified. As far as why they didn't call 9-1-1 first, I'm not for sure. I wasn't there.

Q Wasn't there a policy that forbid them from calling 9-1-1?

A I don't believe that there's a policy that says you can not call 9-1-1. They are supposed to call medical.

But, to the best of my knowledge, the policy states that you can call -- you call medical and you can call 9-1-1 for staff or clients who need it.

I have not reviewed that policy in a long time but I am -- I am pretty confident the policy states -- doesn't state that you're not allowed to call 9-1-1.

Q I'm going to show -- I have the policy here. It's Policy -- Booneville HBC Policy 4-B-10, Bates Stamp 4423.

MR. GILLISPIE: Eric, we previously used this. This was Exhibit 2 in Ms. Jones' deposition.

(Brief discussion off the record.)

BY MR. GILLISPIE:

Q All right. So we'll call it Exhibit 1 for Ms. Schmitt's deposition. I'm going to read it out loud and I'm going to show it to you.

(WHEREUPON, the document was marked for identification as Exhibit No. 1 and is attached hereto.)

THE WITNESS: I can't see it. I can't see --

MR. GILLISPIE: I know. I haven't shown it to you. I'm going to.

COURT REPORTER: She can't see us though.

MR. GILLISPIE: Okay. That's right.

BY MR. GILLISPIE:

Q This is Booneville Policy 4-B-10. This was produced to me by Booneville and DHS in discovery. And I'm going to read from it.

Procedures, number one -- I'm sorry. Procedures, number two.

In all cases in which a serious medical injury or illness is suspected either to clients or staff, a call to the medical department should be made. This should be the first call so medical staff can respond immediately to the situation.

A call to medical at 1422 should be made and the following information should be given; caller's name and title, victim's name, location, situation and condition of the victim, parentheses, alert, unconscious, et cetera.

Medical will assess the situation and call an ambulance if appropriate.

So my understanding all along has been -- and it was also the direct care staff's understanding, at least the ones I've deposed so far, which is Amanda Jones.

It was her understanding that only medical staff were supposed to call 9-1-1. Are you saying that's not your understanding?

A My understanding is that, as a nurse, I can make a determination to call 9-1-1 whenever the staff doesn't --

Q Well, I know you can.

A -- necessarily think it needs to be done. But --

Q I know you can do that.

A -- my understanding is not that they're not allowed to call 9-1-1.

Q Okay.
A But they are supposed to call us first, but --
Q So you're surprised to hear that that's their understanding of it then?
A Not -- I -- I can't speak to what somebody else would read into that situation. And I can't speak to how they would feel about it.
I do know that, regardless of what my policy is, if somebody is obviously fixing to die in front of me, I'm going to call 9-1-1.
Q Uh-huh.
A I don't think that they knew that he was not -- did not have a pulse.
When we got there, I do not believe that they, in any way, thought that he did not have a pulse. They were still thinking that they were just dealing with somebody who was choking.
Q Well, he was choking and he was turning purple; he was vomiting. And Amanda testified that he'd stopped breathing at the time they made the call.
So, in your opinion, that should have been a call to -- there should have been a call to 9-1-1 made at the same time; right? Or even before y'all?
A I believe, per policy, they have to call us first.
Q All right.

A That is the policy that they were given, that they have to call us first.

My understanding is this went from him having a behavior to him being on the floor very quickly.

[redacted]

Q Is Ryann the only person that you talked to about what went on before you arrived on the scene?

A They were all kind of trying to tell us what happened. That he had had a behavior, that he was choking.

But they were all standing in the same area trying to give us information.

Q What all did they tell you, specifically, that you can recall?

I guess I'm asking, what's your understanding -- as you sit here today, what's your understanding -- I know you weren't there.

But, based on what you've been told or what you've heard, what is your understanding of what exactly happened prior to you arriving on that scene?
A My understanding is that he got upset inside of the dining room, that he started having a behavior, that they were taking him into the hallway, and he vomited and choked.
Q Okay. What about how he got to the ground? Do you know anything about that?
A I don't.
Q Okay. What about direct staff restraining him on the ground by holding his legs, holding his head, things like that? Do you know anything about that?
A Ryann told me that she was holding his legs and noticed that he had a liquid bowel movement.
Q Okay.
Did she also tell you that Amy Jones was holding his head to prevent him from spitting?
A She -- I don't -- no. I don't recall her telling me that.
Q Okay. Do you recall anything about anyone holding his head, at any point, to restrain him during the restraint?
A I -- no. I wasn't -- I wasn't there for the restraint. And they didn't tell me any details of the

restraint, just that he had choked.
Q Okay.
And what are all of the medical tools available to y'all in a situation like this that you have there?
I know you told me about some of them. I just want to make sure I'm not missing something. You've told me about the suction mask, you told me about the shock device.
What other tools did you guys have at your disposal to save his life?
A We -- we only do -- we can't do a chemical code.
Like, in a hospital, they can give medications to help get a heart -- you know, to --
Q The paramedics --
A -- start to get a rhythm and stuff. We don't have those --
Q Paramedics that come in an ambulance --
A Yeah. Paramedics do that.
Q -- (inaudible) that too; right?
A Yes. They -- they can do a chemical code.
Q Okay.
A In facility, we can not. We can not do deep suctioning.
We have just a hard suction tube that we can put into the mouth. We can't do like deep suctioning into

the throat --
Q Paramedics --
A -- and the bag mask --
Q Paramedics can do the deep suctioning though; right?
A Yes.
Q And they can do the chemical -- what did you call it?
A Like a chemical code.
Q Uh-huh.
A They can do that part of it. They can administer IV medications. We can not.
Q And, if David had -- done in time, is that chemical code like the most effective thing that could have been done, maybe, based on your knowledge and training?
A In any -- in a hospital setting where you can do advanced life support, that is.

But, inside of a long-term care facility, we are not able to do advanced life saving. We have what is called basic life support.

Q Okay.

I guess what I'm getting at is, in a perfect world -- and I get that it's not -- you have no responsibility for what tools you're given there. This isn't a -- I'm not, in any way, trying to criticize you.

I'm just asking, in a perfect world, what would you

have liked to have had when you got there to try to save his life?

A Any emergency room physician, an ICU staff, a ventilator. All of the things that you can only provide inside a hospital, that is what would have been needed to save his life.

Q But, even then, things that a paramedic can provide such as deep suctioning or the chemicals, that would have even been better than what you had; right?

A It would have been better. But I don't think that it would have made a difference. I really don't.

Q Okay.

[redacted]

Q I understand.

And do you have any idea how long the choking, whatever it is that went on prior to them calling you, do you have any idea how long that went on?

A I do not know.

Q And about how long do you think it took you to get to the scene after the call was made to Debbie Noah?

A It didn't take any time at all. I was parked

directly in front of the building.

I actually have a really bad habit of jumping the curb and parking in the grass right in front of Judge Hill.

It's where we're not purposed to park; but it's where I purposely park my vehicle because there is no parking in front of Judge Hill. And I want to be able to get to somebody in an emergency. Commons is just right up the road from where we were.

Q Yeah.

Let me ask it this way. Approximately how long do you think it took from the time Debbie Noah got this call to the time you got to your car?

A Until the time I got to my car?

Q Yeah. Thirty seconds?

A Thirty second. Forty-five seconds.

Q Okay. And --

A It was -- it's a very small building and it was a dead run.

Q And you had to grab -- and you stopped to grab the thing you needed, of course.

A Yes. It is -- it is by the front door.

Q Okay. And Nurse King is with you? She gets in the car with you; right?

A Yes.

Q And about how long -- about how many seconds or minutes did it take to drive from Judge Hill to the Commons building?
A It's going to be less than a minute or maybe right at a minute.
Q Okay.
A I mean, it was -- we pulled out and I hit the gas.
Q Okay.
And then about, approximately, how long would it take for you to then get out of your -- or park at Commons, get out of your car, and reach the scene?
A I parked directly in front of the front doors.
So we jumped out of the car, ran up the stairs into the building, and he was right inside the front doors, right up the stairs.
Q So maybe 45 seconds?
A So that wouldn't be long. Forty-five seconds to a minute, maybe.
Q Okay.
A I mean, like I'm -- I'm overshooting the amount of time it would take, so I'm not -- I don't know. We were running.
Q Okay.
A These are people that we deeply care about. This is not just a job. These are people that we care about.

These are people that we go to bed at night still thinking about.

Q Uh-huh. I believe --

A We -- we don't slowly respond to this kind of thing.

Q I know. I know you were -- I get that. I get that. And I'm not suggesting you weren't.

A These clients are almost like our children.

Q Yeah. I can appreciate that. And I can tell that you cared about David.

A Very much.

Q I know that will make his family feel good to hear when they see this deposition.

A Kelly King and I were probably the two nurses that were the closest to David.

He -- he'd always say Kelly's a big fat witch; and she's like this little bitty, tiny, skinny thing. And so I taught him to say that Kelly's a big fat witch and Amanda's a pretty, pretty princess.

I mean, like we played with him. We had a good relationship with him. And he was -- he was one we were especially close to.

Q So this had to be terribly upsetting for both of you, I'm sure.

A Yes.

Q It still is.

A Yes.
Q Now --
A As a nurse, I have coded and lost a lot of people but this one really hit hard.
Q I can tell from sitting here and talking to you that you did absolutely everything that you possibly could. And I totally believe that.

Do you have any opinion as to what could have or what could have occurred differently that might have avoided all this?

I understand you did absolutely everything you could do. But do you know -- do you feel like staff, direct care staff, messed up in any way here?

I just want to know how you feel about it.

A I feel like they responded to a behavior the same way that they would respond to any behavior.
Q What does that mean?
A I don't feel like there was any malice.

I mean, if somebody -- if they are in a situation where they feel that somebody is going to harm themselves or harm other people, they're going to restrain them.

That is what they are taught to do; and that is what they do every day, is they try to stop somebody from harming themselves or harming somebody else. And I believe that that is what they were doing. And it went

badly.

And, when David would have a behavior, he would often vomit. That was sometimes the whole of his behavior. Sometimes he would become upset and just vomit and then start to cry.

It wasn't always a violent outburst. But he did vomit during times of stress often. And I believe very strongly that that's what happened, that he had a behavior, he was being restrained, and he -- he vomited.

I do not feel that they had any type of malice. They were distraught when this happened. They did everything that was asked of them.

When I asked them to go and get something, they were running to get it.

Mandy pulled -- or Amy pulled a hair tie out of her hair and pulled my hair up while I was giving compressions.

They made phone calls when asked to. They responded exactly -- did every single thing that was asked of them to do. And they never left the scene while we were in there.

[redacted]

[redacted]

Q Okay. And that's what happened here; right? David aspirated?

A Well, what I understand is, what happened here, is David choked on a food bolus. That's my understanding.

Q You have no knowledge that he also aspirated?

A I don't know that you're -- that you understand the exact difference in this. When you -- when you choke --
Q Help me out. Help me out.
A When you have a food bolus and you choke -- okay.
When you have a food bolus and you choke, something comes up into your airway, into your esophagus, and it's -- it's blocking that. And your vomiting around that.
Every time that you try to take a breath in, that liquid is going to go into your chest. That's kind of secondary to the food bolus, to choking on a food bolus.
Q Uh-huh.
A Like you can aspirate just liquids. Like, if you take a drink and you take a breath at the same time, you know how you'll cough sometimes, that's aspiration.
Q So aspirating doesn't mean that fluid, that particles or fluid, is getting into the lungs causing choking? That's not aspiration?
A Yes. Yes, it does. That is aspiration. Aspiration is the part of it actually getting into your lungs.
The choking is what stops you from being able to breath, like there's something lodged in there and you're -- it's stuck in your throat.
Q And it's your under --
A Aspiration is usually caused with that.

[redacted]

Q Uh-huh.
A Choking and aspiration are kind of a different thing. The choking caused the aspiration, not you laying down and stomach acid coming up.
Q Okay. But it's your under --
A They told me he choked.
Q So it's your understanding that a food particle was lodged in his -- where? His throat, his esophagus, and that caused choking, where was it lodged? As far as --
A That, I -- I don't know. I would have had to cut him open and look.
Q But it's your understanding that the --
A They told me that he choked.
Q Okay.
Let's take a quick --
A My understanding was that he had choked on a food bolos.
Q I see. Let me --
A Which means, somewhere between his stomach and his mouth.
Q Okay.

MR. GILLISPIE: Going to take a quick two-minute break, Eric.

MR. COLLINS: Okay.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q All right.

Ms. Schmitt, I just want to -- and I think you're right. I think I don't have a great technical knowledge of these medical terms maybe; so that's why I'm needing your help here.

If I understand you correctly, there's a difference between choking on food that you've been eating and food aspiration. Those are two different things; right?

A Yes. Choking blocks the airway. Aspiration is where part of it goes inside of your lungs.

[redacted]

If you've ever had acid reflux and you feel that burn come up inside the back of your throat and it causes a cough, that -- that's aspiration.

Aspiration, sometimes, is silent, you don't hear it. You don't always know when somebody is aspirating.

Q Okay. But, in that scenario, that could cause --
A And choking, you (inaudible) --
Q That's an area that can cause food particles to get into the lungs which could then cause cardiac arrest; correct?
A Yeah. But you can do both at the same time.
Q But --
A Yeah. Yeah. You can do both at the same time. You can choke and aspirate at the same time.
Q But it's your understanding --
A But choking alone --
Q Okay. Let me finish. Let me finish.
It's your understanding that, in this particular situation, this was a straight up he was choking on some food he was eating; right?
A That is what was told to me, is that he had choked.
Q Which means he would -- he started choking as he was eating or right, you know, as he was taking a bite of food and trying to swallow it; right?
A They said that he -- they said he had a behavior and that he started to vomit and choked.
Q Okay.
A I wasn't there.
Q I know you weren't there. And --
A I didn't see it. But I will tell you --

Q -- yeah. I just needed -- yeah. I know --
A -- the staff that was --
Q -- you weren't there.
A -- with him, I would trust the staff that was with him [redacted]
Q Okay. And I --
[redacted]
Q Okay.
I'm just trying to make sure I understand you correctly. I'm trying to make sure I understand what you understand happened.
Am I correct it's your understanding that he choked on food or he choked on vomit? What was told to you?
A That he choked on vomit. Or -- I mean, they said he had the behavior; that, when they were removing him from the dining room, he choked.
I don't know if that meant he still had food in his mouth when he was leaving the area. I don't know that he didn't have a sandwich in his hand and take a bite as he was coming out.
Q Okay.
A They told me he was choking. And that is all I can tell you.
Q Okay.

MR. GILLISPIE: I'm going to introduce two more exhibits here, Eric.

One is the certificate of death. We'll call that Number 2.

(WHEREUPON, the document was marked for identification as Exhibit No. 2 and is attached hereto.)

MR. GILLISPIE: And the other is the coroner's report. We'll call that Exhibit 3.

(WHEREUPON, the document was marked for identification as Exhibit No. 3 and is attached hereto.)

BY MR. GILLISPIE:

Q And again, just to be crystal clear, there is choking on food or choking on vomit; that's different than food aspiration, because that would mean that it gets in the lungs; right?

A You can have both at the same time. You can choke on food and aspirate.

Q Well, you can have both at the same time but they -- they're still different --

A The reason --

Q They're still different things; right?

A Technically, yes.

Q [redacted]

[redacted]

Q Okay. And that's a --
A But my understating is that he was choking before this -- before he went to the ground.
My understanding was that he -- I don't know though. I wasn't there. I wasn't in the room.
Q Right.
A All they said to me was that he was choking. And, when I got there, he was already on the ground.
Q And nobody said anything to you about food aspiration?
A No. The staff wouldn't be able to tell me if he was

aspirating. That's --
Q Okay.
A You need an x-ray or something to confirm that somebody has aspirated.
You can't tell by looking. You can get a temperature rise after it happens to show that there's an infection or that, you know, something has gotten into their lungs.
But, I mean, they wouldn't have been able to tell the difference between those two things.
Q Okay. That (inaudible) --
A I wouldn't be able to tell you one hundred percent that he aspirated.
[redacted]
Q Right. Okay.
MR. GILLISPIE: So, Exhibit 2, this is the certificate of death. I know the witness can't see it but I'll show Eric. I'm going to read it first.

It says, immediate cause of death,

[redacted]

Exhibit 3, this is the coroner's report. Cause of death, respiratory arrest due to food aspiration. Make this Exhibit 3.

BY MR. GILLISPIE:

Q Okay.

So you weren't aware of the contents of those two documents, I assume, Ms. Schmitt.

A No.

Q Do you know who spoke to the -- did you yourself speak to the paramedics when they arrived?

A I think everybody kind of spoke to the paramedics when they arrived. Told them that we had been doing CPR for quite a while, that the AED had not advised to do a shock.

Q Who do you specific -- do you have any specific recollection of Tyler Mattson speaking with either paramedics or any other emergency responders?

A I do remember that they asked the direct care staff that was with him what had happened.

Q Uh-huh.

A But I -- I wasn't a part of that conversation.

Q Okay.
A And I don't know which one was answering questions.
Q Okay. But it's your understanding that they spoke to Ryann Campos, Tyler Mattson, and Mandy Jones?
A My understanding is they came in the door and they asked what happened; and the people in the room were answering questions.
Q Okay.
A But I don't know who said what to them. There was a lot of people in the room at the time. There was a lot of emotion in the room at the time. And I --
Q Who all was in the room --
A -- don't recall.
Q -- other than you, Nurse King, Mattson --
A When EMS arrived --
Q -- Jones -- yeah.
A -- it -- Joann Miller, I believe, was in the room. Lacey Fleming was in the room. Andy Nelson was in the room.

One of the kitchen staff had, at one point, brought out like a big tablecloth because he had vomited and we were trying to, you know, clean up the areas the best we can.

Q I don't need to know about --
A Put something down to soak up stuff while we were

working.

I don't know if they were in the room. I --

Q Who is Lacey Fleming?

A The paramedics --

Q What does Lacey do?

A Lacey is -- she's another LPN. She was an LPN at the time. She's an RN now, but she was an LPN at the time.

Q And I know Angie was the --

A She had got there right before EMS got there.

Q -- (inaudible) -- if you could, just please let me finish my question before --

A Yes.

Q -- you start talking.

Angie was the assistant director of nursing; right?

A Correct.

Q Okay. And who was the first person that you mentioned before Lacey and Angie that was in the room? Joe --

A Joanna.

Q Okay. Who is she?

A Joanna Miller.

Q Okay. What is she --

A She's an LPN.

Q She's also an LPN? Okay.

Was Sandy Evans in the room that you saw?
A Not to my knowledge.
Q Did you ever see Sandy Evans speak to --
A Not to my knowledge.
Q Did you ever see Sandy Evans speak to paramedics or law enforcement?
A I don't remember seeing Sandy Evans at all that day.
Q Okay. Was Jeff Gonyea in the room?
A No.
Q Okay.
Anybody else that you can recall other than the guy from the kitchen, the other LPNs, Angie --
A Yeah.
Q -- and then the direct care staff that were involved in the restraint? Anybody else that you can recall?
A I don't recall anybody else being in there, no.
Q And who do you specifically remember talking to or speaking to paramedics or police?
A I don't have a direct memory of who said what.
I know they came in, they asked what happened, and the medical staff, the nurses, letting -- you know,

[redacted]

Q Okay.
A And then they asked what happened before that; and that's when the direct care staff said that he had choked and had had a behavior.
But I don't know which one said what to him or exactly what they said.
Q Okay. But it was one of those three direct care staff folks?
A Yes.
Q Okay.
Do you recall any other times that David had either choked or aspirated or had an event like that?
A I do not recall David having any type of medical emergencies. I do recall him vomiting when he was upset.
Q Uh-huh.
A But him not having any issues from that.
Q Okay.
Do you know if those three direct care staff had CNA training?
A I do not know that. But I do not believe that they had been -- had CNA training.
Q Okay. And do you know if that's a requirement for direct care staff?
A It was not a requirement until recently. They have just now started having our staff become CNAs.

Q Okay. And do you have any knowledge as to why they made that change?
A I do not.
Q If a person is laying on their side and they start vomiting and choking, are you supposed to lay them on their back?
A No. But you can't do chest compressions unless you lay them on their back.
Q What are you ideally supposed to do?
A When they're -- when he was vomiting, them laying him on his side was the correct thing to do.
Q Not on his back but on his side when he's vomiting?
A Yes. On his side.
Q And why is that?
A So he -- it will run out the side of his mouth instead of sit in the back of his throat.
Q Okay.
And you don't have any knowledge as to whether the direct care staff did that or put him on his back, because you weren't there?
A I do know he was on his right side. When I came in the door, he was on his right side. And Ryann had her fingers in his mouth, pulling fluid from his -- the side of his cheek.
Q Okay.

Thank you, Ms. Schmitt. I don't have any more questions.

A Okay.

MR. GILLISPIE: Eric, I'm done. Do you have anything for her?

MR. COLLINS: No.

Ms. Schmitt, obviously, I'm not your attorney; but, as Mr. Gillispie can tell you, you do have the right to review this transcript if you want to. That's something you can request or waive at your own will.

THE WITNESS: Okay. I would like a transcript of this.

(WHEREUPON, the proceedings were concluded in the matter at 11:15 a.m.)

* * * * * * * * *

(WITNESS EXCUSED)

CERTIFICATE

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Amanda Schmitt, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 29th day of March, 2022.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

FIRST AID GUIDELINES

POLICY STATEMENT: First Aid Guidelines are available for use in each of the Aide Stations in each living area. This will permit appropriate and immediate attention to medical conditions of sudden onset, including injuries and choking.

PROCEDURES:

1. The First Aid Guidelines have been approved by the staff physician for the Booneville HDC.

2. In all cases in which a serious medical injury or illness is suspected, either to clients or staff, a call to the Medical Department should be made. This should be the first call so Medical staff can respond immediately to the situation.

   A call to Medical at 1422 should be made and the following information should be given:

   1. Caller's name and title
   2. Victim's name, location, situation and condition of the victim (alert, unconscious, etc.)
   3. Medical will assess the situation and call an ambulance if appropriate.

3. All staff members are trained in first aid, CPR, and abdominal thrust for choking so, that if necessary, emergency rescue measures can be initiated before Medical staff arrives.

4. Choking is a serious and potentially life-threatening situation and the following guidelines should be followed:

   a. Staff will supervise clients during meal times and nursing staff will be available by phone at all times;
   b. emergency equipment including oxygen and suction machine will be kept in the dining room for use as needed;
   c. All staff will receive annual training in abdominal thrust and choking precautions.

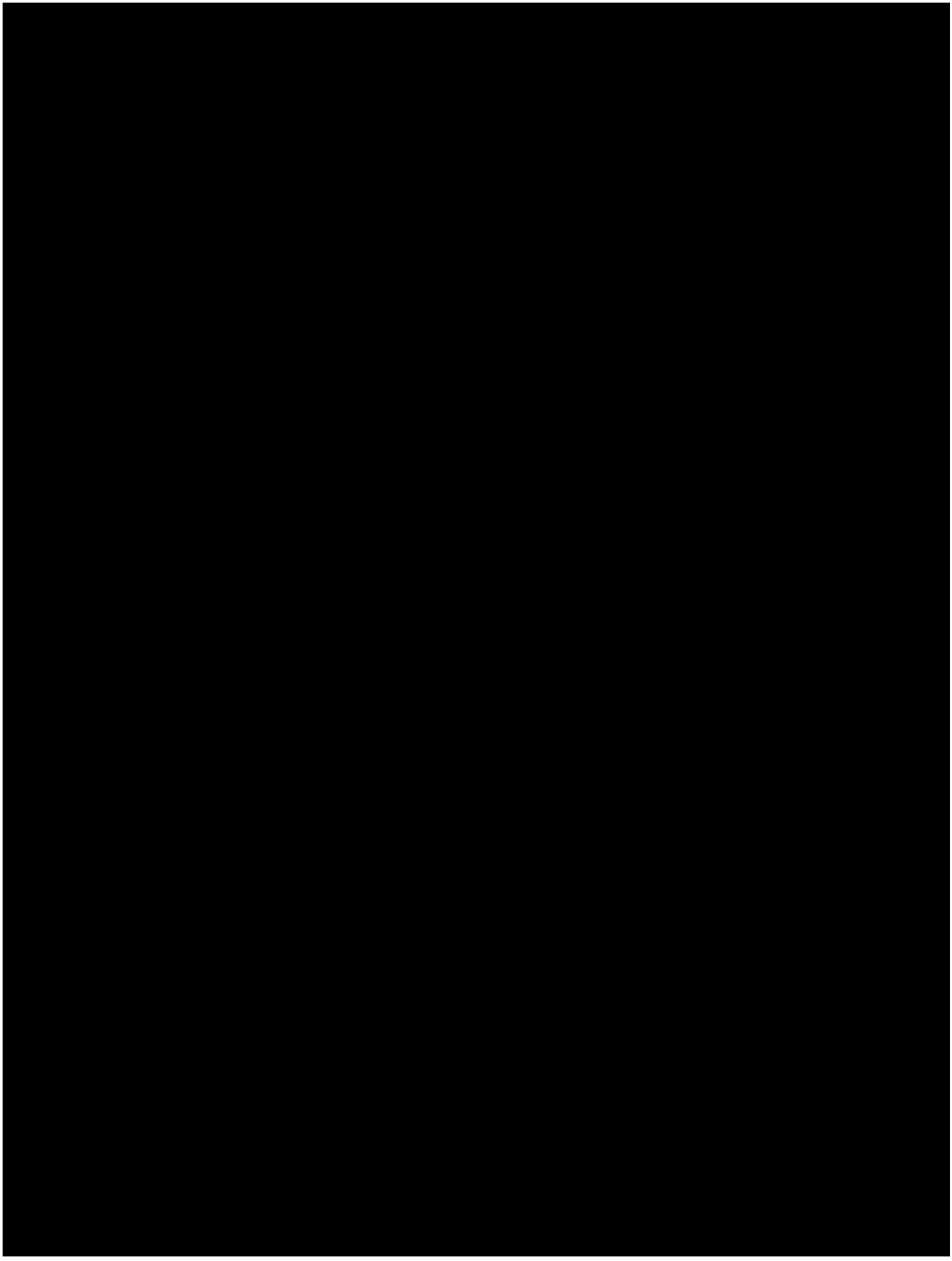
5. First Aid kits, disaster kits, and first aid guidelines will be kept in all areas. Medical will do monthly inspections on first aid kits, and every 6 month inspections on disaster kits, and refill appropriately. If living area staff notice supplies are low, Medical is to be notified and supplies will be replenished.

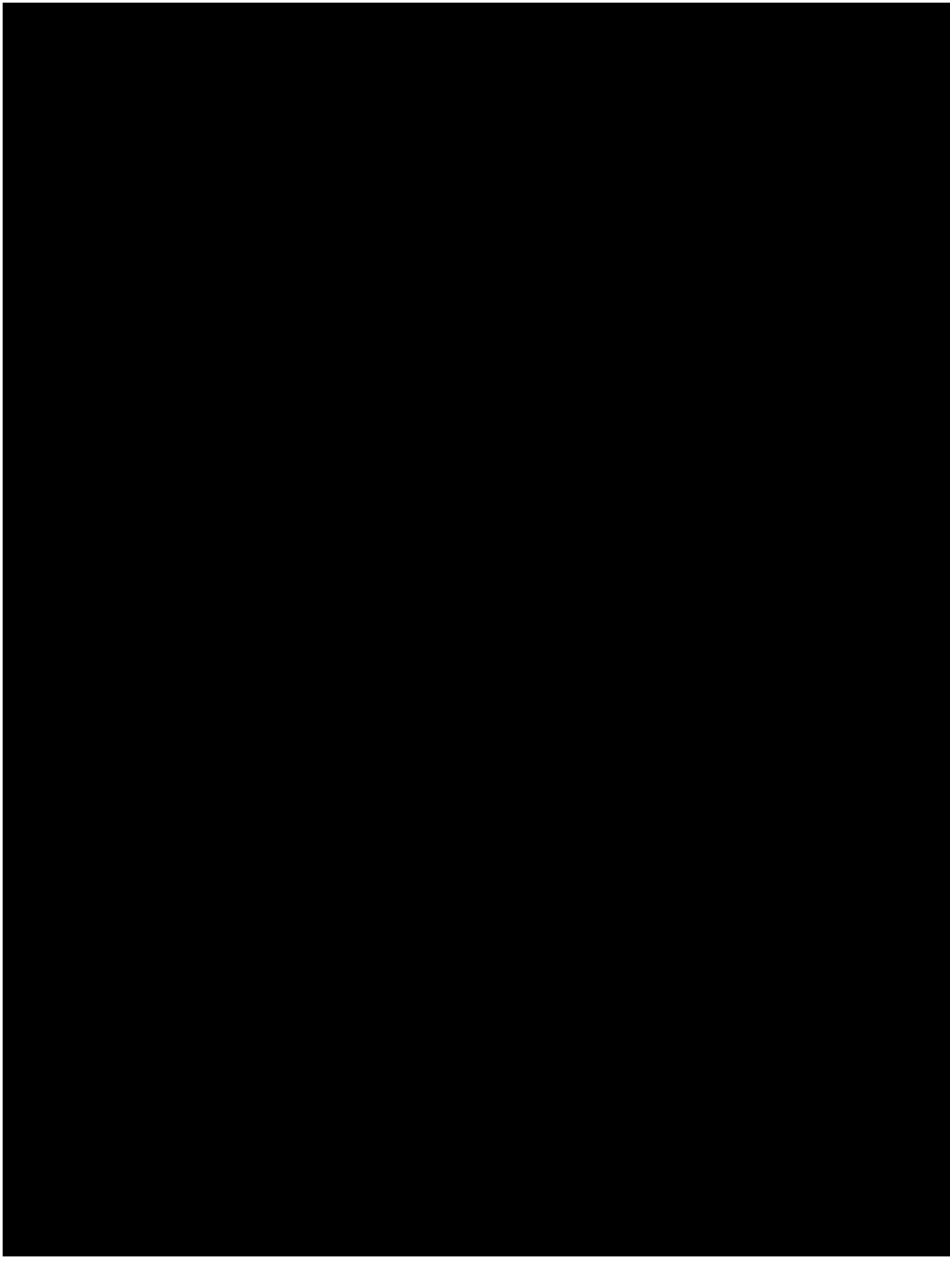
APPROVED: _____ Superintendent

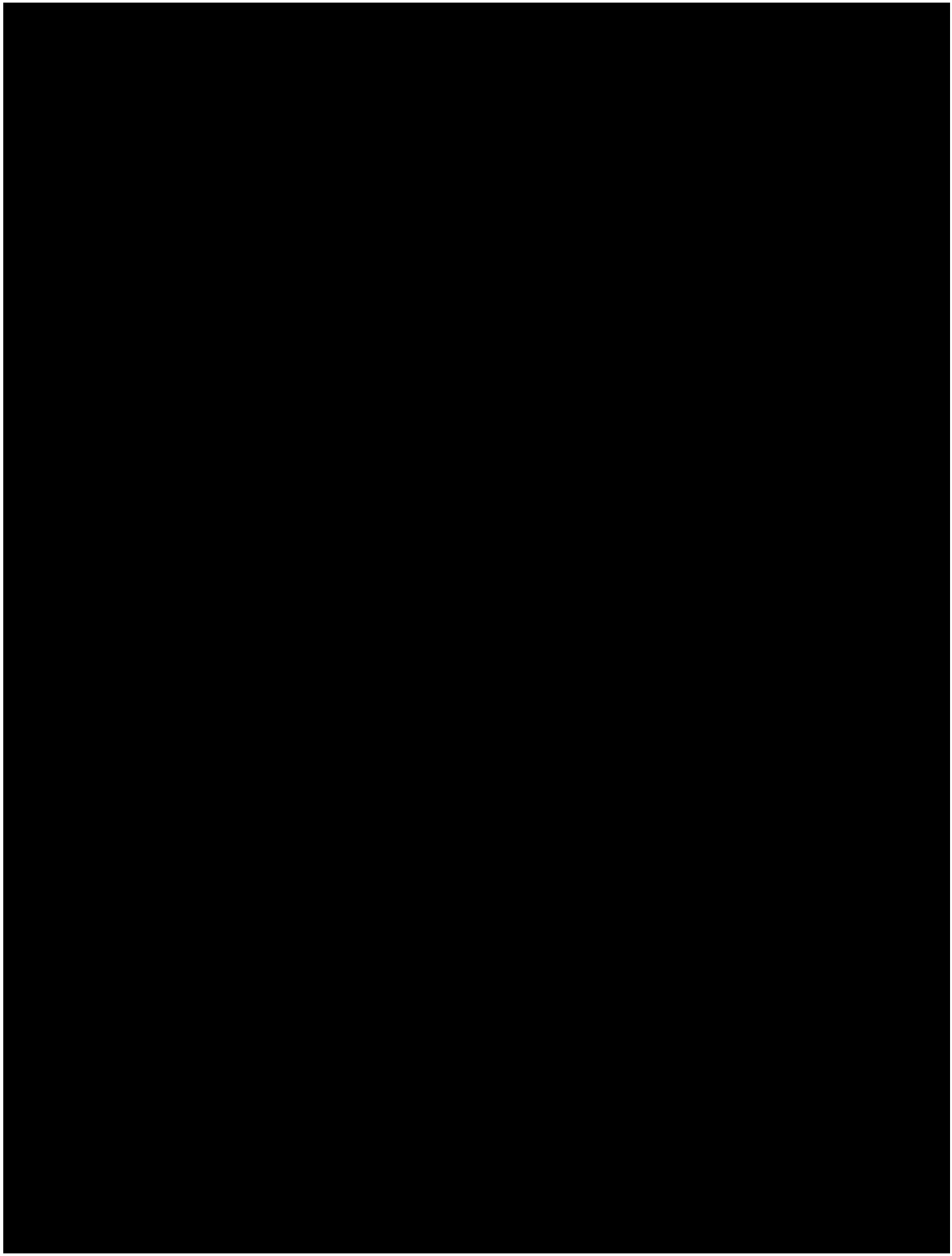
Supersedes BHDC Policy IV-B-10, dated 03/13/15, in its entirety.

EXHIBIT 1

REVIEWED: 11/27/19
VERSION: 12/29/17







BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

Arkansas
State Claims Commission
FEB 16 2023
RECEIVED

ZOOM DEPOSITION OF

DON CARTER

April 21, 2022, at 9:45 a.m.

CRIS M. BRASUELL, CCR
BREPORTING@GMAIL.COM



A P P E A R A N C E S

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I N D E X

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EXHIBITS IDENTIFIED

1. October 26, 2020 Correspondence. 45
2. Notice of Disciplinary Action. 45
3. Notice of Disciplinary Action. 45
4. August 30, 2019 Correspondence. 45

S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Don Carter, produced, sworn, and examined via Zoom, commencing on April 21, 2022, at 9:45 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

PROCEEDINGS

WHEREUPON, Don Carter was duly sworn to tell the truth, the whole truth, and nothing but the truth, and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Mr. Carter, will you state your full name for us?

A Don Carles Carter, III.

Q Okay. And, Don, you and I have spoken on the phone a couple times before.

My name is Josh Gillispie. I'm the attorney for the estate of David Cains. And am I correct that you called -- you saw a news piece about this case and contacted my office? Is that correct?

A Yes, sir. That is correct.

Q Okay. And what's your address, Mr. Carter? Where do you live?

[redacted]

Q Okay. And how old are you?

A Booneville, Arkansas. I'm 67.

Q Okay. And you worked at -- when did you work at -- were you an employee at the Booneville Human Devolvement Center at one point?

A Yes, I -- yes, I was.
Q Okay. And approximately what years were you employed there, sir?
A I think I may have told you 2015, but it could have been I began working in 2016 and I worked up until 2020. I worked four and a half years.
Q Okay. What month in 2020 did you leave that job?
A I think it was September of 2020.
Q Okay.
A I'm sure it was.
Q Okay.
A The very end of September.
Q Okay. And what was your job at Booneville?
A My title was equipment operator. But my actual job was to run the recycle route which -- in which paper was picked up and brought back to the center for material for clients to have a job in processing.

However, I was also trained just like any -- any direct care staff. I went through the same training where, when I wasn't driving the truck, I could fill in and be used for coverage.
Q Okay.
A And that -- and, basically, my -- my truck driving was two-thirds of the time, on the average, and the other was one-third of the time.

Q So, if I'm hearing you right, about one-third of the time, you would fill in as direct care staff to the clients?
A Yes. But that could vary. One time, I could be doing the truck a hundred percent; and, the next time, during holidays and slow periods, I might only be doing it 25 percent.
Q Okay. And was that common for the other employees in -- was that common for other employees that were not -- let me not ask such a bad question.
A Well, I --
Q What I'm asking is, was it common for employees to fill in as direct care staff when it maybe wasn't their normal job? Or was that something --
A Yes.
Q -- just you did?
A I was one of the few. But that could happen if they were trained; and I was trained.
Q And were you given, as far as you know, were you given the same training as some of the -- as the full-time direct care staff?
A Yes.
Q Do you recall what any of that training was called or if there was a name for that training course you might have gone through?

A Yes. It was called PHASE, F-A -- excuse me.
P-H-A-S-E.
Q Okay.
A That was what it was referred to.
Q Okay.
A And it consisted of two weeks of training.
Q Okay. All right.
A Basically, PHASE I week and PHASE II week.
Q Okay.
And did you know David Cains?
A Yes, I did.
Q Okay. Did you serve as direct care staff to David Cains at times?
A Yes.
Q Okay. And was David Cains -- did David Cains ever cause you any physical injury?
A No, he did not.
Q Are you aware of David Cains ever causing physical injury to any person?
A No.
Q Okay.
Were you ever involved in physically -- in doing personal holds on or physical restraints on David Cains or any other clients?
A I have been involved in one, what we would call a

behavior, with David Cains, in which I actually had to touch him.

Q Okay.

A I have been involved with several with other clients.

Q Tell me about the one with that you were involved -- so you were involved with one personal restraint.

And, when I say personal restraint or physical restraint, I'm talking about incidents in which you or another staff member had to lay hands on them for some reason. Do you understand that?

A Yes.

Q Okay. And you're saying there was one such incident that you were involved in with David Cains where you personally, you know, had to participate in a personal restraint?

A Yes. It was approximately three years ago. Excuse me.

David had just returned from lunch or arrived from lunch and we, at that point of the day, it's probably our -- we're a little short staffed because some staff are still accompanying clients to lunch.

But David was in a bad mood. He was sitting at a desk and he -- he rose up in a violent manner, not to attack a person, but in a -- when he is agitated like

this, he is prone to kick the chairs and kick tables and kick things. As I said, not people, but sometimes the object could fly, could strike a person accidentally, another client.

A coworker, which I will refer to as a senior staff member because she's been there about ten years, tried to control the situation and she -- the best -- in this situation, the best thing to do is to try to get the client to come to the floor where you can keep them from hurting themselves or other people.

I noticed the commotion and I walked over and my -- the part I played was just to, with minimal pressure, just to hold his leg, legs, to keep him from kicking somebody.

Q Okay. And this female, do you remember this female employee's name? If you don't remember the name --

A Yes. Rhonda Harris.

Q Okay. And so are you saying that this staff member, who you remember to be Rhonda Harris, sort of took David to the ground and then your role was to kind of hold his legs to keep him from kicking while he -- once he's on the ground?

A Yes. Basically, the role I played was just to be there as a backup. However, I did hold his legs.

Q And I think --

A Rhonda --
Q And I think when we talked -- and Rhonda, where would Rhonda kind of hold him? Just kind of by his shoulders or --
A Yes.
Q And, in that particular incident, was it just the two of y'all?
A Yes. My supervisor heard the commotion and walked up. David McLemore walked up and saw everything was okay and then just kind of -- just kind of stood back --
Q Okay.
A -- and observed.
Q So David McLemore witnessed this and observed; is that right?
A Yes. He would have made any calls to -- if any judgments needed to be made, he was in a position to provide that.
Q And about how many minutes do you think that you and the staff member you remember to be Rhonda had to hold him there on the ground?
A Approximately five minutes. However, it could have been seven. It may have been ten.

But, when this situation occurs, David normally calms down fairly rapidly.
Q Okay. And you said this was shortly after he'd had

lunch, as you recall?
A Yes. Yes.
Q And I think you may have told me, even though this was the only one with David you personally participated in, is it fair to say this, that this type of physical restraint on the ground like you're describing, was that the normal way or the best way to handle David?
A In an extreme situation, yes.
We had a lower classification, it was called redirection. And I've seen probably 20 redirections with David, in which case it would not -- it would not accelerate to be in -- to a full behavior like this was.
Basically, you could just tell -- you could just -- as it describes, just redirect David. David, go sit down; David, put your head down on the desk. And those do not have to be documented.
Q Right.
A Now, the situation that I just described is a behavior and it does have to be documented.
Q Right. Right. And on this particular day, the -- again, the reason that it was necessary to do it on this day was because he was kicking at desks; is that right?
A Yes.
Q And who is it that specifically -- can you recall who specifically, what supervisor, what person,

specifically told you or anyone else that you know of that restraining them, restraining him on the ground, was the proper way to do it?

A It could have been in just talk with coworkers.

It also derives from my experience being in that building, assigned to that building, and observing the way other staff members would hold situations, would control situations.

Or it could have possibly been from Randy's -- from my supervisor's instructions. I do not remember. But I have witnessed 20 or 30 of these with various clients of these documented behaviors. So, after a while, you kind of -- you --

Q And when you say you -- when you say you've witnessed 20 or 30, are you saying you witnessed 20 or 30 times where clients have been restrained on the ground?

A At least that many, yes.

Q And it's always -- and no staff member's ever been in trouble for restraining clients on the ground, as far as you know? It's always been an accepted practice?

A There have been problems at BHDC, but I have never witnessed one of those that was questioned.

Q Well, actually what I'm asking is -- I'm sorry. My question's actually simpler than that.

And I think the answer is no, but I'm just asking,

do you know if anybody ever -- if any direct care staff or any staff was ever reprimanded for restraining a client on the ground in the way that you described the incident you participated in with David?

A No.

Q Okay.

A If -- if the staff was more physical, people have been reprimanded and people have been terminated.

Q But it was your understanding that it was proper procedure to use the ground that way? To have the --

A Yes.

Q -- client on the ground that way?

A Yes. That is the way we were instructed.

Q Okay. Who instructed you to do it that way?

A In the PHASE class I previously mentioned.

Q And was that instructor, Mark Hise?

A No. It was prior to Mark's arrival or Mark's -- Mark had not reached that position yet. It was Sandra Shiggly.

Q Okay. And, in PHASE, you were actually trained in doing essentially what -- doing the type of restraint that you and Rhonda used on David?

A Yes. We were shown videos and we practiced on -- in the training class on fellow attendees. We were walked through the situations.

Q And, again, you would say, in your approximately four-and-half years there, you witnessed at a minimum of 20 times clients were restrained this way? Or was it more?

A It would be between 20 and 30 times. We're talking about 125 clients on the whole facility, so it was a -- it was a common occurrence.

Q Okay. And, again, I'm just talking about on the ground. So, on the ground, you're saying between 20 and 35 times probably?

A On the ground, probably 20.

Q Okay. And how many times -- other than the time that you were involved yourself, did you ever see David taken to the ground?

A Yes.

Q About how many times?

A Probably one other time.

Most of the time, with David, the redirection would be used.

Q Because he wasn't dangerous, was he?

A No. He was just -- just kind of out of control.

Q In your opinion, was he capable of legitimately harming a grown man?

A Not intentionally.

Q Okay.

A That would only occur if a -- for example, if a chair was kicked or a table was turned over.
Q Let's say there's no furniture, there's no tools of any kind, it's just him and his hands and his feet.
In that situation, where he was no access to any chairs or tables or desks or any sort of weapon of any sort, in that scenario, in your opinion, based on your experience, was he capable of causing any actual harm to another grown man?
A No.
Q Okay. And, again, I think you said this, but you know of no incident, you know of no time where he did cause any harm to another person, do you?
A That is correct.
Q Okay. And was there a certain time -- you mentioned that this incident you were involved with happened after lunch.
Did you ever notice if there was a certain time of day where David seemed to be more irritated than others?
A To me, it appeared in the period after lunch or an hour following lunch. That would -- that would be my answer.
Q And did you ever discuss this with another staff member? You know, just this observation?
A Yes, I did.

Q And who was that person?
A The person's name was Elaine Demint. Elaine Demint. And she --
Q Could that have been Elaine Dewitt?
A -- Dewitt. Yes.
Q Okay. And what did Ms. Dewitt -- what did you and Ms. Dewitt discuss about noticing David being more prone to behaviors after lunch?
A Ms. Dewitt arrived at the observation that this occurred more after lunch. And she also speculated that it could be because he wasn't feeling well.
Q Did she further speculate, you know, in what way he might not be feeling well?

[redacted]

Q And about when did you and Ms. Dewitt have this discussion? If you can remember.
A About six months before the aforementioned behavior that I was involved in.
Q When was the aforementioned behavior incident you were involved in?
A It was approximately three years ago.
Q Three years ago from now?
A Yes. It was a --

Q So sometime in --
A -- year before -- a year before I left the job.
Q Okay. So you left the job around September 2020; correct?
A Yes.
Q So the behavior incident that you were personally involved in with David would have been probably in the fall of 2019?
A Yes.
Q And you're thinking that you and Ms. Dewitt discussed this mutual observation y'all had maybe six months before that, sometime maybe in the spring of 2019?
A Yes.
Q Okay. And did y'all talk about any -- you know, did y'all discuss anything, any solution or possible solution? Did the conversation veer towards that?
A No, we did not discuss a solution. It was just a casual conversation in which we were discussing David's behavior. David's -- we were discussing David.
Q Okay. Do you know if any other staff members or administrators ever made the same observation?
A I'm not aware of that.
I do know that this -- that Elaine's observation was relayed to Randy. So he -- our building supervisor. So he was aware of it.

Q And how do you know it was relayed to Randy?
A Well, we discussed -- any information like that was passed around to fellow staff members.
If they were not a party to the conversation, they would have -- they would be made aware second hand.
Q I'm sorry. I misunderstood you, I think.
I'm asking, how do you know that -- and when you say Randy, do you mean David Randy McLemore?
A Randall David McLemore, yes.
Q Randall David McLemore? That's his full name?
A Yes. On the paperwork, he would -- he may sign it David. But we called him Randy.
Q But when you say Randy, you're talking about a man named McLemore?
A Yes.
Q Okay. And my question was, how do you know that McLemore was made aware of y'all's observation about the problematic time period after lunch with David?
A I have heard Randy also discuss it.
Q Okay. And who with?
A With -- I can't be more specific because of my memory, but just fellow staff members.
Q Okay. Let's see.
Now, you never saw David be placed on a papoose board or in a mechanical restraint?

A No.
Q Okay.
And, again, you've witnessed David be restrained, taken to the ground and restrained on the ground at least one other time besides the incident that you were involved in with Rhonda?
A I would say that's an accurate statement.
Most the time, David would be just redirected to sit down and would be monitored one-on-one with a staff member within -- a staff member within three foot or four foot standing next to him for possibly an extended period of time, like 30 minutes.
Q And were you involved with any incidents like that where you were able to just calm him down without having to have any physical contact?
A Yes. I have filled in as that person to provide the one-on-one.
Q If you could, could you give us a sense or an idea of how often -- I know you said you filled in as direct care maybe a third of the time, is that right?
A On the average, yes.
Q And when you worked at Booneville, was that a full-time job for you? Meaning, did you work around 40 hours a week?
A Yes. I worked full time.

Q Okay. And what hours of the day did you typically work at Bonneville?
A I worked regular hours, eight to five, with some overtime.
Q Okay. And was that consistent throughout your employment there?
A Yes.
Q And so my question is, are you able to say, you know, roughly how much contact or how often you would have been around David Cains?
A I had -- generally, I would be in a position to be in contact with David for ten minutes or 30 minutes a day.
Q Just about every day?
A Yes.
Q Okay. And was it the same for several other clients as well?
A Yes.
Q So David wasn't --
A That would apply to approximately 30 clients.
Q Okay. And why those 30 clients specifically?
A Those were the ones assigned to our building.
Q And your building was the Stone building?
A It was called the Stone building or the recycling building.

Q Okay. And David was assigned there for vocational purposes?
A Yes. Half a day.
Q Okay.
A In the evenings. Or in the afternoon.
Q Okay. All right.

MR. GILLISPIE: We're going to take a quick break. Mr. Carter, you're almost done. Don't do anything or go anywhere because I don't want to lose you.

THE WITNESS: I'm not.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:
Q I wanted to ask you, in your training or really at any time, at any point in your time at Booneville, were you given any instructions about 9-1-1 and who's allowed to call 9-1-1 in case of emergency?
A Yes.
Q Okay. And what were you told?
A We were told we were not -- staff members were not allowed to call 9-1-1.

The nurse would be the one that would call 9-1-1. And I questioned this as early as my first week of work

in training. And they said that was the procedure to be followed.

And, to add more, over the -- over the period of time, I felt like that was a bad -- that was a bad policy. And, if the situation presented itself, that I would violate protocol and call 9-1-1 in an emergency, even if it would cause me to get fired. Because I would probably be fired anyway.

Q And so you're saying the policy was, no matter what, no matter what, you were told that you can not call 9-1-1 unless you're a member of the medical staff?

A That is correct.

Q And there were no exceptions?

A No exceptions.

Q And do you recall when you were told this or who told you this specifically or if it was -- how this was imparted to you, told to you?

A That was told -- that was the instructions presented in the first week of that PHASE one training, the first week of my employment, in the training class.

And it was the prevalent policy the duration of my employment.

Q What do you mean prevalent policy?

A That -- that was the policy. You did not call 9-1-1.

Q Do you remember who gave you those instructions?
A Sandra Shiggly.
Q Okay. And did you ever personally witness an occasion where you felt like 9-1-1 should have been called but it wasn't?
A No, I've never witnessed that.
Q Do you know of any situations where you feel like -- did you ever hear about any situations or did any other staff member ever talk to you about a situation where they would have liked to call 9-1-1 but couldn't?
A I've had casual conversations with other staff members where that exact subject was talked about.
Q Do you remember any specifics of those conversations?
A Just that -- that, in the conversation, we agreed that that was a dangerous protocol. Delaying an emergency call.
Q Do you have any idea why that was the rule?
A Yes. It was to control a situation.
To be blunt with you, BHDC administration wanted to present their narrative in the documentation in an event like an emergency.
Q What do you mean?
A They wanted total control of what was -- would appear in the documentation.

Any emergency event would have been documented. And they just presented an attitude where they wanted complete control.

Q Do you know why that was so important to them?

A It was just -- they had had problems in the past where things leaked out that was not in their interest.

Q Do you know, do you specifically recall what any of those things might have been that leaked out?

A There over -- in the last ten years, I -- I know of at least three incidences, emergencies, that resulted in death. And I'm sure that played a -- that played a part in their decision.

Q Are you saying that you think that they -- what other deaths other than David's?

What other deaths do you know of? If you can recall. So it would be two other deaths then?

[redacted]

[redacted]

Q Do you believe that administration -- do you have any information or any belief as to whether administration in their desire to, as you said, to control the narrative of this -- well, scratch that. Let me withdraw that question.

You used the term -- when I asked you why, what your understanding was as to why this rule was in place, you said it was so that they could control the narrative.

Could you elaborate a little bit or maybe say more clearly what you mean by that? By control the narrative, what does that mean?

A The -- from my experience, the administration were what I would call control freaks.

They -- if something was out of their control, it made them uneasy. They had to -- they had to be in control.

Q Are you suggesting they would cover things up if they had to?

A I wouldn't go that far. But I would say they would paint a picture that would show them in the best light.

Q Okay. And that's what you mean by control the narrative?

A Yes.

Q And that's your belief as to why that prohibition on calling 9-1-1 was in place?
A Yes.
Q And did you ever discuss -- did anybody ever talk to you about this? Did you ever talk about this with anybody, this reason?
This controlling the narrative, was this a known thing?
A Yes.
Q I guess what I'm getting at, this wasn't just your personal opining, Don Carter's personal opinion, was it?
A No.
Q Okay.
A I had opportunity to have casual conversation with fellow staff members while we would ride -- when we were on the truck route.
And this was -- this subject was talked about on several occasions with different staff members. And, basically, that was our -- we concurred that that was our conclusion.
Q And did you ever discuss it with any senior staff or administrators?
A No.
Q Did Sandra Shiggly or anyone else ever explicitly tell you, hey, this is the reason for this rule?

A No.
Q Okay.
A I -- I will say, on my first week in the training class, my first week of employment, I -- I spoke out in class and questioned, I said -- to make sure I understood that -- what she was saying.
And she said, explicitly, no staff member is to call 9-1-1. Only a medical person, which meant a nurse, would call 9-1-1.
Q Okay. And were you aware at that time of negative reports that had been written about Booneville by Disability Rights or any other criticism of Booneville?
A Yes.
Q And do you -- I mean, is it your understanding that they played into it? You said things have leaked out, there have been some criticism.
I'm just trying to understand, you know, everything you believe or know about why they may have been so concerned with controlling narratives and --
A From the administrative point of view, our perception was that this Disability Rights was the enemy.
Now, the lower staff members didn't feel that way. But that's the observation that was made by -- that myself and obviously other staff members has confirmed in our causal discussions.

Q And can you recall the names of any of these other staff members that you had casual discussions with about any of this?
A Yes. A previous employee, Gary St. Pierre, he's retired now.
And I have also with other staff members that are currently employed, but I'd rather not -- since my memory may not be --
Q Well, Mr. Carter, I understand that. But, unfortunately, in such a serious proceeding like this, we have to get those names and we'll give them an opportunity to tell us what they remember. And, you know, they're not going to be in any trouble.
A Okay.
Q There are no individuals being litigated against in this matter, sir.
A Okay. Ken Matthews. David Poore.
Q David what?
A Poore. P-o-o-r-e.
Q Okay.
A Issac Sirk.
Q How do you spell that last name?
A Sirk. S-i-r-k.
Q Okay.
A Billy Wilkins.

Q Okay.
A And Elaine Dewitt.
Q Okay. And these are the people that you would have had, as you said, casual conversations with about the 9-1-1 policy?
A To the best of my remembrance.
Q Okay.
Did you ever speak directly with any senior staff or administrators about Disability Rights?
A No.
Q Okay.
A I mean, I've heard Randy McLemore comment that, you know, we have to be careful because of that -- because of that. But nothing in detail.
Q Okay. And, when you say be careful, just in general or be careful like when auditors from Little Rock are coming?
A Be careful in that we have to make sure we do what we're supposed to do.
Q Okay.
A Meaning follow the rules.
Q Okay.
Do you recall ever being given a document of any kind that laid out what types of personal restraints were allowed to be used on the clients?

A I think that would have been in the training manual.
Q Okay.
A I can not say for sure, but I'm almost positive that that would be documented in a training manual.
Q Okay.
Were there times when supervisors or auditors, I don't know what you would call it, but folks from Little Rock and maybe DHS would come and survey or check up on how things are going at Booneville?
A Yes. Approximately every four to six months.
Q And what did you call that? What did y'all call that?
A Basically, fellow staff members would just say the surveyors are on campus or the auditors are on campus.
Q On the days that that would happen, would you be given advance notice that they were coming?
A Yes.
Q And would everybody be given advanced notice?
A Yes.
Q And how was that advanced notice imparted to y'all?
A Just casual conversation.
Q Would supervisors tell sections or areas, hey, auditors are coming, be on your best behavior?
A Yes.
Q Do you recall ever being told that by any

supervisor?
A Yes. My supervisor, Randy McLemore.
Q And describe as best you can remember what that communication from him would have been.
A He was -- we were in a large work area and he would just walk around and tell the staff members that they, the auditors are -- would be there to see them. You know, just a kind of heads up.
Q Were you supposed to be getting advanced notice of that? Do you know?
A I do not know the answer to that question.
Q Okay. Who was your supervisor when you would perform direct care functions?
A That would -- normally would be in our work area, which would be Randy McLemore.
If I was assigned to a living area, it could be a different person.
Q And was Randy McLemore also trained in direct care?
A Yes.
Q Did you ever see Randy McLemore take anyone to the ground?
A Yes. He -- he was a very good supervisor. And he has been involved in more behaviors than any person.
If he was available, he would be the first to respond.

Q Why do you say that?
A Because I observed that. He would normally be in his office and the closest staff member would respond.
But if -- if Randy was close by, he would insert himself, because he is the most experienced.
Q And I think you're saying good at his job. You respected the man?
A Yes. Yes.
Q And you've witnessed Randy restrain clients while on the ground?
A I've witnessed Randy redirect David Cains and that probably resulted on several occasions from it escalating.
Q Okay. But you said you've also seen Randy have to participate in restraining clients on the ground personally; right?
A Yes.
Q About how many times do you think you've seen that?
A Fifteen to twenty.
Q Okay.
My last question for you is, are you familiar with -- I imagine you're familiar, you drove a truck on the campus, you're familiar with the layout of the campus?
A Yes.
Q You know where the Commons building is?

A Yes.
Q And you know where the Judge Hill building is?
A Yes.
Q I will represent to you -- I know you weren't there -- well, you were not there the day David died; correct?
A Correct.
Q Okay.
I will represent to you that, on that day, David -- the incident that resulted in David's death occurred in the Commons building. Is that your understanding as well?
A In the cafeteria. Yes, the cafeteria.
Q Okay. The cafeteria is in the Commons building; right?
A Correct.
Q Okay. And the incident occurred in a hallway outside of the cafeteria in the Commons building. That would still be the Commons building; correct?
A Yes.
Q Okay.
A There would have been a hundred people, probably, in the Commons cafeteria, so --
Q What I'm asking you, Mr. Carter is -- I'll represent to you that three direct care staff were involved in a restraint of David Cains in the Commons building.

David started vomiting and struggling to breathe and was vomiting and aspirating and couldn't breathe. And one of these staff members called medical and medical was in the Judge Hill building. You follow me so far?

A Yes.

Q Okay. Do you think it would have been possible -- well, based on your experience at this facility, your experience on these grounds, how long would it -- what's the least amount of time it would have taken for a nurse in the Judge Hill building to receive this call, get in a car, drive over to the Commons building, go inside the Commons building, observe the scene, and then call 9-1-1?

A A very minimum of five minutes. It could have been longer.

Q Why do you say that?

A Well, the parking areas are very cramped.

By the time a person would get in their car, navigate the narrow parking area -- this is a 1940s design. And the parking areas are -- the driveways are narrow.

To back out of a parking area, to navigate, and to arrive at that location, a minimum of five minutes.

Q Even on a Saturday?

A Yes.

Q So it wouldn't matter how busy the parking lot was?

A No. It could have been longer on a weekday. But, even on a Saturday, I would say, for me to do that in a hurry would be five minutes.
Q Did you have any conversations with anybody, do you have any knowledge of, based on things you've heard or people you've talked to, about what happened this day and whether a call to 9-1-1 right away could have made a difference for David?
A No, I have not had conversations with fellow employees.
Q So you never talked to anybody about what happened to David?
A I have talked to people about David's tragedy. But it did not include as to what might have -- it was not Monday morning quarterbacking of what might have --
Q Right.
A -- been done.
Q Who have you spoken to about what happened with David?
A Probably all the staff members at some -- immediately after the vent. And some possibly extended while riding on the truck route.
Q Did anybody directly involved in it like Tyler Mattson or Mandy Jones or Ryann Campos or any of the nurses, did you ever talk with any of them directly about

--
A No.
Q -- what happened?
A No.
Q Okay.
There's been some suggestions or allegations by the Disability Rights that emergency authorities were intentionally given some bad information about what went on with David. Do you have any knowledge of that?
A No, I do not.
Q Okay. And, again, to clarify, you think it -- this is my very last question.
I'm going back to how long it would take for somebody to get from Judge Hill building over to the Commons building on a Saturday. So let me lay it out one more time.
And you got a call -- you have a person in the Commons building. They call over to the Judge Hill building where -- the nurse's station.
Are you familiar where the nurses --
A Yes. Yes.
Q -- where the nurses spend their time in the Judge Hill building?
A Yes.
Q You are? Okay.

So a nurse I believe --
A Let me just say this. I have -- I have picked up recycle at all the offices. So I am very familiar with the layout of all the offices.
Q Okay. So you've driven from the Judge Hill building to the Commons building many times?
A Yes.
Q You've picked up recycling, your job was to literally pick up recycling and go from building to building?
A Yes.
Q And you're saying it is simply not possible for these nurses to have taken this call in the Judge Hill building, grab their stuff, hop into a car, driven over to the Commons building, and gone inside in less than five minutes?
A That is correct.
Q Okay. Would you say it's more likely even longer than five minutes?
A Could very possibly be. But, again, under optimal conditions, it would take five minutes.
Q And, one more time, in as much detail as you can, tell me why that is.
A Several factors, as I've mentioned. Narrow driveways dating back to the '40s, possibly other cars

parked along the -- those passageways which probably was not the case on a weekend.

But it's just a -- it's kind of like a rat maze going from one building to another.

Q Okay. So it's not a straight shot across a flat parking lot?

A No. It's a 1940s design for smaller cars.

Q Okay.

A It's just not of modern standards.

Q Okay.

And what's the distance from where you would park at the Commons building to the entrance to the Commons building? The part you have to walk.

A She would have probably parked right in front. But, if she parked in the parking lot, it would have been 200 feet.

Q Okay. And what's the difference -- same question but for the Judge Hill building from where the nurses station is in the Judge Hill building to the parking lot at the Judge Hill building.

A Two hundred feet.

Q Also you think 200 feet?

A Approximately.

Q Not from the front door of Judge Hill but from where the nurses hang out in Judge Hill.

A Right. She would have exited the back door to the parking lot so approximately 200 feet.
Q Okay.
All right. Well, Mr. Carter, that's all the questions I have for you. I'm going to pass you over to Eric here; but I appreciate your time.
A Thank you, sir.

CROSS EXAMINATION

BY MR. COLLINS:
Q Mr. Carter, real quick, I'm just going to pick up where we kind of left off and then I'll go back from there.
So you're identifying -- you said they were at the Judge Hill building, and they went to the Commons building? Is that your understanding of it?
A Yes.
Q Okay. How far is the Judge Hill building from the Commons building?
A As the crow flies, I would say close to a quarter of a mile. Now, driving, it would be farther.
Q Okay. And you identified that the main hassle of that would be getting out of a parking spot? Navigating parking spots?
A Yes.
Q Okay.

Do you think it would be as much of a hassle if their car was not in a parking spot, where it was instead parked on the curb?

A There are very few parking spots. Most likely, the car would have been parked on the curb.

Q Okay. Would there still have been as much of a hassle?

A Yes.

Q And why is that?

A The parking area is very small behind the Judge Hill nursing area, so it -- there's only like two parking spots. So most of the nurses park along a curb.

Q Uh-huh. And if there were parked in front of the front door --

A There's also an overflow area which is 500 yards away that, during the week, some of the nurses park in the overflow area.

Q And what if they were parked in front of the front door?

A Excuse me?

Q And if they were parked in front of the front door on the curb?

A The nurses never park -- even on a weekend, the nurses -- to the best of my nurse -- the best of my knowledge, the nurses would not park in front of the

front door.

The front door would be in front of a living area. And the bus runs. And, because of the narrow restrictions, you do not park in front of Judge Hill. So the nurses would have parked in the back.

Q Okay.

I want to move on real quick to, you said you quit in September 2020; is that correct?

A To the best of my knowledge.

Q Why did you quit?

A As I had said, I was the -- I was the truck driver on the recycle route. And we covered five counties in this area. We went to approximately 20 different schools.

And there have always been two people, the driver and an assistant, who would be rotated among other staff members. So there's always been two people on the truck route.

Well, when the pandemic hit and there were staff shortages, I was told to just do it by myself which meant, basically, I was doing the work of two people.

And it -- my job was considered the hardest job on the hill. And it was beginning -- by doing all this work myself, it was beginning to take an effect on my body.

I am 67 years -- I was 65 years old at the time.

And, basically, I was being overworked.

And then my immediate supervisor was aware of this and he -- my immediate supervisor who was Randy McLemore. And he was managing it as things -- for example, we would pick up the priority stops and let the small volume stops maybe sit for a day or two.

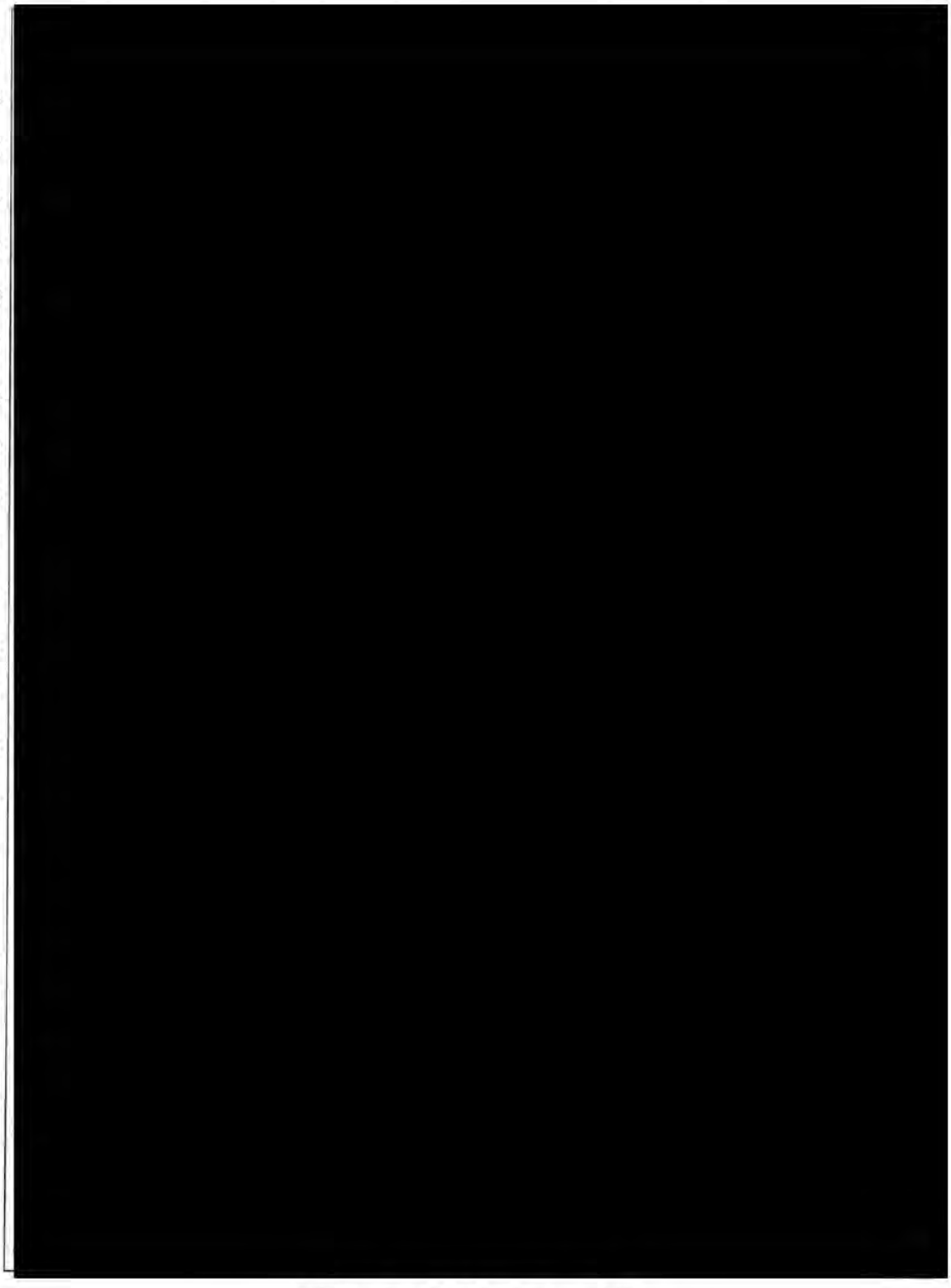
And Randy had no problem with that. He was managing it in a successful and adequate manner.

Randy took a week's vacation. And Randy's supervisor was a lady named, excuse me just a second, was a lady named Carey Johnson. And Carey Johnson did not like me.

[redacted]

When -- in Randy's absence, she called me. I'd been working all day in the rain. I was soaking wet. When I arrived back at the office of the building, the secretary said Carey Johnson wants to see you right now.

[redacted]



[redacted]

Q Okay.

Are you able to see us? I don't know if you have video of us or not.

A No, I do not have video.

Q Okay.

MR. COLLINS: Josh what we might want to do is I'm going to enter some of these exhibits, would be his resignation letter as well as his write up.

After this, I'll scan them to you and possibly e-mail them.

MR. GILLISPIE: That's fine.

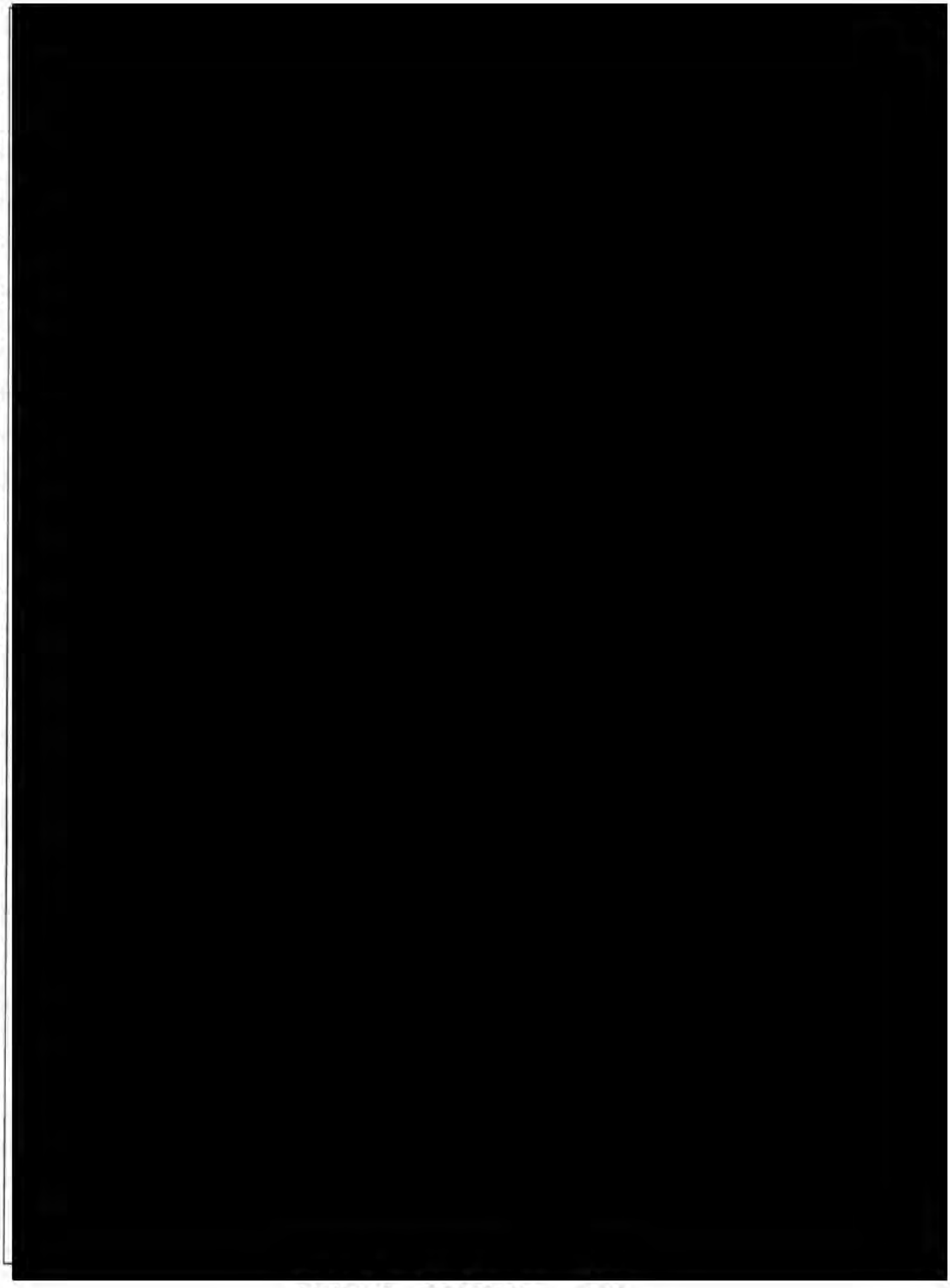
MR. COLLINS: Okay.

(WHEREUPON, the documents were received and marked for identification and are attached hereto.)

BY MR. COLLINS:

Q Okay.

[redacted]



Finally, did you apply to other jobs with DHS?
A Did I apply?
Q Yes, sir.
A Yes, I did.
Q And what other job did you apply for?
A I applied for a computer technician job on the hill. And I had previously worked for DHS in Little Rock back in the '80s for food stamps and I had five years experience at that job as assistance programmer.
And there was an opening in Little Rock and I applied for that. A current -- when I say current, I mean like 2019 period, and I applied for that. And I --
Q And which --
A -- interviewed (inaudible) --
Q I'm sorry. Go ahead.
A I interviewed for that job in Little Rock.
Q And which job was that?
A It was a computer related job. Probably a -- I don't remember the title. But it was in -- it was commensurate with my previous experience.
Q Okay. And was your application rejected?
A No. I -- at first, it was rejected.
I have a -- I have a degree in computer science.
Q Uh-huh.
A The people on the hill thought I -- I mean, when

I -- personnel on the hill, I had the impression that they didn't believe me. Because I was working at a lower job.

The reason I was working at a lower job, I had to get ten years in with the state to collect my employment.

Q Uh-huh.

A My retirement.

Q Okay. So did you ever write a letter saying that your application was erroneously rejected?

A I think I wrote a letter to verify that I did have a Bachelor of Science degree and that I felt I was qualified.

I can't remember if I wrote a letter or I -- I was told that on the phone or I discussed that on the phone. But I remember something like that.

Q Okay. So your background is in computer science or something along those lines?

A Say that one more time.

Q Your background is in computer science; is that correct?

A Yes. Back in the '80s.

Q Okay.

Have you ever had any medical training?

A No, I have not, except CPR.

Q Okay.

So do you know how many times 9-1-1 was called from Booneville HDC during your time of employment there?

A I have no idea.

Q Do you know how many times medical was called?

A I have no idea.

Q Okay. Do you know how many times medical was called to an emergency that turned out not to be an emergency at all?

A I'm sure that has occurred, but I have no information or no idea how many times that might have happened.

Q Okay. And so your impression of the 9-1-1 policy, that it was, in your words, possibly a coverup because administration was controlling and wanted to control the narrative?

A Now, would you ask -- will you repeat that question?

Q Okay. I'm saying your impression of the 9-1-1 policy was that it was due to the fact that administration wanted to control the narrative and possibly cover up things?

A Yes.

Q Okay. It sounds like you're guessing or that's a bit of a conspiracy.

Do you have any actual basis or knowledge or have you spoken to anyone in administration that would lead

you to believe that?
A No.
Q Okay.
MR. COLLINS: I have nothing further.
MR. GILLISPIE: Me neither. Thank you, Mr. Carter.
(WHEREUPON, the proceedings were concluded in the matter at 11:06 a.m.)
* * * * * * * * *
(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Don Carter, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

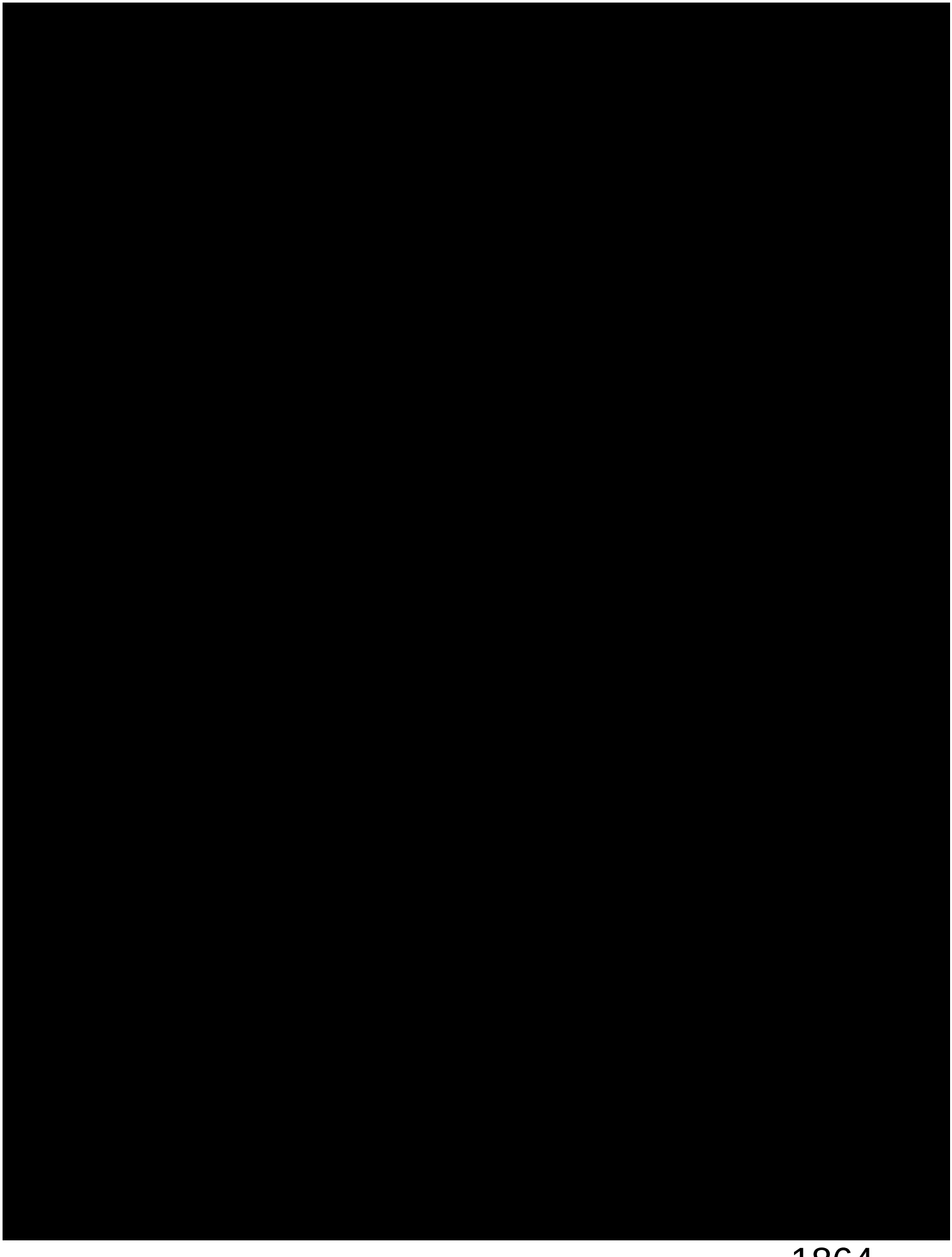
I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

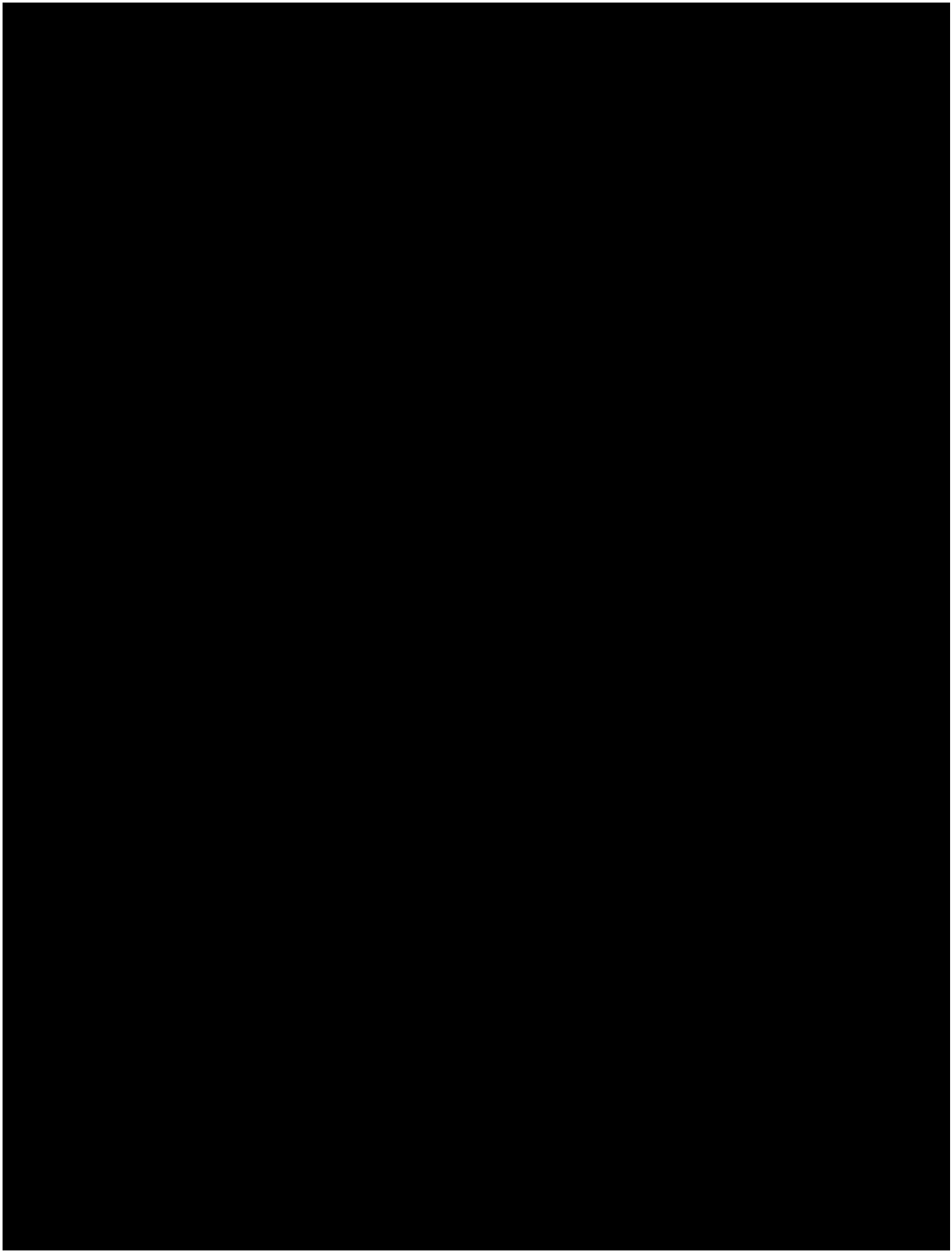
WITNESS MY HAND AND SEAL this 2nd day of May, 2022.

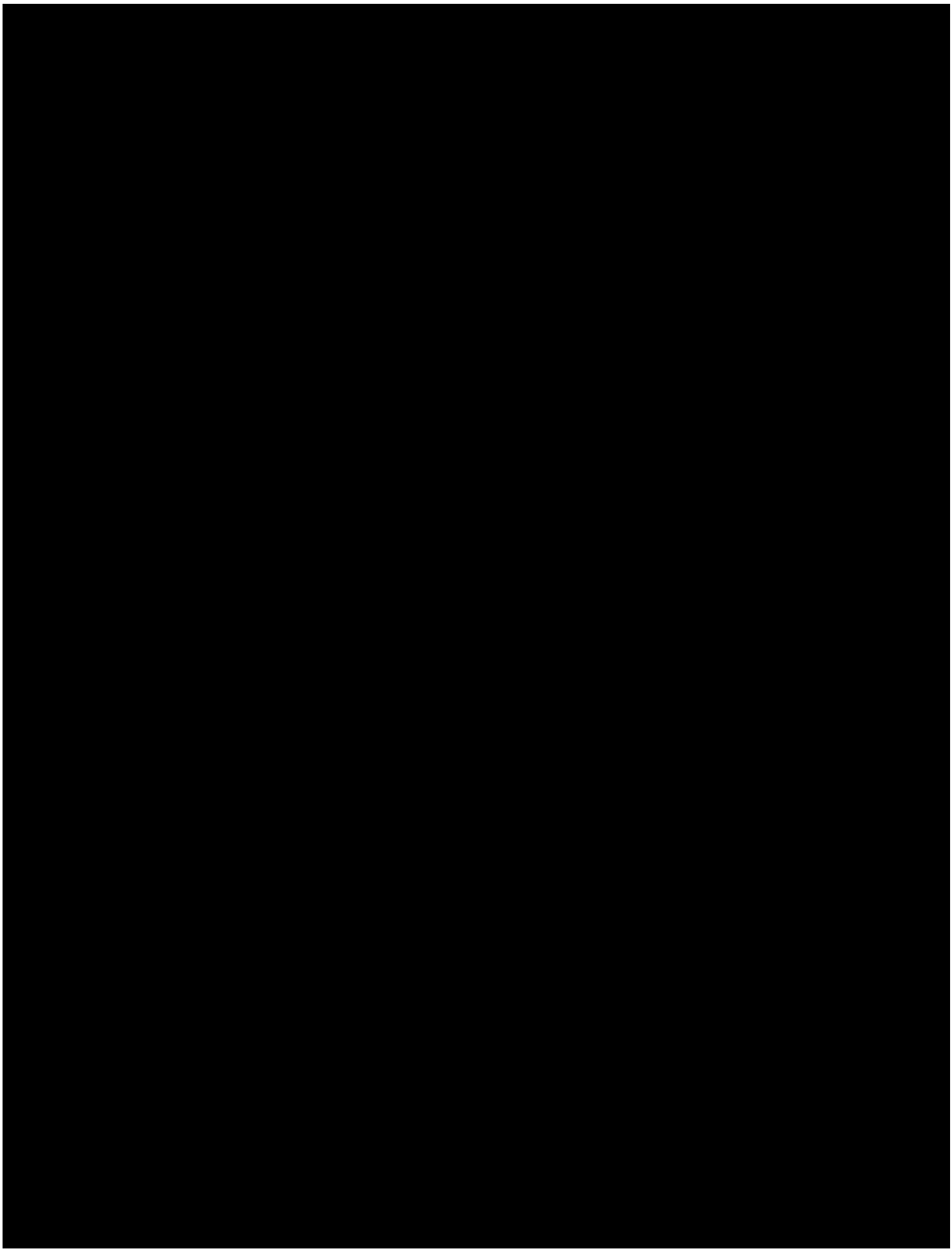
Cris M. Brasuell

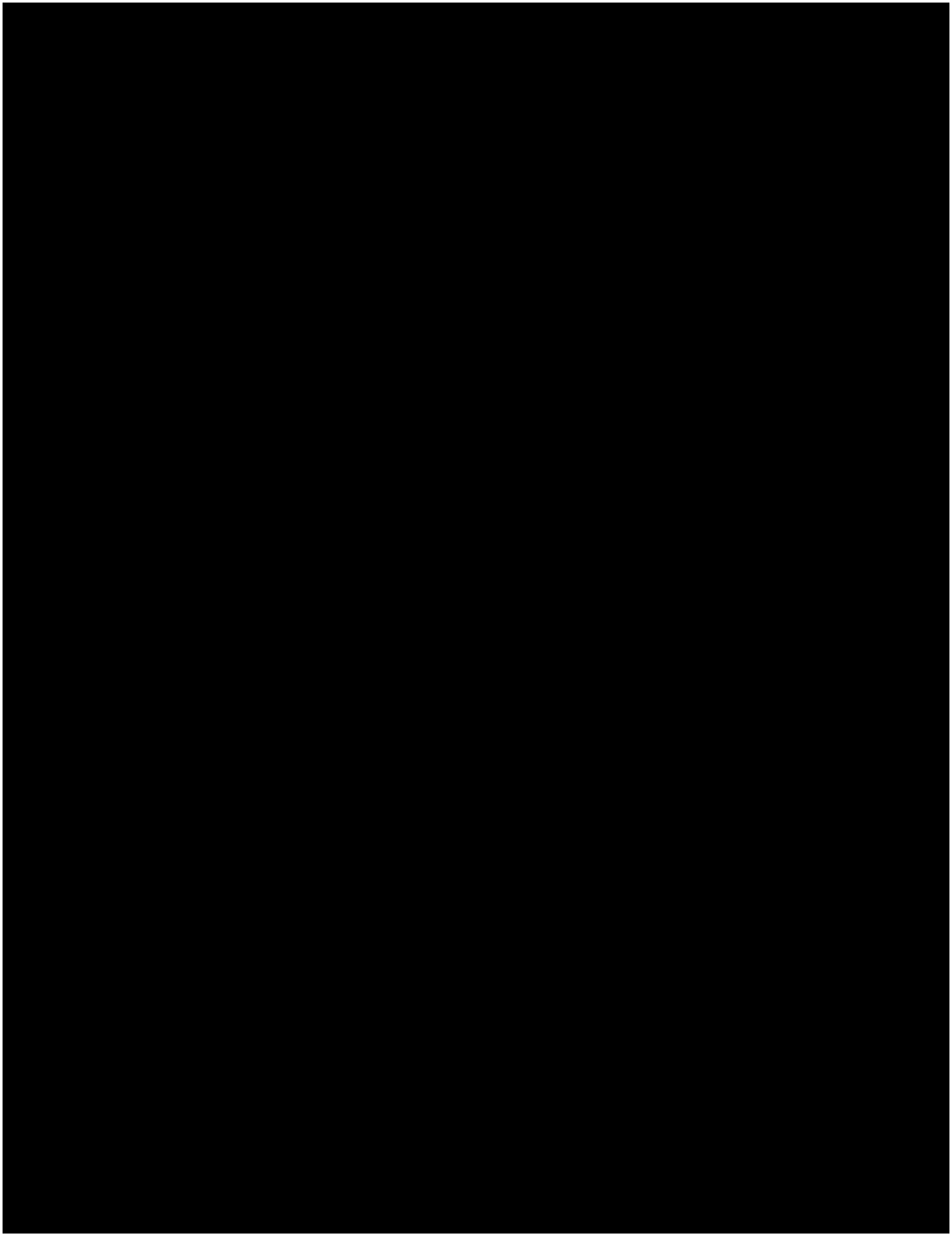
CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

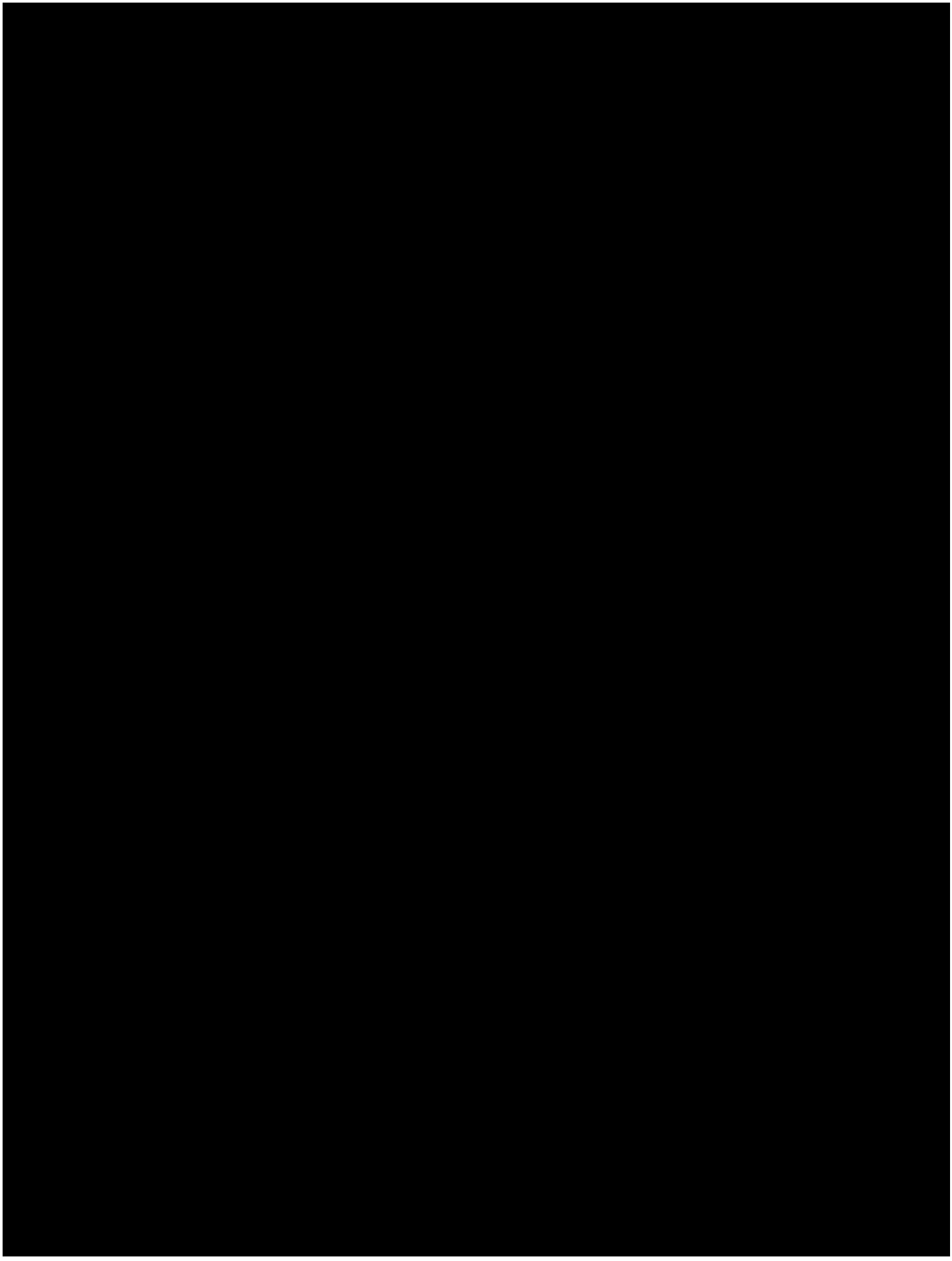
My Commission Expires:
August 16, 2031











BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

Arkansas
State Claims Commission
FEB 16 2023
RECEIVED

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS

CLAIMANT

VS. CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)

RESPONDENT

VIDEOTAPED ORAL DEPOSITION

OF

MIKE ALVIS

March 31, 2022

Arkansas Department of Human Services
700 Main Street
Little Rock, Arkansas 72203

Shyloa Myers, RPR, CCR
Arkansas Lic. No. 710



A P P E A R A N C E S

ON BEHALF OF THE CLAIMANT:

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ALSO PRESENT:

GARRETT GRELLNER

JOHN SIMS, Videographer

I N D E X

STYLE AND NUMBER 1

APPEARANCES 2

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WITNESS: MIKE ALVIS

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COURT REPORTER'S CERTIFICATE 73

E X H I B I T S

DESCRIPTION		MARKED
Exhibit 1	Booneville Human Development Center Psychological Evaluation	29
Exhibit 2	Behavior Treatment Program	50
Exhibit 3	Behavior Treatment Program Addendum	51

Shyloa Myers, AR CRR No. 710
StenoScribe, Inc.
alldaydepo@gmail.com

C A P T I O N

ANSWERS AND ORAL DEPOSITION OF MIKE ALVIS, a witness produced at the request of the CLAIMANT, taken in the above-styled and numbered cause on the 31st of March, 2022 before Shyloa Myers, CCR, RPR, and Notary Public, at 10:00 a.m. at the Arkansas Department of Human Services, 700 Main Street, Little Rock, Arkansas 72203.

S T I P U L A T I O N S

NO STIPULATIONS ON THE RECORD

Shyloa Myers, AR CRR No. 710
StenoScribe, Inc.
alldaydepo@gmail.com

(Deposition commences at 10:01 a.m.)

PROCEEDINGS

THE VIDEOGRAPHER: We are on the audio and video record. Today's date is March 31, 2022. The time is approximately 10:01 a.m. This is the videotaped deposition of Michael Alvis. This is the case of *McAuliffe V. Arkansas Department of Human Services, Booneville Human Development Center.*

My name is John Sims. I'm a videographer out of Little Rock, Arkansas.

Will counsel please make a record of your appearances.

MR. GILLISPIE: Josh Gillispie on behalf of Plaintiff.

MR. COLLINS: Eric Collins on behalf of DHS.

MIKE ALVIS,

Called as a witness, having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. GILLISPIE:

Q. Hello, Mr. Alvis. How are you today?

A. I'm doing all right.

Q. And your name is Michael Alvis, right?
A. Yeah.
Q. And it's --
A. I go by Mike.
Q. Mike, okay.
A. Yeah.
Q. And are -- are -- you're not a -- you're not a doctor?
A. No.
Q. Okay. What is your title at -- or at the -- at the Booneville facility?
A. Psychological examiner.
Q. Psychological examiner, okay.
A. Uh-huh.
Q. So what kind of credentials do you have for that?
A. I have a master's degree in counseling psychology.
Q. Okay. A master's. I was thinking that's what it was. Master's in psychology, okay.
A. Uh-huh.
Q. How old are you, Mr. Alvis?
A. 60.
Q. 60, okay.
Well, let me start by saying my name is Josh Gillispie. I'm an attorney for David Cains and his family.

A. Uh-huh.
Q. I just want to ask you a few questions about your time with David and about the facility that shouldn't take too long.
Have you ever been deposed before, Mr. Alvis?
A. Not really, no.
Q. No? Never been in part of a -- you never had to go and be questioned --
A. I've been in court.
Q. Okay.
A. A -- two to three times.
Q. Okay. What have you been in court for?
A. One time was back in the nineties I think it was. I was working for the Centers for Youth and Families in helping DHS take the children out of the home.
Q. Okay. Oh, okay. D --
A. That was --
Q. Okay. That sort of thing?
A. Yeah.
Q. Was --
A. So --
Q. -- were all the times that you had to go to court involving that sort of --
A. Client thing, yeah.
Q. -- thing?

A. Yeah.
And in Hot Springs I've been to court twice I think trying to get a client into a hospital.
Q. And how long have you been employed at the Booneville Human Development Center?
A. Currently? Since nineteen eight -- I mean 2018 currently.
Q. What do you mean "currently"?
A. I was employed there before in ninety -- not ninety. Excuse me. Yeah, it was 19 -- I was there for four years, so 2008 to 2002, before.
Q. You mean 1998 to 2002?
A. Yeah. Uh-huh, yeah. That's it.
Q. And then you -- you came back to Booneville in 2018?
A. January, yeah.
Q. Okay. And you're still there?
A. Yes.
Q. And is that your -- your full-time job?
A. Yeah.
Q. Meaning you don't work at other facilities with --
A. No.
Q. Okay. Okay. And -- let's see. All right.
Mr. Alvis, where are you from originally?
A. What do you mean? Like --

Q. Where'd you grow up?
A. Mena, Arkansas.
Q. Mena.
A. Mena, yeah.
Q. All right. And where did you go to -- where did you get your master's degree?
A. University of Central Arkansas.
Q. Okay. And what year did you graduate?
A. 1989.
Q. 1989 from there. All right.
And you said it's a master's in --
A. Counseling psychology.
Q. -- counseling psychology.
A. Yeah.
Q. Okay. Where did you work -- what was your first job after that?
A. Counseling Associates.
Q. Okay.
A. In Russellville.
Q. And what kind of work did you do for Counseling Associates?
A. I was an outpatient therapist.
Q. Okay. Just a general therapist for --
A. We were -- yeah.
I covered whoever they gave me, a client.

Q. Kind of like you'd have a client that comes in once a week or once a month --
A. Yeah.
Q. -- and does talk therapy?
A. Yeah, yeah.
Q. Okay. And how long were you at Counseling Associates?
A. Technically I started my internship in January, and that job ended in June.
Q. That job ended in June.
A. Yeah.
Because they hired me while I was still in grad school. And I had already finished my internship hours, and they hired me through -- my first job.
Q. When you first came to work at Booneville in 1998, what did you do at the facility? What was your job?
A. The same -- the same job that I was in now, I'm in now: Psychological examiner.
Q. Psychological -- and that's your title, psychological examiner?
A. Yeah, yes.
Q. What does that mean?
A. I provide testing, psychological evaluations, individual and group counseling type deals. I'm -- I go to meetings; annual IPP, Individual Program Plans.

Q. So --
A. And special staffings and . . .
Q. So you administer testing to the clients; you administer counseling to the clients, and you're an integral part of their IPPs as well?
A. I don't know about integral; but I am part of it, yeah.
Q. Or -- what is the other acronym I'm looking for? The IDT?
A. In Per- -- In- --
Q. Individual Development Team? Or are you familiar with that?
A. Really I -- to be honest with you, yeah, that's the first time I've heard that one.
Q. Okay.
A. IDT, yeah.
Q. Well, every client has a --
A. IPP.
Q. -- has a -- okay. And, well, maybe -- tell me what your understanding of an IPP is.
A. Individual Program Plan.
Q. Okay.
A. And it's a review of what they're going to be doing for the following -- the coming year.
Q. Okay.

A. In terms of programming; you know, like, work and training to -- you know, self-care and medication.

There's lot's -- I'm -- I'm not really responsible for the IPP things, so I'm not really -- I'm not -- we cover a lot of topics through that, through that meeting.

Q. Is there a person that is primarily or ultimately responsible for IPPs?

A. Oh, yes; the Q.

Q. The who?

A. The Q, the qualified -- is it -- it's -- it used to be QMRP, but I think it's QIDP I think.

Q. Yeah, I -- I think I -- I've seen that, that acronym.

A. Yeah.

Q. And that's a person?

A. Yes, uh-huh. Yeah, that's, like, the leader of the team.

Q. Do you know --

A. That --

Q. -- who that is for David? Or who that was for David?

A. I really couldn't tell you. I don't --

Q. Is it different for everybody?

A. Everybody has a different Q but some people -- I mean, we have the same caseloads sometimes; but . . .

Q. How many -- how many coworkers do you have that function as a -- well, let's call them Qs, as Qs?
A. I think there are four right now I think.
Q. Okay. And -- and who are they?
A. Frances Preston.
Her name is -- her last name is Hoopa. I forget what her first name is.
And then Crystal Strain I think. Strain, yeah.
And Justin Jobb is covering as a QIDP and as a team leader too.
Q. Okay. That name rings a bell. Could that have been his Q?
A. It could have been.
Q. But you're not sure?
A. Yeah.
Q. And is there another one that you can recall? You said four.
A. There was a -- yeah. That's -- there's four.
Q. That was four. Okay.
A. Yeah, yeah.
One person had just quit, but he had moved up to the -- a team leader position and he just quit a while ago.
Q. And --
A. And he was a Q that was there.

Q. -- IPP, Individual Patient Plan?
A. Program Plan.
Q. Program -- or Individual Program Plan?
A. I think that's --
Q. Individual Program Plan; I think you're right.
A. Uh-huh.
Q. And it -- it's your understanding that when a patient is -- is first admitted, an IPP is created for that patient?
A. Within a certain -- like, yeah.
Q. And then once a year it's reviewed and --
A. Uh-huh.
Q. To see if it needs to be modified?
A. Yeah, yes.
Q. Is that correct?
A. Yeah, and -- and it's -- yeah, you -- generally once a year, yeah. But there's, like, special team meetings that happen throughout the year about -- if there's situations or things that happen.
Q. So if -- if a patient is behaving in a way or -- or showing symptoms that warrant extra care, the IPP might be reviewed by his --
A. Yeah.
Q. -- providers, and you might modify it --
A. I think so.

Q. -- as needed?
A. Yeah. Yes, I think so.
Q. You think so. Okay.
A. But I'm not -- like I said, I'm not a Q; so I'm not really sure what all the --
Q. I understand.
A. Yeah, they -- I know that if there's -- I forget the number, but so many chemical or phys- -- mechanical interventions we have to meet. And, you know, that -- that's about all I know, is it . . .
Q. So if --
A. I'm not the one who calls the meetings.
THE COURT REPORTER: I'm sorry. Say that again.
THE WITNESS: I'm not the one who calls the meetings.
Q. Let me -- let me -- since you've never been deposed before --
A. Yeah.
Q. -- that's a court reporter.
A. Uh-huh.
Q. She's writing down everything we say.
A. Uh-huh.
Q. Of course, you're testifying under oath; you understand that.

A. Uh-huh.
Q. It's important to speak clearly.
A. Okay.
Q. So that she can make an accurate record of what is said here.
A. Okay.
Q. If you don't understand one of my questions or if you can't hear me, which won't be an issue --
A. Right.
Q. -- everybody can hear me --
A. Yeah.
Q. -- probably in the next room.
I want you to stop me and ask me to rephrase or ask me to -- to say it again.
A. Okay.
Q. Because I really want you to understand my questions.
A. Uh-huh.
Q. I would also ask that you let me finish the question before you start speaking, and I'm going to do the same thing for you. I'm not going to interrupt your answer, if at all possible.
A. Uh-huh.
Q. Again, this is for a clean record. It makes it easy -- it makes it easier on her.

Another thing is it's important in a deposition to verbalize yes and no.
A. Uh-huh.
Q. Because if we were just sitting here talking, I'd be doing a lot of this or a lot of this. Unfortunately, while we are being filmed, she still needs to make a record and needs to hear the yes or the no.
Does that make sense?
A. Yes.
Q. Okay. And I do not plan on having you here very long; but if you need to take a break at any point, you let me know and we'll stop.
A. Yeah.
Q. Okay?
A. Yeah. I've been driving for two hours -- and the -- I had to go to the restroom when I first got here. And I think I'm okay, but I drank a lot of coffee and was drinking; so --
Q. Well, I --
A. -- it may hit me.
Q. I -- I certainly understand that. And you just let me know; I won't hold it against you.
A. Okay.
Q. Not a problem.
Okay. So let's -- let's get into the testing.

Your -- your -- you said that -- that a psychological examiner --

A. Uh-huh.

Q. -- examiner, it makes sense that you administer tests.

What are some of the -- what are the tests that you administer to --

A. The --

Q. -- the clients?

A. Intellectual assessments. You want to know the names of them?

Q. Yes.

A. The Slosson, that's about -- and the Wechsler Adult -- Adult Intelligence Scales. And those are the two intelligence tests that I've given up there.

Q. Okay. Aside from intelligence tests, are there any other tests that would have been administered to David Cains?

A. A Vineland or an individual -- or let me see what the name of it was. It was -- it's an ICAP but we don't use the ICAP anymore.

Q. Sure.

A. But it's an older test. Inventory for Client and Agency Planning is the ICAP, was the last one.

Q. What is -- and what is the purpose of that test?

What are you looking for?
A. That is mainly adaptive behavior stuff and also to de- -- it measures how much care they need or the level of care they that are -- they need; that they function at.
Q. Okay.
A. But, like I said, we -- I haven't used that test in years.
Q. Did you ever use it on Mr. Cains?
A. I never did.
Q. Do you know if anyone else did?

[redacted]

Q. What does that indicate? I don't know what a "service score" means.
A. I'm not -- yeah, okay. Yeah, I -- I haven't used this in so long, so I'm not really completely sure what the levels are.

[redacted]

[redacted]

Q. Okay. But it's not an intelligence test?
A. No.
Q. It's a --
A. No. It's a . . .
Q. So in laymen's terms what -- what is it? And I'm not trying to trip you up here. I just want to make sure I understand what --
A. Yeah.
Q. And if you don't -- I know you said you haven't used it in a while; but, just to the best of your recollection --
A. Uh-huh.

[redacted]

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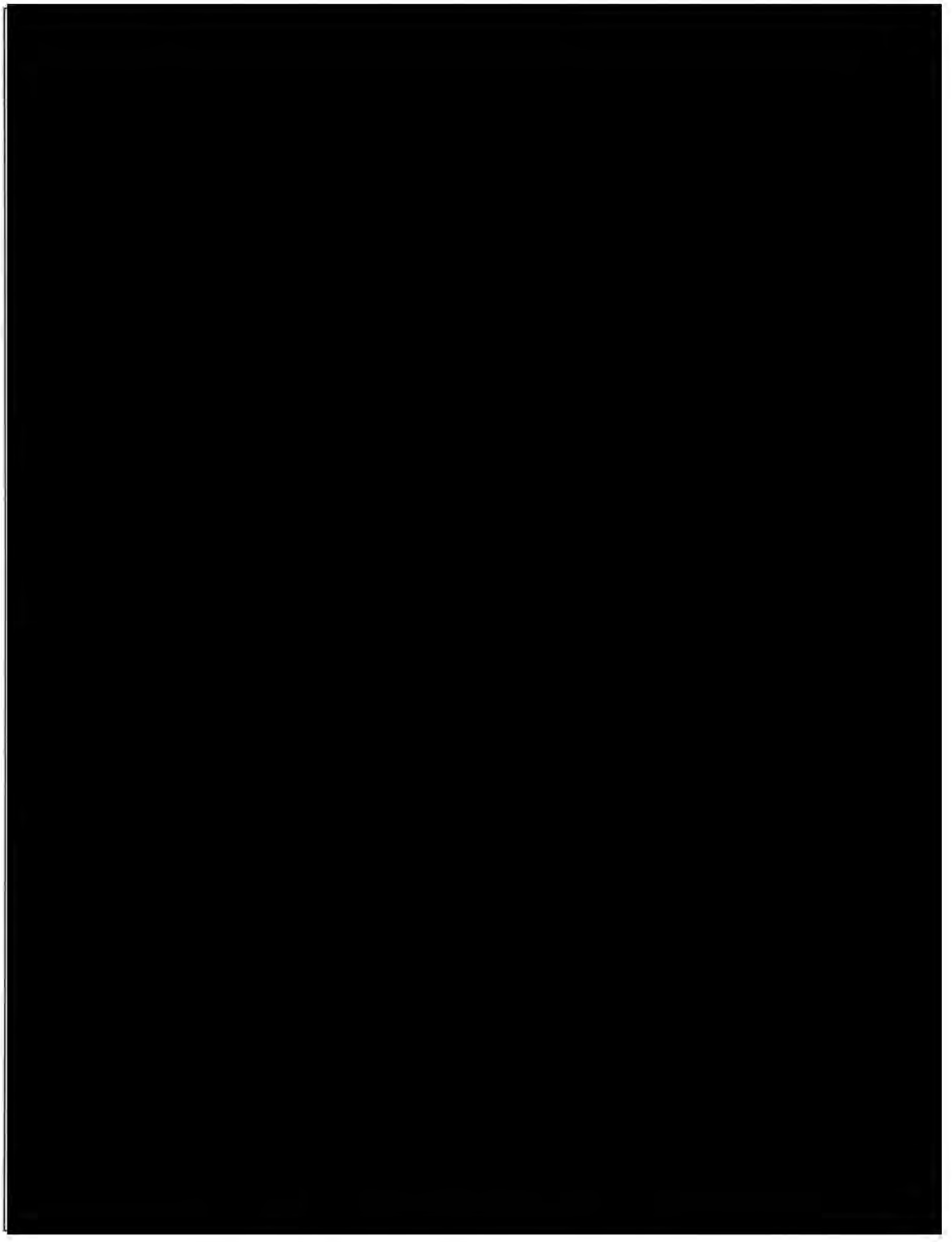

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Q. Okay. I'm -- okay. Okay.
So what test did you personally administer to -- to David Cains?
A. Nothing. I've never --
Q. You've never administered a test to David Cains?
A. No.
Q. Okay. I may have the wrong person here.
Do you know who did administer tests to David Cains?
A. I really don't know. I didn't bring it, no. Or I didn't -- I don't have it.
Q. Okay. He was one of your patients, though; wasn't he?
A. Yes.

Q. Okay. And not every client there is your patient, correct?
A. No, correct.
Q. There's other psychological examiners that work there as well?
A. Yes, one.
Q. One other? And who is that?
A. Kathy Edwards.
Q. Okay. Now, I saw your name on a lot of documents. I don't recall seeing any with her name on it, so that's why I have you here today.
But you -- you're saying you never administered any intellectual or -- or IQ tests or any other tests to David?
A. Correct.
Q. And you don't know who did?
A. No.
I didn't know I was going to be asked that.
Q. Okay. And are they not administered yearly?
A. No.
Q. How often are they administered?
A. A person over the age of 21, it -- whatever the IQ testing was done is generally carried throughout their stay while they're there.
And a Vineland is about the same thing. If they're

test -- if they're given the test over the age of 21, we just basically keep that original score because it doesn't change much.

Q. It doesn't change once they're fully developed?

A. Yeah, pretty much.

Q. Okay. And so you're famil- -- you -- you've -- you're -- him being -- since he was your patient, I assume you're familiar with the results of his IQ test testing; correct?

A. Yes. I guess, yes. Yes.

Q. Okay. And could you tell us about what his IQ testing revealed?

A. Well . . .

Q. What tests he was given, what scores he -- he -- what the scores were, and what those scores indicate?

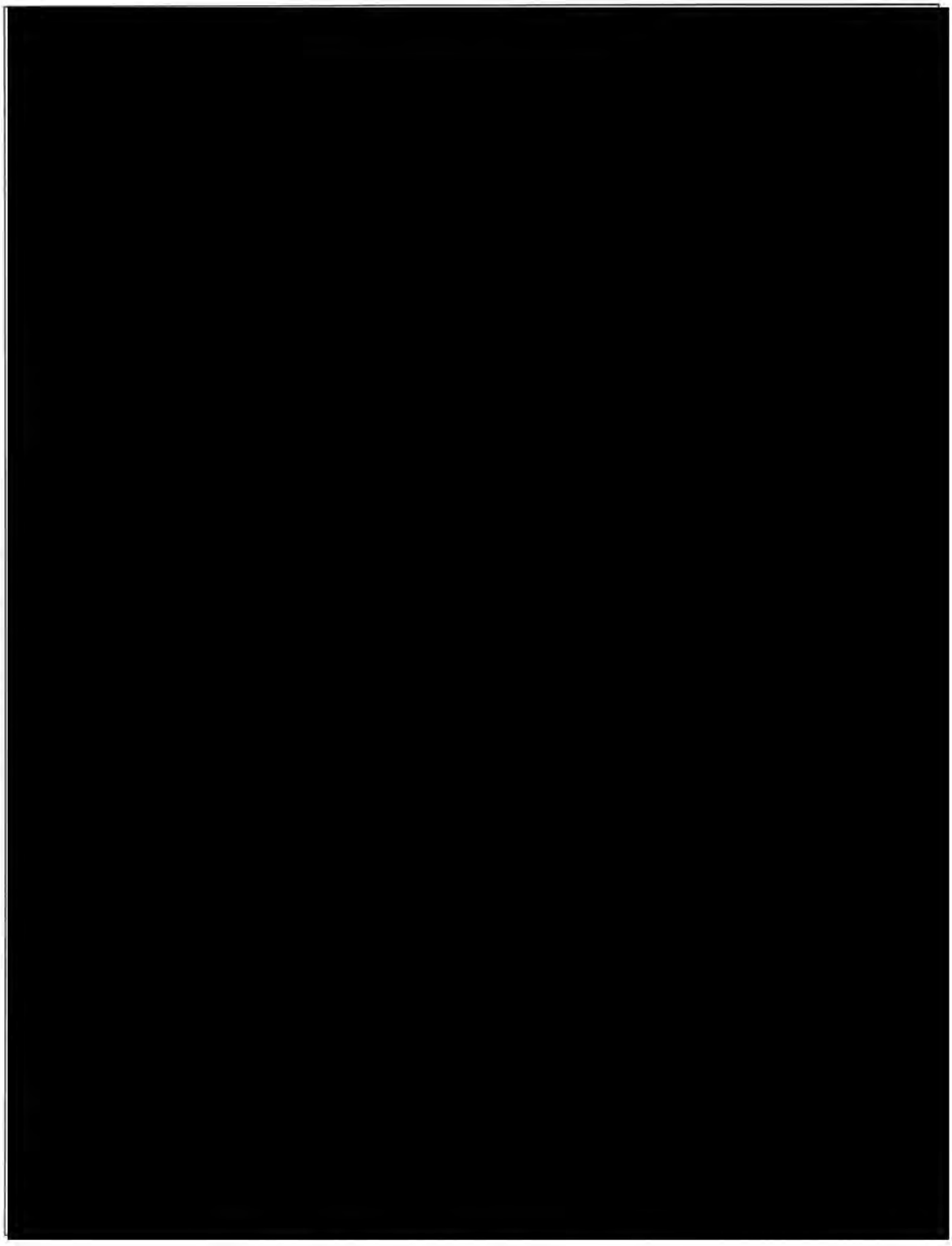
[redacted]

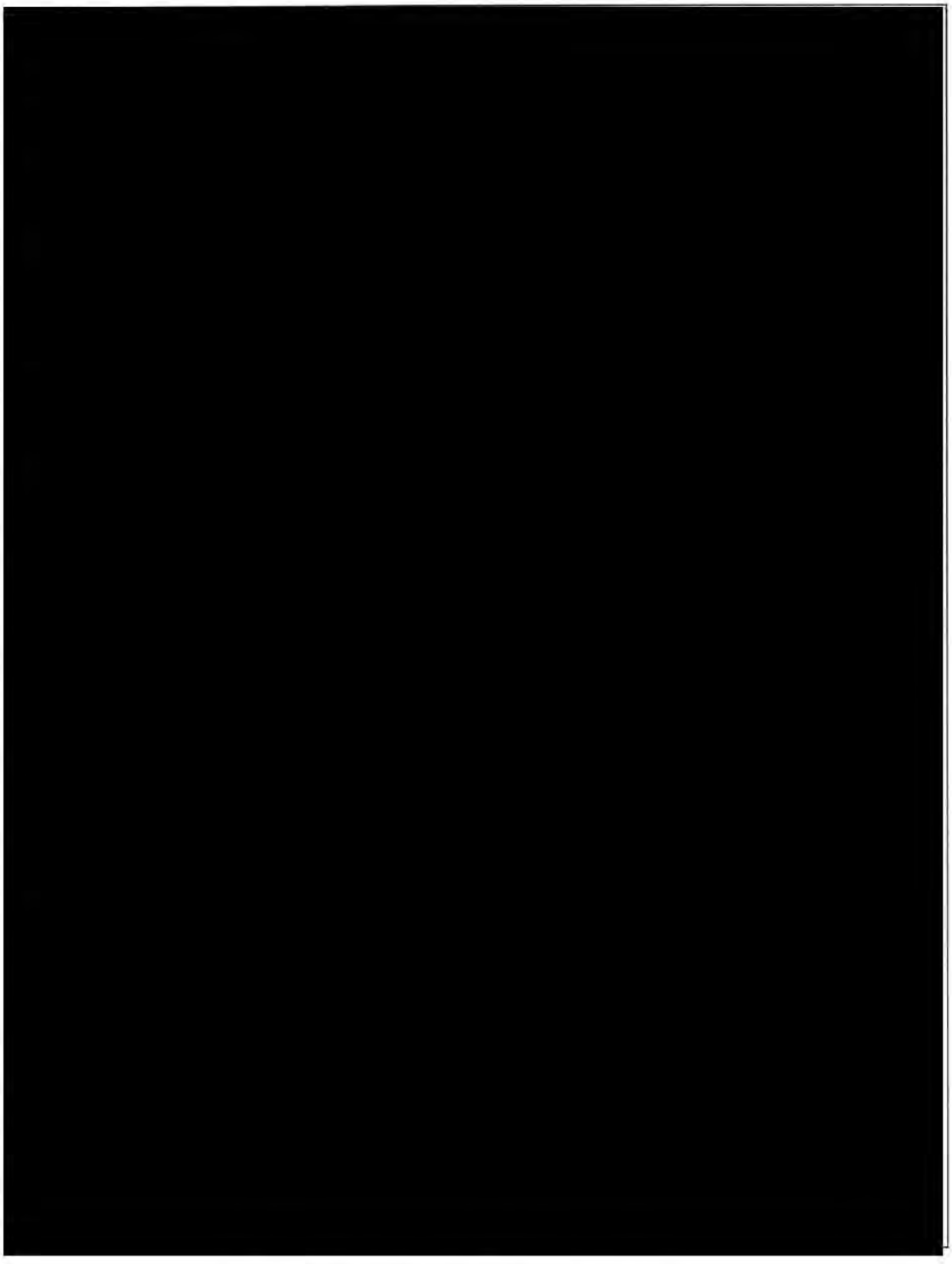
Q. What's a- -- what is the average score on this test for just the average --

A. 100.

Q. 100.
A. Yeah.
Q. And what is considered intellectually disabled?
A. Anything below 70.
Q. Okay.
A. A score of 70, below 70.

[redacted]





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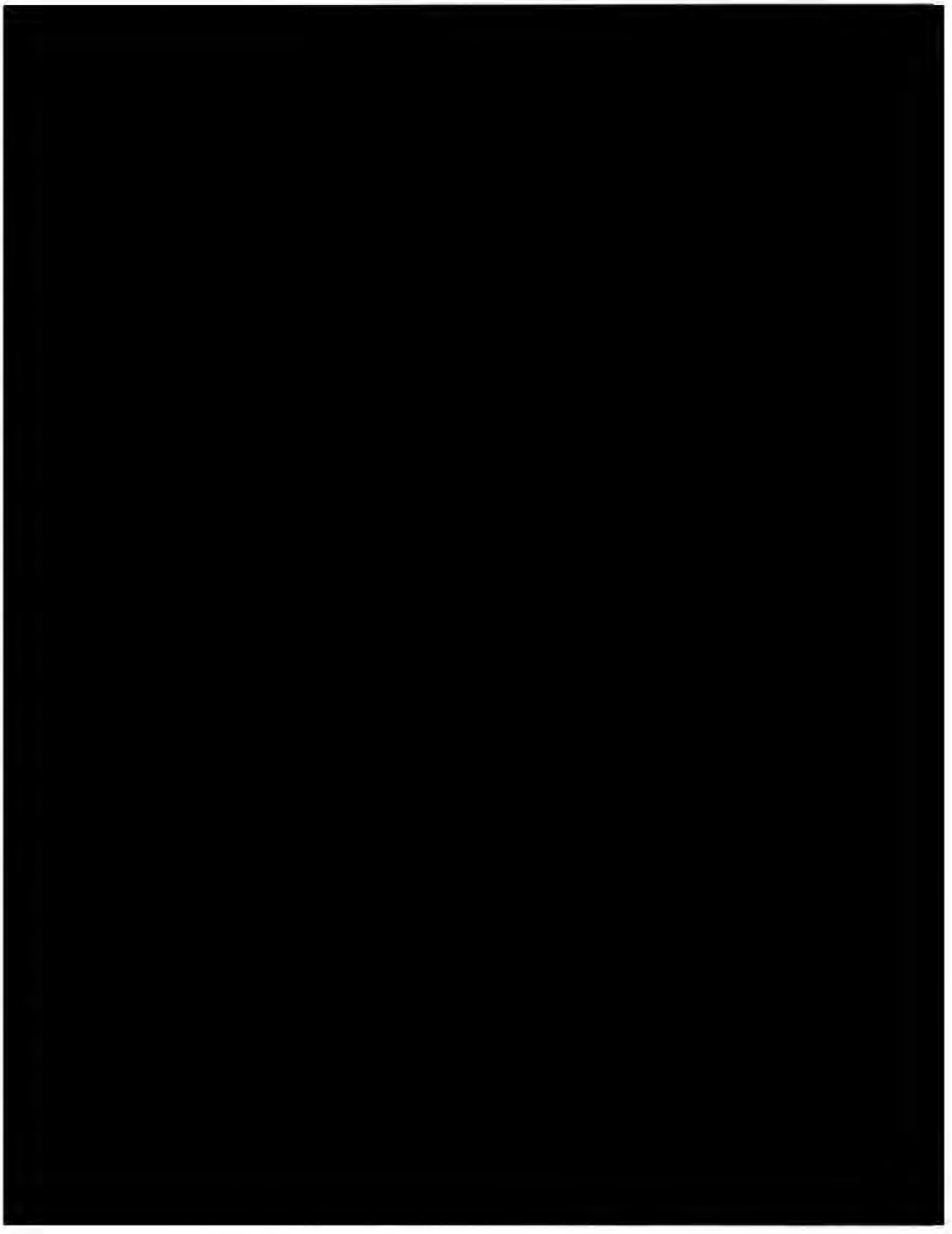


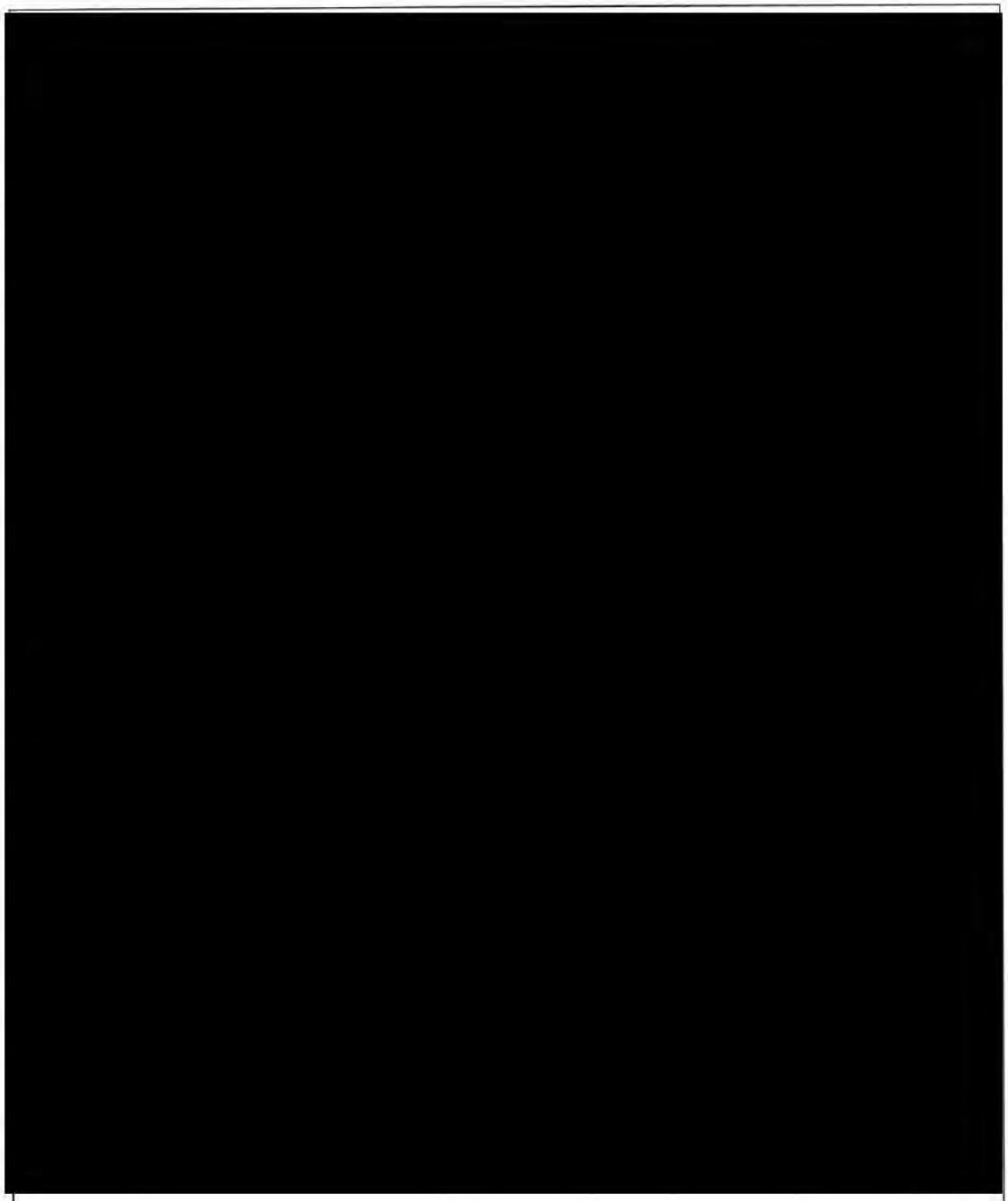
[redacted]

Q. All right. Let's make this Exhibit 1. I'm sorry to take your -- your paper.
A. Yeah.
Q. But I don't have this and --
A. Oh.
Q. -- it's become an exhibit now.
A. Okay.

(Exhibit 1 marked for identification.)

Q. Let's keep it there for now. You can have it back for now. We've just got to give it to her before we leave.
A. Okay.

[redacted]



Q. But you -- you would a- -- based on -- how much interaction did you have with him?

A. Limited. I've saw him at the annual reviews. I seen him in the dorms in the hallways.
Q. Uh-huh.
A. You know, a few times.
Q. You never administered counseling to him?
A. Not necessarily, no.
Q. What does "not necessarily" mean?
A. I have -- I haven't.
Q. Okay.
A. No.
I've seen him in the hallways and said hi to him and "How are you doing today?", those kind of things. But sitting down and talking with him and helping him process his feelings and those kind of things, I did not do that.
Q. Okay.
A. Counseling.
Q. Did he have a counselor that did that?
A. No.
I mean, I was the -- I'm the psychology person there.
Q. So if he --
A. He was on my team, yeah.
Q. So if he were being provided counseling, it would have come from you?

A. More than likely, yes. Yeah. And, the staff, when they interact with him, they're trained in that; how, you know, to talk with them and those kind of things too.
Q. But they don't have a master's in psychology?
A. No. Right, correct.
Q. I mean, is there anybody else that -- that -- other than you that during the last couple of years of his life -- again, he -- he died in June of 2020; you started back in January of 2018.

Between when you began or when -- between the start of your working there in 2018 and his death in June of 2020, was there anybody that you know of that provided actual counseling or therapy to -- to David?
A. No.
Q. And if he had been required to do counseling or if he had been -- if counseling had been part of his plan, regular counseling, it more than likely would have fallen to you to provide that counseling?
A. Correct.
Q. Okay. Is it -- is it unusual for -- for the clients at -- at Booneville to receive regular counseling?
A. When you say "unusual," it's not a daily practice. I'm not really sure what you mean by that.
Q. I guess I sort of assumed that -- that most of them

went to -- did some sort of counseling or therapy on a regular basis.

Is that not the case?

A. That's not the case.

Q. Okay. And if -- if -- so what -- what then -- why have a counselor there? What -- when would your services as a counselor be needed?

A. Really the ID- -- the IDT.

Q. Okay.

A. I guess inter- -- interdisciplinary team.

Q. Which you were a part of?

A. The -- yeah.

I mean, we'd have to meet and say that he needs counseling; and then they'd leave it up to me to -- how often and those kind of things.

Q. Okay. So, the interdisciplinary team, the IDT?

A. I think so, yeah.

Q. Okay. I think you're right.

A. Yeah.

Q. And he had an IDT; I think they all had IDTs.

A. Everybody does, they -- all the clients.

Q. Okay. They had a team.

A. Yeah.

Q. And, for instance, I know Caleb Murray was on that team; I've talked to him.

You were also on that team, correct?
A. Correct.
Q. And how often did you meet about David?
A. I really can't recall. I know that we have the annual IPP meeting, and I'm not sure about any special team meetings that we've had about him.
Q. Do you specifically recall any meetings about David Cains?
A. Not really, no.
Q. When you do the annual reviews, what month are those done in?
A. Usually the month before about --
Q. The month before what?
A. The I -- Individual -- the meeting, the IPP. Sometimes two weeks, sometimes a week.
Q. All right. I'm not -- I'm not following you. Maybe I -- let me rephrase that question.
On an annual basis every client has an IPP that is reviewed by their interdisciplinary team, correct?
A. Correct.
Q. What I'm asking is: Is that done -- are those done at -- in January for every client? Are they done in June for every client? When -- you know, what's the schedule?
A. My understanding is it's within a year of the last IPP.

Q. Okay.
A. So -- and I'm thinking that it's generally, like, within 11 -- on the eleventh month is when they usually schedule it on the, you know . . .
Q. How often -- how often are you -- not just for David, but how often are you in IPP sessions, IPP review meetings with -- with --
A. It varies. You know, some weeks I have none.
Q. Uh-huh.
A. I mean, I -- at the end of this month I have -- I don't have -- I don't have any meetings that week. One to two a week, sometimes more.
Q. Okay. And are those held in a conference room there on the campus?
A. Yes.
Q. Okay. Where on the campus are they held?
A. In the Nyberg building.
Q. Okay. And --
A. Or at Social Services. I've had IPPs there.
Q. And who all -- who all is present at these typically?
A. The Q.
Q. Uh-huh.
A. Social services, the nurse.
Q. What nurse?

A. The RN.
Q. Okay.
A. The RN that's over his care there.
And then a vocational representative, the client, and me.
Q. Are the client's guardians or family ever there?
A. And guard- -- yes, they're always invited.
Q. And my understanding is that -- that David's mom and/or sister was often present.
Do you recall that?
A. Not really.
Q. Okay.
A. No.
Q. But you don't really recall any specifics about any specific meeting involving David, though; do you?
A. No.
Q. Okay. And you -- I assume you have no knowledge about what his behavior was like around the time of his death, meaning: Had there been more noncompliance or physical aggression issues in the months leading up to his death than perhaps the months before that, that sort of thing?
A. I don't really know.
Q. Do you have -- okay. And that's okay. I just want to make sure.

A. Yeah, yeah. Yeah, yeah.
Q. You don't have any --
A. No.
Q. So if you were to be in a courtroom and asked, you know, was David extra aggressive at the time of his death, you wouldn't have an answer?
A. No.
Q. No?
A. I would not have an answer.
Q. Yeah. Sorry. It just -- again, try to verbalize those nos as best you can.
A. Okay. Yeah, yeah.
Q. So I don't have to . . .
A. Yeah.
Q. Okay. So you never gave David any tests; you never gave David any counseling; you don't recall any details from team meetings going over his IPPs.

With regards to these specific things that we've already talked about, is there anything that you do recall that -- that you think I need to know about? Again with just regard to the things we've already talked about?

Any specific memories --
A. Nothing --
Q. -- you might have that would shed light on David's

condition towards the end of his life?
A. Nothing, nothing I can think of.
Q. Okay. And that -- that's okay. That's okay. I -- it's not a memory test. I just --
A. Yeah.
Q. If you do know it, I need to know it; that's all.
A. No.
MR. GILLISPIE: Let's take a quick break.
THE VIDEOGRAPHER: We are going off the record. The time is approximately 10:40 a.m.
(Recess taken.)
THE VIDEOGRAPHER: We are back on the record. The time is approximately 10:48 a.m.
Q. (Mr. Gillispie) Okay, Mr. Alvis. I'm going to show you a document marked -- well, it's Bates stamped 013959. If you would take a look at that for me.

[redacted]

[redacted]

Q. Did I read that correctly?
A. Yes.
Q. Okay. So those are kind of the reasons that -- that this, this was updated; is that right?
A. Correct.
Q. Okay. And above that paragraph -- well, let me ask you this: What caused the team to review this to begin with, to review the BTP?
A. I really can't recall. I'm not sure when his IP --
Q. Well, take your time and kind of --
A. Yeah. I --
Q. -- familiarize yourself with the document.
A. Yeah.
Q. Please, take your time.

A. It doesn't tell me why it -- we had this -- why it had it updated -- when I got there, I mean, the practice is to update the programs with my name on it because I'm the new provider.

And there -- and, I'll be honest, there are probably a couple of them that I have not updated yet because the programs are still good.

Q. Uh-huh.

A. And -- and I updated it -- I -- because the team said we need to update it, so I did it.

Q. So the team said you need to update it.

So who -- who asked you to update it?

A. The IDT whenever we were having the staff meeting.

Q. Okay.

A. You know, and basically I -- I suggested it; and then everyone says, "Okay, yeah. We need to update it."

And I say, "Okay." Then we do it.

[redacted]

[redacted]

Q. But you wrote this document?
A. Yes. That part, yes.
Q. But you don't know why you wrote that? Why you

added that to this document?

A. Oh.

[redacted]

Q. I -- I'm just trying to get an understanding of just how it works. I'm not trying to give you a hard

time. I just -- I'd just like to understand, you know, how it works; how -- how these patients are monitored, how often their -- their -- their needs are re-evaluated, that sort of thing.

A. It's on a monthly basis that we review the data, because we have to re- -- record what numbers of Behavior Reports that are sent to us, and the -- their Q gets the an -- the monthly data part, our data entry or whatever it is.

[redacted]

Q. What is -- what is "Phase"?

A. Phase is the first part of the training that all staff go through.

Q. Okay.
A. When they first -- it's like an orientation kind of thing, process; and . . .
Q. And I -- I'm correct that personal restraints are not part of Category I procedures, correct?
A. I think you're right. Yeah, correct.
Q. Category I procedures are -- are --
A. Verbal redirection.
Q. Just a moment. I'll help us both out here. I just have to find my copy of 3011-D.

So from what I'm seeing, Category I procedures include: Verbal intervention, separation from activity up to 30 minutes, separation from setting up to 30 minutes, assignment of additional chores, restitution, withholding privileges, and personal property removal for not longer than one hour. And that's everything.

Would you -- would you agree with that; that that's what Category I in- -- allows?
A. Yes.

MR. COLLINS: Do you mind if I look at it for review?

MR. GILLISPIE: Absolutely.

We'll mark it as Exhibit 2.
Q. (Mr. Gillispie) It's on -- starting on Page 2.
A. Yeah.

Q. Ending on Page 4.
A. Okay. Yeah.
Q. And -- and so are you done reviewing it?
A. Yes.
Q. Okay. Is your answer the same; that you would agree that -- that those -- those things that I enumerated there is everything listed under Category I?
A. Yes.
Q. Okay. All right. Turning back to --
MR. GILLISPIE: Well, do you mind if I -- thank you. I'm actually going to use this for the next one, so . . .
MR. COLLINS: May I see it real quick?
MR. GILLISPIE: Sure, sure. But I'm not . . .

[redacted]

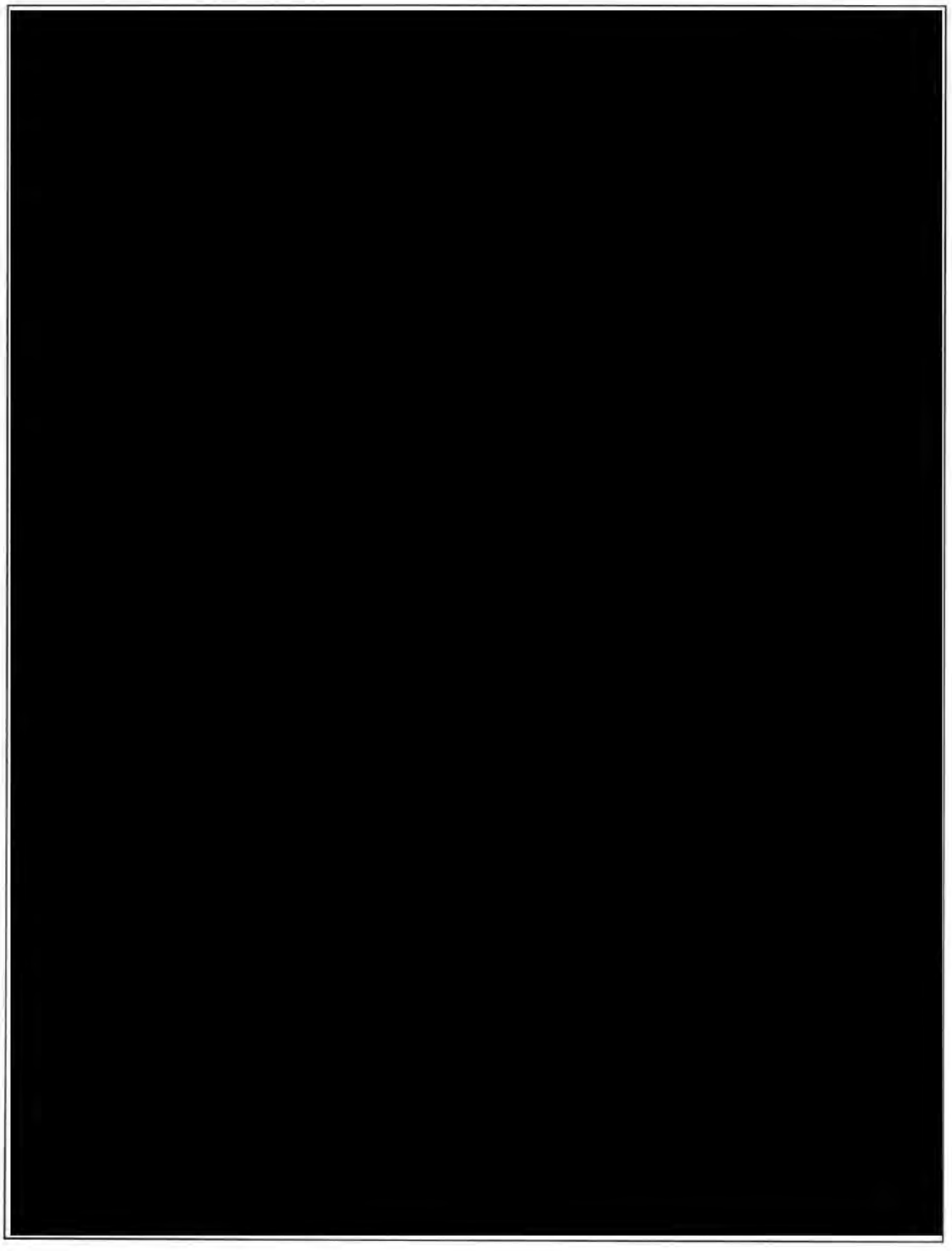
[redacted]

Q. That's good. Thank you. Thank you.

So -- and you wrote this document, and you signed it there at the bottom; correct?

A. Correct.

[redacted]



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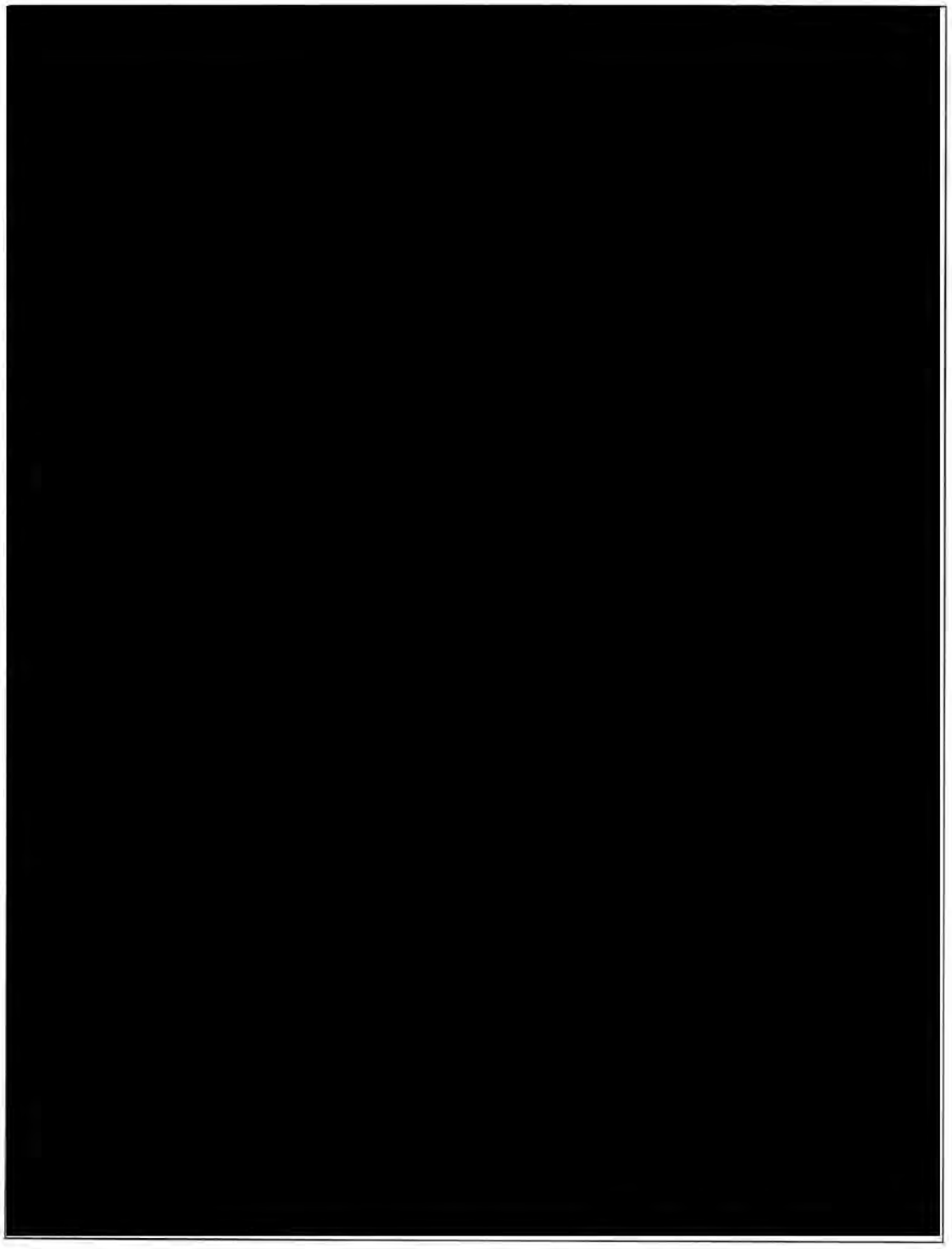

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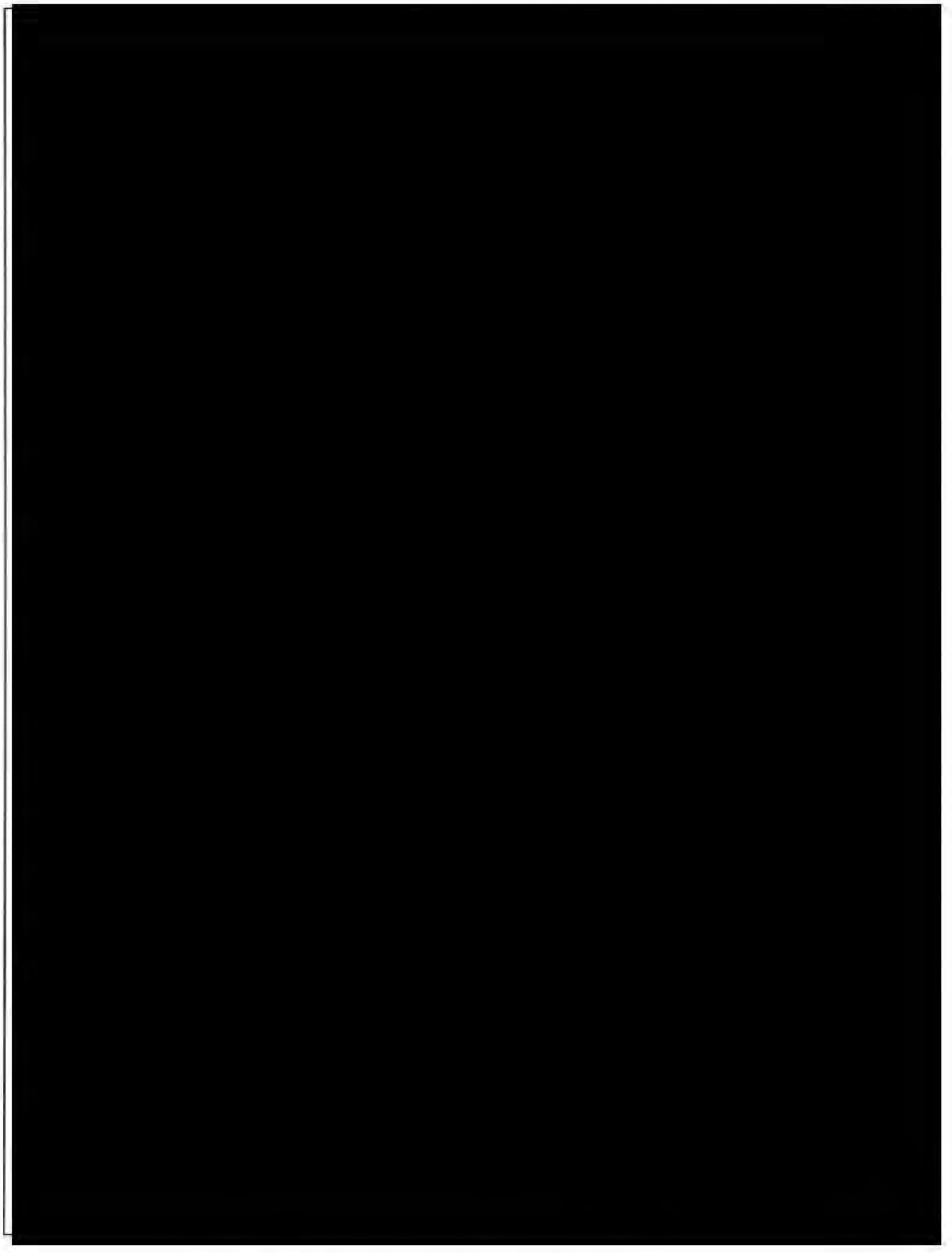

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[redacted]

Q. Okay. Could I have your copy back, please. Thank you.

MR. GILLISPIE: Do you want to see this?

MR. COLLINS: Yes.

MR. GILLISPIE: Okay. I'm going to mark this as Exhibit 2 to this deposition.

(Exhibit 2 marked for identification.)

Q. (Mr. Gillispie) Okay. Did you know Mike Wyrick, Ph.D.?

A. Yes.

Q. Okay. And -- and was he -- did he have your job at some point before you?

A. No.

Q. Okay. Who was he --

A. I mean, he's a psych -- he's a psychologist.

Q. Is he still there?

A. On a contract basis, yes.

Q. Has he always been there only on a contract basis?

A. No.

He retired -- I want to say -- I mean, 2017 whenever I started, that would be -- he was already -- he

was retired. And then he came back a year and a half ago I guess maybe.

Q. Okay.

A. Maybe two years. I'm not really sure when he started, started back his contract.

(Exhibit 3 marked for identification.)

[redacted]

[redacted]

Q. Okay. So you were not the primary author of David's IPP?
A. Correct.
Q. That would have been whoever his QIDP was, right?
A. Correct, yes.
Q. And did you say you knew it was Justin Jobb? Or you just thought it --
A. No --
Q. -- could have been Justin Jobb?
A. -- it could have been. I know that it -- it couldn't have been Frances because she's new; Hoopa is new; Strain is new. And Jobb is --
Q. Okay.
A. Justin Jobb may be --
Q. I think it's --
A. I'm not really --
Q. I think it's "Job," but . . .
A. Oh, okay.

Q. It's one of those names that you read and it kind of pops out. I think I've seen it.

Let me ask you this: How many patients do you have now?

A. 42 to 43.

Q. Okay. And how many did you have in June of 2020, best guess?

A. Probably about the same, forty something.

Q. Okay. And there's one other examiner as well?

A. Correct, yes.

Q. And would that person have a similar number?

A. Yes.

Q. Okay.

A. She has a -- right now I think she has -- I counted. She has, like, three or four more people than I do on my caseload.

Q. But at any given time you have at some -- around 40, give or take?

A. Yes.

Q. Is that right?

A. Correct.

Q. And, again, that would -- and David was one of yours, correct?

A. Yes. At the time, yes.

Q. Was he your patient the whole time you -- you

worked there? The whole time after you came back up to his death, was he your patient?

A. More than likely. You know, we -- we did some switching clients, those kind of things. I'm not really a hundred percent sure that he was --

Q. Yeah.

A. -- on my caseload when I first started. He might have been, but we've -- we've switched -- back then we had another psychologist. She was -- she had some clients that were in other areas, and so -- and then whenever she left, we had to juggle; so I'm not sure.

Q. So what is -- Dr. Mike Wyrick, if he's there on a contract basis now, what -- what -- what kind of things does he do that are different than what you and -- and Ms. Edwards do?

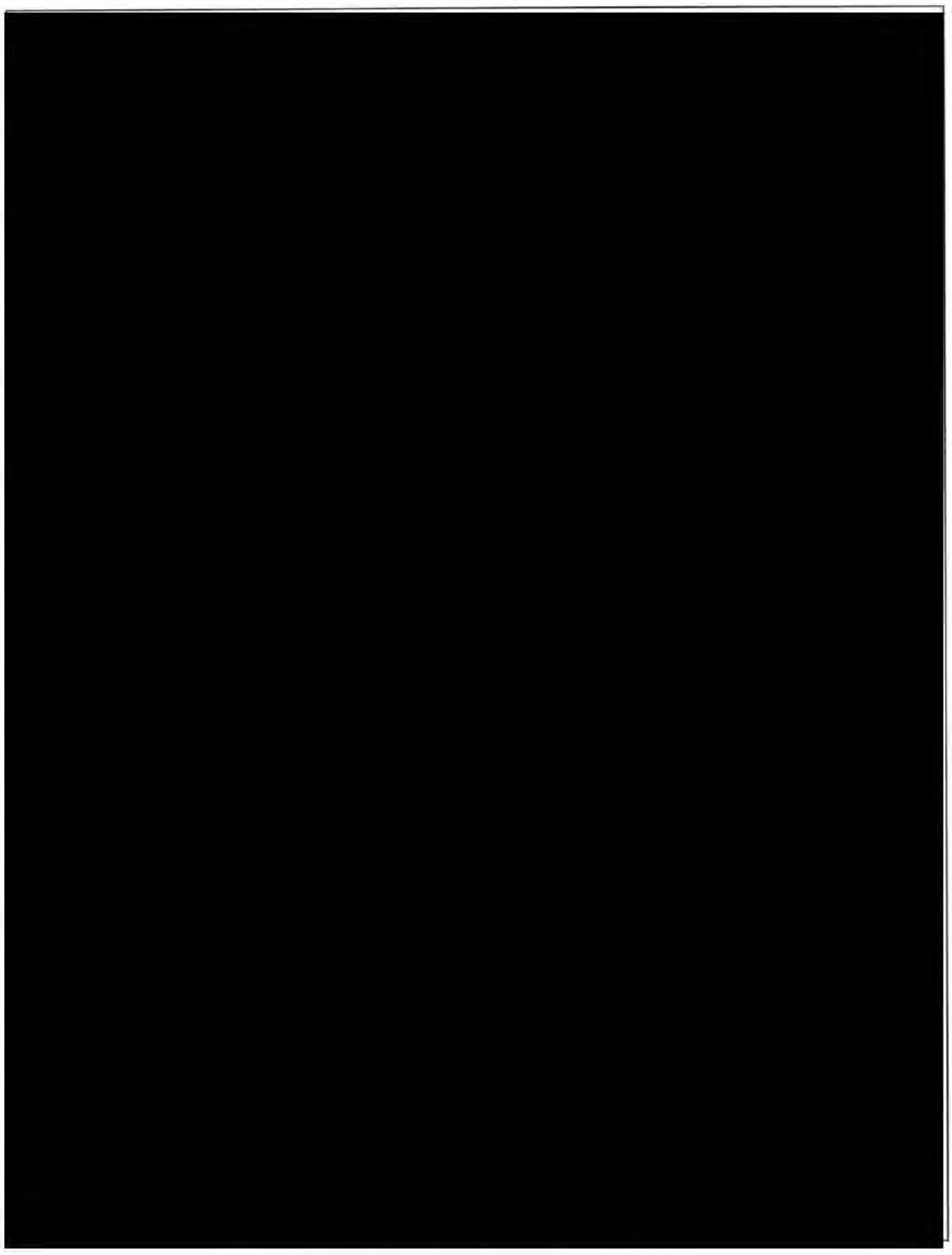
A. Basically everything that we do, except he has a Ph.D. And, you know, and then he signs off on our Category III programs.

[redacted]

Q. Okay. And I know that it is not your choice at all who gets counseling and who doesn't, but don't -- do you

feel like David might have benefited from some regular counseling?
A. Personally and professionally, probably not.
Q. Okay.
A. Because the level of retention that people have with the -- their disability, it -- the -- I mean, they could sit there and tell you things and act like they understand it, but then they really don't understand it. Because just minutes later they go back and, you know, say I -- you know, so and so did this to me. I -- you know . . .
Q. It would be like trying to do talk therapy with a four year old?
A. Correct, yeah.
Q. Okay.
A. Yeah. Because it doesn't really stay, stick with them.

[redacted]



[redacted]

Q. Okay. Did you ever speak to his guardian? Do you recall ever having any inter- -- any interaction with his guardian? His mom or his sister?

A. I can't really recall. I was in -- I -- it seems like I've been in so many meetings, I'm not sure who's

been there and who --
Q. Right. And I understand that.
A. Because we cover for others when they're not there; and, you know . . .
Q. The Category I stuff notwithstanding, do you -- and I assume you don't -- but do you have any personal knowledge about the types of physical restraints or personal restraints that direct care staff were permitted to use on David?
A. I don't know. I really . . .
Q. No?
A. No. Mainly --
THE COURT REPORTER: I -- did you say "no," sir?
THE WITNESS: I said "no."
THE COURT REPORTER: Or "don't remember"?
THE WITNESS: No.
MR. GILLISPIE: Okay.
THE WITNESS: I said no. No.
Q. (Mr. Gillispie) Did you ever witness David being physically restrained at any time?
A. No, never.
Q. Did you ever hear stories about David being physically restrained or rumors?
A. I -- when I've reviewed the Behavior Reports, I

probably had -- did see him -- see it, you know, used.
Q. But nothing that you specifically recall?
A. Yeah, nothing that I really specifically recall.
Q. Okay. Do you have any knowledge about David Cains causing injury to other people at the facility, whether it be staff or other patients?
A. No.
Q. I guess --
A. I have -- no.
Q. Okay.
A. No.
Q. Okay. So you have no knowledge -- as you sit here today, you have no knowledge about David having ever physically harmed somebody else at the facility, correct?
A. It's -- correct, yeah.
Q. Okay. And you've never heard about that happening with David either?
A. I might have. I just don't remember hearing it, to be honest with you.

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Q. Do you know how many -- how many behavior incidents he was having a month at the time of his death?
A. I'm going to -- no. But if -- if I were to extrapolate from the past, it's probably about the same on Behavior Re- -- whatever the Behavior Report at the time was.
Was it two Behavior Reports a month? Is that . . .?
Q. I -- I've heard from a couple witnesses, I believe Amy Jones and Amanda Schmidt, that --
A. He --
Q. -- that the facility may have been short-staffed in June of 2020.
Do you recall that being the case?
A. No, I don't recall that.
Q. Okay.
A. But they -- we've been running short of staff for -- I mean, they're always running -- it seems like they're running short staffed, but I'm not --
Q. And does -- does that fall to -- does the brunt of

that fall to the direct-care staff mainly?
A. Okay, what? What falls to the direct-care staff? I'm not . . .
Q. Well, if you're running short staffed, I assume somebody's having to do more than they're supposed to do; somebody's being overburdened.
Does that overburdening fall more on the direct-care staff or everybody?
A. It's probably everybody.
Q. Everybody.
A. I would think. But more -- probably moreso on the direct-care staff though.
Q. So staffing is -- is generally an issue. You just don't remember it being specifically something that sticks out in June of 2020?
A. (No audible reply.)
Q. Correct?
A. Correct.
Q. Were you ever questioned by law enforcement or paramedics or anybody about David's death?
A. No.
Q. Were you ever questioned by Sandy Evans about David following his death?
A. No.
Q. Have you ever discussed his death with anybody

before other than -- other than what you might have discussed with Mr. -- Mr. Collins? I don't -- you can't tell about that.

A. No.

Q. But anybody else?

A. When a person dies up there, I mean, I usually go to my support staff. I mean, Kathy Edwards; Wyrick; and -- and -- to them and I -- you know, we talk about it, processed what happened.

But I didn't really -- I don't -- I didn't -- I don't remember really processing his death as much as it was just that -- I mean, when it happened, I was probably just in -- in shock and in grief the whole time. It just -- you know, it take -- it -- the way I process grief is it takes me a while and -- to even express it, so . . .

Q. But you -- you recall grieving over David's death?

A. Everyone that passes away up there, I grieve, yes.

Q. Okay.

A. And, yes, I did with David.

Q. Would -- and that -- I appreciate that; that -- that makes sense.

But, just to be clear, I think you told me earlier, though, that you didn't -- you didn't know him well, though? You didn't -- you haven't spent a lot of time

with him, right?
A. Correct.
Q. If you had to guess how often you personally interacted with him, what would you say? Once a week? Once a month?
A. Once every two to three months.
Q. Once every two to three months.
A. Yeah.
Q. And what would that be for?
A. Maybe --
Q. What would be the reason for that interaction?
A. I was in the dorm and I saw him and I said hi to him. One time I recall -- I remember saying something about nice clothes that he had or something like that. I just -- him standing in the hallway, that's . . .
Q. Okay.
A. I mean, that's what comes to mind.



[redacted]

Q. Who would be the best person to ask about that?
A. The lady who I think -- I guess the speech and language person who developed those and the RNs. And then they -- they would have conveyed it to the direct-care people, what the . . .
Q. Who was David's RN?
A. I really don't know.
Or the LPN? I mean, the LPNs are the ones who directly work with them. So I'm not . . .
Q. Give me just a moment here. I want to make sure I didn't miss anything. And then you, sir, can be done.
Do you have any knowledge or opinion based on your evaluations of David and your time spent with David on his physical capabilities as far as coordination, strength, that sort of thing?
A. I have no knowledge, no.
Q. Okay. And I -- I believe from what I've -- I've heard, you would have had no hand or you -- you would have had no role in training direct-care staff on how to deescalate David, anything like that?
A. I covered it in Phase, yeah.

Q. What?
A. I'm taught -- well, labeling and redirecting, that's about the main . . .
Q. And you -- you teach Phase?
A. Sometimes I do. Or Kathy Edwards teaches Phase.
Q. Okay. What is Phase?
A. That's the first --
Q. I have no idea what that --
A. It's the orientation that all staff get when -- when they're there.
Q. Okay. How long does it last?
A. The psychology part, four hours.
Q. It's done --
A. 4 1/2 hours.
Q. And it's done in one day?
A. Our part, yes.
Q. And that would have been the only part you would teach?
A. Yes.
Q. Okay. And what do you teach in that psychology part?
A. I don't teach it all the time. I taught it whenever Kathy Edwards weren't -- wasn't teaching it or when Dr. Wyrick wasn't teaching it.
Q. When you have taught it, what have you taught?

A. Behavior management, psychiatric diagnosis. What is it? Trauma-informed care was one that we started.
Q. What would you have taught with regards to behavior management?
A. Reinforcement. The ABCs of behavior, understanding behaviors. The ABCs are antecedent, behavior, and consequence. And breaking that down in terms of what the antecedents are, the behaviors --
Q. So --
A. -- what they could be and . . .
Q. Give me the Cliff Notes on what that is?
A. What is? The ABCs?
Q. Yes.
A. Oh, okay. The ABCs is -- antecedent is the behaviors that happen before the behaviors happen. It could be anything from someone looked at them wrong, someone said something to them, or they just -- their mental health kicked -- you know, symptoms kicked in, and they got paranoid or they thought something or those kind of things.

The antecedents, that's the time that staff need to intervene and say, you know, "Hey, let's do this. Let's do that." Redirecting them away from what they're saying or doing.
Q. So --

A. And then --
Q. -- are you talking about -- kind of talking about teaching staff to notice patterns in patients or notice triggers for patients --
A. Yeah.
Q. -- so they can anticipate behavior?
A. Before -- that's -- it's done with everybody. I mean, everyone -- you know, they -- these are the things that you've got to look -- the ABCs is the things that happen.

And then, the behavior part, there's nothing that you can do to do -- to change that behavior, unless you change something in the -- in the antecedent or the consequence. And so the -- that part's covered.
Q. So antecedent includes what?
A. The redirection, separation; the Category I procedure stuff.
Q. Okay. And how do you -- you know, if you were teaching --
A. What can --
Q. -- somebody how to redirect somebody like David Cains, what would you tell them?
A. Just notice any changes in their behaviors.

And mainly it's people -- and what I tell them is, you know, once -- once you know the client, you know what

the -- specifically what's different about them.
Q. Uh-huh.
A. You know, so it -- it would be hard to tell with David. I couldn't -- can't really say anything specifically about that.
Q. Okay. Just in general what's an example of how to --
A. If I knew him --
Q. -- give me an example of how you would teach somebody like Tyler Mattson to redirect a client.
A. Noticing any changes in how the person acts or reacts. And then when you notice that change and see what's going on with them, you know, try to change their mind or get them engaged in some other activity other than what they're doing at the time.
Q. But are there specific techniques for doing that? I know what reduction means.
A. It's just -- yeah, that's --
Q. I'm asking you for the -- sort of the expert's take on it.
A. I don't give any -- I don't give any specifics. It's just broad, you know, things to notice.
Q. So you might just say you need to redirect them --
A. We notice --
Q. -- but you wouldn't necessarily say, "And this is

how you redirect them," A, B, C?
A. Generally not, no.
Q. And would you have been involved in any of the training on -- on how to physically intervene in emergency situations?
A. No, I wasn't involved in that training. But I've been trained.
Q. And what were you -- how were you trained in that?
A. During a Phase class, some -- you know, and assist to the floor techniques and those kind of things.
Q. You were taught to --
A. The CPI, the -- I don't even know what all that stands for. It's Crisis Prevention Institute I think or something like that.
Q. And so you --
A. CPI.
Q. -- you yourself were -- were given lessons on how to get clients to the floor if necessary?
A. Yes.
Q. I saw that, yeah.
Did you recall who would have given you that training?
A. It was on a video.
Q. And you -- and this video --
A. Staff development.

Q. What's that?
A. It was through staff development.
Q. Okay. And the head of staff development is Hise, Jeff Hise? Kevin Hise?
A. I don't really know.
Q. Mark Hise?
A. He's one of them up there, yes.
Q. Okay. And this video would have been shown to you during the Phase training?
A. I saw -- it was -- it was -- we saw some of the -- some of that during Phase, but I'm not sure if this video was shown then or what, to be honest with you.
Q. And did you ever undergo any NCI training?
A. It's about the same. I think nonviolent -- is it --
Q. Yeah, nonviolent intervention training?
A. Yeah, that's -- that's what I meant to say is -- yeah. That's --
Q. So you think this was a part of that?
A. I think so.
Q. But you're not certain?
A. Not really, no.
MR. GILLISPIE: Okay. I think that's -- I think that's all I have, Mr. Alvis. I appreciate you being here.

THE WITNESS: Okay.

THE COURT REPORTER: Anything else before we close the record?

MR. COLLINS: No, ma'am.

THE VIDEOGRAPHER: This concludes the deposition. We are going off the record. The time is approximately 11:34 a.m.

(Deposition concluded at 11:34 a.m.)

Shyloa Myers, AR CRR No. 710
StenoScribe, Inc.
alldaydepo@gmail.com

CHANGES AND SIGNATURE

WITNESS: MIKE ALVIS
DATE TAKEN: March 31, 2022

PAGE/LINE CORRECTION AND REASON FOR CORRECTION

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Witness Signature:_____ Date:_____

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My Commission Expires_____ (Notary Seal)

Shyloa Myers, AR CRR No. 710
StenoScribe, Inc.
alldaydepo@gmail.com

CERTIFICATE

STATE OF ARKANSAS)
)ss
COUNTY OF SALINE)

I, Shyloa Myers, CCR, RPR, and Notary Public, do hereby certify that the foregoing testimony of the witness, MIKE ALVIS, was reported verbatim through the use of the stenographic method and thereafter transcribed by me or under my direct supervision to the best of my ability, taken at the time and place set out on the caption hereto.

I FURTHER CERTIFY that in accordance with Rule 30(e) of the Rules of Civil Procedure, review of the transcript WAS requested.

I FURTHER CERTIFY that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise in the outcome of this action, and that I have no contract with the parties, attorneys, or persons with an interest in the action that affects impartiality or that requires me to provide any service not made available to all parties to the action.

WITNESS MY HAND AND SEAL this 18th day of April, 2022.

SHYLOA MYERS
MY COMMISSION # 12359002
EXPIRES: February 3, 2027
Saline County

SHYLOA MYERS CERTIFIED COURT REPORTER LICENSE # 710 ARKANSAS SUPREME COURT

Shyloa Myers, RPR, Notary Public
Arkansas CCR Lic. No. 710

Shyloa Myers, AR CRR No. 710
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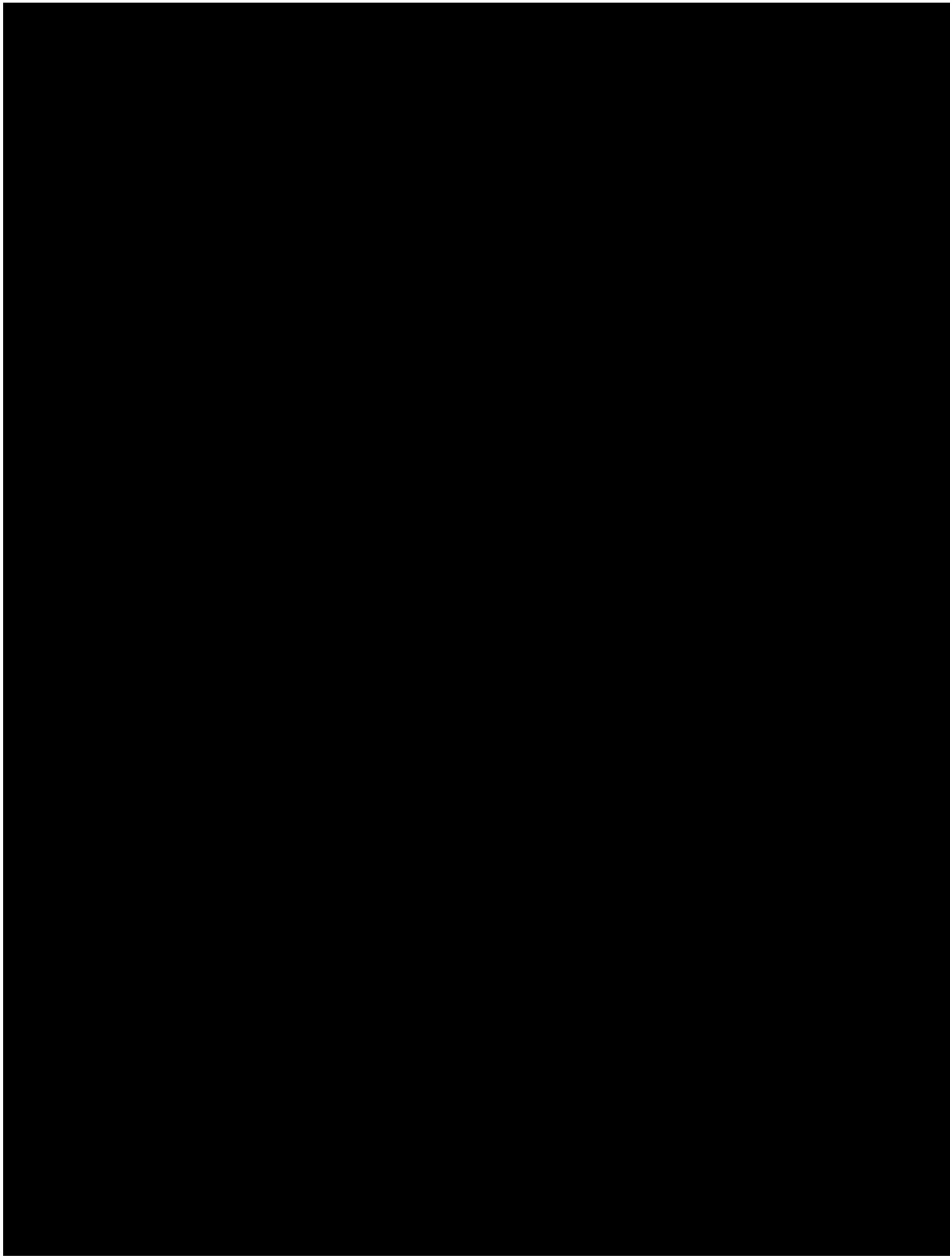

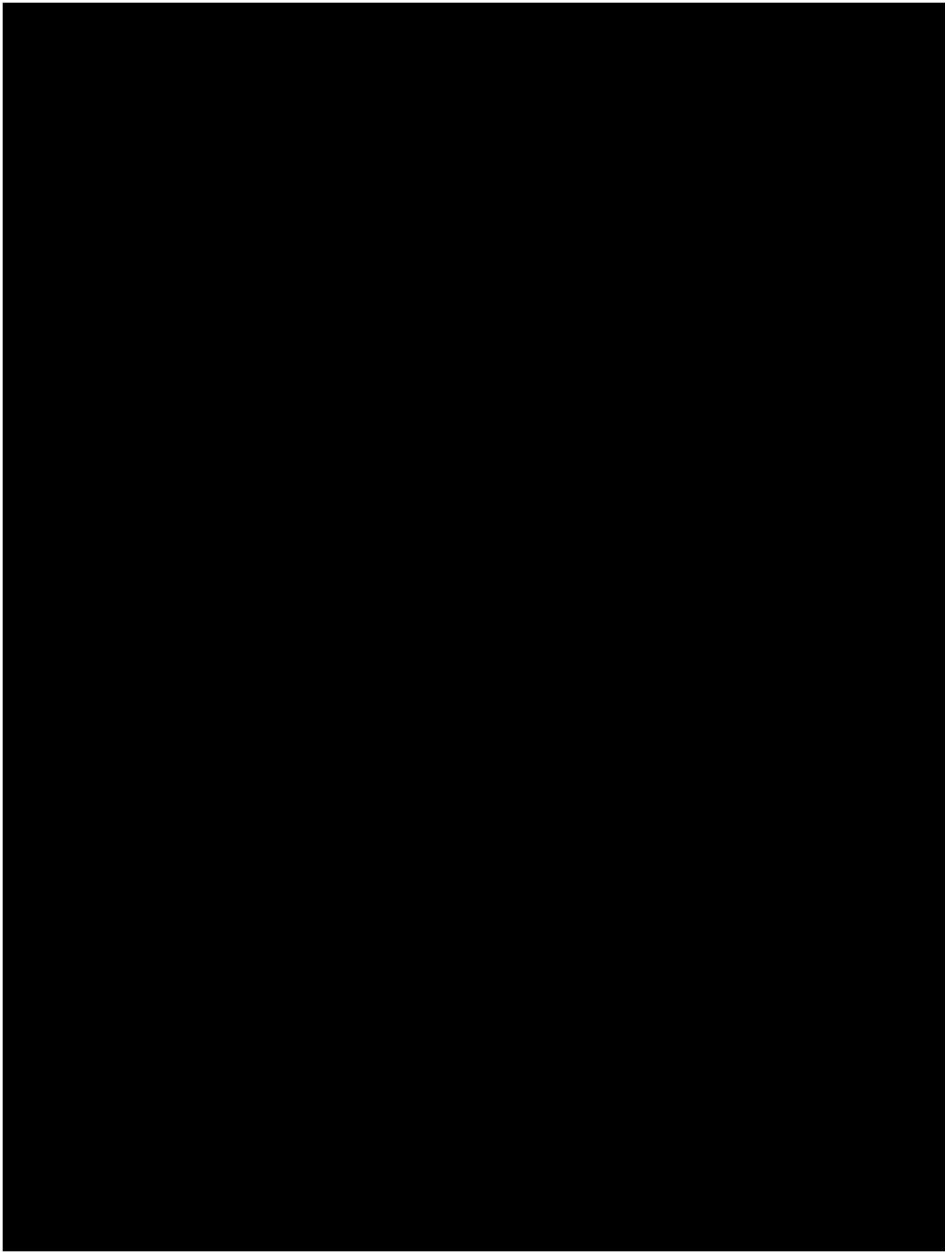

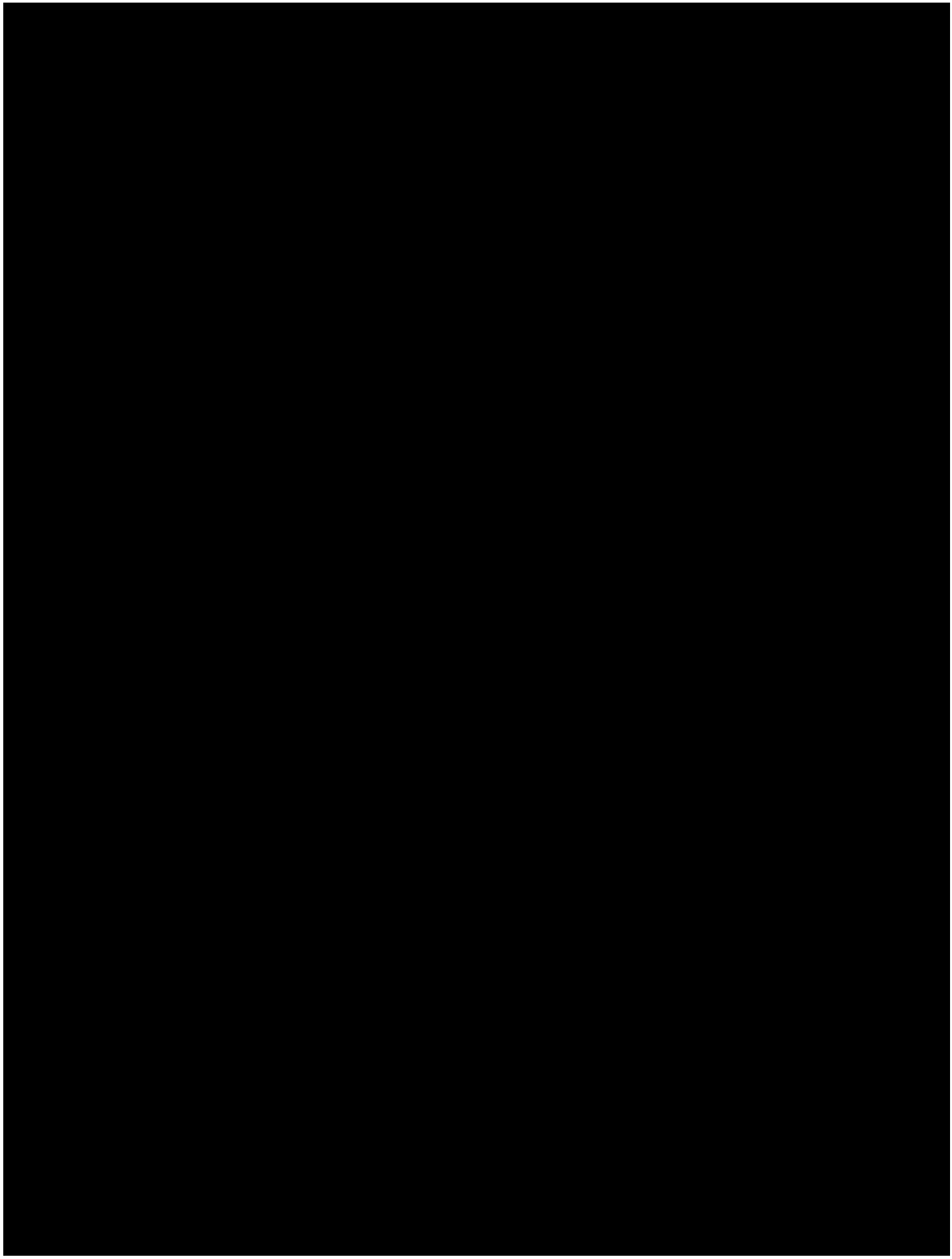

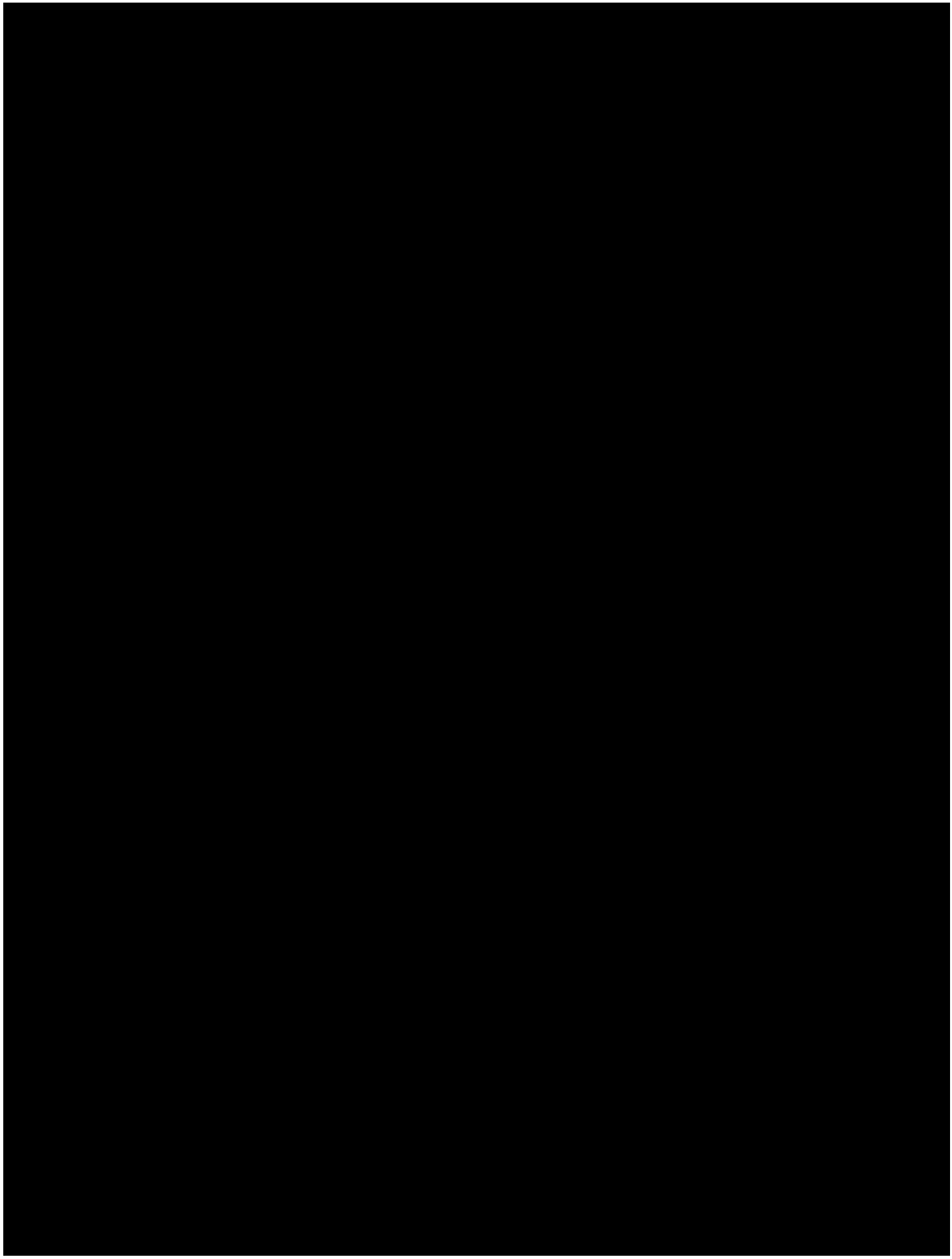

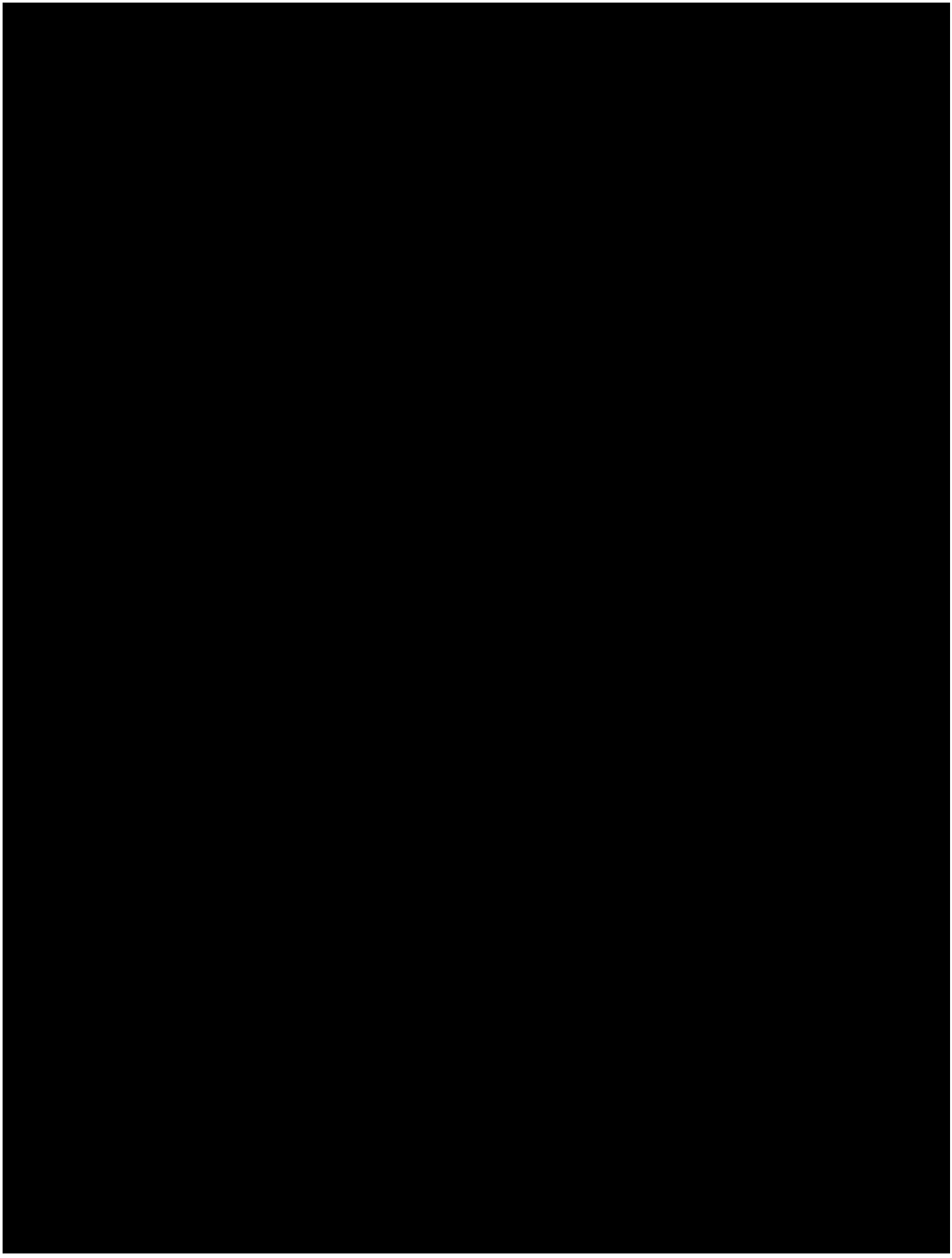

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF
CALEB MURRY

March 3, 2022, at 9:11 a.m.



800-556-8974
www.veritext.com

A P P E A R A N C E S

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EXHIBITS IDENTIFIED

(None Marked)

S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Caleb Murry, produced, sworn, and examined via Zoom, commencing on March 3, 2022, at 9:11 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

P R O C E E D I N G S

THEREUPON, Caleb Murry was duly sworn to tell the truth, the whole truth, and nothing but the truth and gave the following testimony to wit.

MR. GILLISPIE: Eric, you go by the usual stipulations? That -- and I'm good with that. You know --

MR. COLLINS: Yes, sir.

MR. GILLISPIE: Okay. Object to form.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Mr. Murry, thanks for being here today. Again, my name is Josh Gillispie. I represent David Cains and his surviving family members.

I don't expect to be questioning you for too long today. In fact, my plan is, if Eric is okay with this, we could get you wrapped up and then we could take a quick lunch break and then come back and do Amy.

And, you know, I -- there's no reason we need to be here all day, I don't think.

So have you ever been deposed before?

A No, sir.

Q You may want to turn your volume up just a little bit there.

A Okay. I'm not at my computer, I mean, a normal office. Where do I go to do -- turn the volume up for you?

Q I can hear you now.

Maybe you just -- I'm not sure. But I can hear you now better. I think maybe -- that's fine.

A Okay.

Q So I asked, have you ever been deposed before?

A No, I have not.

Q Okay.

Well, I'm just going to be asking you some questions. Only thing I need you to remember to do is to, because this isn't being recorded, videoed I mean, verbalize yesses and nos as best as possible as --

A Okay.

Q -- opposed to uh-huh and hu-uh; because it makes it real difficult for court reporters to determine where that's a yes or a no.

If you don't understand a question, I want you to stop me and asked me. If you don't -- you can't hear me, stop me and ask me.

If, you know, you need to take a break, just let me know. Not a problem.

So let's start by -- your full name is Caleb Murry?

A Yes, sir.

Q Okay. And how long have you -- and what is your position at the facility?

For purposes of this deposition, I'm talking about the Booneville Human Development Center, which I'm either going to refer to as Booneville or the facility. And, as long as Eric's okay with that, I -- that's what I'm referring to when I say facility.

You work at the facility?

A Yes, sir. My title is social service worker, slash, program coordinator.

But my job is in the social services office as a social service worker.

Q Okay. And what does that mean exactly? What does that entail?

A Well, we are the main point of contact between the families and -- or, I'm sorry, between the facility and the family.

We keep them appraised of all medical appointments. If they have any questions, they contact us.

Also, we keep up with the annual consents for the clients. We -- so that's our -- one of our main responsibilities is being the contact with family.

Also, what I do, I will, you know, attend -- every three months, we'll have a meeting with the psychiatrist. I will attend and keep them appraised, you know, if the

client is on the baseline, if there's anything that seems abnormal with him, to let him know.

Q Uh-huh.

A Also, once a year, I meet with each client. And I will go over their rights and responsibilities as well as the rules of BHDC, update their social history.

And then, once a year, we'll have what's called an individual program plan where we'll meet with the whole team --

Q Right.

A -- and the guardian, if they choose, and talk about, you know, if we think they're placed appropriately here, go over, you know, their health, safety, and security plans; if anything needs to be added or rescinded. Talk about their goals for the upcoming year.

Also, when we get a new resident that comes in, I will, you know, go over their records and write the initial social history for them. And that can be a basis that will be updated yearly.

Q Okay. I think that's a really good explanation. Thank you. That gives me a much better sense of what your role is there.

How long have you been at Booneville?

A A little over seven years. I started in late December of 2014.

Q Okay. And have you been in this job role the whole time?
A Yes, sir. For -- now, I worked at the school for about six-and-a-half years before then. And there were some summers I worked in recreation.
But, whenever I came on to work full time in December, this is the role I have been in.
Q When you say you worked at the school for six years, what school are you referring to?
A I worked at the Bonneville High School and the Booneville Middle School or Booneville --
Q Okay. As a counselor or social worker as well?
A No. My role there, the first years I worked -- for three years, at the high school, I ran the business learning lab. And then they did away with that program and so I assist with literacy at the junior high.
And then we had some budget cuts and they were doing reduction courses in the high -- I went to work at the alternative school there. And this position came open in -- you know, I didn't know -- because there was -- there was an ongoing reduction force.
And I had worked up here before. I put my application in and that's when I -- I came up here.
Q Okay. All right. And are you from the area?
A Yes, sir. I've lived in Booneville my whole life.

Q Oh, really? All right.
Where did you go to college?
A University of Arkansas Fort Smith.
Q Okay. How far is Fort Smith from Booneville?
A About 45 minutes.
Q Okay. It's that close? I know it's pretty close to Eureka; isn't it?
A I think Eureka is -- it would be a couple of hour, two or three hour drive. But, yeah, you can get from here to Fort Smith in about 45 minutes.
Q Okay. I had a client some years ago that was from Booneville. And I used to go up there all the time; but it's been four or five years and I've been to many other places since then and it all gets jumbled up.
Okay. Let's see. So you went to college at Fort Smith. Did you graduate with a four-year degree from there?
A Yes, I did.
Q Okay. What was your degree in?
A My degree was in history and historical interpretation.
Q Okay. That's interesting. I was a history minor. Do you have any other degrees?
A No.
Q Okay.

A No school after that.
Q You had -- what about licenses? I assume you have to have some sort of a -- are you an LCSW?
A No, no. In fact, that was -- whenever I started that was something everyone in training did.
The lady who was my supervisor at the time really emphasized to the class, she says I'm an CLSW; she say I'm a social worker, she said these folks here are social service workers. So there's a real distinction between -- between those two things.
Q And you're more social services?
A Yes.
Q Okay. And so there's no additional schooling or license or --
A No.
Q Yeah. And I don't -- I'm just trying to find out. I just want to make sure I understand. It doesn't matter to me either way. I just, you know --
A Right.
Q Okay.
And so your qualifications for this job were more experience based?
A Yes. In a -- if you have -- my understanding, whenever I applied, was that you can have a four-year degree as well as -- or if you have four years of

experience -- or, you know, a year of experience can count as a year of college to apply for this position.

Q Okay. All right. And you've been at the facility since 2014 you said?

A Yes. The very end of the year of 2014.

Q Okay.

And I'm correct that you were David Cains' social services worker or social worker specifically; correct?

A Yes.

Q Okay. And my understanding is there are other folks that also do what you do at the facility, and then they have their own clients assigned to them?

A Yes.

Q Okay. And, approximately, how many clients do you service at a time?

A It has fluctuated a little bit over the years. But, right now, I've got about -- between 40 and 42. Somewhere in there.

Q Okay. And there's typically about 130 people at any given time at the facility?

A Yes, sir.

Q Roughly?

A Roughly, yes.

Q Okay. So are there three full-time social workers?

A Social services workers, yes.

Q Okay.

All right. And was David Cains with you your entire time there?

A No, he was not.

Q Okay. When did he become your client?

A I believe it was in 2017. We had -- whenever I first began, there was -- let's see.

I'm trying to remember how many of us there were. There was a lot more then. There were six, so our case load was significantly smaller at that time.

And one of our workers left, retired, one of them went to another job, and so -- so there was some reorganizing. And so I became his worker in, I believe, in 2017.

Q All right.

Kind of, if you could, give me an understanding of what your relationship was with David. Another way to say that would be kind of the level of interaction you had, you know, just -- that's kind of what I'm asking.

You know, how involved, you know, how much did y'all interact? If you could, just kind of give me an idea of that.

A Sure. We had -- there for a while, he would come to my office usually about once a week.

He -- the reason he would do that was whenever, you

know, the weather was nice and we weren't dealing with COVID and stuff, the clients could -- and the traineers were all up at normal -- normal operating capacity.

Q Uh-huh.

A He would want to, you know, talk on his mom on the phone once a week, so he would swing by my office and, you know, and come in and call his mom.

Q Okay. So that was where he would call his mom. I knew he called his mom or sister once a week. That was --

A Yeah. And then that was where -- a while -- at one point, they increased his health, safety, and security plan to be on enhanced supervision so he would have staff around him closer.

And so he just called from the dorm after that was added to his health, safety, and security plan.

Q Say that again. After it was enhanced, what happened?

A He would call from the dorm.

Q Okay. When was that enhancement done?

A If you will give me just a moment, I'm going to look through my case notes and I can --

Q Okay.

A -- (inaudible) when he would call his mom.

COURT REPORTER: Mr. Murry, if you can

just try to get closer to your mic, maybe, when you're speaking, I'd appreciate it.

THE WITNESS: Okay.

A Okay. I notified her on September 27th of 2018 that he was on enhanced supervision. And I do have here noted that his mother was pleased with that.

BY MR. GILLISPIE:

Q Okay. What are you looking at there?

A It's -- it's my case -- it's just whenever, you know, I would visit with -- I can hold it up here.

Q Sure. No, you don't have to hold it up.

A Okay. It's just whenever we, you know, visit with a family member or a client or something; and it's something that, you know, we just want to have a record of. We make case notes, so --

MR. GILLISPIE: Eric, do you know if those were produced to me? His case notes for David?

MR. COLLINS: I'm not sure if they were in the first batch. We just sent out another batch yesterday.

MR. GILLISPIE: Okay.

MR. COLLINS: You've got another batch probably coming out either tomorrow or Monday, so you should be getting those.

MR. GILLISPIE: Okay. I think what the --

the second thing you said is just communications. But maybe that includes that.

I'll follow up with you, Eric, and see about getting those.

And, if we need to, Eric, we can -- and if we end up getting into personal information here today, I'll agree to a protective order of some sort to the extent we need to.

Of course, case notes on David himself shouldn't be an issue. But if there's PHI about other individuals in there, that sort of thing, that needs to be redacted or we can do a protective order.

MR. COLLINS: Gotcha.

MR. GILLISPIE: Okay.

BY MR. GILLISPIE:

Q And what was the -- do you recall the circumstances, Mr. Murry, surrounding the -- did you say enhanced supervision?

A Yes, sir.

[redacted]



Q Okay. But it wasn't -- it didn't involve any behavioral issues, as far as you know?
A I mean, I don't -- it's been -- I'm trying to think. I -- I don't know, because it's been long enough ago.
I know David would have behaviors not infrequently.
Q I'm just asking about in relation to this enhanced supervision regimen from 2018. Just specifically just talking about that.
If you know the cause or the reason behind that, I'd like to know it. If you don't know, that's fine too.
A I believe it was over concern over his low blood sugar.
Q Okay.
So about how often would you interact, have interaction, with David, you know, see David? Once a week?

A Yeah.
Q Multiple times a week?
A You know, it just kind of depended. Whenever he was coming to make calls, I would see him once a week.
After he was on -- he switched to enhanced, he wouldn't come to my office. But I would see him, not infrequently.
I couldn't give you a -- I mean, I would see him, obviously, every -- in our psychiatric review. But I would see him around. You know, if I was over in the dorm, went by his room, I'd say hi.
You know, if I was -- I had to go to the training area for some reason and saw him -- but just informally like that.
Q Yeah. Do you feel like you had a pretty good relationship with him?
A Yes.
Q Okay. You guys got along well?
A Yes.
Q And was he pleasant with you most of the time?
A Yes. Yes, he was.
Q Okay. Were there ever any incidents where he was physically aggressive towards you specifically?
A No.
Q Okay. And that was -- again, you were his social

worker for, was it, three years or over three years?
A I would say about three years.
Q Okay. And you encountered him, you had interaction with him at least once a week, probably more?
A Whenever he was coming in my office, it was once a week.
After that, it was -- it was, you know, more infrequent, you know, as far as eyes on.
Q Yeah.
A You know, he might would call and say I want to talk to my mom and then I would transfer him.
Q Sure. And I know that -- I don't expect you to answer any of this perfectly, for the most part.
But, you know, if you had to put a number on it, an average over those three years, how many times you personally saw him, just either said hi to him, met with him, anything, just personally walked by and saw him, what would you -- how many times a week would you say that would be on average?
A I would say it -- it would probably average out to at least once every two weeks. I mean. . .
Q Once every two weeks?
A On average, I would say.
Q Okay.
A On average. Because there might be some day --

weeks I might see him two or three times and then times that I wouldn't. So I was just thinking on average, you know.

Q Okay. So some weeks where you'd see him two or three times; and then some weeks when you wouldn't see him at all?

A Right.

Q Okay.

And he didn't come to your office to make phone calls once a week every week?

A No. Not after the enhanced supervision.

Q Okay.

A Because he -- he would need staff closer to him.

Q Okay.

A And so if they were -- you know, they needed the staff in the dorm. It would be harder to get him, them and the staff over to our office to call.

And he was -- he was content with just called from the dorm.

Q Okay. And you said he was never physically aggressive towards you.

Did you ever personally witness him being physically aggressive towards anyone else?

A I saw him, I guess what you would call, sympathetic crying. If another client was ever -- became upset, that

would upset David and he would start crying.
Q I don't mean that. I mean physically aggressive. Hitting people, kicking people. Did you ever personally witness him do anything, attack somebody physically?
A No.
Q Okay.
What was he like? I never got to meet him, you know?
A He -- all of my interactions with him were most -- were good. And part of that was probably because -- well, you know, whenever they're coming to see us, you know, it's something they want to do. They're happy.
And I wasn't with him on a day-to-day basis. He was -- to say what he was like, he. . .
[redacted]
A He was -- he was very friendly whenever he was happy.
I do believe there was one time when I was leaving the door when I heard him go off, you know, having behavior. But I did not witness that.
Q Uh-huh.
A Just heard him verbally being really aggressive.
Q Again, that's not what I'm talking about. Hitting, kicking, attacking --
A I didn't witness that.

He was -- he was very friendly. I would say that, at times, he would probably need reassure -- I'm trying to think how to word this. You know, just reassurance that things were okay. You know, if he -- if he was getting worried about something.

Q What were things that typically triggered his worrying or anxiety?

A I don't know. I just remember -- and it was before my time whenever -- whenever --

Q Who would be the best person to know that? If I wanted to know what his triggers were, what kinds of settings or --

A Okay. I see --

Q -- environments or events --

A His psych --

Q -- were likely to trigger a negative response for him, who would be the best person to ask that?

A His psychological examiner.

Q Okay. And that's Mr. Albus, I think?

A (Witness moves head up and down.)

Q Okay.

You said you did -- you said you had pretty regular contact with his family as well?

A Yes.

Q And, by that, do you mean his mom and his sister or

just his mom?
A Both. His mom quite a bit more by a pretty good margin. But his -- it wasn't uncommon for his sister to call and say, you know, I'm going to be sending him a birthday cake for his birthday or, you know, we're going to come get him.
So it wasn't uncommon; but me and his mom talked pretty frequently.
Q And they were pretty involved?
A Oh, absolutely. Yes, they were.
Q Okay. More so than the average family member?
A Yeah. I would say, as far as family involvement, they were probably one of the top, top ones as far as being involved with any other. They were very close to him.
Q And were you present when his plan, his individual plan, was presented and described to his family? Were you ever present for that?
A Yes.
Q And would the physical restraint, the use of physical restraints, do you recall that ever being talked about to his family --
A Yes.
Q -- or with his family?
A Yes.

Q Okay. What do you recall? What do you recall specifically?
A I remember that, with David, the -- whenever you have worked with some clients for a period of time, you start to get a sense of what their baseline is.
And, with David, we would -- you'd typically see an upswing in behaviors in the springtime. But that would seem to level off whenever -- as the year went on.
And so whenever we would have his IPP meeting, we would go over that stuff. But they -- but, again, it wasn't a sustained increase in behaviors.
It typically, with him, seemed to escalate some in the spring and then he would go back to his baseline during --
Q Why the spring?
A I -- I don't know. It was just something that I -- that was noticed with him, is that it seemed like he would have more incidents of physical aggression in the spring. But then they would level off.
Q I guess, what I'm asking is, did you yourself ever personally explain to his mom or his sister that physical restraints were being used on him or did you ever witness anybody explain that to them?
A Yes. Or I did not witness them, but they were told. I had some notes here.

Q And, again, please give those to -- when you're here, if you could, please make sure Mr. Collins gets a copy of your notes so I can get them as well.
A Okay. When I say my notes, I mean my case notes.
Q Right.
A Okay.
On May 18th of 2018, I sent what's called a marks card.
And that's something I didn't -- I just forgot to mention. But I'll tell you what that is.
You know, any mark they receive, whether it's a bruise, a hangnail, a scrape, any mark whatsoever --
Q Yeah.
A -- that is given to the social services department along with the explanation on there of what caused it and the treatment that was done. And so we will mail that, however the guardian wants to be notified, whether mail or e-mail, and notify them, excuse me, of that mark.
So on the -- on 5/18/18, I did send a marks card to his mom that said he had scrapes he received in being in personal restraints.
I talked to her on the phone on September 20 of 2018, informed her he was in chemical and personal restraints. On September --
Q When was the scrape? What was the date for the

incident where he was scraped in a personal restraint?
A I sent the marks card on 5/18/18. What day it occurred, I -- I don't have the marks card in front of me, but it would be somewhere a day or two previous to the 18th.
Q And a marks card, is that -- what is a marks card?
A That was what I was talking about.
Whenever a client has a mark of any kind, you know, whether it's anything -- I mean, any mark whatsoever, from a hangnail to a bruise, a scrape.
You know, if they had razor burn from shaving, you know, any mark or injury on the body is received by social services and it has the location and the date and time of the mark along with what caused the mark and then what -- what treatment was done.
And then we either -- a lot of clients use e-mail -- or -- I'm sorry. A lot of our families get sent via e-mail. But, with Ms. Cains, I sent that in the mail.
And I put that in the mail to her on May 18th of 2018, that he received scrapes from personal restraints.
Q Okay. Do you happen to know how many other marks cards you've sent to her?
A No. Those are -- I suspect it would be a very high number; because, like I said -- not because of anything unusual.

We do, like I said, anything whatsoever. Like I said, it can be a razor burn, a hangnail.
Q Uh-huh.
A You know, absolutely anything is documented.
Q Okay.
A And so --
Q You have these marks cards?
A They would be --
Q You've got --
A They would be in our master file.
Q Okay.
A Yeah.

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MR. GILLISPIE: Eric, I'm going to take just a five-minute break, if y'all don't mind.

MR. COLLINS: All right.

MR. GILLISPIE: And, Caleb, if you want to try to toy with that, turning that volume up, you may try to do that. If you can't, that's fine, but --

THE WITNESS: We're completely alone, but is it okay if I had someone come in to show me how to turn the volume up while we're on break?

MR. GILLISPIE: Sure.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as

follows, to wit.)

BY MR. GILLISPIE:

Q All right.

Mr. Murry, I want to move on to injuries that David may have caused. Do you have any personal knowledge of David having caused injury to a staff member or another client at the facility?

A No.

Q You do not?

A No.

Q Okay. So, as far as you know, you've never heard about, you know, David sending someone to the hospital or anything like that?

A There was -- I don't remember what year it was. And I never saw any paperwork and I was not told --

Q Can you scoot up just a little? I'm sorry, Caleb, I --

A This computer is set kind of far off, so I'm leaning forward. Can you hear me okay?

Q Yeah, that's better.

A Okay.

I didn't know if it was a rumor or not. Again, I did -- I wouldn't be told anyway. But I had heard one time, a few years ago, that David had punched a staff member in the chest and broke his sternum.

Now, again, I did not see anything. I was not there. But it was -- so I didn't know if it was a rumor or anything like that. But that was what I heard.

But, as far as personal knowledge, that was a -- you know, again, that's hearsay. You know, I didn't know if that was a rumor or if that was just something I heard. But just to be --

Q Do you know where you heard that?

A No, sir, I don't.

Q Do you know who the person he would have punched was?

A No, sir.

Q But, other than that, you have no information on that?

A No.

Q Okay.

Do you have any personal knowledge of David's physical capabilities? I don't know that you'd be involved with that part of his treatment plan. But, just in case, I wanted to ask.

A Sure. I mean, he was -- he was a big guy. He was able bodied.

I know that -- and I don't have this in my notes or anything, but it may be pertinent. So just to tell you, I remember, it was a few years ago, his mom told me, when

they had taken him to town one time, you know, to get something to eat or, you know, just do a family visit with him, she said he went nuts on them.

Now, what that included or what that entailed, I don't know. But, as far as how much damage he can actually do, you know, or how he could hurt somebody, you know, it -- I don't know.

Q You don't know?

A No, sir.

Q You've never played sports with him or seen him play sports, seen him move around?

A No. I mean, as far as moving around, when you said that, I remember one time I went by his room and he was listening to the Monkees. I mean, he was walking around his room, shaking a tambourine.

Q Uh-huh.

A I mean, so he had full -- not talking about a position. But he had full use of his, you know, arms and legs. Had no problem ambulating. You know, like I said, he was able bodied.

Q Okay. And his mental -- his age relative to his mental functioning, his sister puts it at about that of a six-year-old.

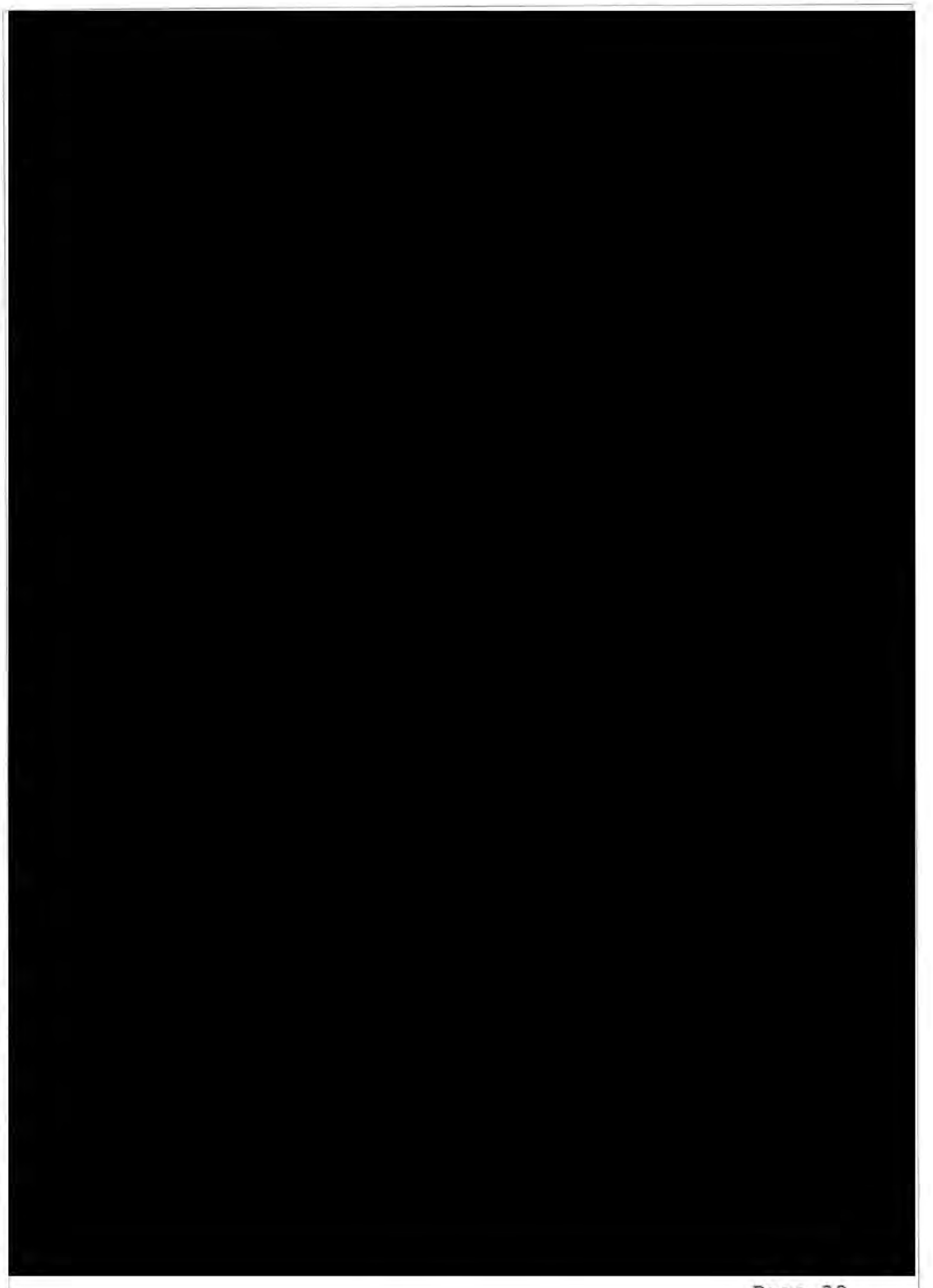
Based on your experience with him, would you say that's about right? Or do you feel differently?

A That would -- I would say -- that would -- to get a more -- a better answer, I would ask one of the psychologists.

Q Uh-huh.

A But he was -- so, you know, just that disclaimer because I'm not a psychologist.

[redacted]



Q Uh-huh.
A You know, whenever he would come by my office, I would say, did you have a good day today; he'd say, oh, yeah; and he said, but I'm tired. You know, that was what he would always say.
Something else, talking about this that came to mind when you asked that question, you said did I know of his triggers. I believe one of them would be like -- one time, we were going to have his IPP meeting. His mom usually always attend in person.
Q Yeah.
A And, if I'm not there to take him off, he would get upset. You know, so like if he would see them on campus but not be able to leave with them, that would be something that would trigger him.
Q Sure.
A But, again, to give you a better idea of that, what would be -- it would probably be best to talk to one of the psychic examiners. But, yeah, I would --
Q And did you personally witness some of those incidents where he'd get upset when his mom would leave and he can't go with her?
A No. No. Because she would always try to arrange it where, you know, she was going to be on campus and see him, then they would -- he would be able to go with them.

Q Okay.
A So, no, I never saw that.
But, again, go back to your original question --
Q Sure.
A -- how would I compare that to -- that kind of --
Q And I'm just trying -- I don't mean to -- it may be a bad question.
I'm really, honestly, just trying to -- again, I've never met him. I'm trying to go by what the family has told me, what these medical records say.
I'm just trying to get an idea of what you were dealing with, with him.
A Yeah. He was very childlike in his understanding. But, again, you know, he did have -- because he liked routine and liked things the same.
Once he fig -- you know, and whenever I became his worker, he'd been here for several years. And so his routine was well established.
So it's -- it's hard to say he was like a kindergartner or something because, you know, I saw him functioning, you know, within his environment as best he could.
Q Okay.
A And he did have, you know, an understand -- you know, he could answer questions and things like that.

This may not be pertinent but I was going to -- just to -- on his social history, whenever I -- I put in -- whenever we get our annual meeting, I was explaining to him his rights and possibilities.

Like I said, I go over the rights, responsibilities, the rules. I always, with our clients, go over what abuse and neglect is and be sure they know, you know, that -- who they can tell and stuff like that.

And what I wrote was --

Q You wrote that he has very little understanding of abuse and almost no understanding of neglect; correct?

A Yes, sir. Yeah, but he was not -- I was just finding my paragraph here.

He was not able to communicate a full understanding of his rights and needs the support of his guardian and the staff here at BHDC to ensure his rights are protected.

David was unable to provide a description of abuse and neglect. I explained to David what each means and provided examples. David stated that he would tell his staff if this were to occur.

I reminded him that all BHD staff are mandated reporters and he can tell any one of us along with his guardian.

So, you know, I think, if David thought he was being

bothered, my personal opinion, he would know that he could tell staff. But, as far as being able to articulate things well, he -- he really couldn't do that.

But, again, I think, if he knew somebody was you know, like somebody was hurting me, somebody was being mean, he would know that he could tell staff to help him.

Q And he never told you about that happening, did he?

A No, he did not.

Q And do you know of him telling anybody else about something like that happening to him?

A No.

Q Okay.

I want to real quick ask about -- do you know of any physical injuries that David has caused but that -- are you personally aware of any physical injuries that other clients have caused at the facility to either staff or to other clients?

You know, the kind of physical injury that has required medical attention, are you aware of anything like that happening?

A No. And that's not to say it doesn't happen. The reason is because of HIPAA regulations and stuff.

Q I just want to know what you know. I'm not asking you to speculate. I just want to know what you know.

A No. I did run in -- I don't even know if this is

relevant, but I will tell you.

I ran into a guy that used to work up here at Walmart one time. And he said that he had to leave because he was hurt at work and was on disability. I have no details on that. But that's the only thing.

Q Okay.

A Oh, and there was another one where I believe I saw a staff member who had their leg injured. It was in a cast. But, again, any details, I don't -- I don't have.

Q Okay. You don't know who would have hurt -- who, if anybody, would have hurt either of those people specifically?

A No, sir, I don't.

Q Okay.

What is your knowledge of physical restraints being used on -- and, again, I'm talking about your personal knowledge.

A Uh-huh.

Q Again, I'm also not yet asking you about the death incident.

A Sure.

Q I'm talking about before that.

What is your personal knowledge of physical restraints having been used on David Cains?

Are you aware of them having been used on him?

A Yes. Yes.

I did -- I was trying to -- I didn't know exactly what you were asking, like what --

Q Yes.

A What -- what form -- you know, that was something else we always cover in our pre-IPP meetings, before the meetings.

Q Uh-huh.

A The restraints are just -- are not for punishment. They are for the safety of the client or others. But, yes --

Q I understand. I'm just asking what your knowledge is about personal restraints; physical restraints, actually. Physical restraints.

A Yes. I was aware that David -- that that was an occurred -- a not infrequent occurrence. I had -- go ahead.

Q No, you, please, finish.

A Yes. We were talking earlier and I was looking through my notes on the restraints.

Also, yeah, on the 20th of September -- September 20th of 2018, in a phone conversation with his mom, I informed her of chemical and personal restraints.

On September 7th of 2018, I informed her that mechanical restraints were used. On June 13th of 2018,

he had a behavior on the mobile van. I'm sorry. That -- there's no mention of restraints on that one.

She was notified on October 5th, 2018 it required chemical intervention. But, yes, I was aware of restraints.

Q Okay.

A And the -- I would say that the family was too.

Q Okay.

Were you required to be notified every time a physical restraint was used on David?

A No, sir. No. What every medic heard, a person would have to -- a person who was authorized to give authorization for restraints would have to be contacted. I'm not qualified to do that.

Q Okay.

A So it would be what we call a team leader, a QIDP, which is a --

Q Uh-huh.

A Or the program supervisor. Someone like that could give --

Q Is who had to be notified?

A That they had -- and they had to give authorization for restraints --

Q Right.

A -- on the (inaudible).

Q Okay. Okay. I understand that's not your role.
So why would you be charged with notifying his mom about some of these restraints and not others?
A She had requested, at one point, to be notified of his behaviors that he was having; again, because we would see an upswing in the spring.
And, whenever I would call and notify her of those behaviors, those are in my case notes. So that -- that was a request she made. And that's why --
Q When did she make that request?
A I don't know.
Q Would it have been before 2018?
A I would say, to the best of my knowledge, sometime in 2018.
Q Okay. And, if I'm hearing you right, you're saying, from that point on, you tried to make a point to personally update her and send her information on behavior incidents?
A Yes. And that is reflected in my case notes.
Q Okay. And about how many of those incidents did you notify her of?
A If you'll give me just a second, I can count some here for you.
Q And, ultimately, I just need to see them. But for --

A Sure.
Q I don't have that luxury at the moment, I'm just going to have to ask you.
And, to further clarify, I'm only interested in incidents that involved a physical restraint of some sort being used.
A Okay.
Q At least for the purposes of today.
A Okay.
I informed her of restraints on September 20th of 2018. It was chemical and personal. September --
Q Let me stop on that one, the September 18th of, you said what?
A I said September 20th of 2018.
Q Okay. What do you know about that particular behavior incident?
A I don't. It's been -- because I just noted that I had called her and notified her of that. Not the --
Q Okay.
A Yeah.
Q So you don't know what kind of physical restraint was used?
A Chemical and personal.
Q Okay. Do you know what the personal restraint consisted of?

A No.
It would probably be holding the arms or some. . .
Q Okay. How do you know that?
A I don't.
Q Why do you assume that?
A Because -- it was an assumption. If he was trying to strike somebody or hurt himself or say, for instance, bit his arm or something -- and there's an instance of that where he had bit himself.
Q Uh-huh. I think I saw that.
A So that would be why I would assume that.
Q So do you have some knowledge -- were you trained in the personal restraints?
A Yes. All of us go through -- are required to do that whenever we are in what's called our phase class.
Q Okay. Well, I wasn't expecting you to say that; so I'm going to go back.
Tell me about the training that you have received with -- and, again, I'm really only interested in the training that you have received that would pertain to behavior control. You know, restraints.
It's called the what?
A I don't -- whenever I first had it, it was called nonviolent conflict intervention.
Q Okay. NCI?

A Yes.
Q Okay. So you've been trained in NCI?
A Yes.
Q And is everybody there, everybody on staff, trained in NCI?
A I only had the phase one part of that. Phase two is more on the ground. I say on the ground; like on the -- on the floor type stuff.
Since my job was not work -- indirect here, I only completed the phase one.
Q Okay. When you say on the floor, do you mean direct care staff?
A Yes, sir.
Q Yes?
A Yes.
Q Okay. And when did you receive phase one training in NCI?
A It would have been in 2014 or 2015, right there when I started. I don't know the exact dates.
Q Okay. And how long did that training last?
A I don't remember.
Q Was it a class? Was it an online class? Did you have to go somewhere? Did you have to travel to Little Rock?
A It was -- they had an instructor come in and go over

that with us.
Q And you don't have any recollection of how long the training lasted? Whether it was one day, two days, all week?
A You know, I believe it was a -- I believe it was two days. I believe, but I'm not sure.
Q Okay. And can you give me any understanding of what it is you were taught?
A How to -- really, it was how to de-escalate the situation. You know, use calming rapport. Try to get them -- get the client back -- you wanted to avoid personal restraints.
Q Uh-huh.
A You know, talking to --
Q You want to avoid physical contact if at all possible; right?
A Yeah. So it was on -- you know, I remember one of the things was calming, you know, calming rapport with them, trying to, you know, to negate anything physical happening.
Q And did you ever have an opportunity to use that with David?
A No.
Q Okay. You never had to?
A No.

Q Okay.

And then were you ever separately taught -- my understanding is that the facility had staff go through NCI training but then also allowed staff to use physical holds that were, I believe, not used by or not endorsed by NCI.

Were you ever separately trained on how to do physical restraints? Whether it be holding arms or anything like that?

A I know whenever I completed phase -- for my -- when I worked up here in the summer, we went over that. But I don't remember doing it when I came up here full time.

Q Okay. So you don't remember any kind of specific training or class that you went to or written materials that you might have received concerning specifically physical restraint, a physical restraint, of clients?

A Not other than just that general training. And I know that there was --

Q What is -- what do you mean by general training. Are you talking about the NCI?

A Yeah.

Q So you're saying NCI taught -- as far as you remember, you think NCI taught physical restraint?

A I mean, I remember -- I believe it taught personal. But it's been so long. When I went through phase, I -- I

don't remember.
Q Okay. If they did teach some sort of personal restraint, you're not -- you couldn't tell me specifically what it was at this time?
A No.
Q Okay.
A And I know there was some, I guess, some updated procedures on -- that was some training available that was on -- it was updated, some training we went through.
I mean, the only thing I remember from that was when they talked about from transitioning to the ground. But that was after phase, but I don't really remember anything about that.
Q Transitioning to the ground?
A Uh-huh.
Q When was the -- you were taught transitioning to the ground?
A Well, there was a video we watched on that.
Q Okay. When was that video? Where and when did you watch that video?
A That was made available, I believe, on our share page. I -- I don't remember what date that was.
Q Okay. Let's see.
You started in 2014, you got your NCI training sometime around then. When would you have had this --

you know, so this was after that, that you had been shown this video; right?
A Yes.
Q Okay. Was it done there at the Booneville campus?
A Yes. Staff development filmed it and placed it on our web where we could access it.
Q You're saying that staff at Booneville developed a video, put it on a webpage for you to watch; and that the topic of this video was how to -- essentially how to restrain clients on the ground?
A No. It was -- my understanding it was an up -- and I may be wrong.

But my understanding, it was an updated version of -- or an updated thing. You know, if a client had to be held in personal restraints, the correct way to transition them to the ground if mechanical restraints were going to be needed.
Q Okay. And what was the correct way to do it?
A I don't know. You would have to -- I don't -- I don't know.
Q Okay. You saw the video, but it's not something that stuck with you?
A Yes.
Q Correct?
A Yes.

Q So if, today, let's say you were put in a situation where you were forced to have to transition David or somebody else to the ground, you would not be able to do it in the way that video taught because you don't remember; right?
A Right. I -- I would -- if that was -- if I was in the position where a client was a danger to themself or somebody else, I would use the radio to call for assistance and for direct care staff to come.
Q Okay. Fair enough.
So it's your understanding that Booneville does authorize restraining clients on the ground, while they're on the ground?
A They --
Q That's what you're telling me; right?
A When you say restrain them on the ground, they -- they use what's called a papoose board which --
Q Well, I'm not talk -- I know what a papoose board is and I know what a mechanical restraint is. I'm not talking about mechanical restraints, because that's not what killed David. And I'm not talking about chemical restraints.
I'm talking about personal physical restraints on the ground.
Is it your understanding that that's authorized,

that that's a thing that's allowed at Booneville? To restrain a client while their on the ground?

MR. COLLINS: Josh, I'm going to object to the question. I believe it's mischaracterizing his earlier testimony. He testified that -- or he said that this was a video that showed how to transition to the ground in order to put them on mechanical restraints.

I believe you're mischaracterizing his testimony.

MR. GILLISPIE: Fair enough. Let me back up and try to rephrase it and break it down.

BY MR. GILLISPIE:

Q Let me ask it this way. Caleb, you just tell me yes or no, if possible.

Do you know, do you personally know, if there is a policy at Booneville that authorizes taking clients to the ground?

A No.

Q Okay. Do you personally know if there is a policy that authorizes restraining clients while they are on the ground?

A No.

Q Do you know if there's a policy at Booneville that allows or provides for transitioning clients to the

ground?
A I believe so.
Q And do you know where that policy could be found?
A It would be -- I would assume it could be accessed on our share webpage under policies. Also, we have an employee handbook.
Q How many times do you know of David being transitioned to the ground?
A I don't know.
Q Do you know of any times, other than the time of his death, do you know of any times of David being transitioned to the ground?
A I know he was in mechanical restraints on September 7th of 2018.
Q Okay. And you feel like that would have entailed transitioning him to the ground?
A Yes.
Q Okay. And is that -- are you saying that transitioning to the ground is something that's done prior to all mechanical restraints in order to get them on the papoose board?
A I believe so, yes.
Q But you're not a hundred percent sure on that?
A No.
Q Okay.

Did you ever talk with David's mom or his sister about times David had been taken to the ground or transitioned to the ground?

A I know on the incident on the 7th of September 2018, yeah, she was informed that he was in mechanical restraints.

Q Was she informed that, prior to being put in mechanical restraints, he was taken to the ground?

A I don't know. No, I didn't say that, so. . .

Q Okay.

Any other training -- that video, do you still have that video?

A No.

Q Do you know who would have that? Who would be the best person to ask for that video?

A Staff development.

Q Okay.

Other than the phase one of NCI training, the taking to the ground video, is there any other training that you've received that pertains to restraints?

I'm not asking about the training that's more pertinent to what your actual job is. I know you're not direct care, so I'm not trying to ask you questions that are better meant for direct care.

But I do need to know if you've had any other

training related to restraining clients who are having behavioral problems.
A No.
Q Okay.
Have you ever personally witnessed David being restrained in any way?
A No.
Q Okay. Have you ever personally witnessed any other client being restrained?
A Yes.
Q Have you ever personally witnessed any other client being restrained while laying down or in a horizontal position?
A Yes.
Q Okay. How many times would you say you've seen that?
A Maybe three.
Q Okay. And do you recall any -- I'm not asking you for names of people or at least not names of the clients.
Do you recall who the staff were involved in that?
A I remember one was Michelle Welch who was a team leader.
Q Okay.
A It wasn't with -- it wasn't with David. It was another client.

Q Okay. Yeah, I know. You said you've never seen it with David, so I'm talking about the other clients.

So any other staff members you recall seeing involved in any of those three restraints that you witnessed where a client was being restrained while laying down? Any other staff members you recall being involved in that?

A And it was -- it was a different incident. I believe -- no. No, I was trying to think if I'd saw somebody involved in a restraint, you know, if I could remember who it was. No.

Q Have you ever seen Tyler Mattson involved in a restraint?

A No.

Q You ever seen Amy -- do you call her Amy or Mandy Jones?

A I call her both. I know who you're talking about.

Q Okay. Have you ever seen Amy Jones involved in a restraint?

A No.

Q Okay. Have you ever seen Ryann Campos involved in a restraint?

A No.

Q Okay.

And do you know any other details or circumstances

around the three restraints you think you witnessed where a client was restrained on the ground? Do you know any of the details about what had happened or the circumstances?

A No.

Q One of those things where you just happened to be walking by?

A Thinking back to the most recent -- what I said, I don't remember when it was. The one I gave you, the name Michelle Welch.

And so I believe what had happened -- and, again, I don't know. I wasn't -- I just happened to be in the general vicinity.

I don't know if this is correct, but what I believe happened was the client had either left functional control in the living area because he was upset or had become upset and was leaving.

I remember him screaming at staff what he was going to do to them and do to their mother and it was -- so I believe what happened was they were upset and had left functional control when that happened.

Q Okay.

I'm going to move on to something else.

What knowledge, if any, do you have about the what I believe now is a former policy whereby only medical

personnel were allowed to call 9-1-1?

First of all, do you have any knowledge of that? Did you know that was a policy?

A Well, I know that our emergency (inaudible) --

Q Say that again.

A No, I don't.

Q Okay. So was it your under -- let me ask it a different way.

Was it your understanding, was it ever your understanding, that only medical personnel were supposed to call 9-1-1 at the facility?

A No.

Q Okay. What was your understanding regarding that?

A That we would call medical if medical assistance was needed.

Q Okay. So we may be talking about the same thing. What was your understanding of -- your understanding of the policy was that, if a medical emergency arose, you were to call the facility medical team; right?

A Yes.

Q Okay. And then they were the ones that would determine whether or not 9-1-1 was to be called; right?

A Yes.

Q And I believe it would have been -- was it your understanding then that -- you're not considered medical

personnel, are you?
A No.
Q Okay.
And am I correct that, at the time of David's death, the policy was that, if you or anybody else that's not a medical personnel sees an emergency situation, you're supposed to call medical, not 9-1-1; right?
A Yes.
Q Do you know why -- do you have any idea as to why that was the policy?
A No.
Q Okay. Has a new policy been instituted since David's death?
A We all -- we notify all -- we sent out a form with our annual consent packets that has, you know, either ECI, emergency chemical intervention or emergency mechanical --
Q Let me ask that a different way.
As we sit here today, has the policy changed whereby you, as a non-medical staff member, can now dial 9-1-1 first if you feel the need to?
A No.
Q That's not changed?
A Not to my knowledge.
Q Okay. Again, you have knowledge or understanding as

to the rationale behind that particular rule?

I know it's not your rule, your job to make that rule. I'm just asking, you have no understanding or --

A No.

Q -- of why that's the rule or what the reason is?

A No.

Q Okay.

Did you know Tyler Mattson?

A I know who he was. To say I knew him, no.

Q Okay. Did you witness him interacting with clients?

A Very briefly.

Q Okay. Did you ever witness him interacting with David?

A Not that I recall, no.

Q Did you ever witness or hear, even if it's a rumor, anything about Mattson acting improperly or harming a client or anything like that?

A No.

Q Okay.

Same questions but as regards to Amy Jones. I think you already told me you never witnessed Amy perform a physical restraint.

Did you ever witness Amy interact, in any way, with David Cains?

A No.

Q Do you have any knowledge, whether hearsay knowledge or whatever, about Amy's relationship with David Cains?
A No.
Q Okay. Did you ever talk to either Mattson or Amy about David Cains?
A No.
Q Okay. Did you ever talk to Ryann Campos about David Cains?
A No.
Q Did you ever see or hear about Ryann restraining David Cains?
A No.
Q Okay. Did you ever hear any rumors about any of those people, Amy Jones, Tyler Mattson, or Ryann Campos, having problems with David Cains of any kind?
A No.
Q Okay.
What is your understanding -- well, I'm moving on to the incident in question, June 13th, 2020, date of his death.
Were you on the campus that day?
A No.
Q Where were you that day?
A I was at home. It was a Saturday.
Q Okay. So, obviously, you didn't personally witness

anything that happened?
A No.
Q Okay. Do you recall when the last time was that you spoke to David? I assume it would have been earlier that week, but maybe not.
A No, I -- I don't remember.
Q Okay. So you don't have any information about what his behavior or mood was like in the days leading up to his death as in whether it was different or whether he'd been acting more aggressive? Anything like that?
A No.
Q Okay.
And, as far as you know, there was nothing out of the ordinary going on in his life at the time of his death? No, you know, what we would call, stressors?
A No.
Q Okay. Other than just the things that are always stressors. I mean, like you know --
A Sure. And I don't know -- when you ask that, just to --
Q I'm really just asking like -- I'm just trying to find out if, you know, if something that I haven't heard about had been going on, is going on in his life, that was unusual that you know about.
A Well, yeah, that's what I was about to tell you.

Nothing that -- I say nothing. We -- the campus, due to COVID-19, had been closed for a few months. And he was used to having regular family contact. And so that was different. You know, that was something that was different.

Whether or not that -- I was just going to tell you that because that was something --

Q Sure.

A -- that was --

Q Sure.

A -- (inaudible) because he was used to having so much contact.

Q Sure. Yeah. I guess that's a -- in retrospective, that's kind of a dumb question when you're talking about June of 2020; because we all had a big unusual thing happening in our lives, didn't we?

I got COVID in June of 2020 and had to go live in my grandparents' Victoria carriage house in their backyard for a week. Brought me my meals on a tray at the door like a prisoner.

But, anyways, what's your understanding of the incident that caused his death? I know you weren't present. I just need to know what you know and how you know it, essentially. If anything.

A I don't -- the truth is, I don't know anything. I

know that he -- he died. I -- believe he choked to death.

The reason I know that is the social worker, social service worker, excuse me, who was on call called me that Saturday to inform me that he had passed.

But, as far as any details, I don't know anything.

Q When did you first learn that there had been a restraint incident that precipitated his death?

A I don't know.

Q Well, you know about it now, I assume.

A Yes. Yes.

Q I assume you would have learned about it fairly, fairly, soon after the incident.

His mom learned about it nine days after the death. What about you?

A I'm looking at my -- the reason -- when you ask that, I was looking at the case note here from June 24th of 2020.

It says -- talking about the mom, it said she stated she was seeing the summary and was unaware that David had been in behavior and that this was different information than what she was originally told.

She stated she was originally told David had got up to use the restroom and was found on the ground. She said she did not know who told her that.

So I -- I don't know when I became aware of that.
Q Have you ever spoken to anybody about his death?
A No.
Q You've never talked to -- you've not spoken to the administrators, anybody at Booneville, about the fact that David Cains died? I would think that would have been a pretty big event, particularly in the days and weeks to follow.
A Yeah. I -- we had -- as -- I'm trying to think how to answer that.
Q The only right way is just to tell me honestly what you remember.
A Other than not knowing that he passed, when that's a tragedy; but, due to policy and stuff, I didn't -- wasn't made aware of any details or anything like that.
I do remember talking to my -- we had a new supervisor at the time. Or she's still here in social services. I remember talking to her on Monday, that David had passed away.
And we went -- me and Susan went down that Monday and met with the family at the funeral home.
Q Okay. Did you ever -- okay. And, at that point, were you aware that there'd been a restraint incident?
A I don't know.
Q Okay. Did anybody ever describe the restraint

incident to you?
A No.
Q What do you know about the restraint incident as we sit here today?
A I don't know anything about it.
Q You don't know who was involved in the restraint that led to his death?
A No.
Q Okay. You've not read this lawsuit?
A No.
Q Aside from your attorney, or aside from Mr. Collins, who did you speak with in preparing for this deposition?
A Mr. Collins.
Q Just Mr. Collins?
A Yes, sir.
Q Okay. Well, I certainly don't want to know anything you talked about with him.
But, aside from Mr. Collins, you've not spoken with anybody else? Not Jeff Gonyea, nobody?
A No.
Q Were you questioned after his death by the police?
A No.
Q Were you questioned by Disability Rights of Arkansas?
A No.

Q Were you questioned by Sandy Evans?
A No.
Q Were you questioned by anybody or any entity about the facts surrounding his death?
A No.
Q All right.
And, as we sit here today, your testimony here is that, even now, you don't have any information as to how your client died?
A I have the coroners report; which was provided to the family.
Q Okay.
A But, as far as details, I don't -- I don't know.
Q Just tell me everything you do know about this.
A Okay. I know that he -- all I really know for sure is that he died on June 13th of 2020.
Q Uh-huh.
A I don't know any details.
Q You don't even know the cause of death?
A I would have to look at the corner's report again. I provided that to the family, but I don't recall what it said.
Q Other than what the corner's report says, you have no other information or knowledge about his cause of death?

A No.
Q Okay.
And you've never talked to Amy Jones about any of this?
A No.
Q Because, Amy, she was just in the office with you before we started this deposition. You guys didn't talk about, you know, what this is about?
A No. That all -- we -- no.
Q Okay.
So I assume you don't know anything about what Amy Jones or Tyler Mattson or Jeff Gonyea or anybody else might have said to the paramedics or any other emergency responders?
A No.
Q Okay. And you've never talked to anybody about that?
A No.
Q Never talked to David's mom or his sister about their concerns, that they weren't given all of the information right away?
A If you'll -- if you have it and you look at my case note, I can read to you the last time I spoke with his mother, which was on the 24th. I can read that to you --
Q Sure.

A -- in its entirety. And this is dated 6/24/20.

It said I was contacted by Sharleen Robinson at 1530 this afternoon. She said she received the summary and was unaware that David had been in a behavior and that this was different information than she was originally told.

She stated she was originally told David had got up to use the restroom and was found on the ground. She said she did not know who told her that.

She stated she had received the EMS report, which was approximately seven pages long. She inquired as to whether I had obtained the coroner's report; and I had informed her the -- informed her I had and had -- and placed it in the mail to her.

Ms. Robinson also asked if staff are retrained after every incident. I informed her I do not know of an investigation taking place unless it involves a client on my case load. I notified Jennifer Berry, assistant superintendent, of our call.

At approximately 1535 today, I received a call from Christine Mcauliffe, David's sister, slash, advocate. She said she did not know if I had spoke with her mother yet but the summary provided by BHDC was not good enough.

She said the family was upset and there were things in the summary that did not make sense. She mentioned

the fact that David was vomiting with -- the Heimlich was also performed, did not make sense to her.

She seemed upset by the information that David was in a behavior. Christie said there were discrepancies between the EMS report and the BHDC summary. She requested we provide witness statements in details concerning the restraints used.

She said that, if BHDC could not provide this, they would seek other avenues to obtain the information. I informed her I would submit her request to administration.

I contacted Jeff Gonyea, superintendent, and relayed the information concerning my calls with the family. He instructed me to document the calls and make Jennifer Berry aware of our conversations.

Q Okay.

And what did you do after that phone -- I mean, how did you -- did you follow up on that? What was your next step then after having that interaction with them?

A I contacted the superintendent and told him I provided a copy of my case note.

Q Okay. And what did you tell him?

A That the fam -- what I just read in my case note. The family --

Q Okay. What was his response?

A I don't remember.
Q Okay. And what happened next? What did you hear about this concern next?
A I did not hear anything after that.
Q Okay. Is that the --
A Until I saw -- until I saw it in the newspaper, about the lawsuit.
Q I guess that makes me the other avenue, huh? I've been called worse. I promise.
Have you had any other communication, direct communication with Charlene, his mom, or Christie, his sister, since then?
A No. The only thing, it was -- I believe it was in Christmas of that year, his mom did send me a card, I don't have it anymore, to say, you know, thank you, I think David enjoyed working with you, thank you for working with him. You know, something just like that.
Q Did you enjoy working with David?
A Absolutely.
Q Okay. You seem like you did. You seem like a caring dude.
A Thank you.
Q We're really close to being done here.

[redacted]

[redacted]

Q Okay. Because you were part of his IPP so I guess you would -- you would have knowledge of anything in his IPP; correct?

A Yeah. I couldn't point it to you verbatim because --

Q Sure.

A -- (inaudible) like 30 pages long. But it's easily accessible.

[redacted]

Q Right. So you would learn about it because you're part of the IPP team, in other words?
A Yes.
[redacted]
Q Who's the best person to ask about that?
A I would think that the dorm supervisor would be the one to ask.
Q The who?
A The -- I'll lean in here. The dorm supervisor.
Q Okay. And that's a title I've not come across yet. What's a dorm supervisor?
A They're the supervisor over the direct care staff in the living areas.

That may be listed as an A-2 position. I'm not entirely sure what the technical -- I guess what I'm saying, dorm supervisor is probably more of an informal term.

But I believe, if I'm remembering correctly, that that's probably an A-2 position. But that would be the one that I would ask for that information.

Q Okay.

Caleb, what we're going to do now is we're going to take a five-minute break. And my associate and I are going to go through our notes and make sure we don't have anything else to follow up on; and then we're going to be done. So this is the end.

We're going to take a five-minute break, then we'll come back on and we'll either have one more question or wrap it up right then. Okay?

A Okay.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

THE WITNESS: Mr. Gillispie?

MR. GILLISPIE: Yeah.

THE WITNESS: I didn't leave the room and nobody came in. I was just thinking about your question and I was going to tell you, when I said dorm supervisor and you said that's not a term you've heard before, I believe the formal tile of that is RCSS, residential care shift supervisor.

MR. GILLISPIE: Okay. Like Amy Jones?

THE WITNESS: Yeah. I believe that's what that is. So I -- that just -- I was thinking about that and I remembered that was -- I

believe that's the correct title.

MR. GILLISPIE: Okay.

BY MR. GILLISPIE:

Q Mr. Murry, I just need to make sure I know what you have in front of you there.

A Okay.

Q What are those -- what all documents do you have in front of you there?

A Okay. This, incase I needed to write anything down. There's nothing about David on here. This is just my stuff that I need to get done for the day that I keep my --

Q Yeah, not that. I meant the stuff you've been referring to --

A Okay.

Q -- and helping you answer.

A I have his social history here. That's actually -- I'm sorry. That's -- it's his discharge summary. But it has all the information of his social history.

And I also have my case notes regarding David.

Q And the marks cards, are those part of your case notes?

A No, they are not. But they should be in -- but we -- no. No, they're not.

Q And wasn't there something else there you were

referring to in addition to your case notes?
A I said -- yes. I had a list of dates. I can -- it's shuffled in here. Let me get it real quick.
All right. Here it is. Yeah, a list of dates on when I had called Ms. Robinson to tell her about David having behaviors.
Q Okay. And is that a list or is it -- is there like a note for each notification you made?
A Yeah, I made a list.
Q Can you hold it up for me?
A Yes.
Q Okay.
MR. GILLISPIE: Eric, I just want to make sure I get all of that, all of those, and then all of his case notes and all of these marks cards.
MR. COLLINS: Yeah. I'm sure most of it is in the complete medical file which we received yesterday.
It's being Bates stamped now. I've got to review it one last time to make sure nothing's in that that shouldn't be produced; and I imagine it will be in the mail tomorrow.
MR. GILLISPIE: Okay.
MR. COLLINS: At the latest, it will be

Monday.

BY MR. GILLISPIE:

Q Caleb, are these things that would be in his case file?

A Yes.

Q They would be? None of this stuff is just yours?

A No, no.

Q Okay.

And I guess I cut you off before you could answer earlier, but about how many of those -- according to those records there, about how many times did you notify, did you have to notify her, his mom, about behavior incidents?

If it's going to take a real long time to figure that out, just don't worry about it. But, if you can quickly look through and give me an idea.

A Thirteen.

Q Okay.

And did you say that you did or did not know of other times that David had been transitioned or taken to the ground in a restraint?

A I would -- whenever -- I would always review the behavior reports. And that would be, you know, to keep up with the clients and see, you know, if there's anything unusual going on.

And I believe those would be -- you know, if restraints were used, they would be included in that.

But I don't have any -- I don't remember any details about that.

Q Okay. You don't remember any specific incidents whereby David was restrained on the ground?

A No.

Q But you believe it had happened in the past, you just can't recall the details?

A Yes.

Q Okay. And is that the kind of thing that, if it occurred on the ground, is that something that would be in the documents that you're referring to?

A Yes.

Q Okay.

And am I correct that his, I believe, his IPP, his -- and that stands for individual program plan? Is that right?

A Yes, sir.

Q And you're part of the team --

A Yes.

Q -- that develops his IPP; correct?

A Yes. And my main role there is to go -- review with the client and review with the family to see --

Q Okay.

A -- to be sure they're aware of their rights --
Q Okay.
A -- and to be sure that they -- you know, that I feel that he's still appropriately placed here, you know, and what his wishes and goals are and communicate with the family and see, you know, if -- what their wishes and goals are.

If they're wanting them to remain, if they're wanting them to transition to, you know, potentially a less restrictive environment, you know, move them out of the community.

Q And does this IPP indicate the types of restraints that are allowed to be used on David?
A No. I say -- I don't know. I don't believe so, but I -- I don't know for sure.
Q Okay.

Do you know of any document or any -- well, let me ask you this.

Are you aware of the types of restraints that are allowed to be utilized, that were allowed to be utilized, for David Cains at the time of his death?

Whether they be DDS category one, category two, category three, personal restraints, arm holding?

I mean, do you have any knowledge of what was allowed and what wasn't allowed? Because I know it's

different for every patient.
A Right. When you're asking about DDS category one, category three, I assume you're referring to his behavior treatment program. That, I don't know.
But I do believe that the restraints that would be allowed to be -- or interventions that were allowed to be used with David would be chemical, mechanical, or personal.
Q Okay. And is it your understanding that staff was authorized to transition or take David to the ground in a restraint if necessary?
A Yes.
Q Okay.
I think that's all I have.
Did you understand my questions, Mr. Murry?
A Yes.
Q Okay. Well, I appreciate you being here today.
MR. GILLISPIE: I'll pass the witness.
MR. COLLINS: I have no further questions.
I just ask that Mr. Murry be allowed to review the testimony and either make changes or document anything that may have been mistranscribed due to the nature of this deposition.
MR. GILLISPIE: Sure.

(WHEREUPON, the proceedings were concluded in the matter at 11:09 a.m.)

* * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Caleb Murry, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 11th day of March, 2022.

_____
CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

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Eric Collins
eric.collins@dhs.arkansas.gov

March 16, 2022

RE: CHRISTINE MCAULIFFE, ET AL v. THE ARKANSAS DEPT. OF HUMAN RESOURCES ET AL
3/3/2022, Caleb Murry (#5061142)

The above-referenced transcript is available for review.

Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.

The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at errata-tx@veritext.com.

Return completed errata within 30 days from receipt of testimony.

If the witness fails to do so within the time allotted, the transcript may be used as if signed.

Yours,

Veritext Legal Solutions

CHRISTINE MCAULIFFE, ET AL v. THE ARKANSAS DEPT. OF HUMAN RESOURCES ET AL

Caleb Murry (#5061142)

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Caleb Murry Date

CHRISTINE MCAULIFFE, ET AL v. THE ARKANSAS DEPT. OF HUMAN RESOURCES ET AL
Caleb Murry (#5061142)

ACKNOWLEDGEMENT OF DEPONENT

I, Caleb Murry, do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

_____ _____

Caleb Murry Date

*If notary is required

SUBSCRIBED AND SWORN TO BEFORE ME THIS

_____ DAY OF _____, 20___.

_____

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BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE McAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS, CLAIMANT,	
VS.	CLAIM NO. 220374
THE DEPARTMENT OF HUMAN SERVICES, RESPONDENT.	

Arkansas
State Claims Commission
FEB 16 2023
RECEIVED

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DEPOSITION

OF

CHRISTINE McAULIFFE

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FRIDAY, OCTOBER 28, 2022

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COURT REPORTER:

DONNA K. PETRE, CCR
P. O. Box 1027
Little Rock, Arkansas 72203

PETRE'S STENOGRAPH SERVICE

EXHIBIT
tabbies
16

A P E A R A N C E S:

ON BEHALF OF THE CLAIMANT:

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RICHARD N. ROSEN, ESQUIRE
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ALSO PRESENT:

JOHN SIMS, VIDEOGRAPHER

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The deposition of Christine McAuliffe was taken before me, Donna K. Petre, Certified Court Reporter within and for the County of Pulaski, State of Arkansas, duly commissioned and acting, on Friday, October 28, 2022, beginning at the hour of 9:30 a.m., at the Offices of Green and Gillispie, 1 Riverfront Place, Suite 605, North Little Rock, Pulaski County, Arkansas.

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THEREUPON, the following proceedings were had, to-wit:

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* * * * * *

P R O C E E D I N G S

* * * * * *

WHEREUPON,

MR. ROSEN: All right. Let's go on the record.

VIDEOGRAPHER: We're on the record at 9:30 a.m. Today is October 28th, 2022. The video deposition of Christine McAuliffe in the matter of McAuliffe and Cains versus Arkansas Department of Human Services, Claim Number 220374, before the Claims Commission in the State of Arkansas.

Will counsel please make a record of your appearance?

MR. ROSEN: My name is Rich Rosen for the Department.

MR. GILLISPIE: My name is Joshua Gillispie on behalf of the Claimant.

VIDEOGRAPHER: Thank you. Will the reporter please swear the witness?

(WHEREUPON, the witness was duly sworn.)

COURT REPORTER: She's sworn.

VIDEOGRAPHER: You may proceed.

MR. ROSEN: Thank you.

WHEREUPON,

CHRISTINE McAULIFFE,

having been called for examination, and having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. ROSEN:

Q All right. You know my name. My name, as you heard, is Rich Rosen. I'm with the Arkansas Department of Human Services, and I'll be taking your deposition today. You've been sworn in, and I'm going to be asking you a series of questions. If you don't understand the question, please just let me know and I'll try to reword it. If you answer the question, I'm going to assume you understood the question. If you would, I'm going to ask you to officially state your name.

A Christine McAuliffe.

Q Christine, Ms. McAuliffe. And we're here today for the taking of your deposition in the matter before the Claims Commission. And this is a Notice of Deposition that I'm going to introduce into this case, and I'm going to show your counsel. Is that a deposition -- is that your name on the deposition?

A Yes.

MR. ROSEN: I'm going to introduce that as DHS Exhibit Number One.

(WHEREUPON, DHS Exhibit Number One was marked for identification.)

BY MR. ROSEN:

Q Now, Ms. McAuliffe, tell me your -- where do you live?

A I live in Clinton, Vermont.

Q How long have you lived in Vermont?

A Since 2016.

COURT REPORTER: I can barely hear her.

BY MR. ROSEN:

Q Can you speak up a little bit?

A Sure. Since 2016.

Q Okay. And before you lived in Vermont, where did you live?

A Russellville, Arkansas.

Q So, you moved to Vermont in 2016?

A Yes.

Q Okay. And you've lived there ever since?

A Yes.

Q Okay. And what is your educational background?

A I graduated from Russellville High School, and I attended Arkansas Tech University.

Q Okay. Did you graduate?

A I have one class left actually to get my Bachelors.

Q Okay. And what -- are you employed?

A Yes.
Q And where are you employed?
A I'm a member of a Labor Union. So, I do construction work, I work for different contractors.
Q Okay. So, freelance?
A I mean, it's not freelance, but when you're in a Labor Union you get sent out to different contractors.
Q So, you work for the Union?
A Yes, I work for the Union.
Q I understand. And how long have you been doing that?
A Since 2008.
Q So, you've been doing it the whole time you've been in living in Vermont since 2016; right?
A Correct.
Q And you did it here in Arkansas before that?
A Yes.
Q Okay. And what type of work do you do for the Labor Union?
A Mainly I work the nuclear power plants. I also just recently started working in new construction. But most of my career has been working on maintenance shutdowns and the nuclear plant shutdowns for different types of work.

Q Okay. And what type of duties would you do?
A Laborers have lots of duties, but mainly I would work with scaffold builders, I would get their material. We do anything from digging ditches to cleaning bathrooms to paperwork to logging decontamination work. There's a big array of what laborers do.
Q Okay. And what was your -- when you worked here in, I guess, from 2008 until you moved to Vermont in '16, what were your hours? Let me ask it this way. Was it a shift or did you work just hours? Tell me about that.
A So, I worked at Arkansas Nuclear One, but I also traveled to other nuclear plants. So, normally when they're shut down for maintenance, they're shut down anywhere from two weeks to four to six weeks. So, you're working seven days a week, six or seven, 12 hours a day.
Q Okay. So, you didn't have a shift, so to speak, at your home, you would be sent to -- if you didn't work here in Arkansas, you would be sent to other states?
A Yes.
Q Okay. And between 2008 and 2016, how often would you be sent to other states?
A I mean, it would depend on the year, but I would say I would go to maybe two or three other states in a year.

Q Okay. And when you went to the other states, it was for several weeks?
A Yes.
Q And you would stay there and then come back?
A Yes.
Q Okay. And when you worked here in Arkansas during that time period, would you work a regular shift or would you stay at the plant for a couple of weeks and then come home?
A Sometimes my time at Arkansas Nuclear One, I was there full-time, so I would work a regular -- we always worked 12-hour shifts, almost always. But when they would shut down for maintenance, regular work during the year was a regular shift, 40 hours a week. But when they shut down for maintenance, it was seven days a week, 12-hour shifts. But sometimes they would give us a day off.
Q Oh, I guess you would be pretty tired after that?
A Yeah.
Q Okay. What was your relationship to David Cains?
A He was my older brother.
Q And when was he born? What is his birthday, do you know?
A [redacted]
Q And when were you born?

A [redacted]
Q So, there was a three-year difference?
A Three years, yes.
Q Okay. And you're the claimant in this claim, are you not?
A Yes.
Q And you're also the personal representative of the estate of David Cains; correct?
A Correct.
Q And do you have any -- who is your mother?
A Charlene Robinson.
Q And is she one of the -- well, strike that question. Was she the legal guardian of David Cains?
A Yes.
Q And what time periods was she the legal guardian?
A I wouldn't be able to answer that. I mean, she was the guardian when we were kids, and she was the guardian when he passed away.
Q All right. And do you have any siblings, or step or half-siblings?
A I have an older sister who is a step-sister.
Q What's her name?
A Her name is Shelly Keith Canulla.
Q Can you spell that last name?
A I'll try. She just got married. C-A-N-U-L-L-A.

Q Okay. What was her maiden name?
A Keith.
Q And where did she live?
A She lives in New York.
Q New York State or New York City?
A New York State. She just moved there, so I can't remember -- she lives in upstate New York.
Q Do you know what town?
A I believe Rochester, but I don't know that for a fact.
Q I take it you're not very close with her?
A We talk, but I mean --
Q Okay. And do you have any other siblings or half-siblings or step-siblings?
A My brother and I have a half-sister named Sarah Ashley Cains. She is younger than us.
Q When was she born?
A She was born [redacted]
Q Okay. And where does she live?
A She lives in Gulfport, Mississippi.
Q Are you close with her?
A Yes.
Q Are there any other siblings, step-siblings, half-siblings?
A No.

Q Do you know -- well, when David Cains passed away in June of 2020, do you know what his weight was?
A I believe it was around 250 pounds.
Q Do you know how tall he was?
A He was about 6'2".
Q So, he was a big guy?
A Yes.
Q Okay. Do you know -- and so, he was residing at the Booneville Human Development Center; right?
A Yes.

[redacted]

Q So, you had mentioned there's about a three-year difference between your age and his age, and about a seven-year, I guess, with Ashley?
A Eight years.
Q Eight years with Ashley?

A Yes.
Q Okay. So, there came a point in time when he -- well, strike that question. Did y'all grow up together in the same house?
A Me and my brother did, and since my sister has a different mother, she was around us, but she wasn't with us full-time.
Q Did she live there at all?
A Yes.
Q And where was that?
A That was in Pottsville, Arkansas.
Q And that's where you and David grew up?
A Yes. I mean, between my mother lived -- my parents were divorced. My mother lived in Russellville, my father lived in Pottsville, and we went back and forth.
Q Okay. So, when your -- what year did your parents divorce?
A I don't know. It was, I believe it was maybe 1982. It was when I was little.
Q Okay. So, from the time that -- before they were divorced, did you live with David Cains?
A Yes.
Q Okay. And how -- and so, if they got divorced -- if your parents got divorced in 1982, you were two years old, approximately; is that right?

A Two, yes.
Q Okay. So, you don't really remember that part?
A No.
Q Okay. Kind of young?
A Yes.
Q Okay. So, then, when they got divorced, which house did you go with, your father or with your mother?
A Well, from what -- my parents still lived together after they were divorced for a few years. And I don't know that he -- obviously I was a child, but -- so, we lived with both of them. At some point, my mother moved out, and we lived with her, my brother and I lived with my mom.
Q And do you know when, about what time that was, what year?
A I would say maybe when I was four or five. I mean, I remember that. So, I guess that I was four or five.
Q Okay. So, for another two years or so?
A Yes, yes.
Q Okay. And then, your mother moved out, even though they were already divorced, and you went with your mother?
A Yes.
Q Did David Cains go with your mother?
A Yes.

Q And how long did you live with -- you and David live with your mother?
A I would like to say three or four years. I believe until I was eight. If I'm remembering correctly, I was eight or nine.
Q Okay. And then, what happened?
A And then, we moved in with my father.
Q You and David Cains moved in with your father?
A Yes.
Q Okay. And approximately what year was that?
A I would like to say 1988, '89.
Q Okay. Where did -- at that time, where did your father live?
A Pottsville, Arkansas.
Q And what county is that? I don't know.
A That's Pope County.
Q Okay. And then, how long did you live with -- did you and David Cains live together with your father?
A Until 1991.
Q And then, you moved somewhere else?
A My father passed away.
Q Okay. And so, you moved with your mother?
A No. I moved in with my aunt and uncle.
Q Oh. Who are they? What's their names?
A Ron Cains, and his wife at the time, Lori Cains.

Q Okay. Where did they live?
A They lived in Germany.
Q Oh, you moved to Germany?
A I did.
Q Okay.
A My uncle was in the Army.
Q All right. And so, you went with your uncle and not with your mother?
A Yes. Because my -- there were details -- my father was murdered, so me and my brother were there, we witnessed it. So, after his death, I was sent off for my protection, and from my recollection, so was my brother.
Q Where did your brother, David Cains, go? Hold on one second.

COURT REPORTER: Wait, I'm sorry.

MR. ROSEN: We're off the record.

(WHEREUPON, a brief discussion was held off the record.)

BY MR. ROSEN:
Q All right. So, where did your -- I'm sorry. So, where did your -- in 1991 when you went to Germany, where did your brother go?
A I don't know where he went immediately after. I know that he was not with my mother. I believe he went into Friendship Community Care into an alternate housing

placement.
Q And how old was he at that time?
A He was 14 and I was 11.
Q And so, your mom didn't take him?
A No. They -- me and my brother, because we were both witnesses, it's my memory that for our own safety, we got sent to different places for our own protection. So, that's why neither one of us were living with my mom, because --
Q Okay. Well, was where you went to live secret?
A Yes.
Q So, how long did you live in Germany after that?
A I lived there for, I believe -- my uncle was still stationed there for another year, and I lived with him. And then, we moved to Louisiana. He was transferred.
Q Okay. And so, did you ever live with David Cains again?
A Not full-time, no.
Q Well, you mean part-time you did?
A I mean, he would come home on the weekends, on holidays, but --
Q Okay. But he never lived there, he would visit?
A Yes.
Q Okay. That's what you mean?
A Yes.

Q Okay. So, just to make the record clear, after 1991, you never lived with David Cains again?
A Correct.
Q And how old were you then?
A I was 11.
Q And he was 14?
A Fourteen.
Q Fourteen; right?
A (Indicated yes.)
Q Sorry, I didn't mean to talk over you, and she -- because this lady has to get everything down. And so, when you lived -- did you ever testify in a court?
A Yes.
Q Okay. And when was that?
A That was in May of 1992.
Q Okay. So, it wasn't -- that was public; right?
A The trial?
Q Yes.
A I don't understand.
Q Yes. The trial, when you testified, that was public?
A Yes, yes.
Q Okay. So, did -- after 2000 -- or excuse me. In 1991, or before 1991, do you recall any behavioral problems with David Cains?

A No.
Q After 1991, or during 1991 and thereafter, were there any behavioral problems with David Cains?
A After 1991? Just for -- I don't understand.
Q Well, okay. Let me reword it. So, in 1991, from what you're telling me, David -- when your father died, David did not go to live with your mother, he went to live somewhere else?
A Correct.
Q And tell me, again, do you know where that -- who that somewhere else is?
A He went into a placement, and I believe his first placement was with a lady named [redacted]
Q Okay. So, he went to live with another family?
A Yes.
Q Okay. And they cared for him?
A Yes.
Q Okay. But he didn't go to live with your mom. And he was only 14 at the time; right?
A Yes.
Q Okay. Was it she couldn't care for him?
A Because my father was just murdered, and me and my brother were both witnesses, and it was for our safety. So, they didn't allow either of us -- the local authorities didn't want me or my brother being with

family that was nearby, because they were afraid for our safety.

Q And so, what authorities told you this?

A That was -- I mean, I was 11 at the time. My mother and my grandfather, her father, handled most of it. But I spoke -- that was at the time Sheriff Jay Winters.

Q Okay. So, Sheriff who?

A Jay Winters.

Q Of Pope County?

A Pope County; correct.

Q And what was your grandfather's name?

A John Riley.

Q And so, we know that you never lived with David Cains again, except for when he came to visit; right?

A Correct.

Q After 1991, did your mother ever live with David Cains again?

A No.

Q Okay. So, in 1991, do you recall any aggression or behavioral issues associated with David Cains' behavior?

A I know my brother dealt with -- he was hyper, but not -- I don't recall any behavior issues.

Q Did he ever threaten you?

A No.

Q Did he ever hurt you?
A No.
Q What about your friends?
A No.
Q Now, so, you mentioned that David Cains -- let's start again. That he went to live with the [redacted] another family, in 1991; right?
A Yes, yes.
Q And did they live in Pope County?
A From what I recall, yes.
Q Okay. And how long did he live with them?
A This will just be a guess. But from my memory, I believe maybe four or five years.
Q Okay. And during that four or five years, did you ever go visit David?
A Yes. Actually I spent a lot of time with the Greens. I would spend the night with them. They -- you know, so Davie would come home on the weekends. I actually hung out with them a lot to spend time with my brother.
Q Okay. But explain to me -- if you spent time with him in Pope County for the four or five years after 1991, you were in Germany for a year, and then you went to Louisiana; right?
A I was in Germany for a year, and then I was in

Louisiana for a very short time, and then I came back to Arkansas.

Q Okay. So, when you were in Germany, did you visit David Cains at all?

A No, nobody was allowed to know I was there.

Q Okay. So, when you returned to -- when you went to Louisiana, did you visit David Cains at all?

A I believe I was only in Louisiana for maybe a couple of months.

Q Okay. And when you came back, did you visit David Cains when he was at the Greens' home?

A Yes, yes.

Q Okay. So, it wasn't a secret, then, anymore at that point in time?

A After the -- no, after the trial, it wasn't a secret anymore.

Q Okay. And did you ever spend the night over at the [redacted] house?

A Yes.

Q Okay. Tell me about their house.

A I mean, they lived in different places through those years. They had a house, they had an apartment. At some point, my brother transitioned from living with [redacted]

[redacted]

Q Okay. And were the [redacted] -- are they family members?
A No.
Q Are they good friends of the family?
A No.
Q Did you know them before David went to live with them?
A No.
Q Okay. So, after the [redacted] -- you said that he lived there four or five years, then where did he go?
A I believe he was in like an interim placement for maybe a couple of weeks. But he ended up going to live with [redacted].
Q I'm sorry. What was their last name?
A [redacted]
Q
A Yes.
Q Okay. And where was that?
A That was in Russellville.
Q Okay. And are they family members?
A No.
Q Were they close friends?
A No.
Q Did you know them before they went to live with -- before David went to live with them?

A No.
Q Okay. So, it was just another family?
A Yes.
Q Okay. And so, in about what year was that?
A I mean, this would just be a guess. I would guess maybe around 1996, '97.
Q Okay.
A I mean, I was in high school. So, like I said, that's a guess, an estimate.
Q Okay. And so, where did the [redacted] live?
A They had a house in Russellville.
Q Okay. Did they live -- how long did -- how long was David with the [redacted]?
A He was there until 2007.
Q Okay. And lived with them for 2007 -- until 2007?
A Correct.
Q And they took care of him?
A Correct.
Q Okay. And did you ever visit him at the [redacted] house?
A Yes.
Q Okay. In Pope County?
A Yes.
Q Okay. Tell me about their house.
A I mean, I don't remember a lot about their house. I

mean, when I would go over there, like I would hang out with my brother in his bedroom. I mean, we would listen to music. And what do you mean, their house?

Q And well, I mean, did they -- was it in Russellville, was it in a rural area, was it an apartment?

A The house I remember was in town, yes.

Q Okay. And did you spend the night there?

A I don't believe I ever spent the night with the Robertsons, no.

Q [redacted]

A [redacted]

Q Okay. And so, he lived with them there until 2007?

A Well, at some point they moved to the Fayetteville area.

Q Oh.

A But he lived with them, just not in that house.

Q Okay. So, they all moved to Fayetteville, Arkansas?

A Or that area, yes.

Q Yes, it's in northwest Arkansas?

A Yes.

Q About when was that?

A If I had to guess, an estimate, I believe it was around when I graduated high school. So, around '98, '99.

Q So, in '98 or '99 David would have been approximately 17 or 18 years old?
A No. He would have been 21, 22.
Q What year was he born?
A 1977.
Q Oh, 1977. I'm sorry. But from 1991 when he moved out of your mom's house until this date, that had been -- that was about how many years?
A From 1991 until when?
Q Until he moved to northwest Arkansas?
A I would say seven or eight years.
Q Okay. Now, tell me about the Roberts' home in northwest Arkansas. Did you ever go there, first of all?
A Yes, we went there a lot.
Q Okay. How often?
A We would go up there to pick Davie up to bring him back to Russellville for his birthday, holidays, for just random visits, and then we would also go up there just to visit him. So --
Q Did you ever spend the night there?
A No, I never spent the night there.
Q Tell me about their home in northwest Arkansas.
MR. GILLISPIE: Object to the form.
BY MR. ROSEN:
Q Go ahead.

A It was a house in town, like in a neighborhood. They always had a lot of dogs and they had some older children.

Q Did you ever -- okay. Did the [redacted] live in other homes or areas?

A At some point, they moved from that neighborhood to somewhere farther out in the country.

Q Okay.

A But it was still in northwest Arkansas.

Q Did you visit them there?

A I did.

Q Okay. So, you would go to pick up David Cains and to hang out in his room?

A Yes.

Q Okay.

A Or, I mean, we would take Davie into town, just to visit him, you know.

Q So, when you would go up there, tell me about -- this would be a day visit; right?

A I'm sorry?

Q You didn't spend the night there, did you?

A No.

Q So, it was during the day?

A It was either a day visit or we were going there to pick him up and bring him back to Russellville.

Q Okay. And when you would pick him up and bring him back to Russellville, was there ever any incidents or behavioral problems that you encountered?
A I mean, he dealt with, you know, behaviors.
Q Tell me about them.
A Like he would get anxious, sometimes he would cry, he would get upset. Yeah, you know, he dealt with those types of things.
Q Did he ever become violent?
A No.
Q Aggressive?
A I mean, he would get agitated.
Q Tell me what that means.
A Like he might raise his voice, he might start cussing or crying.
Q Did he ever threaten violence?
A No.
Q Did he ever spit or scream?
A He was known to spit sometimes when he was upset and he would yell, yes.
Q Did you ever notice that he would vomit at times?
A When he was upset, or just in general?
Q Anytime?
A Yeah. I mean, his whole life he dealt -- you know,

[redacted]

Q So, he would vomit often?

A I wouldn't say that he vomited often, no.

Q Okay. So, you've taken us to the point where the Roberts' moved in, I guess, in the country, in a rural area?

A Yes.

Q Do you remember when -- what year that was?

A I do not remember.

Q And did there come a point in time where he stopped living with the [redacted]

A Yes.

Q When was that?

A That was in 2007.

Q And why?

[redacted]

[redacted]

MR. GILLISPIE: Object to the form.

THE WITNESS: Yes.

BY MR. ROSEN:

Q Okay. And how often, right before that happened, did you visit?

MR. GILLISPIE: Object to the form.

THE WITNESS: I mean, it would be -- what do you mean, right before, would you rephrase, could you repeat that?

BY MR. ROSEN:

Q So, approximately, do you remember what year and month that he left the [redacted] home?

A I know it was 2007. I believe it was around February. I don't know that for a fact.

Q Well, let's talk about the, say, several months before --

A Okay.

Q -- that happened, before he left. Did you visit David?

A Yes. We visited him and he came home to Russellville.

Q Okay. And was there anything unusual or that you

noticed about him, about his behaviors, his appearance, his health?
A I remember at the time they were, you know, changing up some of his medicine and he was a little more withdrawn than normal.
Q And you had gone to the -- in that month period you had gone to the [redacted] home?
A I mean, I would say, I don't know if it was a month prior, but I would say definitely in the six-months prior, in that time period, yes, I had been to see my brother.
Q Okay. About how many times?
A I mean, it would be a guess. I would say two, maybe.
Q And during those maybe one or two times during that six months prior to -- and we're talking about early 2007 when he left the [redacted] home. Did you notice anything unusual about th[redacted] home?
A Nothing about their home, no.
Q Did you notice anything unusual about David Cains's health or appearance?
A I do remember that at the end they -- the last house that I was at, I believe, was not that last house they had lived in. So, the very last house, there -- I have to -- I'm trying to remember. Towards the end of him

living with the [redacted] I believe they moved and I don't believe I was at that house. The last house I remember, I don't remember anything different to either.

Q And so, approximately when did they move?

A I don't remember that. I just remember it was towards the end, because that was part of the issue, that the provider that they worked for, they didn't communicate with us about, you know, their whereabouts, about Davie.

Q Okay. And so, are you -- so, what happened to David Cains' -- so, there came a -- strike that question. So, there came a point in time in early -- sometime in early 2007 that David Cains left the [redacted] home; is that right?

A Yes.

Q Where did he go?

A He was taken to Booneville Human Development Center.

Q And why did he leave the [redacted] home?

A [redacted]

Q [redacted]

A [redacted]

Q [redacted]

[redacted]

A [redacted]

Q [redacted]

MR. GILLISPIE: Object to the form.

THE WITNESS: From what I recall.

BY MR. ROSEN:

Q [redacted]

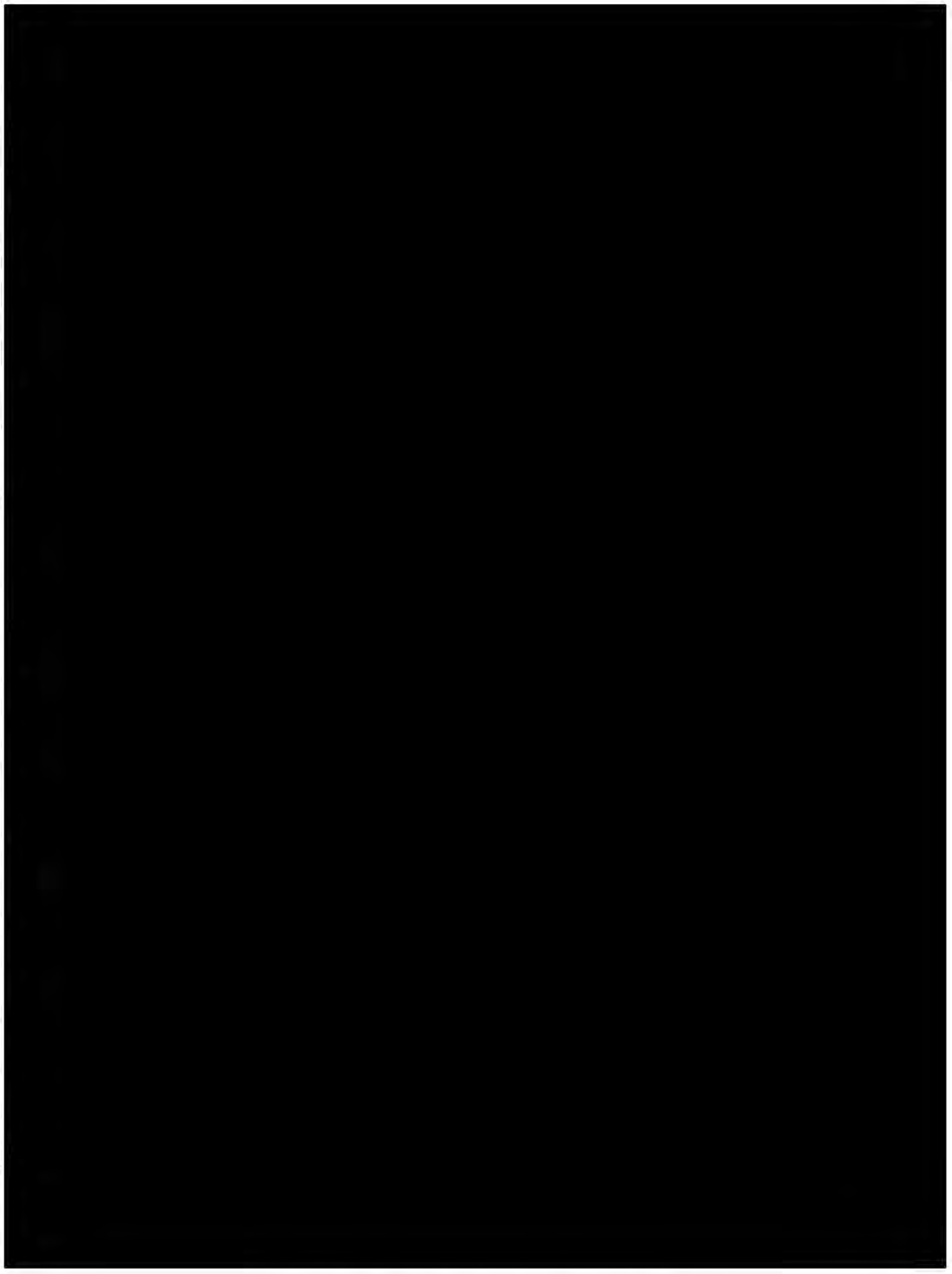
Q Tell me what -- okay. Tell me what your --

MR. GILLISPIE: Please let her finish her answer before you ask the next question.

MR. ROSEN: Yes. There was a pause. I'm sorry.

BY MR. ROSEN:

[redacted]



[redacted]

Q Okay. But you never went to the last house that he lived in; right?

A Not that I recall.

[redacted]

[redacted]

MR. GILLISPIE: Object to the form.

THE WITNESS: He was placed -- on an emergency basis, he was placed at Booneville Human Development Center.

BY MR. ROSEN:

Q Okay. And did you ever say, "Well, I'll take him in my home"?

A There was a discussion, because I had never heard of the HDC. But I remember, you know, talking with my mom, because when that happened, when he arrived there, I remember it being pretty hectic trying to figure out, "Okay. You know, what actually is going on," and it was -- since it was considered an emergency situation at the time he was there, but we didn't have an option, from what I recall, because --

[redacted]

[redacted]

Q Okay. Well, what I'm asking is, did you step forward and say, "Hey, I'll take David Cains. He can come live at my house"?

A I mean, there, through the years, especially when I got older, I always talked about what was best for him, and if that was ever a possibility.

Q And what did you find was best for him?

A I felt like once he came to the HDC and he started living there, they -- from the way it was set up, you know, I felt at that time that was good for him, because my brother was very social and outgoing, and it was like a little college campus. And I felt like that place had everything that, you know, that he deserved, you know, his own -- his independence and a job and his own friends.

Q Okay. But -- and just go back to my question. So, we're talking about in 2000 -- early 2007.

A Yes.

Q [redacted]

[redacted]

A That -- for me, that was always a conversation. But what it came down to was, you know, I worked two, three jobs. My brother needed 24-hour care. I mean, ideally, I would have loved to have done that. I love my brother, we had a good relationship, and I felt like, you know, in theory, I could have provided him a safe home. I mean, I could have provided him a safe home. But I worked multiple jobs, and since my mom -- and my brother needed 24-hour care, I wasn't capable of giving him 24-hour care.

Q Okay. So, the answer is "no", for those reasons?

A Yes, for those reasons.

Q Okay. And he also, at that time -- I think you mentioned that your mom couldn't take him, either; right?

A Correct.

Q Okay. What about your -- the other siblings, Ashley, was she able to take him?

A No.

Q Okay. And she didn't step forward and take him, or offer, did she?

A My -- our little sister, Ashley?

Q Yes.
A No.
Q Okay. And the other sibling -- and I can't remember her name right now.
A Shelly.
[redacted]
Q And why is that?
A Well, I call her my sister. She was. My father was married to her mother for maybe a year. So, she lived with us for, you know, a year or two. I continued to have a relationship with her, I talked to her now and then. But, you know, she had her own life and, you know, she wasn't as involved with us.
Q When David Cains came -- when I guess the [redacted] relationship, when he was removed from that in early 2007, did you know anything about him forcing himself to vomit?
A No.

Q Did you know anything about him throwing rocks?
A Not rocks. I've known my brother to throw things, but not rocks.
Q What type of things?
A I mean, if he was having a behavior, he may pick up, you know, something that was close to him.
Q Such as?
A Such as anything that was close to him. A piece of clothing, a cup, and whatever might have been near him.
Q Are you aware that he has also in the past been said that he threw a fire extinguisher at people?
A I am not aware of that.
Q Okay. Now, let's go back to 2007, because that's what we're talking about. Are you aware in 2007 that he took off his belt and threw it at people?
A Not that specific incident, no.
Q And during that time period, did you ever witness him to have emotional behavioral outbursts?
A I mean, he dealt with, yeah, behavioral outbursts and --
Q Tell me about that. This is back in 2007.
A In 2007? After he had come to the HDC?
Q No. Before.
A Oh, before. I mean, my brother --
MR. GILLISPIE: Object to the form, that's

been asked and answered. Go ahead.

THE WITNESS: For a while,I mean, he dealt with behaviors for a long time. So, he would get upset, we didn't know why, he would start cussing. Sometimes he would spit, but not very -- it wasn't like every time.

BY MR. ROSEN:

Q And he would throw things?

A He would throw things that were near him. He was -- yeah. And his behaviors generally lasted a short period of time. And immediately after, he would always start crying and apologize.

Q And he wasn't like that all the time, was he?

A No, he didn't have behaviors all the time, no.

Q Just but periodically?

A Periodically, yes.

Q And would he ever try to swat at people?

A He had a tendency, yeah, to swing his arms when he had a behavior, yes.

Q Now, there came a point in time, I think you had mentioned that your mother -- your mother is Charlene Robinson; right?

A Correct.

Q Okay. And she became the legal guardian of David; correct?

A Yes.
Q And do you know when that was?
A I do not know. I believe when he -- there was -- I don't know the circumstances, but she had to go to court when he came to the HDC to get guardianship, either again, or I don't know the details of that.
Q But to your -- and I think you mentioned earlier that you had discussed about his placement at the HDC and how good it was --
MR. GILLISPIE: Object to the form.
BY MR. ROSEN:
Q -- and how he needed that, I think your --
A He needed 24-hour care, yes.
Q Okay. And at that time, you felt that the HDC was a good placement for him; right?
A Yes.
Q Because you were working jobs, your mom was working?
A Yes.
Q Okay. Now, so, did the family -- so, the family was good with the placement at the Booneville Human Development Center?
A At that time, yes.
Q Okay. Now -- hold on one second, okay? Now, there came a point in time when David passed away.
A Yes.

Q What day was that?
A June 13th, 2020.
Q And where did you live at that time?
A I lived in Vermont.
Q Okay. And someone told you that this happened?
A My uncle called me the day that it happened.
Q And your uncle, what's his name?
A My Uncle Patrick Riley.
Q And where does he live?
A He lives in London, Arkansas.
Q Where is that?
A Right next to -- it's right next to Russellville.
Q Okay. And he was your mom's brother?
A Correct.
Q And I'm sorry. What was his name again?
A Patrick Riley.
Q Okay. And did you come back to Arkansas?
A In general, or --
Q I mean, right after -- after you heard the news, did you return?
A Oh, yes. I flew in as soon as I could get a flight.
Q Okay. And did there -- there came a point in time when you filed this particular lawsuit, which we call a claim --
A Yes.

Q -- in the Claims Commission; right?
A Correct.
Q Okay. And according to the documents, it was filed in October of 2021. Is that your recollection, approximately?
A Yes.
Q Okay. The Complaint is many pages long, and makes several allegations in there. Did you review this Complaint before it was filed?
A I read the Complaint.
Q Okay. And I'm going to show you what we're going to mark as DHS Exhibit Two.

(WHEREUPON, DHS Exhibit Number Two was marked for identification.)

BY MR. ROSEN:
Q And it's -- there aren't any page numbers on it, but it's the Claim Submission Signature Page of the claim and the Complaint without the exhibits, which are numerous pages. I'll ask if you can identify that?
A (Witness reviews document.)
Q Is that your signature on the front page?
A (No response.)
Q And I'm going to point, if I may approach. This under that says "Claimant Signature". Is that yours?
A (No response.)

Q And you seem to have a little difficulty recognizing it. So, let me ask it this way. Do you recognize that signature?
A Where?
Q Claimant Signature?
A I mean, I --
Q And if it's not yours it's okay. I just want to know whether that's yours or not.
A I don't recognize the initials. I know I signed something.
Q Okay. Let me see it again. So, we're going to mark this as Exhibit -- I think it has already been marked as Exhibit Number Two. Do you recognize this as the Complaint?
A Yes. I received this and I read it.
Q Okay. But you're not -- you're saying that where it says "Claimant Signature" that's not your signature?
MR. GILLISPIE: Are you asking her where I signed?
MR. ROSEN: Okay.
BY MR. ROSEN:
Q Oh, okay. So, is that your signature or not your signature?
A I mean, that doesn't look like CM, no.
Q Okay. All right. But you did review this with your

counsel before it was filed; right?
A My counsel provided me those documents.
Q Okay. Did you go over it with your counsel?
A I mean, we went over what --
MR. GILLISPIE: Objection, I object. Don't answer that. It's privileged.
BY MR. ROSEN:
Q I'm not asking about what you said, I just want to know whether you went over it with your counsel?
A Yes.
Q Okay. Now, so, you're familiar with the allegations that are in this Complaint? And I'll give you the Complaint, it's in front of you, so you can review it if you want to, because I'm going to ask you about a few things in it.
A Okay. (Witness reviews document.)
Q So, did you -- you did review it with counsel; right?
A I did review this claim, yes.
Q Okay. Now, I want to refer you to paragraph seven of the Complaint. And the Complaint doesn't have page numbers on it, it just has paragraph numbers. So, it's on -- really on the second page, second page of the Complaint, paragraph seven. Keep that one. And I'll let you read it for a second.

A (Witness reviews document.) You mean that's labeled number seven under "Factual Background"?
Q Yes.
A Okay.
Q And I'm going to ask you about the last line in that. You see where it says, "And the residents have access to limited recreation and a cafeteria for meals"? Do you see that?
A Yes.
Q In reality, Booneville Human Development Center has full access to a range of recreational activities, do they not?
A I'm not aware of all their recreational activities.
Q Well, would you call their recreational activities limited, as you did in this Complaint, or would you say that they're broader than limited?
MR. GILLISPIE: Objection. Object to the form.
THE WITNESS: I mean, I don't know what -- I would say they had some recreation.
BY MR. ROSEN:
Q Okay. Tell me about the types of recreation -- well, you went -- did you go visit David at the --
A Oh, yes, all the time.
Q Okay. So, tell me about the recreation activities

they had.
A I mean, I wouldn't know about all of them, because my brother -- I don't believe he involved himself in a lot of recreation. I remember in the beginning he would -- we would take him into town to go see a movie, and I know they had a pool. But other than that, I can't think of what other recreation activities they would have.
Q Did you see -- when you went to visit him, what would he be doing during the day?
A Well, he had a job that he would go to, he had a life skills class. And most of the time he was in his room watching TV, listening to music, could be talking to other residents.
Q Socializing?
A Socializing, yes.
Q Okay. Activities?
A Well, activities like watching his own TV and listening to music, yes.
Q Did they ever go on field trips?
A The only time I remember him leaving was every now and then he would go to see a movie in town.
Q Okay. Well, that would be a recreational activity, would it not?
A Yes.

Q Okay. Now, did he also have educational activities?
A I don't know of any educational activities.
Q Did he have vocational activities?
A He had a job, if that's what you're referring to as vocational.
Q Yes. So, what did he do?
A I know they had a recycling center where he would say he tore books where I believe they made things out of recycled paper.

MR. GILLISPIE: I'm sorry. Is it hot? I'm sorry. Is it too hot in here for anybody?

MR. ROSEN: I'm okay, but you can adjust it if you would like.

THE WITNESS: Would I be able to use the bathroom?

MR. ROSEN: Yes.

THE WITNESS: Okay.

VIDEOGRAPHER: We're off the record at 10:20.

(WHEREUPON, a break was taken.)

VIDEOGRAPHER: We're back on the record at 10:28.

BY MR. ROSEN:
Q Okay. During the break, did you talk to anybody about my questions to you?

A No.
Q Now, we were -- let's pick up where we left off. Well, actually, let's change the pace a little bit. When David Cains was at the Booneville Human Development Center, did he have any favorite staff members that cared for him?
A Oh, yeah.
Q Who would that be?
A Let's see. Probably his favorite was a lady named Audra DeLay.
Q Okay. And what did she do?
A I believe she was one of his bosses at his work when -- where he tore books and stuff.
Q Oh, okay. So, he liked his work?
A I don't know. I mean, he wasn't -- I don't know if he liked it. He liked the social aspect of it, you know. And he really liked Audra.
Q Did he like going to work or did he not like going to work?
A Well, it depended on the day, you know, like most people.
Q Okay. And what time period, was this at the end, at the beginning, in the middle of while he stayed at the Booneville Human Development Center?
MR. GILLISPIE: Object to the form.

THE WITNESS: What?
BY MR. ROSEN:
Q That he liked this person?
A I believe she was there --
MR. ROSEN: Hold on.
COURT REPORTER: I'm sorry.
BY MR. ROSEN:
Q Let's go on.
A I believe she was there for the majority of the time, if not for the entire time that he was there. I don't know if she was in that capacity as his boss. But I mean, it has been years that he has known her.
Q Okay.
A And talked about her.
Q What about anybody else?
A There was a lady in the beginning when he first arrived. Her name was Vickie, I believe, Bradford. I can't remember her last name. And maybe the first couple of years he really liked her.
Q Was there anybody that you got to know?
A Yeah. I got to know Vickie pretty well, and his last case manager, Caleb Murray, I felt like, you know, I talked to him frequently, and I had a good relationship with him.
Q Okay. And I think in Booneville Human Development

Center, they are different cottages or houses; is that right?
A Well, they have like a dorm style. They have a couple of buildings, and they call them the dorms, and that's exactly what they look like. And I believe -- I don't know about now, but they used to have like cottage style also.
Q Okay. So, where did David live? Did he live in a cottage or a dorm?
A He lived in a dorm.
Q Okay. And did it have a name?
A Davidson House.
Q Okay. And was it -- was it a single floor, more than one floor?
A There were at least -- there were two floors for residents. And I don't know if there was a basement or anything, but I know there were two floors.
Q Okay. And which floor did he live on?
A When he first arrived there, he was on the second floor up until, I believe, around 2012, when they moved him. There was an incident with another resident, and they moved him to the first floor.
Q Incident, what, between him and another resident?
A He was actually -- he was attacked by another resident, and they -- that resident ended up, from what

we were told, being removed from the facility, and they moved Davie to the first floor.

Q And your mother was the legal guardian of David Cains during the whole time that he was at the Human Development Center; right?

A Yes.

Q Okay. And as -- you're the claimant here. Is it your understanding that at any time the legal guardian could have removed -- voluntarily just removed or withdrawn David from the Human Development Center?

A Yes, I understand that.

Q Okay. And you would agree with that statement?

A Yes.

Q But neither you nor mom or any other family member chose to remove him, did they?

A No.

Q And we'll come back to the document that's in front of you, but I want to kind of move on to something. David -- do you know what an Individual Program Plan is, or IPP?

A Yes.

Q And what is it?

A It's a plan that they would do at that facility yearly that included all kinds of things about his living situation, about his -- how to respond to behaviors, his

medical needs, his things that work -- just like the class, things that they wanted him to work on. It encompassed a large amount of things.
Q Okay. And it was basically his Treatment Plan; right?
A Yes, yes.
Q And it includes medical and behavioral and social and recreational activities?
A Yes.
Q And, in fact, you participated in at least one of them, did you not?
A Yes.
Q Did you participate in more than one?
A Yes.
Q Okay. What years did you participate, do you recall?
A The last one was 2019. I couldn't tell you -- I was there in person for another one, and I couldn't you what year that was.
Q Okay. But in 2019, which -- the 2019 Individual Program Plan, or IPP, you did participate in?
A Yes.
Q Okay. And your mom participated in it; correct?
A Correct.
Q As a matter of fact, it's a team effort; right?

A Correct.
Q Okay. And there's discussions; right?
A Correct.
Q And there's reports given, written or oral reports; right?
A Yes.
Q Okay. About what his needs -- what David's needs were, or are at that time, about what his health conditions were, about what his Treatment Plans were, about his behaviors, as well; right?
A Yes.
Q Okay. And in the Treatment Plan, everybody signed off on it and agreed that this Treatment Plan was appropriate; correct?
A Correct.
Q Okay. Including you?
A Correct.
Q Including your mom?
A Correct.
Q And when I say "your mom" I mean as legal guardian.
A Yes.
Q Okay. So, whatever -- in that Treatment Plan, everybody agreed that was the appropriate plan for that year?
A What was in that Treatment Plan, yes.

Q And that Treatment Plan was, I think, from approximately May of '19 through -- until the new Treatment Plan was coming up in June, I think?
A It would have been -- they told me it would have been for about 11 to 12 months.
Q Yes.
A For the year.
Q Let's talk about that for a minute. Okay. I'm going to show you -- first of all, I'm going to show this to you and ask if you can identify that. Is that the Treatment Plan for 2019? And I want to note that it's Bates marked, stamped CM001453 through CM001544. Does that appear to be the Treatment Plan?
A That looks like it. Yes.
Q Okay. We're going to have this identified and marked as Exhibit Three, okay?

MR. ROSEN: And if you want to give me a sticker, I'll put it on this one.

(WHEREUPON, DHS Exhibit Number Three was marked for identification.)

BY MR. ROSEN:
Q Okay. Now, on -- I'll ask you to turn to page five of the plan, which is Bates stamped 1350 -- excuse me -- which is Bates stamped -- let me see what it is.

MR. GILLISPIE: 1459?

MR. ROSEN: 1450 -- yes, thank you. 1459.
BY MR. ROSEN:
Q It mentions, "David's Sister, Chrissie Cains" -- that's you; correct?
A I'm -- that was my maiden name.
Q At the top.
A Yes, at the time.
Q Okay. "And his Mother/Guardian, Charlene Robinson, attended his Annual Review and an IPP will be sent to them for approval"; correct?
A Correct.
Q Okay. And y'all -- I think we've already established that y'all did approve it?
A Yes.
Q Okay. And if you look on page -- page two, which is Bates stamped 1455, your name, your signature is on there, as is your mom's; is that correct?
A Correct.
Q Okay. I'll move on. So, I'm going to ask you to turn to page four of this document, which is Bates stamped 1459 at the bottom. It starts out in 1991.
A (Witness reviews document.)
Q Do you see that part?
A Yes.
Q And says -- it talks about your father's death. And

it says, "David began having problems after this and subsequently his mother sought assistance through [redacted] in Russellville as she was unable to handle him alone." Do you see that?

A Yes.

Q Okay. Now, tell me about your recollection about that. Does that change anything you've said today?

A No.

Q Okay. So, in this document, which you approved, it says that your mom wasn't able to handle him alone.

A Yes, that's what it says.

Q Okay. Do you agree with that or do you disagree with that now?

A I agree, exactly what I said before, my brother needed 24-hour care, and my mom wasn't able to provide that to him.

Q Okay. All right. Now, you're aware that David had some behavioral issues while he was at the Human Development Center; right?

A Yes.

Q Okay. And what's your understanding what those behavioral issues were while he was at the Human Development Center?

A My understanding is that they were -- he would get upset, he would yell, he might cuss, he would spit

sometimes, he was known to pick something up that was near him and throw it, he was known to, you know, swing his arms out, he would get -- you know, you didn't always know why, you know, but he would get upset. And he was known to do those types of things.

Q Okay. And you're aware that he -- because of that, there were certain behavioral management techniques that were required to manage those behavioral outbursts when that happened; right?

A Well, I understood that they were allowed to. I don't know if they were required. But I mean, they were allowed to be used.

Q But you understand that -- did David ever hurt himself?

A Not that I can recall.

Q Okay. Did David ever break things?

A He has broken things, yes.

Q Such as what?

A I mean, like his own things, he has broken his radio a few times.

Q TV?

A I do believe he did break his TV.

Q Glass?

A I'm trying to think of, I mean, if he ever broke glass. I do recall his TV and his radio.

Q Okay. And I'm going to -- I'm going to show you -- reference, ask you to look at page six of the IPP for 2019, which is Bates stamped 1463, and the bottom paragraph.
A (Witness complies.)
Q And if you could read, starting with, "David has demonstrated".
A Read to myself or out loud?
Q No. Out loud, because I want to ask you some questions about it.
A "David has demonstrated a history of the following behaviors: physical aggression, noncompliance, destroying personal belongings (TVs, radios, DVD players; etc.) breaking windows, shaving inappropriately causing skin irritations on his face and he appears to display aggression at times when his blood sugar becomes low."
Q Would you agree with that statement?
A Yes, I would agree with that.
Q In fact, because of his behaviors and breaking things, where was his TV in his room placed?
A It was hung on the wall.
Q Okay. And it was anchored to the wall?
A Yes.
Q And there was a plexiglass screen in front of it; right?

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A Yes.
Q And why was that?
A I believe it was after he had broken his TV when they did that.
Q It was to keep him from breaking it again; right?
A Correct.
Q Okay. And how many times did he destroy his DVD player and radio and TV?
A I'm only aware of one time when he broke his TV. And I think maybe he broke a couple of radios. I'm not aware of the DVD player.
Q Okay. Now, when you -- during this time he was at the HDC when you would go to visit him, with him there, would you go alone or would you go with other people?
A Most of the time I would go alone. Sometimes me and my mom would go together. But, yeah, the majority I would be alone.
Q Okay. And so, when you went there, what would you do?
A Normally I would pick him up around lunchtime and I would take him out to lunch somewhere in town, in Booneville. Sometimes I might drive -- you know, we might go to Fort Smith or the next town. But generally it was in Booneville. And after we ate lunch, which was always a -- you know, he had very -- he had a routine,

and the KFC or McDonald's, we would go to Wal-Mart after that where he would pick something out, a hat, a DVD, a t-shirt. Sometimes we would go to Dollar General, and we would always go to Sonic and get a shake. And then, we would usually drive around and just talk and listen usually to the Monkees.

Q Okay. And so, how long would the visit take?

A I mean, it varied. But anywhere from two hours to five. I mean, I would say on average two or three hours.

Q Okay. And how often would you do this?

A Between me, my mom, and my uncle, we tried to go monthly.

Q Okay.

A Like one of us would go up there.

Q One would go up per month?

A Yes.

Q Okay. So, it would be a couple months -- as part of the rotation --

A Right.

Q -- you would see him maybe this month, and then maybe in about three or four months, because your uncle would come, your mom would come in the other months?

A Well, we -- I mean, it's not like we did that. We didn't have an actual rotation. But, yes, we did rotate. But it would just depend on our schedule. But I

personally tried to always see him within two to three months, always.
Q And what about your mom?
A Same, the same.
Q And is it Uncle Patrick?
A Uncle Patrick, yes.
Q Tell me, are you aware of any incidents that Uncle Patrick had with David Cains at McDonald's one time?
A Yes.
Q Tell me about that.
A I know my uncle went up there to -- normally he would just bring food to the dorm, but he took him off-campus and they went to McDonald's. And from what I recall, Davie got upset, for whatever reason, I don't know, agitated, and he had a cup of soda and he threw it at my uncle.
Q Okay. And that was right in the McDonald's?
A That was inside, yes.
Q And there were other customers there?
A I don't know if there were other customers there.
Q Do you know what happened next?
A I know that at some point my uncle called the HDC and asked if they would come down and get him.
Q And they did, didn't they?
A They did, yes.

Q Your uncle didn't bring him back, did he?
A No. Not that day, no.
Q There was an incident, your uncle called, and the HDC came and got him?
A Yes.



Q Okay. And tell me what your understanding is of that.
A Of the chemical?
Q Yes. What does that mean to you, emergency chemical intervention?
A From what it was explained to me is that meant if he

was, you know, extremely anxious or upset and they couldn't calm him down, that they were allowed to give him medication to help calm him down.

Q And what is your understanding as to when emergency behavior management procedures or holds would be allowed to protect David from himself and to protect others? When would that be allowed?

A Could you ask that again?

Q Okay. Sure. On page -- of the IPP, on page 1471, it states that the -- among other things, that the

[redacted]

MR. GILLISPIE: Where is that on here?

MR. ROSEN: On the top of the page, page ten.

MR. GILLISPIE: 1471, you said?

MR. ROSEN: Yes. Up at the very top. It continues from the page before, but -- or the two pages before.

BY MR. ROSEN:

Q So, what's your understanding as to behavior, as to when an intervention would be allowed when David was a danger to himself or to others?

A I mean, it was explained to me that in the case that someone felt that they were going -- that David was going

to severely harm himself or someone else, that they would, per the physician, I understood that it was a nurse or physician had to authorize it.

Q Okay. Does it say that in here, for emergency?

MR. GILLISPIE: Object to the form.

THE WITNESS: It said -- what you just read?

MR. ROSEN: Yes.

THE WITNESS: "Center emergency procedures", yes, it does say that.

BY MR. ROSEN:

Q Okay. It says "emergency". It doesn't say anything about a physician; right?

A No. I said, that's what was explained to me.

Q Now, you're aware that -- do you know what dysphagia is?

A I believe it has to do with choking. I don't have -- I don't know the definition.

Q Well, let's talk about choking. You're aware in here that each year they do a choking risk assessment; correct?

A Correct.

Q Each year?

A Yes.

[redacted]

[redacted]

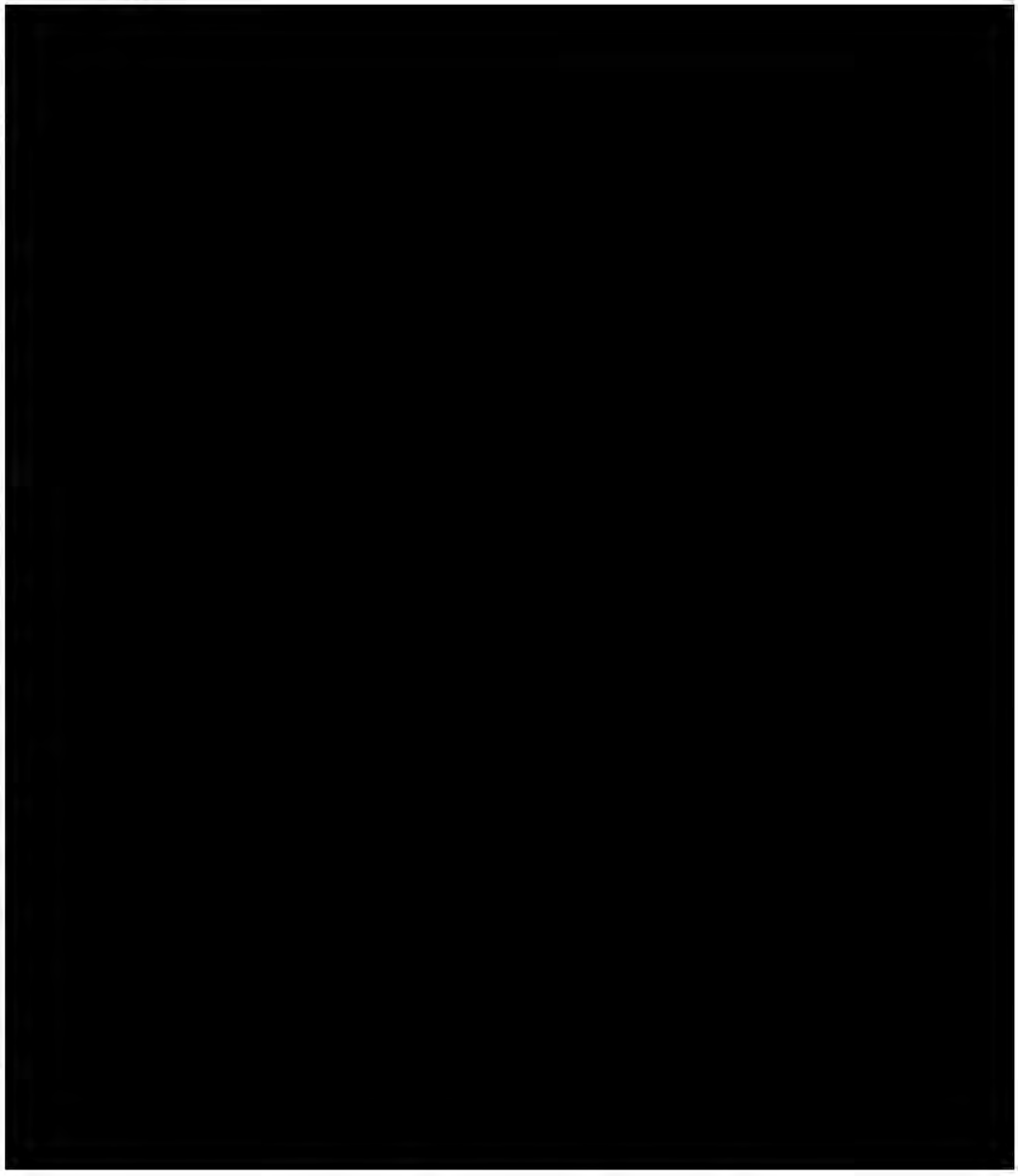
[redacted]

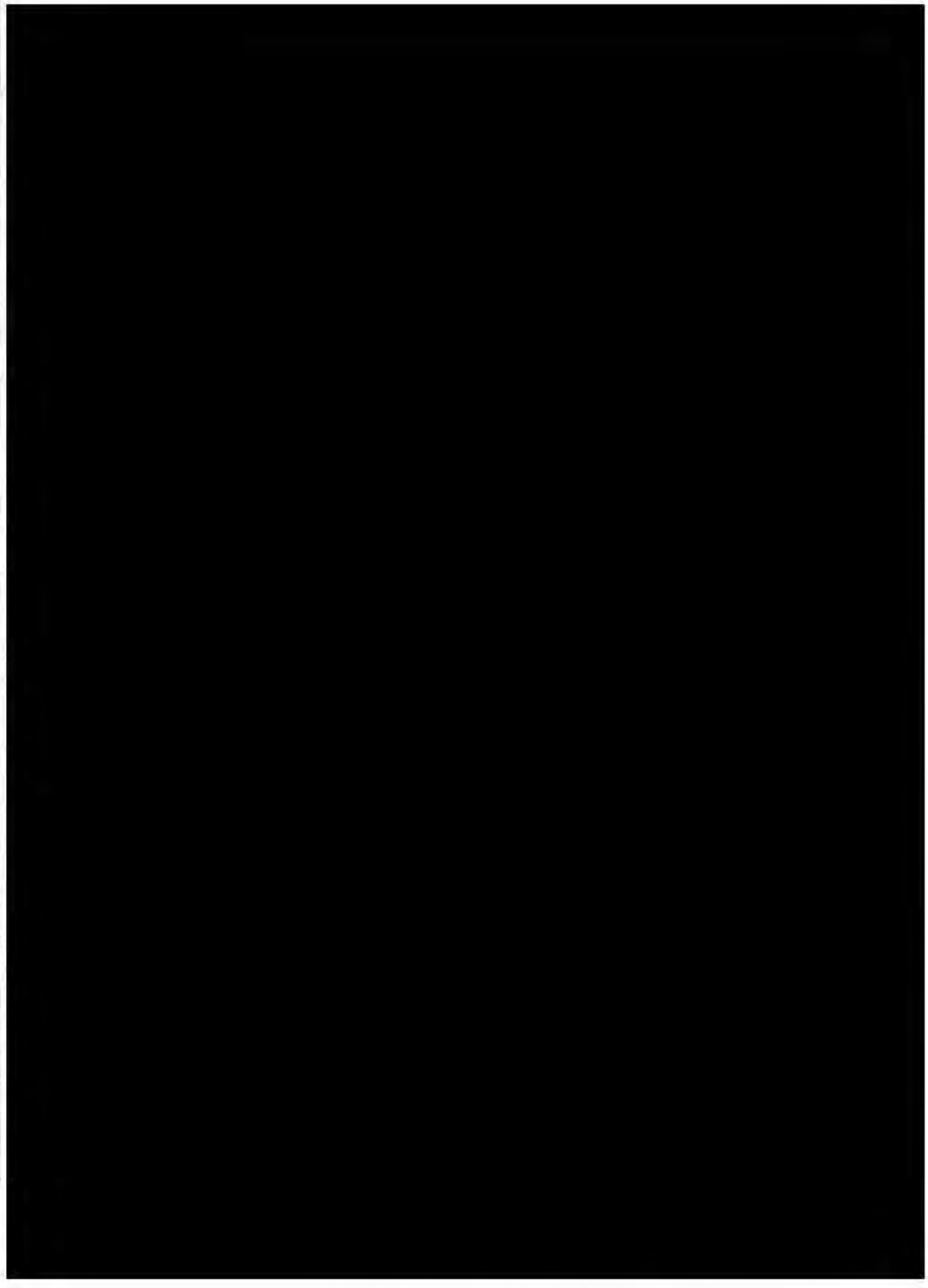
Q Okay. So, you would agree with that?
A Yes.
Q And your recollection since you attended some of these in -- well, even when you -- strike that question. Even when you didn't attend and participate as you did in this 2019 report, were you made aware of the findings here and the recommendations in the years prior?
A Yes.

[redacted]

Q Now, I'm going to ask you to turn to page Bates stamped 1525 of the 2019 IPP. And again we're talking about Exhibit Three.
A (Witness complies.)
Q Okay. Do you see that, it says "Medications"?

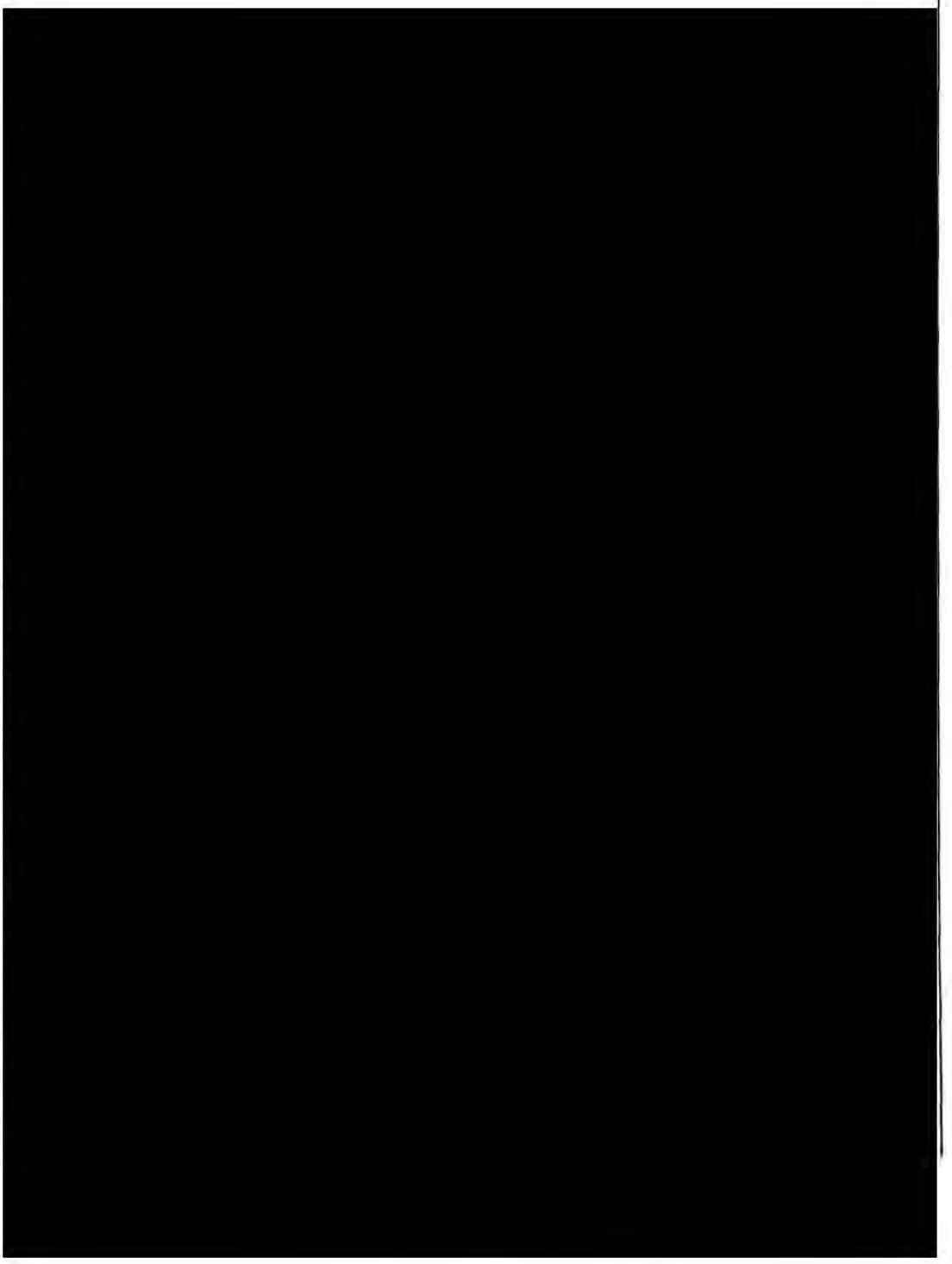
A Yes.
Q Okay. And there's a whole long list of medications on there; right?
A Yes.

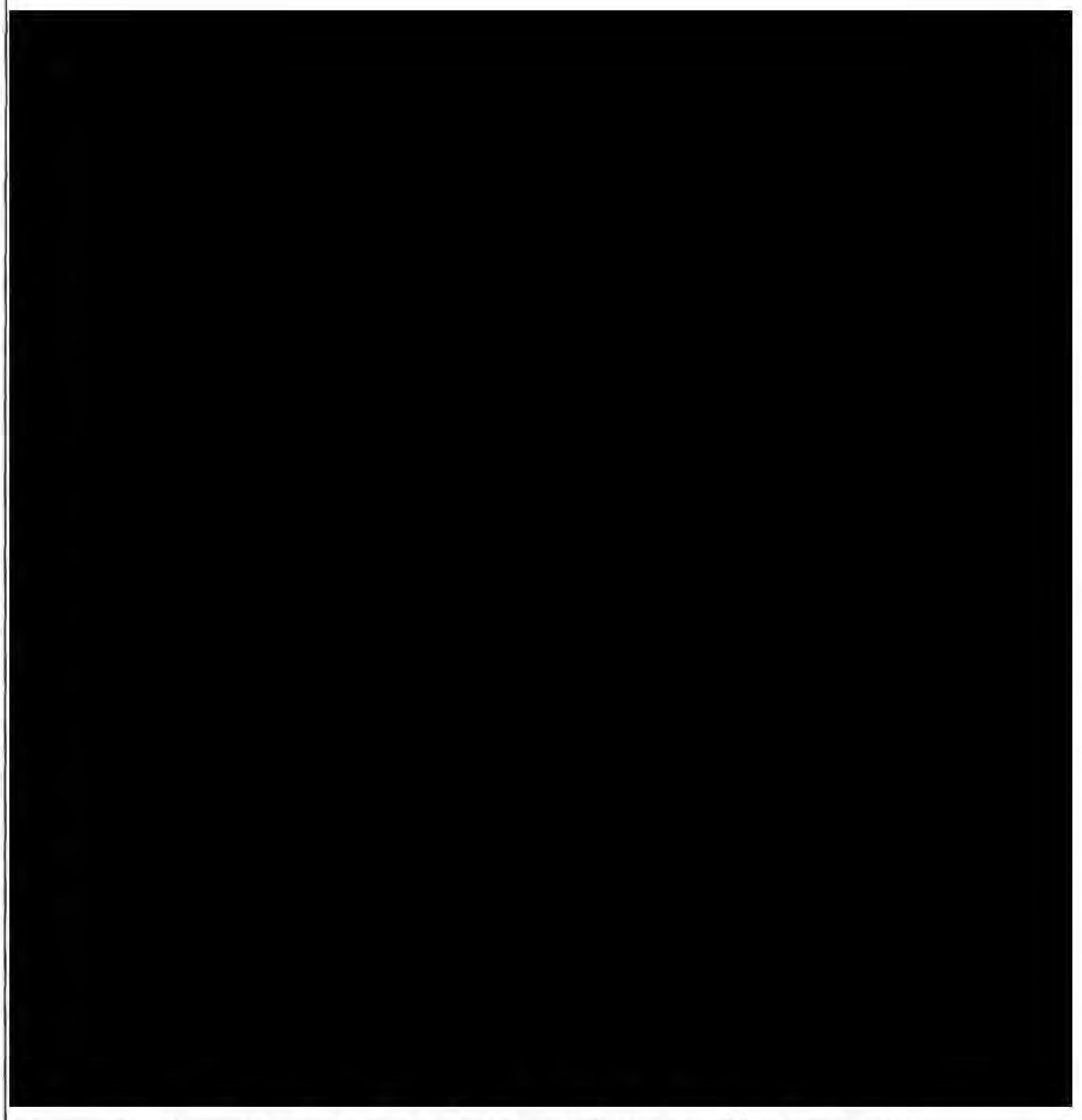




A Yeah, according to this, yes.
Q Okay. And he had been for at least a couple of years before this, or do you know that?
A Well, I knew he dealt with it, yeah. I mean, I didn't know about every, you know, single medication, but I knew that he dealt with that, yes.

[redacted]





Q Okay. Now, so, and I'm going to direct your attention to this exhibit, the IPP from 2019, and particularly page 14 -- Bates stamped page 1483, which on the document itself, is page 16.

MR. GILLISPIE: 1483?

MR. ROSEN: Correct.

BY MR. ROSEN:

[redacted]

Q Okay. That's what is in the care plan; correct?

A Correct.

MR. GILLISPIE: Object to the form. Object, object to the form of that question.

MR. ROSEN: All right. I think we are done with that. Hand it to the Court Reporter so she can keep track of them.

BY MR. ROSEN:

Q Okay. Now, going back to the Complaint, which was marked as Exhibit Number Two, and it's in front of you, I'm going to direct your attention to paragraph eight. Do you see at the beginning line, it says -- in paragraph eight, you state that, "The BHDC has a," quote, "checkered past", unquote? Do you see that?

A Yes.

Q Yet during that time period, the family, including the court-appointed guardian, voluntarily elected to keep David Cains at the Booneville Human Development Center; did it not?

MR. GILLISPIE: Object to the form.

THE WITNESS: I was made aware of some of their checkered past, as it's quoted right here, by my -- when I -- after my brother's death when I started looking into advocacy groups and people who would help me when I felt like my brother was killed and I was lied to. So, I became aware of investigations that I was never made aware of while he was living there.

BY MR. ROSEN:

Q But you didn't see -- when you went the many times that you testified when you went to visit David, you didn't see any of that at the Booneville Human Development Center, did you?

MR. GILLISPIE: Object to the form, object to the form.

THE WITNESS: See what?

BY MR. ROSEN:

Q Any of this, what you call -- and we'll get into what, if anything, that was quote "checkered past", unquote. Did you see that with your own eyes?

A No, I didn't personally see the things that I learned of later, no.

Q And so, your -- you cited in this Complaint somebody else's conclusions, did you not, not what you witnessed

with your own eyes?
A Things that I had witnessed personally, and I brought this up to my brother's case manager, is the amount of restraints he had and maybe, you know, what were alternatives, you know. So, I had brought up with Caleb Murray, when I was made aware, when I would go over. And in this particular IPP meeting, we talked about his number of restraints the previous year and behavior incidents.

So, later, me and Caleb Murray had a discussion about that, and my concerns about him being, you know, restrained too many times.
Q Okay. But you understand that the restraints for his sake -- were for his sake and for the safety of other people; correct?
A I understand that that's the way that they are trained to make that decision.
Q Okay. And so, even though you had -- you said -- you say now you had concerns, you didn't express them in this IPP or at the meeting; did you?

MR. GILLISPIE: Object, object to the form.

THE WITNESS: I did express them to Caleb Murray, yes.

BY MR. ROSEN:
Q In the meeting?

A His case manager, we actually -- we did talk about it, because that was something that everyone at the table, you know, that was one thing they discussed was -- because they looked at numbers from the previous year, and they did bring up his amount of behavior events and restraints had risen from the previous year.

And I did talk about that at the table, because everyone as a whole talked about why -- if anybody thought that, made their opinions, and what may have been causing that, or it was really just a discussion out loud acknowledging that and being aware of that moving forward.

Q Okay. And so, when you had this discuss -- first of all, the group, including you and the legal court-appointed guardian, all agreed to continue the restraint policy that was in effect; correct?

A We agreed to continue the restraint policy as it was explained to us by Caleb Murray.

Q Okay. And you were aware that there were -- that David Cains, due to his behavior, had to be restrained numerous times the year before; correct?

A I was -- I understood that those restraints were used. I don't know if they had to be, but that was part of the discussion.

Q Well, do you know that they didn't have to be? Are

you saying that?
A I'm saying that I had a discussion with Caleb Murray about it was my concern for my brother that we needed to figure out, you know, why we thought he was having so many behaviors, because as his sister and being protective over him, of course, I didn't like the idea of him being physically restrained.
So, I had a conversation with Caleb Murray about, "Okay. We have talked about, you know, previously different techniques, and we specifically talked about that the staff could use de-escalation tactics and how they were working on redirection, and they were actually working with my brother to learn how to calm himself down."
Q Okay. And as a matter of fact, on the day that your brother died, they had -- right before the incident that we'll get into, he had been calming down; correct? There was de-escalation in process?
A From what I remember of the witness statements, I remember reading that Tyler Murray spoke with him.
Q Okay. Are you -- do you know whether David Cains --
A I'm sorry. Tyler Mattson. I'm sorry.
Q Okay. Are you -- do you know whether Tyler Mattson -- well, excuse me. Do you know whether David Cains was sitting in a chair to calm down right before

this happened, the outburst?
A I remember -- I mean, I read that.
Q Okay. Would that be a -- would calming in a chair be a de-escalation technique?
A I would think that if you are sitting down and you are talking to someone, that would -- that might, depending on what you are saying to them and where you are standing. You know, if you're standing over them, next to them, below them.
Q So, when David Cains was sitting in the chair calming down, do you know what happened next?
MR. GILLISPIE: Objection, object to the form.
MR. ROSEN: I don't know what the form is wrong.
BY MR. ROSEN:
Q But what, if anything, do you know -- do you know if anything happened then?
A I know what I read in Tyler's original statement, and I know what I read --
MR. GILLISPIE: The form is, she never said he was sitting and calming down. She didn't say that.
BY MR. ROSEN:
Q Are you saying that your brother was not calmed

down?
A I wasn't there.
Q Okay. So, you don't know one way or another?
A I wasn't there. All I know is what I've read by the people who were there.
Q And so, what you read was that David was in the dining room and was getting agitated and they took him to the bathroom, and then they -- when he came out of the bathroom, he sat down in the chair to calm down?
A I read that that's what Tyler said, yes.
Q Okay. Do you have any evidence that that didn't happen?
A All is know is what I read by the statement of the person who was there.
Q Okay. I'm asking you whether you have any evidence that that didn't happen.
A I mean, there's no video footage.
Q Okay. I'm not asking that. I'm asking you, do you have any evidence or information that did not happen?
A I have evidence of what the persons who was there, what they said. That's the only evidence I have, is what the persons who was there, what they wrote down and what they stated had happened.
Q Okay. So, would it be safe to say, would you agree, then, that you have no evidence that that's not the way

it was?

MR. GILLISPIE: Object to the form.

BY MR. ROSEN:

Q It's very simple. I'm just trying to ask you --

A I mean, I feel like I've answered your question.

Q Well, not -- you haven't directly answered my question. And the question is, do you have any evidence that what Tyler Mattson said about the calming --

A What do you mean by "evidence", physical --

Q Let me -- let me ask my question, okay?

A I'm sorry. Yes.

Q I'm saying, do you disagree that your brother -- that the de-escalation techniques were utilized right before the outburst?

A Do I disagree?

Q Yes.

A So --

Q Do you agree that they were used or do you disagree that they were used?

MR. GILLISPIE: Form.

BY MR. ROSEN:

Q Or you don't know?

MR. GILLISPIE: Form.

BY MR. ROSEN:

Q Go ahead.

A I know that I read that Tyler, in his statement, said he talked to him and tried to calm him down. Yes, I do -- that's what I read.
Q Okay. I understand that's what you read.
A Okay.
Q I'm asking whether you agree or disagree with that statement?
MR. GILLISPIE: Form, asked and answered.
MR. ROSEN: She hasn't answered it yet.
THE WITNESS: I feel like I have. I mean, I wasn't there.
BY MR. ROSEN:
Q Do you agree -- okay. So --
A So, I only -- sorry.
MR. GILLISPIE: She's agreeing that was the statement.
MR. ROSEN: Okay. And I'm not asking whether she's agreeing that's the statement.
BY MR. ROSEN:
Q I'm asking whether you agree factually that that happened, do you disagree that factually that happened, or do you not know whether that happened?
A Well, I don't know if that happened. I wasn't there.
Q Okay. All right. So, you have -- in other words,

you don't have any information that it didn't happen?
A I don't have any -- no, I would say I don't have information that that didn't happen, except what I have read from Tyler, from between the deposition and the statement, his story changed and it wasn't consistent. So, it gives me questions if that happened. That's my opinion. But I don't know.
Q Okay. So, are you saying that his story, whatever that is, and you're talking about his statement to investigators, that he at some point in time said that de-escalation techniques were not used?
A I'm saying, from my own -- by me reading Tyler's witness statement and his deposition, his story about details changed. So, that makes me question what really happened if his own story changed.
Q What changed in his story?
A In my opinion, from what I read, there's a discrepancy of how my brother -- how they ended up on the ground, if Davie fell on his own, if he landed face first, if his face hit the ground, if my brother charged at him, if he initially hit him. I feel like what I read, there's multiple discrepancies.
Q Okay. Well, that's what I want to talk about, what you read and what discrepancies you're describing right now. So, let me -- I want to write it down. So, tell

me, what's the first discrepancy that you're referring to?
A I question how my brother ended up on the ground initially.
Q Well, that's not a discrepancy, that's just a question you have, what the facts were --
A Well, so, there's a discrepancy because he can't say how it happened. He doesn't, from what I recall reading, he doesn't know if they tripped each other up. In one he said, "Oh, Davie fell to the ground, I fell with him, we tripped each other up." And then he said -- he himself said, "I don't know."
Q So, the first one is, you're not sure whether they toppled over or whether they fell over?
A I don't know if Tyler purposely took him to the ground, I don't know if he fell, if they toppled.
Q Well, do you have any -- what do you mean by "took him to the ground"? What do you mean by that?
A I mean, physically used a technique to take my brother to the ground himself.
Q Okay. And do you have -- so, let me tell you -- you weren't there; right?
A No, I wasn't there.
Q Okay. So, tell me what facts, what documents, what evidence do you have to show that he was, quote, "taken

to the ground", unquote?
A The evidence that I've seen, the only thing I have to go by is by Tyler Mattson's own statement.
Q Okay. Did Tyler's own statement say he "took him to the ground", unquote?
A No, he didn't use those words.
Q So, then, in other words, you don't have -- what you're saying is, you don't have any factual support for what you are saying, that he may have been taken to the ground?
A No. I feel I do have support. Because --
Q Tell me what support, because I'm going to write it down. I want to --
A I feel my support is that his own story that he -- his own story changed.
Q Okay. Well, that's what we're kind of talking about, because I'm writing down here what changed. And I want to make sure that I understand what you're saying, okay?
A I'm saying that I have read --
Q Okay. So, first of all, the first is whether he was taken to the ground or they toppled to the ground; right?
A Yes.
Q That's the first one.
A Yes.

Q And you're saying that in Tyler Mattson's statement that you read that he was taken to the ground, or did you not read that from Tyler Mattson?
A No. I question that because of what I did read.
Q Okay. So, these aren't -- so, whether he was taken -- you are questioning whether he was taken to the ground, but you don't have any evidence to show that he was taken to the ground. Is that what you're saying?
A I'm saying I don't -- I'm asking that because of his own statements to me that don't seem to match up. So, that is my question.
Q Okay. And the statements that don't seem to match up is that they fell over versus they tripped and fell over?
A Well, first Davie fell to the ground, they tripped over each other, they fell together.
Q Okay. And so, you think those are discrepancies?
A I personally do, yes.
Q Okay. And what's the significance of -- even if they are discrepancies, which I'm not --
A What's the significance?
Q Yes.
A My brother is dead, that's the significance.
Q Well, but how they got to the ground, well, how is that significant?

A It's my understanding that they're not allowed to do that.
Q Okay. And if they were not allowed to do -- well, you authorized mechanical restraints in your IPP?
MR. GILLISPIE: Object to the form, object to the form.
BY MR. ROSEN:
Q Did you not?
A This was not a mechanical restraint.
Q But mechanical restraints are on the ground, are they not?
A We --
Q Yes or no?
A Mechanical restraints are on the ground?
Q Yes. So --
A But that's with a physical -- with a board. That's not taking a person to the ground and restraining them.
Q Okay. So, I want to --
MR. GILLISPIE: Let her finish her answer.
BY MR. ROSEN:
Q Are you finished?
MR. GILLISPIE: She wasn't finished.
MR. ROSEN: I don't know how you would know that, but --
THE WITNESS: It's my under --

MR. GILLISPIE: Because she was still talking.

BY MR. ROSEN:

Q Okay.

A My understanding is that a mechanical restraint involves a papoose board or a smaller type of board. And from everything I've read, there wasn't one there, they didn't intend to do that.

Q Okay.

A So, it was explained to me that they -- there was never -- this is what was explained to me. They were allowed, which we authorized personal restraint. Caleb Murray explained to me because I asked, a personal restraint was holding one or both arms to the side of the body. And I was explained -- I didn't know what a papoose board was when my brother first arrived there.

I was explained that that was a board where they would restrain him physically with a mechanical -- you know, a physical strap of some type of restraint on the ground. I was never told that they are allowed to take him physically to the ground just for the sake of holding them on the ground.

Q Okay. So, let's talk about that. And that's -- I just want to know -- I understand that you have your story and your positions, and you're entitled to that,

okay? I just want to know --

MR. GILLISPIE: Have it be exactly the facts, the truth.

BY MR. ROSEN:

Q I just want to know the facts upon which those opinions are based.

A I want to know the facts, too.

Q All right. Well, that's why I'm asking you. This is your deposition, and you've made allegations in this lawsuit, and I -- that's what I'm asking about. So, we were talking about the discrepancies that you believe are in Tyler Mattson's statements about whether they fell to the ground or were taken to the ground.

And I want to know, basically, what facts you're relying upon, facts, not your opinions, not -- I want to know what facts so I can write them down as to what you're relying upon when you say that he was, quote, "taken to the ground", unquote.

A I feel like I've answered that, but I'll answer it again. I feel like, by reading the statements of the staff who initiated this, that because of the discrepancies that I read, I feel that those are discrepancies, whether you can call it opinion or fact, but when a story appears to change, that's a discrepancy. So, I feel like, by reading Tyler Mattson's witness

statement and deposition, that he can't pinpoint exactly how they ended up on the ground, because he changes that part of his statement.

Q Okay. And to your knowledge, have you or any of your representatives of the claimant stipulated or represented that they just toppled to the ground?

A What do you mean "stipulated"?

Q Have they -- to your knowledge, has it been represented by you or by any of your agents that the way they got to the ground was that they toppled over?

A Has it been represented in what way? I don't understand.

Q I'm just asking you whether you know that or not?

A I don't understand the question. I'm asking, I don't understand.

Q Okay. That's fine. Now, are you aware that the DRA report that's referenced in your Complaint, that the Disability Rights Arkansas is an organization that has publicly taken the position to close every human development center in the state, and they've been saying that for ten years?

A I was not aware of that in the beginning, no.

Q Okay. And so, are you -- did you know -- well, were you aware of any of the -- you mentioned a lawsuit, I believe, in your Complaint. Yes. On page -- in

paragraph -- the same paragraph, the next page, it says, "The United States Department of Justice has twice sued the State of Arkansas regarding the failure to provide adequate services and care at its Human Development Centers; however, those cases were dismissed based on procedural grounds." Tell me what you know about that.

A I have a -- what I know about the cases or --

Q Yes. You've alleged them in here.

A I have -- you know, I don't know all the legal terms, but I -- when I felt like my brother was killed and I was not happy with everyone I had reached out to investigate it, I started searching for advocacy groups or any type of groups that investigate abuse and death of people with disabilities. And that's when I first even learned of Disability Rights Arkansas. And I learned of them because I found their report, a report they made around 2015, '16 about a death, and I started reading. So, my knowledge is to the extent of what I've read online that I found.

Q Okay. I'm asking you what you're alleging here about the United States Department of Justice lawsuit that you have referenced in your Complaint.

A Well, I mean, that's why I have a lawyer. I hired a lawyer to handle the legal aspect of this.

Q Okay. But you state in there, it says that these

cases were dismissed based upon procedural grounds, you state in there; right?
A Well, those are legal terms that I have left up to my lawyer to interpret.
Q Oh, okay. So, you didn't know -- you don't know anything about that, then, is that what you're saying?
A Know anything about what?
Q The Department of Justice lawsuit?
A Like I have just mentioned, what I know is limited knowledge based on what I've read online when I was researching to find advocacy groups who would investigate my brother's death.
Q Well, then, when you're researching, you saw that the statement in there that they were dismissed on procedural grounds, the main lawsuit wasn't dismissed on procedural grounds, you would know that, you would know that it was -- the State of Arkansas won against the Department of Justice; right?
A What I just said, I have limited knowledge based on what I read. The terminology in this claim I left up -- I put my faith in my lawyer to handle the legal aspect of this claim.
Q So, that allegation, you don't know, is it safe to say, whether it's accurate or not?
A I wouldn't say that.

Q Well, what would you say?
A What exactly I've already said.
Q Well, I don't know what it -- so it --
MR. GILLISPIE: She doesn't know anything about these Department of Justice cases.
BY MR. ROSEN:
Q Is that a true statement?
A That is a true statement.
Q So, when you -- when you approved the filing of this lawsuit, you didn't have any concerns about whether that statement in there in paragraph eight was true or not?
A Like I said, I hired a lawyer, I have faith in my lawyer, and I have faith that anything that he represented in this claim is based on facts that he investigated and learned himself.
Q Okay. Do you -- do you know anything about any of these -- well, strike that question. So, do you know -- do you have any reason why -- your brother died in 2020; right?
A June 13th, 2020.
Q Okay. And so, the first DRA report that you've referenced in this claim came out in 2015 saying -- calling for the closure of the Booneville Human Development Center?
A Are you asking or are you telling me?

Q Well, that's what it says; right?
MR. GILLISPIE: Sure.
BY MR. ROSEN:
Q That's what you've said in your Complaint; right?
A But if you're asking, are you asking is that in this Complaint?
Q Yes.
A Yes, it's right here.
Q Okay. And so, but in 2015, you didn't want it to be closed, did you?
A In 2015 I had no knowledge that someone had died at the facility my brother lived in because no one gave us that information, which I think they should have.
Q Well, did you go out and research it?
A What do you mean?
Q Did you do any due diligence before you continued placing your brother in the human development center each year, did you decide, "Well, maybe this isn't the best place for him"?
MR. GILLISPIE: Object to form.
THE WITNESS: I went by what I saw in person when I visited the place, when I was there in person by my brother, by his -- how he was doing, that's what I based it on.
BY MR. ROSEN:

Q Okay. Your own eyes --
A Sure.
Q -- told you that he was -- that this was the place for your brother?
A From what I could see when I was there, yes.
Q Tell me, what does the word "approximately" mean to you?
A An estimate.
Q Now, in paragraph 22 of the Complaint, do you see -- you use a few words, and I'm going to ask you about that. I'll let you turn to it. Are you there?
A Yes.
Q Okay. Now, you characterized David Cains' behavioral outbursts as a, quote, "temper tantrum", unquote?
A Correct.
Q Okay. Tell me what evidence you have it was a temper tantrum and not an aggressive or violent behavioral outburst.
A Because I had 40 years of experience with my brother, because I had been with him when he has had behavioral incidents when he -- when he, you know, swung his arm out, because of my own experience and my own knowledge.
Q You didn't see him that day, though, when this

happened, did you?
A I did not.
Q So, you're characterizing it in your Complaint as a simple temper tantrum; is that correct?
A That's what -- yes.
Q Okay. Do you know what he tried to do to Tyler Mattson?
A I know that -- I know by what I've read in his statement.
Q And what was that?
A Well, that also changed. Because, I mean, he --
Q Well, first of all, tell me what it was, first, and then you can tell me what you think was changed.
A In his original witness statement, from what I recall, he said first David was trying to hit him, that he was cussing and yelling at him.
Q Did he lunge at him?
A That was never in the original statement. That came up in his deposition.
Q Okay. And so, is trying to hit or lunging or any of those things, spitting, is that a temper tantrum, in your mind?
A Yes.
Q Okay. Would you consider -- or do you consider violence and aggression to be a temper tantrum?

A In regards to what?
Q Trying to hit somebody?
A Would you ask that again?
Q Sure. Would you consider violence and trying to hit somebody to be a temper tantrum?
MR. GILLISPIE: Object to form.
THE WITNESS: I don't consider trying to hit someone violence, no.
BY MR. ROSEN:
Q Oh. Trying to strike at another human being is not violence?
A I don't think, with my brother's capabilities and my knowledge of my entire life, my brother didn't have the capability, because he never had done it, he had never severely injured someone, he had never hurt someone. I've been hit by my brother, I've been spit on by him. I've dealt with his behaviors, my brother has never injured me.
Q Okay. So, tell me about when he -- when did he hit you?
A I mean, there has been -- I've dealt with his behaviors my whole life. And if you happened to be in his line of fire when he swung his arms, you might get hit.
Q Okay. So, is it safe to say that it was on more

than one occasion that he hit you?
A I would say on a few occasions.
Q Okay. What about when he spit at you?
A It would maybe be one or two occasions.
Q And what else has he done to you?
A I mean, I wouldn't say he did that to me. I would say he was having a behavior event, and I was there with him. So, no, it wasn't directed at me.
Q And did he ever lunge at you?
A No. My brother -- absolutely not, my brother didn't attack people. If you were in his general area when he was having a behavior event, he would swing his arms, he would pick something up and throw it. He didn't have the physical capability or strength to fight another person, to take on another person, and he never did that, to my knowledge.
Q Well, okay. Okay. But you're aware that he used to break the things in his room, such as the TV and the DVD player and mirrors; right?

MR. GILLISPIE: Object to the form.

THE WITNESS: I'm aware that he broke his TV one time, and he broke approximately two of his radios, that I recall.

BY MR. ROSEN:
Q Would that be violent, in your opinion?

A In my opinion? No.
Q Tell me exactly, as the claimant in this lawsuit, what you are alleging here that the Booneville HDC staff did wrong for which there is liability.
MR. GILLISPIE: Object to the form.
BY MR. ROSEN:
Q And I'm going to write it all down so I can just understand it. So, go ahead.
A Would you ask that one more time?
Q Yes. Tell me exactly what you're alleging in this lawsuit that Booneville Human Development staff did wrong for which they should be held liable.
MR. GILLISPIE: Object to the form. Are you asking her to read the lawsuit to you?
MR. ROSEN: No.
BY MR. ROSEN:
Q I'm asking you what did they do wrong? Do you have an opinion as to what they did wrong?
A Yes, I do.
Q Tell me what that is.
A I believe that they used excessive unnecessary physical force to restrain my brother and for a behavior incident that didn't call for that. I believe that they used improper techniques once he was on the ground to continually hold him on the ground, which wasn't

necessary. I believe they caused him to -- to choke and to die because of the decisions they made.
Q Well, you're not alleging they actually choked him, are you?
A I'm alleging that because of their restraint and excessive force, that they caused him to choke and die.
Q Okay. And so, was he -- in the lawsuit, you say he was pinned. Tell me what evidence you have that he was pinned to the ground. You used that term "pinned".
A Because the -- the three staff members said -- I have read their witness statements, and by their statements they all say my brother was on his side, and one -- Tyler was in the middle, another girl had his legs, another girl was at his head, and either holding his arms, his wrists, or his head. That's pinned to the ground. If you're holding someone at all three points of their body on the ground and they can't move, that's pinned to the ground.
Q How do you know he couldn't move?
A I mean, their witness statements said they were -- that was their purpose. They said that their purpose was to keep him from kicking his legs, so they held it down. Their purpose was to hold his arms so he couldn't swing. Their purpose was to hold him on the ground. They all

three said that that was their purpose.
Q Okay. Anything else?
A Well, I think that that explained it all.
Q Okay.
MR. GILLISPIE: Object to the form of the last question, "Anything else," I object to the form of that question.
MR. ROSEN: It has already been answered.
BY MR. ROSEN:
Q Okay. Some of this we've touched on. I only have a few more questions, though.
A Can I take a break?
Q Sure.
MR. ROSEN: And it's -- what time is it?
MR. GILLISPIE: 11:30.
VIDEOGRAPHER: We're off the record at 11:30.
(WHEREUPON, a break was taken.)
VIDEOGRAPHER: We're back on the record at 11:42.
BY MR. ROSEN:
Q Okay. During the break, did you speak to anybody about the questions I've asked?
A No.
Q Now, I just have a few more questions about --

you're seeking money damages here; is that correct?
A That's part of the claim.
Q Okay. What's the other parts of the claim?
A My claim -- I mean --
Q Go ahead. I mean, what are you seeking here, is what I'm asking?
A I mean, there's a monetary amount attached to the claim, but I have left all that up to my lawyer.
Q Okay. So, your lawyer quantified it in discovery. You've left that all up to him?
A Yes.
Q Okay. So, let me talk about -- we've talked about a lot of things here today, but now I want to talk about -- kind of more about you, okay? And I know you live in Vermont.
A Yes.
Q Okay. So, your -- David Cains died in June of 2020?
A Correct.

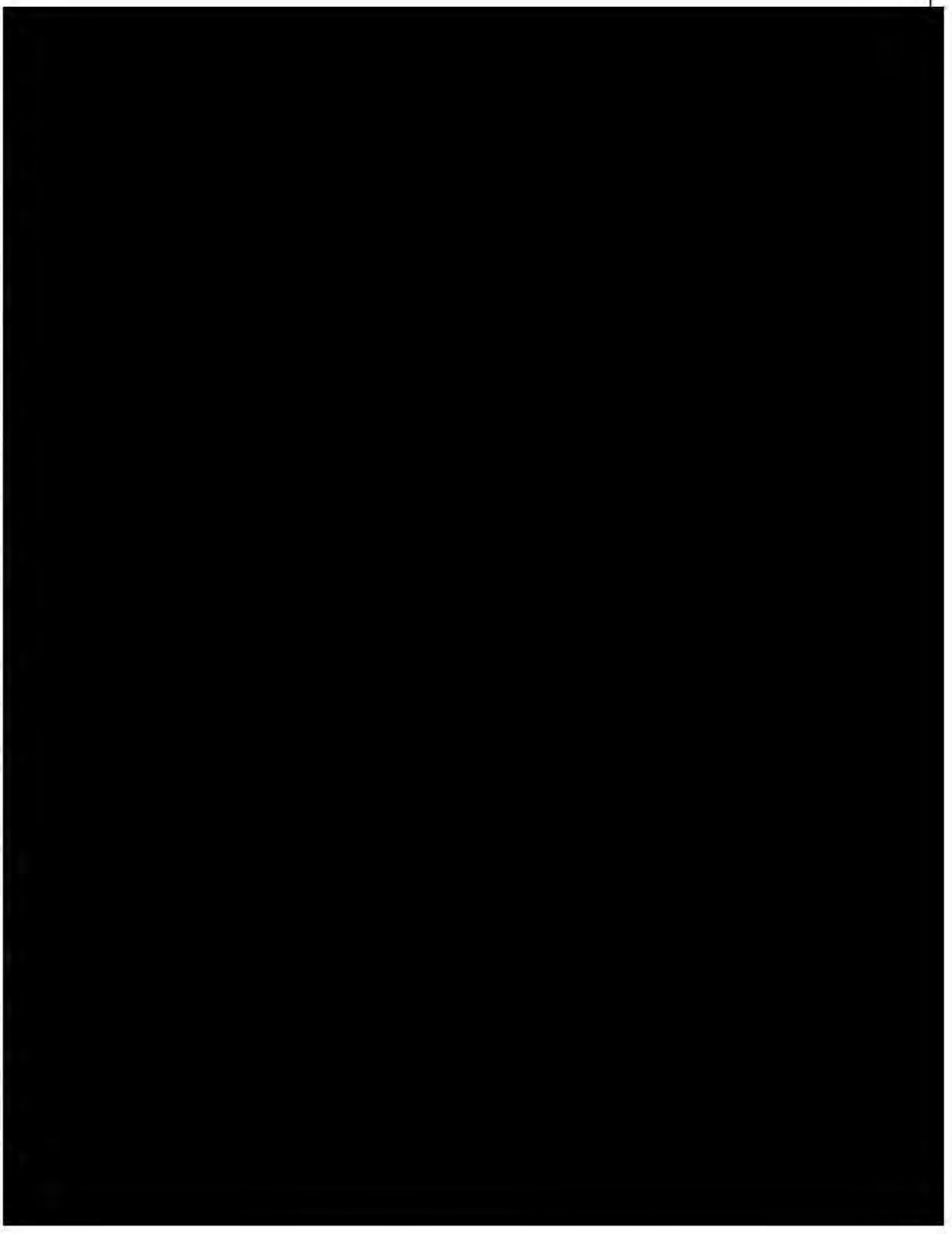
[redacted]

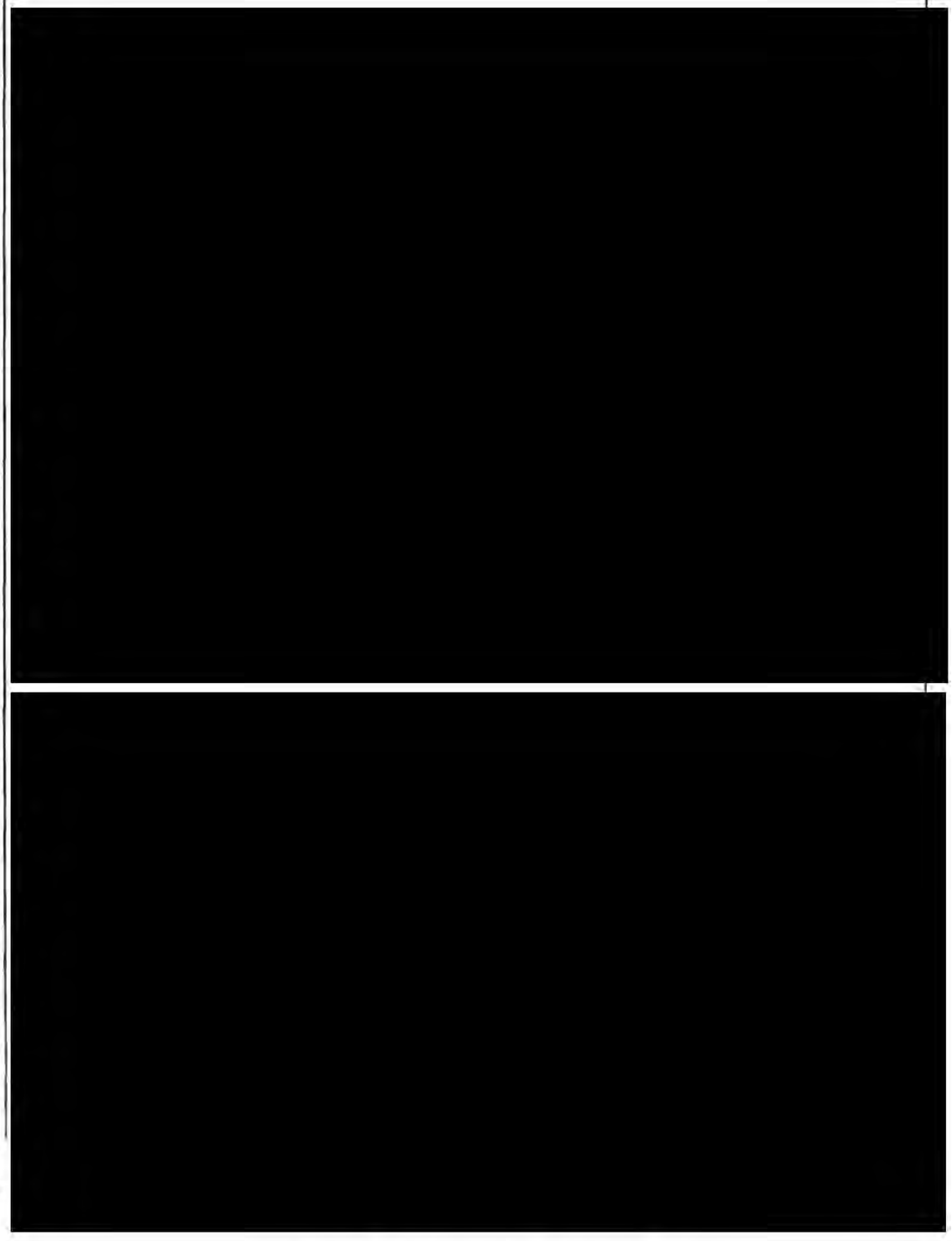
[redacted]

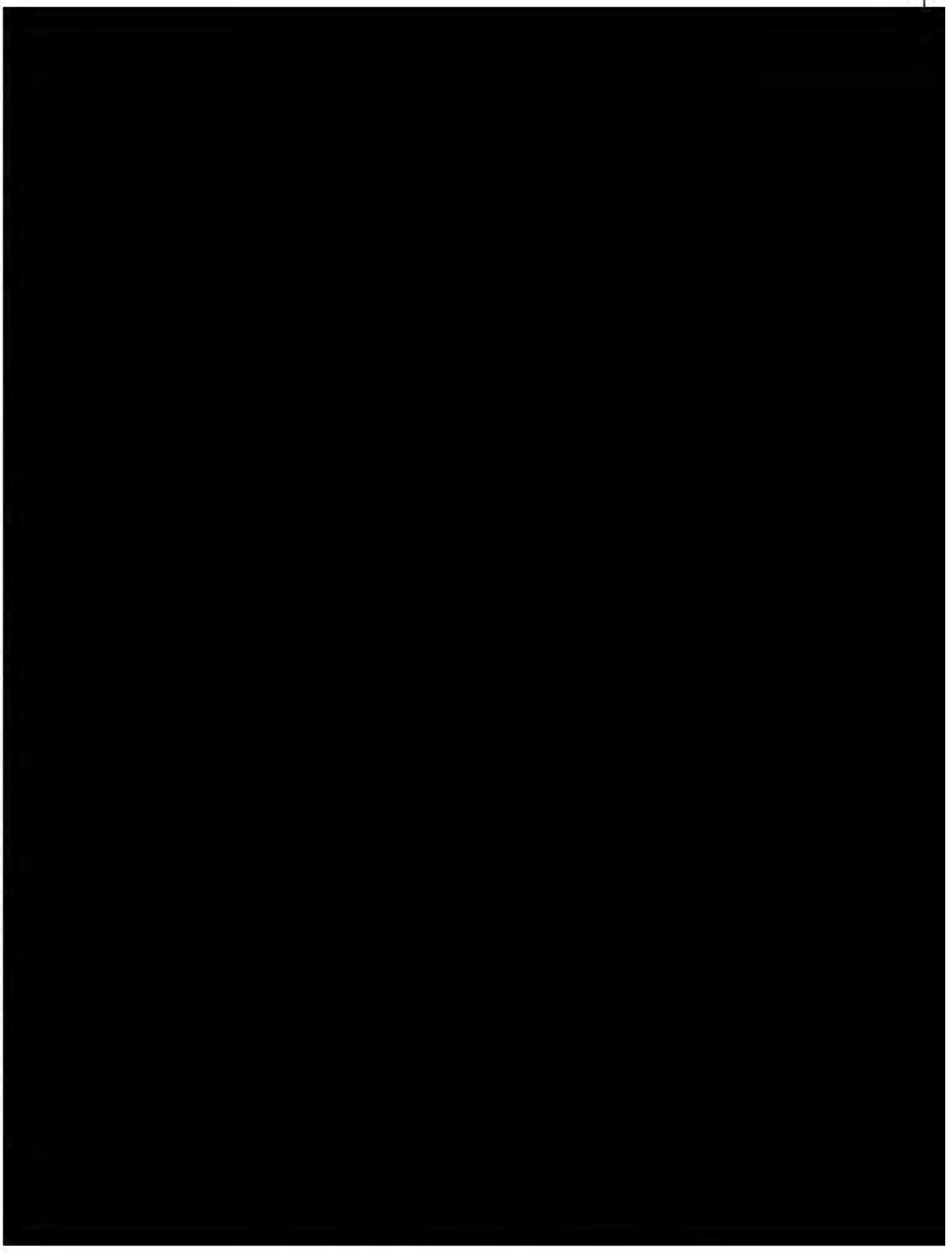
Q Okay. Then we don't have to talk about it.

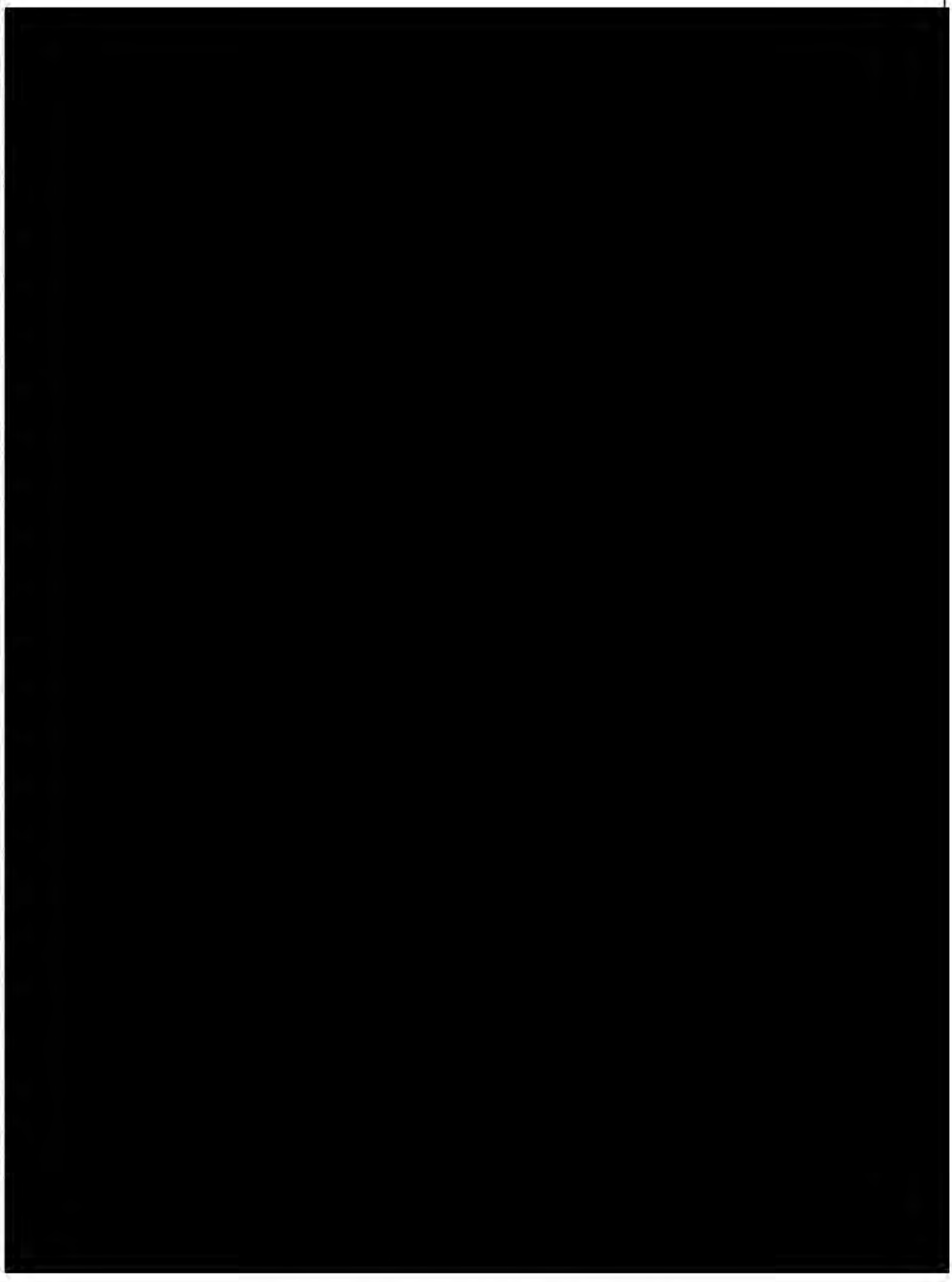
A Okay.

[redacted]









[redacted]

(WHEREUPON, there was a telephone interruption.)

MR. ROSEN: We will just wait for a second.

MR. GILLISPIE: I'm sorry. It's not supposed to ring. I apologize.

MR. ROSEN: It's all right. It happens.

MR. GILLISPIE: Even though it did ring. It's bizarre.

BY MR. ROSEN:

[redacted]

[redacted]

A I mean, my whole life has changed since my brother is not here.

Q Okay. Tell me how that changed.

A I mean, my brother was three years older than me and, you know, we -- so he was literally there my whole life, and he was like my best friend. He was kind of like a kid to me. I had step-kids. I don't have my own kids. But my brother, because he was so child-like, he was like my best friend, he was like, you know, a child, I was protective of him.

But for our whole life, I mean, we were always -- we had a special bond, and he was probably the person, you know, that I was closest to in my family. Like, we just -- we have always been that close. And the months after his death, it was just -- it was hard to deal with, like losing that connection.

[redacted]

[redacted]

Q But physically, he was a man; right?
A I mean, he was tall.
Q And big?
A Yes. But he didn't have the strength of a grown man, no. I mean, you -- it's misleading to say he was a man. I mean --
Q Well, I mean, chronologically and physically he was six something feet tall; right?
A Yeah, he was 6'2".
Q 6'2" and he weighed --
A Yes.
Q -- you said 250 pounds?
A That's right. But when you said, but he didn't have the -- when you think about a man who is 6'2" and 250 pounds, you think about a strong, big man. And my brother wasn't physically strong.
Q How do you know that?
A Because I know that, because I grew up with him, because I've been on the receiving end of his punch, I've been with him when we played in the yard, when we had to do the work at home, and he couldn't do a lot of things. He didn't have the dexterity, he didn't have the

capability.
Q Okay. Let me ask this, switch a little bit. And did you pay for the funeral?
A I borrowed money from two of my uncles, and so yes.
Q Okay. So, the answer is "yes", you did pay?
A Yes.
Q And how much was that?
A I believe it was around, for just the funeral, over $6,000.00, from what I recall.
Q And what type of -- and was that here in Arkansas?
A It was at the funeral home in Booneville. So, he was buried in our family cemetery in Atkins, Arkansas.
Q Okay.

MR. ROSEN: And I can't remember, counsel, have you supplied the funeral bill to us?

MR. GILLISPIE: I'm pretty sure.

MR. ROSEN: I don't remember seeing it.

MR. GILLISPIE: Yes. As far as I know, we have.

MR. ROSEN: Okay.

MR. GILLISPIE: If there's something else that we're missing, let me know and I'll certainly do that.

MR. ROSEN: Okay. If -- well, I'll check, because I haven't seen it.

BY MR. ROSEN:
Q Other than what you mentioned, the funeral bill, are there any other expenses that you're claiming in this lawsuit?
A What do you mean, as related to burying him or -- I don't understand.
Q I'm asking you about the expenses.
A The expenses for after his death, for his funeral, his headstone.
Q How much was his headstone?
A I believe around $1,100.00, $1,200.00.
MR. ROSEN: Have you provided that? If not, we can talk about that.
MR. GILLISPIE: I think we provided all of it.
BY MR. ROSEN:
Q And who paid for that?
A I did. Well, I mean, I paid for it, but we received money -- actually, my brother, part of his money that they gave us from the HDC, because he had a job. So, after he passed away, they sent us what was left in his account.
Q Okay. How much was left?
A My mom received that check. I want to say, as an estimate, maybe around $300.00 to $500.00.

Q Okay. So, that was his money that was used -- part of it was used to pay the funeral?
A That amount. But the rest of it, I paid for.
Q Okay. So, let's change subjects a little bit, then, and just a few more questions. You had mentioned that you had spoken to Disability Rights Arkansas, or what we call DRA. When did you first speak to them, and who did you speak with?
A I left -- when I learned of who they were, and I reached out to them, I left a voice mail, and I believe it was around July 4th weekend in 2020, I received a call from his advocate. I believe it was Kris Stewart. I believe she's the only one, that initial call, and then she has like continued to speak with us.
Q And how many communications did you have with her?
A We spoke on the phone, we exchanged e-mails. I would have to make a guess, 15 or 20, approximate.
Q Approximately?
A Fifteen or 20, approximate, maybe between e-mails and speaking on the phone.
Q And did she -- during those conversations, did she ever -- well, did -- so, wait a minute. You said 15 or 20 e-mails?
A That's -- well, and phone calls, most of them.
Q Okay. Total?

A Total.
Q Okay. Between the two?
A Yes.
Q And did she e-mail anything, any documents to you, or statements to you?
A The only thing I remember that she e-mailed me, I had to sign some type of -- I don't know even what it was called. Giving information basically to investigate on my brother's behalf, from what I understood, some type. That's the only thing I remember her e-mailing to me.
Q Okay. Did she ultimately give you a report of some sort?
A Oh, she did. Yes. You're right.
Q Okay.
A She did give me her final report.
Q Okay. And so, did the final report include the witness statements that you've mentioned that you saw?
A No. It was -- I already had those.
Q Oh. Where did you get those?
A I got them from DHS. I requested them.
Q I'm talking DRA.
A Oh, from their witness?
Q Yes.
A No, I never saw their report.
MR. ROSEN: Well, I'm moving all these be

introduced that we identified, all the exhibits. And at this point in time I have no other questions. Thank you very much.

CROSS EXAMINATION

BY MR. GILLISPIE:

Q Chrissie, while we're still kind of -- well, strike that. When you say that your brother lacked the strength and you used the word "dexterity" to do violence to another person in the same way that a person his size of normal intelligence and normal intellectual development could do, what do you mean?

A I mean, like my brother, he couldn't -- you know, he couldn't ball up his fist and aim it and land it on you and hit you. Anytime I witnessed my brother, it was just, you know, swinging his arms. And when he did hit you -- like I've been hit by my brother, it never even left a bruise. He just -- he didn't physically have that capability. Like even little tasks, picking things up and moving them, opening jars, those types of things, he didn't have the strength to do a lot of that. I would have to do it or my mom, somebody would have to do it for him, those types of tasks, you know.

Q Like opening a pickle jar?

A Like a pickle jar, because he loved pickles, actually. So, we would have these big, huge jars that we

would have to open because he couldn't do it.
Q Claussen or Vlasic?
A I think he liked the Kroger brand, actually.
Q I had a roommate in college, and that was a debate, sometimes a fight. He couldn't open a pickle jar?
A Not on his own, no.
Q Okay. Well, did he have any athletic skills?
A No. Actually, it was -- I mean, we would joke about that. I mean, when we were little kids, we would play in the yard and stuff. But he was always -- he was terrible at sports. I mean, I played sports, I loved it. And we would play ball in the back yard with our dad, but he couldn't -- he would wear my dad's baseball glove on the wrong hand, he couldn't catch a ball, and he couldn't throw it and actually, you know, get it to a person.

Throughout his life he always participated in Special Olympics, and actually one of the last years that he was there, it's one of my favorite memories of him, I didn't tell him I was coming, it was at the Booneville High School. And because if I couldn't make it, I didn't want him to be upset. So, I get there and I'm in the stands, and I don't know how he saw me, but in the middle of the field, somehow he saw me and yelled, "Yeehaw," like he was taking a hat off, which he didn't have on. And he said, "There's my sister, there's my sister." He

yelled it. But so, it was just really funny.
Q Did everybody turn and look at you?
A Yes. Everybody was like -- because he was loud, like you could hear it, and -- but after that, he had -- he did different events, he was never -- he got a ribbon because he participated. But that particular year is the only time I remember he actually won a race. And I have a picture of that. It's one of my favorite ones, because he came up to me afterwards and he was so proud.

And he said, "Look, did you see me, Chrissie, I ran fast as hell." And I mean, he was just -- but like I said, his whole life, he was in his 30s and he -- you know, he participated, but he never -- you know, he wasn't really good at it.
Q Is that a favorite memory of your brother?
A That's probably one of my favorite memories, just because he was so happy and so proud of himself. Because he literally never, I don't think ever, won anything.
Q Okay. And that was towards the end of his life?
A Well, no. That was towards the beginning of him moving to Booneville.
Q Okay.
A So, he was in his, probably, mid, early 30s.
Q Okay. What are some -- do you have an other -- are there any other stories about Davie that stick out in

your mind as favorite?
A I mean, it would be hard to pick one, because he just -- he was a character, but --
Q Tell us about him.
A Oh. And he was really funny and outgoing. He didn't like violence. He never -- anybody that was around him would tell you he never stopped talking. I mean, even when he went to the bathroom, he never stopped talking. So, he -- I guess one of my favorite stories is, you know, me and mom were probably the two closest people to him, but we still had different relationships.

My mom was his mother, you know, I was his sister. So, he could always get, you know, extra stuff out of my mom. And he knew that I wouldn't do that. Like we would buy him dinner, and he would be at the HDC and we would take him out for the day, we would always get him dinner for later, and he would get a Big Mac meal and a Diet Coke.

Well, he would always talk her into getting him an extra cheeseburger, too. But I wouldn't do that when he was with me, but he knew he could get my mom to buy him, you know, an extra cheeseburger. But -- yes.
Q Is this at McDonald's?
A This was -- yes, this was at McDonald's, I think, when he --

Q Did he always order the Big Mac meal at McDonald's?
A He always. He was very much a creature of habit, he -- and but he was just very, you know, sweet. When he first came to the HDC, we would get him sugar-free snacks, sugar-free sodas. And they would let him keep them in his room. But he would give them away to everybody. So, he had to start -- they would put it in the hall closet and ration it out to him. He was just -- he was just funny and he was a happy guy.
Q Did he love food?
A Yeah, he loved food. That was -- when we were eating lunch, he would say, "Hey, what are we having for dinner," I mean, while we were eating lunch. That was probably -- eating was one of his favorite things.
Q And did you say that at McDonald's he would get the Big Mac meal, but then he would try to get you to get him an extra cheeseburger?
A A little cheeseburger. I would never do it, because I would tell him, "You don't need that," but he could always talk my mom, you know, into getting it -- or at Wal-Mart, like if we would go in there, I would give him a $10.00 limit. I would say, you know, "You can pick whatever you want, a hat, a CD," when they still had CDs, and stuff like that, and he knew he had that. If we would go with my mom he could always get a little extra.

So, if I tried to go to Wal-Mart with him, he would say, "No, no, you stay here," because he didn't want me to talk, you know, my mom out of it.

Q Were you his favorite person?

A I would like to think -- probably me and mom, you know. I would like to think we were definitely his two favorite people. I mean, I feel like me and him had a really special relationship that he didn't have with anybody else. And I feel like, of our childhood and, you know, we went through some pretty traumatic things together, and nobody else experienced that. I feel like that definitely bonded us, and I just -- it's hard to explain, but his disability as far as our relationship, you know, it didn't factor in as far as personality. You know, we still had that connection. And that's, you know, what I miss the most.

Q Real quick on this. You mentioned what you went through as children, are you referring to your father's murder?

A Yes.

Q And very briefly, since it was addressed earlier, do you have an understanding as to why your father was murdered?

A Yes, I do.

Q Okay. What is that?

A Well, my father had become -- I don't know all the circumstances, but he became a confidential informant for law enforcement, and he was supposed to testify on September 5th, '91 against a few men that -- it all was related to drugs and drug trafficking. And he was murdered the day before he was supposed to testify.
Q Okay. So, is it your understanding he was killed to prevent him from testifying?
A Yes.
Q And you testified earlier that you later -- years later testified against the man who killed him?
A Yes.
Q Did you come to learn that there was a connection -- did you come to learn that that man had been involved with the person or persons your father was set to testify against?
A That has never been substantiated as far as factual basis. But there were things that happened later on, other people who were arrested, that have told that story. This man still, you know, declared his innocence and he doesn't -- he has never admitted that, but there are other people who were arrested later on who had told law enforcement that he was hired to do that.
Q Okay. To prevent your father from testifying?
A Yes.

Q Okay. Against some drug dealers, is your understanding?
A Yes.
Q Okay. What are some other things that Davie loved? And actually, let me stop you there. We've been referring to him as David Cains. He was Davie to you; right?
A He was Davie to me and my family and my close friends. We never called him David.
Q Okay. And what are some other things that Davie loved besides -- aside from his sister and food?
A He just -- he loved music. Everybody that has been around him for five minutes knows he loved the Monkees, because he would listen to it 24/7 every day. That's not even an exaggeration. I'm sure the people at Booneville would tell you that. But, you know, ever since he was a little kid --
Q And how did he come to love the Monkees? Being, you know, born in the late '70s, he was -- the Monkees were around in the '60s. How did he discover the Monkees?
A Me and my brother, when we were kids, we watched Nick At Nite all the time. We didn't -- you know, that's about all we watched. So, I remember me and him, we watched things like I Love Lucy, The Monkees, Leave It To

Beaver, those types of shows. And for whatever reason, he just -- he just latched onto the Monkees and the rest is -- you know, he never stopped.
Q He got himself some CDs and that was it, huh?
A Yeah. CDs, tapes, vinyl records, he had them all, DVDs.
Q Was there a particular Monkees song that he favored?
A Yeah. There were two, Not Your Stepping Stone and Last Train to Clarksville. And actually, thankfully, I have a few videos of him, he would play tambourine, and he had some maracas I had gotten him from Central America, and I actually have a few videos of him playing those, and one of my friends playing them with him, which he did all the time, you know.
Q He played the tambourine?
A I mean, he made noise. I don't know if you would call it playing. But he played the tambourine and the maracas, and -- yeah.
Q And was the tambourine something he associated with the Monkees?
A Yes, yeah.
Q I vaguely remember those reruns of that. What else did he -- what else was he into?
A He loved the Dukes of Hazzard. He probably -- we would buy him, you know, DVD sets. And he probably had

300 DVDs, but he always watched -- and he would buy them with his own money, but he always watched the same things, you know. And so, just like he listened to the Monkees on repeat, he would watch the Dukes of Hazzard on repeat, except for one season that had the cousins, Coy and Vance, which he would say, he would say, "I hate them", because they weren't going with the Dukes. So, he would watch all of the DVDs except the season that had those two on it.

Q So, Bo and Luke were the main guys?

A Yeah.

Q And then, at the end of the -- are you saying at the end of the show those main actors left and they were played by some cousins?

A That was part of the storyline somewhere in there. And he wouldn't watch those, because he said he hated them, and they weren't Bo and Luke.

Q I bet a lot of people did.

A Yeah.

Q I don't remember the show that well.

A Yeah.

Q I bet a lot of people did.

A Yeah. So, I mean, he loved music, he loved, you know, DVDs, watching TV, he loved food, he loved -- really, he loved -- he was very social. He loved making

people laugh and being around people. He didn't like being alone, he didn't like silence. He just -- I don't know. He just -- he loved those things, he loved being a part of something, you know. I feel like, you know, being part of -- he had friends. I don't know how to explain it.

Q And is it fair to say that the Booneville Human Development Center provided him a lot of those things?

A I feel like overall, you know, and before -- you know, until his death, that overall he did well there. I mean, he -- he would -- like he loved -- he had his own friends, and he was friends with a lot of the staff, and I feel like, you know, they loved him, too. And he was very social. He would sit in the TV room and just talk to people. He would walk around, you know, he didn't like being, you know, still or quiet.

So, I feel like overall they gave him that. He had a job, because he was proud of that. He would talk about, "Oh, I've got to go to work Monday." Sometimes he would stay with us an extra day or something, but he was like, "Oh, got to go see my friends, I've got to get back to work," you know. So, I feel like, you know, most of the time, in general, that that place gave him all those things he deserved.

I mean, he deserved to have a -- you know, I hate to

use those words, but a normal life, like he would have had independence, he had his own room, his own friends that were separate from, you know, me and my mom. And I wanted that for him, and I was happy that he seemed to excel there.

Q And as far -- are you saying that -- or is it true to say that as far as you knew, he was happy there?

A Yes. I mean, I think a lot of people that I -- you know, I've read this in their statements, like Davie, you could tell as his demeanor, I mean, he was a happy-go-lucky guy, and I feel like, you know, the majority of the time he -- yeah, he loved being there. I feel like he had two homes. He called Russellville his home, where me and, you know, where my mom was, and he called Booneville his home. So, I feel like he actually -- he enjoyed it there.

Q He was well liked there, as I understand it. Is that your understanding, as well?

A That's my understanding. Anyone we ever -- I mean, we had different relationships with different staff because, you know, they would change. But some of the people that they were there a long time, they never had anything but nice things to say about him. His laugh, his smile, how funny he was, you know, all the same things that we loved about him.

Q You mentioned Russellville was also his home. When would he come to Russellville? I mean, from the time -- during the time he -- during the years he lived at Booneville, when would he come stay with family in Russellville?
A He came home for every Thanksgiving and Christmas, he came home for his birthday every year, even if it wasn't like on his actual birthday, he came home for that purpose. He would also -- he would come for random other visits through the years. And then, also, when he wasn't -- when we didn't bring him home, we would go up there and visit him for the day, take him out. So, I mean, it was pretty often, I think.
Q Did you still, after moving to Vermont, make a point to see your brother in person?
A Yeah. I mean, that was something that was like nonnegotiable. I mean, at the time, he was my boyfriend, he's my husband now, but that was a discussion, and just for me personally, like, "Listen," I said, you know, "Financially, whatever I've got to do, I have to make sure that I can see my brother, you know, every couple months, and fly home, drive home, you know, make it work around working." That's what I did. To me, it was important, but I know it was important to Davie, too.
Q Did you actually do that, come back to Arkansas

every two to three months?
A I did, yes. Once I moved to Vermont, yes, I came back to Arkansas to see Davie every two or three months. There might have been, you know, a six -- you know, a month here where I came a month later, but I made it a point to continue to do that.
Q And --
A And we also called him every week. We sent him stuff in the mail. You know, there was all kinds of forms of, you know, communication.
Q I know you and your husband both work. But you're not wealthy people?
A No.
Q Were those plane tickets -- would you drive or fly when you would come back?
A Both. I mean, it just depended. Honestly, to drive either way is 24 hours, you know, so it would take two days to get there and two days to get back. So, whether I drove or flew just had to do with work, you know, how much time I could take to drive.
Q Was it a significant financial expense for you and your husband when you would fly to Arkansas?
A I mean, I don't know if I would characterize it as significant, but, yeah, I mean, it was some -- it was significant enough that I had to budget that. And before

I moved, I made sure I started saving up money so I had money set aside to make sure that no matter what happened, I was always able to come home.

Q Okay. Yes, you were part of -- well, scratch that. Were you ever told by anyone at Booneville about specifically how they could personally restrain your brother? In other words, were you ever told specifically what techniques were allowed and what techniques you thought you were approving?

A I had a conversation, I don't know how many years ago. I didn't understand all of their restraints many years ago, and someone explained to me what they each meant. Like I wasn't aware of what the papoose board even was for, that was mechanical. The most recent is, I had -- I actually had a conversation with Caleb Murray to clarify. And it was around the time -- I wanted him to clarify again, to make sure I understood. It was around the time of his last IPP.

Q Okay. In 2019?

A In 2019. And he explained to me what a chemical, you know, restraint was, what it meant by personal restraint.

Q Did he explain to you what "personal restraint" meant?

A He told me a personal restraint meant holding one

or both arms to a person's side by their arms and their wrist.

Q Were you aware of any other form of personal restraint, or was that the only personal restraint that was explained to you?

A That's the only thing that was explained to me.

Q Were you ever -- were you ever told that your brother would or could be restrained on the ground, in a personal restraint on the ground?

A No. I was only explained that a papoose board was obviously on the ground, but I was never told that there was any type of holding someone on the ground.

Q As far as you know, was your mother ever told that?

A Not as far as I know.

Q Okay. Were you ever told of the policy that was in place at the time whereby -- at Booneville whereby only medical staff could call 911?

A I was never aware of that prior to my brother's death.

Q Okay. Had you been made aware of that, would that have caused you concern?

A Yes, absolutely.

Q Had you been made aware that your brother was maybe restrained on the ground for -- held on the ground in a personal restraint, would that have caused you

concern?
A It definitely would have, because when I learned of what the papoose boards were, I actually had multiple conversations. I was concerned that I didn't -- I didn't like the idea of it, and I -- that's why in the initial conversation was to explain to me why those were even used. So, I was concerned with that type of restraint. I feel like I would have been concerned with any restraint holding him to the ground.
Q Okay. I only have a couple more questions, Chrissie. But I am correct that you know how -- you know how your brother died?
A I mean --
Q Scratch that. Did your brother -- is it your understanding that your brother choked and suffocated on his own vomit?
A It's my understanding that that happened while he was being restrained, yes.
Q And is one of the things that you have discussed with your counselor, or one of the issues you had in dealing with the loss of your brother his -- what you imagined his last minutes to be like?
A Yeah, I mean --
MR. ROSEN: Objection, leading.
THE WITNESS: One of the things that

actually --

BY MR. GILLISPIE:

Q Let me rephrase that. Do you ever think about your brother's last moments?

A Yeah. I think about my brother every day, and I wouldn't say at this point, a few years later, I think about how he died every day, but I mean, especially the month, you know, the year after, I mean, it's still something -- I try not to let myself go there now, because, you know, just thinking that my brother's last moments were on the ground choking to death, I just can't imagine that there's a worse death than that, gasping for air and choking.

And then to add to it that there was three people that he presumably knew and trusted, I just can't imagine how scared he was and what that was like for him. And so, that has been a really hard part of -- I mean, it would have been hard, obviously, losing him, but knowing, it upsets me just because, you know, he's a human being, just to know that that's how his story ended, it -- I mean, it breaks my heart.

Q Why did you -- ultimately, why did you bring this suit?

A I feel like my brother shouldn't have died that day, first of all. I feel like I went through the proper

chain of command, I went to get answers of, I feel like, we were purposely misled and just flat out lied to about how he died. It was withheld from us that there was even a restraint, and the behaviors. And in my experience, especially with Caleb Murray, he always told us about these before he ever had an incident report, he was always forthcoming.

Q Okay.

A So, we didn't learn about that until it was too late to get an autopsy.

Q Chrissie, what I would like for you to do, please, is, if you will, take us step by step through what you recall from the moment you got a call informing you about your brother's death up until the point you started reaching out to lawyers.

Q That Saturday, June 13th, 2020, I had gone to town to go grocery shopping. I was a couple miles from my home. My uncle called me, and I answered and he just said, "Davie died." I said, "What are you talking about?" He said, "Davie died." I said, "Davie who?" I was confused, and he just kept saying, "Davie."

He was obviously hysterical. I said, "What do you mean, my brother, Davie?" He said, "Yeah, he's dead." I said, "What are you talking about?" He said, "Your mom" -- you know, "Your mom was called today, they told

her that he choked while eating his lunch, they tried to do the Heimlich, they couldn't get his throat clear, they took him, you know, to the hospital, but he was dead."

And it was -- I mean, it was pretty -- you know, wasn't the best way -- I mean, there's no best way to get that information, but, you know, my uncle was hysterical, too. So, I said, "Where's my mom?" He said, "She's hysterical right now. She can't talk on the phone. She asked me to call you." So, I hung up the phone, I was a few miles from home, I wanted to get home as fast as I could to my husband.

And, I mean, I was -- you know, I was sick to my stomach, I couldn't make any phone calls, I was crying. My husband actually talked to my uncle. I had reached out to a friend to make it to Russellville to go sit with my mom. My husband booked a ticket for me to come home. I came into town, flew to Little Rock that Monday.

Somehow we found out my brother's body was sent to the Robertson Funeral Home in Booneville. My uncle made arrangements for us all to meet there. As soon as I got into town, I met them in Russellville. On our way to the funeral home that Monday, I stopped -- we stopped at the Logan County EMS paramedics to get a copy of the report.

Q Why did you do that?

A Because my brother was -- just wasn't a choking

hazard, so I was confused. I wanted to know what happened. I got that report, and that's the first thing I saw that didn't make sense. It said they were told he was found in the hall. So, we got to the funeral home. Caleb Murray --

Q Are you saying your family was told that your brother died after -- died while -- after choking on his lunch?

A Yes, that's what we were told initially.

Q Okay.

A Yeah. So, when I got that EMT report, it said they were told he was found in the hall. So, I was confused by that. Caleb Murray, his case manager, met us at the funeral home because we had asked him to bring some of Davie's clothes. And his supervisor was with him. She introduced herself. She -- I don't know her, I don't remember her name. She said she was new, she didn't even know Davie. I don't know why she was there, but she was.

We thought -- I had the report in my hand, I showed it to Caleb Murray, and said, "I don't -- why does this say he was found in the hall?" I said, "Y'all told us he choked while eating lunch. What happened?" I said, you know, "This doesn't make sense." And all he said is, "I don't know, I don't know, I wasn't there. It was

Saturday, I wasn't there." I said, "Well, you know, this doesn't make sense to me."

After that, we started worrying about coming up with the money for the funeral, planning the funeral. We had the funeral that Friday. During that week, I had actually talked to Caleb Murray a few times on the phone, just trying to get answers. I said, "Listen, I don't understand." I said, "Can you walk me through this?" He told me, you know, "I don't know, I wasn't there." That's all he would say. He wouldn't answer me.

He actually showed up to the funeral with a few other staff members, Audra, the one Davie was really close to, and a few other people my mother knew but I didn't really remember. And I asked him that Friday, since it was during COVID, they had brought a lot of Davie's stuff, because we weren't allowed to go to the facility.

I asked him again, I said, "Listen, I don't -- I mean, we need someone to tell us what happened." He told me there was an investigation and it was concluded and we would get a paper in the mail so that --

Q Did you know what he was talking about?

A No. I just -- at the time I assumed because it was a state facility and my brother died, I just assumed it was probably protocol that they did some type of

investigation. At that time I didn't, you know, think that was out of the ordinary. That Monday or Tuesday, my mom called me and she received the synopsis of what had happened.

And she -- all they said was, "You're not going to like this." She told -- she read it to me, and that's when we first learned that it talked about a behavior event, a restraint. That was the first time we heard anything of it.

Q That's the very first time --

A That's the very first time.

Q -- that you and your mother ever heard the word "restraint" used related to his death?

A Restraint, restraint or behavior incident.

Q And that -- your mom received that letter --

A A week --

Q -- approximately nine or ten days after his death?

A Yes.

Q And had Davie been -- had the funeral occurred, had Davie been buried at that point?

A Yes.

Q And how long had Davie been buried at that point?

A His funeral was that Friday, the 19th, and my mother received that paper that Monday or Tuesday.

Q Okay. And that was the -- again, that was the very

first time you or your mother learned that there had been a restraint incident involved in his death?
A Yes.
Q What did you do then?
A I immediately called Caleb Murray, and I wasn't very nice. I said, you know, "This is ridiculous. Why did nobody tell us this?" I said, "Why is this the first we're learning of this?" All he said was, "I don't know, I wasn't" -- he just keep repeating the same thing, "I don't know, I wasn't there. I don't know." I said, "Well, somebody needs to give me some answers."
He said, you know, "I can't answer anything for you." I said, "Well, then, who do I need to talk to?" He gave me the number of Jeff Gonyea. I left multiple messages with him, he never returned my call. I finally, I think on the third try, he picked up the phone, I had a conversation with --
Q Was this over a period of days that you tried to get ahold of Mr. Gonyea?
A This was over a period of a few days. Jeff Gonyea.
Q G-O-N-Y-E-A.
A I mean, I finally spoke with Jeff Gonyea. I said all those same things. I said, "You know, this is the first we have heard about a restraint, a behavior." I said, "Why is this, why has nobody told us this?" I

said, "I need to see, you know, reports, investigation, whatever you have. I want someone to explain this to me."

He said, "I can't help you or give you any of that information." I said, "Well, then, who can?" He directed me to Tammy Bimbrook, he gave me her number.

Q Mr. Gonyea gave you no explanation whatsoever?

A None, no.

Q He would answer no questions?

A He wouldn't answer any questions.

Q And he never actually called you back, you just happened to catch him on your -- on what you think was the third time you tried calling?

A Yes. So, then, I reached out to Tammy --

Q What was his -- do you recall what his demeanor was like over the phone, his tone?

A He was very short, and I considered it rude. I mean, I know I wasn't particularly nice to him. I was infuriated, you know, and he --

Q Because you felt like you had been lied to?

A Yes.

MR. ROSEN: Objection, leading.

BY MR. GILLISPIE:

Q Did you feel like you had been lied to?

MR. ROSEN: Objection, leading.

THE WITNESS: I had been lied to.
BY MR. GILLISPIE:
Q Okay.
A Yes. So, I called Tammy Bimbrook, I did get her on the phone. She told me that -- I said, "I need -- I want to see this investigation, any witness reports." And she said, "Your mother is the guardian. She'll have to request that in writing either through e-mail or a letter." My mother doesn't have e-mail, so she drafted a letter and I sent it via e-mail to Tammy Bimbrook.

I requested any witness statements, reports, everything to do with the investigation, any video footage. I requested multiple -- I requested any incident reports involving my brother going back one year, the restraint policy from the State of Arkansas, any video footage, any witness statements, the investigation. We requested that through an e-mail.

And I would say within a week DHS provided all of those things. The file was about 300 pages they provided to me. And that's when I first read the actual witness statements that Sandy Evans had taken down.
Q And so, the letter that your mom had received nine or ten days after his death, do you recall what all that said?
A It was only about five or six sentences, and it just

said that David had a behavior event, he was restrained. There was obviously redacted information on it. It basically just said there was -- David had a behavior incident, he was restrained, he choked, and that 911 was called and he was transported to the hospital.

Q And that's it? It provided --

A Yes.

Q Did it provide any details about the behavior, or about the restraint, or about who was involved --

A No.

Q -- or about any details whatsoever?

A It only provided what I just mentioned. It was literally about five or six sentences long.

Q And that was the only thing that you and your family ever received from Booneville or from DHS that they voluntarily gave you?

A Yes.

Q And is it your understanding that's the only information they were ever going to give you, had you not sought it yourself?

A That was my understanding.

Q Okay. Well, let me ask it this way. Were you ever given any other details or information, either verbally or in written form or in any other form from DHS or from Booneville about your brother's death other than what you

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yourself requested?
A No.
Q Okay. And what are the things that you were able to learn from the documents that you finally got them to give you?
A Well, mainly, I read, you know, the three witness statements for the three people who were involved in his restraint. So, I learned what they wrote down of what happened that day.
Q Okay. And that was -- that's the very first time that you or anybody else in your family, as far as you know, learned what exactly happened or what they were saying happened, and who was involved?
A Yes.
Q Okay.
A That's the first time I learned of any of the details.
Q Okay. First time you learned about Tyler Mattson and his involvement, et cetera?
A Yes.
Q What did you do then?
A I was -- you know, I was upset, I was beyond livid, I mean, to learn those -- to read those statements was really difficult. So, after that, I started -- I called --

Q How long after --
MR. ROSEN: Let her finish. Let her finish her statement.
BY MR. GILLISPIE:
Q How long after his funeral --
MR. ROSEN: She was saying something.
BY MR. GILLISPIE:
Q Okay. You're done, aren't you? How long after your brother's funeral did you get those documents?
A I would say within a week or two.
Q Okay.
A I mean, once he --
Q So, about how long was it, then, from the time of his death until receiving those documents and learning the first details you ever learned about how he died?
A I would have to estimate two to three weeks.
Q Okay. All right. Keep going about --
MR. ROSEN: There's no question pending.
BY MR. GILLISPIE:
Q What did you do next after getting those documents?
A After I received those documents, I called, I reached out to Office of Long Term Care to, you know, request an investigation. I waited to receive -- you know, they told me it would be about a week. So, I waited until I received notification from them, and I

received just an e-mail that said, you know, they found no grounds for maltreatment. After that, because I -- after reading the details, I was just shocked that nobody, you know, had -- you know, that this even happened.

So, next I just started googling and looking up advocacy groups and people who investigate abuse of people with disabilities. And that's when I found the -- actually a report from Disability Rights Arkansas from 2015. I read it, and I went to their website. That's when I first contacted them. So, that's when I -- you know, I started with an advocate or talking to them, explaining to them what happened.

Q Okay.

A And so, for the next however long it took them, a few months, I believe, as an estimate, to do their investigation. So, they did their investigation, that's when I -- actually I felt like my brother shouldn't have died that day, and I felt like nobody -- the people I had talked to with the State, I didn't feel like any of them were taking this seriously. So, after they completed their investigation, I started reaching out to legislators.

I don't -- and especially since I didn't actually live in Arkansas any more, I wasn't up-to-date on who

those were. So, I just started -- I went on the Arkansas State website and started looking up who would have been over Pope County or Logan County. I sent e-mails, I left voice mails. Nobody -- a lot of them never responded.

So, the last -- a few of the senators explained to me they were over federal entities, so they directed me to my local representative. I sent an e-mail to Joe Cloud, who was a representative from Russellville. I told him everything I've told y'all, that, you know, I felt I was lied to, you know, I felt like it wasn't investigated properly. He told me he would look into it. He requested some documents, I believe, from DHS.

He sent those to me, but they were documents I already had. I thanked him for that, but I said, you know -- I actually in the e-mail explained to him, you know, why I felt like my brother shouldn't have died, why I felt like, you know, this wasn't investigated properly.

And I actually talked to him about my concerns, what I thought, you know, what I felt that I have learned since his death that needed to be changed, and I wanted to speak to someone about it, the staff not being able to call 911, the type of restraints that they used. And his response to me was, "You can reach out to another person

with DHS or you can obtain a lawyer." So, that's when I started looking for a lawyer.

Q Okay. And did -- I think you already testified to this. But did -- did DRA draft a report at the end of their investigation into your brother's death?

A Yes.

Q And are you able to describe what their -- what their findings were?

A I mean, I know it was seven pages long, I did read it, it has been awhile. But the thing that I -- that stuck out to me, basically their concerns were a lot of the same concerns I had, that staff weren't able -- you know, they weren't allowed to call 911 themselves. The main thing that stuck out to me is that one of their findings was that the restraint either directly or indirectly related to my brother's death. And that's what I remember the most about it.

MR. GILLISPIE: Let's go off the record real quick.

VIDEOGRAPHER: We're off the record at 12:38.

(WHEREUPON, a brief discussion was held off the record.)

MR. GILLISPIE: Let's go back on the record.

VIDEOGRAPHER: We're back on the record at 12:42.

MR. GILLISPIE: What exhibit number will this be for the deposition?

MR. ROSEN: Why don't you put Claimant's One? That way we'll make these DHS One and Three -- One through Three.

MR. GILLISPIE: Okay. I'm fine with doing that. Eric and I always just did it consecutively.

MR. ROSEN: It makes it a little confusing, but I don't care.

MR. GILLISPIE: Okay. I don't care about it being consistent, it doesn't matter to me. Claimant's One. I'm showing you what we'll mark here as Claimant's One.

(WHEREUPON, Claimant's Exhibit Number One was marked for identification.)

BY MR. GILLISPIE:

Q Do you recognize that to be the report that DRA authored after conducting the investigation into your brother's death?

A Yes.

Q Okay. If you would, just read for us, starting at "Findings", the Findings section. It starts at the

bottom of Bates stamped 4527 and continues through the top of 4528.

MR. ROSEN: And I'm going to say, if she's going to read, please read it slow so the Court Reporter can get it.

MR. GILLISPIE: Yes, please read it --

MR. ROSEN: I mean, it's already in the record, though. Okay.

BY MR. GILLISPIE:

Q Please read it clearly and slowly, Chrissie.

[redacted] Instead of releasing David when he was lying down on the floor, David was restrained on the hard floor by three BHDC staff after finishing his lunch. Prior to the restraint, Staff failed to use other less intrusive interventions such as NCI/CPI, for which they are trained. Staff failed to leave him on the floor, unrestrained, until he was calm. Subjecting an [redacted]

"This restraint likely either directly or indirectly led to David's death. The facility failed to properly communicate the circumstances of this incident to EMS.

We found no evidence that the facility properly communicated the circumstances of this incident to the Arkansas State Police, the Logan County Sheriff's Office, or any other law enforcement agency."

Q And do you agree with the findings of DRA?

A Yes.

MR. GILLISPIE: Claimant's Exhibit One. Give me just a moment, folks.

BY MR. GILLISPIE:

Q Chrissie, let me get you to authenticate some photos, showing you what will be Claimant's Exhibit Two. Is that a photograph of your brother?

A Yes.

Q I would like you to please hold that up for the camera. And I want the camera to get a good shot of this, as well, of this photo.

A (Witness complies.)

Q And is that -- was that taken on your brother's 42nd birthday?

A Yes.

Q Okay. And so, when would this have been taken?

A If it wasn't exactly on [redacted] it was around that date.

Q Okay. This was his last birthday?

A It was his last birthday we celebrated.

Q Okay. And I see he's wearing a Monkees shirt.
A Yes.
Q Where was this photo taken?
A At my mom's apartment.
Q Okay. Is that, as far as -- is that pretty close to what he looked like physically at the time of his death?
A Yes, it's pretty close. He might have gained a few pounds in that last year. But that's pretty close.
Q Okay.
MR. ROSEN: Did you put the exhibit on it?
MR. GILLISPIE: Not yet.
BY MR. GILLISPIE:
Q What about that one? What is that a picture of?
A Well, he was a big Razorback fan, and he loved music, like I said. So, for one of his -- I believe this was one of his previous birthdays or Christmas, I had gotten him a big bluetooth speaker and some bluetooth headphones. So, that's -- he was sitting in my mom's room just listening to the Monkees.
Q Okay. Hold that up for us, please.
A (Witness complies.)
Q Did you say that picture was taken at your mom's house?
A That was at her house, also.

Q Could you give an approximate age for him in that picture?
A This -- just because he weighed a little less here, I think that would have been maybe three or four years before that other picture.
Q Okay. And two more. What about that picture?
A That was at --
Q You can look at it.
A He always did this squinty thing, really happy.
Q Is that you and Davie?
A Yes. That was in downtown Russellville. He wanted to go see the Christmas tree.
Q And about when -- what year would this have been?
A I believe this was 2018, Christmas.
Q Okay. And where did they -- where do you -- where do they place the Christmas tree in Russellville?
A It's right on Main Street, kind of almost across from the courthouse.
Q Is that something y'all would do every Christmas?
A Yes.
Q You would get --
A We would drive around and look at lights ever since we were kids, and he always wanted to get out and stand in front of the Christmas tree.
Q Did that make him happy?

A Yes. Christmas was one of his, other than his birthday, probably his favorite time of year.
Q Okay. And the last photo. Is that Davie as a child?
A Yes.
Q Do you know how old he might have been in that photo?
A I believe he was around four or five.
Q Okay.

(WHEREUPON, Claimant's Exhibit Numbers Two, Three, Four and Five were marked for identification.)

MR. GILLISPIE: Okay. I don't believe I have any more questions for you. Thank you, Chrissie.

THE WITNESS: Okay.

MR. ROSEN: Okay. I have a few more.

MR. GILLISPIE: I have smaller copies of these that I'll -- I'll just e-mail them around. Do you want copies? You have copies of this given through discovery.

MR. ROSEN: If you send them -- if you are e-mailing them to us --

MR. GILLISPIE: Yes.

MR. ROSEN: -- include me in the e-mail.

MR. GILLISPIE: Okay. Sure.

REDIRECT EXAMINATION

BY MR. ROSEN:

Q So, I just want to --

MR. ROSEN: If you could hand me the exhibit of the DRA report, Claimant's Exhibit Number One.

MR. GILLISPIE: Sure.

BY MR. ROSEN:

Q This report was issued in October of 2020; is that correct?

A Yes, correct.

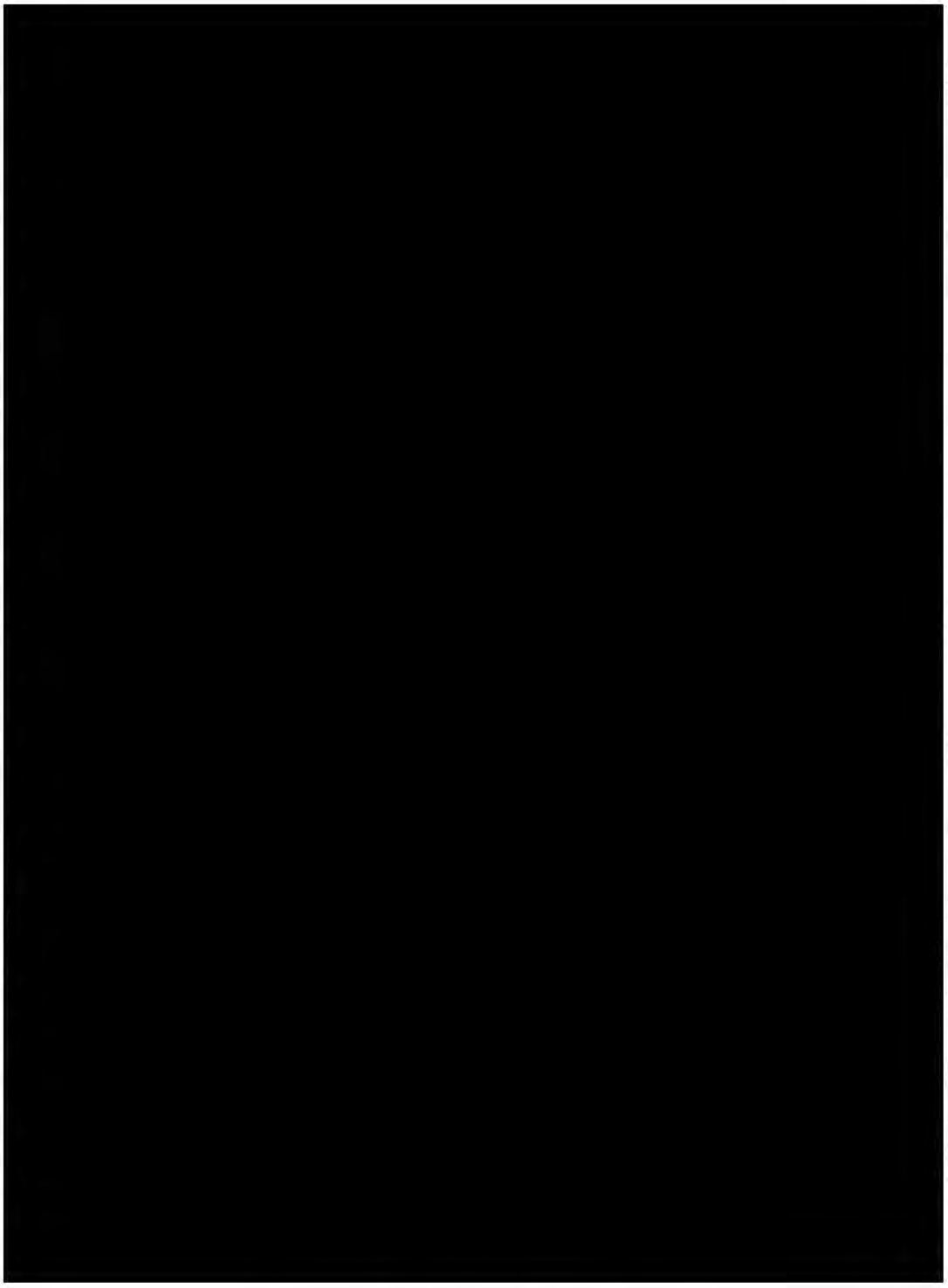
Q Okay. And if you want to see the report again, that's fine. So, you had mentioned -- let me -- and I made a note of it here, so let me just get to my note. You had mentioned, in the DRA report, just stated that the DRA report said they had concerns because one hour after eating, that --

MR. GILLISPIE: Let's actually look at what the report says.

MR. ROSEN: Okay. That's the best.

BY MR. ROSEN:

Q Yes. In the Findings that you read, you stated and you read this, that, [redacted]



[redacted]

MR. GILLISPIE: Object. I'm going to object, as the physician's order is different than that.

MR. ROSEN: Well --

MR. GILLISPIE: [redacted]

[redacted] We were provided two different copies by DHS, this original --

MR. ROSEN: That might be your statement. I understand.

BY MR. ROSEN:

Q But what I'm asking you is, that doesn't jibe with the "elevate head of the bed" from the treatment team, does it, what the DRA stated?

A I think the -- it's my understanding, what I just said is, that does jibe with what that said.

Q So, does that say, [redacted] Is that what DRA found?

A It says --

MR. GILLISPIE: Object to the form. There is more in place than that.

MR. ROSEN: I'm not asking you for testimony, counsel. I'm asking the witness, who is the Claimant, what it says.

MR. GILLISPIE: Okay.

THE WITNESS: It says right here, [redacted]

BY MR. ROSEN:

Q Okay. And that's what DRA says?

A Yes.

Q Okay. But that's not what the treatment -- the IPP says, is it?

MR. GILLISPIE: It is what it says, and that's why I keep interrupting you. Okay. You are going to let me show it to you.

MR. ROSEN: Okay. Okay. I really object to counsel testifying. This is the -- and you can recross if you want.

MR. GILLISPIE: Okay. Well --

MR. ROSEN: Or introduce other documents. But I'm asking the Claimant, and for you to try to influence the Claimant's testimony is inappropriate. I'm just asking questions as to what the DRA's recommendations were and what the actual IPP states.

BY MR. ROSEN:

Q So, would you agree that they state two different things?

MR. GILLISPIE: Object to the form.

MR. ROSEN: Okay. Go ahead.

MR. GILLISPIE: Object to the form.

THE WITNESS: It's my understanding that those two say the same thing, that he needed to be upright for an hour after --

BY MR. ROSEN:

Q Okay. That's what the Findings in the DRA state?
MR. GILLISPIE: Rich, the IPP in a different place does say what she is saying.
MR. ROSEN: Counsel, I'm not cross examine -- if you want to, I can cross examine you in a second. But I'm not. We're here for fact, and this is the Claimant, you're not the Claimant.
MR. GILLISPIE: So, I was trying to save time.
MR. ROSEN: I really --
MR. GILLISPIE: But okay.
MR. ROSEN: We're not here to save time, we're here to get the facts.
MR. GILLISPIE: Well, you're asking questions based on --
MR. ROSEN: Now I'm referring to what has been introduced --
MR. GILLISPIE: -- false information.
MR. ROSEN: It's not false information. This is what it says. I'm going to ask her. You can ask her other questions, if you want.
BY MR. ROSEN:
Q Exhibit Three, that was introduced and we already know that this was the 2019 Treatment IPP; correct?

A Correct.
Q Okay. And here is the -- on page 1483 of the Bates stamp, which is page 16 of the report, what does it say?
A Do you want me to read it out loud?
Q Yes.
[redacted]
Q Thank you. Now, so, tell me, what does the word -- what is an investigation, to you? What does it mean, to you?
MR. GILLISPIE: Object to the form.
THE WITNESS: In reference to what, just in general?
BY MR. ROSEN:
Q Yes. What does an investigation mean?
A An investigation means looking into something to the best of your ability, taking every avenue you can to try to come to a conclusion. When you have a question, you are trying to study and -- I'm trying to find a word, you know, other than looking into the -- to find the facts of something to come to a conclusion.
Q Okay. And we don't know, at the beginning of the investigation, where that conclusion is going to go, do we?

A No, I don't think you know when you start.
Q Okay. That's the purpose of an investigation?
A Right, right.
Q I mean, we all agree on that; right?
A Uh-huh.
Q Is that "yes" or "no"?
A Yes, yes.
Q This lady is taking it down. So, and investigations would take a little bit of time at least; right?
A Yes.
Q As a matter of fact, the DRA, their findings from their own investigation wasn't issued until October, four or five months -- four months after David Cains passed away; right?
A Correct.
Q Okay. So, you wouldn't expect an investigation to take a day, would you?
A No.
Q It would be reasonable for it to take a week or two, would it not?
A I would think, if you're referring to in my brother's case, in something like this, I would expect it to be -- if it was done thoroughly, to take a good amount -- I wouldn't expect it to be done in three or four days, no.

Q Okay. All right. I just wanted to clarify that. Thank you. Now, so, there was the Booneville Human Development Center investigation, right, that you talked about?
A Yes.
Q And I understand you had concerns about it?
A Yes.
Q Okay. Then, there was the -- you mentioned the State of Arkansas, Office of Long Term Care investigation; correct?
A Correct.
Q And did you have concerns about that, too?
A Well, I was never -- the only thing I ever received was an e-mail saying that their investigation was concluded and there was no maltreatment. I requested the details or whatever I was allowed to get of that actual investigation. And they -- I was not -- I didn't receive it, because they told me I wasn't allowed to, that my mother wasn't allowed to, because her guardianship no longer applied.
Q Now, did you -- are you talking about -- you're talking about a maltreatment investigation?
A When I called, after my brother's death, after I received this -- the synopsis from Booneville, I called the Office of Long Term Care and I told them exactly what

had happened with my brother and what I was concerned about, and I asked them to investigate. And they said -- and they told me that they would look into it.

Q Okay. Are you aware that Office of -- the State of Arkansas, Office of Long Term Care is a dually certified state and federal investigative -- investigators at the long-term care facilities?

A I mean, I --

Q Are you aware of that?

A I wasn't aware about federal.

Q Okay. Are you aware that the Long Term Care -- State of Arkansas, Long Term Care investigators are federally trained, as well as state trained?

A I don't know the details of their credentials, no.

Q Okay. Were you aware, or are you aware that they are -- have to be licensed, or certified maybe -- I don't remember whether it's licensed or certified, are you aware of that?

A I'm not aware of any of that.

Q And so, were you aware that they investigated this and found it to be unfounded, or unsubstantiated, whatever it's called?

A All I received was an e-mail that said they found no maltreatment. And I wanted the details of that investigation, and I never received them.

Q Okay. Now, so, then, you went -- when that -- and when was that? When did you -- what timeframe was this?
A That was probably -- it was after I received -- my mother received the synopsis from Booneville. And I would assume it would have been within a few days.
Q Okay. So, as I recall, it was about a week later or nine days later or so, approximately, that you got the Booneville investigation. And then, when did you inquire into the Office of Long Term Care for their investigation?
A I would say within a few days.
Q Of what?
A Of receiving -- well, after we received the synopsis, and I reached out to Jeff Gonyea, he directed me to Tammy Bimbrook. I received -- my mother and I requested all the information as pertains to their investigation. So, I would say within a few days of reading all those witness statements of what they said happened that day, I reached out to the Office of Long Term Care.
Q Okay. So, you reached out to them. And then, when did you -- after you reached out, how long did it take to get what you said was their e-mail or a conversation from them?
A I mean, it -- I would guess that if it didn't take a

long time, maybe I received that e-mail within a week or two of reaching out to them.
Q Okay. Did you know who you spoke to?
A I do not.
Q Now, and so, you weren't satisfied with that investigation, either; right?
A Well, I don't know what the -- all I got was that they found no maltreatment. I wanted the details of why, how they came to that conclusion, and I was never given that.
Q Okay. Now, do you know whether a survey was taken to see if there was any failed facility practices at the Booneville Human Development Center related to David Cains, that episode on June 13th, 2020?
A A survey by who?
Q By the federal surveyors, the state and federal surveyors?
A I don't -- I'm not aware of what that is.
Q Okay. Well, then, you're not aware that it was unfounded and unsubstantiated?
A I've never heard of that.
Q Okay. So, then, you reached out to -- when you were dissatisfied with that, with those surveys and those investigations, you reached out to DRA; right?
A Correct.

Q Okay. I just wanted to get the sequence. Okay. And you initially reached out to them approximately what month?
A I received the first call from them around July 4th weekend.
Q Okay. So, then, it took them all that time until October to issue the report that was introduced as Claimant's Exhibit One; right?
A Correct.
Q And so, you were -- it sounds like -- so, you were dissatisfied with the Booneville investigation, you were dissatisfied with the State of Arkansas, Office of Long Term Care investigation, too; is that correct?
A Correct.
Q Okay. So, you searched out to find an organization that you would be satisfied with; right?
A No. I went through all the proper channels through -- that was offered to me and suggested through the State of Arkansas, and I wanted to find a -- find someone to investigate who was not -- who I felt was impartial, who was not associated with the State of Arkansas.
Q So, you felt that DRA was impartial?
A I know that they're a nonprofit and they're not -- they're not a government agency.

Q Well, they get their money from the government.
A They're a nonprofit.
Q And so, but you weren't aware that they're against all human development centers' operations?
A I was not aware of that when I reached out to them.
Q So, knowing that, does that skew your belief in the credibility of their investigation at all?
A No.
Q Now, just moving on to a different subject. So, I think that -- you had mentioned something about -- to counsel's questions about the 911 or the EMT's arrival at Booneville. And they arrived, as I recall, at 11:50 that day, and they left at 12:10. They were there 20 minutes. Does that -- do you agree with that?
A I mean, that sounds --

[redacted]

[redacted]

A I do have concerns. I have many concerns about what happened once my brother left that bathroom.
Q Okay. Now, so -- and you're aware that Booneville HDC has a medical team that responded within one or two minutes of David's stopping breathing; right?
A I'm aware that they had a medical team that responded.
Q Okay. And are you aware -- do you know who the EMTs, when they arrived, who they spoke with?
A No, I don't know who they spoke with.
Q Okay. But did you know that -- or do you know whether or not that when they arrived, it was the nurses who were providing assistance to David Cains?
A I've read that in their statements.
Q And you know that, from their statements, then, that they arrived about one or two minutes after David Cains stopped breathing; right?
A I know that's their statement.
Q Okay. Do you disagree with that statement?
A I don't agree or disagree. I just know that I read it. I don't know how long it took them to get there.
Q Okay. But you don't have any evidence that it took

longer or less, do you?
A I don't know. All I can go by is what they said. I've been to that facility, I mean, I've been on that campus, but I don't -- I wasn't there.
Q So, you know that what we call Judge Hills, where the nurses are, is right down by --
A Yes.
Q So, it wouldn't take long to get there, would it, by car?
A I don't know how long it would take. I know that they're in close proximity to each other.
Q All right. Fair enough. Now, did you find any discrepancies in the EMT statements as to what he claims was said and what he told the emergency room physician about where they found David Cains?
A I'm not aware of what, I don't recall what he told the emergency, other than he choked while eating lunch.
Q Okay. Now, when you -- changing to another area, when you would -- right after you moved to Vermont, and I think you testified that you would either drive or fly, depending on your schedule and the amount of time, when you would come down to visit David. How long would you be in Arkansas, typically?
A Anywhere from one to two weeks.
Q Okay. And so, would you stay at your mom's?

A Yes.
Q Okay. So, you were here to visit family, as well?
A No. I was here -- I wouldn't have come that often if it wasn't for my brother.
Q So, did you spend one or two weeks with David Cains?
A I would go up there and see him, and I would usually bring him home for the weekend, you know, at least Friday to Sunday. Sometimes if he -- we would go by his, you know, how he felt, if he would stay longer.
Q So, sometimes he wanted to go back to the Booneville HDC?
A Sometimes he wanted to go to work, or see his friends, you know. But I was -- my time at home, I would go see him, you know, as often as I could.
Q Because -- yes. Because he felt -- Booneville was his home; right?
A Right.

MR. ROSEN: I don't have any other questions. Thank you.

MR. GILLISPIE: Let's go off the record just a second.

VIDEOGRAPHER: We're off the record at 1:07.

(WHEREUPON, a brief discussion was held off the record.)

VIDEOGRAPHER: We're back on the record at 1:17.

RECROSS EXAMINATION

BY MR. GILLISPIE:

[redacted]For the record, this is the IPP introduced by the State as State's Exhibit Three, or Respondent's Exhibit Three. And page 15 -- or Bates marked page 1525 of that exhibit I'm showing you here, I would like for you to, if you can, read for me what it says there at the bottom right-hand page numbers.

A Page one of two. Page -- is that what you're talking about?

Q Does it appear that somebody marked out the printed word two and handwrote in the number one?

A It says, what it looks like is there is ink marked over the number.

COURT REPORTER: I'm sorry. I can't hear you.

THE WITNESS: Okay. And yes, it does look like that there is ink marked over the numbers, the printed number.

MR. GILLISPIE: Okay. And I will represent

that -- and I don't think anybody --

MR. ROSEN: I don't want any representations. You can ask questions.

BY MR. GILLISPIE:

Q Would you disagree with me that there is no -- in the exhibit introduced by the State, there is no page two?

A Right.

Q Would you agree with that?

A Right, yes.

Q You have looked through this exhibit?

A Yes.

Q Okay. There is no page two in the IPP introduced by the State; correct --

A Correct.

Q -- here today. Please hold that up for the camera.

MR. GILLISPIE: And, John, I would like for you to zoom in on this document, and particularly zoom in on the bottom right-hand corner where that two is marked out and replaced with a handwritten one.

VIDEOGRAPHER: (Complies.)

MR. GILLISPIE: Got it? All right.

BY MR. GILLISPIE:

Q And again, this was Bates marked page 1525 of

Respondent's Exhibit Three. Bates marked page 1526 of Respondent's Exhibit Three, is this -- Chrissie, does that say Bates marked 1526?

A Yes.

Q Does 1526 come after 1525?

A Yes.

Q Okay. Please hold that up for the camera.

A (Witness complies.)

MR. GILLISPIE: Have you got that page number, John?

VIDEOGRAPHER: One moment. I've got a stamp at the bottom and --

MR. GILLISPIE: Okay. And again, this is Bates marked 1526 of Respondent's Exhibit Three, which again, is the version of the IPP that the State introduced today.

(WHEREUPON, Claimant's Exhibit Six was marked for identification.)

BY MR. GILLISPIE:

[redacted]

[redacted]

Q And your brother died on June 13th, 2020?
A Correct.
Q Okay. Now, I'll represent that this was produced to us by Respondent as indicated by the Bates mark at the bottom, and what is the Bates number on that document?
A 1327.
Q Okay. And how many pages is that exhibit?
A It says page one of two.
Q Okay. And has it been marked out -- is anything marked out and replaced with handwriting?
A No.
Q Okay. Well, hold that up for the camera, please.
A (Witness complies.)

MR. GILLISPIE: And, John, if you could, make sure you get the whole thing real close.

VIDEOGRAPHER: (Complies.) It is.

BY MR. GILLISPIE:
Q Okay. And, now, is there a page two to this exhibit?
A Yes.

[redacted]

[redacted]

Q Okay. Hold that up for the camera, please.

A (Witness complies.)

MR. GILLISPIE: So that he can zoom in on the highlighted portion, and then also the dates at the top.

VIDEOGRAPHER: (Complies.)

BY MR. GILLISPIE:

[redacted]

MR. ROSEN: Objection. The document speaks for itself. So, I don't know what you're clearly trying to represent. She just testified.

BY MR. GILLISPIE:

[redacted]

MR. GILLISPIE: Okay. Got it? That's all I have. Thank you.

MR. ROSEN: I would like the document, please, because I have questions.

MR. GILLISPIE: I gave you a copy of it.

REDIRECT EXAMINATION

BY MR. ROSEN:

Q Okay. Well, I want you to -- if you could take a look at this document and hold up the second page, that highlighted part that your client -- excuse me, that your attorney referenced and that you read.

A (Witness complies.)

[redacted]

A Correct.

Q Okay. Now, what's the date printed on this document up at the top right-hand corner?

A Date printed June 15th, 2020.

Q Okay. And is this signed by Doctor Hamid? Is there a signature on there where it says "Signed" and "Reviewed"?
A I don't see a signature. I see his name printed.
Q Printed, but no signature; right?
A Correct.
Q And there is -- so, I want you to hold up the document. And this is Claimant's Exhibit --

MR. ROSEN: What number is this?

MR. GILLISPIE: Six.

THE WITNESS: (Complies.)

MR. ROSEN: And if you could zoom in on the part that says "Elevate HOB", head of bed.

VIDEOGRAPHER: Is it the highlighted version?

MR. ROSEN: Yes, the pink part.

VIDEOGRAPHER: (Complies.)

MR. ROSEN: And then go up to the part where it says "Date Printed: 06/15/2020" in the upper right-hand corner of the document, facing it.

VIDEOGRAPHER: (Complies.)

MR. ROSEN: And if you could then go to the upper left-hand corner of the document where it says "Active Orders: 06/01/2020 to 06/30/20".

VIDEOGRAPHER: (Complies.)

MR. ROSEN: And then, go down to the part that's signed -- or where it's not signed, where "Signature" is.

VIDEOGRAPHER: (Complies.)

BY MR. ROSEN:

Q Okay. You can put it down now.

A (Witness complies.)

Q So, the questions that I'm going to ask, this is part of this -- what we were talking about was the existing IPP for 2019, which was the one that was in effect when your brother died; isn't that correct?

A Correct.

Q This was prepared for the next year, for 2020, and it was going to be his IPP, if that's what the treatment team agreed to; isn't that correct?

A I don't -- I mean, if that's what you're telling me.

Q Well, I'm asking the questions.

A I mean, for the date, is this -- what are you asking?

Q Okay. So, this is the one that was in effect in -- that we talked about in the IPP that governed his -- that governed David Cains' treatment for the time period that we're talking about; right?

A Yes.

Q Okay. And the one that you introduced is for -- wasn't even printed until after he passed away; right?
A That's what it says up here.
Q Yes. And he was about to -- you were about to all meet, and they were preparing all the documents for the new IPP for 2020 at the time that, right before -- right after -- well, they were preparing for it at the time that your brother passed away; right?
A Correct.
Q Okay. So --

MR. ROSEN: All right. I have no other questions. Thank you.

MR. GILLISPIE: I don't think I do. Give me one second.

VIDEOGRAPHER: We're off the record at 1:27.

(WHEREUPON, at 1:27 p.m., the taking of the above-entitled deposition was concluded.)

---o---

DHS Exhibit One:

DHS Exhibit Two:

DHS Exhibit Three:

Claimant Exhibit One:

Claimant Exhibit Two:

Claimant Exhibit Three:

Claimant Exhibit Four:

Claimant Exhibit Five:

Claimant Exhibit Six:

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, DONNA K. PETRE, Certified Court Reporter in and for the County of Pulaski, State of Arkansas, duly commissioned and acting, do hereby certify that the above-entitled proceedings were taken by me in Stenotype, and were thereafter reduced to print by means of computer-assisted transcription, and the same fully, truly, and correctly reflects the proceedings had, with portions dependent on the quality of the Zoom audio or video taken.

I FURTHER CERTIFY that I am not attorney or counsel of any of the parties, nor am I relative or employee of any attorney or counsel or party connected with the action, and have no interest in the outcome or results of this proceeding.

WHEREFORE, I have subscribed my signature and seal as such Court Reporter in the City of Little Rock, County of Pulaski, State of Arkansas, this the 20th day of November, 2022.

_____
DONNA K. PETRE, CCR #125
COURT REPORTER IN AND FOR
PULASKI COUNTY, ARKANSAS

---o---



BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS — CLAIMANT

VS. CLAIM #220374

THE ARKANSAS DEPT. OF HUMAN SERVICES — RESPONDENT

NOTICE OF DEPOSITION

To: CHRISTINE MCAULIFFE

PLEASE TAKE NOTICE that pursuant to Rule 3.3 of the Rules and Regulations of the Arkansas State Claims Commission and the Rule 30 of the Arkansas Rules of Civil Procedure, the Respondent, the Arkansas Department of Human Services, by counsel, will take the deposition of Claimant **CHRISTINE MCAULIFFE** on the date and time and at the place identified below.

The examination shall cover all matters, issues and factual allegations raised and/or related to the matters, issues and factual allegations raised in the claim. The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date: **FRIDAY, OCTOBER 28, 2022**

Time: **9:30 a.m.**

Place: **1 Riverfront Place, Suite 605**
North Little Rock, AR 72114

ARKANSAS DEPARTMENT OF HUMAN SERVICES

By: Rich Rosen

Richard N. Rosen, Bar # 97164
Office of Chief Counsel
P.O. Box 1437, Slot S-260
Little Rock, Arkansas 72201
(501) 682-8608

CERTIFICATE OF SERVICE

This is to certify that a copy of the foregoing Notice was mailed, postage prepaid, and emailed this ~~15th~~ 16th day of September, 2022 to:

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114

josh@ greenandgillispie.com

Rich Rosen
Richard N. Rosen

ARKANSAS STATE CLAIMS COMMISSION

(501) 682-1619
FAX (501) 682-2823

KATHRYN IRBY
DIRECTOR

101 EAST CAPITOL AVENUE
SUITE 110
LITTLE ROCK, ARKANSAS
72201-3823

CLAIM SUBMISSION SIGNATURE PAGE

The undersigned attorney certifies that to the best of my knowledge, information, and belief, this claim is not being presented for any improper purpose; this claim is warranted by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law or for establishing new law; and the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery.

Claimant Name (must be printed legibly)

Claimant Signature

Acknowledgement



State of Arkansas

County of Pulaski

On this the 12th day of October, 2021, before me, the undersigned notary, personally appeared [illegible] known to me (or satisfactorily proven) to be the person whose name is subscribed to this instrument and acknowledged that he she executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

Dana E. Henderson
Signature of Notary Public

My Commission expires: 7-6-26



Please note that all sections must be completed, or this form will be returned to you, which will delay the processing of your claim.

1. Claimant's Legal Counsel - (If representing yourself (Pro Se) please check this box and proceed to section 2)

2. Claimant(s)

3. State Agency Involved: (must be an Arkansas state agency. The Arkansas Claims Commission has no jurisdiction over county, city, or other municipalities)

4. Incident Date

5. Claim Type

5a. Check here if this claim involves damage to a motor vehicle.

5b. Check here if this claim involves damage to property other than a motor vehicle.

All property damage claims require a copy of your insurance declarations covering the property or motor vehicle at the time of damage.

All property damage claims require ONE of the following (please attach):
1. Invoice(s) documenting repair costs, OR
2. Three (3) estimates for repair of the damaged property, OR
3. An explaination why repair bill(s) or estimate(s) cannot be provided.

6. Was a state vehicle involved? (If Yes, please complete the following section)

7. Check here if this claim involves personal injury.

All personal injury claims require a copy of your medical insurance information in place at the time of the incident.

8. Amount Sought:

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains — CLAIMANT

V. Claim No. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

COMPLAINT

COMES NOW the Claimant, Christine McAuliffe, as Special Administrator of the Estate of David Cains, by and through her attorney, Joshua D. Gillispie, and for her causes of action against the above-named Respondent, states the following:

JURISDICTION AND VENUE

1. This claim is brought pursuant to the Arkansas Claims Commission's jurisdiction over claims for monetary damages brought against an agency of the State of Arkansas, pursuant to A.C.A. § 19-10-204.

2. Venue is proper pursuant to A.C.A. § 19-10-201, et seq. The incident complained of herein occurred in Arkansas, in Logan County.

PARTIES AND SERVICE

3. Claimant hereby incorporates by reference all previous paragraphs as if fully set forth herein.

4. Claimant Christine McAuliffe (hereafter "Claimant"), Special Administrator of the estate of her brother, David Cains, brings this cause of action for survival on behalf of the

Estate of David Cains; and for the wrongful death of David Cains, on behalf of the following statutory beneficiaries: Charlene Robinson, mother of the deceased; and herself, as sister of the deceased. Claimant's Letters of Administration and the Order of Appointment are attached hereto, respectively, as ***Exhibit 5*** and ***Exhibit 6***.

5. At all times relevant to this cause of action, and at the time of the incident described further herein, Respondent, the Department of Human Services (hereafter "DHS"), was at all relevant times an Arkansas state agency. DHS, through its Division of Developmental Disability Services (hereafter "DDS"), operated five Human Development Centers throughout the state, including the Booneville Human Development Center (hereafter "BHDC"), which is where David Cains lived for 13 years and where he died. All tortious acts alleged herein occurred at the BHDC. David Cains' Death Certificate, as well as his health insurance identification cards, are attached hereto, respectively, as ***Exhibit 7*** and ***Exhibit 8***.

FACTUAL BACKGROUND

6. Claimant hereby incorporates by reference all previous paragraphs as if fully set forth herein.

7. The Booneville Human Development Center (BHDC) is a state facility established to provide care for people with developmental disabilities. It is located on the grounds of the former Arkansas Tuberculosis Sanatorium, which originally opened in 1910. The Sanatorium closed for tuberculosis patients in 1973. The BHDC can house up to approximately 150 people with disabilities, and the residents have access to limited recreation, and a cafeteria for meals.

8. The BHDC has a checkered past, and a serious history of abuse against some of the most vulnerable in our community. The facility has demonstrated indifference to improving

the training of staff to provide safe services for those with disabilities. The United States Department of Justice has twice sued the State of Arkansas regarding the failure to provide adequate services and care at its Human Development Centers; however, those cases were dismissed based on procedural grounds.

9. In 2010, a resident choked to death because staff were not providing adequate supervision to ensure the safety of a young man with known disabilities related to his ability to eat. In February of 2015, a young woman died after being regularly and improperly restrained without regard to her known seizure issues, which led to her choking to death.

10. Disability Rights Arkansas (hereafter "DRA") issued a scathing report recommending the closure of the BHDC in January of 2015, which is attached hereto as ***Exhibit 1***. The title of this report was "A New Approach to Care in Arkansas: Why the Time Has Come to Close the Booneville Human Development Center." Disability Rights Arkansas (DRA) is the designated federal Protection and Advocacy System for individuals with disabilities in Arkansas. One of DRA's core functions is to investigate the deaths of persons with developmental disabilities in facilities that provide services to them. DRA has authority under federal law to thoroughly investigate deaths occurring in any public or private entity that provides care, services, treatment, or habilitation to individuals with disabilities.

11. One year later, the DRA issued another report criticizing the lack of improvement at the BHDC titled "The Excessive Use of Restraint at Booneville Human Development Center," attached hereto as ***Exhibit 2***. DRA concluded that the restraint practices at the Booneville HDC are contrary to recognized best practices and put residents and staff at risk of physical and emotional harm. The DRA report notes that restraints should only be used on individuals who repetitively engage in dangerously aggressive behavior, and less restrictive

methods of addressing the person's behavior should first be tried and documented. Restraints should be a method of last resort. The BHDC uses a significantly higher rate of restraints on residents than the other Human Development Centers in Arkansas. Additiona ly, according to the DRA report, the BHDC uses restraints often as a first option to handle a "problem" resident, instead of using less restrictive methods. Restraints are used on residents for not complying with requests even when there is no danger of imminent violent behavior from the resident.

12. The Booneville HDC has not improved since the 2016 investigation and rep ort by the DRA. Improper and abusive restraining techniques were used in 2019, which caused a disabled resident to suffer a broken arm. And, just last year the improper rest aint of David Cains led to his death from choking on his own vomit. As further stated herein, the employees at BHDC did not disclose that Cains had been restrained to emergency medical services, the coroner, or any other government officials. The cover-up of the use of restrain ts on David Cains is troubling; it further demonstrates the lack of professionalism and proper care at the Booneville HDC.

13. David Cains, bor[redacted]as admitted as a fulltime resident to BHDC on May 1, 2007. He lived there for 13 years, until his death on June 13, 2020. He liked watching the Dukes of Hazard, loved the band the Monkees, and he didn't like to be alone. Most of all, he loved being with friends and family. His mother and sister (Claimant) were very active in David's life, regularly visiting him and taking him on outings. David always spent the major holidays at home with his family.

[redacted]

[redacted]

15. Disability Rights Arkansas (DRA) performed an investigation into David's death and issued a written report on October 22, 2020, attached hereto as ***Exhibit 3***. DRA concluded, as further stated herein, that policy failures at BHDC and the conduct of BHDC staff resulting from those policy failures, including the use of an excessive restraint, failure to follow David's GERD precautions, and failure to call 911 when David stopped breathing – caused David Cains' death, "either directly or indirectly."

16. Based on the written statements of BHDC staff, interviews conducted by DRA with BHDC staff, EMS and medical records, and various reports issued by DHS personnel, the following facts are currently known about David Cains' death:

17. David had an egg salad sandwich for lunch on the day he died. He had his lunch at the cafeteria in the BHDC Commons Building, sometime before 11:30am. After lunch David was accompanied to a nearby restroom by staff member Tyler Mattson. According to Mattson, David became irritated after exiting the restroom, began screaming, ripping paper off the wall, and attempting to hit Mattson. Mattson immediately applied physical restraints, referred to by BHDC as "personal restraints," beginning at approximately 11:30am, according to Mattson. Mattson states he grabbed David's arms, causing David to fall over and land on his face. Mattson then rolled David onto his left side where he continued to physically restrain David, who Mattson says was still resisting. Another BHDC staff member, Amy "Mandy" Jones, arrived on the scene and joined in restraining David by holding his head in place. A third BHDC staff member, Ryann Campos, then arrived and participated in the physical restraint by holding David's ankles. According to Campos, she noticed shortly after arriving that David had

defecated. At some point they saw food coming out of David's mouth, that his face was purple, and that he was not breathing. Though their participation in the physical restraint began at different times, both Mattson and Jones claim the physical restraint on the ground lasted one minute, stopping only when they realized he was no longer breathing. These conflicting statements have not been resolved or explained by Respondent.

18. None of the three staff members called 911, even though they knew David had stopped breathing. BHDC Policy IV-B-10 specifically prohibits all non-medical staff from calling 911 in response to a medical emergency. Instead, Ryann Campos called staff LPN Deborah Noah, who was present on campus at the Judge Hill Building, informing her of what was happening and that David Cains was not breathing. According to Deborah Noah, it was approximately 11:33am when Ryann Campos called her. Rather than dialing 911 right then, Noah instead relayed Ryann's message to staff LPNs Amanda Schmidt and Kelly King. Rather than dialing 911 right then, Schmidt and King instead drove by car from the Judge Hill Building to the Commons Building across campus. LPNs Schmidt and King then entered the Commons Building, located the scene, observed David, and only then did they instruct another staff member to dial 911.

19. It is of concern that all BHDC staff members, including the LPNs, claim in their written statements that Ryan Campos called medical staff at 11:33am and that 911 was called at 11:34am. In order for this to be true, it would mean LPN Noah received the call from Ryann Campos, then relayed that message to LPNs Schmidt and King, who then walked (or ran) to a parked car, drove the car across campus to the Commons Building, walked (or ran) inside, located the scene, observed David on the floor not breathing, then instructed a staff member to

call 911, which that staff member then did, all in the span of 60 seconds. That is simply not possible.

20. Furthermore, Logan County EMS records reflect the 911 call was placed, not at 11:34am, but at 11:37am, which means that a minimum of four precious minutes elapsed between the time staff realized David had stopped breathing and the time 911 was called. The Logan County Coroner's report also identifies 11:37am as the time 911 was called. At least 4 minutes, and quite possibly more, given there were no visible clocks in the area where the restraint occurred, elapsed from the time staff noticed David was not breathing to the time 911 was called.



23. At the time of David's death, BHDC was the only Human Development Center in Arkansas that did not have cameras in place to monitor the facility.

24. BHDC staff misled EMS responders as to how David died. BHDC told Logan County EMS that David simply began choking on his lunch, aspirated, and stopped breathing, intentionally omitting all mention of the physical restraint. This misinformation was then relied upon by Mercy Hospital and ultimately the Logan County Deputy Coroner, who, after later learning the true circumstances of David's death, stated that an autopsy likely should have been performed.

25. The true circumstances of David's death were also kept from his family. BHDC told David's mother only that he had choked on his lunch and that they would need to contact Mercy Hospital if they wanted additional information. It was not until nine days after David's death, the Monday after his funeral, that his mother learned of the physical restraint. His mother and sister (Claimant) had requested additional details from BHDC, and on this Monday after David's funeral they received in the mail a letter from BHDC containing a "Final Synopsis" of the incident, attached hereto as ***Exhibit 4***. This final synopsis, signed by Jeff Gonyea, the Superintendent of BHDC, not only contained the first mention of the physical restraint David's family had heard, but stated there was insufficient evidence to corroborate maltreatment and that, in fact, "[a]ll staff conducted themselves in an appropriate manner." Prior to this letter nine days after David's death, his family was not even aware a maltreatment incident was being investigated. At this point, David had been buried three days and it was too late to request an autopsy.

26. The BHDC conducted an internal maltreatment investigation into David's death. That investigation, upon information and belief, was led by Sandy Evans, a DHS Residential

Services Director and Adult Maltreatment Investigator who, upon information and belief, was herself employed by the BHDC. Upon information and belief, she worked alongside the very people she was supposed to be investigating. This BHDC investigation, which, according to DRA, suppressed or omitted crucial facts, concluded that no individual involved in the incident did anything wrong. It was endorsed by Jeff Gonyea, who, as Superintendent of BHDC, was ultimately responsible for the actions of the employees being investigated.

27. The Division of Provider Services and Quality Assurance (DPSQA) also investigated the circumstances surrounding David's death. According to DRA, very little could be gleaned from this investigative report. This investigation basically concurred with the BHDC investigation, while providing no independent reasoning, no description of the events, and no statements from witnesses.

28. BHDC's policy failures, given its extensive history of problems with excessive use of physical restraints, can fairly be described as willful. BHDC was fully aware that the overuse of physical restraints greatly increased the risk of physical harm and death to its disabled patients yet did nothing to change policy or practice. As previously stated, one patient was killed during a physical restraint in 2015, another suffered a broken arm in 2019, and the problem was so bad that DRA was calling for the facility to be permanently closed. Despite all this foreknowledge, BHDC did nothing, and this failure by omission directly caused David Cains' death.

29. BHDC explicitly acknowledges, in writing, the extreme risk to disabled patients caused by physical restraints. The BHDC's "Restraint Incident Debriefing Form," which was provided to staff and used to document physical restraints *prior* to Cains' death, states the following in bold lettering: "**The Booneville Human Development Center is dedicated to the**

reduction of restraint use at the facility. The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program), when a very real risk of personal injury or severe property damage is imminent."

30. Despite knowing, and even memorializing in its internal documents, that physical restraints "dramatically" increased the risk of injury to disabled patients, BHDC did nothing to enforce a policy reflective of this dramatic risk. In fact, according to BHDC records, **staff used physical restraints on David Cains at least 16 times in the one year preceding his death.** One of these was a mechanical restraint, whereby David was bound to a chair or bed with straps on each wrist and three straps across his body. Despite knowing of safe and effective alternatives, BHDC did nothing to enforce the use of these safer alternatives. In this case, there is no evidence Mattson or any other staff member ever attempted to use any form of non-physical intervention on David Cains before taking him to the ground.

31. According to the most recent DRA report, BHDC, in April of 2012, participated in a training survey with H & W Independent Solutions to evaluate and improve the quality of care to the residents. During the evaluation, H & W found that significant improvement was needed due to, in part, the BHDC staff's reliance on emergency restraint. This is further evidence of the foreseeability of David's death on the part of BHDC.

32. Despite the fact that BHDC claims to certify its staff in the use of NCI/CPI crisis intervention (which are non-violent), BHDC also trains and allows its staff to restrain residents using methods that require no certification and are not evidence-based, such as the physical

restraint used on David Cains. The most recent DRA report states that it "is concerning that BHDC staff are then left to choose between non-violent crisis intervention and physically/emotionally traumatizing physical restraint," which in this case led to David's death.

COUNT ONE: NEGLIGENCE

33. Claimant hereby incorporates by reference all previous paragraphs as if fully set forth herein.

34. The Respondent Arkansas state agency, DHS, at all times relevant to this action controlled and operated BHDC. Respondent, at all times relevant to this action, owed David Cains a duty of ordinary care. In agreeing to accept the custody, care, and control of David, Respondent expressly assumed a duty of care for David Cains. The relationship between Respondent and Cains imposed a duty in this case. Duty can be assumed or created through actions, and "where a person undertakes to act, they must do so carefully or they will be liable for negligence." *Yanmar Co., Ltd. v. Slater*, 2012 Ark. 36, 16, 386 S.W.3d 439, 449 (2012). The moment Respondent agreed to take care, custody, and control of David, a duty was created.

35. Respondent breached its duty and proximately caused Claimant's damages in at least the following ways:

(a) By failing to set policies reflective of its knowledge that physical restraints are unreasonably dangerous to patients;

(b) By failing to train and require BHDC staff to use non-violent methods of deescalation, despite knowing the unreasonable risks of physical restraints;

(c) By using an excessive and unreasonable physical restraint on David Cains;

(d) By using this physical restraint without first even attempting to deescalate in a non-violent way;

(e) By regularly physically restraining clients in unreasonably dangerous and violent ways, such as by pinning them to the floor, which is what happened here;

(f) By allowing staff to take clients to the floor during physical restraints and engage in other means of physical restraints not based on any specific training or guidelines, but rather just the judgment of its poorly trained staff;

(g [redacted]

(h) By ignoring known choking and seizure precautions necessary for Cains' safety;

(i) By failing to set policy allowing non-medical staff to call 911 in emergency medical situations;

(j) By failing to call 911 the moment David Cains stopped breathing, if not before;

(k) By failing to have cameras in place to monitor how residents are treated;

(l) By failing to honestly communicate the circumstances of David's death to emergency responders, law enforcement, and David's family;

(m)By failing to exercise ordinary care for David's safety;

(n) By engaging in conduct that BHDC knew or should have known would endanger the life life and safety of David Cains;

(o) By failing to train, oversee, supervise and otherwise equip its staff;

(m) By failing to anticipate the danger to Cains, given the circumstances, and failing to use commensurate care to prevent the harm; and

(o) By failing to maintain and adhere to safety policies, protocols, and procedures that meet the heightened risks and vulnerabilities of the disabled residents at the BHDC.

36. All of the foregoing acts and omissions on the part of DHS (and BHDC), taken separately and/or collectively, constitute a direct and proximate cause of the injuries and damages suffered by Claimant, as set forth herein.

37. The negligence or tortious conduct of known and unknown employees and staff of DHS, DDS, and BHDC is imputed to DHS, as these staff were all acting within the scope of their employment.

DAMAGES

38. Claimant hereby incorporates by reference all previous paragraphs as if fully set forth herein.

39. As a direct and proximate result of the occurrence made the basis of this lawsuit, Claimant, on behalf of the estate of David Cains, claims the following damages:

a. Loss of life of David Cains, commencing at death and ending at life expectancy;

b. Conscious pain and suffering of David Cains prior to death;

c. Medical care and expenses incurred as a result of David Cains' death; and

d. Funeral expenses incurred as a result of David Cains' death.

40. As a direct and proximate result of the occurrence made the basis of this lawsuit, David Cains' statutory beneficiaries sustained injuries, and Claimant claims the following damages on their behalf:

a. Mental anguish and emotional distress, including grief and despair, suffered up to the present time; and

b. Mental anguish and emotional distress, including grief and despair, that will continue well into the future.

PUNITIVE DAMAGES

41. Plaintiff hereby incorporates by reference all previous paragraphs as if fully set forth herein.

42. Arkansas Supreme Court decisions permit the recovery of punitive damages in a wrongful death case. *Vickery v. Ballentine*, 293 Ark. 54, 732 S.W.2d 160 (1987); Fields v. Huff, 510 F. Supp. 238 (E.D. Ark. 1981). *See also* Comment, The Arkansas Wrongful Death Statute, 35 Ark. L. Rev. 294, 306 (1981).

43. When viewed from the standpoint of Respondent, at the time of the acts and omissions, their conduct involved an intentional and reckless disregard of the known risks and dangers to disabled individuals in their care, given the occurrence of recent similar injuries and the BHDC's known history of excessive restraints.

44. Respondent had actual subjective awareness of the risks and dangers to David Cains and other disabled individuals at BHDC. Respondent intentionally and recklessly disregarded known prior similar acts and events, placing Cains at unreasonable risk of harm.

45. DHS intentionally and recklessly failed to assess the risk of this foreseeable event, failed warn of the risk, and failed to maintain adequate safety and prevention measures.

46. Respondent's conduct displayed a conscious indifference to the rights, safety, and welfare of David Cains and other disabled people in Cains' position.

47. Claimant seeks punitive damages, in an amount deemed appropriate by the Commission, to punish Respondent, and to deter further such conduct.

RELIEF SOUGHT

48. Claimant hereby incorporates by reference all previous paragraphs as if fully set forth herein.

49. Claimant seeks damages in the amount of $7,000,000.00. Neither Claimant, nor any beneficiary, has received any prior payment on account of this claim.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, by and through her attorney, Joshua D. Gillispie, respectfully requests recovery for all damages previously pled herein, and for compensatory damages for the reasons previously pled and in an amount previously prayed for and/or allowed by common law or by statute, in an amount left to the sound discretion of this Commission, for punitive damages, for her attorney fees and all costs herein expended, and for all other relief to which Claimant is justifiably entitled.

Respectfully submitted by:

/s/ Joshua D. Gillispie
ABA # 2010131
GREEN & GILLISPIE
1 Riverfront Pl., Ste. 605
Little Rock, AR 72201
(501) 244-0700
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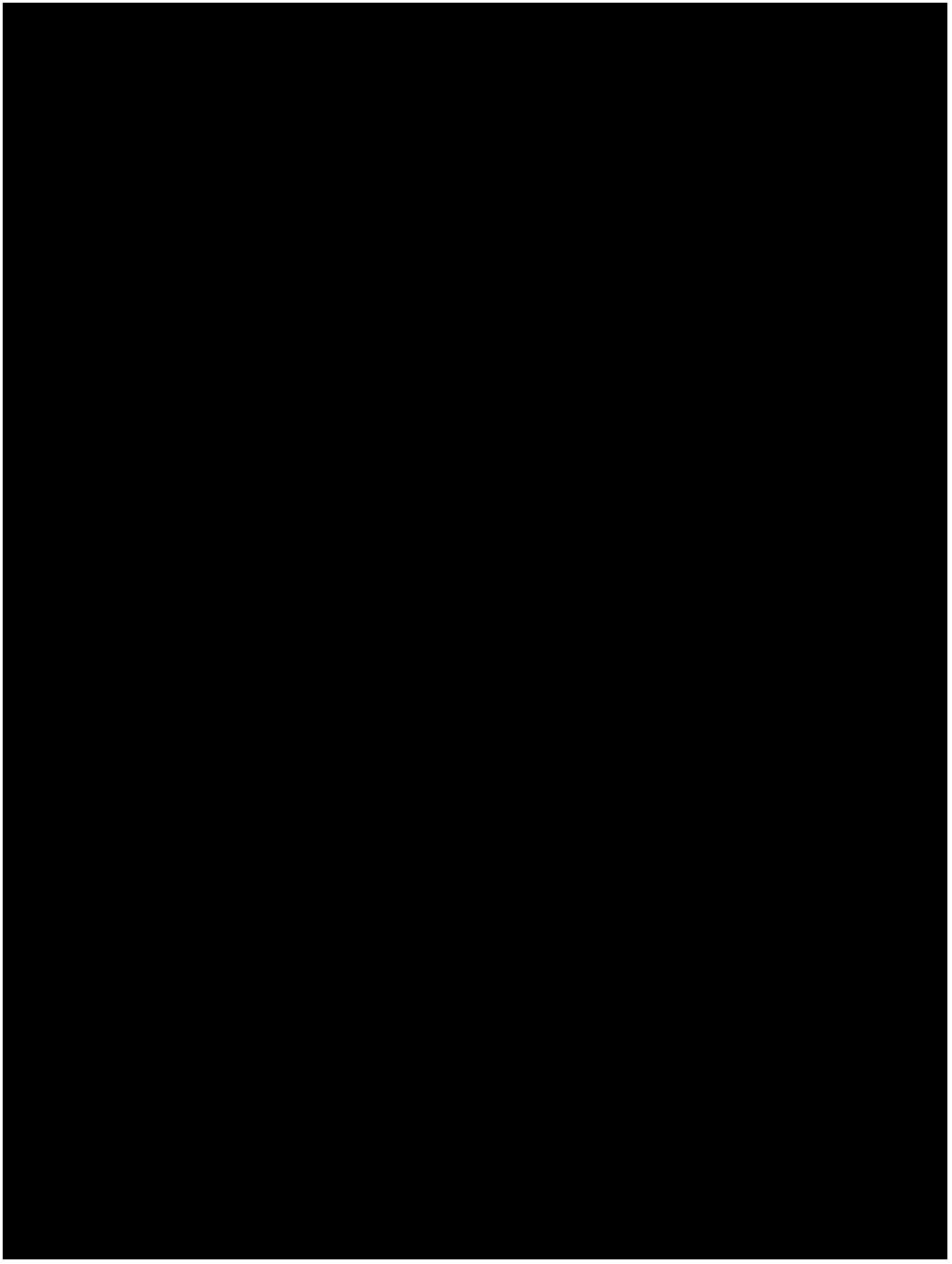
josh@greenandgillispie.com



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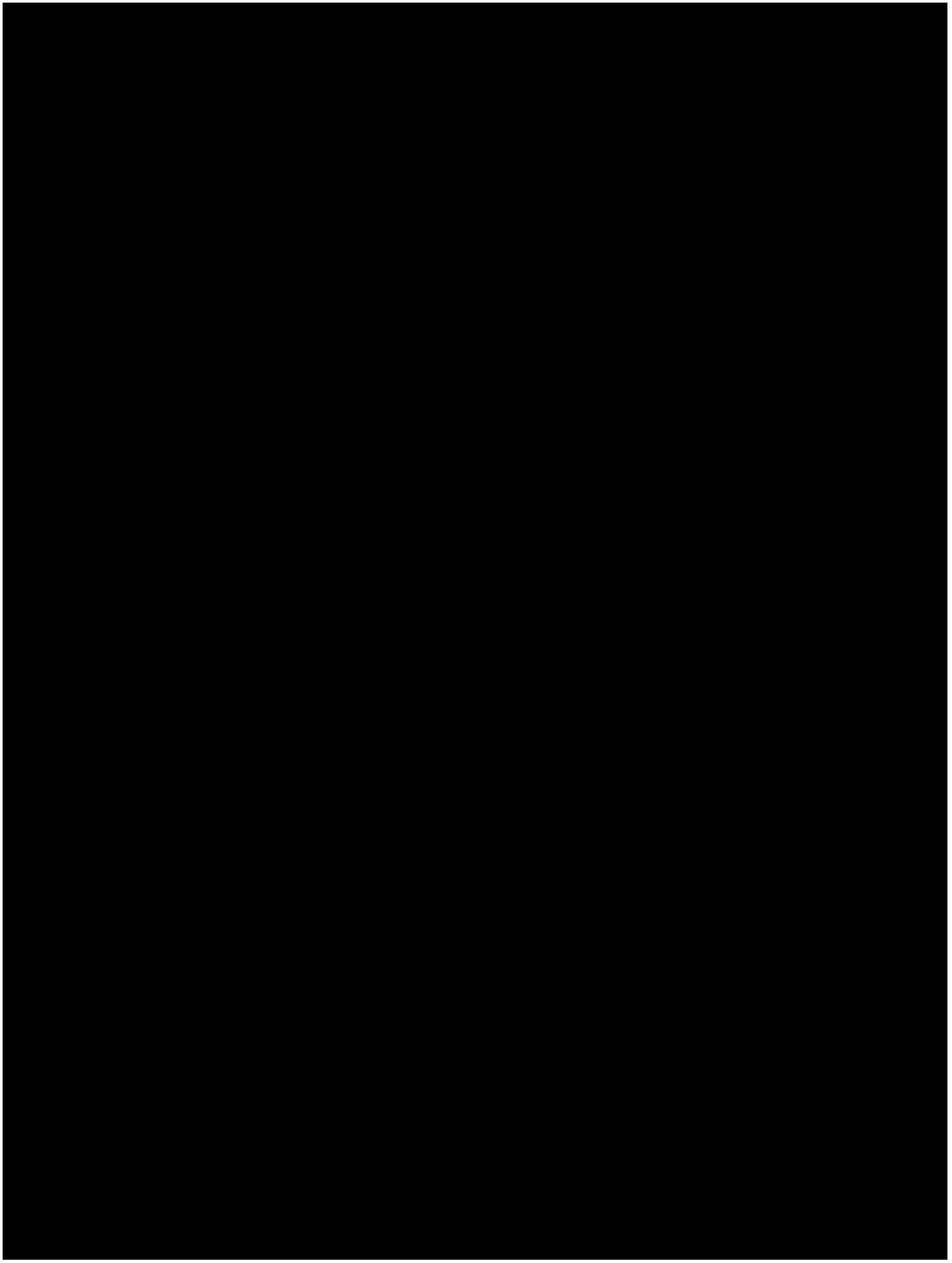

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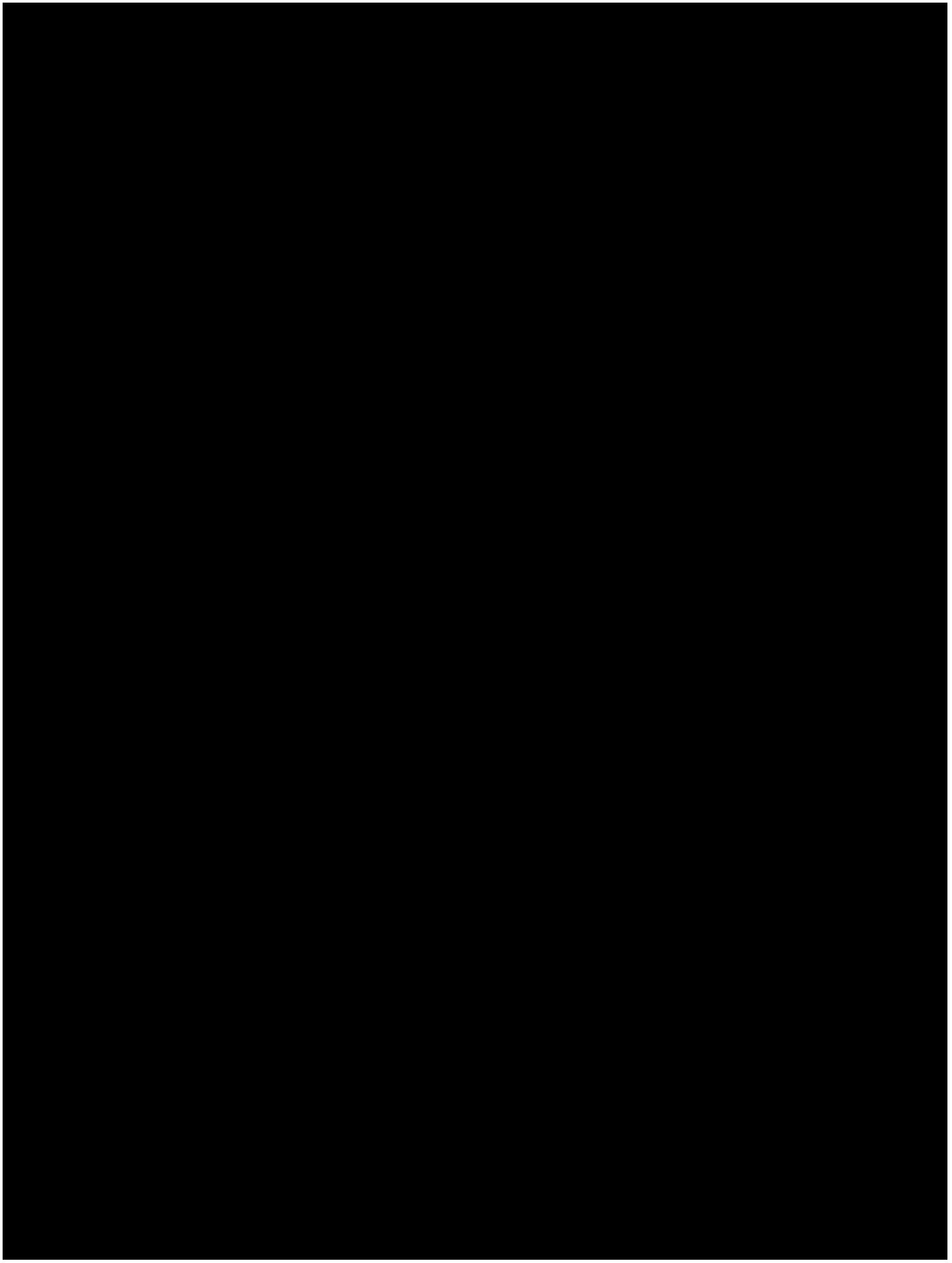

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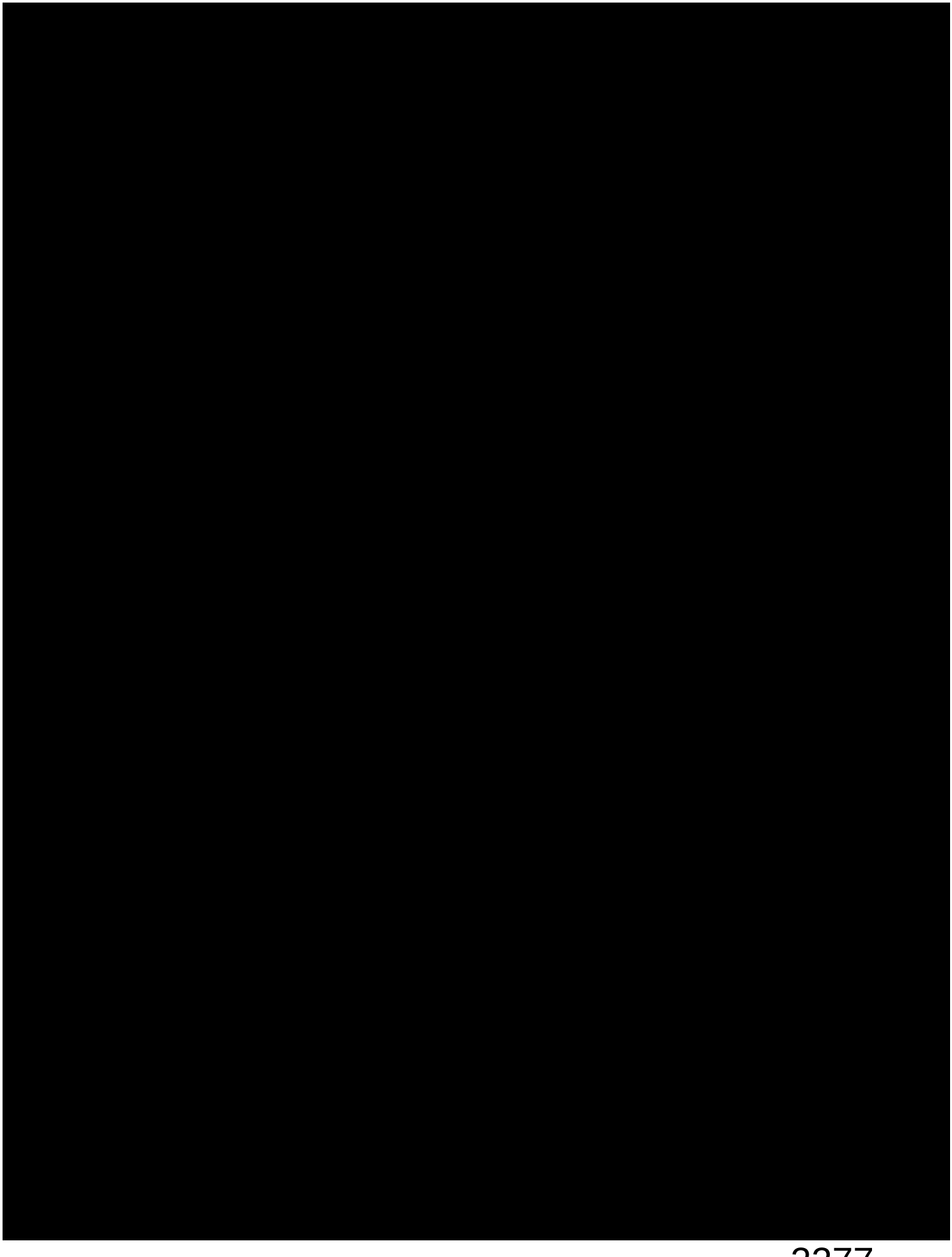

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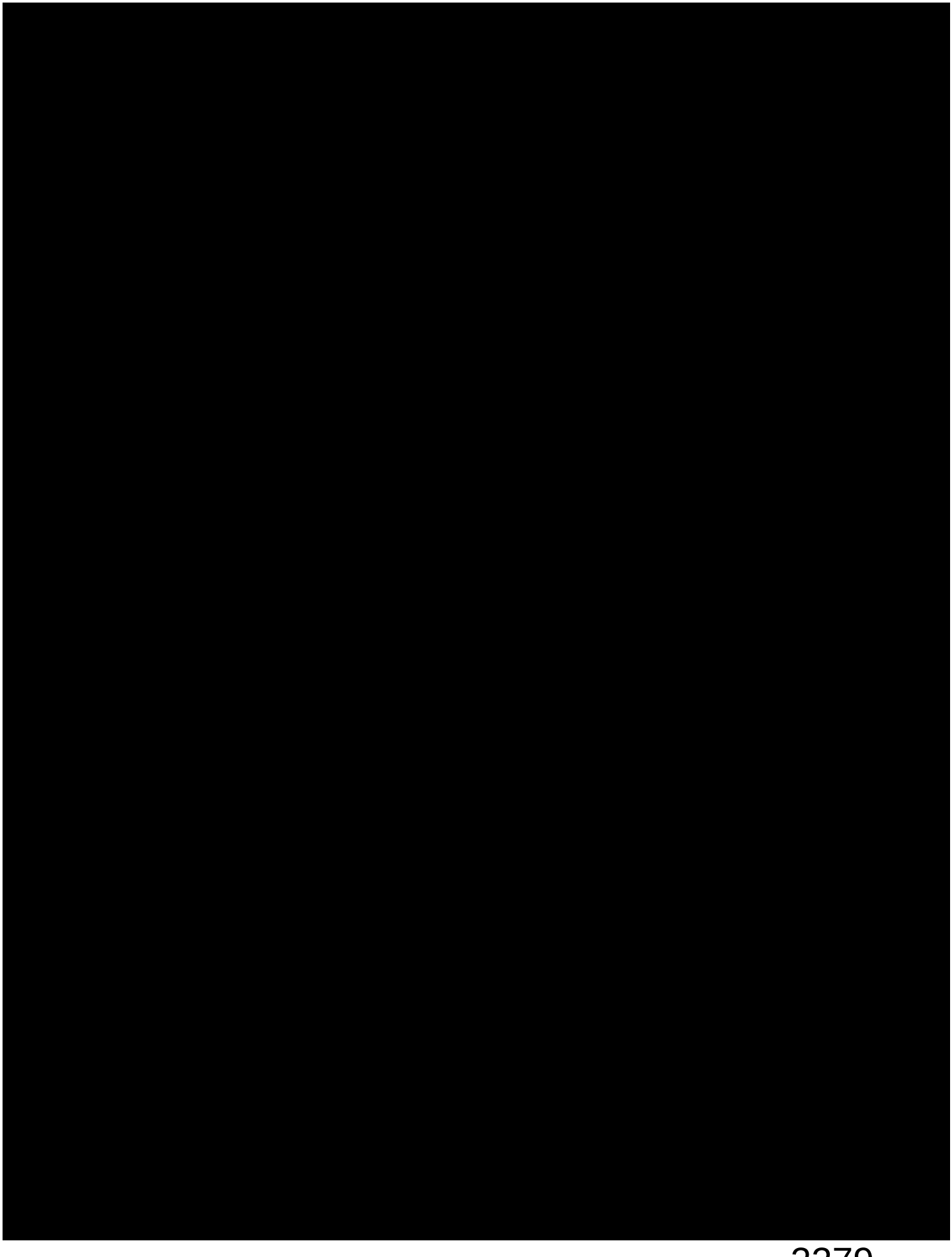

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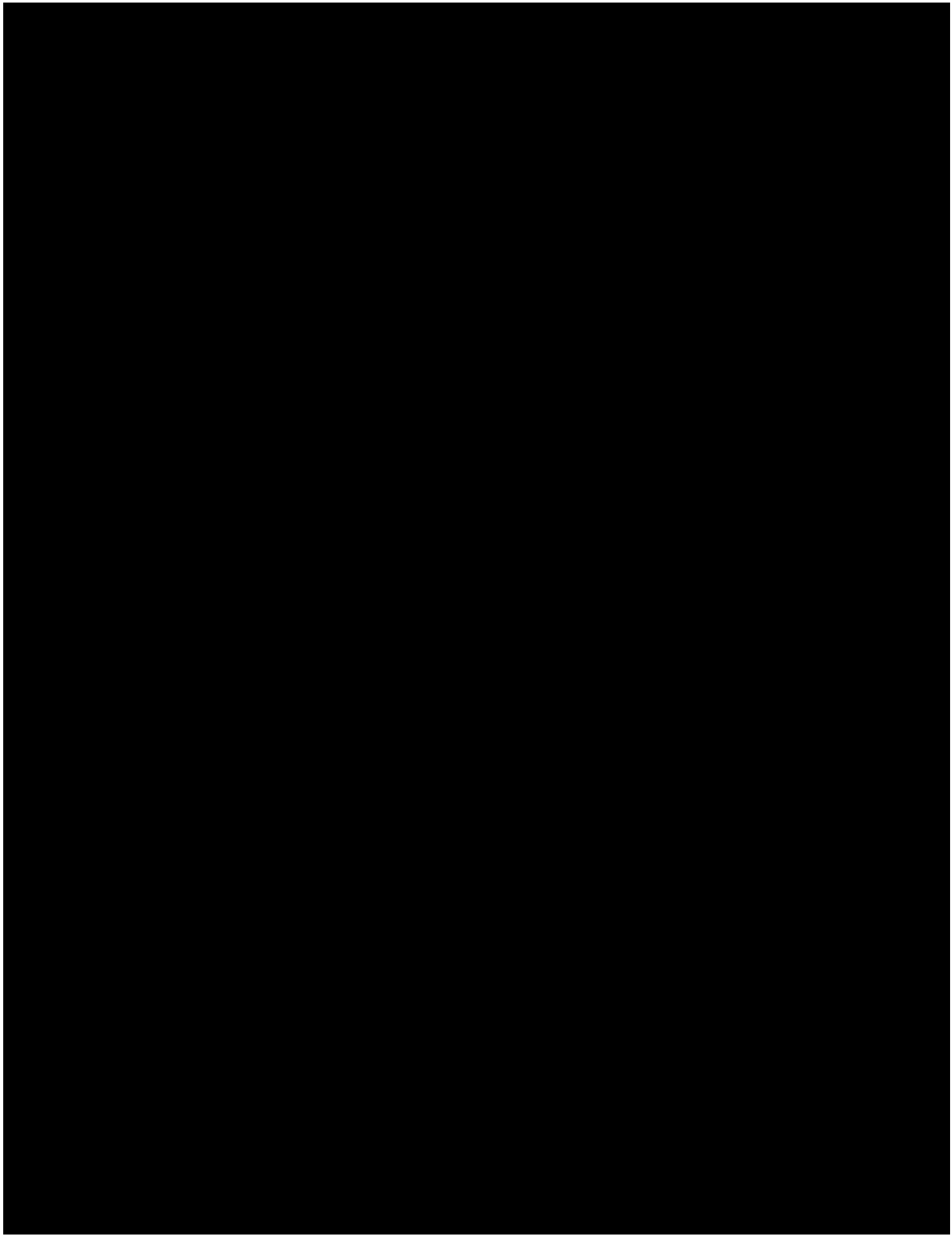

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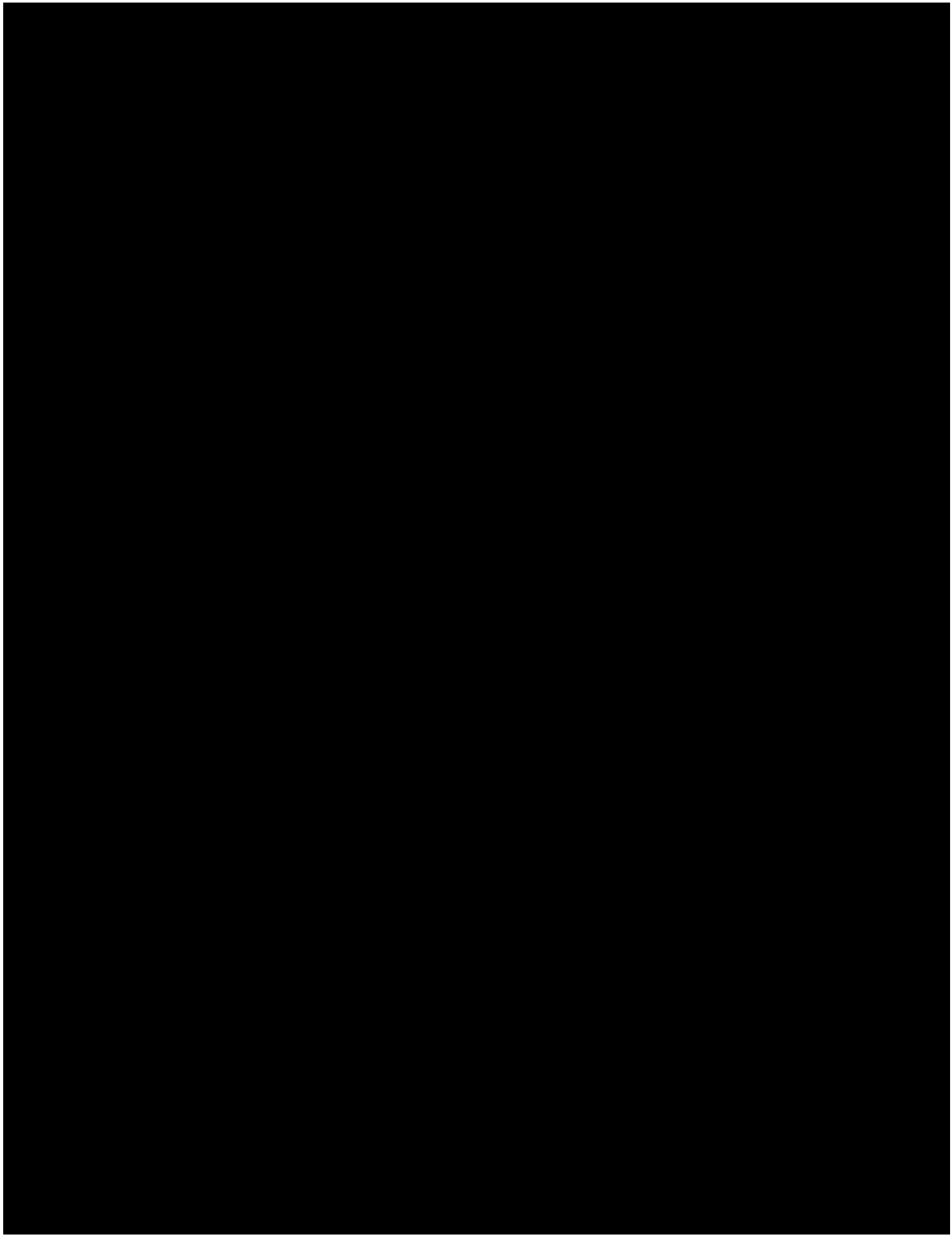

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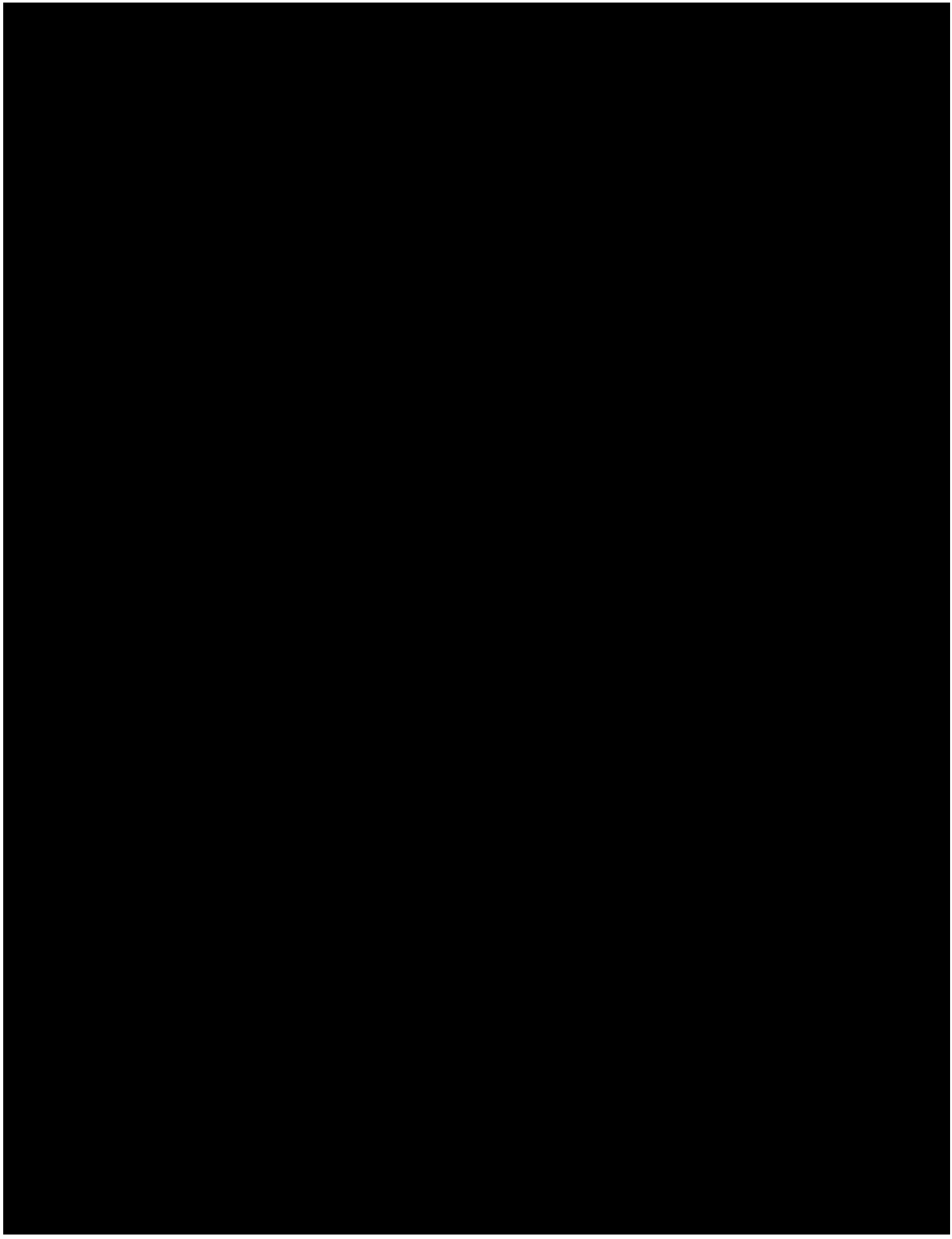

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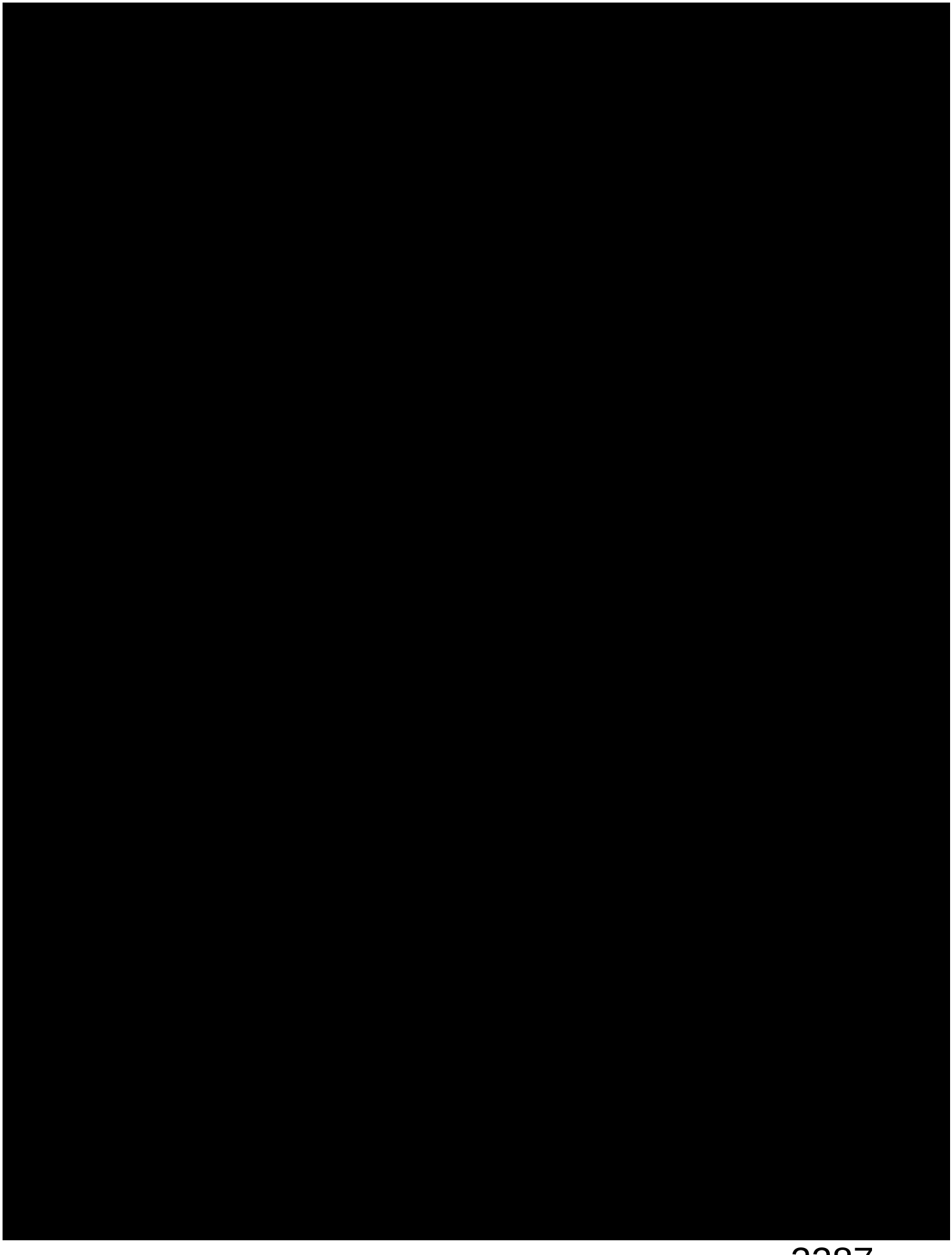

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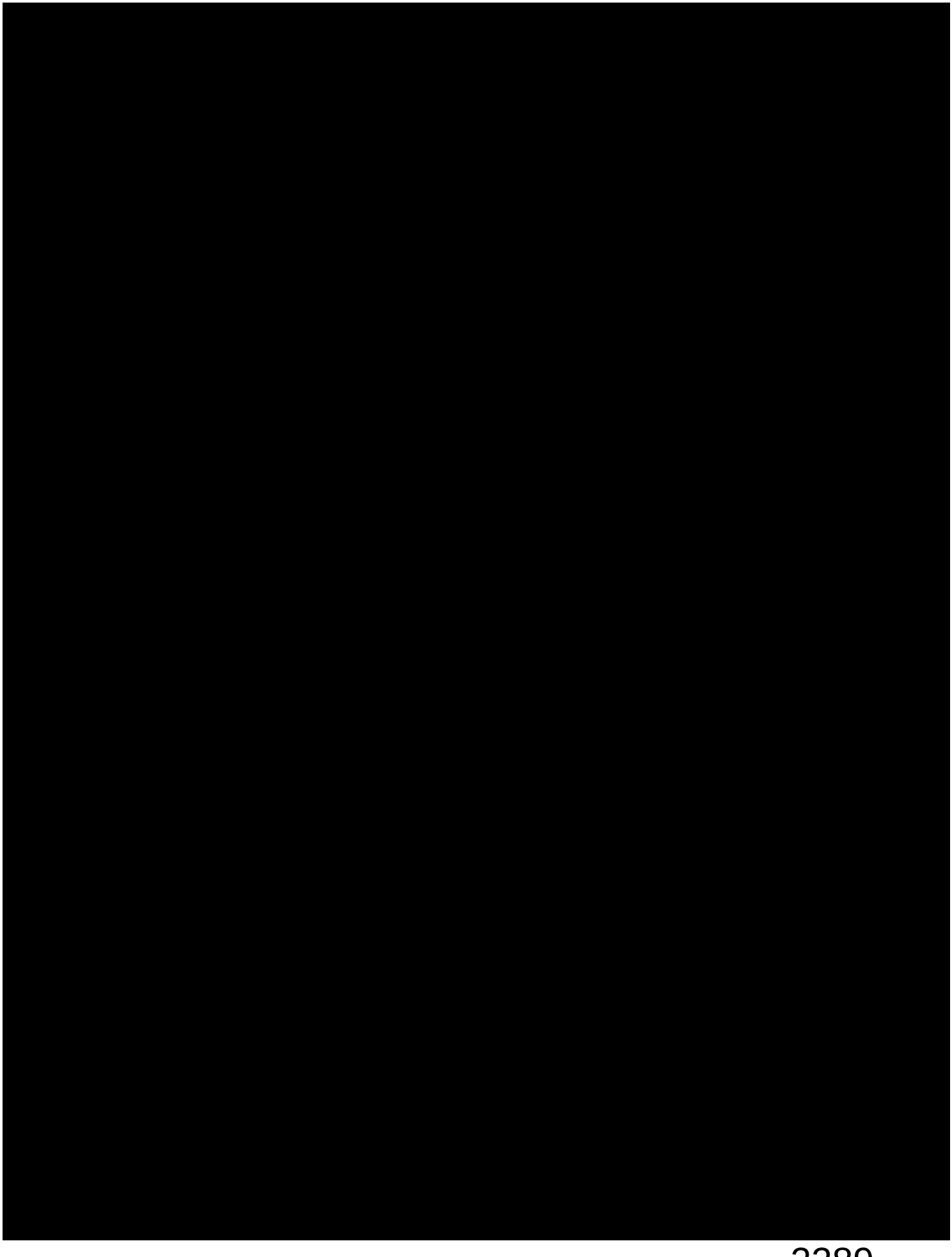

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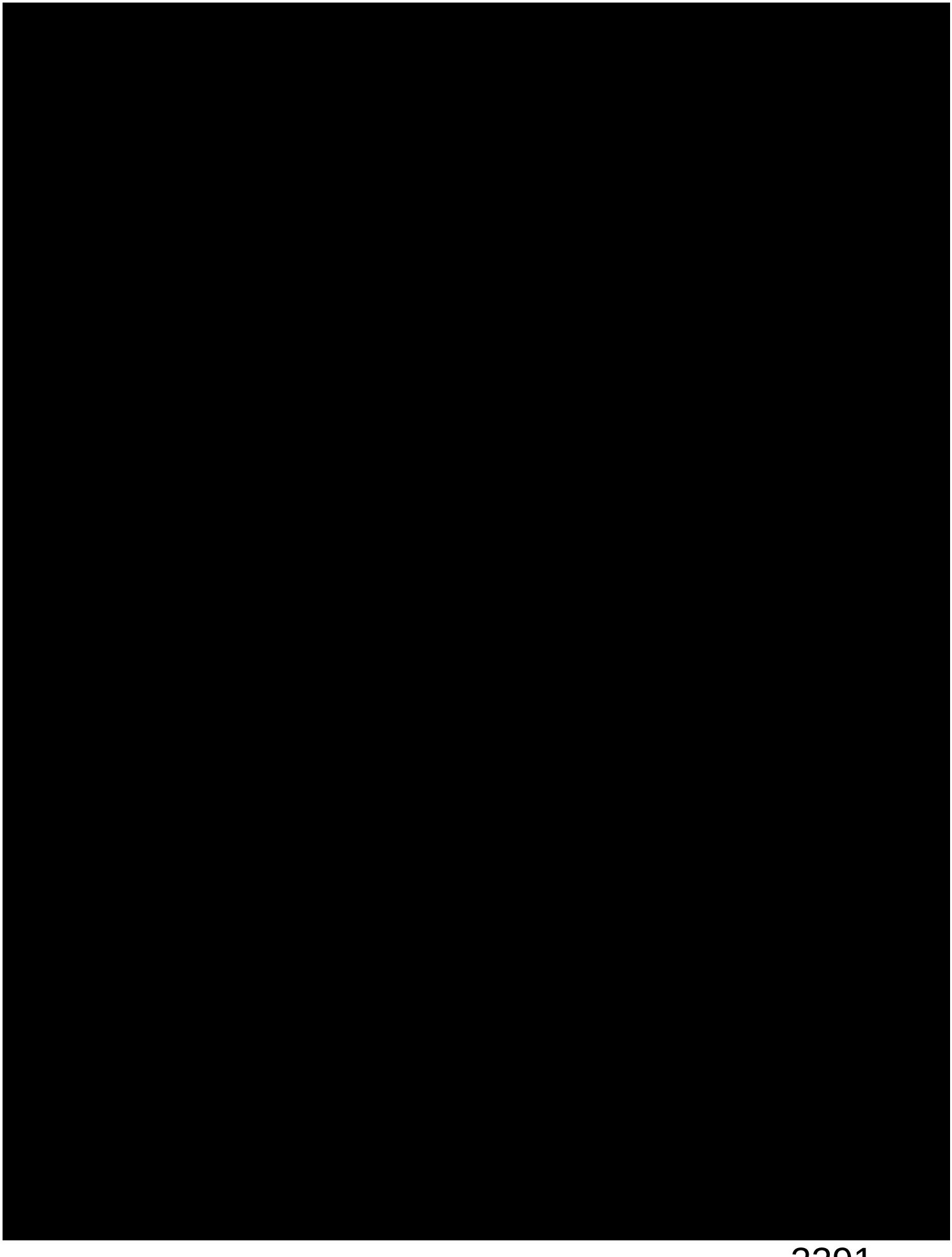

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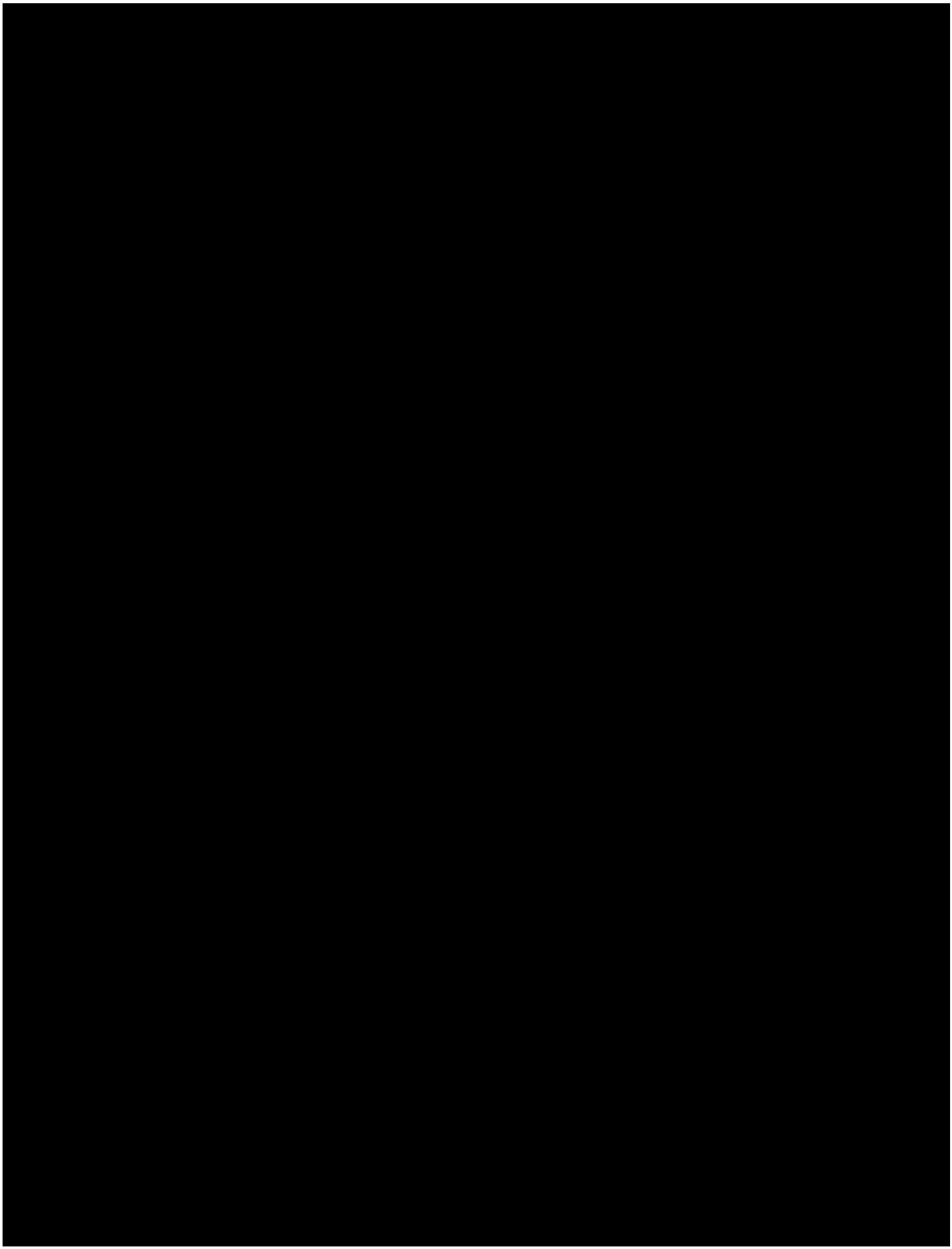

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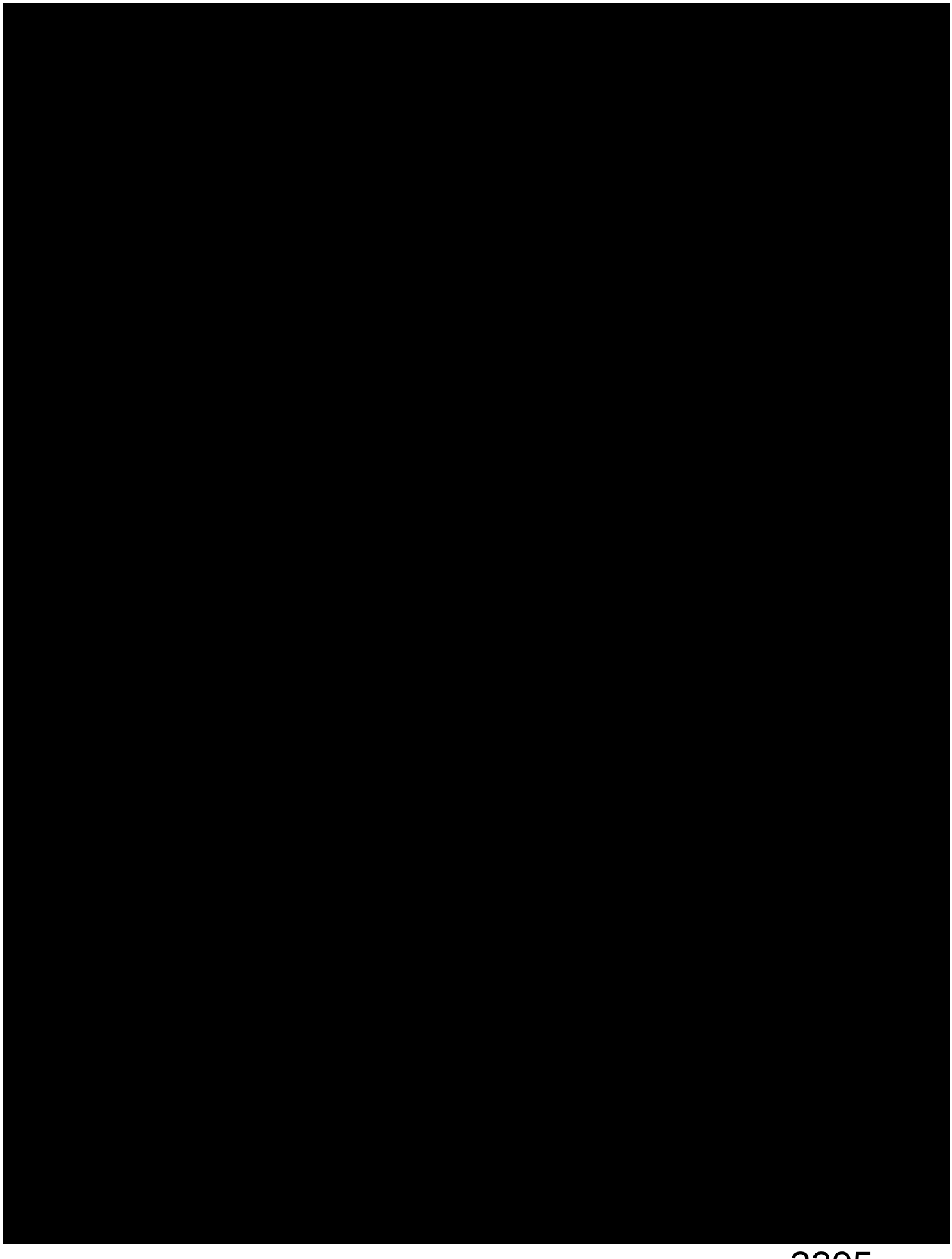

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Disability Rights Arkansas

Dignity. Respect. Advocacy.

Tom Masseau, Executive Director

October 22, 2020

Director Melissa Stone
Division of Developmental Disabilities
Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72203-1437

Director Stone:

Disability Rights Arkansas (DRA) is the designated federal Protection and Advocacy System ("P&A") for individuals with disabilities in Arkansas. One of DRA's core functions is to investigate the deaths of persons with developmental disabilities in facilities that provide services to people with developmental disabilities. DRA has authority under federal law to thoroughly investigate deaths occurring in any public or private entity that provides care, services, treatment, or habilitation to individuals with disabilities.

As you are aware, resident David Cains of Booneville Human Development Center (BHDC) died on June 13, 2020. His death occurred while three BHDC staff restrained David on the floor outside of the cafeteria. David's family contacted DRA and requested we investigate his death and the circumstances surrounding it.

DRA completed an extensive investigation into David's death. Our investigation involved reviewing the Adult Maltreatment Investigation Report, all witness statements, the DPSQA Complaint Investigation Report, the EMS report, hospital records, and the Coroner's report. Our office interviewed BHDC staff, including Tyler Mattson, Amy (Mandy) Jones, and Ryann Campos, the individuals who restrained David; Sandy Evans, the Adult Maltreatment Investigator; Jeff Gonyea, the Superintendent; and Mark Hines the NCI instructor. Our office also interviewed the Emergency Medical Services provider, Samuel Scow, who provided emergency services that day, as well as Michael Chrisman, the Deputy Coroner who was assigned to David's case.

Summary

[redacted]

According to the BHDC Staff written statements and interviews with DRA staff:

EXHIBIT
Claimants 1

On June 13, 2020, David ate his lunch in the cafeteria at the Commons Building. After finishing his meal, David put his tray away, asked to go to the restroom, and was accompanied to do so by Tyler. According to Tyler, David seemed irritated, asked to sit in the lobby to calm down after exiting the restroom, and then began screaming, ripping paper off the wall, and attempting to hit Tyler.

Tyler stated that he, "applied personals[1] by grabbing [David's] arms and ended up falling over."[2] David landed on his face and Tyler then rolled him to his side.[3] Tyler believes that this restraint began at 11:30 a.m., although all times are estimates as there are not any visible clocks in the area where the restraint occurred, according to all staff interviewed. Mandy Jones arrived shortly after David was brought to the ground and assisted in the restraint. According to all written witness statements, David was resisting the restraint at that time. Ryann Campos arrived sometime later and began holding David's legs. Within seconds of arriving Ryann noticed that David had defecated on himself and she

[redacted]

From EMS Report and BHDC Staff written statements:

[redacted]

This entire event took place on the floor while three people were holding David by his legs, torso, and head. A fact that was omitted in reports to EMS, the hospital, the Coroner, and the family.

During our investigation, we noted several unresolved discrepancies between written statements, subsequent interviews, and investigative conclusions:

1) There is not a consensus between the employees involved regarding the positioning and

---

[1] Tyler, during his interview, acknowledged that this is a restraint.
[2] OLTC Witness Statement, Tyler Matteson, Page 2 of 3
[3] Interview of Tyler Mattson by DRA staff on July 29th.
[4] OLTC Witness Statement, Ryann Campos Page 1 and 2
[5] OLTC Witness Statement, Tyler Matteson, Page 2 of 3
[6] OLTC Witness Statement, Amanda Schmidt, LPN
[7] BHDC Policy IV-B-10 states that on-site medical should be the first call and that "medical will assess the situation and call an ambulance if appropriate." All persons interviewed, including Superintendent Gonyea, interpreted the policy to prohibit non-medical staff from calling 911 in response to a medical emergency and confirmed that as the BHDC practice.
[8] Logan County EMS patient record.
[9] *Id*
[10] *Id*

actions of each employee, information pertinent to identifying not only potential wrongdoing, but also possible missteps to be avoided in the future.

a. Ryann's written statement and subsequent interview by DRA staff were consistent with one another. She states that when she arrived David was on the ground on his left side, Tyler was on his knees facing David and holding his wrists, and David's hands were by his sides. Mandy "came to assist to position David's head so he wouldn't spit"[11] and then Ryann attempted to assist by holding David's ankles when he began to kick.

b. Mandy stated that when she arrived, "David was on his left side with his arms held up with his elbows bent slightly."[12] She states she assisted by holding David's hands so that he could not strike Tyler, who was positioned behind David. Mandy denied ever holding David's head during the restraint.

c. According to Tyler's written statement he was "squatted over him, not putting [his] weight on him during any of this, holding his shoulder and sides,"[13] Mandy assisted by "grabbing his hands," and Ryann held his legs down. During our interview, Tyler deviated from his written statement, stating "she [Mandy] was on his side behind him, holding his head on the side, keeping close to ground but not pushing on it"[14] because David was trying to bite. He also clarified his positioning as being behind David, who was laying on his left side and "spread out T-style"[15] with his left arm on the ground. Tyler was holding his right arm (not Mandy) and trying to get it to the ground. David's arms were never above his head.

d. Adult Maltreatment Investigation Report #5-2020, completed by Sandy Evans, fails to resolve discrepancies regarding the placement of David's hands and whether a staff member was holding his head in place during the restraint.

e. Cameras at the facility would have been immeasurably helpful in resolving the discrepancies and ultimately understanding the circumstances surrounding David's death.

2) A timeline of events included in two separate documents we received completely omits any reference to a restraint having occurred.
   a. The DHS Incident Report includes a timeline of events provided by Stacy Weinbrenner, RN/DON, who does not appear to have been at the scene of the incident at any time.
      i. According to the timeline at "11:30 a.m. – Immediately after lunch, David Cains headed to common area kicking, yelling, and biting. Tyler and Mandy attempted to settle client. Suddenly started vomiting and turning cyanotic."
         1. Tyler and Mandy's written statements and interviews with DRA indicate that Mandy did not arrive until Mr. Cains was already on the ground and being restrained by Tyler, in conflict with the assertion here.
         2. There is no evidence of either staff member attempting to "settle" David.
   b. A similar statement is included in a "Timeline of Events" that appears to be a word document included in David's medical file. The statement is not attributed to anyone in this document.

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[11] OLTC Witness Statement Form, Ryann Maria Campos, Page 1 of 2
[12] OLTC Witness Statement Form, Amy Amanda Jones, Page 1 of 4.
[13] OLTC Witness Statement Form, Tyler Mattson, Page 2 of 3
[14] Interview of Tyler Mattson by DRA staff on July 29th.
[15] *Id*

When DRA interviewed Emergency Services Worker, Samuel Scow, he stated BHDC staff never informed them that David had been in a personal restraint prior to or during this incident. Samuel stated that they were told that David was found in the hallway, unconscious, and staff attempted abdominal thrusts prior to CPR. They were told that he had choked on his lunch. EMS relayed the same information to the ER staff at Mercy Hospital in Booneville.

[redacted]

The same misinformation was passed on to the investigating coroner, Deputy Coroner Michael Chrisman, leading him to list the cause of death as respiratory arrest, due to food aspiration, and cardiac arrest. Mr. Chrisman stated:

[redacted]

When our office interviewed Mr. Chrisman, he stated he had no knowledge that David was restrained prior to or during this incident. He confirmed that his office would have further investigated had they received that information and would likely have requested an autopsy.

When BHDC staff contacted David's mother, they told her that David choked on his lunch and that the family would need to contact the hospital for any additional information. When the family called Mercy Hospital, they were informed David was deceased. David's family did not find out about the personal restraint until June 22nd – nine days after David passed away and three days after David's funeral. By the time the family learned of the circumstances surrounding his death it was too late for them to request an autopsy.

This was a tragic event. Any time an individual passes away while in the custody and care of the state a meaningful, critical evaluation of the policies and practices that led to that incident should be required. In this case, that evaluation included: (1) an investigation by an individual who is employed by the BHDC, working alongside those who she is charged to investigate; (2) a review and endorsement of that investigation by the superintendent who hired or who is ultimately responsible for the actions of those employees investigated; (3) the suppression or omission of relevant, if not crucial facts from agencies who would further investigate the circumstances of this gentleman's death.

The BHDC review of this death, endorsed by Superintendent Gonyea, concluded that no individual involved in this incident did anything wrong; therefore, nothing could have been done differently to prevent it and nothing can be learned from it. To date, we have not been informed whether BHDC has reviewed or revised their restraint policies or practices following this event.

At some time after the internal investigation concluded the Division of Provider Services and Quality

[16] Logan County Coroner Report.
[17] *Id*

Assurance (DPSQA) investigated David's death and the circumstances surrounding it. Very little information could be gleaned from the DPSQA Complaint Investigation Report reviewed by DRA. Despite the ability to attach narratives of staff interviews, none were found or made available upon our request. Ultimately, the DPSQA investigation concluded similarly to the internal investigation conducted by BHDC with no description of the events or statements from witnesses.

Practice of Restraints at BHDC

In 2012, DDS retained H&W Independent Solutions, who are self-described "skilled trainers and workshop facilitators on a wide range of topics pertinent to organizations supporting people with disabilities." In April of 2012, BHDC participated in a training survey with H&W to evaluate and improve the quality of care to the residents. During the evaluation of BHDC, H&W found that significant improvement was needed due to, in part, the BHDC staff's reliance on emergency restraint.

Nearly four years later, in January 2016, our office issued a report regarding the use of restraint at BHDC. We warned that risks associated with restraint include physical injuries, significant trauma, and death. We pointed out that the overuse of restraint could cause physical and emotional trauma to both the residents and the staff at BHDC. We recommended that BHDC retain an independent expert to implement evidence-based alternatives aimed to reduce or eliminate the use of restraint at BHDC.

NCI/CPI trains staff to respond to crisis by intervening in non-violent ways to prevent escalation and offers programs to certify staff in this skill. At the same time BHDC certifies its staff in the use of NCI/CPI, BHDC also trains its staff to restrain residents using methods that require no certification, are not evidence-based, and, when practiced, conflict with NCI/CPI training. It is concerning that BHDC staff are then left to choose between non-violent crisis intervention and physically/emotionally traumatizing physical restraint.

Findings

- [redacted]
- Instead of releasing David when he was lying down on the floor, David was restrained on the hard floor by three BHDC staff after finishing his lunch.
- Prior to the restraint, Staff failed to use other less intrusive interventions such as NCI/CPI, for which they are trained.
- Staff failed to leave him on the floor, unrestrained, until he was calm.
- [redacted]
- This restraint likely either directly or indirectly led to David's death.
- The facility failed to properly communicate the circumstances of this incident to EMS.
- We found no evidence that the facility properly communicated the circumstances of this incident to the Arkansas State Police, the Logan County Sheriff's Office, or any other law enforcement agency.

- BHDC's investigation failed to resolve discrepancies in statements from witnesses.
- It is not the policy or practice of BHDC to permit direct care staff to call 911 in an emergency.
- NCI/CPI does not endorse or instruct any maneuver that involves physically restraining an individual on the floor.
- During interviews, BHDC direct care staff reported that they, "take people to the floor often."
- BHDC could not articulate what kind of "restraint technique" is being taught to staff.
- The conclusion from Superintendent Gonyea failed to find that anyone violated any policy or procedure and inexplicably failed to find that any policy or procedure might need review or modification.
- No corrective actions were made or recommended by BHDC or DHS - Division of Provider Services and Quality Assurance.
- BHDC failed to adequately inform David's family of the circumstances surrounding his death.

Recommendations

1. ***Install video cameras on campus***. Video cameras on campus would greatly assist investigators in determining whether maltreatment has occurred. Presently, we have differing statements from individuals regarding a restraint on the floor that led to an individual's death.
2. ***Retrain all staff in NCI/CPI.*** NCI/CPI does not endorse the use of restraint while an individual is lying down on the floor. The very fact that NCI/CPI is touted as the intervention strategy implemented by BHDC, and yet this individual was restrained on the floor long enough to aspirate and die means that NCI/CPI was either ignored or forgotten.
3. ***Reevaluate the use of restraint in all forms and employ evidence-based, nonviolent methods of crisis intervention.*** A greater problem that exists is the overall reliance on restraint at BHDC. It is a culture of compliance that we see often in prisons. When individuals are not compliant, they are made to comply. If DHS does not address restraint and physical, mechanical, and chemical intervention as a system-wide problem, the culture cannot be meaningfully changed. Further, the physical restraints BHDC employs are not based on any professional training or sanctioned method.
4. ***Clarify or Modify policy to permit staff to contact 911 in response to emergency medical situations.*** Staff must have permission to identify and respond in an emergency. BHDC is a large campus in a rural area of the state. While it is comforting that nursing staff is available to respond to medical issues, the current policy forces staff to ignore what many first aid/CPR certification programs insist is the first step in responding to a crisis – calling 911.
5. ***Engage qualified, independent investigators to complete thorough, meaningful investigations on ALL deaths.***

a. *Utilize investigators that are completely independent of the Human Development Centers they investigate.* While it is important that BHDC review incidents internally for quality improvement and staff oversight, there must be a truly independent investigation by a disinterested third party. At one time, DDS employed an attorney whose role was to investigate deaths at any HDC. We are unaware whether or why such a position no longer exists. Anyone DDS authorizes to investigate serious incidents should have no connection to the Human Development Centers they investigate. Investigators should be informed regarding the requesting of an autopsy and empowered to make such a request when warranted.

b. *Ensure all investigations are reflective of the gravity of the circumstances investigated.* Death investigations must be both thorough and critical. Investigations that lack specificity in their investigative processes and findings, do not include interviews of all involved parties, and by design can only substantiate maltreatment or declare nothing could have been done differently undermine confidence in the process. When a family is left to gradually learn new information regarding the death of their loved one, including that the coroner was not accurately informed of the circumstances surrounding the death, what else are they to be left with other than suspicion and anger? Instead, the trauma surrounding the death is amplified and revisited with each new fact they learn. That is not closure; that is not justice.

DRA requests a response, delivered electronically, to this letter by October 31, 2020.

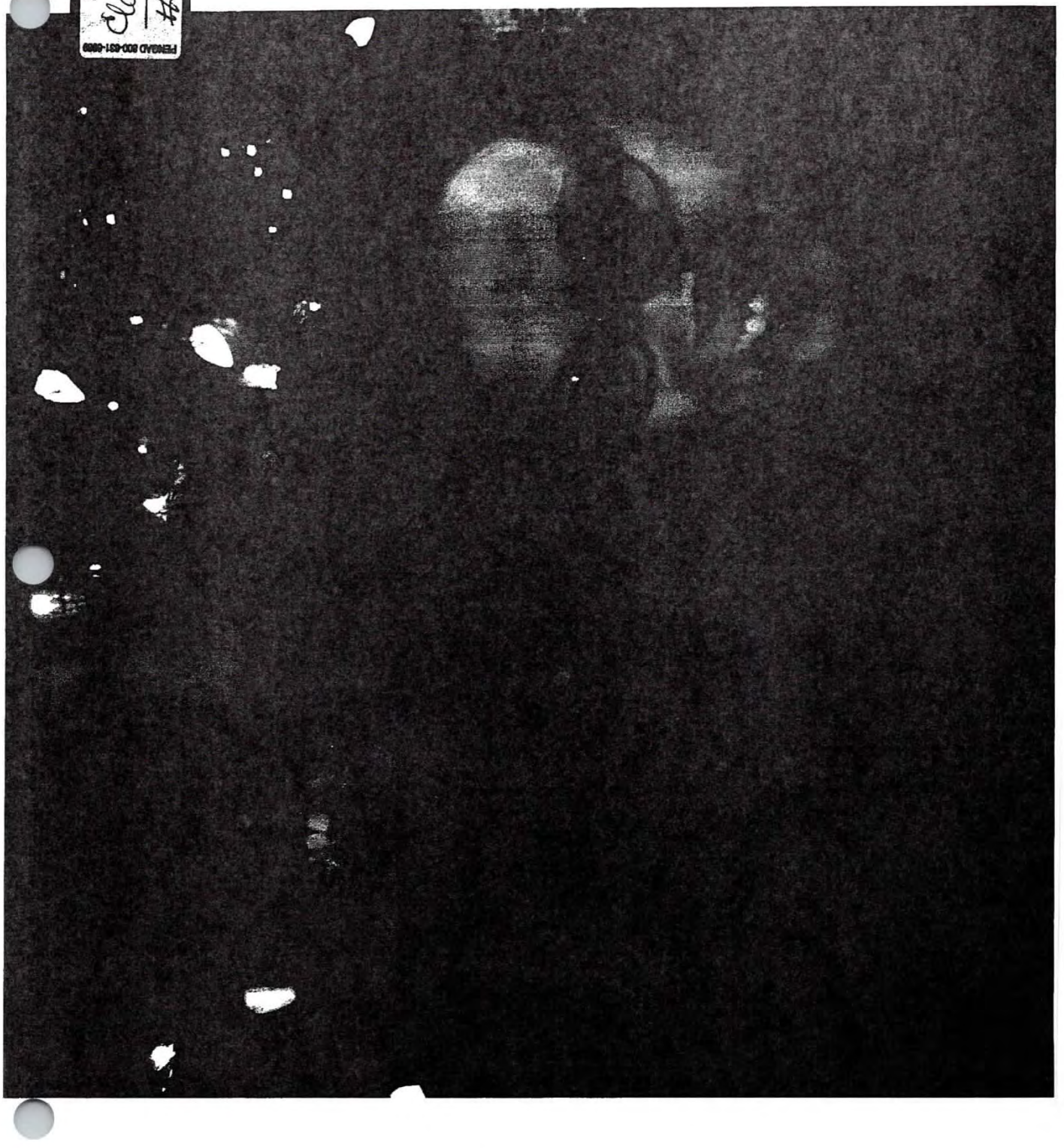
Sincerely,

Kris Stewart, Advocate
Disability Rights Arkansas

Reagan Stanford, Attorney
Disability Rights Arkansas

EXHIBIT
Vasquez
#2
PENDAD 800-631-6989

EXHIBIT
Documents
#3
PENDAD 800-631-6989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Clarinets
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EXHIBIT
Plaintiff's
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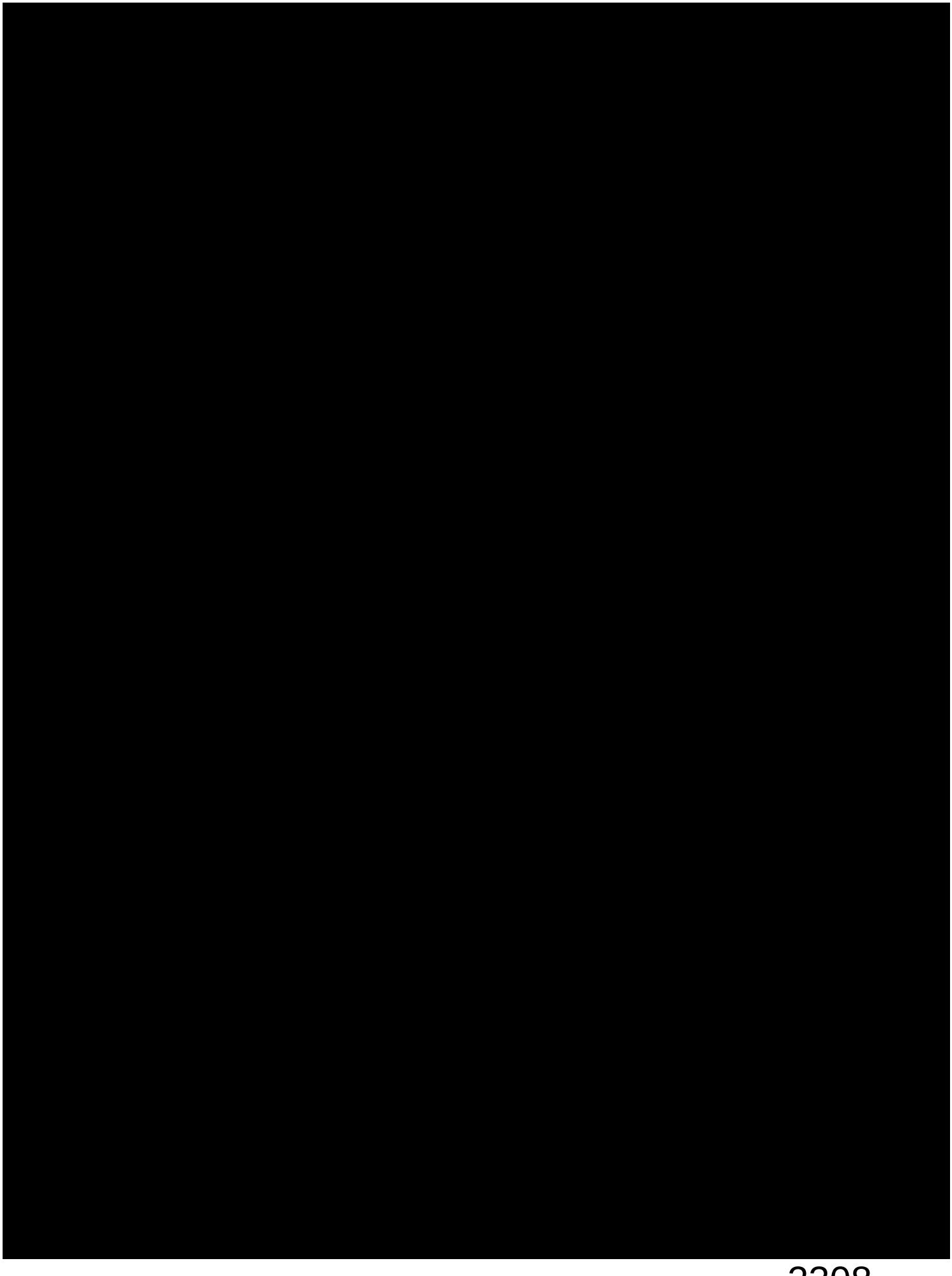

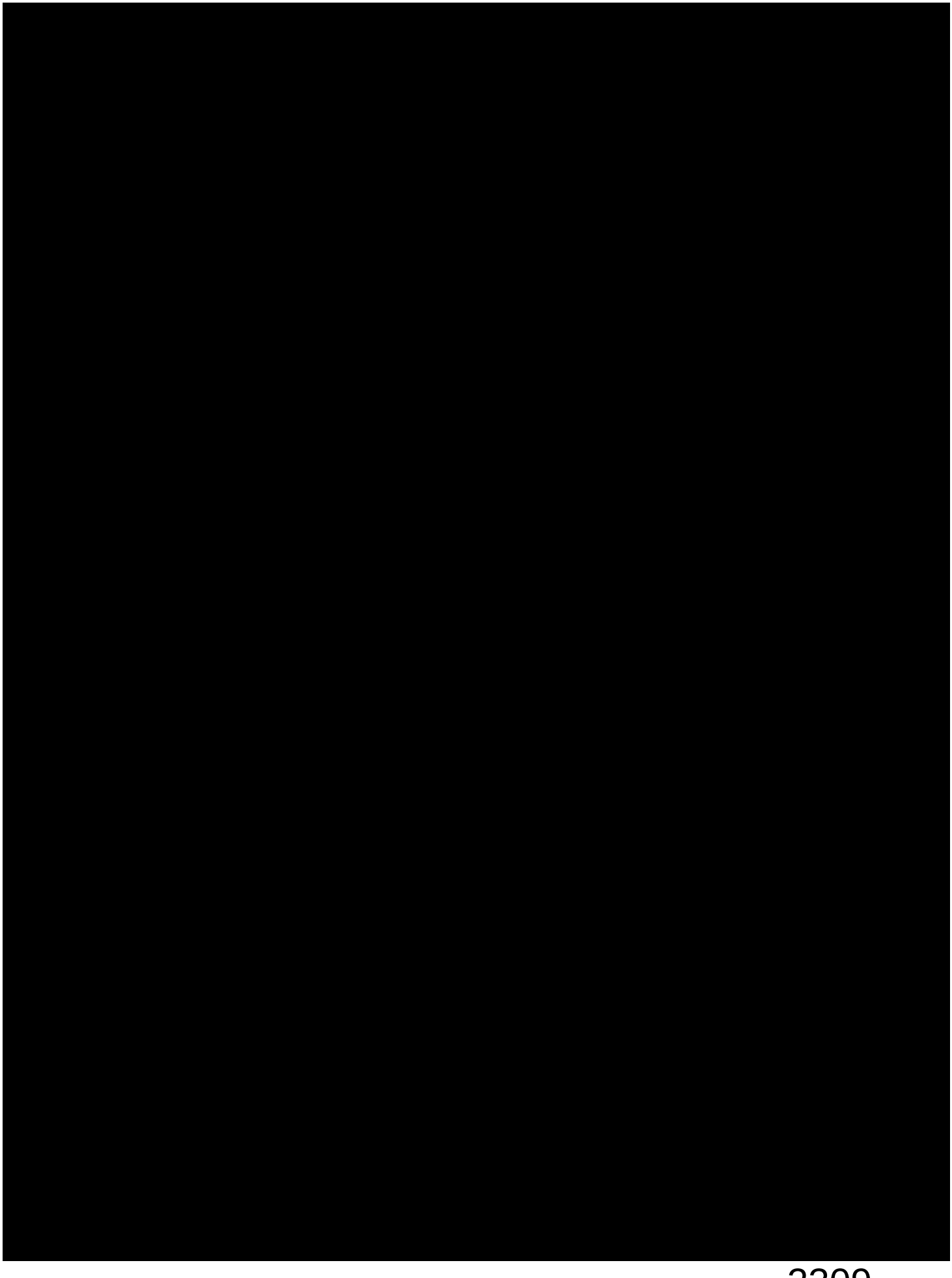

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

1. **Purpose**. This policy is intended to provide guidelines for managing challenging behaviors of individuals residing in DDS operated programs (Human Development Centers).

2. **Scope**. This policy applies to all DDS operated programs (Human Development Centers) and their employees/volunteers. All such programs will include a review of this policy as part of the employee orientation process.

3. **Definition of Terms**

Behavior management, as covered by this policy, serves as a guide to ensure that an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others are managed with the least restrictive method. Behavior management is not a substitute for other forms of active treatment and is incorporated into program plans, based on individual needs.

Qualified Mental Retardation Professional (QMRP) or QMRP designee is used in this policy as a person designated to monitor, supervise, and make decisions regarding specific behavioral situations. QMRP/designee will be assigned by the administrator of the DDS program in which he/she works. Criteria for selection will involve prior training, experience, and demonstrated ability in the area of behavioral management. The QMRP/designee must be in a position that is on a level involving supervisory or decision-making responsibilities. The QMRP designee is authorized to perform any of the duties of the QMRP as outlined by regulations or policy.

Interdisciplinary Team (IDT) is defined as a group of persons (professionals, paraprofessionals and non-professionals) who develop an individual's program plan and whose participation is required in order to identify the needs of the individual and to devise ways to meet those needs. The IDT includes the individual and may also include those persons who have worked or will work most closely with the individual, those persons who provide needed assessments or services, and the individual's family, guardian, or advocate. In general, the IDT includes persons professionally qualified in such fields as health care, education, psychology, and social work.

Licensed nurse is defined as a registered nurse or licensed practical nurse. The agency may use a physician, in lieu of a licensed nurse, but this is not required.

Replacement: This policy replaces DDS Commissioner's Policy 3011-D, dated January 28, 1981, March 13, 1981, and DDS Director's Policy dated October 1, 1991; December 1, 1993; and January 30, 1998.

Reviewed: Arkansas Legislative Council Rules and Regulations Subcommittee _____, 2003



Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

4. Policy

NOTE: It is the philosophy of the agency to utilize all positive approaches to behavior management prior to and in conjunction with more restrictive programmatic techniques. Positive approaches may include, but are not limited to: positive reinforcement, gentle teaching, redirection, graduated guidance, and modeling of appropriate behaviors. Measures to address positive behavior should be incorporated into formal program efforts to the extent feasible.

Efforts at positive programming prove to be successful with the majority of maladaptive behaviors. All Human Development Centers will maintain policies and procedures for positive programming. The use of behavioral programming other than positive is designed for the individuals who repetitively engage in dangerously aggressive behavior and for whom other interventions have not been effective. All behavior programs developed in accordance with this policy will be designed to reduce or eliminate the target behavior(s) within a specified time frame, will be supported by documentation that positive, less restrictive methods have been systematically attempted and failed, will be monitored regularly by the individual's QMRP and Interdisciplinary Team (IDT), and will be revised if proved to be ineffective. The potential harmful effects of each procedure will be weighed carefully against the harmful effects of the targeted behavior and the IDT will determine if the harmful effects of the behavior outweigh the potentially harmful effects of the procedure.

Category I:

Category I procedures are those which may be used without prior approval of the Human Rights Committee or psychology staff. To ensure consistency, they should be addressed by the IDT. Frequent use (as determined by IDT) of these procedures with an individual indicates the need for consideration of the development of a behavior plan by the individual's IDT.

The individual must be supervised during these procedures. With the exception of verbal intervention, any use of Category I procedures, whether part of a formal behavior program or not, requires documentation on a Behavior Incident Report, Data Sheet, or other locally used behavior documentation system.

A. Verbal Intervention: Verbal intervention is utilized to stop an inappropriate behavior in progress and involves telling the individual "no" or "stop", identifying the behavior, and redirecting to an appropriate activity. The command is given in a firm but normal tone of voice. Threats, screaming, yelling or issuing repetitive or multiple sets of commands are not considered verbal correction and are inappropriate.

B. Separation From Activity Up to 30 Minutes: The individual is prevented from engaging in a reinforcing activity in which he/she has displayed inappropriate behavior. Separation is maintained within the same room or outdoor area where the activity is conducted. This is considered a Category I procedure if compliance by the individual can be

accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

C. Separation From Setting Up to 30 Minutes: The individual is removed from the area where the reinforcing activity is taking place. Separation must occur under observation either outdoors or in a living or training area (bathrooms, storage rooms and closets do not constitute living/training area). This is considered a Category I procedure if compliance by the individual can be accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

Note: Separation to Allow Calming (STAC) – Also available is the positive procedure of STAC whereby the person is encouraged to move to an area away from the person or situation that upset them. At the same time, they are assisted in directing their attention to talking about the problem, listening to music, talking about family, relaxing quietly, going for a walk, etc. The activity should be chosen by the person in need of calming. When sufficiently calm, staff will assist the person in resuming normal activities.

D. Assignment of Additional Chores: The individual is assigned additional chores as a consequence for inappropriate behavior. Additional chores may be assigned only if such chores are already a part of the Individual Program Plan (IPP) and are not designed to replace work assignments of housekeeping personnel.

E. Restitution: The individual is cued to restore any property damaged, stolen or defaced. If appropriate to the individual's level of functioning, he/she may be cued to offer a verbal apology to the offended person. If appropriate to the individual's ability to comprehend, monetary reimbursement for the value of the damaged or stolen property may be required if this is a part of the IPP. In lieu of full value, a symbolic portion of the value may be required. Monetary reimbursement requires Human Rights Committee approval and Guardian consent.

Note: The individual is not degraded nor put on display while restoring damage. The individual is given the same equipment and protection to complete the restitution as would normally be given to a person not responsible for the damage.

F. Withholding Privileges: The individual loses a particular privilege following the occurrence of an inappropriate behavior. Privileges include such things as special planned community activities. However, trips off grounds are special and should only be curtailed if problem behavior is anticipated during that trip. Examples of situations where problem behaviors may be anticipated include a problem behavior having already occurred and the person is not fully calm, or, a problem behavior has not yet occurred, but there are indications that a problem behavior is likely. The curtailing of trips off grounds should be done after consultation with psychology staff, or with supervisory staff if psychology staff is not available. Privileges do not include basic living activities, such as meals, habilitation activities, or basic rights afforded all individuals.

G. Personal Property Removal (less than one hour): Removal of an individual's personal item that is being used in an inappropriate or unsafe manner or location. For example, if an individual disturbs others in a common TV room by playing his radio too loudly and will not reduce the volume when instructed, the radio may be removed from that individual for a time not to exceed one hour. The item will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate (See Section 6, *Page 8 of 9*).

Category II:

Category II procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian.

A. Response Cost: The individual loses reinforcers previously earned in a behavior management system, (i.e., Token Economy Program)

B. Overcorrection - includes the following procedures:
   1) Restitutional Overcorrection: Requires the individual to restore the environment to a state that is better than it was before the occurrence of the inappropriate behavior.

   2) Positive Practice Overcorrection: Requires the individual to engage in an intensive practice period in which the alternative appropriate behavior is practiced.

C. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or individual directly, as appropriate. This procedure is considered Category II if the individual voluntarily (without duress or coercion) surrenders the property upon request.

Category III:

Category III procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, other professionals, as indicated by the nature of the program, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian. The individual's record documents the IDT's conclusion that the potential harmful effects of each restrictive procedure (restraint, etc.) are clearly outweighed by the harmful effects of the targeted behavior.

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

A. Separation Time Out (Activity or Setting): Placement of an individual in a quiet area away from reinforcing activities or persons as a result of an inappropriate behavior occurring. The individual will be visually monitored during the time out. Further conditions include ***either:***

1) Separation lasting for over 30 minutes to one (1) hour maximum.

2) Separation (any length of time) requiring physical intervention/personal restraint to ensure compliance.

B. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate. This procedure is considered Category III if the individual does not voluntarily surrender the property upon request, and it must be physically removed.

C. Sensory Deprivation: Involves the temporary impeding of one of the individual's senses for a period of time, contingent upon the occurrence of the target behavior. Most often, this procedure includes only the use of a blindfold or cloth placed over the individual's eyes when it has been shown to facilitate calming. The individual must be visually supervised during the use of this procedure, which may be used in combination with other Category III procedures, as designated in the individual program. It could also include lessening auditory input by covering the individual's ears, or covering a body part (usually the hands) to limit tactile stimulation, hand in mouth, or biting.

D. Restraint: When utilizing restraint as a programmatic option, a hierarchy of lesser restrictive procedures will be attempted prior to restraint, except in limited cases where this is clearly clinically contraindicated. IDT consideration will be given to parent/guardian notification of the use of restraint and address it in the behavior program.

1) Personal Restraint: **In order to prevent personal injury or serious property damage**, the individual or a portion of an individual's body is immobilized by another person or persons in order to prevent personal injury or serious property damage. Approved methods of intervention must be in the individual's behavior program. This is planned personal restraint, contingent upon occurrence of a target behavior. When available, a licensed nurse should monitor the personal restraint and/or check the individual's physical condition as soon as possible following restraint.

Excluded as <u>personal restraint</u> are: physical assistance, prompting of graduated physical guidance to assist individuals during such procedures as toothbrushing and feeding, or to control random head or arm movements during such procedures

as haircutting, or the use of physical assistance in escorting, redirecting, or in manual guidance techniques are not considered personal restraint and do not require documentation as personal restraint. Also excluded as programmed personal restraint is the use of personal restraint in an emergency situation (Section 6, ***Page** 8 of 9*) or during a necessary medical or dental procedure.

In the event of personal restraint, the QMRP/designee of the area must be notified as soon as possible. Programmed personal restraint will occur until the individual is calm and will not exceed fifteen (15) minutes. The IDT will define what constitutes calm behavior for this individual when used in a behavior program.

2) Mechanical Restraint: **In order to prevent personal injury or serious property damage,** the individual or a portion of the individual's body is immobilized until calm by an approved device or devices which may also prevent normal functioning, as described in section C, above. Restraints must be checked for safety and integrity prior to use. The device's use will not exceed 15 minutes without an extension of time approved and documented by the QMRP/designee, preferably, after face-to-face attention. Unless otherwise determined by the IDT, QMRP/designee extensions will be obtained every 15 minutes until the individual is calm. The IDT should define what constitutes calm behavior for this individual when used in a behavior program. Unless determined clinically contraindicated by the QMRP/designee, should the time in restraint reach 55 minutes, the individual must be released for five minutes for motion, liquid intake, or toileting.

Should time in restraint reach 1 hour and 50 minutes, the individual must be released for at least 10 minutes–for motion, liquid intake, or toileting. If this 10-minute release is judged to be a danger to the individual and/others, additional staff should be called to ensure safety for all concerned. In addition, the individual will be checked, face to face, at least every 15 minutes for safety, well being, and integrity of the restraint. Constant observation is required.

Note: On-site monitoring by the QMRP/designee is recommended. When available, a licensed nurse should monitor the mechanical restraint. If unavailable to monitor, a licensed nurse shall check the individual's physical condition as soon as possible following restraint, but in no case later than thirty minutes after the initiation of the restraint.

Excluded as programmed mechanical restraint is the use of restraints in an emergency situation (Section 6, *Page 8 of 9*), during a necessary medical or dental procedure, or to promote healing following a medical procedure or injury. Devices such as a helmet which are not prescribed for the purpose of restricting an individual's movement and/or normal functioning, but rather for their safety and protection are not considered a mechanical restraint.

Note: For medical management, please refer to local site Policy on drugs to manage behavior (Behavior Management/Psychiatric Interventions).

5. **Conditions for Use of Behavior Programs.**

A. A formal behavior program will be developed by the IDT, written by a licensed psychological professional, and approved by a psychologist. It will include the following elements:

1) Description of the behavior to be modified;
2) Functional Analysis;
3) Thorough description of each step of the program to include duration and intensity of specific procedures, the methods of monitoring and analyzing the process, and special precautions that will be taken;
4) Description of any alternatives to the specific procedures;

B. The Individual Program Plan or behavior program will include:
1) Description of all procedures already attempted;
2) Side effects and risks, if any, of the intervention, in comparison with those of allowing the maladaptive behavior to continue; and
3) Behavioral objectives.

C. Behavior Management Procedures should be used in order of least restrictive, unless clinically contraindicated. Exceptions to this order must be fully documented and substantiated as to why more restrictive procedures are advisable before less restrictive ones.

D. All persons administering Category II and III procedures must have been trained in the administration of those specific procedures and have personally experienced those particular procedures, unless medically contraindicated for that person.

E. The Human Rights Committee will review all Category II and III programs at least every 6 months.

F. IDT consideration will be given to seeking consultation from outside expertise when IDT staff resources have been exhausted, as evidenced by the use of Category III procedures for over one (1) year without significant progress. If an outside consultant has been used without success, the agency should continue to access this or other outside expertise until an effective strategy is realized.

An outside consultant is defined as a professional of any discipline and who is not a member of the IDT. For instance, the outside consultant may be a member of the HDC

staff not on the identified IDT, the agency staff, or a professional not affiliated with the agency.

6. **Emergency Procedures**. Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. This includes the use of restraint procedures in the course of an established program, when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy. However, it is emphasized that emergency procedures may not be used at frequent intervals, becoming a routine method of intervention. If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. The emergency use of restraint must conform to ICF/MR regulations and must be reported immediately to the facility administrator or designee.

7. **Prohibitions**: These activities are expressly prohibited.

   A. Corporal punishment - refers to the application of painful stimuli to the body as a penalty for certain behavior, and includes, but is not limited to, hitting, pinching, the use of electrical shock or other infliction of pain, whether or not applied as part of a systematic behavior intervention program.

   B. Individuals who receive services from the agency disciplining other individuals unless involved in an organized and approved self-governing program. Individuals will not participate in the actual administration of discipline.

   C. Seclusion of an individual alone in a room or other area from which entry/exit is prevented. This does not include placement in a time-out area for brief, programmed time segments, as part of a behavior program that meets all applicable standards.

   D. ***Unless specifically requested by family/guardian,*** any procedure that denies visitation or communication with family members.

   E. Any procedure that denies sleep, shelter, bedding, food, drink, or use of bathroom facilities.

   F. Inappropriate vocalizations, maltreatment, neglect, or forced exercise.

8. **Informed Consent**. The individual served and/or guardian, as appropriate, will be provided a copy of the behavior program which utilizes Category II and III procedures. Informed consent will be obtained PRIOR to the implementation of the program, with the following procedures:

A. Persons 18 years of age or older who have no legally appointed guardian may give informed consent for their behavior program. If there is a question about the individual's ability to give informed consent and no guardian can be located, appropriate legal action must be pursued to have someone appointed who can give consent.

B. Consent by the legal guardian(s) is required if guardianship has been established.

C. The legally adequate consent will:
1) Specify, in terms that are easily understood, the restrictive or intrusive procedure(s) involved;
2) Inform the person(s) giving consent of any potentially harmful effects of the procedure(s);
3) Be time-limited, not to exceed one year; and
4) State that consent may be withdrawn at any time.

9. **Uncategorized Procedures**. In the event a proposed procedure does not readily fit in one of the prescribed categories, it may be utilized on an emergency basis, if necessary, at the discretion of the administrator or designee until the appropriate category is determined.

NOTE: Behavior Management Policy 3011-D does not preclude the use of other restrictive/intrusive procedures that would prevent serious bodily harm and/or destruction of property or death. These procedures can only be considered when lesser restrictive procedures have been proven ineffective or their implementation are determined to be clinically contraindicated. Approvals required are the same as those for Category III procedures. Additional approvals may be required as deemed necessary by the facility administrator.

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF
AMY JONES

March 3, 2022, at 12:25 p.m.



800-556-8974
www.veritext.com

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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Amy Jones, produced, sworn, and examined via Zoom, commencing on March 3, 2022, at 12:25 p.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

PROCEEDINGS

THEREUPON, Amy Jones was duly sworn to tell the truth, the whole truth, and nothing but the truth and gave the following testimony to wit:

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Okay. Ms. Jones, how are you today?

A I'm okay.

Q Where are you? Where are you right now?

A I'm in Jennifer Berry's office.

Q Okay. Is there a -- what are you speaking into?

A The computer mic.

Q It's just a computer mic and it --

A I'm trying to move it closer.

Q Maybe you need to ask Ms. Berry, but is there a way -- we can barely hear you. I can barely hear you.

A Okay. Is that any better?

Q Yes.

A Okay.

Q That's better.

Okay. And, if you don't mind, swing that camera around the office so I know nobody else is in there. Okay. What's to your left?

A A wall.

Q Just a wall? Okay. All right. Let's see.
All right. Ms. Jones, state your full name for me.
A Amy Amanda Jones.
Q Amy Amanda Jones. Okay. And how old are you, Ms. Jones?
A I'm 37.
Q Thirty-seven? And where do you live?
A [redacted]
Q
A
Q Are you from the area?
A Yes.
Q Did you grow up there and go to high school there?
A Yes.
Q All right. Did you attend college?
A No.
Q Okay. When did you graduate high school?
A I went back and got my GED in 2012.
Q Okay. What year did you drop out of high school?
A 2000.
Q And what grade was that?
A Ninth.
Q Okay. You dropped out of high school in ninth grade?
A Yes.

Q Okay. And why did you do that?
A I homeschooled for a while. And I got married young.
Q Okay. How old were you when you got married?
A Seventeen.
Q Seventeen? Okay. So you dropped out of high school in ninth grade because you were going to do homeschool?
A Yes.
Q But then you ended up not getting any credit for that homeschool?
A No.
Q Okay. Why is that?
A Because I didn't -- I just didn't do it.
Q What does that mean?
A I mean, I -- I was young and I ended up getting married.
Q Did you live with your mom and dad? Did you live with your parents?
A Yes.
Q Okay. Did they -- were they okay with you dropping out of high school?
A No.
Q Did you get into trouble? Did you have problems at school? What --
A I was having problems at school.

Q What kind of problems?
A With teachers and other kids and --
Q Tell me a little about that.
A I had -- I had trouble making friends as a kid.
Q Okay.
A A loner.
Q Were your grades suffering?
A Yes.
Q Okay. And so that was 2000, you said?
A Roundabout, yes.
Q And did you start working after you dropped out of high school in ninth grade?
A No.
Q And you got married at age 17?
A Yes.
Q Who did you marry?
A Benjamin Karo.
Q Are y'all still married?
A No.
Q Did you have children with Benjamin?
A No.
Q Okay. When did you divorce?
A It was four years later, so around --
Q At 20?
A -- 21.

Q Okay. What were you doing at 21?
A I came to work up here for a while. And then I left to take care of my mom. She was sick.
Q What did you do -- so you came to work at Booneville when you were 21? And that was -- is that right?
A Yes.
Q And that's before you got your GED?
A Yes.
Q And what did you do at Booneville at that point?
A I was a -- I believe it was called LST, at the time, life skills trainer or --
Q A life skills trainer?
A Yes.
Q What does a life skills trainer do?
A Helping our individuals learn every day life skills, so that they may be able to live in the community.
Q And where were you living at the time when you were 21?
A I was living in Booneville, actually, with my parents at the time.
Q Okay. So, at that time, you were living with your parents, you had dropped out of high school in ninth grade. And you'd not gotten your GED, and you were working as a life care -- life skills coach?
A Yes.

Q For the Booneville Human Development Center?
A Yes.
Q How long did you keep that job?
A Around three months. My mom got sick and I quit to take care of her.
Q Uh-huh. So you quit your job or you were fired?
A I quit.
Q Did you have any disciplinary issues at Booneville during that three-month stint?
A No.
Q Okay. So you quit, what did you do after that, other than take care of your mom?
A I stayed at home with her.
Q You didn't work?
A No.
Q Okay. So you lived at home, how long did this go on?
A A couple of years.
Q Okay. Then what happened?
A I started work for Cargill Meat Solutions.
Q Cargill Meat Solutions?
A Yes.
Q Like meat, like you eat meat, solutions?
A It's a processing plant.
Q Okay. I probably don't want to know what that

means.

All right. So you worked there for two years?

A I work -- yeah.

Q Okay. And did you quit that job?

A Actually, it burned while I was still employed there.

Q Okay. What did you do after that job?

A I had my daughter. And I stayed home with her for a while.

Q Oh, okay. When did you get remarried?

A I didn't.

Q Okay. Who did you have your daughter with?

A Joseph Jones.

Q Okay. How many children did you have with Joseph Jones?

A One.

Q Okay. And what year was that?

A 2008.

Q And were you still living at home with your mom then?

A No. I had moved in with him.

Q Okay. Do you still live with him?

A No.

Q Did you ever get married to him?

A No.

Q Okay. And what were you doing -- you weren't working then while your daughter was young?
A No. I took some time off.
Q Okay. When did you next work?
A She was around two.
Q Okay. Where did you go to work then?
A Rockline Industries.
Q Say that again.
A Rockline Industries.
Q Okay. And what did you do there? What is that?
A It -- they make paper products, like wet wipes and cleaning products. I was a packer, palletizer, and I did some QA work with them.
Q And how long did you work there?
A About two years.
Q Okay.
Did you have any more children?
A Yes, I had one more. And I had gotten pregnant with her when I was working at Rockline.
Q Okay. Same father, Joseph Jones?
A No. It's Timothy Walls.
Q Okay. And did you get married to him?
A No.
Q Okay. Do you have any other children?
A No.

Q So you have two daughters?
A Yes.
Q Okay. Did you work after your second child was born?
A No. I actually moved to Fayetteville for a while. And I was working for Lifestyles and I was going to cosmetology school.
Q Okay. Did you finish cosmetology school?
A No. I had a knee injury and they made me resign because I was on crutches.
Q Okay. What did you do then?
A I moved back to Booneville and pretty much started all over again and came back --
Q What year -- what year are we at now that you moved back to Booneville?
A 2016.
Q Okay. What did you do for work then?
A I came back to work here in 2017.
Q Okay. So you came back to work at the Booneville Human Development Center in -- around 2017?
A Yes, in the kitchen.
Q Okay. And so you've only -- and you also work there now; right?
A Yes.
Q And you've worked there since 2017?

A Yes. I had to take -- well, that was two -- that was 2016 when I went to work in the kitchen.

I had to resign for a while because I had -- I had to have surgery on my knee. And I didn't have enough time for FMLA.

And then when I got -- my knee got better, I came back to work here in 2017 as an aid. And I've been here since.

Q You came back in -- so you started in 2017, then you had to leave for a little while, and then you came back in 2017?

A I came back in 2016 and then had to leave for a while and then I came back in 2017.

Q Okay. I see. But then, before that, you'd worked there briefly in the 2000s?

A Yes.

Q Okay. Tell me again what that first job -- life skills what? That first job you had?

A Life skills trainer.

Q Life skills trainer. And then what was your job title when you came back in 2016?

A I was a cook.

Q Okay. How long did you stay a cook? The whole time you were there until you had to leave for FMLA or for injury purposes?

A Yes.
Q Okay. And, when you came back in 2017, were you still a cook?
A No. I came back as residential care technician.
Q Residential care technician. And that was in 2017?
A Yes.
Q Okay.
How old are your daughters?
A [redacted]
Q Okay. And do they live with you?
A Yes.
Q And does anybody -- you said you're not currently married?
A No.
Q Okay. Does anybody else live with you?
A No.
Q Okay.
So since 2017 -- you came back in 2017 as an RCT, residential care tech. And you've either done that job or I think you became a supervisor, but you've worked in direct care since then; right?
A Yes.
Q Do you want me to repeat that?
A Yes. No. I -- no. I said yes. Sorry.
Q Oh, okay. I couldn't hear you. Yeah, it's not your

fault. It's just the -- do you think Jennifer Berry knows how to fix it?

A I can ask her if you need me to.

Q Why don't -- just in -- yeah. Why don't we just take two minutes just to let her come in and see if she can fix it. And then we'll have to have her leave again.

MR. GILLISPIE: We'll go off the record for a couple minutes.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Okay. And, Amy, do you go by Mandy?

A Yes.

Q Yes?

A Yeah.

Q Okay. And part of this is my fault because I forgot to instruct you on verbalizing yes or no. It's just something I'm supposed to tell everybody I depose beforehand.

But, instead of doing this or that, like in normal conversation, or uh-huh, hu-uh, because she has to type it in and make a record of it, in depositions, people have to clearly say yes and no.

So -- but that's my fault because I didn't tell you

that.

So, since you've been back, since you've been back in your role as a direct care provider at Booneville, have you received any disciplinary -- have you been disciplined for anything? Obviously, you've not been terminated, but have you been disciplined for anything?

A No.

Q Received any sort of flags, like anything like that?

A No.

Q Okay.

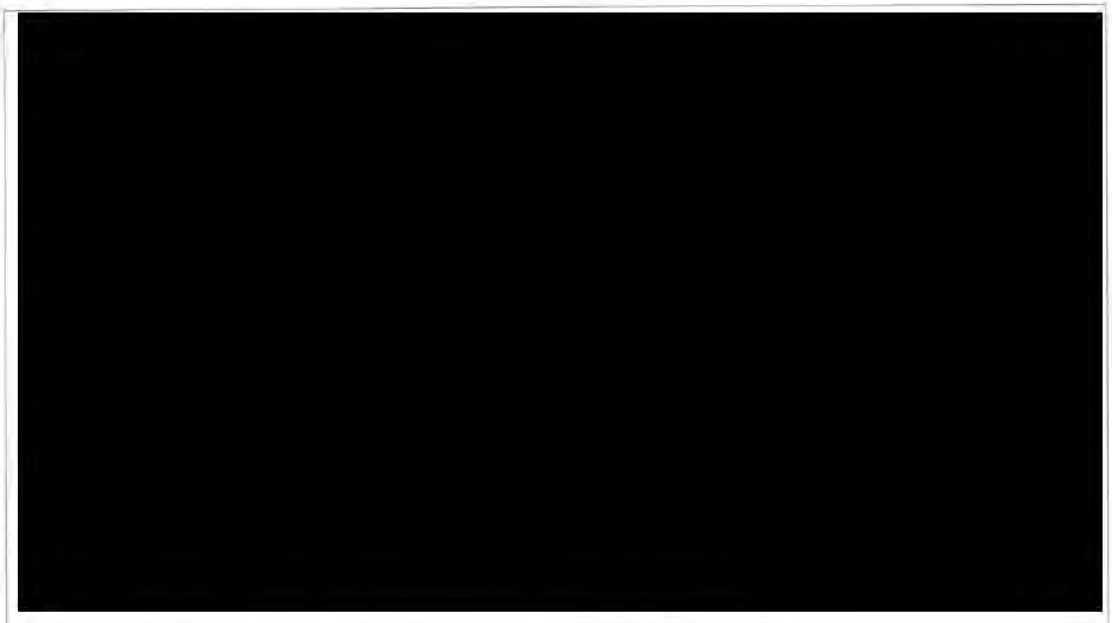
Did you undergo a criminal background check prior to coming back to Booneville --

A Yes.

Q -- in 2016?

A Yes.

[redacted]



Q Okay. Any misdemeanor convictions?
A No.
Q Okay. Obviously no felony convictions?
A No.
Q Okay. Have you ever been investigated for either child or adult maltreatment?
A No.
Q And you're not on any maltreatment registry with the state?
A No.
Q Okay.
And what is your current title at Booneville?
A Residential operations manager.
Q Okay. What was your title at the time of David Cains death --

A I --
Q -- which was in June of 2020?
A Care shift supervisor.
Q Care shift supervisor?
A Yes.
Q And when did you first become care shift supervisor?
A Actually, a couple of weeks prior to that happening.
Q Okay. And what had you been -- what had been your title or role prior to that?
A Residential care supervisor.
Q Residential care supervisor?
A Yes. There was residential care shift supervisor. It was an upgrade from the residential care supervisor.
Q Okay. So you were promoted from residential care supervisor to residential care shift supervisor?
A Yes.
Q And the shift supervisor position is an upgrade from what you had been?
A Yes.
Q Okay. And, in this new role, I guess it was new at the time of David's death, the shift supervisor role, what was -- what were your duties?
A I was stationed out of the Kelly Building. And I was overseeing like transportation and medical appointments and making sure all those were kept up.

Q Uh-huh.
A And pretty much every -- anything that they needed me to help with, as far as going out, marking coverage in the areas.
Q Let's see. I need a little bit more detail than that. Kind of, what was your average workday like in that role in June of 2020?
A Well, that's about the time we started with the COVID stuff too, so it was a bit of a mess, but --
Q I'm just trying to get a sense of what your job duties were, duties to residents and clients, just kind of get a general sense of what you did as a --
A The current --
Q -- under that role.
A -- position wasn't in any of the living areas. It was in our Kelly Building.

And I would go pull all the medical appointments and make sure that they were all kept up and that our transporter had the paperwork she needed for those appointments.

And I would make sure our mobile driver was doing the job she was supposed to be doing. And mostly filing at that point. I had just started training for it.
Q Okay. So your job consisted of making sure appointments were kept and that the mobile vehicle was up

and running?
A Yes. And I also filled in for the program supervisor when they couldn't be here.
Q Okay. And who was the program supervisor?
A It was -- well, the one we had had just retired. So we were having Ashley Craigbaum fill in at that time.
Q And who was your direct supervisor at this time in June of 2020?
A Sandy Evans.
Q And she was the direct --
A Coordinator.
Q Director of Residential Services?
A (Witness moves head up and down.)
Q Yes?
A Yes.
Q And -- okay. So she was your direct supervisor in June of 2020? Sandy Evans?
A Yes.
Q There was nobody in between you and Sandy Evans?
A Our -- we didn't have a program supervisor assigned at that time; so, yes, it was Sandy Evans.
Q But, normally, if there'd been a program supervisor, the program supervisor would be above you --
A Yes.
Q -- and then above her, Sandy?

A Yes.
Q Okay. What was your -- what were your duties with respect to just the direct care of the clients in this role?
A Making sure that their program needs were being met and that staff was following their programs.
Making sure they got to lunch and to schedule when they were supposed to and. . .
Q Okay. And did this job -- was this mainly work you did from the confines of your office or was this a job that required you to be up, moving around, and overseeing the direct care personally?
A Most of the time, at that point, I was working coverage in the areas.
Q You were -- say that again.
A We were very short staffed at that time, so I spent a lot of time at that point working coverage in the areas.
Q You were very short staffed in June of 2020, at the time of David's death?
A Yes.
Q Okay. Tell me about that.
A COVID had just started hitting up here and we had a lot of staff off at that point in time. So I was --
Q Which made everybody's jobs a little more difficult?

A Yes.
Q Or a lot more difficult?
A A lot more.
Q Okay. Where did you notice these staffing shortages the most?
A Probably -- it was in every area in direct care.
Q So there just simply -- at this time, there just weren't enough direct caregivers to meet the needs of the number of clients you had?
A It was bare minimum. I mean, we had enough, but we didn't have any extra at all at that point.
Q But it was a lot less than you're normally comfortable operating with?
A Yes.
Q Okay. And so who would you supervise specifically? And I'm sorry if that's a stupid question; but I just -- you know, I don't know what any of these titles mean and I'm just trying to get a feel for it.
A Direct care staff and supervisors.
Q Okay.
So somebody like Tyler Mattson, is that somebody just directly below you that you would be supervising?
A Yes.
Q And Ryann Campos as well?
A Yes.

Q And did you also supervise the LPNs?
A No.
Q Okay. Who supervised them?
A Our nursing director.
Q Okay.
A Stacy Weinbernner.
Q Do you happen to have -- do you have any idea -- and it's okay if you don't.
But do you know how many direct care staff were under you at the time of the death?
A No.
Q Could you guess?
A We have to have at least 20 -- I think it was 23 at that point. So there would have had to have been at least 23 people here in direct care.
Q Okay. But you're not -- but you don't know if that's the case or not? You're not sure?
A We're not allowed to run without the adequate amount of coverage, so. . .
Q What would you do in a situation where you didn't have the adequate amount of coverage?
A Someone would have to work over from a shift, the previous shift, or we would have to call people to come in.
Q Had there ever been a time where you had to run a

little while with less than whatever that minimum number of people is?
A Not when I've been up there, no.
Q Okay. Oh, I was going -- I meant to ask you, do you have any other kinds of licenses? Like have you done CNA training?
A Yes.
Q You are a CNA?
A Yes.
Q When did you get your CNA license?
A Last year.
Q In 2021?
A Yes.
Q Okay. And isn't it true that all direct care providers are supposed to have an LPN?
A Excuse me?
Q Aren't all direct -- weren't all direct care providers supposed to have LPN credentials?
A No.
Q You're saying that's not a -- that was not the policy?
A That we're all supposed to be LPNs?
Q Right.
A No. No.
Q So, as you sit here today, your understanding of

Booneville policy is that direct care staff are not required to be LPNs?
A No.
Q Okay. What prompted you to get your CNA in 2021?
A The -- our facility requires it of all direct care staff now.
Q Wait, what?
A Our facility --
Q Am I going crazy here? I thought you just said they didn't.
A No, they do. They require it for all direct care staff.
You said LPN. We're all required to have CNA training but not LPN training.
Q I'm sorry. CNA training. Okay.
So what did you get in 2021?
A My CNA.
Q Okay. You're not an LPN?
A No.
Q Okay. All direct care -- that's -- this is my fault. I apologize. Too many acronyms.
But I am correct that all direct care staff are required to have CNA training?
A Yes.
Q And that was the case when David died too; right?

A No.
Q It wasn't?
A No.
Q When did that change?
A It was awhile after that. I'm not sure exactly how long.
Q I assume because of his death.
A I -- I don't know.
Q You weren't ever told?
A No.
Q Okay.
And CNA training, that's like a four-week course? Six-week course?
A Three.
Q Three week? It's a three-week course?
A Yes.
Q Three-week course.
But your testimony here today is that, in June of 2020, direct care staff were not required to have CNA training?
A No.
Q And do you know when exactly that changed?
A No.
Q But it was after David died?
A Yes.

Q And do you have any other licenses or certifications?
A No.
Q Okay.
Do you enjoy your job?
A Most of the time.
Q What's the hardest part of your job?
A Actually, directing staff.
Q Directing staff how? What do you mean?
A I mean, it can be difficult sometimes.
Q Okay. Some staff are -- give you problems? Some don't, I imagine.
A Yeah.
Q All right.
I need to know about the training that you received upon your rehire in -- well, the training you received upon being hired as a direct care, as a member of the direct care staff.
Tell me, if you can, what kind of training you were given when you came back, I believe in 2017, to do direct care.
A You go through a two-week phase class where we learned --
Q Is that the NCI, nonviolent --
A Crisis intervention.

Q -- crisis intervention class?
A Yes.
Q Okay. And that was a two-week course?
A It's part of it. That's not the whole class.
Q Okay. Well, how long does the -- well, how long did the NCI course take?
A A day.
Q One day?
A Yes.
Q And I understand it's phase -- there's phases, phases one, phase two. How many did you go through?
A I went through phase two. But phase two is later on. It's about six months after phase one.
Q Oh, okay. And how long did phase two take?
A I think it was a week.
Q Okay. And what kind of things are you taught in both of those phases?
A The phases --
Q Those NCI phases.
A Learning how to properly help people with developmental disabilities and their training and everyday life skills.
Q Well, it's called nonviolent crisis intervention. So I assume it's mainly involved -- mainly --
A That's just for that particular part of the class.

Q Okay. Well, tell me about what you're taught with regards to nonviolent crisis intervention.
A How to intervene when a client is having a behavior that could possibly hurt themselves or someone else.
Q Okay. And how did they teach you to intervene in NCI?
A They teach you techniques to put them in personal restraints without causing harm.
Q Okay. They taught you personal physical restraints in NCI?
A Yes.
Q Okay. What did they -- what are those techniques that they taught you?
A It's how to maneuver someone to a position where they're not going to hurt themselves or anyone else without causing harm to that individual.
Q Okay. Give me an example.
A Okay. So, if someone was to swing to hit you, they teach you how to grab that person's hand or arm and maneuver it to where they're not able to hit you or hurt themselves.
Q Okay. And tell me how you do that.
A How I do that?
Q Yeah.
A By grabbing their arm and pushing it back away from

their body.
Q Okay. Where do you grab them on the arm? I mean, where on the arm?
A Usually the wrist.
Q You believe the wrist?
A No, it's the wrist.
Q It's the wrist?
A Yes.
Q Okay. And that's the only part of the body they teach you to grab?
A No. I mean, they teach you how to interlock your legs in front of the individuals so that they can't kick you in other situations. It depends on the situation.
Q Okay. Tell me about interlocking your legs on them. Tell me about that.
A Well, if they're kicking -- and you would have to do it with two -- two people.
Q Uh-huh. Describe it for me in great detail, please.
A Each person would get -- one person would get on one side and one person would get on the other. And they would have their wrists, like I showed you.
And you'd put one foot in front of their -- the client's foot, like around the front of the client's foot on each side, so that they can't kick.
Q Okay. And is the client standing in this scenario?

A Yes.
Q Okay. And so this involves two staff members?
A Yes.
Q Okay.
So you're staff member one, John Doe's staff member two. What do you do? You grab one wrist and he grabs the other wrist?
A Yes.
Q Okay. And then you intertwined your legs with the client?
A Not intertwine, really. You put your leg in front of the client's to keep them from being able to kick.
Q Okay. And what's the other guy do then? Who's got the other wrist?
A No, it's a two people helping. You have the wrist and putting -- you put your -- the inner leg in front of the client's leg.
Q You said -- I thought you said you have one wrist and then the other guy would have -- the other staff member would have the other wrist. No?
A Yes.
Q Okay. So you're using -- presumably, they teach you to use -- you'd use one hand to grab a wrist, the other staff member would use one hand to grab the other wrist.
And then what does the other guy with his legs to

restrain the client?
A You both put your inner leg, the leg closest to the client, in front of the client's leg.
But you use both hands to hold their arms. You hold one -- one holds the wrist and the other at the elbow --
Q Okay.
A -- and the arm in front of you.
Q Okay. And what's that called? That maneuver.
A I don't remember.
Q Okay. So we have that maneuver. Back up to the first maneuver you told me about which was the -- and that's where you grab them by both wrists or just one wrist?
A The one -- if you have two people, you grab them by one. Each person grabs a wrist (inaudible).
Q Okay.
Let's talk about a scenario where it's just you. I'm talking about what you were taught here in this -- again, we're talking about things you were taught in NCI training; correct?
A Yes.
Q These are all things you were taught in NCI; right?
A Yes.
Q Okay.
Let's say it's just you and a client's having a

temper tantrum and you think he's going to hit you. Are you taught to grab both -- are you taught at any point to use both of your hands to grab both the client's arms?
A No. If you're by yourself you -- we're taught techniques to maneuver away from that client so the client can't hit us.
Q Oh, Okay. Tell me about that.
A So like, if a client went to swing at you, they show you how to push a client's hand away and move around the side of him.
Q So that you don't have to grab onto both the client's wrists at the same time?
A Yes.
Q Because you're not supposed to do that, I guess?
A No.
Q Okay. Because that could lead to the client -- it could lead to more injury, I presume?
A Yes. For the client and the staff.
Q Okay. So you grab one wrist and you kind of just -- they teach you how to basically sort of --
A I mean, you don't grab. You just --
Q -- sweep away from -- kind of just like a matador? It's like kind of get out of the way of the client but control their exertion with holding one wrist so they don't hurt themselves; but you just kind of get out of

the way so they can't harm you too; right?
A Yes.
Q And is it fair to describe it as sort of like sidestepping?
A Yes.
Q Okay. So the one hand side step maneuver. And I don't mean to put you on the spot here. This isn't a memory test. I just need to know what you remember.
So are there any NCI maneuvers like that that you can recall?
A Not that I can recall right off hand.
Q Okay.
A There are (inaudible), I just can't --
Q Does -- NCI does not teach anything about restraining clients while they're on the ground, does it?
A No.
Q Okay.
A Just has to put the clients in the safest position possible. We're not taught to put a client on the ground, no.
Q Okay. And, in fact, you're expressly prohibited from doing that, aren't you?
A Yes.
Q Okay.
MR. GILLISPIE: I need to take a quick

bathroom break. Can we take five minutes, y'all?

MR. COLLINS: Yeah, sounds good.

MR. GILLISPIE: Thanks.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Okay.

Amy, we were talking about NCI training and you couldn't think of any other -- at this time, you can't recall any other specifics of what you would have learned at that, those two NCI trainings phases; right?

A They teach you how to move someone to a chair, to a sitting position.

Q Uh-huh.

A And we do have the from standing to ground position if we're having to use a papoose board. And that's the only time I've ever --

Q And is that taught in NC -- that couldn't have been taught at NCI because they wouldn't ever say use a papoose board; right?

A If we have to use one, yes, they do teach that to us.

Q NCI does?

A Well, it's part of phase class.
Q Okay.
I know that you have other training other than the NCI. It's just that my understanding of NCI was that they're firmly against anything like that.
A It's the last measure we use. We only use it --
Q Okay.
A -- if it cannot be helped.
Q Other than NCI training -- you said you had other training when you came back in 2017.
What other training did you have that would relate in any way to restraints used on clients? I'm not concerned about your administrative training or training that has to do with all of the other supervised, you know, the higher-level stuff you were doing with appointments and that.
I mean training that pertains directly to or has something to do with restraining clients.
A We go over chemical intervention. We go over how to de-escalate situations.
Q Tell me about that. Like what are the things that you're taught, whether it be from NCI or from anyone else, about de-escalation techniques that do not involve physical contact.
A A lot of times it's -- it depends on how you talk to

the individual.
Q Okay.
A How you hold yourself, your stature.
Q Okay. I think I know what you're -- I think I've seen what you're talking about.
Are you referring to the avoiding, diffusing violent behaviors training?
A Yes.
Q Such as, you know, keeping your hands at your sides with palms open?
A Yes.
Q Do you remember learning that?
A Yes.
Q Speaking in a reassuring voice, not raising your voice, not making -- trying to keep a neutral face?
A Yes.
Q Are those all things you recall?
A Yes.
Q Okay. And are those things that -- and I know this because I got it from the annual training documents that y'all produced to me. Not you but that DHS produced to me. But those are things you were trained in.
I'm going to -- this is difficult by Zoom, but what I'm going to do is I need to make an exhibit. And we're going to call this Plaintiff's 1. But can you -- hell,

that doesn't work at all. Can you -- well, does it look right when I hold it up to you?
A Yes.
Q It looks backward. Okay.
A It's okay.
Q So just take a look at this. Let me know when you want me to move it up.
I just want you to briefly kind of scan over it and then I'm just going to kind of ask you if you recognize this type of training.
A Okay. You can move it up.
Q Okay. Tell me when. Take your time though.
A Go ahead.
Q Okay.
A Okay.
Q So what I just showed you, I'm going to mark this as Exhibit 1.

(WHEREUPON, the document was marked for identification as Exhibit No. 1 and is attached hereto.)

MR. GILLISPIE: This is from the annual training documents dated 2020. This one is dated 2020. It's Bates stamped at 2716. Again, marked as Exhibit 1.

And, I guess, Cris, at the end of the

deposition, I should just e-mail everything to you and Eric?

COURT REPORTER: Yes, please.

MR. GILLISPIE: Okay. All right.

BY MR. GILLISPIE:

Q Okay.

So, Ms. Jones, you had a chance to look at this. And you recognize this type of training as training you were given?

A Yes.

Q And would this also be training that Tyler Mattson and Ryann Campos would have been given as well?

A Yes.

Q Okay. And so, while this document appears to be from 2020 training, it's identical to what you would have been taught in recent years, '17, 2017, 2018, and 2019, I assume?

A Yes.

Q Okay. And some of these things are, you know, know the person you're dealing with, listen, try to appear calm and relaxed?

A Yes.

Q You recognize those as techniques?

A Yes.

Q We talked about keeping your hands at your sides

with palms open in a reassuring stance.
A Yes.
Q Judge the distance you keep, if you feel like you need to, and allow space and room to escape.
Are those things you were taught?
A Yes.
Q If an upset client is standing, you should stand. If an upset client is sitting, you should sit.
Is that something you were taught?
A Yes.
Q Why is that? If you know.
A To make them more comfortable.
Q Okay. So if a client's sitting and upset, if you have -- if you also sit, am I correct that that would make you appear less threatening to the client rather than standing over them, I guess?
A Yes.
Q Okay. And then, of course, just, you know, generally be calm and polite and reassuring, I suppose; right?
A Yes.
Q Okay.
(Brief Discussion off the Record)
BY MR. GILLISPIE:
Q Okay.

Was there any other specific training that you were provided about physical restraints?

And, honestly, I'm not really that interested in mechanical restraints, you know, the papoose board type stuff. And I'm not really that interested in chemical restraints.

I'm really just asking about the physical restraints because that was what was used in the incident in question.

So any other training you can tell me about that relates to the use of physical restraints on a client who's acting out?

A Not -- no.

Q Okay. Did you receive any sort of certification from NCI or through any of these other training programs you might have undergone?

A No.

Q And you were never taught to physically restrain clients on the floor, were you?

A We're taught that transitioning to the ground.

Q Who teaches that?

A Mark Hise.

Q Who?

A Mark Hise.

Q How do you spell that?

A H-a-i-s. Or H-i-s-e. Sorry.
Q And who is he?
A He is our staff development. He trains all of our new staff.
Q Okay. And he trains how to, what you call, transitioning clients to the ground?
A Yes.
Q And what would be the purpose of transitioning a client to the ground?
A If we're going to have to put them in mechanical restraints.
Q Is there any other scenario where you would need to transition a client to the ground or be allowed to do so?
A No.
Q Okay. And how do you transition a client to the ground?
A It -- you don't do it unless you have more than one person.
Q Okay.
A And it's better with three so somebody can hold their back and kind of lay them --
Q How do you do it if you have the right number of people?
A One on each side. And, rather than having your feet in front of the client's legs, you put them behind, like

I was saying earlier, and you just lay them back.

Their arms, you put them up. You've got their wrist and their elbow on each side. One person's at each side.

Q Okay.

A And you lay them back on the third person and so that you can --

Q And --

A -- get to the ground.

Q -- are you taught to get them to the ground just long enough to apply the mechanical restraint or are you also taught to literally restrain them on the ground for a period of time?

A Just for the chemical restraint.

Q Okay. So there's no training that you're given for restraining them for other purposes on the ground?

A No.

Q Okay.

And, in fact, you're not authorized -- as far as you know, you're authorized to do that, are you?

A Not unless it can't be helped.

In a lot of cases, our clients, if they are in conflict and they're -- they became violent, a lot of times, they go to the ground. Like they put themselves in -- onto the floor.

Q And you're saying, in that scenario, you're

authorized to then keep them kind of pinned to the ground like that?
A Well, no. We usually transition them to the papoose board if we can't get them to calm down.
Q But you're certainly not authorized to keep them pinned to the ground for any period of time if you're not going to the papoose board; right?
A No. Just long enough to get them to the papoose board if one's available.
Q Okay. But if one -- but are you saying that you've been taught or told -- I guess, let me ask it this way.
Where were you instructed that there are -- how were you instructed and from whom were you instructed that you can restrain clients on the ground in certain situations?
A If they are hurting them -- causing harm to themselves or anyone else.
Q And in that --
A I mean, it's --
Q And, in that scenario, you're saying you can restrain them on the ground regardless of whether you're putting them in a papoose board or not?
A Long enough to get them to a different position, yes.
Q And how long is that? As long as it takes?
A As long as it's safe for the client.

Q And how long might that be? I mean, how long -- what's the longest you've done that?
A Maybe a minute.
Q And where in your policies, in the written policies that I've been provided, would I find something authorizing that?
A I don't know.
Q And what if I told you that there's nothing in your written policies that specifically authorizes that?
A I can't recite the policy. I don't know.
Q Do you know what the policies are with regards to physical restraints?
A Not off the top of my head, no.
Q Off the top of your head, you can't tell me what circumstances have to be present before you transition a client to the ground?
A I can't recite the policy, no.
Q I'm not asking to recite verbatim.
I'm just asking you to tell me in your own words what you understand the policy to be about when it's okay to transition a client to the ground.
A When the client is a harm to themselves or someone else.
Q Okay.
A And all other means have been used.

Q Like what other means?
A Like any other means other than -- any other restraints other than taking them to the ground.
Q And what those other means be? Other techniques other -- like what should you -- what are the things that should be exhausted before you ever do something like that?
A Well, first, you should try to de-escalate the situation before you even put them in restraints, any kind of restraints.
Q All right. And how would you go about doing that?
A Talking calmly to the client, offering other choices.
Q Uh-huh.
A Direction.
Q What was your relationship with David Cains? Did you know him well?
A Not well.
Q Okay. You know, how often would you come in contact with him?
A Not often at all. It would be every once in a while in his training area, usually.
Q In his what?
A His training area.
Q What's that mean?

A Where he worked.
Q Okay.
A Our recycling department.
Q So you wouldn't see him every day?
A No.
Q Would you see him at least once a week?
A Yes.
Q Okay. Typically more than once a week?
A Maybe once or twice.
Q Okay. And, more often than not, that was in his vocational setting?
A Yes.
Q What did he do for work there? I can't remember.
A I believe he shredded paper --
Q Okay.
A -- and he would tear books.
Q Do you have any distinct -- other than the date of his death, do you have any distinct memories of David or fond memories of him or bad memories of him?
Or did you just not know him that -- just not know him well enough to have such things?
A There were times when I worked coverage in that area, not many, maybe two or three times in all.
Q Uh-huh.
A And I do remember sitting with him and talking to

him about music.
Q Yeah. What did he have to say about music?
A He would tell me the bands he liked. I liked them too. And he would -- he'd play the music and --
Q Was that the -- I know he liked the Monkees. Is that what he played for you?
A Yeah. He liked the Monkees.
Q Any other band that you recall?
A It was usually the Monkees he was playing.
Q Okay. Did you consider David to be a particularly dangerous or violent client?
A In his training area, his vocational training area, he would become violent and he didn't -- he didn't like being there. He didn't like going to training. He wanted to be back in living area --
Q Yeah.
A -- and he would become violent.
Q Did you ever personally witness him being violent prior to the date of his death?
A Yes.
Q Okay. Tell me about that.
A I remember him breaking a window at his training area. I remember him throwing things such as books and trying to hit his training staff.
Q Uh-huh.

A I was never involved with any of that. When I went to his training area, I was with a one-to-one client, so --
Q Okay. You were with another client?
A Yes.
Q Yeah. And, again, I'm really only interested in things that you saw with your own eyes at this point. If I want to know what you heard from somebody else, I'll specifically ask you.
So, as far as things you actually saw about him, you know, being violent, that's what I'm asking about. And you saw him throw books and break a window. Anything else that you saw?
A I have seen him on a couple of different occasions throw up and --
Q Vomit?
A Yes.
Q Okay. I don't really mean that. I mean -- I'm talking about violence, so --
A Mostly, it's just throwing books. And I seen him break a window --
Q Okay.
A -- and try to hit his training stuff.
Q Okay. You've never seen him, you know, cause an injury to someone?

A No.
Q Okay.
Have you ever heard of him causing an injury to someone that required medical attention?
A I believe she -- there was a girl that had worked with him that was pregnant that he had pushed down and hit.
Q Okay. When did that happen?
A It would have been around 2018.
Q Okay. And how did you learn about this?
A She told me. I don't know if she had any medical attention over it or not.
Q She told you?
A Yes.
Q Okay. Is there documentation concerning this somewhere?
A I don't know.
Q Okay. If there is --
MR. GILLISPIE: I guess, Eric, if there is, that would be in what you've already sent me?
MR. COLLINS: I believe it should be within the behavioral reports, but there is documentation for that.
MR. GILLISPIE: All right.

MR. COLLINS: I have not seen it personally with my own eyes, but I would imagine it would be in there.

MR. GILLISPIE: Garrett, you went through all those, did you see anything like that?

MR. GILLISPIE: Well, it's not in what we got, so --

MR. COLLINS: I'll inquire about it.

MR. GILLISPIE: Okay.

BY MR. GILLISPIE:

Q Without telling me, do you know the name of this person that he supposed did this to, Amy?

A Yes.

Q Okay. She's still a resident there?

A Staff? No.

Q Oh, she's a staff member?

A Yes. She recently quit.

Q Okay. And you're saying that you heard he pushed her down and -- but you're not -- you have no idea whether it required medical attention?

A No. I don't know.

Q Okay. Anything else like that?

A He would -- there was a few times that he throw his tray at the lunch room. I do remember that. I wasn't working with him at the time.

Q Yeah. And, again, I'm talking about like things, you know, that could cause somebody an injury.

Pushing them down, that counts. Throwing a lunch tray, I'm not sure it does, unless you're saying you saw him hit somebody in the head was a lunch tray.

A No. I -- well, I haven't seen him hit anybody with them. But he would throw them.

Q Oh, that's right. You said you haven't seen anything. These are just things you heard about.

So you heard about him throwing a lunch tray. Did you hear that the lunch tray caused somebody an injury?

A No. I saw him throw the lunch tray.

Q Okay. And did that cause anybody injury?

A No.

Q Okay. So, other than the staff member who he may or may not have pushed, is there any other potentially injury causing violence that you've heard of David committing?

A Not that I'm aware of.

Q Okay. You said you saw him throw a lunch tray in the cafeteria. What kind of interventions were used in that occasion? On that occasion.

A Staff was able to talk him into going out of the lunch room.

Q Okay. So there was no physical restraint used in

that?
A No.
Q Have you ever seen -- I think you said you -- other than the day of his death, you'd never personally taken part in a restraint on David?
A No.
Q Had you personally witnessed a physical restraint used on David?
A No.
Q You never have? Okay. No?
A No.
Q Okay. Just making sure you.
Do you know, do you have information that you've heard about past physical restraints used on him?
A No.
Q You don't? Okay. Nobody ever came up to you and said, hey, you know, did you hear David had to be put on the board again? Nothing like that?
A No.
Q Okay. Do you know of any other clients, not David, but other clients, who have ever caused a serious injury to a staff member at the facility?
A Yes. But that's irrelevant. I can't really talk about that.
Q Well, you don't have to give me the names, but I do

-- you do have to tell me about it though.

I'm just trying to -- so how many of those injuries do you -- how many incidents that fit that description do you know of personally?

A Clients hurt staff?

Q Yeah. Where a client has actually caused an injury to a staff that, you know, an injury, injury that has required, you know, medical treatment.

A It happened -- it has happened a lot.

Q Okay. Well, you've been there the last few years. About how many times has that happened?

A I've had to go to the doctor twice because of injuries.

Q I'm sorry?

A I've had -- I've had to have medical treatment twice because of injuries.

Q Okay. Again, I'm not asking you to tell me who the client is, but just tell me about both of those incidents.

A My finger -- I got my fingers bit. And --

Q I'm sorry, Amy. Could you maybe speak up just a little bit or get a little closer?

A I got two of my fingertips bit.

Q Bit?

A Bit.

Q Okay.
A And I had a client fall into me. That was when he went to hit me and I moved out of the way.
He lost balance and fell over on me and fell on knee. I had to go get x-rays.
Q Okay. So you personally experienced two such incidents then?
A Yes.
Q Okay.
All right. But, of course, never with David?
A No.
Q Okay. Is your knee doing okay now?
A Yeah.
Q Those things can be bugaboos --
A Yeah.
Q -- lasting a long time. Other than the incident where David was throwing a tray in the cafeteria and he was successfully de-escalated through verbal mean, do you know -- do you have any knowledge -- have you heard or witnessed any other -- I think you said you've never seen a restraint incident with David, physical restraint incident with David, so you've already answered that.
But have you ever heard of another physical restraint incident with David where he had to be, you know, grabbed or physically restrained?

A No.
Q Okay. Do you know of any other incidents where David was taken to the floor?
A No.
Q Did you ever have any contact directly with David's family? His mother or sister?
A No.
Q Okay.
Am I correct that the policy regarding -- the 9-1-1 policy at Booneville at the time of David's death, am I correct that the policy was that only medical staff were supposed to call 9-1-1? Everyone else was supposed to call medical staff?
A Yes.
Q Okay. Is that still the policy?
A I -- I believe so.
Q Okay. Do you know why that is the policy? I know it's not your job to make that policy or probably even to know the answer to this, but I'm just asking.
A No, I don't.
Q Okay. Does it make sense to you?
A It makes sense that our medical staff could get there before EMS could. But I don't -- it don't really make sense that we couldn't call them and then call 9-1-1 as well.

Q Right. I agree. I agree.

MR. GILLISPIE: I am only going to have like four exhibits, but this is the next one. I wanted to call it 2. I'm going to call it 2 because it is 2. It is the second one.

(WHEREUPON, the document was marked for identification as Exhibit No. 2 and is attached hereto.)

BY MR. GILLISPIE:

Q I'm showing you here what I've marked as Exhibit 2. It's been Bates stamped in this case as 4423, Booneville HDC policy, Roman numeral IV-B-10, first aid guidelines.

If you can, you see where this says -- the second paragraph. I just want you to read that. If you can, just read that second paragraph for me.

Let me know if I need to move the paper. I'm sorry. Read it out loud, Amy. I apologize. I meant for you to read it -- I didn't say that.

A First-aid guidelines have been approved by the staff position for the Booneville HDC. In all cases in which a serious medical injury or illness is suspected, either to a client or staff, a call to the medical department should be made.

This should be the first call to medical staff, so -- this being the first call to medical staff so they

can respond immediately to the situation.

A call to medical at 1422 should be made and the following information should be given; caller's name and title, victim's name, location, situation, and condition of the victim. Okay. You can go up.

Q Oh.

A Medical will assess the situation and call an ambulance if appropriate.

All staff members are trained in first aid, CPR, and abdominal thrusts for choking so that, if necessary, emergency rescue measures can be initiated before medical staff arrives.

Choking is a serious and potentially life-threatening situation and the following guidelines should be followed. Staff --

Q So you can -- that's good.

A Okay.

Q Thanks. I just meant for paragraph two.

A Oh, I'm sorry.

Q Okay.

What you just read, does that -- do you recognize that as, in fact, the policy that was in place at the time of David's death?

A Yes.

Q Okay.

Do you know if -- actually, I think this was a discovery, written discovery response. But do you know whether Mattson, Tyler Mattson, had CNA training at this time?

A No, he did not.

Q Okay. What about the Ryann Campos?

A No.

Q No?

A No, they didn't.

Q No? But all of you were given some form of CPR --

A Yes.

Q -- Heimlich maneuver training?

A Yes.

Q Yes?

A Yes.

Q When were you given that training?

A In our phase one before -- before we're allowed to work on the floor.

Q Okay. So you would have gotten that training back in 2017?

A Yes.

Q Okay. And how many weeks was that training?

A Two.

Q Two weeks?

A Yes.

Q Okay. And so, during that two weeks, the training was solely focused on CPR and lifesaving training?
A Yes. The whole phase class was two weeks --
Q Okay. No, I'm --
A -- and first-aid --
Q I'm sorry.
A -- is a day.
Q Yeah, first-aid. How long was the first-aid training?
A It was first-aid and CPR, and it was done in one day.
Q It was one day?
A Yes.
Q Were you ever given that same training again as a refresher?
A Yes.
Q How often?
A I believe it's once a year.
Q Okay. So you think it's one day a year you go, you do the same training?
A Yes.
Q Okay. Where is that done?
A At our staff development.
Q And who's in charge of that?
A Mark Hise and Vanessa Wyrick.

Q Mark Hise. And who? Vanessa what?
A Wyrick.
Q But she works under Mark?
A I believe they're the same position.
Q Okay. But you seem to have a better memory of Mark doing your training than Vanessa?
A Yes. He's -- he's been in there longer.
Q Okay.
When did Tyler Mattson begin working there?
A I'm not sure.
Q Was it after you came back in 2017?
A No.
Q Or he might have already been there?
A Yes.
Q Okay. And you were his boss?
A Yeah.
Q Or supervisor? How long were you his supervisor before David died?
A A couple of weeks.
Q Just a couple of weeks?
A Yes.
Q Before that, were you his peer or -- meaning, were you, you know, just basically coworkers?
A Yes. But we never worked in the same area.
Q Did you know him well?

A No.
Q Have you ever had any issues with him?
A No.
Q Have you ever seen him mistreat a client or go overboard with a restraint?
A No.
Q Have you ever heard of him doing such a thing?
A No.
Q Have you ever heard of him getting in trouble at work for any reason?
A No.
Q Being disciplined for any reason at work?
A No.
Q Have you ever heard of -- have you ever heard any clients complain about him in any way?
A No.
Q Okay. Same questions but about Ryann Campos.
A No.
Q Okay.
All right. Moving on. Should be able to wrap up in about 30 minutes, hopefully. So I want to move on now to the date of the incident itself, June 13th, 2020.
I think that was a Saturday; is that right?
A Yes, I believe so.
Q And, obviously, you were working that day; right?

A Yes.
Q What is your normal shift?
A Eight to four.
Q 8 a.m. to 4 p.m.?
A Yes.
Q Okay. I'm sorry. Speak up just a little bit. I can barely hear you.
A Yes.
Q And, on this day in question, my understanding, correct me if I'm wrong, but my understanding is -- well, did you have any interaction -- let me ask it this way.
Did you have any interaction with David Cains on this day prior to the restraint itself?
A No.
Q You didn't see him in the cafeteria, nothing like that?
A No.
Q Okay. What was happening at the very first moment you laid eyes on David Cains on June 13th, 2020? What did you see?
A I went into the lobby out of the dining room and David was on his left side and Tyler was behind him trying to gain control.
Q But you did not see how he got to the ground?
A No.

Q He was already on the ground when you walked in; right?
A Yes.
Q Okay. Did Tyler later tell you how he got to the ground?
A No.
Q Okay. Tyler never told you how he got him to that -- and do you know now, do you have any understanding now of how he got to the ground?
A No.
Q Okay.
So Tyler was behind him. David's on his left side, is Tyler on his knees?
A Yes.
Q Okay. What is Tyler doing exactly?
A He's trying to gain control of David's arms because David was reaching behind him trying to hit Tyler.
Q So you're saying David was laying on his side on the floor, Tyler's behind him, but you're saying David was still --
A Behind --
Q -- trying to hit Tyler?
A Yes.
Q And so what exactly was Tyler doing to try to control him?

A He was holding onto his shoulder and his waist.
Q So he's holding on, so you're saying Tyler had one hand on his shoulder, one hand on his waist?
A Yes.
Q Okay. And what was Tyler saying?
A Tyler wasn't saying anything. David was yelling that he was -- he wanted to kill Tyler.
Q Okay. But, again, David was on his side with his back to Tyler, so how exactly would David have hit Tyler?
A He wasn't hitting him. He was hitting at him. He was trying to hit him.
Q Okay. Well, why didn't Tyler just back up and give him some space since he's already neutralized on the ground?
A I don't know.
Q Okay. So you walk in, does anybody say anything to you? Do you say anything to anybody?
A No.
Q Had you heard a commotion? Is that why you walked in?
A Yes.
Q What had you heard?
A I heard yelling coming from the lobby of the dining room.
Q And you believe that yelling to be David yelling?

A Yes.
Q Okay. Do you know what he was yelling?
A When I opened the door, he was yelling, he -- I'm going to kill you, Tyler.
Q Okay. What was he yelling before you opened the door?
A I don't know.
Q You just heard some excitable vocalization and you went to check it out?
A Yes.
Q All right.
So you opened the door, you told me what you saw, and nobody says anything to you?
A No.
Q Tyler doesn't ask for your help?
A No.
Q Okay. What do you do next?
A I walked up to them and I got David -- I held David's arms, held them down in front of him with his elbows slightly bent.
Q Okay. So you -- where on his arms did you grab him?
A Right above his wrists.
Q Okay. Above both of his wrists?
A Yes.
Q But he's on his side, his arms are in front of him.

His arms are in front of him when you go to do this?
A Yes. I put his arms in front of him.
Q Okay. And you hold them down there, what, kind of like -- kind of like this?
A Yes. But more up by his face.
Q Up by his face?
A Yes.
Q Were his hands in a praying motion like this?
A Yes.
Q They were? The whole time?
A I don't -- I don't know about the --
Q But, either way, you're -- you got him here and here?
A Yes.
Q Okay.
Does anybody say anything to you then?
A No.
Q Do you say anything to anybody?
A I told David he should calm -- I asked David to calm down.
Q Okay. And what did he -- how did he react to that?
A He didn't react to me. He told -- he kept telling Tyler he was going to kill him.
Q Okay. Is he crying?
A No.

Q He wasn't crying?
A No.
Q How's his coloring at this point?
A It was a bit red. He was very agitated.
Q His face is red?
A Yes.
Q Is his breathing labored at this point?
A No.
Q Okay.
So his face is red, he's not crying. His breathing is not labored at this point; correct?
A Correct.
Q But he's still on his left side; correct?
A Yes.
Q And Tyler is still behind him; correct?
A Yes.
Q And Tyler's on his knees still; correct?
A Yes.
Q And Tyler still has his left hand on David's shoulder and his right hand on David's waist still?
A Yes.
Q Pressing down on him?
A I don't know.
Q But the purpose of him -- he's trying to control him from moving; right?

A Yes.
Q And you're only -- and you're only holding his wrists; right?
A Yes.
Q And you're in front of him; right?
A Yes. I'm to the front and the head -- his -- like the top of his head.
Q Oh, okay. So are you on your knees or are you standing?
A On my knees.
Q You were on your knees. But I think what you're saying is you're in front of him but also kind of --
A Back behind his head.
Q -- behind his head kind of --
A Yes.
Q -- is how you're angled?
And so you're actually -- grab his arm, his hand -- you're grabbing his wrist from above his head, I guess, is what you're saying then?
A Yes.
Q Okay. If that make sense. I mean, I -- okay.
And how long does this -- how long is this the status of things? This exact scenario you've just described, how long does this happen?
A Well --

Q I know Ryann -- I know that somebody else shows up. But, before that, how long does this last?
A Maybe 15 or 20 seconds before Ryann came in.
Q And about how many seconds -- about how many seconds would you say there were between when you first heard screaming while you were still in the cafeteria and between the time you -- I'm sorry. Let me rephrase.
Between the time you first heard screaming in the cafeteria and the time that you got down there to help Tyler, and you started helping Tyler, how much time, how many seconds elapsed, seconds or minutes?
A Twenty seconds, maybe.
Q Okay. So you think it took about 20 seconds to get from the cafeteria into the lobby, see what's going on, and then place yourself on your knees and then help by holding his wrists; right?
A Yes.
Q And then you think you guys stood in that position for maybe 15 or 20 more seconds?
A Before Ryann came through the door, yes.
Q Okay. So the next thing that changes then is -- is it Ryan?
A Ryann.
Q Ryann. The next thing that changes in the setting or in the environment is that Ryann comes through the

door?
A Yes.
Q Where had she been?
A She was coming into our dining for lunch to help monitor clients.
Q Well, I guess what I'm asking is, did she also hear a commotion? Is that why she came in or did she just happen to be coming through the lobby?
A Happened to be coming through the lobby.
Q Okay. So she happens to be coming through the lobby. She walks in the lobby, sees y'all, what does she do?
A She bends down to hold David's legs because he was still kicking and. . .
Q Okay. Did she say anything to anybody, that you recall?
A I don't recall.
Q Do you recall if you or Tyler said anything to her?
A No.
Q Do you recall if David Cains said anything to Ryann?
A No.
Q Okay.
So, at this point, Tyler Mattson is on his knees behind David. David is on his left side. Tyler's hands are on David's shoulder and waist.

You're on your knees kind of above his head, but in front, more in front of him, in front of him kind of behind his head, and you're controlling his arms by holding his wrists; right?
A Yes.
Q And, at this point in time, Ryann is grabbed -- has him by the ankles; right?
A Yes.
Q Is she kneeling or standing?
A Kneeling.
Q Is she in front of him or behind him?
A Behind, I believe.
Q Or is she just, you know -- or just directly facing the bottoms of his feet?
A I'm not sure.
Q Okay. But somewhere down there where she can -- she's kneeling, grabbing his ankles?
A Yes.
Q So we know she's somewhere down there; right?
A Yes.
Q Okay.
And, at this point, has his face changed from red to any other color?
A No.
Q At this point, has anybody noticed any trouble with

his breathing?
A No.
Q At this point, has he defecated on himself?
A No.
Q At this point, is he crying or saying anything?
A No.
Q Is he doing anything? What's he doing?
A He was -- he kept moving his head and looking back at Tyler.
Q Uh-huh.
A And it wasn't a few -- probably ten to 15 seconds after Ryann was holding his legs that he started -- vomit started coming out of his mouth.
Q Okay. And is that the first sign of serious trouble that anybody noticed?
A Yes.
Q The vomit coming out of his mouth?
A Yes.
Q It wasn't that he'd gone to the bathroom on himself?
A No.
Q Okay. And it wasn't that his face had turned purple? The first thing that happened was he started vomiting?
A He -- he started vomiting, yes.
Q Okay. And you think that happened about 20 seconds

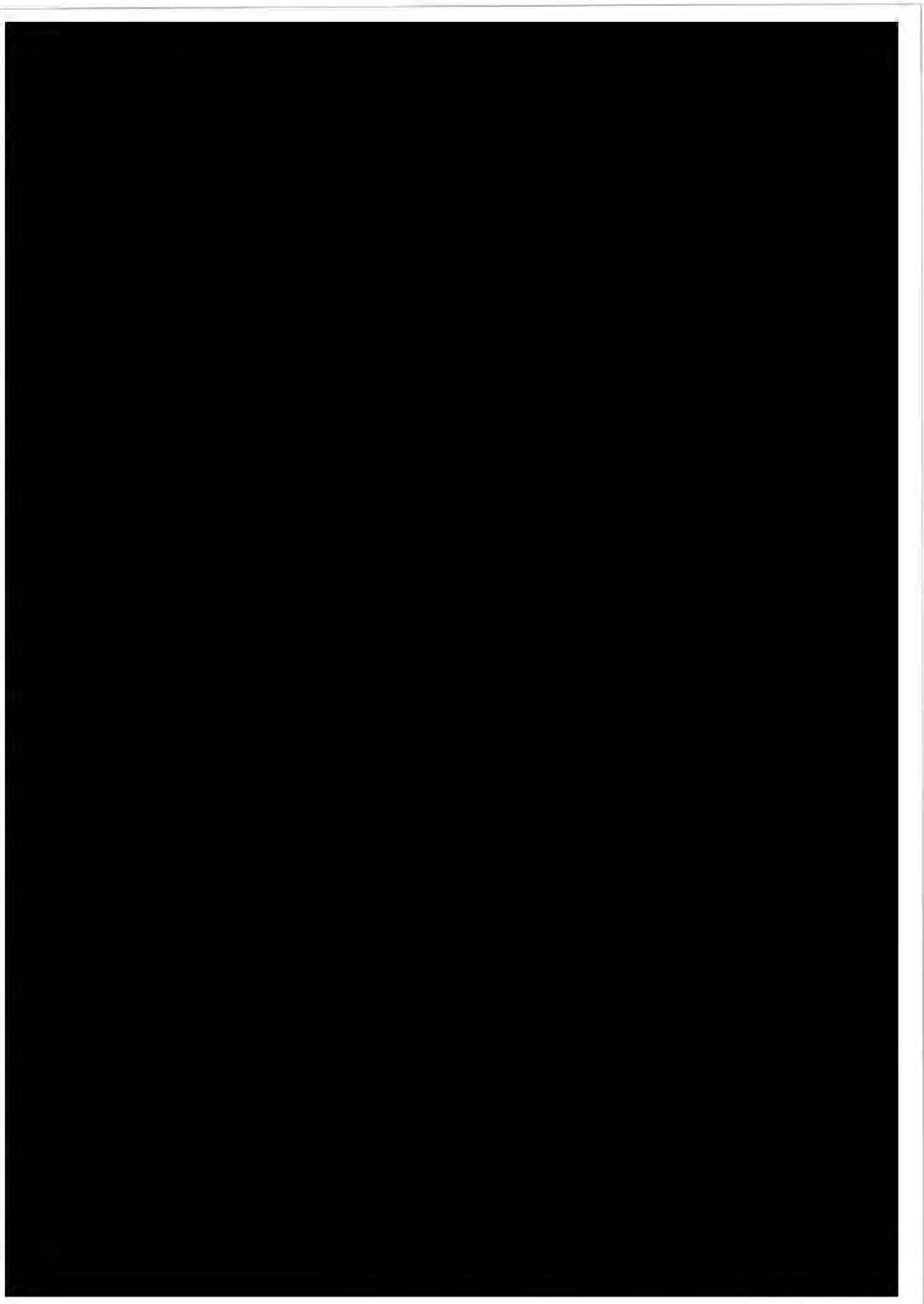
after Ryann started holding his ankles?

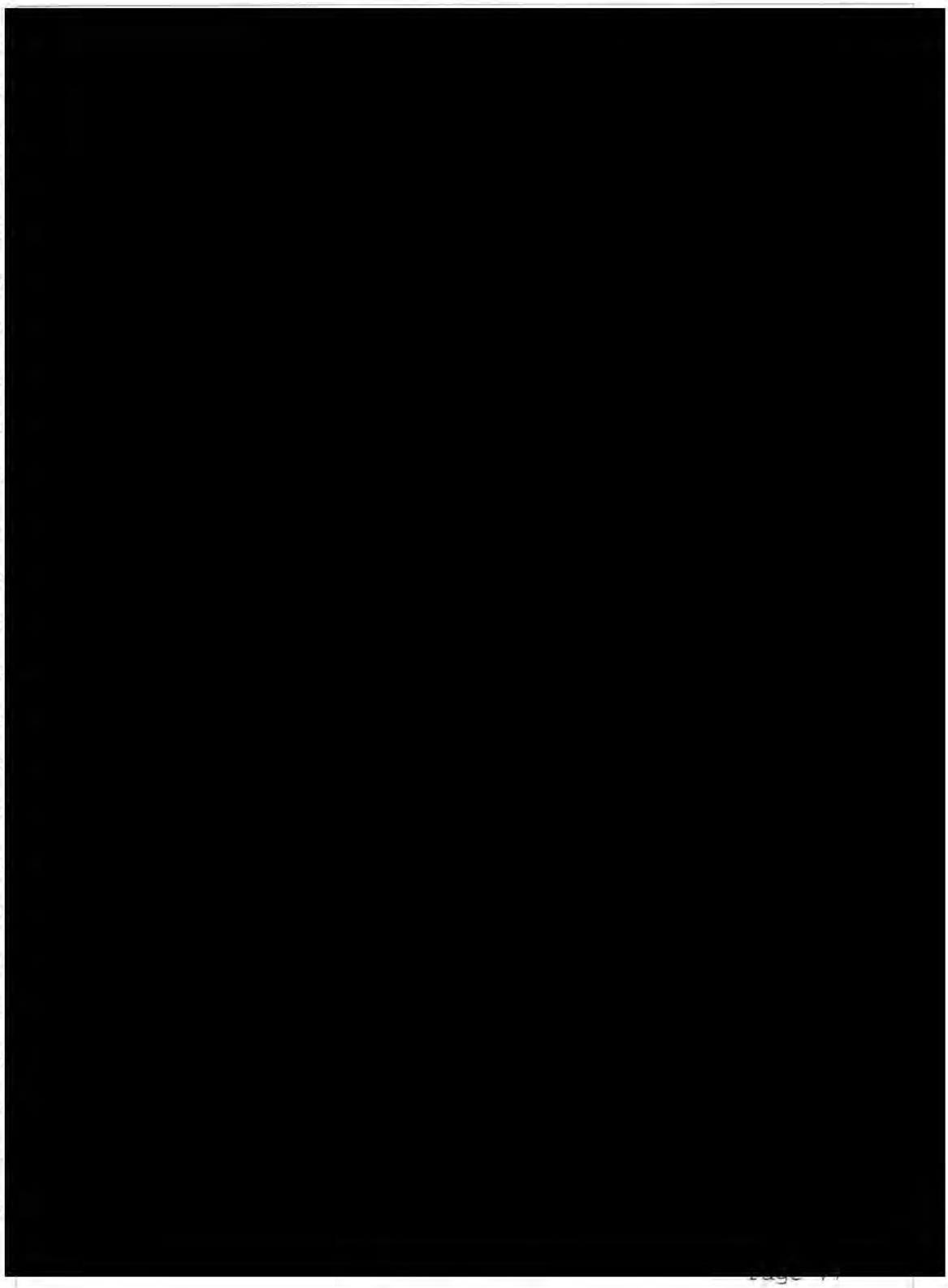
A Yes.

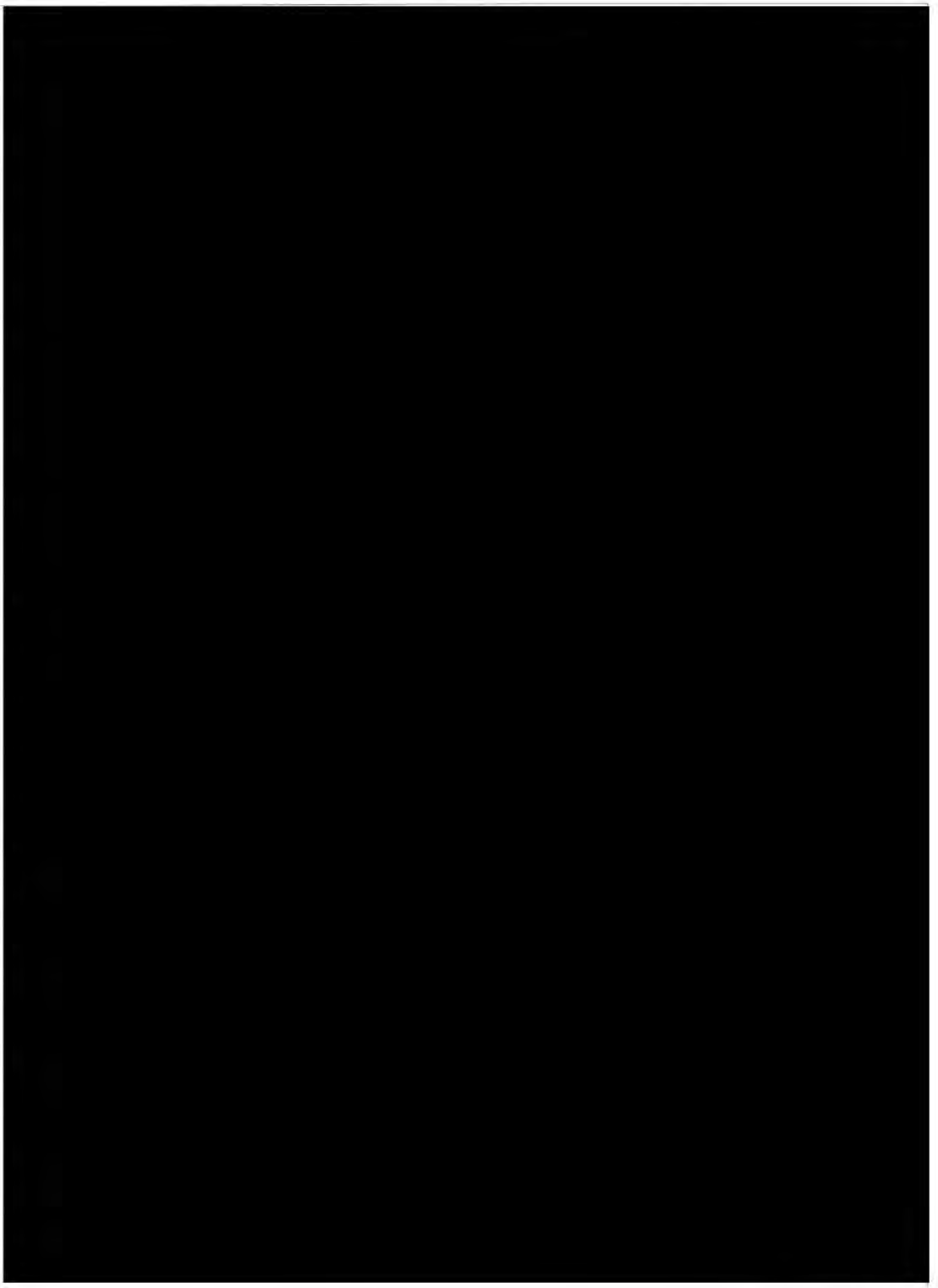
Q Okay. What happens next?

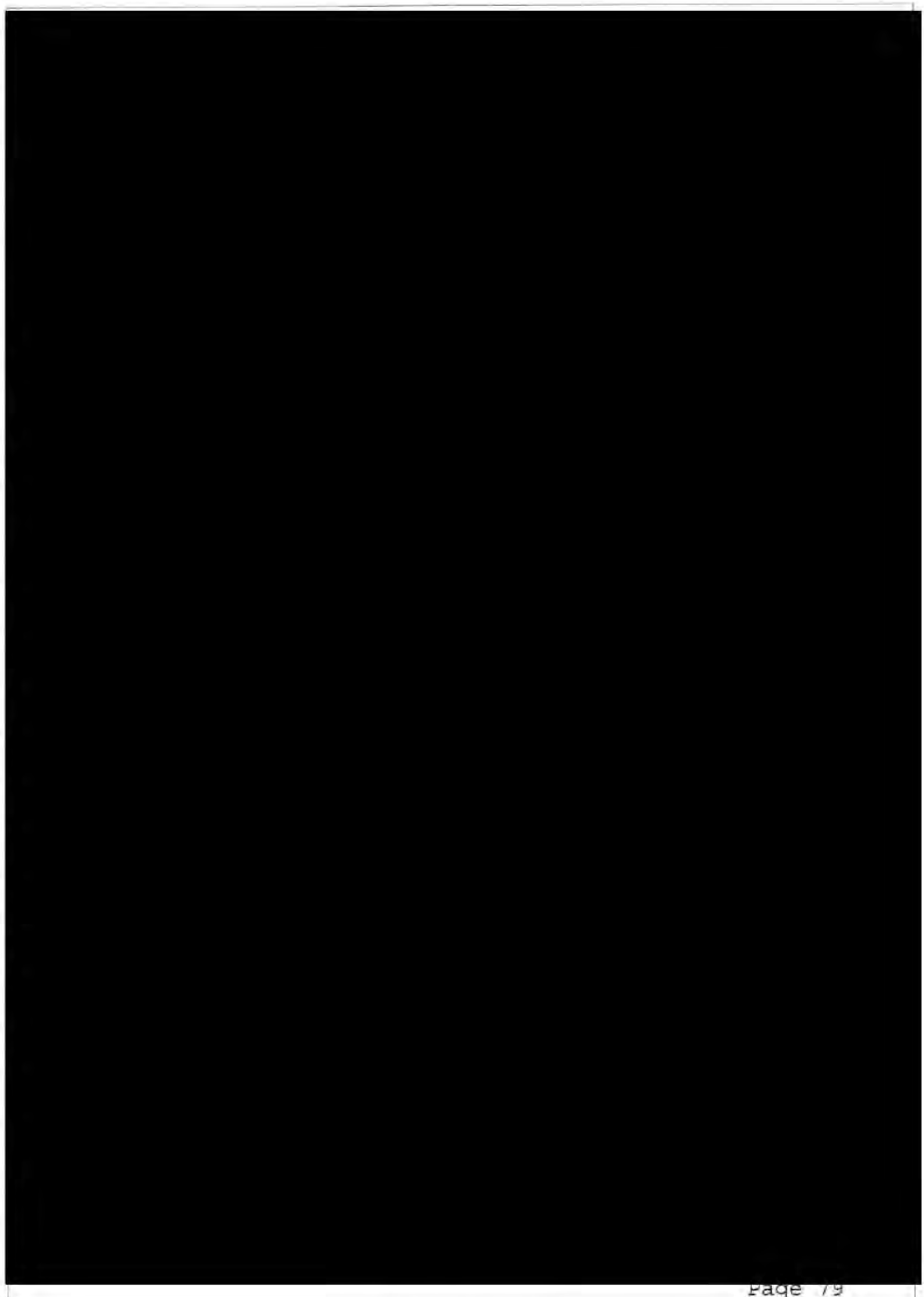
A I --

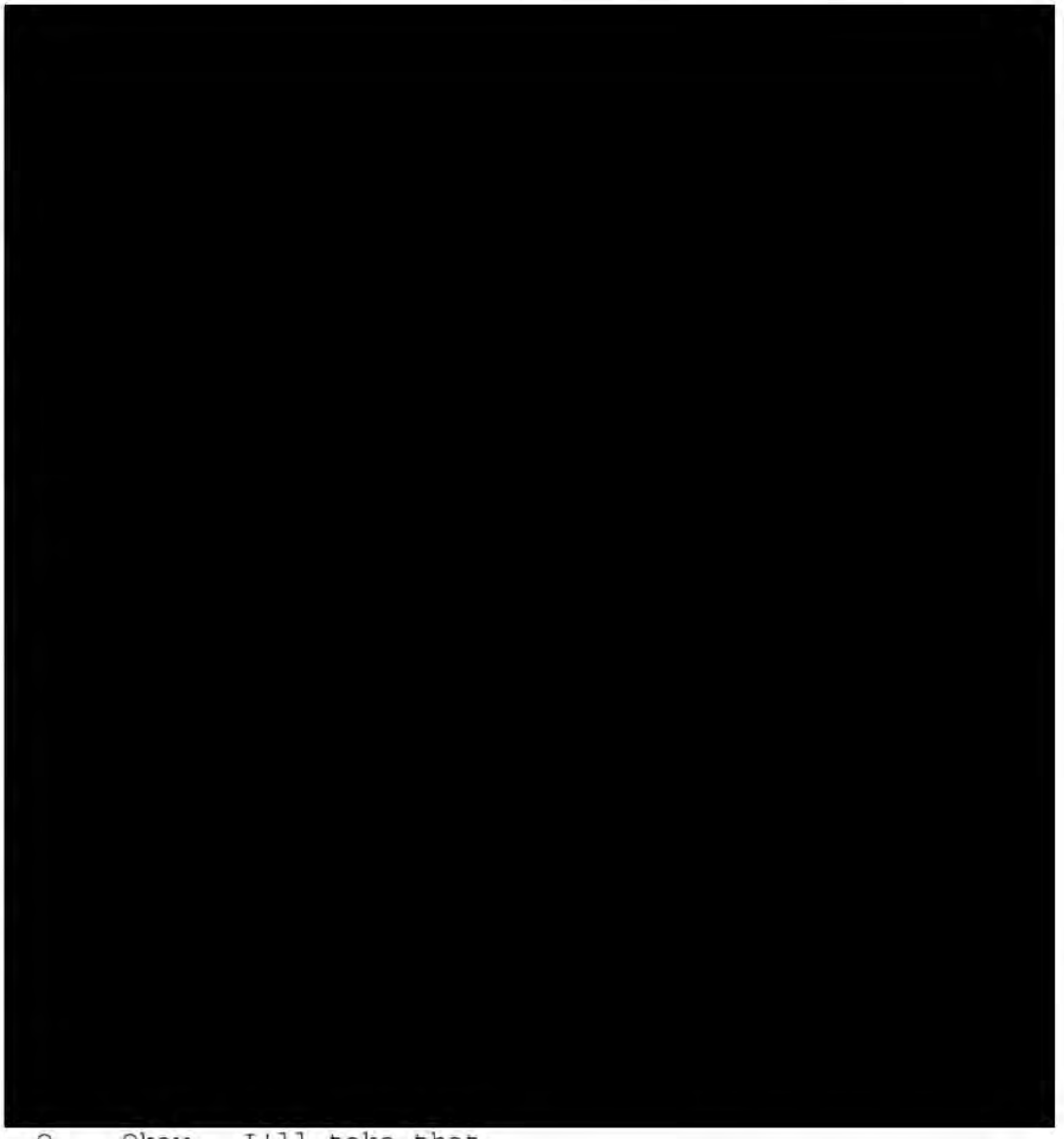
[redacted]











Q Okay. I'll take that.

So did you know -- at what point did you realize -- I mean, I understand the point where you realized he's vomiting and probably not breathing.

At what point did you know that he was choking also, that this was a choking matter?

A I didn't know that he was choking. He was vomiting. And, while vomiting, he stopped breathing.

[redacted]

A He tried --

MR. COLLINS: Objection. I'm going to object to that. That's very --

MR. GILLISPIE: I'll rephrase.

MR. COLLINS: -- (inaudible) to the earlier testimony.

MR. GILLISPIE: Understood.

BY MR. GILLISPIE:

[redacted]

Q Okay.

All right. So then at this point -- is the next thing that happens that one of you calls medical?

A Yes. I instructed Ryann to call medical.

Q Okay. And about how much time elapsed between the time that he starts vomiting and when you instruct Ryann to do medical? Call medical.

A When we -- as soon as we figured out or assumed that he was choking, when he couldn't breathe --
Q Uh-huh.
A -- when we realized that he couldn't breathe.
Q Uh-huh. Okay. So about how much time -- you said it took you a while to figure out he was choking. You didn't know he was choking, you said. So you just knew he was having trouble breathing.
You're saying you didn't call medical until you realized it was a choking problem?
A Yes.
Q So how long did that take? Two minutes?
A No. It didn't take two minutes.

[redacted]



Q Okay. And does she use a cell phone or a phone -- a wall phone? What does she use?
A I don't know.
Q Okay. You had other things to --
A Yes.
Q -- concern yourself with. That makes sense.
So she calls, do you know who she talks to?
A No.

Q Do you know anything about the conversation between her and medical?
A No.
Q Okay.
Did it had to have popped into your head that, hey, I wish I could call 9-1-1; right?
A At that point, all I was thinking about was trying to help him.
Q Right. I believe that. I believe that. But, if it was me, I'd be thinking, damn, I wish I could call 9-1-1. That never occurred to you?
A No. I honestly was thinking about helping him.



Q Okay. And any idea how long -- do you have any idea -- what time was it when you first entered into this fray?
What time was it when you first started helping control David?
A 11:20, maybe. I don't -- I don't remember the exact time.

Q Well, according to the --
A (Inaudible.)
Q According to the documents I was provided, the nurse -- medical says it received the call at 11:33.
Do you have any reason to think that that's wrong?
A It's probably pretty close.
Q Okay.
A I don't remember the exact time. But I'd --
Q Sure.
A -- just gotten up to do the lunch room.



[redacted]

Q Okay. And so you're not sure exactly when -- thank you.

You're not sure exactly when Ryann called medical but you -- and this would make sense if this would be what you know because it's you.

But you do feel like you had done at least three sets of 30 of that by the time medical got there; right?

A Yes.

Q Okay. And medical was -- the people that showed up were two LPNs, King and Schmidt; is that right?

A Yes, I believe so.

Q Anybody else? Was anybody else present that I haven't named?

A Those are the --

Q Let me ask it this way.

A -- only two I remember.

Q Let me ask it this way.

Before medical got there, did anybody else show up to the scene that you recall?

A I don't know.

Q Okay. So, as far as you know, the next people that showed up at the scene were medical; meaning, Nurses Schmidt and Nurse King?

A Yes.

Q Okay. And, at that point, you, Ryann, and Tyler, I assumed you guys backed off and let them do their thing; right?
A Yes.
Q Okay. And what did they -- can you tell me what they did?
A No.
Q Okay. I'm sure you're upset at this point; right?
A Yes.
Q It had to be traumatizing, I'm sure.
So you weren't really paying close attention to the kind of medical techniques they were using to try to save his life?
A No.
Q Okay. And it's okay if you can't. I just want to make sure.
Basically, the point of this is, this whole thing, this deposition, Amy, is I just need to know what you know because I need to know what you're going to say at trial.
And I don't care what you tell me here, as long as you tell me everything. And the only problem we're going to have is if you try to say something at trial that I gave you an opportunity to say here and you didn't say here.

So if you -- it's okay not to know. I just need to know what you know. I just don't want to get in trial and then you suddenly recall some, you know, well, they did A, B, and C.

You don't know what these nurses did?

A No.

Q Okay.

Who called 9-1-1?

A I don't know.

Q Do you know which nurse authorized someone to call 9-1-1?

A No.

Q Okay. Do you know -- do you recall the paramedics getting there?

A I remember seeing them pull up and come in through the front doors, yes.



That's all I remember seeing.

But I went back into the dining room because, at that point, I was responsible for monitoring several other staff and clients inside of the dining room.

Q Okay.

A I was trying to get them through lunch and get them out so that they wouldn't see the paramedics and --

Q Freak out, sure.

A Yes.

Q Okay. And did you re-enter the scene after that?

A I walked out once and paramedics was out there with him.

[redacted]

Q Uh-huh.

A I don't know what it was.

Q Were the police there?

A No.

Q Did the police ever show up that you saw?

A Not -- not that I saw.

Q Were you ever questioned by the paramedics?

A No.

Q You never gave any statement whatsoever to the paramedics?

A No.
Q Okay. Do you know who did give a statement to the paramedics? Do you know who it was that did provide the paramedics with the story of why they were there?
A No.
Q No idea?
A No idea.
Q Okay. Who would be the best person to ask if I wanted to find that out?
A Jennifer Berry.
Q Okay. Who is she? I know I've seen her, but what is she again? What's her role?
A Assistant superintendent.
Q Assistant superintendent?
A Yes.
Q So she's directly under Jeff Gonyea?
A Gonyea, yes.
Q Gonyea? She is?
A Yes.
Q Okay.
I can see you're getting tired and I promise you this is not going to be too much longer. We're through the worst of it.
Did you ever give any statement to law enforcement?
A No.

Q Okay. You were never questioned by law enforcement? Never said anything to them about this; correct?
A Correct.
Q I assume you would have never given a statement to the coroner or any hospital staff either; correct?
A No.
Q Okay.
Did you know at that point, when they -- by the time they carted him off, did you know he was dead or going to die at that point?
A No. Sandy Evans, our director at the time, let me know before I went home that day.
Q What was your reaction?
A I was upset.
Q How did it make you feel?
A It made me feel sad.
Q Did you talk with anybody about it? Did you ever -- did you talk to Ryann or Tyler? Did y'all talk?
A No.
Q Have you talked to either of them about the incident since?
A No. I don't know either one of them, really.
Q Really? Y'all have never gotten together and -- I mean, it's kind of a big deal. You guys --
A No. We work in different areas. I think Tyler's on

my Facebook. That's about it.
Q Yeah. I mean, you're probably going to go through the rest of your life and never experience anything like this again, hopefully.
You guys never -- you never powwowed about it at all?
A No.
Q Okay.
A I don't know if they did or not, but --
Q Okay. Well, fair enough. No, fair enough. I believe you. I'm just -- I totally believe you. I'm just making sure.
MR. GILLISPIE: Let's take another five, please, and then we'll try to wrap up.
(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)
BY MR. GILLISPIE:
Q All right.
Ms. Jones, I know you didn't see it, but do you happen to know if Tyler had attempted any nonphysical interventions prior to you arriving on the scene?
A I don't know.
Q Okay. At some point, did you hold David by his head while he was on the ground?

A No.
Q You never did that?
A No.
Q Okay. So, you know, the reason I'm asking is because Ryann says that you were holding him by the head in her written statement to the Office of Longterm Care.
A No. I was --
Q And then --
A -- leaning over his head. Like I had my arms up, but I never touched his head.
Q So she's just mistaken?
A Yes.
Q Okay. And then Ryan -- I mean, Tyler told -- according to Disability Rights, Tyler specifically said the same thing to them in his recorded statement, that you were holding him by the head.
A No. The only time I touched his head was when I went to clear his mouth.
Q Okay. So both Ryann and Tyler would just be mistaken about the same thing?
A They -- it might have looked like I was, the way I was holding his hands, because I had my arms over his head. But I was not touching his head.
Q Were you trying to control his head like with the insides of your arms?

A No.
Q Like kind of in like a vice, you were doing that?
A No.
Q You were not doing that?
A No. I didn't do that.
Q But it might have looked like that to them, is what you're saying?
A It might have looked like my arms were touching his head at some point, but they -- they wasn't. I was holding his hands.

My elbows and my arms were above his head.

Q So I'm just going to read from Ryann's statement. This is the written statement Ryann gave to the Office of Longterm Care.

I, Ryann Campos, arrived at commons for lunch. I noticed David Cains on his left side fighting Tyler in the lobby, comma, Tyler on his left side holding both wrists, period.

I saw David Cains look up at Tyler and spit, period. Mandy Jones came to assist to position David's head so he wouldn't spit, period. Then I seen David Cains' legs start to kick. I then stepped in to assist by holding both ankles.

Within a couple of seconds, I could smell that David Cains had a bowel movement. I then told Mandy and Tyler.

I then told Mandy and Tyler.

I then looked up and seen food coming out of David Cains' mouth. Mandy Jones then told me to call medical. I then called Judge Hill and spoke with Debbie Noah.

After I hung up with Debbie, I called Amanda, comma, LPN; Lacey, LPN; Joanna Miller, LPN.

[redacted]

MR. GILLISPIE: Okay. So we'll make this Exhibit 3. This is the Ryann Campos OLTC witness statement.

MR. COLLINS: Josh, let me interrupt you real quick. Is that Bates numbered?

MR. GILLISPIE: No. That was in the -- David's medical -- or the file that DHS produced to David's family.

MR. COLLINS: Okay.

MR. GILLISPIE: It's not Bates numbered. You may have sent me a copy of it with Bates numbers, but I didn't see it.

MR. COLLINS: I appreciate it. Thank you.

MR. GILLISPIE: Yeah.

(WHEREUPON, the document was marked for identification as Exhibit No. 3 and is attached hereto.)

BY MR. GILLISPIE:

Q So some of what she's saying matches what you're saying and some doesn't. Obviously, the part about whether or not you had his head held is a big difference.

Again, you think she must have just been mistaken about what she saw?

A Yes.

Q Okay. Is there anything else in that statement that you heard me read that you disagree with?

A It's -- I believe she stated that she was in there helping Tyler or observing or whatever and then I came in, which is not true --

Q Okay.

A -- because we -- me and Tyler were in there before she even --

Q Yeah.

A -- (inaudible).

Q You're right. It did sort of suggest -- or it suggested that it's not clear who got there first. Yeah.

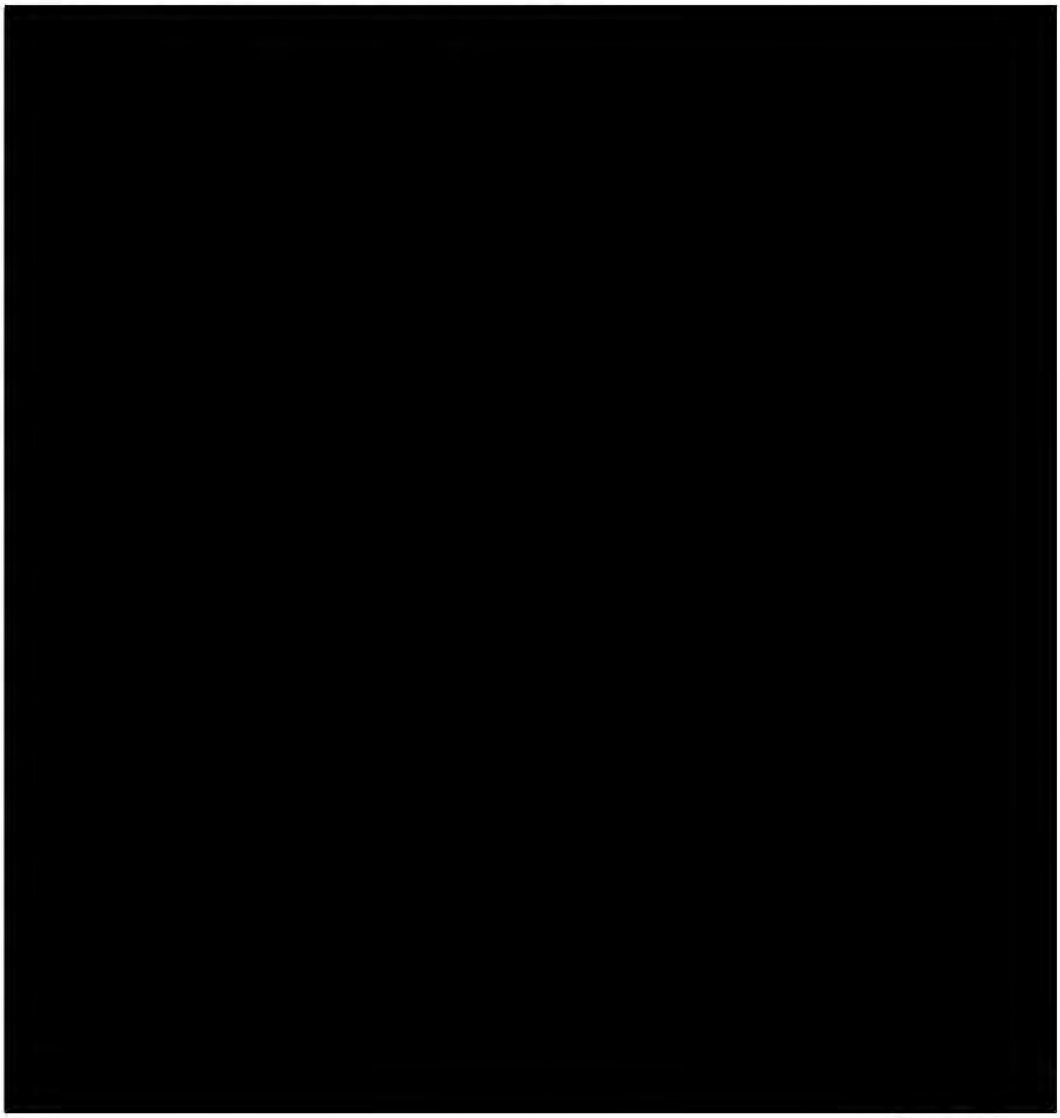
She says that you told her to call medical. Does

that sound right?
A Yes.
Q Okay.
Okay. Moving on. Your statement, your OLTC statement, I'm going to read that as well. This is dated 6/13/20.
I sat down -- I sat down in the dining room at commons to do meal head checks and I heard screaming coming from the lobby.
When I went out to see what was happening, David Cains was in behavior and was hitting staff Tyler Mattson. I went to help -- although he couldn't have been hitting him if he -- in that position, could he have?
A He was hitting behind him at Tyler.
Q At Tyler, but he wasn't actually hitting Tyler?
A I didn't see him make direct contact, no.
Q I mean, I'm a pretty athletic guy, but I don't think I could even do that laying on my side with my damn arm under me hitting a man behind me. That's just not realistic.
I went to help and held David's hands. He was on his left side with his arms held up with his elbows bent slightly. Tyler Mattson was holding his shoulder and his side.

Ryann Campos came in through the front door and held his legs as he was trying to kick Tyler. We held David in personal restraints for about one minute. Does that sound about right?

A Yeah, roundabout.

Q He then started vomiting. We released him from personal restraints immediately.



[redacted]

But you told me you don't really know how long it took them to get there because you're not even sure exactly when you would have told Ryann to call them; right?

A I was guessing about how long it was when I said one to two minutes.

Q Okay.

A I didn't give an exact time.

Q And you would have told her to make the call?

Based on this, it sounds like you told Ryann to make the call to medical after you realized he was choking, which was about a minute after he started vomiting? Does that sound about right?

A No.

Q Okay. What's wrong there? What do I have wrong?

A A minute after he -- it wasn't a minute after he started vomiting. It was a lot quicker than that.

Q Okay.

MR. GILLISPIE: This is your statement. We're going to make that Exhibit 4.

(WHEREUPON, the document was marked for

identification as Exhibit No. 4 and is attached hereto.)

MR. COLLINS: Jeff, before we move on, I need to check on something. Can you give us about a five-minute break?

MR. GILLISPIE: Sure.

MR. COLLINS: Okay. Thank you.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Amy, did either you or Ryann, either of you, attempt any nonphysical methods prior to joining in on the ground restraint?

A No.

Q Neither of you tried any verbal techniques or anything like that prior to joining in?

A I did ask him to calm down when I knelt down and I had his arms, his wrists.

Q You did? So you did speak to him then?

A I --

Q Because I asked you that specifically earlier and you said, no, you -- you didn't say anything.

A I told you that I asked him to calm down.

Q Okay.

And you said that to him as you have hold of his wrist though; right?
A Yes.
Q Okay. But, prior to grabbing hold of him and joining on that ground restraint, you didn't try anything like that, did you?
A No. It had already escalated before I even went in.
Q Escalated to what? He's on the ground.
A He was trying to hit Tyler.
Q He was trying to hit a man behind him with one arm and that was a big danger?
A Behind him -- no. But could have hurt hisself as well.
Q We'll address that later.
Do you know, do you have any information, about a client having his arm broken in a restraint at Booneville in 2019?
A I do remember hearing about that.
Q Okay. What staff members were involved in that?
A I don't know. That's HIPAA.
Q Not the staff members, it ain't. What do you know about that incident?
[redacted]
Q Okay. What do you know about the event? What were

the circumstances?
A I know that -- I heard that he grabbed the client and pulled his arm and broke his arm.
[redacted]
Q Okay. What about another choking death --
MR. COLLINS: Hold on.
Before we move on real quick, Amy, maybe I misunderstood. Did you say that [redacted] was the name of the client or the staff?
THE WITNESS: The staff.
MR. COLLINS: Okay.
MR. GILLISPIE: That's how I understood it as well.
MR. COLLINS: That's fine. Go ahead.
BY MR. GILLISPIE:
Q What about another choking death in 2015? Do you have a -- that was before -- you weren't there then --
A No.
Q -- but do you have any knowledge of that?
A I remember hearing about the client. Like I knew her -- I know of her name, but I don't know --
Q Okay.
A -- what really happened with that.
Q Do you have any idea -- and I know Eric is going to

--

MR. GILLISPIE: I'll say this with a caveat, Eric, that I know you don't concede that the event was misrepresented to the authorities. But, for the purpose of this question to Amy --

BY MR. GILLISPIE:

Q Amy, my question is, do you have any idea -- I know you didn't give any statements to authorities and I know you have no direct involvement in this, per your testimony.

But do you have any knowledge or understanding as to why the event was misreported to authorities? Assuming it was.

A No. I wasn't aware that it had been.

Q Okay. And did I ask you already who is most likely going to have the most information about what was said to the paramedics?

A Actually, it would probably be Sandy Evans because she was our director at that point in time. She's the person who had us write out our statements.

Q Who was the most senior staff member that you personally saw at the scene? Arrive at the scene at any point.

A I -- the only ones I even remember is Ryann and the

nurses. I don't remember anyone else coming in.
Q Well, how do you know Sandy Evans talked to anybody then?
A I don't. I -- you asked me who I thought would have the most information, and it would be her.
Q But you don't recall seeing her at the scene?
A No.
Q And you don't recall seeing anybody above the nurses or above -- Jennifer wasn't -- didn't show up? Nobody?
A No. Sandy came and took my statement after it had happened, very shortly after the incident.
Q Okay. I should clarify.
And, at this point, when I say the scene, I'm talking about, you know, as the paramedics are there or even as they're taking David to the hospital, you know, shortly thereafter.
Who showed up and -- who showed up shortly thereafter? Sandy?
A I don't know. Not -- Sandy didn't show up at the cafeteria. I had -- she instructed me to go back to the Kelly Building and start my statement; and she came in while I was doing it. Her and Jennifer Bancroft.
Q Okay.
A Jennifer came in to take my place.
Q Did you witness anybody speaking to the paramedics?

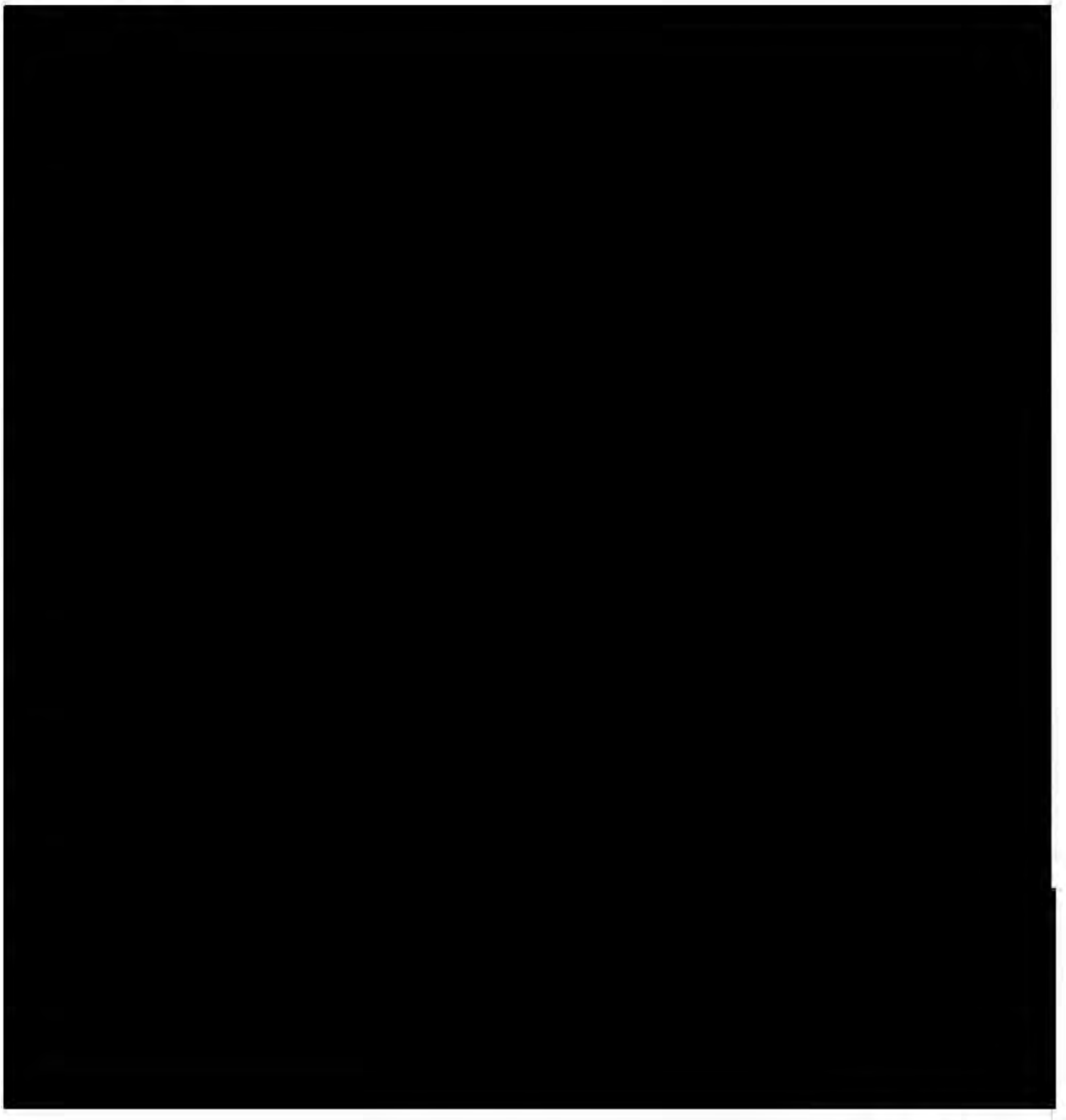
A No.
Q But, again, the only people that you know were there at the same time as the paramedics were yourself, Ryann, Tyler, and Nurses Schmidt and King?
A Yes, in the lobby. There were other people in the dining room.
Q Okay.
Were you aware at the time of David Cains's GERD precautions?
A No.
Q Okay. Okay. Well, as the shift supervisor, why -- you know, isn't that something you would need to be aware of?
A Yes. We have 120 clients. We do have quick looks for all of them that we can go to for reference, if we need to.
I didn't work with David often at all. I didn't work in his area but a few times ever, so I'm not as familiar with the clients in his area as I am with the clients that I worked more directly with.
Q But, on this particular day, you were the residential shift supervisor for David?
A I had just -- I had been doing that job for approximately five minutes when that incident happened.
Q Five minutes?

A Yes.
Q Okay. Five minutes?
A Yes.
Q I thought you had --
A It was --
Q -- said two weeks earlier?
A There was -- I was working coverage that day at another living area. The person that was --
Q You'd been a shift supervisor for two weeks though?
A Yes. But I was pulling coverage in one of the areas that morning.

I came to relieve the person that was the program supervisor that day.

Q Well, surely there's a system for transferring important information about the clients to new shift supervisors so everybody has all the necessary information, isn't there?
A We have a quick look book if we have any question over any of the clients we can go to. And it has their -- any information that we need to know about them in it.
Q Quick looks?
A Yes.
Q Okay. And is that a computer program?
A No. I mean, we do have that information on the computer as well, but it's books that are placed in every

area with all of the clients on -- or in this facility.
Q Okay. So there was -- on this day, there was a book that you guys refer to as a quick look --
A Yes.
Q -- that would've contained this kind of information?
A Yes.



[redacted]

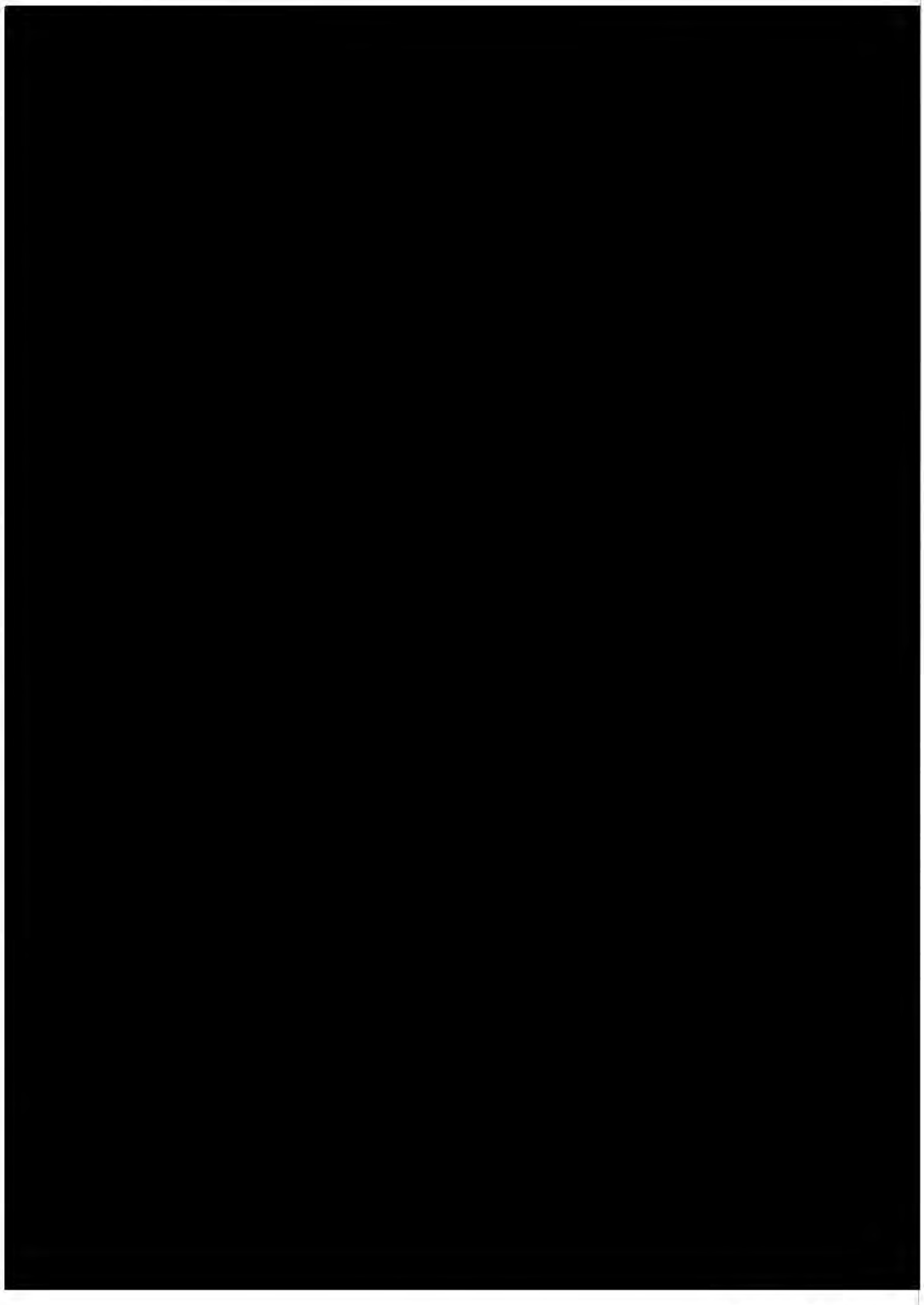
Q And so prior to this, on this day, you were supposed to have reviewed that stuff prior to this shift?
A I have reviewed it. But, at the same time, we have 120 clients that's --
Q And you said you're also short staffed at this time too; right?
A Yes.
Q Which makes all of this probably more difficult for you; right?
A Yes.
Q Okay.

MR. GILLISPIE: One more exhibit here. This is a list of physician orders. This is Bates stamped 1327. We'll make this Exhibit 5.

(WHEREUPON, the document was marked for identification as Exhibit No. 5 and is attached hereto.)

BY MR. GILLISPIE:

[redacted]



[redacted]

Q Well, I haven't heard that you tried.

Nowhere in any of this, nowhere in anything you've said, has it been suggested that any of you attempted just to get him back on his feet at any point before he started choking.

A He hadn't calmed down at any point until he started choking.

Q Okay. And you made the determination then that the threat of him spitting or the threat of him slapping behind himself at Tyler was a greater risk than his [redacted] That was the decision y'all made?

A We didn't make that decision. It --

Q But you did. You did make that decision. And he's

dead.
A We made the decision to try to keep from harming himself or someone else. No one asked for what happened. No one wanted that --
Q He didn't harm himself. He didn't harm himself. You three harmed him.
A Had he gotten up -- we did not harm him. We -- we did not harm him.
Q All right.
We've just got some exhibits here and then we'll be done.
(WHEREUPON, the document was marked for identification as Exhibit No. 6 and is attached hereto.)
MR. GILLISPIE: I have here what I'm marking as Exhibit 6. This is DDS Policy Number 3011-D. I don't know why there's not a -- I got this myself off of -- you did produce this, but I printed off my own version of it. Well, not my own version of it but a copy directly from the DHS website. But you did produce it. It's the same thing, 3011-D, Eric.
BY MR. GILLISPIE:
Q Just a moment.
So I'm going to show you this. Have you ever seen

this policy, 3011-D? Does this look familiar?
A Yes.
Q Okay. If you can, just read that highlighted part for me.
A Behavior management, as covered by this policy serves as a guide to ensure that the individual's actions that are aggressive, disruptive and/or present and danger -- present a danger to the individual or to others are managed with the least restrictive method.
Behavior management is not a substitute for forms of active treatment and is incorporated into program plans based on the individual's needs.
Q Okay. The least restrictive method possible. And you would agree that you're always required to utilize the least restrictive method possible when managing a client's behavior; correct?
A Yes. Yes.
Q Okay. And then the last thing I have for you, is the -- this is a Booneville policy. Booneville Policy Roman Numeral I-D-4, Documentation and Response to Maladaptive Behaviors. And this is Bates marked 4348.
If you could, at the -- read that the bottom for me in the highlighted part.
A Emergency restraint is defined as the use of the least restrictive procedure and for the least time

necessarily, necessary, to control a severely aggressive or disruptive behavior.

The use of emergency restraint will comply with all relevant standards and regulations.

Q Okay. Least restrictive procedure for the least time necessary to control severely aggressive or destructive behaviors. That's what Booneville's own policy says, severely aggressive or destructive behaviors.

Is that your under -- are you aware that was the policy at the time of his death?

A Yes.

Q Okay. And do you recall how that had been communicated to you? That policy?

A It was gone over in phase class and those policies are posted in every area.

MR. GILLISPIE: And this will be Exhibit 7.

(WHEREUPON, the document was marked for identification as Exhibit No. 7 and is attached hereto.)

MR. GILLISPIE: Let me take one minute to make sure I don't have anything else, but I think we're done.

Just go off for one minute, Cris.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Amy, as you sit here today, thinking back on all this, talking to me, if you had it all to do over again, would you have done anything differently? And, if so, what?

A I would've maybe made Tyler let go and leave him there and let me try to calm him down; called 9-1-1 one myself. I don't -- I don't know.

Q Because it's possible, you know, that could have worked. Tyler, right, Tyler could have -- you could have made Tyler let him go and see if he calmed down. Could have at least tried that; right?

A Could have. And he may have hurt himself in that case too. I don't -- I don't know.

Q Okay.

MR. GILLISPIE: I'll pass the witness.

MR. COLLINS: I have no questions for her at this time.

But we would, as with the previous one, like an opportunity to review the testimony in a written form to verify the accuracy.

MR. GILLISPIE: Sure.

Thanks, everybody.

* * * * * * * * *

(Witness Excused)

(WHEREUPON, the proceedings were concluded in the matter at 3:18 p.m.)

* * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Amy Jones, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 11th day of March, 2022.

_____
CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

Eric Collins
eric.collins@dhs.arkansas.gov
March 16, 2022
RE: CHRISTINE MCAULIFFE, ET AL v. THE ARKANSAS DEPT. OF HUMAN RESOURCES ET AL
3/3/2022, Amy Jones (#5061142)
The above-referenced transcript is available for review.
Within the applicable timeframe, the witness should read the testimony to verify its accuracy. If there are any changes, the witness should note those with the reason, on the attached Errata Sheet.
The witness should sign the Acknowledgment of Deponent and Errata and return to the deposing attorney. Copies should be sent to all counsel, and to Veritext at errata-tx@veritext.com.

Return completed errata within 30 days from receipt of testimony.
If the witness fails to do so within the time allotted, the transcript may be used as if signed.

Yours,
Veritext Legal Solutions

CHRISTINE MCAULIFFE, ET AL v. THE ARKANSAS DEPT. OF HUMAN RESOURCES ET AL

Amy Jones (#5061142)

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Amy Jones Date

CHRISTINE MCAULIFFE, ET AL v. THE ARKANSAS DEPT. OF HUMAN RESOURCES ET AL

Amy Jones (#5061142)

ACKNOWLEDGEMENT OF DEPONENT

I, Amy Jones, do hereby declare that I have read the foregoing transcript, I have made any corrections, additions, or changes I deemed necessary as noted above to be appended hereto, and that the same is a true, correct and complete transcript of the testimony given by me.

_____ _____

Amy Jones Date

*If notary is required

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_____ DAY OF _____, 20___.

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AVOIDING / DEFUSING VIOLENT BEHAVIORS

Employees are reminded that we must continue to strive to calm upset individuals without injury or damage. The following steps may help defuse or avoid violent behaviors:

1. Know the individual.
2. Breathe slowly and deeply to relax
3. Try to appear calm and relaxed before intervening- even if you are not.
4. Speak slowly and softly, keeping voice low at all times.
5. **Listen.**
6. Keep hands at sides with palms open in a reassuring stance. Do not trap or corner the angry person. Do not double your fist, point your finger, cross your arms, put your hands on your hips, in your pockets, or behind your back.
7. Judge the distance you keep by your knowledge of the individual and your rapport with him/her; allow both of you space and room to escape.
8. Stand if he/she stands; sit if he/she sits. Squat or sit down if the individual is in a wheelchair.
9. Do not ask "Why." Do not argue, threaten, raise your voice, or become judgmental.
10. **Listen.**
11. Let the individual know you are there to help in any way you can, but do not make promises you cannot keep.
12. Keep your face passive and neutral – do not frown, scowl, or laugh.
13. Reassure the individual that you are there to help and you will wait with him/her until he/she works through whatever is bothering them. Let them express his/her fears, frustrations, and accusations without censor.
14. Stay relaxed, keep a monitor on your voice tone, body stance, muscle tension, and breathing so that you present yourself as a source of stability and model of how to remain calm.
15. **Listen.**

NONVIOLENT CRISIS INTERVENTION TRAINING PROGRAM OBJECTIVES (NCI)

Identify behavior levels that contribute to the development of a crisis and choose appropriate staff intervention for each level. This program is used to provide guidance to the acting out individual and the employees that are dealing with de-escalating the behavior.

When writing a Behavior Report, be careful not to include any of your personal feelings (opinions) about the incident or behavior. Instead, always rely on the Five 'Ws'- *Who, What, Where, When, and Why.*

PREVENTION / REPORTING OF MALTREATMENT

BHDC strictly prohibits the maltreatment of clients residing at this facility. Maltreatment is defined as:

- Physical abuse or assault.
- Psychological abuse.
- Verbal abuse.
- Negligence.
- Failure to provide necessary care.
- Exploitation or sexual abuse.
- Misappropriation of personal property or moving furniture or belongings without permission.



FIRST AID GUIDELINES

POLICY STATEMENT: First Aid Guidelines are available for use in each of the Aide Stations in each living area. This will permit appropriate and immediate attention to medical conditions of sudden onset, including injuries and choking.

PROCEDURES:

1. The First Aid Guidelines have been approved by the staff physician for the Booneville HDC.

2. In all cases in which a serious medical injury or illness is suspected, either to clients or staff, a call to the Medical Department should be made. This should be the first call so Medical staff can respond immediately to the situation.

   A call to Medical at 1422 should be made and the following information should be given:

   1. Caller's name and title
   2. Victim's name, location, situation and condition of the victim (alert, unconscious, etc.)
   3. Medical will assess the situation and call an ambulance if appropriate.

3. All staff members are trained in first aid, CPR, and abdominal thrust for choking so, that if necessary, emergency rescue measures can be initiated before Medical staff arrives.

4. Choking is a serious and potentially life-threatening situation and the following guidelines should be followed:

   a. Staff will supervise clients during meal times and nursing staff will be available by phone at all times;
   b. emergency equipment including oxygen and suction machine will be kept in the dining room for use as needed;
   c. All staff will receive annual training in abdominal thrust and choking precautions.

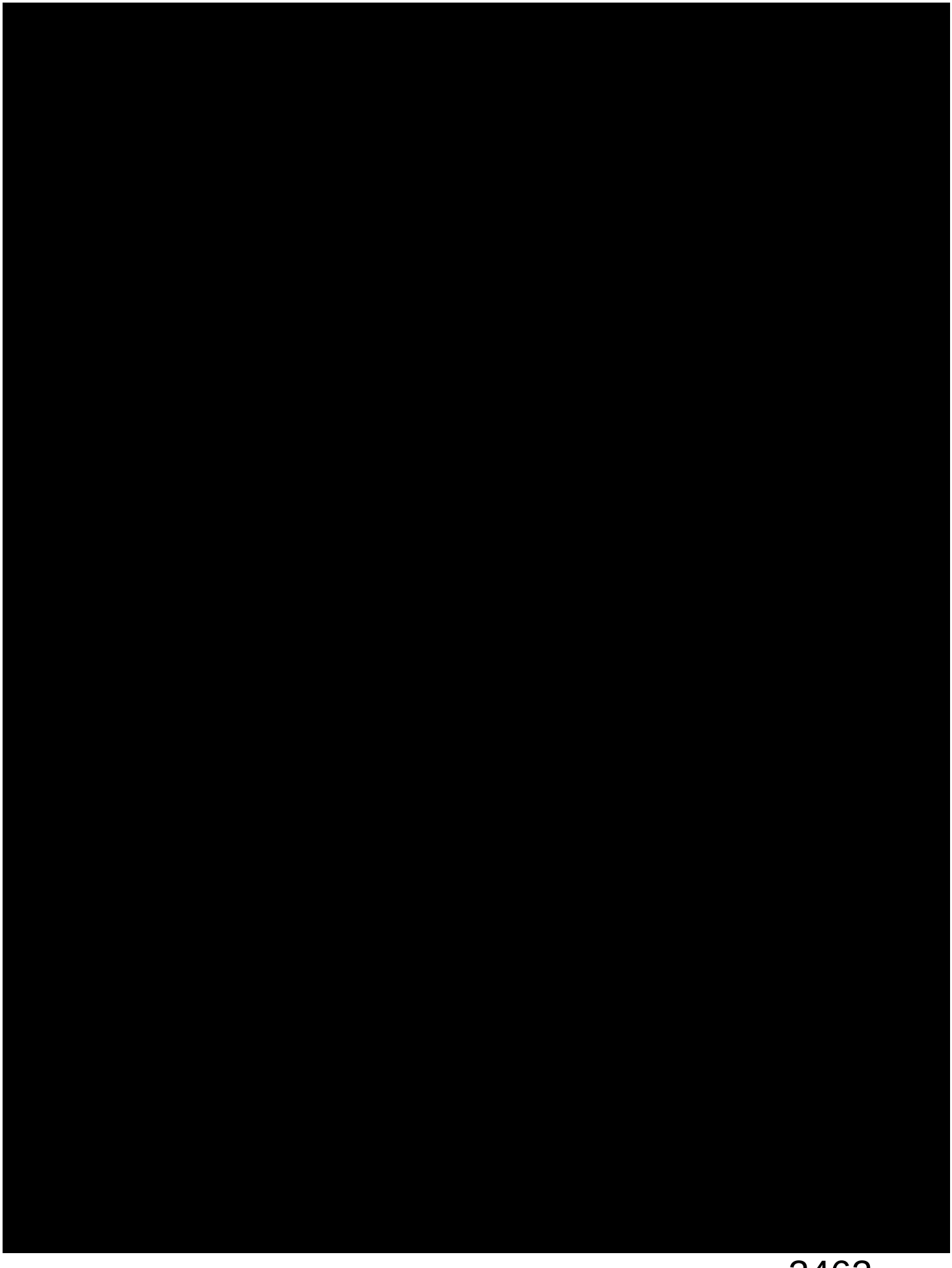
5. First Aid kits, disaster kits, and first aid guidelines will be kept in all areas. Medical will do monthly inspections on first aid kits, and every 6 month inspections on disaster kits, and refill appropriately. If living area staff notice supplies are low, Medical is to be notified and supplies will be replenished.

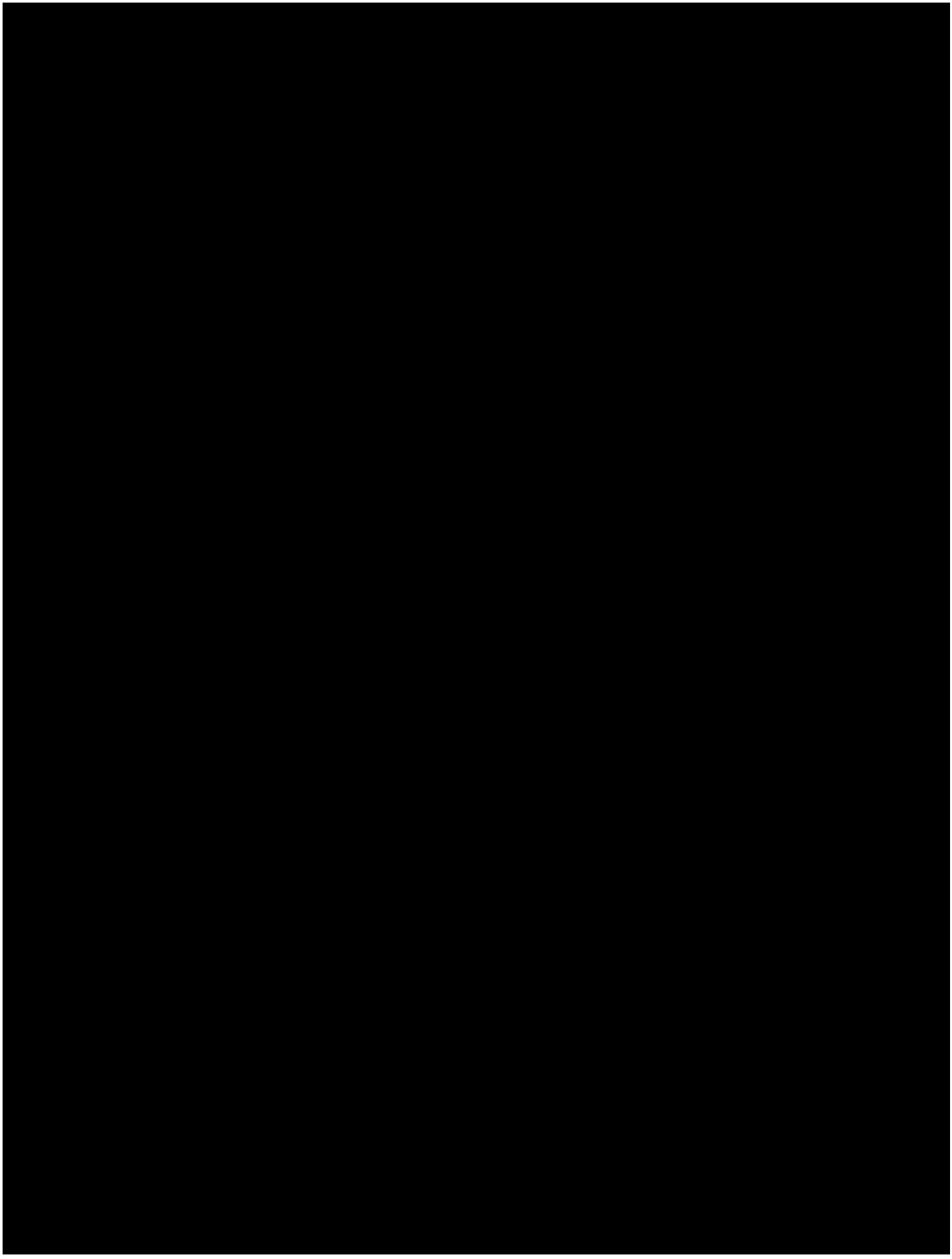
APPROVED: _____ Superintendent

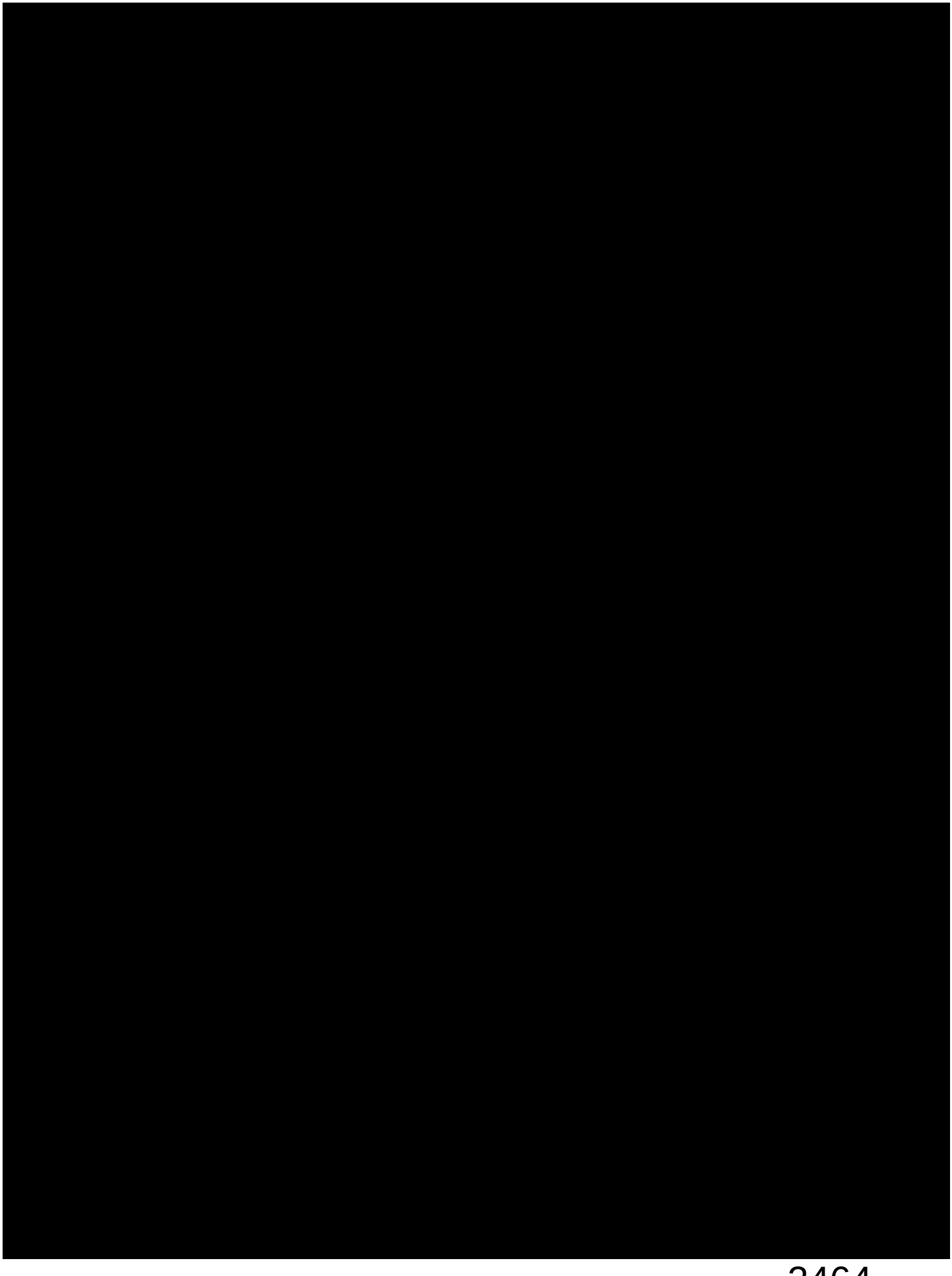
Supersedes BHDC Policy IV-B-10, dated 03/13/15, in its entirety.

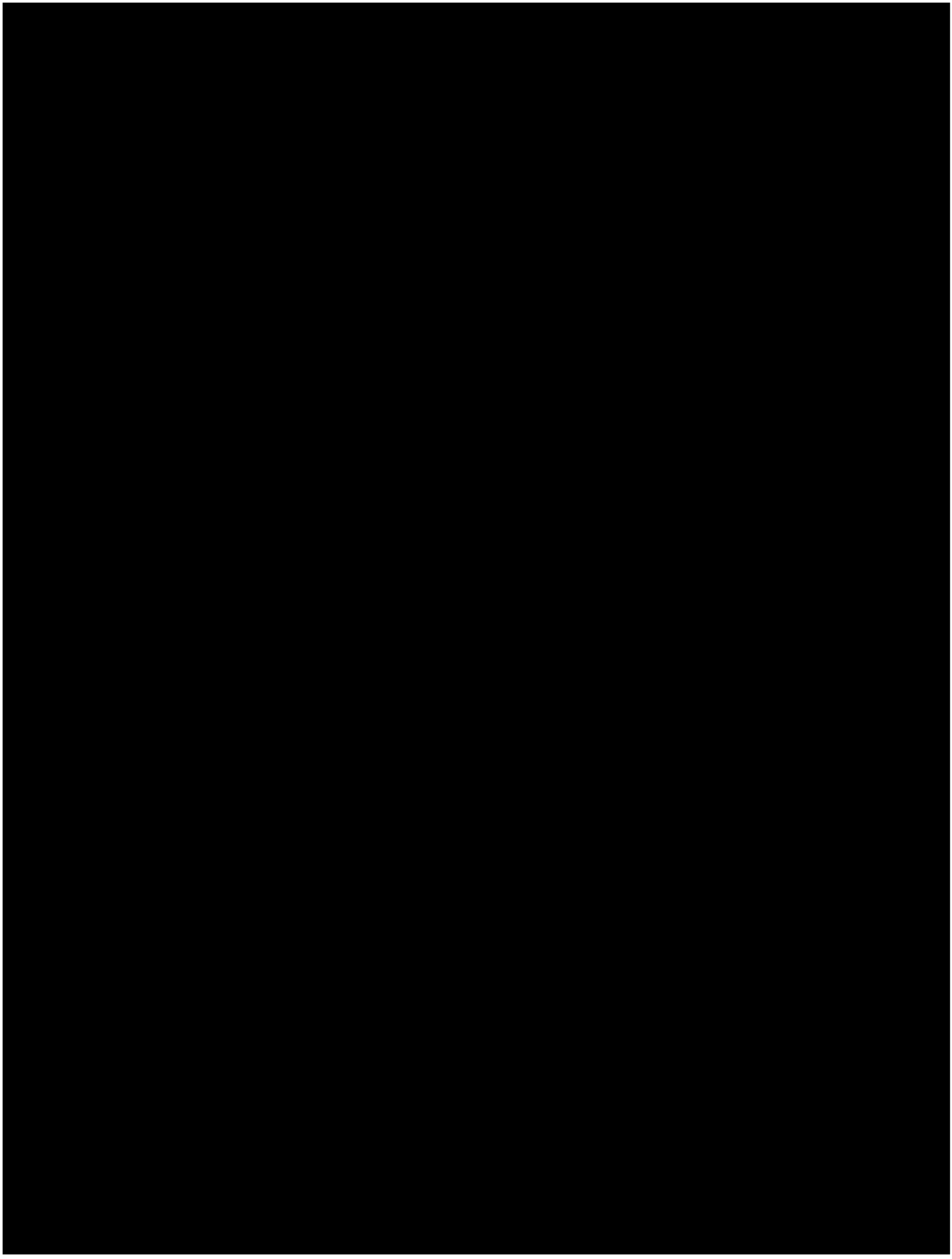


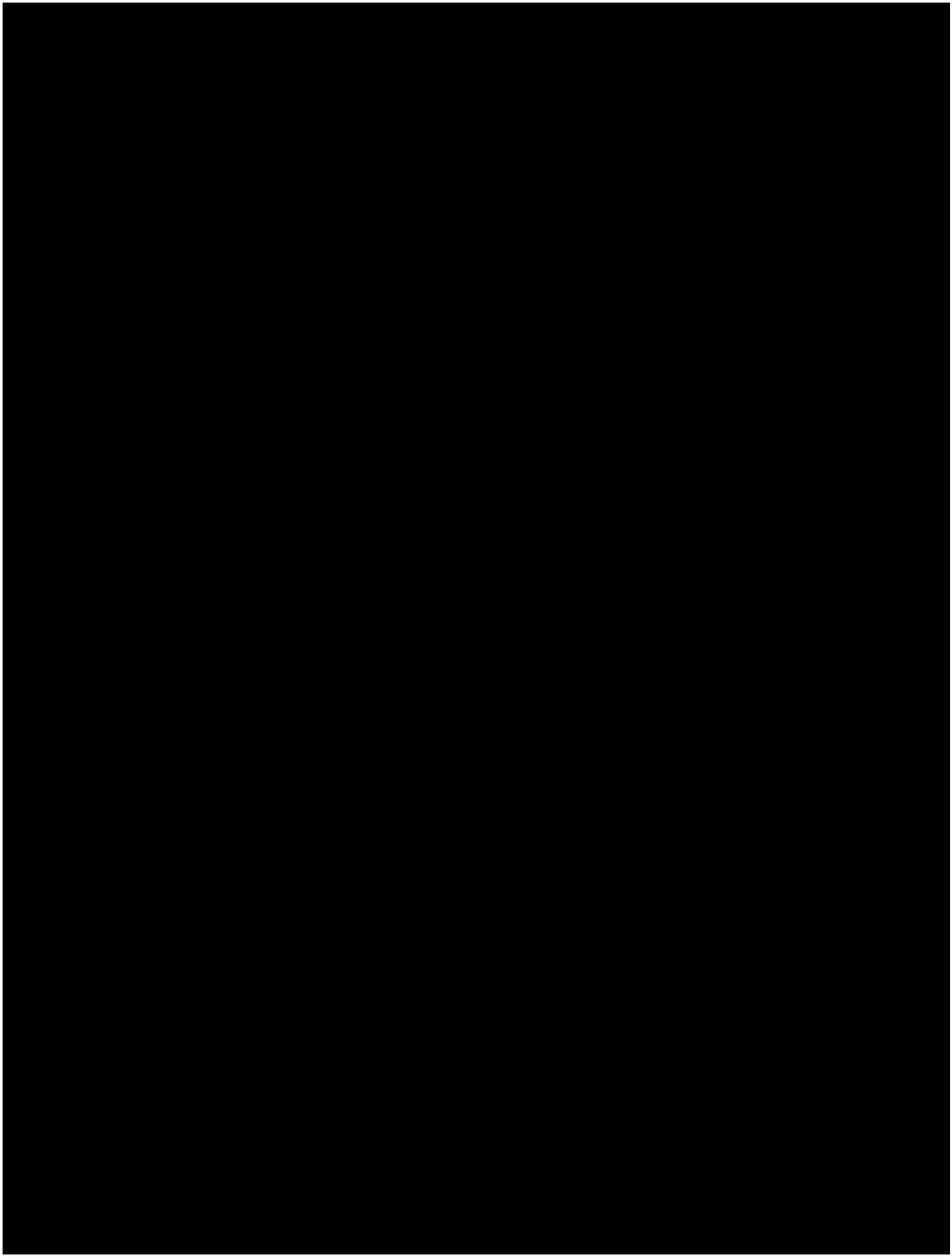
REVIEWED: 11/27/19
VERSION: 12/29/17

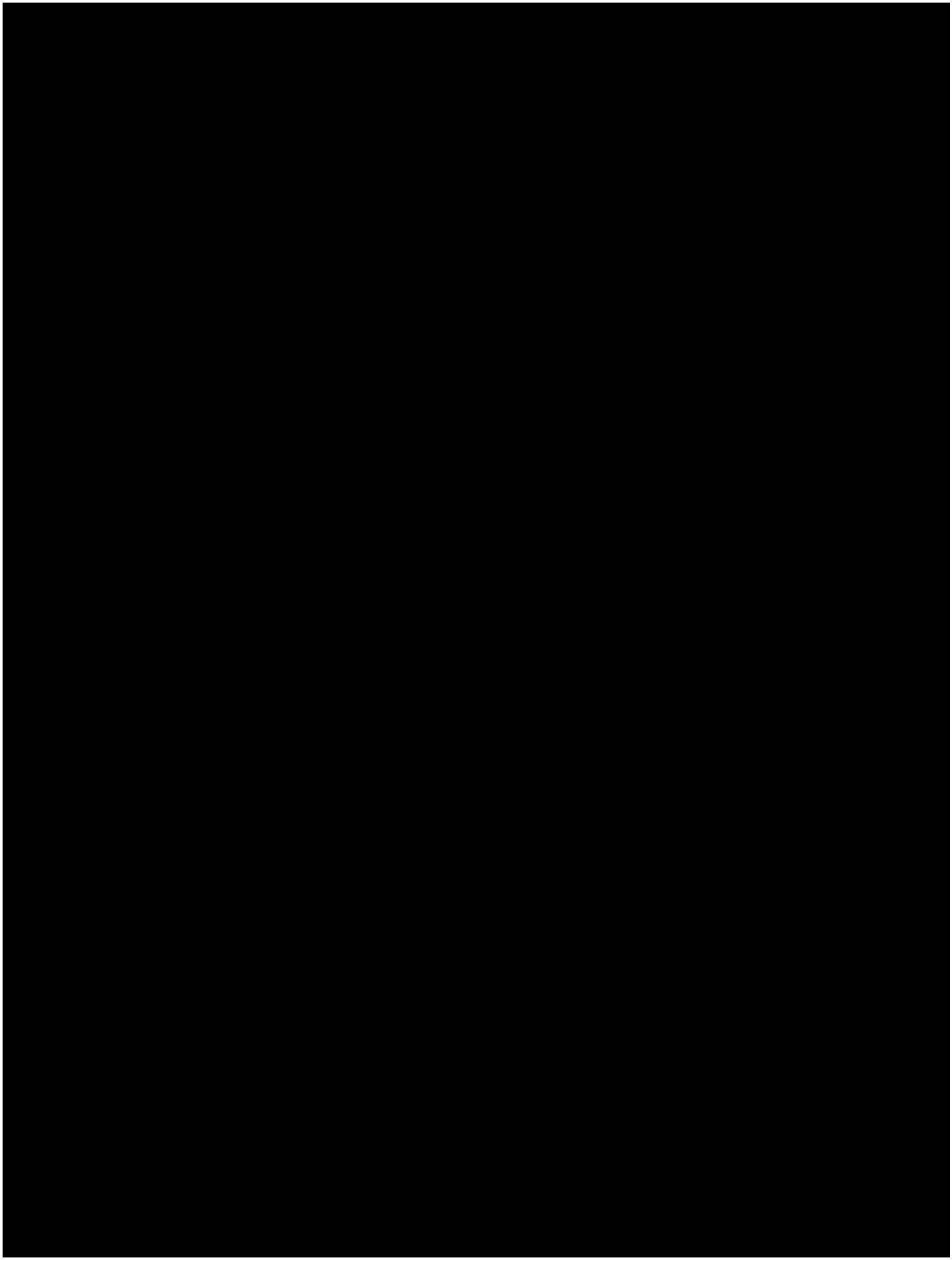


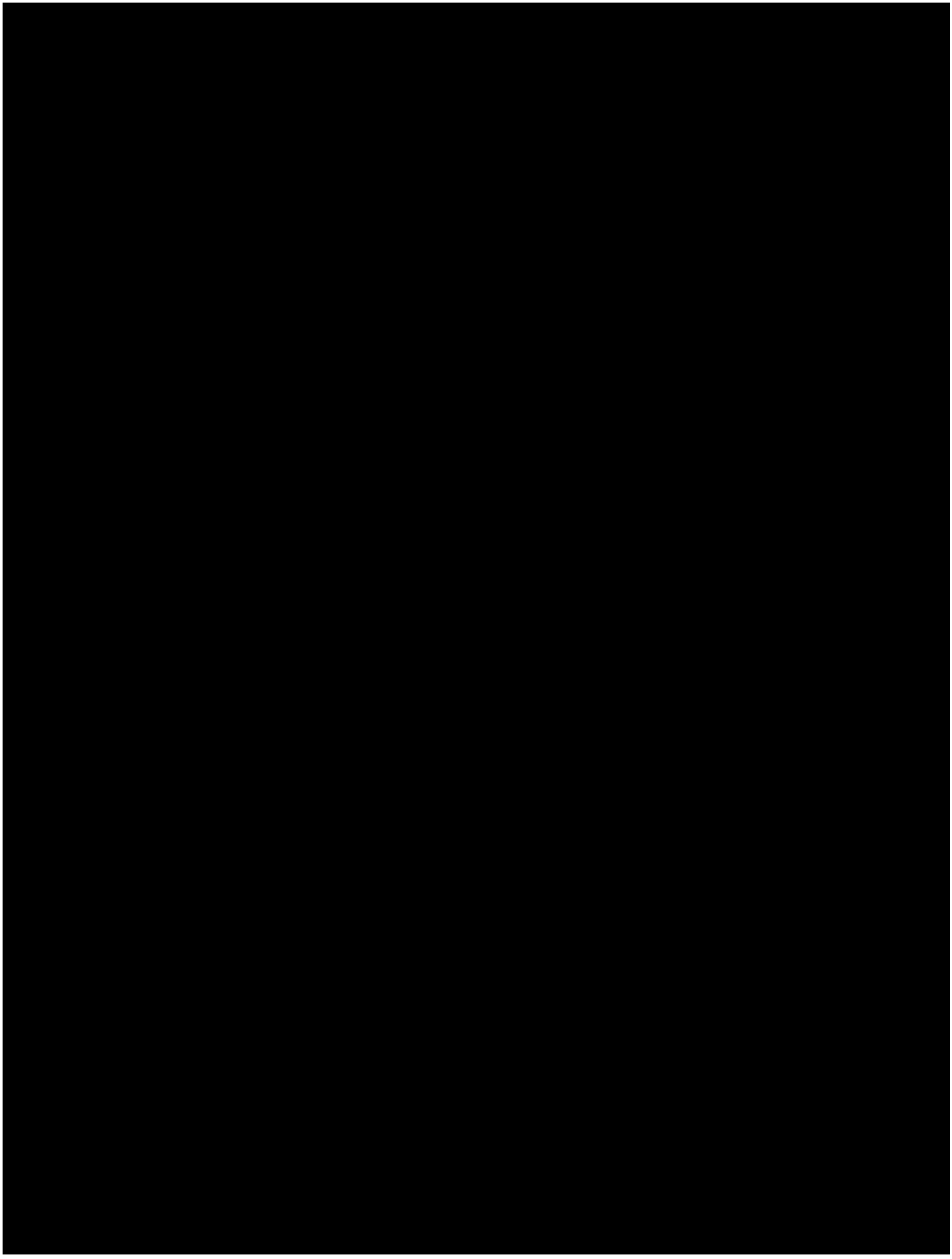


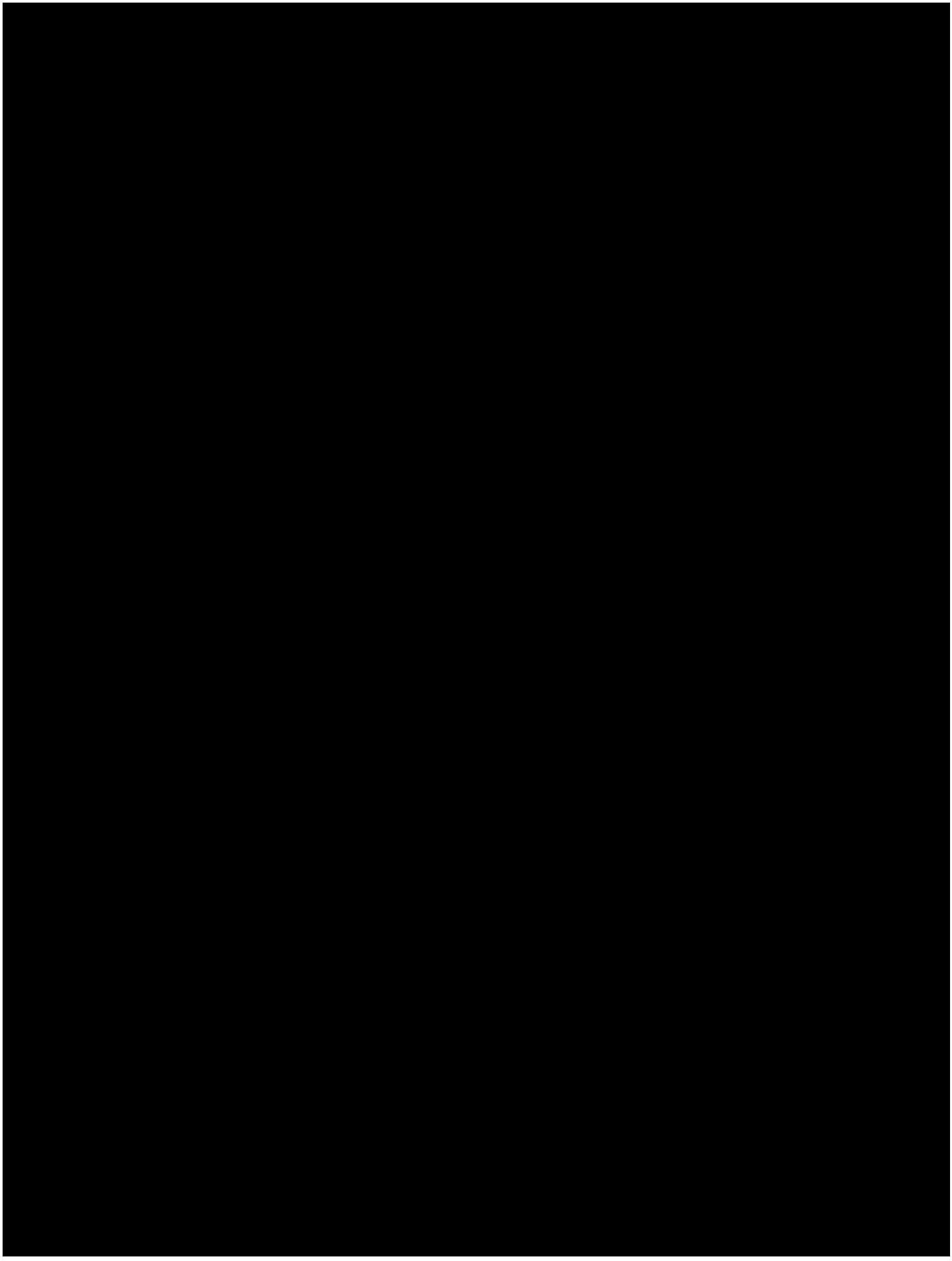












ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

1. **Purpose**. This policy is intended to provide guidelines for managing challenging behaviors of individuals residing in DDS operated programs (Human Development Centers).

2. **Scope**. This policy applies to all DDS operated programs (Human Development Centers) and their employees/volunteers. All such programs will include a review of this policy as part of the employee orientation process.

3. **Definition of Terms**

Behavior management, as covered by this policy, serves as a guide to ensure that an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others are managed with the least restrictive method. Behavior management is not a substitute for other forms of active treatment and is incorporated into program plans, based on individual needs.

Qualified Mental Retardation Professional (QMRP) or QMRP designee is used in this policy as a person designated to monitor, supervise, and make decisions regarding specific behavioral situations. QMRP/designee will be assigned by the administrator of the DDS program in which he/she works. Criteria for selection will involve prior training, experience, and demonstrated ability in the area of behavioral management. The QMRP/designee must be in a position that is on a level involving supervisory or decision-making responsibilities. The QMRP designee is authorized to perform any of the duties of the QMRP as outlined by regulations or policy.

Interdisciplinary Team (IDT) is defined as a group of persons (professionals, paraprofessionals and non-professionals) who develop an individual's program plan and whose participation is required in order to identify the needs of the individual and to devise ways to meet those needs. The IDT includes the individual and may also include those persons who have worked or will work most closely with the individual, those persons who provide needed assessments or services, and the individual's family, guardian, or advocate. In general, the IDT includes persons professionally qualified in such fields as health care, education, psychology, and social work.

Licensed nurse is defined as a registered nurse or licensed practical nurse. The agency may use a physician, in lieu of a licensed nurse, but this is not required.

Replacement: This policy replaces DDS Commissioner's Policy 3011-D, dated January 28, 1981, March 13, 1981, and DDS Director's Policy dated October 1, 1991; December 1, 1993; and January 30, 1998.

Reviewed: Arkansas Legislative Council Rules and Regulations Subcommittee _____, 2003



Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

4. **Policy**

NOTE: It is the philosophy of the agency to utilize all positive approaches to behavior management prior to and in conjunction with more restrictive programmatic techniques. Positive approaches may include, but are not limited to: positive reinforcement, gentle teaching, redirection, graduated guidance, and modeling of appropriate behaviors. Measures to address positive behavior should be incorporated into formal program efforts to the extent feasible.

Efforts at positive programming prove to be successful with the majority of maladaptive behaviors. All Human Development Centers will maintain policies and procedures for positive programming. The use of behavioral programming other than positive is designed for the individuals who repetitively engage in dangerously aggressive behavior and for whom other interventions have not been effective. All behavior programs developed in accordance with this policy will be designed to reduce or eliminate the target behavior(s) within a specified time frame, will be supported by documentation that positive, less restrictive methods have been systematically attempted and failed, will be monitored regularly by the individual's QMRP and Interdisciplinary Team (IDT), and will be revised if proved to be ineffective. The potential harmful effects of each procedure will be weighed carefully against the harmful effects of the targeted behavior and the IDT will determine if the harmful effects of the behavior outweigh the potentially harmful effects of the procedure.

Category I:

Category I procedures are those which may be used without prior approval of the Human Rights Committee or psychology staff. To ensure consistency, they should be addressed by the IDT. Frequent use (as determined by IDT) of these procedures with an individual indicates the need for consideration of the development of a behavior plan by the individual's IDT.

The individual must be supervised during these procedures. With the exception of verbal intervention, any use of Category I procedures, whether part of a formal behavior program or not, requires documentation on a Behavior Incident Report, Data Sheet, or other locally used behavior documentation system.

A. Verbal Intervention: Verbal intervention is utilized to stop an inappropriate behavior in progress and involves telling the individual "no" or "stop", identifying the behavior, and redirecting to an appropriate activity. The command is given in a firm but normal tone of voice. Threats, screaming, yelling or issuing repetitive or multiple sets of commands are not considered verbal correction and are inappropriate.

B. Separation From Activity Up to 30 Minutes: The individual is prevented from engaging in a reinforcing activity in which he/she has displayed inappropriate behavior. Separation is maintained within the same room or outdoor area where the activity is conducted. This is considered a Category I procedure if compliance by the individual can be

accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

C. Separation From Setting Up to 30 Minutes: The individual is removed from the area where the reinforcing activity is taking place. Separation must occur under observation either outdoors or in a living or training area (bathrooms, storage rooms and closets do not constitute living/training area). This is considered a Category I procedure if compliance by the individual can be accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

Note: Separation to Allow Calming (STAC) – Also available is the positive procedure of STAC whereby the person is encouraged to move to an area away from the person or situation that upset them. At the same time, they are assisted in directing their attention to talking about the problem, listening to music, talking about family, relaxing quietly, going for a walk, etc. The activity should be chosen by the person in need of calming. When sufficiently calm, staff will assist the person in resuming normal activities.

D. Assignment of Additional Chores: The individual is assigned additional chores as a consequence for inappropriate behavior. Additional chores may be assigned only if such chores are already a part of the Individual Program Plan (IPP) and are not designed to replace work assignments of housekeeping personnel.

E. Restitution: The individual is cued to restore any property damaged, stolen or defaced. If appropriate to the individual's level of functioning, he/she may be cued to offer a verbal apology to the offended person. If appropriate to the individual's ability to comprehend, monetary reimbursement for the value of the damaged or stolen property may be required if this is a part of the IPP. In lieu of full value, a symbolic portion of the value may be required. Monetary reimbursement requires Human Rights Committee approval and Guardian consent.

Note: The individual is not degraded nor put on display while restoring damage. The individual is given the same equipment and protection to complete the restitution as would normally be given to a person not responsible for the damage.

F. Withholding Privileges: The individual loses a particular privilege following the occurrence of an inappropriate behavior. Privileges include such things as special planned community activities. However, trips off grounds are special and should only be curtailed if problem behavior is anticipated during that trip. Examples of situations where problem behaviors may be anticipated include a problem behavior having already occurred and the person is not fully calm, or, a problem behavior has not yet occurred, but there are indications that a problem behavior is likely. The curtailing of trips off grounds should be done after consultation with psychology staff, or with supervisory staff if psychology staff is not available. Privileges do not include basic living activities, such as meals, habilitation activities, or basic rights afforded all individuals.

G. Personal Property Removal (less than one hour): Removal of an individual's personal item that is being used in an inappropriate or unsafe manner or location. For example, if an individual disturbs others in a common TV room by playing his radio too loudly and will not reduce the volume when instructed, the radio may be removed from that individual for a time not to exceed one hour. The item will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate (See Section 6, *Page 8 of 9*).

Category II:

Category II procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian.

A. Response Cost: The individual loses reinforcers previously earned in a behavior management system, (i.e., Token Economy Program)

B. Overcorrection - includes the following procedures:
   1) Restitutional Overcorrection: Requires the individual to restore the environment to a state that is better than it was before the occurrence of the inappropriate behavior.

   2) Positive Practice Overcorrection: Requires the individual to engage in an intensive practice period in which the alternative appropriate behavior is practiced.

C. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or individual directly, as appropriate. This procedure is considered Category II if the individual voluntarily (without duress or coercion) surrenders the property upon request.

Category III:

Category III procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, other professionals, as indicated by the nature of the program, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian. The individual's record documents the IDT's conclusion that the potential harmful effects of each restrictive procedure (restraint, etc.) are clearly outweighed by the harmful effects of the targeted behavior.

A. Separation Time Out (Activity or Setting): Placement of an individual in a quiet area away from reinforcing activities or persons as a result of an inappropriate behavior occurring. The individual will be visually monitored during the time out. Further conditions include ***either:***

1) Separation lasting for over 30 minutes to one (1) hour maximum.

2) Separation (any length of time) requiring physical intervention/personal restraint to ensure compliance.

B. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate. This procedure is considered Category III if the individual does not voluntarily surrender the property upon request, and it must be physically removed.

C. Sensory Deprivation: Involves the temporary impeding of one of the individual's senses for a period of time, contingent upon the occurrence of the target behavior. Most often, this procedure includes only the use of a blindfold or cloth placed over the individual's eyes when it has been shown to facilitate calming. The individual must be visually supervised during the use of this procedure, which may be used in combination with other Category III procedures, as designated in the individual program. It could also include lessening auditory input by covering the individual's ears, or covering a body part (usually the hands) to limit tactile stimulation, hand in mouth, or biting.

D. Restraint: When utilizing restraint as a programmatic option, a hierarchy of lesser restrictive procedures will be attempted prior to restraint, except in limited cases where this is clearly clinically contraindicated. IDT consideration will be given to parent/guardian notification of the use of restraint and address it in the behavior program.

1) Personal Restraint: **In order to prevent personal injury or serious property damage**, the individual or a portion of an individual's body is immobilized by another person or persons in order to prevent personal injury or serious property damage. Approved methods of intervention must be in the individual's behavior program. This is planned personal restraint, contingent upon occurrence of a target behavior. When available, a licensed nurse should monitor the personal restraint and/or check the individual's physical condition as soon as possible following restraint.

Excluded as <u>personal restraint</u> are: physical assistance, prompting of graduated physical guidance to assist individuals during such procedures as toothbrushing and feeding, or to control random head or arm movements during such procedures

as haircutting, or the use of physical assistance in escorting, redirecting, or in manual guidance techniques are not considered personal restraint and do not require documentation as personal restraint. Also excluded as programmed personal restraint is the use of personal restraint in an emergency situation (Section 6, ***Page** 8 of 9*) or during a necessary medical or dental procedure.

In the event of personal restraint, the QMRP/designee of the area must be notified as soon as possible. Programmed personal restraint will occur until the individual is calm and will not exceed fifteen (15) minutes. The IDT will define what constitutes calm behavior for this individual when used in a behavior program.

2) Mechanical Restraint: **In order to prevent personal injury or serious property damage,** the individual or a portion of the individual's body is immobilized until calm by an approved device or devices which may also prevent normal functioning, as described in section C, above. Restraints must be checked for safety and integrity prior to use. The device's use will not exceed 15 minutes without an extension of time approved and documented by the QMRP/designee, preferably, after face-to-face attention. Unless otherwise determined by the IDT, QMRP/designee extensions will be obtained every 15 minutes until the individual is calm. The IDT should define what constitutes calm behavior for this individual when used in a behavior program. Unless determined clinically contraindicated by the QMRP/designee, should the time in restraint reach 55 minutes, the individual must be released for five minutes for motion, liquid intake, or toileting.

Should time in restraint reach 1 hour and 50 minutes, the individual must be released for at least 10 minutes–for motion, liquid intake, or toileting. If this 10-minute release is judged to be a danger to the individual and/others, additional staff should be called to ensure safety for all concerned. In addition, the individual will be checked, face to face, at least every 15 minutes for safety, well being, and integrity of the restraint. Constant observation is required.

Note: On-site monitoring by the QMRP/designee is recommended. When available, a licensed nurse should monitor the mechanical restraint. If unavailable to monitor, a licensed nurse shall check the individual's physical condition as soon as possible following restraint, but in no case later than thirty minutes after the initiation of the restraint.

Excluded as programmed mechanical restraint is the use of restraints in an emergency situation (Section 6, *Page 8 of 9*), during a necessary medical or dental procedure, or to promote healing following a medical procedure or injury. Devices such as a helmet which are not prescribed for the purpose of restricting an individual's movement and/or normal functioning, but rather for their safety and protection are not considered a mechanical restraint.

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Note: For medical management, please refer to local site Policy on drugs to manage behavior (Behavior Management/Psychiatric Interventions).

5. **Conditions for Use of Behavior Programs.**

A. A formal behavior program will be developed by the IDT, written by a licensed psychological professional, and approved by a psychologist. It will include the following elements:

1) Description of the behavior to be modified;
2) Functional Analysis;
3) Thorough description of each step of the program to include duration and intensity of specific procedures, the methods of monitoring and analyzing the process, and special precautions that will be taken;
4) Description of any alternatives to the specific procedures;

B. The Individual Program Plan or behavior program will include:
1) Description of all procedures already attempted;
2) Side effects and risks, if any, of the intervention, in comparison with those of allowing the maladaptive behavior to continue; and
3) Behavioral objectives.

C. Behavior Management Procedures should be used in order of least restrictive, unless clinically contraindicated. Exceptions to this order must be fully documented and substantiated as to why more restrictive procedures are advisable before less restrictive ones.

D. All persons administering Category II and III procedures must have been trained in the administration of those specific procedures and have personally experienced those particular procedures, unless medically contraindicated for that person.

E. The Human Rights Committee will review all Category II and III programs at least every 6 months.

F. IDT consideration will be given to seeking consultation from outside expertise when IDT staff resources have been exhausted, as evidenced by the use of Category III procedures for over one (1) year without significant progress. If an outside consultant has been used without success, the agency should continue to access this or other outside expertise until an effective strategy is realized.

An outside consultant is defined as a professional of any discipline and who is not a member of the IDT. For instance, the outside consultant may be a member of the HDC

staff not on the identified IDT, the agency staff, or a professional not affiliated with the agency.

6. **Emergency Procedures**. Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. This includes the use of restraint procedures in the course of an established program, when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy. However, it is emphasized that emergency procedures may not be used at frequent intervals, becoming a routine method of intervention. If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. The emergency use of restraint must conform to ICF/MR regulations and must be reported immediately to the facility administrator or designee.

7. **Prohibitions**: These activities are expressly prohibited.

   A. Corporal punishment - refers to the application of painful stimuli to the body as a penalty for certain behavior, and includes, but is not limited to, hitting, pinching, the use of electrical shock or other infliction of pain, whether or not applied as part of a systematic behavior intervention program.

   B. Individuals who receive services from the agency disciplining other individuals unless involved in an organized and approved self-governing program. Individuals will not participate in the actual administration of discipline.

   C. Seclusion of an individual alone in a room or other area from which entry/exit is prevented. This does not include placement in a time-out area for brief, programmed time segments, as part of a behavior program that meets all applicable standards.

   D. ***Unless specifically requested by family/guardian,*** any procedure that denies visitation or communication with family members.

   E. Any procedure that denies sleep, shelter, bedding, food, drink, or use of bathroom facilities.

   F. Inappropriate vocalizations, maltreatment, neglect, or forced exercise.

8. **Informed Consent**. The individual served and/or guardian, as appropriate, will be provided a copy of the behavior program which utilizes Category II and III procedures. Informed consent will be obtained PRIOR to the implementation of the program, with the following procedures:

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A. Persons 18 years of age or older who have no legally appointed guardian may give informed consent for their behavior program. If there is a question about the individual's ability to give informed consent and no guardian can be located, appropriate legal action must be pursued to have someone appointed who can give consent.

B. Consent by the legal guardian(s) is required if guardianship has been established.

C. The legally adequate consent will:
1) Specify, in terms that are easily understood, the restrictive or intrusive procedure(s) involved;
2) Inform the person(s) giving consent of any potentially harmful effects of the procedure(s);
3) Be time-limited, not to exceed one year; and
4) State that consent may be withdrawn at any time.

9. **Uncategorized Procedures**. In the event a proposed procedure does not readily fit in one of the prescribed categories, it may be utilized on an emergency basis, if necessary, at the discretion of the administrator or designee until the appropriate category is determined.

NOTE: Behavior Management Policy 3011-D does not preclude the use of other restrictive/intrusive procedures that would prevent serious bodily harm and/or destruction of property or death. These procedures can only be considered when lesser restrictive procedures have been proven ineffective or their implementation are determined to be clinically contraindicated. Approvals required are the same as those for Category III procedures. Additional approvals may be required as deemed necessary by the facility administrator.

DOCUMENTATION OF AND RESPONSE TO MALADAPTIVE BEHAVIORS

POLICY STATEMENT: Maladaptive behaviors must be documented on a **Behavior Report (BR)**, a **Behavior Report Documenting Emergency Restraint** (also called the Restraint Log), or other authorized data keeping device. Personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure. Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, or the destruction of property. Nothing in this policy removes or alters requirements as stated in other policies of verbal notification of incidents to the Superintendent and/or other staff.

PROCEDURES:

1. REQUIRED DOCUMENTATION

   a. When indicated, a **BR** must be completed following the maladaptive behavior. Incidents that are to be documented on the **BR** are the following:

      i. Behaviors that pose a threat to the physical or mental well being of the client or others.
      ii. Behaviors that have a direct negative impact on the client's programming.
      iii. Behaviors that directly contribute to the client remaining in a setting requiring a greater degree of supervision rather than a less restrictive one.
      iv. Target Behaviors identified by the Psychology Department and the Interdisciplinary Team.
      v. An incident requiring personal restraint (also requires notification of a QIDP). See Attachment #1.

   b. If the incident requires emergency mechanical restraint, a **Behavior Report Documenting Emergency Restraint** must be completed. Such behaviors are defined as those emergency situations in which behaviors may result in, or have the potential to result in, injury to self or others, or the destruction of property and cannot be controlled through the use of less restrictive measures.

   c. The rules of confidentiality will be followed when documenting these incidents. Any reference to a client other than the identified client in an incident report must be by initial only. Reference to other staff members involved will include their full name and title. All corrections must be made by a single line through the incorrect entry and the writer's initials. The **Behavior Report Documenting Emergency Restraint** must include the signature of the QIDP or other staff member authorizing the restraint.

2. EMERGENCY USE OF RESTRAINT

   a. Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors. The use of emergency restraint will comply with all relevant standards and regulations. Restraint

EXHIBIT 7

will not be used as punishment or for the convenience of staff in lieu of adequate programming.

b. Seclusion will not be used as either an emergency or programmatic procedure.

c. A QIDP must be notified when personal restraint is used and it must be documented on a **Behavior Report**.

d. Personal restraint of a client is used when the behavior is such that verbal control has been lost and other less restrictive measures have failed to control the behavior.

e. Personal restraint will be implemented by staff who have been trained in the use of approved methods. **Personal restraint must not exceed 10 minutes**. During the period of personal restraint if the client becomes calm no further restraint procedures are to be implemented. If the client shows no indication of calming and becomes violent, staff will proceed as indicated in Paragraph f. below.

f. The request for the emergency use of mechanical restraint will be based on need as exhibited by the client who is so aggressive that restraint is necessary to prevent imminent physical harm to themselves, others, or property. Mechanical restraint may be used only when all other means of controlling the behavior have been exhausted. Staff will proceed in the following manner:

   i. A Restraint Incident Leader will be identified. The attending staff will immediately implement emergency mechanical restraint. As soon as possible staff will notify the on duty Program Supervisor who will contact a QIDP or other authorized staff for authorization for the use of emergency mechanical restraint.
   ii. The authorization for the mechanical restraints must not exceed 15 minutes. Continued use of mechanical restraint must be re-authorized every 15 minutes.
   iii. Immediately after emergency mechanical restraint has been applied, staff must contact the nurse on duty. The nurse will examine the client to ensure the restraint is applied in a pain free and harmless manner and present no physical danger to the client. The nurse will make a notation of the examination on the **Behavior Report Documenting Emergency Restraint**.
   iv. A client in emergency mechanical restraint must be:

      1. Kept under constant visual observation. This observation will be for the client's physical condition (e.g., distressed breathing, bleeding, adequate blood flow to the head and extremities) as well as for signs of calming.
      2. Checked for security of restraint, current behavior and general status. A synopsis will be documented every 15 minutes.
      3. Released for 5 minutes every hour for motion and exercise.
      4. Given the opportunity for fluid intake, meals, baths and toileting. These needs will be addressed and documented as the need arises.

5. Released from emergency mechanical restraint as soon as possible. This is defined to mean as soon as the client is calm and no longer a danger to self or others. Verbal outbursts do not necessarily mean a person is still out of control or that restraint should continue.

v. After release from emergency mechanical restraint, using the **Restraint Incident Debriefing Form**, the Restraint Incident Leader will conduct and document a debriefing discussion with the other staff members involved in the restraint and the client that must include the following:

1. The behavior which resulted in the use of the personal or emergency mechanical restraint.
2. Any environmental factors involved in the incident.
3. The antecedents to the behavior including interactions with peers or staff
4. Any action by staff that might have kept the incident from escalating to restraint.
5. The client's reaction to the use of restraint.
6. Any changes to the client's programming which might have prevented the incident.
7. Options that the client could have used to avoid the use of restraint.

3. COMPLETION OF DOCUMENTATION

a. The person authorizing the use of emergency mechanical restraint must sign the authorization. During deviant hours authorization may be obtained by telephone. Attending staff will note on the **Behavior Report Documenting Emergency Restraint** that such authorization was obtained by telephone.

b. The on duty Program Supervisor will be responsible for ensuring that the appropriate reports are completed in a timely and accurate manner.

c. Completed **Behavior Report Documenting Emergency Restraint** and **Restraint Incident Debriefing Form** will be filed in the client's Master File "Behavior Incident File".

4. REVIEW AND DISTRIBUTION OF THE COMPLETED DOCUMENTS

a. Upon completion of the report it will be sent to the appropriate Team Office.

b. The Team Leader will review all reports for content, accuracy and appropriateness and sign in the appropriate place. If corrections are required the Team Leader will contact the writer of the report and ensure corrections are made. As soon as possible the report will be given to Quality Assurance to be scanned, copied, and distributed to appropriate staff. The original report will be sent to the Record Center Operator and filed in each client's file within five days.

c. The Record Center Operator will review **Behavior Report, Behavior Report Documenting Emergency Restraint**, and **Restraint Incident Debriefing Form** for completeness and errors. The originator will be notified to correct errors found by the Record Center Operator.

d. The QIDP and Psychology staff member will review copies of all reports for programmatic issues, patterns of use, and the appropriate follow-up.

e. The authorized data keeping device (i.e., **Behavior Report, Behavior Report Documenting Emergency Restraint**, and **Restraint Incident Debriefing Form**) will be forwarded to the Psychology Department depending on the program requirement.

5. FUNCTIONAL AND ENVIRONMENTAL ANALYSES OF BEHAVIORS

a. The purposes of conducting functional and environmental analyses are to determine:

1. The pragmatic utility of a behavior for a client, i.e., what the behavior "does" for the client.
2. What role the environment may have played in the causation of the behavior.

These analyses assume aberrant behavior does serve a functional purpose, but that a functionally equivalent (appropriate) communicative response can be taught, and will serve to substitute for the aberrant behavior. Further, the aberrant behavior will reduce in frequency as the more appropriate response becomes systematically reinforced.

b. These analyses will provide the data needed to formulate programmatic responses to teach and reinforce appropriate behaviors to replace aberrant behaviors and inappropriate behaviors.

6. APPROVED RESTRAINT PROCEDURES, TECHNIQUES, AND DEVICES

a. **Personal Restraint,** an emergency procedure limiting movement by the holding of a hand or limb.

b. **Chemical Intervention** ordered by the Physician.

c. **Protective Helmet**.

d. **Papoose Board**, a Mechanical Restraint device limiting movement and range of motion.

f. **Wrist Restraint**, a Mechanical Restraint device limiting movement and range of motion.

7. AT BHDC ONLY ICF/IID QUALIFIED QIDP's SHALL BE APPROVED TO AUTHORIZE THE USE OF RESTRAINT

The Program Coordinator/QIDP is the first choice person to authorize restraint for clients on their caseload. After hours and on weekends the Team Leaders or other qualified QIDPs may be notified.

The following positions are recognized as being qualified QIDPs:

Program Coordinators/QIDPS, Team Leaders, Director of Residential Services, Superintendent, Assistant Superintendent, Director of Quality Assurance; Chief Psychologist, Psychological Examiners, Registered Nurses, and Staff Physician.

Current work telephone numbers for these persons can be obtained from DHS/BHDC Share.

THE STAFF PHYSICIAN MUST REVIEW, BY SIGNATURE, THE USE OF ALL EMERGENCY MECHANICAL RESTRAINT.

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-D-4, dated 01/07/16, in its entirety.

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS — CLAIMANT

VS. CLAIM NO. 220374

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) — RESPONDENT

ORAL DEPOSITION

OF

CARRIE JOHNSON-MILLER

(Taken July 14, 2022, at 9:06 a.m.)

GR[illegible]NG



APPEARANCES

(ALL APPEARANCES VIA VIDEOCONFERENCE)

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EXHIBITS

(NONE MARKED)

CAPTION

ANSWERS AND ORAL DEPOSITION OF CARRIE JOHNSON-MILLER, a witness produced at the request of the Claimant, taken in the above-styled and numbered cause on the 14th day of July, 2022, before Kristina R. Gray, Arkansas Supreme Court Certified Court Reporter #725, at 9:06 a.m., via Zoom videoconference, pursuant to the agreement hereinafter set forth.

* * * * * * * * * *

STIPULATIONS

IT IS STIPULATED AND AGREED by and between the parties through their respective counsel that the oral deposition of CARRIE JOHNSON-MILLER may be taken for any and all purposes according to the Arkansas Rules of Civil Procedure.

PROCEEDINGS

WHEREUPON,

CARRIE JOHNSON-MILLER,

Having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. GILLISPIE:

Q Ma'am, your last name is hyphenated. It's Johnson-Miller; is that right?

A Yes.

Q Okay. Carrie Johnson-Miller. And you were a residential services manager at the Booneville Human Development Center at the time of David Cains' death; is that correct?

A Yes.

Q Okay. And my understanding is that your direct supervisor would have been the residential services director, who at that time was Sandy Evans; is that correct?

A Yes.

Q All right. How long did you work at Booneville?

A I was hired in 2011.

Q Okay. What did you do starting out there?

A I was a Q, and then I was promoted in 2014 to the manager.

Q Okay. To residential services manager?
A Yes.
Q And you held that role until you left Booneville?
A Yes.
Q When did you leave employment there?
A I retired December 1st, '21.
Q Okay. And as residential services manager, was there any other level of supervisor between you and the direct care staff?
A Yes.
Q Okay. And what was the name of that position?
A Okay. The positions change. Let's see. There was an RCT and an RC -- I can't remember. RCT and RCA, I believe.
Q I assume you know Tyler Mattson?
A Yes.
Q Okay. And was he a direct care under your -- under you in 2020 at the time of David Cains' death?
A I believe so. And then there were his direct supervisors that actually were in the dorm.
Q And who would those have been?
A Let's see. Tracy Lloyd, Kim Ross. I think at the time David was upstairs, so it would have been Tracy Lloyd, and then Kim Ross would have been over managing or supervising Tracy at the time. I believe I have

that correct.
Q Okay. So it would have been -- to my understanding, Tyler was an RCT, is that right, or was he an RCA? I get it confused as well.
A I think at the time -- I told you wrong about their titles, about Tracy Lloyd and Kim Ross' titles. I believe he had been promoted to an RCT.
Q But would he have still -- as an RCT, would there still have been a supervisor there in Davidson house?
A Yes.
Q And you think that --
A And the prog- -- I'm sorry. The program supervisor runs the hill. That means they put staff where needed and they sort of oversee a supervisory thing with the -- I can't remember the title. I can't remember Kim Ross' and Tracy Lloyd's title at the time. But anyway, they would have overseen in some manner as far as who is assigned where for the day and how many staff is where.
Q So I see that there -- I'm sorry. So Sandra Evans was the residential services director. You would have been one of three residential services managers, and I believe you were the Team White leader. Does that sound familiar?
A Yes.

Q Okay. And then directly under you there was a level of supervisor and you think that -- you're not sure what that was called, but you think it was Tracy Lloyd and Kim something?
A Yeah.
Q Tell me Kim's name one more time.
A Kim Ross.
Q Okay. They're the ones -- at this time, again, we're talking about 2020. They're the ones who would have more directly monitored or supervised what a staff member like Tyler Mattson was doing?
A For the day, yes.
Q For the day.
A And in addition to the program supervisor or the PS.
Q Okay. Who is the program supervisor? Where does the program supervisor fit into the hierarchy?
A They are assigned at the Kelly Building. They are responsible for transportation. They are responsible for the staffing ratio for the day and they alert team leaders and/or the director if there's issues.
Q And when you say "team leader," you were -- team leader is another word for what you were?
A Yes.
Q Okay. And so the program director -- do you have

any idea who the program director -- did it change every day?
A It could have, yes.
Q Do you have any idea who served as program directors in June of 2020?
A I can't remember. I mean, I'm sorry. I can't remember.
Q Okay. That's okay. Ms. Johnson-Miller, did you attend phase training?
A Yes. When I was first employed, yes.
Q And do you recall who taught your phase training? Was it Mark Hise?
A No, not at that time. Mark Hise, at the time, he may have been -- he may have been the program supervisor at the time. A James Harbison taught the program and his brother assisted him.
Q Okay. And you're talking about your phase training?
A Yes.
Q Do you recall the part of phase training where you're taught about the forms of personal restraints or personal holds that can be used on clients?
A My phase training didn't go into that initially. That was something -- no, I didn't -- usually at that time phase was two weeks and I think I spent a week and

then I went to, you know, being a Q at the time after one week.

Q Okay. Do you recall ever receiving any training on acceptable forms of physical restraint or personal holds on clients?

A Yes.

Q When did you receive that training if you can recall?

A I think maybe that was a yearly thing that we did.

Q And do you recall that the forms of personal holds or physical restraints that you are taught could be applied in emergency situations?

A Well, your holds are the emergency situation and then -- yeah. Yes.

Q Well, specifically what are the holds that staff are authorized to use in emergency situations?

A Well, you don't shut off their airway. You don't -- I can't remember. I mean, you know about their airway. You know how to place people in different restraints.

Q I assume you were never trained or taught to restrain clients on the ground, were you?

A We were taught, but I never had to actually take anyone down.

Q Were you taught that for -- were you taught to do

that -- my understanding is you may have been taught to do that for purposes of transitioning into mechanical restraint; is that correct?
A Yes.
Q Were you taught that for any other reason, meaning you weren't taught to restrain them on the ground as a form of a personal hold that does not intend to transition to a mechanical restraint, did you?
A As far as on the ground or on the floor, it depends on what the situation is at the time. It depends on the severity of their violence at the time and keeping them safe and other clients safe and yourself safe.
Q So are there situations where you were involved with physical restraints of clients on the ground?
A I never did hands-on.
Q What does that mean?
A I never took them down first.
Q Okay. But you witnessed?
A I would witness. At times, I would be there and I would witness it. You know, sometimes the staff are just out on their -- I mean, they're in a situation they have to react on their own.
Q What are some -- about how many times would you say you've either witnessed or know of staff taking

clients to the ground? Was it fairly common?
A No. That's not something you want to do. You redirect. It depends on their behavior treatment program and staff are trained on the behavior treatment program.
Q Why is it that you would not want to take anyone down to the ground?
A Well, unless your being hurt or the client is out of control and they're going to hurt themselves, that's when you have to react. Otherwise, you're redirecting. You're -- you know, you're trying to do everything to redirect them and get out of that environment.
Q You said that taking a client to the ground is something that you wouldn't want to do or that you want to try to avoid. I was just wondering if you could tell me what you meant. Why is it something that you would want to avoid or not do?
A Because everyone -- I mean, staff and -- you know, you realize that hands-on is not something you want to do.
Q Because it's more likely to lead to injury, to be dangerous for everybody involved?
A Yes. Number one, safety of the client and the other clients. Your safety. I mean, it depends on the situation, but we weren't taught just to take people

down because we -- they were upset or we tried -- you know, we tried to do --

Q Right. So when were you taught or what were you taught about when you can take them to the ground?

A If they're out of control, if they're going to hurt themselves, if, you know, other clients -- you've got to get the safety of the other clients. I mean, if you go between two clients that have become aggressive with each other or sometimes clients, when they go off, their body parts are flailing and you have to secure things. You have to secure those limbs to keep them from being hurt, including their head.

Q And so in those situations, it might require taking them to the ground?

A If that's all you can do. If that's your last resort, yes.

Q And, again, we're not talking about -- you understand that I'm not asking about mechanical restraints or transitioning to mechanical restraints, right?

A Right.

Q I'm just asking about personal holds on the ground separate and apart from taking them to the ground for purposes of transition. I'm not interested in the latter. You understand that?

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A Yes. When they're out of control, sometimes their head is going back and forth. Their arms will be going back and forth. They're kicking you. They're kicking walls. They're hitting walls. And it's very difficult at times to provide safety for someone like that.
Q Okay. And so describe for me then -- I guess in that situation, you might have to -- or you might need to take the client to the ground in that situation if there's no other option?
A If you can't get them to stop, yes. I mean, if you can't get a hold of their arms and just get them calm, you may have to.
Q And if you had to, how would you do it?
A Well, there's different holds that people are -- the staff were taught that they could do to just keep their limbs from moving. And a lot of times, if some of those clients can just feel a closeness, not a tightness -- I mean, sometimes just a touch, a feel will just get their energy to go down, not all the time. You're doing the best you can to keep that client safe.
Q My question, Ms. Carrie, was, how would you -- in that situation where you had to take a client to the ground, how would you do it? How was it to be done?
A Hopefully there's other staff that can help you

just -- you can hug. Sometimes a hug.
Q How would hugging and -- you would hug them and then wrestle them to the ground?
A No. If they're not that out of control, you could just give compressions. Just a touch sometimes will . . .
Q Ms. Johnson-Miller, I'm asking can you -- if you can't tell say that, that's fine. I'm just asking you, you were a residential services manager for roughly seven years and these staff members who had to do these things were under your supervision as well as under Ms. Evans' supervision and I just want to know, do you know specifically the way that these staff members took clients to the ground? Physically how did they do it and how were they supposed to do it?
A Well, like I say, there's different holds were taught and I don't know all of the holds and I don't remember all the different holds that they use.
Q Well, is there a hold you were taught specifically for taking clients to the ground?
A You can hold them on each shoulder. You can hold their arm. You can take them down. If their legs are flailing, you would need other staff probably to help assist with the legs. And then you just lower them to the ground as gingerly as you can.

Q And then what do you do? Then what do you do once they're on the ground?
A Hopefully by then they have -- you've been able to have a quiet place. You let them chill out. They're able to calm and then you may not have to go to mechanical restraint. You might -- there may be a doctor's order that you call a nurse and ask for a chemical.
Q And how many times did you see this done?
A Maybe eight. Seven, eight maybe.
Q Did you ever see it done to David Cains?
A I didn't see them doing him, but I went over and observed him in mechanical restraints. You know, at that time he was already on the board and he would calm down.
Q Well, remember, Ms. Carrie, I'm not really asking about mechanical restraints. I'm asking about personal holds or physical restraints used on clients on the ground to, you know, get them to calm down, kind of like what was happening on the day of David's death, you know, where there's no papoose board, where there's no Joey Board, where there's no mechanical restraint that they're intending to use but, rather, just a ground restraint for the purpose of intervening in an emergency situation. Do you understand?

A Yes.
Q So getting that clarified, when would -- you know, have you ever heard of this happening to David Cains?
A Yes. He could be quite violent.
Q Okay. Tell me about that.
A The one time that stands out in my mind is I was a Q and I was at the dorm observing the client at the time. And David and I had -- David had been at the nurses' station or at the station and we had been talking about Razorbacks and The Monkees and that's something he always enjoyed talking about. He was in a good mood. He had his Razorback shirt on. There's nothing going on on the hall. He walked down to his room. He was fine. He was walking back up the hall and he wasn't -- his arms were at his side. There was nothing going on. And I noticed a staff member coming up and walking beside him. The staff member said nothing to him, you know. It was early morning and staff were going about their work and his fist came out at his side and he plowed -- he took his fist and he plowed that staff member into the wall, and I thought, oh, my, we will have to peel him off the wall.
Q Where did David's fist strike the staff member?
A His head.
Q His head?

A Yes.
Q And who was the staff member?
A Oh, I don't know. I don't remember.
Q Do you remember, did an ambulance have to come? Was there an injury?
A I remember the staff was pretty well shook up. I think probably -- I don't recall an ambulance.
Q You don't recall the staff requiring any medical care?
A No. Well, I'm sure he filled out a workers' comp form probably.
Q Why do you say -- you don't know who it is, so you're just guessing at that, aren't you?
A I'm guessing it because that's protocol when you're hurt on the job.
Q But you don't know if he was hurt. You don't know if he needed medical attention or if he just shook it off and went about his day, do you?
A No, because at that time, I was a Q and I was in a supervisor observation. And I can remember just -- that was one of the first times I had seen David, and it was so violent. I thought, oh, dear. So that really stands out.
Q Are there other instances of -- so you would describe David Cains as having been a violent patient?

A He certainly could have been.
Q Do you have any other memories of David harming anyone physically?
A Not that I can remember, no.
Q That one memory is the only memory you have of David specifically physically harming someone?
A David could be -- yes. David could be violent and just because I don't remember, like I say.
Q Well, you've given me one example. Can you specifically give me any other examples of instances where David was violent?
A Yes. His family member came up on campus to take him out to lunch, and I believe it was at McDonald's. And we got a phone call that there was -- he was aggressive with his family at McDonald's, so we got some staff to get in a van, go after David, and get him out of that situation.
Q Okay. Is that it?
A When I talked to the -- who were the guys that went and got him? I believe Justin was one of the other Qs that went and got him. I asked him how it was, and he said, well, he could tell that there had been some -- the uncle -- I believe it was his uncle was --
Q Ma'am, let me ask it this way: Do you have any --

you personally, do you personally have any -- did you personally ever witness David cause physical harm to anybody other than the staff member who you said he punched him in the head?

A No.

Q And you've not even heard of any other situations other than this situation that happened with his family on campus at McDonald's, correct?

A Right. That our staff had to go intervene, yes.

Q But you don't know any specifics about exactly what happened there, do you?

A No. We weren't there, but we --

Q Other than those two things you told me about, are there any other recollections or things you've been told about that you can describe to me involving David being violent?

A David, his IPP and his other document should support this.

Q No, ma'am. No, ma'am. I'm asking --

A No.

Q I'm asking what you know. I have his records. I know how to read records. I'm asking what you know.

A All right. Well, as his Q at the time and as his team leader, he was prone to be violent without any warning.

Q Okay. But your personal knowledge of that is limited to one incident of him striking as staff member in the head; is that correct?
A At the time I saw it, actually witnessed it, yes.
Q Okay. And after he struck that staff member in the head, was he restrained?
A I don't recall because, like I say, at the time I was a Q and he had been able to talk him down.
Q And, again, you don't know what year this happened or who the staff member was, do you?
A I just remember I was a Q and I hadn't been here very long.
Q Okay. And you have no personal knowledge of -- when I say "personal knowledge," I mean, things that you know, things that you saw or things that you have, you know, read or truly know. You have no personal knowledge of whether or not this staff member was injured, meaning required medical care?
A No.
Q And therefore, you cannot yourself identify any single incident involving David Cains where he caused an actual injury to somebody necessitating medical care, correct?
A Correct.
Q And when you started to tell me about David being

violent, it was in response to a question that I have asked about whether you witnessed David being taken to the ground. So back to that. Have you ever witnessed David being taken to the ground?

A I don't believe so or not that I can remember, one.

Q Okay. Have you ever been told about David being taken to the ground that you can recall?

A I can't recall it, but, like I say, as a Q or a team leader, I would have known at the time.

Q But it is your testimony as you sit here today that staff were authorized to take clients to the ground in emergency situations in order to restrain them there on the ground, correct?

A Yes, for their safety of the clients and the other clients.

Q Who specifically told you that that was allowed?

A Well, that was, to my knowledge, part of your training. I mean, you have -- no matter where you're at, you have to keep the client safe.

Q Well, Mark Hise, who does the training now, says that -- and he was doing training at the time of David's death as well. Mark Hise says it's not allowed and that it's not trained. So I'm trying to figure out where you got the idea that it was an authorized form

of restraint. So where did you get the idea that this was an authorized form of restraint?
A That's what I'm remembering as part of the training.
Q That's it?
A Yeah.
Q I mean, there's no other -- you know, Sandy Evans never came to you and said or anybody else ever said, okay, this is allowed, this is allowed, this is allowed as far as restraints?
A We reviewed restraints all the time, but as far -- okay. What are you calling a takedown?
Q Just the restraining of a client on the ground where the client is being restrained or put in a personal hold, Carrie, put in a personal hold while on the ground. That's what I'm talking about.
A Maybe not while on the ground, but they may -- I mean, it may go to the ground.
Q I'm not following you. I'm sorry.
A If you've got someone in a personal hold and they decide to get on their -- go to the ground because they get on their knees or they get -- I mean, you don't necessarily -- you do the best you can to keep off the ground, but you may wind up on the ground.
Q Okay. But you said you were also taught and

authorized to take them to the ground if necessary, right?
A Well, as part of it. That may be where you land. It may not be initially where you start.
Q But you were taught then that once on the ground that if you need to, you can hold them there on the ground in a personal hold, right?
A If it requires it. I mean . . .
Q What I'm asking is I just want to know every reason you believe that that was a proper way to restrain clients at Booneville.
A If you're holding someone, it doesn't mean you're taking them to the ground. It may mean you end up on the ground and you're there.
Q And then once you're on the ground, you may need to stay on the ground and hold him on the ground longer to -- if the situation requires it, right?
A Well, yes.
Q But then also there are times where -- you said there were also times where I believe you described situations where a client is flailing where taking them to the ground is the only option, right?
A Okay. What I meant was you may not be intentionally taking them to the ground. That may be where the -- where it winds up.

Q You specifically said you were taught to take them to the ground and that you had to do that sometimes. Are you saying that's not the case now?
A Well, that's some of it, yes, but initially you're not going to just slam somebody on the ground.
Q Sure. I'm not suggesting that it would be done for no reason. I'm just trying to get to the bottom of why staff members -- some staff members understood that that was not allowed and other staff members thought it was totally allowed. I'm trying to figure that out. I was wondering if you --
A Well, it's not a -- it's not where you start and that's not where the restraint would start. But you may have to go because the client may take you there.
Q So is it your understanding that -- from your seven years at Booneville, was it always your understanding that the type of personal hold used on a client may differ from situation to situation and that ultimately the staff member has to make a choice about the best way to do it in each given situation?
A They start with verbal trying to redirect them, do anything they can to stop the situation or get them -- sometimes getting them out of the situation. They always go to the least restrictive before they put hands on.

Q But if a situation required it, a staff member may have to restrain a client on the ground, correct?
A They wouldn't start on the ground. They're not going to slam somebody on the ground. They're not going to do that. But sometimes you are in a situation where the aggressiveness of a client will take you to the ground.
Q And once you get to the ground, are you supposed to continue holding them on the ground?
A You've already called for help. You hopefully have backup that will maybe find another staff that he is or she is more friendly with or have a history with. You call the nurse. You ask for a chemical.
Q Ms. Johnson-Miller, are you now saying that initiating taking a client to the ground was not allowed, that it was only something that could be done if going to the ground sort of occurred naturally in a struggle?
A Yes. And sometimes that -- most of the time that helps.
Q Before you said that sometimes you could initiate taking the client to the ground to restrain them if the situation required it, in a situation where you said where they might be flailing or kicking. You can take them to the ground purposefully to restrain them on the

ground.
A Yes.
Q Are you now saying that that is not the case?
A No, and I never intended for that to sound like that either. I mean, you might -- you're going to do least restrictive. You're going to get help. You're going to do everything you can, and if it takes you there, then you're going.
Q So now your testimony is that you can only restrain a client on the ground if you accidentally end up on the ground with your client?
A But yes, you're not going to slam somebody to the ground.
Q And are you now saying that you're not even going to transition them to the ground in a way that was taught to you?
A Well, you may have to.
Q Right. Yeah. You may have to do that.
A You may have to do that. You're there. I mean, they're -- you're trying to keep yourself and the client safe, so you're going to do the best you can.
Q And in your mind, what would be a situation -- what would be client behavior that would require doing something like that? Like if the client swings at a staff member, is that enough of an emergency to do

this?
A They swing after you step back.
Q What if they move towards you after you step back?
A You go back.
Q What if you can't keep going back?
A Hopefully by then, you've got extra help or you've got extra staff there or you've been able to contact the nurse.
Q And what if you don't have any of that? What if you don't have extra help? What are you taught to do? What are you taught to do in that situation?
A If you're being hurt or another client is being hurt because a lot of times, you've got clients behind you that you've got to worry about their safety, too. You just try to watch your body posture, keep out of their way. You know, sometimes if they're butting their heads against the wall, you may have to get them and back them up from the wall.
Q Do you recall there being an issue with bed bugs at the Davidson House?
A Yes.
Q All right. Tell me about that.
A Well, we had bed bugs and we had -- we set protocol in place for checking the mattresses, checking the rooms. We trained staff for bed bugs, to look for

bed bugs. When they found a bug, they were supposed to put the bug on a piece of paper and send it to -- I believe it was the infection control nurse.

Q How long did the bed bug problem at the Davidson House persist?

A I don't remember a specific timeframe.

Q Ryann Campos testified that she actually quit her job there because of the bed bugs at Davidson House. She said it was so bad that they would be crawling on clients during the night and that she actually brought bed bugs home to her home and it infected her home and then she quit for that reason. Were you aware of that?

A Not of -- I don't believe I was aware of her quitting. We did have staff that quit, yes.

Q Because of bed bugs?

A Yes.

Q What other staff quit because of bed bugs?

A I don't remember their names and I don't remember how many, but yes, we had some.

Q So it was a pretty terrible bed bug problem, I take it?

A Well, you know, I don't know if you've ever been around bed bugs, but they --

Q No, ma'am.

A You know, they're from Hades, let me assure you.

Q Was this problem still going on when you retired?
A No. I don't remember it going on, no.
Q Do you recall bed bugs ever being on -- do you recall bed bugs being on both floors at Davidson House?
A I believe both were infested, yes.
Q Would this have been for a period of years, months? Do you recall?
A I don't recall.
Q Do you feel like everything that possibly could have been done was done to get rid of the bed bugs?
A Yes. We had protocols set in place for when clients returned from visits. Everything went in a hot dryer for so many minutes after that. We had an exterminator. Our housekeeping department or custodial department was trained. We had chemicals. We had cleaning. We had staff trained. We were always monitoring the beds and the living areas for bed bugs. We moved people to keep them safe. We did extra cleaning.
Q Do you recall specifically if David Cains' room was infested?
A I don't remember if his room was or not.
Q Okay. And you're saying there were multiple staff members who quit because of bed bugs?
A I wouldn't say multiple, but we had some staff

quit.
Q More than one?
A I don't remember, but yes, there were staff that quit. I don't remember the number.
Q Okay. But multiple just means more than one.
A Well, I don't -- you know, when you go from one, are you going to 30 or are you going to -- what number are you going to?
Q I'm just asking -- multiple just means more than one. And we know Ryann Campos quit for this reason.
A Probably more than one.
Q Okay. Because you know of at least one other than Ryann that quit for this reason, it sounds like?
A I believe I do, yes.
Q Okay. Did you ever -- did you work closely with Mr. Tyler Mattson?
A Somewhat. I wasn't in the dorm as a supervisor -- as his immediate supervisor, but I was in the dorm. I knew him and yes.
Q Did you have a positive impression of him as a direct care staff?
A Yes. He came a long way. He worked hard to learn.
Q Did he have some struggles at the beginning?
A Yes, but just because of the setting that --

Q What are some of the struggles that he had at the beginning that he learned to overcome?

A Well, it was the formality of the job. It was the -- you know, that's a learning process that staff have, anybody has when they come to a unit like this. To keep you safe, there's things in place that must be done and just the paperwork he learned. You know, he did learn.

[redacted]

[redacted]

Q Is that something that typically -- how long was he on your team? I know he was on your team at the time of David's death. And I think he started -- I want to say he started working there about 2017. Does that sound right to you?

A Probably, yes.

Q How many other team members would there have been on Team White that you supervised or managed?

A Well, like I say, Tracy Lloyd, Kim Ross.

Q I understand, yeah. They were the next level of supervision, but you were the manager of that team. I'm just asking how many staff members typically were there on Team White.

A You mean the staff at Davidson House, the number of staff at Davidson House?

Q No, the number of staff Team White. There's Team White, Team Red, and Team Blue. You're the residential services manager in charge of Team White, according to what I'm looking at and what you told me earlier.

A Yes.

Q How many direct care staff are part of Team White? That's all I'm asking.

A Okay. I have no idea. Those -- yeah.

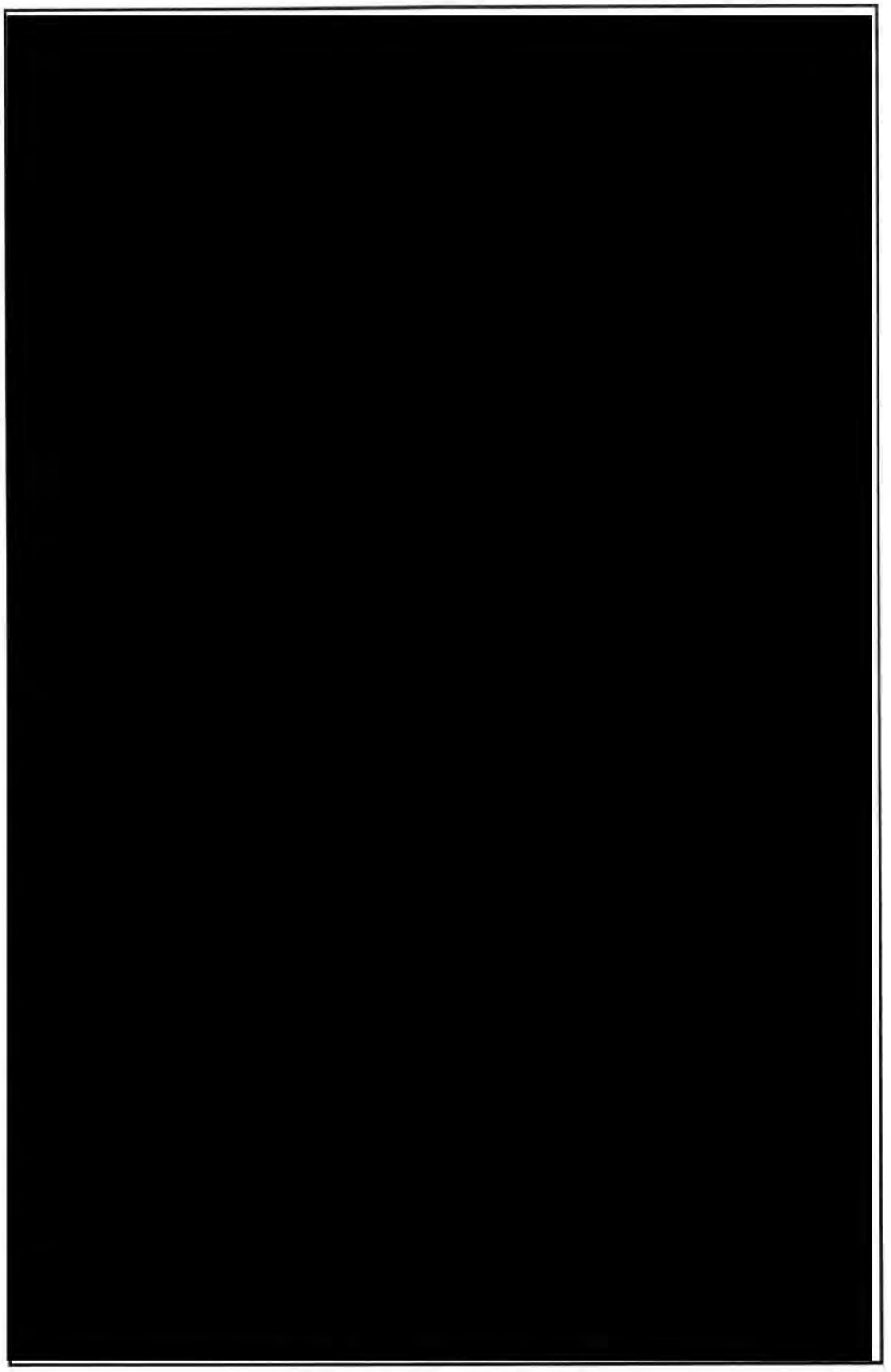
Q You have no idea how many staff members were on the team you were the manager of?
A The program supervisor was responsible on a daily basis for the ratio of the clients at the dorm.
Q So you're telling me you don't know how many staff members were on the team you were supposed to be the manager of?
A The team changed. I had three shifts, two staff at each nurses' station on a day probably, two or three at a station depending on how many clients we had.
Q What would have been the -- let's say that a staff member -- well, let me back that up.



Q Let's say -- and I don't mean him specifically, but let's say there's a staff member who is using excessive force in restraining clients. What is the oversight process in place that would prevent that type of bad behavior from persisting?
A You have your supervisors in the dorm. You have your PS. The PS went to the dorm at different times during the day. I was over there at different times of the day. It would be brought to our attention from

mine or the director's.
Q Okay. And what's a PS again?
A Program supervisor.
Q Was that person under you?
A No. They were under the director.
Q So they're a separate department; they're not residential services?
A Yes, they are.
Q They're just not in the hierarchy of Sandy, you, et cetera?
A The director of residential services would have supervised the PS's.
Q Okay. And so was the PS above you?
A No. I mean, no, they -- no, not on hierarchy, but . . .
Q I'm just trying to figure out who was in charge, who would have been in charge on the day of David's death, June 13, 2020. Tyler Mattson was the direct care staff working with him that day. The incident in question happened at the Commons Building, but of course David lives at the Davidson House. I know you were the residential services manager. I understand that Amy Jones, I believe, was a -- had just been promoted to some form of supervisor and she was Tyler's, I guess, most immediate supervisor. Does that

ring a bell to you?
A She may have been the PS for the day, yes. I don't remember who the PS was.
Q Okay. I wanted to go back to something that you had said earlier. So if a staff member was mistreating clients, it would be reported to -- it would be witnessed and then reported up the chain; is that right?
A Yes.
Q All right. Do you recall that ever happening?
[redacted]
Q About any staff member.
A I don't remember specifics, but yes, that would have been reported.
Q I mean, do you remember specifically any incident or any -- I should say anytime where it was reported to you that a staff member was mistreating clients?
A Yes. As long as I was there, yes. I'm sure there would have been something reported to me, yes, about disciplinary or some kind of action.
[redacted]



[redacted]

Q Okay. We deposed Mr. Mattson a few months ago, and in his deposition, page 25 of his deposition, he described his job as a glorified babysitter. Do you agree with that description of his role at Booneville?

A No.

Q You would agree that that's kind of a crass way to describe what y'all do there?

A Yes.

Q Do you agree that that statement does not suggest that the person making the statement took what they did very seriously?

A Well, that statement, you know, is not -- is certainly questionable as to what in the world he was thinking.

Q Is that the kind of things he would say? Do you

recall? Was that kind of his attitude as an employee there? He said several things like that in his deposition. Was that kind of your impression of him or does that statement fit with your impression of him?

A He could say things like that, I believe, not directly to me.

Q And another place in his deposition, page 26 of his deposition, he testified that on the day of David's death that he and one other RCT were responsible for approximately 10 clients. Does that ratio sound about right to you?

A Yes.

Q What is the correct ratio supposed to be?

A Oh, God. Okay. Ten -- okay. I'm remembering -- it's been a while.

Q I understand. Just do your best. It's not a test. If you don't remember, it's okay.

A Less than 10, but -- because that was on day shift, right?

Q Yes, ma'am. It was a day shift. It was a Saturday.

A Okay. Maybe it was eight. I can't remember.

Q You think eight may have been the minimum number of clients that two RCTs should have been responsible for?

A I'm recalling eight.
Q And, again, when you say "eight," you're talking about the number of clients that two RCTs would typically be responsible for?
A Yes.
Q And does it differ on the weekends or would it be the same on a Thursday day shift as what a Saturday day shift?
A It would go differently on the 12 to eight. It decreases. And I'm not even going to give you a number because I can't remember.
Q What do you mean 12 to eight?
A The shift.
Q Oh, okay. I see what you're saying. But it doesn't differ from a weekday to a weekend day?
A No.
Q Just differed night shift to day shift?
A Right.

[redacted]

Q Okay.
MR. GILLISPIE: Can we take five, Eric?

MR. COLLINS: Yeah, that is fine.

(WHEREUPON, after a break was taken, the proceedings resumed as follows:)

BY MR. GILLISPIE:

Q Ms. Johnson-Miller, Tyler testified -- I'm referring to page 55 of his deposition transcript. He described the use of physical restraints or personal holds on a client as a pick your own battle, pick your battle kind of thing that could be -- and that he would use physical restraints on an as-needed basis if the circumstances require. Do you agree with that description of when to use physical restraints on a client, that it was on an as-needed basis, that it's up to the particular staff member to use their discretion?

A His wording I don't agree with, but the staff are using their judgment based on their training, yes.

Q So a physical restraint might occur -- might need to be used even if the situation is not an absolute emergency; is that correct?

A An emergency to me says the safety of the other clients or the client is involved.

Q Would a staff member ever -- should a staff member ever use a personal hold on a client where there's not an emergency?

A No.

Q So laying hands on the client should only occur in an emergency situation; is that correct?
A As a last resort.
Q As a last resort in an emergency situation?
A They're the same. They can be the same.
Q Okay. But I'm asking about an emergency situation. What's the same?
A What are you calling an emergency?
Q Well, you tell me. What's an emergency? How was an emergency situation defined at Booneville?
A If the client was out of control and they were going to get hurt. The safety of the client or the safety of the other client.
Q And is that the only situation where you were allowed to lay hands on the client or to put them in a personal hold?
A Yes. You're not taught to put hands on.
Q And as you sit here today, you cannot say specifically which holds were allowed and which holds were not?
A I cannot specifically give you the guidebook of the holds and sit here and name them all and tell you, no.
Q But also, as you sit here today, it's your understanding that if a situation called for it, taking

a client to the ground was authorized, correct?
A Authorized is questionable. If the client takes you there and you're found there on the ground, then you've still got to provide a level of safety to that client.
Q And so if you end up on the ground with a client, it's your testimony that you're authorized to continue holding that client on the ground?
A If you have no other choice. If that's where the client is and you can't lift them back up to a standing position, you're there.
Q And that was a thing that occurred fairly regularly during your years there?
A Regularly? I don't know if that's the term to use or not, but that's something that with the type of clients that we serve that was a reality at times, yes.
Q And you were never taught that having a client on the ground increased the danger of the personal hold or that it was particularly dangerous. You were never taught that it was particularly dangerous to the client to have them on the ground?
A A personal hold is dangerous if you are the client period wherever you're at. That's why you use the least restrictive method you can that's available to you at the time.

Q So you'd agree that staff is only allowed to use the least restrictive intervention for the least amount of time possible in any situation?
A Right.
Q And have you discussed the restraint that led to David's death with anybody?
A No.
Q Do you know anything about it?
A No.
Q Have you discussed it with anybody?
A No.
Q You've never spoken to Sandy Evans about it?
A Sandy did the investigation. It was -- you know, I knew it happened at Commons. I knew he was transported to the hospital, and as they're -- you know, he passed away. We do a need-to-know basis. That's about all I knew about it. I knew she did the investigation. It was taken care of and . . .
Q What do you mean "it was taken care of"?
A The process, the investigation was taken care of and completed by her. And as far as -- you know, he had passed away at the time, so I didn't need to know any of that.
Q Do you have any recollection of David Cains having problems with -- having choking problems?

A I can't -- he may have been a choking risk. I don't remember if he was or not.
Q No, all I want to know is if you specifically have any knowledge about that.
A Well, like I say, I don't know if medical had deemed him a choking risk or not. I can't remember.
Q Again, I don't want you to speculate about what may be in his medical records. I just want to know from your personal experience. So given that, what would be your answer?
A I don't remember.
Q Okay. Do you have any -- and, again, I'm asking about your personal experience. Do you have any memory or recollection of David having issues with vomiting?
A He could vomit at will.
Q Okay. Have you witnessed that?
A There have been times I've seen him regurgitate, yeah.
Q At will?
A If he got upset, he could, yes.
Q So you're saying he would vomit after getting upset. He would vomit intentionally when he was upset. Is that what you're saying?
A Yes, and sometimes he has kept it in. You know, he would put it in his mouth and spit maybe, but yes,

there was an issue with that.
Q Okay. Could you put a number on how many times you saw him do that yourself?
A No, I couldn't.
Q Can you think of one single time you ever saw him do that yourself?
A Actually being there and witness it, no, but he did have the history of this.
Q How do you he had the history of it if you've never witnessed it or were never there?
A Well, you depend on other staff, your supervisors, your medical team.
Q Okay. So your knowledge -- you can't think of a time of it ever happening. You just sort of --
A I do not remember the times that I was told it had happened. It was, yes, he does have that history.
Q Ms. Carrie, can you see this document here? It's a behavior report.
A It's before me. This is one of my triggers for the issue I was telling you about. So, again, I could be -- I'm having trouble visually.
Q Oh, okay.
MR. GILLISPIE: Eric, you can see it?
MR. COLLINS: I just see the folder. I don't actually see the document.

MR. GILLISPIE: Oh, okay. I had this problem last time. Hold on a second.

BY MR. GILLISPIE:

Q Ms. Carrie, I know you're having a medical issue, so can you see this?

A I can visualize some of it, yes.

Q Okay. Will it help if I get it closer to you or do you need it to be further away?

A That's not the issue. The issue is the brightness and the . . .

Q Okay. Well, Eric can see it, so I'm going to do my best to try to view. This is a behavior report involving David from May 29, 2020, describing an incident in which Tyler Mattson used a personal restraint on David for one minute. And then at the bottom here, it has your name. It says "If personal restraint was used, QIDP notified" and then it has your name, Carrie Johnson-Miller, and then it has your initials, reviewed by. Does that mean that you were the supervisor who approved this use of restraint?

A I could have been, yes.

Q If it has your name there at the bottom, does that mean it was you?

A I was notified. Personals don't have to have a prior approval like we do with mechanicals.

Q Okay. So you were notified of it and then you reviewed it because it says "reviewed by CJM." That's you, right?
A Yeah.
Q And what does it mean that you reviewed it?
A I read the behavior report. I think at the time we were presenting them to the other department heads and we had a discussion during that meeting with possibly psychology, medical. The QA person would have been in attendance, but I think at that time, we were -- we were --
Q There's several of these where you reviewed -- that you were the person notified and you reviewed them. I'm just asking when you put your initials on there saying you reviewed it, what would you have done specifically prior to signing off on it?
A I would have been told. I would have read it. If there had been questions in my mind about what was written, I would have gotten in contact with staff.
Q Okay. And so if you had had a fear that something -- that a client was -- that a restraint was used unnecessarily, you would have done what?
A I would have got with the client -- or not the client, but the staff member and possibly the director depending on what it was.

Q Do you recall ever doing that for any of these? Do you recall specifically anytime where you were asked to review a behavior report and it caused you to notify someone up the chain about the possible use of unnecessary restraints?

A Yes.

Q Okay. And do you remember who the staff member was?

A No, because that was just part of my job description. That's something I just did.

[redacted]

Q So in this incident, I'm going to read -- this is his description of it. In this incident, Tyler describes being called to help get David out of the mobile. And then it says, "We got inside. He began screaming and tried to pull the fire alarm. I removed him from that area. When he got into the blue, he began screaming and attempted to smack me. I put him in personal hold for one minute. He seemed to calm down and went to his room." Then signed Tyler Mattson.

So in this incident, Tyler Mattson used personal

restraints on David he says for one minute in response to David trying to pull a fire alarm and attempting to smack him. Do you recall reviewing this incident?

A I don't recall it, but I did, I'm sure, because I've got my signature on it.

Q Do you recall testifying earlier today that personal restraints can only be used in emergency situations?

A Yes. And I guess at the time him trying to smack him was he was out of control and that's what --

Q Well, it doesn't say he was out of control. It just says he attempted to smack him.

A Well --

Q Let's not add facts that aren't there. Just going by this, it says, "He began screaming, tried to pull a fire alarm, began screaming and attempted to smack me."

MR. COLLINS: Hey, Josh, I'm going to object right here. If we're not going to allow her to add facts, I don't think we should allow you to omit facts. This statement right here clearly says that he had already hit one staff member. You left that out. I think it should be told to her if you're asking her to opine on it.

MR. GILLISPIE: I'll just read the whole

thing.

BY MR. GILLISPIE:

Q Do you see, "Arrived from schedule OA mobile crying and screaming. TA Rick Libby told me he, for no reason, slapped him. I went outside to get him after mobile called saying they needed help. I went outside and asked him to come in to take a shower, relax. DC complied, but when we got inside, he began screaming and tried to pull the fire alarm. I removed him from that area. When he got into the blue, he began screaming" -- I think it says "at me" -- and attempted to smack me. I put him in personals for one minute."

So my question is, Ms. Carrie, does that meet the definition of an emergency situation to you?

A At the time, it could have. I don't recall all the facts of that.

Q Well, you've reviewed it and signed off on it, so if it -- I'm assuming that means that you found it to be an emergency situation; is that correct?

A Yes, or it was escalating. But yes. And like I say yes, you're right.

Q So just based on what I read there, if this was all you knew about a situation, that could meet the standard for an emergency in your mind?

A Yes, because he had already escalated at the other

place and he had transitioned to another place and he was still fighting them, so, you know -- yes, it could have been interpreted as an emergency situation at that time.

Q Okay. Moving on to the next one. This is the same day. This is also a May 29, 2020, different time of day, but Tyler Mattson put David in a personal restraint for three minutes during this one. This one was also -- you were also the staff member notified and then you were also the staff member who reviewed it. Your initials are here at the bottom. And this one says -- the description is, "The nurse, Kelly King, called for meds. David Cains went down there. Soon after, he began screaming at the nurse threatening to throw a thermometer at her. I ran down there as I was in the aid station because I was the only one on the floor. When I got down to her, I immediately put him in personals for about three minutes."

A He was probably giving him time to chill out.

Q And, again, you testified earlier, and you testified correctly because it is the rule, that personal holds can only be used in emergency situations.

A And that could be deemed as an emergency, you know.

Q Tell me how this could be deemed as an emergency. He's screaming and threatening to throw a thermometer?
A Because he's escalating. He may have been escalating at the time.
Q Screaming and threatening to throw something could meet the definition of an emergency necessitating physical force, yes or no?
A No.
Q Okay. So did you report Tyler for improperly using a physical restraint for this incident?
A At that time, it was not deemed improper.
Q What does that mean?
A At that time, it was an acceptable -- evidently an acceptable thing that we did. What date was that anyway?
Q It was May 29th of 2020, two weeks before David was killed. You're saying the rules were different -- what are you saying? Are you saying the rules changed?
A No. I'm saying there's probably information in that narrative that was not written down.
Q Are you alone in the room you're in now?
A Yes.
Q Okay. Go ahead. You were saying there was probably information not written down. How do you know what?

A I may have talked to him at the time. I may have learned more information about it. I don't remember.
Q Okay. Hypothetically, let's take Tyler at his word and say that this is all it was. If this is all it was, was that sufficient to meet the definition of an emergency necessitating physical force?
A No.
Q As far as you recall, you did not flag this as a bad act by Tyler?
A No. I do not remember flagging it at the time, no.
Q If this is all that had happened -- and, again, we have no indication that there was anything else other than this. If this is all that it was, should you have flagged him?
A Yes.
Q Okay. I'm moving to an April 28th of 2020 behavior report. This is obviously David Cains. Rhonda Harris is the staff member directly involved in the personal restraint here. Again, it's April 28, 2020. You are the supervisor who was notified and once again, you were the supervisor who reviewed it. Well, actually you and -- it looks like maybe Randy McLemore also reviewed it or somebody else also reviewed it. See, your initials are there at the bottom here.

A Yes.
Q So this one says, "DC arrived at work. Sat down, finished drinking his soda, got up and throw it away, walked back to chair, picked it up and threw it at staff. Tried to going to window with his fist up, but staff prevented him from getting to window. Staff held him in personals for approximately three minutes."
Do you recall this incident?
A No.
Q So in this incident -- and this is Rhonda Harris who wrote this -- DC or David picked up a chair and threw it at staff and tried to going to window with his fist up. They held him in personals here. Is this an emergency situation?
A I would say yes, because as many clients as we had at that work area.
Q Okay. How are you as the supervisor reviewing these documents supposed to know what kind of personal restraint was used? It just said "personal restraint" in most of them. It doesn't always say exactly what happened or meaning it doesn't always say how they restrained them. How are you supposed to know that if it's not on the form?
A Well, there's a definition of personal restraint.
Q There is, and that definition, I'll represent to

you, because I've read that definition in lots of these depositions and it's restriction of a client's -- well, let's pull it up. I don't want to -- just one second.

MR. GILLISPIE: Actually, let's take another five minute break and then we'll be able to wrap up when I come back, Eric.

MR. COLLINS: Okay.

(WHEREUPON, after a break was taken, the proceedings resumed as follows:)

BY MR. GILLISPIE:

Q So I wanted to find the definition for us, Ms. Carrie. And Booneville policy, Booneville HDC policy roman number i(d)(4) defines personal restraint as "an emergency procedure limiting movement by the holding of a hand or a limb." You'd agree with that?

A Yes.

Q And it defines emergency restraint as "the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors." Then it goes on to say "the use of emergency restraint will comply with all relative standards and regulations."

Would you agree with that as well?

A Yeah.

Q Can y'all see this behavior report dated 3/2020?

A I can see it somewhat.

MR. GILLISPIE: Eric, can you see it?

MR. COLLINS: Yeah, I can see it.

BY MR. GILLISPIE:

Q And this is the last of these reports I'm going to be asking you about, but this one involves Tyler Mattson applying personal restraints to David Cains this time for four minutes. And it has your initials for some reason by the four minute where it says -- there's an X by personal restraint, four minute. Then it has your initials there, CJM. And then at the bottom, of course, it says you're the QIDP that was notified and then reviewed by you, CJM. Can you see that?

A I can.

Q Why would you have initialed up here as well by the four minutes?

A Because I wrote four minutes. He failed to complete out the form so I would have gotten with him and asked him what it was.

Q Did you write the description as well?

A No.

Q He wrote that?

A Yes.

Q What do you mean he failed to complete the form?

A There was some -- he forgot part of the form, and so I went and evidently found him and he would have verbally told me four minutes.

Q Okay. So it looks like he filled out most of it and just left this part off. Is that probably what happened?

A He left off that and it looks like up above. I can't visualize what that says, but . . .

Q Laundry basket. It indicates he was kicking his laundry basket.

A Okay. That looks like my writing, so I went to him and he told me what it was.

Q Okay. So let's read his description of this one. "I was walking through the hall and heard banging. I went to see what it was and it was David Cains kicking his laundry basket. I walked in and asked him what was wrong and he needed to relax. He said no, bitch, and tried to spit and swing on me. I applied personals to him and he continued to fight and resist calling me a bitch. I continued personals. He began to apologize and say he was calm. I told him to relax and let him up. He apologized and behavior ended."

Then it goes on. Then he signs it, dates it, and writes there "four minutes of personals, time of behavior 1550." This is Tyler describing using a

personal -- he says he let him up. Do you recall this incident?
A No, but go up above and let me see what else he -- there was something else.
Q Up here?
A Doesn't that say biting?
Q It says that he bit his own right and left hand, I think. Yes, it says that David bit himself in the hand, bit his own hand.
A He was trying to protect him from hurting himself, number one, and --
Q Well, that's not what it says in this description. It says, "I walked in and asked him what was wrong," because he'd heard him kicking his laundry basket, so Tyler walked into his room, asked him what was wrong, told him to relax. David said, no, bitch, and then tried to spit and swing on Tyler, so Tyler then, according to this, put him in restraints on the ground for four minutes.
A I don't know about on the ground, but he was fighting himself and he was probably trying to protect him.
Q Well, it says here that he let him up. What else could that mean other than let him up off the ground?
A David may have gone on his knees.

Q Well, this says "let him up." This is Tyler saying he was restraining him and then Tyler let him up. So you tell me, is that a proper form of personal restraint?

A As far as let him up, I'm not for sure exactly what happened.

Q Well, then why did you approve it? Why did you review it?

A When I approved it, I probably knew exactly what happened and it made sense to me. Right now, I don't know.

Q Well, based on this, just based on what he wrote here, right, just based on what's right in front of us, and I read it exactly as it's written. Based on that, you would agree with me that this is describing a situation where Tyler heard David kicking something. It ended up being his laundry basket. So Tyler enters David's room, tells him to relax. David says, no, bitch, and then tried to spit and swing on Tyler. Taken that alone as it's written here, is that right there -- does that meet the definition of an emergency restraint -- or does that meet the definition of an emergency situation where there is severely aggressive and destructive behaviors?

A Right now I could not tell you that.

Q Well, let's say that's all it was. Let's say all it was is that David called him a bitch and then tried to spit and swing.
A And he was biting.
Q Well, may have been biting himself, but Tyler didn't think that was a big enough deal to even add to his narrative.
A It was in the report, though.
Q All right. Well, in the scenario that Tyler described where David calls Tyler a bitch, tries to spit and swing on him, that in and of itself, does that meet the threshold for an emergency situation necessitating physical restraint?
A If you want to leave out biting, yes, and being harm to himself, yes.
Q Okay. Let's say there's no biting. Same question, no biting. Does that necessitate physical force?
A There was biting. He was providing safety for that client from his biting.
Q Well, why does it not say that in his narrative?
A It's in the report.
Q Is that your handwriting or his handwriting?
A No, that's his.
Q And did he put that there originally or did you

have to ask him to go back and add it?
A It looks like it was there originally.
Q So if a client is biting their hand, that is an emergency that would necessitate holding them on the ground or holding them down for four minutes?
A It would require an intervention because the severity of the biting could be very detrimental to that client, yes.
Q And that biting combined with him trying to spit at Tyler calling him a bitch and swinging on Tyler, that, to you, justifies taking him down and holding him down there for four minutes in personals?
A It could.
Q It could. And, again, we talked about the definition of personals. A procedure limiting movement by the holding of a hand or limb. Nowhere does it say anything about taking clients down, does it?
A I don't know if he had him down.
Q Well, yes, you do. Yes, you do because it says, "He was calm. I told him to relax and let him up." What else -- you know, we all speak English. That's what that means, ma'am.

MR. COLLINS: I'm going to object to this. You're getting argumentative and you're badgering her. She's answered that

question and she's given you an alternative, which could be reasonably read into that as well. You're just badgering her at this point.

MR. GILLISPIE: No. There is no other reasonable --

MR. COLLINS: I can think of four off the top of my head, Josh. He could let him up out of a chair, let him off his bed, let him off her knees as she stated. You're badgering her.

BY MR. GILLISPIE:

Q Ms. Carrie, the fact that he wrote "let him up," that indicates that he had him down on something, whether it be the ground, the bed, on his knees, something, right? You'd at least agree with me on that?

A No.

Q You would not. Why?

A He may have gone down on his own.

Q Well, if he went down on his own, why would he need to be let up? Why would Tyler need to be the one that lets him get up he you went down on his own?

A He may have helped him up.

Q But this says "he let him up." You don't know one

way or another what happened here?
A Today I do not remember.
Q If the situation had been where Tyler told you that he restrained him on the ground for four minutes, let's say that's what happened here. He restrained him on the ground for four minutes, which is clearly what happened. Would you have had any issue in reviewing that? Would you have felt the need to flag that or would that have been something that you would have --
A Flagged it.
Q You would have flagged it? That's a yes, you would have flagged that?
A Yes.
Q Okay. So if this had indicated that he had him on the ground restraining him, you would have flagged that?
A Yes, depending on how he got to the ground.
Q Depending on how he got to the ground. How would it depend on how he got to the ground?
A Client will go to the ground on their own.
Q So if the client had gone to the ground on his own and then Tyler had restrained him there on the ground for four minutes, that would have been okay?
A If there was no other way, yes. I mean, he didn't start -- he was protecting that client from biting

himself.
Q That's your story and sticking to it on this one, huh?
A Yes.
Q I may be done here. Give me just a moment, please.
Ms. Carrie, do you know of any definition of personal restraints other than the one that I read to you and we talked about?
A It should list -- on that form you're looking at, it should list the different types.
Q Well, it says, "Approved restraints: A, personal restraints, which is an emergency limiting movement by the holding of a hand or limb." That's all it says about personal restraints. And then the list then says "chemical, protective helmet, papoose board wrist restraint," different things. But for personal restraints, the entirety of the definition is an emergency procedure limiting movement by the holding of a hand or limb. I'll represent to you that Ms. Evans, Ms. Sandy Evans testified that that was the only definition of personal restraints that she knew of, page 40 of her deposition. Do you agree with that? Is that the only definition of personal restraint that you were aware of?

A At this moment, yes. From what I remember.
Q Do you remember there being some other definition that lists taking clients to the ground or getting on the ground or being on the ground and holding clients on the ground for personal restraints? Is there something that you can remember seeing like that?
A I don't believe so.
Q You've never seen any written policy that you can recall that states ground restraints are allowed?
A It's been a while since I looked at those definitions, but --
Q As you sit here today.
A That's what I'm recalling today, yes.
Q Okay. So you cannot recall any policy that authorizes ground restraints. You cannot recall any written policy that authorizes ground restraints, correct?
A Well, mechanical, you're going to be, but not for personal, no, I don't believe so.
Q That's all I was asking. Thank you. I think that's all I have, Ms. Carrie. I appreciate your time today.

EXAMINATION

BY MR. COLLINS:

Q Ms. Carrie, before you go, I'm just going to ask

you a few questions.
A Okay.
Q Real quickly, you were speaking about Justin having to pick up David Cains at McDonald's. Can you elaborate on that just a little bit for me?
A His uncle had taken him out to McDonald's. He called us for assistance. The uncle called us for assistance. We got a van. We got two trained people that David had a good relationship with and we -- they went to McDonald's and they got him and brought him back to the campus. And when I discussed it with the other Q that went, one of them, Justin, he said -- Justin said -- I asked him, I said "Well, how was it?" And he said, "Well, he was visibly" -- the uncle was visibly shook up. I think he alluded to the fact that there were some scratches or some facial thing that had happened to the uncle.
Q And do you by chance remember the uncle's name?
A No, I don't.
Q When you were looking at these behavioral reports, you get them from, I guess, one of the staff members, correct? They send them to you?
A Yes. They're sent over to the team members, yes, and then we go to a conference with the rest of the staff or the department heads.

Q When you get those behavior reports, do you discuss them with the team members sending them to you?
A When I review them, if I have any questions, I pull them. I go to the dorm. I find the staff member, and I have a discussion with them. And I would always try to find the supervisor and maybe have a discussion with them. And if I had a question about my thoughts, I would go to the director.
Q How often do you think that you discussed these with the staff member or the supervisors? I know you probably don't have an exact number or percentage, but just about how often?
A It was something I did often. It wasn't a rare occurrence because I always had questions about -- in my mind, I wanted to know what I was reading was correct, yeah. I mean, that was just something -- that was just part of what I did on a daily basis.

[redacted]



Q Thank you. I have nothing further.

FURTHER EXAMINATION

BY MR. GILLISPIE:

Q Just one follow-up question, not about any of that but about the behavior reports. We went and collected all of the behavior reports that you signed off on involving David Cains between 2016 and 2020, Ms. Carrie. And on a lot of those, the times that personal restrains are used on a lot of those it's David swung or tried to hit. And my question is, does a client attempting to strike with his hand a staff member in and of itself justify an emergency personal restraint?

A It depends on the environment you're in. I mean,

how many clients are around you when he's swinging?
Q Well, let's think of it in a vacuum where in and of itself, a one-on-one situation, let's say. One-on-one situation, whether it be in David's room or some other room, one-on-one situation where David or any other client takes a swing at the staff member. In and of itself, can that meet the definition of an emergency situation that necessitates physical force?
A You're taught to step back.
Q You're taught to step back. Are you taught anything else that might prevent having to use physical force on a client other than stepping back?
A Watch your posture. Sometimes your posture tells whether or not -- what you're ready for.
Q You mean your posture because the client takes cues from your posture. Is that what you mean?
A Yes.
Q But other than stepping back and making sure that your posture isn't threatening to the client, is there any other technique that you were taught that you can think of to use in that situation prior to actually laying hands on the client?
A Redirect. If you think a client is escalating and you know his warning signs or her warning signs, you're taught to get extra staff, call for assistance, call a

nurse, can you redirect him.

Q So all of those things should be done before you lay a hand on a client who took a swing?

A Yes. That is what we would strive to do, yes.

Q Thank you, Ms. Johnson-Miller. That's all I have. Thank you very much.

(WHEREUPON, the proceedings were concluded in the matter at 11:30 a.m.)

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CERTIFICATE

STATE OF ARKANSAS)

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COUNTY OF PULASKI)

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I FURTHER CERTIFY that in accordance with Rule 30(e) of the Rules of Civil Procedure, review of the transcript was not requested.

I FURTHER CERTIFY that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested, or otherwise, in the outcome of this action, and that I have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original deposition transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties to the action.

WITNESS MY HAND AND SEAL this 21st day of July, 2022.

Kristina R Gray

Kristina R. Gray
Arkansas State Supreme Court
Certified Court Reporter #725

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

PART TWO OF ZOOM DEPOSITION OF

JUSTIN JOBB

May 13, 2022, at 12:06 p.m.

CRIS M. BRASUELL, CCR
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A P P E A R A N C E S

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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Justin Jobb, produced, sworn, and examined via Zoom, commencing on May 13, 2022, at 12:06 p.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

PROCEEDINGS

WHEREUPON, Justin Jobb was duly sworn to tell the truth, the whole truth, and nothing but the truth, and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Mr. Jobb, I've got a few more questions for you today following up on the first time we spoke.

I wanted to start by asking you about whether the use of personal restraints are ever addressed during the -- addressed with the family during the IPP annual meetings.

So in this case, it would have been there were two IPP -- we established that you were his Q and did the IPP for 2018 and 2019, so the last two that were done.

And so my question is -- and I know the mother attends those and the sister has attended them as well as part of the -- that the mother was part of the core team, as you explained to me.

A Uh-huh.

Q Are the personal restraints ever addressed amongst the team and in those annual reviews, annual meetings?

A They are. Some of the clients that we serve do not utilize -- or we don't utilize any form of restraint.

It's just not required.
Q Uh-huh.
A But, in his case, it was required periodically, so, yes.
Q And I think you told me before that you're the Q is not the person or the department that dictates what those restraints are; correct? That comes from psychology?
A That's correct.
Q And so that would be the behavior treatment program?
A Yes, sir.
Q Okay. And, in David's case, I believe that the most recent one was dated August 20th of 2018.
Are the contents of that behavior treatment program included anywhere in the IPP?
A A portion of the I -- I mean, a portion of the behavior treatment program will be included, yes.
I don't in -- I don't copy and paste the entire thing. But I do try to hit the high points on it.
Q So I'm going to pull up David's treatment program here on a new tool that I've learned called share screen that Cris taught me last week. It'll make all this easier for us.
A Okay.
Q Do y'all see it?
A Yes.

Q Behavior treatment program.
A Yes, sir.
Q Okay. I'm going to just scroll slowly so you can just familiarize yourself with this.
A Okay.
Q Kind of, to me, the high points here would be that the program employs category one procedures as defined by DDS 3011-D.
A Right.
Q Do you see that?
A Yes, sir.
Q That is in the IPP somewhere, isn't it?
A I believe it is, yes.
Q Okay.
A (Inaudible) --
Q But --
A Go ahead.
Q Go ahead.
A Well, I was just -- right there where you're at, with the primary symptoms, I usually include those as well.
Q Okay.
A Also the reinforcement menu that you have right above that, those are some of the things I like to include.

Q Okay. And what I'm getting at is, do you recall anybody ever explaining to David's mother or sister the types of personal restraints that were authorized to be used on David?

A I don't recall that specifically, no.

Q Do you recall anyone ever, in the 2018 and 2019 meetings for which you were the Q, do you recall anyone ever addressing with the mother and sister that David might be restrained on the ground?

A No.

Q Okay. And I'm correct, aren't I, that staff development is responsible for training the direct care staff in the use of personal restraints; correct?

A That is correct, yes.

Q Okay. But staff development is not responsible for then enforcing what they train, are they?

A Well, they -- they do --

Q Meaning they're not the ones, the staff development is not, at least I wouldn't think, tell me if I'm wrong, staff development is not the department at Booneville that would be responsible for monitoring how staff are performing their jobs and monitoring staff to make sure that they are only using personal restraints that comply with authorized training?

A No. They -- they do the training. And then there's

a point where they do a retraining.
Q Okay.
And so my question would be, who would be responsible, most responsible, on a day-to-day basis for enforcing the rules concerning how to use personal restraints?
A Well, the training takes place. And then, once the staff have that training, it's on that particular staff to -- to conduct that training in a proper manner.
Q Okay. I would agree with that. But are you saying that there's no supervision of staff by anybody to make sure that they're not using improper restraints?
A Well, they have -- supervisors are assigned, but they're certainly not everywhere at all times.
These restraints have to be approved by a Q, a program coordinator, or another -- nurses can also approve the restraints.
Q Right.
A They call the program supervisor, would largely be one that you could put in the category that you're speaking of.
They call the program supervisor, who is essentially a person that is responsible for that shift hill-wide training. And so they would be called and notified.
And then the Q is then notified. And they have to

make the -- the approval or -- or a nurse, like I said, could make the approval.

Now, once they're in restraints, they have to have reauthorization.

Q But you're talking about -- you're talking about mechanical restraints now, aren't you?

A Yes.

Q Okay. I'm not really concerned with mechanical restraints, because that's not the type of restraint that led to David's death.

It was a personal restraint by three staff members on the ground. And it's a restraint that Mark Hise told me yesterday was not taught and not authorized by NCI training that's conducted in Phase One.

Were you aware that these types of restraints were being used on clients, these types of restraining clients on the ground?

And, not for the purpose of transitioning to a mechanical restraint, were you aware that was going on?

A No.

Q And you'd agree with me, you'd agree with Mark, I assume, that that that's not a proper way to restrain clients?

A That's correct.

Q Okay.

And so knowing that then, I'm assuming that, you know, nobody would have ever explained to David's mom or David's sister that that was a type of restraint that might be used on David --

A Well --

Q -- correct?

A I don't -- the thing is, when these restraints take place, it -- it could end up on the ground. It could end up over a desk. It could end up -- you know, I mean, it just -- you can't -- there's not a textbook that every behavior is dealt with this -- I mean --

Q There actually is. I mean, there actually is.

I mean, that's not what I'm asking you about, but there -- you know, there is an NCI textbook.

A I'm just saying --

MR. COLLINS: I'm going to object right here, Josh. He was answering the question. I'm going to ask that you allow him to answer the question thoroughly before you interrupt him and tell him that wrong.

You can ask a further question if you want to, but let's let him finish his answer.

MR. GILLISPIE: Okay. Well, I don't think he was -- I think he was answering a question that I didn't ask and --

BY MR. GILLISPIE:
Q You know, my only question really about this is -- well, first, do you recall ground restrains ever being discussed at any time with David's mom or David's sister?
A No.
Q Okay.
And so my next question is, if a direct care staff, if an RCT, was utilizing improper restraints or had forgotten his or her training and were just having difficulty in general following the rules as it relates to personal restraints, who would be the person that is supposed to catch that and then try to, you know, get them some more training or correct their behavior?
You know, who would be the person that would be responsible for, you know, making sure that an RCT is not just kind of running wild and doing things improperly?
A Every staff member up here is a mandated reporter of abuse. So if it was not conducted in an appropriate manner --
Q Uh-huh.
A -- any one of those staff could report that and it would be investigated.
Q Okay.
A (Inaudible.)
Q But there's nobody that you know of responsible for

supervising how staff conduct or implement personal restraints?
A No. There's not going to be an on-site person making a call.
It's going to be the staff that have taken the initiative to handle that emergency and to use appropriate discretion.
Q So there's no -- there's absolutely no mechanism for knowing how a staff member, how an RCT, is treating the clients?
A Well, they're trained.
Q Okay. But, other than that, I mean, every job I've ever had, I've had a supervisor that's supervised. Maybe not 24/7, but, you know --
A That's not --
Q -- there's always a --
A Well, you made the point yourself, that 24/7 doesn't happen. There are times --
Q Right.
A There's are times where a supervisor would be on the scene and would, if saw anything inappropriate, they would correct it on site.
But, like you said, there's not always going to be supervision 24/7.
Q Okay. Sure. But --

A They're trying to handle emergency situations. And that's the way they use appropriate discretion when doing so.

Q Let me ask it -- I hear what you're saying. And I'm not trying to trip you up. So let me ask it this way.

In a scenario where a staff member gets their training, they finish Phase Two but then they use their discretion poorly and start regularly implementing things like ground restraints, which, you know, Tyler Mattson said that was the thing that he was allowed to do; which is not the case.

Is there not a safety mechanism in place to catch that so that that doesn't continue to go on?

A Well, it would have to be reported.

If anything was witnessed or observed that was inappropriate, we have -- everybody on campus is a mandated reporter. And it should be reported to our superintendent.

And our superintendent would determine what type of investigation needs to transpire.

Q Okay. So you're saying that any type of ground restraint like I'm describing would constitute maltreatment that needs to be reported?

A Not necessarily, no.

Q Okay. Well, then if it's not maltreatment, but

still improper, against policy, dangerous and, you know, you found out it was going on, what would you do?
A Well, anything that I deemed inappropriate or abusive, I would report it.
Q Okay. Despite whether it constitutes maltreatment or not?
A Well, it's not for me to determine. Our superintendent would make that determination.
Q Okay.
A We do have maltreatment investigations and we have administrative reviews for both investigations --
Q Okay.
A -- but that's not my call.
Q Okay.
Are you able, as David's Q, as the person that drafts his plan, his IPP and is responsible for implementing his plan, are you able to articulate to me what, if any, supervisory, supervision techniques or safety mechanisms are in place to ensure that RCTs are not regularly using improper personal restraints?
Or is it simply there's no system in place, it's just, if somebody sees something, they report it?
A Well, they are trained.
Q We've covered that.
A And we count on them doing the correct procedure,

correct job. And, if anything is not carried out properly, we are counting on other staff to report it.
Q Okay.
A And then there's --
Q And who typically would that be? Who would that typically -- who's the staff member in the best position to observe how an RCT is using restraints and then report it if necessary?
Who is in the best position to do that?
A It could be a fellow RCT.
Q Okay. Who else could it be?
A It could be anybody.
Q Okay. But who?
A Any staff member.
Q Okay. There's not a senior staff member? There's not a -- it's not the residential services director?
A That's going to -- I don't know what your question is. I'm sorry. You lost me there.
Q My question is, is there a staff member that is in the best position to monitor and, if necessary, take action, when an RCT is not following the rules with respect to personal restraints?
A No. There would be times where there would be supervisors on site and there'll be times where they're not.

Q Okay. So there's no formal system of supervision for the RCTs?
A I'm sorry?
Q There's no formal system, no formal plan of supervision, for the RCTs?
A Well, they have their supervisors. But, like I said, there'll be times where the supervisor is not present.
Q Okay. And there's -- but there's no --
A The (inaudible) is who you have to answer to. There's always -- there's a chain of command, certainly.
Q Okay. And are you able to articulate what that chain of command is?
A For the RCT?
Q Correct.
A Well, they -- they would have their -- you know, the titles have all changed now.
But they would -- they would have their dorm supervisor.
Q What --
A Go ahead.
Q What would -- I'm talking about in June of 2020. What would the chain of command been?
A Well -- well, an RCT, then they have the -- their -- and I don't remember the titles. They've changed so

often.

But it would be a shift supervisor and then a dorm supervisor, a team leader, and then the residential services director. It'd be something pretty close to that.

Q Okay. So three or four levels with residential services director on top?

A That'd be pretty close, yes.

Q Okay.

And are you able to articulate any formal plan or policy used for supervising the RCTs?

For instance, supervisor has to be present for this many, you know, this many times a week for this long --

A No.

Q -- that sort of thing.

A No. That would not have been in my job capacity.

Q That would what?

A That would not be in my job capacity at that time. I -- I think --

Q It would not be in your job capacity to know if a system for supervising the staff existed or it would not be in your job capacity to be that supervisor?

A Well, even to put that in place; because the -- my position at that time was not a supervisory role and did not give any directives.

Q Okay. I under -- okay. Understood.
A So we could encourage and -- and try to put forth some guidelines to be followed.
It's very difficult to enforce each and everything when you're not the one giving directives or doing the training themselves.
Q And the person giving the directives to these RCTs would ultimately be the residential services director?
A That person -- yes. It would certainly be more on the line of the person you need to talk to about those -- those sorts of things.
Q Okay. But, as far as you know, as far as you're aware, personally, in June of 2020 -- and I get that it's not your job, but I'm just asking if you're aware anyways.
In June of 2020, are you aware of there being any sort of formal system, formal policy in place for the purpose of supervising RCTs?
A No. That's not in my capacity. I mean --
Q I understand that. I'm just asking you, are you aware if there was a system or not?
A Well, they have a system that they have a direct supervisor. They have a chain of command.
Q Okay. And it's not a -- I just want to know if you know if there was a system, if you know what it was.

And, if you just don't know, that's fine. Just tell me that too. I just need to know.

A My answer is that they have direct supervisors to answer to and a chain of command to adhere to.

I mean, I don't know how more I can answer that question for you. We all have someone to answer to all the way up to the top.

Q Okay. But a chain of command, I understand that exists. That's different than a formal plan for supervising RCTs isn't it?

A Well --

Q It's not the same plan.

A -- I mean, if you look at it as a plan, they -- the RCTs have direct supervisors.

Q Uh-huh.

A Those direct supervisors are not going to be present 24/7.

Q Uh-huh.

A There will be times that they are present, but there's times that they're not.

Q Do you know how often direct supervisors are required to be present?

A No, I do not.

Q Okay. Do you know if there is a requirement about direct supervisors being present --

A No.
Q -- to supervise RCTs?
A No, sir.
Q Okay. And your answer would be the same for June of 2020?
A That's correct.
Q Okay. Thank you.
So every time Mr. Cains, a personal restraint was used on Mr. Cains, you would be notified of that? At least during the time you were his Q; right?
A I -- not always immediately. But I would become aware of it at some point, yes.
Q Okay. And what was your responsibility at that point after you -- they were required to make you aware; right?
A Well, not always at the moment.
Like the restraint of the day of the incident, I did not authorize that restraint. I was not aware of it.
I eventually became aware of it. Not all the details because there was obviously an investigation. And those detail, I was not privy to those details, because -- as far as him being restrained.
We did monitor the numbers. And we were taking some proactive stances to assist him in reducing those numbers.

Q Okay. Like what?
A Well, we were having our medical staff go on site.
Anytime that Mr. Cains' was demonstrating any kind of verbal aggression or physical or just seemed anxious, they would go check his blood level to see if -- because he was, I'm sure you know, he was diabetic.
And to see if that might have been a contributing factor.
Q Uh-huh.
A That maybe he had low blood sugar or high. I don't really have a medical background, but that was something we had in place.
Q And is that when they noticed that they were -- that he was having more behavior issues shortly after lunch --
A I can't --
Q -- or after eating?
A I don't really recall what led to it. It was just, we -- we, as a team, get together and we try to be proactive and -- and see what we can put in place.
And, actually, his year leading into that annual review that never took place, the numbers were reduced over that year.
Q The number of personal restraints used on him?
A Of personal, mechanical, chemical, everything was reduced. And also his non-compliance was reduced. His

physical aggression had been cut in half -- I don't have the numbers in front of me.

But I did see some of those numbers come in from the psychiatric or psychology evaluation. That was a report that was leading into the meeting that I never got to take, that never took place.

So I got to look at those numbers and compare them. So --

Q Do you know what that psychology department document was called? I want to see if I have it.

A Should be a psychology evaluation. Let me -- I don't know if I have it. Yeah, psychological evaluation.

Q Are you able to email that to Eric, by chance, so he can send --

A I don't have --

Q -- it to me?

A No, sir, I can't. I mean, I -- I can at a later date, but not -- not as we speak.

Q Okay. And, real quick, give me the title, just the title of it real quick, so I can add it to a list.

A Yes. It's a psychological evaluation.

Q What's the date?

A 6/16/20.

Q Okay.

MR. GILLISPIE: And, Eric, I don't think

I've seen this. It doesn't mean I don't have it. I'll double check first, but --

MR. COLLINS: I can double check. I imagine, since we pulled his entire medical file, I can't see a reason that wouldn't be in it, be in there.

MR. GILLISPIE: It probably is.

A It might be relevant, Mike Alvis and -- and he was the psychological examiner. He -- he wrote that.

BY MR. GILLISPIE:

Q Yes, sir. Yeah, I've met Mike or I -- we've --

A You may have covered it, because I know you're covering a lot. But you -- you've likely seen this document that I speak of.

Q Okay. But, basically, it reflects progress though?

A Progress in every department, yeah.

I mean, he -- well, he had a good year leading in to that meeting, as far as -- I mean, those are the kind of things we look to do, is reduce any form of restraint and reduce his target symptoms of non-compliance and physical aggression.

We saw improvement in every area, which is pretty rare. I mean --

Q Uh-huh.

A -- so we do see it. It goes ups and downs. It

depends on who we're dealing with; but, in this case, some of the things we had in place appeared to be working.

[redacted]

Q I hear you.

A (Inaudible) from medical.
Q I hear you.
Mr. Jobb, did you ever -- so you're now, I think, generally familiar with the type of the restraint incident on the day of his death.
Previous to that, had you ever received any report or notification of that type of a ground restraint being used on David in the past?
A No, I don't. No.
Q And --
A As far as -- I know very little about the incident itself. They kept a good lid on that. It was investigated. So as far as that particular -- go ahead.
Q I was going to ask you, what is your understanding, as you sit here today, what is your understanding of what that restraint was on that day?
A I don't know. I -- I don't know what the emergency was. I don't know the details. I'm just --
Q Well, we don't need to get into an extensive --
A No. See, that was ones -- things like that, not just anything -- when things are investigated, they keep a lid on that.
Q Okay.
A It's --
Q Well, I'll just tell you the --

A -- (inaudible) --
Q -- I'll just tell you the bare bones basics of what happened.

There were three staff members, Tyler Mattson and Mandy Jones and then Ryann Campos. And there was a behavior incident that -- it ended up with Tyler and David on the ground.

And then Tyler restrained David on the ground. David was on his left side and Tyler was kneeling behind him with his hands on him, restraining him on the ground.

And Mandy arrived at the scene, you know, a couple minutes later. She holds him by the arms or by the head, depending on who you're asking.

And then, a couple minutes later, Ms. Campos arrives at the scene. And she assists those two by grabbing his legs.

So the three of them are restraining him on the ground for, depending on who you're asking and when, you know, anywhere from, you know, four to seven minutes, probably, before he starts vomiting and before he aspirates and starts choking on his own vomit.

So I understand you weren't there. I understand you don't have the same information that Eric and I have. You haven't been to these depositions.

But, for the purposes of my questioning, assuming

what I told you just there is accurate for the purposes of these questions, what would be your thoughts on that? Would you --

MR. COLLINS: I'm going to object for the limited period that I do not think that recall is accurate. I think looking at all the facts that led to, even if you disagree with them, what those individuals thought created the emergency situation.

So you can answer, obviously, but I just wanted to put that --

MR. GILLISPIE: I understood --

MR. COLLINS: -- (inaudible).

MR. GILLISPIE: -- noted. I understand.

BY MR. GILLISPIE:

Q But for purposes of my questions, assume that what I'm telling you is true.

And, based on that, would you agree with Mr. Hise that that was an improper restraint procedure?

A It's certainly not ideal.

Q Okay. Would you be able to expound on that a little?

A Well, I -- I can. I mean, it's -- when you've had to restrain individuals -- and I don't know, you know, what led to, what the emergency was.

But there's times where they might knock you to the ground. You might get tripped over a chair or table. It's -- we teach a technique.

But, you know, in the real world with -- with clients, you know, that can be very violent and strong and twisting and turning and -- and knocking people over, there have been times, you know, obviously you end up on the ground.

Q Well, respectfully, that wasn't my -- that's not an answer to the question that I asked in any way.

A Well, without more details, I wouldn't be comfortable answering. I don't -- I mean --

Q Well, were you aware -- were you aware that ground restraints are not allowed, except for this specific purpose, narrow purpose, of transitioning a client to a papoose board? Were you aware of that?

A Well, they had to be released. I mean, there would be a time where you'd end up in that position, but then they --

Q Again --

A -- (inaudible) --

Q Again, and I'm not going to just let you just talk in a way that doesn't answer my question at all, sir. We'll be here all day.

Are you or not -- are you or are you not aware that

ground restraints of clients are prohibited, not allowed, unless for the specific purpose of transitioning to a mechanical restraint?

Are you aware of that rule or not?

A That's correct, yes.

Q You are aware of that rule?

A Yes.

Q And you were aware of that rule when David was alive?

A Yes.

Q Okay.

And my next question is, were you ever informed or notified of such an improper restraint being used on David other than on the date of his death?

A No.

Q Okay. Had you been made aware of that, what would you have done?

Had you been made aware that that was going on with David or any other client, what would you have done?

A I would have reported that to the superintendent.

Q Okay. As part of your duties as a mandated reporter to report maltreatment?

A Well, it's -- it's possible. It's not my -- it's not for me to decide.

But anything that would be questionable needs to be

turned in. And then --
Q Well, I guess --
A -- superintendent makes that decision.
Q For mandated reporting purposes, you hotline that. You don't -- that doesn't go to the superintendent, does it?
A Yes, it does. Reporting?
Q Yeah. Like mandated for maltreatment purposes, you're a mandated reporter for maltreatment.
If you saw were aware or had suspicion of -- reasonable suspicion of maltreatment and you had to report it, per your requirements as a mandated reporter, who do you make that report to?
A To the superintendent.
Q Okay. Well, I know --
A Or the acting -- whoever may be the acting superintendent, in case he's out of town or whatever, but --
Q Okay. There's not a hotline that you make that report to in Little Rock like there is for child maltreatment?
A Not for me, no. No. Our superintendent may need to make those. But we report it to our superintendent. That's our job.
Q Are you saying that, when maltreatment is suspected

at Booneville, you report that to the superintendent and no one else?
A That would -- now, I'm not saying other people aren't notified, but not by me.
Q Okay.
A My job is to notify or other mandated reporters to notify our superintendent.
And then I'm sure a number of people will be notified after that. But that's not my -- that's not my capacity either.
Q You're not the one that's supposed to make the actual hotline report to Little Rock?
A That's correct.
Q You're just supposed to tell the superintendent and then he decides whether something gets hot lined?
A I don't want to speak for him, what he does afterwards. But, yes, it's reported. That's our --
Q But you don't --
A -- (inaudible) superintendent.
Q You don't know what he does after you report it to him?
A That's right.
Q So you don't know if suspected maltreatment ever even ends up being officially reported to the hotline? You said you don't know what he does with it.

A I'm not sure who all he relays that -- I -- I'm certain he doesn't just keep it to himself. I'm sure he notifies the appropriate people.
Q But you're not made privy to what Mr. Gonyea does or doesn't do at that point?
A That's correct.
Q You're just assuming; right?
A That's correct.
Q And do you happen to know if that's in a written policy somewhere?
A I'm sure it is. I don't have that policy offhand. But I'd be comfortable saying that it was policy, yes.
Q Really? Okay.

MR. GILLISPIE: Take five minutes if you guys don't mind.

MR. COLLINS: Okay.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:
Q All right. Mr. Jobb, so just a couple more questions here.

So, one more time, you would agree with me that David's IPP that was in place at the time of his death did not contain anything about the use of physical

restraints or personal holds on the ground; correct?
A Correct.
Q Were you on the incident review committee for David's death?
A No.
Q Okay. Were you questioned by any investigators or anybody following his death?
A I don't recall. I don't recall that --
Q I know --
A -- specifically. Sorry, I don't.
Q I know Sandy Evans conducted the maltreatment investigation for the facility --
A If any --
Q -- did she speak to you?
A If anybody did, it was her. But I would just be guessing. She may have asked me some questions, but I don't recall.
Q Okay. Nothing you recall specifically?
A I -- I just know that she conducted that investigation.
Q I understand that David Cains was not in counseling or therapy and I don't think had been in quite some time.
Is that something that was ever considered or discussed and addressed in any way in the creation of his treatment plans?

A I recall that we -- we do have some pet therapy in place. And our psychology department would have to answer that.

He may have been a candidate for pet therapy, but I'm not certain.

Q Well, would Mr. Alvis be the right person to ask about that?

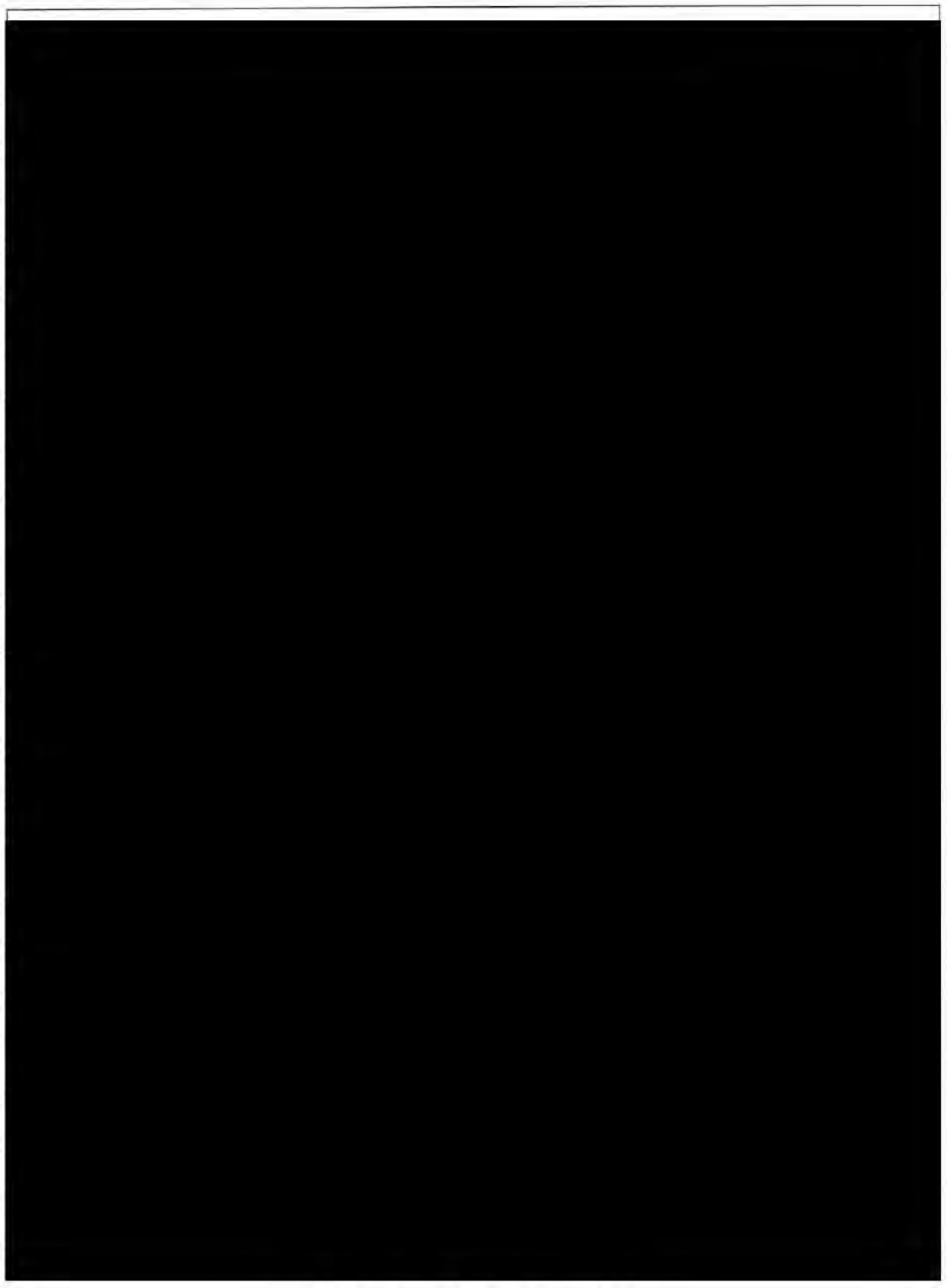
A Yes.

Q Okay. And he, Mr. Alvis, told me in his deposition that he didn't think David would be a good candidate for therapy, didn't think, you know, talk therapy or counseling, didn't think that it would be effective on him.

Do you recall ever discussing that with Mr. Alvis or anybody else during the planning of his treatment?

A I do not recall that.

[redacted]



[redacted]

Q So David had been at Booneville for 13 years. Is that an unusually long amount of time for a client to remain at the facility?

A No, that's not unusual. I mean, we are an intermediate facility.

But sometimes families are comfortable with their loved ones staying with us. And they ultimately had that decision of bringing them here, even if it's against the team recommendation.

So sometimes they're -- they're here for long periods of time. Sometimes it's short. It just varies.

Q Yeah. And, with David, was there ever a time that you recall where anybody on the team ever broached the suggestion that maybe he be transitioned into a less

restrictive environment in the community?
A Well, we bring it up at every meeting.
Q Yeah.
A But I don't remember specifically anyone wanting him to be transferred or -- I don't recall that, no. But we do have that discussion.
Q Do you discuss with the family what the, you know, what options would be for outside placement --
A I'm not --
Q -- meaning outside of the facility?
A I don't specifically. But our social services department does.
Q That's who would say, okay, hey, Charlene, if you want to move him out of here, these are some options, and he'd kind of go through with her?
A Yes, sir.
Q Okay. But you don't recall -- and that's Caleb Murray. You don't recall Caleb ever, you know, any specific back and forth or discussion on the matter between Caleb and David's family?
A During the meeting or prior?
Q Anytime.
A No, I don't recall that. No.
Q I'm just trying to find out, you know, was it ever an -- was it ever a realistic option for David to

transition to a less restrictive environment?
A Certainly.
Q I'm sorry?
A Yes, sir. It would be.
Q It was? Okay.
A Yes, sir.
Q And I understand that, as far as I know, you know, his mother and sister never, I don't think, ever specifically asked that he be moved, did they?
A No. They didn't ask me, no.
Q Okay.
A If you'd give me a moment, I want to look at my IPP.
Q Okay.
A Okay. You can look on Page 5. I don't know if you have my IPP in front of you.
Q Yeah.
A Okay. On Page 5, somewhere in the middle, it says, team transition plan --
Q Yeah.
A -- recommendation. That's where the so -- says Social Services Department did advise David, as well as his guardian, of the services available to him in Arkansas. That kind of -- so I documented that.
These are some -- Caleb, in this case, I believe he was the worker. He has a pre-IPP meeting with David or

any other individual we serve to ask some of those things.
Q Yeah.
A Now, if you look in the next --
Q In a community setting?
A Yes, sir.
Q Oh, and by --
MR. GILLISPIE: Hey, Cris, this was an exhibit. This is already an exhibit to Mr. Jobb's deposition. I think it's Exhibit 2, but this is the 2019 IPP.
BY MR. GILLISPIE:
Q But, yeah, in a community setting.
Go ahead, Justin.
A Well, that's just if -- you know, you were talk -- you were asking if -- if he would ever be feasible, or I can't remember what the word used, suitable for --
Q Yeah.
A -- going to another -- these were some of the things we would have to put in place.
He would have certainly needed 24-hour supervision --
Q Yeah, I see all this.
A -- environment. So, yes, I mean, there's like a group home setting. Even an apartment.

But he certainly could not have lived by himself. He would've needed appropriate supervision --

Q Yeah.

A -- so --

Q Well, and I see --

A -- (inaudible) -- go ahead.

Q I see where, you know, y'all did a good job of laying out what would be required.

He would need 24-hour supervision seven days a week, protected environment, semi-competitive employment, assistance with meal planning, meal preparation, budgeting, shopping, assistance with medical care and medications, assistance with transportation, attending and participating in activities and accessing community services. So, I mean, that's a pretty good description of the needs.

Are there places that exist that could have met those needs --

A Yes.

Q -- for somebody in David's condition?

A Yes.

Q Okay. And I'm not suggesting that that should have been done or shouldn't have been done. I'm honestly just trying to figure out whether the team thought that that was ever -- ever considered that a realistic possibility.

And, if so, why? And, if not, why not?
A Well, and that's just -- the thing is. . .
Q And, again, I'm not -- I'm not suggesting that you're wrong --
A Right.
Q -- in either way. I'm just asking if it --
A I just want to remind you that, at any point, if his mother or guardian requested that, she didn't have to wait for the meeting. She could --
Q Right.
A -- request it any day of the week. And that ball has to go in motion.

Doesn't mean he's going to get accepted somewhere else.
Q Right.
A But, certainly, our social services department would certainly assist in trying to find an appropriate place for him.
Q Okay. But she -- she would have the complete say on that.

The team would simply just make a recommendation. It's not a mandation. I think a lot of people get confused with that. We -- we make a lot of recommendations, but we don't make mandations.
Q Yeah. You told me before, you were clear that his

mom could have taken him out of there whenever she wanted. I get that.

And, as far as who would have explained what the possibilities were, the options for a different setting, that would have been the social services worker?

A Yeah. That would be Caleb Murray in this --

Q Okay.

A In this instance.

Q Okay. Okay.

I think you told me that you typically have about -- I think you said you typically have about 20 or 21 clients who you serve as Q for; is that right?

A Well, that number varies. I think the lowest I've had is probably around 20. And the most I've had is probably about 38. So it would be somewhere in between there.

Q Okay.

A That number changes all the time.

Q And approximately what percentage of your clients do you think have been at Booneville or stay there for longer than one year?

A Oh, it'd be a high percentage. I -- I can't -- I'd be guessing. But I would say it'd be a high percent.

Stay here more than one year?

Q Right.

A Yes.
Q Is that almost all of them?
A I would say pretty -- yes.
Q And what about more than five years?
A I'd -- I'd be speculating. I don't have those numbers in front of me.
Q Okay. Are you able to -- well, what would be your best -- I get that you're speculating, but -- and that, you know, I'm asking you to speculate, which is objectionable. But this is a deposition and not a courtroom.

So what would be your -- and I get that you're speculating, you don't have the numbers in front of you. But, you know, gun to head, best guess on how long the average client typically remains at Booneville, based on your experience?
A I would say we probably -- geez. I don't know how to answer that.

In my caseload, I'd say the majority of them stay probably more than five years.
Q Okay. Are there clients that stayed forever?

You know, in the event had David not died, you know, would it have been unusual for him to just live the rest of his life out there, you know, living to be --
A Well, it's --

Q -- 60, 70?
A It depends -- it depends on how medically fragile they get.
Q Uh-huh.
A We're not -- we can't -- we're not equipped for individuals to be in wheelchairs or on breathing machines and are tube fed, that sort of thing. So it just depends.
Q Uh-huh.
A Honestly, I'd -- I'd rather medical address that. But those are some of the things that we're not equipped for on this campus.

So, no, it's not a stay -- it's not a retirement facility.

Q Right. So, like I said, David had been there for over 13 years or about 13 years.

And you said it's not unusual for clients to be there for that length of time?

A It's -- it's not unusual. Because there's -- there's cases where sometimes individuals just seem happier or better behaved under our care and their -- their families become real comfortable and they want them to remain here.
Q Okay. All right.

And, over the last, let's just say the last year,

the last 12 months, how many of your clients have transitioned out of the BHDC?
A I would be guessing, but let me see. I don't have an exact number because a lot of -- several of my clients have moved to different areas on campus, so they're no longer on my caseload.
Q Can you specifically think of a single client who has transitioned into off of the campus into a less restrictive environment in the last 12 months?
A Give me a moment. I think -- I know we have one getting ready to transition. He's having his meeting today.
Q Okay.
A Yes, I can think of one.
Q Okay. Can you --
A I -- I can take another one. And I have one that's having his meeting today.
Q Okay.
A You actually got me out of that meeting so, (inaudible).
Q So -- okay.
A (Inaudible.)
Q So at least three over the last 12 months then?
A I would say so. And we do have -- I am guessing. I can think of -- now, that one might have been in the last

two years.

I can't remember exactly when he left, but I do remember him leaving, moved to the Fort Smith area. We have another one looking to go to Jonesboro.

Oh, I did have another one that ended up going to -- he got medically fragile and he went to a nursing home type facility.

Q Uh-huh.

A So, yeah, I -- I -- probably three or four, I'd say, in the last couple of years. I -- I am speculating.

Q Okay.

A But, yes, it does happen. And -- go ahead. It does happen.

Q Okay. Just writing something out real quick.

A Uh-huh.

Q Okay.

Let's see. We're going to make this -- do you see this document, behavior treatment program?

A Yes, sir.

Q All right. We already talked about this. This is the one that was in effect at time of his death.

It states that the program employs Category One procedures for David, as defined by DDS Behavior Management Policy 3011-D; correct?

A Yes, sir.

Q Okay. And that basic information would have been contained in the IPP you said; right?
A I believe it is, yes.
Q Okay.
MR. GILLISPIE: We'll make this Exhibit 4, Cris.
(WHEREUPON, the document was marked for identification as Exhibit No. 4 and is attached hereto.)
A I'm looking as we speak.
BY MR. GILLISPIE:
Q Okay. And then --
A Yes, that is. It's on Page 9.
Q Okay. Thank you very much.
All right. You see this one, this is policy 3011-D.
A Okay.
Q Is it showing up on your screen?
A Yes, sir.
Q Okay. Under behavior management --
A Okay.
Q Behavior management is covered by this policy, serves as a guide to ensure that individuals actions that are aggressive, disruptive, or present a danger to the individual or to others are managed with the least restrictive method. Did I read that accurately?

A Yes, sir.
Q Okay. And you would agree that BHDC is required to comply with this DDS policy, obviously; right?
A We are, yes.
Q Okay. And that that means that only the least restrictive method available can be used for a behavioral intervention; correct?
A That's correct.
Q Is that a yes?
A Yes, sir.
Q Okay. Thank you.
All right. You should see -- okay.

MR. GILLISPIE: And that last one there will be -- or 3011-D will be Exhibit 5, Cris.

(WHEREUPON, the document was marked for identification as Exhibit No. 5 and is attached hereto.)

BY MR. GILLISPIE:
Q Okay. And then I'm showing you here Booneville HDC policy I-D-4 documentation of and response to maladaptive behaviors. You see that?
A I do.

MR. GILLISPIE: Okay. And this will be Exhibit 6.

(WHEREUPON, the document was marked for

identification as Exhibit No. 6 and is attached hereto.)

BY MR. GILLISPIE:

Q So, down here on the bottom, so this Booneville policy reiterates that broader DDS policy.

But this says Paragraph 2, emergency use of restraint. Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors.

The use of emergency restraint will comply with all relative standards and regulations.

Do you agree that I read that correctly?

A Yes.

Q Would you agree that that is a BHDC policy?

A Yes.

Q Okay.

All right. Go to the last page here. Number six, approved restraint procedures, techniques and devices under A, personal restraint; an emergency procedure limiting movement by the holding of a hand or limb.

Do you see that?

A I do.

Q Okay. And you'd agree that this part of the policy defines what authorized personal restraint is for

Booneville; correct?
A Yes.
Q Okay.
MR. GILLISPIE: Make that Exhibit 6.
BY MR. GILLISPIE:
Q Okay. This will be -- okay.
You should be seeing Booneville HDC Policy, Roman numeral III-A -- yeah. Roman numeral III-A-8. You see that?
A I do.
Q All right. Qualified intellectual disability professional process. Are you familiar with this?
A Yes.
Q Okay.
Paragraph 2 states that the program coordinator/QIDP monitors the implementation of training objectives and the delivery of services for clients on their assigned caseload, as determined in each client's IPP.
They do on-site observations, in parentheses, tracking for each of their clients in the living areas and training areas at least once a month. They may also observe their clients in other areas.
Did I read that correctly?
A Yes, you did.
Q Okay. And you'd agree that that's an accurate or

that is, in fact, a BHDC policy describing what a QIDP -- or one of the things a QIDP does?

A That is accurate, yes.

Q Training objective, as used in this paragraph, what is that referring to?

A The training objectives is a variety of things. It could be personal care skills, domestic management, social skills, medication training.

Q But it's solely related to training given to the client as opposed to training given to the staff?

A That's correct. Yes.

Q Okay.

A Now, if you look in my IPP, starting on Page 18 all the way through 22, those are some examples of the training objectives that David was working on.

Q Okay. I got it. I got it. And I don't have any -- I don't see any need to really ask you about those or get into that.

But I just wanted to make sure that I was understanding this correct. I thought that's what it meant, but I just wanted to make sure.

Okay. Then it's next paragraph, program coordinator/QIDP also reviews monthly progress notes and other documentation relative to each client. And then they submit monthly plan reviews to summarize information

from their observations and their record reviews.
So these are submitted on monthly basis. Who are they submitted to?
A They are submitted to the QA director.
Q Quality Assurance Director?
A Yes, sir.
Q Okay. So, among the things that you would review monthly, would those include behavior incident reports and documentation on the times David was placed in restraints?
A No. That -- that would only be -- not necessarily that, no. That would -- mainly the things we're looking at is the objectives that I just laid forth.
Q Uh-huh.
A Also monitor his weight. I do --
Q So --
A I do monitor the amount of behavior reports that were written that particular month, but not always the specifics.
Q So you don't track -- you don't have to specifically cover the types of restraints and how often they were used in a given month?
A Well, there is -- if individuals are -- have mechanical restraints for three months in a row, then we would have to have a special team meeting.

So it's monitored. But, in his case, I think he only had one for the whole year.

Q Okay. Are mechanical restraints -- if David was given a mechanical restraint in a given month, is that information that you would be provided?

A Yes.

Q Okay. Would it be part of your monthly progress notes?

A It -- it could be. I mean, it's not required --

Q It doesn't have to be?

A No.

Q Okay.

Same questions; but, instead of mechanical restraints, personal restraints or physical restraints.

Let's just, you know, for a given month, let's say David's put in personal or physical restraints three times for that particular month. Are you required to document that in your monthly progress notes?

A It's -- it's optional. I mean --

Q It's optional?

A Yeah.

Q Is it something you would typically do?

A It depends on the individual.

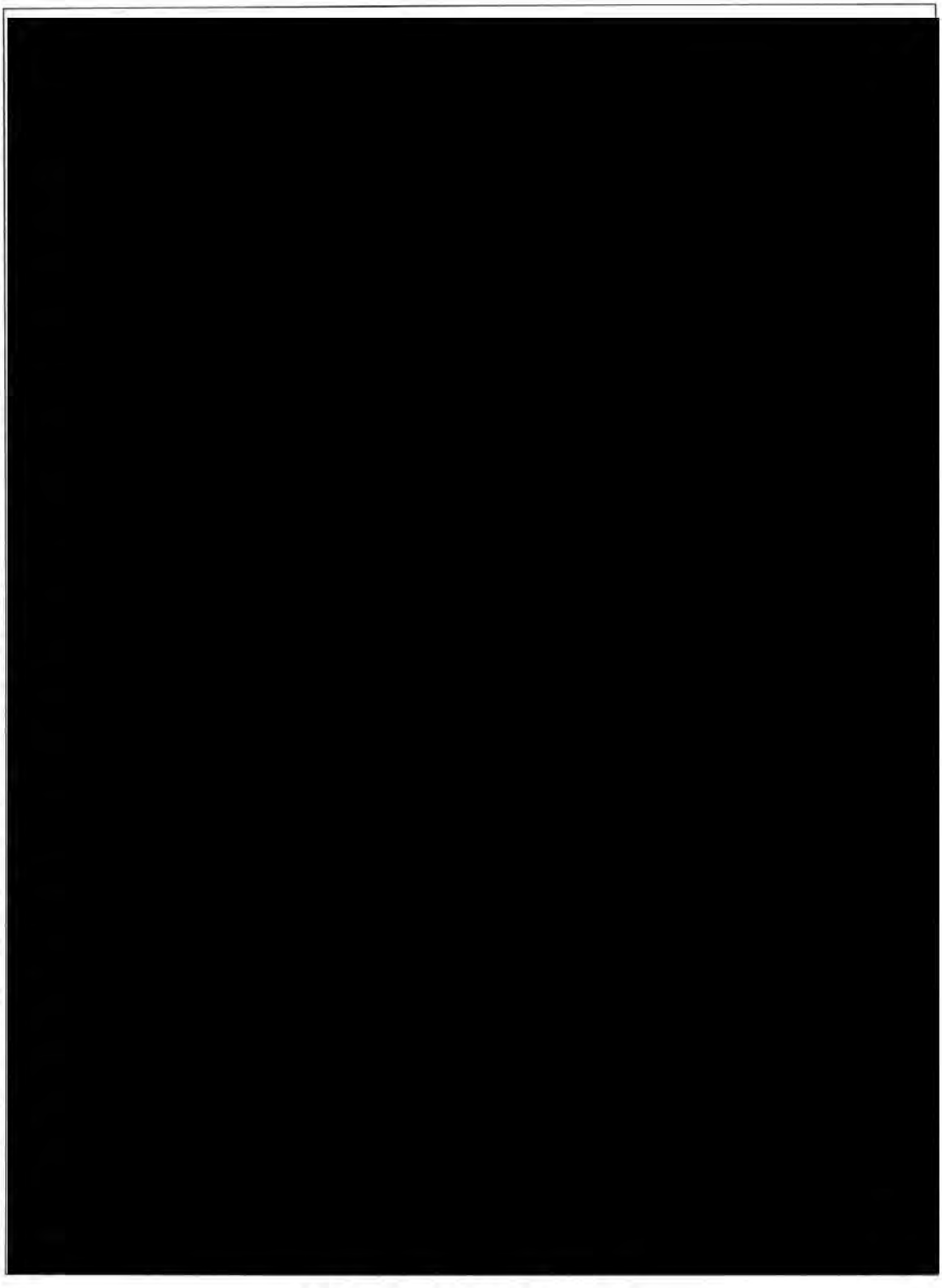
Q For David? David?

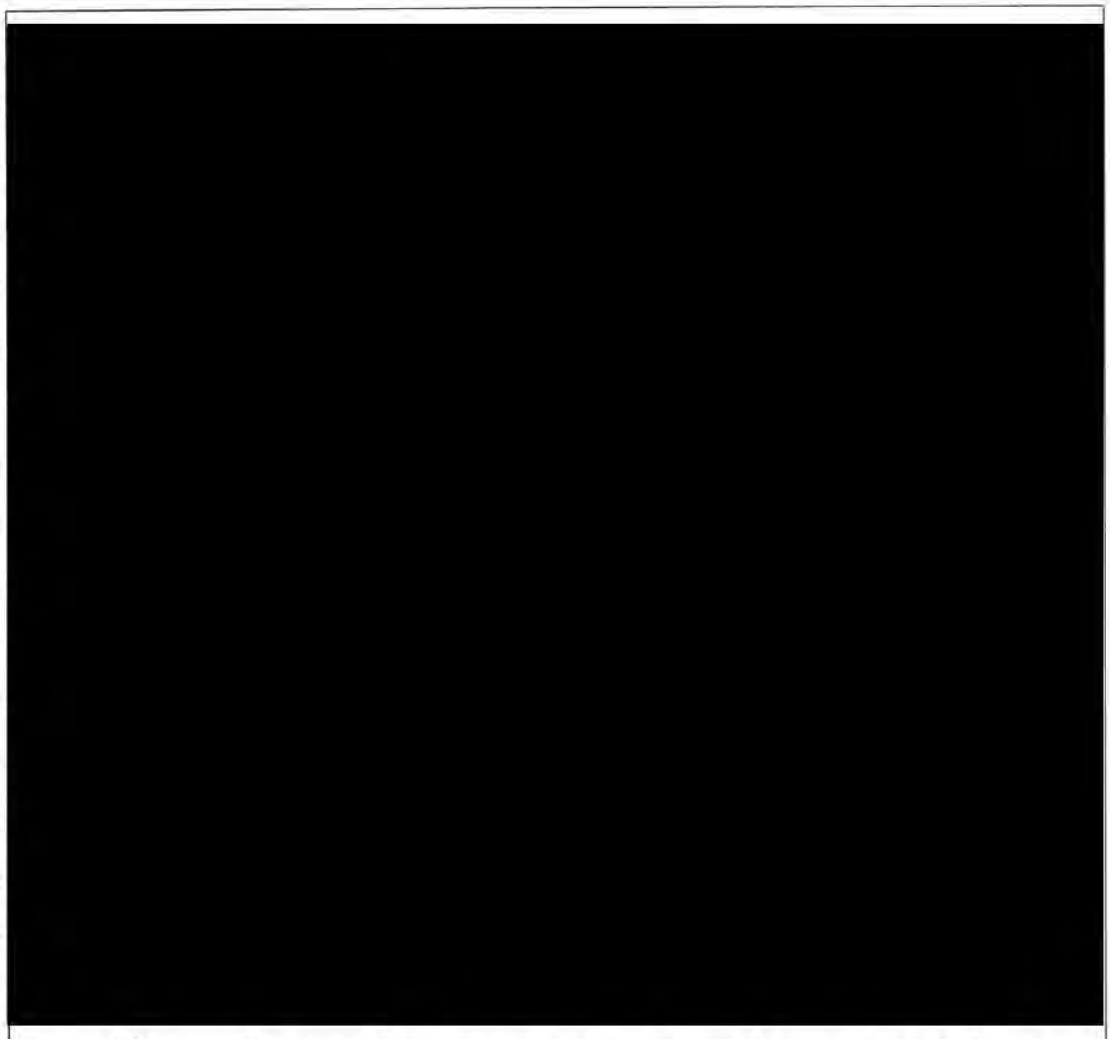
A I don't recall documenting his personals. I kept

track through --
Q Who --
A -- other methods.
Q Who does keep -- okay. What other methods did you use to keep track of that?
A Well, our central records department keeps good track of that and they're --
Q And how -- how does that work?
A Well, that's their job. But I just go and ask for numbers and they -- they give them to me.
So you'd have to ask them how they monitor that, but it's through quality assurance.
Q But a Q does not have to sign off on behavior reports?
A No.
Q And the Q is not even required to receive behavior reports?
A Well, they are -- they are posted on Share, on our computer, and you read them.
Q But they're not specifically meant for the Q?
A No.
Q Okay. So anybody that works there can --
A Yes.
Q -- access Share; right?
A Well, what they -- well, not everybody.

Q Sure.
A You have to have permission. But --
Q Yeah.
A -- the technique we do is we have a morning meeting.
And, actually, in my new capacity now, as a team leader, I read the behavior reports every morning, well, Monday through Friday, to a QA panel. And everybody does.
So we read them and we address anything as issues come up, so -- and I think that was also taking place at that time too. I just was not in that capacity at the time.
Q At the time of his death, when you were his Q, were you required to keep up with the number of restraints being used on David or keep up with any information relating to him being restrained?
A I -- just mechanicals, emergency mechanicals.

[redacted]





Q Okay. So quality assurance is -- keeps records on all restraints?
A Yes.
Q Okay. But those won't -- those aren't necessarily going to be in your monthly progress notes though?
A Only if I felt -- if it deemed necessary. I mean, if I felt it was pertinent information, but --
Q Okay. Was it --

A In his --
Q -- to be in there?
A In his case, we were seeing such an improvement. So I might even have included it for that reason, you know --
Q Okay.
A -- so -- we wanted to show progress.
Q Right.
A So there might have been an opportunity that I -- I may have mentioned that. I don't know.

But when you have that opportunity to -- it's not all negative. We want to show positive things, progressive things.

And he was actually doing well in that department.
Q Okay. Under 2, 2A, this -- the program coordinator QIDP functions as an advocate for the client by assuring he/she receives the maximum benefit of active treatment.

Did I read that correctly?
A Yes. Yes.
Q Okay. And so this is saying that you were David Cains' advocate at the time of his death tasked with assuring that he received the maximum benefit of his active treatment?
A Yes.
Q Okay. And you'd agree with that?

A Yes.
Q Okay.
The program coordinator/QIDP observes actual delivery of services by randomly visiting the living areas as well as the training areas, work areas each month to observe each client and his caseload.
These observations, along with any problems noted are documented by the monthly plan review.
Did I read that correctly?
A **Yes, you did.**
Q And would you do that on behalf of David? Randomly visit his living areas monthly?
A **Yes, I did.**
Q Okay. And so you're required to do that at least once a month; right?
A **Right. And it's documented.**
Q Okay. I'm sure it is.
A **(Inaudible) --**
Q I just want to make sure I understand what your role is.
A **Yes.**
Q So random visitation, you know, visiting him in the living area randomly.
And would you go to all those areas each on a monthly basis? So the living areas, his training areas,

and his work areas, you'd go to all three once a month?
A Yes. Well, his training area is his work area.
Q Okay. So you'd go to -- but you'd go to both of them once a month?
A Yes.
Q Okay. And did you ever have occasion to witness David being restrained in any way?
A I don't recall a specific time, no.
Q Okay.
A It's likely that I did. But I cannot -- I don't have a --
Q I'm assuming --
A -- date and time.
Q I'm assuming you never witnessed him being restrained on the ground.
A Right.
Q Okay. Had you observed -- you think, had you had walked in on a restraint incident, is that -- do you think you would have -- would that likely have made it to your monthly report?
A Oh, yeah. It would have, I'm sure.
Q Okay.
A It'd been up to me, but, you know --
Q Okay.
A -- if I happen to be -- because like you said, it's

once a month.

If I happened to be there and he was in restraints, I'd be kind of -- you know, because I usually document what -- you know, if they are well dressed, what they --

Q Uh-huh.

A -- were actually working on what they were doing.

Sometimes I'll even mention what movie they're watching in their bedroom. So if he -- it's very likely, if he was in any form of restraints, I would have included that, yes.

Q Uh-huh.

A But, a lot of times, I remember specifically with him, he'd be listening and dancing and singing to the Monkees --

Q Yeah.

A -- in his bedroom. So you'll probably see a lot of that in my progress notes, because that happened a lot.

Q I've seen a lot of mention of the Monkees everywhere.

A It was a big part of his life, yes.

Q Yeah.

And finally, G, the program coordinator/QIDP must guide the interdisciplinary team and assure that team decisions comply with established policies as well as ICF regulations; correct?

A Yes.
Q Okay.
MR. GILLISPIE: Will this be Exhibit 7, I think?
COURT REPORTER: Correct.
MR. GILLISPIE: Okay.
(WHEREUPON, the document was marked for identification as Exhibit No. 7 and is attached hereto.)
BY MR. GILLISPIE:
Q Can you hear me, sir?
A Yes, sir.
Q I lost you on the video there for a second. Okay.
Did you, at any point, ever or do you recall at any point, ever following up on behavior incidents requiring restraint on David Cains that you learned of?
And, when I say follow up, I mean, you know, have a conversation with the, for instance, the direct care staff involved in the restraint to find out, you know, kind of what happened, how it happened, you know, what could have been done differently, that sort of thing?
Or even their supervisor or the residential services director, do you recall ever specifically doing any follow-up of that nature?
A Not specifically. I do recall the, you know, having

[redacted]

And -- but I don't remember any specific conversations. But it is very common, because I do -- I'm in a position where I authorize restraints. And I don't just do them in the blind. I want to know what's going on.

Q Uh-huh.

A If I have the time, in many cases, I'll go on site to visit and just to make an observation. And then you can ask questions.

But I don't remember any specifics with Mr. Cains.

Q Uh-huh. Okay. Just a moment. There's, you know, hundreds of them. And I haven't isolated every single one of the behavior incident reports that you either signed off on or it's noted somewhere in there that it was reported to you as the Q.

But your name is mentioned on the document in several of them. I don't know how many, but in several of them.

And, again, these are restraints that -- incident reports for behavior incidents, oftentimes resulting in the use of different kinds of restraints.

And, you know, when you would have to -- am I saying

that right? That you would have to sign off, after the fact, sign off on the appropriateness of the use? Is that a correct characterization?

A Well, I would sign off that I authorized the restraints. That I was notified and that I authorized.

And then personal holds, anything over a minute has to be authorized.

Q Uh-huh.

A And then, in mechanic -- emergency mechanicals, it has to be reauthorized every 15 minutes.

So they would call me back and I would have to -- once I seen the document, it might be a day or two later, I'd have to go sign my name and initial (inaudible).

Q And what would you do before signing off on it? I mean, what kind of things would you need to know before you gave it your stamp of approval?

A Well, that I -- you know, I try to recall. Because, like I said, it's not always same day. So I want to make sure I was indeed the one that authorized it and try to recall that phone call --

Q Yeah.

A You know, it's so many of them. So sometimes they all mix together. But just want to make sure it's accurate.

And then, sometimes, we have to send back these

documents that -- requesting more information about the incident itself. Sometimes --
Q So --
A -- it's just too vague.
Q -- every time David would have been held in a personal restraint for longer than one minute, you're saying you would have had to been notified after that one minute?
A Yes.
Q Do you recall --
A Well me --
Q -- that ever happening?
A -- or somebody that can -- is in a position to authorize.
Q Sure.
A It's not -- you don't always -- sometimes I authorize clients that's not even on my caseload and vice versa. It's just --
Q Somebody at this level of seniority that's allowed to do that. Sure.
Do you recall that ever happening for you, where you had to authorize, you were asked to authorize a personal restraint that was beyond one minute for Cains? Do you have any specific recollection of that?
A I do not.

Q Okay.
A I'm probably certain it happened, but I --
Q Sure.
A -- do not.
Q Yeah. And it did. I just -- I didn't pull them all.

But would you inquire about what led to having to use the personal restraint? You know, would you question -- would you sort of -- I guess what I'm asking is, to what extent would you sort of conduct an audit of the event?

In other words, to what extent would you try to find out, okay, why did this happen, what could have been done, what could have been done differently to prevent the use of physical contact? What was the environment, what was the trigger that started the behavior?

You know, to what extent would you do things like that?

A Well, usually, the phone call I'd received would be from one of the program supervisors. And I would usually have a conversation with them about the incident; because they're privy to the incident and they might even been on site. It just depends.

But they could give me the clear picture; because, you know, it's something you can't take lightly. You

know, you're -- authorizing restraints is, you know, you have to take it very seriously and you want to make sure it's appropriate.

Q Right. Because the goal is not to have to lay hands on them, period?

A Right.

Q Right?

A Right. Well, you -- ideally, you'd like to verbally redirect.

Q Right. Right.

And so am I correct that part of the reason or part of your job, as the Q, would be to keep up, you know, try to determine if there's some common factor that is causing a behavior incident? And, if so, you know --

A Yes.

Q -- try to remove that factor? Things of that nature so that progress can be made?

A That's correct. And makes sure that behavior reports are accurate and --

Q Uh-huh.

A -- and documented accordingly. Because a lot of medical changes, medication changes, are made by viewing a lot of this documentation.

So that's essential, that they document as much and not be vague, give a real clear picture of what's going

on so you can try to determine the fact that -- common denominator.

Q Can you recall any time where you felt like a restraint could have been avoided on David?

A No. I don't recall.

Q Okay. Out of all of the ones that at least -- nothing comes to mind?

You can't think of a single time where you felt like maybe some other non physical de-escalation could have been attempted prior to the physical restraint?

A Are we talking about David specifically?

Q Yes.

A No, I do not recall.

Q Okay.

And how long were you his Q?

A I don't think we ever nailed that down.

Q Well, we know it was at least 2018 and 2019 and --

A I'll just say several years.

Q Okay.

A Several years.

Q Okay. So, out of all those years, there was not a single incident that caused you to be suspicious?

A No.

Q I mean, when I say incident, a single restraint incident that raised your eyebrows or gave you concern?

A Well, the thing -- no. And the thing is, a lot of times, it's a day or two after the fact or I get a phone call sometimes.

But I don't see the documentation for sometimes a couple of days later, you know, so --

Q Uh-huh. But same question then, as regard -- just no matter when you learned of it, was there any documentation that you saw a couple days later that caused you concern --

A No.

Q -- that you can think of?

A No.

Q No? Okay.

[redacted]

[redacted]

Q I'm familiar with all that.
A -- on that as well. We try to --
Q Okay.
A -- put those things in many places to --
Q Yeah.
A -- work.
Q Yeah.
A Not just (inaudible) staff, but sometimes you have staff that's working in from different areas. And we want to make sure that information is out there.
Q Yeah. Obviously, it's critical that every direct care staff, every RCT, be aware of a client's medical precautions; right?
A Yes, sir.
Q And I assume you'd also agree that it's critical that every RCT have a crystal clear understanding of the rules and the policies regarding physical restraints; correct?
A Yes.
Q And my last question, I think we basically are in agreement here, but I just want to make sure, because we kind of danced around it for a while. And it's my very last question here.

So I think we definitely agreed that staff development is -- with regards to physical restraints and

personal restraints, staff development is responsible for training the direct care staff in that, training the RCTs in that; correct?

A Correct.

Q And then it would mainly fall on the shoulders of the, I think you said, the direct care chain of command, all the way up to the residential services director to enforce those, that training, to ensure -- in other words, to ensure that the RCTs and other direct care staff are following the rules with regards to physical restraints; correct?

A Yes.

Q Yes?

A Yes.

Q Okay.

All right. Well, I thank you for your time.

A Thank you.

MR. GILLISPIE: You're on mute, Eric.

THE WITNESS: Good to go?

BY MR. GILLISPIE:

Q Hey, Mr. Jobb. Did you have any -- is there anything you need clarification on? Were there any questions you didn't understand?

A No. I think you did a good job.

Q Thank you. You did a good job too. I appreciate

you.

(Brief discussion off the record.)

MR. GILLISPIE: Go ahead.

MR. COLLINS: I was muted for some reason and it wasn't letting me unmute, so I had to reconnect real quick.

I only have two quick follow-up questions, Cris, if we could get those done real quick.

CROSS EXAMINATION

BY MR. COLLINS:

Q Justin, real quick, you reviewed the IPP and you guys discussed what the Category One procedures were on, I think you said, Page 9; is that correct?

A I believe -- let me double check, please. Page 9 of my IPP?

Q Yep. You referenced that as having Category One procedures?

A Yes.

Q I don't know if it's on that page or the next page. Sorry, I don't it in front of me --

A It's on Page 9.

Q Okay. Does that paragraph or that section also include emergency procedures? It may be on the next page.

A Let me see. Yes, it's on the next page.

Q Okay. And what emergency procedures are those referring to?
A Well, anything that constituted an emergency.
Q Okay. Does that include emergency restraints?
A Yes.
Q Okay.

MR. COLLINS: Okay. I have nothing further then.

MR. GILLISPIE: I don't have anything else.

THE WITNESS: Okay.

COURT REPORTER: All right. Thank you, guys.

MR. COLLINS: Thank you very much.

MR. GILLISPIE: Thanks.

(WHEREUPON, the proceedings were concluded in the matter at 1:53 p.m.)

* * * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Justin Jobb, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

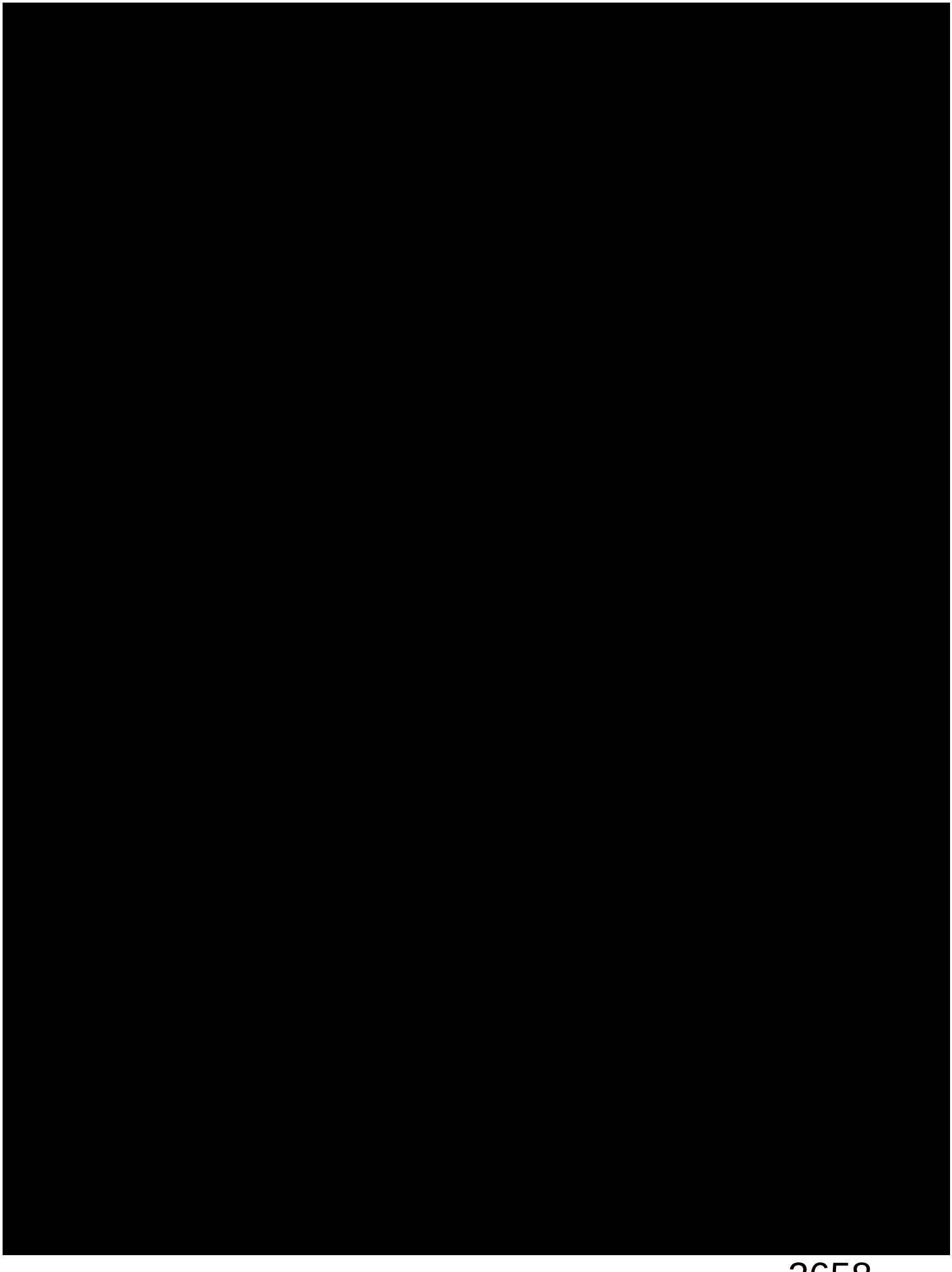
I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 26th day of May, 2022.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031



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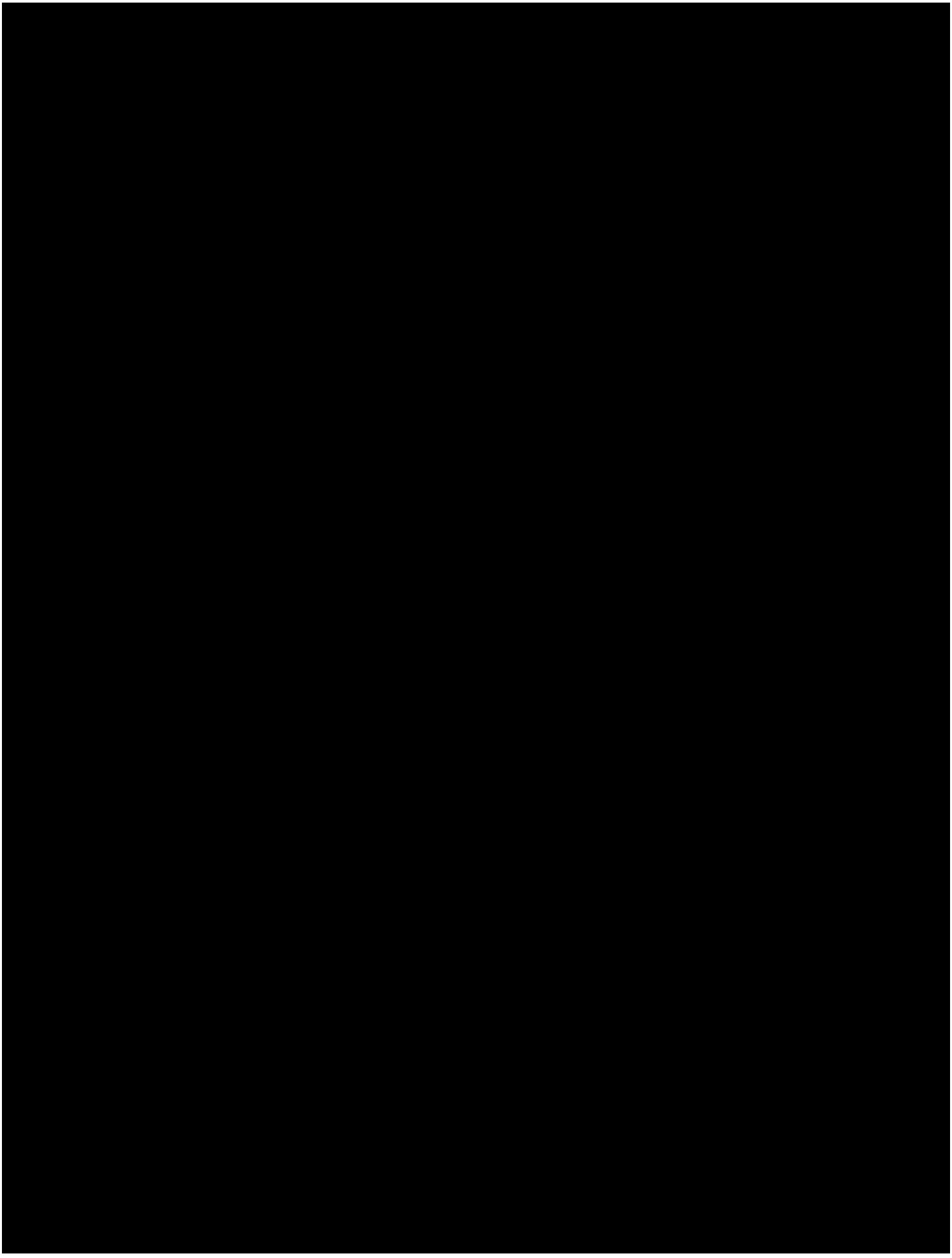

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ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

1. **Purpose**. This policy is intended to provide guidelines for managing challenging behaviors of individuals residing in DDS operated programs (Human Development Centers).

2. **Scope**. This policy applies to all DDS operated programs (Human Development Centers) and their employees/volunteers. All such programs will include a review of this policy as part of the employee orientation process.

3. **Definition of Terms**

Behavior management, as covered by this policy, serves as a guide to ensure that an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others are managed with the least restrictive method. Behavior management is not a substitute for other forms of active treatment and is incorporated into program plans, based on individual needs.

Qualified Mental Retardation Professional (QMRP) or QMRP designee is used in this policy as a person designated to monitor, supervise, and make decisions regarding specific behavioral situations. QMRP/designee will be assigned by the administrator of the DDS program in which he/she works. Criteria for selection will involve prior training, experience, and demonstrated ability in the area of behavioral management. The QMRP/designee must be in a position that is on a level involving supervisory or decision-making responsibilities. The QMRP designee is authorized to perform any of the duties of the QMRP as outlined by regulations or policy.

Interdisciplinary Team (IDT) is defined as a group of persons (professionals, paraprofessionals and non-professionals) who develop an individual's program plan and whose participation is required in order to identify the needs of the individual and to devise ways to meet those needs. The IDT includes the individual and may also include those persons who have worked or will work most closely with the individual, those persons who provide needed assessments or services, and the individual's family, guardian, or advocate. In general, the IDT includes persons professionally qualified in such fields as health care, education, psychology, and social work.

Licensed nurse is defined as a registered nurse or licensed practical nurse. The agency may use a physician, in lieu of a licensed nurse, but this is not required.

Replacement: This policy replaces DDS Commissioner's Policy 3011-D, dated January 28, 1981, March 13, 1981, and DDS Director's Policy dated October 1, 1991; December 1, 1993; and January 30, 1998.

Reviewed: Arkansas Legislative Council Rules and Regulations Subcommittee _____, 2003



ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

4. Policy

NOTE: It is the philosophy of the agency to utilize all positive approaches to behavior management prior to and in conjunction with more restrictive programmatic techniques. Positive approaches may include, but are not limited to: positive reinforcement, gentle teaching, redirection, graduated guidance, and modeling of appropriate behaviors. Measures to address positive behavior should be incorporated into formal program efforts to the extent feasible.

Efforts at positive programming prove to be successful with the majority of maladaptive behaviors. All Human Development Centers will maintain policies and procedures for positive programming. The use of behavioral programming other than positive is designed for the individuals who repetitively engage in dangerously aggressive behavior and for whom other interventions have not been effective. All behavior programs developed in accordance with this policy will be designed to reduce or eliminate the target behavior(s) within a specified time frame, will be supported by documentation that positive, less restrictive methods have been systematically attempted and failed, will be monitored regularly by the individual's QMRP and Interdisciplinary Team (IDT), and will be revised if proved to be ineffective. The potential harmful effects of each procedure will be weighed carefully against the harmful effects of the targeted behavior and the IDT will determine if the harmful effects of the behavior outweigh the potentially harmful effects of the procedure.

Category I:

Category I procedures are those which may be used without prior approval of the Human Rights Committee or psychology staff. To ensure consistency, they should be addressed by the IDT. Frequent use (as determined by IDT) of these procedures with an individual indicates the need for consideration of the development of a behavior plan by the individual's IDT.

The individual must be supervised during these procedures. With the exception of verbal intervention, any use of Category I procedures, whether part of a formal behavior program or not, requires documentation on a Behavior Incident Report, Data Sheet, or other locally used behavior documentation system.

A. Verbal Intervention: Verbal intervention is utilized to stop an inappropriate behavior in progress and involves telling the individual "no" or "stop", identifying the behavior, and redirecting to an appropriate activity. The command is given in a firm but normal tone of voice. Threats, screaming, yelling or issuing repetitive or multiple sets of commands are not considered verbal correction and are inappropriate.

B. Separation From Activity Up to 30 Minutes: The individual is prevented from engaging in a reinforcing activity in which he/she has displayed inappropriate behavior. Separation is maintained within the same room or outdoor area where the activity is conducted. This is considered a Category I procedure if compliance by the individual can be

accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

C. Separation From Setting Up to 30 Minutes: The individual is removed from the area where the reinforcing activity is taking place. Separation must occur under observation either outdoors or in a living or training area (bathrooms, storage rooms and closets do not constitute living/training area). This is considered a Category I procedure if compliance by the individual can be accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

Note: Separation to Allow Calming (STAC) – Also available is the positive procedure of STAC whereby the person is encouraged to move to an area away from the person or situation that upset them. At the same time, they are assisted in directing their attention to talking about the problem, listening to music, talking about family, relaxing quietly, going for a walk, etc. The activity should be chosen by the person in need of calming. When sufficiently calm, staff will assist the person in resuming normal activities.

D. Assignment of Additional Chores: The individual is assigned additional chores as a consequence for inappropriate behavior. Additional chores may be assigned only if such chores are already a part of the Individual Program Plan (IPP) and are not designed to replace work assignments of housekeeping personnel.

E. Restitution: The individual is cued to restore any property damaged, stolen or defaced. If appropriate to the individual's level of functioning, he/she may be cued to offer a verbal apology to the offended person. If appropriate to the individual's ability to comprehend, monetary reimbursement for the value of the damaged or stolen property may be required if this is a part of the IPP. In lieu of full value, a symbolic portion of the value may be required. Monetary reimbursement requires Human Rights Committee approval and Guardian consent.

Note: The individual is not degraded nor put on display while restoring damage. The individual is given the same equipment and protection to complete the restitution as would normally be given to a person not responsible for the damage.

F. Withholding Privileges: The individual loses a particular privilege following the occurrence of an inappropriate behavior. Privileges include such things as special planned community activities. However, trips off grounds are special and should only be curtailed if problem behavior is anticipated during that trip. Examples of situations where problem behaviors may be anticipated include a problem behavior having already occurred and the person is not fully calm, or, a problem behavior has not yet occurred, but there are indications that a problem behavior is likely. The curtailing of trips off grounds should be done after consultation with psychology staff, or with supervisory staff if psychology staff is not available. Privileges do not include basic living activities, such as meals, habilitation activities, or basic rights afforded all individuals.

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

G. Personal Property Removal (less than one hour): Removal of an individual's personal item that is being used in an inappropriate or unsafe manner or location. For example, if an individual disturbs others in a common TV room by playing his radio too loudly and will not reduce the volume when instructed, the radio may be removed from that individual for a time not to exceed one hour. The item will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate (See Section 6, *Page 8 of 9*).

Category II:

Category II procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian.

A. Response Cost: The individual loses reinforcers previously earned in a behavior management system, (i.e., Token Economy Program)

B. Overcorrection - includes the following procedures:
   1) Restitutional Overcorrection: Requires the individual to restore the environment to a state that is better than it was before the occurrence of the inappropriate behavior.

   2) Positive Practice Overcorrection: Requires the individual to engage in an intensive practice period in which the alternative appropriate behavior is practiced.

C. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or individual directly, as appropriate. This procedure is considered Category II if the individual voluntarily (without duress or coercion) surrenders the property upon request.

Category III:

Category III procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, other professionals, as indicated by the nature of the program, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian. The individual's record documents the IDT's conclusion that the potential harmful effects of each restrictive procedure (restraint, etc.) are clearly outweighed by the harmful effects of the targeted behavior.

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

A. Separation Time Out (Activity or Setting): Placement of an individual in a quiet area away from reinforcing activities or persons as a result of an inappropriate behavior occurring. The individual will be visually monitored during the time out. Further conditions include ***either:***

1) Separation lasting for over 30 minutes to one (1) hour maximum.

2) Separation (any length of time) requiring physical intervention/personal restraint to ensure compliance.

B. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate. This procedure is considered Category III if the individual does not voluntarily surrender the property upon request, and it must be physically removed.

C. Sensory Deprivation: Involves the temporary impeding of one of the individual's senses for a period of time, contingent upon the occurrence of the target behavior. Most often, this procedure includes only the use of a blindfold or cloth placed over the individual's eyes when it has been shown to facilitate calming. The individual must be visually supervised during the use of this procedure, which may be used in combination with other Category III procedures, as designated in the individual program. It could also include lessening auditory input by covering the individual's ears, or covering a body part (usually the hands) to limit tactile stimulation, hand in mouth, or biting.

D. Restraint: When utilizing restraint as a programmatic option, a hierarchy of lesser restrictive procedures will be attempted prior to restraint, except in limited cases where this is clearly clinically contraindicated. IDT consideration will be given to parent/guardian notification of the use of restraint and address it in the behavior program.

1) Personal Restraint: **In order to prevent personal injury or serious property damage**, the individual or a portion of an individual's body is immobilized by another person or persons in order to prevent personal injury or serious property damage. Approved methods of intervention must be in the individual's behavior program. This is planned personal restraint, contingent upon occurrence of a target behavior. When available, a licensed nurse should monitor the personal restraint and/or check the individual's physical condition as soon as possible following restraint.

Excluded as <u>personal restraint</u> are: physical assistance, prompting of graduated physical guidance to assist individuals during such procedures as toothbrushing and feeding, or to control random head or arm movements during such procedures

as haircutting, or the use of physical assistance in escorting, redirecting, or in manual guidance techniques are not considered personal restraint and do not require documentation as personal restraint. Also excluded as programmed personal restraint is the use of personal restraint in an emergency situation (Section 6, ***Page** 8 of 9*) or during a necessary medical or dental procedure.

In the event of personal restraint, the QMRP/designee of the area must be notified as soon as possible. Programmed personal restraint will occur until the individual is calm and will not exceed fifteen (15) minutes. The IDT will define what constitutes calm behavior for this individual when used in a behavior program.

2) Mechanical Restraint: **In order to prevent personal injury or serious property damage,** the individual or a portion of the individual's body is immobilized until calm by an approved device or devices which may also prevent normal functioning, as described in section C, above. Restraints must be checked for safety and integrity prior to use. The device's use will not exceed 15 minutes without an extension of time approved and documented by the QMRP/designee, preferably, after face-to-face attention. Unless otherwise determined by the IDT, QMRP/designee extensions will be obtained every 15 minutes until the individual is calm. The IDT should define what constitutes calm behavior for this individual when used in a behavior program. Unless determined clinically contraindicated by the QMRP/designee, should the time in restraint reach 55 minutes, the individual must be released for five minutes for motion, liquid intake, or toileting.

Should time in restraint reach 1 hour and 50 minutes, the individual must be released for at least 10 minutes–for motion, liquid intake, or toileting. If this 10-minute release is judged to be a danger to the individual and/others, additional staff should be called to ensure safety for all concerned. In addition, the individual will be checked, face to face, at least every 15 minutes for safety, well being, and integrity of the restraint. Constant observation is required.

Note: On-site monitoring by the QMRP/designee is recommended. When available, a licensed nurse should monitor the mechanical restraint. If unavailable to monitor, a licensed nurse shall check the individual's physical condition as soon as possible following restraint, but in no case later than thirty minutes after the initiation of the restraint.

Excluded as programmed mechanical restraint is the use of restraints in an emergency situation (Section 6, *Page 8 of 9*), during a necessary medical or dental procedure, or to promote healing following a medical procedure or injury. Devices such as a helmet which are not prescribed for the purpose of restricting an individual's movement and/or normal functioning, but rather for their safety and protection are not considered a mechanical restraint.

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Note: For medical management, please refer to local site Policy on drugs to manage behavior (Behavior Management/Psychiatric Interventions).

5. **Conditions for Use of Behavior Programs.**

A. A formal behavior program will be developed by the IDT, written by a licensed psychological professional, and approved by a psychologist. It will include the following elements:

1) Description of the behavior to be modified:
2) Functional Analysis:
3) Thorough description of each step of the program to include duration and intensity of specific procedures, the methods of monitoring and analyzing the process, and special precautions that will be taken:
4) Description of any alternatives to the specific procedures;

B. The Individual Program Plan or behavior program will include:
1) Description of all procedures already attempted:
2) Side effects and risks, if any, of the intervention, in comparison with those of allowing the maladaptive behavior to continue; and
3) Behavioral objectives.

C. Behavior Management Procedures should be used in order of least restrictive, unless clinically contraindicated. Exceptions to this order must be fully documented and substantiated as to why more restrictive procedures are advisable before less restrictive ones.

D. All persons administering Category II and III procedures must have been trained in the administration of those specific procedures and have personally experienced those particular procedures, unless medically contraindicated for that person.

E. The Human Rights Committee will review all Category II and III programs at least every 6 months.

F. IDT consideration will be given to seeking consultation from outside expertise when IDT staff resources have been exhausted, as evidenced by the use of Category III procedures for over one (1) year without significant progress. If an outside consultant has been used without success, the agency should continue to access this or other outside expertise until an effective strategy is realized.

An outside consultant is defined as a professional of any discipline and who is not a member of the IDT. For instance, the outside consultant may be a member of the HDC

staff not on the identified IDT, the agency staff, or a professional not affiliated with the agency.

6. **Emergency Procedures**. Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. This includes the use of restraint procedures in the course of an established program, when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy. However, it is emphasized that emergency procedures may not be used at frequent intervals, becoming a routine method of intervention. If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. The emergency use of restraint must conform to ICF/MR regulations and must be reported immediately to the facility administrator or designee.

7. **Prohibitions**: These activities are expressly prohibited.

   A. Corporal punishment - refers to the application of painful stimuli to the body as a penalty for certain behavior, and includes, but is not limited to, hitting, pinching, the use of electrical shock or other infliction of pain, whether or not applied as part of a systematic behavior intervention program.

   B. Individuals who receive services from the agency disciplining other individuals unless involved in an organized and approved self-governing program. Individuals will not participate in the actual administration of discipline.

   C. Seclusion of an individual alone in a room or other area from which entry/exit is prevented. This does not include placement in a time-out area for brief, programmed time segments, as part of a behavior program that meets all applicable standards.

   D. ***Unless specifically requested by family/guardian,*** any procedure that denies visitation or communication with family members.

   E. Any procedure that denies sleep, shelter, bedding, food, drink, or use of bathroom facilities.

   F. Inappropriate vocalizations, maltreatment, neglect, or forced exercise.

8. **Informed Consent**. The individual served and/or guardian, as appropriate, will be provided a copy of the behavior program which utilizes Category II and III procedures. Informed consent will be obtained PRIOR to the implementation of the program, with the following procedures:

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Service	Behavior Management	3011-D

A. Persons 18 years of age or older who have no legally appointed guardian may give informed consent for their behavior program. If there is a question about the individual's ability to give informed consent and no guardian can be located, appropriate legal action must be pursued to have someone appointed who can give consent.

B. Consent by the legal guardian(s) is required if guardianship has been established.

C. The legally adequate consent will:
1) Specify, in terms that are easily understood, the restrictive or intrusive procedure(s) involved;
2) Inform the person(s) giving consent of any potentially harmful effects of the procedure(s);
3) Be time-limited, not to exceed one year; and
4) State that consent may be withdrawn at any time.

9. **Uncategorized Procedures**. In the event a proposed procedure does not readily fit in one of the prescribed categories, it may be utilized on an emergency basis, if necessary, at the discretion of the administrator or designee until the appropriate category is determined.

NOTE: Behavior Management Policy 3011-D does not preclude the use of other restrictive/intrusive procedures that would prevent serious bodily harm and/or destruction of property or death. These procedures can only be considered when lesser restrictive procedures have been proven ineffective or their implementation are determined to be clinically contraindicated. Approvals required are the same as those for Category III procedures. Additional approvals may be required as deemed necessary by the facility administrator.

DOCUMENTATION OF AND RESPONSE TO MALADAPTIVE BEHAVIORS

POLICY STATEMENT: Maladaptive behaviors must be documented on a **Behavior Report (BR)**, a **Behavior Report Documenting Emergency Restraint** (also called the Restraint Log), or other authorized data keeping device. Personal or mechanical restraint for maladaptive behaviors is to be used only as an emergency measure. Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, or the destruction of property. Nothing in this policy removes or alters requirements as stated in other policies of verbal notification of incidents to the Superintendent and/or other staff.

PROCEDURES:

1. REQUIRED DOCUMENTATION

   a. When indicated, a **BR** must be completed following the maladaptive behavior. Incidents that are to be documented on the **BR** are the following:

      i. Behaviors that pose a threat to the physical or mental well being of the client or others.
      ii. Behaviors that have a direct negative impact on the client's programming.
      iii. Behaviors that directly contribute to the client remaining in a setting requiring a greater degree of supervision rather than a less restrictive one.
      iv. Target Behaviors identified by the Psychology Department and the Interdisciplinary Team.
      v. An incident requiring personal restraint (also requires notification of a QIDP). See Attachment #1.

   b. If the incident requires emergency mechanical restraint, a **Behavior Report Documenting Emergency Restraint** must be completed. Such behaviors are defined as those emergency situations in which behaviors may result in, or have the potential to result in, injury to self or others, or the destruction of property and cannot be controlled through the use of less restrictive measures.

   c. The rules of confidentiality will be followed when documenting these incidents. Any reference to a client other than the identified client in an incident report must be by initial only. Reference to other staff members involved will include their full name and title. All corrections must be made by a single line through the incorrect entry and the writer's initials. The **Behavior Report Documenting Emergency Restraint** must include the signature of the QIDP or other staff member authorizing the restraint.

2. EMERGENCY USE OF RESTRAINT

   a. Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors. The use of emergency restraint will comply with all relevant standards and regulations. Restraint

PLAINTIFF'S EXHIBIT 3

will not be used as punishment or for the convenience of staff in lieu of adequate programming.

b. Seclusion will not be used as either an emergency or programmatic procedure.

c. A QIDP must be notified when personal restraint is used and it must be documented on a **Behavior Report**.

d. Personal restraint of a client is used when the behavior is such that verbal control has been lost and other less restrictive measures have failed to control the behavior.

e. Personal restraint will be implemented by staff who have been trained in the use of approved methods. **Personal restraint must not exceed 10 minutes**. During the period of personal restraint if the client becomes calm no further restraint procedures are to be implemented. If the client shows no indication of calming and becomes violent, staff will proceed as indicated in Paragraph f. below.

f. The request for the emergency use of mechanical restraint will be based on need as exhibited by the client who is so aggressive that restraint is necessary to prevent imminent physical harm to themselves, others, or property. Mechanical restraint may be used only when all other means of controlling the behavior have been exhausted. Staff will proceed in the following manner:

   i. A Restraint Incident Leader will be identified. The attending staff will immediately implement emergency mechanical restraint. As soon as possible staff will notify the on duty Program Supervisor who will contact a QIDP or other authorized staff for authorization for the use of emergency mechanical restraint.
   ii. The authorization for the mechanical restraints must not exceed 15 minutes. Continued use of mechanical restraint must be re-authorized every 15 minutes.
   iii. Immediately after emergency mechanical restraint has been applied, staff must contact the nurse on duty. The nurse will examine the client to ensure the restraint is applied in a pain free and harmless manner and present no physical danger to the client. The nurse will make a notation of the examination on the **Behavior Report Documenting Emergency Restraint**.
   iv. A client in emergency mechanical restraint must be:

      1. Kept under constant visual observation. This observation will be for the client's physical condition (e.g., distressed breathing, bleeding, adequate blood flow to the head and extremities) as well as for signs of calming.
      2. Checked for security of restraint, current behavior and general status. A synopsis will be documented every 15 minutes.
      3. Released for 5 minutes every hour for motion and exercise.
      4. Given the opportunity for fluid intake, meals, baths and toileting. These needs will be addressed and documented as the need arises.

5. Released from emergency mechanical restraint as soon as possible. This is defined to mean as soon as the client is calm and no longer a danger to self or others. Verbal outbursts do not necessarily mean a person is still out of control or that restraint should continue.

v. After release from emergency mechanical restraint, using the **Restraint Incident Debriefing Form**, the Restraint Incident Leader will conduct and document a debriefing discussion with the other staff members involved in the restraint and the client that must include the following:

1. The behavior which resulted in the use of the personal or emergency mechanical restraint.
2. Any environmental factors involved in the incident.
3. The antecedents to the behavior including interactions with peers or staff
4. Any action by staff that might have kept the incident from escalating to restraint.
5. The client's reaction to the use of restraint.
6. Any changes to the client's programming which might have prevented the incident.
7. Options that the client could have used to avoid the use of restraint.

3. COMPLETION OF DOCUMENTATION

a. The person authorizing the use of emergency mechanical restraint must sign the authorization. During deviant hours authorization may be obtained by telephone. Attending staff will note on the **Behavior Report Documenting Emergency Restraint** that such authorization was obtained by telephone.

b. The on duty Program Supervisor will be responsible for ensuring that the appropriate reports are completed in a timely and accurate manner.

c. Completed **Behavior Report Documenting Emergency Restraint** and **Restraint Incident Debriefing Form** will be filed in the client's Master File "Behavior Incident File".

4. REVIEW AND DISTRIBUTION OF THE COMPLETED DOCUMENTS

a. Upon completion of the report it will be sent to the appropriate Team Office.

b. The Team Leader will review all reports for content, accuracy and appropriateness and sign in the appropriate place. If corrections are required the Team Leader will contact the writer of the report and ensure corrections are made. As soon as possible the report will be given to Quality Assurance to be scanned, copied, and distributed to appropriate staff. The original report will be sent to the Record Center Operator and filed in each client's file within five days.

c. The Record Center Operator will review **Behavior Report, Behavior Report Documenting Emergency Restraint**, and **Restraint Incident Debriefing Form** for completeness and errors. The originator will be notified to correct errors found by the Record Center Operator.

d. The QIDP and Psychology staff member will review copies of all reports for programmatic issues, patterns of use, and the appropriate follow-up.

e. The authorized data keeping device (i.e., **Behavior Report, Behavior Report Documenting Emergency Restraint**, and **Restraint Incident Debriefing Form**) will be forwarded to the Psychology Department depending on the program requirement.

5. FUNCTIONAL AND ENVIRONMENTAL ANALYSES OF BEHAVIORS

a. The purposes of conducting functional and environmental analyses are to determine:

1. The pragmatic utility of a behavior for a client, i.e., what the behavior "does" for the client.
2. What role the environment may have played in the causation of the behavior.

These analyses assume aberrant behavior does serve a functional purpose, but that a functionally equivalent (appropriate) communicative response can be taught, and will serve to substitute for the aberrant behavior. Further, the aberrant behavior will reduce in frequency as the more appropriate response becomes systematically reinforced.

b. These analyses will provide the data needed to formulate programmatic responses to teach and reinforce appropriate behaviors to replace aberrant behaviors and inappropriate behaviors.

6. APPROVED RESTRAINT PROCEDURES, TECHNIQUES, AND DEVICES

a. **Personal Restraint,** an emergency procedure limiting movement by the holding of a hand or limb.

b. **Chemical Intervention** ordered by the Physician.

c. **Protective Helmet**.

d. **Papoose Board**, a Mechanical Restraint device limiting movement and range of motion.

f. **Wrist Restraint**, a Mechanical Restraint device limiting movement and range of motion.

7. AT BHDC ONLY ICF/IID QUALIFIED QIDP's SHALL BE APPROVED TO AUTHORIZE THE USE OF RESTRAINT

The Program Coordinator/QIDP is the first choice person to authorize restraint for clients on their caseload. After hours and on weekends the Team Leaders or other qualified QIDPs may be notified.

The following positions are recognized as being qualified QIDPs:

Program Coordinators/QIDPS, Team Leaders, Director of Residential Services, Superintendent, Assistant Superintendent, Director of Quality Assurance; Chief Psychologist, Psychological Examiners, Registered Nurses, and Staff Physician.

Current work telephone numbers for these persons can be obtained from DHS/BHDC Share.

THE STAFF PHYSICIAN MUST REVIEW, BY SIGNATURE, THE USE OF ALL EMERGENCY MECHANICAL RESTRAINT.

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-D-4, dated 01/07/16, in its entirety.

QUALIFIED INTELLECTUAL DISABILITY PROFESSIONAL PROCESS

POLICY STATEMENT: Every client will have an assigned QIDP (Qualified Intellectual Disability Professional), as defined in ICF/ID Regulation 483.430. The Program Coordinator/QIDP has an assigned caseload. They are responsible for chairing the interdisciplinary team and completing Individual Program Plans for clients on their respective caseload.

The Program Coordinator/QIDP monitors the implementation of training objectives and the delivery of services for clients on their assigned caseloads, as determined in each client's IPP. They do on-site observations (tracking) for each of their clients in the living areas and training areas at least once a month. They may also observe their clients in other areas.

The Program Coordinator QIDP also reviews Monthly Progress Notes and other documentation relevant to each client. They submit Monthly Plan Reviews to summarize information from their observations and their record reviews. Monthly Plan Reviews document monthly observations tracking and are submitted on a monthly basis. The original Monthly Plan Reviews are filed in the client's master file.

PROCEDURES:

1. PROGRAM COORDINATOR/QIDP ASSIGNMENTS

   a. Each Program Coordinator/QIDP works with an assigned caseload or group of clients. A master list of Program Coordinator/QIDP caseload assignments is maintained on the secure drive.

   b. Each client is assigned a Program Coordinator/QIDP when he/she is admitted to BHDC. Changes in Program Coordinator/QIDP caseload assignments are generally made if a client moves to a different living area, but may be appropriate for other reasons. Team Leaders are responsible for making the caseload assignments.

2. DUTIES AND RESPONSIBILITIES OF PROGRAM COORDINATOR/QIDP

   a. The Program Coordinator/QIDP functions as advocate for the client by assuring he/she receives the maximum benefit of active treatment.

   b. The Program Coordinator/QIDP is chairman of the client's interdisciplinary team. As chairman he/she is responsible for scheduling and conducting 30-day reviews and annual reviews, and for conducting special meetings to discuss various problems or concerns that may occur throughout the year. IPPs are to be completed by the 15th working day after a given 30-day review or annual review. However, an additional requirement is that 30-day IPP's must be completed and distributed within 30 days after admission. Annual review IPP's must be completed and distributed within 365 days after the previous annual review and by the 15th working day following an annual review.

e. The Program Coordinator/QIDP observes actual delivery of services by randomly visiting the living areas, as well as the training areas or work areas each month to observe each client on his/her caseload. These observations, along with any problems noted, are documented on the Monthly Plan Review.

d. If a change of caseload assignment is made, the current Program Coordinator/QIDP completes the documentation for the current month and then forwards that client's file to the new Program Coordinator/QIDP. The majority of the file is available on the secure drive. File information includes the client's IPP and their activity schedule, as well as other information pertaining to that client.

e. The Program Coordinator/QIDP reviews Progress Notes and data posted on the secure drive, monitors progress on objectives, and works with service providers to make any necessary modifications in training objectives and service objectives.

f. The Program Coordinator/QIDP completes the Monthly Plan Reviews, as outlined in the BHDC policy. These reports include documentation of their monthly observations (tracking), follow-up, and/or other significant information. Monthly Plan Reviews for each client are to be completed monthly and are due by the 15th working day after the end of the month.

g. The Program Coordinator/QIDP must guide the interdisciplinary team and assure that team decisions comply with established policies, as well as ICF regulations.

3 INTERNAL REVIEW OF INDIVIDUAL PROGRAM PLANS

Every IPP will be reviewed by Residential Services managerial staff prior to publication/distribution. The reviewer will complete an IPP Proofing Sheet and will include any questions they have, or any corrections that are needed by the Program Coordinator/QIDP. The Program Coordinator/QIDP will make any necessary corrections, post the IPP to the secure drive, and send the original IPP to the master file. A copy with signatures is sent to Social Services for the guardian, with a request for guardian approval or input.

APPROVED: _____
Superintendent

Supersedes Policy III-A-8, dated 10/02/18, in its entirety.

BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE McAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS, CLAIMANT,	
VS.	CLAIM NO. 220374
THE ARKANSAS DEPARTMENT OF HUMAN SERVICES, RESPONDENTS.	

Arkansas
State Claims Commission
FEB 16 2023
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DEPOSITION

OF

DIAN ELLIOTT

---o---

MONDAY, JANUARY 23, 2023

---o---

COURT REPORTER:

DEBBYE L PETRE, CCR
P. O. Box 1027
Little Rock, Arkansas 72203

EXHIBIT
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tabbies

A P P E A R A N C E S:

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The deposition of Dian Elliott was taken before me, Debbye L. Petre, Certified Court Reporter within and for the County of Pulaski, State of Arkansas, duly commissioned and acting, on Monday, January 23, 2023, beginning at the hour of 11:35 a.m., at the Offices of Arkansas Department of Human Services, Seventh and Main Streets, Second Floor Library, Little Rock, Pulaski County, Arkansas.

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THEREUPON, the following proceedings were had, to-wit:

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P R O C E E D I N G S

* * * * * *

MR. ROSEN: Good morning. This is the deposition of Dian Elliott in the matter before the Arkansas Claims Commission of Christine McAuliffe, As Special Administrator of the Estate of David Cains, versus DHS, Claim Number 220374. This is set by agreement with counsel for today. And today is January 23rd, 2023 at approximately 11:35 a.m.

WHEREUPON,

DIAN ELLIOTT,

having been called for examination, and having been first duly sworn by the undersigned notary public, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. ROSEN:

Q Good morning. Please state your name.

A Dian Elliott.

Q And, Ms. Elliott, please spell your name.

A D-I-A-N E-L-L-I-O-T-T.

Q And, Ms. Elliott, are you employed?

A I am.

Q And for whom do you work?
A I work for the Department of Human Services, the Office of Long Term Care.
Q And what is the Office of Long Term Care?
A It is -- we regulate the -- like nursing homes, ICFs, PRTFs.
Q Okay. And as part of the Office of Long Term Care, what division are you in, what division of DHS?
A I believe they call it DMS, Division of Medical Services.
Q All right. Now, how long have you been with the Department of Human Services?
A Twelve years.
Q And do you hold any degrees?
A I do. I have an Associate degree in Medical Assisting, an Associate degree, RN, I do have a certificate as far as Legal Nurse Consulting.
Q Okay. And have you served in any nursing homes in any capacity?
A I have.
Q In what capacities?
A I have served as a certified nurse assistant and as a DON --
Q Okay.
A -- and as an RN.

Q So, we know what an RN is. What is a DON?
A Director of Nursing Services.
Q Okay. And are you familiar with Intermediate Care Facilities for Individuals with Intellectual Disabilities?
A I am.
Q You mentioned that Office of Long Term Care regulates. Do they regulate what I'm going to call ICF/IIDs, which are Intermediate Care Facilities for Individuals with Intellectual Disabilities?
A Yes. But actually, it's CMS who does -- we have to follow -- we go in and survey and make sure they are following their regulations.
Q Okay. And is that what you do?
A Yes.
Q Okay. And did you do that with the Booneville Human Development Center in Booneville, Arkansas on or about June of 2020?
A Yes.
Q And about how many surveys do you think that you have performed in your capacity as a surveyor with the Arkansas Department of Human Services?
A Probably close to 700.
Q And before you worked for the Arkansas Department of Human Services, Office of Long Term

Care, did you work for any other state as a surveyor?
A I did. I worked in Oklahoma.
Q And actually, when I say "state", you actually -- are you a state employee or a federal employee?
A I am a state employee. We are contracted -- the state is contracted through the CMS.
Q Okay. And CMS is the federal government?
A Yes. Centers for Medicare and Medicaid.
Q And before you are allowed to survey, do you have to meet any qualifications or tests or go through any training whatsoever?
A Yes. You have to be what is SMQT certified, which is the State Minimum Qualification Testing. And that is put out by CMS.
Q Okay. And so, is this a national test?
A Yes.
Q Okay. And do you also receive -- do you receive training in any particular category or nursing home, or long term care facility?
A Yes. You do -- you have to be certified as far as the nursing home, and then you have to be certified to be able to survey in the ICF/IIDs.
Q You mentioned survey, and I have mentioned survey. What is a survey?
A That's where you -- you go in and you do regular

reviews and observations and interviews and -- just to make sure that they are following all of the regulations.

Q So, it's a compliance issue?

A Yes.

Q Is it, for lack of a better word, an inspection of some sort?

A Yes.

Q Now, how long have you been certified by CMS, you call them the SMQT, Surveyor Minimum Qualification Training certification?

A Since 2001.

Q How long have you been trained by -- are you trained by CMS for ICF/IIDs, as well?

A Yes.

Q And how long have you been trained for that one?

A Since 2011.

Q And this training by CMS, is this classroom, is it a test? What is it? Can you just give us a few words on that?

A When I did my training, it was a -- I had to go to Mississippi. CMS actually put on the training, and then we also went into the field. After that was over, then you have to have a certain amount of going into the field under supervision in order to finish

your certification.
Q Okay. So, you are watched by a more experienced surveyor?
A Yes.
Q And how many types of surveys for ICF/IIDs are there?
A There is just the annual surveys, which is the recertifications, and then there are complaint surveys.
Q And in each survey, what are you looking for?
A Once again, to make sure that they have done everything that they were -- the facility is doing what they are supposed to do, following all of the regulations.
Q Okay. And the regulations are -- what are the regulations called?
A Appendix Q -- or Appendix J, rather.
Q Appendix J. And that's the State Operations Manual?
A Yes. I'm sorry. Yes.
Q And that's for what type of facility?
A This one is for the ICFs.
Q Okay. And so, you are there -- and that's what you do for -- do you survey all types of facilities or just the ICF/IIDs?

A I do the ICF/IIDs, and then also we do PRTFs.
Q Okay. Well, we are going to concentrate on the ICF/IIDs.
A Okay.
Q So, how many of those do you think that you have done over the past in your -- since 2001, or at least since 2011 when you were certified in ICF/IIDs?
A Probably 400 or 500.
Q Okay. And so, an annual survey kind of speaks for itself. I assume it's done once a year?
A Yes.
Q And what is a complaint survey?
A That is where either the facility has reported that something has happened, or if a family or anonymous caller comes in and says -- you know, complains about something regarding the facility, then we go out and we investigate it.
Q And when you investigate it, you investigate and apply what standards?
A I'm not sure --
Q When you investigate, I assume that there is a factual investigation and you apply it to --
MR. GILLISPIE: Object to the form, leading.
MR. ROSEN: Let me reword it.

BY MR. ROSEN:
Q When you go out to the facility, I think you had said earlier, you are looking for compliance?
A Yes.
Q Compliance with what?
A The CMS regulations.
Q And that would be Appendix J?
A Yes.
Q And so, during the course of your -- well, tell me what a complaint investigation would consist of, who would you talk to and what would you do?
A When we first go in, it's depending on what the complaint is about. If it's something that needs to -- like observations, if it is something that, say, the staff are doing wrong, or there is something wrong with the building, or something like that, once we enter and let the administrator know that we are there, we will immediately go out and make observations.
Q Okay. So, basically you come in there and you speak to the administrator first?
A Yes.
Q Or whoever is in charge?
A Yes. To let them know we are on his campus.
Q Okay. And then, you said you make observations?

A (Indicated yes.)
Q What else do you do?
A We would do record reviews and we interview any people that we think are relative to the complaint.
Q Okay.
A And that can include the residents themselves.
Q And so, you would also look at, I think you said a record review. What records would you look at?
A We would look at their medical records, we would look at anything that would have to do with the complaint, we would look at what they call the master record, which is basically their care plan type things, and then we also would look at medical records. We would -- if it's something that is like hospital or something, we would also read the hospital records.
Q Okay. And if the complaint was self-reported and not reported by somebody else, would that -- what does that mean, actually, to you?
A Really, I mean, even if it's something that is self-reported, I would investigate it the same way.
Q Okay. All right. And the purpose of the investigation is to determine compliance?
A Yes.
Q And then, when you leave the facility when you

are done with your investigation, what, if anything, happens?

A Once we are done with the investigation, then it's just a matter of writing up the reports and the 2567, which is --

Q What is a 2567?

A A Statement of Deficiencies, if there is any.

Q So, in a 2567, what are the possible outcomes?

A Well, it could be unsubstantiated, it could be -- or the complaint could be substantiated or unsubstantiated.

Q Let's talk about those terms.

A Okay.

Q What does "unsubstantiated" mean?

A "Unsubstantiated" means that the event could have happened but at the time of the event and how the facility responded there was not any deficient practices that were identified.

Q Okay. And what does "substantiated" mean, then?

A It means that the way the facility responded or what happened, that the event happened and that there were -- they were not in compliance with the federal regulations.

Q And again, that's Appendix J?

A Yes.

Q All right. And so, the form that you use, that is called a 2567?
A Yes.
Q Now, I'm going to ask you -- I'm going to show you a document, see if you recognize this document.
A (Witness reviews document.)
Q And if so, what is it?
A This is the 2567 that the facilities get sent.
Q I'm sorry. What?

MR. GILLISPIE: I'm sorry. What? I'm sorry. I didn't understand.

THE WITNESS: Oh, that's all right. This is a copy of the 2567 which the facilities get sent, either from annual or complaint surveys, expressing our findings.

BY MR. ROSEN:
Q Okay. So, this is a -- what is the date that this survey was completed?
A 6-30-20.
Q Okay. And have you seen this before?
A I saw the back page.
Q Do you know what this is a survey of?
A Yes. This is -- we did an infection control survey for COVID, and this is also a complaint survey.

Q And the complaints are identified on the back page; correct?
A Yes.
Q So, that's what you were talking about you have seen before?
A Yes. This page, yes. (Indicating.)
Q So, did you do the survey?
A I did.
Q And so, there are three complaints there. All three are what -- what is the outcome of all three of them?
A They were unsubstantiated.
Q Okay. Now, do you know which ones -- let me ask it this way. What if any of these complaint numbers on here were related to David Cains?
A 26043.
Q I don't see a 26 -- oh, I see.
A On the very last one, yes.
Q Okay. So, that was David Cains?
A Yes.
Q Were any of the other ones, or were they unrelated to David Cains?
A They are unrelated.
Q Now, you were looking at something when you said that. What were you looking at?

A This is a complaint investigation report that we complete.
Q Okay. So, let's mark the 2567 as DHS Exhibit One.
(WHEREUPON, DHS Exhibit Number One was marked for identification.)
BY MR. ROSEN:
Q So, this doesn't mention David Cains on it, does it?
A No, it doesn't have any names.
Q Would a 2567 ever have names on it?
A No.
Q And in this case, whatever you were investigating on that day with regard to David Cains, was there compliance with the CMS State Operations Manual, Appendix J, or was there noncompliance found?
MR. GILLISPIE: Objection. Objection, lack of foundation.
BY MR. ROSEN:
Q Well, let me ask you this. Office of Long Term, do you determine whether there were any deficiencies found based upon your investigation?
A Yes.
Q And what was the outcome of that determination?
A That there was no deficient practices.

Q Okay. And that's what unsubstantiated says?
A Yes.
Q And I understand this happened a long time ago.
A A long time ago, yes.
Q Okay. But you also have -- I'm going to show you a document and ask if you can identify this?
A (Witness reviews document.)
MR. ROSEN: And we are going to mark that document as Exhibit Two.
(WHEREUPON, DHS Exhibit Number Two was marked for identification.)
THE WITNESS: Yes. This is my Complaint Investigation Report.
BY MR. ROSEN:
Q And tell me -- walk us through this document. What is the date of this?
A 6-30-20. Well, actually, 6-30-20 is the date that I did the complaint. And so, I typed -- actually completed the report on 7-1-20.
Q Okay. And so, this is for the Booneville Human Development Center; correct?
A Yes.
Q And it has the exit date and time, which was what?
A 6-30-20 at 3:07 p.m.

Q And is that the time you finished your investigation and left that day?
A Yes.
MR. GILLISPIE: Objection, leading.
BY MR. ROSEN:
Q What was the time that you finished your investigation that day?
A 3:07 p.m.
Q And you have here, it says "Resident/Client's Identifier Number: Number Three". What does that mean?
A That when we do a complaint or an annual, we have a client list, which would be client number one, number two, and number three. And so, he evidently was number three.
Q Okay. And in going to the second page of Exhibit Number Two, under Section 4, it lists "Records Reviews". Do you see that?
A Yes.
Q And did you review all those documents?
A I did.
Q And were there any interviews conducted?
A There was.
Q Okay. Do you recall who you interviewed?
A I interviewed three of the staff members, I

believe they called them RCTs, three of them that was involved in the incident, and then also an LPN who responded to the incident.

Q Actually, that's noted on page three, isn't it, in the middle, Staff Interviews, number three?

A Yes.

MR. GILLISPIE: Objection, leading.

BY MR. ROSEN:

Q And under Staff Interviews, item number three, what is marked as who you interviewed -- what types of people you interviewed?

A One LPN and then three RCTs.

Q Okay. And do you have -- do you recall -- well, strike that question.

And so, in Section 5 on page three of Exhibit Number Two, it states "Guidance". Do you see that section?

A I do.

Q And it says -- what box is marked?

A Regulations.

Q And then, there are some letters and numbers. What are those?

A Those are the regulations that I looked at that we have concerning this investigation.

Q Okay. And so, the first one is W127. Is that a

regulation?
A It is.
Q And is that a reference to the State Operations Manual?
MR. GILLISPIE: Objection, leading.
BY MR. ROSEN:
Q What is it a reference to?
A It is the federal regulations in Appendix J.
Q I'm going to show you a document. (Indicating.) It's a rather thick document. Have you seen that before?
A I have.
Q What does it say it is?
A It says "State Operations Manual, Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities".
Q So, these are the standards we discussed earlier; right?
A Yes.
Q Now, just to kind of -- so, you looked at section -- what section did you first look at?
A I looked at Regulation 127.
Q Okay. And so, there are a lot of regulations in this manual; correct?
A Yes, sir.

Q So, you are looking for certain things that are relevant to what?
A To the investigation.
Q Okay. To what the complaint was?
A Yes.
Q And so, in this instance, with regard to David Cains, the first one you mention here is W127?
A Yes.
Q So, in the State Operations Manual, Appendix J -- can you turn to 127?
A (Witness complies.) Yes.
Q You might want to mark the pages so we can come back to it.
A Okay.
Q And so, that's the first -- and what is 127?
A "To ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment."
Q Okay. And so, that was what you were determining in your investigation as to whether the facility, Booneville Human Development Center, complied with?
A Yes.
Q And what did you find?
A I found they were in compliance with this

regulation.
Q And what about -- you also stated -- the next one is what, what section?
A W128.
Q Okay. And W128 says what?
A "Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints."
Q Okay. And so, you know that during the course of this incident with regard to David Cains that you were investigating there was a restraint utilized; correct?
A Yes.
Q Now, under this and from Office of Long Term Care policy, are restraints allowed?
A Yes.
Q Okay. So, you are checking to see if it was an unnecessary physical restraint. Is that what this is about?
A Yes.
MR. GILLISPIE: Objection, leading.
BY MR. ROSEN:
Q What were you looking for in this 128?
A To make sure that there was adequate reason to

apply physical restraint.
Q Okay. With regard to this particular regulation, W128, what was your determination as to whether the facility complied?
A They were in compliance with this regulation.
Q So, the next one is W153; correct?
A Yes.
Q Okay. And what does 153 require?
A (Witness reviews document.)
Q Actually, it might be out of order.
A Okay. 153 is the notification of the administrator.
Q Okay. So, what does that require?
A Administrator -- any kind of incidents that happen, the administrator is to be notified immediately.
Q So, this would be that there was an incident with David Cains and whether --
MR. GILLISPIE: Objection, leading.
BY MR. ROSEN:
Q Okay. In relation to David Cains, what would compliance with W153 provide?
A To make sure that the necessary -- that the required notifications were made.
Q Okay. And what about W154?

A That is, "The facility must have evidence that all alleged violations are thoroughly investigated."
Q And were you able to determine whether the facility itself investigated?
A Yes.
Q And how do you know that?
A I looked at their investigative report.
Q And did that include anything? What was in the investigative report?
A That includes what they -- the incident that happened, who was involved, when it happened. Also, it would -- it includes what the facility did to immediately protect any of the clients, any of the other clients that may have been in the facility and also that client. It also, they look and make sure that their staff and the facility -- well, that the facility actually -- that the staff responded correctly and that the facility was in compliance with the regulations.
Q All right. Now, the next one is?
A 285.
Q W285. If you would turn to that, please.
A (Witness complies.)
Q Are you there?
A Yes.

Q And what does W285 provide, generally?
A Okay. It is to make sure that everything was done correctly to try to ensure that there was no harm to the client.
Q Okay. And so, harm sometimes arises, does it not? It's just whether that the -- to ensure that it was not inappropriate?
MR. GILLISPIE: Objection, leading.
BY MR. ROSEN:
Q What, if any -- let's re-word it a little bit. So, under W285, interventions are allowed to manage inappropriate client activity; correct?
A Yes.
Q And behaviors; correct?
A Yes.
Q And they have to be employed with sufficient safeguards --
MR. GILLISPIE: Objection, leading.
BY MR. ROSEN:
Q -- are they not?
MR. GILLISPIE: Objection, leading.
BY MR. ROSEN:
Q Well, what does it say?
A It says, "Interventions to manage inappropriate client behavior must be employed with sufficient

safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected."

Q And so, were you able to -- based upon your investigation, observations, and interviews, were you able to determine whether there was compliance with that section?

A I was.

Q Okay. Was there?

A Yes.

Q The next section is W286. And what is that?

A No intervention was -- physical restraint cannot be applied for disciplinary actions.

Q Okay. During the course of your investigation with regard to the complaint with regard to the death of David Cains, were you able to determine whether the physical restraint applied prior to the incident was for disciplinary purposes?

A It was not.

Q What was it for?

A It was a safety for the client and for the staff.

Q And so, were you able to determine whether the facility complied, based upon your investigation and your interviews and observations and review, with

W286?
A They were.
Q Okay. They were compliant?
A Yes.
Q And so, the last one is W331. Let's turn to that one.
A (Witness complies.)
Q And what is the requirement there?
A "The facility must provide clients with nursing services in accordance with their needs."
Q And were you able to ascertain whether the Booneville Human Development Center provided David Cains services in accordance with his needs?
A Yes.
Q And was that based upon your investigation?
A Yes.
Q And what, if anything -- as a result of your investigation, what if any determination did you make as to whether the facility complied with W331?
A I determined that they were in compliance with it.
Q And so, those determinations are reflected on DHS Exhibit One, are they not?
A Yes.
Q And that's the 2567?

A Yes.

MR. ROSEN: I have no other questions. Thank you.

MR. GILLISPIE: Let's take a five minute break.

(WHEREUPON, a break was taken.)

MR. ROSEN: We're back on the record.

CROSS EXAMINATION

BY MR. GILLISPIE:

Q Okay. Ms. Elliott, my name is Josh Gillispie. And I'm just going to ask you some questions here today about this case. You testified earlier that you are employed by the Arkansas Department of Human Services; is that correct?

A Yes.

Q Okay. Are you from Arkansas originally?

A No. Are you talking about where I was born or --

Q How long have you lived in Arkansas?

A Oh, gosh. Well, I lived in Arkansas from the time that I was in third grade until I was like 24 or so, and then I moved to Tulsa, and then I have been back to Arkansas for 12 years.

Q Okay. Do you have family in Arkansas?

A I do.

Q Do your children live in Arkansas?
A No.
Q What part of Arkansas do you currently live in?
A Paris.
Q Okay. Is that -- how far is that from Booneville?
A It's approximately maybe 20, 25 miles.
Q Okay.
A It takes about 30 minutes to drive it.
Q Okay. What documents did you look at prior to today's deposition?
A I looked at my notes, I looked at a copy of the 2567, and I looked at the complaint report, and I also looked at the client's IPP.
Q Okay. Tell me about your notes that you reviewed.
A (No response.)
Q You said you looked at your notes?
A Yes.
Q What are those?
A It's just where I document who I interviewed, what they said, what I see.
Q Okay. Do you have those with you here today?
A No.
Q Are those handwritten notes?

A Yes.
Q Were those produced, or provided to the Office of Long Term Care or to the department?
A I'm not sure I understand. When we finish our investigation, everything goes on -- goes into a U-drive, and that's where --
Q Including your handwritten notes?
A Yes.
Q Okay. Because I have not seen those. That's why I was curious about those. But you have reviewed those handwritten notes to prepare for today?
A Yes.
Q And did that allow you to refresh your memory about the death of Mr. Cains?
A About what I -- it helped refresh my memory on what I had done during that investigation on that, yes.
Q Okay. Fair enough. And how many days did your investigation take place?
A As far as being at the facility, one day.
Q One day. Do you know approximately how long you were at the facility that day?
A From 8:40 in the morning until 3:07 in the evening.
Q Okay. And that was the only time that you spent

at the facility in regards to Mr. Cains?
A Yes.
Q All right. And did you speak with Mr. Rosen prior to this deposition?
THE WITNESS: Is that you?
(Indicating.)
MR. ROSEN: That's me.
THE WITNESS: Oh, yes.
BY MR. GILLISPIE:
Q And what did you discuss with Mr. Rosen?
A Just basically what he asked me during the first part of this. It was what I did, my qualifications, asked me where I had -- you know, he asked me about the State Operations Manual. And basically, that was about it, I think.
Q Did he provide you with any documents to review?
A No.
Q Exhibit "A", which I believe was the 2567 report, are you there?
A Yes, sir.
Q And is that your signature there at the bottom?
A No.
Q Okay. Whose signature is that?
A That's the superintendent of the facility.
Q Okay. And is that supposed to be where the

superintendent signs?
A Yes. I'm pretty sure, yes.
Q Why does the superintendent sign there, and not you?
A I don't know. I don't know the answer to that. This is not something that I produce.
Q Okay.
A This is something the office produces after I do my investigation.
Q Oh, okay. And on the second page of this document, it shows three separate complaints that were all unsubstantiated; correct?
A Yes.
Q And which one of these involved the death of David Cains?
A I believe it was the 26 -- yes, 26043.
Q And is that the only complaint related to David Cains?
A As far as I can recall.
Q Is there any reason that there would have been more than one complaint related to this same incident that you would have investigated?
A Well, yes. The facility could have -- when they sent in their report on what happened, and then if somebody else, another person had called in, such as

like family or a staff member or somebody like that --
Q Okay.
A -- they would have taken those as two different complaints.
Q Complaint 26043, how was that complaint initiated? Meaning was it initiated by the facility itself or was it initiated by a third-party complainant, such as a family member as you described?
A I don't recall.
Q I believe Exhibit Two --
A Okay. I'm sorry. Go ahead.
Q Oh, no. Go ahead. Did you have something to say?
A I was just going to say that it looks like APS might have called in a complaint or something. I don't know.
Q Okay. What are you looking at?
A On page three.
Q Of what document?
A Of Exhibit Two.
Q Okay. Page three of Exhibit Two.
A Oh, never mind. I was wrong.
Q Okay.

A I was reading something that was not -- it looks like it may have called the complaint. So, it looks like somebody must have called it in.
Q So, we are looking -- again, we are looking at page three of the Complaint Investigation Report --
A Yes.
Q -- for complaint number 26043; correct?
A Yes.
Q And the -- go ahead and have some water.
A I have allergies, and they like to hit at the wrong time.

MR. ROSEN: If you want to take a break, that's okay, for one minute.

(WHEREUPON, a break was taken.)

MR. ROSEN: All right. Let's go back on the record.

BY MR. GILLISPIE:
Q Okay. So, we were looking at page three of the Complaint Investigation Report for complaint number 26043, and you were looking at number two. So, I will take you to that number two where it says "Resident/Client/Resident Representative/Family Interviews". And then, it says, "How many were interviewed that were named in the complaint intake?" And what did you indicate there?

A One.
Q What does that mean?
A That somebody was named in it and I interviewed them.
Q Okay. Who?
A I don't remember. And it may just -- I'm thinking -- because I remember doing the staff.
Q I don't believe you ever spoke with David's mother or sister, did you?
A Evidently, I talked -- I don't know. Whoever called in the complaint, I evidently talked to them, but I don't remember who that was, and we do not name them. But, no, I don't recall talking to them.
Q Okay. I wasn't aware that you had if you had. So, I just wanted to make sure that you don't have some memory of speaking to --
A Not that I recall, no.
Q You cannot recall speaking to David's -- any members of David's family?
A No.
Q And obviously you couldn't have spoken with David, either?
A No, sir.
Q All right. So, given that it wasn't a family member and it wasn't David, what would you -- who

would you assume that it was?
A It was maybe somebody who was named in the complaint.
Q Who typically -- who are named in the complaints?
A Usually, it is like the client or the staff that was involved.
Q Okay.
A I have no idea.
MR. ROSEN: I just want to look at the document itself.
THE WITNESS: (Complies.)
BY MR. GILLISPIE:
Q Ms. Elliott, have you ever spoken with a Doctor Theodore Kastner?
A No, not that I recall.
Q Other than this document that we are talking about here, this Complaint Investigation Report, complaint number 26043, do you know of any other documents or written materials of any kind pertaining to -- well, I'm sorry. Withdraw that.
Other than this document, Complaint Investigation Report 26043, and other than the 2567, and other than your handwritten notes, do you know of any other documents or written materials that would

pertain to your involvement in the Cains' case?
A Are you talking about during my investigation what I would have looked at?
Q I'm talking about any other documents that would have been produced as a result of your investigation?
A Oh, as a result, no.
Q Okay. I'm not talking about the documents that you have reviewed from the facility --
A Okay.
Q -- in doing your investigation.
A Okay.
Q I'm talking about do you know of any other documents that would have been produced as a result of your investigation other than Complaint Investigation Report 26043, perhaps your handwritten notes, and perhaps this 2567?
A No.
Q Okay. Going back to the Exhibit Two, which is this, (Indicating), I want to take you to the first page of this, under Section 2, Allegation of Noncompliance Categories. And what category is listed here?
A "Quality of Care/Treatment".
Q Okay. What are other categories of noncompliance? What are some other ones that --

MR. ROSEN: Hold on a second. I have a different document.

MR. GILLISPIE: Okay.

MR. ROSEN: Do you want to go off the record for a second?

(WHEREUPON, a discussion was held off the record.)

MR. GILLISPIE: So, Exhibit Two is not complaint 26043, then.

MR. ROSEN: Say that again.

MR. GREEN: Yes, it is.

THE WITNESS: Yeah, it is.

MR. GREEN: That's what he just handed her.

MR. ROSEN: Okay.

MR. GREEN: I think he is making that Exhibit Number Three.

MR. ROSEN: I will. Do you want me to do that now or do you want to just wait?

MR. GREEN: Let him make that Exhibit Three.

MR. GILLISPIE: Yes, it's fine.

MR. ROSEN: Okay.

MR. GILLISPIE: So, you are going to make complaint 25996 Exhibit Three?

MR. ROSEN: Yes, I will. I'm going to ask you to identify this. And I know we are out of order.

MR. GILLISPIE: That's fine. Go ahead.

MR. ROSEN: Make it easier. Do you see that document?

THE WITNESS: Yes.

MR. ROSEN: And what is that?

THE WITNESS: That is a Complaint Investigation Report.

MR. ROSEN: For what complaint number?

THE WITNESS: 25996.

MR. ROSEN: So, going back. So, there were two complaints related to David Cains; right?

THE WITNESS: Evidently, yes.

MR. ROSEN: All right. We will move to introduce it now. I will turn it back over to Mr. Gillispie.

(WHEREUPON, DHS Exhibit Number Three was marked for identification.)

BY MR. GILLISPIE:

Q So, looking at Exhibit Two, Ms. Elliott, which is complaint number 26043, Allegation of Noncompliance Categories, this one states "Quality of

Care/Treatment"; is that correct?
A Yes.
Q Well, first of all, what does Quality of Care/Treatment encompass? What does that category of noncompliance encompass?
A It would encompass client care, nursing services, basically, yes.
Q Okay. Anything more specific than that, perhaps?
A I'm not sure what you are -- I'm not sure of the question. I mean, it has to do with -- quality of care would have to do with client care, that would be such as personal care --
Q Okay.
A -- and things like that. Nursing services would be like --
Q Treatment?
A -- treatment, doctors, following doctors' orders, that sort of thing.
Q So, the treatment part of this category would pertain to medical treatment received from doctors or nurses or that sort of thing?
A It could, yes.
Q Okay. Anything else that the treatment part would typically pertain to as a noncompliance

category?
A It could also include how the staff in the facility treat the clients.
Q Okay.
A Physically, mentally, socially, that sort of thing, yes.
Q Okay. So, things like abuse would fall under quality of care and treatment?
A It could, yes.
Q Okay.
A It could.
Q What do you mean, it could?
A There is also a category that we use that is specifically abuse and neglect.
Q Oh, okay. So, there is a specific category for abuse and neglect?
A Yes.
Q But that was not one of the categories that was used for this complaint?
A I would say "no".
Q Well, do you see any other categories listed here other than Quality of Care/Treatment?
A No.
Q So, the only category for this complaint was quality of care and treatment; correct?

A Yes.
Q But there is also a separate noncompliance category for abuse and neglect?
A Yes.
Q And would unnecessary restraints fall under abuse and neglect?
A It could.
Q Okay. Why do you say it could?
A Because there could also be a category that could list as restraints.
Q So, there is also a specific noncompliance category for restraints?
A Yes.
Q Okay. And do you know why restraints -- the noncompliance categories such as restraint or abuse and neglect were not categories that you looked at for noncompliance in this case?
A No.
Q Okay.
A But it would all come under -- it would come under that, I mean. It could encompass a lot of things. And I don't make the categories that they are listed under.
Q But you choose which -- meaning you don't create the categories as options; right? You don't come up

with what category -- the list -- I'm assuming there is a list of different categories; right?
A I'm sure there is.
Q And you don't come up with that list?
A No.
Q But you choose which categories to focus on in these complaint investigations when you do your investigation; right?
A I do not say that the category has to be quality of care or treatment. Whatever the complaint is, I will investigate whatever it is. If it could have been that there possibly could have been some abuse or something, I would have investigated that, also. So I don't just stick with these categories. This is just something that the office lists them under.
Q So, somebody else wrote this category -- somebody else helped you write this document?
A No, nobody else helped me write the document.
Q You are the one that would have written, "Quality of Care/Treatment" here under categories?
A No. Well, I type it in there, but it is off of a complaint report that the office generated. They chose the category. I did not choose the category that is listed there.
Q Would that suggest that there was no complaint

related to restraint usage?
A No, that's not what that suggests. What it is, is that they put it underneath that category. When I investigate it, I look at the whole complaint. And because it had to do with a restraint, I also looked at that, also.
Q Okay. And what did the complaint say? What was the substance of the complaint in this case, of complaint 26043? Because I have not gotten to see that complaint.
A I believe that it was that he got up from the dining room table and went to the bathroom and started -- and had physical aggression, and they put him in a physical hold, and then he passed away, that he died.
Q Okay.
A I believe. You are asking me two and a half years ago, you know. I believe that that is not word for word what it was. But looking at what I have done, that's --
Q Do you know what kind of physical restraint and/or hold was being used when he died?
A Well, when he died, he was not in a restraint.
Q Okay. Tell me what your -- tell me what your knowledge is about that.

A That he had been restrained. He was restrained on his either left or right side, and then during, you know, that he vomited. They turned him loose and sat him up, [redacted]

Q And do you know what kind of physical hold or physical restraint was being used on him around this time that he died?

A I'm not sure how to answer that question. I know that it was just a hold to keep him from hurting himself.

Q And I'm just asking if you --

A Like I said, he was on -- from documentation, they had him on his side. (Indicating.)

Q Okay.

A So, I was not there to actually look at exactly what they did. And there is really not a name for it. I know that they use the techniques of CPI, which is Crisis Prevention Intervention.

Q All right. Let's turn to the next page of the same exhibit.

MR. ROSEN: What exhibit are you on?

MR. GILLISPIE: Still Two, which is complaint 26043.

MR. GREEN: I'm not sure she is on the right one, Charlie.

MR. GILLISPIE: Let me look. Yes. You are on the right one. I'm sorry. My partner thought maybe you were on the wrong one.

MR. GREEN: I'm sorry, I couldn't keep it straight over here.

BY MR. GILLISPIE:

Q Under Section 3, Opening Remarks, kind of the fourth bullet point, "How many residents or clients were chosen for the sample?" You marked one here.

A Uh-huh. (Indicated yes.)

Q Explain to me what that passage means.

A I'm not sure I understand.

Q Do you see the question that says, "How many residents or clients were chosen for the sample?"

A Yes.

Q And you marked one?

A Yes.

Q What client was chosen?

A David -- was his last name Cains? Yes, David

Cains.
Q So, that's just indicating David Cains is the one?
A Yes.
Q Okay. And then, the sixth bullet point, third box, you marked that the, "Complaint was done in conjunction with additional complaints, 52772, 25772." Do those additional complaints also pertain to David Cains?
A I don't know.
Q Typically, what would you list here? How do you define -- withdraw that.
How do you define when a complaint is done in conjunction with another complaint? What does that mean?
A It just means that I had not one, but maybe two or three different complaints.
Q Okay. So, this would mean that on this same day, June 30th of 2020, you investigated at least two other complaints in addition to David's?
A Yes.
Q All in that same day; right?
A Yes.
Q From 8:40 a.m. to, I believe you said --
A If I'm not mistaken, I believe that -- I don't

know that. Never mind.
Q Do you want to --
A I can't recall whether there -- you know, if they were also something that had to do with him or what. So, yes, it's possible that I investigated those others. I did investigate those two complaints, also.
Q Okay.
A Because that's the reason they are listed there.
Q Okay. Going back to Exhibit One, page two, where it lists -- again, this is the 2567. It lists three complaints that were unsubstantiated, 26043, the one that we are discussing now, 25996, which we know also involved David Cains, and then 25772.
A I may have typed one of those wrong, typed it in there wrong or something. I don't know. I can't answer what the other one was. I don't know.
Q Do you have any reason to suspect that either 52772 or 25772 as listed on page two of Exhibit Two were David Cains-related?
A I can't make speculation of that. I don't know.
Q When you reviewed your notes in preparation for today, did you come across these complaint numbers?
A No. Complaint numbers wouldn't have been written on there.

Q Okay. And other than your notes, what did you review for today?
A Just my notes and his IPP, which was his program -- individual program.
Q Okay. Did you review the complaints themselves?
A No.
Q Do you have access to those complaints?
A I could, if I -- yes, if -- somebody would have to pull them up for me and print them off.
Q But the bottom line is, you did as many as three -- according to this, at least, according to Section 3 that we are talking about, you did three investigations that same day?
A Yes.
Q At least one of which was involving David Cains?
A Yes.
Q Section 4 of Exhibit Two, you marked records that you reviewed?
A (Indicated yes.)
Q And I'm going to read off the ones that you marked. "Ambulance Records, Clinical Record, Facility In-Service Records, Facility Investigative Reports, Hospital Records, Incident Records or Critical Incident Reports, Nurses Notes, Personnel Records/Background Check, et cetera, Physician

Orders, Physician Progress Notes, Roster Matrix/Resident, Client Census, Staff Training," and then also you marked his "IPP and Speech/Language Evaluation". Did I read that correctly?

A Yes.

Q All right. So, that means that that's -- so, that's everything that you would have reviewed as far as records for purposes of this investigation?

A Yes.

Q And over to the next page. Up at the top, "Was the complainant notified?" You marked "Yes". And under that, "Were they interviewed for further details?" You also marked "Yes". So, who would the complainant have been that you are referring to here?

A I don't know. I can't remember. It could have been APS, it could have been -- I don't know. It could have been the staff that called it in. I have no idea.

Q And then, under that, it gives a date and time for when the complainant was notified; right?

A Yes.

Q And so, you notified the complainant on June 30th, the day you were there, at 11:06 a.m.?

A Yes.

Q Okay. What would you have been notifying them

of?
A We just come in and I tell them who I am, and I'm with the Office of Long Term Care, and that I am investigating the complaint.
Q That's what you would say to the facility; right?
A No. That's what I say to the people that I call.
Q Okay. I see.
A Whoever the complainant was, that they -- if they want us to notify them when we are doing the investigation, then that's who I call.
Q You call them. And this would have been about halfway through your day there at the facility on June 30th. And tell me, again, what you would have said?
A I would have introduced myself and let them know that I was at Booneville HDC to work to investigate their complaint.
Q Okay.
A Then, you know, if they volunteer some more -- you know, if they have any more information, they usually tell me.
Q And again, as you sit here today, you have no idea who you would have been notifying that day?

A I have no idea.
Q And that's not in your notes, that's not anywhere?
A No.
Q And below that, "How many were interviewed that were named in the complaint," again you put one. Is it still your testimony that you have no knowledge of who that person was that was involved in the complaint that you also interviewed?
A I have no idea.
Q That's not anywhere in your notes?
A Because that would have been staff.
Q Okay.
A Now it might have been family interviewed. It could have been that I interviewed -- maybe that's who the complainant was, and I put one, when I notified them and talked to them. It's possible.
Q So, it's possible it was a staff member?
A No. It's possible that it could have been the family member or whoever it was, APS, the family member, the staff member, whoever it was who called in the complaint is who I could have put that I talked to and note -- and put that number one there.
Q So, if APS had been the one that made the complaint, they could have been the one -- they would

have been considered a named party to the complaint?
A They would not have been involved in the complaint -- I mean, in the incident that happened. I mean, I'm not sure what that one is. I'm speculating. So, I do not know.
Q Well, maybe this -- I just noticed that the heading here at number two, it actually says "Resident(s)/Client/Resident Representative/Family Interviews". So, that forecloses on the idea that it would have been anyone other than someone from -- that one was either the resident, the client, resident representative, or family interview. Given that, does that allow you to surmise who it might have been?
A I have no idea who it was.
Q You would agree, though, that it must have been somebody from one of these four categories?
A Yes.
Q And that those categories are resident, client, resident representative, and family?
A Yes.
Q Okay. And then, Staff Interviews below that. This indicates you spoke with one LPN; is that right?
A Yes.
Q And do you know who that LPN was?

A I don't remember her name, no.
Q That wasn't in your notes?
A It could have been, but I don't remember the name. I know that she was involved in the incident.
Q Okay.
A She was one of the nurses that responded.
Q Okay. Fair enough. Tell me about your notes. What do your notes consist of?
A It's just my observations, interviews, documentation of maybe records that I looked at, like client's records, what I would have found in the client record or something. Yes. Anybody that I would have interviewed or something like that.
Q In reviewing your notes, does anything stick out to you as particularly relevant to this case that you wanted to tell one of us?
A Just that as far as the staff was concerned, they responded the way they needed to. It showed, even, that they were not able to -- they tried, were

[redacted]

what is the word? But when he vomited, when he got into a serious situation, the staff and facility, they all responded the way it needed to respond.

Q Okay. And you base that off of your -- the documents that we have already gone over that you reviewed in --
A The documents that I reviewed, and as my experience and expertise of being an RN for over 32 years.
Q And the interviews that you did with staff, you interviewed three RCTs?
A Yes.
Q Were those the three RCTs involved in the restraint?
A Yes.
Q So, other than the one LPN and the three RCTs, you did not conduct interviews with any other employees of the Booneville facility?
A No.
Q Under Section 5, Complaint Investigation Guidance, Regulations, and Mr. Rosen took you through these, the federal regulation tag numbers 127, 128, 153, 154, 285, 286, and 331, those were the specific CMS regulations that you looked at as part of your investigation; correct?
A Yes.
Q You did not use any other CMS regulations, other than what is listed here; correct?

A I can't really say -- no, that would probably not be correct, because I kind of -- I encompass all of the regulations that are in Appendix J, that those were specific ones to this complaint. So, I would have looked at --

Q Let me ask it this way.

A I would have thought of all of the regulations.

Q Let me ask it this way. Other than these that you have listed on page three of Exhibit Two, were there any other regulations that, as you said, you felt specifically related to the incident with David Cains that you were surveying?

A No. These would have been the specific regulations that I was looking at. There could have been others. I'm not sure. But as far as the ones specific to the complaint, I would have -- those are the ones that I really, I guess, concentrated on.

Q If there had been another one that you concentrated on, certainly, you would have listed that; right?

A I should have, yes.

Q Okay. These staff interviews that you did, did you do those in person?

A Yes.

Q All right. Would those have been one-on-one

interviews?
A Yes.
Q Any recollection about -- as to how long your interview with each of those staff members might have taken?
A No.
Q Moving on to the final page of this exhibit. This is a continuation of Section 5. And again, Section 5 is Complaint Investigation Guidance. And then, "A" is Guidance, which we just discussed as being the federal regulation tag. But section 5B is Care Areas/CE Pathways. Did I read that correctly?
A Yes.
Q What are CE Pathways?
A Critical elements that -- that is more to do with the nursing home side. We both use these forms.
Q And what are Care Areas?
A Care Areas are just as it says here, different areas that have to do with client care.
Q Okay. And for purposes of this investigation, which client care areas were part of your survey?
A The abuse, neglect, and restraints.
Q Okay. And again, tell me what this means, Care Areas. How do you determine -- for a particular survey, how do you determine what care area to check

the box of?
A It depends on what the complaint is about, what it encompasses. And then, I would go from there. Like this one had -- of course, had to do with restraints. So, that would have been one of the areas.
Q And I notice that you did not mark "Death". Mr. Cains died during this incident. So, is there a reason you would not have selected "Death" as a care area in this particular case?
A I may have overlooked it. But, no, I mean, it -- you know, but I looked at the -- I looked at the circumstances around his death.
Q You would agree that death is -- that his death was certainly an important subject matter to your survey?
A Yes.
Q And again, Restraint and Abuse, I think you said earlier, are separate categories of noncompliance themselves; correct?
A Yes.
Q You do not list those as categories of noncompliance that you were investigating on page one, Section 2?
A I do not make those categories. That's

something the office generates.
Q The office generates which noncompliance category you are required to list under Section 2?
A Yes.
Q Section 6, "Surveyor investigation findings for this complaint are documented on separate surveyor notes." Are those separate surveyor notes the handwritten notes that you have told me about?
A That's some of them, yes.
Q You said "some of them". Where are the others?
A Whatever there is that is in regards to this investigation that I looked at -- or I felt -- like the survey, my personal notes all go on the U-drive. And then, they go into a doctor share program.
Q And what about "Program specific forms/worksheets," what are those?
A Oh, okay. That's sort of like where we -- that's where we list our clients and who we looked at. It would be where we list the names of the employees and how we identified them, if we wrote a citation on the 2567. It is also their facility census, their key personnel.
Q And what is the "Aspen Complaint Tracking System"?
A That is what the office uses to log all the

complaints that come in. And that's their -- I don't have access to none of that. That's their system.
Q Okay.
A How they keep track of all that.
Q And you didn't look at any of those things in preparation for today?
A No.
Q Am I correct that you did not review any previous restraints used on David Cains by the three staff members directly involved?
A I may have looked at them but -- I may have looked at them, because sometimes I do that. Usually, I will do that. When it involves a restraint, I will look back and make sure that all the restraints have followed CMS regulations in how it was applied, when it was applied. I would have looked -- I usually do that.
Q I asked you earlier if -- we went over the Section 4 of the Complaint Investigation Report, which lists all the documents you reviewed.
A Uh-huh. (Indicated yes.)
Q And I asked you earlier if these were all the documents that you reviewed in relation to this, and you said they would have been. So, are you now saying that that's not the case, that you might have

reviewed prior --
A No, that's not what I'm saying.
Q Help me understand what you are saying.
A I'm saying that I might have looked at other restraint things. But as far as looking at what I said I reviewed, I did not look at anything else.
Q Meaning as far as what you marked here as having reviewed, this does not -- at least, this document does not indicate that you reviewed any prior restraints that had been used on David by these three staff members?
A It does not.
Q Okay. And would I be correct in assuming that you also did not review previous allegations of maltreatment that had been lodged against any of these three staff members unrelated to the incident you were investigating?
A I would have -- I would not have known had -- have any access to any kind of thing like allegations before that.
Q And I agree with you. I didn't think there would be any reason that you would have, I just wanted to make sure.
A Okay.
Q So, your answer is, no, you would not have

reviewed prior allegations of maltreatment against the staff who were involved in this restraint?
A Not if I was not aware of them, no.
Q Do you recall having been made aware?
A No.
Q You do not recall having been made aware of any prior allegations of maltreatment against the three RCTs involved in this restraint?
A No.
Q All right. Let's look at Exhibit Three real quick.
A (Witness complies.)
Q I appreciate your patience today, Ms. Elliott. Before we get into this. These -- Appendix J, the CMS regulations that you use, you use those to determine if a facility is in compliance with -- you use Appendix J to determine whether a facility is in compliance with federal regulations; correct?
A Yes.
Q Okay. And you would also use those same Appendix J guidelines to determine if the staff members of the facility are in compliance with federal regulations?
A I don't really -- this, I do not -- I do not investigate -- what I do is, I determine whether the

facility is in compliance with all the regulations.
Q And if a staff member of the facility were to violate those regulations, would that not be a violation of the facility?
A It would be on the facility, yes.
Q Okay. And so, in that sense, the Appendix J applies to the actions of the facility staff?
A It applies to -- it applies to the facility -- it applies to if the facility is in compliance, because they are responsible for their staff's behaviors and actions.
Q A facility is an abstract -- or a nonliving, breathing thing is a facility. You would agree with me that a facility is made up of administrators and staff?
A Uh-huh. (Indicated yes.)
Q Right? And for a facility to be either in compliance or not in compliance, that would have to be based on what the people working there do or do not do?
A Yes.
Q Okay. At just the most basic level?
A (Indicated yes.)
Q And you already said that if a staff member does something in violation of the federal regulations,

then that violation is attributed to the facility?
A We cite the facility.
Q Okay.
A But it is the facility's responsibility to take the appropriate actions to ensure that the staff -- that that doesn't happen again. And we look at that, too.
Q Right. So, for instance, let's just take the most basic of -- the most basic federal regulation, tag 127, which is the first one that you have listed. That's the one that says that a facility must -- I will let you get there.
A (Witness complies.)
Q And this is going to sound like a really stupid question, Ms. Elliott, but just bear with me.
A Okay.
Q And it's my stupid question, so just humor me. Are you at 127?
A I am.
Q Essentially, what this regulation is saying is that it would be a violation for a facility to subject a client to physical, verbal, sexual, or psychological abuse or punishment?
A Yes.
Q Is that fair to say?

A (Indicated yes.)
Q And so, bear with me. But if a staff member, let's say an RTC, were to subject a client to physical abuse or punishment, that would be a violation of this regulation; correct?
A Yes. And --
Q Okay.
MR. ROSEN: I think she was about to continue her statement.
THE WITNESS: Yes. And if the facility -- but the facility -- the facility or the administrative higher-ups, once they are aware of anything that is abuse or neglect, then they have to take the appropriate steps --
BY MR. GILLISPIE:
Q Sure.
A -- to ensure that that doesn't happen again --
Q Sure.
A -- such as protecting a client or doing an investigation --
Q Okay.
A -- to make the staff be held accountable. But we would hold the facility accountable --
Q Right.

A -- because they should have done -- they do background checks, they do training.
Q That makes sense.
A Okay.
Q Thank you. That makes total sense. I appreciate that. But the -- again, back to the dumb question part. W127, this is a regulation that says that clients cannot be subjected to physical, verbal, sexual, or psychological abuse or punishment?
MR. ROSEN: Objection. That's not what it says.
MR. GILLISPIE: Okay.
MR. ROSEN: You should read what it says and answer the question.
BY MR. GILLISPIE:
Q Well, Ms. Elliott, take a look at W127 for me.
A (Witness reviews document.)
Q Do you take this to mean that a facility such as Booneville must ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment?
A Yes.
Q Okay. And would you agree with me that the facility's staff members must comply with this rule, that the facility's staff members are required not to

subject clients to physical, verbal, sexual, or psychological abuse or punishment?
A Yes. They cannot do that.
Q Because these regulations -- these Appendix J regulations, of course, apply to the facility's staff, that's how the staff's behavior are measured for terms of whether or not they are in compliance with the federal regulations; right?
A If the staff were to commit physical or verbal, sexual, psychological abuse, the facility is -- what this says is that the facility must take steps to ensure that the clients are protected, that that staff doesn't do it again, because these underneath here, in the guidance, that is what CMS says we look at to determine whether they have met this regulation. Okay?
Q Uh-huh.
A And as it says, "The facility must implement, through policies, oversight and training, safeguards to ensure that clients are not subjected to abuse by anyone."
Q Uh-huh.
A Okay? And the facility must take whatever actions necessary to protect the clients residing there. So, the staff member may have done that. But

then, we look at when that happened, did the facility take all the steps that it needed to take to protect the clients and to investigate this and make sure that if -- because there's a lot of allegations that are not true. But if they determine or we determine that that actually happened, what did the facility do. Because I don't regulate as far as staff, I regulate the facilities.

Q When a complaint is made alleging abuse or neglect or sexual abuse or what have you, that complaint is not a complaint -- that complaint is going to involve a specific staff member, assuming it's a complaint that a staff member abused or sexually abused or neglected a client; right?

A Yes.

Q And so, I think what I'm hearing you say is what you do, then, in that situation, or any of these situations, is you look at that staff member's behavior and that staff member's actions to determine whether the facility is in compliance with the regulations. Is that fair to say?

A I look at the staff's -- I look at the staff's actions, and then I look at the response the facility took related to the staff's actions.

Q Okay. But you also looked at the staff's

actions?
A Absolutely.
Q For instance, here I know you have testified that you thought that staff did the things that they needed to do; right?
A Yes.
Q So, you look at staff actions?
A Yes.
Q And when you say that a staff member, for instance, here when you say that a staff member did what you think they needed to do, you are measuring that against what Appendix J says they are supposed to do; right?
A Appendix J is not going to say that the staff members should have given CPR, should have tried to suction the client, should have tried to do the Heimlich.
Q Are you saying --
A Appendix J is not going to tell you that.
Q Are you saying Appendix J doesn't have anything to do with what a -- excuse me. Are you saying that Appendix J doesn't pertain at all to how a staff member is supposed to treat a client?
A I'm not saying that.
Q So, Appendix J does pertain to how a staff

member is supposed to treat a client?
A In certain areas, yes.
Q Including areas such as restraints?
A Yes.
Q Are you aware of any other written documents, other than Appendix J, other than perhaps the facility's own written policies, or perhaps DDS' and DHS' own policies, that might pertain to how a staff member is supposed to treat a client with regards to restraints? And I can -- take your time. And let me know if you didn't understand.
A Like how they are supposed to be applied, is that what you are saying? How you would do a restraint, how you would actually apply a restraint, or apply a hold?
Q I'm talking a little more broadly. So, let me withdraw that question. You just testified that Appendix J does pertain to how staff in a facility are required to treat a client, specifically with regards to restraint, and -- let me withdraw that and back up and make this a little simpler. Appendix J is the only set of policies that you, in your capacity as the surveyor, use to determine compliance at a facility; is that correct?
A Yes.

Q Okay. And you would agree with me that Appendix J covers restraint use? That's one of the subject matters in Appendix J?

A It covers -- yes, it addresses it.

Q Okay. And you would agree with me that Appendix J addresses -- I will withdraw that and kind of get back to the question I'm trying to ask you, which is, are you aware of any other written policies, other than Appendix J, that would potentially dictate or control the actions of staff towards clients of a facility like Booneville?

MR. ROSEN: I'm going to object and say that this has been asked and answered a couple of times. You have asked her what she relied upon or what she uses to make her determinations.

MR. GILLISPIE: From time to time you will hear us objecting. And unless he tells you not to answer, you can kind of let it go in one ear and out the other and answer.

MR. ROSEN: That's not the way to take an objection. But you can answer the question, which I think you have already answered a couple of times here. But counsel has asked it again. So, the

question ultimately is, what did you use to make the determination.

MR. GILLISPIE: If you don't mind, I will create my own questions. And I have not exactly asked this question, so please just humor me. Objection noted.

BY MR. GILLISPIE:

Q Ms. Elliott, I'm going to ask that last question again.

A Okay.

Q Are you aware of any other written policies, other than Appendix J, that would dictate or control how staff at the Booneville Human Development Center are to treat clients?

A To include their own policies.

Q Okay. Also the facility policies?

A Yes.

Q Other than that, are you aware of anything else?

A No.

Q Okay. So, the only written policies that you are aware of that staff at Booneville would have to comply with are Appendix J and the facility's own written policies?

MR. ROSEN: I'm going to object. I mean, this is the CMS -- Ms. Elliott is a

surveyor here, and you are getting in way beyond the survey, because we already know the survey results. So, it would not be relevant or lead to admissible evidence. If you want to talk about the survey in which she did, that's one thing, but you are steering away from the survey. So, I object.

MR. GILLISPIE: Speaking objection noted. Please go ahead and answer.

THE WITNESS: I don't think I remember the question.

BY MR. GILLISPIE:

Q Are there any other written policies that the staff -- that you know of, that the staff would be required to comply with, other than Appendix J, and as you said, the written policies of the facility itself?

A No.

MR. GILLISPIE: Let's take a break.

(WHEREUPON, a break was taken.)

BY MR. GILLISPIE:

Q Hopefully not too much longer. I'm going to move down to Exhibit Three. That was an additional complaint that was apparently related to David's

death. You should be looking at the Complaint Investigation Report for complaint number 25996. Is that what you have?
A Yes.
Q And what Allegation of Noncompliance Category did you look at for this one?
A Well, what the office listed the noncompliance category as was "Accidents/Supervision". But I look at any categories that I think would be included in the investigation. That is the office listing.
Q And what office are you referring to?
A Office of Long Term Care.
Q Okay. And given that this was a death of a client that occurred during or around the time of a restraint, are you surprised that "Restraint" is not one of the categories that they chose to look at?
A Not really. I don't know how they determine what categories to put it under.
Q Okay.
A This is not necessarily what I look -- you know, just the category that I would look at.
Q Why --
A Theirs is a whole different thing than what I do.
Q Who is "they"?

A The Office of Long Term Care, the people up there that determines this category.
Q I thought you were with the Office of Long Term Care.
A I am with the Office of Long Term Care. But whoever the intake people, complaint people, they determine that -- what to list the category as.
Q So, this document comes to you -- when this document comes to you -- or when the assignment, rather, comes to you, it has already been determined what category -- what the category is?
A Yes. For them, yes.
Q And you are not allowed to -- you are not allowed to add additional categories?
A I do not type the additional categories. This is strictly what is off the intake that is given to me. I look at whatever categories I deem necessary for the complaint allegation.
Q You just may not list those categories under Section 2?
A I don't list these categories.
Q Somebody in the Office of Long Term Care lists these for you?
A When the intake comes to me, it is listed under the -- it will say -- okay. It will say

"Accidents/Supervision". Then, it will have the complaint allegation underneath it. So, that doesn't say that I only look at that category. That's just their interpretation.

Q Do you complete this first page of this document?

A I do.

Q Are you the one that types in "Accidents/Supervision"?

A I typed that in off of -- in accordance to the intake form that the office has provided me.

Q Would you have been within your rights to type in an additional category had you wanted to?

A No.

Q Okay. Why a second Complaint Investigation Report -- or maybe this one was the first and that one was the second. I don't know.

A I don't know.

Q But why multiple ones?

A Because evidently -- I have no idea. It may be because -- well, I don't remember. But it could be because the facility sent in their -- what we call Incident/Accident Report to the office, and then somebody, a staff, a family, somebody, could have called and made that same complaint. So, it would be

-- there would be one intake for what the facility had sent in and there would be one intake for whoever happened to call in the same complaint.

Q Are you assuming that's the explanation here?

A I can't assume anything at this point. I don't know. But since it is the same -- it is the same client --

Q Right.

A -- I would say that's what happened.

Q And you know it's the same client because of this ID number, number three?

A Yes.

Q All right. Take a look at page two for me. Just look closely at it for me and tell me when you are done looking at page two closely.

A (Witness reviews document.) Okay.

Q Does anything appear to be different on this report from the previous report we discussed, Exhibit Two?

MR. ROSEN: I just want to note for the record that the document -- she doesn't have the Exhibit Two in front of her that she is looking at.

MR. GILLISPIE: Yes. Feel free to pull up Exhibit Two.

BY MR. GILLISPIE:
Q And the purpose of my question, Dian, is just to figure out if they are different, how they are different, and why.
A Well, "Explain why this sample was chosen" is different.
Q Okay. What is different?
A I put "Named in complaint" and then "No other deaths".
Q All right. The difference being "No other deaths"?
A Uh-huh. (Indicated yes.)
Q And why would you put that there and not on the other one?
A I can't answer that question. I don't know.
Q What does "No other deaths" mean? In this context, what does it mean?
A It would mean that the facility had no other deaths --
Q Okay.
A -- that I could have looked at to ensure, you know, that they did the right thing.
Q All right. Let's turn to the next page.
MR. ROSEN: We are talking about Exhibit Three; right?

MR. GILLISPIE: Yes, Exhibit Three.
BY MR. GILLISPIE:
Q And if you want to pull up the corresponding page to Exhibit Two, feel free.
A What am I looking at? Oh, page two. Okay.
Q Now, I notice on this one the complainant was not notified and the complainant was not interviewed for further details. What does that signify?
A Well, this probably -- I am assuming, since I don't have all my stuff, you know, that I was looking at, I'm assuming this was where -- this probably was where the facility sent in their I&A form. And so -- and this was whoever called it in, I would assume.
MR. ROSEN: Are you referring -- just for clarification, because you are saying "this", and the record can't say which.
THE WITNESS: Oh, I'm sorry.
MR. ROSEN: Which documents are you referring to for "this".
THE WITNESS: Okay.
BY MR. GILLISPIE:
Q You are saying Exhibit Three indicates that the facility called this one in; right?
A Yes.
Q Yes.

A Because it says "IRIS Generated Complaint".
Q All right. So, that would mean that the other one must have been generated from a complaint by a family member or representative of the deceased?
A Or it could have been a staff member or it could have been some outside person. Just somebody called it in.
Q Well, I thought we established that it had to have been -- if you look at number two here, that it had to have been -- and I could be wrong, but I thought that it would have been a resident, or the client, or a representative of one of them, or a family member.
A This isn't necessarily -- number two doesn't necessarily mean that it was a complainant.
Q It is just talking about if you interviewed them or not?
A Number one is. The first one is, yes.
Q Okay. I got you. Got it. Okay. And then, under Staff Interviews, again, you interviewed one LPN and three RCTs?
MR. ROSEN: Are you referring to --
MR. GILLISPIE: Exhibit Three.
MR. ROSEN: Three. What page, again?
MR. GILLISPIE: Page three of Exhibit

Three, Section 3.
BY MR. GILLISPIE:
Q So, Section 3, page three, Exhibit Three, where you describe what staff interviews you did, am I correct that this indicates you interviewed one LPN and then three RCTs; is that right?
A Yes.
Q And I assume those would have been the same RCTs and the same LPN?
A Probably, yes.
Q Okay. And then, we will skip down to Regulations. Again on the same Exhibit Three, under Section 5, these same federal regulation tags. These are the same exact federal regulation tags listed in Exhibit Two; correct?
A (Witness reviews document.)
Q Feel free to compare, but I believe they are.
A Yes.
Q Okay. Why is the category -- I understand that they were -- these complaints were most likely initiated by -- in different ways. But why would the category for this one be Accidents and Supervision whereas the other one is Quality of Care and Treatment?
A I don't know. I can't answer that. I don't

decide the categories that go in there.
Q Okay. On page four of Exhibit Three. And again, Exhibit Three is Complaint Investigation Report 25996. Presumably the investigation that was done after being initiated by an IRIS report. This one lists Care Areas and CE pathways. Am I correct that the Care Areas that you indicated were studied or reviewed were "Abuse, Mood/Behavior, Neglect, and Restraints"?
A Yes.
Q Not "Care Plan"?
A Not what?
Q Not "Care Plan"?
A Well, they don't have Care Plans, they have IPPs, Individual Program Plans.
Q Okay. Not "Death"?
A Well, I mean, I looked at the "Death". But, no, I probably -- I do not mark that.
Q You didn't -- and is that because it --
A It was just probably overlooked on my part.
Q And then, Section 7, the last sentence in bold, would you read that for me?
A On number three?
Q Yes. Exhibit Three, page four, Section 7, the last sentence under Section 7, in bold, starting with

"Accidents".
A "Based on record review and the Code of Federal Regulations, this allegation was unsubstantiated due to the facility's ability to demonstrate they were in compliance with regulations related to Accidents/Supervision."
Q Okay. Am I correct that this sentence does not say that they were in compliance with regulations related to restraint use?
A No, it doesn't, because that's not the category that the office had listed on the complaint.
Q Okay. And going back to Exhibit Two, that same Section 7 on Exhibit Two, read that for me.
A "Based on record review and interview and the Federal Code of Regulations, this allegation was unsubstantiated due to the facility's ability to demonstrate they were in compliance with regulations related to Quality of Care/Treatment."
Q And you would agree with me that that does not say that the facility was able to demonstrate they were in compliance with regulations related to restraint use?
MR. ROSEN: The actual wording?
MR. GILLISPIE: Yes.
MR. ROSEN: The wording, I didn't hear

that in her statement as to what the actual wording is.

BY MR. GILLISPIE:

Q I asked you to read that statement, you read it correctly. You would agree with me -- it's a stupid question, but humor me. You would agree with me that this says that, "This allegation was unsubstantiated due to the facility's ability to demonstrate they were in compliance with regulations related to Quality of Care/Treatment." But it does not specifically say that they were in compliance with regulations related to restraint use; is that correct?

A That's correct, because that is not the category that the office listed. Though restraints were -- the restraint categories was looked at on both of them. But when we write our -- under Decision-Making and Closing Remarks, we use the category that the office decided to put on the intake form.

Q Okay. But to be clear, there is literally a separate noncompliance category for restraint use?

A I really don't know what all their categories are. I can't answer that.

Q Well, you testified multiple times earlier that there was.

A Well, there may be, yes. Can I say absolutely for sure, no.
Q Where would the categories of noncompliance be listed?
A I don't know. I don't know where they get those -- where they get that from. But that is -- the Complaint Department generates the intakes.
Q Okay. When we first started, you testified that there were categories for abuse and neglect, and then also categories for restraint use. Are you now changing your testimony?

MR. ROSEN: I'm going to object to this. Anything that she said earlier is what she said earlier. There is no need to -- unless she wants to change something.

BY MR. GILLISPIE:
Q I just want to make sure you are not changing.
A No, I'm not changing anything. It could be, yes.
Q Okay. You are not changing your previous testimony?
A No.
Q Okay.
A Because there are many categories.
Q Okay. If you want to go to page three of either

one of those exhibits, either one of Two or Three, I'm going to -- I want to talk to you a little bit about the regulations that you looked at.

MR. ROSEN: Off the record.

(WHEREUPON, a brief discussion was held off the record.)

BY MR. GILLISPIE:

Q You have your copy of the Appendix J that he gave you?

A Yes.

Q If you would, turn to tag 127.

MR. GILLISPIE: And is the copy you gave her Bates numbered?

MR. ROSEN: No.

MR. GILLISPIE: I printed off copies of each of them to make it easier for her.

THE WITNESS: I have them marked.

MR. ROSEN: She has it.

MR. GILLISPIE: You have them marked?

MR. ROSEN: We already discussed it. And we already discussed -- are we going to go over 127 again?

MR. GILLISPIE: We are.

MR. ROSEN: We already discussed it in your cross examination. I want to make a

note in the record.

MR. GILLISPIE: We discussed it where?

MR. ROSEN: You've already asked her about W127. Now we are going to go over it again?

BY MR. GILLISPIE:

Q Ms. Elliott, my question -- you testified when Mr. Rosen was questioning you that you determined that the facility and staff did not violate 127; correct?

A I determined that the facility did not violate 127.

Q Okay. Do you think perhaps individual staff members abused Mr. Cains?

A Not according to the investigation that I did.

Q Okay. And specifically, what is the basis for your opinion that staff members did not physically abuse Mr. Cains?

A Because during my investigation I could not -- I did not determine that there was any abuse or neglect by the staff.

Q Would you agree with me that unnecessary -- unnecessary physical restraint is a form of abuse?

A Unnecessary?

Q Unnecessary.

A Yes.
Q Look at 128, tag 128.
A (Witness complies.)
Q What does this regulation require?
A That there is a reason to place a client in a physical restraint or give them drugs that would alter their mental status.
Q Okay. This is a prohibition on unnecessary physical restraint; correct?
A It's a regulation on unnecessary physical restraint.
Q Right. Saying you can't do that?
A That's right.
Q And under Guidance here, you would agree with me that it says that, "The facility must implement an aggressive active treatment program, which includes appropriate replacement behaviors, to address the reduction/elimination of physical restraints and drugs to manage behaviors"?
A Yes.
Q Skipping 153 and go to 154. This is federal regulation tag, or Appendix J tag 154.
A (Witness complies.) Okay.
Q You went over this with Mr. Rosen. And this involves -- this regulation requires that there be

evidence that all the alleged violations are thoroughly investigated; correct?
A Yes.
Q And in this case, what specifically -- if you can say, what specifically did you base your opinion on that Mr. Cains' death and the incident surrounding his death were thoroughly investigated?
A By the facility, it is from their internal investigative reports that they do.
Q You looked at the maltreatment investigative report done by the maltreatment investigator; right?
A Yes.
Q Okay. And do you recall who that maltreatment investigator was?
A I have no -- I don't know. I don't know.
Q Did you speak to the maltreatment investigator, as far as you recall?
A No.
Q Okay. But that would have been a document, I assume -- that investigative report would have been a document that I assume that you would have relied upon in your own investigation?
A No.
Q No?
A I would -- the only reason that I would look at

that is to ensure that they did their investigation and that they sent it all back -- everything was done according to the regulations, which is reporting it to us, to Office of Long Term Care, to doing their investigation, to sending in their findings or whatever in their five-day report within the time limit. That's the only reason I look at that.

Q Well, understood. But this also says that the investigation has to be thorough. What does that mean to you, "thorough"? What makes an investigation sufficiently thorough?

A That they have done their interviews and looked at all the records, you know, documentation theirself. If there have been any videos, because a lot of places have video cameras, that they have looked at the video of the incident, that they talked to the residents, that they made sure that the rest of the residents were protected during the investigation, that they put monitoring in place while their investigation was going on to ensure that the residents are being taken care of appropriately.

Q Would you have looked at the manner in which the maltreatment investigator conducted his or her interviews with witnesses or staff that might have been involved?

A No. I just make sure that they have done them.
Q You just make sure that the interviews were done?
A I make sure -- yes, I make sure. Because I do my own investigation. I don't rely on anything that they have done.
Q Okay.
A Because they may find that one way, you know, and I determine by federal regulations, I determine myself whether they are in compliance with it. So, I do not rely on their investigation, I completely do my own from step one.
Q And I understand that. But I'm more -- I was asking simply about what you look at in determining whether or not their -- the facility's investigation was thorough.
A Yeah. And like I said, it's -- you know, I look at -- I look and make sure that they have done everything that I named before.
Q Right. And I don't mean for your overall determination, but for your determination as to whether or not specifically 154 is complied with. Am I correct in hearing -- am I hearing you correctly that you looked to see if the facility conducted all of the interviews that they should have conducted,

but not necessarily -- you are not necessarily looking at how that person -- or how that investigator handled those interviews, or conducted those interviews?

MR. ROSEN: I don't know what you just asked. Can you repeat that? I don't know what you just said. I don't know what your question is.

BY MR. GILLISPIE:

Q Do you understand what I'm asking, Ms. Elliott?

MR. ROSEN: I don't. Can you repeat it so that we can understand it? It doesn't make any sense.

THE WITNESS: I'm not real sure.

MR. GILLISPIE: Okay.

BY MR. GILLISPIE:

Q You looked to see if -- with regards to compliance with 154, you looked to see if the facility's maltreatment investigation included interviews with witnesses and staff that were involved; correct?

A Yes.

Q Okay. The fact that they conducted those is evidence of compliance?

A It's part of it, yes.

Q Okay. I'm asking -- I guess what I'm asking is, you said you didn't speak to the maltreatment investigator in this case.
A Huh-uh. (Indicated no.)
Q So, you would not have asked that maltreatment investigator to describe for you how he or she went about interviewing the staff?
A Oh, no.
Q Okay. Move to 276.
A (Witness complies.) Is this one of --
Q No, 276 is not one of the ones you had listed. Let me know when you are there. This is federal regulation, Appendix J tag 276.
A Okay.
Q Are you there?
A Uh-huh. (Indicated yes.)
Q All right. Am I correct that this regulation requires that a facility's approved interventions to manage inappropriate client behavior be specified?
A It kind of goes from 274 all the way down. So, I'm kind of reviewing, because that's their policy and procedure.
Q I will withdraw that question and then let you -- I'm going to withdraw that question and let you kind of take a -- go back and take a look at 275, and

then I'll ask it a little bit -- in a little bit different way.

A (Witness reviews document.)

Q Let me know when you are ready.

A Any time.

Q Okay. So, looking at -- what we are looking at here -- we are using tag numbers, but what we are looking at here is regulation Section 483.450, little (b)(1); is that correct?

MR. ROSEN: Well, there are several here. So, let's be specific as to what you are asking her a question about.

MR. GILLISPIE: Everything I'm about to ask her here is 483.450(b)(1). And if there is a little (i) -- if there is an additional subpart, I will specify.

THE WITNESS: Okay.

BY MR. GILLISPIE:

Q All right. And so, my question is, would you agree that this, starting at right above W275, where it says, "These policies and procedures must be."

A Uh-huh.

Q Withdraw that. Let me back up.

You are on the right page, 274. Ms. Elliott, read for me that regulation there where it says

Section 483.450(b)(1).

MR. ROSEN: I'm going to object. I mean, we have been going for quite a while. This is not even a regulation that was directly implemented. But to the extent that you want to ask her about it, just ask her a question instead of having her read it. I mean, it's not a test of her reading ability.

MR. GILLISPIE: Nevertheless --

MR. ROSEN: Just ask her a question.

BY MR. GILLISPIE:

Q Nevertheless, Ms. Elliott --

MR. ROSEN: It's getting to be abusive to this witness to ask her to read things into the record when it's all in front of us and in the documents, and just ask her a question about it. We know what W274 is. Just ask her a question, counsel.

MR. GILLISPIE: I'm happy to try to do that. I just want to --

MR. ROSEN: Just ask her the question.

BY MR. GILLISPIE:

Q Ms. Elliott, would you agree that it is a -- that the facility is required to develop and

implement written policies and procedures that govern the management of inappropriate client behavior?

A Yes.

Q Okay. And then, under Guidance there, would you agree with me that says that, "At a minimum, the facility must have written policies and procedures regarding the management of maladaptive behaviors addressing the following"? And then it says, "The use of a functional behavior assessment in the development of behavior management programs; a hierarchy of least to most intrusive measures; and incorporation of behavior management programs into the IPP"?

A Yes.

Q All right.

MR. ROSEN: Is there a question other than now you are asking her whether you are reading it accurately? I mean, just ask her a question about it if we are going to explore this issue. We can read.

MR. GILLISPIE: Respectfully, I'm not doing this for my health. I have a purpose here.

MR. ROSEN: Right.

MR. GILLISPIE: So, if you will just

allow me to --

BY MR. GILLISPIE:

Q So, you don't have to read it. To make it easier for you, I'm doing this, because I certainly don't want to appear abusive, or read to you, or make you do things that are unnecessary. But we are going to go through these.

MR. ROSEN: Well, you can go through it all you want. Why don't we just introduce them into evidence so nobody has to read it, you can just ask her the question?

BY MR. GILLISPIE:

Q Ms. Elliott, would you agree with me, based on your knowledge and reading of 274, 275, and 276, that a facility's policies and procedures must be consistent with the provisions of paragraph (b) of this section?

A (Witness reviews document.)

Q I will withdraw that. Essentially, Ms. Elliott, what I'm asking is, would you agree with me that the procedures of a facility must specify all facility-approved interventions to manage inappropriate client behavior, as stated under the 276 tag?

MR. ROSEN: 276?

THE WITNESS: Yes.
BY MR. GILLISPIE:
Q Yes, you would agree with me, Ms. Elliott?
A Will you repeat that question?
Q Yes. Would you agree with me that a facility's policies and procedures must specify all facility-approved interventions to manage inappropriate client behavior?
A Yes, that's what it says.
Q Okay. I know it's what it says. But that's also your understanding of how it's supposed to work?
MR. ROSEN: I think the question -- I object. She just said, "That's what it says." You asked her, "Is that what it says," she said what it says, now you are asking her what it says. I'm not following, counsel. Whatever it says, and you have asked her a couple of times what it says, and then you asked her -- to ask her again what it says. Let's ask her a question about it.
BY MR. GILLISPIE:
Q All right. Ms. Elliott, I'm still on tag number 276.
A Okay.

Q Under Guidance.
A Yes.
Q Do you see where it says Guidance Section 483.450(b)(1)(i)?
A Yes.
Q All interventions -- I'm going to read this. "All interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy." Did I read that correctly?
A Yes.

MR. ROSEN: I'm going to object to the reading test here. Counsel, just ask her a question. If you want to introduce this into evidence -- this is getting abusive of the witness. Just introduce this document and then we don't have to read it.

BY MR. GILLISPIE:
Q And, Ms. Elliott, would you agree that -- would you agree that all -- in your -- you said you have been doing this job for 12 years?
A Yes.
Q Okay. And you have conducted hundreds of these surveys using this Appendix J; right?
A Yes.

Q And would you agree that all interventions for the management of inappropriate client behaviors which are approved for use in a -- which are approved for use in a facility have to be stated and described in its policy?

MR. ROSEN: I'm going to say, that's what it says in the Guidance for that section.

BY MR. GILLISPIE:

Q Then, it should be easy for you to answer, Ms. Elliott.

A Yes.

Q Moving to 277 on the same page.

MR. ROSEN: I'm going to object again on the relevance of all these. I mean, there is no question to this witness as to whether the facility violated this and there's no -- the facility didn't violate these. So, I don't know why you are asking her about it. I mean, it's not relevant and we are just spending hours on this.

BY MR. GILLISPIE:

Q Would you agree that -- take a second to look at 277 for me. And look at the Guidance, as well, and let me know when you are done.

A (Witness reviews document.) Okay.
Q Would you agree that this Appendix J regulation requires that a facility's policies and procedures define the entire hierarchy of possible interventions that can be used with a client?
A Yes.
Q Would you also agree that this Appendix J -- this Appendix J regulation --
MR. ROSEN: Which regulation is counsel referring to?
BY MR. GILLISPIE:
Q Requires --
MR. GILLISPIE: We are at tag 277.
MR. ROSEN: 277. Okay.
BY MR. GILLISPIE:
Q Ms. Elliott, would you agree that this same regulation requires that a facility specifically identify the specific techniques that can be used for behavioral intervention in a client's IPP?
MR. ROSEN: I'm going to object. Are you reading from something? I don't see that in here. And so, I want to know what are you asking her? This is a regulation that is not in the --
BY MR. GILLISPIE:

Q Ms. Elliott, please answer the question.

MR. ROSEN: No. Hold on. Hold on, counsel. Because we've been here, you've been going for hours and hours, and you are asking her to read stuff, and you are reading stuff into this. Show her where it says that. Why don't we just go ahead and introduce this document into evidence, because then it says whatever it says?

BY MR. GILLISPIE:

Q Would you like me to rephrase the question, Ms. Elliott?

MR. ROSEN: Yes. Yes.

BY MR. GILLISPIE:

Q Ms. Elliott, would you like me to rephrase the question?

A Yes.

Q Let's look at the last sentence of this paragraph, the second from the top -- the last big paragraph there where it says, "Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client." Do you see that?

A I do.

Q Did I read that correctly?

A Yes.
Q Okay. Do you -- in your capacity as a surveyor who uses these regulations, do you take that to mean, or would you agree with me that that means that a client's individual plan should specify the specific techniques for behavioral intervention that should be used on that client?
A According to this, it says that, "The specific techniques that have been determined through assessment to be least restrictive for each client." So, it isn't -- and I think I understand your question, I'm not real sure. But it isn't that it needs to list every single one, but it needs to list what they need to do before they go on to possibly a restraint or something like that.
Q Okay. And there is further guidance on this one stating that, "The facility policy for unexpected behavioral incidents must provide direction for the staff in the utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others"; is that correct?
A Yes.
Q Okay. And you would not agree with me that the

types of restraints that can be used on a client must be identified in the client's IPP?

MR. ROSEN: I'm going to object. You've already asked her that. That's why you are asking it again. Her testimony is whatever her testimony was a few minutes ago. Now you are asking if you wouldn't agree with me. I don't know what your statement is, you know. But she has already answered that question, counsel. So, I object, asked and answered.

BY MR. GILLISPIE:

Q My question, Ms. Elliott, is do the potential physical restraints that can be used on a client have to be contained within the client's IPP -- described within the client's IPP?

A No.

Q They do not?

A They do not have to be described in the IPP. The instruction in the training that the staff get explain the physical restraints to the staff and how to utilize them. Most of them -- most of the IPPs are going to state if behavior starts, you, you know, don't say "no", to like back away, or to like try to talk to them, or try to get them to go over here and

do something that they like to do.
Q But it's your testimony --
A They are not going to specifically say, "You restrain them this way."
Q Okay. So, it's your testimony, as you sit here today, that the type of physical -- the types of physical restraint are not required to be contained in a client's IPP?
A They are not going to -- it depends. It's not a "yes" or "no" question. I mean, there are some -- are you asking me to --
Q Let me tell you exactly what I'm asking you.
A Okay.
MR. ROSEN: Yes, please.
BY MR. GILLISPIE:
Q I'm asking you, are the types of physical -- are the types of restraints that can be used on a particular client -- are the types -- withdraw that.
Are the types of restraints that could potentially be used on a particular client required to be described in the client's IPP?
A I still have to say "no" --
Q Okay. Let's take a look --
A -- because --
MR. ROSEN: Well, look. We are here on

a specific matter within this surveyor's knowledge, and you are going through --

MR. GILLISPIE: Are you saying she doesn't have knowledge of everything in Appendix J?

MR. ROSEN: No. The document speaks for itself. You are asking her and you are twisting a little bit of the language here and there and asking her to comment on this. Why don't you just introduce the document? You can argue it for whatever it means. We don't need this witness -- this witness is here to testify as to what she did in this investigation, and she has. And now you are asking her about some other issues that who knows what, and you are only -- and you are selectively pulling out certain things. So, why don't we just introduce this document and you can argue it?

BY MR. GILLISPIE:

Q We are going to move to tag 295.

MR. ROSEN: Is that one of the ones that she cleared the facility on, 295, or is that something different, counsel? That's a question to you. No, it's not. Well, I

strike that. I will withdraw that. Go ahead.

THE WITNESS: (Reviews document.)

BY MR. GILLISPIE:

Q Let me know when you get there.

A Okay. I'm there.

Q So, we have now -- this is 483.450, section (d), which applies to physical restraints; correct?

A Yes.

Q Okay. I want to move down to, on the next page, Guidance. Let me know when you are there. Do you see where it says Guidance 483.450(d)(1)?

A Yes.

Q Roman Numeral I?

A Yes.

Q Now, take a moment and look at that. But does this not say that the use of physical restraint must be specified within the IPP, and specifically that the plan must address the type of physical restraint, seen there at number four?

MR. ROSEN: Counsel, the document speaks for itself. And you are selectively going through certain parts to make a point that is unknown to all of us. But I don't know what the relevance of your question to

the surveyor is and what she did in the survey. She made certain findings. Okay? So, you may disagree with those findings, and you can ask her about her findings. But this is not -- you are just going through a several hundred page document word for word that was not part of her specific findings. So, why don't you ask her if it was included in her findings and then we can go through this? But I certainly object, because this is abusive of the witness and I'm going to make a point of it to the Claims Commission.

BY MR. GILLISPIE:

Q Go ahead, Ms. Elliott.

A It does say type of physical restraint. But you asked me, does it not have to describe the types, or how you -- I took it as how you do them, no. Because that -- and it will say -- the IPP will give you -- it gives you less restrictive measures, such as talking them -- trying to talk them down, trying to -- they might say, you can put in a physical hold. Now, if there is something in a physical hold that will trigger them worse, that may be included in the IPP. Like they are not -- you are not allowed to maybe take them to the floor. (Indicating.)

Q Okay.
A You are not allowed to -- bear hugging them is going to be worse than taking them to the floor. So, don't, you know, do that. (Indicating.) But every facility has very strict protocols that they use. And that is CPI, which is one type of restraint protocol, and all of them have to be instructed on that. Okay? So, the type of physical restraint -- a physical restraint is a physical restraint, it's not a --
Q You are not suggesting that staff could use any form of physical restraint that they want, are you?
A Absolutely not. Because there is a difference in what they have been instructed and have been taught and that's acceptable for them to use. I am not saying they can use any type, no. I don't know how else to say it.
Q Staff can't use methods that aren't approved by the facility, can they?
A No.
Q They can't use methods that aren't taught to them by the facility, can they?
A No.
Q Those would be violations of Appendix J, wouldn't they?

A Yes.

MR. GILLISPIE: Let's take five minutes.

(WHEREUPON, a break was taken.)

BY MR. GILLISPIE:

Q Okay. Ms. Elliott, going back to what is or isn't required to be described in a facility's policies and procedures regarding physical restraint, is it your testimony that -- let me back up. Ultimately, there was a -- I think there was a little confusion about where you landed on whether or not physical restraint has to be -- the types of physical restraint to be used has to be specified within a client's IPP. Are you saying that it does not or it does, and if it does, how?

MR. ROSEN: Counsel, you are -- objection. You are misquoting what the Guidance says on W295. It says the use of physical restraint is specified within the IPP, and then it talks about the specific type of behavior. It doesn't say the specific type --

BY MR. GILLISPIE:

Q Ms. Elliott, on that same Guidance, and this is on 295, it says, "The plan must address," and then it

lists six things. The fourth thing is, "The type of physical restraint." So, based on this, would you now agree with me that the plan must address the type of physical restraint that could be used?

A If it's not -- if it's -- yes. But there are emergency restraints that may come up, you know, something that -- if this client has never been physically aggressive or violent before, and a physical restraint may have to have been used. So, in that case, it's not going to be in the IPP. Okay? And it may be a one-time thing. But I'm not -- so, a physical restraint, usually the IPP will say, you know, to use it -- the physical restraint is the very last thing that they ever want to use. Okay? Or that we want to see used. We don't want to just see them have physical aggression and the first thing they do is grab them and throw them on the ground or whatever. What I'm saying is, there is no way to specify -- they can say the type of physical restraint, but that's usually -- you are not going to have -- there is not all kinds of physical restraints, you know. You are not going to grab them by the neck, you know. That is -- you know --

Q You are not saying that in an emergency situation staff can use any form of physical

restraint that they want, are you?
A Absolutely not. But I am saying it has to go according to their training --
Q Right.
A -- and their instruction.
Q Right. And you are aware that at Booneville all physical restraint is done for emergency?
MR. ROSEN: Is that a fact or is that a statement -- an opinion of yours, counsel?
MR. GILLISPIE: That's what Mr. Gonyea testified to, the only physical restraint at Booneville is done for emergency purposes.
MR. ROSEN: So, this is a --
BY MR. GILLISPIE:
Q Is that your understanding, as well?
MR. ROSEN: Stop, stop, stop. Hold on. Let me make my objection. Because we have gone far afield from a surveyor determination and investigation as to compliance. Now, you are getting into the minutia of detail that would not be relevant for this witness. And it seems to be an abuse of time and the witness for you to keep asking her about these things, unless she knows about them specifically and it is

applicable to this case. Because you are talking about some speculative -- we don't know that there wasn't, we don't know about this.

MR. GILLISPIE: I'm talking about the specific state regulations.

MR. ROSEN: I am asking you to be relevant to what this witness has knowledge of and knows. And tell me, if you have facts, then -- strike that part of it. But there are -- you are making insinuations here that have no reference to facts. And we are going to be here all day. And this is going to be over in a little bit, because we have not had lunch yet and it is now 3:05 and we have been going on for over three hours for your cross examination.

BY MR. GILLISPIE:

Q I want to move back to tag 280, Ms. Elliott. And I don't have too much longer. If you will take a look at that and I will ask you a couple of questions.

A (Witness reviews document.)

Q Let me know when you are done.

A Okay.

Q Would you agree with me that based on this, a facility's policies and procedures must address the types of physical restraint that are allowed in the facility?
A Yes.
Q Okay. For example, if a facility allowed clients to be physically restrained in a seated position, you would agree that would need to be addressed in that facility's policies and procedures?
A No. Because -- and the reason that I'm saying that is because CPI encompasses certain kinds of restraint, holds that are taught.
Q Okay.
A There is other forms of teaching of these forms of restraint that are not CPI, by other names, and those are different. Okay? So, as far as types of restraint that can apply, that would be, to me, can they apply a physical restraint, can they apply a mechanical restraint. Okay? Not specifically you are going to just -- because if you try -- if that was all in the policy, if all the teaching of a CPI was in the policy, which is two-person standing, two-person sitting, two or three persons -- you know, I mean -- so, the type of restraint, to me, means either like you can do a physical restraint or you

can do a mechanical restraint. Mechanical is totally different than a physical restraint. So, it can say absolutely you are not -- you will never apply a mechanical restraint, you will never use seclusion, you will never -- you know. So, when you are speaking types, you are trying to get into just specifically standing, sitting, two-person, one-person, on the sides, you know. They would not be -- when you look at this and when you go to like the IPPs or something, in each instance it's going to be different, depending on the client's behavior, what is happening, you know. So, you can --

Q But the staff still can only do --

MR. ROSEN: Let her finish, counsel. Hold on. Let her finish.

BY MR. GILLISPIE:

Q They still can only use the methods that they are taught?

A Only the methods that they are taught, yes.

Q But you don't believe that the methods that are taught have to be stated in the policies and procedures?

A Not individually. Okay? Not like two-person standing, two-person sitting, one-person hold, two-person hold. You know, I mean -- no. "According

to CPI instructions" would be on there, or whatever their program is that they use, because there are different types of programs. But, no, I would not say that they have to just specifically say, "You can only use these," because that would set them up for failure, because all behaviors are different, all restraints are different. They are according to the type they are taught. Okay?

Q Okay.

A But you can't say that you are only going to use two-person -- you know. Okay. Take them down to the floor and hold them, you can't say that. Because if you -- because there may be an easier way of doing that, and that is maybe because they hug them like this for a minute and they calm down. (Indicating.) They only take them to the floor if that's the least restrictive and they will calm down that way. So, when you get into specifics, that's a whole different thing. So, according to the type -- like the CPI, you can -- you know, according to their policy, you know, according to CPI techniques and instructions or something like that, it would be okay, too --

Q Okay.

A -- because we know -- because you can get those instructions and you can look at them. I've gotten

an instruction book before. So, that -- but if that's what they are taught, that's what they have to do, okay, within those boundaries or that teaching instruction.

Q So, if CPI is what they are taught to do, that at least broadly should be stated in the policies and procedures?

A Yeah.

Q Okay. But you didn't specifically use this tag 280 in your survey of the David Cains matter; correct?

A I looked at it. I'm sure I looked at their policy and their procedure on the physical restraints.

Q Okay.

A If I'm doing an investigation on a restraint, I'm going to look at their policy and procedure.

Q And where did you -- did you see anywhere in their policies and procedures that it described the type of ground restraint that was used on David?

MR. ROSEN: I'm going to object. What do you mean by "ground restraint"? I don't know what that means.

MR. GILLISPIE: The restraint whereby the three staff members restrained him while

he was on the ground on his left side.

MR. ROSEN: You mean, when he fell to the ground? What do you mean?

BY MR. GILLISPIE:

Q Did you see that anywhere?

MR. ROSEN: Is counsel not going to respond to that and clarify?

BY MR. GILLISPIE:

Q Go ahead, Ms. Elliott.

MR. ROSEN: I guess not. Okay. To the best of your knowledge, go ahead.

THE WITNESS: Honestly, to tell you that I remember seeing that in there, I cannot tell you that. It has been two and a half years ago.

BY MR. GILLISPIE:

Q Okay.

A So, I don't know. It could have been in there. It may not have been.

Q And you never spoke to Mark Hise, the staff development coordinator that does the NCI training, did you?

A The CPI training?

Q He does the restraint training for the facility, including the -- yes, the CPI training.

A Did I talk to him? No, I don't recall talking to him.
Q Okay.
A I would have spoken with him had I found -- saw something in the documentation of the restraint that I thought was not what they were taught.
Q Had you -- hypothetically, had you learned that the restraint that was used on David, the restraint on the ground was not taught and not authorized by the facility, would that have changed the outcome, or could that have changed the outcome of your survey?
MR. ROSEN: I'm going to object to the hypothetical, because she did certain things. But go ahead.
BY MR. GILLISPIE:
Q Again, I'm asking if you had learned -- if you had learned in your investigation, or been --
A Uh-huh.
Q If you had learned in your investigation that the restraint that the three staff members used on David on the ground was not taught and was not CPI and was not authorized by the facility, could that have changed your --
MR. ROSEN: Objection.
BY MR. GILLISPIE:

Q Could that have changed the outcome of your survey?
A (No response.)
Q In other words, if you learned this was an unauthorized restraint?
MR. ROSEN: Is this a fact or is this a hypothetical that counsel is referring to? Because I need to know whether it's a hypothetical or not. Counsel, is it a hypothetical question?
BY MR. GILLISPIE:
Q If you can answer that question, Ms. Elliott.
MR. ROSEN: Is it a hypothetical question or is it a fact question? Please identify.
MR. GILLISPIE: (No response.)
MR. ROSEN: Are you going to ignore me, counsel?
BY MR. GILLISPIE:
Q Go ahead, Ms. Elliott.
MR. ROSEN: I'm going to tell the witness not to answer until counsel clarifies, is he stating a hypothetical or is he stating a fact.
MR. GILLISPIE: We can call it a

hypothetical for now.

MR. ROSEN: Okay.

BY MR. GILLISPIE:

Q Hypothetically, if you had learned in your investigation that this was an unauthorized restraint that was used on David on the ground, could that have changed the outcome of your survey?

A It's possible that it could have as far as the use of an unauthorized restraint, yes. As far as the facility being responsible for his death, probably not. Because he had [redacted] I do not know. According to the documentation that I looked at, food could have even gotten into the airway, you know.

Q Okay. Thank you. Now, we are going to look at 278. Take a look at 278, and let me know when you are done.

A (Witness reviews document.)

MR. ROSEN: Is there a question?

MR. GILLISPIE: She is going to let me know when she is done taking a look at 278.

THE WITNESS: Okay.

BY MR. GILLISPIE:

Q All right. This has to do with the least restrictive techniques. I assume you are fully aware that only the least restrictive form of physical restraint that is available can be used in any situation?

A Uh-huh. (Indicated yes.)

Q Least restrictive available?

A You would like, yes. Yes.

Q Least restrictive option that is available?

A That is appropriate for the situation, yes.

Q All right. And under Guidance, the last paragraph for this particular tag, tag 278, which is -- the regulation is Section 483.450(b)(1)(iii). That last sentence there, "In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible." Did I read that correctly?

A Yes.

Q And you would agree with me that in a situation that a staff member determines is an emergency

situation, that staff member can only use the least restrictive appropriate technique possible?
A Can only use it, no.
MR. ROSEN: Hold on. Let me get my objection out.
THE WITNESS: I'm sorry.
MR. ROSEN: That's not what this says that you just read. You asked if you read it correctly, and now you have twisted it. So, transparency is important.
BY MR. GILLISPIE:
Q Well, Ms. Elliott, can a staff member use something that's not the least restrictive technique possible?
MR. ROSEN: Oh, go ahead.
THE WITNESS: Yeah, depending on -- it depends on the situation. I mean, it depends on the situation. Because it may not be possible to get them in the least restrictive hold at first. It may not -- it may be such a violent episode that the least restrictive is not going to prevent them from harming theirself or others. There is -- I mean, you are --
BY MR. GILLISPIE:

Q Least restrictive is a scale; right?

MR. ROSEN: Ask a question. Don't argue with the witness, please.

THE WITNESS: Is a scale?

BY MR. GILLISPIE:

Q Every situation is different?

A Uh-huh. (Indicated yes.)

Q Is that fair to say?

A Yes.

Q And in every situation -- how do you define -- how do you define "least restrictive appropriate technique possible"?

A How do I define that? I would define that as the least restrictive restraint that can be used at that moment in time in that situation.

Q Right. So, my question is simply, in an emergency situation at Booneville -- any given emergency situation at Booneville, is a staff member -- is a staff member required to use the least restrictive technique that is possible for that situation?

MR. ROSEN: I'm going to object because you asked -- a few minutes ago you read something into the record with regard to W278 that said in an emergency situation

that the technique chosen is the least restrictive appropriate technique possible. That's what you read into the record and asked the witness if she agreed with that. Now you are saying something different, you are asking her about something different. In an emergency situation, the technique chosen is the least restrictive, according to CMS. So, I object to the extent that your question is something other than you have already established in this record.

MR. GILLISPIE: When he is done, let me know.

MR. ROSEN: I'm done.

BY MR. GILLISPIE:

Q Did you understand my question?

A What was your question, again? I'm sorry.

Q That's okay.

A There has been a lot of questions thrown at me today. So, I'm sorry, I apologize. But if you can repeat the question, please.

Q Are staff required to use the -- let me withdraw that. Well, that sentence that I read there, "In emergency situations where an unanticipated behavior requires immediate protection of the client or

others, the technique chosen is the least restrictive appropriate technique possible." What does that mean to you?

A That means according to whatever the behavior or the -- whatever the situation, the behavior, the -- you know -- did they use the least. There is not a hierarchy for that. I mean, it's like -- because if he has a knife, or something to that effect, or is just -- has already hurt, you know, a couple of clients and they have tried -- you know, "least restrictive" means appropriate for the situation that they are in. So, I can't say what would be a least restrictive in any situation, actually.

Q No, I'm not asking you to speculate on what would be --

A Okay.

Q -- what would be the least restrictive technique in any situation.

A Okay.

Q I'm just simply asking -- basically, at this point I'm asking if you agree with what this is saying?

A Yes.

MR. ROSEN: So, take a look --

THE WITNESS: I'm sorry. Yes.

BY MR. GILLISPIE:
Q You do?
A Sure.
Q Okay.
A I mean, because it says that's appropriate, you know, chosen as the least restrictive appropriate technique possible.
Q Okay.
A So, yes --
Q Even in an emergency, it has to be the least restrictive appropriate technique possible?

MR. ROSEN: Counsel, that is not what you asked -- you read into the record and asked her to agree to it, and that's not what it says. So, I don't know why you keep going back to switching it a little bit. But why don't we read it again and ask -- because it speaks for itself. It is unethical for you to ask her about something different than what you read to her by switching the words. Just this has been established and it was established by you, that the technique chosen is, in fact, the least restrictive appropriate technique possible in an emergency situation where

protection of client or others is necessary. So, I don't understand why we are spending time on this, counsel. You established that.

BY MR. GILLISPIE:

Q Well, Ms. Elliott, you are not testifying that in an emergency situation whatever technique the staff member chooses is the least restrictive because they chose that, are you?

MR. ROSEN: Objection. If we read what the guidance is, it answers your question. And we have gone through this millions of times. I know you don't like the answer, but that is what CMS has told us. So, that has been established, and it was established by you, counsel.

BY MR. GILLISPIE:

Q So, the same question that hasn't been answered yet, Ms. Elliott. Are staff, in emergency situations, required to choose the least restrictive technique possible?

MR. ROSEN: Counsel, it says that the -- in emergency -- I'm going to read it now because this is part of my objection, because I want the Claims Commission to know

what is going on here. It says, quote, "In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible." They have designated that, CMS did. So, why are you asking her for something different when you have established this?

MR. GILLISPIE: What that is saying is that the technique must be the least restrictive.

MR. ROSEN: It doesn't say that.

MR. GILLISPIE: Well, that's what it means.

MR. ROSEN: Oh. It doesn't --

BY MR. GILLISPIE:

Q And I just want to make sure that you understand -- that you agree with that?

MR. ROSEN: Hold on, counsel. That's not what it says. It doesn't say that they have to choose. It says the technique chosen is the least restrictive. We can read. Ms. Elliott can read, I can read, and I know, counsel, you can read because you

have read it into the record. So, I find it unethical and problematic that you are looking not at the clear language.

MR. GILLISPIE: Objection noted, objection noted. So, this is a separate question.

MR. ROSEN: Okay.

MR. GILLISPIE: This is a separate question, regardless of whatever is stated here in 278.

BY MR. GILLISPIE:

Q So, listen to this question and answer this question, please. Are staff required, in emergency situations, to choose the least restrictive technique possible?

MR. ROSEN: And your question is caveat to the extent it varies from the CMS guidance?

MR. GILLISPIE: Not at all. This is an independent question.

MR. ROSEN: I'm going to object.

MR. GILLISPIE: Okay.

MR. ROSEN: And we -- this is really getting to be problematic, because you are asking for her to opine on something that

you have established in the record in this deposition.

MR. GILLISPIE: I understand you don't want her to answer this question.

MR. ROSEN: No. You are twisting language. It says the technique -- this is CMS. This is not her, it's not me. And she actually has to enforce CMS. So, it tells her that, "In an emergency situation where an unanticipated behavior requires immediate protection of the client or others, the technique chosen" -- meaning the technique chosen by the person, the staff -- "is the least restrictive appropriate technique possible." That's what it says. So, to the extent that you are asking her to vary from that, or you are substituting words and giving new meaning to it, I object, because that is what it says, you can put it in the record, you have established that.

MR. GILLISPIE: I think your objection is noted and in the record.

BY MR. GILLISPIE:

Q Ms. Elliott, please answer.

MR. ROSEN: What is the question so

that the Claims Commission knows exactly how to address this issue?

BY MR. GILLISPIE:

Q Are staff required to choose the least restrictive technique available or possible in responding to emergency behavioral situations with clients?

MR. ROSEN: Same objection. But go ahead.

THE WITNESS: Because every situation is different, if you are asking me if they have to use the very least restrictive technique that is available to them, no, because the very least restrictive technique may not be appropriate for that behavior or for that situation. So, it all depends on the situation and the behavior that's being exhibited by the client. So, I can't say they have to use the least available to them, no, because it may not be appropriate in that situation.

BY MR. GILLISPIE:

Q Do they have to use the least restrictive available to them that would be effective in that situation?

MR. ROSEN: Objection. Same objection. We know what the requirement is by CMS. But go ahead.

THE WITNESS: Yes.

BY MR. GILLISPIE:

Q And do you check for that when you do your surveys that involve restraint use?

A I investigate -- yes, I investigate the restraint and make sure -- and see if it's appropriate for the behavior that is documented as exhibited. And of course, I am not there when the behavior is going on. So I don't know what was -- so, I can't say that the choice they made was not a right one unless it's just something really outrageous and pops out at me. I don't know if that makes sense to you. But if they went over and banged on the table and somebody took them to the ground, that would not be appropriate without, you know -- because (Indicating) is not a reason for restriction -- for a restraint. But if they are ripping things off the wall, they are attacking -- trying to attack other clients, they are trying to attack staff, they are hurting theirself, which they do, and pound their heads up against the wall or something, then the least restrictive is not going to work in that

situation. I mean, every situation is different. So, I don't --

Q Well, every --

A I don't want to just say "yeah" -- I don't want to say, "Yeah, they have to use the least restrictive, start with that," because I cannot say that.

Q Well, every situation is going to have its own -- every situation is going to have its own least restrictive -- its own least restrictive option, meaning --

MR. ROSEN: Are you talking, counsel, in an emergency situation, or are you talking in a program situation? What are you talking about here, because we already know the answer to all these questions, we know it from about 20 minutes ago.

BY MR. GILLISPIE:

Q I just want to make sure I understand what you are saying.

MR. ROSEN: Well, whether you understand it or not is a different matter. If you can read the manual, she has told it to you about three or four, five, six times now. And the fact that you are trying to

switch words here is not appropriate questioning. You established what the standard is.

BY MR. GILLISPIE:

Q What is least restrictive in one situation -- the least restrictive potentially effective option in one situation may be different than the least restrictive potentially effective option in another situation; right?

MR. ROSEN: Are you talking hypothetically, or with David Cains?

MR. GILLISPIE: I'm talking hypothetically.

BY MR. GILLISPIE:

Q Would you agree with that?

A Yes.

Q Okay. And the least restrictive -- and so, if I'm hearing you right, what you are saying is -- or how you interpret the regulation is that they would be required to use the least restrictive technique that could work for any given situation? Does that make sense?

A They have to use the least restrictive technique that would be appropriate for that behavior or situation that is happening at that time, yes.

Q Okay. Thank you. And hypothetically, if the adult maltreatment investigator who investigated this incident with David Cains for the facility were to admit to you that the restraint used by the staff was not the least restrictive method that could have been used there, could that have possibly changed the outcome of your survey?

A I --

MR. ROSEN: Hold on. Objection. Because we are going back now, it has been about 30 minutes, and it says that in an emergency situation, and your hypothetical was an emergency situation, counsel, because if it was, CMS tells us that the technique chosen is the least restrictive. So, it's not something that is -- whatever the -- in an emergency situation, whatever the staff does is the least restrictive.

MR. GILLISPIE: You are saying that anything they choose to do in response to an emergency is the least restrictive?

MR. ROSEN: That's what CMS says. It says, "In an emergency situation where an unanticipated behavior requires immediate protection of the client or others, the

technique chosen is the least restrictive appropriate technique possible." That is not me, counsel.

MR. GILLISPIE: That is an interesting reading of that. But we'll move on.

MR. ROSEN: That is what it says. And we know that because a half an hour ago you established that by asking her if you read it correctly. And your interpretation of that, it's clear. So, let's move on and agree to disagree.

MR. GILLISPIE: I look forward to you making that argument.

MR. ROSEN: I'm not making an argument, counsel. That's what it says.

MR. GILLISPIE: Just a moment, Ms. Elliott, and we will wrap up here.

BY MR. GILLISPIE:

Q I understand that you did not interview Sandy Evans, who was the adult maltreatment investigator for this matter; correct?

A Yes.

Q If you had and if Sandy Evans had admitted to you that the restraint used on David on this occasion was not the least restrictive option available, would

that have made a difference in the outcome of your survey, or could it have made a difference in the outcome of your survey?

MR. ROSEN: Objection. Same objection. Look at W278 that you established in the record here, which is true in what it says. So, to the extent that you are asking her something that we know has already been determined by CMS, I object.

BY MR. GILLISPIE:

Q Go ahead, Ms. Elliott.

A I do my own investigation. So, if she -- even if she told me something like that, I would have to investigate and see what I found out, because I do my independent investigation. I do not go by what their facility has investigated.

Q Okay. Would that have been useful information to you?

A Not until after -- that might have been something -- if I had decided in my investigation that that was an inappropriate restraint and it was not the least restrictive or whatever, then what we would do is, then I would go to the CPI person, trainer, and I would ask -- I would ask him questions.

Q Okay.
A So, if he told me -- then at that point, if he looked at me and I would have said, "Was that the least restrictive that they could have used," and he looked at me and said, "No," that would have been in my investigation, that's part of my evidence. So, it would have been after I did my investigation if I would have asked her that. But she is just the investigator. I would go to the CPI person.
Q And if the CPI person told you that the restraint used was something he did not teach, something that was not part of CPI, and not the least restrictive option, that would have been a big deal to you?
A That would --
MR. ROSEN: I'm going to object because of W278 guidance.
BY MR. GILLISPIE:
Q That would have been a big deal to you?
A I would have considered that strongly in my investigation, yes.
Q Thank you.
A But like I said, that would have been after I investigated.
MR. ROSEN: Stop. There is no question

pending.

MR. GILLISPIE: Okay. If you will give me just a moment to make sure I don't have anything else.

BY MR. GILLISPIE:

Q Ms. Elliott, what if one of the three staff members involved in the restraint on David Cains on this day also told you that the restraint used was not the least restrictive option available, would that have been important information to your survey?

MR. ROSEN: Objection. W278 Guidance tells us what the least restrictive is in an emergency situation.

THE WITNESS: I would have had to decide myself whether the least restrictive was used, because staff will say whatever about other staff if they don't like them. So, I use my evidence.

BY MR. GILLISPIE:

Q Okay.

A Okay. I ask them what happened, how they responded, and then I make my own decision.

Q Ms. Elliott, is it your testimony, as you sit here today, that in response to an emergency situation staff are allowed to use any technique that

they want?
A Oh, no.
Q Is it your testimony, as you sit here today, that in an emergency situation anything that staff does in response is, by definition, the least restrictive possible?
A Anything they do in response would be the least restrictive? No.
Q Okay.

MR. GILLISPIE: Thank you, Ms. Elliott. That's all I have for you.

THE WITNESS: Thank you.

MR. ROSEN: I only have one question. So, it will be real quick. And you can refer to it.

REDIRECT EXAMINATION

BY MR. ROSEN:
Q But under W296, which counsel, I believe, asked you about earlier, are restraints allowed as an emergency measure to protect the client from harm or others from harm or injury?
A Yes.

MR. ROSEN: No other questions. Thank you very much.

MR. GILLISPIE: Thank you, Ms. Elliott.

THE WITNESS: Thank you.

MR. ROSEN: Thank you. I know you have a long drive.

(WHEREUPON, at 3:50 p.m., the taking of the above-entitled deposition was concluded.)

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DHS EXHIBIT ONE.

DHS EXHIBIT TWO.

Arkansas
State Claims Commission
FEB 16 2023
RECEIVED

DHS EXHIBIT THREE.

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, DEBBYE L. PETRE, Certified Court Reporter in and for the County of Pulaski, State of Arkansas, duly commissioned and acting, do hereby certify that the above-entitled proceedings were taken by me in Stenotype, and were thereafter reduced to print by means of computer-assisted transcription, and the same fully, truly, and correctly reflects the proceedings had.

I FURTHER CERTIFY that I am not attorney or counsel of any of the parties, nor am I relative or employee of any attorney or counsel or party connected with the action, and have no interest in the outcome or results of this proceeding.

WHEREFORE, I have subscribed my signature and seal as such court reporter in the City of Little Rock, County of Pulaski, State of Arkansas, this the 31st day of January, 2023.

_____
DEBBYE L. PETRE, CCR, #118
COURT REPORTER IN AND FOR
PULASKI COUNTY, ARKANSAS

---o---

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G003	A. BUILDING _____ B. WING _____	C 06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONEVILLE HUMAN DEVELOPMENT CENTER	87 REED ROAD, HWY 116 SOUTH BOONEVILLE, AR 72927

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare and Medicaid Services (CMS) on June 30, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6). Client Census: 117	E 000		
W 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on June 30, 2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Preventions (CDC) recommended practices to prepare for COVID-19. Client Census: 117	W 000		

EXHIBIT
DAS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

7/14/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2020
FORM APPROVED
OMB NO. 0938-0391

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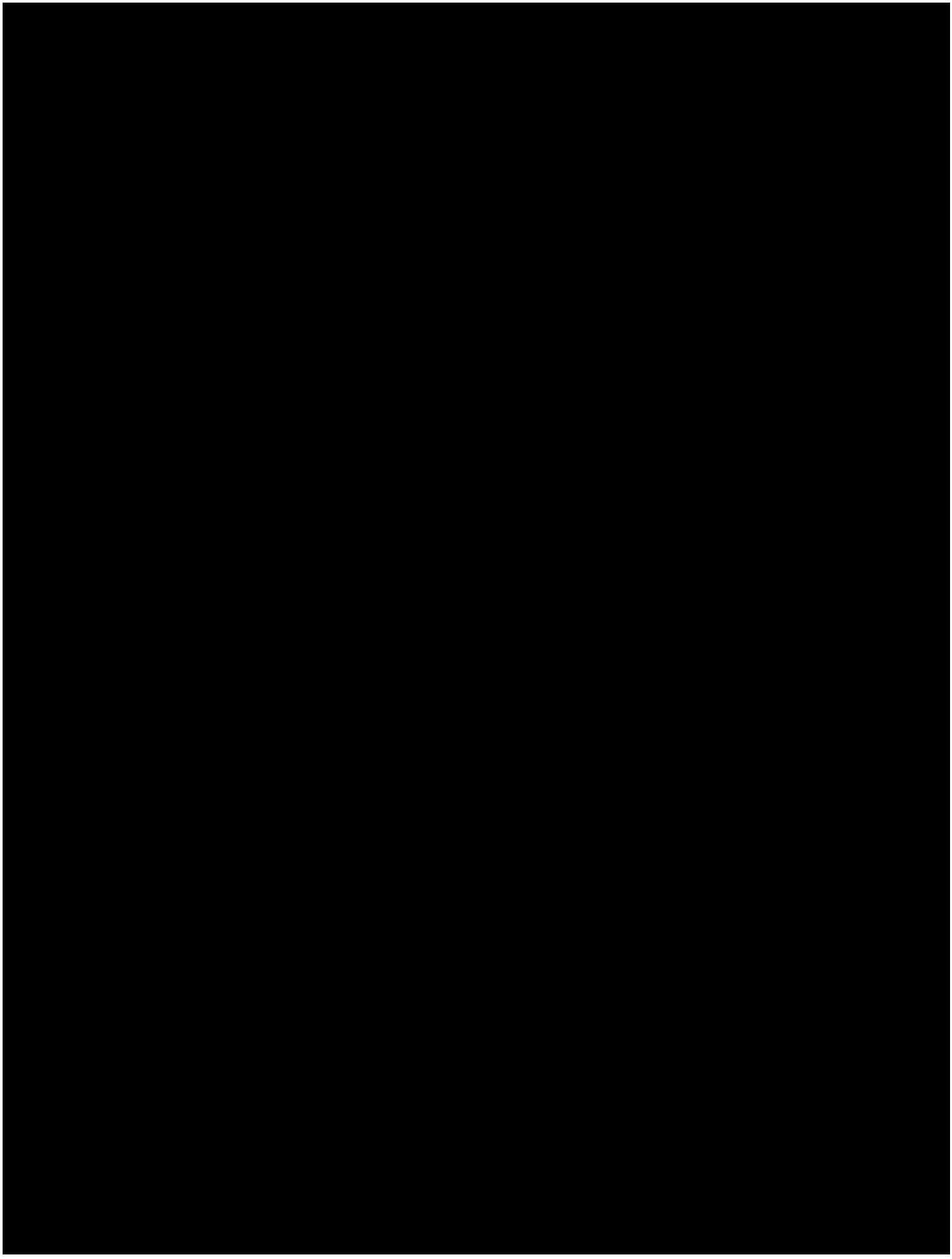
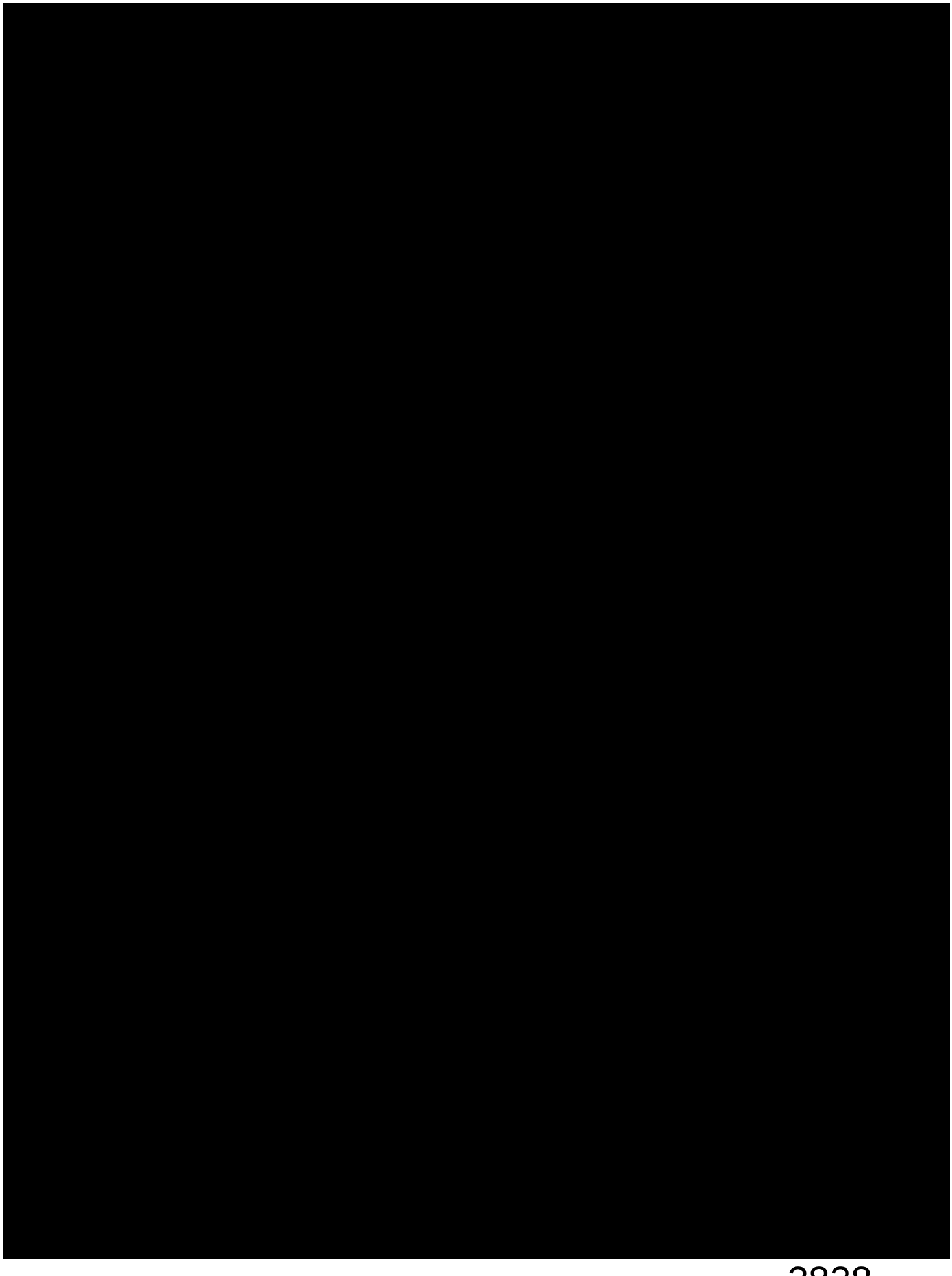
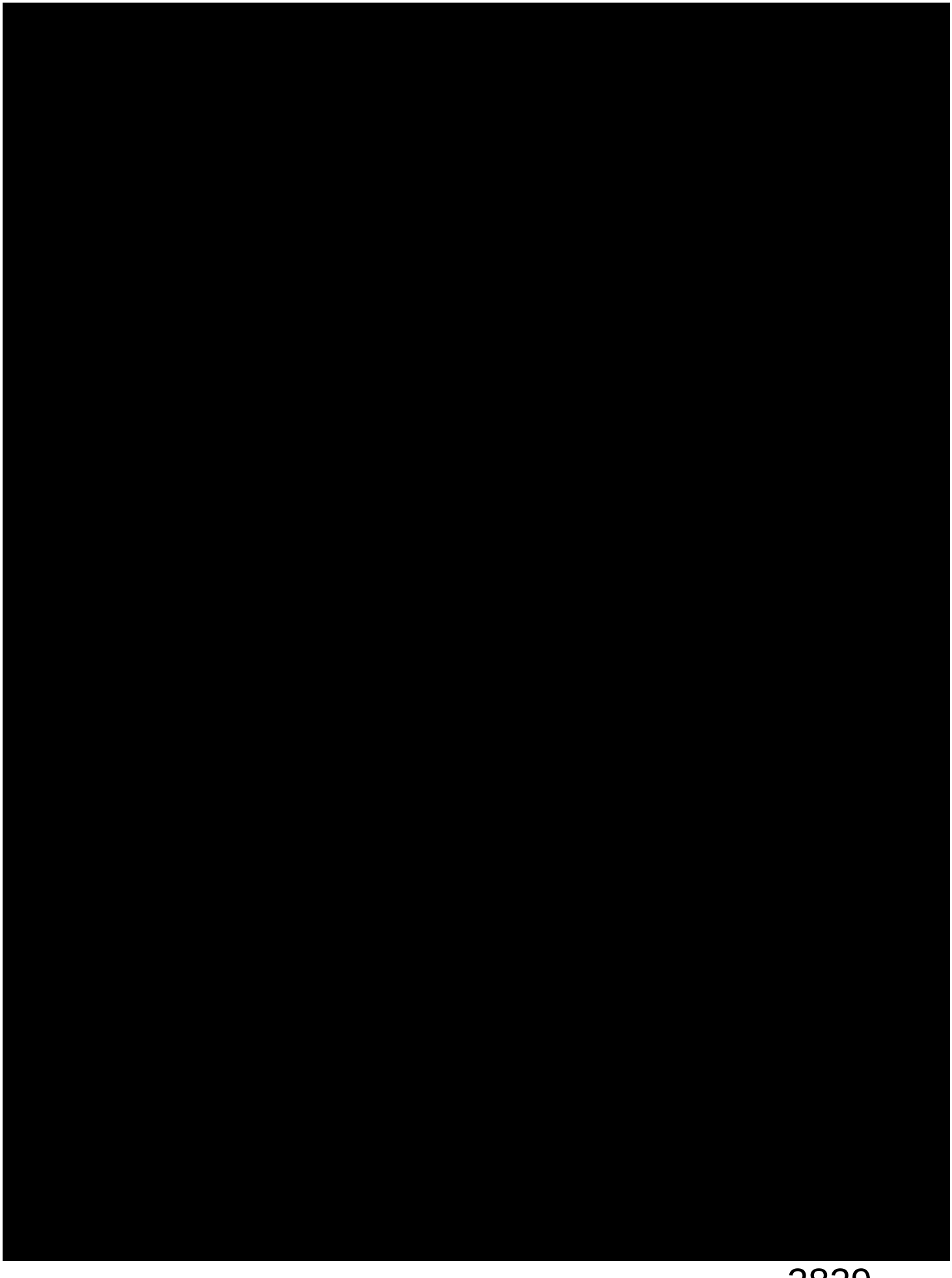
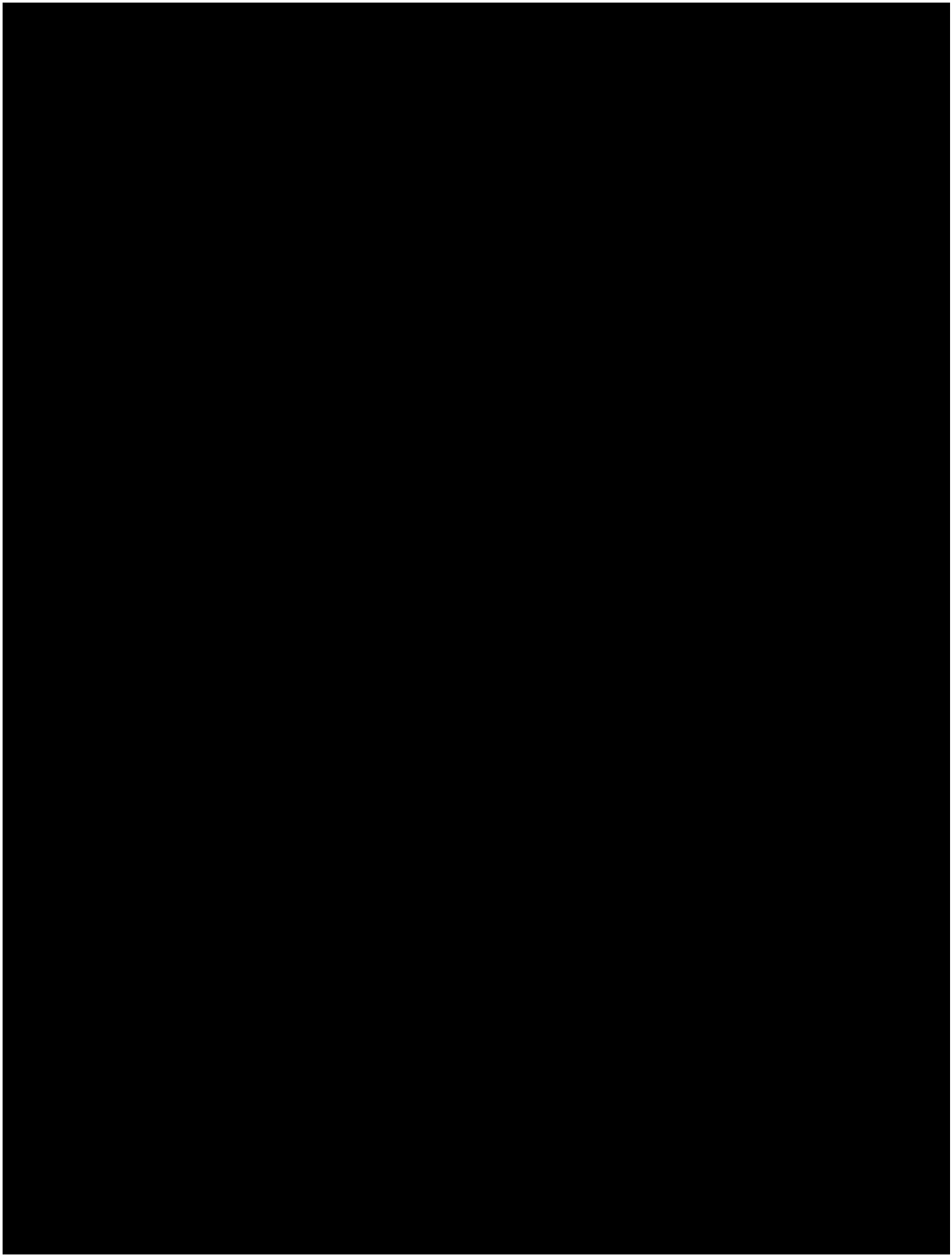
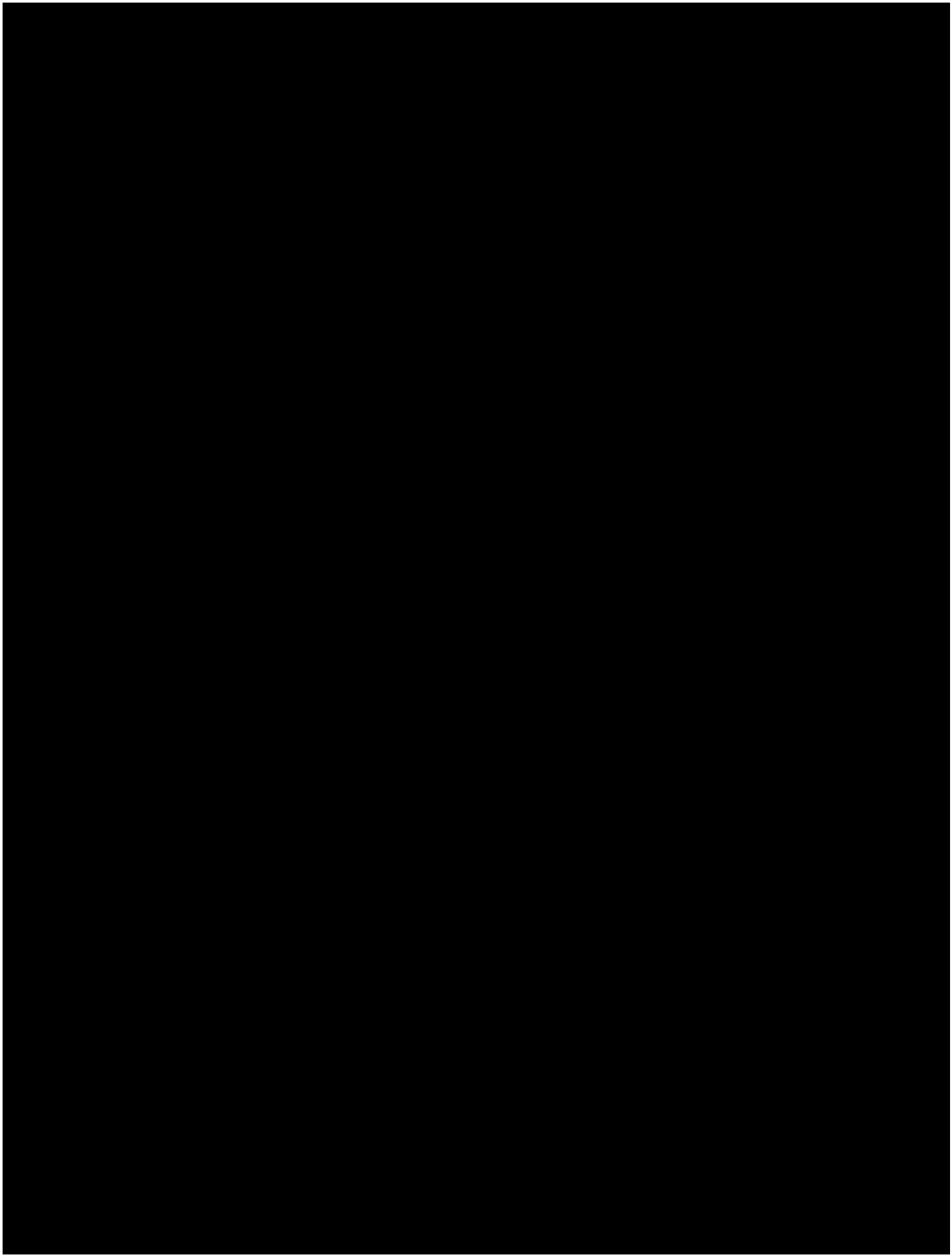
W 000	Continued From page 1 The facility was in compliance with the requirements of the 42 CFR, Part 483, subpart I for the Intermediate Care Facilities for Individuals with Intellectual Disabilities. Complaint #25772 (AR00024518) was unsubstantiated. Complaint #25996 (AR00024946) was unsubstantiated. Complaint #26043 (AR00024997) was unsubstantiated.	W 000		

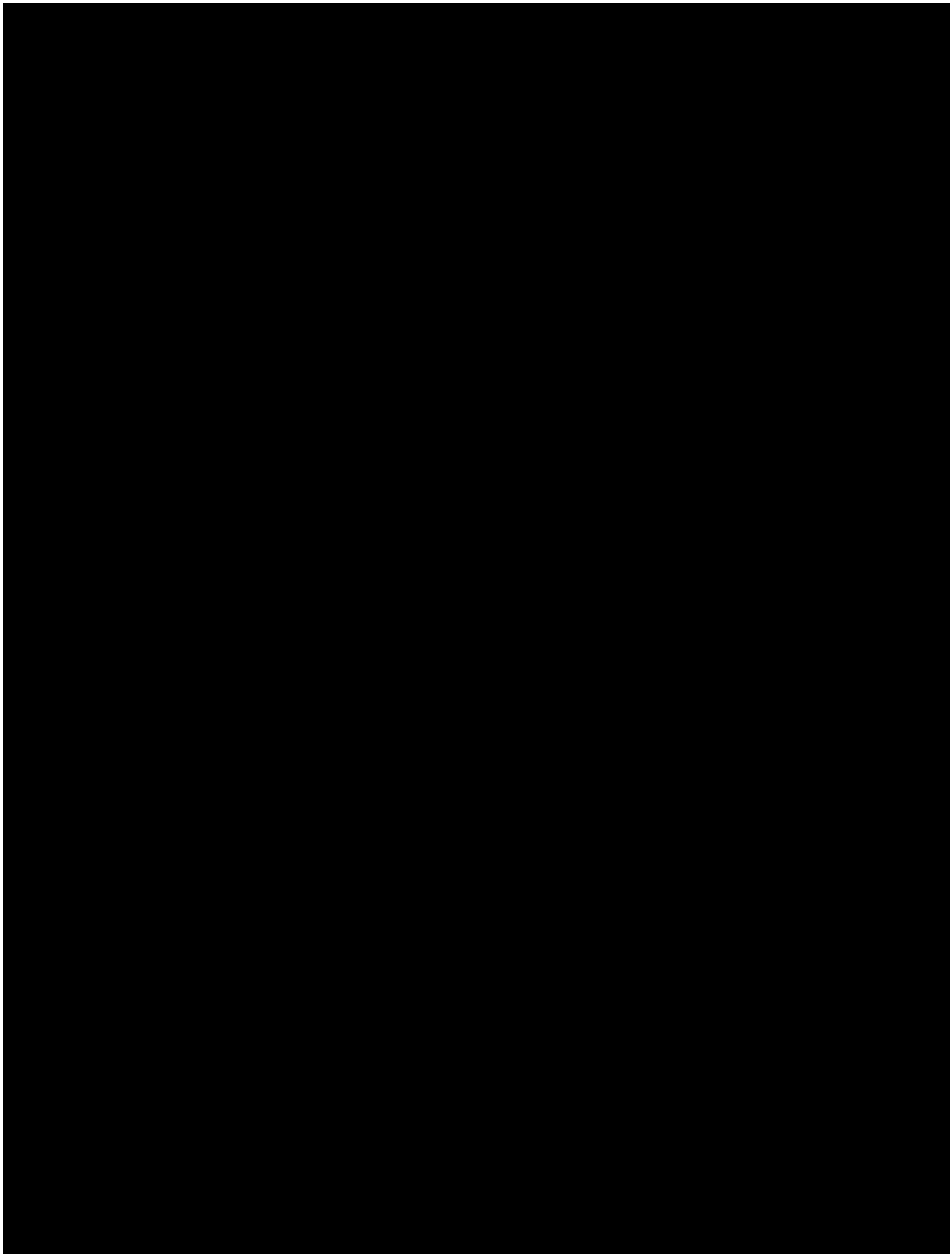


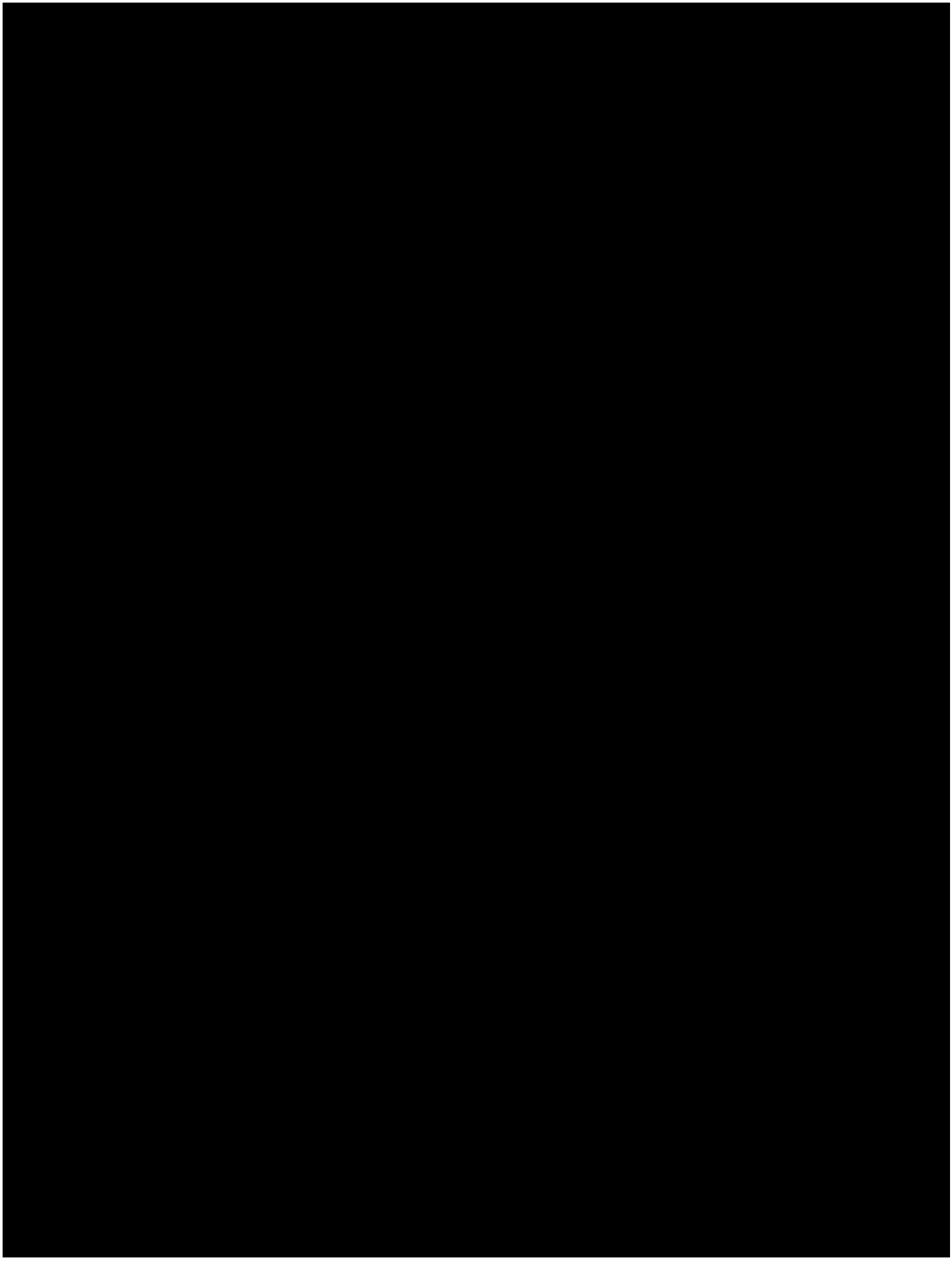


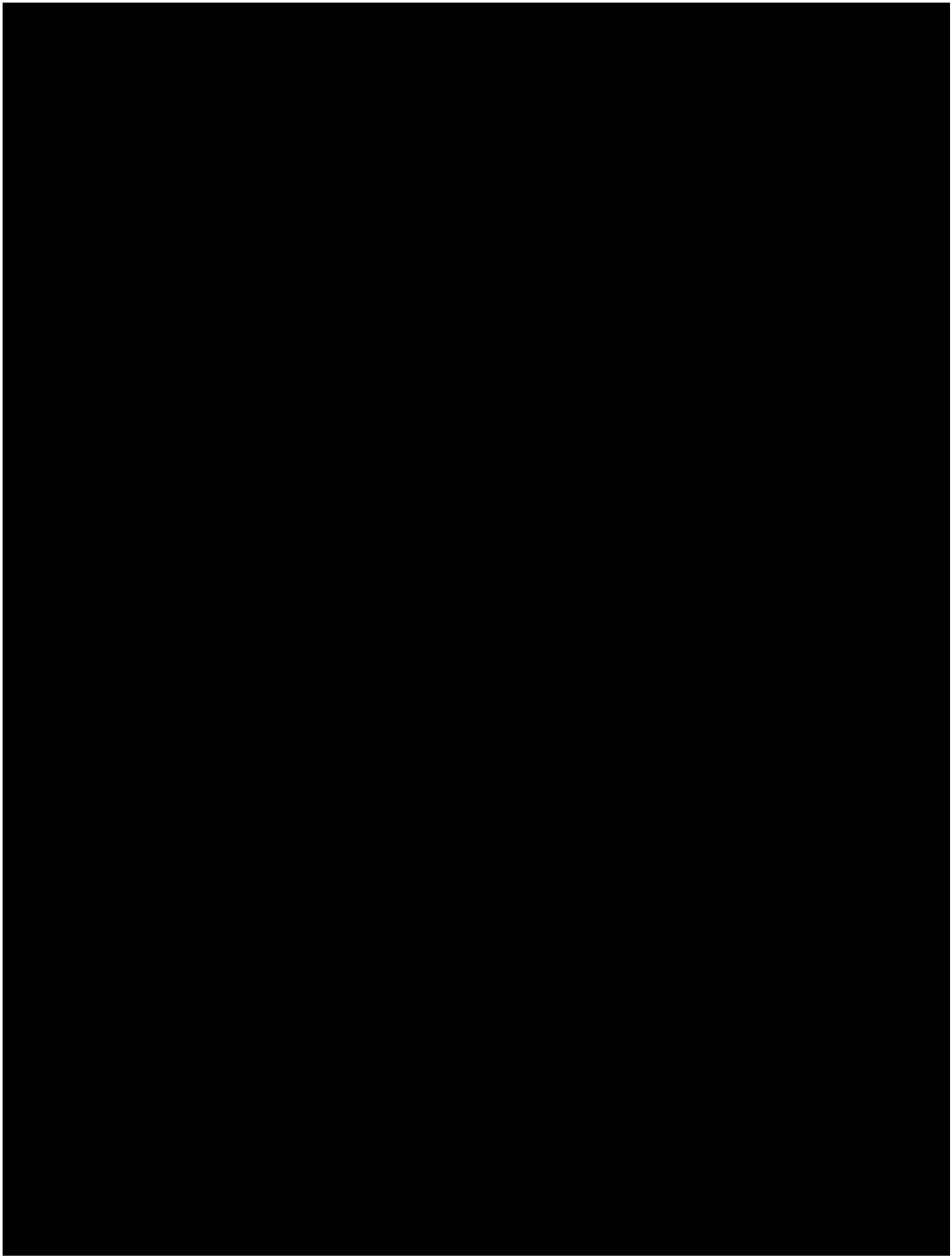












Dr. Janice L. LeBel
Board Certified, MA Licensed Psychologist-Provider #4950
One Chestnut Street
Salem, MA 01970

December 28, 2022

Joshua D. Gillispie
Green & Gillispie Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114

Re: Review and Analysis of Documents and Expert Opinion Regarding Restraint use in the Matter of the Estate of David Cains v. Arkansas Department of Human Services (AR DHS) (Booneville Human Development Center)

Dear Attorney Gillispie:

At the request of your office, I was retained as an expert who has worked nationally and internationally with publicly-funded and private service settings such as psychiatric facilities, general hospitals, developmental centers, correctional facilities, residential programs, juvenile justice programs, and schools serving people with various disabilities and different ages in reducing and preventing the use of restraint and seclusion.

I was asked to review documents regarding the death of David Cains (DC) including but not limited to: the pleadings, the witness deposition transcripts, Booneville Human Development Center (BHDC) policies and procedures, portions of DC's medical record, DC's individual treatment plan (IPP), behavior reports, restraint data, ambulance and emergency room records, the Adult Maltreatment Report, DHS Incident Report, Disability Rights Arkansas Investigative Report, OLTC Witness Statements, etc. Based upon this document review, I have rendered my professional opinion regarding the use of restraint with DC at BHDC.



My opinions, based upon my expertise and the document review process, are:

1) The physical restraint used on DC proximal to his death fell below the standard of care established by recognized standard setting entities. In addition, the physical restraint used on DC fell below the standard of care established by BHDC.

2) The BHDC emergency response policy, whereby direct care staff were prohibited from calling 911, fell below the standard of care and created a dangerous situation for DC and other clients and resulted in a delay in emergency service response and intervention.

These opinions are provisional. If additional information or documents are produced by the Respondent and submitted for review, the opinions may be modified, the report may be amended, and a revised report may be issued if necessary.

My opinions will be addressed in the order above. Deposition transcript citations/Bates Stamp numbers (where identified or applicable), standard setting citations (e.g., United Nations, World Health Organization, Centers for Medicare and Medicaid Services, AR Developmental Disability Services (DDS), other state DDS services, and BHDC Policies & Procedures) and professional literature references will be provided to support the opinion as necessary. The reference section will follow the American Psychological Association, sixth edition, formatting requirements. The facility, Booneville Human Development Center, will be referred to as BHDC. The patient may be referred to as: patient, resident, person-served, DC, he, or his. For purposes of this review, DC's history will not be restated but relevant elements of his history may be identified and cited as indicated.

Opinion One: The physical restraint used on DC proximal to his death fell below the standard of care, including BHDC's standard of care.

Standard of Care

The standard of care required the Respondent to comply with federal CMS/ICF Regulations found at 42 C.F.R. § 483.00 et seq.; Arkansas DDS policies and procedures; and BHDC's own policies and procedures. These policies establish that: a) only the least restrictive approved form of physical restraint can be used, b) for only the least amount of time necessary, c) only to prevent imminent and serious harm in emergency situations, d) only as a last resort after nonviolent techniques have been exhausted, e) the form of physical restraint used must be an authorized method clearly stated in the client's IPP, f) the form of physical restraint must be clearly identified in the facility's policies, and g) the authorized form of physical restraint must be taught to staff. The Respondent failed to meet the standard of care in this case.

Specifically, the Respondent failed in the following ways:

- The physical restraint was not necessary or justified and violated DC's right to be free from abuse and restraint;
- The physical restraint was not implemented in response to a life-threatening emergency or behavior that presented a risk of serious injury/harm;
- The physical restraint was not the least restrictive option;
- The physical restraint did not follow a reasonable effort at nonviolent de-escalation;
- [redacted]
- The physical restraint method used by staff was not an approved, authorized or instructed technique recognized by BHDC or documented in DC's IPP.

Right to be Free from Abuse and Restraint

The Respondent's use of restraint in this case was a violation of patient/resident rights and a violation of the facility's obligation to uphold the patient's right to be free from abuse and restraint use. Physical restraint is defined by the federal government (Centers for Medicare & Medicaid Services [CMS]) as: *Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a*

patient to move his or her arms, legs, body, or head freely 42 C.F.R. § 482.13 and C.F.R. § 483.420. Physical restraint is a potentially lethal procedure of last resort which is used in an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or ruled out (42 C.F.R. § 483.450). Patients/residents in health care settings have a right to be free from restraint. To affirm this position and prevent the risk of serious harm associated with restraint use, standard setting organizations such as the United Nations(UN) (2006), World Health Organization (WHO) (2019), and the Centers for Medicare and Medicaid Services (CMS 483.12; CMS 483.420) mandate that **patients/residents of facilities have the right to be free** from abuse and neglect including but not limited to …**any physical** or chemical **restraint** … (emphasis added) imposed for purposes of discipline or convenience. When physical restraints are used, the facility is obligated to use the least restrictive alternative for the least amount of time and ensure that staff have and demonstrate needed competencies to effectively and appropriately interact with clients; monitor and take immediate action to address circumstances where possible abuse, neglect or mistreatment has occurred and prevent reoccurrence of abuse (CMS 483.12; Halverson et al., 2023; Huckshorn et al., 2021; AR DDS 3011-D; UN, 2006; & WHO, 2019).

Threshold for Restraint use was not Met

In health care settings, physical restraint is an emergency procedure of last resort and should only be used in the event of imminent danger to the patient/resident or others (Deposition testimony of BHDC Residential Services Director, S. Evans, 2022; Halverson et al., 2023; Huckshorn et al., 2021). BHDC staff documented and described DC's behavior as:

1. "yelling" (Jones, deposition testimony, p. 67); "screaming" (Jones OLTC Witness statement, labeled exhibit 4, p. 1)
2. "slightly agitated …became aggressive in common area" (IRIS report)
3. "irritated…screaming and cussing…ripped paper off the wall… jumped up … spitting and attempting to hit…" (Mattson, OLTC Witness statement, labeled exhibit 9, p. 1-2)

The behavior described above (# 1-3) is not lethal or life threatening, nor does it pose a risk of serious injury. The behavior described above does not require the use of force or a hands-on containment procedure. The antecedent actions described in the various documents do not meet the BHDC threshold of imminent danger requiring the implementation of physical restraint (BATES: 4348: *Booneville policy, Policy I-D-4, Documentation and Response to Maladaptive Behaviors; Booneville Behavior Management policy)* or accepted health care or restraint standards of practice (Halverson et al., 2023; Huckshorn et al., 2021; Huckshorn & LeBel, 2015; Ridley & Leitch, 2019).

In addition, **it does not appear that DC initiated physical contact with staff or physically harmed anyone** (emphasis added). Per Mattson's OLTC Witness Statement (labeled exhibit 9, p. 2), he (Mattson) initiated physical contact with DC ("*I applied personal by grabbing his arms*"). Mattson grabbed DC's arms. Mattson activated an autonomic, defensive physical response from DC referred to as the "Withdrawal Reflex" (Clarke & Harris, 2004). Mattson initiated the physical interaction with DC; he did so without first utilizing required supported stance and blocking

techniques or any other form of nonviolent de-escalation required to be exhausted prior to physical restraint.

No Reasonable Effort at Least Restrictive Intervention and Non-violent De-escalation Intervention

The documentation provided does not identify any reasonable effort to de-escalate DC's distress. The most basic de-escalation strategies (time and physical space) were not apparent in the direct care staff OLTC witness statements (Campos & Jones). Mattson appears to be the only staff member with DC at the time the problem started. Mattson's written OLTC witness statement (p. 1-2) regarding the sequence of actions is disjointed. Mattson describes DC as: 'sitting, then screaming and cussing, then ripping paper off the wall to throw'. It is unclear how ripping paper off a wall occurs in a seated position. Mattson says DC then "jumped up … spitting and attempting to hit me." If DC was holding paper and attempting to throw it, one of DC's arms was likely elevated and rotated. It is not clear how quickly DC could rise to a standing position and attempt to hit Mattson. DC's physical actions were likely to have been slow, given his physical limitations. Mattson offers no detail about any verbal attempts he made to aid in calming DC, redirecting him, asking him to stop, offering DC any form of support, or utilizing the "supported stance" training.

Use of Restraint Violated BHDC Attending Physician's Order

The use of restraint violated BHDC's treatment plan (IPP) for DC. [redacted]

[redacted]

125; Campos, 66, 67) and medical risk associated with restraint use is covered "pretty intensely" in staff training (Hise, 40). Staff could have and should have taken DC's medical risks into consideration (Evans, 58) and used another approach to help DC manage his distress. Moreover, Dr. Hamid did not approve of the use of floor/ground restraint for DC (77) nor was any restraint method identified in the IPP (483.450(d)(1)(i); Evans, 29, 35). Given the medical risk of restraint use with DC, BHDC could have put DC on their *Do Not Restrain List* but did not.

Use of Restraint Violated Policy Standards

The use of restraint was not consistent with BHDC policies (BATES: 4342). According to the deposition testimony of S. Evans, Residential Services Director, restraint is to be used, *"Only as an emergency measure but only if absolutely necessary* ***to protect client or others from injury****" (p.30)*; per ICF/CMS regulation 483.450(d)(5) and Evans (2022, p.32), *"restraints must be designed and used* ***so as not to cause physical injury to the client"*** *(emphasis added) and implementation of behavior management policy and practices is done when an individual's actions are aggressive, disruptive, and/or present a danger to the individual or others, are* ***managed with the least restrictive method*** *(emphasis added)."* In this case, less restrictive interventions were not documented and the client (DC) was not protected. The client (DC) was fatally injured as a result of unwarranted restraint. No injury to staff was documented and no

threat of serious injury was documented. Furthermore, the unwarranted restraint used was not described, addressed or documented in the facility's policies or in DC's IPP, as required by federal regulation (483.450(b)(1)(IV)); it was, in fact, unauthorized. This use of restraint was not justified per BHDC policy.

Use of Restraint Violated BHDC Staff Training and Practice Standards

DC died as a result of being physically restrained by staff on the floor/ground. According to the deposition of BHDC Staff Development Coordinator and Non-Violent Crisis Intervention Restraint Trainer (Hise, 2022):

- (p. 21, 18-20): *"The only reason that they would use the transition to the ground is putting a resident in mechanical restraint."*
- (p. 22, 8-9): *"I do not teach staff to hold a resident on the ground."*
- (p. 22,19-21): *"The training that we teach in NCI is a standing personal hold and a seated personal hold. There is no on-the-ground personal hold."*
- (p. 24, 20+): *"... use verbal strategies to de-escalate and redirection also teach blocking, stepping back..."*
- *(p. 25): "In the supported stance, if a resident was coming at you, you would put your hands up and deflect and step away."*
- (p. 28, 6) *"No, sir; do not restrain by yourself, use a supported stance to prevent falling over, if restraint on the ground, then prepare for mechanical restraint."*
- (p. 34*) So Booneville Human Development Center does not authorize the use or train staff in the use of restraining clients on the ground except when doing so for the specific purpose of transitioning to a mechanical restraint; correct? Hise's Answer: "Correct."*

BHDC Staff Development Coordinator and Restraint Trainer Mark Hise affirms that the fatal restraint used on DC was not authorized, that the facility did not adhere to relevant restraint-related policies, and BHDC direct care staff did not follow the training they were provided.

There are several steps the Respondent should have taken to prevent this situation including but not limited to:

1) Adhering to international, federal, state, and facility standards identified above,
2) Adhering to AR DDS policy 311-D,
3) Adhering to BDHC relevant policies,
4) Using only BHDC approved and taught restraint methods,
5) [redacted]
6) Not laying hands on and grabbing DC's arms,
7) Attempting non-violent de-escalation techniques, both before initiating the restraint and after DC was taken to the ground, when staff could have simply given DC space as opposed to forcefully holding him on the ground,
8) Per Hise (2022), following BHDC restraint training and NCI protocol and using supportive stance blocking and/or a pivoting technique, particularly if there was a location/position concern,
9) Adopting an organized approach to preventing the use of restraint such as the Six Core Strategies© or Ukeru which was developed with a DD population,
10) Allocating resources to train, retrain, and support/maintain staff competence in restraint prevention and establishing a culture of non-violence,

11) Teaching staff to not restrain any patient with a comorbidity that compromises digestion, respiration, cardiac functioning, etc.,

12) Obtaining external consultation to more effectively respond to DC's distress without hands-on procedures, e.g., considered safety circles, Ukeru approach (blocking pads and ensuring soft items in the environment), etc.,

13) Ensuring patients with [redacted] are put on the *Do Not Restrain List*,

14) Ensuring physician's orders are known and followed by staff,

15) [redacted]

16) Emphasizing restraint prevention and implementing effective alternatives to restraint use such as sensory-based approaches and other methods for staff to support clients in distress without hands-on procedures,

17) Ensuring greater medical oversight of the use of restraint including nursing presence for initiating, monitoring, and determination of earliest possible release,

18) Explicitly prohibiting ground restraint unless medically contraindicated,

19) Developing an organizational action plan of restraint prevention/reduction with a committee representing leadership, staff and families/persons-served.

In short, the Respondent should know the standard of care is rising. In an era of evidenced-based practice, accountability to the persons-served and others is owed. Exemplar programs and organizations serving a similar population have done significant work in creating low/no restraint services for people with developmental disabilities. This information should have compelled the organization to action to change their use of

restraint with persons-served creating a safer environment of care for staff and patients alike.

Opinion Two: The respondent facility's emergency response policy fell below the standard of care.

Standard of Care

The Respondent facility's policy, which prevented non-medical staff from calling 911, created an unnecessary obstacle to emergency response and life-saving intervention. The artificial layer of on-site communication created a dangerous circumstance for DC and all residents and likely contributed to DC's death. This approach to emergency intervention no longer occurs in other DDS state systems, such as Massachusetts, New Jersey, and Washington. Massachusetts DDS policies have required staff working in DDS settings to report events that they have reason to believe are harmful, including calling 911, since 1999 (#1999-4). New Jersey DDS enacted *Danielle's Law* in 2003 requiring staff working in services for people with intellectual/developmental or traumatic brain injury to call 911 when there is a life-threatening emergency to prevent delayed medical response Division of Developmental Disabilities | Danielle's Law (nj.gov). Washington state encourages staff and caretakers serving people with developmental disabilities to dial 911 and reach out online in the event of emergency circumstances (Report Concerns Involving Vulnerable Adults | DSHS (wa.gov)).

Recognizing the importance of unimpeded 911 access, broad federal legislation (Kari's Law) enacted in 2020 establishes that employers have a duty of care and a legal

responsibility to help protect anyone using their phone system. When an emergency call takes place from within an organizations' network and the caller cannot connect to 9-1-1, or if dispatchers cannot pinpoint the caller's location, the employer can be liable in the event of an unfavorable outcome due to a delayed response. New legislation has also introduced penalties for any business or organization that does not comply.

The opinions contained in this report are based on my professional opinion and are within a reasonable degree of certainty within my field of practice. In the previous 20 years I have not testified as an expert at trial or by deposition. I hope these opinions are useful to you. If a more detailed analysis is desired, I would be happy to continue to review the documents provided or other materials made available to you. In the meantime, thank you for the opportunity to provide this expert opinion regarding the use of restraint with DC.

Best regards,



Janice LeBel
Board Certified, MA Licensed Psychologist-Provider, #4950

JLL/mht

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF

JANICE LEBEL, PH.D.

January 9, 2023, at 9:05 a.m.

CRIS M. BRASUELL, CCR
ARKANSASCOURTREPORTER.COM



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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Janice LeBel, Ph.D., produced, sworn, and examined via Zoom, commencing on January 9, 2023, at 9:05 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

P R O C E E D I N G S

(WHEREUPON, Janice LeBel, Ph.D.,was duly sworn to tell the truth, the whole truth, and nothing but the truth and gave the following testimony to wit.)

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q All right. Dr. LeBel, thanks for being here today. If you could, just state your name for the record.

A My name is Janice LeBel.

Q All right. And, Dr. LeBel, currently what is -- what do you do currently, Dr. LeBel?

A Currently, I'm employed by the Massachusetts Department of Mental Health.

I am the Director of System Transformation and have been employed by the Commonwealth for 38 years. I am on the faculty of UMass Medical School Department of Psychiatry.

I am a consultant on the use of the six core strategies and also the building bridges initiative, which is a SAMSA supported initiative to transform residential care. I am the coprincipal investigator of the six core strategies and do significant teaching and training on this model.

In my state role, I am also the agency lead for a

restraint, seclusion, prevention initiative for the past 20-plus years, and also lead an interagency effort that was endorsed by the Executive Office of Health and Human Services for seven state agencies in the Commonwealth who use restraint and seclusion to lead an initiative to reduce the use of restraint seclusion across our different treatment settings.

Q All right. Thank you, Dr. LeBel.

And if you could, if you don't mind talking a little bit about your background and how you got -- how you came to have this specialization and -- or a career in restraint reduction.

A My career and focus on restraint reduction started early on in my professional life.

As a student, I worked in inpatient settings and witnessed my first restraint and was asked to participate in it and thought it was just patently wrong. It was horrifying to watch. It was horrifying to participate in and there was no need for it.

I took that response and reaction to this untoward event with me in my professional career as I move from inpatient settings where restraint was used sparingly on occasion into my role at the Department of Mental Health where I have a statewide purview.

And, in that role, every person who uses restraint

in a facility that is contracted or licensed by the Department of Mental Health must report on every episode of restraint that's used on every person every month.

And, more than 20 years ago, as I assumed, my more administrative role was receiving box loads of restraints on a monthly basis and started to read the restraint forms.

And the patient comment forms became abundantly clear to my colleague in the licensing division and I, that restraint was being used as a primary intervention. It was not being used as an emergency response in the event of imminent harm.

And we started to launch a period of investigation, and this was a 1999, looking for low, no restraint programs, looking for better and best practices, looking to study, learn, visit, and bring back what we could to be able to use our role in the Commonwealth, the Department of Mental Health has the statutory authority as a State Mental Health Authority to set the clinical standards.

And so our decision was to bring back the best practice that we could find. And we launched with our commissioners support, who then became the Secretary of Health and Human Services, an initiative that has continued to this day to really transform care.

So, whether it's inpatient care, residential care, if you're laying hands on in a health and human service setting, we are going to help people to develop the skill set.

So it was really that early experience participating in restraint and then seeing how much it was being used in our state, and then looking for better practice that led to appreciating what we could do differently.

It also led to being -- my being tapped by the federal government in a SAMSA supported effort to look for best practice and be able to come up with teaching and training.

Because there was a national expose by the Hartford Current in 1998 that led to congressional response and national uproar.

It was a series of six articles that really got Congress's attention and lead to funding to SAMSA, which found its way to NASMHPD, the National Association of State Mental Health Program Directors, to come up with solutions for the country; because state mental health authorities across the country were asking for support and learning how to do things differently.

So my colleagues and I, who had already been doing this work, were asked by the federal government to come and participate in a series of experts meetings, which we

did, with about a dozen other people, including persons served, who had experienced restraint and seclusion in systems of care or in individual treatment settings.

And what we found by really looking at what we had each done separately was a set of six core common strategies that had been used to reduce, prevent, and sustain reduced use of restraints seclusion over time.

So we developed a training curriculum based on these six core strategies to prevent conflict and violence in treatment settings. We got national funding to roll it out and done many, many trainings, have gone to all 50 states.

This training has then gone to other countries as well, and had been picked up and adopted by Australia, New South Wales. It is their template for inpatient care. It has been used in Canada, in multiple facilities in Finland and Germany and Turkey and England and Ireland, Australia and New Zealand.

So the framework was studied by the federal government and determined to be an evidence-based practice, and was included in the National Registry of evidence based programs and practices in 2012; which means it was studied in more than 42 settings in which restraint was used.

The curriculum was applied and researched and

reductions were seen.

And the litmus test for inclusion recognized that significant reductions, episodes and duration of restraint, were in fact bona fide using this curriculum. So it was incorporated as an evidence based practice. And, since that, we've continued to teach and train and publish and report out.

I should also say that my expertise, and I'm humbled by this, led to being asked by Congress to come in and do a congressional briefing on the use of restraint and seclusion and prevention efforts that could be gained.

It also led to my being asked by SAMSA to write a white paper on restraint, seclusion, prevention, and the benefits associated with restraint seclusion reduction efforts, which I did and was published.

I was then asked to write several issue briefs on best practices associated with restraint and seclusion reduction. I've been asked to present many times across the country and internationally.

I have been a keynote speaker at several conferences, including two of CPI's international conferences in 2016 and then in 2019, in Bristol and Birmingham in the UK. I've about also have been a keynote speaker for the Wyoming Developmental Disability Services back in 2006.

I have been asked to study, as part of my white paper work, a facility in Virginia run by Grafton Integrated Health Network, in which they had substantial reductions. They reported out on their cost benefit analysis. And I studied their work and published on it and included their findings in my white paper analysis and also the issue brief.

This led to my being asked to do teaching and training with Kim Sanders who went on to develop the Ukeru curriculum, which is broadly based on the six core strategies. And Ukeru was specifically designed with a developmental disability population in mind.

Their organization, Grafton Integrated Health Network, operates just about all levels of services where people with developmental disability services across all ages, they operate in multiple states and also had services in Australia as well.

I have done teaching and training with Kim Sanders, the developer of Ekeru. We have consulted and trained at developmental disability centers in California together and also with the State of Maryland who picked up the core strategy framework in adopting this in their developmental disability services.

So I've been afforded one -- many wonderful opportunities to learn about best practice from people

who have done this work and continue to do this work.

I have also done significant research. I'm the only author that I know of that has done a time-cost analysis on the mechanics of restraint use and the benefit of restraint reduction. I have authored several chapters in textbooks. I'm the editor of a book on transforming residential interventions.

I have published many journal articles. I am on the professional review board of more than a dozen journals. I've been asked to be an expert witness in 12 cases so far and two with the Federal Department of Justice.

So I will pause here.

Q Well, thank you. Thank you.

Couple follow-ups. Is it fair to say, that in your 39 years of experience with the Department of Mental Health of Massachusetts, that restraint reduction has been your key focus of both research and application?

A It has been a key focus. I incorporate that knowledge into the work that I do overseeing facilities and take that knowledge into advancing the practice standards for the facilities I oversee.

So it's not just the knowledge of restraint and seclusion reduction and prevention and affording the training to the staff, but it's also pushing our practice standards within the services that we contract for and

oversee.
Q Could you talk a little bit, if you would, about how the -- how your research and how the six core strategies and how what you've done in Massachusetts is applicable to the developmental disability population?
A Certainly. The work that we started in Massachusetts that informed the development of the six core strategies is really not population bound or dependent; which is why our Secretary of Health and Human Services asked us to go beyond mental health and include juvenile justice, developmental disabilities, Department of Public Health, early elementary care, which is the licensing agency, child welfare, and also the public elementary and secondary education, the schools.

So any place that used restraint and seclusion was asked and tapped to be part of this initiative. Because the six core strategy framework is not population bound. It is intended to be an organizational framework for leaders.

Ultimately, the use of restraint and seclusion falls on leadership. And it is their responsibility to create the conditions and support staff to give them the skills to set policy teaching, training standards, and including the voice of those that we serve in prevention efforts.

So it is an organizational framework that has been

applied to prison settings and nursing homes. It's been used in preschool, day schools.

It's been applied in juvenile justice settings. It's been applied in nursing home settings.

Again, this is an approach for leaders, managers to take to understand how to address a problem of conflict violence and how to learn how to move upstream and prevent it from occurring in the first place. So that's why it -- it doesn't require that this be exclusively residing within a mental pop -- health population.

Q And in your experience and in your studies, why is it important to reduce restraints? What's harmful about it that would necessitate reducing the use of restraints?

A Restraint and seclusion use is a devastating impact. It has untold consequences when used with persons served.

These moments are akin to hand-to-hand combat. These are acts of violence that have, according to Charlie Curie who is the head of SAMSA, the national leader and spokesperson, these are disgraceful practices that have no place in the human service setting that serves people with disabilities, with mental illness, who are seeking care from us.

These are aggressive, violent acts, that are extraordinarily harmful. They're harmful to the person served, they're harmful to staff.

And then there is secondary trauma to those who hear, witness, observe. Wherever that restraint is happening, you get vicarious trauma as well to those who are aware that it's going on. It conflicts with treatment and recovery settings because this is not treatment.

It has no place, as Charlie said, in a treatment service that's focused on helping people to be able to recover and improve their circumstance.

It is extraordinarily harmful to the body, physically. It has a traumatic effect on the homeostasis of the body. For people who are experiencing restraint, there is traumatic, emotional effect that lasts for years.

If you wouldn't mind by giving you an example of this.

Q Sure.

A I had the opportunity to present in Texas, for the Hogg Foundation, for a statewide conference with people representing a range of different types of treatment settings.

And I participated in a panel presentation with a gentleman who identified himself as having been in an inpatient setting almost 20 years earlier. He said his name was Rick Hansen. And, since he was in a treatment

setting where he'd experienced physical restraint, he had left that treatment experience, gone on, graduated from college, obtained a job, gotten married, had two children. He said, I even have a home, I have a mortgage; by all accounts in life, I am a successful human being. But I still remember that episode of being restrained like it was yesterday. It stings so bad. So I take that, that testimony, very much to heart.

I studied children in our own inpatient treatment setting at Cambridge Health Alliances Pediatric Inpatient Service that serves children aged six to 12. This was our first inpatient setting in Massachusetts that stopped using restraint and seclusion.

And they interviewed the children after a restraint had occurred. And this was interviewing them, probably three to four weeks later after the event. The vast majority of their hands-on procedure is almost 70 percent were less than one minute.

When they asked the children about their experience of that less than one minute hands-on intervention, their memory that came back was one that they felt wounded, harmed, scared, frightened. Their sense of time was grossly distorted.

All of them thought it lasted anywhere from ten minutes to over an hour. That memory lingers. Just

because it is over for the staff, administrators who process paperwork, and think it's resolved through discussion, it is not. It lives on in the body, in the mind, in the memory of those that we serve.

I take that very much to heart as part of my ethical responsibility, as a Board Certified psychologist, and as a steward of the Commonwealth of Massachusetts and the resources that we deploy for serving the Commonwealth citizens to give the very best that we can.

You can't walk away from that knowledge and just, well, hope it really wasn't a bad situation, hope they get over it. They don't.

Q Are there physiological things that happen during a restraint that make it such a profound experience for those on the other side of it or on the receiving side of it?

A Yes. For people who experience restraint, there is, as I said, it's akin to hand-to-hand combat.

This is a physical, violent interchange between human beings. So what you see is a rise in the heart rate. You see respiratory compromise, you see a heightened -- you see an increase in blood pressure. You can see people who can lose control of themselves.

You can see vomiting, you can see defecation. You can see any number of physical traumatic impacts on the

body. And this is well taught in CPI and NCI's curriculum about the physiologic response.

There is also something that happens when people are repeatedly exposed to this kind of circumstance called catecholamine rush or a cortisol flood. And catecholamines and cortisol, they're called a stress hormone.

And after minutes of, really, agitation and extreme physical exertion, you see a flood of the stress hormone, which then exacerbates the cardiac function. You see cardiac instability. You see respiratory compromise. You can see air hunger. And you can see a collapse of the body.

What you see also over time, with people who've been repeatedly exposed to this kind of traumatic stress, is an allostatic load. It is an over -- it is an abuse of the physiologic system where people's physiology really starts to become seriously compromised because of this traumatic load on the body, particularly if it's repeated over time.

So there is absolutely a physiologic response. People get injured, you see broken bones, broken teeth. You see contusions, you see abrasions, cuts, and you can also see -- see people rendered comatose. And sadly, as in David's circumstance, he died. He died.

Q And so a person can become habituated, so to speak, to being restrained?
A I don't think people become habituated to being restrained. I think every restraint is like the first time.
Q Okay.
A I don't think people get comfortable being restrained.

I think there is an emergent, physiologic response that happens each time somebody is restrained. And, when people have been repeatedly restrained, the body is significantly compromised.

You know, I think we only have to look at our federal government. And we look at people, look at our soldiers coming back from conflict, violence, and war. We don't see people with just, you know, a general anxiety. You see people with post traumatic stress disorder.

This has an extraordinary effect on the body, on the mind and behavior.
Q Okay.

Moving back to the six core strategies, could you describe -- take the -- and we'll get into the specifics of what happened with Davie more as we move through your deposition.

But I would like to hear from you how the six core strategies, which, as you've said in Massachusetts and other states have applied, could have been utilized in Davie's case. What that would have looked like, so to speak, so that we can get a better understanding of, you know, kind of what the six core strategies, what they do.

A Well, the six core strategies, as I said earlier, it's an organizational framework to address a problem.

In this case, it's the problem of conflict and violence that leads to the use of restraint. What the six core strategies could have afforded Booneville and could have afforded David and anybody else that's restrained is an organized approach; meaning, that first and foremost, leaders would have recognized that restraint is an extraordinarily damaging procedure that should only be used in an emergency circumstance or a last resort.

And leadership, which is the number one core strategy, would have adopted the imperative that we will do whatever it takes.

One of my colleagues, Dr. Maggie Bennington Davis, medical director of an inpatient service in Oregon that stopped using restraint and seclusion, under her leadership said, quite simply, you have to, as a leader of a health care service, adopt the perspective that

every episode is a big damn deal. That's her language, not mine.

So when leaders adopt that every event of a hands-on procedure is a sentinel event, then you do whatever it takes.

In this case, the leadership should have organized a multidisciplinary cross-discipline approach to having all levels of staff who, who participate in, witness a restraint or a seclusion, participate as part of an action committee to address it.

They should have adopted basic core strategies as a place to start. The second most important place to start is in workforce development. So an organized committee would have looked at what are we teaching staff, what are we training staff.

They would have looked at when restraint is occurring, under what circumstances. They would have been using their data to look at the frequency of restraint use, when it was occurring, what shift, what staff are involved.

What staff need, more training, support or what staff, as my colleague in Tennessee who's done my teaching and training with me, when you have to say to staff, take their gifts and graces to other places because they can't learn how to take a reflective pause,

keep their hands off, and do something else.

Another core strategy is the use of prevention tools; which is a perfect fit for developmental disability center like Booneville. Because this is where you give your staff the tools to be able to assess what is happening and to be able to use alternatives to hands on.

In this case, they should have been using sensory integration, sensory modulation. These are perfect tools for people with developmental disabilities who may have expressive or receptive language challenge.

In this case, we go right to sensory experience, sound, music, olfactory intervention. We look for other ways to be able to help people calm and soothe. So prevention tools is another important strategy.

Debriefing is another core strategy in which it's the only tertiary prevention strategy that's used in this framework. But this is acknowledging it happened, we don't want it to happen again.

Leadership commits to this and so leaders conduct a debriefing. Executive leaders assume the responsibility for reviewing each and every occurrence like it was a heart attack. As I said, as Maggie Bennington Davis calls it a big damn deal.

And I can tell you that debriefing is so much of an

important core strategy that it's been adopted by the Pennsylvania State System of Care. Their state hospital system has been doing this work longer than any other state with extraordinary outcomes. They've used and published on their use of the six core strategies.

But they've eliminated mechanical restraint in their hospital settings that do serve people with developmental disabilities. There is no seclusion use. There is no unscheduled forced medication use.

There is physical restraint use in their settings, but it is standing only. No one goes to the ground. And the maximum order is three minutes --

Q Uh-huh.

A -- standing. That's it. And they -- they served 2600 patients. And so they have done an extraordinary work.

But the reason I tie into debriefing is they hold it as a leadership responsibility to understand why this big damn deal, sentinel event, occurred in the first place. What we can do to learn about it, what does staff need to know, what competencies do they need to have to be able to prevent this from occurring again.

So we have exemplar states, we have exemplar programs that have taken the six core strategy frameworks, but the essential number one core strategy is

leadership.

So leadership could have organized and had a strategic action committee. They would have been focused on workforce development. They would have studied, applied, used their data. They would have involved persons served, those that they serve, the families involved, involve them in -- in understanding what happened, why and what they could do differently next time if -- if it did, in fact, happen.

So that's the core strategy framework in a nutshell. If you'd like more information.

Q All right.

A But I think it could have served them very well if they had made restraint, prevention, and reduction a priority. And it clearly wasn't.

Q On a more micro level, in an incident or in an event where there is aggression, would the six core strategies -- I think you referred to some tools.

Are there any tools you can give me as an example that could be used that would not require laying hands on a patient?

A The six core strategies is not a restraint technology. It does not teach any kind of hands-on procedure whatsoever. They teach alternatives to restraint and the prevention tools, core strategy. And

these tools are many.

One is -- you start with the fundamental assessment of the person served and their history, their needs, what they respond to, what they don't respond to. And you take that information and you use that to continually update something that we would call like an individual crisis prevention plan.

I didn't see evidence of an individual crisis prevention plan for, for David. But it's a fundamental plan that supports staff and persons served, to know what to do if things are getting difficult. So it's a teaching of the staff what to do in the alternative.

So some of those alternatives could be time, space. When I say sensory integration, sensory modulation, that's using sensory experience.

Sound, you know, I'm aware that, that, David, liked the Monkees. If I was working on that unit and I know he liked the Monkees, you bet, if he's -- if he's upset and agitated, I might be trying to think what kind of Monkee song was going to work right then.

Q Uh-huh.

A You know, I might be using something like he likes certain taste items and foods. That can be used under certain conditions, not when someone's extremely agitated. But there's a whole host of actions that can

be used.

Movement can be done. We -- we teach, and in most of my services, we have gliders, rocking chairs or gliders. The gliders promote the vestibular sway, which is considered the single most efficient method of calming down. That's why you see airports full of rocking chairs and gliders, to help people calm down.

So I would have been looking for any kind of physical opportunity to create a possibility of calming the body down.

And there -- there other methods as well. It really depends. What you have to do is match the intervention to the level of distress. You don't use all interventions at all times. Some interventions are just not going to work and shouldn't be attempted. But there are a number of interventions that can be used.

Q And, if a patient has been at the same facility for 12, 13 years, presumably the facility should know that patient well enough to know what works, what doesn't, what triggers are, what triggers -- what his triggers are and so forth?

A Presumably. If someone's been at facility 12, 13 years, they should be very well known by the facility.

Q You talked about some benefits that states that have adopted this hands-off approach, the six core strategies,

have found.

Have there been -- has the State of Massachusetts, for example, have there been benefits to the State of Massachusetts since adopting the six core strategies?

A When we started this work, back in -- the study period was in 1999 and we launched in 2000. And I studied in my own state, particular inpatient service and their use of restraint. And then we looked at the reduction.

And then we looked at all of the hidden benefits that people weren't explicitly focused on. I'm not only a psychologist, I'm an administrator, so I care where the dollar goes.

So, when we did the time motion task analysis and realized that something like what would be considered like a one-hour episode from start to finish actually claimed more than 13 hours of staff time. There was so much hidden time attached to every event that you realize you were quickly draining your staff resource away from the reason that they're there, which is to provide care and treatment to persons served at an exponential number.

So when we studied the time benefit analysis, we found that a person served got better faster. We found shorter lengths of stay. We saw significant reduction in injuries to staff and to persons served. We saw

significant reductions on the order of workers compensation claims and injuries and case-made claims.

And we also saw that there was a significant benefit to staff retention. There was an 86 percent reduction in staff turnover, which was extraordinary. So people were happier on the job. They weren't getting hurt. They felt more competent and confident in what they were doing. People were getting better.

The culture of care became much more peaceful. And people felt connected again to the reason they went into health care environment.

So that work was published in Psychiatric Services. It helped to fuel our interagency effort. And it was our director, our Secretary of Health and Human Services, who said we've got to branch this beyond mental health into all of Health and Human Services wherever restraint is occurring.

So that was the fuel, was understanding the hidden benefits that people don't focus on; because they're so busy counting the number of episodes, maybe the duration, but they're not seeing the negative impact of restraint and how it ripples in a toxic way across the organization.

Q And, again, to be clear, the -- Massachusetts has saved money since doing this?

A Massachusetts has saved money.
Q Okay. And this program and the work that you've done has been applied to developmental disability, intellectual disability populations --
A Yes.
Q -- as well in Massachusetts?
A Correct.
Q Okay. All right.

MR. GILLISPIE: Let's take just a three or four minute break here.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:
Q All right.

Dr. LeBel, if you don't mind, I'd like to kind of move into the standard of care that was in place here in Arkansas that applied to the facility at the time of David's death and what your opinions are with regards to whether that standard of care was met in the case of David's death.
A As I had the opportunity to review the policies, the procedures, the state's regulations, as well as the CMS standards, it would appear that there was a reasonable standard of care conceptually in place, but it was not

adhered to.

At a very basic level, the standard of care was breached. When you look at international standards from the United Nations and the Convention on Rights of Persons with Disabilities, the World Health Organization, in 2019, put out a fantastic quality rights training that is explicitly for people with mental disabilities, cognitive impairments, mental health issues.

And it is an elaborate training that really bespeaks the need to attend to people to be able to avoid the use of restraint and seclusion.

So, internationally, the standards have been set, resources have been provided. We look at the federal government and their ICF/IDD standards. CMS has made it abundantly clear, you know, this is a treatment service. People have the fundamental right to be free from abuse and unnecessary restraint use. They have the right to be protected by the facility, that these rights be upheld.

They have the right for at least restrictive interventions to be used for the least amount of time. And if they're used, for release to happen as soon as possible and as soon as the person has calmed.

These procedures should be designed to not cause injury. They should have and use a hierarchy of interventions from least intrusive, most positive to most

intrusive, least positive.

They should identify the type of physical restraints that are allowed. They must specify which approved physical restraint can be used and document that in the client's IPP. It should be an emergency measure, if absolutely necessary, to protect the client and others from injury. It's used only when the client is exhibiting behavior that the client has not exhibited before.

It's identified in the FBA, the Functional Behavioral Analysis, or the client is in the act of harming other people or themselves. CMS goes further than that. And I appreciate that those are really helpful standards that, in theory, Booneville applied and adopted.

However, CMS goes that much further by declaring the use of restraint that leads to serious injury or death as a never event. CMS has declared that this is something that is a shockingly medical error and should never occur in a treatment healthcare setting.

They identified this back in 2002, came up with a list of procedures that are considered never events, and have actually started doing the physical clawback and refusing to pay for care in which a never event occurs.

So, while CMS has set a standard, they've also

declared and gone further, that if there is serious injury or death that occurs as a result of restraint, it is a never event, it should never have happened. So they set a clear bar.

And I appreciate that the Arkansas Developmental Disability Services followed, you know, the CMS standards set. And they require that the, through their regulations, that the CMS IDD standards must be upheld.

And they uphold that client actions must be aggressive, disruptive and/or present a danger to the individuals or others and manage with the least restrictive method.

They acknowledge that there must be imminent danger to health and safety in which death or severe bodily injury could reasonably be expected to occur without intervention. That's a very clear bar.

Q Uh-huh.

A Imminent danger in which death or serious bodily harm could be expected. They also --

Q So any form of restraint used, absent the presence or absence of imminent danger, defined as death or severe --

A Severe --

Q -- bodily harm --

A -- bodily injury.

Q -- would be a violation of the standard of care?
A That's my understanding.
Q And any restraint used that's not the least restrictive approach possible would be a violation, a violation of the standard of care, according to CMS?
A According to CMS and also developmental disability regulations who adopt the CMS IDD standards.
Q Can you --
A What I also appreciate was that they identified -- the DDS regulations also said that restraint may not become routine method of intervention. And, if you used three times in six months, that there should be an IDD conducted with another FBA and a plan of action.
Q Uh-huh.
A And I don't know if that occurred. I didn't see evidence of it.
Q Okay. You saw no evidence that that occurred in anything --
A No.
Q -- that you reviewed?
A But I also see, you know, there are a levels of layers here.

We've got an international standard. We've got a federal standard. We've got a state standard. And then we get right to the facility and Booneville's policy.

Clearly, they are not following the CMS standards. They're not following the DDS policies.

They did not use least restrictive intervention. They did not use it for the least amount of time. There was no imminent danger. There was no emergency.

The type of restraint that was used was not approved. It was not part of the CPI or NCI teaching and training. It was not in his individual IPP. It is a violation of the physician orders regarding his problem with GERD.

It was not an approved technique where he was restrained on the ground. That is not consistent with CPI and NCI. CPI has their own standards and practice standards. And that is not part of their teaching and training. It is seated or standing only.

As I read the Booneville policy, it's the only -- there use is -- the only approved personal restraint is holding a hand or limb. I read one and a.

Q Uh-huh.

A A hand or limb. Not both.

Q Right.

A It's only used as an emergency measure to control severely aggressive behavior. So I read multiple levels of failure there.

I also read in the behavior treatment plan that was

authored by Mike Alvis, that the -- all the medical orders would supersede anything and everything and would take precedent over all forms of personal restraint or interventions.

So I see multiple levels of a lack of adherence to a framework, which on paper would be reasonable, if they in fact adopted it and practiced it. But there were multiple failures there.

And I have to say, though you didn't ask this question, I'm really shocked. But looking at the investigation findings, the mortality review findings, looking at the timeline that was provided, the events, the timeline makes no reference to the restraint event.

And the mortality review done by the Department of Developmental Disability Services has no recommendations and felt they met the standard of care. Well, they just flew in the face of CMS, who said this is a never event, it does not happen.

Q Uh-huh.

A So how you can say that this met the standard of care. Death is not part of standard care, period.

Q Uh-huh.

A So I -- I really am terribly disappointed and shocked that this would be an outcome and a finding.

This is a tragedy that should have been used as a

teaching experience for the facility, for staff, to make sure this never ever happened again. This ultimately is a failure of leadership at multiple levels.

Q Okay. Well, and let's get into how, how these violations of standard of care were applied in this particular case. Or how what happened, how the incident, the restraint incident that caused Davie's death was a violation of the standard of care.

We've talked about -- or you've talked about that the restraint use wasn't in his IPP. It wasn't in the Booneville policies and procedures. It wasn't a form of restraint that was taught or authorized by the facility or by NCI which the facility uses, wasn't the least restrictive method. There was no emergency.

If you could, just get into how, why it's your opinion that there was no emergency and why it's your opinion that it wasn't the least restrictive option available.

A As I read the description that was written by Tyler Mattson in his OLTC witness statement, I didn't see the criteria that would warrant laying hands on.

He talked about screaming and cussing. He talked about ripping paper off a wall and throwing the paper. That is not imminent harm standard. There is no reason to activate a hands-on procedure.

I found his statements confusing because they conflicted with one another. It's hard to get a clear narrative.

But, looking at his very first statement, which is most recent to the event, the criteria for touching someone against their will --

Q And he also says that David tried to hit him; right?

A He said spitting and attempting to hit.

Q Right.

A So I don't read that contact was made.

As I read in the deposition, that he did not hit, that he did not have a history of being harmed by David. And I read that Mattson said that he applied personals by grabbing his arms and he, David, ended up falling over.

Mattson says I did not land on him. Well, I guess it's a tumble, for one. And I don't know if Mattson lowered his body down. It's hard to really discern from his description.

But spitting, tearing papers, screaming, cussing, absolutely not, does not require a hands-on procedure. What Mattson did is he activated a behavioral sequence by touching him against his will.

He activated what's been called the withdrawal reflex, which is where a noxious stimuli, like a hand on an arm is placed on someone with pressure. You're going

to see that sensory experience lead to a withdrawal by the person of their hand and activation of the other half of the body. So this is a procedure that is well known that -- that he has activated by starting the behavioral conflict.

David's behavior, as its described, once he's on the floor, he's attempting to squirm. Of course he is. He is trying to flee and escape a noxious situation. His behavior makes sense.

Mattson's behavior does not make sense. Given the restraint on the ground was not taught by CPI/NCI. What Mattson should have done is released him, backed away, given him time, given him space.

There was no reason in the first description that he should ever have touched him. He should have been quiet and observed and assessed and tried to provide him with some of the, the sensory interventions that they said he liked.

So he liked staff attention. He liked staff support. He liked music. He was, you know, someone who was described as someone like a four-year-old. So you give that four-year-old time and space. I didn't see any of that in what I read.

Q And understanding that that there was no -- there was no testimony or evidence that David did hit or make

contact with Mattson, hypothetically, if David had attempted to hit Mattson or looked like he was going to hit Mattson or looked like he was going to grab Mattson, would your opinion change at all?

A Well, if it looked like he was actually going to make contact, if he was actually going to land a blow, you know, NCI teaches a supported stance and a pivot response for staff to be able to use to escape that circumstance so they don't get hit. As I read --

Q Is that the blocking technique described by Mark Hise in his deposition?

A Correct. I think Mark Hise did a nice job describing the techniques that they teach to staff to avoid having the situation of being hit, you know, and if there is a lack of distance between them and how to physically shift your body, your weight.

How to block a blow, he described a sweeping like a matador to be able to block that blow and to not incur injury. So it appeared that staff are well taught, reasonably taught. Mark Hise's testimony was very clear about what Mattson did was not taught, not approved, not something that comes from the approved curriculum at Booneville, that what he did and what the -- his colleagues did, Mandy and Ryann, also were not taught and not approved.

So that restraint on the ground was not part of the Booneville policy. If they had adhered to their policy, you know, we wouldn't be talking now.

Q And so that's a standard of care violation at its most basic level; right? A violation of the facility's own policies?

A Correct. The staff did not follow the facility policy or their teaching and training.

Q Okay.

Are you able to speak to the sort of inherent danger of restraining a person on the ground?

A Well, I will be clear that I'm not a physician. But I've been doing this work for more than 20 years.

And I have participated in other legal proceedings in which people have died. And I have been teaching and training on the medical risks associated with restraint use. This is part of a curriculum that's been developed with physician practitioners. And I have written and published with medical experts on the physical implications of restraint use.

So I believe I previously said, that when someone is physically restrained, it is an aggressive interchange between people. So you're going to see physical agitation that's going to lead to an elevation in the heart rate, an elevation in respiration, an elevation in

blood pressure.

You're also going to see -- likely, you're going to see the cortisol flood, catecholamine rush. It takes a physical toll on the body.

And I should say this isn't just, you know, my teaching and training. This also comes right out of the CPI/NCI training manual. You know, they also identified the medical risks associated with restraint use.

And, sadly, they also profile what the likelihood is of restraint death, and the profile of people, which I think David met most of the criteria. Males, overweight, people with mental health or developmental disabilities.

So they -- they did a profile of those most at risk. And, sadly, David met most of those criteria.

So this isn't just my teaching and training but this is also what occurs in the teaching and training that's been afforded the staff at Booneville.

Q Have you found over the years that any population that's particularly vulnerable to the harmful effects of restraints?

A This is very sad. In my experience in the teaching and the training through the core strategy framework, we teach a module on the traumatic effects of restraint and seclusion.

And we talk about the experiences of different

populations and the history of trauma, that in -- of those who are served in Human Services is extraordinary. But people with intellectual and developmental disabilities are considered most at risk for abuse and the use of restraint and the traumatic effect of restraint.

And, why is that, because they have expressive and receptive language challenge. They are not seen as credible reporters. They are at risk for being victimized by people who know they can take full advantage of them.

So they are particularly at risk for being traumatized in care settings, being abused and neglected in care settings. And I'm happy to send our literature citations. There are several who have published on the risk associated with people with intellectual and developmental disabilities simply by virtue of being in care, their risk of being abused, neglected, or traumatized is quantumly increased.

And that would include the use of restraints seclusion. They are, as a population, horribly victimized by virtue of their impairments.

Q Okay. Thank you.

And, based on your experience and training and expertise in this field and also based on your review of

the different levels of regulation, you mentioned international, federal, state, and facility level regulations and policies that Booneville was bound by, based on all that, what is your understanding of the -- what is your understanding of what would, in fact, meet the criteria of an emergency situation, that, pursuant to the NCI training given at Booneville, authorized at Booneville, would allow a staff member to place hands on a client?

What would be that level of -- what would meet that standard of emergency?

A Well, the standard of the emergency, you know, would have to be something in which there was severe aggression, the risk of serious harm and danger, that you would see a level of lethality attached to it. Like somebody has a weapon --

Q Uh-huh.

A -- and they are threatening to severely hurt someone. By weapon, I'm not talking about a piece of paper. I'm not talking about throw on a chair. That can happen in any home in America at any day. I am talking about something that could seriously hurt someone.

So we're looking at how to prevent the likelihood of serious, serious bodily harm. So anything that speaks inherently dangerous, lethal consequence is when we would

use restraint.

That's the intent of restraint. The intent of restraint, is to save a life when a life is threatened. It has a purpose. It was --

Q And what was the -- and what would you say the intent of the restraint was in this case? Based on your review of everything.

A It would appear, based on my reading of what Tyler Mattson did, is he's attempting to control David physically.

Q Behavior control?

A Behavior control.

Q And based on your -- and I understand you also reviewed -- you reviewed David's prior restraint incidents. And they were, you know, hundreds over the years.

But, specifically, you reviewed the ones that occurred most recent, most proximate to his death; is that correct?

A That's correct.

Q And I believe three of those, perhaps maybe the three most -- the three restraints that occurred just prior to his death were by Tyler Mattson.

And what did your review of those indicate to you?

A Well, my review of those events in which Tyler

Mattson was directly involved, just before the restraint that led to David's death, is that Tyler Mattson uses restraint as a primary intervention. That there is no attempt to de-escalate, to calm, to support.

There may have been one comment about, you know, calm down; but, otherwise, he -- and, in one case, went directly into hands-on procedure. He's using it as a first level of response repeatedly.

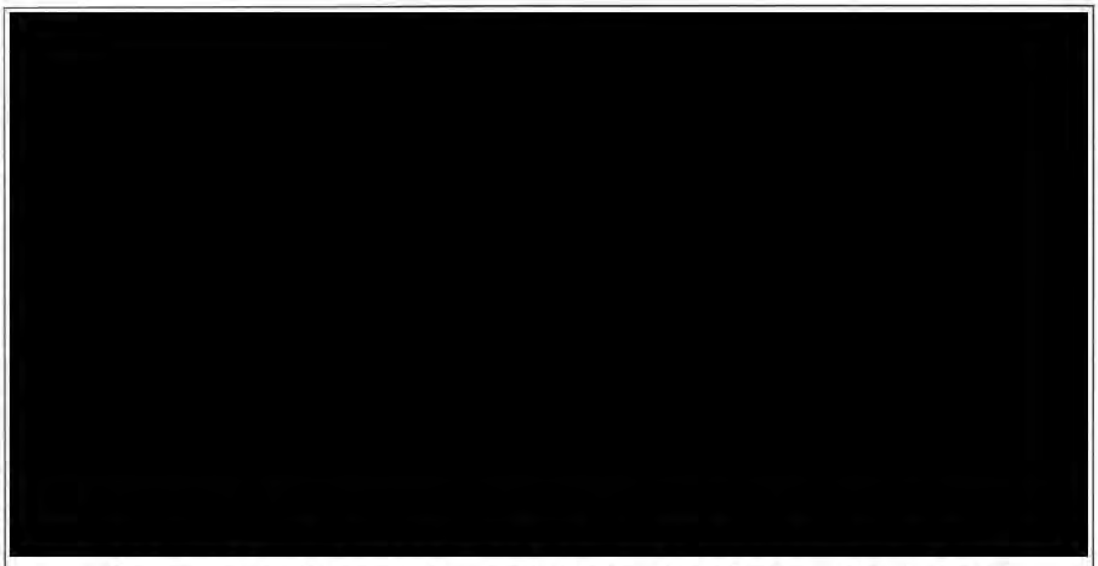
Q And the fact that he's doing this and getting away with it, what does that indicate to you about the facility --

A The fact that --

Q -- and/or the leadership?

A The fact that he's doing this repeatedly really bespeaks a serious leadership problem. It bespeaks a lack of supervision. It bespeaks a culture of care that allows for restraint to be conducted and to continue.

[redacted]



Because any person, and this is where, as I said earlier, leadership assumes the responsibility of looking at these debriefings and treating it like a big deal. While I gave you the example of what Pennsylvania does by seeing your leaderships, that's the CEO, the CMO, the Director of Nursing, they look at these events on a daily basis. They start their morning rounds this way.

They then go take responsibility and do the debriefing. So when an organization is committed to a culture of care that is nurturing, kind, and supportive to both persons served on staff, you take these events seriously. And you read through the statements and you ask what could have been done differently.

And that's not just that you're doing this and you're listening. The authority and responsibility vested by leadership is then to take that information and

do something with it.

[redacted]

Q And, in the three restraints that Mattson applied to David just prior to his death, I believe there were two in May and one in March, two on the same day in May and one in March, I believe, two of those, if not all three of them, were also clear violations of the standard of care, clear violations of protocol. Am I correct in that?

A Correct. Correct.

Q All right.

A There -- there was no effort made, at least restrictive, no imminent danger, laying hands on. No, there was -- there's nothing that bespoke of conformance with the facility policy and procedures.

There was no severe aggression. There was no

emergency circumstance.
Q For instance, he -- Tyler testified to this, but it's also in the incident report itself, that he restrained David simply because David -- he thought David was threatening to throw a thermometer. Do you recall that?
A I do recall that. No, threats, screams, these are not reasons to lay hands on.
Q And had this been flagged and properly addressed by leadership, that could have saved David's life?
MR. ROSEN: Objection; speculation.
BY MR. GILLISPIE:
Q Would you agree with that, Dr. LeBel? That had, you know, the restraint that Tyler performed on March 29th, you know, roughly two weeks before David's death, had that, the improper nature of that restraint and the rule violations that occurred within that restraint been properly addressed by the facility, either through discipline or through retraining, that could have at least increased the likelihood that David would still be here?
MR. ROSEN: Objection. Same objection, but also foundation as to whether this witness is qualified to make such a medical determination.

BY MR. GILLISPIE:
Q You -- go ahead, Dr. LeBel.
A Could you restate the question, please?
Q Sure. Do you feel like that, had Booneville had leadership properly address the rule violations that occurred in those restraints done by Mattson on David just prior to his death, had those properly been addressed -- well, should those have been addressed differently? Let me ask it that way.
A Should those violations have been addressed, absolutely.
Q Should Tyler have still been -- should the facility have required him to, at a bare minimum, undergo retraining prior to putting him back on the floor?
A At a bare minimum, when a staff member does not use restraint training correctly, they should automatically go through retraining. They should automatically go through increased supervision.

And, as I have seen with other facilities where there's been great concern about a staff person's capacity to understand when to use restraint, they don't allow staff who they are worried about use restraint inappropriately. They don't allow them to restrain.

So they may be trained, they may be on the floor, but they are prohibited from using restraint when they

have abused their training and knowledge about when restraint is used. If they don't have the capacity to use it, I have seen facilities not allow staff to participate in restraint.

Q Okay.

MR. GILLISPIE: I want to take another five minute break here.

MR. ROSEN: Okay.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Hey, Dr. LeBel, don't have too much more for you. If you would, could you -- I may have asked you this already. But, if you don't mind, could you kind of describe a little bit more what happens physiologically to a person when they're restrained?

A I'd be happy to. Appreciating that I am a psychologist, I'm not a medical personnel. However, I have been studying and working with physicians who have published on restraint --

MR. ROSEN: I'm sorry, Dr. LeBel. Let me just interrupt with an objection as to the foundation because she is not a physician and not medically trained.

MR. GILLISPIE: Okay.
BY MR. GILLISPIE:
Q Well, let me ask you this, Dr. LeBel. What are you basing this opinion on that you're about to give?
A My opinion is based on my reading, my research, my teaching, my training, my consultation, and my work with physicians, including pathologists, who have published on restraint related physical impact on the body, which we've incorporated their work into our core strategy framework, and teach the medical risks associated with restraint use.
Q And even though you're not a physician, why would you need to know these things? Why would you need to research these things?
A Well, when you're trying to prevent the use of restraint, you want to make sure that the staff that you are trying to reach, whether it's direct care staff, managers or leaders, understand the high risk nature and the lethal potential for the use of restraint.
So you need to have an understanding, as just CPI and NCI does. And they're teaching their technology, you want to make sure that people understand the significant danger and lethality attached to using these emergency procedures of last resort.
Q And you are a psychologist, a Ph.D. psychologist?

A That's correct.
Q Okay. And what is your Ph.D. in specifically?
A I have a dual concentration doctorate in psychology and administration.
Q The administration side of it, what is that?
A The administration side was focused on running health care organizations.
Q Okay. And, in your training as a psychologist, are you -- well, in your training as a psychologist and in psychology is -- I would assume that brain function and neuro responses are within the purview of --
THE WITNESS: Josh is frozen.
(Audio/Video Interference)
(Brief Discussion off the record)
(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)
BY MR. GILLISPIE:
Q Okay.
Dr. LeBel, so I was -- basically, I was asking you how it is you're able to give an opinion about kind of what happens to a person during a restraint.
What is your basis of knowledge on that?
A Well, my -- my basis of knowledge about understanding what happens to the body during a restraint

comes from my research. It comes from my writing on restraint use and writing with Dr. Wanda Moore and Dr. Ron O'Halloran.

Dr. Moore is an advanced practice psychiatric nurse. And, with her husband Dr. Brian Moore, a cardiologist, along with Ted Pettit, wrote the first article on the adverse effects, physical effects, of restraint on the body and published that. And then they later published with Dr. Ron O'Halloran from California, a pathologist, on the physical effect of restraint use.

So I have published with Dr. O'Halloran. I have published with Wanda -- I have -- and Ron. I have read their material. I have done teaching and training with physicians on the medical risks associated with restraint use.

So, while I am not a physician, I have read and studied; and, in my own doctoral program, took neuro anatomy and have been studying the neurobiological and psychological effects of trauma.

I work closely with Dr. Glen Sacks, a psychiatrist, who has published on this and provided -- whoops. I'm getting a pop-up message here. Sorry.

And provided a foundational module that we use in the core strategy training on the neurobiological and psychological effects of trauma on the body.

So, while I'm not a medical practitioner, I have done much more reading, research than most on the issue of restraint and its impact on the physical body.

Q Okay. And what is that? Based on your research, what is that impact on the physical body?

A Well, the physical body takes a terrible toll when it is engaged in --

MR. ROSEN: Just let me interject an objection. I'm sorry. I was on mute so I couldn't get it out quicker.

But objection on the basis and grounds as before, the found -- lack of foundation.

MR. GILLISPIE: Okay. Noted.

BY MR. GILLISPIE:

Q And, Janice, that's -- you still go ahead and answer. He's just making a record there.

So my question was, and noting Counsel's -- I asked this while noting Counsel's objection, but please state what your understanding is of what happens to a person when they're restrained.

A As I said, I have studied, taught, written, learned from a number of medical experts in this arena and incorporated their knowledge into our own teaching and training.

And my understanding from this work is that

restraint takes a terrible toll on the physical body. It can lead to elevated heart rate, elevated respiration, elevated blood pressure, elevated in cortisol, which is a stress hormone. It can create cardiac instability. It can create respiratory compromise.

Particularly, if you're restraining somebody on the ground where you've got any kind of compression against a hard surface, you are limiting the bellows action of the lungs. The lungs want to expand in either direction. And when they're compromised, you are limiting respiration.

You're also creating a level of serious emotional distress. You create the risk of people -- of regurgitating the contents of their stomach, which is a particular risk for people who are prescribed psychiatric medications, many of which produce hyper salivation.

[redacted]

[redacted]

You know, repeated exposure to restraint, as I said earlier, can create an allostatic load, which just compromises the physical health and integrity of the body. So there's also that possibility as well.

So it's an -- I'm sorry.

Q Go ahead.

A So it's an extremely high risk procedure to be used. And that's why it should only be used in the face of imminent danger to save a life; because it can kill.

Q And a physical restraint can, in fact, in your experience and studies, induce or trigger vomiting?

A In my experience, yes. In my experience.

And I have reviewed and I have presented on many case reports in the media that cite children, adolescents, adults who have vomited, who have lost control of their physical functions in the course of restraint and have died.

It's one of the very sad parts of the core strategy training that we do, where we give real examples as reported so that people are aware of how risky these procedures are and how quickly someone can be seriously injured or die as a result of restraint use.

Q And thank you for that. And, in your experience consulting on -- let me back up.

In your career, have you had occasion to either consult on or learn about other instances of improper restraint usage leading to serious harm to a patient?

A Yes, I have. I am aware of, I've consulted on other circumstances where there have been restraint related serious harm or death.

Q Including in facilities similar to the Booneville facility?

A Yes.

Q And, in your experience, have you noticed any commonalities amongst, or any commonalities with respect to the explanations given by the facilities or the staff at those facilities?

A When I've worked with facilities that have had serious sequela from restraint use, serious harm, death or have excessive use and been sanctioned by regulatory bodies, licensors, funding entities, what we typically see is a lack of leadership attention to the use of restraint within the organization.

What we typically see is a blaming of the victim in which it's the patient's fault that the restraint occurred. And we typically see a -- what I would call a perverse special argument. And, by that, I mean, in the work that I have done with many organizations, more than 70, all different types of organizations, doesn't matter

if you're a prison, if you're a nursing home, you're an elementary school, people typically justify their use of restraint because they are treating a special population.

Special, to me, is proxy for we're not interested in doing this work, we're not about to commit to the extra work it takes to learning different approaches to not lay hands on.

It becomes an excuse in which people look to, as I said, blame the victim, attribute the problem to the person served. And, when that typically happens, as I look at the restraint documentation, you see a restraint recipe that is paraphrased over and over and over again, and what some of my colleagues have called awfulization, which there's an exaggeration, a distortion, an amplification of the behavior, rather than an accurate description.

I find that many staff don't have the skill to accurately describe what is happening and will often use an exaggeration of language to justify what they've done; which is typically the inappropriate use of restraint.

Q Okay.

Did you mention fight or flight? Is fight or flight something you've found to be a reaction that a person has upon being restrained?

MR. ROSEN: I'm going to object because I

don't see anything in Dr. LeBel's opinions that were provided to us, only about a week ago or so, that mentioned anything about fight or flight. So that'd be something new that we were not advised about.

MR. GILLISPIE: Okay.

BY MR. GILLISPIE:

Q Yeah, Dr. LeBel, go ahead and -- Dr. LeBel, you can go ahead and answer.

MR. GILLISPIE: And your objection is noted, Rich.

BY MR. GILLISPIE:

Q But my question is, is fight or flight something else that is -- is that a fair way to describe what happens to a person when they're being restrained?

A Fight or flight is a natural response to the body under stress and threat.

Fight or flight, I did just use earlier as we were speaking. And I described it when I talked about the withdrawal reflex, which was in my written report.

The withdrawal respect, reflex, is in fact a flight or fight response in which Tyler Mattson, in this case, activated the fight or flight response in David Cains.

Q Okay.

A So, in this case, it was the application of his

hands, by grabbing him with his hands, he set off a defensive response by David, which is a physiological response that has been well documented.

You can even go to Google it and see something on YouTube when they do this with, in fact, with infants who will try to escape a noxious stimulus.

So, in this case, the noxious stimulus is the application of the hand, touching the body against the will in which you will then generate a motor response from the person who's being subjected to this unwanted touch. So fight or flight is part of a restraint process.

Q And can a person who's restrained often get used to being restrained such that they don't have this type of response to it?

A In my experience, no. It is not possible to habituate to hand-to-hand combat.

Otherwise, the federal government would not be investing millions of dollars in attending to soldiers coming back from war with PTSD. This is not something that becomes habituated, routine. These are individual circumstances.

And certainly, in the case of David, given his [redacted] every time is like the first time for him. One doesn't expect it. And

his body would be responding to the stress and the threat of being physically contained against his will.

As Tyler Mattson describes the restraint scenario, David's behavior, particularly when he is on the ground, makes perfect sense to me. He is physically trying to move away from having the level of pressure from Tyler, whether it's his shoulder, his side, his testimony jumps around a little bit, it's hard to follow, but he is being contained against his will.

And it's likely a painful circumstance that is leading to a physiologic agitation. He's described as having been short of breath, turning red. This man is in physical distress. He is not comfortable. This is not routine. This was something he was subjected to. And he was absolutely demonstrating fight or flight.

It's not clear to me why Mr. Mattson would do that when all he had to do was stand up, take his hands off David, and stop the interchange.

Q Okay. Thank you very much.

Real quick, I wanted to go back to something from the beginning of your testimony. You mentioned that, at one point, I think earlier, much earlier in your career at the department, you were receiving boxes of these restraint incident debriefings.

First of all, when in -- what was your role in the

department at this time when you were receiving these boxes of restraint incident debriefings?

A My role at the time was the director of program management. So I had a statewide purview over the contracted services within the Department of Mental Health Central office.

So I was receiving restraint reports from facilities that are contracted or licensed by the Department of Mental Health; which, by virtue of our statutory authority, anyone practicing restraint in a behavioral health setting would have to report and have to send that to the central office.

Q And you were the person who got these reports and had to sift through them or were you receiving these for purposes of your research to find a better way?

A I received the reports, along with my colleagues in the licensing division, and our offices were colocated right across the hall from each other. So we both received and reviewed the restraint reports.

Q And that was part of your job duties, to review these restraint reports and determine the efficacy of what was going on at these facilities --

A That's correct.

Q -- with regard to restraint?

A That's correct.

Q And it was in -- was this around the same time that you determined that -- that you began your research into an alternative method that could be used at places like this that might reduce or eliminate restraints?

A That's correct.

In particular, you know, my -- my focus had been on children, adolescents and young adults, that we saw this inverse relationship.

You know, the younger, the smaller the person served, the more likely they were to be restrained. And we had great disparity in our state that every child in certain settings had anywhere from four to 17 times higher rate of restraint or seclusion than every adult setting. So it was extremely compelling information.

And then, when you looked at the restraint documentation of a person served at any age, you could see that people were being restrained for the very behavior that had been admitted in the first place. So it made no sense to us and it was clear that this was being used as a primary intervention, as a method to stop the behavior, but it only stopped and solved the problem for staff. It did nothing in terms of a positive treatment effect.

So it was very compelling to see that, to see the disparity, and then to appreciate that not all facilities

had high use and that there were some that had lower use of restraint.

So it was compelling to start understanding and studying that what are the elements of a service that has low or no use of restraint.

Q And, in doing this, you also -- it would have been -- in order to do this properly, in order to achieve this goal of eliminating or reducing restraints in facilities, would it have been necessary for you to have a precise understanding of the harm caused by restraints and the adverse impacts on both physical and mental health of restraints?

A Well, it was essential to have that knowledge that people could be harmed.

And, the year or two before I arrived in my role in Boston with the statewide purview, there was a restraint related death. And my predecessor decided the best course of action was to teach people how to do restraint more safely.

Q Yeah.

A And my orientation was how do we teach people to not do it in the first place.

Q Right.

A It is never going to be a safe procedure. That's why it's considered an emergency procedure of last

resort.

Nothing will ever make it safe. Any form of restraint is high risk. But it was understanding that. And then, basically, it was having that knowledge teaching that.

But I needed inherent credibility. I had been working in hospitals. I had participated in some restraint. I saw where -- and felt it was patently wrong. I didn't have the skill set.

So my colleagues and I went looking out of state and visited other programs. In fact, we went to Bellevue in New York City and watched for a long weekend as staff intervened without the use of restraint and seclusion in a child serving program. And we watched problems unfold and the staff took time and space and kindness to be able to stop an aggressive interchange.

And I saw things happen that could easily, in my state, have led to an immediate hands-on procedure. And staff knew how to weather the behavioral storm. They took that time, they gave space. And we did not see restraint use.

And, in fact, their top three nursing leaders with a combined tenure of over a hundred years had not used restraint in many, many years in that setting. And I had to go see to believe.

So I needed inherent credibility to bring it back to my state. Not just knowledge based on textbook reading and study, but I needed to see it, because I had to be able to help staff understand that there was someone who understands the challenges of their role and that it was possible.

So, when I went on my road trip to New York City, I brought residential direct care staff with me. I wanted them to see what I had seen on an earlier trip. So I made two trips, one with my colleagues, and then two with direct care staff, nursing staff, a social worker came; because I wanted them to see that it was possible to do this work. They came back and they were able to sell it and that's when we launched our statewide initiative.

So it was really important to have credibility in multiple ways to be able to help all of our facilities. Our initiative was statewide, it was all facilities.

So simply telling people to do things differently was not enough. We had to be able to give them resources, tools, teaching, training, and support.

And, frankly, that's what I saw was missing at Booneville. I just didn't see it.

Q And did you also form an -- did you also form an opinion based on the sheer number of restraints used on Davie over the years as to whether -- as to whether

restraints were being used only in emergency situations?

MR. ROSEN: Objection. I didn't read that in her opinions that was provided to us either. So that would -- foundationally, I don't think she's qualified to do that. And I don't know what records you see.

But, more importantly and more significantly, that was an opinion that was required to be disclosed to us and to date hasn't been.

MR. GILLISPIE: Okay.

BY MR. GILLISPIE:

Q Dr. LeBel, you looked at -- you reviewed and saw that there were many, many, hundreds, in fact, physical restraints used on David Cains over the years of Booneville; correct?

A Yes, I saw several -- I saw several written reports of restraint use.

Q And I'll make this simpler. If you just speak to your understanding of based on everything reviewed, speak to your understanding of what the culture was at Booneville?

MR. GILLISPIE: Rich, your objection's noted.

BY MR. GILLISPIE:

Q But speak to what your -- what's your understanding of what the culture was at Booneville with regards to, with regards to whether restraints were being used strictly on emergency basis or more often for some other reason.

MR. ROSEN: I'm going to also interpose an objection to that question, because I don't know, that foundationally, that she's done the investigation as to what the culture was that at Booneville, talking to people, interviews --

MR. GILLISPIE: Okay.

MR. ROSEN: -- that whole one thing. So I don't know that she's qualified to make such an opinion that hasn't been disclosed to us before either.

MR. GILLISPIE: Okay.

A My response to that question, frankly, is you don't have to walk a talk and meet with all the staff and all the leaders.

But, when you look at the number of incidents that were reported -- and I did see aggregate restraint data at that facility over several years duration that told me that restraint is accepted as part of a culture. It's part of the routine of the service there. It is an accepted practice. So that tells me the culture allows

it, the culture supports it.

I also represent -- you know, read Mark Hise's deposition. And I was really impressed with the work that he does and how he represented their use of NCI and what he teaches. Very clear to me that he's teaching on not taking people to the ground.

And I'm reading that people are taking people to the ground. So I see a profound disconnect. We see as, again, somebody has -- setting reasonably the training and the expectation. And the culture allows, permits to taking people to the ground and not following policy.

So the volume of episodes tells me that this is, in fact, an accepted practice within the facility.

BY MR. GILLISPIE:

Q Thank you.

MR. GILLISPIE: Let's just take two minutes and then, Rich, I think I'm done. Let me just go back through my notes and I'll pass the witness, I think, when we come back.

MR. ROSEN: Okay.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Just two more questions, Dr. LeBel.

A Uh-huh.
Q Your first expert opinion was that the response -- that the facility's -- that the use of the restraint in this case fell below the standard of care. And we've talked at great length about why that is. One thing that we didn't cover with regards to that, and then I'm going to move into your second opinion, though. But one thing that we didn't quite cover with regards to your first opinion was, Did you form an opinion in your review of the materials about Davie himself, about what kind of patient or client he was?
A You know, based on the reading that I did from his treatment notes, as well as the deposition statements from the people involved in David's last restraint, my opinion is that -- I won't use their words. He was fun. He never harmed anyone. He was sweet. He was funny. He was easily redirectable. He liked attention. You could engage him in a conversation about Mr. Potato Head or the Monkees and that he never intended to hurt anybody. And to their knowledge never did hurt anyone. So the opinion I had that this was a lovely gentleman, with some serious, you know, cognitive challenge and intellectual challenge, who was likely easily read directable when someone would just pay attention to him, give him time and space to calm down. And likely, he's very easily

redirected with the things that he likes. And there were many. And it seemed as though he had some good relationships with some staff. So my opinion of David is that he was, you know, a lovely human and had, you know, a disposition and a personality that should not have led to the use of a hands-on procedure. And if his behavior was in distress and he was dysregulated, there were any number of strategies that one could use to help him calm and soothe and settle down.

Q Thank you. And then my last question is: If you could, just get a little testimony about your -- the second written opinion in your report with regards to the facility's emergency response -- emergency response system.

A As I read the policy, it appeared that the emergency response system created an untoward obstacle for staff in the activation of emergent medical response; that in a rural area and a multi-building campus, that you're creating an untoward circumstance by preventing direct care staff from activating 9-1-1 and possibly shortening the emergent response timeframe by having outside support personnel called earlier. I haven't seen that in my work with my facilities. I don't know why that obstacle and barrier would exist to involving emergency response personnel. In my own State Department Developmental

Disability Services require that staff call 9-1-1. They don't want staff second guessing if emergent response is needed. They don't want an untoward delay imposed on a medical circumstance like this. So it's not something that I'm familiar with. And it created an obstacle that was unnecessary.

Q And in your -- I believe you said 39 years of experience as an administrator in the Massachusetts Department of Mental Health. Based on that experience and based on your experience working with other facilities, both in Massachusetts and, I think, internationally and in other states, is a policy such as this emergency response policy at Bonneville below the standard of care?

A Well, it's a policy I was not familiar with. So I went researching and then I found the New Jersey requirement and law that requires staff employed in DDS contracted or operated services to call 9-1-1. I consulted with colleagues who work for international human service work and found out if they were familiar or aware of any kind of limitation on a 9-1-1 response. I've spoken with national colleagues who have multi-state services and no one was familiar with that kind of layered of emergent response. So it's not something I was familiar with and nor my colleagues, so it seemed --

Q You never -- in other words, in your 40 years, you've never seen anything like this?
A In my timeframe, no.
Q And neither have the colleagues you've consulted with?
A No, neither had they.
Q Okay.

MR. GILLISPIE: Pass the witness. Thank you, Dr. LeBel.

THE WITNESS: Thank you.

MR. GILLISPIE: I'll pass the witness.

CROSS EXAMINATION

BY MR. ROSEN:
Q All right. Thank you, Doctor.
I don't think I was introduced, but my name is Rich Rosen and I represent the Department of Human Services.
So let me ask you just a few things. Are you a neurologist?
A I'm a psychologist.
Q Well, are you a neurologist as well?
A No.
Q Okay. Are you a pathologist?
A No.
Q Are you a medical doctor?
A No.

Q Are you a medical examiner?
A No.
Q Are you a physician of any sort? A medical doctor, a doctor of osteopathy or any of the order --
MR. GILLISPIE: Objection; asked and answered.
BY MR. ROSEN:
Q Are you a physician of any sort?
A No.
MR. GILLISPIE: Same objection.
BY MR. ROSEN:
Q Okay. Now, in looking at your CV, and you've mentioned it here, you have -- you state you have a dual doctorate in what areas?
A In psychology and administration.
Q Okay. Now, I noticed on your writings, you identify yourself as a doctor of education.
A The program I was admitted to was first located in the department of education and then moved to the department of counseling psychology. So the Ed.D. program became a Ph.D. program.
Q Okay. So all right. So, Massachusetts, you can call yourself a phycologist?
A I am a licensed psychologist practitioner; which, yes, I am a licensed psychologist.

I'm also considered a health service provider. I'm also registered by the National Board of Psychology.
Q Okay. So the opinions that you've expressed today in this deposition, when asked by Mr. Gillispie, and any of the opinions that you're giving, going to give in response to my inquiries, those are not to a reasonable degree of medical certainty, are they?
MR. GILLISPIE: Object. Objection. Object to form.
BY MR. ROSEN:
Q Well, let me ask you -- I'll rephrase it just to make it clearer.
None of your opinions today are to a reasonable degree of medical certainty, are they?
A My opinions are based on a reasonable degree of expertise in the arena of restraint reduction and prevention.
I'm considered a national and international expert. So my opinion is offered within that context. I am a licensed board certified psychologist.
Q Okay. But, again, just so the record is clear, and I certainly understand your high opinion of yourself, but none of your opinions today are to a reasonable degree of medical certainty, are they?
A I don't know how you define a reasonable degree of

medical certainty.
Q Well, you're not a physician, so it can't be to a reasonable degree of medical certainty, can they?
MR. GILLISPIE: Object to the form.
A I'm expressing my opinions based on a reasonable degree of certainty within my expertise, which is in restraint reduction and prevention and an inappropriate use of restraint. So I consider myself an expert.
I am not a medical expert. I am not a physician.
BY MR. ROSEN:
Q Okay. So none of your opinions are to a reasonable degree of medical certainty? It's a simple question.
MR. GILLISPIE: Same objection. I'm not sure she understands the question.
But you can answer it, if you know how to, Dr. LeBel.
A I believe I've answered the question.
BY MR. ROSEN:
Q Okay. Well, it's really a yes -- would you agree that none of your opinions that you're expressing here today are to a reasonable degree of medical certainty?
Would that be a yes or would you disagree with that?
MR. GILLISPIE: Same objection.
Answer if you can.
A My opinions are based with a great degree of

certainty based on my expertise which is relevant to this case which is regarding restraint use.
BY MR. ROSEN:
Q Okay.
A So I would say I am a restraint reduction prevention expert.
BY MR. ROSEN:
Q Okay.
Now, so let's go back to your formal education because I'm not familiar with what people say a dual degree is.
So you have -- what does your diploma grant you? Or what did your diploma from Northeastern University grant you? What degree?
A A doctorate in counseling psychology.
Q Okay. So that's what's on the certificate itself?
A Yes.
Q Okay. And what college was that?
A Northeastern University in Boston.
Q Well, that's the university, but there's a separate college, I assume, that awards the degree.
A It's the Boston Bouve College of Health Sciences.
Q And so what college awarded you the doctorate in education?
A Northeastern University gave me the doctorate.

Q Okay. But what college within Northeastern University gave you the doctorate --
A Boston --
Q -- in education?
A -- Bouve College.
Q What's that?
A Boston Bouve.
Q Can you spell that?
A B-o-s-t-o-n B-o-u-v-e.
Q And what does that teach?
A It's a college within Northeastern University. It is their Health Science Division.
Q Okay.
Is there any reason that you, in your writings, the numerous ones that I saw, that you identify yourself as a doctorate in education only?
A No.
Q But you do have an actual doctorate in psychology?
A I have an actual doctorate in psychology. I am board certified in psychology.
Q And --
A By the American Board of Professional Psychology.
Q Okay.
A My credentials have been vetted within every level of the trade.

Q I just asked you what degree you were awarded.
I see from your CV that you identify as an instructor at the University of Massachusetts Medical School.
A That's correct.
Q Are you currently an instructor?
A Yes.
Q Okay. And you've been so since 2008?
A Correct.
Q Okay. That's about 14 years as an instructor; right?
A Correct.
Q Okay. Is this full time or part time?
A This is adjunct work.
Q Okay. So you're hired to teach courses?
A I'm given the title of Instructor of Psychiatry as part of the role that I have within the department of mental health in my role with the UMass Medical School and the services that they provide.
Q So this is part of your job within the department of mental health within Massachusetts?
A Yes. I oversee programs that have been delivered by the University of Massachusetts and their medical school.
Q And so, in the medical school, in your part as an instructor, you're not on a tenured path there, are you?

A No, I'm not.
Q Okay. So instructor is the lowest level of teaching in a university system; correct?
A Correct.
Q Okay. And, above that, there's assistant professor, association professor, and then a full professor; right?
A Correct.
Q Okay.
I also saw on your CV that you're a member of the Board of Professional Psychology that certified you in counseling psychology.
A Correct.
Q Does that mean that you're an individual, that you give individual therapy or counseling to people?
A I'm licensed and credentialed to do that. And I have been accepted to deliver that kind of service by several health insurance companies.
So I'm qualified, but I do not practice at the independent level.
Q So you don't do clinical psychology?
A I don't do that now.
Q Okay. Have you done it recently?
A I did that several years ago.
Q Okay. When did you stop?
A I'd say about 1990.

Q Okay.
Have you ever been to the Booneville Human Development Center?
A **No.**
Q Have you ever been to Arkansas?
A **No.**
Q Have you ever been to Logan County, Arkansas?
A **No.**

MR. GILLISPIE: Objection; asked and answered. She's never been to Arkansas.

BY MR. ROSEN:
Q Do you know what city the Booneville Human Development Center is in?
A **Presumably Booneville.**
Q Okay. But you don't know?
A **I've never been there.**
Q Okay. Are you aware whether Booneville is in a urban or rural setting?
A **Based on the information that I've read, it's been described as a rural environment.**
Q Okay. And so do you know how many ambulances Logan County Arkansas had or had in 2020?
A **No, I don't.**
Q And do you know, did you do any research or do you know what the typical response time for Logan County EMS

is to respond to calls at the Booneville Human Development Center?
A No, I don't.
Q Are you aware that it can sometimes take 45 to 60 minutes after a 9-1-1 call for EMS to respond?
A No, I'm not.
Q Are you aware that Booneville Human Development Center has a team of nurses on the premises at all times?
A Based on the documentation that I've reviewed and received, it appears that there are nurses that were on site.
Q Did you know, that in David Cains' case, it took EMS 13 minutes to arrive at the facility after the call to 9-1-1 was made?
A That's what I read.
Q Okay. Do you know how long it took the Booneville Human Development Center nurse team to arrive at the Commons building where the incident happened once they were called?
A I saw a divergence of opinion between the two nurses who were deposed about the amount of time that it took. And, because there was no accurate time reporting, it's impossible to know.
Q Okay. Well, they said it was between one to two minutes; right?

MR. GILLISPIE: Objection. Assumes evidence not in the record.

MR. ROSEN: Well, it is in the record, in their deposition.

BY MR. ROSEN:

Q But I'm asking you, did you read that it was one to two minutes?

MR. GILLISPIE: Same objection.

A I read divergence of time and estimations between the two nurses.

BY MR. ROSEN:

Q And so what was the estimation of time that you read? And which nurses?

A Am I allowed to look at my notes?

Q If you look at your notes, you're going to have to show me your notes.

A I'm sorry?

Q If you look at notes, I want to see the notes.

A Then I'll rely on my memory.

Q Rely on your memory. You're here to testify and you seem to have testified to counsel's questions, so now I'm asking you my questions.

A More than a minute, less than two minutes --

Q Okay.

A -- is my memory.

Q So under two minutes, you would agree; right?
MR. GILLISPIE: Same objection. Assumes evidence not in the record.
BY MR. ROSEN:
Q That's what you read, that's what the response time was that you read from the nurses; right? One to two minutes; correct?
A Approximate time.
Q Okay.
Tell me, do you have any medical training to determine the cause of death?
A No.
Q Have you previously been allowed by any court of law to opine on an individual's cause of death?
A No.
Q Have you previously been allowed by any court to opine on any factors, whether directly or indirectly, contributing to a cause of death?
A No.
Q Have you ever testified in court before?
A No.
Q In your report to Mr. Gillispie, it was December 28th, 2022, you identify yourself as Dr. Janice LeBel. And, just for clarification, the doctor is due to your Ph.D., not because of any medical training; correct?

MR. GILLISPIE: Objection; asked and answered.

A Correct.

BY MR. ROSEN:

Q And so you also stated, and I think you mentioned earlier, you stated in your December 28th, 2022 report to counsel, that you're board certified; and I think you stated that you are board cert -- what are you board certified in?

A Counseling psychology.

Q Okay. Counseling phycology, and what is that?

A That is the practice of psychology within a counseling framework.

Q Okay. So when you say counseling, you're talking giving individual group therapy type counseling; right?

A Well, actually, I was board certified within the rubric of counseling psychology; but, within that, administration as well.

So it's a knowledge of counseling psychology, techniques, methods of diagnosis and treatment, but in the delivery with an administrative management framework; so understanding how the intersection of clinical treatment dovetails with the oversight and the operation of clinical services whether they be practice-based in the community or facility-based.

Q Okay.

Now, I mean, I'm just looking at your CV, under education, and you talk about the ABPP, that's your board certification in counseling psychology?

A That's correct.

Q Okay. And that's all that you're board certified in; correct?

A Board certification takes years to obtain. It's based on experience, expertise.

The American Board of Psychology is the largest governing body for board certification in the practice and discipline of psychology.

Q Okay. Well, let me ask you this. Does that board have different certifications for psychologists? Or is it just counseling psychology?

A There are different divisions within the American Board of Professional Psychology that people can get specialized certification.

Q And yours is in counseling psychology?

A In counseling psychology and administration and management.

Q Well, I didn't see that in there. I just saw counseling psychology. That's what it's called; right? That's what you put on your CV.

A That's the division. And, within that, my

certification was at a specialty track and administration in management.

Q And so they certify you in administration as well?

A They certified me within a counseling psychology.

Q Okay.

And I think you've said you gave up counseling psychology many years ago; is that correct?

A That's correct.

Q Okay.

Now, do you claim you -- do you profess to be an expert in restraint policy?

A I believe I have substantial experience in reading restraint policy and recognizing when there is reasonable policy, when there's policy that require improvement or enhancement.

So I would say that I am very familiar, in my expertise, at reviewing policy and recognizing where policies are reasonable and where policies fall short.

Q Okay. Nice. But the question is, do you profess or do you claim to be an expert in restraint policy?

A I don't know what the qualifications would be for being an expert in restraint policy, per se.

As someone who has expertise in the reduction and prevention of restraint use, I am aware when policy is consistent with restraint reduction prevention and when

it is written in a way that supports or promotes the kind of practice to be able to avoid the use of restraint and to be able to put into place practices that help mitigate a use of hands-on procedures.

Q Okay. Well, I know you mentioned it earlier, but have you ever restrained anyone for their safety or the safety of others, including yourself?

A I've participated in restraints when I was employed as a direct care staff member at a general hospital and a state hospital.

Q And what year was that?

A This was in 1983, 1984.

Q Okay. And, when you say you participated, was the individual -- was that done for the safety of the individual or the safety of the staff around him or her or others?

A In my opinion, then, as a brand-new staff person and in my opinion now, the first restraint that I was asked to participate in and directed to participate in was entirely necessary.

Q I didn't ask that. What I asked you, was it done for the safety of the individual or the safety of others?

MR. GILLISPIE: Object to the form. She just answer that question, Rich.

MR. ROSEN: She didn't answer the

question. She answered a different question that I didn't ask, but that's okay.

BY MR. ROSEN:

Q So I'm asking it again. Have you ever participated in the restraint of someone that was done for the safety of the individual or the safety of other individuals?

A I participated in a restraint. And the reference that I made to that first restraint was allegedly for the safety of others.

But, in this case, there was no safety breach or any others. There was no need for the restraint.

Q Okay.

A I participated and was directed to participate in other restraints where I also felt the same circumstance to be true, that it was unnecessary and unwarranted.

Q So how many restraints do you think you participated in back in 1983 and 1984?

A I participated and was directed to participate in about a dozen restraints.

Q Okay. And, in your opinion, none of those were really for the safety of the individual or the safety of others; is that correct?

A It was one restraint that I would say was for the safety of the individual.

Q Okay. So you've done about a dozen of them in the

40 years ago, almost, late 38, 39 years ago, would you -- well, strike that.

Based upon the fact that you did about a dozen restraints, 11 of which you fundamentally disagreed with, do you consider yourself to be an expert in restraint use?

A I consider myself to be an expert in restraint reduction and prevention. I teach people to not use restraint.

Q So you're against restraint use at all?

A I'm against restraint use when it is used inappropriately, when it is used when there is no emergency circumstance, when it's used with no imminent harm or imminent danger. Restraint has its place as a life-saving method of last resort.

Q Okay.

A I have seen it used most often and most circumstances, that in circumstances that do not meet that, that standard.

Q Okay.

So let's just briefly, and we'll talk about it a little later, but since you mentioned it, the standard. So do you know what the Centers for Medicare and Medicaid Services is?

A Yes.

Q We often refer to it as CMS, do we not?
A **Yes.**
Q But you know what I'm talking about?
A **Yes.**
Q And you're familiar with -- do you know what the Code of Federal Regulations are?
A **Yes.**
Q And can we also call them CFRs; right?
A **Yes.**
Q Okay. And so CMS issues a promulgated state operations manual regarding many things, but it includes restraint use; correct?
A **Correct.**
Q Okay. And so that CMS manual, those code of regulations promulgated, those are the standards that facilities such as the Booneville Human Development Center comply with; is that right?
A **Conceptually, they should be applied.**
Q Okay. Well, I don't know about conceptually. Are they the standard or are they not the standard?
A **They're the standard. Whether or not they're adhered to, one doesn't know until you --**
Q Okay.
A **-- review how they're implemented.**
Q Okay. Well, in looking at the -- so I think we all

can agree then that the Code of Federal Regulations governing restraint use, CMS's state operations manual governing restraint use, those are the standard by which the Booneville Human Development Center had to comply with in its restraint of David Cains; correct?

A They're the standards that they had to comply with in order to get funding and reimbursement for the level of care and service that they were operating.

But my view on standards of care is that they're minimal standards. They're not aspirational.

Q Well --

A These are always standards that start as the foundation, the platform, and nothing prevents any organization from exceeding the standards. They are a minimal threshold.

Q Okay. But I'm just saying this is what the standard of care for restraint is in the United States in what we call an intermediate care facility for individuals with intellectual disabilities, which is what Booneville Human Development Center is licensed as; correct?

A Correct.

Q And those are the standards that they had to follow, at least the minimal standards?

A Correct.

Q Okay.

So I think what you're saying here today is, notwithstanding CMS and the Code of Federal Regulation, in your opinion, there should be, at least aspirationally, a higher standard?

A There's nothing that prevents an organization from adopting aspirational standards, as we've seen other states and other facilities do.

The testimony that I gave earlier was that the Pennsylvania State Hospital System, that far surpasses the CMS standards.

Q Okay. But they're not required to do so to meet the standard level of care; correct?

A They're not required to do it to meet the standard level of care but they do from a quality and treatment perspective.

Q Let me ask you -- well, that's what I want to ask you to clarify. Because if the CMS state operations manual and the promulgated Code of Federal Regulations is the standard, then that's all that needs to be met legally; correct?

A All that needs to be met legally. But, in Booneville's case, they failed to meet that standard.

Q Well, we're going to talk about that in a few minutes. Because I'm a little confused by the standards; because, in your report and here today, you're talking

about the standard set by the World Health Organization, standards set by international -- other countries' standards set by the United Nations.

But those aren't the standards applied in this country now or in June of 2020, were they?

A The standard that Booneville had to follow was the standard that was imposed through their own DDS regulations which rolled up into the federal standards imposed by CMS.

Q Okay. Well --

A The UN (inaudible) convention on the rights and the World Health Organizations are international perspectives that are informed by many people from the United States as another platform for preferred practice.

Q Okay. But, just to make it clear, because I don't want the Claims Commission to be confused, the standard of care for restraint use is the Code of Federal Regulations governing restraint use for intermediate care facilities for individuals with intellectual disabilities and the CMS state operations manual that enforces that against such licensed facilities; correct?

A Correct.

Q Okay.

Now, did you know David Cains?

A No.

Q Do you know how tall he was?
A No.
Q Do you know how much he weighed?
A I believe I read that he weighed about 250 pounds.
Q Okay. Do you know whether he was a big guy or not?
A I believe he was a big guy.
Q Okay. Was David Cains a physically aggressive individual?
A It is difficult to answer that question. And let me just explain why.

My dissertation was on aggression in children. Aggression can sometimes be in the eye of the beholder. And this is one of the points that I was trying to make earlier in my testimony, that one person can describe a level of behavior that might be called aggression when, in fact, it's not aggressive.

The United Nation spent more than 75 years trying to define what aggression is and failed and gave up on trying to define aggression.

So when you ask me if he's aggressive, I know the verbiage that's been used. And I also juxtapose that with the descriptions that the staff have also used to describe him as lovable, likable, a nice guy, wouldn't hurt anybody, never hurt anybody. If he gets frustrated, he flapped his hands.

So I don't know how to interpret and answer your question, whether or not he's aggressive. I didn't meet him, I didn't see him.

I read language that says one thing and behavior that came out something different by description.

Q Do you know what an interdisciplinary team is?

A Yes.

Q What is that?

A It's a team of professionals from different disciplines who come together to typically form a treatment plan or a plan of care and review and weigh in and oversee that plan.

Q I see that you, in your written report, that you were provided with a -- at least one interdisciplinary team plan which we call a individual program plan or an IPP. Did you read that?

A Yes.

Q Okay. And so was -- were you provided the one for 2019 that was in effect at the time that he passed away?

A I believe so.

Q Okay. Now, so then you saw in there that the -- in the IPP, on Page Six of that IPP, that under background information, that David demonstrated a history of the following behaviors. And it included physical aggression, destroying personal property, TV, radios, DVD

player, breaking windows. Did you see that?
A Yes.
Q Do you believe that?
A If the rep -- if it wants to believe the written documentation, then, yes, I would believe it.
Q Okay. Now, this was created by the interdisciplinary team and -- right? I mean, you saw that?
A Correct.
Q And that included David's mother and legal guardian, did it not?
A I believe so.
Q And it included his sister, Christine Cains McAuliffe, who is the -- a claimant in this case; right?
A I believe so.
Q And that's on Page Two of the IPP. You saw that; right?
A I answered that question already.
Q Okay.
And so they determined that he had a history -- and the team agreed that he had a demonstrated history of physical aggression.
Now, as a psychologist, people who are physically aggressive aren't necessarily physically aggressive 100 percent of the time, are they?

MR. GILLISPIE: Object to the form.
A Presumably not.
BY MR. ROSEN:
Q Okay. So you could be a nice, lovable person, and still have a darker side that causes you to be physically aggressive at times; correct?
MR. GILLISPIE: Object. Object to form. Calls for speculation.
MR. ROSEN: Well, I'm asking her opinion on that based on her experience as a clinical psychologist.
MR. GILLISPIE: I object to the broadness of the question as well, as well as it calling for speculation.
BY MR. ROSEN:
Q Well, let me ask it this way, Doctor.
Have you experienced, in your clinical psychology or in your training as a psychologist, a person who can be lovable and kind at one moment and destructive, violent, and physically aggressive in another moment?
A I have seen people from -- go from calm to disruptive or destructive. I've seen that, yes.
Q As a matter of fact, we know here from Tyler Moore's deposition, Tyler Mattson's deposition, that David Cain went from being -- from calming down in a chair to

jumping up and lunging at him; right?

MR. GILLISPIE: Object to the form.

A It's difficult to know what happened because I saw no reference to lunging when I read the OLTC statement from Tyler Mattson; which is the most recent testimony to the event itself.

There's no reference to lunging --

BY MR. ROSEN:

Q Okay. Did you --

A -- so I don't know how to, how to understand how lunging then came into the play when it was not discussed.

When he was interviewed by Disability Rights, there was no reference to a lunge.

So, somewhere along the line in his thinking and testimony, lunging appeared. It wasn't; so, when we looked at his response to what he said most quickly, after the event, there's no lunge.

Q Okay. So you're --

A I don't know if he actually lunged or not.

Q Okay.

A But, by Taylor's, Tyler's description, there was no lunge.

Q Okay. By Tyler's description, even counsel said that he tried to -- that David Cain tried to hit Tyler

Mattson. Do you disagree with that?
A I saw the language attempting to hit. That's not hitting.
Q Okay.
A We might see anything from flailing to arm movement. We have no way of knowing what was actually happening.
Q Okay. And so you don't know what actually happened then; right? You admit that?
A I admit that.
Q Okay.
Now, are you aware that the testimony that Tyler Mattson gives at his deposition, which was more detailed, was in response to prompting from counsel from the claimant Mr. Gillispie? He asked more detailed questions.

MR. GILLISPIE: Objection. Object to the form.

If you want to take her through that, do you have his -- I mean, can you --

MR. ROSEN: No. I --

MR. GILLISPIE: -- make it an exhibit if you're going to ask her --

MR. ROSEN: No. I don't -- I don't need to. I'm asking her. She's rendering an opinion so I want to know what it's based upon.

And she made a statement and I'm just following up on that.

BY MR. ROSEN:

Q So let me be clear. Okay?

Did you read the deposition testimony of Tyler Mattson and the questioning by counsel for the claimant Mr. Gillispie?

A Yes.

Q Okay. So then you saw that Tyler Mattson, when asked more details about what happened, stated more details about what happened; correct?

A I read details that didn't exist in his OLTC statement. I read detail that didn't exist at the Disability Rights Arkansas report.

References to a lunge and lunging appeared two years later in Mr. Mattson's testimony. So I find it difficult to understand. And only Mr. Mattson and David would know what happened.

Q Okay. So, in your opinions here today and in your report, you didn't mention David, excuse me, Tyler Mattson's deposition testimony, did you?

A I believe I did reference that I reviewed depositions when I talked about the documents that I had reviewed.

Q Yeah, but you didn't mention -- you didn't cite to

Tyler Mattson's statements under oath in his deposition, did you?
A I believe I did cite Mr. Mattson's descriptions about David Cains' behavior. Screaming, cussing.
Q Okay.
A And his rationale for the use of hands on.
Q Okay. But you didn't mention anything about the lunging or attacking, did you, in your report or earlier today in your testimony?
MR. GILLISPIE: Object to -- objection.
MR. ROSEN: I don't know what the objection would be. I'm just asking whether she referred to it or not.
MR. GILLISPIE: I believe it was addressed. But it doesn't matter.
Answer if you can, Dr. LeBel.
A I believe I referenced the lunging with respect to the testimony earlier about the techniques that Mark Hise described could be used to help intervene in that circumstance; which was the pivot, the sweeping motion like a matador, the blocking, the supported stance.
BY MR. ROSEN:
Q Okay. Well, I'm not asking you about that though. I'm asking you simply about -- you said you read Tyler Mattson's testimony. And I'm asking you, that in your

testimony earlier today and in your report, you didn't mention anything about Tyler Mattson's stating in response to Mr. Gillespie's questions under oath about the lunging or the attack, did you?

MR. GILLISPIE: Same objection.

A Sir, I'm getting lost in your question. Can you simplify it for me?

BY MR. ROSEN:

Q Well, I -- it's a very simple question, Doctor.

Did you or did you not cite in your report and your testimony earlier today that Tyler Mattson testified under oath in his deposition that David Cains jumped up from the seat, words to this effect, lunged at him and tried to hit him and then made physical contact?

MR. GILLISPIE: Object to the form.

MR. ROSEN: I don't know what form. This is cross examination.

MR. GILLISPIE: I don't even understand the question. I don't even understand the question.

MR. ROSEN: Yeah, you do. And so does the doctor.

BY MR. ROSEN:

Q So let's just be simple because I've asked this every time, Doctor.

Did you, in your -- let's break it down. In your report, did mention anything in your report that Tyler Mattson testified under oath in response to Mr. Gillispie's questions that David Cains lunged at him and made contact? Did you say that in your report?

A I believe my report extracted quotes from Mr. Mattson and his attribution of David's behavior.

I believe I cited that as not meeting the facility's emergency standard.

Q Okay. I'm just asking --

A And I didn't reference --

Q Go ahead.

A I did not reference, in my report, the exchange between Mr. Gillispie and Mr. Mattson and the degree of questioning.

Q Okay. And you didn't reference any, the physical contact or the lunging of David Cains from a seated position towards Tyler Mattson, did you?

MR. GILLISPIE: Same objection. Why don't you get a --

MR. ROSEN: Well, counsel, I'd like to know what your objection is.

MR. GILLISPIE: Why don't you --

MR. ROSEN: I'd like to know.

MR. GILLISPIE: If you --

MR. ROSEN: Don't tell me how to practice.
MR. GILLISPIE: The report speaks for itself.
MR. ROSEN: I'm asking you for your objection. What is the basis for your objection on cross examination about what was or what was not in her report and in her testimony?
Tell me what your objection is so I can respond to it.
MR. GILLISPIE: Repeat the question one more time.
MR. ROSEN: This is very simple. I don't understand why the doctor can't seem to answer.

BY MR. ROSEN:

Q Let's go through your report.
In your report, does it mention anything about Tyler Mattson's deposition testimony under oath to Mr. Gillespie's questions that talks about lunging or making contact, David Cains lunging at and making contact with Tyler Mattson from a seated position? Yes or no?

A No.

Q Okay. And so -- but you saw that in his deposition when you reviewed it; correct?

A I saw the inconsistency between --

Q I didn't ask you that. I asked you --
A -- that --
Q -- whether you saw it.
MR. GILLISPIE: Let her finish her question, please. Let her finish her answer, please.
BY MR. ROSEN:
Q Did you see it or did you not see it?
A I saw the description of David seated. And, from the seated position, starting to tear paper from a wall.
I did not see, in the description, the shift of how he got up and then the lunge suddenly appeared. I could not put those pieces together. It was not --
Q So you didn't see that in Tyler --
A -- in the --
Q I'm sorry. You did not see that in Tyler Mattson's deposition under oath?
A I did not see what? I'm sorry.
Q You did not see that Tyler Mattson said words to the effect that David Cains was in a seated position and got up and lunged at him and made contact? You didn't see that?
A I saw that he made a statement that David had lunged at him in his deposition.
Q Okay. Great. That's all I was asking.

Now, you chose to be selective in the facts that you stated in your opinion; correct?

MR. GILLISPIE: Objection. Objection.

MR. ROSEN: What is the objection, Counsel? Just because you disagree with the question doesn't make it objectionable.

This is cross examination. I want to know why it's not in the report.

MR. GILLISPIE: You're wanting to know why what's not in the report?

MR. ROSEN: Tyler Mattson's statements about the lunging and the contact.

So what is your objection, Counsel?

MR. GILLISPIE: Well, first of all, I'm not sure that it's not accounted for, to some degree, in the report.

MR. ROSEN: I didn't see it.

MR. GILLISPIE: It looked to me like it was. Well, use the report. Use it as an exhibit and ask it that way. We've gone through this, we've had this problem before in depositions.

MR. ROSEN: I'm simply asking -- she's here -- Doctor?

BY MR. ROSEN:

Q Dr. LeBel, do you understand what I'm asking --
MR. GILLISPIE: Show her the report. Show her the report --
MR. ROSEN: I'm not showing her --
MR. GILLISPIE: -- and let her look at it --
MR. ROSEN: She your witness.
MR. GILLISPIE: -- so she can answer it clearly.
MR. ROSEN: She is your witness. Okay? She wrote the report. She testified here today.
BY MR. ROSEN:
Q I'm simply asking whether you selected certain facts that you saw in the deposition that you chose not to put in the report including the lunging and physical contact by David Cains towards Tyler Mattson. Simple.
A I chose to use Mr. Mattson's description based on his OLTC statement because it is part of the recency effect.
This gentleman had just provided his current experience with very little time lapse, with very little opportunity to be part of a process that would start to conflate his thinking, confuse his thinking, distort his thinking.

The human memory, it's grossly fallible. So the closer we get to looking at real-time testimony to what happened is the soonest account that we have.

The more time that lapses, the more discussions that go on, the more we try to convince ourselves that something else happened, the more our descriptions start to shift. And that's what we see here.

So what was very interested and focused --

Q And (inaudible) --

A Let me speak.

On Tyler's first words and first words that he was documenting with, I believe, some support and supervision from Sandy Evans and the completing of this, so I was very interested in how he characterized what occurred, how he described it. I was interested in the level of risk that he was describing that would warrant his grabbing David's arms.

As I read his description, he described David as requesting to go to the bathroom. That testimony changed later. He -- he said that David asked to sit down and he said that that was fine and then David started to scream and cuss and rip paper off the wall and then he jumped up.

I don't read any descriptor in there that would justify the use of restraint. So I relied very heavily

on Mr. Mattson and his experience and his recounting his experience, particularly the closest to the event as possible, so I could get purity of thought and best understanding of what happened.

Because, in truth, none of us will know what actually happened to this gentleman. But what we do know is that David was killed.

COURT REPORTER: You're on you mute.

Rich, you're on mute.

BY MR. ROSEN:

Q So it's your testimony that David Cains was killed? And you're not a medical doctor to render a medical opinion. Is that your testimony?

You just said that, and is that your testimony that you're sticking by?

A My testimony --

Q I asked you, yes or no. This is very important.

A You asked if that's my --

Q You used the word killed --

A -- testimony and I am saying that my testimony is that David Cains was alive, he was functional until that restraint occurred. Now he's dead.

Q Do you know why he vomited? Medically, why he vomited, can you testify to that, Dr. LeBel?

A The statements that have been --

MR. GILLISPIE: Hold on. Objection.

Rich, I'm not going to let you harass my witness. You need to --

MR. ROSEN: I'm not harassing her.

MR. GILLISPIE: You need to tone it down.

MR. ROSEN: I'm asking her questions based upon what she has just testified to.

MR. GILLISPIE: You need to be respectful.

MR. ROSEN: I am respectful.

MR. GILLISPIE: You need to be respectful, sir. You're not being respectful.

MR. ROSEN: She used -- she's using medical terms, legal terms, criminal terms, and yet she can't seem to justify them --

MR. GILLISPIE: Just take it down a notch, Rich.

MR. ROSEN: -- and she's not even a doctor.

MR. GILLISPIE: Take it down a notch. Be respectful.

MR. ROSEN: I am respectful. And there's nothing -- I'm not leveling it up. I'm responding to Dr. LeBel's statement. And I want to know, we've determined she's not a pathologist, she's not a medical examiner,

she's not a doctor.
BY MR. ROSEN:
Q And I guess I have to ask, Dr. LeBel, are you a prosecutor?
A No.
Q Are you a lawyer?
A No.
Q Uh-huh. Okay. Do you stand by your word that he was killed on that day?
MR. GILLISPIE: Asked and answered, Rich. She testified to it.
BY MR. ROSEN:
Q Do you stand by that?
MR. ROSEN: Giving her a chance to retract it.
A David Cains is dead.
BY MR. ROSEN:
Q Okay. I didn't ask you that. You used the word killed.
A Perhaps the language was harsh. But, when you're the family of David Cains and your son or brother is alive one day and dead the next, what do you think they think?
Q Okay. Well, I don't -- I didn't ask you --
A I'm saying that David Cains was alive and functional

and relatively healthy --
Q Okay.
A -- until that restraint occurred.
Q Okay. But there are other factors that happened. He vomited; correct?
A Correct.
Q Okay. So do you -- just so the record is clear, you're retracting your characterization of that David Cains was killed; right?
A It's a descriptive term that describes a loss of life.
Q Okay. So you --
A It is not meant to be incendiary or provocative. But we had a gentleman in a care institution receiving care and treatment who went from being alive to dead because a restraint was inflicted on him. A restraint --
Q Well --
A -- that ensued that he did not cause.
Q Okay. So you're not saying that he was choked by any of these people, are you?
A I'm not saying that he was choked by these people.
Q Okay. So we all can agree, that while he was being restrained, he vomited and choked; correct?
A I have no way of knowing if he aspirated. I know, based on the statements of the staff who participated and

provided their OLTC reports, that they say that he vomited. He regurgitated his lunch which he ate minutes before.

Q Do you have any reason to believe that's not what happened?

A I believe he did vomit.

Q Okay.

A I believe he did aspirate. I believe he did have clogging of his airway.

Q Okay. Now, we kind of got off track.

So under the IPP -- and let's go back to the IPP. You're aware that it defined -- when it used the term that David was physically aggressive, it also defined on Page Nine of that report, the IPP, what physical aggression meant; correct?

A I don't have the IPP in front of me, so I'll rely on your statement.

Q Well, no, I'll read it to you.

Physical aggression, PA, defined as the attempted or actually striking, hitting, or kicking or other -- or kicking other people or objects with the intent to cause injury or damage.

MR. GILLISPIE: What's the question?

BY MR. ROSEN:

Q Were you aware that that defined physical aggression

as hitting, striking, or attempting to hit or strike or kick?
A I was aware that it did define aggression that way. But, particularly, attempting.
Q Okay. Now, you are aware that the IPP, on Page Ten, allowed center emergency procedures when necessary; correct? To protect --
A Again, I don't have --
Q -- the patient --
A -- the document in front of me. I will rely on your statement.
Q Okay. But you saw that? You reading something to that effect rings a bell; right?
A Yes.
Q Okay. So all right. Hold on.
Now, I think we all can agree you were not there on June 30th, 2020, to see David's behavior incident or the response, were you?
A Correct.
Q Okay. Now, we were talking earlier before we were kind of sidetracked, and you were talking about, you know, David being what you described as a lovable, nice person; but, in your experience, you know that people can also be violent and aggressive at other times; right?
A No. What I described was a statement of staff.

Again, I never met David Cains, so I rely on the statement of staff who described him as lovable, fun, funny, easy to work with, and that he never harmed them or anyone that they were aware of.

So I'm not relying on my personal knowledge. I'm relying on the statement of staff at Booneville who described him that way.

Q Okay. Well, did you read the staff statements about where he bit a staff member twice?

A No.

Q Did you read the statements from the Booneville -- the depositions, were you given the depositions where the staff member described how David used to open up the door to the fire extinguisher and throw it at people?

A I read about an incident that he opened the door.

Q But he --

A I read about the incident of throwing a fire extinguisher, but not with the intent of harming.

Q Okay. Well, how do you know what his intent was?

A I don't. I rely on the statement of the staff and that was her interpretation.

Q So did you read about where he punched his sister?

A I read reference to it.

Q Okay. Did you read where, the day after Christmas, David Cain in, I don't know what year, that

Mrs. Robinson, the mother and legal guardian of David Cain was at the facility, David Cains overturned a table and hit his mother? Were you aware of that?

A I'm aware of overturning a table.

Q But you didn't see where he hit the -- where he hit his own mother?

A I don't remember reading that.

Q Okay. All right.

But I didn't -- none of those -- so would that be -- so, as a psychologist, going back to the question, people can be lovable and calm and also have a darker side where they're aggressive and violent and destructive; right?

A I think the same could be said about any human being.

Q Okay. I would agree with that.

Now, you also saw in the IPP that he had destroyed his television set in his room, several radios, and a DVD player and had broken class; correct?

A Correct.

Q Okay. Hold on one second.

And we got a little into the substance but -- so I want to kind of go back and ask you some preliminary questions again or some questions.

When were you -- you were identified to DHS in approximately January of '21 as a potential expert in

this case. When were you first contacted by someone on this as a potential expert?
A I believe in January of 2021.
Q Okay. And so we didn't get your report and your report is not dated until December 28th of 2022, approximately a year later; right?
A Right.
Q Do you know any reason why there was such a delay?
MR. GILLISPIE: Object to the use of the term delay. Obviously, we were conducting depositions that whole year and those were important for her to review in order to render an opinion.
MR. ROSEN: Okay.
BY MR. ROSEN:
Q So you didn't -- when you were first contacted about being a restraint, of being a restraint expert, so to speak, did you -- who'd you talk to?
A I was contacted about being a restraint prevention expert. Not a restraint expert.
I was contacted by Mr. Gillispie.
Q Okay. Do you know how he got your name?
A No, I do not.
Q Are you listed with any service or agency as a potential expert witness?

A Not that I'm aware of.
Q Okay.
All right. Let me ask you about -- since you're with the Massachusetts Department of Mental Health, does that in -- is there a separate department for like developmental disability services? Or is that within the department of mental health?
A Development disability services used to be within the department of mental health but split out. And now it's its own department.
Q Okay. When did that happen?
A (Inaudible) department services.
Roughly 1990, '91, '92.
Q Oh, so 30-something years ago? About 30 years ago?
A About.
Q Okay. So you don't -- so you're over mental health, not over DDS services, disability services; right?
A I work for the department of mental health.
Q Okay. So does Massachusetts have ICF/IIDs, which are intermediate care facilities for individuals with intellectual disabilities, which is what an HDC is, do they run those?
A They run those.
Q Okay. So they -- you have them in Massachusetts?
A Yes.

Q Okay. State run?
A State run or contracted.
Q Okay.
And so they don't use restraints at all?
A They use some restraint.
Q Oh, okay. So, even in your own state, restraints are used in the equivalent of human development centers, ICF/IIDs; correct?
A I believe so.
Q Okay.
So now let's get back to a topic we kind of jumped into but I want to explore a little further.
How do you define what is a standard?
MR. GILLISPIE: Objection to the form.
MR. ROSEN: I'm not sure how that would be objectionable.
BY MR. ROSEN:
Q But go ahead.
A How do I define what is a standard?
Q Yes. What is a standard to you?
A A standard for what?
Q A standard of care.
A A standard of care, to me, is a reasonable practice.
Q In whose opinion?
A Well, you just asked me for mine.

Q Okay. In your opinion then. Okay. Fair enough.
In your December 28th, 2022 report, you used the term proximal. What did you mean by that?
A I used the word proximal because his death followed the use of restraint. It was proximal to restraint.
Q Okay. So proximal, does that mean like close in time?
A Close in contiguity of time, yes.
Q Okay. But you're not insinuating or stating that one had anything to do with the other, are you, in that statement?
A Oh, I believe one absolutely had something to do with the other.
Q Okay. Well, that's where I want to go back, because you're not a physician; right?
A I'm not a physician. But, as a member of the lay public and reading reports from the coroner, reading reports from EMS, reading reports from the hospital, I can recognize when somebody is describing that somebody died.
So, as a member of the lay public, I'm able to read and appreciate that someone died as a result of being restrained.
Q Well, that's what I'm asking you. How do you make the medical connection, to a reasonable degree of medical

certainty, that the restraint caused the death?
A Well, I would say, if you look at the statements that have been rendered, whether it's from the emergency personnel on site, the nurses, whether it's the direct care staff, that in the course of restraint, David became
[redacted]
Q Well, it stopped because of an event that happened while he was being restrained, and that was vomiting; right?
A He vomited because he was being restrained.
Q Well, that's where I -- so, Dr. LeBel, I understand you're a licensed psychologist in Massachusetts. Okay?
But you're not a physician, you're not a coroner, you're not a pathologist, you're not a neurologist. You have no formal medical training whatsoever. You're not a lawyer, you're not a prosecutor.
So on what -- this is just -- you base that connection based simply on your lay observation?
A I make that observation based on reading the CPI/NCI training, that they describe the sequela of restraint, they describe the possibility of positional asphyxia, they described the possibility of choking, aspiration, they described the possibility of cardiac arrest.

They described a number of physical possibilities associated with the high risk of using a restraint. So I rely on that industry, CPI and NCI, which was the policy and practice adopted by Booneville as a method to intervene in the event of behavioral distress.

I rely on --

Q So you're --

MR. GILLISPIE: Please let her finish.

A -- CPIs, NCI, written description about the possibilities of adverse events.

I rely on the expertise of my colleagues who I have worked with, studied with, published with, trained with, who have, in fact, opined, as medical professionals, about the lethality of restraint use.

So I feel quite comfortable in relying on this education, this learning, this experience, to render an opinion that David Cains was alive and relatively healthy before this restraint occurred.

And, during the course of restraint, a series of medical events happened, and he died.

BY MR. ROSEN:

Q Okay. Okay. So you're saying -- well, proximal is not proximate in your -- you didn't use the word proximate in your opinion, in your written report. You used proximal; which means close in time.

So two events happened close in time does not necessarily, to a reasonable degree of medical certainty, mean that one caused the other, does it?

MR. GILLISPIE: Object to the form; asked and answered.

MR. ROSEN: Please tell me your objection to the form so that we can address it. Because this is cross examination of an expert witness.

MR. GILLISPIE: It's borderline unintelligible. I'm not sure what you're asking; but, other than that, it's -- you've asked the same question about that word and she answered it.

MR. ROSEN: Okay.

BY MR. ROSEN:

Q So, Dr. LeBel, I want to make the record clear so that we know what you're saying and we know what you're not saying. Okay?

So are you saying to a reasonable degree of medical certainty, in your medical opinion, that the restraint caused David Cain to vomit and to choke? Is that what you're saying?

A Yes.

Q Okay. And your qualifications to say that is based upon? What medical training do you have? What medical

training do you have? That's all I want to know.
A I have been employed in healthcare settings. I have been given education within hospital-based settings on medical procedure and practices, including the use of restraint. I have received a medical education.

And let me just also say, that when I received this medical education about the use of hands-on procedures and the use of restraints, I'm sad to say that none of the psychiatry attending physicians that were on staffing ever participated in that medical training.

So, while they're authorized to give the order, they didn't participate in that level of education and training. I did.

I have also learned, I'm relatively educable and have taught and have presented with a number of physicians, cardiologist, pathologists, psychiatrist, who have all educated me about the use of restraint, the stress on the body, and the likelihood of serious harm when restraint is used that could lead to death.
Q Okay. So if there is a connection between the restraint and vomiting, that means that every time a restraint was used, there would be vomiting, is that your opinion?
A No, that's not my opinion.
Q Okay. Okay. So how often, when a restraint is

used, would there be vomiting?
A I have no capacity to respond to your question.
Q Okay. Fair enough.
Now, you're aware that David Cains was able to make himself vomit at times; correct?
A I wouldn't --
MR. GILLISPIE: Object to form; assumes evidence not in the record.
BY MR. ROSEN:
Q I'm asking you, are you aware of that or not aware of that?
A I'm aware of --
MR. GILLISPIE: Same objection. Assumes evidence that's not in the record.
BY MR. ROSEN:
Q Dr. LeBel, are you aware that David Cains frequently vomited?
A I'm aware that Tyler Mattson made reference to that.
Q Okay. Are you aware that his sister made reference to that?
A No.
Q Okay. Would that change your opinion, if your sister, if David Cains' sister mentioned that he frequently vomited?
A Possibly.

Q Okay. But you weren't provided that information, were you?
A No.
Q Okay.
Now, I think we've already established that you do agree that the Code of Federal Regulations governing intermediate care facilities for individuals with intellectual disabilities and the corresponding CMS operations manual, which we call Appendix J, are the applicable standards to be applied by Booneville Human Development Center for restraints; correct?
MR. GILLISPIE: Asked and answered.
BY MR. ROSEN:
Q You agree with that; right?
A I already answered to that question. Yes.
Q Okay. And so, if the Booneville Human Development Center followed those restraint provisions, then they met the standard of care; correct?
A If they followed those provisions.
Q You would agree, that if they followed it, they would have met the standard of care?
A Well, the standard of care is broad. There are multiple dimensions of the standard of care.
And the use in the application of this discussion with respect to restraint, then yes, they would have met

the standard of care. But the standard of care doesn't just apply to the use of restraint.
Q Okay. And so, just to be clear, would you agree that physical restraints may be employed in an ICF/IID like the Booneville Human Development Center as an emergency measure but only if absolutely necessary to protect others from injury? The client and others from injury, would you agree with that statement?
A I would agree with that.
Q Okay. And so would you agree that the employment of restraints for -- the employment of emergency restraints in an ICF/IID is allowed, pursuant to 42-CFR-483-450(d)(1)(ii)?
A I would agree with that. And also that it preferences that restraint is only to be used when the client is exhibiting behavior that the client has not exhibited before and is not identified in the functional behavior assessment or the client is harming other people or themselves. So there's --
Q But that's actually not the --
A -- many facets.
Q But that's actually not the standard in the state operations manual or the CFR, is it?
A That's the standard that I made note of.
Q Okay. Well, you might have made note of it, but

that's not what it says, is it?

And let's go to that. So it's your testimony -- so the state operations manual -- and let's set the stage a little bit.

Appendix J, which is the state operations manual under which facilities are judged as to whether they are compliant with federal regulations or not compliant and deficient with federal regulations; correct? You would agree with that; right?

A What was the question?

Q The question is, that Appendix J, the state operations manual for ICF/IIDs like the Booneville Human Devolpement Center, is the guidance to surveyors for determining whether a facility is in compliance with federal regulations or not in compliance with federal regulations; right?

A I don't know that; because I do know that CMS has issued separate guidance to surveyors, so I don't know.

I don't have a copy of the state operations manual.

Q Okay. So you're not -- are you familiar with Appendix J from CMS? The state operations manual?

A I don't know. I don't believe that I've reviewed Appendix J.

Q Okay. Fair enough.

So your opinion that you've expressed here today and

those in your reports are not based upon Appendix J, the state operations manual, is it?

A My opinion comes from looking at the CMS regulations, 483.420, 483.450; so I'm looking at those standards. I'm not looking at the state operations manual.

Q Okay. And have you ever heard of that before?

A The state operations manual?

Q Yes.

A Yes.

Q Okay. And so you know it's a promulgated document from centers of Medicare -- from the federal government; right?

A Right.

Q Okay. And do you know what we commonly call as a TAG?

A Yes.

Q What is a TAG?

A A TAG is a citation to a specific referenced within the manual of the regulation.

Q Okay. And this is the manual that the TAGs are related to. They have certain requirements that a facility must meet with regard to, in this case, restraints.

And, if they violate that, then they're going to get

a deficiency. And, if they don't violate that, then they're okay, they're cleared; right?
A Conceptually.
Q Yeah. That's how it works; right?
A I presume so.
Q Okay.
A I'm not a --
Q Do you know so?
A I'm not a CMS surveyor.
Q Okay. Fair enough. But you know the process is that when there's a -- well, you know that a facility like the Booneville Human Development Center has annual surveys and compliant surveys by CMS surveyors; correct?
A I don't know the frequency with which CMS conducts their surveys. I don't know that.
Q Okay. Do you know what the regulators, how often they survey at all?
A I do know that COVID has dramatically stepped on the frequency of surveys, so I don't know the frequency in Arkansas.
Q Do you know whether there was a survey by the state regulator as a result of an investigation into David Cains' death?
A No, I don't.
Q So then, if you don't know that there was a survey,

you don't know what the outcome of that survey was, do you?

A I don't know the outcome of the CMS survey following David's death.

Q Okay. Fair enough.

Would you agree, that under federal regulations and -- well, I'm not going to ask you about the Appendix J state operations manual because you're not familiar with it, so let's --

MR. GILLISPIE: Object. Object to the form of that. The term Appendix J may be throwing her off, but we're talking about the same federal regulations, the same CMS/ICF regulations, 483.450, et cetera. We're talking about the same thing.

MR. ROSEN: Well, I'll just go on what Dr. LeBel said.

BY MR. ROSEN:

Q Anyway, what I'm going to ask you is, in response to an emergency -- well, is it your opinion that the emergency situation that would allow restraints must have a potential consequence, that without the restraint or the intervention, there would be some lethality to it?

A Yes.

Q So that's your requirements?

A That's not my requirement. That comes directly from the DDS regulations.
Q Okay. When --
A And the (inaudible) health or safety in which death or severe bodily injury could reasonably be expected to occur without intervention.
Q Okay. So it's not just death, it's bodily injury as well; right?
A Severe bodily injury. Not just bodily injury. It's severe bodily injury.
Q And where are you looking at for that statement? Where did you get that statement?
A The DDS regulations 311-D.
Q Okay. 311-D?
A And they also roll up to CMS standards. And the CMS standards, as Mr. Gillispie has identified and what I'm referring to and, yes, they inform Appendix J --
Q Okay.
A -- in the operations manual.
Q Okay. In looking at -- where in 311-D, 3011-D, does it talk, does it say that?
A I don't have it open in front of me.
Q Okay. What subsection? Do you know?
A I don't have it open in front of me.
Q Because I don't see it; and that's why I'm asking.

MR. GILLISPIE: I think it may be DDS 30 (inaudible) --

MR. ROSEN: Well, I'm not asking you, Counsel. I'm asking --

THE WITNESS: I'm sorry. You're correct. It's 3004.

MR. ROSEN: 3004?

BY MR. ROSEN:

Q And what is that?

A That's Appendix A, the imminent danger to health and to safety.

Q Okay. And what --

A DDS 3004.

Q Okay.

A Appendix A.

Q Okay.

MR. ROSEN: We're going to take a break here. We've been going for a while. Let's take about a five-minute break. Okay?

THE WITNESS: Okay.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. ROSEN:

Q Okay. So we were talking about the restraint policy

and 3011-D. And I just want to make sure, is your opinion of DHS policy, excuse me, DDS policies based upon 3011-D regarding restraints?

A Yes.

Q It is?

MR. GILLISPIE: Which -- what's the --

MR. ROSEN: I was asking about 311-D.

BY MR. ROSEN:

Q And, Dr. LeBel, you had said that you relied upon 3004 with regard to serious injury or death. Or I can't exactly --

A It was referenced there and 311-D, as well, I relied on.

Q Okay. Well, let's talk about 311-D first. Okay. So 311-D, emergency provisions don't include the words the requirement that there be any lethality in the absence of intervention, does it?

A I read the word and phrase imminent danger.

Q Okay. Where is the word imminent danger in DHS or DDS policy 3011-D?

A 3004, Appendix A.

Q Okay. I'm talking about 3011-D --

A One-one-D?

Q -- which is the behavior management restraint policy for DDS.

A I don't have that in front of me.
Q Okay. Did you rely upon that at all?
A Oh, yes. I read them.
Q Okay. And is it your testimony here today that the DDS policy 3011-D requires imminent danger or harm?
A I said that with respect to 3004.
Q Okay.
A DDS regulation and policy.
Q Okay. So you said that's with 3004.
So, in 3004, what is -- the behavior management and restraint policy of DDS is in Policy No. 3011-D. So I'm asking you, you looked at something different, at DDS Policy 3004, which deals with what?
MR. GILLISPIE: I object to the form. I'm not sure what --
MR. ROSEN: Well --
MR. GILLISPIE: I'm not sure what that question is asking at all.
BY MR. ROSEN:
Q I'm asking you, what is the subject of the policy?
MR. GILLISPIE: You're asking her what is the subject of a DDS policy?
MR. ROSEN: Of the policy she relied upon.
BY MR. ROSEN:
Q Well, I'll make it a little easier since there's

been a pause and I don't think you know.
So 3004 is the maltreatment prohibition prevention and reporting investigation policy; right?
A Sir, I don't have these documents in front of me.
Q Okay.
A You're asking me to paraphrase the language that's used to describe these. I read different DDS regulations that pertain to the use of restraint.
Q Okay. So is it your testimony that DDS Policy 3004 deals with restraints?
A It's my testimony that it deals with the imminent danger to health or safety --
Q Okay.
A -- in which death or a severe bodily injury could be reasonably expected --
Q Okay.
A -- to occur without intervention.
Q Okay. In regard to what context?
A The context of behavior management.
Q Okay. Well, I'm going to -- but you don't have the document in front of you; right?
A Sir, I don't have these documents in front of me.
Q I'm going to show you, I'm going to try to show you if I can. Apparently, I can't.
All right. So the DDS Policy 3004 is -- the subject

of that policy is maltreatment prohibition, prevention, reporting, and investigation.

MR. GILLISPIE: What's the question?

BY MR. ROSEN:

Q Well, do you agree with that or you disagree with that?

A Sir, I don't have it in front of me. I did not commit the DDS regulations to memory.

I've read them and I opined based on reading them.

Q Okay.

A I did not commit them to memory.

Q Okay. So, just to be sure though, do you know whether the subject of the policy that you're citing is behavior management and restraints or maltreatment investigation and reporting?

A I will restate, I read DDS regulations that pertain to the circumstance and I've rendered an opinion.

I did not commit them to memory. I don't remember the title of the specific -- and, clearly, you have the advantage of both the regulation and the citation in front of you. I did not commit them to memory.

Q Okay. And are you aware of whether the definition of imminent danger to health or safety has to due with the statutory definition of abuse as opposed to what we're talking about here, being a restraint?

MR. GILLISPIE: Objection.
MR. ROSEN: I'm just asking.
MR. GILLISPIE: It's asked and answered. She already said it's her understanding that definition of imminent danger applies to restraints. And it's worth mentioning that Superintendent Gonyea specifically said that definition is the definition of emergency use at BHDC in his testimony.
MR. ROSEN: Okay. Well, we're not asking Mr. Gilllispie to testify. We're asking Dr. LeBel to testify.
BY MR. ROSEN:
Q And so, Dr. LeBel, is it your testimony that imminent danger to health or safety -- well, actually, the definition from -- well, what is your definition from 3004 of imminent danger to health or safety? What does it mean?
MR. GILLISPIE: Object to the form. She's read what she believes that definition to be.
MR. ROSEN: Well, no, I'm asking her.
MR. GILLISPIE: You're asking her what a definition means? What does that even mean?
BY MR. ROSEN:
Q What is the definition -- what are you using that to

mean? Define that.
A Sir, I don't have these documents in front of me. I don't know what you're citing. I'm getting lost in your questions.
Q Okay.
A I don't know how to answer them.
Q I'll make it very simple for you.
When you use the word imminent danger to health and safety as stated in DDS Policy 3004, what does that mean to you?
MR. GILLISPIE: Object to the form.
MR. ROSEN: What objection? Please tell me.
MR. GILLISPIE: I don't understand the question.
MR. ROSEN: Well, I can't be simpler. Just because you don't like the answer -- I mean, I don't know what the answer is.
BY MR. ROSEN:
Q But I'm just asking you, Doctor, how do you -- would you use the term as applied in DDS Policy 3004? What did you mean it -- what did it mean to you?
A Sir, it's not what it means to me. It's what it means to the State of Arkansas, the Department of Developmental Disability Services when they adopted this

standard of imminent danger to health or safety.

My opinion is less relevant than the State of Arkansas'. Their definition likely means the likely risk of life and limb is imminent danger. Serious bodily harm.

Q Okay. Define serious bodily harm.

A Serious bodily harm could be any number of things in which there is a severe injury to the physical body that could compromise health, vitality. It could compromise functioning, any number of things.

Q Can it mean just physical injury?

A Not likely.

Q Do you know whether that's the definition or not? Or are you guessing?

A Just physical injury could be falling down and getting a scrape. I believe the attempt of the verbiage is to elevate the importance of how these interventions are in fact used.

Imminent danger implies something of significant risk posing a potential loss of life.

Q Okay. And that's what you base your statements about imminent serious bodily harm, is on 3004; correct?

A Well, it's looking at the federal standards from CMS.

Q Okay.

A It's looking at the state regulations. It's looking at Booneville's policy. It's looking at the CPI/NCI training. There are many sources that inform that opinion.
Q Okay. Well, I'm going to ask you about -- did you rely upon DDS Policy 3004 for your, at least as for part of your claim, that it had to be imminent and serious harm when used, before you can use a restraint?
A Yes.
Q Okay.
A Along with the other DDS regulations and the CMS standards and the Booneville policy and the CPI/NCI training curriculum.
Q Okay. Well, I'm going to ask you individually, so you don't have -- I understand your mantra of -- you said that before. But I just asked you about 3004. And that's all I asked you about.
So the answer is you did rely upon that with regard to use of restraints; correct?
A I relied on that as part of the information that informs my opinion.
Q Okay. And did you rely upon DDS Policy 3011-D as part of your opinion on imminent or serious bodily harm before you can use a restraint?
A Yes.

Q Okay.
A It also helped to inform my opinion.
Q Okay. And did you rely upon 42-CFR-483.450 as well, requiring imminent physical harm or lethality before a physical restraint may be used?
A Yes. I relied on CMS regulation 483.450; which is, I know, used to inform the operations manual and the guidance thereof as guidelines for use.
But the regulations cited by CMS, yes, I used those to inform.
Q Okay. So in reading your report of December 28th, 2022, I saw only -- really, only two references to 482-CFR-450.483. One on Page Four and one on, I believe, it's Page Eight.
And so let's talk about the one on Page Four of your report. Okay? Hold on.
MR. GILLISPIE: Are you going to show it to her?
MR. ROSEN: You don't have your report? Okay. Well, I'm going to ask her questions about her report.
MR. GILLISPIE: Well, give her a second to grab it then, if you -- if she could pull it up.
THE WITNESS: Okay.

BY MR. ROSEN:
Q Okay. Now, on Page Four of your report, you state, and I'm going to quote, physical restraint is a potentially lethal procedure of last resort which is used in an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or ruled out.

And you cite, in parentheses, 42-CFR, Section 483, closed parentheses, unquote. Okay? You agree? You there with me?

A Yes.

Q Okay. That's what you said; right?

A Correct.

Q Okay. Tell me where in 42-CFR-483.450 does it say, use the word imminent?

A I don't see the word imminent.

Q Okay. Fair enough.

Now, all right. And so just to make clear, the state operations manual, Appendix J, that's what -- you're not familiar with that; right? Because I won't ask you questions about it if you're not familiar with that.

A I'm familiar with Appendix J to the extent that the regulations rolled out to interpret a guidance for the state facility operating manual.

Q Okay. So you are familiar with it?
A I don't refer to it as Appendix J. That's interpretive guidance. I rely on the regulatory language, so the citations I'm more familiar with. I don't call it Appendix J.
Q Okay. But that's what it's called. It says state operations manual, Appendix J, guidance to surveyors, intermediate care facilities for individuals with intellectual disabilities; right?
A Okay.
Q Okay. I mean, you agree?
A I agree.
Q Okay. So, in this state operations manual, it talks about restraint; right?
A Right.
Q And, in the guidance, CMS guidance to state regulators for compliance, it says, under W -- well, first of all, W-296, you look at that?
A Yes.
Q Okay. That's what we were talking about as the TAG; right?
A I'm assuming so.
Q Okay. So that's the -- if a state regulator found that a facility didn't do what's required in there, they would find a deficiency at that TAG number; right?

A Presumably.
Q Okay. And, if they found that they were in compliance, there would be no deficiency; right?
A I don't know.
Q Okay. Well, in there, under W-296, which cites 42-CFR-483.450, it specifically says restraints can be used as an emergency necessary, if necessary, to protect the client and others from injury; right? You agree with me?
A No, I don't.
Q Okay. What does it say?
A Because it's qualified.
Q Okay.
A You skipped over the word only. Only is very important to me.
Q Oh, okay. Okay. So --
A It can only be used as an emergency -- only is absolutely necessary to protect the client and others from injury. Only --
Q Okay.
A -- if absolutely necessary to protect.
Q I agree with you.
And so the guidance, the CMS guidance to state regulators and federal regulators is that physical restraints may be used as an emergency intervention only

in situations where the client is exhibiting behaviors which -- and it lists three things; correct?
A Correct.
Q Okay. And, after the second, it uses the disjunctive or, does it not?
A Correct.
Q And so any one of those things would be reason for emergency, employment of emergency conditions for restraints; right?
A Presumably so.
Q Okay. Not all of them, but any one of them; right?
A It demands on the interpretive guidance.
As I read it, the three conditions are the client has not exhibited the behavior before, they were not identified in a functional behavioral analysis, or they're harming other people or themselves.
Q That means any one of those three is grounds for the restraint; correct?
A I'm reading.
Q Well, I mean, there's not that many words there. Would you agree or not agree?
A I don't see them as mutually exclusive. I see them as specific criteria.
Q Okay. So --
A They've not exhibited the behavior before. They

weren't identified in the functional analysis or.
Q Okay. So tell me your definition of --
A I don't read them as -- I'm sorry.
Q Tell me your definition of the disjunctive or. What does that mean?
A It only occurs in number two. It doesn't occur after number one as well.
So, to me, I see room for client has not exhibited before, were not identified in the functional analysis of behavior or are harming other people or themselves.
Q Okay.
So your interpretation is that you have to -- that it has to be -- when you have three items listed with the last one, with the second to last one having -- divided by semicolons. And the last one having an or means that you -- it's not either or, it's some of which, not just one of which; right?
Is that your interpretation? Because I want to make the record clear.
A I have a hard time following your question, sir.
Q Okay. Fair enough. Let me re-ask it.
So it says here in the guidance from CMS to state and federal regulators, physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which, colon, one, the

client has not exhibited before, semicolon; two, were not identified in the functional analysis of behavior, semicolon; or, three, are harming other people or themselves, period, unquote.

Now, what does that mean to you as to what the requirement is?

A I read that as a requirement that one and two are satisfied or numbered three.

Q So you're saying that there's at least two elements to that and not just one? That any one of them would not do it? Is that your interpretation?

A That's my interpretation.

Q Okay. Good. All right. We'll move on. Thank you.

Now, so it's your interpretation -- actually, we're not going to move on.

It's your interpretation that you would need -- the client would have to not have exhibited behavior before and be harming to the other people (inaudible) or it would have to be it was not identified in the functional analysis and harming other people. That's your testimony?

A Could you please restate that?

Q Okay. Well, let's go back a little bit.

I know that you have a -- you've stated you have a Ph.D. Okay? And tell me what the disjunctive or means

to you.
A To me, when I read the word or in this list of three conditions, I read that number one and number two are rolled up as requirements or number three.
Q So does that mean -- in your interpretation, would -- physical restraint may be used as an emergency intervention when the client exhibits behaviors which are harming other people or themselves? Would that be sufficient?
A It could be.
Q Okay. So you don't need one and two, you just need three, if that's the facts?
A Possibly.
Q Okay. Well, I'm asking you, in your opinion.
A And I've answered the question.
Q Well, what's the answer? That three could stand alone if the resident is harming other people or him or yourself, that would be sufficient to implement and employ restraints?
A That's my interpretation of the CMS standard.
Q Okay. Thank you.
I'm just catching up. We went a little further than I was prepared so I'm just going through my outline. So, if you would, just give me a moment.
On a few other things, are you opposed to the use of

physical restraints in the human development center?
A I'm opposed to the use of restraint in the human development center when it is used for nonlethal, nondangerous circumstance.
Q Okay.
A When it's used as a matter of routine, when it's not used for the method in which it's intended, as a lifesaving measure of last resort.

I'm opposed when it's used as a first resort. I'm opposed when it's used for the convenience of staff. I'm opposed when it's used in the face of adequate training and support for staff and competency development.

I'm opposed to the use of restraint in the vast majority of times that it's used. It's intended to be a lifesaving method of last resort. It serves its purpose there.

It is an extraordinarily high risk, dangerous procedure, that should only be used with strict authorization requirements, oversight training and a high standard with which to lay hands on a person against their will.
Q Okay.

Do you know the difference, in the State of Arkansas, between a -- among state regulators of HDCs, ICF/IIDs, between a maltreatment investigation and a

survey?
A I can't comment on the state of Arkansas' practices. I'm aware of the difference between a survey and a maltreatment investigation in other states. I can't speak to Arkansas practices or standards.
Q Generally, a survey, you understand a survey by long-term care surveyors is an inspection of the facility for compliance; right?
A That's my understanding.
Q Okay.
And I might have asked you this before and I think -- but I'll ask you just to make sure the record is clear.
Are you aware whether or not the state regulator, Office of Long-term Care performed a survey or inspection of the Booneville Human Development Center as a result of investigating David Cains' death and whether the facility complied with federal regulations?
A I know that documentation was developed and prepared and submitted. I did not see their investigation.
Q So you don't know the outcome of that investigation, do you?
A I don't know the outcome based on the record from the Disability Rights Arkansas, looking at the mortality review committee findings. I've read other references

but not the specific report.
Q So you don't know if they were found not to be deficient or not, do you?
A I read reference to no findings of significance and no breach in standard of care and other documents.
Q Okay. And you know that surveyors are CMS federally trained to investigate compliance; right?
A I know they're CMS employees. I can't comment on whether or not they're adequately trained to conduct those types of reviews or investigations.
Q Now, on Page Three of your December 28th, 2022 report, you opined -- and it's a little different than you said today.
But you opined that David Cain had a, quote, right to be free from abuse and restraint, unquote. And that's the first bullet point, approximately mid page.
Is there anything in federal regulation that says a resident of an ICF/IID has a right to be free from restraint?
A Yes, I believe it is incorporated in the federal standards, that the patients have a right to be free from unnecessary restraint and abuse.
Q Okay. So you're qualifying it to be unnecessary; right?
A That's the language of CMS, I believe.

Q Okay. Well, that's not what you put in your report, on Page Three.

So your report, where it says, quote, right to be free from abuse and restraint, unquote, in the first bullet point mid page, didn't use the word unnecessary, did it?

A No, it did not.

Q Okay. So that's an omission that you made; right?

A Yes.

Q Okay. Also on page -- well, strike that question.

So would you agree, since you're here to testify as an expert, if a dually diagnosed person with severe intellectual disabilities and mental illness attacked staff, would that be sufficient to employ emergency restraints? In your opinion.

A I'm going to go back to my earlier testimony that questions language. I have no way of knowing what your definition of attack is. I have no way of knowing what staff's definition of attack is.

In my experience of reviewing records and looking at the testimony of staff and the language used, there is a great tendency to exaggerate, distort, alter, the actual behavior that -- staff capacity to accurately describe is often inaccurate.

I don't have a way of responding to your question

about his developmental disability, mental illness, and attacking staff makes restraint justified.

Because I look at it with a lens in which staff who tend to use restraint tend to exaggerate, distort, or not have a good working knowledge about what is actually happening, what behavior is actually dangerous, what is destructive versus disruptive versus agitated.

There are levels of behavioral distress, so I don't have a way of answering that because I don't have a good way of knowing what your definition of attack means.

Q Well, do you know whether the staff at the Booneville HDC in their behavior reports or on -- in their behavior reports, exaggerated or distorted or are you just saying based upon your experience in other facilitates?

A I'm saying in my experience in reading documentation from other facilities as well as Booneville's. I'm looking at the staff characterization and staff description of --

Q Well, how do you know they're distorted?

A Because I see inconsistencies in the way people are labeling and describing the behavior.

Q Do you know the educational level of the direct care staff at the Booneville Human Development Center?

A No, I do not.

Q Okay. Do you think that might play a factor in the ways it's described?
A I don't know.
Q Fair enough.

[redacted]

[redacted]

Q Okay.

You state in your report, on Page Seven, that Dr. Hamid, who was David Cains' physician at the time,

did not approve of the use of floor or ground restraints for David Cains. Do you recall that?
A That's my understanding.
Q I'm sorry, say that again.
A That's my understanding.
Q Okay. Did he disapprove them? Did he prohibit them?
A That, I do not know.
Q Okay.
A It was in his individual program plan.
Q Do you know what a papoose board is?
A Yes.
Q What is it?
A It's a mechanical device used to contain a body in the form of restrain.
Q Now, although that didn't happen here on this day, you're aware that Dr. Hamid determined that it was safe for David Cains to be placed on a papoose board when necessary; right?
A It's my understanding that a restraint authorization, as indicated or a standing order, is prohibited by the facility.
Q I didn't ask you that question. I asked you whether Dr. Hamid determined it was safe to do.
A I did not read that determination.

Q That wasn't provided to you?
A **I did not read that in the medical orders.**
Q Okay.
So a papoose board is -- you have to be on the ground to be put in a papoose board, do you not?
A **Yes.**
Q Okay. So, even though that's not what happened here at all, by necessity, if it was -- if a papoose board was authorized in the IPP or in the medical orders as safe to do, it, by necessity, would require the person to be on the ground; right?
A **Conceivably.**
Q Okay. And I'm talking whether David Cains or any other person, that's how it operates; right? If you're going to use one?
A **If you're going to use one.**
Q Yeah.
Now, let's talk about your testimony here today and I guess, in your report, you mentioned it briefly on Page Five of the report, about withdrawal reflex. Okay?
I didn't see anything in there about fight or flight; and now you're saying that's the same thing? Is that your testimony?
A **If you look up withdrawal reflex, you will see a greater detailed explanation than I put in my report.**

It's considered a fight or flight response.
Q Okay. And so would it be a withdrawal reflex if I put my hand -- accidently touched a hot surface, I automatically pull it back; right? Withdrawal it, could that be an example?
A It could.
Q Okay.
And I understand that you don't accept Tyler Mattson's deposition testimony. But at what point did David Cains, in your opinion, withdrawal?
A I have no way of knowing when David Cains withdrew. But I would assume, that if Tyler Mattson had an element of accuracy when he said he grabbed David and he laid hands on first, that David's response would have been to try to escape from that noxious stimuli. He would have tried to withdrawal from being grabbed.
Q But you're assuming -- your opinion is premised, your assumption is premised on David Cain not being the aggressor; correct?
A My assumption, based on Tyler Mattson's language and his OLTC statement is that he grabbed David, that he laid hands on first.
Q Okay.
A He activated the behavioral sequence that led to the use of physical restraint.

Q Okay. So I take that as a yes, you do agree that that's -- your opinion is pressed on the assumption or presumption that David Cains was not the aggressor; correct?
A That's my assumption. And I also note, that once he's on the ground, there's ample opportunity for Mr. Mattson to step up, step away, give time and space, and he did not.
Q Okay.
A So if one assumes that Tyler is accurate in his first statement right after the event, that he grabbed David and David fell to the floor -- it doesn't say that Tyler fell to the floor.

So he later describes it as a supported lowering to the floor. He still -- he, Tyler, had the opportunity to pull away from David and not put pressure on his shoulder, his side, or his waist.

He had the opportunity to create a condition for David that would have allowed him to escape from the noxious circumstance; which is the basic withdrawal reflux continuing on the ground.
Q Okay. So at what point in time did David Cains calm down while on the ground?
A I have no way of knowing.
Q Okay. So would you agree or disagree with the

statement, that in the state Operations manual, under W-302 that says documentation should support that the client was released from restraint as soon as they became calm.

A I would agree that the client should be released as soon as they become calm.

Q So I'm asking you, at what point in time did David Cains become calm?

A I don't know.

Q Okay.

A I wasn't there.

Q Okay. Just a few more questions, actually.

So had mentioned several times NCI is a de-escalation protocol; right?

A As part of the CPI program of restraint use --

Q Okay. So that's the --

A -- that includes de-escalation.

Q That's one protocol within the CPI portfolio dealing with de-escalation; correct?

A That's correct.

Q What does NCI stand for?

A Nonviolent crisis intervention.

Q So it's really noncontact crisis intervention, would you agree?

A I can't comment on that.

Q But do you know whether CPI, which is a company that sells this, they have more advanced, more contact training protocols?
A I believe they have different programs for different settings.
Q So they would have one that would be more interventionalist as of more de-escalation; correct?
A I can't comment. I don't work for CPI. I'm not aware of all of their programs. I've only been their keynote speaker and consultant for CPI.
Q So CPI, you worked for CPI or you --
A No, I do not work for them. I was asked to be a keynote speaker at two of their international (inaudible).
Q Did they pay you for that?
A They pay for my travel expenses.
Q They didn't give you a peridium or some type of payment to --
A Not that I remember.
Q Okay.
Now, let me ask you -- let me change the topics a little bit. The six core principles that you mentioned earlier, and I know -- you go around the country lecturing on that; correct?
A It's called the six core strategies. And I have --

Q Yeah. Do you --
A -- traveled extensively in the United States and teaching and training on the use of the core strategies.
Q Okay. Is that some type of -- is that an entity or a corporation or a partnership? Is there a business associated with that?
A No, there's not a business associated with that.
Q When you lecture on this topic, are you paid to lecture on this topic or given some type of compensation for lecturing on this topic?
A Yes. Most of the time, I'm given compensation to speak about the six core strategies.
Q Okay. Just a few more questions.
Let me ask you, from speaking to you today and reading some of your articles and -- you fundamentally disagree with, do you not, with CMS's allowance of the employment of restraints, do you not?
A I would not say that.
Q Okay. So you agree that restraints can be used in certain instances?
A I said before that restraint has its place as a lifesaving method of last resort.
Q Well, okay. And that's the only time?
A Yes.
Q Okay. So have you ever had comments, publicly

spoken out, against CMS particularly allowing restraints in situations that are not potentially lethal?
A Not that I'm aware of.
Q Okay. Hold on. Just a few more questions.
Do you not see yourself as part of a movement to ultimately eliminate restraints from use in facilities?
A I'm not sure what you mean by movement.
I certainly would define myself as somebody who works tirelessly to help facilities, organizations, state public health systems, to try to prevent, avoid, the use of restraint seclusion.
I'm not sure what you mean by a movement.
Q Okay.
A Anything that helps improve the quality of care and treatment for persons served along with a staff who serve them is a very good thing.
Q I have no other questions. Thank you.

REDIRECT EXAMINATION

BY MR. GILLISPIE:
Q All right. Dr. LeBel, real quick, I'm going to share the screen here.
MR. GILLISPIE: Just a moment. I'm trying to pull something up as an exhibit.
Can y'all see the state operations manual?
THE WITNESS: Yes.

MR. ROSEN: Yes.
MR. GILLISPIE: Okay. Is that the only thing y'all see?
THE WITNESS: Yep.
MR. ROSEN: Yes.
MR. GILLISPIE: All right.

BY MR. GILLISPIE:

Q Real quick, Dr. LeBel, I just want to clear up any confusion that there might have been with regards to the state operations manual.

On Page Three of your written report, you write that the standard of care required the respondent to comply with the federal CMS\ICF regulations found at 42-CFR Section 483, et sec., and also the Arkansas DDS policies and procedures and BHDC's own policies and procedures; is that correct?

A Correct.

Q Okay. So I want to make sure that we're talking about the same thing. I'm going to take you through this state operations manual.

And I just want to make sure that the CMS regulations that you based your opinion on with regards to standard of care are the same as found in what the respondent refers to as their state operations manual Appendix J.

In other words, that we're talking about the same thing. Does that make sense?

A **Yes.**

Q Okay. So is one of the policies -- I'm sorry.

Is one of the federal regulations that you relied on 483.450(b)(1)(iii)? And I'm going to show you that before you answer.

Okay. I've stopped here. This is Regulation 483.450(b)(1)(iii). And this is -- this document I'm showing you, again, which I'm going to call Exhibit 1 to your deposition, is in fact the Appendix J, state operations manual.

So do you recognize this 483.450(b)(1)(iii) as one of the federal regulations that you based your opinion on?

A **Yes, I do.**

Q Okay. And, specifically, I'm going to highlight this part here.

In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.

Is that a regulation that you relied upon?

A **Yes, it is.**

Q Okay.

Moving on to 483.450(b)(1), and I'll highlight the part I'm talking about, all interventions for the management of inappropriate client behaviors which are approved for use in the facility are to be clearly stated and described in its policy.

Is that one of the federal regulations that you relied upon?

A **Yes, it is.**

Q Okay. Section 483.450(d)(1), the facility may employ physical restraint only -- and then we move down to Roman Numeral Two, as an emergency measure but only if absolutely necessary to protect the client or others from injury.

Is that a federal regulation that you relied upon that is also part of this Appendix J?

A **Yes.**

Q And is that some of the language found in various policies that informs your opinion regarding imminent danger and the necessity that there be a risk of either lethality or at least severe personal injury?

A **Yes, that's correct.**

Q Okay.

And, in reviewing the BHDC policies, did you find anywhere in any BHDC policy any reference to or description of the type of ground restraint that was used

on David?
A No, I did not.
Q Did you find it in David's IPP?
A No, I did not.
Q Moving to 483.450(d)(1), right here, guidance, Section 483.450(d)(1)(i), the use of physical restraint is specified within the IPP. The plan must address the specific type of client behavior to be managed. And then, here, the type of restraint, under Section Four, do you see that?
A Yes, I do.
Q Okay. And, again, this is among the federal regulations that you based your opinion on; correct?
A That's correct.
Q And, of course, your opinion is that one of the violations of standard of care was that the restraint that led to Davie's death was not described anywhere in the facility's policies or anywhere in his IPP as required by CMS; correct?

MR. ROSEN: And I'm objecting to the question because of the characterization. There's nothing here that led to death, but she can do a hypothetical.

MR. GILLISPIE: Okay.

BY MR. GILLISPIE:

Q That would be correct; right?
A That's correct. And I also relied on the testimony of Mark Hise, the staff development training of NCI who affirms the same.
Q Okay. But, ultimately, all of these policies here that are found in this Appendix J, these are the same -- well, let me rephrase that.
While you may not have referred to it as Appendix J, you were referring to the same thing in your report and in your testimony when you were testifying about the CMS regulations and the violation of those regulations?
A That's correct.
Q Okay.
MR. GILLISPIE: Let me make this Exhibit 1 and I'll e-mail it to Cris.
(WHEREUPON, the document was marked for identification as Exhibit No. 1 and is attached hereto.)
MR. ROSEN: Are you making the whole manual Exhibit 1?
MR. GILLISPIE: Yeah. I'll send it to you as well.
MR. ROSEN: Okay.
MR. GILLISPIE: If you have an issue with it, we can address it post deposition.

But I don't want to take her through every single part of it. I just wanted to establish that we were all talking about the same thing.

MR. ROSEN: Okay.

BY MR. GILLISPIE:

Q And then one more question, Dr. LeBel.

With regards to what informs your decision -- I'm sorry. With regards to what informed your opinion that -- regarding the definition of an emergency situation and/or the type of risk that needs to be present before restraints should be used, was the BHDC policy, the facility policy, ID-4, also informative to that conclusion?

A Yes, it was.

Q And do you recall that being the facility policy which states the following, that -- well, actually, it defines emergency restraint as use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors.

And then it goes on to say that the use of emergency restraint will comply with all relevant standards and regulations. Is that also your understanding of what that facility policy says?

A Yes.

Q And severely aggressive is actually their term,

written term, is it not?
A It is.
Q Okay.
And then, lastly, very, very lastly, I promise, do you see here? It should say the Zoom Deposition of Amanda Schmitt. Does everybody see that?
A Yes.
Q Okay. And I wanted to go back to something Rich asked you about at the very beginning of his questioning, and that was the -- what these nurses who were called and responded, said about how long it took them to get there, I just want to put this in front of you. This is Page 57.
So this Exhibit 2, this is just two pages and the cover page from Nurse Amanda Schmitt, one of the LPNs who responded. And I'll let everybody look through this, but tell me when y'all are done reading and then I'll take you to the next page and then I'll have one question.
A Okay. Okay.
Q Okay. Am I correct that what Ms. Schmitt is testifying to here is, that after they got the call at Judge Hill, it took she and LPN King approximately 45 seconds to get to Schmitt's car and then approximately one minute to drive from their building to the Commons building and then another 45 seconds to one minute to get

out of the car and arrive at the scene?
A Yes.
Q Okay. So, according to Nurse Schmitt who made the trip along with Nurse King, it took anywhere from two minutes and 45 seconds -- I'm sorry.
Anywhere from two minutes and 30 seconds to three minutes, based on what Nurse Schmitt is saying here; is that correct?
A Yes.
Q Okay.
MR. ROSEN: Are you going to introduce this as an exhibit?
MR. GILLISPIE: Yes. I'd like to introduce this as Exhibit 2. Thank you.
MR. ROSEN: Okay. And it's just those pages; right?
MR. GILLISPIE: Yeah. It is, Rich. Yeah, it is.
(WHEREUPON, the document was marked for identification as Exhibit No. 2 and is attached hereto.)
MR. GILLISPIE: And that's all I have for you, Dr. LeBel. I appreciate you being here.
THE WITNESS: Okay.
MR. ROSEN: I have no other questions.

So I guess this ends the deposition.

Thank you, Dr. LeBel.

THE WITNESS: Thank you.

MR. ROSEN: Thank you, Counsel.

(WHEREUPON, the proceedings were concluded in the matter at 1:55 p.m.)

* * * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Janice LeBel, Ph.D., was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 12th day of January, 2023.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

State Operations Manual

Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities

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(Rev. 178, 04-13-18)

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PLAINTIFF'S EXHIBIT 1

CONDITION OF PARTICIPATION	Key Standard(s) Regulatory Reference within the CoP	W-tag associated with the key standard regulation	Corresponding standard(s) under the key standard (W-tag reference)
	employ physical restraint only— (i) As integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.		W302, W303, W304, W305, W306, W307, W308, W309
	42 CFR 483.450(e)(1) The facility must not use drugs in doses that interfere with the individual client's daily living activities	W310	W311, W312, W313, W314, W315, W316, W317
42 CFR 483.460 Health Care Services (W318)	42 CFR 483.460(a)(3) The facility must provide or obtain preventive and general care	W322	W319, W320, W321, W323, W324, W325, W326, 327, W328, W329, W330, W331, W332, W333, W334, W335, W336, W337, W338, W339, W340, W341, W342, W343, W344, W345, W346, W347, W393, W394
	42 CFR 483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including, licensed dentists and dental hygienists either through organized dental services in-house or	W348	W349, W350, W351, W352, W353, W354, W355, W356, W357, W358, W359, W360

2. The ability to make choices;
3. The ability to identify preferences; and
4. Cognitive abilities including tracking, attention span, communication, and the client's ability to understand the cause and effect. (The client understands of cause and effect is significant in the determination.)

Money management includes a broad spectrum of programs with varying levels of participation by the client ranging from the use of choice in money expenditures, to an understanding of the concept of money, and ultimately to actual money handling and budgeting. The IDT must not conclude that a money management program is inappropriate based solely upon the level of intellectual or physical disability of the client.

The CFA must be reviewed at least annually per 42 C.F.R.483.440(f)(2). As a part of this annual review, a client's ability to participate in money management will also be reviewed. The annual review should always include an update to the CFA and take into consideration any changes in the client's circumstances since the last IPP. The need for a formal money management program must be addressed in every client's IPP by the IDT on an annual basis.

The determination of the appropriateness of a formal money management program is made by the IDT and must be based upon a CFA. The IDT discussions resulting in that determination must be established through documentation in the client's IPP.

W127

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

Guidance §483.420(a)(5)

Identification of patterns or isolated instances of physical, verbal, sexual or psychological abuse or punishment without prompt identification and corrective action by the facility would result in a non-compliance determination for this Standard and Condition level non-compliance.

The facility must develop and implement systems that protect clients from all forms of abuse, neglect, or mistreatment, including client to client abuse, neglect, or mistreatment.

a. The facility is expected to ensure that staff possess and demonstrate needed competencies to effectively and appropriately interact with clients.

b. The facility must monitor to assure that systems are effectively implemented and the facility takes immediate actions to address circumstances where abuse, neglect, or mistreatment have occurred and prevent reoccurrence.

c. The facility must be organized in such a manner as to proactively assure clients are free from any threat to their physical and psychological health and safety.

d. The facility must act to prevent physical, verbal, sexual or psychological abuse.

If the facility fails to implement appropriate corrective action, the potential of additional threats to the clients remain at the facility.

"Threat", for the purposes of this guideline, is considered any condition/situation which could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of clients, or in their death.

"Abuse", for the purposes of this guideline, is the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or personal anguish.

Physical abuse refers to any action intended to cause physical harm or pain, trauma or bodily harm (e.g., hitting, slapping, punching, kicking, pinching, etc.). It includes the use of corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment.

Verbal abuse refers to any use of insulting, demeaning, disrespectful, oral, written or gestured language directed towards and in the presence of the client. Psychological abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation, sexual

coercion and intimidation (e.g. living in fear in one's own home). Since many clients residing in ICF/IIDs are unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, would also be viewed as abusive by the client residing in the ICF/IID, regardless of that client's perceived ability to comprehend the nature of the incident.

Sexual abuse includes any incident where a client is coerced or manipulated to participate in any form of sexual activity for which the client did not give affirmative permission (or gave affirmative permission without the attendant understanding required to give permission) or sexual assault against a client who is unable to defend him/herself.

The facility must implement, through policies, oversight and training, safeguards to ensure that clients are not subjected to abuse by anyone including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the client, family members or legal guardians, friends, other clients, or the general public.

The facility must take whatever action is necessary to protect the clients residing there. For example, if a facility is forced by court order or arbitration rulings to retain or reinstate an employee found to be abusive, the facility must take measures to protect the clients of the facility (such as assigning the employee to an area where there is no contact with clients).

W128

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

Guidance §483.420(a)(6)

The facility must implement an aggressive active treatment program, which includes appropriate replacement behaviors, to address the reduction/elimination of physical restraints and drugs to manage behaviors.

For purposes of this Guideline drugs to manage behavior are "unnecessary" if there is evidence the drugs are being used:

- In excessive dose (duplicate therapy);
- For excessive duration;
- Not monitored adequately;
- Without adequate indications for its use;
- With adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combination of the reasons listed above.

The long term use of a drug/physical restraint to manage behavior combined with one or more of the following may indicate unnecessary use:

- The client's developmental and/or behavioral needs are not being met and the appropriateness of less restrictive approaches to manage inappropriate behaviors should be questioned;
- Staff behavior may be prompting behaviors in clients which result in the chronic use of physical restraints and drugs to control behavior;
- Staff may have inadequate training and/or experience to provide active treatment and employ preventive measures;

Restraints applied for behaviors when less restrictive measures have not been tried or have been tried and found to be just as effective.

W129

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.420(a)(7) Provide each client with the opportunity for personal privacy and

Guidance §483.420(a)(7)

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.430(e)(2) developmental,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- developmental programming principles and techniques (e.g. techniques to involve clients in their programs to their highest capability, use of positive reinforcement, use of assistive technology, use of appropriate materials and providing informal opportunities to practice skills);
- use of adaptive equipment and augmentative communication devices and systems; and
- effective recordkeeping procedures.

W191

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) behavioral,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- use of behavioral principles during interactions between staff and clients;
- use of accurate procedures regarding abuse detection and prevention, restraints, drugs to manage behaviors, client safety, emergencies, etc.;
- use of least restrictive interventions;

- use of positive behavior intervention programming; and
- training clients in appropriate replacement behaviors.

W192

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) and health needs

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- signs and symptoms of the client's changing health (e.g. constipation, urinary tract infections, adverse drug reactions, as indicated);
- exercise and diet;
- first aid;
- infection control;
- reporting to appropriate healthcare professionals; and
- for those staff who can administer medications, how to include clients in their medication administration by recognizing and encouraging the use of applicable skills.

W193

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

Guidance §483.430(e)(3)

Staff correctly and consistently implement the interventions specified in the behavior plans of clients with whom they are working.

§483.440(f)(3)(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

Guidance §483.440(f)(3)(i)

Any program that utilizes restrictive or intrusive techniques must be reviewed and approved by the specially constituted committee prior to implementation. This includes, but is not limited to:

- restraints;
- drugs to manage behavior;
- restrictions on community access;
- contingent denial of any right; or
- restrictions of materials or locations in the home.

The committee should ensure that consequences within a written behavior management program do not violate the client's rights.

There is no requirement for the committee to evaluate whether the proposed program is consistent with current practices in the field. Documentation should verify that the specially constituted committee considered factors, such as whether less intrusive methods have been attempted, whether the severity of behavior outweighs the risks of the proposed program and whether replacement behaviors are included within the plan.

Any revision to a behavior plan that increases the level of intrusiveness must be re-reviewed by the specially constituted committee. The committee need not reapprove a program when revisions are made in accordance with the approved plan. For example, if the physician changes the dosage of a medication in accordance with the drug treatment component of the active treatment plan to which the legally authorized person has given consent and which has already been approved by the committee, then there is no need for the committee or the legally authorized person to reapprove the plan. Generally, this would also apply if the medication was changed to another within the same therapeutic class or family.

W276

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(i) Specify all facility approved interventions to manage inappropriate client behavior;

Guidance §483.450(b)(1)(i)

All interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy. Examples of positive interventions include, but are not limited to, verbal praise reward systems, and prompting. Examples of negative interventions include, but are not limited to, removal of a privilege, implementation of restraint, and/or the use of exclusionary time out.

W277

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;

Guidance §483.450(b)(1)(ii)

Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior.

Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.

The facility policy for unexpected behavioral incidents must provide direction for the staff in the

utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others.

W278

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iii) Insure prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and

Guidance §483.450(b)(1)(iii)

Policies must be implemented to ensure that all restrictive procedures begin at the lowest level of the hierarchy unless there is documented evidence that less intrusive interventions have been tried and have been found to be ineffective.

The facility is not required to justify discontinuing the use of a more restrictive technique before initiating a less restrictive technique, since the intent of the regulation is to use the most positive, least intrusive technique possible.

In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.

§483.450(b)(1)(iv) Address the following:

W279

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(A) The use of time-out rooms;

Guidance §483.450(b)(1)(iv)(A)

"Time-out room" is defined as a separate room that is used to remove a client from stimulation that may be triggering and reinforcing maladaptive behavior. The facility must have written

policies and procedures for the use of time out rooms which address all the requirements of 483.450 (c) (1-4) standard: time out room.

W280

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(B) The use of physical restraints;

Guidance §483.450(b)(1)(iv)(B)

"Physical restraint" is defined as any manual hold or mechanical device that the client cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of a client's body. Examples of mechanical devices may include arm splints and mittens.

Policies and Procedures must address:

- the types of physical restraint that are allowed in the facility;
- the persons who apply such restraints;
- the parameters for duration of application;
- the methods that assure the health and safety of clients while in restraints; and
- the specific training required for staff allowed to apply such restraints.

W281

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(C) The use of drugs to manage inappropriate behavior;

Guidance §483.450(b)(1)(iv)(C)

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

Guidance §483.450(c)(3)

Because placement in the time out room is typically secondary to extreme behaviors, it is acceptable that there be no furniture in this room.

A door that opens inward can potentially be held closed, either intentionally or inadvertently, by the client in the room, thereby denying staff immediate access to the room.

W294

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(4) A record of time-out activities must be kept.

Guidance §483.450(c)(4)

The documentation in the client's record accurately reflects planned (e.g. part of the IPP) usage and presents a picture of events prior to, during, and following the use of time-out. The IPP should include direction as to how often data must be collected during each use of time out for each individual client.

(d) Standard: Physical restraints

§483.450(d)(1) The facility may employ physical restraint only- -

W295

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;

Guidance §483.450(d)(1)(i)

The use of physical restraint is specified within the IPP. The plan must address:

1) The specific type of client behavior to be managed by this plan;
2) The less restrictive behavioral approaches which were previously used, but were unsuccessful;
3) The hierarchy of measures that must be utilized prior to the application of physical restraint;
4) The type of physical restraint;
5) The type of client behavior that would indicate that the patient is calm and can be released from the restraint; and
6) The replacement behavior being taught to the client to reduce the need for future restraints.

W296

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(ii) As an emergency measure, but only if absolutely necessary to protect client or others from injury; or

Guidance §483.450(d)(1)(ii)

Physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which:

1) the client has not exhibited before;
2) were not identified in the functional analysis of behavior; or
3) are harming other people or themselves.

When there are repeated episodes of the use of physical restraint as an emergency safety measure, these episodes should be assessed for their predictability by the IDT, and revisions to the IPP considered addressing the behaviors through a formal behavior plan in order to reduce/eliminate the use of physical restraint.

W297

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

Guidance §483.450(d)(1)(iii)

Physical restraint during medical procedures must be utilized only when absolutely necessary and be used as a last resort in order for the facility or practitioners to deliver needed medical care to the client. The restraint must be released as soon as the medical procedure is completed unless it is necessary to continue restraint for a longer period of time to continue to deliver care or to prevent the client from displacing tubes or dressings. These restraints may only be used as long as the physician indicates them to be necessary.

For instances where physical restraint are used by the facility or a practitioner during a medical procedure, the client record and interviews should verify that less restrictive measures were attempted before using physical restraint and verify whether any injuries occurred during the use of the physical restraint. Written orders by medical personnel for the application of a physical restraint should include the reason that the restraint is necessary, the type of restraint to be used and the length of time the restraint will be applied.

A restraint device used to prevent a client engaging in self-injurious behavior is not considered a restraint for medical condition.

§483.450(d)(2) Authorizations to use or extend restraints as an emergency measure must be:

Guidance §483.450(d)(2)

Facility policies should list who in the facility is allowed to authorize the emergency use of restraints or to extend the use of an emergency restraint, and the training that is required for those persons who may authorize. Documentation in the client record in those instances should confirm that the facility follows that policy.

W298

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(2)(i) In effect no longer than 12 consecutive hours; and

Guidance §483.450(d)(2)(i)

This regulation does not mean that restraints may be authorized to be applied for up to a 12 hour period. The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. Once the behavior has ceased, the emergency has ended, and the client has been released, another authorization would be required for any new emergency situation.

The 12 consecutive hour period is the absolute maximum period of time that emergency physical restraint may be utilized for a client during an individual behavioral incident. It is reasonable to expect that the facility will reassess the emergency situation for any client who remains in physical restraint for longer than one hour and reassess the situation at least every 30 minutes thereafter up to 12 hours when the physical restraint must be removed.

W299

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(2)(ii) Obtained as soon as the client is restrained or stable.

Guidance §483.450(d)(2)(ii)

There may be instances where the maladaptive behaviors of a client or clients escalate into a serious and immediate event that must be de-escalated quickly in order to prevent harm to clients, staff, other clients, or by standers when incidents occur in the community. In these instances, the staff should contact the appropriate person to obtain authorization for the use of physical restraint as soon as the situation is stable. Retrospective documentation of the incident should confirm the need for authorization after application.

W300

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(3) The facility must not issue orders for restraint on a standing or as needed basis.

Guidance §483.450(d)(3)

All instances of physical restraint must be ordered on a case by case basis with individual assessment of the situation and authorization based upon the individual client. Authorizations should include the rationale for the use of the physical restraint versus other less restrictive measures.

W301

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints,

Guidance §483.450(d)(4)

The frequency of monitoring will vary according to the type and design of the device and the

psychological and physical well-being of the client. The facility should be checking the client often enough to adequately assess the physical status of the client (e.g., circulation, respiration and vital signs) of the client and the need to continued restraint. The more restrictive the intervention, the greater the risk to the client and the more often the client must be assessed. Frequent assessment will assure that the client will be released as soon as possible, however, in no instance may the staff go longer than 30 minutes without checking the client.

W302

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) released from the restraint as quickly as possible, and

Guidance §483.450(d)(4)

"As quickly as possible" means as soon as the client is no longer a danger to self or others. Documentation should support that the client was released from restraint as soon as they became calm.

W303

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) a record of these checks and usage must be kept.

§483.450(d)(5) Restraints must be designed and used

W304

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(5) so as not to cause physical injury to the client

Guidance §483.450(d)(5)

Physical restraints to include mechanical devices must be the correct size for the client and be applied with the correct amount of pressure according to manufacturer's directions. In addition to observation of any physical mechanical restraint in use at the time of the survey, review incident reports for any injuries as a result of restraint use.

W305

§483.450(d)(5) and so as to cause the least possible discomfort.

§483.450(d)(6) Opportunity for motion and exercise must be provided

W306

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(6) for a period of not less than 10 minutes during each two hour period in which restraint is employed,

Guidance §483.450(d)(6)

This requirement does not apply to cases of medical restraints that are specifically ordered for the immobilization of bones and joints during the physical healing process involved with fractures, sprains, etc. (e.g. a broken bone immobilized by a cast or splint). See 331 483.460(c) regarding surveillance of skin integrity during the use of medical restraints.

However, if a mechanical physical restraint is applied to an extremity to prevent a client from removing post-operative sutures, the restraint must be released every two (2) hours for a period of not less than ten (10) minutes in order to maintain adequate circulation.

Mechanical restraints placed on the client during sleeping hours must be medically based and specifically ordered by a physician. There should be evidence in the client's record why the mechanical physical restraint is necessary during sleeping hours. While it is not necessary to wake the client every two (2) hours to release the restraint and provide opportunity for exercise, the staff must check the restraint frequently during the night to ensure that the

restraint is still properly applied and the client appears comfortable.

W307

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(6) and a record of such activity must be kept.

§483.450(d)(7) Barred enclosures

Guidance §483.450(d)(7)

A bed or play equipment with bars that prevent the client from leaving the bed or voluntarily climbing out of the bed are barred enclosures. The use of such enclosures must be a part of the written IPP and behavioral assessments must clearly state why such an enclosure is necessary, the risks of using the enclosure versus not using it and what less restrictive measures have been tried prior to the implementation of the barred enclosures.

Such devices may not be used in lieu of adequate staffing.

W308

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(7) must not be more than three feet in height and

W309

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(7) must not have tops.

(e) Standard: Drug usage

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF

AMANDA SCHMITT

March 17, 2022, at 9:15 a.m.

CRIS M. BRASUELL, CCR
BREPORTING@GMAIL.COM

directly in front of the building.

I actually have a really bad habit of jumping the curb and parking in the grass right in front of Judge Hill.

It's where we're not purposed to park; but it's where I purposely park my vehicle because there is no parking in front of Judge Hill. And I want to be able to get to somebody in an emergency. Commons is just right up the road from where we were.

Q Yeah.

Let me ask it this way. Approximately how long do you think it took from the time Debbie Noah got this call to the time you got to your car?

A Until the time I got to my car?

Q Yeah. Thirty seconds?

A Thirty second. Forty-five seconds.

Q Okay. And --

A It was -- it's a very small building and it was a dead run.

Q And you had to grab -- and you stopped to grab the thing you needed, of course.

A Yes. It is -- it is by the front door.

Q Okay. And Nurse King is with you? She gets in the car with you; right?

A Yes.

Q And about how long -- about how many seconds or minutes did it take to drive from Judge Hill to the Commons building?
A It's going to be less than a minute or maybe right at a minute.
Q Okay.
A I mean, it was -- we pulled out and I hit the gas.
Q Okay.
And then about, approximately, how long would it take for you to then get out of your -- or park at Commons, get out of your car, and reach the scene?
A I parked directly in front of the front doors.
So we jumped out of the car, ran up the stairs into the building, and he was right inside the front doors, right up the stairs.
Q So maybe 45 seconds?
A So that wouldn't be long. Forty-five seconds to a minute, maybe.
Q Okay.
A I mean, like I'm -- I'm overshooting the amount of time it would take, so I'm not -- I don't know. We were running.
Q Okay.
A These are people that we deeply care about. This is not just a job. These are people that we care about.

BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE McAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS, CLAIMANT, VS. THE ARKANSAS DEPARTMENT OF HUMAN SERVICES, RESPONDENTS.	CLAIM NO. 220374

Arkansas
State Claims Commission
FEB 16 2023
RECEIVED

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DEPOSITION

OF

JENNIFER BERRY

---o---

TUESDAY, DECEMBER 6, 2022

---o---

COURT REPORTER:

DEBBYE L PETRE, CCR
P. O. Box 1027
Little Rock, Arkansas 72203

EXHIBIT
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tabbies

A P P E A R A N C E S:

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The deposition of Jennifer Berry was taken before me, Debbye L. Petre, Certified Court Reporter within and for the County of Pulaski, State of Arkansas, duly commissioned and acting, on Tuesday, December 6, 2022, beginning at the hour of 11:00 a.m., at the Offices of Arkansas Department of Human Services, Seventh and Main Streets, Second Floor Library, Little Rock, Pulaski County, Arkansas.

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THEREUPON, the following proceedings were had, to-wit:

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* * * * * *

P R O C E E D I N G S

* * * * * *

MR. ROSEN: This is the deposition of Jennifer Berry in the case of McAuliffe/Cains versus DHS, Claim Number 220374 in the State Claims Commission. I'm going to introduce as Exhibit Number One the Notice of Deposition. I will introduce that.

(WHEREUPON, DHS Exhibit Number One was marked for identification.)

WHEREUPON,

JENNIFER BERRY,

having been called for examination, and having been first duly sworn by the undersigned notary public, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. ROSEN:

Q This is the deposition -- as I said, this is the deposition of Jennifer Berry. Ms. Berry, please state your full name.

A Jennifer Berry.

Q And, Ms. Berry, are you employed?

A Yes.

Q Where are you employed?

A At the Booneville Human Development Center.

Q And what do you do there?

A I'm the Assistant Superintendent.

Q And as Assistant Superintendent, what do you do?

A Well, I am the, I guess you would say, co-administrator of the facility.

Q How long have you been doing that?

A Since March of 2020.

Q Okay. And is this a licensed or certified position?

A Yes, it is.

Q What certification do you hold?

A I have a nursing home administrator's license.

Q And that's issued by the State of Arkansas?

A State of Arkansas.

Q Let me just -- I'm going to be asking you a series of questions. I should have started this at the beginning. This lady here is the court reporter and she is going to take everything down. So, try not to talk over me and I will try not to talk over you, or counsel, because it makes it difficult for her. We are going to need a response, "yes" or "no", just because "uh-huh" and "huh-uh" doesn't come out on the transcript.

A Right.
Q If for some reason you need a break, you just let me know.
MR. ROSEN: And the same with you, counsel, if you need a break, just let me know.
BY MR. ROSEN:
Q Okay. Back to the questions.
A Okay.
Q How long have you been licensed as an administrator?
A Since February of 2020.
Q Is there a test involved with that, or training?
A Yes, there is a test.
Q Okay.
A There is a state test, and then there is a national test.
Q And have you taken both?
A I have.
Q And have you passed both of them?
A I have.
Q And do you need to do that before you become an administrator?
A Correct.
Q Now, what is your employment history with the

Department of Human Services?
A I first started working with the Department of Human Services in January of 1999, and I worked for Children and Family Services, DCFS, until March of 2004. And then, I started working at the Booneville Human Development Center in February -- no. January of 2008 and then until present time.
Q What did you first do with the Booneville Human Development Center?
A I worked in the Social Services Department. I was the social service worker.
Q Now, I'm probably going to just refer to it as maybe the BHDC or Booneville -- you know what I'm talking about?
A Right.
Q What is the Booneville Human Development Center? Can you tell us what it is?
A It's an intermediate care facility for adults with intellectual disability. We train individuals in independent living skills, pre-vocational skills, and behavior management.
Q And do individuals reside at the facility?
A They do.
Q Okay. And how many human development centers are there in Arkansas?

A There are five.
Q Are they all under the Department of Human Services, Division of Disability Services?
A Correct.
Q And tell me a little bit about the history of Booneville Human Development Center.
A Well, it originally was the Arkansas Tuberculosis Sanitorium, and it opened in 1909, and it was that until January of 1973 when it switched over to what it is today. At the time they called it the Children's Colony.
Q And so, this is facility-based care for what population?
A For adults with intellectual disabilities.
Q Okay. In Arkansas, are there other options for adults with developmental disabilities?
A Yes, there are.
Q What are those other options?
A Well, they can reside at home, they can receive Community Employment Service Waiver, otherwise known as Medicaid Waiver. There are also small ICFs that are privately owned by different providers throughout the state. And those are typically 15 beds or less. And they also -- they can live in a group home or in a nursing facility.

Q Okay. And so, this is just -- the human development centers in Arkansas is just one option that is available?
A Correct.
Q And you mentioned some other facility-based options, but there are also community-based options?
A Correct.
Q And in June of 2020, and in the years prior to that, were there community-based options available for individuals with intellectual disabilities?
A Yes, there were.
Q Is admission to the human development center, particularly the Booneville Human Development Center, voluntary?
A Yes, they are all voluntary.
Q And is continued staying at the facility voluntary?
A Yes.
Q Are there any involuntary commitments at the Booneville Human Development Center?
A No.
Q So, people are there because somebody wants them there?
A Correct.
Q Either family or guardian?

A Correct.
Q All right. So, who is it that decides whether they stay or not, or whether they are admitted or not, more or less?
A Do you want me to kind of walk through like the admission process?
Q Yes, sure.
A Okay. So, if somebody is interested in human development center services, they make an application through the DDS intake and referral office, and they submit all the required paperwork that is needed for such application. At that time, once it's completed, then they have what is called a Human Development Center Appropriate Review Team Committee, and we meet and we discuss that particular referral to determine if they meet the criteria for HDC placement or not. And if they do, then, because there are five HDCs, each HDC will look to determine if that particular individual would fit in their center. Because of the centers are a little different. Like at Booneville, you know, everybody has to be ambulatory, and we also service the individuals that have mental illness, on top of just intellectual disability.
Q So, everybody who -- so, basically, the different facilities, HDCs in Arkansas, cater to a

different type of developmentally disabled individuals?

A They do.

Q Before we get any further, let's talk about, is Booneville Human Development Center accredited or licensed by any organizations or state?

A Yes, we are licensed through Office of Long Term Care, Arkansas Department of Human Services, and then we are CARF accredited.

Q What is CARF?

A CARF is a national standard of -- well, they review different committees -- I mean, different facilities throughout the nation and they come in and evaluate to determine if we meet the standard nationwide.

Q So, is it a voluntary organization or is it mandatory?

A It's voluntary.

Q So, they will accredit you if you meet their national standards?

A Correct.

Q And so, in June of 2020, was the Booneville Human Development Center accredited by CARF?

A We were.

Q You were?

A Yes.
Q And what does CARF mean, do you know?
A I don't know what the acronym stands for. Sorry.
Q But it's C-A-R-F?
A Yes.
Q And that's just a national standard?
A Correct.
Q And is Booneville Human Development Center currently, as of today, accredited by CARF?
A Yes.
Q And has it been continuously?
A Yes.
Q When was it last renewed by CARF?
A This year.
Q Okay. And do they come out to the center?
A They do.
Q And they do an inspection?
A They do.
Q And do you know whether Booneville Human Development Center was accredited by CARF in 2014?
A We were.
Q And has it been continuously, since that time, been accredited by CARF?
A We have.

Q And does the Booneville Human Development Center -- is it licensed?
A Yes.
Q By whom?
A Office of Long Term Care.
Q And as what?
A As an intermediate care facility for adults with intellectual disabilities.
Q And is Office of Long Term Care the State of Arkansas regulatory body?
A Yes.
Q And when was it last -- when was the license of Booneville Human Development Center last renewed by Office of Long Term Care?
A July 1st, 2022.
Q And was it licensed by Office of Long Term Care in June of 2020?
A Yes.
Q And have the state regulators -- tell me, how do you get licensed?
A Well, we have to follow CMS guidelines, Centers for Medicaid and Medicare Services.
Q That's the federal requirement?
A That is, uh-huh.
Q Is that a "yes"?

A Yes. Sorry.
Q All right. And so, as part of the state regulation, does the Office of Long Term Care send out inspectors or surveyors at least once a year?
A At least annually, yes.
Q And they also inspect more than annually?
A They do, if needed.
Q Just jumping ahead real quick. Did the Office of Long Term Care inspect the Booneville Human Development Center in June of 2020 after David Cains passed away?
A Yes, they did.
Q And what was the outcome of that regulatory -- state regulatory inspection?
A No deficiencies found.
Q And what is a deficiency?
A It means that we did something incorrect.
Q So, they didn't find anything incorrect?
A No.
Q And they came out as a result of David Cains' death?
A In conjunction with a followup survey, yes.
Q So, they looked into it?
A Yes.
Q All right. Tell me a little bit about -- we

were talking about just Booneville Human Development Center. Tell me a little bit about the campus.

A Well, our campus is old. It is a thousand square feet -- not a thousand square feet, it's not that. It's a thousand acres, is what our main campus is. We have 5,000 acres, total. We have different dormitory style settings for our individuals to live in. Our buildings are older, because they built -- a lot of them were built in the 1940s, late '30s, early '40s. However, we've got some new buildings that have been built recently, and we are in the process of building some more. We have our own water treatment plant, we have our own sewer plant. We are pretty self-sufficient. And that's just because it came from the Arkansas, when it was the tuberculosis sanitorium. We have various departments on our campus. Is that kind of what you were looking at?

Q Yes, whatever your answer is.

A Yes.

Q But let me ask you. So, Booneville is in what county?

A Logan.

Q And how many employees -- how many employees work at the Booneville Human Development Center, approximately?

A Approximately 250.

[redacted]

Q Is that a large employer in the county?
A It is.
Q Do you know if it's the largest?
A At one point we were. But I believe a manufacturer has come in.
Q But you are right up there; right?
A Correct.
Q And so, you mentioned some new construction. There is new construction in the facility?
A There is.
Q So, the state has invested money into it?
A They have.
Q So, they are committed to the Booneville Human Development Center; right?
A Yes.
Q I'm going to show you some photographs. Hold on. And ask if you can -- ask if you can identify

some of these photographs. What is that?
A That is one of our new living residences.
Q And did you take that photograph?
A Yes.
Q When did you take that?
A Recently.
Q Okay.
A Because it has got the Christmas decorations on it, and we just put them up.
Q Okay. And is this one that is currently lived in?
A It is.

MR. ROSEN: We are going to mark that as DHS Exhibit 2A.

(WHEREUPON, DHS Exhibit Number 2A was marked for identification.)

BY MR. ROSEN:
Q And I'm going to show you another document, and ask if you can identify this document, this photograph.
A This is another one of our living areas.
Q So, this is like a cottage, a dormitory?
A Yes.
Q Is that different from the other one that we just showed a picture of?

A Yes. This is our most recent one, and it is not occupied at the moment. We are waiting to get it -- for the beds to be -- for the beds to be certified.
Q So, it is a brand new facility?
A Correct.

MR. ROSEN: That we will mark as Exhibit 2B.

(WHEREUPON, DHS Exhibit Number 2B was marked for identification.)

BY MR. ROSEN:
Q And I'm going to finally show you a third picture, and ask if you can identify this. What is that?
A This is the same building as the last one, just on the front side during the construction phase.
Q So, this is the same picture?
A Correct.
Q All right. And how many new cottages are there?
A We have three.
Q So, I have showed you two. So, there is one that's not in these pictures?
A No. It's right next door, to the left of it. You can see that.
Q And so, is that one still in the stages of construction?

A No. This one is -- as you can see, this is taken beforehand.
Q No. I meant the third one.
A No, no. It is completed and lived in.
Q Oh, it is. So, there are two that are lived in?
A Two lived in.
Q And one that is pending, I guess, occupancy?
A Correct. We're waiting for Office of Long Term Care to certify the beds.
Q Okay. And so, I'm going to show you this one --
A Do you need to label this one?
Q Which one is this? Well, this is the --
A Same building?
Q Yes. So, we are not going to introduce this.
A Okay.
Q While we are looking at photographs, I'm going to show you some other photographs, as well.
A Okay.
Q What is this a photograph of?
A This is a photograph of the inside of our -- one of our training areas. The stone building is what we call it.
Q And what is it depicting? I know it's a little light.
A Yes. It's the work area. This is where we do

our recycling program. And so, this is where the material goes in. Our clients are in here, and they separate the recyclable materials. Some will tear from books, because we do collect like school books from places and other locations, and then there are some shredders that are around there.

Q So, this is part of the vocational program for the residents?

A Correct.

Q Did you take that photograph?

A Yes.

Q And did you take it recently?

A Yes.

Q Was the building essentially the same way or was it different in June of 2020?

A Essentially the same.

Q Okay. And so, tell me what type of vocational services were offered to the residents of the facility in 2020.

A The recycling program.

Q Okay. And was that it?

A And we have a rug program where our clients make rugs.

Q So, let's talk about the recycling program. What do you mean by "recycling program"?

A We pick up recyclable materials in the River Valley from different businesses, schools.
Q Paper, or more than paper?
A Paper, cardboard boxes, books.
Q Okay.
A Confidential material, nonconfidential material. And then, we bring it back and our clients unload the trailer and then they separate it. And then, once it's shredded we actually have a bailer, and some of our clients work the bailer.
Q And you say "clients". You mean the residents?
A Yes.
Q These are the developmentally disabled individuals?
A Correct.
Q And so, as part of this vocational program, are they paid?
A Yes.
Q Okay. Tell me, why do you have a program -- recycling program that pays the residents?
A Well, we want to give them a purpose to their day. We also want to give them a skill set so that when they transition into a lesser restrictive setting into the community, that they could, you know, develop some kind of employment skills when

they transition out.
Q And so, in addition to this, there are -- you had mentioned rugs.
A Correct.
Q So, what is the vocation area of rugs?
A What do we do with the rugs?
Q Well, I mean, tell me about the process. Do they make the rugs?
A They do make the rugs. So, they are made out of socks, sock loops. There is a company that makes socks. And the toe loop where the seam is, it is cut off. And so, it forms a loop. And so, we get that material. And it is a multi-step process where the clients sort the loops, they clean the loop. And then, there's a dyeing process. And then, they kind of -- I don't know. It is very fascinating to watch them separate them out, and then our clients -- then it goes into the weaving room where our clients actually weave the rugs.
Q And so, they do all these things, and as part of their vocational training?
A Correct.
Q And do they also get paid for this if they are in there?
A They do.

Q And in 2020, did David Cains do any of these programs?
A He was in the recycling program.
Q And did he get paid for that?
A He did.
Q And so, as part of the payment process, what are -- in the vocational -- is money skills part of the vocational process?
A For some of them, correct, yes.
Q And tell me, what does that mean?
A Money skills?
Q Yes.
A Some of them -- well, some of them don't have any concept of money. But some of them have a basic understanding, and we just teach them like, "This is how much you have worked, this is how much you are going to get paid." They will get money that they have earned into their account, they will have a payday. So, they get paid the same, you know, every other week, and they will get, you know, a certain amount for that.
Q And what do they do with the money?
A They will buy whatever they want to. They will go to our canteen, they will go to the vending machine, some of them will save up and we will go

into town, some will get something from, you know, one of the local establishments.

Q So, let me ask you this. A canteen, you mean like a little snack store?

A Uh-huh, yes.

Q Is that a "yes"?

A Yes.

Q So, snacks. Is there anything else in there?

A Drinks.

Q Or a vending machine?

A Correct.

Q So, it teaches them how to use money?

A Yes.

Q And you mentioned they go into the town.

A They do.

Q Into Booneville?

A Into Booneville, Fort Smith.

Q And this is an outing for them?

A Yes.

Q And so, they interact with the community?

A They do.

Q And is that part of their vocational --

A Yes.

Q -- their training?

A Yes.

Q Okay. So, in other words, it teaches them responsibility with money and interaction with the local community?
A Correct.
Q And do they ever go to movies or lunches?
A Yes.
Q Tell me about that.
A Well, each living area has different activities that they do. So, sometimes they will go into town to a local restaurant. We used to have a movie theater in Booneville which they would go to often, but unfortunately they shut down. So, our clients don't get to go to movies nearly as much. Of course, this is all pre-COVID. COVID has kind of, you know, put a damper on everybody's life. But beforehand they would go into Fort Smith. There is a movie theater in a town south of us called Waldron. They would, you know, run out and go to those places.
Q And they paid for their movies and lunches?
A They did.

MR. ROSEN: Let's mark that photograph as Exhibit 2C.

(WHEREUPON, DHS Exhibit Number 2C was marked for identification.)

BY MR. ROSEN:

Q And I'm going to show you another photograph, and ask you what that is.
A It is the same building, just a different view.
Q Okay. So that's marked as what, 2D?
A Yes.
(WHEREUPON, DHS Exhibit Number 2D was marked for identification.)
BY MR. ROSEN:
Q And so, that's the work area?
A Correct.
Q Did you take that photo?
A Yes.
Q And was it taken recently?
A Yes.
Q And did it look substantially the same as it did in June of 2020?
A Pretty close.
Q I'm going to show you another photograph that has been marked as 2E.
(WHEREUPON, DHS Exhibit Number 2E was marked for identification.)
BY MR. ROSEN:
Q And ask, what is that?
A That's another one of our vocational training areas. It's the Hamp Williams building.

Q And is this as it looks today?
A Yes.
Q And is it currently used?
A Yes.
Q And are all floors used or just some of the floors?
A No. Just the first floor.
Q And so, this Hamp building -- what is it called?
A Hamp Williams.
Q The Hamp Williams building -- let me back up a second. Are you familiar with the Disability Rights Arkansas, or DRA, report issued in January of 2015?
A I am.
Q Did the Hamp Williams building figure in in that report?
A Yes.
Q And so, this is what it actually looks like, correct, from the outside?
A From the outside, yes.
Q And there were photos in that DRA report in January of 2015 of holes in the roof of the building.
A That was a different building.
Q Holes in the floors. Was that a different building, or was that this?
A It could have been this building.

Q But there was a report -- there was a report -- in the report, there were photographs of trash and debris in the DRA report in a building.
A Correct.
Q Was that this building?
A It was.
Q And that trash or debris, was that actually trash or debris --
A It was the --
Q Let me finish my question.
A Sorry.
Q What was that trash and debris as classified by the DRA?
A It was actual rug material to make rugs, the sock loops.
Q So, what DRA called in that January 2015 report as trash and debris featured prominently in a photo was actually work material for the vocation?
A Correct. And it was on the third floor of this building that was not occupied.
Q So, it was a storage area?
A Yes.
Q I don't remember them saying that in that report. Did they?
A Not that I recall.

Q And so, were you surprised or --

MR. GILLISPIE: I'm sorry. What was that question, what report?

MR. ROSEN: The 2015 -- January 2015 DRA report that called the work material trash and debris.

MR. GILLISPIE: Oh, I'm sorry. Go ahead.

BY MR. ROSEN:

Q And was this building used in 2014 or '15 as the vocational training area for the residents and storage?

A It was.

Q Do you have any idea why DRA -- well, first of all, did DRA talk to you about what that material was that they called trash and debris?

A Not that I recall.

Q Do you know that anybody in the -- they just took a photograph of it; correct?

A Correct.

Q Did they issue the report to you or did they just do a report?

A They just issued the report.

Q It wasn't directed towards you, or the human development center, was it?

A It was directed about the Booneville Human Development Center.
Q It was about it, but it wasn't issued to the Superintendent, was it?
A No.
Q Now, do you have any idea why DRA would label the resident work product or their materials as trash and debris?
A Not really sure --
Q Okay.
A -- why they would -- why they would classify that.
Q Okay. Going back to -- okay. So, what is the last number on that one?
A 2E.
Q All right. Let me ask you a little bit about -- furthermore about the Booneville Human Development Center. And you had mentioned that it employed a large number of people. Does it also have contracts with other service providers, as well as employees?
A We do.
Q And what types of things are contracted out, type of services?
A We contract with a psychiatrist, a neurologist, a podiatrist, a dentist, Ph.D. level psychologist.

Q What about any therapists, or are they on staff?
A Our psychological examiners are on staff.
Q Speech therapist, physical therapist?
A We have a speech therapist on staff, but we also contract with occupational therapy and physical therapy.
Q And is that the way it was in 2020?
A Yes.
Q And before that?
A Yes.
Q What about dieticians?
A Well, that's through a purchase order, but, yes.
Q So, it's a contract?
A Right.
Q What is an RCT?
A At the time it was a residential care technician.
Q Is that an aide?
A Yes.
Q Tell me what an aide is.
A They manage the direct care of the clients that we serve.
Q And what does it stand for?
A RCT?
Q Yes.

A Residential care technician.
Q You mentioned that. And so, in June of 2020, were the aides RCTs?
A They were.
Q And tell me about the training for an RCT.
A Well, they are hired on and they go through a three-week phase, is what we call it, two weeks in the classroom, one week on on-the-job training, and then they have sporadic training throughout, you know, every year that they are there.
Q Okay. And what are they trained in?
A They are trained in understanding our population, they are trained in the skills that they will be providing to our clients to learn, they are trained in behavior modification. Essentially every aspect of client care, they are trained in.
Q Okay. And are they also trained in CPR?
A Yes.
Q And are they all certified in CPR?
A Yes.
Q And do you have -- do you employ a medical team on campus, or nurses on campus?
A We do.
Q Tell me about that.
A We have a medical director, and then we also

have a nurse manager, an assistant nurse manager, we have RNs and LPNs.

Q Okay. And so, at any given time, how many nurses are on the facility grounds?

A At any given time?

Q Well, let's just say during the business hours of 8:00 to 4:00.

A Oh, goodness. Fifteen.

Q Okay. And what about -- and is there a medical center?

A Yes. We call it the Judge Hill building, is where the medical is located.

Q All right. What is the Commons Building?

A The Commons Building is where our dining room is, it's where our storeroom is. At the time -- well, right now our staff development is up there, and then down below we have an auditorium and an exercise room.

Q Okay. And so, how many floors is it?

A There are two.

Q And so, it's kind of a split level?

A Yes.

Q So, I'm going to show you what I'm going to mark as two documents, one is marked as Exhibit 3A and one is 3B.

A Okay.

(WHEREUPON, DHS Exhibits Numbered 3A and 3B were marked for identification.)

BY MR. ROSEN:

Q And ask if you can identify that?

A (Witness reviews documents.) Yes.

Q What is 3A?

A 3A is the main floor of our Commons Building.

Q And what happens in the Commons Building?

A This is where our residents, well, go and eat their lunch.

Q Okay. And in June of 2020, that's where residents ate lunch?

A Yes.

Q And so, this is a -- it is call Evacuation Plan, but it's really a layout of the facility; correct?

A Right.

Q And this is the top floor; right?

A Yes.

Q What is on the bottom floor?

A The bottom floor is where we have an auditorium, and then there is some storage, a stage, and then we have our fitness center.

Q And that's marked as 3B?

A Correct.

Q All right. You can put those down.
A (Witness complies.)
Q Now, in the dining room -- let's talk about the Commons Building a little bit as it was in June of 2020. You mentioned this is where residents have lunch?
A Yes.
Q Do they have other meals there?
A No. They eat their breakfast and their dinner in their living areas.
Q Back in 2020?
A Yes.
Q And so, they would come here for lunch back then; right?
A Yes.
Q And how is it served?
A Cafeteria style.
Q Okay. So, they go get their food?
A Yes. There is a line, and they go through the line and our kitchen staff give them their food based on their diet and their desires, what the client wants that day.
Q So, going back to the map of the Commons Building, the top floor where the dining room is. So, as you walk into the building, what happens?

A You go into a little foyer, and then to the left you go down to the stairs, or to the right you go up the stairs.
Q And if you go up the stairs, you go to the dining room and some other rooms; correct?
A Correct.
Q And so, on this map that I have given you as 3A, the top floor, it's marked "dining room". Is there a bathroom nearby?
A Yes. It's at the end of the hallway.
Q Can you point that out?
A I can. It is right here. (Indicating.) These are the restrooms at the back.
Q I'm going to ask you to mark in yellow --

MR. GILLISPIE: Could she mark mine, please?

THE WITNESS: Okay.

BY MR. ROSEN:
Q In yellow where the restroom is.

MR. GILLISPIE: And just hold onto that until he's done having marked things.

THE WITNESS: Okay.

BY MR. ROSEN:
Q And I'm going to have you mark where the dining room is.

A (Indicating.)
Q Okay. Now, back in June of 2020, were there any chairs in the lobby area?
A Yes.
Q And can you put an "X" where the chairs were?
A There were chairs here, and there's usually chairs kind of here, and sometimes here. (Indicating.)
Q Just put an "X" where the chairs were.
A (Indicating.)
Q Put an "X".
A Oh, an "X". Sorry. (Witness complies.)
Q Now, I'm going to show you some photographs. All right. I'm going to hand you a photograph I will mark 4A, and ask if you can identify that.
A Yes. This is the Commons floor.
(WHEREUPON, DHS Exhibit Number 4A was marked for identification.)
BY MR. ROSEN:
Q So, did you take this photograph?
A Yes.
Q When did you take it?
A Several months ago.
Q So, recently; right?
A Yes.

Q And with the exception of maybe the exact layout and that yellow sign, did it look essentially the same --
A Yes.
Q -- back in June of 2020?
A It did.
Q And in this -- what are we seeing in here?
A Well, this is when you first come up the stairs.
Q I see on the lower left-hand corner there is a little half wall there.
A Correct.
Q Tiled?
A Yes.
Q As you are coming up, that's on your left-hand side?
A Yes.
Q So, where would the dining room be?
A It's on your right.
Q And where are the bathrooms?
A They're straight down the hallway. They're the last two doors on the right.
Q Past the water fountain?
A Yes. The men's is the first one and the women's is the second.
Q That one is marked 4A. I'm going to show you

this one marked as 4B.

(WHEREUPON, DHS Exhibit Number 4B was marked for identification.)

BY MR. ROSEN:

Q And ask you, what does this photograph depict?

A (Witness reviews document.) This is the little area that goes into the dining room.

Q Okay. So, this is as you come into the building, go up the steps, it would be on your right-hand side?

A On your right-hand side.

Q What we are looking at is on the other side of the steps, is that correct, right there, in 4A?

A Yes. It would be like that. (Indicating.)

Q This wall here, what is that? There is a door and a wall?

A Yes. So, on the other side of this wall is the foyer when you first come into the main doors. So, it's like a drop-off straight into the foyer.

Q So, it's a half wall?

A Yes.

Q And so, you can stand at the wall and look down into the foyer?

A You can.

Q And it's the same on the other side?

A The other side you look straight down to the bottom of the steps to the second level.
Q Okay.
(WHEREUPON, DHS Exhibit Number 4C was marked for identification.)
BY MR. ROSEN:
Q I'm going to show you another photograph that's marked 4C, and ask you if you can identify that?
A This is at the top of the stairs when you come in the front.
Q So, those doors are at the front of the building; correct?
A Correct.
Q And so, you can see that there is a half wall that you just mentioned on the left-hand side of this photograph; correct?
A Right.
Q And these are the steps coming into, I guess, the upstairs?
A To the main floor.
Q Okay.
(WHEREUPON, DHS Exhibit Number 4D was marked for identification.)
BY MR. ROSEN:
Q I'm going to show you a document marked 4D, and

ask you if you can tell us what that is?
A Again, this is another view of the main level of the Commons Building.
Q And did you take this photograph?
A Yes.
Q And recently?
A Yes.
Q And with the exception of the exact layout of the chairs, was it basically the same in June of 2020?
A Yes. It just wasn't the TV monitor up there.
Q But there were chairs near or at where they are now?
A Right.
Q Now, on the left-hand side there is that little half wall you described.
A Yes.
Q On the right-hand side there are these double doors and the sign above it.
A Correct.
Q What does the sign say?
A "Hilltop Store and Canteen".
Q What does that mean?
A That's where our clients go and get their snacks.

Q So, that's the store, the canteen?
A That's the store, uh-huh.
Q That's the canteen that you discussed earlier?
A Yes.
Q They can go in there and use their money that they earn?
A Correct.
Q So, there is also a half wall right after that -- right before that door; correct?
A Yes.
Q And then, the steps going down?
A Yes.
Q And so, back in June of 2020, were there similar type of chairs located at or near where these chairs are depicted in the photographs?
A Yes. And there could have been more chairs at that time.
Q But there were chairs?
A But there were chairs there.
Q Okay.

(WHEREUPON, DHS Exhibit Number 4E was marked for identification.)

BY MR. ROSEN:
Q I'm going to show you a document marked 4E, and ask you to tell us what that is.

A It's just again showing the main stairs going up to the main floor.
Q This is in the Commons Building?
A In the Commons Building.
Q So, to the left-hand side would be the canteen?
A Correct. And the right-hand side would be the dining room.
Q So, those two doors in the back towards the back of the building, what are they?
A Those are the bathrooms. On the right-hand side?
Q Yes.
A Yes. The first door that you see is the men's bathroom, and the door -- the second door you see on the right is the women's.
Q Just a few more.

(WHEREUPON, DHS Exhibit Number 4F was marked for identification.)

BY MR. ROSEN:
Q I'm going to show you what has been marked as Exhibit 4F, and ask if you can identify what that is?
A That is the common area in the Commons Building, main floor.
Q This is looking at it from -- I'm sorry.
A Oh. This is looking at it from the steps.

Q From right at the top of the steps?
A Correct.
Q Towards the left by the canteen?
A Yes.
Q And it hits that half wall?

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MR. GILLISPIE: I'm sorry. Could you tell me, which one was the men's bathroom?

THE WITNESS: It's the first one on the right.

MR. GILLISPIE: So, that one?

THE WITNESS: It's this one right here. (Indicating.) That's the men's bathroom.

BY MR. ROSEN:

Q And just for the record, you are pointing to --

MR. ROSEN: Which exhibit is that?

MR. GILLISPIE: I don't know.

MR. ROSEN: No. She will tell you.

THE WITNESS: It is 4A.

BY MR. ROSEN:

Q Okay. And 4A is the first door --
A So, it's the -- one two. It's the third door on the right, that's the men's bathroom.

MR. GILLISPIE: Okay.

BY MR. ROSEN:

Q And that's what you pointed to; correct?

A Yes.
Q Okay. Now, let's go back to the current photograph.
A Which is this one. (Indicating.)
Q 4F?
A Yes.
Q Okay. And so, this is -- and again, this is -- I forgot where we were. But this is where the -- this was depicting the canteen and essentially looked the same except for the chairs might have -- there might have been more chairs slightly, and they're along the wall definitely --
A Correct.
Q -- back in 2020; is that correct?
A Yes.
Q And the TV wasn't there?
A Right.
Q But the building has stayed the same?
A The building has stayed the same, correct.
Q Okay.

MR. ROSEN: 4G.

(WHEREUPON, DHS Exhibit Number 4G was marked for identification.)

BY MR. ROSEN:
Q And I'm going to show you a document labeled 4G,

and ask if you can identify that?
A That is the bathrooms at the end of the hallway at Commons on the main floor.
Q And the door that's open is to the men's room; right?
A Correct.
Q And with the exception of possibly the exact location of the chairs, in that picture the building is essentially the same as it was in June of 2020; right?
A That's correct.

MR. ROSEN: 4H.

(WHEREUPON, DHS Exhibit Number 4H was marked for identification.)

BY MR. ROSEN:
Q Okay. I'm going to show you what has been marked as Exhibit 4H, ask if you can identify that?
A Another view of the canteen floor/wall area on the Commons Building.
Q It is a closer-up view?
A Right.
Q And it shows the half wall there?
A Correct.
Q And did you take this photo?
A I did.

Q You took it recently?
A Yes.
Q And has anything in the layout of the building itself been changed since June of 2020?
A No.

MR. ROSEN: I think this is the last one. I'm going to mark this Exhibit 4I.

(WHEREUPON, DHS Exhibit Number 4I was marked for identification.)

BY MR. ROSEN:
Q And ask if you can identify that document?
A It's just the foyer when you come in to the main doors. That's just to the right when you come in to the doors.
Q And did you take this photo?
A Yes.
Q And did you take it recently?
A Yes.
Q And aside from the little cone there, was the building format the same when you took the picture as it was in June of 2020?
A Yes.
Q And what are those doors above on the top floor?
A That's going into the dining room.
Q So, this is a view from the foyer looking up the

steps, up the half wall into the dining room?
A Correct.
Q So, tell me, are you aware of the distance? You mentioned Judge Hill where the nurses' station is.
A Correct.
Q How far is that from the Commons Building, do you know?
A Approximately 932 feet.
Q And how do you know that?
A Because I had our maintenance men measure from the front door of Judge Hill to the front entrance at Commons.
Q So, this building, it is kind of like a college campus, is that --
A It is.
Q And the dormitories would be somewhere nearby?
A Yes.
Q You referenced this early in your testimony. Tell me about the population of the Booneville HDC in June of 2020 and before.
A Well, our population is majority dually diagnosed.
Q What does that mean?
A That means that not only do they have an intellectual disability, but they also have a mental

illness diagnosis. So, schizophrenia, bi-polar, depression, anxiety, ADHD, schizoaffective disorder, various others.

Q And so, do all the human development centers in Arkansas take patients like that?

A They take some. But we take the ones that have the most severe behavioral outbursts.

Q So, the Booneville -- in other words, the Booneville Human Development Center would have a higher population of behavioral problems?

A Correct.

Q Patients?

A Correct. A lot of our clients will come from the Arkansas State Hospital, they will come from jail, they come from other inpatient psychiatric facilities.

Q Okay. So, they are kind of funneled to Booneville?

A They are.

Q So, they most likely wouldn't go to one of the other HDCs?

A They may go to, you know, one temporarily and then they will get transitioned to us.

Q If there is a behavioral problem at another HDC, say the Conway HDC, that really isn't within -- well,

tell me -- so, do you ever accept transfers from other HDCs?
A We do.
Q And why is that?
A Various reasons. Some is because they can't, behaviorally, manage them at their particular center. Some, their families live closer to our side of the state. Conway has children. And so, they also have a behavioral unit for children. And so, when they age out of that behavioral program, they would come to our center.
Q So, do you know the percentage of the Booneville population that is dually diagnosed?
A As of right now, it's 96 percent.
Q Do you know what it was in June of 2020?
A Probably not -- probably between 90 and 94.
Q So, about the same range?
A Correct.
Q Nothing has changed; is that right?
A Yeah.
Q And so, having the higher percentage of dually diagnosed and those with behavioral problems, was that the way it was in 2020?
A Yes.
Q Was it that way in 2014?

A Yes.
Q What about 2015?
A Yes.
Q What about 2016?
A Yes.
Q Has it been that way at least since 2014 to 2020?
A Yes.
Q So, if you were comparing populations of the Booneville Human Development Center with -- and comparing it to populations at other development centers --
A Our population is different.
Q So, you would have a -- you have a higher percentage of behavioral residents; right?
A Correct.
Q To your knowledge, back in June of 2020 and before, did you -- did the Booneville Human Development Center have a higher percentage, or a higher number of mental -- of dually diagnosed residents with behavior problems than the other human development centers?
A We did.
Q So, in this population of developmentally delayed people with behavioral problems -- strike

that question.

I'm going to ask you, did you know David Cains?

A I did.

Q And did you know him well, or did you just know him from being a resident there?

A I knew him from being a resident there. I mean, I have seen him in activities and, you know, various things. And, you know, I knew his love of the Monkeys and Dukes of Hazzard.

Q Okay. Do you know, as an administrator over at Booneville HDC, are you familiar with Individual Program Plans?

A I am.

Q And they are called, also -- what are they also called?

A IPPs.

Q And what does that mean? What do they do?

A Well, it's a program that is laid out for a year to address every need that the client may have in that particular year, from medical to psychological, pre-vocational, independent living. And it also lists social history and ultimate goals for that individual and things to achieve.

Q Okay. And who develops it?

A The program coordinator, which is also known as

the QIDP.
Q I'm going to show you a document, and ask if you can identify that?
A (Witness reviews document.) Yes.
Q Have you seen it before?
A I have.
Q And what is it?
A This is the Individual Program Plan for David Cains.
Q Okay. For what year?
A August 9th, 2018.
Q Okay. 2018?
A Yes. That's what it says on this one.
Q Oh, I'm sorry. I might have given you the wrong one, then.

MR. GILLISPIE: Yes. Mine is '18, too.

MR. ROSEN: Yes. Sorry.

BY MR. ROSEN:
Q We will come back to it, because I have to get the right one that is sitting on my desk. Okay?

MR. ROSEN: Actually, why don't we take a break for five minutes? Are you okay?

THE WITNESS: I'm good.

MR. ROSEN: We will go off the record and I will go get that one.

(WHEREUPON, a break was taken.)

(WHEREUPON, DHS Exhibit Number Five was marked for identification.)

MR. ROSEN: All right. Back on the record.

BY MR. ROSEN:

Q I'm going to show you what I'm marking as Exhibit Five. Let me make sure it's the right year. And ask you if you can identify that?

A (Witness reviews document.) Okay. This is the Individual Program Plan for David Cains for July 18th, 2019.

Q Okay. And what is the significance of the date?

A That this was his last program plan.

Q So, this was the one in effect at the time that he passed away?

A Correct.

Q And so, how often are IPPs created?

A They have to be completed and approved every 300 -- within 365 days.

Q So, this one was completed and approved on what date?

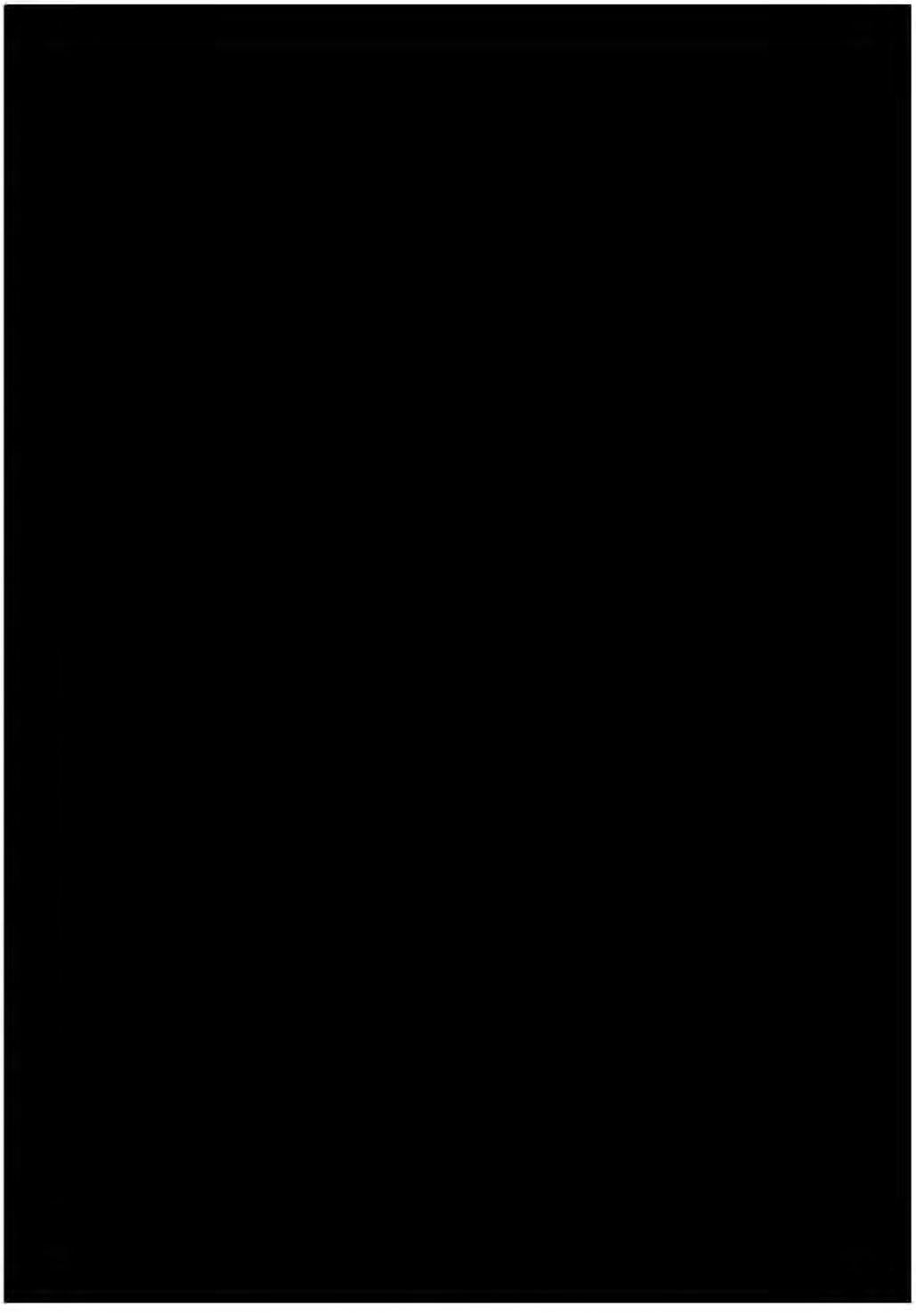
A It was completed on July -- well, the meeting was July 18th, 2019.

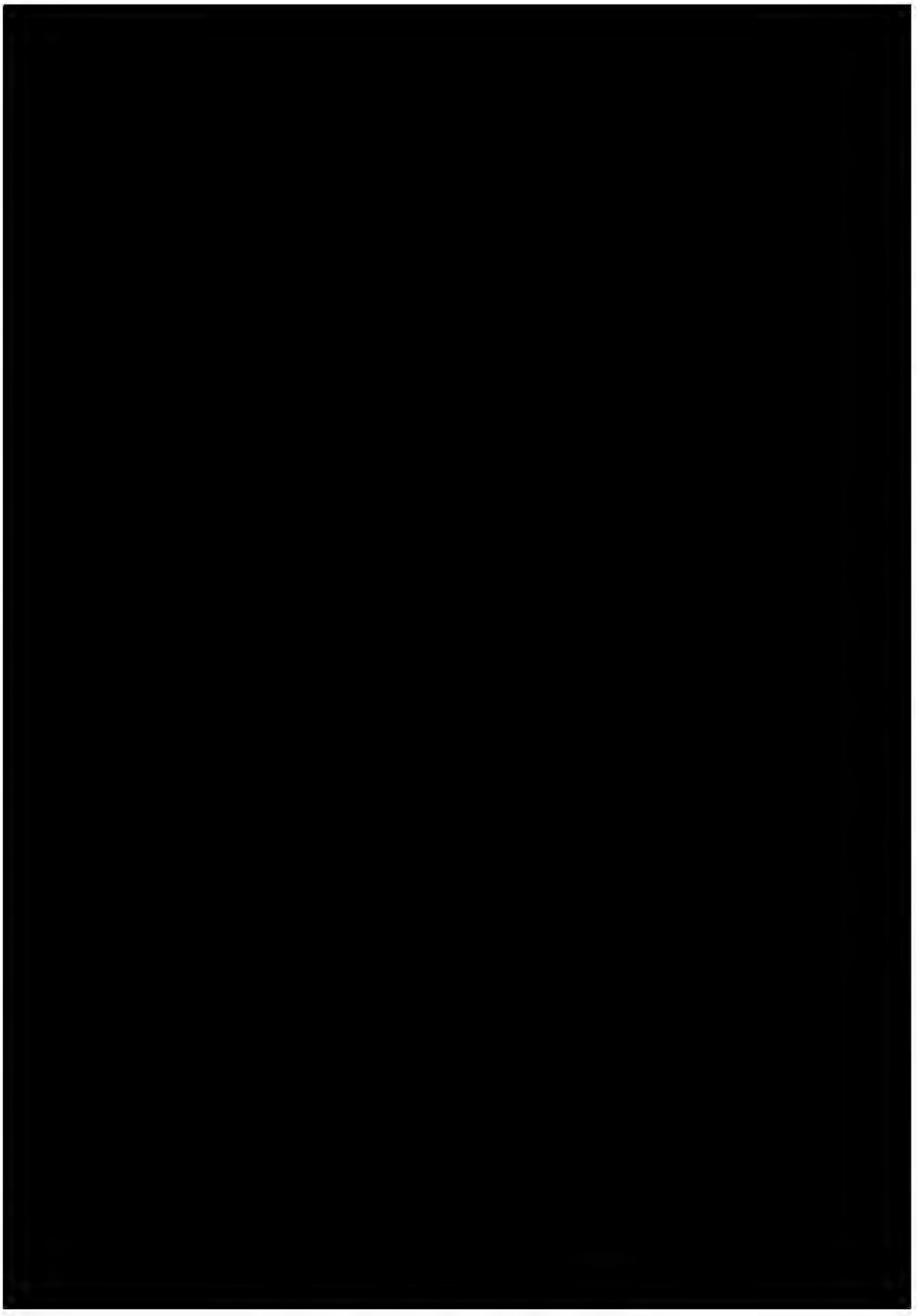
Q And so, therefore, when would the next review be

required?
A It would be due by July 17th, 2020.
Q Okay. And so, who is on the -- is this a team effort that creates this?
A It is. It is an interdisciplinary team.
Q And who is on the -- who participated in the interdisciplinary team?
A Well, there are core team members. And the core team members consist of the client, the guardian, the QIDP, Social Services, the team RN, residential, direct care, and then the psychologist.
Q And on this document, if you will turn to like the page --
A I see it.
Q It is page two, and it is Bates marked 1455.
A Yes.
Q People signed in; correct?
A They did.
Q And that includes the guardian. Did she sign in?
A Yes.
Q And who was that?
A Charlene Robinson.
Q And her signature is on that page; right?
A Yes.

Q And Chrissie Cains?
A Yes, I see her signature on there.
Q Did David Cains, himself, was he present?
A He was. His signature is in between Chrissie and Charlene.
Q And those are the people that directly participated in the development of the plan on that day; correct?
A Correct.
Q And then, on page three of the document, which is 1457 on the Bates numbering, it identifies -- what does it identify?
A It shows the following people attended the annual review on the signature sheet. So, that's the typed-out names of everybody involved. And then, the names below are people that participated in the annual review through written reports.
Q So, it's not just the people talking about it, there were medical and other reports that were submitted?
A Correct.
Q And so, I'm going to ask you to turn to page 1463 of this document, the Bates stamp, and it is page six of the document, but it's Bates stamped 1463.

A Okay. (Witness complies.)
Q And so, at the bottom of the page, under Background Information, it identifies David Cains as [redacted] does it not?
A Yes.
[redacted]







Q In the event that his aggression or symptoms interfere with anything, what does the IPP allow to be done?
A They can employ the category one procedures, which is part of DDS' 3011-D Policy.
Q And that specifically said "3011-D Policy"; right?
A Yes.
Q And it also says "TACT procedures"?
A Correct. Which would be actually NCI.
Q "And other center emergency procedures if necessary to protect from injury to client or others"; correct?
A Correct, yes.
Q So, let's shift gears a little bit and talk

about the 3011-D Policy. Okay?
A Okay.
(WHEREUPON, DHS Exhibit Number Six was marked for identification.)
BY MR. ROSEN:
Q I will give you what I have identified as Exhibit Number Six, and ask you if you can identify that?
A Yes. This is the DDS Policy 3011-D, Behavior Management.
Q And was this in effect in June of 2020?
A Yes.
Q And what is the purpose of this, the stated purpose?
A Well, it's to -- it's for staff to follow the different behavioral -- we have different categories for behavioral incidents. And this allows us -- to give us guidance on what we are supposed to do.
Q Okay. I'm going to specifically, on page one of the document, section one, it says "Purpose". Can you state what that is?
A "This Policy is intended to provide guidelines for managing challenging behaviors of individuals residing in DDS operated programs."
Q Okay.

A "(Human Development Centers)".
Q All right. And so -- and it goes on, and I'm going to ask you to turn to page six, Emergency Procedures -- I'm sorry, page eight, section six. Okay?
A Yes.
Q And what are Emergency Procedures as defined in this Policy?
A It says, "Nothing in this policy prohibits the use of emergency restraint (mechanical or personnel), confiscation" --
Q I'm going to ask you to slow down, because the court reporter has to take down your words. So, if you start again and read a little slower.
A Okay. "Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. This includes the use of restraint procedures in the course of an established program, when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy. However, it is emphasized that emergency procedures may not be used

at frequent intervals, becoming a routine method of intervention. If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. The emergency use of restraint must conform to IFC/MR regulations and must be reported immediately to the facility administrator or designee."

Q And the IDT is the interdisciplinary team; is that correct?

A Correct.

Q And that's reflected in the IPP?

A Correct.

Q So, they did address these issues --

A Yes.

Q -- for David Cains?

A Yes.

Q When you mention the emergency restraint, and it's actually in parenthesis, "(mechanical or personal)", what does "personal" mean?

A It's a personal hold, emergency personal hold.

Q Okay. Now, I'm going to show you what I'm going to mark as Exhibit Number Seven.

(WHEREUPON, DHS Exhibit Number Seven was marked for identification.)

BY MR. ROSEN:
Q And ask you if you can identify what that is?
A This is the HDC Policy I-D-4, "Documentation of and Response to Maladaptive Behaviors".
Q Okay. And so, this is the Booneville Human Development Center Policy; correct?
A Correct.
Q And so, it defines "Emergency situation", does it not?
A Yes.
Q And that's under the Definitions, number three?
A Yes.
Q And 3(c), what is -- tell me what 3(c) is for.
A "Emergency situation in which the clients are harming other people and/or themselves."
Q And what is "Physical restraint"?
A Physical restraint is what we call -- well, "Any manual hold or mechanical device that the client cannot remove easily and which restricts the free movement to a portion or portions of a client's body."
Q And what is a "Personal hold" as defined in this document?
A It's "The actual physical holding of a client by staff using manual methods that restrict the free

movement of the client or restrict movement of or access to a portion or portions of the client's body until the client reaches a state of calm and cooperation, signalling the dangerous behavior has ended and safety no longer is at immediate risk."

MR. GILLISPIE: Rich, are you intentionally using the 2021 policy?

MR. ROSEN: No.

MR. GILLISPIE: This is not the policy that was in place at the time of David's death.

MR. ROSEN: Oh, okay. Then, we will not -- was there a different policy in effect?

THE WITNESS: We revise our policies every year. But it is essentially the same.

MR. ROSEN: Then, we won't introduce this one.

BY MR. ROSEN:

Q Tell me what the policy was in June of 2020.

A Pretty much the exact same thing that I just read.

Q What was revised, do you know?

A Probably the wordage, in terms of from personal holds, from personal restraints to personal holds.

Q So, it was called a personal restraint previously?
A Correct.
Q We will come back to that. Going back to the IPP, let's go to page nine of the IPP, which is Bates marked -- let's go to page nine and ten, which is Bates marked 1469 through 1471.
A (Witness complies.) I have it.

[redacted]

Q Now, per the note on page nine of the document, which is Bates 1469 -- strike that. I already asked that.

So, the IPP reflects -- what is in there is David Cains' treatment program for that year; correct?
A Correct.
Q As approved by the treatment team?
A Yes.

Q And the treatment team, on page ten, Bates marked 1471, in the first paragraph, last sentence says, 'The team agreed that David's Behavior Treatment Program is appropriate and recommended no revisions'; is that correct?
A That's correct.
Q And on that treatment team, besides all the medical team, was Christine Cains McAuliffe; correct?
A Well, she is not a core team member, no.
Q She signed off on it; correct?
A She was at the meeting, yes.
Q She was at the meeting?
A At the permission of her mother.
Q But the team, then -- I guess she is not on the team?
A She is not.
Q But Ms. Robinson, the legal guardian and the mother of David Cains, is on the team?
A She is.
Q So, she agreed to these terms; correct?
A Yes.
Q And so, this is what was agreed at the annual meeting, was it not?
A It was.
Q Okay. So, let's put this aside for a second and

go to some -- so, we know from this that David Cains' [redacted]

A They do.

Q I'm going to show you -- let me get these straight. I'm going to show you a document that -- we are going to go through some of these documents, so I'm going to ask you about them. We will label them individually.

MR. ROSEN: The top document I'm going to label as 8A.

(WHEREUPON, DHS Exhibit Number 8A was marked for identification.)

BY MR. ROSEN:

Q What is that document?

A This is a Behavior Report.

Q And what is the date?

A It is December 26, 2019.

Q And it is two pages; correct?

A Yes.

Q Bates marked 541 and 542; is that right?

A Yes.

Q Okay. And what is a Behavior Report?

A It documents a client's maladaptive behaviors.

Q Okay. And in this particular report, what happened? What does it depict?

A It shows where David was visiting with his mother.
Q In the facility?
A In the facility.
Q So, his mother came to the facility?
A Yes.
Q And that's Ms. Robinson, the legal guardian?
A Yes.
Q What is the date of this?
A December 2019.
Q What is the date?
A December 26, 2019.
Q This is the day after Christmas?
A Yes.
Q So, the day after Christmas, he was at the facility?
A He was. She returned him from leave, from Christmas break.
Q So, she brought him back the day after Christmas?
A Yes.
Q And what happened?
A They were sitting in the kitchen, and he had just come back from LOA.
Q LOA means what?

A Leave of absence.
Q So, he was with his mom?
A He had been, yes. Staff heard a loud commotion, went into the kitchen, and David had hit his mom and flipped the kitchen table.
Q And that's what the narrative report says?
A Yes.
Q And so, staff intervened?
A They did.
Q And what happened?
A David went to his room.
Q And what did the mom do?
A She left and did not return. He also shouted at her and called her an "F"ing bitch.
Q Okay. All right. Now, if you will put that one aside, that's 8A. I will mark -- let's just go through the next document. I'll mark it as 8B. Actually, we have a lot of documents here, let's go through them each.
A Okay.
Q And then, we will mark them all as 8B.
A Okay.
Q Okay? So, this is December 18, 2019 Behavioral Report. What does it depict?
A It shows another instance where David was

physically aggressive --
Q Okay. And --
A -- towards objects in the dining room, as well as he was biting himself.
Q And so, on the narrative, which does it mention that David -- what does it mention about throwing objects?
A Let's see.
Q On the fourth line, fifth line.
MR. GILLISPIE: Which one are we looking at?
MR. ROSEN: I'm going to mark all these as an exhibit, one exhibit, it will be 8B. But this is the one of December 18, 2019 on page 551.
THE WITNESS: David had -- he was throwing objects.
BY MR. ROSEN:
Q Did he push over an outside table?
A Yes.
Q Did he pick up a Christmas ornament and throw it across the room?
A Yes.
Q Did he almost hit another client?
A Yes.

Q With the ornament?
A Yes.
Q And was he put in a personal hold?
A Yes, for two minutes.
Q Okay. Now, let's go through. So, these exhibits -- here is another one on December 18th.
A Okay. I see that.
Q And he was biting himself?
A Yes.
Q And what was he doing?
A He was waiting in line, talking about work.
Q Was he put in a personal hold?
A For five minutes.
Q To prevent what?
A Because he was biting himself.
Q Okay.
A And because he had picked up a Christmas decoration and was trying to throw it.
Q And so, let's go to another --

MR. GILLISPIE: He had picked up a Christmas decoration and was trying to what?

THE WITNESS: Throw it.

BY MR. ROSEN:

Q Okay. These are all -- so, this is at December 18th at 10:50. And then, the next document on page

554, it's the same date at 9:30, a little bit earlier. Did he have a problem at that time?
A He did.
Q Okay. And what was he doing?
A He was crying for about 15 minutes.
Q As far as physical aggression, what did he do?
A And then, he got up and he began spitting on the staff several times. He took off his hat and hit the staff several times with it. Staff tried to restrain him and he began slapping the staff.
Q Okay. Now, let's talk about the page 564 and 565. December 2nd, 2019.
A Okay.
Q What did he do on that day?
A He picked up an object and he threw it at the staff.
Q Did he do that twice that day?
MR. GILLISPIE: Are we on December 2nd?
MR. ROSEN: Yes. On page 565.
THE WITNESS: Yes, he did, twice.
BY MR. ROSEN:
Q Okay. So, let's go to, now, Bates stamp 566 and 567. He had another behavior incident. What was the date?
A This was November 21st, 2019.

Q And did he jump up and flip a table over?
A He did.
Q And did he call people names?
A He did.
Q And let's go to page 570 and 571. And what is the date of that one?
A It is November 16th, 2019.
Q Okay. And did he try to bite himself?
A He did.
Q And let's go to the next one, page 578 and 579. What is the date?
A November 2nd, 2019.
Q And did he pick up a table and throw it at staff?
A Yes.
Q And let's go to page 580 and 581. What is the date of that one?
A It is October 31st, 2019.
Q Now, they say that he was on a mobile. What does that mean?
A That is our transportation van that goes around campus.
Q So, is it an actual like a bus, a little bus?
A A little bus.
Q So, it's a van?

A Yes.
Q And what did he do on the van?
A He tried to hit another resident, and then staff intervened and he slapped that staff.
Q And so, I'm going to ask you to look at page 582 and 583. What is the date of that?
A October 31st, 2019.
Q What did he do there?
A Screamed for no reason and started biting his right arm.
Q Okay. I'm going to ask you to take a look at 584 through 591. What is this?
A This is an Emergency Mechanical Restraint Documentation Log.
Q And what was he doing that caused this to happen?
A He became upset, spitting, picking up items to throw at staff.
Q And he began hitting and kicking the staff?
A Yes.
Q And I'm going to ask you to turn to page 592 and 593.
A Okay.
Q What is the date?
A It is October 15th, 2019.

Q And did he attempt to hit staff in this incident?
A He did.
Q And he yelled "bitch" several times?
A He did.
Q And so, let's go to 604 and 605. What is the date?
A August 8th, 2019.
Q And again, he is on the van again?
A He is.
Q And while on the van -- so, it's a motorized vehicle and they are going around campus?
A Correct. Picking clients up and dropping them off.
Q And what did he do?
A He started to take off -- he stood up and hit staff that was sitting in the seat across from him.
Q Did he try to bite himself?
A Then, he tried to bite himself on the other wrist. They used personal restraints on him until the mobile stopped, and then they escorted him back to the seat because he was getting out of his seat while it was driving.
Q And did he proceed to bang on the window and start to bite himself again?

A He did. And then, staff had to put him in personals again, and then he bit the staff on the finger.
Q So, he actually bit the staff?
A Yes.
Q And that's on page 605; correct?
A Correct. And then, he continued with his behavior when he ended up to his training area, and he was biting them and hitting windows and attacking staff.
Q And so, let's go to Bates marked 608 and 609 dated June 25th, 2019.
A Okay.
Q What did he do there?
A He was hitting windows in the common area where we eat lunch.
Q We just went through those photographs?
A Yes.
Q Okay. Let's go to 612 and 613. What is the date?
A May 20th, 2019.
Q And in the narrative, what did he do?
A While he was doing his laundry, he grabbed the fire extinguisher and threw it out the laundry room door, hitting the wall in the kitchen.

Q Tell me about the fire extinguishers. How big are they?
A I don't know. Probably decent size. I'm not sure. (Indicating.)
Q So, they're at least two to three feet big?
A Yes.
Q So, they could hurt somebody if they hit them?
A They could.
Q Let's go to 616 and 617. What's the date?
A April 29th, 2019.
Q And did he hit staff with his hat and hit the windows?
A Yes.
Q Let's go to 618 and page 619.
A The date is April 18th, 2019.
Q Okay. And tell me what happened here.
A They prompted him to get his medication.
Q Did he throw a fire extinguisher again at a --
A At a resident, at another client.
Q And then, threw it at staff?
A Yes. He raised the fire extinguisher above his head to throw it. And then, he threw the fire extinguisher at the staff.
Q Okay. And so, let's look at 620, 621. What is the date?

A It is April 18th, 2019.
Q That's the same date as the fire extinguisher you just mentioned. What did he do here?
A He was agitated, he was yelling, spitting, throwing objects, cussing, and attempting to hit staff. He was put in personal restraints for 45 seconds until calm. Then, he went to get his medication, and then he began slamming the cabinet door, biting himself, and attempting to hit staff again.
Q And he was restrained again?
A He was personally restrained for another two minutes.
Q And that's for safety; right?
A Yes.
Q Page 628 and 629.
A The date is April 12th, 2019.
Q What did he do there?
A He became agitated and tried biting himself. He was still agitated.
Q Did he throw anything?
A He picked up his glass of tea and he threw it at staff and began to scream and shout.
Q Did he attempt to bite himself and scratch staff?

A He did.
Q Let's look at what is marked as 636 and 637 dated April 8th, 2019. What did he do here?
A He was in his training area and he didn't want to go to work, so he tried to hit another client.
Q The client is a resident?
A Correct.
Q So, he tried to hit another resident?
A He did. And he was placed in personal restraints to prevent him from harming another client.
Q So, he was grabbed as he was about to hit them there?
A Yes.
Q By the staff to protect the other client?
A Correct.
Q Okay. And there is 638 and 639. Did he throw his juice at staff and threw his plate?
A Yes. This was on April the 6th, 2019.
Q Did he try to hit and spit at staff and bite himself?
A He did, cussing and screaming.
Q 645 through 649. What did he do here?
A Well, this is on April the 2nd, 2019. He was throwing personal belongings, he started spitting and

biting himself and cussing at staff, which they could not calm his behavior and he ended up in emergency mechanical restraints.

Q Did he try to hit staff and kick staff?

A Yes. And to bite staff.

MR. GILLISPIE: Rich, I will stipulate that these documents speak for themselves. If you want to --

MR. ROSEN: Okay.

MR. GILLISPIE: -- you can enter them all in and I will stipulate to them.

MR. ROSEN: All right. Then, that's fine. Yes. So, I'm going to -- okay. We will enter them. And all these documents will be marked as Exhibit "B", but there are a few that I still want to talk about.

MR. GILLISPIE: Okay.

MR. ROSEN: So we don't have to go through each one.

BY MR. ROSEN:

Q So, looking at 665 and 666. In this Behavior Report dated March 15th of 2019, did he grab a fire extinguisher and throw it?

A Yes. And started to bite himself, spit and curse at staff.

Q Okay. And just, on some of them, on 669 and 670, what happened here?
A He was in line for lunch and attempted to rip the papers off the wall, the door to Commons. He couldn't get them because they were taped to the inside of the door. He then turned to another individual standing behind him and he attempted to hit the individual. Staff intervened.
Q Is that individual another resident?
A Yes. He tried to hit another resident.
Q All right. Then, let's move on. And just on number 679 and 680. On March 4th of 2019, did he then -- his behavior, he opened the fire extinguisher door and took it out and tossed it toward staff?
A He did.
Q And let's look at 705 and 706, this Behavior Report dated February 27th of '19. Did he actually rip a thermostat off the wall?
A He did.
Q And hit staff?
A He did, and spit at staff.
Q And 709 and 710, February 21, 2019, did he, in this incident, attempt to attack or hit another --
A Client.
Q -- client, or resident?

A He did.
Q And he spit on staff?
A And screamed and cussed.
Q And he hit staff?
A He did. And he jumped up and he flipped his bike that he was riding.
Q Okay. And the last one on this exhibit is 730 and 731, dated January 14th of '19?
A Yes.
Q In this instance, according to the narrative -- and these are Behavior Reports; right?
A Correct.
Q Did David Cains take a picture off the wall and throw it at staff, shattering the glass?
A He did.

MR. ROSEN: All right. All those documents will be marked as Exhibit 8B.

(WHEREUPON, DHS Exhibit Number 8B was marked for identification.)

MR. ROSEN: All right. Now, I want to -- I also have some Behavior Reports from 2020. We're going to mark these as Exhibit Nine. Do you want me to go through them individually?

MR. GILLISPIE: No, you don't have to

go through them individually. I will stipulate that they are -- there is nothing here that you haven't produced already to me?

MR. ROSEN: No. Yes, they are all Bates stamped.

MR. GILLISPIE: Yes. I will stipulate that these are the Behavior Reports for the times and dates dated.

MR. ROSEN: So, those will be marked Exhibit Nine.

(WHEREUPON, DHS Exhibit Number Nine was marked for identification.)

MR. ROSEN: There are a few other ones. There are too many documents.

BY MR. ROSEN:

Q Do you know what dysphagia is?

A It has to do with swallowing.

[redacted]

Q And is that documented on page Bates marked 1505, under Speech?

A Yes.

Q And that's actually --

A That one was August 11th, yes.

[redacted]

Q And are you familiar with the acronym HOB?

A Yes.

Q What does that mean?
A Head of bed.
MR. GILLISPIE: Just to make sure it is on the record, we have gone over it before, Rich -- what page is she looking at?
THE WITNESS: 1483.
MR. ROSEN: And you can ask her questions in your cross examination.
MR. GILLISPIE: I know.
MR. ROSEN: So, unless you have an objection, there is nothing to be said.
MR. GILLISPIE: Well, it is an objection to the form.
MR. ROSEN: Okay.
MR. GILLISPIE: And I will briefly state my reason why, without getting into a speaking objection. But again, this is the version that it doesn't have that other -- this is missing a page. This version that you use is missing a page containing the [redacted]

BY MR. ROSEN:
Q Let me ask you this. Is this IPP complete?
A Yes.

Q And is that what it says on this IPP on page 1487 that was Bates stamped and provided to claimant as part of discovery?

A 1487 or 1483?

Q 1483.

A Yes.

Q Now, directing your attention to page 1501 of the same document -- of the IPP, it states about two-thirds of the way down the category, "Treatments by LA Staff". Do you see that?

A Yes.

[redacted]

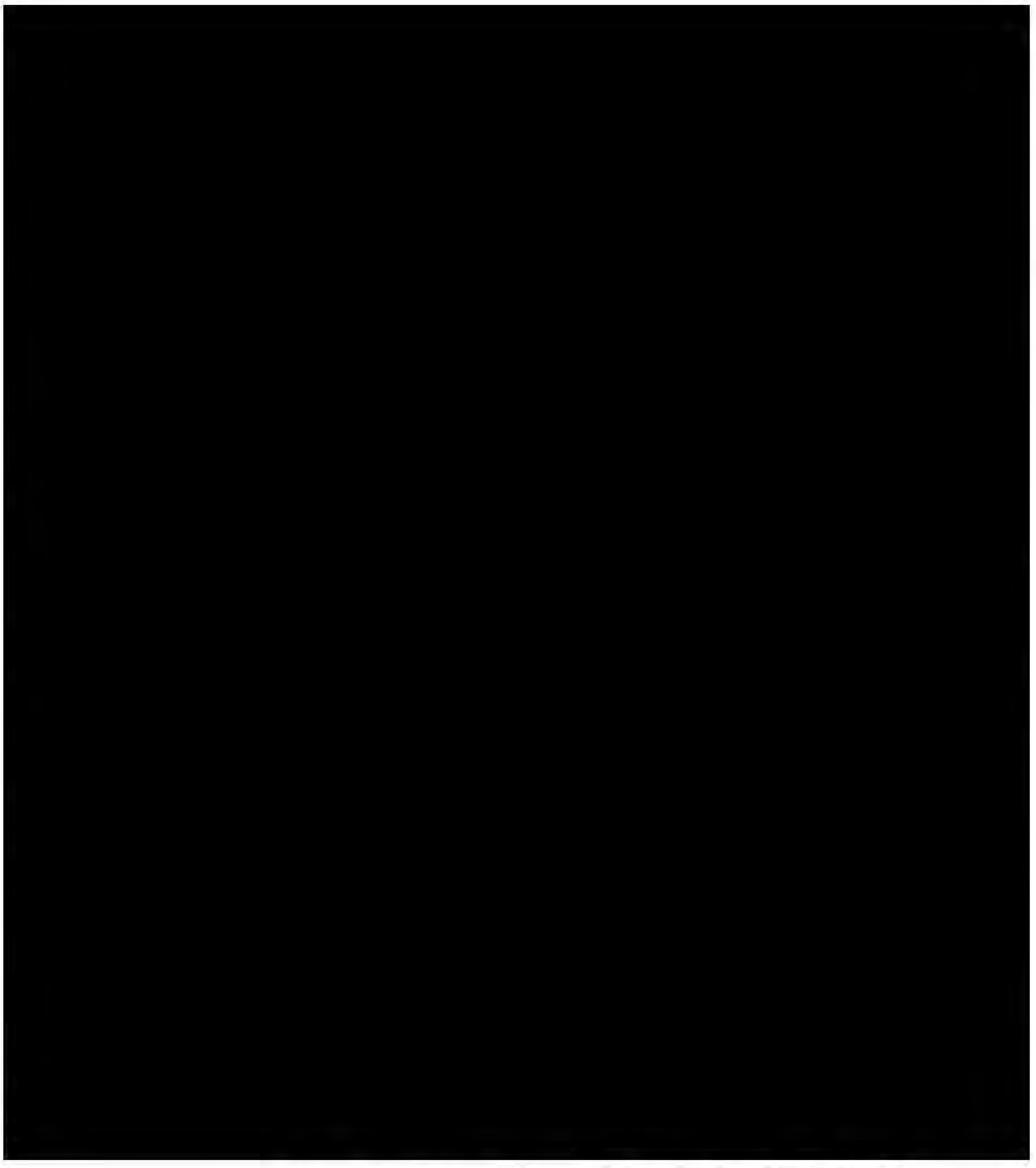
Q What does LA staff mean?

A Living area staff.

Q Okay. And as a matter of fact, on 1497, just a few pages before that, it identifies living area staff -- "Living Area Service Objectives"; right?

A Correct.

[redacted]



MR. GILLISPIE: Object to the form. She has no expertise to the questions you are asking.

BY MR. ROSEN:

Q How long have you been working with

developmentally delayed?
A For 15 years.
Q And during those 15 years, have you ever had or known of a drug that treats developmentally delayed people?
A I do not know of one.
Q We can treat their mental illness; right?
A Correct.
[redacted]
Q We can treat any other medical problems, perhaps, hopefully, that they have?
A Correct.
Q But there is no medication, is there, for developmental delay?
A There is not.
Q Let's talk about, Booneville Human Development Center is licensed -- excuse me, is regulated by the state; correct?
A Correct.
Q And so, you have certain staffing requirements, do you not?
A We do.
Q Okay. And I'm going to show you what we are going to mark as Exhibit Number Ten.

A (Witness reviews document.)

(WHEREUPON, DHS Exhibit Number Ten was marked for identification.)

BY MR. ROSEN:

Q And ask if you have seen that document. Okay. And what is this document in front of you?

A This is the ICF regulations.

Q What does that mean?

A Intermediate Care Facility.

Q So, these are certain portions of the regulations that regulate your facility?

A Correct.

Q And what section is this?

A We are looking at "Standard: Facility staffing".

Q So, the regulations determine what your minimum staffing levels are; correct?

A They do.

Q Where was that in this document? You have seen this before, haven't you?

A I have.

Q And where is the staffing level for direct care staff?

A It is under W187.

Q Okay. So, W187 of Exhibit Ten is the

requirements for direct care staffing; correct?
A That's correct.
Q And it talks about minimum ratios?
A It does.
Q And so, at any time in June of 2020 did the Booneville Human Development Center ever fall below those minimum staffing levels?
A We did not.
Q On June 13th of 2020, did the human development center fall below the staffing levels required by the State of Arkansas?
A We did not.
Q And the State of Arkansas looks into those things, do they not?
A They do.
Q And the incident with David Cains where he choked, did that happen in the dorms?
A No. It happened in the Commons Building.
Q Okay. And so, there were, we know, at least three aides nearby; correct?
A Yes.
Q Were there others in the dining room?
A Yes.
Q So, there were plenty of direct care staff in the area?

A There was.
Q And so, at that point in time, in that location, did DHS -- or in any location, did the Booneville Human Development Center fall below the state required minimum staffing levels?
A We did not.
Q Now, I'm going to ask you -- I'm going to give you some documents. I'm going to mark this Exhibit 11.
A (Witness reviews document.)
(WHEREUPON, DHS Exhibit Number 11 was marked for identification.)
BY MR. ROSEN:
Q And have you seen this document before?
A I have.
Q In fact, you created this, did you not?
A I did.
Q At whose request did you create this?
A Yours.
Q And what does this document do?
A It shows the staffing ratios for all residential areas.
Q For what time period?
A From June 1st, 2020 to June 13th, 2022.
Q Actually, I think it's a repeat on some of

these. But it's actually just a three-page document; correct?
A It is.
Q Does yours have three pages or more than three?
A Mine has more than three pages.
Q It is just repeated. Somebody made copies -- too many copies of it. So, I'm going to give you Exhibit 11. It is just three pages. Okay?
A Okay.
Q If you will give me that back. Okay. So, let's look at June 13th of 2020.
A Okay.
Q This is for all residential living areas, this is facility-wide; correct?
A Facility-wide, yes.
Q And so, what is the ratio looking at June 13th?
A So, our required ratios from midnight to 8:00 in the morning is one staff per 16 individuals.
Q How many were there?
A Well, our daily census was 123 that day, and we had 25 staff present.
Q So, are there different requirements for different shifts?
A There is.

Q So, which is the most -- which shift requires the most staff?
A The 8:00 to 4:00 shift and the 4:00 to 12:00 shift.
Q So, during the day and then to midnight?
A Right.
Q And so, this is facility-wide. How many did you have on staff, direct care?
A For 8:00 to 4:00, we had 30, and then for 4:00 to 12:00, we had 29.
Q And what was the requirement?
A One to eight.
Q All right. So, you were over the limit?
A We were.
Q So, you did not have any -- you did not fall short -- you were not short-staffed that day?
A We were not.
Q And you did this for the whole first 13 days of June of 2020; correct?
A Correct.
Q And when you looked at your staffing levels, did any of those dates -- this is residential areas. Facility-wide, did they fall below the minimum staffing levels for any shift?
A They did not.

Q All right. We're going to look at what I'm going to mark Exhibit 12.

(WHEREUPON, DHS Exhibit Number 12 was marked for identification.)

(WHEREUPON, a discussion was held off the record.)

(WHEREUPON, a break was taken.)

MR. ROSEN: All right. So, back on the record.

BY MR. ROSEN:

Q What you have in front of you is -- what do you have in front of you? It is marked as Exhibit 12.

A It is the staffing ratios for Davison House from June 1st, 2020 to June 13th, 2020.

Q Okay. It is marked "June 13th, 2022" at the top?

A Yeah, I guess. That's a typo.

Q Did you prepare this document?

A I did.

Q Were these staffing ratios from 2022 or 2020?

A 2020.

Q So, individually, per day, they are marked correctly?

A Yes.

Q That's just a typo; right?

A It is a typo.
Q Okay. And so, directing your attention to June 13th, 2020 -- well, first of all, what is the difference between this Exhibit Number 12 and what we just discussed on Exhibit 11?
A This is specific to Davison House living area.
Q So, the other one was facility --
A Facility-wide.
Q And this is to the Davison House. And what is the significance of Davison House?
A This is where David Cains lived.
Q And I see there are different categories here. There is blue, green, yellow/orange?
A Yes. That's the different living areas within the building.
Q Within Davison House, which is a dormitory --
A Yes.
Q -- there are different areas labeled different colors?
A Correct.
Q And that's what you have broken down here?
A Yes.
Q So, what were the staffing levels -- what was the census of that house that day on June 13th, 2020?
A The census was -- we only -- well, for the 12:00

to 8:00 shift for Davison House Blue, if we're looking at that specifically, that was the area that David lived in, was we had ten clients in that area, we had two staff, so we were more than covered under that ratio from one to 16.

Q So, just so I understand, you say one to 16. So, that's one staff per 16 individuals?

A Correct.

Q And you had ten?

A We had ten, and we had two staff per ten.

Q So, then, you had well more than --

A Yes. We were one to five, actually.

Q And you have it broken down for the other shifts, as well?

A Correct.

Q And for the different areas. I guess are they different floors?

A Blue is on -- blue and green are on the first floor, and then orange and yellow are on the second floor.

Q And for those areas where David Cains wasn't, you met the minimum staffing levels; correct?

A We did.

Q And so, from June 1st of 2020 through June 13th of 2020, in Davison House in any color -- any area

marked by a color, were the minimum staffing levels met or exceeded?
A They were met and some exceeded.
Q All right. Let's talk a little bit more. Let's talk about -- I'm going to show you about the next what we are going to mark as Exhibit Number 12?
A It would be 13.
Q Thirteen. I'm sorry.
(WHEREUPON, DHS Exhibit Number 13 was marked for identification.)
BY MR. ROSEN:
Q And ask if you can recognize that document?
A (Witness reviews document.) Yes, this is CMS 2567.
Q And what does that mean?
A This is the form that Office of Long Term Care uses when they come for any sort of annual review or complaint.
Q And so, this is dated up at the top, "Survey Completed 06-30, 2020"?
A Right.
Q Now, do you recognize this particular document?
A I do.
Q And what do you recognize it to be?
A This is the outcome of the Office of Long Term

Care visit.
Q With regard to David Cains?
A It has various complaints.
Q But was one of these -- do you recognize this as being at least one of them?
A One of them was for David Cains, yes.
Q Now, how do you know that?
A Because when they came to visit at our facility the date that they came to visit, which was June 30th, 2020, that was part of their investigation.
Q And so, you recognize this as being from that?
A Correct.
Q But it doesn't mention David Cains?
A It doesn't.
Q But do you recall it?
A Yes.
Q Okay. And do you know which one of the three complaints that they looked at was David Cains?
A I couldn't tell you which one.
Q But all of them were unsubstantiated, whatever they looked at?
A They were.
Q And what does "unsubstantiated" mean with regard to an Office of Long Term Care complaint?
A That means they found no fault at the facility.

Q No violation of any --
A No violations.
Q No violation of any regulation?
A Correct.
Q And we don't know from this document what they specifically looked at, do we?
A I do not, no.
Q But whatever it was, Booneville was found not to be deficient?
A Correct.
Q Okay. And did Office of Long Term Care interview people?
A They did.
Q And did they actually come to the facility?
A They did.
Q And so, they were there, present, to look into this?
A They were.
Q You are also familiar with the Disability Rights of Arkansas report on David Cains' death?
A I am.
Q And that was conducted -- do you know who it was conducted by?
A Chris Stewart.
Q And did Chris Stewart actually come to the

facility to inspect it?
A She did not.
Q Who is Sandy Evans?
A She was our Residential Services Director.
Q And as Residential Services Director, did she -- do you know whether she conducts any Long Term Care, or maltreatment investigations?
A She did.
Q Internally?
A Yes. She was one of our adult maltreatment investigators.
Q And to be a maltreatment investigator, is there any training or certification?
A There is a course that they attend.
Q Do you know anything about that?
A I do.
Q Tell me about it.
A Well, it's a couple day course, or even a one-day course, depending on which one they send you to, and you go and you learn the ins and outs of investigating at a facility.
Q Okay. And so, what was Sandy Evans' position?
A At the time of her retirement, she was Residential Services Director.
Q What about on --

MR. GILLISPIE: I'm sorry. This is my call.

MR. ROSEN: Why don't we take a break?

(WHEREUPON, a break was taken.)

MR. ROSEN: We are back on the record after a break. I just have a few more questions.

BY MR. ROSEN:

Q Tell me, again, how long you have been at the Booneville Human Development Center.

A It will be 15 years in January.

Q And during the course of those 15 years, have there been incidents where a call to 911 had to be implemented?

A Yes.

Q And do you have personal experience with that?

A No.

Q Do you know, as formerly the Social Services Director, or in that division, and as Assistant Superintendent, are you familiar with the response times of the Logan County EMS system?

A I am.

Q Tell me what your experiences at the Booneville -- what the Booneville Human Development Center's experiences with calling 911 is.

A Typically -- we have two units in the county.
Q Two, what do you mean?
A Two ambulances.
Q Okay.
A And it covers the entire county of Logan County. So, if it's on the other side of the county, it may take a while for them to get to us. We did have an incident where it took 45 minutes for the ambulance to arrive, and another incident recently where it took an hour for them to arrive.
Q And sometimes they arrive sooner?
A Sometimes they do. But typically, you know, within 15 minutes. But we have also been told when we have called the ambulance that they have to get an ambulance from another county to come in because both of their units are out.
Q But you have a medical team of nurses; correct?
A We do.
Q And so, are they able to respond to many of these instances?
A They are.
Q And about how long does it take for them to respond?
A A couple of minutes.
Q Okay.

A Depending on where the location is.
Q I'm going to ask you a few terms and ask you if you are familiar with them and if you can identify them. Do you know what NCI is?
A Yes.
Q And what does that stand for?
A Nonviolent Crisis Intervention.
Q And tell me about that. Do you know anything about NCI?
A I do.
Q Tell me about it.
A It's a de-escalation program where our staff are taught how to de-escalate behaviors. And then, it also entails doing certain personal holds to kind of de-escalate a situation.
Q Okay. And so, is that the only protocols or policy that Booneville Human Development Center implemented for behavior modification or management for residents in June of 2020?
A No.
Q What else?
A We also use emergency mechanical restraints and emergency chemical interventions.
Q What are they for?
A To help with behavior modification.

Q And so, what did you say that -- what else do you use?
A Emergency chemical intervention.
Q Other than that, what was the other one?
A Emergency mechanical restraint.
Q Okay. Mechanical. So, what is mechanical restraint?
A Papoose board.
Q And it's --
A It's a board that lays on the ground that is cushioned, and there are straps that go around their legs.
Q In some of the behavior reports that we went over earlier and some that are in there, you referenced a papoose board or mechanical restraint.
A Correct, correct.
Q Is that what you are talking about?
A Yes, it is.
Q And that's for behavior management?
A Well, it's to ensure the health and safety of individuals.
Q Oh.
A Everything we do, we use for emergency purposes.
Q So, are restraints used for therapeutic purposes?

A No.
Q Are they used for disciplinary purposes?
A No.
Q Do you know what CPI is?
A I think it's like Crisis Prevention Institute.
Q Yes. What is that?
A That's the organization that developed the NCI.
Q Okay. So, that's the company and NCI is one of the programs?
A It's a program.
Q I got you. Do you know whether CPI has other programs that teach more?
A They do. They have an advanced NCI.
Q In 2020, Booneville Human Development Center didn't buy those protocols, did it?
A We did not.
Q And is that what you do, you buy the protocols and teaching materials?
A Well, we send instructors to go to those programs.
Q But it's a paid thing?
A It is.
Q And so, what is a personal hold?
A A personal hold is where an employee has their hands on the individual to calm them.

Q Okay. And so, that's --
A And prevent them from harming themselves and others.
Q In the behavior reports, that was also referred to as an alternate hold or a restraint.
A Right.
Q And what is the purpose of that?
A The health and safety of the individual and the individuals around them.
Q What is early chemical intervention?
A Early chemical intervention is where it's identified by the medical staff that this person would benefit from having an Ativan or Haldol or whatever as their behaviors start to increase. That way -- let me reframe that better. So, if a client is agitated and they are showing signs of distress, some of our clients can get quite violent. And so, before it gets to that point, if we can get them an early chemical intervention, then that client won't escalate to the point of severe harm to self or others.
Q And was David Cains in 2020 and before authorized for early chemical intervention by his physician?
A Not to my knowledge.

Q Do you know one way or another?
A I do not off the top of my head, no.
Q Tell me, are you familiar with maltreatment investigations?
A I am.
Q So, tell me the different type -- are there different types of maltreatment investigations?
A There is the maltreatment investigation, and sometimes we have admin reviews.
Q What is an admin review?
A Just where there is a situation that is presented to us and we look further into it to determine if we need to expand upon it and make it a full-fledged investigation.

[redacted]

Q And that's a lesser than an investigation?
A We still do a full-fledged investigation with a review. It's not much different.
Q So, what is the significance? What is the difference?
A Well, the difference is if it's, you know, if it's reportable or not.
Q Okay. Oh, okay. So, only certain things are reportable?
A Correct.
Q And what is the standard that -- what is the standard, do you know?
A No.
Q Okay. You are not an investigator?
A I have investigated.
Q Oh.
A But I'm currently not an investigator at the moment, with my current position. But previous, I did investigations.
Q All right. So, the behavior incidents of David Cains that we introduced into evidence, and some we went over in detail and some were stipulated to, were those -- and they were from 2019 and 2020. Do you know whether those were all the behavior incidents or were they just certain ones?

A Those were just certain ones.
Q You are familiar -- you reviewed the records?
A I did.
Q And there were more?
A There's a lot more.
Q Okay.

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MR. ROSEN: That's all the questions I have.

CROSS EXAMINATION

BY MR. GILLISPIE:

Q Ms. Berry, why would you -- you are saying that there are a lot more behavior incidents from 2020 that a report was not done for?
A No. From -- I was talking about 2000 -- David was with us from 2007 until 2020. So, there's a lot of Behavior Reports regarding that timeframe.
Q Oh, okay. You are not saying that y'all neglected to do reports for incidents?
A No.
Q You are just saying Mr. Rosen only showed you 2019 and 2020?
A Correct.
Q Not years prior to that?
A Yes.
Q I misunderstood that. Ms. Berry, you are the --

are you the Assistant Superintendent, is that technically the title?

A That's my title.

Q And Jeff Gonyea is the Superintendent?

A Correct.

Q All right. So, he is the one person at the facility above you?

A Yes.

Q And I'm quite happy to have you here today, but I'm wondering, you know, why -- we are deposing him on Thursday. Is there information that you have that y'all determined that Mr. Gonyea may not have, or topics he may not be able to cover as well as you?

A I don't know.

Q Okay. You have no idea?

A I mean, I don't know what topics it is that you are interested in.

Q Would Mr. Gonyea be equally capable of answering questions about the topics that have been addressed with you today?

A No.

Q What topics would he not be capable of addressing and why?

A I mean, he could. But, I mean, in terms of the records, I am the one that, you know, was the one

that produced all the records. So, I don't know.
Q Flesh that out for me.
A Yeah. Ask the question again.
Q What records are you saying you produced?
A All of the records.
Q You are talking about discovery?
A Yes.
Q Okay. You are the one that compiled all of the stuff that was given to the attorneys that was then given to me?
A Correct.
Q Okay. I assume Mr. Gonyea is familiar with the case?
A Yes.
Q Okay. I assume he is familiar with all of the policies that you have been asked about today; right?
A Yes.
Q So, I am simply wondering, is there any specific reason that you know of that you are here to answer questions as opposed to just getting this information from Mr. Gonyea on Thursday?
A Maybe because I give a different insight to it.
Q Sure. Everybody has -- fair enough. Are there any -- as far as you know, are there any topics that you are able to address that he would not be able to

address related to this case?

MR. ROSEN: That you know of.

BY MR. GILLISPIE:

Q That you know of?

A That I know of. Right. Because I don't -- I don't really know where you are going with this. But, okay.

Q Do you understand my question?

A I hear what you are saying.

Q Yes.

A I just don't understand. I mean, yes, I mean, there is really -- I don't know. Yeah. I know what you are saying and I understand the question that you are saying, but there is no real -- I mean, it's perfectly fine for me to be here and perfectly fine for him to be here.

Q I anticipate his deposition to take quite a while. He is the Superintendent, I have a lot of things to address with him.

A Okay.

Q I see no particularly good reason to --

A Ask me questions.

Q -- to ask you questions all the same things that I'm going to be asking him on Thursday.

A Okay.

Q Unless there is something that you are aware of related to this case that you have knowledge of that he would not. So, the question would be, are you aware of anything related to this case that you have knowledge of that Mr. Gonyea does not?

MR. ROSEN: Objection. I'm not sure that she can answer that question. But to the extent that she does have knowledge of that, she can.

MR. GILLISPIE: Right, that she is aware of anything.

THE WITNESS: I'm not aware of anything.

BY MR. GILLISPIE:

Q And I am not going to ask you a lot of questions here, just some quick followup. You testified earlier that Mr. Cains and the other residents of the BHDC are there voluntarily; correct?

A Yes.

Q They or their loved ones choose for them to be there; right?

A Correct.

Q And they can presumably remove them at any time; right?

A Correct.

Q You are not also saying that that means that the facility can use any kind of physical force that they want on them, are you?
A No.
Q Okay. The facility still has to comply with federal regulations?
A Yes.
Q And I'm not going to go through all of them individually, but specifically the ones that Mr. Rosen asked you about, those that pertained to staffing. But the same set of regulations found at 42 CFR, Section 483.000, which y'all commonly refer to as either the State Operations Manual or the Medicare --
A ICF regulations.
Q ICF regulations. The facility has to follow those; right?
A Correct.
Q The facility also has to follow and comply with the DDS policies?
A Correct.
Q And then, of course, the facility has to follow and comply with its own policies?
A Correct.
Q So, to be clear, you would refer to these

federal regulations typically as ICF regulations?
A Yes.
Q And would you agree with me that, in general, the facility has a duty to keep the clients reasonably safe?
A Yes.
Q Okay. And this document, I can't remember what exhibit number Mr. Rosen called it, but --
MR. ROSEN: 13, in front of her.
BY MR. GILLISPIE:
Q Is that OLTC's findings?
A Yes.
Q So, that's the OLTC report that was generated --
A Correct.
Q -- as a result of David's death?
A Yes.
Q There is no other OLTC investigative report, is there?
A Those are the findings. I don't know what their actual report is.
Q Okay.
A Those were the findings.
Q I just want to make sure that my understanding of all the different reports is correct.
A That's the OLTC's findings.

Q And so, my understanding is that Ms. Evans did the maltreatment investigation and then she generated what is called a Maltreatment Investigative Report; correct?
A Correct.
Q And then, my understanding is, correct me if I'm wrong, Mr. Gonyea then uses that to generate what is called the DH Incident Report. Is that correct?
A Yes.
Q And then, both of those documents, along with witness statements, are then sent to DDS, or are they sent to OLTC?
A They are sent to OLTC.
Q Which is a part of DDS?
A No.
Q No. It's different. Okay. They are sent to OLTC. What does OLTC then do?
A They review the investigation --
Q Okay. And so --
A -- and then conduct their own investigation.
Q Okay. And this is what was generated from OLTC's investigation?
A When they came on our campus, correct.
Q Do you know of any other document produced by the OLTC investigation, other than this?

A Not to us. No, I don't know of any others, no.
Q Okay. Thank you for clearing that up for me. So, OLTC conducted this investigation just within weeks of the death?
A Correct.
Q All right. Way before this case was filed; right?
A Yes.
Q Their investigation was done way before any of the depositions in this case were taken; correct?
A Correct.
Q The OLTC investigators would not have had the benefit of reading Sandy Evans' deposition, would they?

MR. ROSEN: Well, how would that happen?

MR. GILLISPIE: It wouldn't. I just want to -- I just wanted to -- it wouldn't.

MR. ROSEN: I mean, it happened three years later.

MR. GILLISPIE: It's a very obvious question. But bear with me.

THE WITNESS: No, it would not.

BY MR. GILLISPIE:
Q And the OLTC investigation --

MR. ROSEN: You are turning towards him, so you will need to speak up.

THE WITNESS: Sorry. No, it would not.

MR. ROSEN: You're turning towards him and away from the court reporter.

THE WITNESS: But I need to talk to her.

MR. ROSEN: No. You can talk to him but just keep your voice up so the court reporter can hear it.

BY MR. GILLISPIE:

Q You would agree with me, as Mr. Rosen pointed out, because it was years before, you would agree with me that when OLTC did its investigation, it did not have the benefit of Sandy Evans' deposition; correct?

A Correct.

Q Nor the benefit of getting to review Mark Hise's deposition; correct?

A Correct.

Q Or any of the other depositions or evidence that has been produced in this case; correct?

A Correct.

Q Was there a single investigator representing OLTC in this investigation, or was it a team?

A They send out a surveyor to the facility.
Q And in this case, they sent out one person, a solo person?
A To the facility.
Q And that person -- that single person they sent out is who conducted the investigation into David's death on behalf of OLTC?
A She is the one that came out to do the survey there. OLTC has a multi-step process.
Q Tell me about it.
A Well, they send a surveyor out, but they also conduct -- they have a whole Internal Affairs that conducts a separate investigation against the staff that are involved.
Q Okay.
A Okay. So, we submit -- we submit the reports to the Office of Long Term Care.
Q Right.
A So, the surveyor is the one that comes out and does the ground work at the facility.
Q Do you know who that person was?
A Diane was her name.
Q Diane?
A But I can't remember Diane's last name all of a sudden.

Q Whoever signed this?
A No. That's Jeff Gonyea's signature.
Q Okay. Keep going. They sent Diane out. Then, what happened?
A And then, they review the investigation, and they conduct their own investigation by contacting staff members, requesting documents.
Q And do you know what staff members they spoke with?
A I do not.
Q Do you know what documents they requested during their review?
A I do not.
Q Do you know who, other than Diane, was involved in this investigation?
A I do not.
Q Do you know who might have the answers to these last few questions I've just asked about this?
A Office of Long Term Care.
Q Okay. And how long did their -- well, this document is dated June 30th, 2020. Does that mean that OLTC's investigation was complete at least by June 30 of 2020?
A That was the day that she was on campus, was on June 30th.

Q So she completed her investigation on the same day?
A No.
Q No?
A That's the day -- in the corner it says the day that she was there, which was June 30th. I don't know what day she completed the investigation. But the day she was on campus was June 30th of 2020.
Q I see that Gonyea signed this on July 14th of 2020. So, does that mean the investigation was complete by at least July 14th of 2020?
A We would have received that by that day, and then we would have submitted -- acknowledged that we received it and signed it. So, yes.
Q Okay. Ms. Berry, Mark Hise, he is the staff development coordinator at BHDC; right?
A He's one of them, yes.
Q One of two; right?
A Yes.
Q And he has been with BHDC -- he told me he has been there for 27 years. Does that sound right to you?
A That's correct.
Q He was a program supervisor over direct care staff for approximately 13 years before moving to

staff development in 2016. Does that sound correct to you?
A It does.
Q And he is responsible for training staff on BHDC policies and procedures, but specifically the use of personal restraints and NCI; is that correct?
A Yes. Personal holds.
Q Sorry?
A Personal holds.
Q Which is the same as personal restraint?
A We call them personal holds.
Q Is it different than a personal restraint? If I say "personal restraint" and you say "personal hold", are we not talking about the same thing?
A We will just go with personal restraints. But we call it personal holds.
Q Okay. And Mark teaches those?
A He does.
Q He still teaches those, as far as I know; right?
A He does.
Q Okay. Mark is certified -- he is NCI certified; correct?
A Correct.
Q I assume you would agree with me, since Mark is the person that teaches staff to do that, you would

agree with me that Mark has expertise in this particular area?
A He has knowledge, yes.
Q You don't agree --
A I mean --
Q -- that your staff coordinator has expertise in --
MR. ROSEN: In what area?
BY MR. GILLISPIE:
Q In the use of personal restraints and NCI?
A He is trained in that. "Expertise" is kind of a word you use when you are, you know -- I don't know.
Q Okay. So, Mark Hise is one of two people on your campus responsible for training all direct care staff in the use of personal restraints; correct?
A Correct.
Q But he is not an expert in it? Is that your testimony here today?
A No.
Q Well, then, what is your testimony?
MR. ROSEN: I think she has already answered it. You don't have to raise your voice. The woman is sitting right here. Her testimony, as I heard --
MR. GILLISPIE: You are not testifying,

are you?

MR. ROSEN: Well, I mean, you have asked the question. How many times are you going to ask it? That is a question to you, counsel. How many times are you going to ask it?

MR. GILLISPIE: Let's go off the record.

MR. ROSEN: No, don't stop the record.

BY MR. GILLISPIE:

Q Please answer the question, Ms. Berry.

A Could you repeat it, please?

MR. GILLISPIE: Read back the question, please, court reporter, starting where -- starting with, "Mark Hise is one of two people on campus," and then just keep going until Rich interrupted, please.

MR. ROSEN: I didn't interrupt. I made an objection. I mean, we are going to need to keep going, we are going to need to put this on the record.

COURT REPORTER: "So, Mark Hise is one of two people on your campus who is responsible for training all direct care staff in the use of personal restraints;

correct?" Answer: "Correct." Question: "But he is not an expert in it? Is that your testimony here today?" Answer: "No." Question: "Well, then, what is your testimony?"

BY MR. GILLISPIE:

Q So, what is your testimony today?

A What is my testimony?

Q Yes. Is he or is he not an expert in the use of personal restraints at BHDC?

A For BHDC, yes.

Q Okay. He is?

A For BHDC.

Q What does that mean?

A To me, when you say "expertise", when you are talking about being the expert of it, I feel like that's somebody that is at CPI. CPI is the expert on NCI and personal restraints. We go to them to receive the training so that we can train it to them.

Q Sure.

A So, I don't see him being the expertise. The expertise is the one that actually works for the company.

Q Well, I'm not suggesting -- I'm not asking if he, you know, wrote the book.

A But when you say "expertise", that kind of leads to that.
Q I'm wanting to know if you believe he has expertise --
A He has a great sense of knowledge of what to do in terms of personal holds and NCI at our facility, based on the training he received from the experts at CPI.
Q Okay. But you would not go as far as to say he is an expert on the use of NCI --
A At our facility.
Q He is at your facility?
A At our facility.
Q Meaning that he is one of two people --
A That conducts that training, correct.
Q Okay. He and the other person, as far as your facility goes, they are the experts on it at your facility?
A At my facility.
Q Okay. Thank you very much. The Behavior -- the 2019 and the 2020 Behavioral Reports that Mr. Rosen had you look at and went through some of them, introduced, I stipulated that, you know, they speak -- those documents are what he purports them to be, stipulated they can go into evidence, they speak for

themselves. But I do want to clarify, and correct me if I'm wrong, but you were not personally present for any of those incidents?

A I was not personally present.

Q Okay. So, as far as you know, you were not personally present for any of the behavioral incidents that were described in those reports from 2019 and 2020?

A Correct.

Q And so, do you have any -- did you try to get -- do you have any personal knowledge of any of those?

A Yes.

Q Okay. And how did you get the personal knowledge? How did you come by personal knowledge of those?

A We have daily meetings at BHDC.

Q Okay.

A And we review all the Behavior Reports and incidents that took place within the last 24 hours.

Q Okay. Who attends those meetings?

A Quality Assurance, Social Services, Administration, Residential Services, Psychology, and Medical.

Q And those are daily?

A Daily.

Q And you are --
A Monday through Friday.
Q And in your capacity, your job title, under your current job duties, you would be present for all of those?
A I was, yes, or the Superintendent -- in my current job title, yes, or Jeff would be there.
Q Okay. And are the staff members -- the specific staff members involved in each of those behavior incidents also present?
A No.
Q Would you have specifically spoken to the staff members -- the specific staff members involved in those incidents about those incidents each time?
A If it was warranted, I would have. But I can't recall me -- recall that, that I did.
Q Okay. Let's just take the ones that Mr. Rosen asked you about today, the ones that he specifically kind of showed you and had you read from and authenticate. Did you reach out to any of the staff members involved in those incidents before coming here today?
A No.
Q No. Okay. Do you recall having ever spoken to any of those staff members specifically about those

specific incidents that you were questioned about today?
A I don't recall.
Q Am I correct that -- and I think you said this. But personal restraints or personal holds can only be used at Booneville in emergency situations?
A Correct.
Q Okay. And I assume you would agree with me that the emergency use of restraint must also conform to ICF regulations?
A Yes. And Policy 3011-D.
Q Okay. Very good. And so, personal restraint is to be used only as an emergency measure?
A For health and safety, yes.
Q So, that would mean that every single one -- every single time a personal restraint or a personal hold, as you like to call it, is used on a client at Booneville, that means that whatever that incident was, y'all are calling it an emergency?
A Correct.
Q Okay.
A Unless there -- it's a medical procedure.
Q Sure. But in the behavioral context?
A Okay.
Q In the behavioral context --

A Yes.
Q -- it would be an emergency every time hands are laid on a client?
A Correct.
Q Is it true that at the time of David's death there was a Policy at Booneville prohibiting nonmedical staff from calling 911 in cases of medical emergency?
A Anyone can call 911. That was in effect, call 1422 ahead of time for the nurses to come. But at any point, anyone can dial 911. They are taught that in First Aid.
Q As you sit here today -- you are testifying, as you sit here today, there was no such policy?
A No, there's a policy that said that they needed to call 1422 first, but that they can call 911, as well, if they needed to, depending upon the emergency.
Q Where does it say that in the policy that you are talking about?
A You are looking at the First Aid Policy. So, the First Aid Policy says -- if you can show it to me again.
Q I'm showing you what we will mark as Exhibit One for us. That is the First Aid Guidelines, the

Booneville First Aid Guidelines, Policy Roman Numeral IV-B-10; correct?

A Correct.

Q And this was the policy regarding medical emergencies in place at the time of David's death; correct?

A Correct.

Q Take a look at there -- take a look there. Point to where it says that nonmedical staff can call 911 if they want to.

A It's not in here.

Q It's not in there?

A Huh-uh. (Indicated no.)

Q Read all of number paragraph two for me, please.

A "In all cases in which a serious medical injury or illness is suspected, either to clients or staff, a call to the Medical Department should be made. This should be the first call so that Medical staff can respond immediately to the situation. A call to Medical at 1422 should be made and the following information should be given. One, caller's name and title; two, victim's name, location, situation and condition of the victim," in parentheses, "(Alert, unconscious, et cetera). Number three, Medical will assess the situation and call an ambulance if

appropriate."
Q Thank you.
MR. GILLISPIE: Make that Exhibit One.
MR. ROSEN: It's already marked Exhibit One.
(WHEREUPON, Claimant Exhibit Number One was marked for identification.)
BY MR. GILLISPIE:
Q But as you sit here today, are you saying that there was another policy?
A There is no policy. But it's in first aid treatment, when you receive first aid treatment, or the training for first aid CPR, it tells you in there that you can call 911. We don't prohibit people from calling 911. We preferred that they would call 1422 so our medical staff could assess the situation because EMS takes a while to get to our facility.
Q Are you aware that every single staff member I've deposed believes that they were -- nonmedical staff member that I've deposed believes that this was your policy, that they were prohibited from calling 911?
A No, I'm not.
Q Okay. Let's address that. Sandy Evans, page 52 and 53 of her deposition, acknowledges that was the

policy that nonmedical staff could not call 911. She assumes that --

MR. ROSEN: Is there a question there to this witness?

MR. GILLISPIE: This is a question.

MR. ROSEN: Okay. Or are you just testifying?

MR. GILLISPIE: This is a question.

MR. ROSEN: Okay.

MR. GILLISPIE: And I will phrase it better.

BY MR. GILLISPIE:

Q But are you aware that Tyler Mattson, Sandy Evans, Amy Jones, Don Carter, Kelly King, and multiple other staff members and former staff members that I deposed all swore under oath that there was a policy at your facility forbidding nonmedical staff from calling 911?

A It doesn't say forbid in there. Does it say "forbid"? I don't remember reading "forbid".

Q My question is, are you aware that that was their belief, that they believed that was the policy?

A That they were forbidden?

Q Yes.

MR. ROSEN: Well, I'm going to make an

objection because you're asking this witness to testify as to somebody's belief. But to the extent that you have knowledge of it, you can answer it.

THE WITNESS: Well, I mean, if you are saying that's what they said in their deposition, then I have to say that's what they said in their deposition.

BY MR. GILLISPIE:

Q Why would all the staff members think that they were not allowed to call 911 if you are saying that they were?

A I don't know why. Anybody can call -- anyone can call 911. We had a policy in place for them to call 1422. But nothing that says -- that forbid them from calling 911.

Q And do you have any explanation for why the staff members, particularly that I just named off, and I can show you exactly in each of their depositions where they say it, do you have an explanation for why they might have believed otherwise?

A No, because they were following, I guess, what they believed the policy to say.

Q Okay. What was the reason for that policy, if

you know?
A I don't know the reasoning behind the policy.
Q Who came up with the policy?
MR. ROSEN: You're referring to what is reflected on Defendant's Exhibit One, I assume; right?
MR. GILLISPIE: I'm referring to the policy regarding calling 911 that we have been talking about.
THE WITNESS: The First Aid Guidelines.
MR. ROSEN: The First Aid Guidelines which is Exhibit Number -- Defendant's Exhibit Number One; right? I want to make sure we are talking about the same policy. You are being vague on that. So, what policy are you talking about?
MR. GILLISPIE: I'm being vague?
MR. ROSEN: What policy are you asking this witness about? That's all I want to know. Is it the one you introduced or is it a different policy? Because I'm looking at --
BY MR. GILLISPIE:
Q Do you know who came up with the policy that we introduced? Do you know whose idea that policy was,

where that came from?

MR. ROSEN: And for clarification, that is Defendant's Exhibit One.

MR. GILLISPIE: Rich, can I depose her or are you just going to keep talking?

MR. ROSEN: I'm going to make sure that there's clarity in the record, because your vague questions could -- you know, if she thinks you are talking about one thing and you are talking about something else. So, I just want to make sure that we are talking about -- when you ask her the policy, we are talking about the policy that you introduced as Exhibit Number One. Because if we are talking about a different policy, let's present it to her.

MR. GILLISPIE: I gave you the courtesy of not interrupting you, not doing speaking objections.

MR. ROSEN: I'm making an objection. And this is a deposition. I just want to know, are you trying to trick the witness or are you going to tell her what policy you are referring to? That's all I want to know. It's simple.

MR. GILLISPIE: I would ask that you kindly let me conduct my deposition.

MR. ROSEN: Okay.

MR. GILLISPIE: Give me the same courtesy that I gave to you.

MR. ROSEN: I give you courtesy. I just want to make sure that it's not -- that you are asking her -- that she understands what question you're asking her about, because I don't understand. Because I see a policy --

MR. GILLISPIE: I know you don't understand.

MR. ROSEN: Yes. Because I see a policy in Exhibit Number One, but I don't know -- you are somehow unwilling to ask -- to commit that that's the one you are asking about. So, if it's not this one, then please tell us what policy you are talking about so that we can know. That's all -- that's very simple.

MR. GILLISPIE: Let's take a couple of minutes. Let's take a couple of minute break, please.

MR. ROSEN: Okay.

(WHEREUPON, a break was taken.)

MR. GILLISPIE: Back on the record.

BY MR. GILLISPIE:

Q Ms. Berry, who does the CPR certification for Booneville?

A Mark Hise.

Q Is it through -- do you know if it's through --

A American Heart Association.

Q American Heart Association. Okay. Then, the very last question I have for you, I'm going to take you to page 1525 of Exhibit Five, which was the 2019 IPP.

A What is the page number?

Q The Bates mark is 1525. It's the page titled "Physician's Orders".

A Right. Okay.

Q Are you the one that marked out that "2" there where it says "Page 1 of 2" and put a "1" there?

A I did not.

Q Do you know who did that?

A I do not.

Q I will represent to you, and it has been made an exhibit in someone else's deposition, that the documents that you put together and produced to me contain another version of this same IPP, except it

included that page two. And on that page two is a

[redacted]

you --

MR. ROSEN: Is there a question there, or are you testifying?

BY MR. GILLISPIE:

Q Can you explain why there are two versions of this document?

MR. ROSEN: Stop, stop. That's argumentative, because we don't know that that statement is correct that you are making. And we know from other depositions that it's not correct.

MR. GILLISPIE: Well, that's absolutely false.

BY MR. GILLISPIE:

Q But assuming that I'm --

MR. ROSEN: Well, let's see the document.

BY MR. GILLISPIE:

Q Assuming that I'm correct, could you give an opinion as to why that might be?

MR. ROSEN: No, there is no opinion. Objection. She's not assuming anything.

MR. GILLISPIE: Are you telling her she can't answer?

MR. ROSEN: That's right. Because she is a fact witness. Now, produce the document and we can discuss it. This trickery is just not correct. If you are going to have her comment on a document that we -- that you believe says something, then show her the document and she can testify on it.

MR. GILLISPIE: Are you instructing her not to answer?

MR. ROSEN: What is the question? I can't remember the question. But if you are asking her to assume your facts and give an opinion, she is not an expert witness here, she is a fact witness. So, give her the facts and let's get on with it.

MR. GILLISPIE: That's what I'm trying to do here.

MR. ROSEN: Then give her the facts, just show her the document and we can talk about it. This trickery is too much.

MR. GILLISPIE: What trickery?

MR. ROSEN: You are asking her to comment about your facts that aren't established. And we know from the other deposition why they are not part of this. But if you want her to comment on a particular document, show her the document and let her review it and then she can answer your questions.

MR. GILLISPIE: I'm not going to go digging for the document.

BY MR. GILLISPIE:

Q Assuming what I'm -- hypothetically, assuming what I'm telling you is true, there is another version of this with a page two, and on that page two is a Physician's Order regarding GERD specifically stating that GERD -- his GERD precautions required him to remain upright for one hour after eating. Assuming that's true -- hypothetically, assuming what I'm representing to you is the truth, do you have any knowledge as to why that might be, that there are -- that there were two versions produced?

MR. ROSEN: I'm going to let her answer the question, but I'm going to make the objection that that's your view of

something. And if she knows the answer --

MR. GILLISPIE: Again, I would ask you not to make any more speaking objections.

MR. ROSEN: Well, no. I have to here because it's argumentative what you are saying. You know, you are assuming facts that aren't in evidence and asking her to comment on it.

BY MR. GILLISPIE:

Q Please answer the question.

A This is part of the Annual Pharmacy Report. So, that's why there is only one page, because this first page shows all the medications. (Indicating.)

Q You gathered these documents and produced them; correct?

A Uh-huh. (Indicated yes.)

MR. ROSEN: Is that "yes" or "no"?

THE WITNESS: Yes, yes, yes.

BY MR. GILLISPIE:

Q Do you know why this number two is marked out?

A I don't know why the number two is marked out, except for the fact that this was attached to the Annual Pharmacy Report. So, the Annual Pharmacy Report only reviews the medications. So, if they have it attached to it, it just shows all the

medications that are right here. (Indicating.) And then it has the report of all the medications past it. So, if you look past it -- so, this is just for -- this report here is just for medication. It is just for the medication. (Indicating.)

Q I see that.

A And so, then, all the medications are back on these sheets of paper afterwards.

Q Okay.

A So, it has nothing to do with -- because, so, the other one has two pages -- if it has two pages, it's the legitimate one. This one here is only for the pharmacy report, only for the medication.

Q Would Physician's Orders pertaining to something like [redacted] not need to be made part of the IPP?

A Is it part of the IPP? It's in the IPP.

Q Okay. Where in the IPP? Where in this version of the IPP is it?

A Go to -- well, if you look at -- I guess it's CM 001501, "Treatments by Living Area Staff" says, [redacted] that's in the Annual Medical Staffing Report --

MR. GREEN: Did you say 15 --

THE WITNESS: 1501.

MR. GREEN: 1501.

THE WITNESS: So, it says, "By Living Area Staff". And then, if you go to 1497, it says it in there, "Elevate head of bed, do not go to bed for one hour after eating."

MR. GILLISPIE: Okay.

(WHEREUPON, Claimant Exhibit Number Two was marked for identification.)

BY MR. GILLISPIE:

Q I will show you what I have marked as Exhibit Two, Bates marked 1327.

MR. ROSEN: Do I have a copy?

MR. GILLISPIE: I don't have one for you right now.

BY MR. GILLISPIE:

Q Take a look at that for me.

A I see it.

MR. ROSEN: Let me see it.

THE WITNESS: (Complies.)

BY MR. GILLISPIE:

Q Then, take a look at the next page.

A (Witness reviews document.)

Q Do you see on the next page where it says [redacted]

[redacted]

A Uh-huh, I do.

Q Do you see where it says -- it has an order

number, and it says -- it does say, [redacted]

A I see that.

Q And it says up here "Active Orders", and it gives a date range of June 1st, 2020 to June 30th, 2020; right?

A I see that.

Q David died on June 13th, 2020; right?

A Yes.

Q And this is a document that was produced to us, clearly, it's Bates stamped. Why was this --

A This was printed on 6-15, 2020.

Q Okay. And why was this not part of the -- why was this second page not part of the IPP that we -- the version of the IPP we have been talking about today?

A Because the section that was looked at that is under, is under the Annual Pharmacy Report.

Q Okay. Well, then, why is this second page not made part of the Physician's Order section of the IPP, then?

A Well, it's in -- I mean, it's in here. And this is dated 2020, where the IPP here is dated 2019.

Q Well, I don't have it with me, but I will

represent to you that you also produced an identical document to this with a 2019 date. So, hypothetically, assuming I'm not lying to you here, why the different versions of documents?

MR. ROSEN: Objection. Because if we are going to talk about a hypothetical 2019 report, let's see the report so that she can testify. Because you are talking about a 2020 report that's not part of the 2019 IPP. So, if you're -- I don't know that there is one, so give it to her and she can comment on it.

BY MR. GILLISPIE:

Q Go ahead, Ms. Berry.

MR. ROSEN: There is no -- you know, if you're -- she is not talking about a hypothetical based upon your representation. Let's see the document, because I don't know what you are talking about. Show it to her. Can you show it to her?

MR. GILLISPIE: There is a question on the table. Unless you're instructing her not to answer, she can answer it.

MR. ROSEN: It's argumentative. She can't answer a question assuming something.

So, what is the question? Tell me what the question is so I can be clear --

MR. GILLISPIE: That is not a deposition objection.

MR. ROSEN: Yes, it is.

MR. GILLISPIE: You can either object to the form --

MR. ROSEN: No. I can object --

MR. GILLISPIE: -- or you can tell her not to answer for privilege. Which is it?

MR. ROSEN: No. You tell me what your question is. What is your question so that we can be clear as to whether it's something that she -- that's in the document in front of her or you are asking her to speculate.

MR. GILLISPIE: I'm not going to --

MR. ROSEN: So, tell me.

MR. GILLISPIE: I'm not going to sit here and clown around with you, Rich.

MR. ROSEN: I want to know, otherwise she can't answer a question that we don't know what the question is. So, tell me the question again. What are you asking her?

BY MR. GILLISPIE:

Q Ms. Berry -- I will wait for your answer, Ms.

Berry.

MR. ROSEN: No. There is no question pending until you ask her one. So, ask her the question so that I can make an objection or allow her to answer. But if you are asking her to speculate about a different document without showing her the document, that's not going to happen.

BY MR. GILLISPIE:

Q What are you looking for right now, Ms. Berry?

A I'm looking for the -- through his IPP about [redacted] That's what I'm looking at.

Q Okay. I will let you look through that, and then I will -- you let me know when you are done.

A I can be done.

Q Okay. My question is, do you have any knowledge as to why this second page of the Physician's Order is not in the IPP we have been talking about?

A Because that order is in the IPP. It is under the Annual Medical Review, Staffing Reports.

Q And what page is that?

A It starts on 1501. It talks about everything that is supposed to go on medically with David.

Q Show me where -- point to the [redacted]

A "Treatments By Living Area Staff".

MR. ROSEN: What page?

THE WITNESS: It's page 1501. That's treatments, there is medication, there is SAMS training, they list the different changes since the last year.

BY MR. GILLISPIE:

Q Under number six, [redacted]

[redacted]

A Yes.

[redacted]

MR. GILLISPIE: That's all I have, Ms. Berry. Thank you.

MR. ROSEN: I have a few followup

questions.

REDIRECT EXAMINATION

BY MR. ROSEN:

Q Particularly on that, on 1497, what does it say -- because counsel asked you something slightly different and you referred to 1497.

[redacted]

Q Okay. It doesn't say anything about upright, does it?

A No.

Q Okay. Now, I want to talk to you about -- the Behavior Reports that were provided that were introduced here, they were from 2019 or 2020. Do you know whether those were all the reports from 2019 and 2020 or just certain reports from 2019 and 2020?

A Some from 2018, 2019 -- from 2019, 2020.

Q Were they all the reports that there were for behavior or were they only certain ones, do you know?

A Those were the aggressive behaviors.

Q All right. Now, were those -- tell me how a Behavior Report is filled out and when.

A After -- if you look at the front of the

Behavior Report, there are different categories to fall under. It talks about like what is going on in the environment, like -- I can show you one.

Q Well, let's show you the -- an actual Behavior Report. Okay. I'm showing you what is marked as Exhibit 8A.

A Okay.

Q What is the date of that report?

A This one is December 26, 2019.

Q Okay. Tell me what you are talking about.

A So, the point of the Behavior Report is, we want to know what happened immediately before the problem occurred. So, what was going on, were they -- was there a change in their routine, was the environment loud, was somebody's personal space invaded. There is a whole list of different things that could have possibly gone on before the behavior. And then, was there aggression involved. Because sometimes there is not aggression, sometimes there is not, you know, physical aggression or verbal aggression. Sometimes they may have -- maybe they are not sleeping or they are falling asleep in class. We document that. Or if they are not eating, we document that in the Behavior Report. If they are in somebody else's bedroom, we will do a report.

Q Okay. So, there are also some other issues plus aggression?
A Correct.
Q All right. I understand. So, there is a host of reasons why a Behavior Report might be filed?
A Yes.
Q All right. So, these are filled out by whom?
A By any BHDC staff that witnessed said behavior.
Q And so -- and is it done at or near the time of the incident?
A Yes.
Q Is there a time requirement that they are supposed to submit one?
A Usually by the end of shift.
Q So, these reports that were -- and you got these reports and you provided -- you are the go-to person for the documents --
A Yes.
Q -- for David Cains; isn't that right?
A Yes.
Q Okay. And so, when you went to the documents and produced them pursuant to a discovery request, were they in David Cains' file?
A Yes.
Q And those are medical records, are they not?

A Well, we call them our master file records, yes.
Q Okay. So, are the master file records, which included these Behavior Reports, kept in the regular course of providing services for David in the business of the HDC?
A Yes.
Q And so, were these recorded at or near the time of the incidents indicated?
A Yes.
Q Okay. And so, those are the records that you pulled out of the file; correct?
A Correct.
Q So, those are his records?
A His records.
Q Now, let's talk about -- switch a little subject, okay, and just talk about the -- yes, give me back the exhibits.
A (Witness complies.)
Q Thank you. Now, counsel asked you about Office of Long Term Care investigations. One of the documents introduced was the -- let's look at it.
A The 2567?
Q The 2567, it's Exhibit Number 13. Okay. And that's done by, you mentioned, a person named Diane?
A Yes.

Q Okay. And is that the Office of Long Term Care surveyor?
A Yes.
Q And what is the form at the top, what is it called?
A What is the form called?
Q What is it called, at the top?
A It is Department of Health and Human Services, Centers for Medicaid and Medicare Services.
Q Who is that?
A That is the federal government.
Q So this is a federal government form?
A It is.
Q And it's Form CMS 2567; correct?
A Yes.
Q Okay. And this is filled out by the surveyors. And what was the surveyor doing when they survey or inspect?
A They are checking to see that we are following all the rules and regulations set forth.
Q So, the survey is to look at the facility practices?
A Correct.
Q And whether the facility practices conform with the CMS standards and DHS standards?

A Correct.
Q Well, state standards?
A Yes.
Q Okay. Is that different from a maltreatment investigation by OLTC?
A Yes.
Q Do you know?
A No.
Q Okay. Well, then, what is a maltreatment investigation investigating, do you know?
A My experience with it --
Q Yes.
A -- is when we submit the report to Office of Long Term Care, they have their own investigators that reach out to obtain different information.
Q Do you know whether those are different from the surveyors?
A Different from the surveyors.
Q So, are there two different investigations by Long Term Care?
A Yes.
Q Do you know that for a fact?
A Yes. Because the other ones determine if the person actually needs to be put on the Maltreatment Registry or not.

Q So, one is a maltreatment investigation, one is a deficiency or standards investigation?
A Correct.
Q What is this Exhibit 13?
A Deficiencies.
Q So, that is whether the facility, meaning the Booneville Human Development Center, met all the applicable standards?
A Correct.
Q And the maltreatment investigation is what?
A Is where they go and they review our investigation and determine if they go along with our investigation or they overturn our investigation.
Q Okay. And your investigation, the internal -- the maltreatment investigation of it is of the individuals involved?
A Correct.
Q And in this instance, do you know what the outcome was?
A No negligence was found.
Q And so, just to make sure -- strike that question.
Do you know what Jeff Gonyea knows?
A No.
Q So, when counsel asked you, "Do you know what

Jeff Gonyea, what he doesn't know or what you know different from him," do you know the answer to that question?

A I don't know the answer.

Q Have you reviewed David Cains' files and produced the documents?

A I have.

Q To your knowledge, did Jeff Gonyea produce the documents in response to counsel's Request for Production of Documents and Interrogatories?

A No.

MR. ROSEN: I think that's all I have. Thank you.

MR. GILLISPIE: No. Thank you.

MR. ROSEN: We will read. Thank you.

(WHEREUPON, at 3:15 p.m., the taking of the above-entitled deposition was concluded.)

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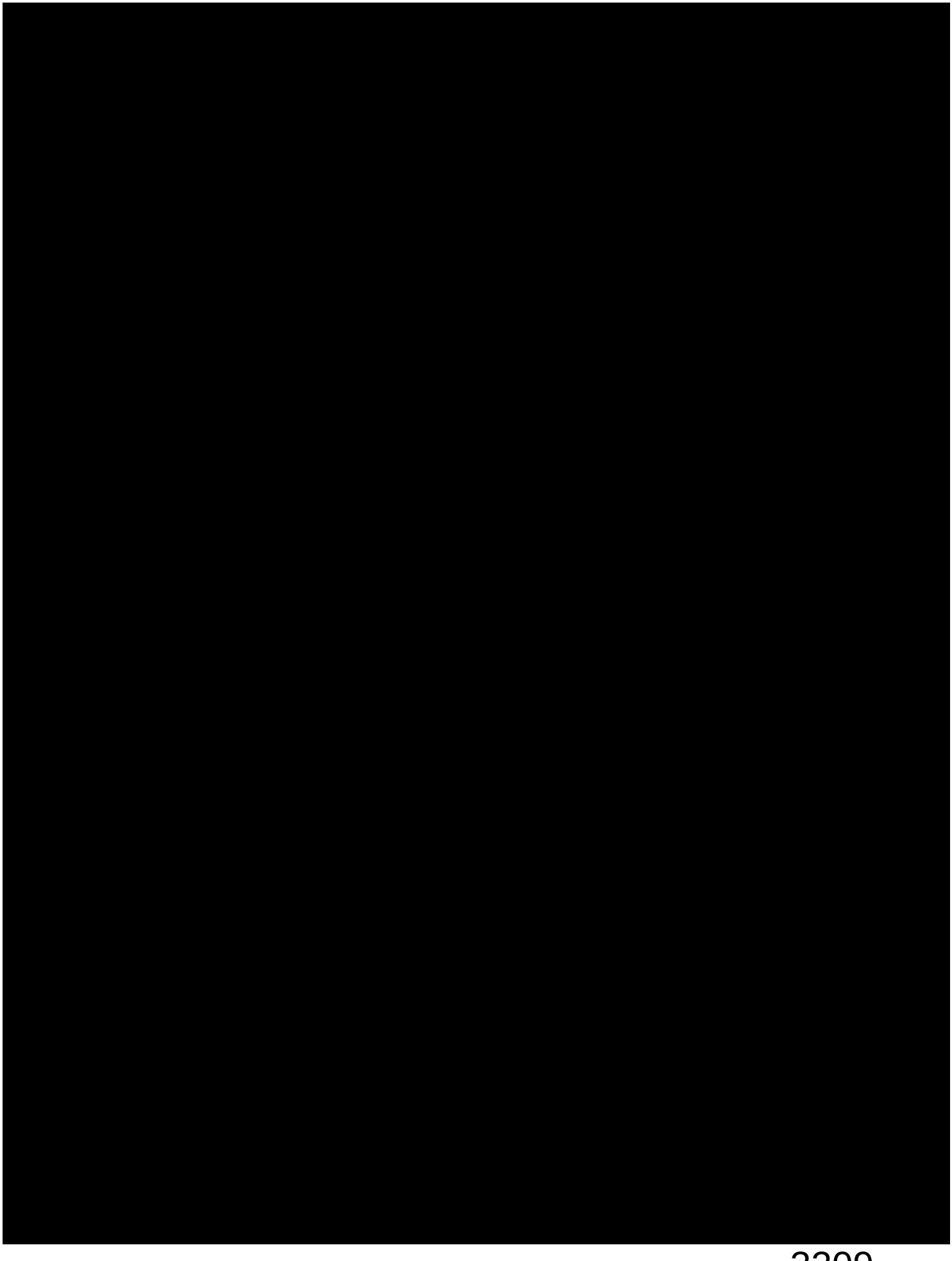
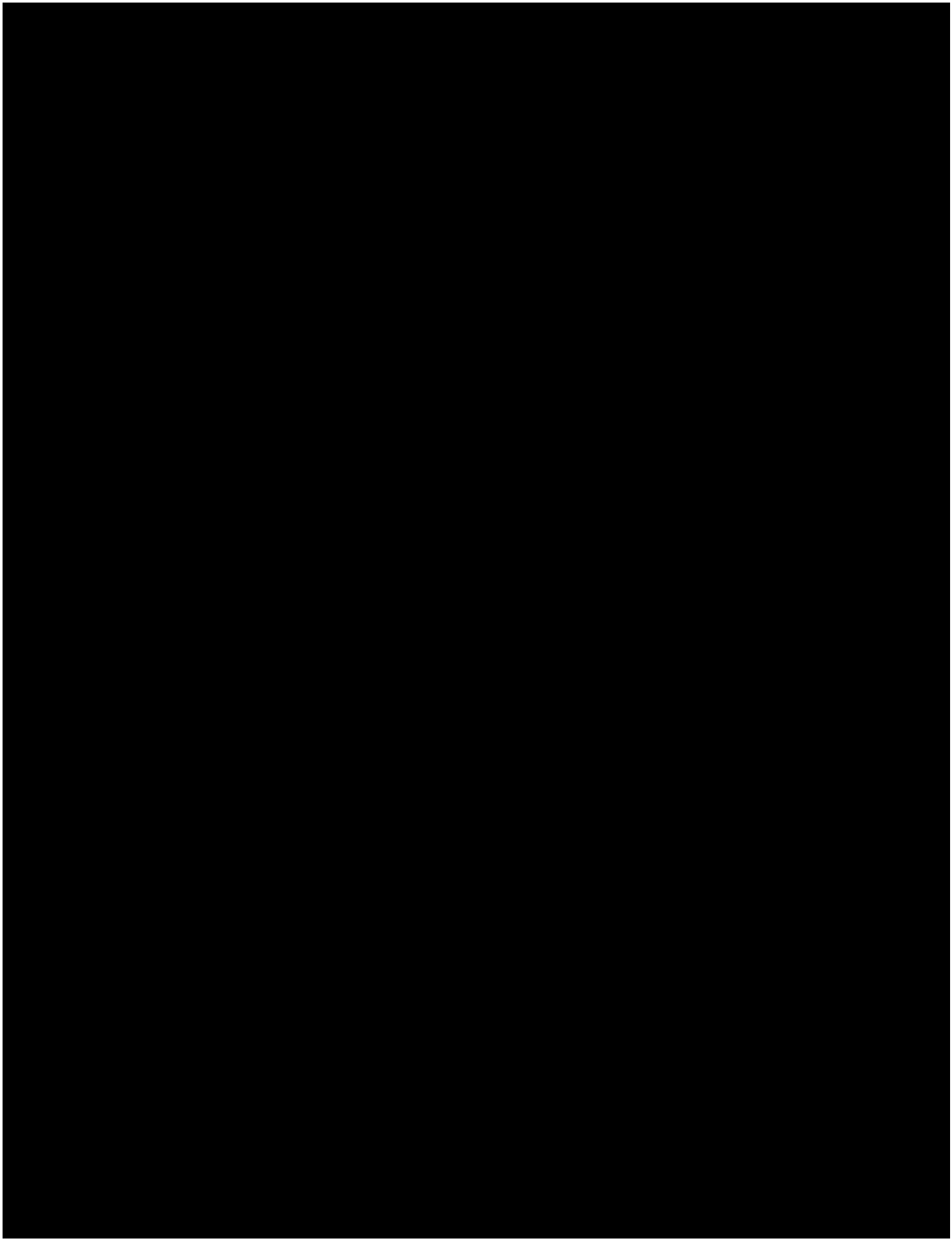
DHS EXHIBIT ONE.

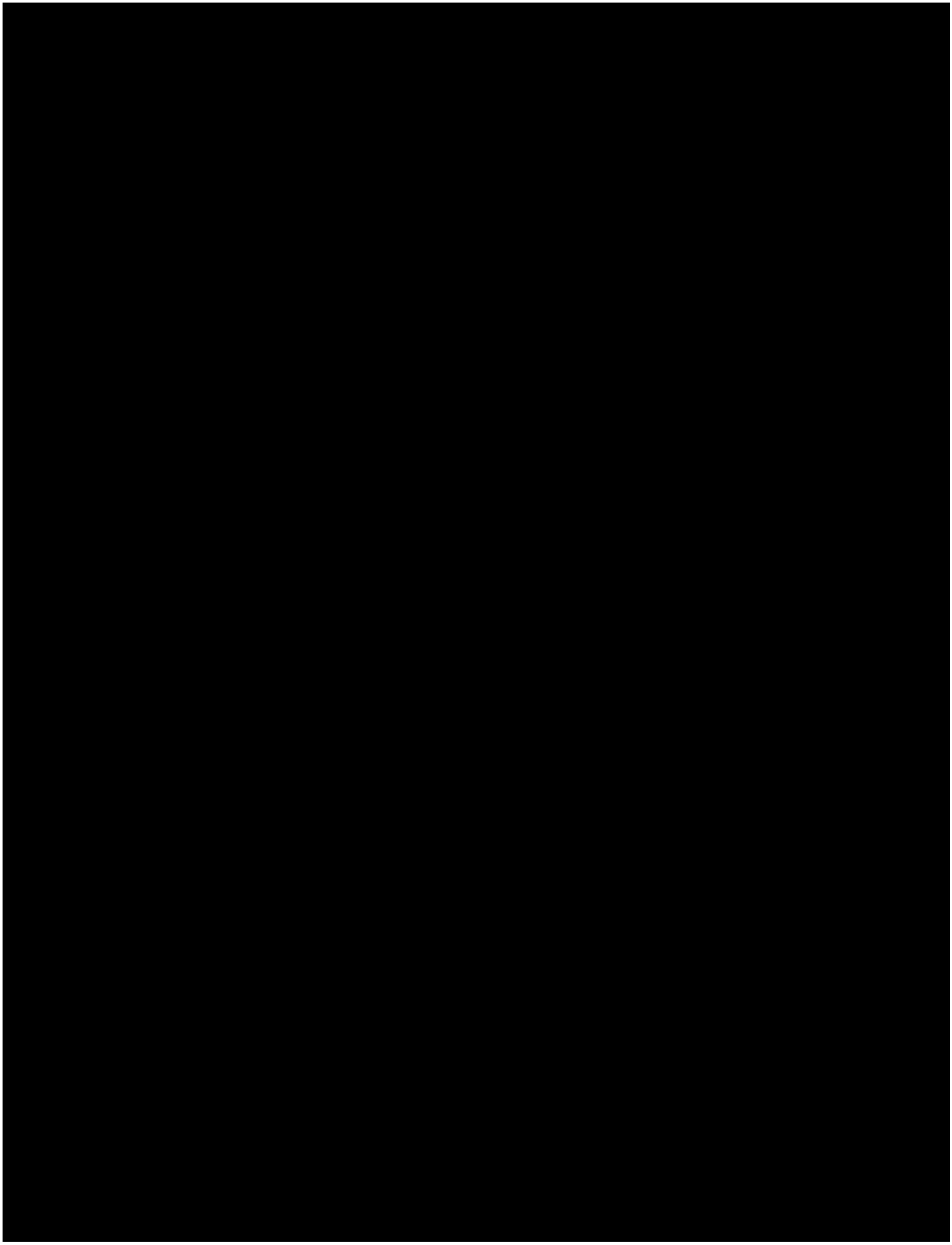
Arkansas
State Claims Commission
FEB 16 2023
RECEIVED

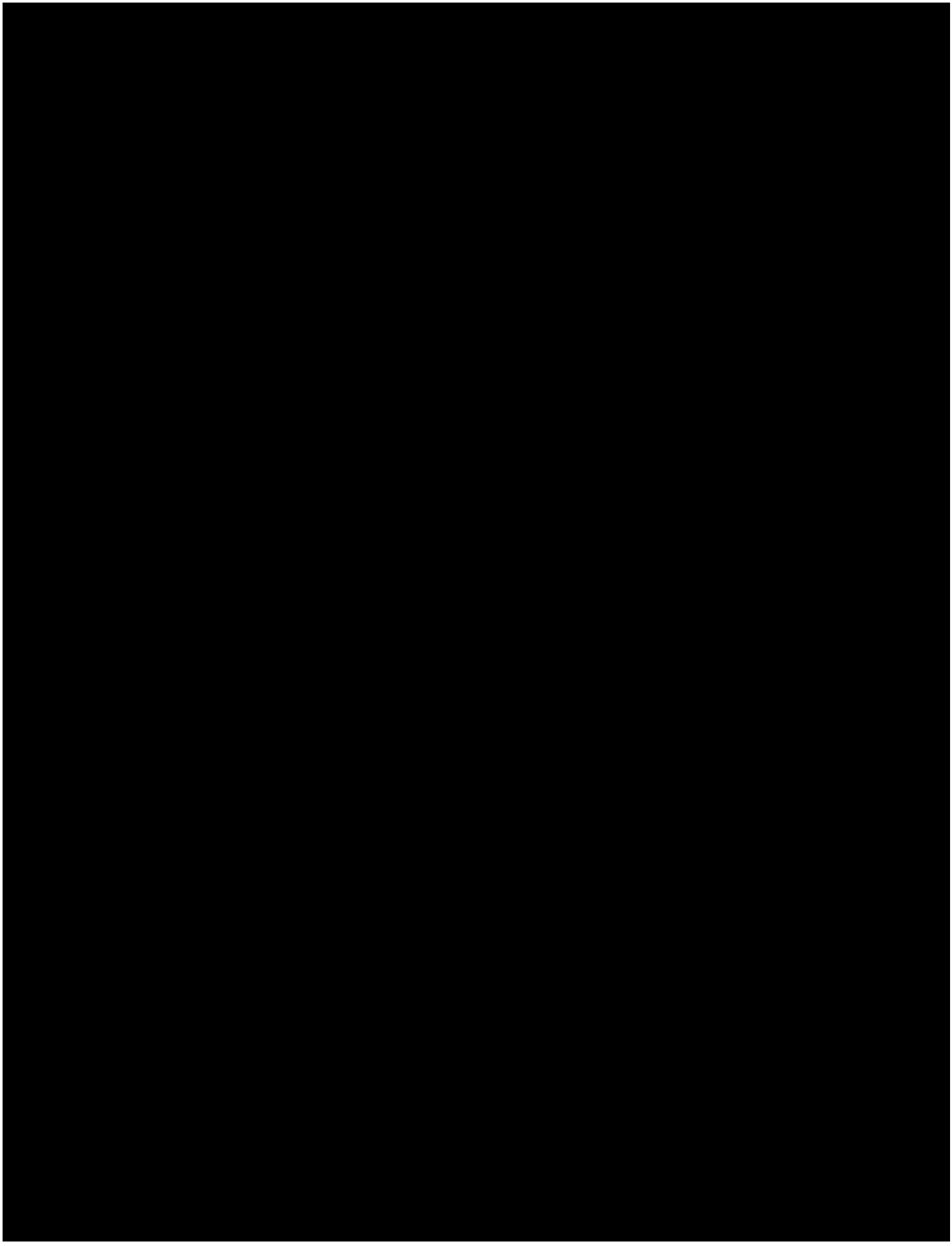
DHS EXHIBIT TWO.

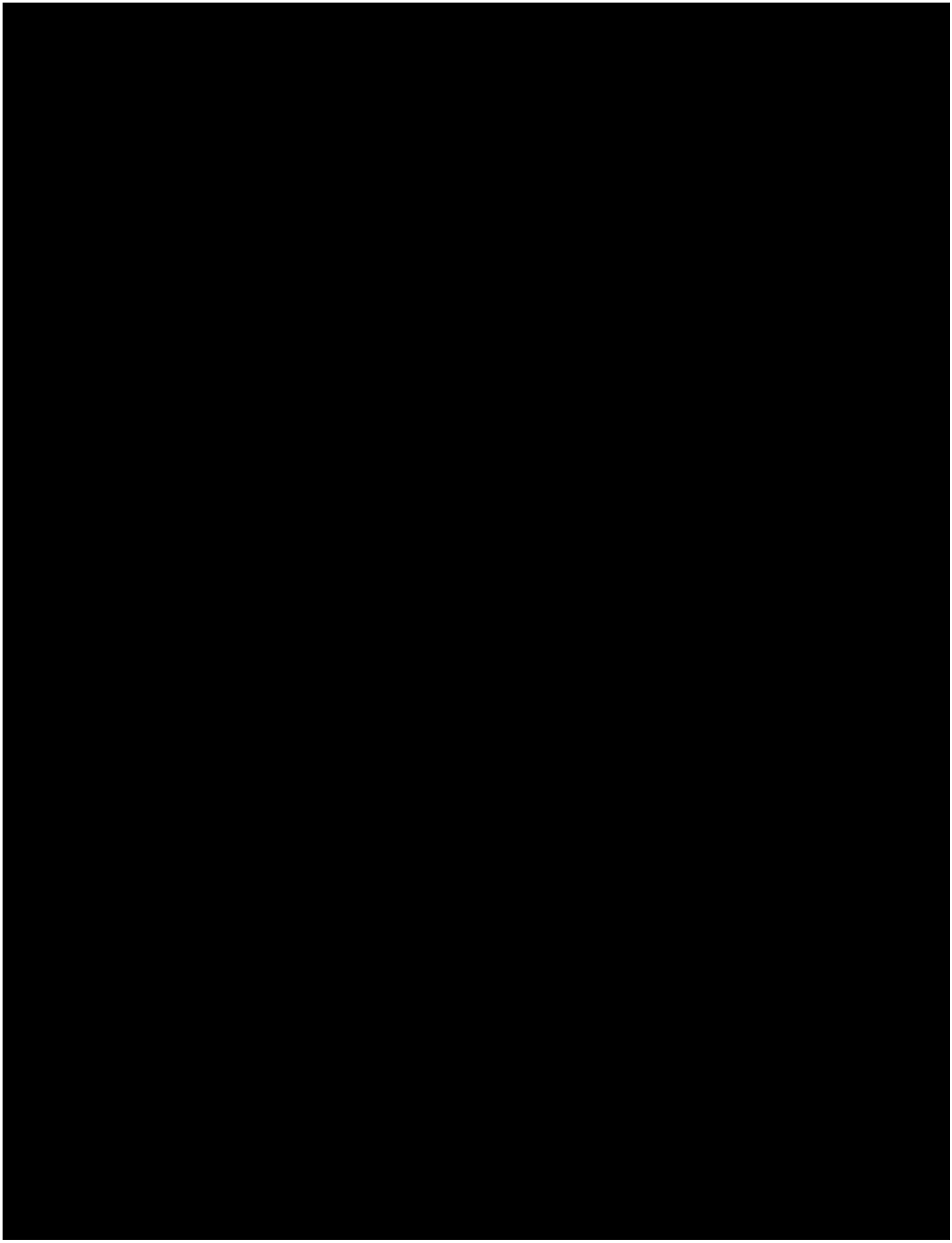
DHS EXHIBIT THREE.

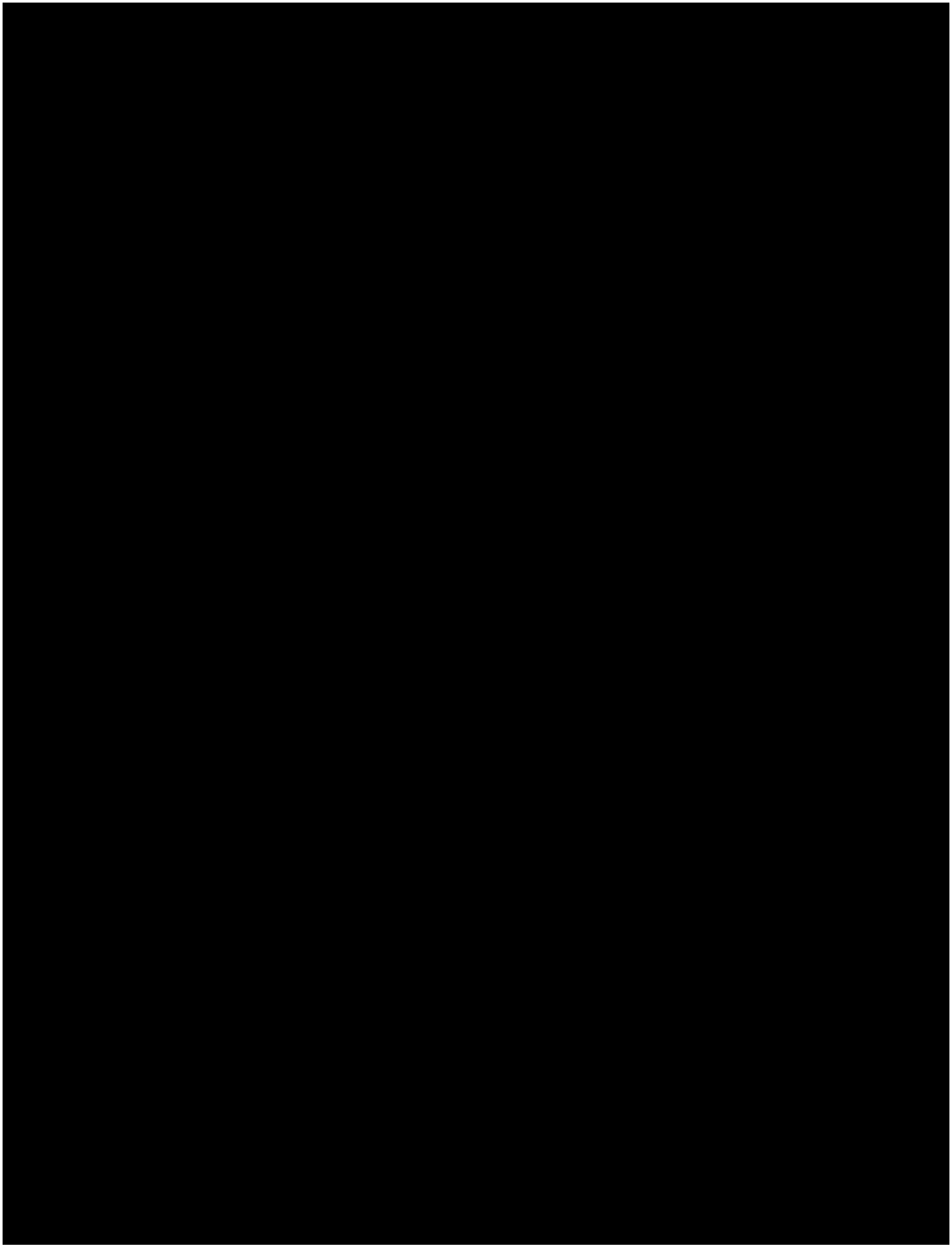


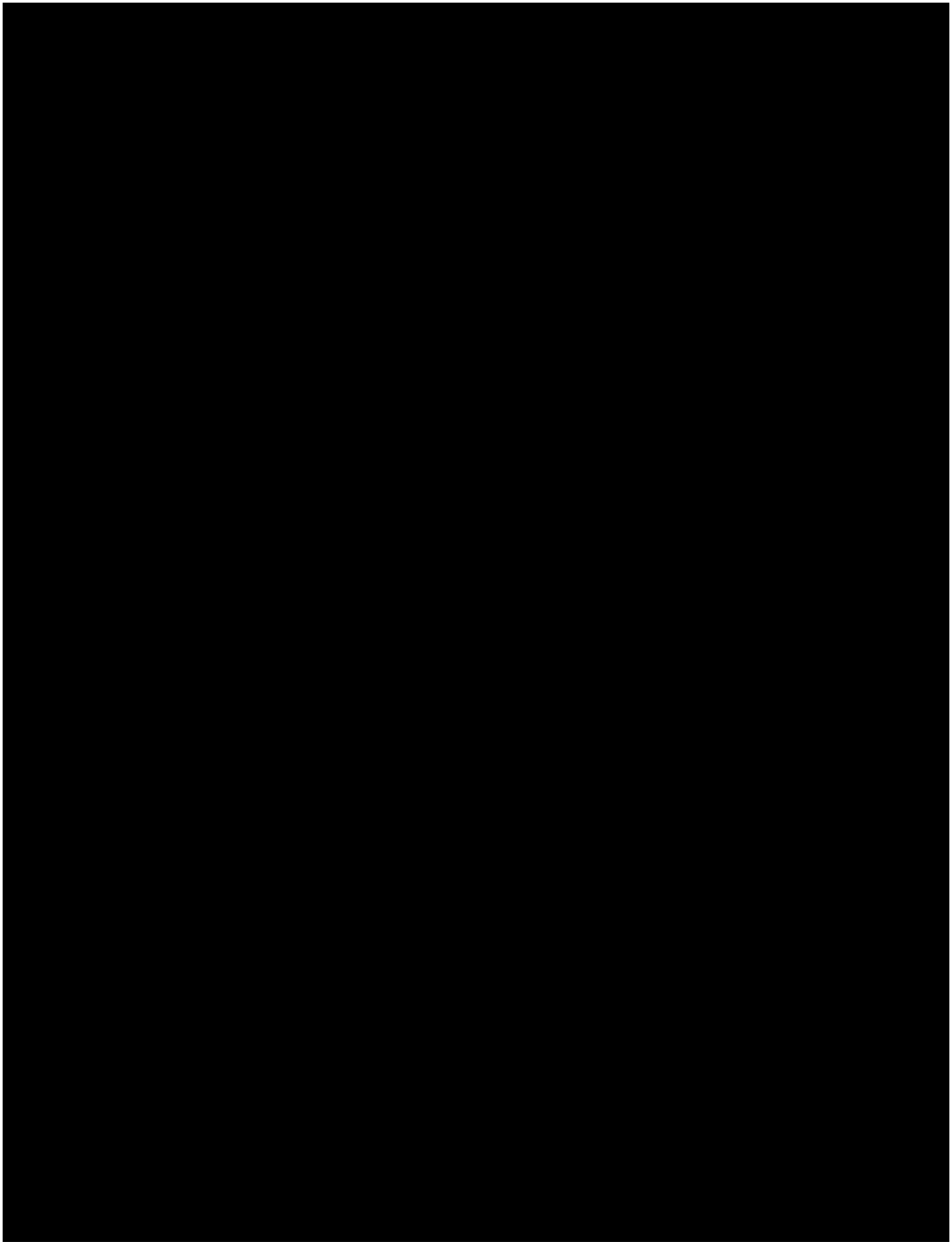


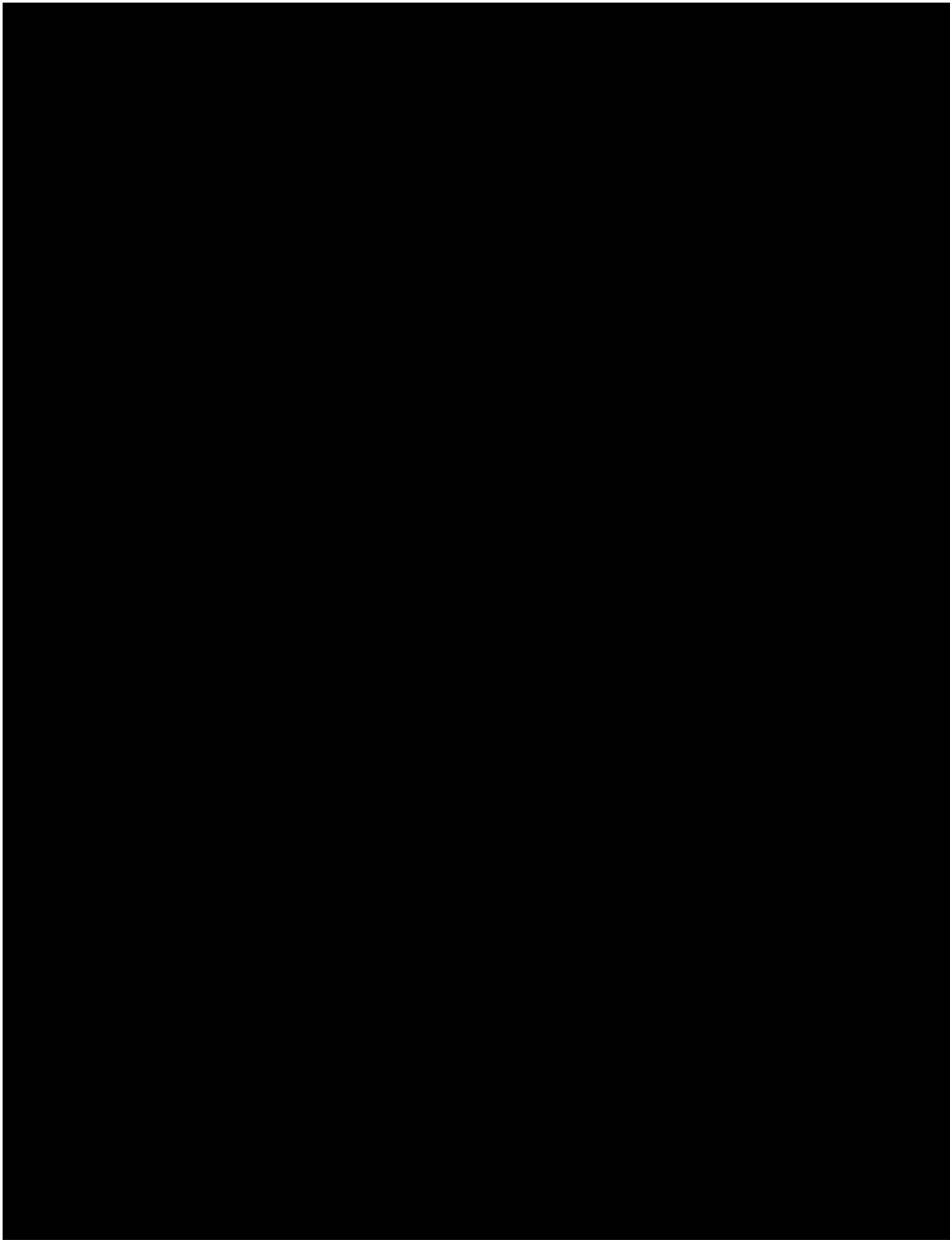


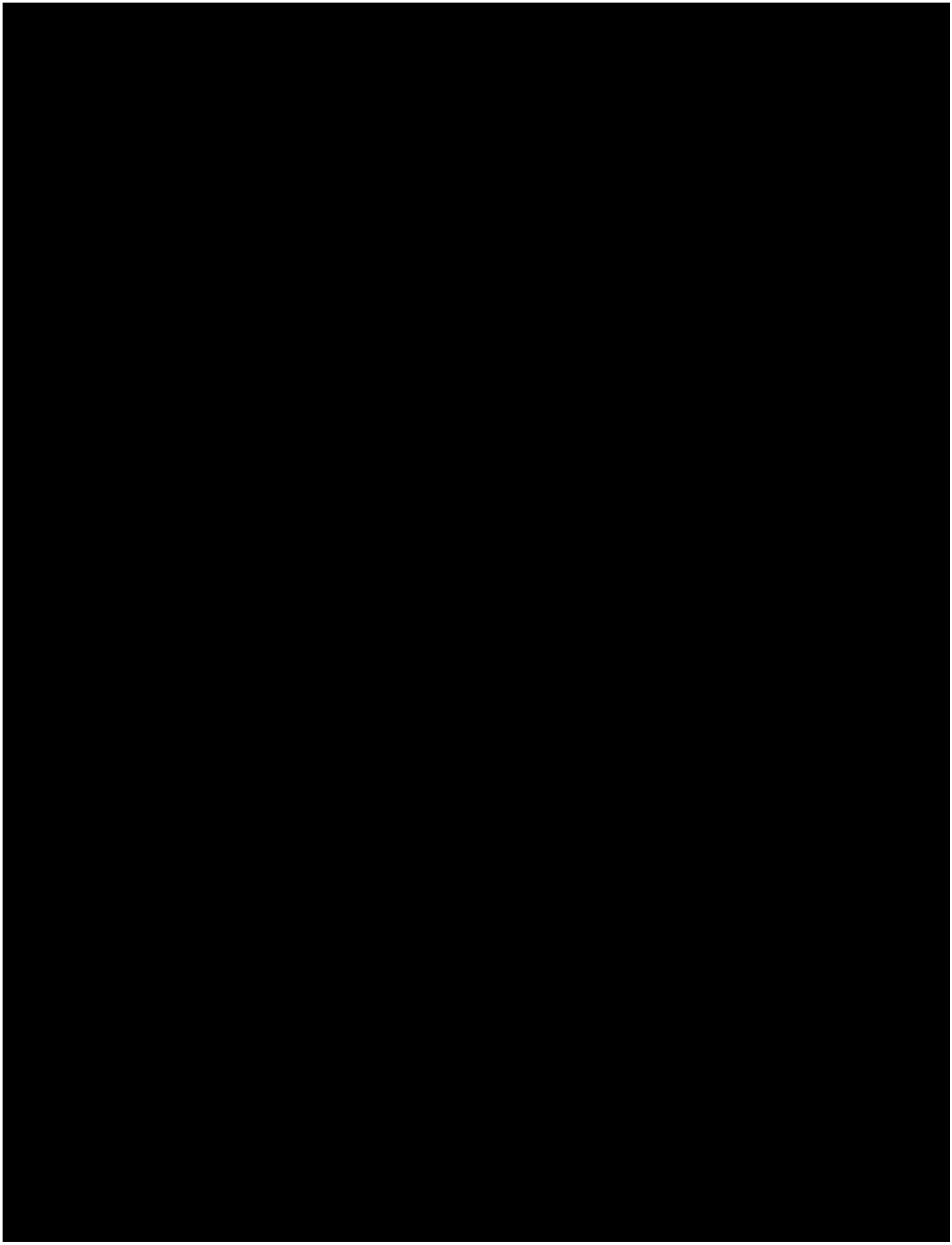


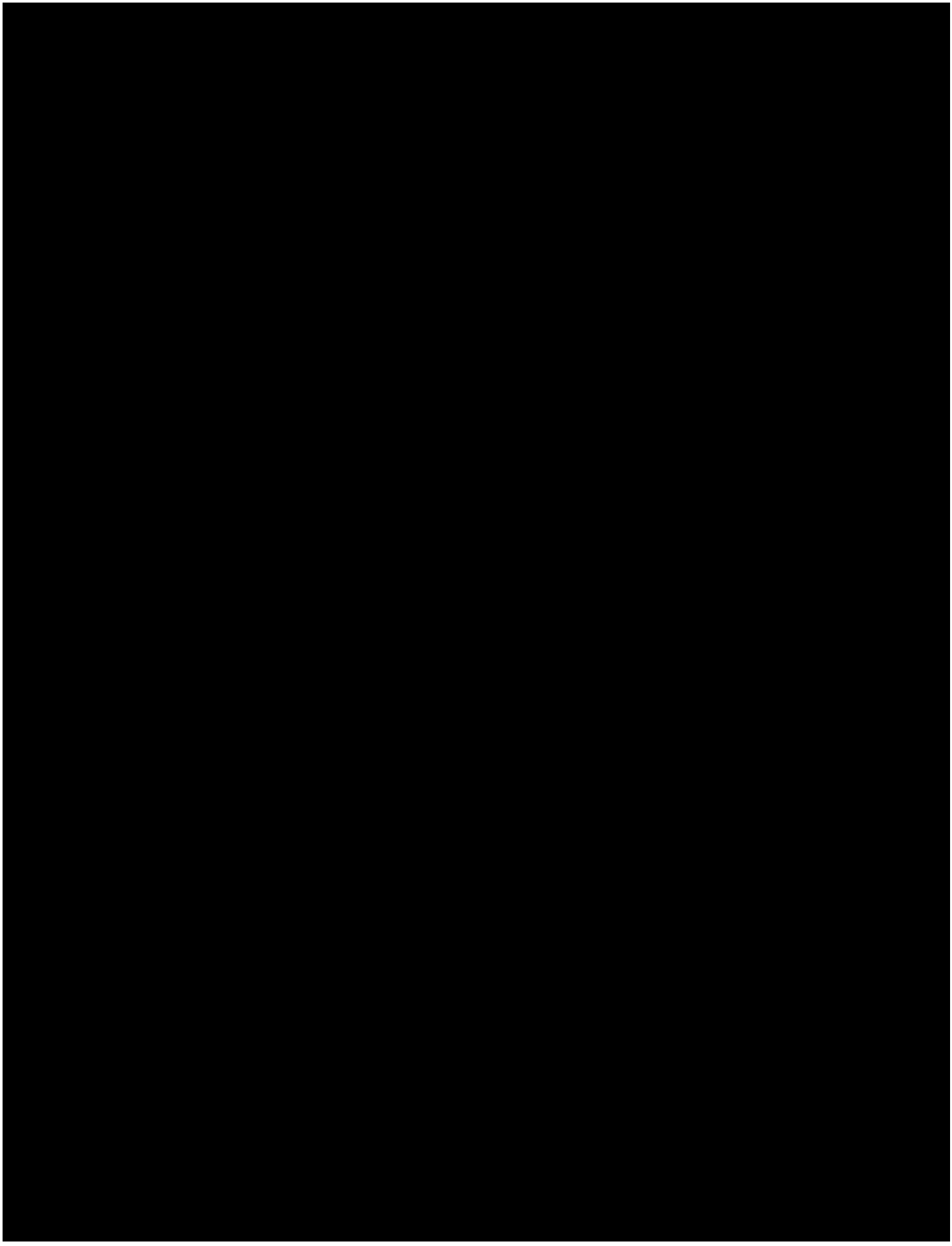


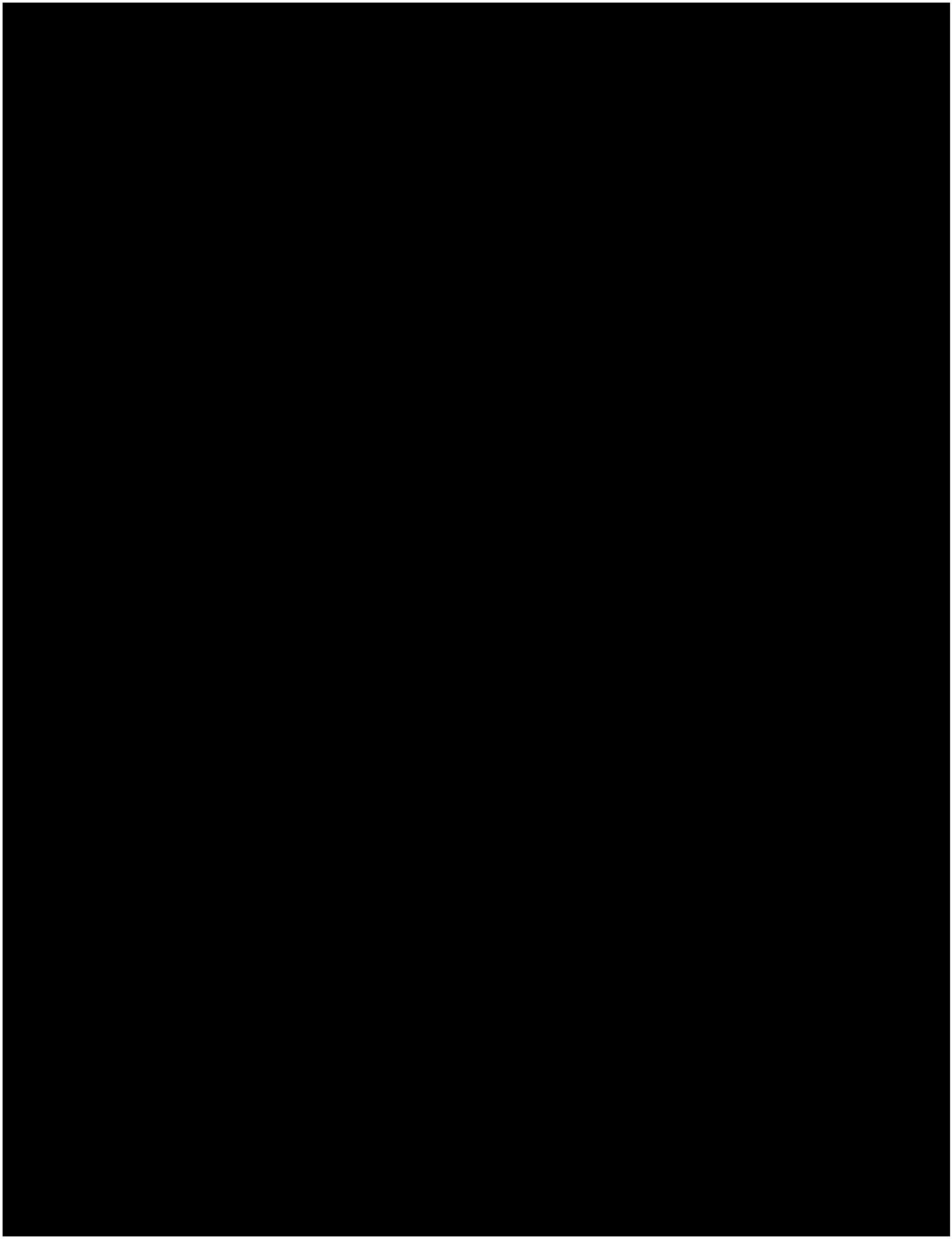


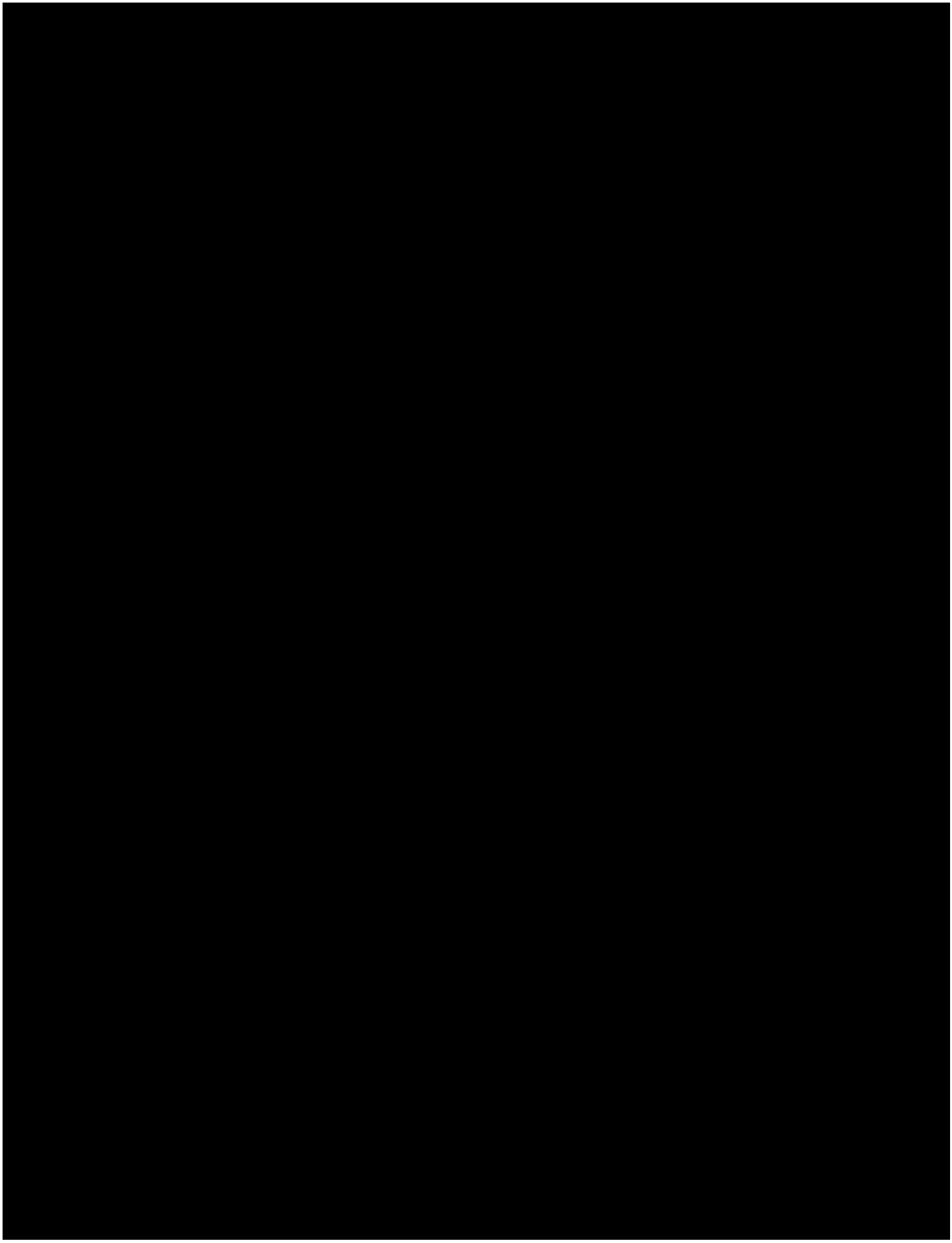


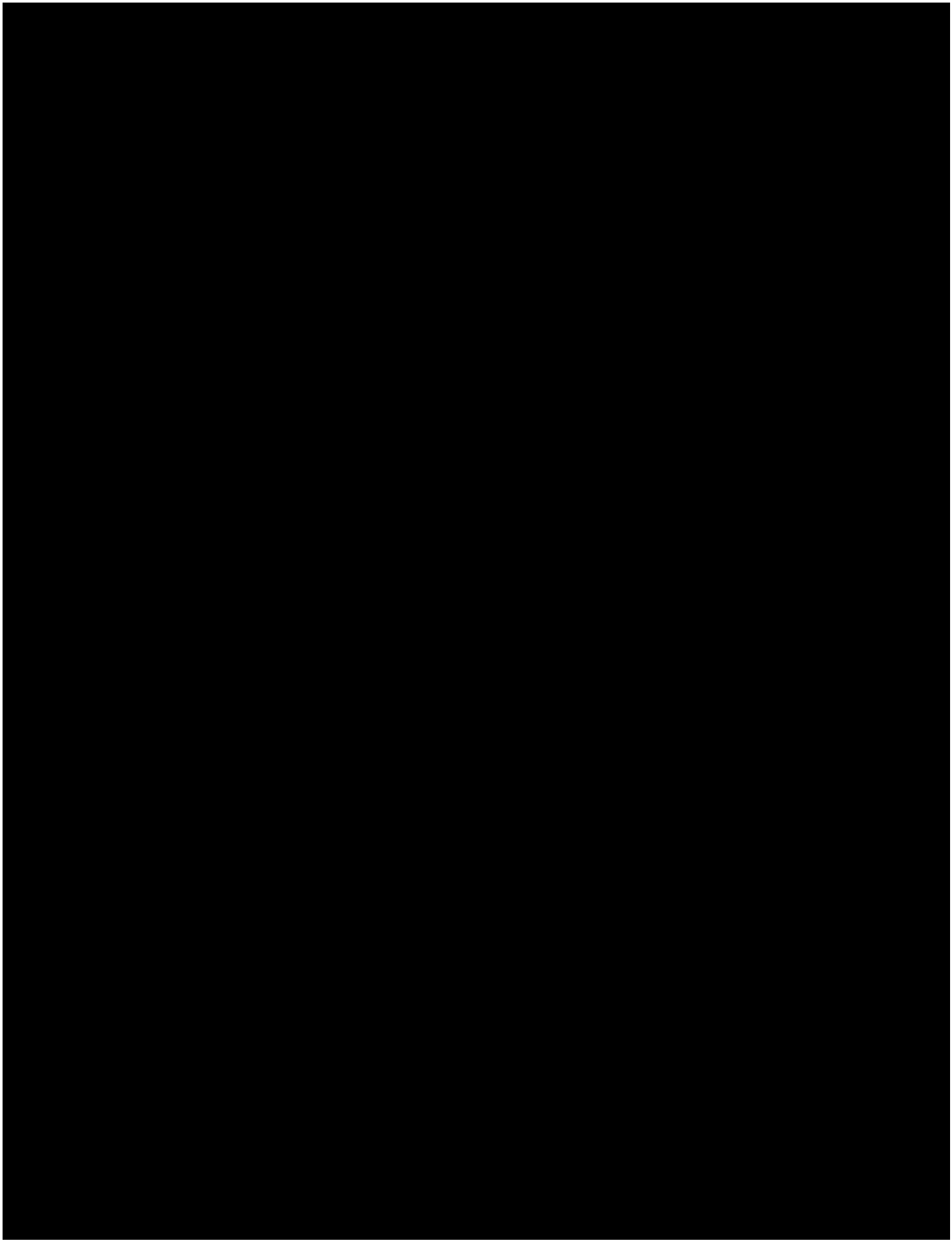


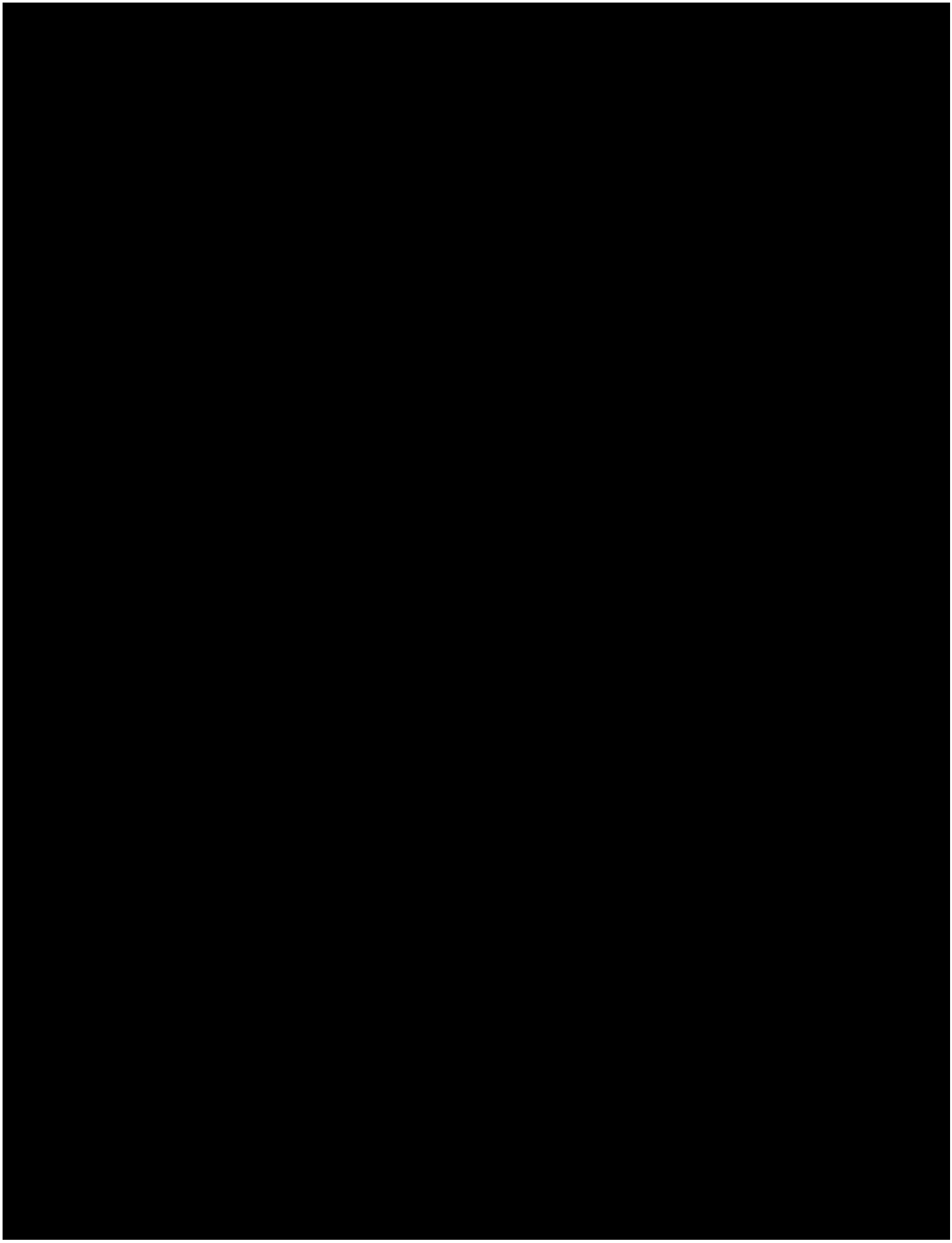


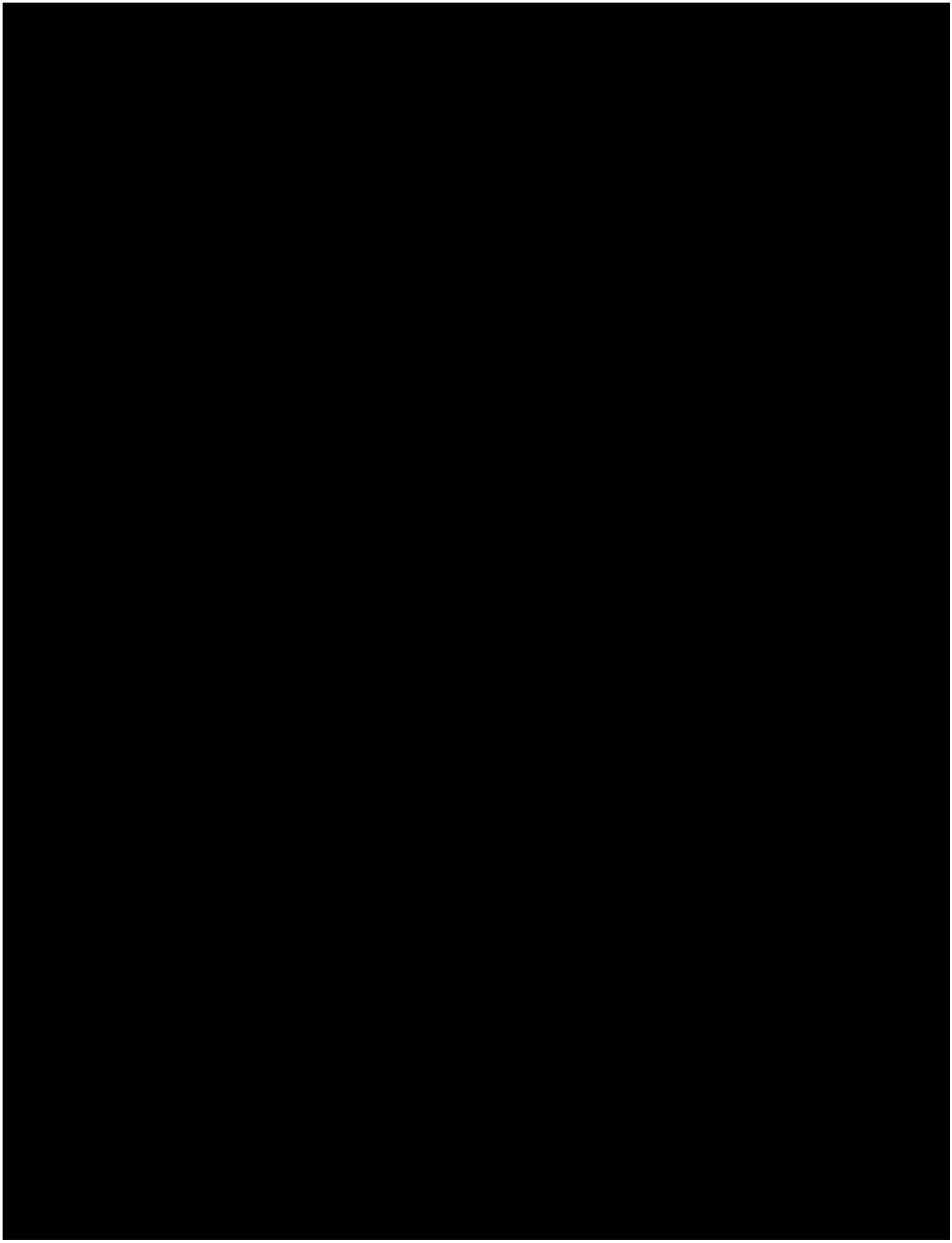


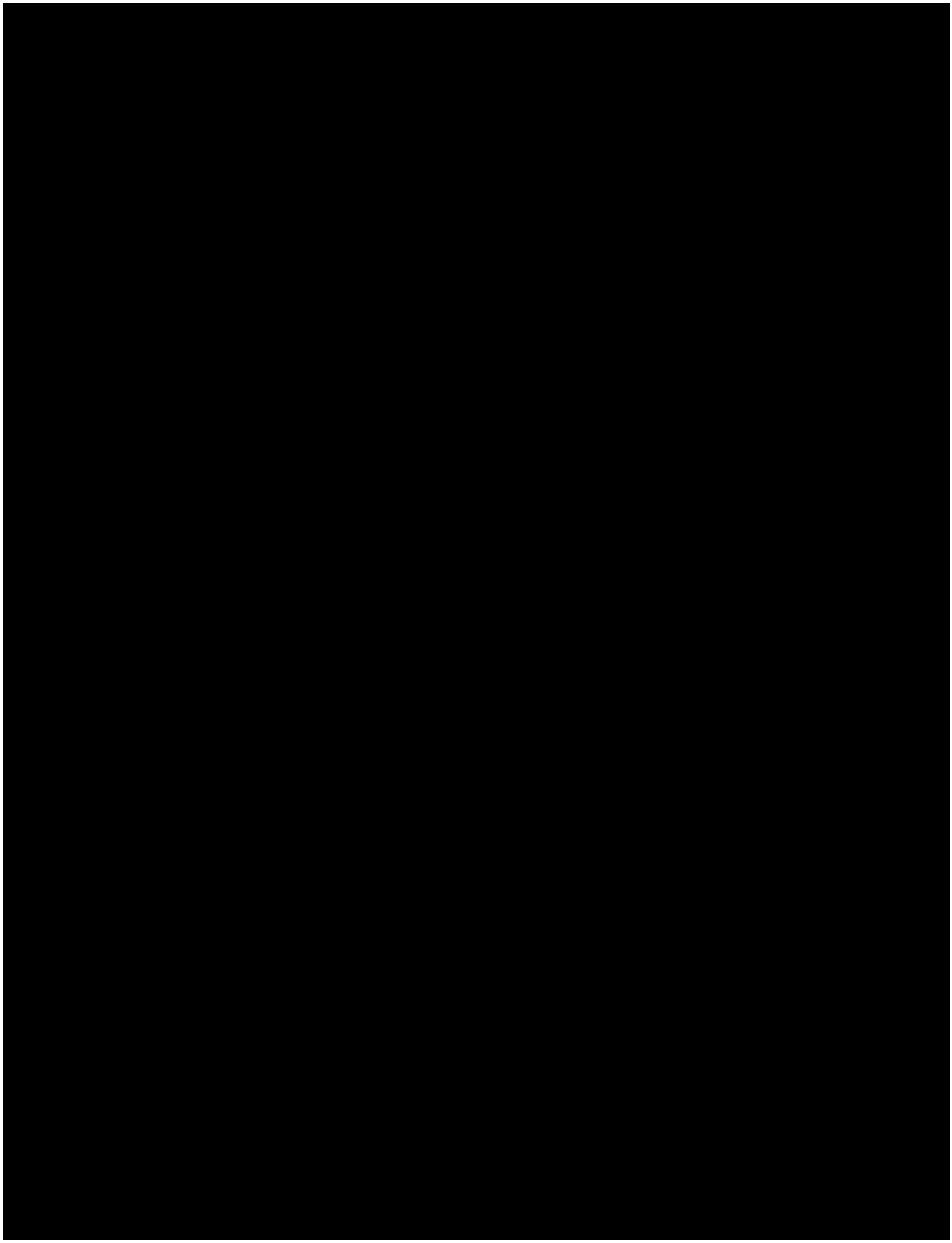


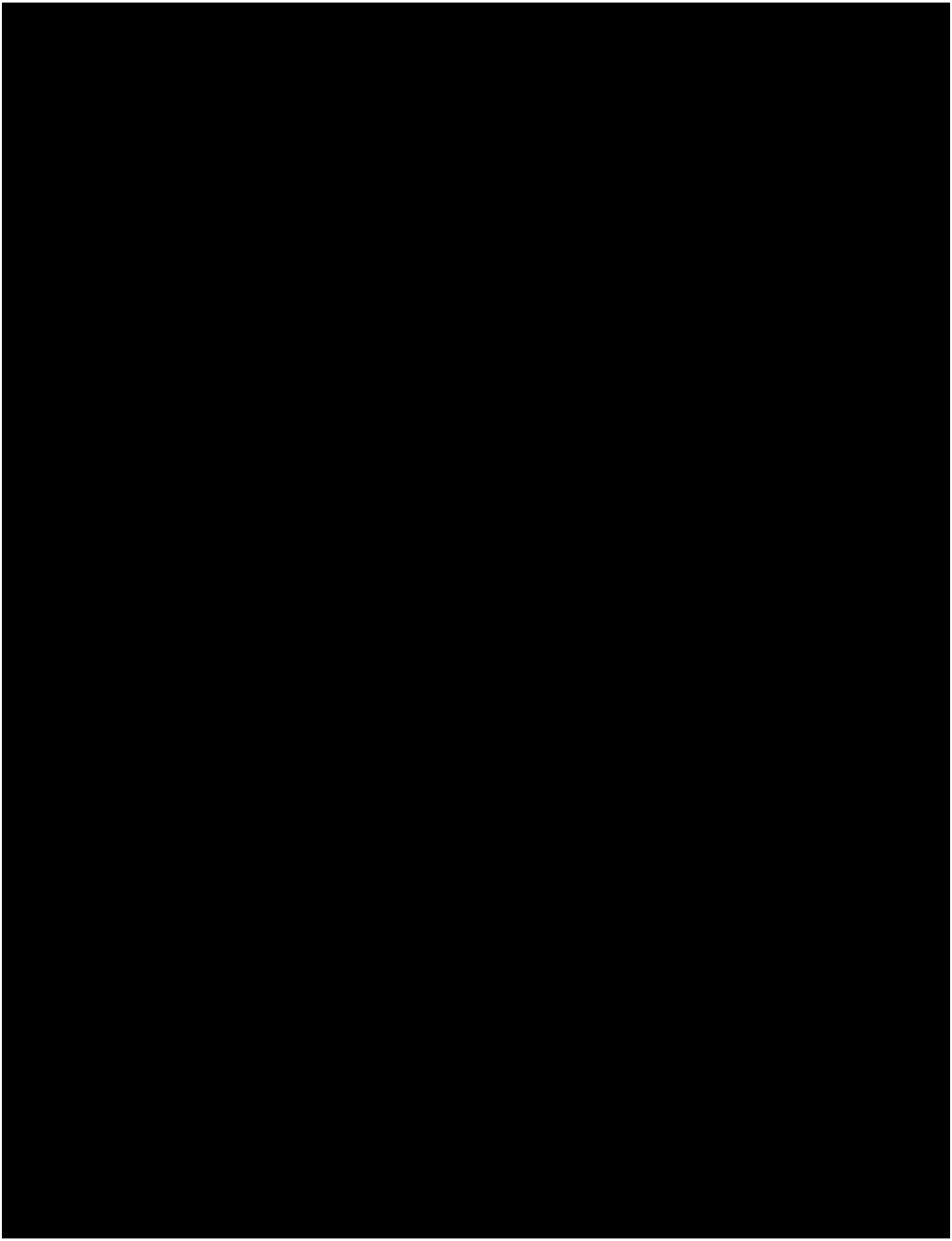


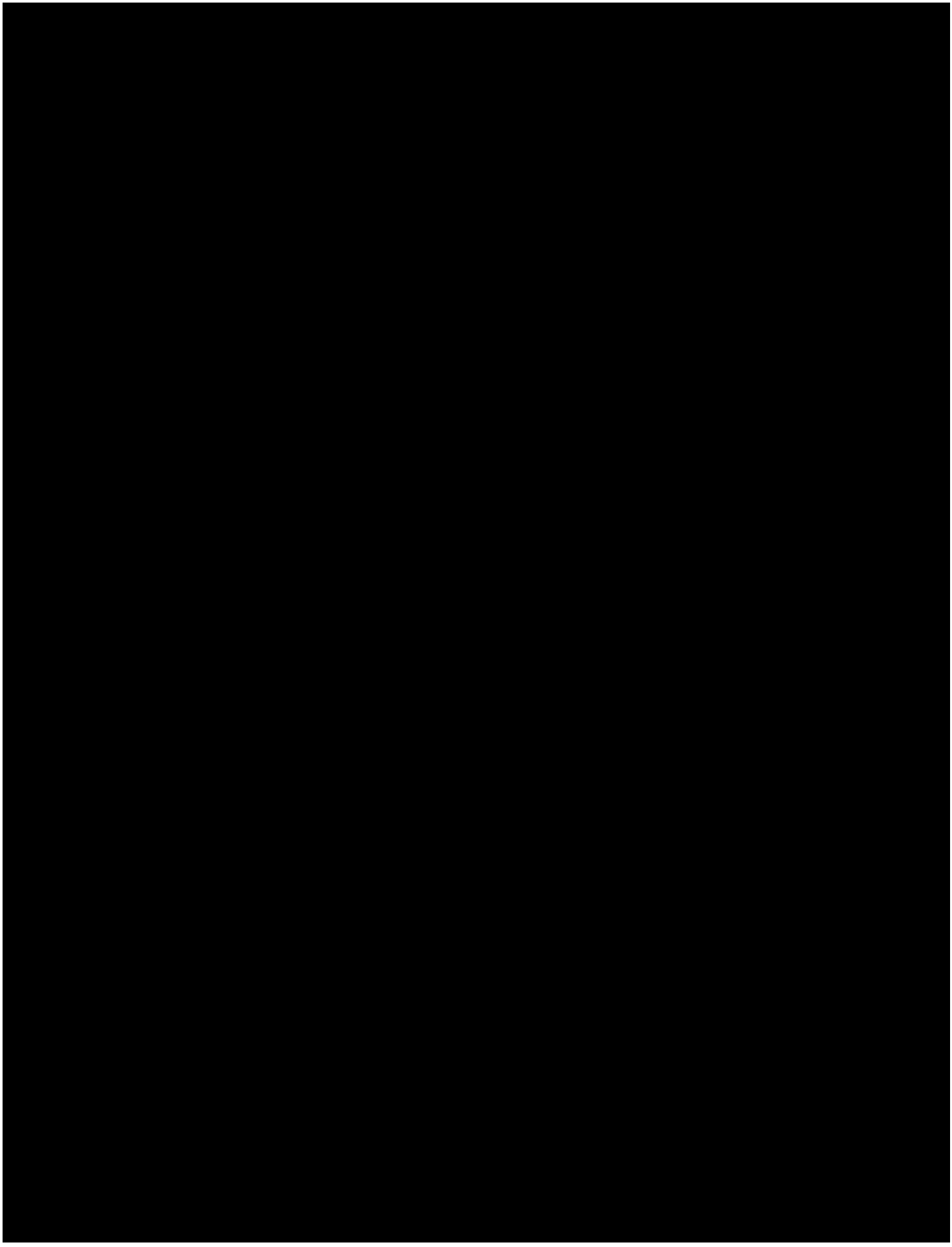


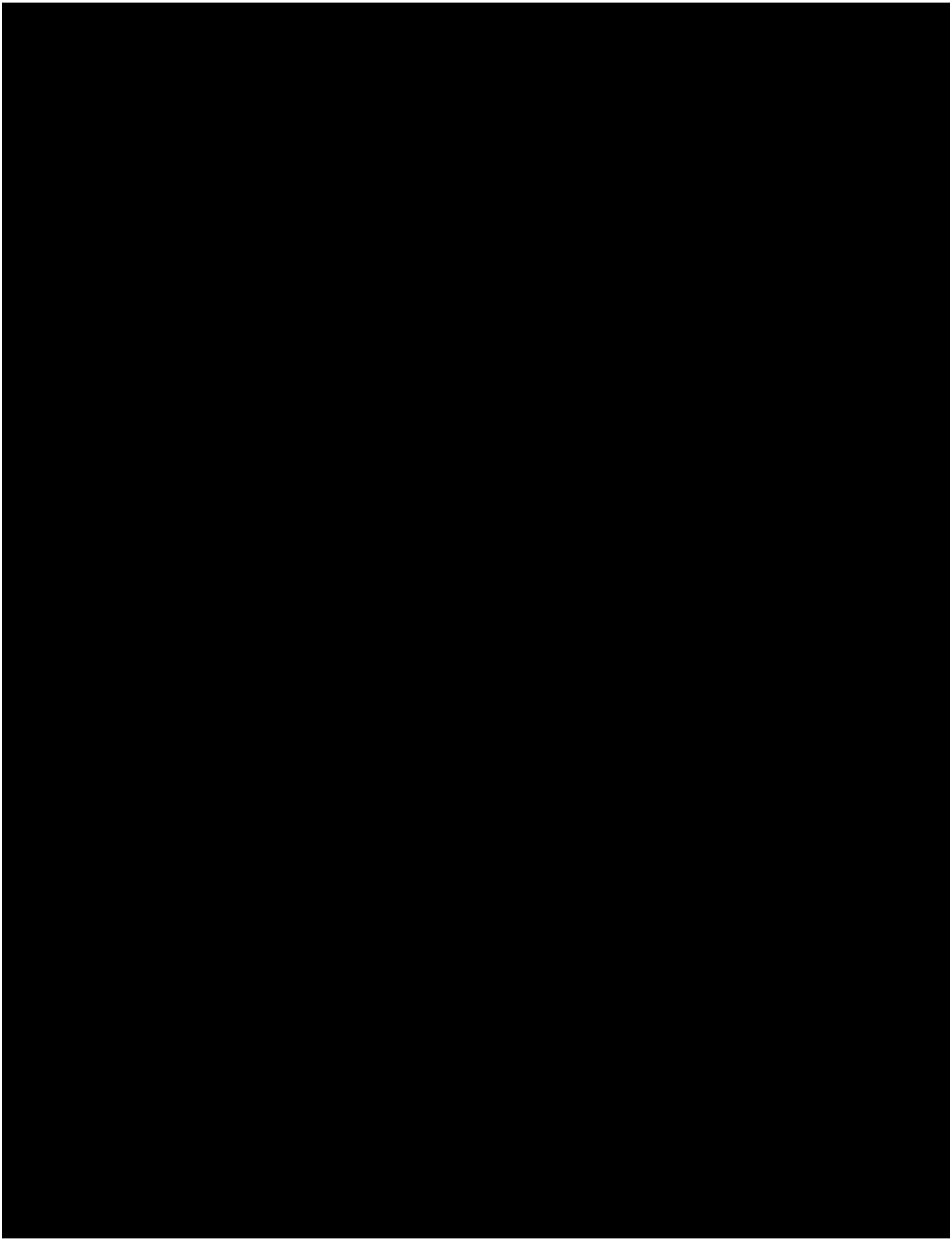


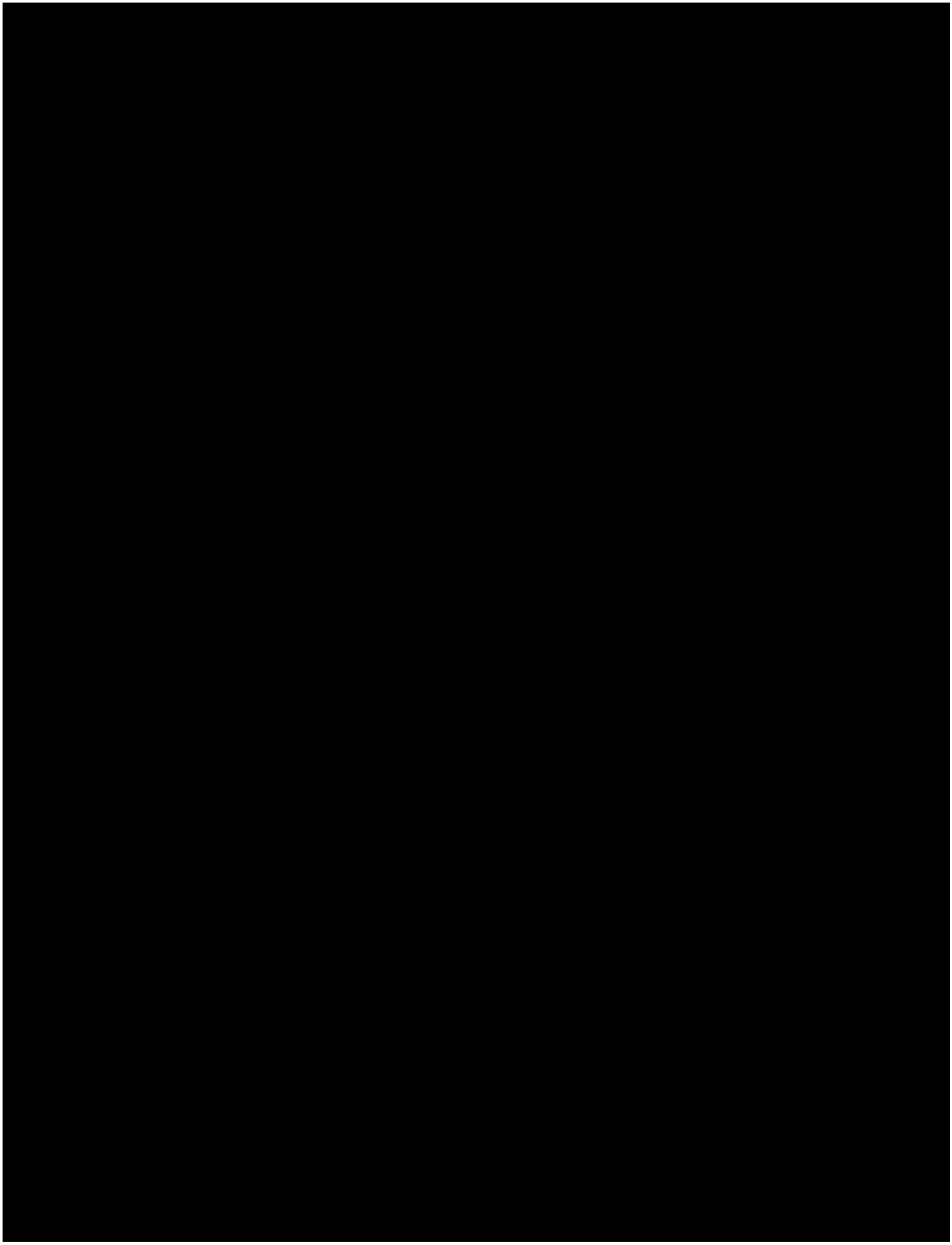


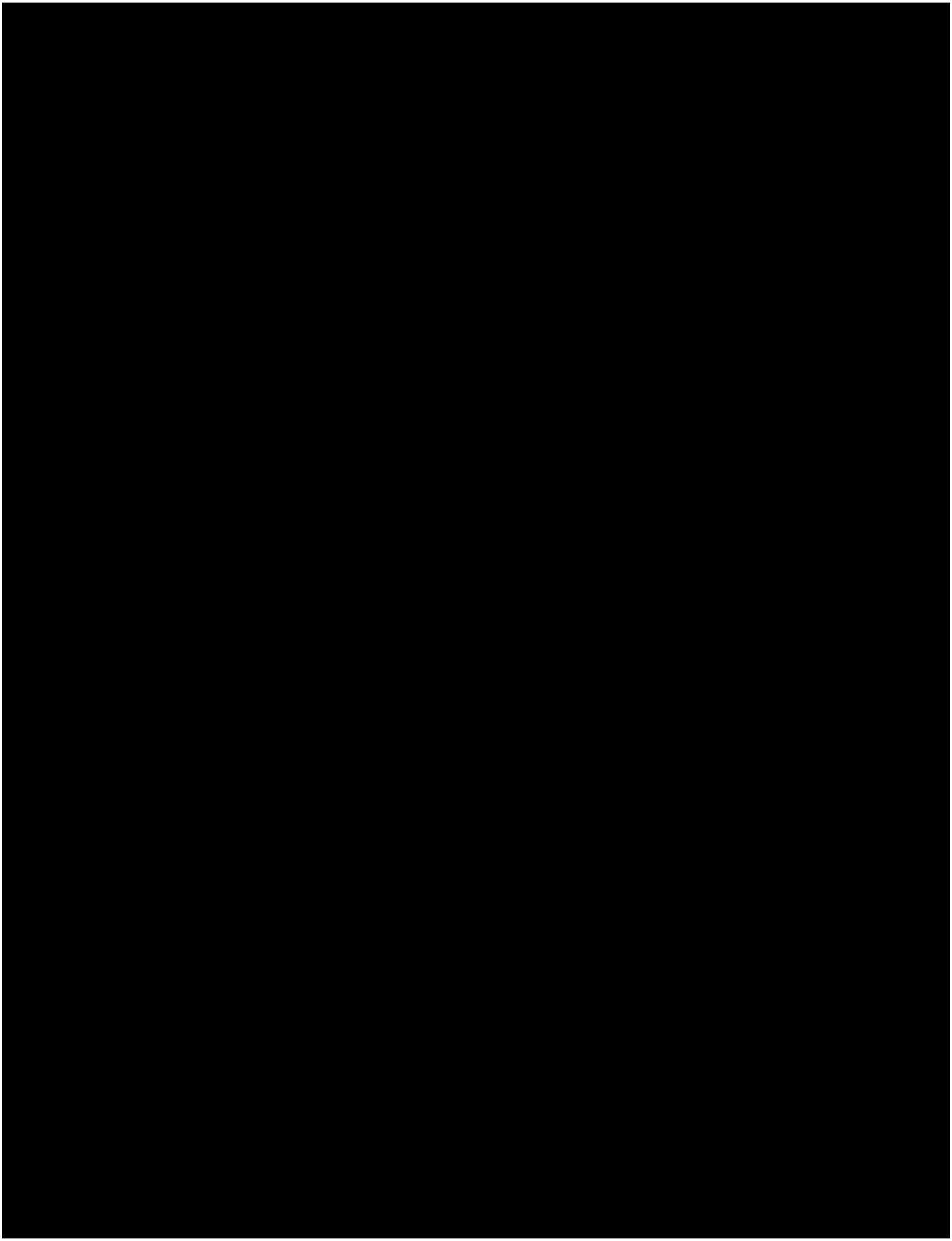


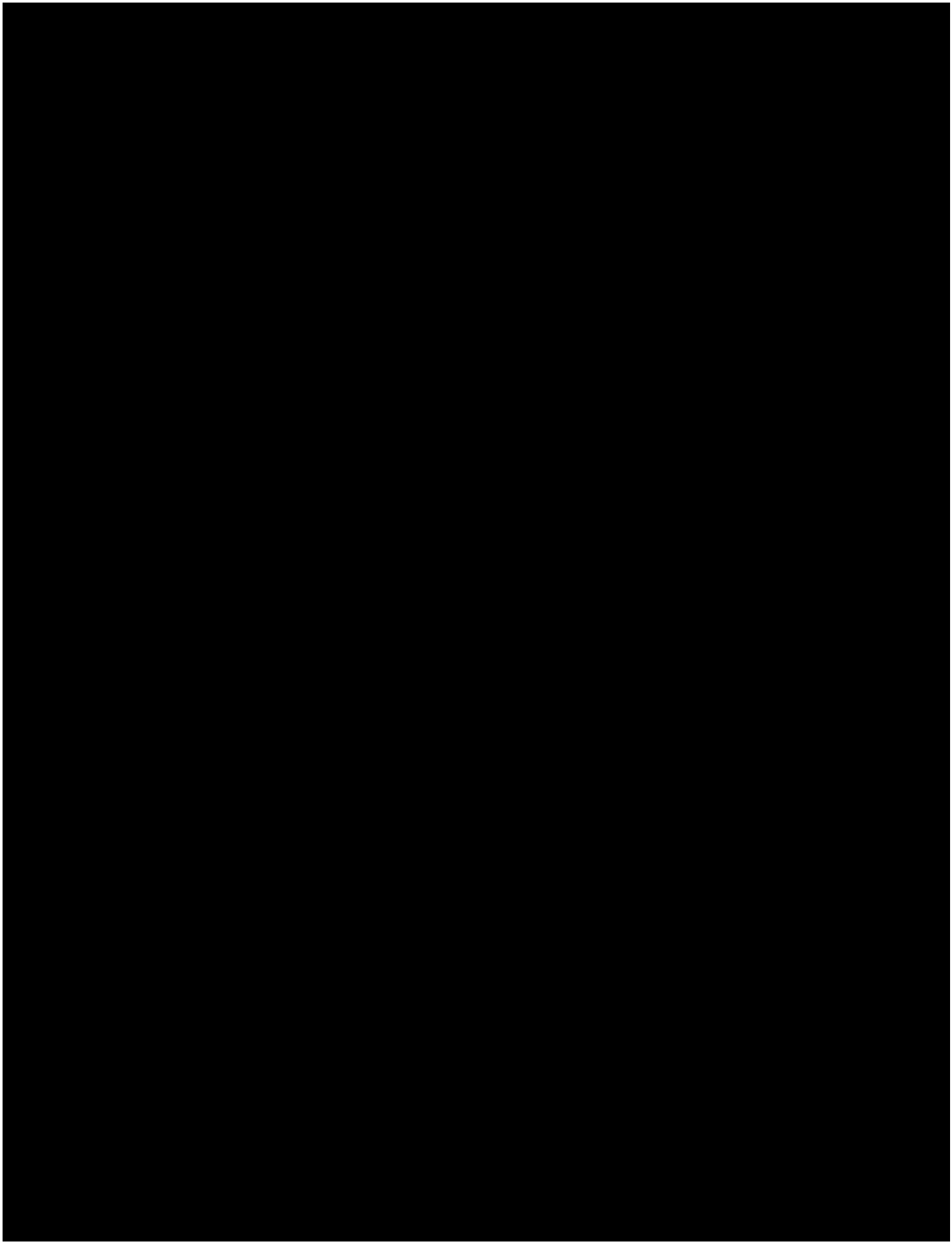


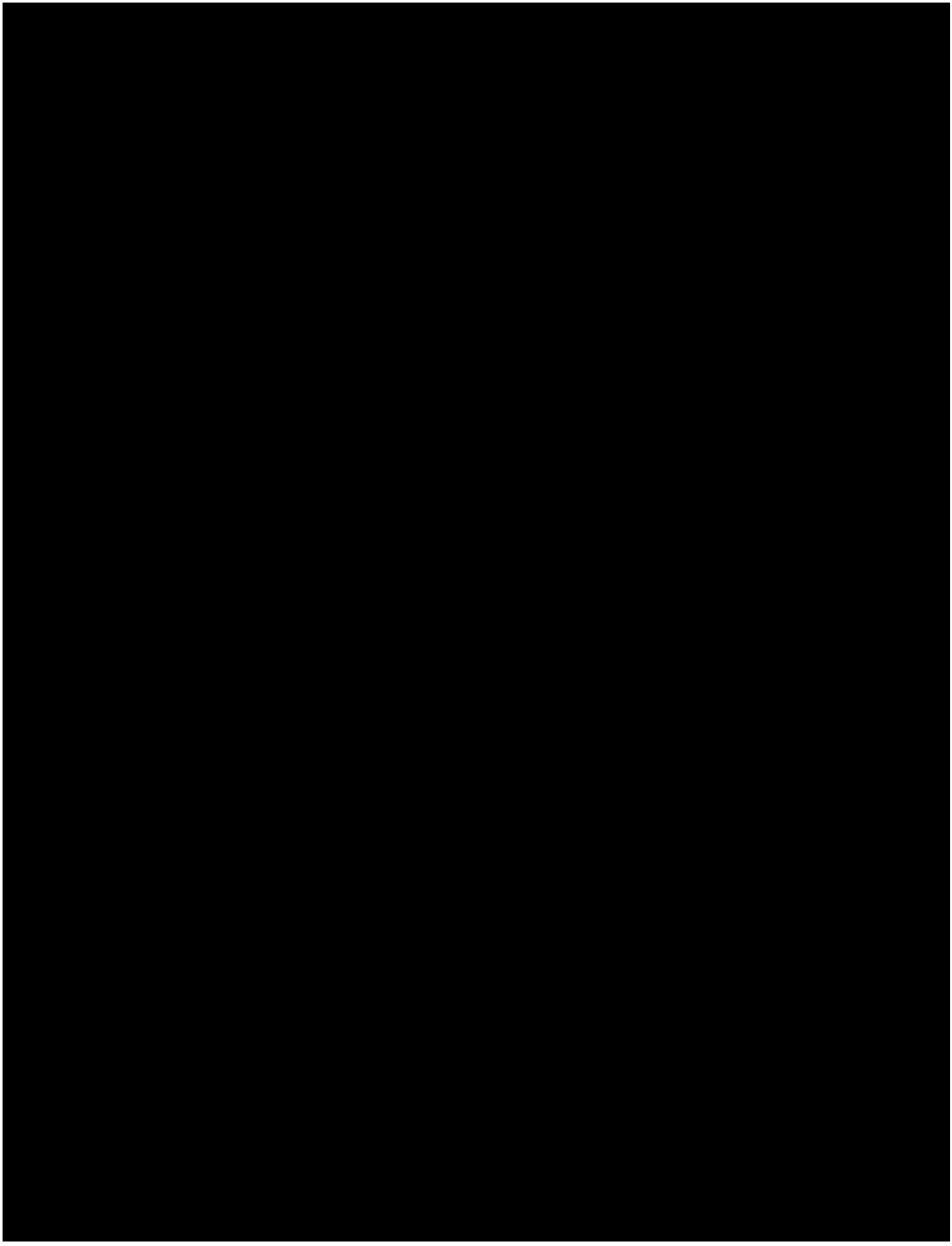












BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 5-29-20 Living Area Blue - DH

Location of Event Blue Time Started 1405 Time Ended 1410

Print Name/Title of person writing BR Tyler Matthson, RCT (COM)

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ✓ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ___ Involved in work/Training activities
- ___ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials ____ Staff, Initials RL TM (CIT) Objects, Own_____

___ Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials _____ Staff, Initials _____

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ✓ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area): To (area):
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ✓ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other_____
- ✓ Demand attention
- ___ Inappropriate toileting
- ✓ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other

INTERVENTIONS (check all that apply; write details on back)

- ___ Allowed processing time
- ✓ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ___ Medical contacted
- ✓ Supervisory staff contacted Name/Title
- ✓ Counseling/instruction
- ___ Ignoring
- ✓ Labeling
- ___ Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other_____
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ✓ Personal restraint 1 min (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Johnson-Miller **Reviewed by** COM/RS

Behavior Report Revised 2019.9.26

9
DHS - Beaver

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

DC arrived from schedule on mobile crying and screaming, TA Rick Libby told me he for no reason slapped him, I went outside to get him after mobile called saying they needed him, I went outside and asked him to come in to take a shower relax, DC complied, but when we got inside he began screaming and tried to pull the fire alarm, I removed him from that area, when he got into the blue he began screaming more and attempted to smack me. I put him in personals for 1 minute, he seemed, to calm down and went to his room. [signature] Rev TM 5-29-20

JUN 01 2020

Behavior Report Revised 2019.9.26 CM 000733 ___QIDP ___Medical ___Psychology ___Social Services ___Living Area

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 4-28-20 Living Area DHB

Location of Event Stone Bldg Time Started 12:40 Time Ended 13:45

Print Name/Title of person writing BR Rhonda Harris TA

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ✓Involved in work/Training activities
- ___Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials RH Objects, Own_____

___Apparent Injury/Marks Card Completed Objects, Others BHDC (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials _____ ✓Staff, Initials RH

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ___Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ✓Repeating self
- ___Left functional control From (area):
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other
- ✓Demand attention
- ___Inappropriate toileting
- ✓Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other
- To (area):

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ✓Graduated guidance
- ✓Time out to calm
- ___Separate from setting up to 30 minutes
- ✓Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted
- Name/Title
- ✓Counseling/instruction
- ___Ignoring
- ___Labeling
- ___Redirection
- ___Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ✓Personal restraint 3 min (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ✓Client complied with request
- ___Excess behavior stopped; client calmed
- ___Other
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Johnson **Reviewed by** [signature] com/RS

Behavior Report Revised 2019.9.26

CM 000736

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date*.**

DC arrived at work set down finished drinking his soda, got up to throw it away walked back to chair picked it up and threw it at staff. Tried going to window with his fist up, but staff prevented him from getting to window. Staff held him in personals for approx 3min. Staff counseled, used graduated guidance to another room. Allowed processing time, time out to calm, and separated him from activity for 30 min. After this he complied with staffs request to come set back down at work area until mobile came to pick him up. Checked for marks before leaving none found at this time.

Rhonda Harris TA
4-28-2020

RECEIVED
JUL 7 2020
RECORDS ROOM
BHDC AR 72937

BOONE[redacted]LLE HUMAN DEVELOPMENT C[redacted]TER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name Daniel Cains **Date** 4-27-20 **Living Area** QH Blue

Location of Event HAMP **Time Started** 9:25 A.M. **Time Ended** 10:35 A.M.

Print Name/Title of person writing BR Dena Hicks RI

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ✓ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ✓ Involved in work/Training activities
- ___ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials BP Objects, Own_____

___ Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self_____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials ✓

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ✓ Noncompliance CST
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area): To (area):
- ___ Fidgety
- ✓ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other_____
- ___ Demand attention
- ___ Inappropriate toileting
- ___ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other_____

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ___ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ✓ Medical contacted
- ___ Supervisory staff contacted Name/Title
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Labeling
- ___ Redirection
- ✓ Verbal intervention
- ___ Mechanical restraint (form completed)
- ✓ Other Chemical intervention CST
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ___ Personal restraint_____ (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** CSM/RSS

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.** ***Legible Signature, Title, Date.***

David came to Hemp showing physical aggression, verbal aggression and non compliance. Staff counseled with David but he refused to calm down. Staff called the nurse and David received 10 mgs of Haldol and 1 mg. of Ativan, David did calm down some, but he was still showing bad behaviors. Staff sent David back to his living area.

David was throwing rocks at mobiles. David was taking his hat off and hitting staff with his hat. David picked up the broom as to hit staff with broom.

[redacted]

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cain 5 Date 4.20.20 Living Area Dawson House

Location of Event Mobile Van Time Started 1425 Time Ended 1427

Print Name/Title of person writing BR Richard Libby, TA

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ✓ Other. Mobile Van
- ___Involved in work/Training activities
- ✓ Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials SW Staff, Initials RL Objects, Own RL

___Apparent Injury/Marks Card Completed SW's glasses Objects, Others_____ (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ✓ Confused/disoriented
- ___Had another's property
- ✓ Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area): To (area):
- ✓ Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other_____
- ✓ Demand attention
- ___Inappropriate toileting
- ___Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ___Graduated guidance
- ___Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted Name/Title
- ✓ Counseling/instruction
- ___Ignoring
- ___Labeling
- ✓ Redirection
- ___Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other_____
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ___Personal restraint_____ (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ___Excess behavior stopped; client calmed
- Other
- ___Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** COM/RSS

Behavior Report Revised 2019.9.26

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

David was crying and upset on the mobile van. He grabbed SW's glasses and threw them. David was counseled with over this behavior. He did stop but was still angry.

4-20-20
Richard Yelly TH

Behavior Report Revised 2019.9.26

__QIDP __Medical __Psychology __Social Services __Living Area

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains **Date** 4-20-20 **Living Area** Blue

Location of Event Outside/Mobile **Time Started** 1425 **Time Ended** 1430

Print Name/Title of person writing BR [redacted]

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ✓ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ___ Involved in work/Training activities
- ✓ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials_____ Objects, Own_____

___ Apparent Injury/Marks Card Completed Objects, Others Mobile (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials_____

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ___ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area): To (area):
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ___ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other_____
- ___ Demand attention
- ___ Inappropriate toileting
- ✓ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other_____

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ___ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ___ Medical contacted
- ___ Supervisory staff contacted
  Name/Title
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Labeling
- ✓ Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other_____
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ___ Personal restraint_____ (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** [redacted]

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

D.C was getting off the mobile van ~~to~~ after class he got to the door turned around started screaming ran in the parking lot grabbed a rock + threw it at the windsheild staff asked D.C to calm down he began crying but followed staff inside to lay down on his bed still crying.

Behavior Report Revised 2019.9.26

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000744

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only____

Name David Cairns Date 3-6-14 Living Area Blue (DH)

Location of Event Blue Time Started 1535 Time Ended 1535

Print Name/Title of person writing BR Tyler Mattson RCT

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- X Difficult / Non-preferred task presented
- X Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials TM, ES Objects, Own X

___Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials _____ Staff, Initials TM, ES

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- X Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area):
- X Fidgety
- X Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other_____
- X Demand attention
- ___Inappropriate toileting
- X Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____
- To (area):

INTERVENTIONS (check all that apply; write details on back)

- ___Allowed processing time
- X Graduated guidance
- X Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- X Medical contacted
- X Supervisory staff contacted
- Name/Title Elizabeth Sye
- X Counseling/instruction
- ___Ignoring
- X Labeling
- X Redirection
- X Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other_____
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- X Personal restraint 5 min (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- X Excess behavior stopped; client calmed
- ___Other
- ___Client was successfully redirected
- ___Excess behavior stopped, client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Johnson Reviewed by com/RCT

Behavior Report Revised 2019.9.26

CM 000759

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.** ***Legible Signature, Title, Date.***

DC was in his room, he had his trash can and threw it down the hall way, Staff intervened and ask what was wrong, DC did not say and began screaming at staff. Staff asked if he need to take a nap, he refused and continual screaming, Staff continued to conver asking if he wanted to sit in his chair and rock, he did and staff went on down the hall, shortly after DC began screaming again, Staff went back down to his room where he was standing and had a shampoo bottle, he then threw it at staff, and reached for a deodorant stick, which he threw in his bathroom he then lunged at staff, Staff placed DC in personal for appox. 5 minutes, he continual to fight. After a few minutes he calmed down and apologized, Staff then contacted medical to check his blood sugar levels, his levels were 81. There were no more issues, DC apologized and behavior ended. Jm Staff Member DC 3-5-20

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BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 2-25-2020 Living Area DAVISON HOUSE

Location of Event Mobile Van Time Started 1455 Time Ended 1459

Print Name/Title of person writing BR Retana DeWitt RBT

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ✓ Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials_____ Objects, Own_____

___Apparent Injury/Marks Card Completed Objects, Others ✓ _____ (Initials)

Self_____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials D.D E.H

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ✓ Had another's property
- ✓ Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area):
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other_____
- To (area):
- ✓ Demand attention
- ___Inappropriate toileting
- ✓ Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ✓ Graduated guidance
- ✓ Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted
- Name/Title
- ___Counseling/instruction
- ___Ignoring
- ___Labeling
- ✓ Redirection
- ✓ Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other_____
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ✓ Personal restraint one minute (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ✓ Client complied with request
- ___Excess behavior stopped; client calmed
- ✓ Other crying
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified N.M Nakita Martin **Reviewed by** R.S, M.S com/RBT

New Behavior Report Revised 2019.9.26

CM 000769

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

we had a party at stone Bldg. and when D.C. got on mobile he was yelling and screaming he grabbed the broom on mobile staff took it from him, Then he strated hitting the window with both hands no visual marks at this time. Staff held him in personal restraints for one minute, Then he refused to get off mobile, Staff gave him cool down time, Then staff took graduated guidance to get him off mobile once off mobile He was crying refusing to go in with his staff after cool down time he went in crying, layed on his bed.

2-25-2020

Delaine DeWitt

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New Behavior Report Revised 2019.9.26

__QIDP __Medical __Psychology __Social Services __Living Area

CM 00077

Name: David Cairns Date: 2/19/2020 Living Area: DH Blue

Location of Event: Mobile Time Started: 8:45 Time Ended: 8:47

Print Name/Title of person writing BR: Eileen Helm RCT

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___ [illegible]
- ___ [illegible]'s routine
- ___ [illegible] activity (phone call, visit)
- ___ [illegible] out of reach
- ___ [illegible] task presented
- ___ [illegible]
- ___ Involved in bathroom/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other:
- ___ Involved in work/Training activities
- ✓ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Personal space interrupted
- ___ Personal space
- ___ Staff left
- ___ Received mean look/client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials _____ Staff, Initials CH, DA Objects, Own _____

___ Apparent Injury/Marks Card Completed Objects, Others mobile window (Initials)

Self _____

Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials _____ Staff, Initials CH

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ [illegible]
- ___ Confused/disoriented
- ___ Hoarding/stealing
- ✓ Noncompliance
- ___ Throwing self in floor
- ___ Dysphagia
- ___ Medication refusal
- ___ [illegible]
- ___ [illegible] self
- ___ [illegible] control From (area):
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other
- ✓ Demanding attention
- ___ Inappropriate toileting
- ✓ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other
- To (area):

[illegible] (check all that apply; write details on back)

- ✓ [illegible] time
- ✓ [illegible]
- ___ [illegible]
- ___ [illegible] from sitting up to 30 minutes
- ___ [illegible] from activity up to 30 minutes
- ___ [illegible]
- ___ [illegible] staff contacted
- Name: _____
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Limiting
- ___ Redirection
- ✓ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other _____
- ___ Distraction
- ___ Implemented BTP
- ___ Restriction
- ___ Reinforcer withheld
- ✓ Personal routine 3 mins (time)
- ___ Suicide precautions started

CONSEQUENCES/INTERVENTIONS (check all that apply; write details on back)

- ___ [illegible] calmed
- ___ Client was successfully redirected
- ___ Excess behavior stopped; client still agitated/angry

CM 000775

BEHAVIOR REPORT NARRATIVE SUMMARY

[redacted] Describe what happened. ***DO NOT INCLUDE*** personal opinions or comments.
[redacted]

DC was getting on mobile to go to schedule when he started to spit and shout at the mobile Driver. He then attempted to hit the driver with his hat. Staff (EH) grabbed DC's Hat to prevent him from doing so and DC then began to spit and cus at Staff and begin to hit the window and then take a swing at Staff. Staff Guided DC to sit down and put DC in P.R. for three mins to calm down. DC was still cussing at Staff and attempting to swing at Staff for a minute before calming down. Staff asked DC if he was calm and ready to talk about it. DC said he was. Once mobile got to Exercise to drop DC off he became upset again. Exercise Staff got DC to calm enough to head into class. DC was calm at that time. No marks where found at this time. PS notified for Restraint.

Eileen Helm
RCT

2-18/2020

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CM 000776

New Behavior Report Revised 2019.9.26 QIDP Medical Psychology Social Services Living Area

BOONE[redacted]LE HUMAN DEVELOPMENT CE[redacted]TER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cans **Date** 2/18/20 **Living Area** DHBlue

Location of Event Hamp Hallway **Time Started** 0905 **Time Ended** 0910

Print Name/Title of person writing BR Amanda Thompson RTS

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ✓ Involved in work/Training activities
- ___ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials AT Objects, Own_____

___ Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self Hands- bitby.
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ✓ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area): To (area):
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other
- ___ Demand attention
- ___ Inappropriate toileting
- ___ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ___ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ___ Medical contacted
- ___ Supervisory staff contacted
  Name/Title
- ✓ Counseling/instruction
- ___ Ignoring
- ✓ Labeling
- ✓ Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ✓ Personal restraint 3min (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ✓ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ___ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Dakita Martin **Reviewed by** CM/RS

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.** ***Legible Signature, Title, Date.***

David was standing @ the end of the hall refusing to go to class. I asked David to come with me & go to class. He walked down with me. then sat on a Bench. He began crying. I counseled with him. David sat there for a min. then attempted to bite me & trying to bite his hands. I held in personals about 3 min counseled & allowed processing time. David then asked if he was in trouble. I redirected him to class. He complied.
Nakita Mastin QIDP
Checked for marks - none found

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Name David Cains Date 2-6-2020 Living Area Del Blue

Location of Event Nurse Station Time Started 1530 Time Ended 1545

Print Name/Title of person writing BR Elizabeth Skye RCSS Peggy Lake

Room

What happened immediately *before* the problem behavior occurred? (check all that apply)

- Involved in work/Training activities
- X Transitioning different setting
- Meal time
- Medication administration time
- Moving from one activity to another
- Other clients receiving attention
- Had seizure
- Toileting accident
- In bed
- Physical aggression by another
- Verbal aggression by another
- Property invaded
- Personal space invaded
- X Demand made
- Request made of client
- Other client displaying problem behavior
- Involved in programming/routine activities
- Involved in leisure activities
- Involved in off-campus activity
- X Other Staff Changes

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials _____ Staff, Initials LF, LS EH Objects, Own Remotes

___ Apparent Injury/Marks Card Completed Objects, Others _____ (Initials)

Self biting hand
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials EH, LF, LS

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- Pacing
- Confused/disoriented
- Taking another's property
- X Noncompliance
- Throwing self in floor
- Day sleeping
- Medication refusal
- Stripping
- Rocking self
- Fecal smearing/odd control From (area): _____
- Fidgety
- Not responding to cues
- Personal space violation (non-sexual)
- Putting inedible items in mouth
- Wet or soiled (unintentional)
- Disturbing programming/environment
- In another's bedroom
- Lying
- X Other Spitting
- X Deliberate urination
- Inappropriate toileting
- X Screaming/shouting
- Meal refusal
- Inappropriate sexual behavior
- Awake during sleep time
- Insufficient control
- Snack refusal
- Other
- To (area): _____

INTERVENTIONS (check all that apply; write details on back)

- X Attention during time
- X Ignoring
- X Time Out to area
- Separation from setting up to 30 minutes
- Separation from activity up to 30 minutes
- Physical restraint
- X Staff assistance contacted
- Name(s): Randy Porter, Thomas Black
- X Counseling/instruction
- Ignoring
- X Labeling
- X Redirection
- Verbal intervention
- Mechanical restraint (form completed)
- Other _____
- Distraction
- Implemented BTP
- Restitution 1.5 x 2
- Reinforcer withheld
- X Personal restraint 8 min (time)
- Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- Client calmed
- Client was successfully redirected
- X Excess behavior stopped; client still agitated/angry

BEHAVIOR REPORT NARRATIVE SUMMARY

[redacted] Describe what happened. ***DO NOT INCLUDE*** personal opinions or comments.
[redacted]

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[redacted] went down to the nurses station and started to take the signs off the wall and yell at Eileen. I went down to the nurses station and david was over by the Coke machine. I tried talking with david and he began to cry. I asked David if he wanted go and see the nurse to have his blood sugar checked. He let Lacy check his sugars. After she checked them he began to yell and spit at Lacy. I tried to talk w/ David and he grabbed my hand and Pinned them between the door and began to scratch them. He continued to spit at Eileen and Lacy. He then went to attack Lacy while still scratching my hand David was held in personals for about a 1½. He then began to cry, said Sorry. Lacy gave him some orange juice. He went down to his room. He was in his room and started to yell and scream. Staff went to check on him and he threw his fan and DVD's out at me. Staff tried to cancile but David came at staff and grabbed them. David started to scratch and bit at staff. Staff had to hold

page 1 of 2

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cairns **Date** 2-5-20 **Living Area** Dawson House Blue

Location of Event Dining Room **Time Started** 11:00 A.M. **Time Ended** 11:10 A.M.

Print Name/Title of person writing BR Dena DeLa RT

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ✓Meal time
- ___Medication administration time
- ✓Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials___ Staff, Initials___ Objects, Own___

Apparent Injury/Marks Card Completed Objects, Others ✓ Kitchen DLB (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ✓Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area): To (area):
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other_____
- ✓Demand attention
- ___Inappropriate toileting
- ✓Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ___Graduated guidance
- ___Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted
  Name/Title
- ✓Counseling/instruction
- ___Ignoring
- ___Labeling
- ___Redirection
- ✓Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other_____
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ___Personal restraint_____ (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ___Excess behavior stopped; client calmed
- ___Other see back
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** CJM/RS

Behavior Report Revised 2019.9.26

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

David walked into dining room, walked over to table, picked up bottle of soap and hurled the soap across the room. He stood there for awhile, then he picked up bottle and threw the bottle at Kitchen stoff. He did calm down some to take his medication Stoff Counseled with David. David returned to his living area.

[signature]
25-20

RECEIVED
FEB 07 2021
RECORDS ROOM
BHDC AR 72927

Behavior Report Revised 2019.9.26

__QIDP __Medical __Psychology __Social Services __Living Area

CM 00079

3253

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cain Date 1-29-20 Living Area DH

Location of Event Hamp classroom Time Started 9:55 Time Ended 10:15

Print Name/Title of person writing BR Jack Featherstor TA

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ✓Involved in work/Training activities
- ___Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials DH ✓Objects, Own_____

___Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials DH

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ✓Had another's property
- ✓Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area): To (area):
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other_____
- ✓Demand attention
- ___Inappropriate toileting
- ✓Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ✓Graduated guidance
- ✓Time out to calm
- ___Separate from setting up to 30 minutes
- ✓Separate from activity up to 30 minutes
- ✓Medical contacted
- ___Supervisory staff contacted
- ✓Counseling/instruction
- ___Ignoring
- ___Labeling
- ✓Redirection
- ✓Verbal intervention
- ___Mechanical restraint (form completed)
- ✓Other chemical intervention
- ✓Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ___Personal restraint_____ (time)
- ___Suicide precautions started

Name/Title COOP

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ___Excess behavior stopped; client calmed
- ___Other
- ✓Client was successfully redirected
- ✓Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** com/RS

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date.***

David came to class. He appeared fine. He then jumped up and went in the hallway. Sat on the bench for a while then got up and turned over the trash can full of pop cans. Client calmed down enough to re-enter the class. He was given his ordered snack and juice, he then threw the juice at staff. Medical was notified and evaluated for intervention. 1mg Ativan administered @ 10:12. After the medical intervention he went back out in the hall slamming the door and cussing at staff. After ample time for the conditions to improve he was taken back to living area.

Jack Featherston TA
1/29-20

JAN 31 2020
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BHDC AR 72227

(C) Unless otherwise specified by State licensure and certification requirements.

Guidance §483.430(b)(5)(xi)

An individual client program may not require that professional staff perform all of the services as outlined by the IPP (e.g. the direct support staff may be trained by the professional to safely and effectively carry out the designed program), however, any specialized therapy must involve evaluation, program development, and re-assessment by the appropriate professional at periodic intervals.

(c) Standard: Facility staffing

W182

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(c)(1) The facility must not depend upon clients or volunteers to perform direct care services for the facility.

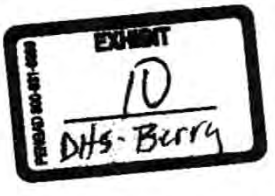
Guidance §483.430(c)(1)

The facility must have sufficient staff to provide needed care and services without the use of volunteers or enlisting the help of clients residing in the facility to perform the duties normally performed by facility staff.

The facility may not rely on volunteers in lieu of paid staff to fill required staff positions and perform direct care services. Volunteers are permissible, but must be in addition to the number of paid staff required to carry out a function. Volunteers should have an orientation to the policies and procedures of the facility and oversight is required by facility staff.

W183

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)



§483.430(c)(2) There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing- -

(i) Clients for whom a physician has ordered a medical care plan;

(ii) Clients who are aggressive, assaultive or security risks;

(iii) More than 16 clients; or

(iv) Fewer than 16 clients within a multi-unit building.

Guidance §483.430(c)(2)

Indicators of staff not being awake in relation to the occurrence of incidents, accidents, and injuries may include, but are not limited to:

- incidents of unplanned client absences;
- untimely reaction to a medical emergency;
- injuries from client to client aggression; or
- a pattern of injuries of unknown origin.

If even one client meets 483.430(c)(2)(i-ii) then staff must be awake on a 24-hour basis.

A client has a medical care plan when an acute or chronic occurrence requires clinical assessment and monitoring on a scheduled basis.

W184

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(c)(3) There must be a responsible direct care staff person on duty on a 24 hour basis (when clients are present) to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing- -

(i) Clients for whom a physician has not ordered a medical care plan;

(ii) Clients who are not aggressive, assaultive or security risks; and

(iii) Sixteen or fewer clients.

Guidance §483.430(c)(3)

At all times, there must be at least one staff person on-duty in the facility if even one client is present. For purposes of this provision, "on duty" staff need not be awake during normal sleeping hours, but do need to respond to injuries, illness, and emergencies promptly.

W185

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(c)(4) The facility must provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

Guidance §483.430(c)(4)

Direct care staff should not be performing support services (e.g., making beds, cooking, cleaning, etc.) independently which takes them away from client interaction and teaching. If support services in the house cannot be done jointly as chores between clients, as part of their training program, and the support staff, additional staff should be added to perform the chores. This does not include any staff chores done during client's sleeping hours.

"Support staff" include all personnel hired by the facility that are not either direct care staff or

professional staff. For example, support staff includes, but are not limited to, secretaries, clerks, housekeepers, maintenance and laundry personnel.

(d) Standard: Direct care residential living unit staff

W186

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(d)(1) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

Guidance §483.430(d)(1)

"Sufficient" means enough direct care staff to effectively implement the active treatment programs as defined in the IPP, to meet client needs, and to respond to emergencies, illness, or injuries.

Even though minimum ratios are defined at §483.430(d)(3), active treatment may require more staff than the minimums required ratios, therefore compliance should not be based on staffing ratios alone.

§483.430(d)(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

Guidance §483.430(d)(2)

"Direct care staff" are those personnel who are assigned to work directly with the clients providing support during activities of daily living and active treatment programs.

Professional staff who work with clients in a living unit on a periodic basis are not included in direct care staff ratios.

Supervisors of direct care staff can be counted only if they share in the actual work of the direct care of clients on a continuous basis (e.g. take client assignment).

Direct care supervisors whose principle assigned function is to supervise direct care staff may not be included in direct care staff ratios although they may occasionally provide direct services to clients.

Non-direct care staff supervisors whose principle assigned function is to supervise non-direct care staff may not be included in direct care staff ratios.

W187

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.430(d)(3) Direct care staff must be provided by the facility in the following minimum ratios of direct care staff to clients:

(i) For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive, assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff to client ratio is 1 to 3.2.

(ii) For each defined residential living unit serving moderately retarded clients, the staff to client ratio is 1 to 4.

(iii) For each defined residential living unit serving clients who function within the range of mild retardation, the staff to client ratio is 1 to 6.4.

Guidance §483.430(d)(3)

The minimum ratios in this standard indicate the **minimum** number of direct-care staff that must be present and on duty, 24 hours a day, 365 days a year, for each discrete living unit. For example, to calculate the minimum number of living unit staff that must be present and on duty in a discrete living unit serving 16 individuals with multiple disabilities: divide the number of individuals "16," by the number corresponding to the regulation "3.2," the result equals "5." Therefore, the facility must determine how many staff it must hire to ensure that at least 5 staff will be able to be present and on duty during the 24 hour period in which those individuals are present.

Using the living unit described above, "calculated over all shifts in a 24-hour period" means that there are present and on duty every day of the year: one direct care staff for each eight individuals on the first shift (1:8), one direct care staff for each eight individuals on the second shift (1:8), and one direct care staff for each 16 individuals on the third shift (1:16). Therefore, there are five (5) direct care staff present and on duty for each twenty-four hour day, for 16 individuals. The same calculations are made for the other ratios, whichever applies. Determine

if absences of staff for breaks and meals results in a pattern of prolonged periods in which present and on-duty staff do not meet the ratios.

W188

§483.420(d)(4) When there are no clients present in the living unit, a responsible staff member must be available by telephone.

§483.430(e) Standard: Staff Training Program

W189

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

Guidance §483.430(e)(1)

Newly employed staff receive a supported orientation program (mentor or ongoing supervision) during their early employment. All staff receive continuing education on such issues as abuse and neglect, handling emergency situations, behavior management, and treating people with respect and dignity, etc.

The primary evidence of an effective staff training program is the observed competent interaction between staff and clients.

§483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients'

W190

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.430(e)(2) developmental,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- developmental programming principles and techniques (e.g. techniques to involve clients in their programs to their highest capability, use of positive reinforcement, use of assistive technology, use of appropriate materials and providing informal opportunities to practice skills);
- use of adaptive equipment and augmentative communication devices and systems; and
- effective recordkeeping procedures.

W191

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) behavioral,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- use of behavioral principles during interactions between staff and clients;
- use of accurate procedures regarding abuse detection and prevention, restraints, drugs to manage behaviors, client safety, emergencies, etc.;
- use of least restrictive interventions;

- use of positive behavior intervention programming; and
- training clients in appropriate replacement behaviors.

W192

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) and health needs

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- signs and symptoms of the client's changing health (e.g. constipation, urinary tract infections, adverse drug reactions, as indicated);
- exercise and diet;
- first aid;
- infection control;
- reporting to appropriate healthcare professionals; and
- for those staff who can administer medications, how to include clients in their medication administration by recognizing and encouraging the use of applicable skills.

W193

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

Guidance §483.430(e)(3)

Staff correctly and consistently implement the interventions specified in the behavior plans of clients with whom they are working.

Inadequate training is evident when staff do not correctly implement behavioral programs, use inappropriate management techniques, cannot explain what intervention is to be used and how it is to be implemented.

W194

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

Guidance §483.430(e)(4)

Staff are observed in various settings during the day correctly and consistently implementing the specific IPPs of the clients with whom they are working.

W195

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440 Condition of participation: Active treatment services

(a) Standard: Active treatment

W196

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.440(a)(1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward-

F.1

3265

JUNE 1, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	29

JUNE 2, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	30

JUNE 3, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	25
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	32



JUNE 4, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	25
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	123
Staffing – 1600 to 2400	30

JUNE 5, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	25
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	123
Staffing – 1600 to 2400	30

JUNE 6, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	123
Staffing – 0800 to 1600	29
Required Ratio – 1600 to 2400	1 to 8
Daily Census	123
Staffing – 1600 to 2400	29

F.1

3266

JUNE 7, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	123
Staffing – 0800 to 1600	29
Required Ratio – 1600 to 2400	1 to 8
Daily Census	123
Staffing – 1600 to 2400	29

JUNE 8, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	30

JUNE 9, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	30

JUNE 10, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	32

JUNE 11, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	31

JUNE 12, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	25
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	123
Staffing – 1600 to 2400	31

• Booneville Human Development Center – All Residential Living Areas

June 1-13, 2022

JUNE 13, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	25
Required Ratio – 0800 to 1600	1 to 8
Daily Census	123
Staffing – 0800 to 1600	30
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	29

F.1

3268

JUNE 1, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	25
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 1600 to 2400	2	2	5

JUNE 2, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	25
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 1600 to 2400	3	2	4



JUNE 3, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	24
Staffing – 0000 to 0800	2	1	3
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 0800 to 1600	3	3	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 1600 to 2400	3	2	4

JUNE 4, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	24
Staffing – 0000 to 0800	2	1	3
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 0800 to 1600	3	2	4
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 1600 to 2400	3	2	4

F.1

3269

JUNE 5, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	24
Staffing – 0000 to 0800	2	1	3
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 1600 to 2400	3	2	5

JUNE 6, 2020	Davison2 House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	25
Staffing – 0000 to 0800	1	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 0800 to 1600	2	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 1600 to 2400	2	2	5

JUNE 7, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	25
Staffing – 0000 to 0800	1	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 0800 to 1600	2	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 1600 to 2400	2	2	5

JUNE 8, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	25
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 1600 to 2400	3	2	5

JUNE 9, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	24
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 1600 to 2400	3	2	5

JUNE 10, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	24
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 1600 to 2400	3	2	5

JUNE 11, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	10	24
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 1600 to 2400	3	2	5

JUNE 12, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	10	24
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 1600 to 2400	3	2	5

JUNE 13, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	10	24
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 0800 to 1600	2	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	9	11	24
Staffing – 1600 to 2400	2	2	5

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G003	A. BUILDING _____ B. WING _____	C 06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONEVILLE HUMAN DEVELOPMENT CENTER	87 REED ROAD, HWY 116 SOUTH BOONEVILLE, AR 72927

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare and Medicaid Services (CMS) on June 30, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6). Client Census: 117	E 000		
W 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on June 30, 2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Preventions (CDC) recommended practices to prepare for COVID-19 Client Census: 117	W 000		

EXHIBIT 13 DHS-Berry

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		7/14/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 000	Continued From page 1 The facility was in compliance with the requirements of the 42 CFR, Part 483, subpart I for the Intermediate Care Facilities for Individuals with Intellectual Disabilities. Complaint #25772 (AR00024518) was unsubstantiated. Complaint #25996 (AR00024946) was unsubstantiated. Complaint #26043 (AR00024997) was unsubstantiated.	W 000		

FIRST AID GUIDELINES

POLICY STATEMENT: First Aid Guidelines are available for use in each of the Aide Stations in each living area. This will permit appropriate and immediate attention to medical conditions of sudden onset, including injuries and choking.

PROCEDURES:

1. The First Aid Guidelines have been approved by the staff physician for the Booneville HDC.

2. In all cases in which a serious medical injury or illness is suspected, either to clients or staff, a call to the Medical Department should be made. This should be the first call so Medical staff can respond immediately to the situation.

   A call to Medical at 1422 should be made and the following information should be given:

   1. Caller's name and title
   2. Victim's name, location, situation and condition of the victim (alert, unconscious, etc.)
   3. Medical will assess the situation and call an ambulance if appropriate.

3. All staff members are trained in first aid, CPR, and abdominal thrust for choking so, that if necessary, emergency rescue measures can be initiated before Medical staff arrives.

4. Choking is a serious and potentially life-threatening situation and the following guidelines should be followed:

   a. Staff will supervise clients during meal times and nursing staff will be available by phone at all times;
   b. emergency equipment including oxygen and suction machine will be kept in the dining room for use as needed;
   c. All staff will receive annual training in abdominal thrust and choking precautions.

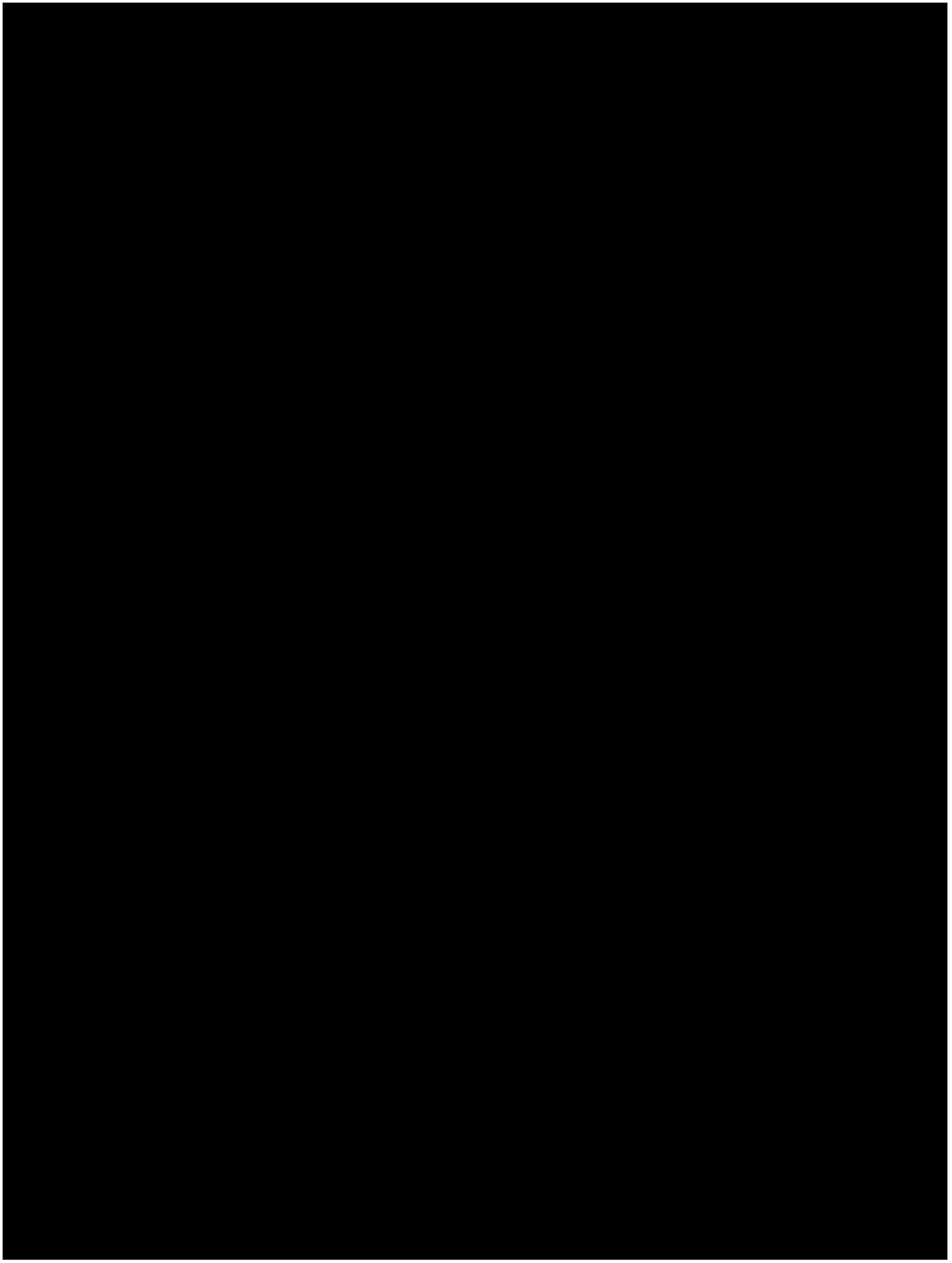
5. First Aid kits, disaster kits, and first aid guidelines will be kept in all areas. Medical will do monthly inspections on first aid kits, and every 6 month inspections on disaster kits, and refill appropriately. If living area staff notice supplies are low, Medical is to be notified and supplies will be replenished.

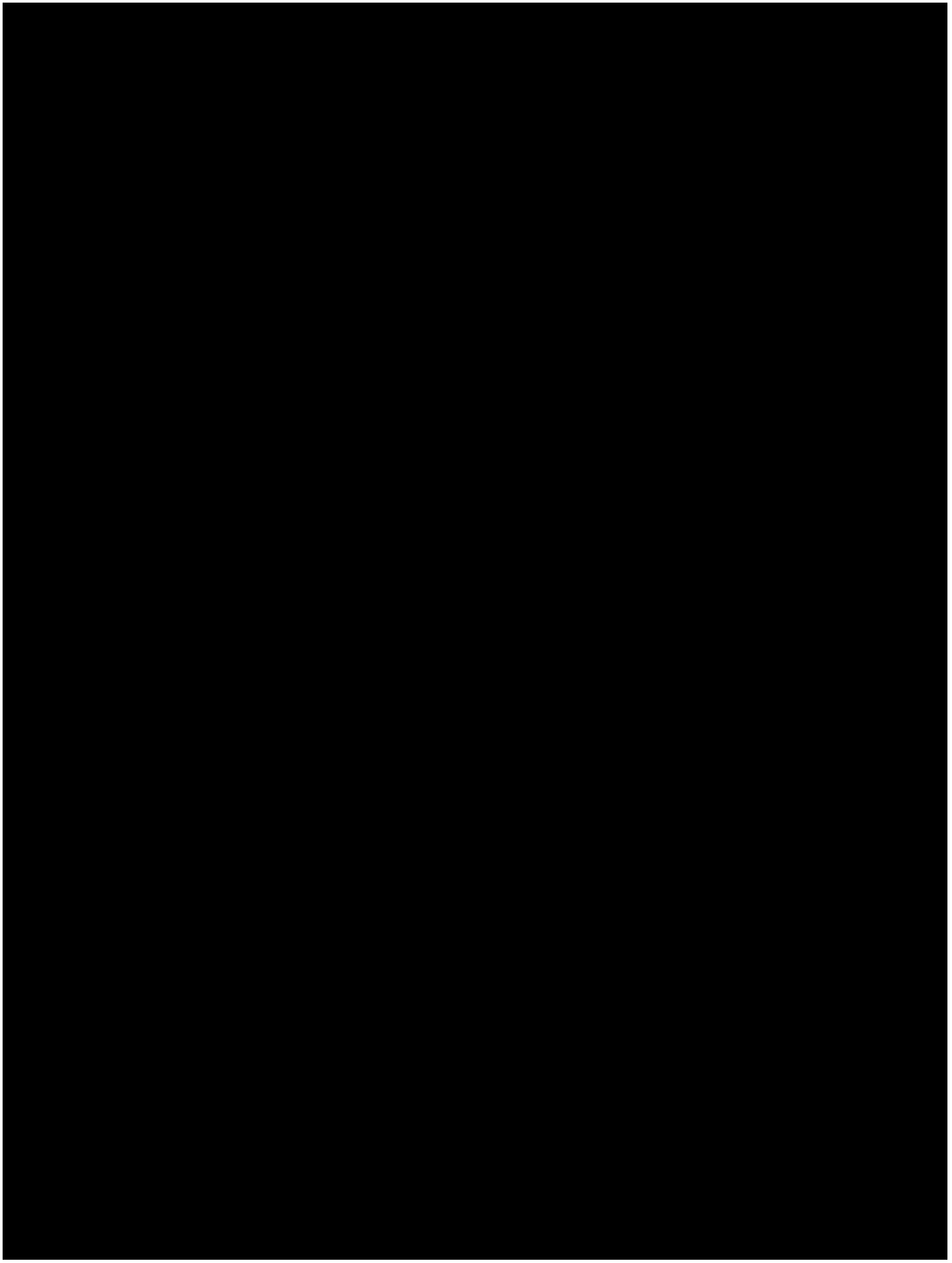
APPROVED: _____ Superintendent

Supersedes BHDC Policy IV-B-10, dated 03/13/15, in its entirety.



REVIEWED: 11/27/19
VERSION: 12/29/17





BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS CLAIMANT

VS. CLAIM NO. 220374

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) RESPONDENT

Arkansas
State Claims Commission
FEB 16 2023
RECEIVED

ORAL DEPOSITION

OF

SYED HAMID, M.D.

(Taken May 26, 2022, at 9:08 a.m.)

GRAY COURT REPORTING



APPEARANCES

(ALL APPEARANCES VIA VIDEOCONFERENCE)

ON BEHALF OF THE CLAIMANT:

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4815 WEST MARKHAM
LITTLE ROCK, ARKANSAS 72205
501-661-2000

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EXHIBITS

(NONE MARKED)

CAPTION

ANSWERS AND ORAL DEPOSITION OF SYED HAMID, M.D., a witness produced at the request of the Claimant, taken in the above-styled and numbered cause on the 26th day of May, 2022, before Kristina R. Gray, Arkansas Supreme Court Certified Court Reporter #725, at 9:08 a.m., via Zoom videoconference, pursuant to the agreement hereinafter set forth.

* * * * * * * * * *

STIPULATIONS

IT IS STIPULATED AND AGREED by and between the parties through their respective counsel that the oral deposition of SYED HAMID, M.D., may be taken for any and all purposes according to the Arkansas Rules of Civil Procedure.

PROCEEDINGS

WHEREUPON,

SYED HAMID, M.D.,

Having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. GILLISPIE:

Q Doctor, did I pronounce your last name correctly, Hamid?

A Hamid.

Q Hamid, I'm sorry. So Dr. Syed Hamid; is that right?

A Syed Hamid.

Q Okay. Well, pleasure to meet you, sir. My name is Josh Gillispie. I'm the attorney for the family of Mr. David Cains, who was a patient of yours at the Booneville facility there. The purpose of your deposition today is purely information-gathering. I'll represent to you that this is not a medical malpractice case. We have no reason to believe that anything you did or didn't do had any effect whatsoever on what happened to Mr. Cains. You're simply here because you were his doctor and I just need to get some information. Does that make sense?

A It does.

Q In other words, we believe there were mistakes that were made by staff, not anything you did is what I'm telling you. So tell me first, you're the medical director of the facility.
A Yeah. I'm the medical physician in the facility. I don't know whether I have the director tag on it, but yes, I'm the medical physician taking care of these clients.
Q Okay. And you're a hospitalist; is that correct?
A Yeah. I am an internist and I do some hospitalist work as well.
Q When did you begin working at the Booneville Human Development Center?
A I think I've been here -- I started, I think, around 2007. And that's when I started, so it's been almost 15 years.
Q I understand that you work at other facilities as well, Mercy Hospital, other places, right?
A That's right. I do some hospitalist trips there.
Q So how much of your time is spent at the Booneville facility, Human Development Center, typically?
A Well, I'm here at least three days a week. I do clinics. I've got a nurse practitioner over here as well, so I do morning clinics at least three days a

week. Then I'm taking phone calls for anything that goes around. We kind of split calls between me and my nurse practitioner, so I'm pretty much available all the time.

Q Okay. And would that mean you began treating David Cains as long as 15 years ago?

A If he has been there this long, then I would have been taking care of him, yes.

Q Well, actually he was in the facility for 13 years before his death, so I think he got to the facility in 2007.

A Around the same time then.

Q And do you recall Mr. Cains?

A I mean, I recall, you know, seeing him in the clinic. I used to see him in the clinic for medical evals and yearly physicals, and that's all the recollection that I have of him.

Q Sure. You see a lot of patients there, I understand.

Are you the only physician, medical doctor that is located on the facility?

A That's right. I'm the medical, and then you've got psychiatrist that comes and works here as well. You've got a neurologist that comes in, you know. Then you got other physicians coming in as well, so there

are other specialty doctors coming in, too.
Q Are you part of a formal clients' IPPs?
A What does that mean?
Q Individual program plan.
A What do you mean by "formal"?
Q Well, my understanding from talking to David's QIDP, Mr. Joe, was that there was a core team of folks who worked on that plan and met yearly to basically produce an IPP every year.
A That's correct.
Q Maybe formal -- formal maybe isn't the right word to use. So same question, remove the word "formal." Do you have any hand in that process of producing that annual IPP?
A I'm not part of that critical meeting if that's what you're talking about, but whatever is discussed in that meeting is brought to my attention. And if you're talking about the same thing, then, you know, the medical staffing reports, I do sign those reports, so. And the nurses would discuss it with me, but I'm not part of that meeting. I'm not present in that meeting.
Q Okay. And have you ever been present at a meeting where David's mom, Charlene Robinson, or sister were present? Have you ever met them?
A I don't recall that. I don't think so. I can't

recall it.

Q And in a normal year or in a normal -- under normal settings, how often would you see a client like David? I understand for yearly physicals, but then you mentioned periodic assessments.

[redacted]

Q Do you have any hand or participation -- do you participate in the forming of policies regarding physical restraints at the facility and the types of physical restraints that can be used on clients? Do you have anything to do with that sector of --

A On clients, you know, we've got some clients that have a lot of behaviors and sometimes it's brought to my attention that this patient will need early chemical intervention or -- and, you know, somebody -- so, again, I've been asked those questions off and on, and I do sign some forms about what kind of prescriptions can be -- apply to these clients.

Q Do you recall ever being approached or ever being asked to approve a physical restraint on David whereby he would be restrained on the ground? Does that sound familiar to you?

A I don't recall that. No, I don't.
Q Do you have any recollection of or knowledge of physical restraints of clients while they're on the ground?
A I mean, what kind of knowledge are we talking about?
Q Do you have any reason to think that that was happening?
A Okay. So on a usual day, if some client needs some intervention, so they would call me for chemical intervention, so the nurse would give me a call that Mr. So-and-so is having some behaviors. Can we give him this? So it's mainly for -- and some of our clients are on early chemical intervention, and I think David was one of them. I cannot recall whether I was called for him and how frequently I was called for that, but on a usual day, I get some phone calls about, you know, clients who are acting out or, you know, going to get into behaviors, so they call me for chemical restraints.
Q My concern with this case is not particularly chemical restraints because that's not what was involved in David's death. The type of restraint that was involved with his death was a physical or personal restraint on the ground. And so I know that you

don't -- you have no -- well, let me ask it.

I'm assuming you have no control or say over what types of physical restraints the direct care staff are trained in and what they use?

A I don't.

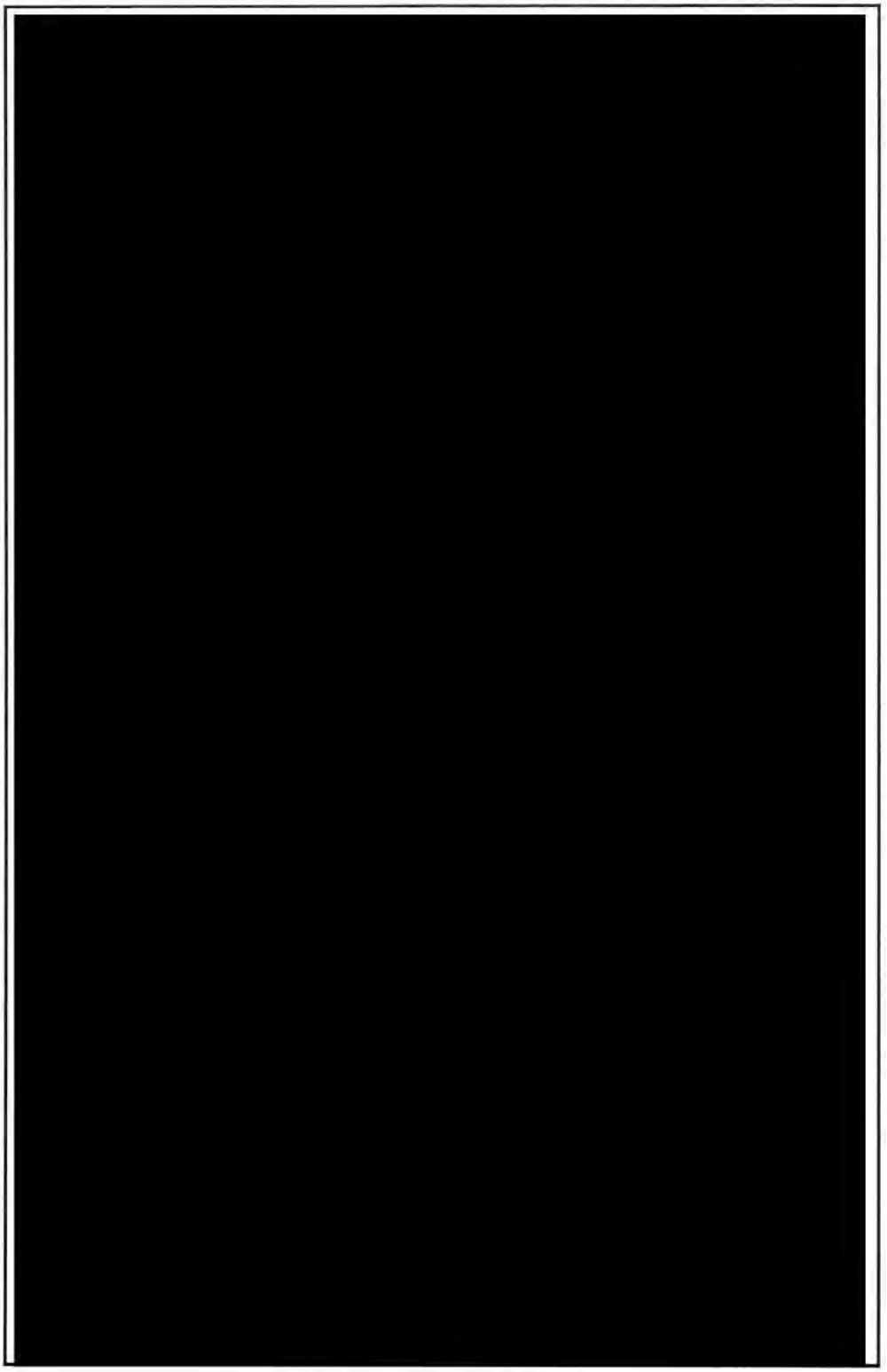
Q And so really my question is, did it ever come across your radar that a particular client was being restrained in an improper way physically, specifically on the ground?

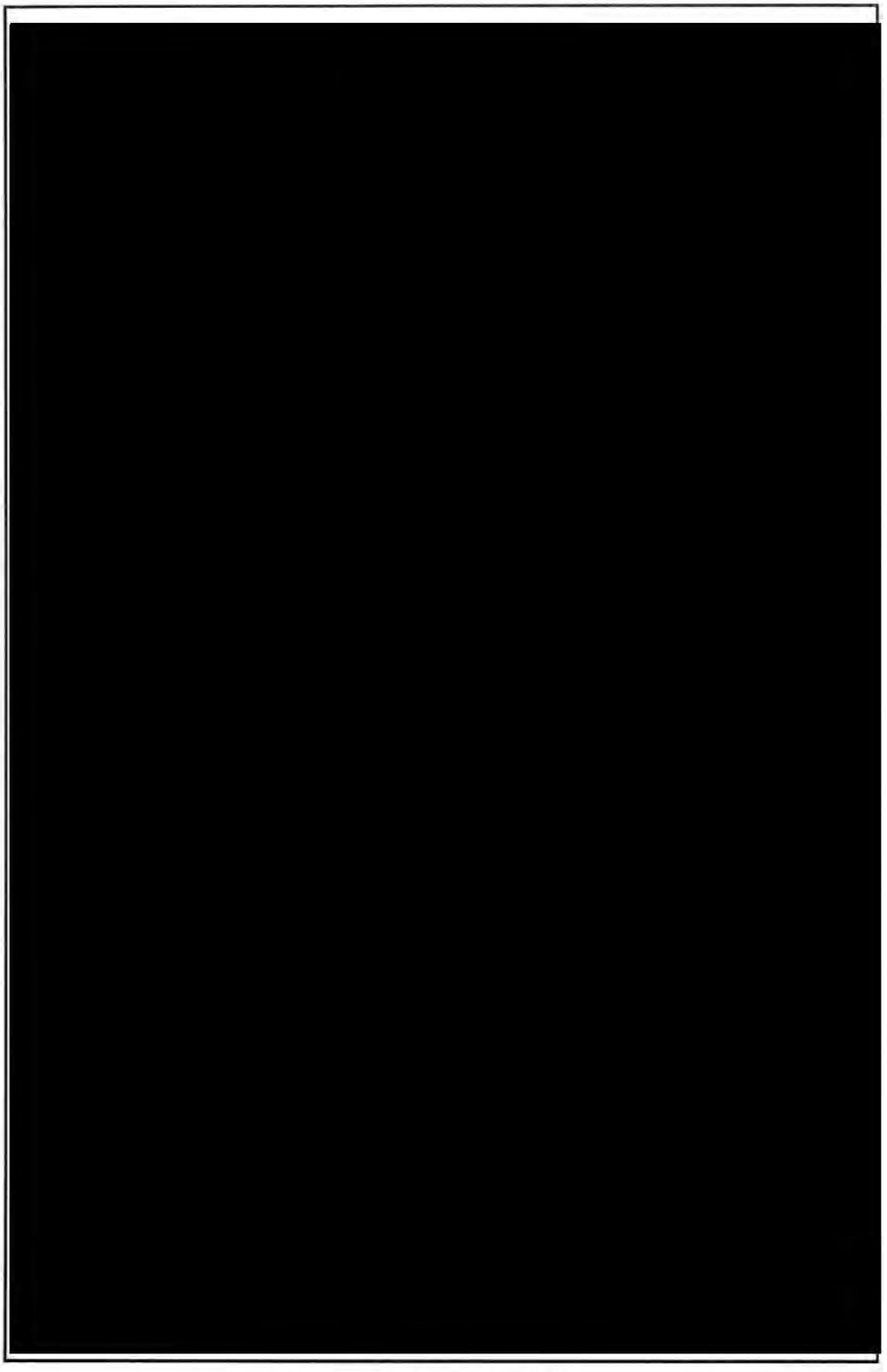
A No, sir. I don't recall.

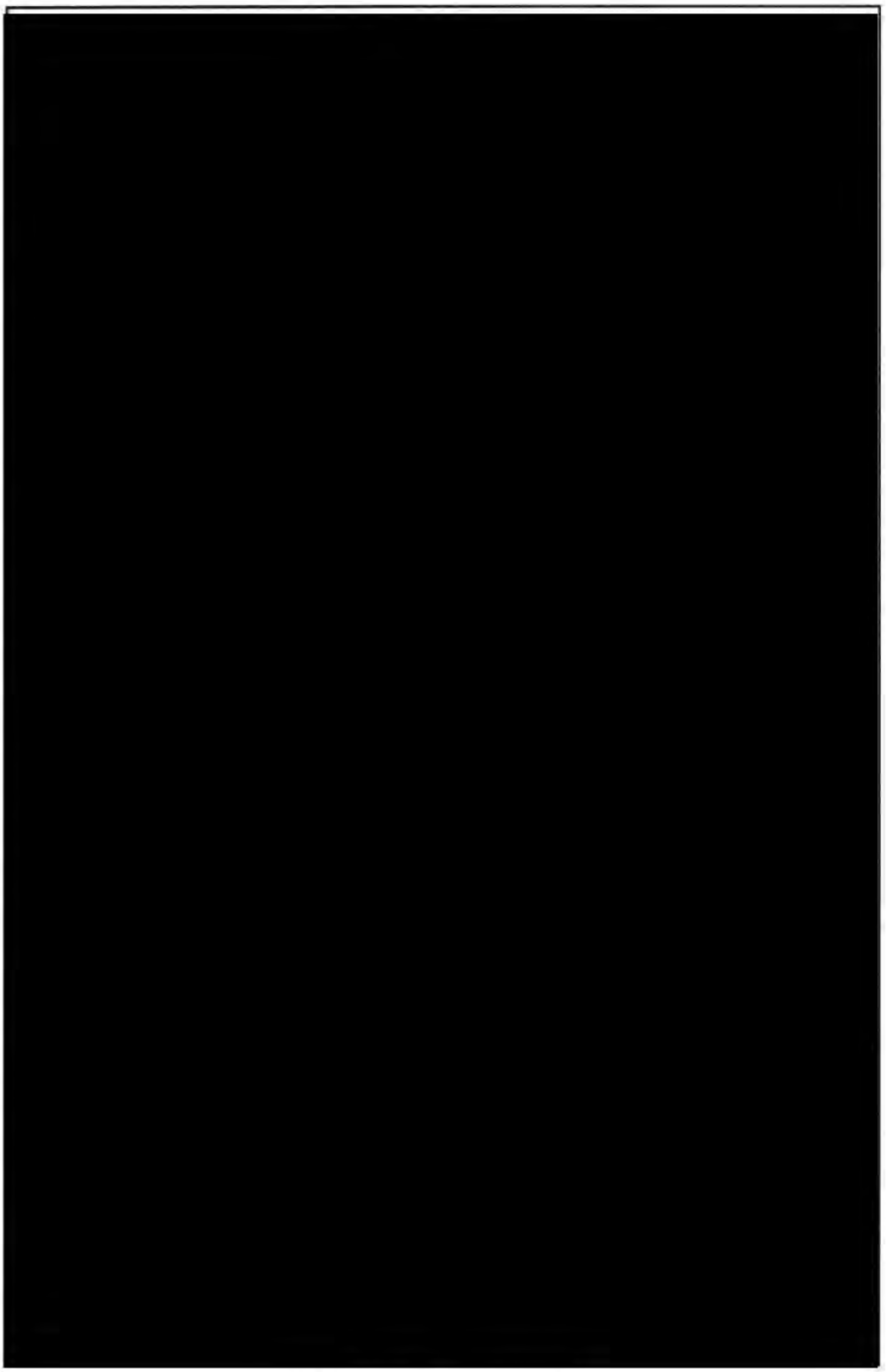
Q Okay. Have you had a chance to review any documents, any of David's chart, for instance, before today?

A Yeah, I did. When I got notice that I had a deposition, so I did review briefly, you know, some of my notes.

[redacted]





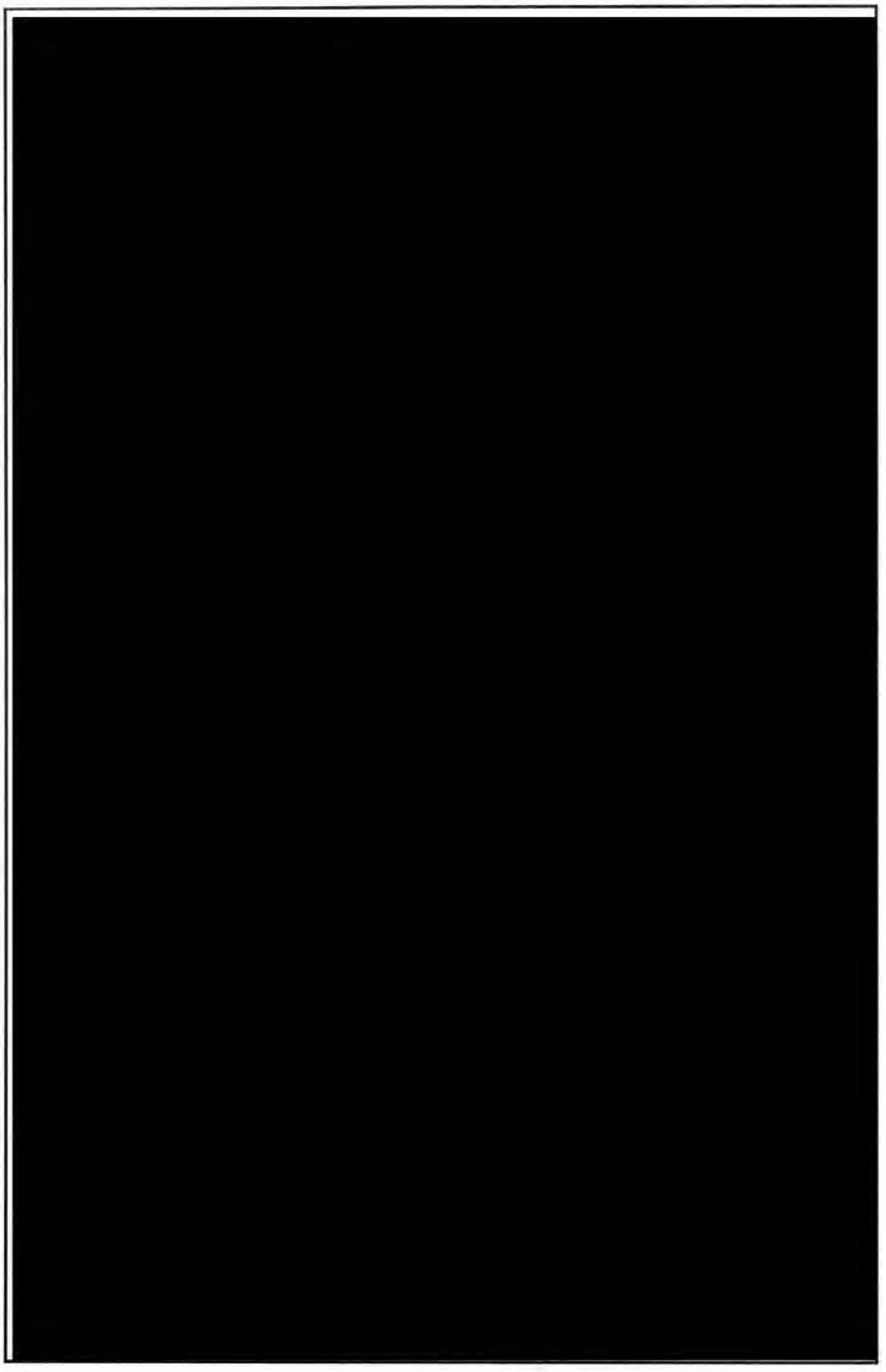


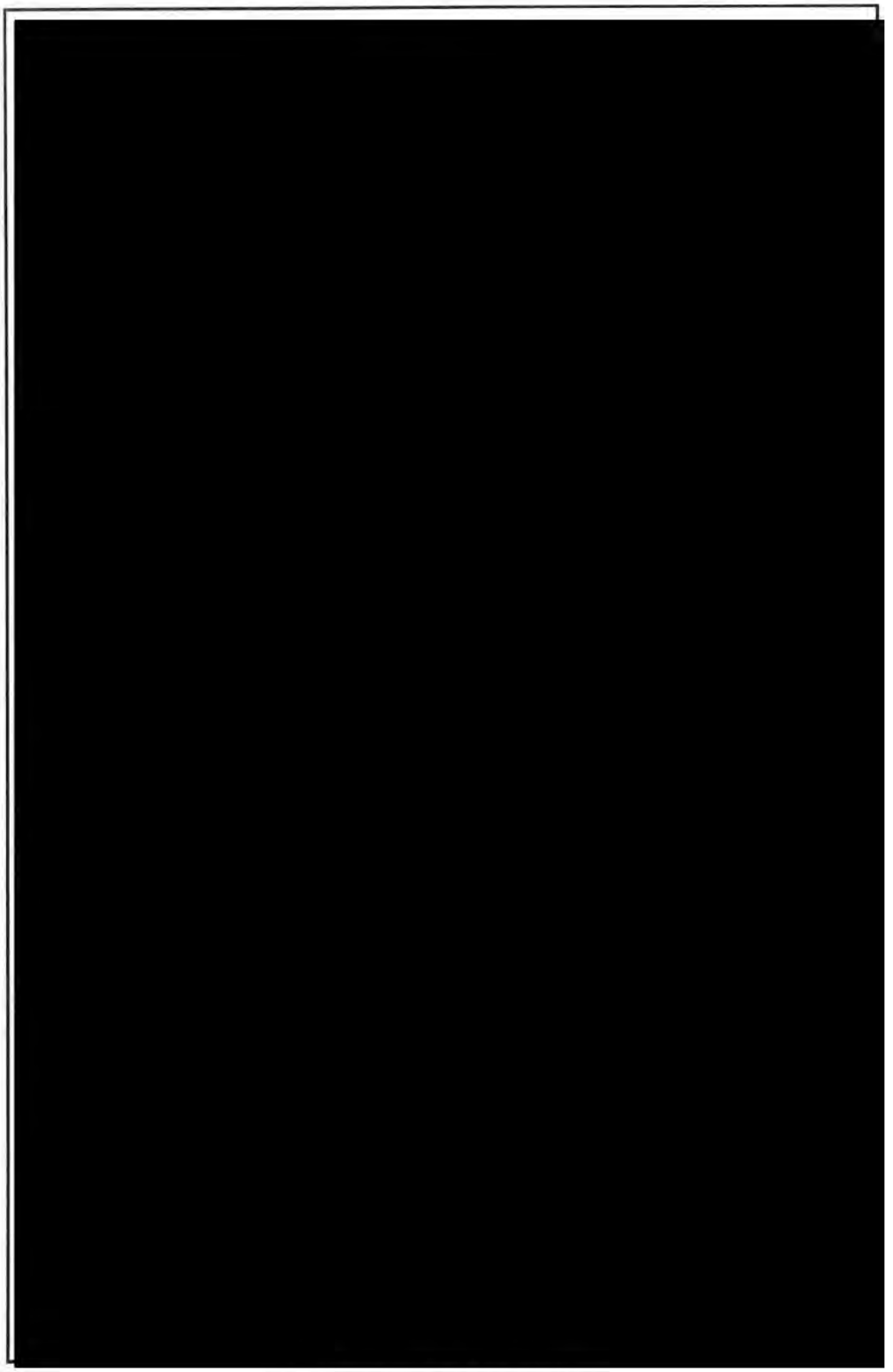
[redacted]

Q Okay. And I'm specifically referring to this order here. [redacted] Reading that, to me, it sounds like a requirement for David. Are you saying it wasn't?

A I don't think so it was a requirement, requirement, you know. So what I see here is that if he was having an active behavior, and that's what happened after he had his lunch looking at the records, and that's when he was physically restrained. So looking at the risk and benefits at that time -- you know, clinically, you know, I don't know what happened at the point in time. I was not there. But, you know, at that point in time, you make him elevated just because [redacted] I really just cannot justify it. This is a very standard recommendation on anybody who's got [redacted]

[redacted]





[redacted]

Q And does that record that you're looking at -- where is that record found in the -- where would I find that in his records? I have his records, but if I wanted to see what you're looking at.

A What I'm looking at is on the Booneville Human Development Center annual medical staffing report, and

this review is from July 17, 2019.
Q Okay. Does it have a Bates stamp at the bottom?
A No, sir. I don't see that.
Q So it's not a document given to you by the attorneys; it's from your own -- or from the facility's copy of the chart then? If it had a Bates stamp, I'd be able to find it easier with what I have, but that's okay.



Q It doesn't give any details about the circumstances or the environment?
A I don't have that information in front of me.
Q Where would it be if I wanted to find that?
A It should be in his chart for sure, you know.
Q What was the exact date again in 2009?
A 10/28/2009.
Q Dr. Hamid, what knowledge do you have of David's behavior issues?
A I don't look at that part. There's a psychiatrist that, you know, is looking at the documents, our psychiatrist that managed the psych medications and

everything. But, again, looking at the -- you know, it seemed like he had, you know, issues with behaviors.



Q I noticed in the emergency chemical intervention checklist that were provided for David -- well, I assume your file of the emergency chemical intervention checklist?

A Yes, I am.

Q I noticed that the first question on that checklist is, is he on the do-not-restrain list. My question to you is, if you know, what clients or what type of clients or what would the reasons be for a client to be on the do-not-restrain list, if you know, if that's your area?

A Well, again, I don't know that, but you talk about medical decision-making and you've got a client who's got a pretty bad back, you know, I would not put that client on a restraint, you know, or, you know, do the early chemical intervention and things like that.

Q If a client was going to be placed on a do-not-restrain list, would that be an order that you make or would that be a decision made by somebody else?
A Can you repeat the question for me?
Q If a client were to be placed on the do-not-restrain list, is that a decision that you would make or would that be a decision that came from another person at the facility?
A Eventually it's going to go past me as well.
Q Do you have any recollection of any clients who -- I'm not asking you about specifics about your other patients, but just in general, do you have any recollection of any clients at the facility that have been on the do-not-restrain list?
A I don't have a recollection of that. I know there are some clients that are on early chemical intervention, but I don't know. I may be wrong, but I don't think so we have any client that's on no physical restraints because if they need it, if they're a danger to themselves and others, we do have to somehow control that.
Q Are there any medical conditions that you can think of that would warrant placing a client on a do-not-restrain list?
A Again, as I just mentioned, somebody who's got a

broken back or a bad back, always trying not to do it. I don't know of any medical condition that would, you know, prevent anybody on going on restraints.

Q Do you work with Mark Heiss and the other folks at staff development on the phase one training and the things that are taught to the staff members as far as how to physically restrain clients? Do you have any participation in that?

A If you're talking about the same thing, I mean, I have to go for the phase training as well. I've been part of it. If you're talking about the same thing or are you talking about something different? I'm not -- I have been part of phase training, but it's not something I do every year. I've been part of it probably a few years ago, but I don't have recollection of it very well.

Q Honestly, what I'm asking is I want to make sure that it's not something that originates in your office, the phase training, what's taught, what's approved. I'm just trying to get a sense of whether you as the medical doctor on staff has any involvement in approving the forms of restraint that the staff members are trained in, if that make sense?

A Again, I didn't get the question right. There is a form that I sign in which there are about, you know,

five boxes in which we click as to which restraints we can offer to these clients. If you're talking about that form, then I do sign that form on every client.
Q What form would that be? because I want to make sure we are talking about the same thing. What form would that be?
A I don't have it in front of me or anything.
Q Could you do your best to describe it for me? I know you said there's five boxes.
A I think there's a chemical intervention and, you know -- again, I have to look at that form to tell you, you know. Probably physical restraint, two point, or it says something like that. I have to look at it.
Q You can't think of what it might be called or where it might be located in the --
A No, I don't, but I can look into that.
Q Okay. We may in a minute take a five-minute break here and let you take a look for that because it may be something I already have, Doctor, but if it's not, I need to know about it.
A I can ask my secretary to look for it.
Q Okay. What knowledge do you have about the event that led to David's death?
A Again, all I have recollection is I was told that, you know, David has been sent to the hospital, and I

looked at the hospital records. I don't have any direct, you know -- all the recollection I have is by reading through the notes.

Q Okay. Have you ever spoken with any other staff members about what happened on that day?

A No, I have not.

Q Well, if you were to -- I understand that your information just comes from things that you've read, but as you sit here today, what is your understanding -- what is your present understanding of what happened to David?

A I mean, I can read you the things that I noticed.

Q Sure.



Q Okay. Yeah, I'm asking about the event that happened. Based on whatever it is that you're looking at or that you heard or read, what is your understanding of what happened? That's what I'm asking.

A This says that after lunch, David Cains started to

kicking, yelling, biting. The staff attempted to settle the client and he started to vomit and turned [redacted] Do you want me to go over all this?

Q No, but I would like you to hold that document up that you're looking at, please. Hold it up to the camera so I can see what it is. Okay. Let me see the bottom of it, too. Do you know who wrote that? Does it say?

A No, it doesn't.

MR. COLLINS: Can we pause for just one second?

MR. GILLISPIE: Yeah.

MR. COLLINS: My apologies. Go ahead.

BY MR. GILLISPIE:

Q So the document that you read from, Doctor, that's part of his chart. Was that in his chart? Where did you come by that document?

A Again, when I was told that I have a deposition, you know, they gave me those records, so that's part of the records that I got.

Q And who did you ask?

A My DON.
Q Who's that?
A The nursing supervisor, which is going to be Stacy.
Q Stacy? What's her last name, sir?
A I'm so bad at the last name. I know her by Stacy.
Q That's fine. I think I know who you're talking about.
And so when you learned you were going to be deposed, you asked Stacy for what exactly?
A Medical records. I need to go over the medical records. And then Jennifer Berry sent me some records as well.
Q This read from there, would with that have come from Jennifer Berry?
A Again, I've got a lot of papers here, so I'm not sure whether this particular one came from Jennifer Berry, but, again, it was on my table, so I'm not sure, you know, which one came through.
Q Okay. So I noticed that that description has no mention of David being taken to the ground and a restraint being used on David whereby he's held on the ground. Does that mean that you have no knowledge that that occurred?
A There's a lot of records that I've mentioned and I

came across some records that mentioned that he was in restraints on the ground. This may not be part of this particular thing that I just read, but there were stacks of papers. I did notice that.

Q And Dr. Hamid, one of my goals here is to figure out for this family, his mother and his sister, what exactly happened medically that caused his death. And that's where I'm going with this. I'm hoping that you could maybe help shed some light on that. Based on the depositions that I've taken of the three staff members that were there and that participated in the restraint, those being Tyler Matson, Mandy Jones, and Ryann Campos, we know that this restraint took place a few minutes after David had his lunch. Are you aware of that?

A I'm not aware of the exact timeline.

Q Okay. Well, for purposes of today, I'll represent to you that this event took place five or ten minutes after he finished lunch, so keep that in the back of your mind as we move through my questions here. I'll also represent to you that a behavior incident occurred. David and a staff member named Tyler Matson end up on the ground. How exactly David landed on the ground, whether he landed on his face, on his back, it's not crystal clear at this point, but he --

according to Mr. Matson, there was a struggle of some sort and they sort of topple over onto the ground. And I'll represent to you that that's how he got to the ground. Are you with me so far?

A Yes, I am.

Q According to Mr. Matson -- and at this point, it's only Mr. Matson and David in the room and this is in the lobby area outside of the cafeteria in the commons building. At this point, Mr. Matson says that he held David on the ground or he turned David onto his left side specifically and held David on the ground for, he says, two to three minutes. Let's just say for purposes of today a couple minutes. And during this time, as Mr. Matson says and as the other two witnesses say, David is agitated and flailing, kicking about and screaming possibly. Are you with me so far?

A Yes, I am.

Q The next thing that changes in the environment is that another direct care staff member, Ms. Amy Jones -- she goes by Mandy. Mandy enters the room and she assists Mr. Matson in restraining David. Specifically she says that she grabbed David by his wrists or arms and sort of knelt in front of his head. Again, David is on his left side. She knelt behind him with his hands on David's body in some capacity. And then at

this point, Mandy is also kneeling but more above his head and holding him by his arms in some way.

There's some conflicting statements about whether Mandy might have been holding him by the head. She didn't admit to that, but there's conflicting witness statements from Mr. Matson and Ms. Campos that Mandy may have been holding his head at some point as well because David was spitting, I think, or supposedly he was spitting. According to Mr. Matson, the two of them continued to hold David there on the ground against his will because he's screaming and flailing for another couple of minutes.

The next thing that happens is Ms. Ryann Campos, another staff member, enters the scene and she joins in on the restraint by grabbing David's legs because she said David was kicking. Are you with me so far?

A Yes, I am.

Q Before we go further, do you have any questions about these details that I just represented to you?

A No, I don't.

Q It's all very clear in your head?

A Yes.

Q David is on his left side, according to these three witnesses. And the three of them hold him there like that for another minute or two. So each of the

witnesses, the amount of time they say passes is a little different. According to Tyler, it could have gone for as long as seven minutes total. According to the others, maybe a little less, so let's say four to seven minutes of -- four to seven minutes of David being restrained against his will on the ground by three staff members. During that time -- during which, according to all staff members, David was extremely agitated, flailing. According to Tyler, he may have been screaming, but very agitated and extremely agitated, flailing, kicking according to these witnesses. Are you with me there so far?

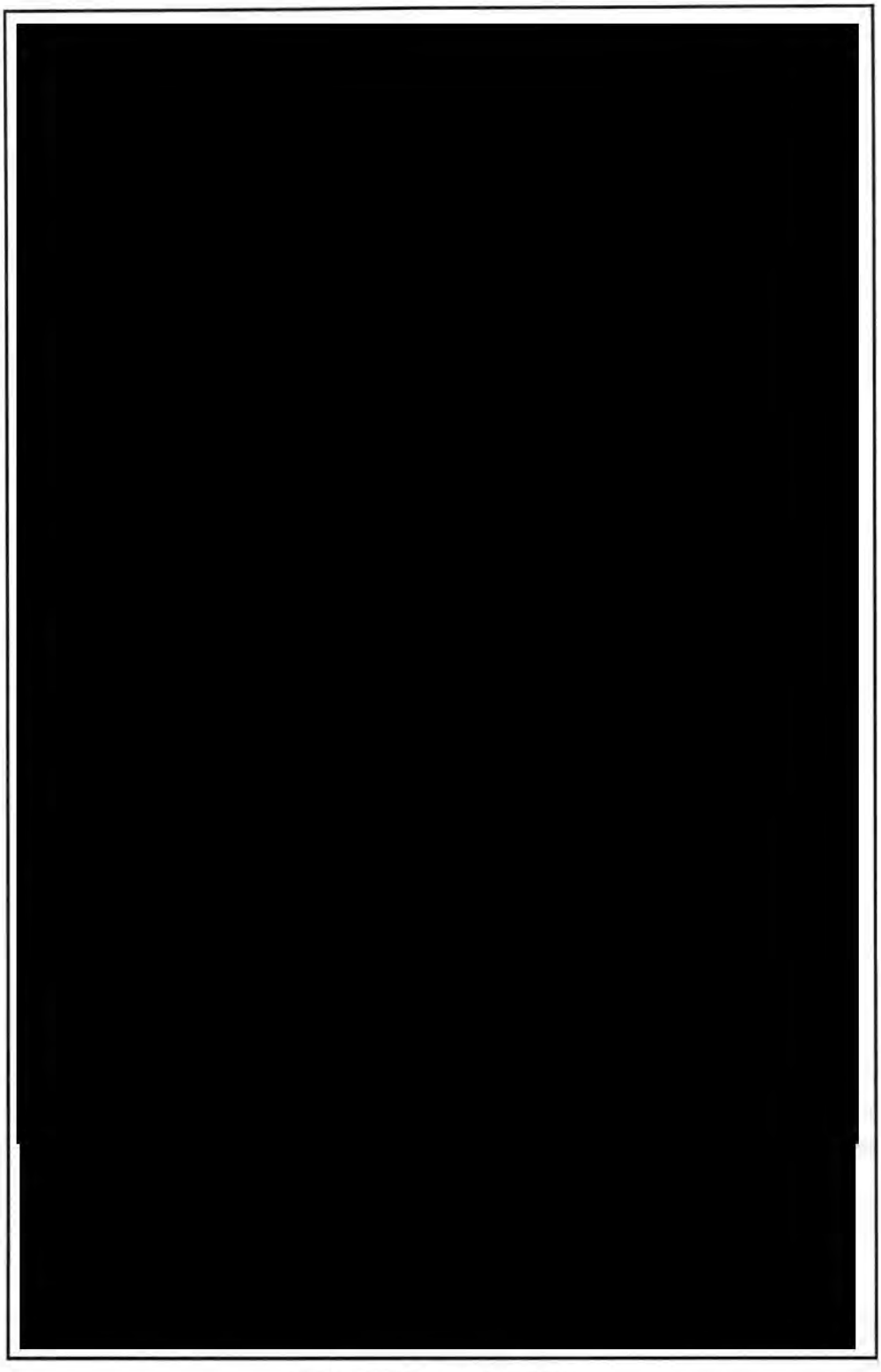
A Yes, I am.

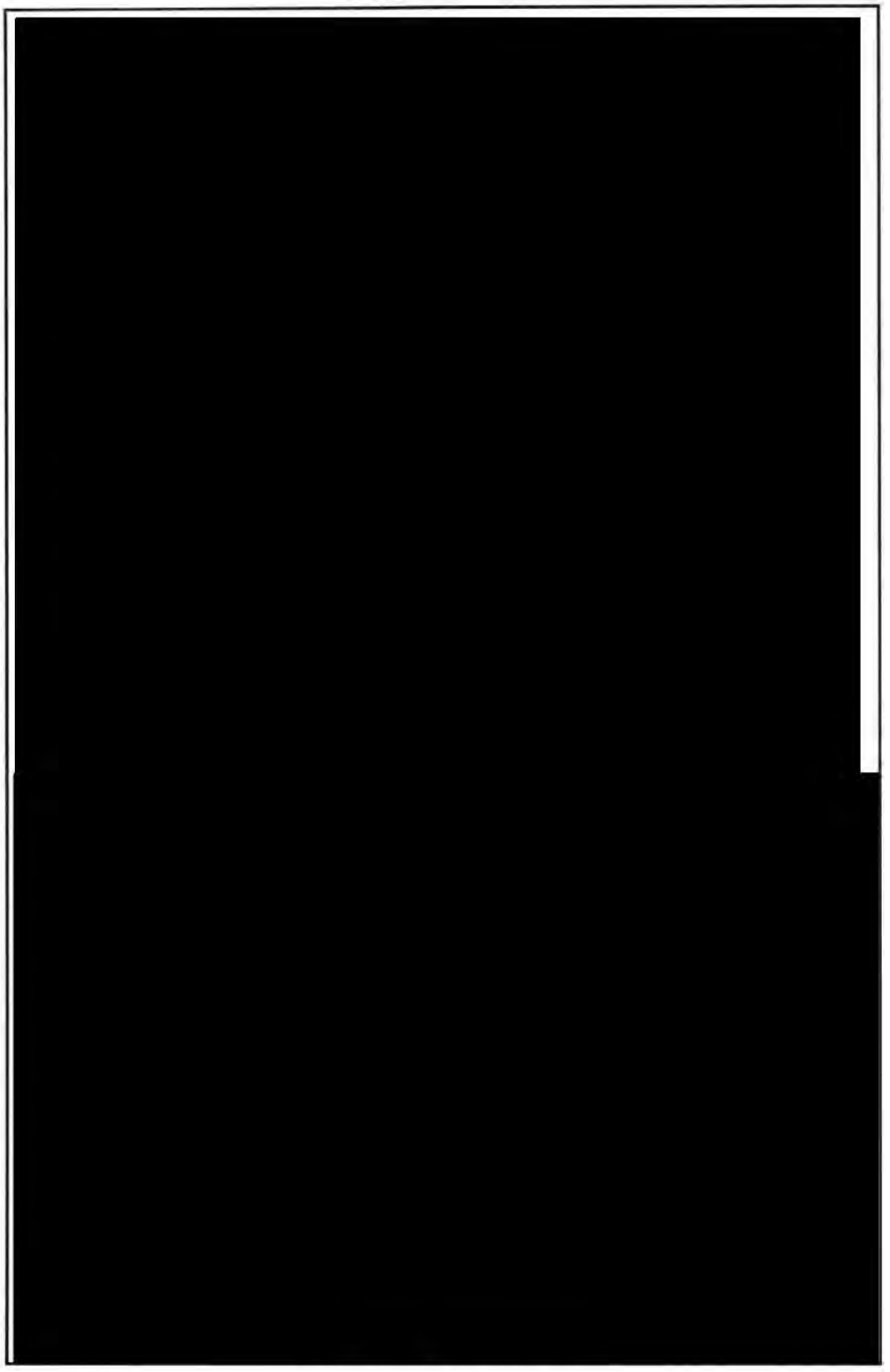
[redacted]

[redacted]

Q Well, I just want to make sure that you're -- I'm trying to paint a picture for you here based on the picture that was painted for me by all these witnesses that I've had to depose.

[redacted]





[redacted]

Q Is it possible for somebody to choke on their lunch after they finish their lunch and several minutes after lunch?

A Sure. I mean --

Q How does that work?

A Anybody can have vomiting, right, after intake of food, after eating. I mean, a healthy individual can have an episode of vomiting, too.

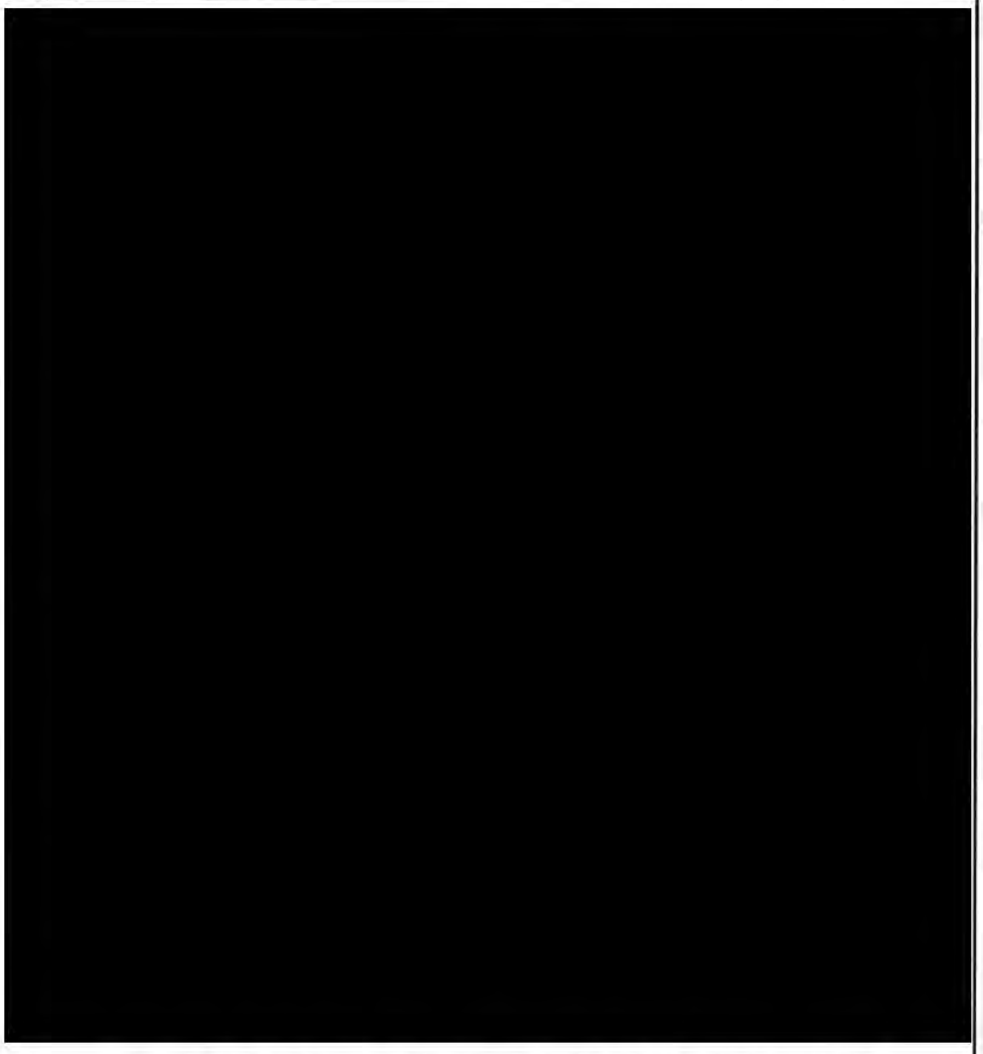
Q How long does it take for food to pass through the esophagus and the stomach? Does it happen --

A Right away.

Q Right away?

A Yeah.

[redacted]



Q Assuming that -- let me ask it this way: Could restraining David in the position that I described to you, restraining him on the floor in the position I described to you, taking him to the ground and then restraining him on the floor in the position described to you, could that have prevented him from having the normal protective reflexes, you know, i.e. protecting his airway from vomit?

A No.
Q Why not?
A He was in the left lateral position, you know. I don't know how else you can restrain this patient. He vomited after and he vomited after being placed on that position. Again, looking at or pointing to the records, he vomited after he was placed in that physician, probably aspirated. Again, you know, there's no definite answer as to that point in time. You can assume that this could be a possibility and there are other possibilities that could happen and lead to his death.
Q Assuming everything that I described to you about what was happening to him is true, what are some of the possibilities that could have led to him -- led to vomit clogging his airways?
A I don't understand the question.



Q But to be clear, you do not think that a physical restraint of this sort -- are you saying you don't

think the physical restraint had any causal effect on him vomiting and going into cardiac arrest?

A I was not there, so I don't know how much strength was used, but in real world, again, physical, if somebody is restrained and he chokes to death, you know, does not happen. So I don't think so physical restraint -- there's no way for me to tell because I'm not there at that particular point in time and how much strength was used. No.

Q I don't think I quite understand something you just said.

MR. GILLISPIE: Hey, Kristi, could you read back his passage just there for me?

(WHEREUPON, the court reporter read back the previous answer.)

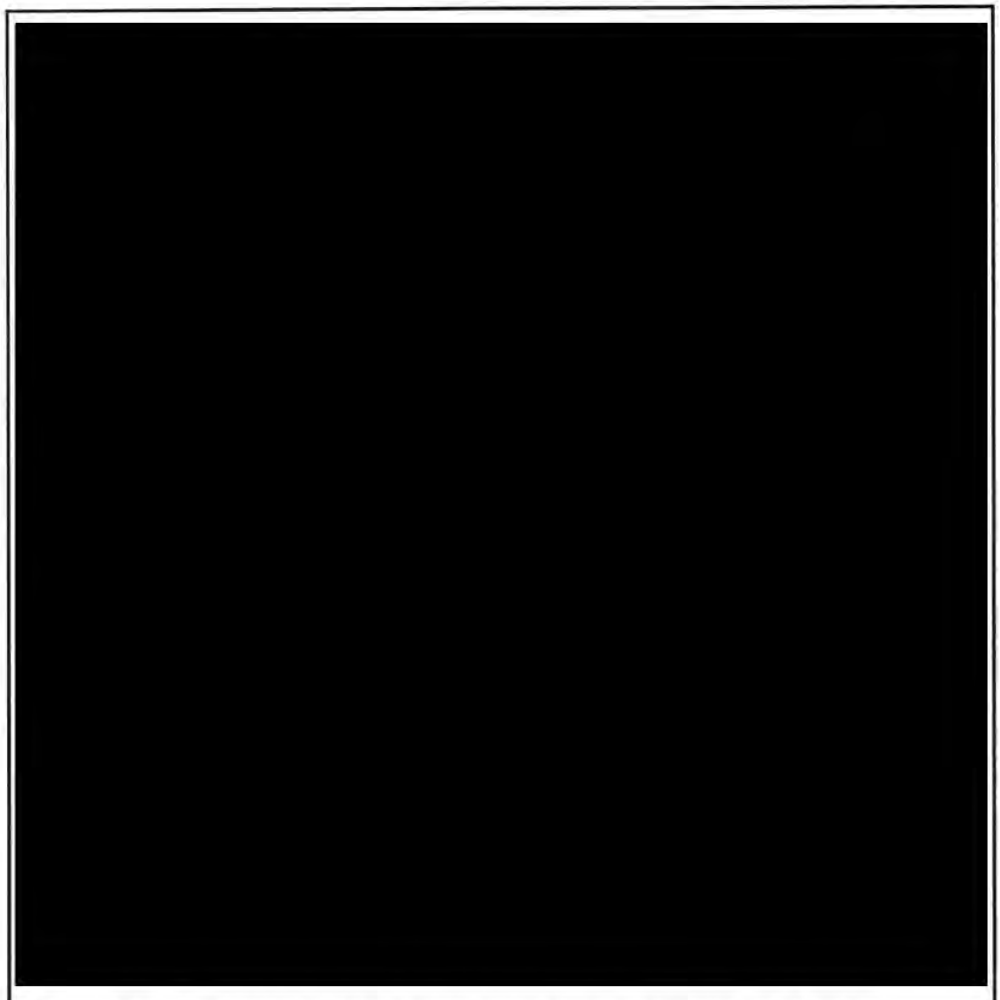
BY MR. GILLISPIE:

Q If you could, finish your thought for me about in the real world. In the real world, what? I don't quite understand what you meant there.

A I mean, I have not come across any case studies that the patient who was physically restrained ended up choking to death because of that physical restraint. I have not seen any case reports. It has not come in my practice, you know, even working at BHDC here and other facilities.

Q You have no knowledge of physical restraints on the ground being dangerous to clients? You have no knowledge of that?
A Physical restraint on the ground, if you're choking somebody by the neck, it can be dangerous.
Q Well, I'm not talking about choking somebody by the neck.
A Right. So I really don't understand the question in the sense that it would depend on how much, you know, strength is being used or how is the patient taken down. I think it would be eventually, you know, how long the patient was on the ground and whether they're doing it appropriately or not.
Q Well, ground restraints in this type of setting aren't allowed at your facility. Mark Heiss, who does the training, confirmed that for me, that this was an improper restraint. So restraint is not allowed. So I'm assuming there's a reason for that, and everything that I read on the standard of care for the intellectually disabled in facilities like this is pretty unanimous about the particular dangers of ground restraints. All physical restraints are dangerous as the facility's own documents say. But ground restraints in particular being dangerous to these clients. What I'm asking you is are you saying you

don't agree with that?
A I don't disagree with that. If it was done properly and we don't have a choice, especially in the circumstances, I mean, there's no time for chemical intervention. You have to hold this client because he's going to be a danger to himself or some others.
Q And what would be the particular risks of restraining a client on the ground? Why is it dangerous then? Since you agree it's dangerous, why is it? What are the risks medically associated with restraining a client on the ground?
A Physical assault on a patient when putting him on the ground. You can break a bone. You can, you know, asphyxiate somebody. It depends on how much physical strength is being used.
Q Okay. Given the event that I described to you, is it possible that -- you know, I'm not able to tell you how much physical strength was being used, but is there any amount of physical strength that could have been used in that setting that could have led to David's vomiting and choking?
A I don't think I'm going to be able to answer this question because I'm not there at that particular point in time. How do you expect me to answer that question?
[redacted]



Q Am I correct that seizures can occur without visible convulsions?

A Yeah. They are absent seizures.

Q And am I correct that seizures can be brought on by extreme distress or agitation?

A Any kind of stress can do it.

Q I'm sorry. Say that again.

A It can.

Q Could severe agitation coupled with a physical

restraint that heightened that agitation induce a vagal response that can lead to emesis and aspiration?
A Possibility. I cannot completely rule that out.
Q Am I saying that word right, vagal?
A That's right.
Q So that would be a possibility then of -- in this scenario, that's a possibility of how he came to vomit?
A There are a lot of possibilities. I mean --
Q What are some other possibilities? What are some other possibilities of -- you know, I don't believe it was a coincidence that this guy -- you know, that Mr. Cains starts vomiting and choking in the middle of his physical restraint. Do you believe that's a coincidence? Is that your opinion that the physical restraint likely had nothing to do with his death?
A I have no way to confirm on that, but I don't think so.
Q And I need to know every reason why and I need you to be as thorough and detailed as possible to me as to why that's your opinion.
A Why is that -- I mean, I feel that, you know, he aspirated on the food particle and that was probably the cause of his death.
Q But you do not feel that the extreme agitation of being physically restrained on the ground in any way

could have triggered that aspiration?
A Again, there's always a possibility. That kind of extreme agitation can trigger a heart attack, can trigger a stroke. So there's a lot of possibilities, you know.
Q Can it trigger vomiting?
A It can. I don't know if it can.
Q It can?
A There's all kinds of possibilities as I mentioned. It can trigger a heart attack. It can trigger a stroke. Any kind of this level of stress can trigger a lot of things.
Q Can it trigger vomiting?
A Again, I don't know.
Q It can or --
A It's a possibility.
Q Well, I just want to be clear. You're saying it can. I don't know, so those are --
A It is a possibility.
Q So it can. Yes, it can. That's all I'm trying to get to. In other words, yes, it can or you're not sure if it can?
A It can, possibly can.
Q Okay. I'm sorry. I'm not trying to harass you. I just want to make -- I want to make sure that the

record doesn't look like, you know, you're giving contradictory answers. I know that's what you're trying to do, but I just have to make a clear record.

Is it also possible that a really bad episode of reflux could have caused vomit to enter his esophagus and obstruct his breathing?

A Anything can be possible, but looking at his records, he was visually monitored while he was eating all the time, so he was not doing it for years. Whether that happened at that point in time, there's no way to tell. Looking at his records, he passed his swallow study without any problems. He didn't have any choking episodes before so, you know, unlikely.

Q I'm not even asking you if that's what you think happened to him. I'm asking is that just -- is that medically possible for somebody to reflux that severely that they begin to vomit like this and choke on their vomit. Is that possible medically?

A I have not seen any case studies where somebody has this bad of reflux that he vomits and chokes to death. Again in my clinical practice, I've not come across it.

Q Have you come across a situation where somebody refluxes and vomit enters the esophagus and they don't die, but --

A No, I have not.
Q Okay.
MR. GILLISPIE: Let's take five minutes, Eric, for a break.
(WHEREUPON, after a break was taken, the proceedings resumed as follows:)
BY MR. GILLISPIE:
Q Dr. Hamid, is vomiting more likely to lead -- in general, I'm asking in general. Is vomiting more likely to lead to choking if a person is on the ground as opposed to if they're standing upright?
A It can, you know, but, again, if you are in a left lateral position, then less chances, you know. Otherwise, you know, if you're laying flat, then obviously you're going to have more chances for aspiration.
Q So you're saying if you're lying flat on your back and you vomit, you're going to have a greater likelihood of aspirating than if you were standing up?
A That's right.
Q Let's say you're lying at an angle, partially on your back, partially on your side. I assume you're also going to have a greater likelihood of aspirating if you vomited than were you standing up.
A I don't know what position is that, but left

lateral position, you've got less chances for aspiration as completely laying on your back.

Q Well, the position -- and I didn't go over this with you before, but if you could, please let me finish my question. I understand that you know where I'm going with it, so that she can make a clean record, it's important that you let me finish speaking before you start speaking, and I'll do the same for you.

Okay. Let's just say laying completely on his left side, laterally on his left side. If a person is laying completely laterally on their left side when they begin vomiting, are they at an increased likelihood of aspiration than somebody standing up? Now, I understand that the likelihood or the risk is not as great as if that person had been lying on their back. What I'm asking, though, is, if it's still an increased likelihood of aspiration when somebody is laying laterally on their left side as opposed to standing up.

A I don't know that answer. You're asking me about whether the person is left lateral versus standing; is that right?

Q Right.

A And I really don't know the answer for it. I don't know if there have been any studies done. I

don't know the answer to that question.
Q Okay. So to be clear, you're not sure whether a left lateral position would lead to an increased risk of aspiration after vomiting?
A Compared to what?
Q Compared to standing completely upright.
A I don't know the answer to that.
Q Okay. What if somebody is positioned partly on their back, and that was what I was trying to describe to you before, meaning positioned at an angle to where the left half of their back is on the ground and they're kind of like this, at an angle. Do you understand what I mean by that?
A Yeah.
Q Partially on their back is what I'm saying. Would that not also be a situation where vomiting would lead to increased risk for aspiration as compared to standing up?
A I do not know the answer to that.
Q So the only thing you can answer about is if somebody is laying completely flat on their back?
A That's right.
Q And if they're slightly at an angle in any way, then you don't know the answer?
A I don't know the answer because it literally says

with left lateral position, you've got with increased chances for aspiration. I don't know the position in between, whether that's an increase or decrease. I'm not aware of any studies that have been done.

Q Are you quoting from something when you say that left lateral means a decreased chance for aspiration?

A That's a pretty, you know, standard of care just like, you know, [redacted] put them in left lateral position so that the secretions are not going to your throat. They're just drooling out through the angle of your mouth.

Q And I want to go back to what I think you said that your position was and I want to make sure I understand correctly. With regards to what happened to Mr. Cains, correct me if I'm wrong, I believe you said that -- you testified that you weren't there, you don't know for sure what happened, but it's your opinion or your belief that most likely this physical restraint whereby David was taken to the ground and held on the ground did not have anything to do with his death. Did I state your position correctly?

A I don't think so. But then again, I'm not there

at that point in time.
Q You don't think I stated your position correctly?
A No. I do not think that physical restraints --
Q Well, first of all, let's just answer -- let's just one question at a time. Yes or no, did I state your position correctly?
A You're going to have to repeat the question again.
MR. COLLINS: That last question he just asked, I didn't hear what you said.
THE WITNESS: Again, I --
MR. GILLISPIE: He sort of anticipated the next question and answered that one. But I'm repeating my question for him. He asked me to repeat it. I'm going to repeat the question.
BY MR. GILLISPIE:
Q So my question is, is it your position here today -- is it your testimony that while you weren't there and while you don't know for certain, you feel like it is most likely that the physical restraint used on David, which included taking him to the ground and holding him down on the ground, one person by his body, one person at his legs, one person at his arms, one person may have had his head, is it your position that most likely that restraint event did not in any way

lead to David's death? I'm just asking is that your position. Did I state your position correctly? Is that your position, yes, no, or --

A It's unlikely, but I cannot promise.

Q Sir, I'm sorry. First, I need you to just -- before you get into describing the whys, just tell me if that is your position or not.

A Yes.

Q Okay. Now you can tell me why that is your position.

A Because I was not there at that point in time. That's why.

Q Well, then why would you have an opinion at all about whether the restraint caused his death or not? Why wouldn't you just say, he could have, I don't know?

A I just said unlikely it could have caused.

Q But why is it unlikely it could have caused it? That's what I'm asking you.

A Because I was not there at that point in time and I don't know how much force was used and what happened at that point in time. That's why, you know, I can't say for certain.

Q I understand that, that you can't say for certain, but when you say "unlikely," that's giving it an opinion as opposed to just saying I don't know. If you

were to say I wasn't there, I don't know, okay, that's fine, but you're saying I wasn't there, I don't know, but it's unlikely.

[redacted]

Q Are you basing this opinion on anything else other than the records that you are referencing right now?
A That's the only way I have the knowledge. That's pretty much. I'm looking at the records.
Q And when you say "the records," are you talking about what is in front of you right now?
A I've got very limited records in front of me right now. I had stacks of paper that I briefly went through.
Q Okay. This is very, very important, Doctor. I need you to -- so at a deposition, anything a deponent brings to use at a deposition, I get a copy of. And it's very, very important that you send to Mr. Collins exactly what you're talking about when you say the records that you used to base your opinion. And I want to go over with you right now exactly what those records are. The records that you've used to base this opinion, what are those records? It's important that

we be thorough here.
A I'm looking at the EMS records right now, so is that part of your --
Q EMS records. I have those.
A I'm looking at those witness statement forms.
Q What do those say at the top?
A Facility investigation report for resident abuse, neglect, misappropriation of property, and exploitation of residents in long-term care facility.
Q Can you hold that up for me real quick so I can see it? I want to see if it's something I have already or not.
Okay. OLTC witness statements?
A That's right.
Q So OLTC witness statements. We have EMS records and now we have OLTC witness statements. Are you using the statements from all five of the people that gave statements?
A Again, I'm going over right now witness full name, so there's one that I see, the second, third.
Q Or maybe just tell me the name of the witness for each of the ones you're relying on?
A Daniel K. Jones, Ryann Mariah Campos, Amy Amanda Jones, Tyler Matson. And then I am looking at roles and names of others involved. I don't know what --

Q Say that again, sir. I'm sorry. Say that one more time.
A On top of this page, it says roles and names of others involved. Again, it talks about the timeline that the whole incident happened.
Q That timeline document. What other documents are you -- I need to make a list of every document and record that you've relied on to make your opinion. And so far, I have EMS records, the OLTC witness statements, and that document titled "Timeline."
A There's some more OLTC statements here. The same name, Tyler Matson.
Q Matson?
A That's right. And I've got this ER record in front of me.
Q Okay. Mercy emergency room records?
A That's right. I've got the Logan County EMS records.
Q Okay. We already got that.
A And then I think I've got his previous records in which they mention about his vital signs and then there's -- you know, all the records that says IPP reports.
Q Start with -- before you got to IPP reports, what was the thing that you had, records that mentions vital

signs?
A They're vital reports.
Q What reports?
A They're vital reports. I think they're talking about blood pressures.
Q Are those Booneville records or are those from another facility?
A No. That's the BHDC records.
Q Okay. Can I just see what those look like? So vital reports. What time period of vital reports did you look at? What's the time period for the vital reports you looked at?
A 06/01/2020 to 06/13/2020.
Q So is that 6/1/20 to 6/30/20?
A 6/13/20, one three.
Q Is that the end date or the start date or the only date?
A From 06/01/2020 to 06/13/2020.
Q Okay. June 1st to June 13th, okay.
A Then I've got others as well that has a different date. Do you want me to go over all this?
Q Yeah. If you used it to give the opinion you just gave me, then yes.
A There's another one that says the same thing, vital reports, and that's dated from May 1, 2020, to

June 30, 2020.
Q May 1, 2020, to --
A June 30th. Although we don't have that --
Q Right.
A And then I'm looking at this annual medical report.
Q Okay. IPP. And what's the date of that IPP? Is it the 2019 one or the 2018 one?
A I've got 2020 in front of me.
Q 2020?
A June 18, 2020, so probably was printed at that time.
Q Oh, is that the print date or the -- I think on the IPP it tells you the date that it was done, that it was actually produced.
A This is July 17, 2019, review.
Q Okay. So the 2019 IPP.
A But there are others as well with different dates, so. I've got another one that says June 18, 2020.
Q You have an PP that appears to have been completed in 2020?
A Or either it was printed at that date. I'm not sure.
Q Go to the next page on that and you should see where it gives a meeting date. For instance, July 18,

2019. I'm assuming what you're looking at it was printed in '20, but I don't know.

A I might find the date here. It's May 30, 2020.

Q And it's an IPP?

A That's right. It's this report, IPP. Do you see it?

Q Well, I see annual medical staffing report, yeah. I don't have a 2020. May what 2020? What was the date on that report, May what?

A June 18, 2020. I don't know --

Q Okay. I thought you had given me a May date.

A No. I don't have any May.

Q So it says June --

A 18, 2020. Then I have these, the timeline of the events. I think there's a lot of duplicates here. I do see the EMS records and everything.

Q How many pages is that timeline itself?

A That's one page that I have under this.

Q It gives no indication as to who wrote that timeline?

A No.

MR. COLLINS: Hey, Josh, let me interrupt real quick. So I was pretty sure I'd seen that before. So I think what that is, we used it obviously -- I'll verify, but

I'm pretty that was created for me by the client to tell me initially when we first got the case, what happened, what their timeline of events were. So I think what probably happened is when they found out he was being deposed, they probably just sent the file over to him and that was in it.

MR. GILLISPIE: I see.

MR. COLLINS: I'll review it. I don't have any issue necessarily with producing it, I think.

MR. GILLISPIE: I'm looking because I recognize it and --

MR. COLLINS: I may have sent it over already.

BY MR. GILLISPIE:

Q Doctor, is that timeline of events, is the date on the left-hand corner June 13, 2020?

A That's right.

Q And then it's a one-page document. And is the very last line a time 12:21 and then it says code called at BHDC?

A That's right.

MR. COLLINS: I'm going to find out if that was actually created for me or if that

was actually --

MR. GILLISPIE: Yeah. That was given to me by my client.

MR. COLLINS: Then I imagine it wasn't created for me. I just know I asked for a timeline.

MR. GILLISPIE: Yeah, she got that before hiring me and then --

MR. COLLINS: Gotcha. Okay. I apologize. Thank you.

MR. GILLISPIE: Yeah, because I knew I recognized it, but it wasn't in my discovery and that's because it was -- okay.

BY MR. GILLISPIE:

Q Okay, Doctor. So we have the IPPs, the vital reports, the Mercy ER records, that timeline, OLTC witness statements, EMS records, Logan County EMS records.

A And I've got this hospital records here.

Q Is that from his -- the day of his death at Mercy?

A That's right. So there is some repetition here. I've got a DHS incident report here. A lot of things that we have already talked about or, you know --

Q DHS incident report?

A That's right.

Q Could you hold that up, please? Okay.
A And I have, you know, those psych reports in here. I've got his full medical records here of at least five or six big stacks of paper.
Q But are those things that you -- you didn't go through all of that?
A I went through a lot of these things. Let me see what else I reviewed. As I told you, I went through the staffing report that's dated July 17, 2019. Then I went through this pneumonia risk assessment for him.
Q Why did you look at pneumonia risk assessment?
A Because I'm going through his chart. Whatever comes -- I mean, I pretty much went through a lot of things.
Q So are you saying you pretty much went through his entire chart in preparation for today?
A I went through the things that -- you know, went through like my office notes as well, I guess. And there's a choking risk assessment here.
Q What's that dated?
A 2019.
Q What are the dates of your progress note that you used?
A On the IPP, it's all mentioned in the IPP, so it --

Q So if it's part of the IPP, then that's all I need to know.
A Yeah.
MR. GILLISPIE: Eric, while he's going through that stuff, let's take five minutes to use the bathroom.
MR. COLLINS: Okay.
BY MR. GILLISPIE:
Q And, Doctor, when I come back, I just want to finish this list of documents and records that you might have relied on to form the opinion that you think it's unlikely that the restraint contributed to his death. So when I get back, just be ready to tell me what other documents there may be that you relied on.
(WHEREUPON, after a break was taken, the proceedings resumed as follows:)
BY MR. GILLISPIE:
Q So any other specific records or documents that you relied on in forming your opinion that you feel like it's unlikely the restraint led to Mr. Cains' death?
A I mean, I've mentioned about the choking assessments. I went through that. And there's a speech 2020 document that I went through as well. He was seen by a speech pathologist over here. And then

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there's a dysphasia disorder survey as well that I went through.

Q A dysphasia survey?

A That's right.

Q From what year?

A Let me check the date of it. This is 2014. There are some nursing reports here as well. On-site doctors as well. Went through those, too.

Q What are the dates on the nurse -- are they nurse notes you're talking about?

A The nurse's notes and, you know, the incident reports sometimes that they place on the chart.

Q What dates for the nurse's notes?

A A lot of these are 2017 that's right in front of me here.

Q Okay. And, again, I'm just asking for documents specifically that would have informed your opinion, not necessarily everything you might have looked at or everything you have.

A I already answered that question.

Q Okay. So you feel like you've told me every document that -- significant document that you would have relied on to form your opinion?

A That's right.

Q Okay. Thank you. And if your opinion were

correct, that would mean that it was coincidental to being restrained on the ground, his choking?
A I have no way to know that. Again, there's no definite answer that I can give that this led to this and this caused the death, you know.
Q And I understand that, but you're giving an opinion that you don't think it caused the death, and I need to know what specific facts you're -- you told me about these documents, but what can you tell me specifically -- what facts can you tell me that informs that opinion of yours?
A I may not have got the question right, but the way that I look at it is this patient had an episode of vomiting on which he aspirated. Whether the vomiting was caused by the physical restraints or taking him on the ground, I don't have the answer or the knowledge about it because I was not there at the scene, right. In looking at those records, what I see here does not seem like to me that excessive force was applied. Again, it's difficult to ascertain that, you know. Then I looked at the ED records and it shows some food particles in his throat. Makes me think that yes, he aspirated. What caused him to aspirate? I don't know.
Q Help educate me about when you say "aspirate," what exactly do you mean?

A How else to -- you know --
Q What happens when somebody aspirates? And I'm sorry to ask stupid questions.
A When somebody aspirates, they can have a choking spell. It can compromise your respiration and you can choke to death.
Q Does aspiration only happen when you're chewing and swallowing your food? Is that what you're referring to, or you referring to aspiration that occurs after food has entered the stomach?
A It can be both ways. You can have regurgitation of, you know, food particles. That's what happens in vomiting. You can have even silent aspiration as well that, you know, there's some trickle that goes in to your windpipe instead of the stomach. You've got a lot of cases of silent aspirations as well.
Q And when you say that from what you're seeing, it sounds like this patient, Mr. Cains, aspirated, which type of aspiration are you referring to?
A If he vomited, most likely he had regurgitation.
Q And is it possible for that regurgitation to be brought on by extreme agitation?
A It can. I mean, extreme agitation can cause a lot of things. Vomiting may be part of it, but I don't have a definite answer to this.

Q Can being on the ground itself increase the likelihood of aspiration in any way?
A I don't think so. I mean, if you have a good swallow reflex, you have passed your speech solo study and this particle applied, then I would say no. But then again, you know, depending on your mental status at that point in time, if you were, you know, mentally cognitively declined at that point in time because you're not getting enough air, you can aspirate.
Q I was wanting to ask about mental status and how that can contribute to something like this. What you're saying is that if your mental status is -- what are you saying about mental status? When you say your mental status could contribute or mental status could play into it, what does that mean?
A Because generally in a hospital setting, you have an altered mental status. You're kind of obtundent. You are drowsy, sleepy, you know, then you are more chances of aspirating. That's what I meant. I was not meaning in this particular circumstances.
Q So you don't mean mental status like an intellectual disability?
A No, sir. No.
Q You're meaning sedation, drowsiness, that sort of thing?

A Right.

Q What about if you take medication that can cause drowsiness or a sedated effect?

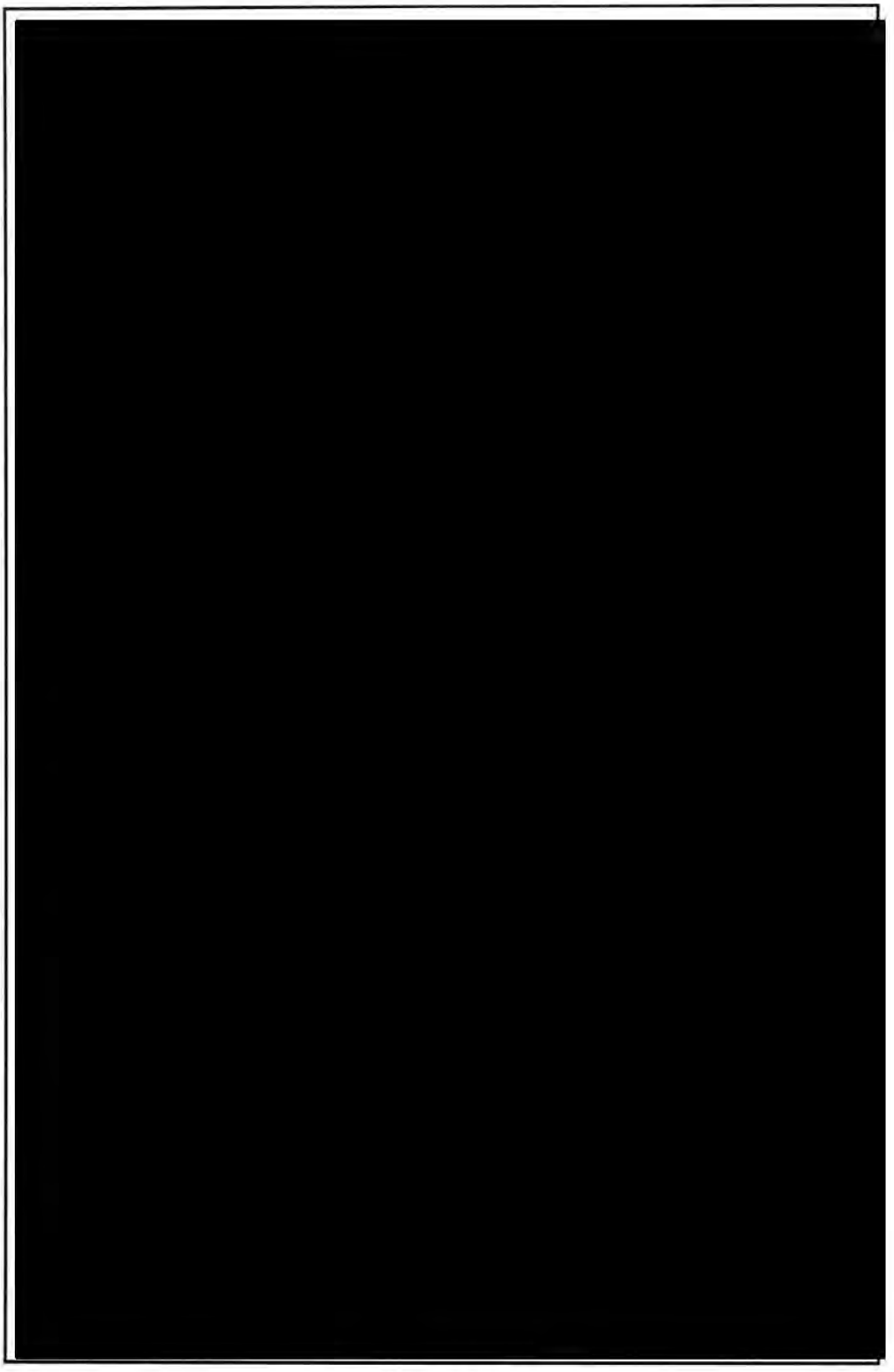
A If you're getting too much of sedation, you always have chances for aspiration.

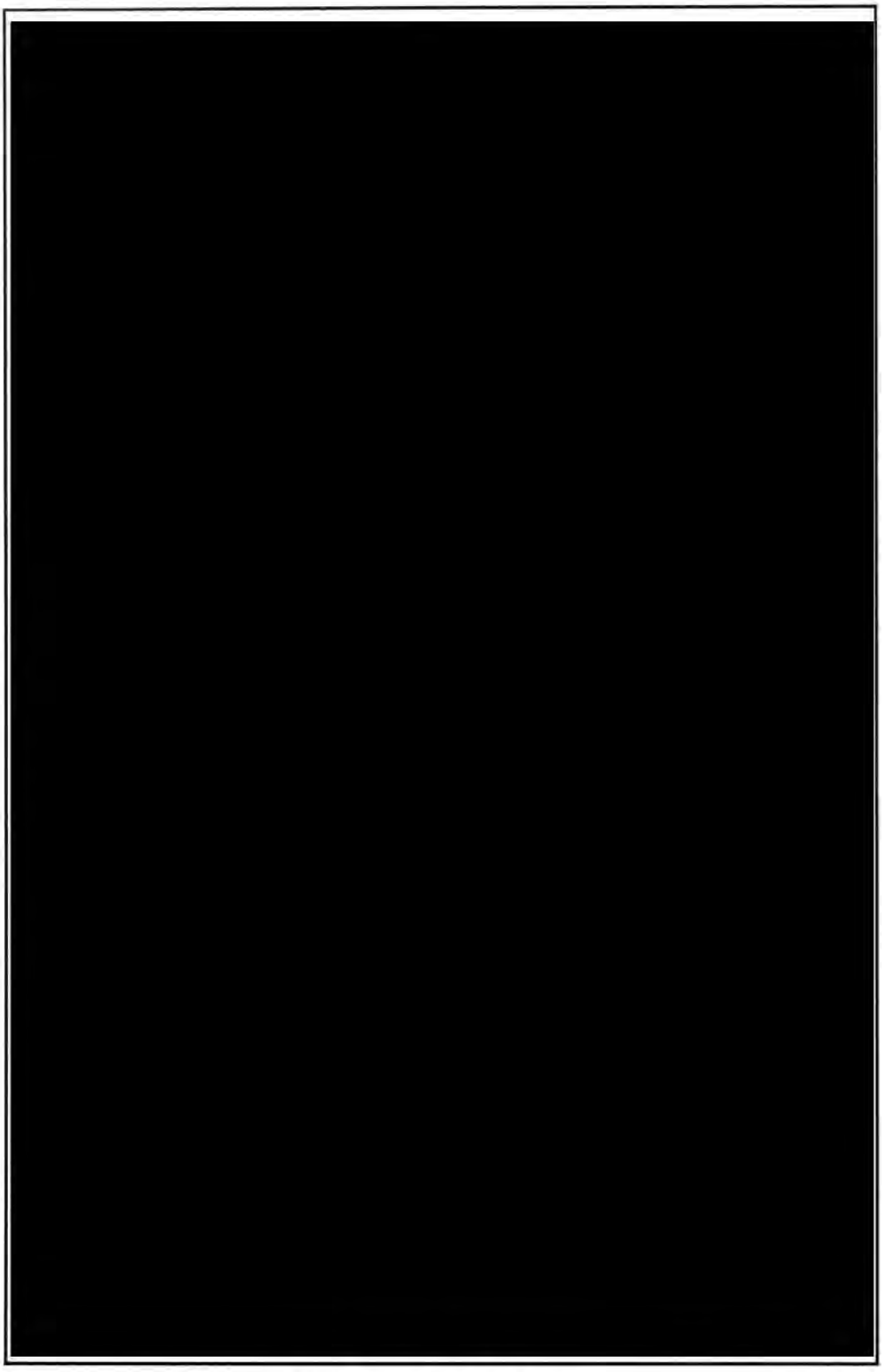
[redacted]

Q And what you said before was that -- or what you might find with aspiration is that patients whose mental status is drowsy or sedated can be more at risk for aspiration?

A If you are overly sedated, then anybody can go into aspiration if he's loaded with, you know, any kind of medications that would interfere with the swallowing mechanism. You're too drowsy to swallow.

[redacted]







Q Assuming that what Mr. Matson, Ms. Jones, and Ms. Campos described to me is accurate, that David began vomiting while on his side and that they then immediately put him on his back, would that have been the best thing to do in that situation, to put somebody who's actively vomiting on their back?

A He was in the left lateral position as required from what I see in the documents. He was involved in a behavior, so, again, I was not there at that point in time. That's what they felt was the right thing to do.

Q I think you misunderstood my question. I'm asking -- they all three told me that after he started vomiting -- he was on his side when he started

vomiting. They say that immediately once they noticed he's vomiting, they put him on his back. They rolled him onto his back. Do you follow me?

A Yes.

Q I'm assuming that's not the best thing to do given that you said that you don't want to be on your back when you're vomiting. So my question is, was putting him on his back, rolling him onto his back, rolling him from his left side onto his back while he's vomiting, was that the safest thing to do in that situation?

[redacted]

Q So let's say you had been present, you personally had been present, and Mr. Cains is on his left side and he begins vomiting profusely, would it have been -- would you have put him on his back at that point?

A If he's pulseless, he is not breathing, you know, I --

Q At this point, they didn't know any of that. All they was that he was vomiting. So I'm just asking is that, you know, what you're taught to do in medical training?

A They do the ABCs, airway, breathing, and circulation. So, again, you have to take all this in

[redacted]

Q I'm simply asking in general is that -- you know, if he's on his left side and he starts vomiting, putting him on his back, could that have made it worse? That's all I'm asking.

A Again, my answer is going to be the same. You have to look at the whole perspective. If he is not breathing, doesn't have a pulse, you have to put him on

the back and start the --
Q What if he is breathing while he's vomiting?
A If he's breathing, he's up and awake and vomiting, then obviously, you know, you're not going to put him on his back.
Q And why?
A Because of risk for aspiration.
Q Other than what you told me already here today, are there any other reasons that you can point to that would suggest that Mr. Cains would have died even if he hadn't been on the ground?
A I didn't understand the question.
Q Well, as we've established, your opinion is that you don't know what happened, you weren't there, but that it's also -- you also think that it's -- I believe what you said exactly is that you think it's unlikely that this physical restraint contributed to his death. And it's very important, Doctor, that I know every single reason that you have for having that opinion, for giving that opinion. I know I've asked you already and you've given me some answers. I just want to make sure that there's not anything else that you're going to say at trial that I haven't already heard.
A I think that's all I have to say. It's my opinion based on not being physically present there and looking

and going over his chart.
Q When you say "his chart," you mean the documents that we specifically listed together, right?
A Yes.
MR. GILLISPIE: Eric, can we take one more break here? We'll come back and wrap up.
MR. COLLINS: Okay.
(WHEREUPON, after a break was taken, the proceedings resumed as follows:)
BY MR. GILLISPIE:
Q Doctor, we're about to wrap up here. You've done a good job clarifying for me your position and that is that based on what you've reviewed, you feel that it's unlikely that the restraint in which David Cains was taken to the ground and held on the ground against his will for several minutes contributed in any way to his death. That would suggest that David would have choked, vomited and choked even had this restraint not occurred, even had he been upright. Is that what you're saying? In other words, are you saying that you think that it's likely that Mr. Cains would be dead even if this restraint had not occurred?
A I've already answered this question.
Q Well, with all due respect it is what you're

saying in a roundabout way. By saying that you think that it's unlikely that the restraint contributed to his death, well, that means that he would have died absent the restraint, doesn't it?

A It doesn't make much sense to me. Anybody can die, you know.

Q Where am I losing you?

A Repeat the question or your thoughts again.

Q Sure. Mr. Cains died on this day, we can agree on that. You stated your position as that you think it's unlikely that the restraint contributed to his death, caused his death. Well, the inverse of that, the logical inverse of that would be that he would have died absent the restraint. Does that not make sense to you?

A He would have died if he had aspirated, yes. There was chances that if he had vomited and aspirated with or without restraints, he would die.

Q Right. And all I'm saying is -- I just want to make sure I understand your position because is it your position -- the implication of your position is that even absent the restraint, Mr. Cains would have aspirated and died.

A If he would have aspirated, then he would die.

Q I think you're misunderstanding me a little bit

still. I'm going to try my best to walk you through this. And I don't mean to confuse you. But I'm asking if the restraint didn't cause his death where -- we've established that he died. He aspirated and choked to death, correct? That's how he died, he aspirated and choked to death?

A That's right.

Q Okay. So if the restraint didn't cause that, in your opinion, or if, in your opinion, it's unlikely the restraint caused that, obviously that suggests that you think he would have aspirated and choked to death anyways, meaning even had there been no restraint. That's what your position -- the only logical conclusion of your position, and I just want to make sure that you agree with that, that that's what you're saying, that you think that Mr. Cains would have aspirated and choked to death even if he had not been restrained and even if he had been on his two feet.

A If Mr. Cains, after an episode of vomiting, aspirated, there were chances of him dying.

Q Sir, with all due respect, you're still not answering the question.

A I mean, I'm trying to understand the question. You're saying that -- you asked me basically whether putting him on mechanical or physical restraints led to

him aspirating; is that right?
Q Yes.
A And I told you the answer that it's unlikely, whether if he was not restraint, he would have still vomited and he could still die of aspiration. Does that answer the question?
Q Well, no, sir, not exactly. I appreciate you trying with me here, but not exactly. I'm going to try to phrase it in a way that all you have to do is answer yes, no, or I don't know. Does that sound fair?
A Okay.
Q Again, he died because -- he died after aspirating and choking. And your position is, once again, that it's unlikely that being restrained caused him to aspirate, correct?
A It's unlikely, yes.
Q Unlikely, right. So if it's unlikely that the restraint caused him to aspirate, does that mean that you believe he would have aspirated anyways, meaning he would have aspirated even if he had not been restrained and even if he'd not been on the ground. And so you can answer that yes or no or however you want, but I don't know how to make that more simple.
A And I still don't understand it, but the answer is I don't know.

Q So you're not saying that you think he would have died anyways absent the restraint? That's not what you're saying?
A In my logic, anybody with or without restraint can die of aspirating.
Q Sure.
A Right?
Q Sure. I guess. You're the doctor. I don't know. But that's not an answer to any question I've asked.
A That's what you've been asking me. If he was not restrained, he would have died if he had aspirated. That's what you were asking me, right?
Q Well, you said "logic" and you brought up logic. That's what I'm talking, logically. We can't have it both ways. Either the restraint contributed in some way --
A I told you my opinion. I don't know.
Q Let me finish. Either the restraint contributed in some way to Mr. Cains' death or it didn't. And if it didn't, well, there's only one logical conclusion there, isn't there? And that's that because he's dead, he died of aspiration and choking -- he's dead. That's a fact. So the only logical conclusion is that aspiration and choking event would have occurred regardless of whether he'd been restrained on the

ground. Surely what I'm describing makes sense to you logically, Doctor.

A I told you I don't know the answer. If he would not have been restrained, whether he would have choked to death, I don't know the answer.

Q If you don't know the answer to that, how can you say it's unlikely the restraint caused the aspiration and the choking?

A With the documentations that I have in here, it does not seem like there was any excessive force that was used. He was in the left lateral position.

[redacted] So, again, that's my observation and that's -- I cannot say it with certainty so that's why I said unlikely.

Q Well, it can't be both things, though. It just can't, sir.

MR. GILLISPIE: What I want to do, Eric, is there's one document he mentioned. It had to do with a -- it was a five-prong checklist about restraint use that he says that he signs off on. I'm not sure what that document is. I'm not seeing that. And I'd also like to see everything that he's using

here today, so what I would like to do is, you know, I may not need to question him anymore, but I'd like to adjourn and keep the possibility open of bringing him back for further questioning if the documents he's been using turn out to be something that -- the documents he's using to answer questions that I don't get to see, if they're something that I haven't seen that might lead to further questioning. Is that all right?

MR. COLLINS: That will be fine.

MR. GILLISPIE: Okay.

BY MR. GILLISPIE:

Q Dr. Hamid, do you feel like you've understood all my questions today?

A Yeah, I think so.

Q I appreciate your time. Oh, one more before we go.

Doctor, did you ever yourself approve the use of ground restraints on David Cains?

A I don't remember that. I don't think so.

Q In your position as the physician, would you typically be put in a position to approve or disapprove those things or is that the Q's job?

A Again, they will call me for a chemical restraint.

I think he was an early chemical intervention, so when clients -- I get phone calls to put them on chemical restraints, so they get the first chemical and some individuals get the second chemical as well, and if they're still not, you know -- the behaviors are not controlled, then they would call me for, you know, physical restraints. That does not happen that often, but I think I would be the person they would call.

Q Do you recall ever being called for restraints involving David Cains?

A I don't remember that.

Q Do you recall ever being called for restraints whereby a client was restrained on the ground, and not for purposes of being transferred to mechanical restraints but just restrained on the ground?

A I have not been called for that that I can recall.

Q Were you aware that such restraints were not authorized at the facility?

A I'm aware of it, but, again, I don't recall being called for such an individual.

Q But you are aware that restraining clients on the ground for purposes other than transitioning to the mechanical restraints is disallowed?

A Yes, I am.

Q And how did you become aware of that?

A Being here for 15 years. I don't know whether I read it afterwards or anything, but I'm familiar.
Q So you're familiar with this type of restraint that I described to you was used on David was not a proper restraint, an allowed restraint, as I've described it to you?
A Yes. I mean, at that point in time, this was the only option. Again, in my understanding, this would have been a transition.
Q How do you know they didn't have any other option?
A I don't know. Again, looking at those documents, they had to control him. There was no time for chemical intervention at that point in time. They had to control him and I never got that far for the chemical intervention because things happened so quickly.
Q I just wonder what would make you think the extra week to get me that opinion if you don't know and you weren't there.
A I didn't understand the question.
Q Well, you said that -- I didn't even ask you this. You just volunteered that you don't think they had any choice at the time, any other option but to do this to him.
A Because the documentation says he was kicking and

hitting other people. He was trying to go to the bathroom, and then all this, you know, transpired.
Q And just based on that, you come to the conclusion that they had no other option than doing what they did?
A Again, I'm not there at that point in time.
Q Well, why give me the opinion if you don't want to -- you know, if you can't tell me --
A Well, you kept asking me for my opinion.
Q Okay.
A -- ask questions in different ways.
Q Sure. I wasn't even going to ask you if I thought that -- if you thought that what they did this was -- if they had a choice or not, but you volunteered that, so now I have to flesh that out.
You're basing that on the OLTC reports and these other documents we've talked about?
A Yeah. That's all I have.
Q And any other reason why you would have the opinion that these staff members had no other options but to do precisely what they did?
A No.
Q Again, your reasons are what again?
A It's just my opinion looking at those records that they may not have any other option at that point in time. That's what I'm saying.

Q Do you make policy decisions at the facility?
A What kind of policy are we talking about?
Q Policies regarding restraining the clients.
A I think it's pretty standard.
Q So you're not involved in tracking or implementing the restraint policies at BHDC?
A No, I'm not.
Q Do you know who is?
A No, I don't.
Q Were you involved in drafting or implementing the policy that prohibited nonmedical staff from calling 911?
A No, I was not.
Q And you've been there for 15 years. Do you know where that policy originated?
A No, sir, I don't.
Q Do you know who insisted on that policy or who came up with that policy?
A I have no idea.
Q And you've been there for 15 years, but you don't know who creates the policy?
A No, I don't.
Q Couldn't even venture a guess?
A I'm sorry?
Q You couldn't even venture a guess?

A No, I don't.
Q Are you aware of the disability rights Arkansas investigations into the Booneville facility that have been conducted over the last 10 years?
A Somewhat, yes.
Q Have you seen those reports, specifically the one in 2016 that -- there's one in 2015 and one in 2016 that were critical of Booneville for the overuse of restraints on clients. Are you familiar with those reports?
A I was a physician at that time as well, so I'm familiar with those.
Q Do you feel like those reports are fair and accurate?
A Are you talking about the 2016 reports?
Q Yes. The report that highlighted what the disability rights described as the excessive use of restraints on the clients at Booneville, particularly in comparison to the number of restraints used at the other human development centers in Arkansas?
A I think the number of restraints are drastically down. I may be wrong there, but I think after that, we looked into that, and, again, you've got the psychiatrist on board as well. And as far as I know, I don't know about the latest numbers, but we were

working on it and the last I heard we had decreased on the number of restraints.
Q When did you last hear about it or talk to someone about it?
A Again, probably in the last couple of years.
Q When you say "last I heard," was that a document you saw? Do you have any idea where you got that?
A I'm thinking. I think, you know, discussing with the DON, the nursing supervisor we talked about.
Q Do you believe there was a time at the facility where physical restraints were being used too often on clients?
A I don't know. It's difficult for me to answer that question.
Q Why is it difficult?
A Because I don't know the answer. I mean, again, it's my opinion I don't think so we were using it excessively. We used it as needed, but I think we were reprimanded or we were looked into that, and after that, we tried to cut down on it as far as I remember. This is probably two or three years old, quite a while back.
MR. GILLISPIE: All right. Eric, we can adjourn now.
Q If you could just please make sure Eric gets a

copy of the things that you used today and also that document that you described early on in the deposition about a list of five types of restraints that you approve or disapprove for a client. I don't think I've seen that document. Do you recall what document I'm talking about, Doctor?

A Yes. I will forward it to you.

Q Okay. That would be great. Thank you, sir.

A Thank you.

(WHEREUPON, the proceedings were concluded in the matter at 12:14 p.m.)

* * * * * * * *

CERTIFICATE

STATE OF ARKANSAS)

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COUNTY OF PULASKI)

I, Kristina R. Gray, Arkansas Certified Court Reporter #725, do hereby certify that the facts stated by me in the caption on the foregoing proceedings are true; and that the foregoing proceedings were reported verbatim through the use of the voice-writing method and thereafter transcribed by me or under my direct supervision to the best of my ability, taken at the time and place set out on the caption hereto.

I FURTHER CERTIFY that in accordance with Rule 30(e) of the Rules of Civil Procedure, review of the transcript was not requested.

I FURTHER CERTIFY that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested, or otherwise, in the outcome of this action, and that I have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original deposition transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties to the action.

WITNESS MY HAND AND SEAL this 16th day of June, 2022.

Kristina R Gray

Kristina R. Gray
Arkansas State Supreme Court
Certified Court Reporter #725

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Zoom [1] 4/7

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF

JOHNATHAN MCCUTCHEON

October 21, 2022, at 1:00 p.m.

CRIS M. BRASUELL, CCR
ARKANSASCOURTREPORTER.COM



APPEARANCES

ON BEHALF OF THE CLAIMANT:

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EXHIBITS IDENTIFIED

(None Marked)

S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Johnathan McCutcheon, produced, sworn, and examined via Zoom, commencing on October 21, 2022, at 1:00 p.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

PROCEEDINGS

THEREUPON, Johnathan McCutcheon was duly sworn to tell the truth, the whole truth, and nothing but the truth and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Hi, Mr. McCutcheon. Your name is -- thank you for being here, by the way.

Your name is Johnathan McCutcheon; right?

A Yes.

Q Okay. And have you ever been deposed before?

A No.

Q No? Okay.

I'm going to ask you a few questions, not that many. Just because the court reporter has to keep a record of it, if you can actually say the words yes or no as opposed to nodding or shaking your head like we commonly do in everyday conversation.

It's hard for me to remember most of the time, but it's kind of the only rule I really have.

If you don't understand a question that I'm asking, ask me to speak up or rephrase it. I'll be happy to.

So, without further ado, I'll just jump right into it with you.

Mr. McCutcheon, am I correct that you used to work as a direct care staff member at the Booneville Human Development Center?

A Yes.

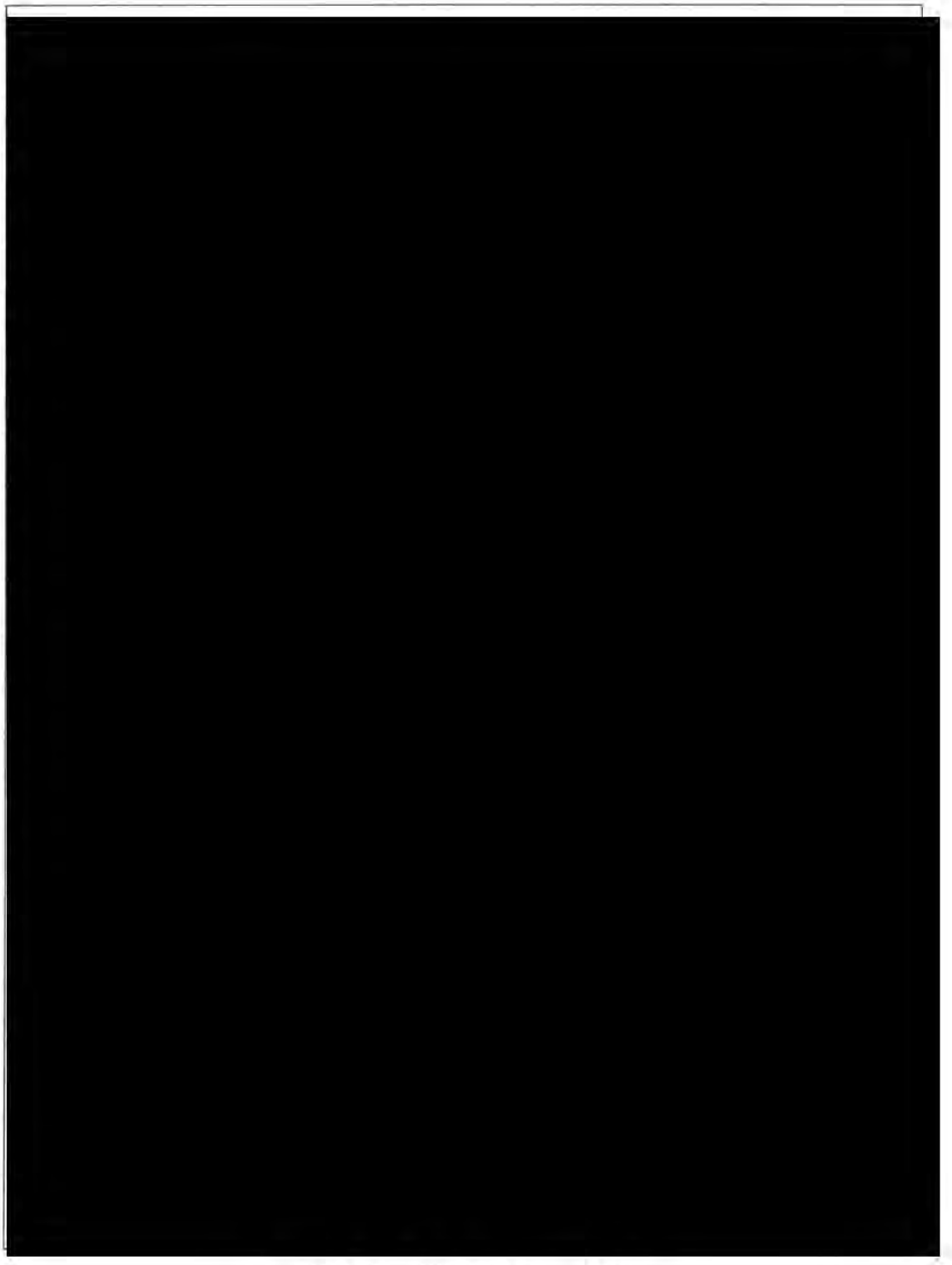
Q Okay. And approximately what years did you work there? What time period did you work there?

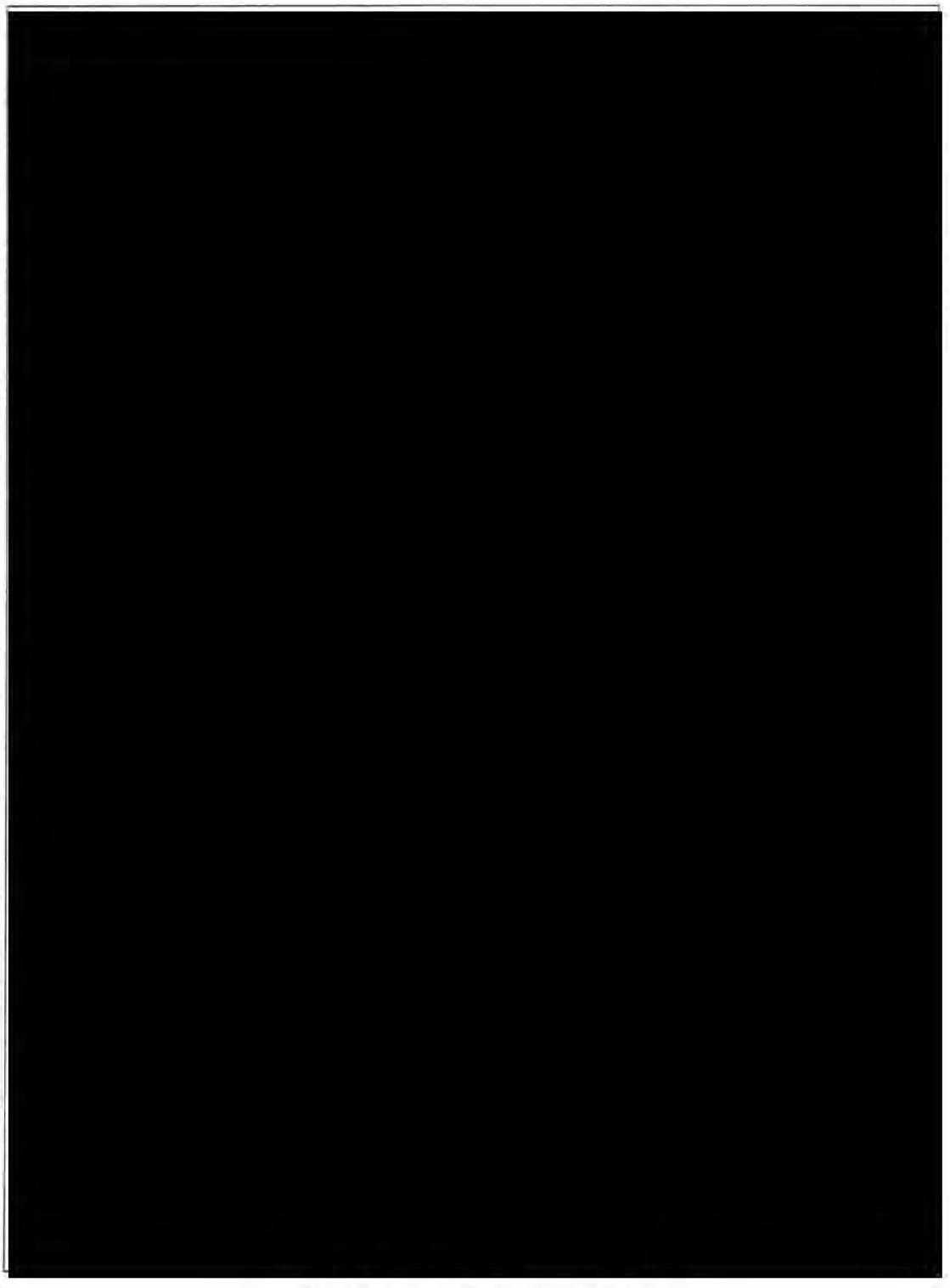
A I'm not for sure exactly the years, but I was there for over eight years, I'm wanting to say.

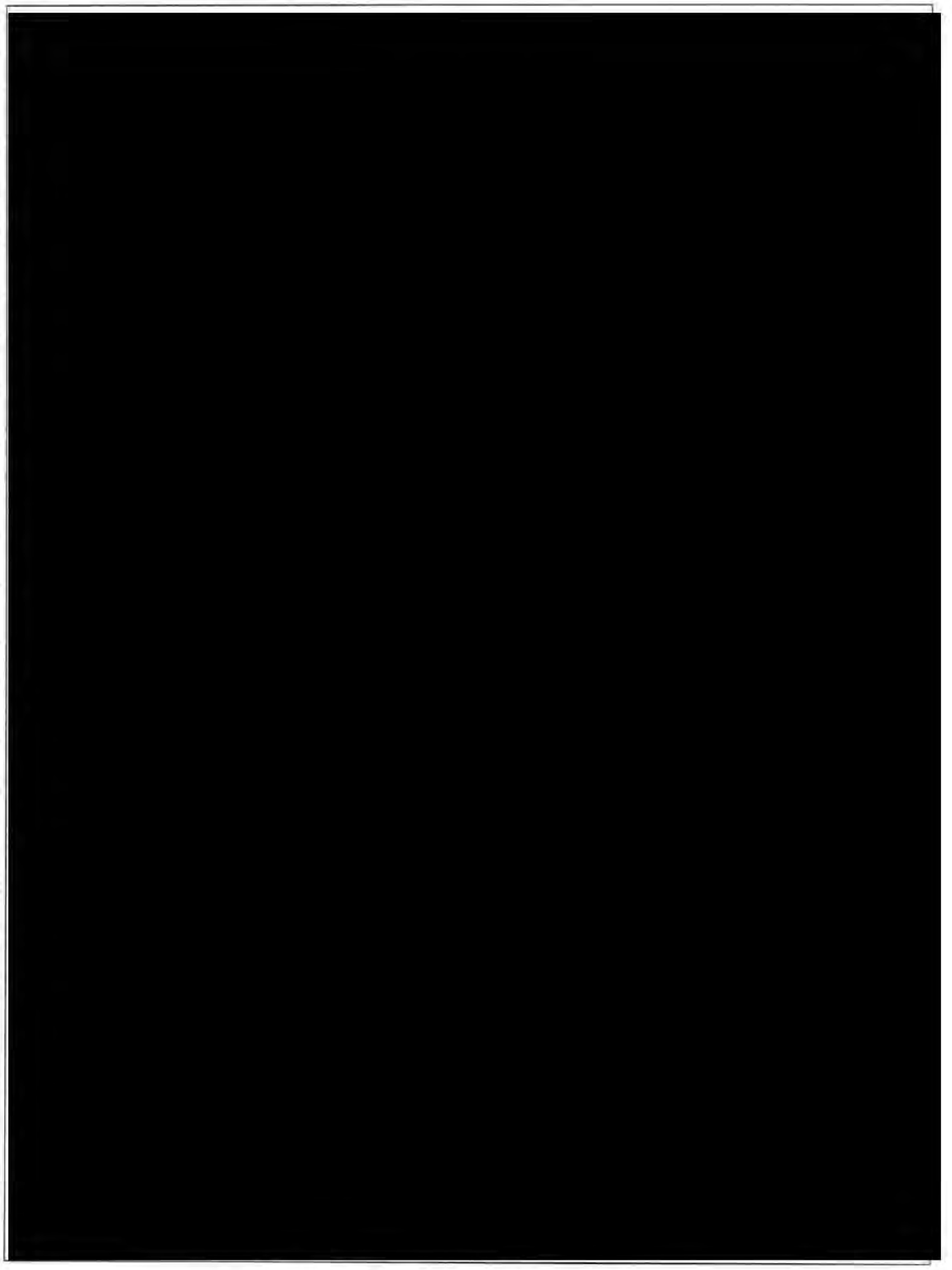
Q Okay. And, during your time there, did you encounter another direct care staff worker named Tyler Mattson?

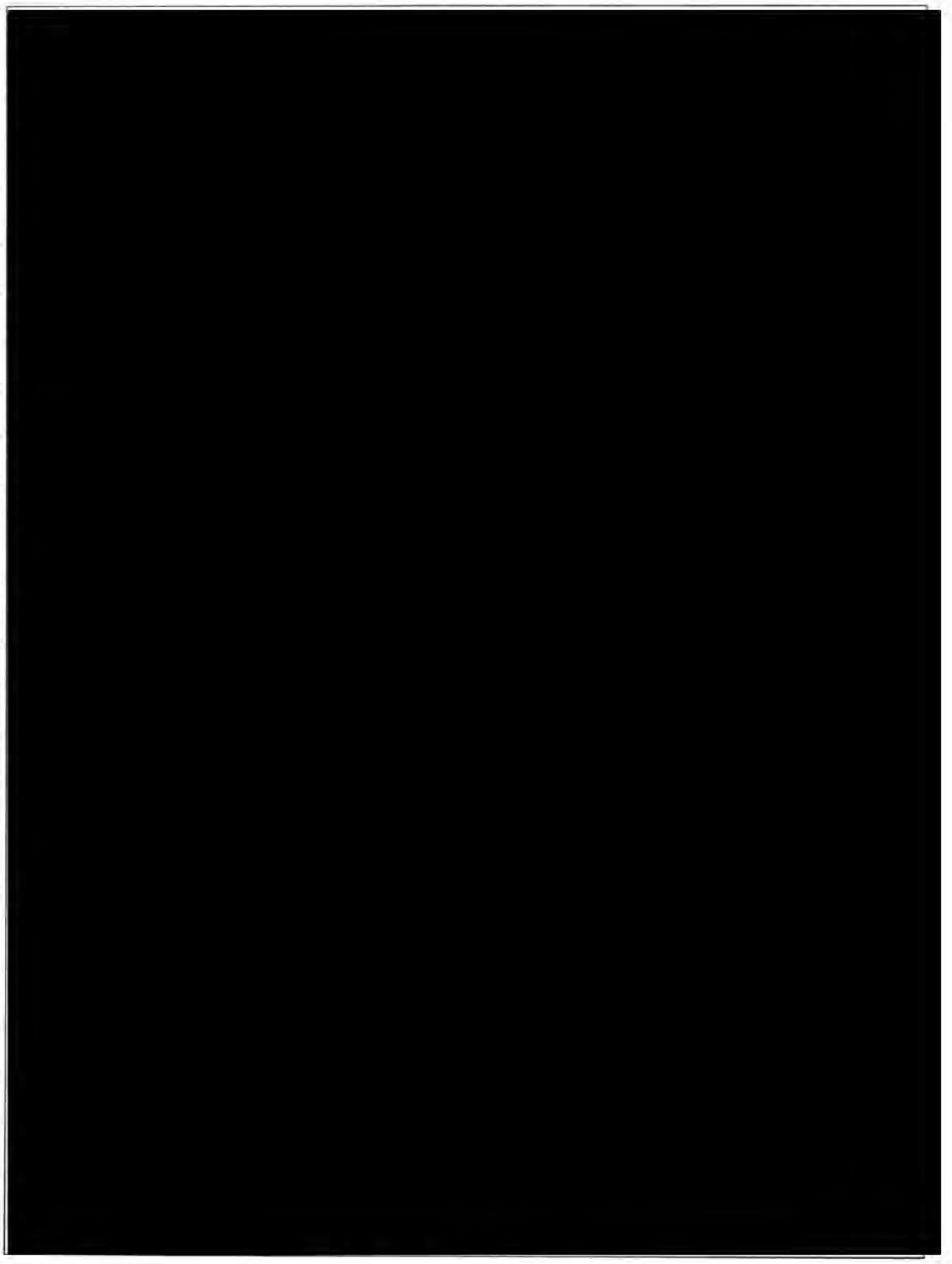
A Yes.

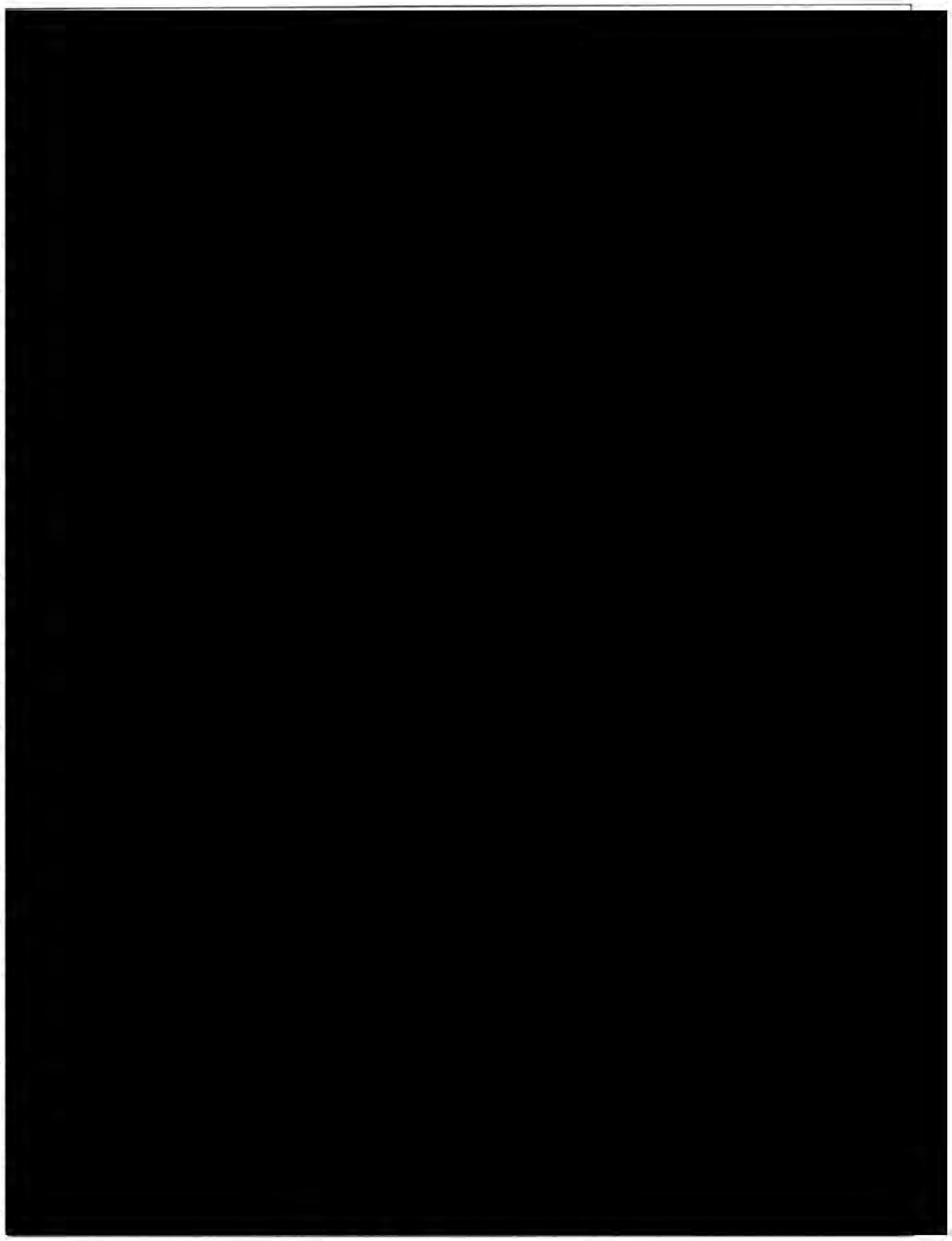
[redacted]

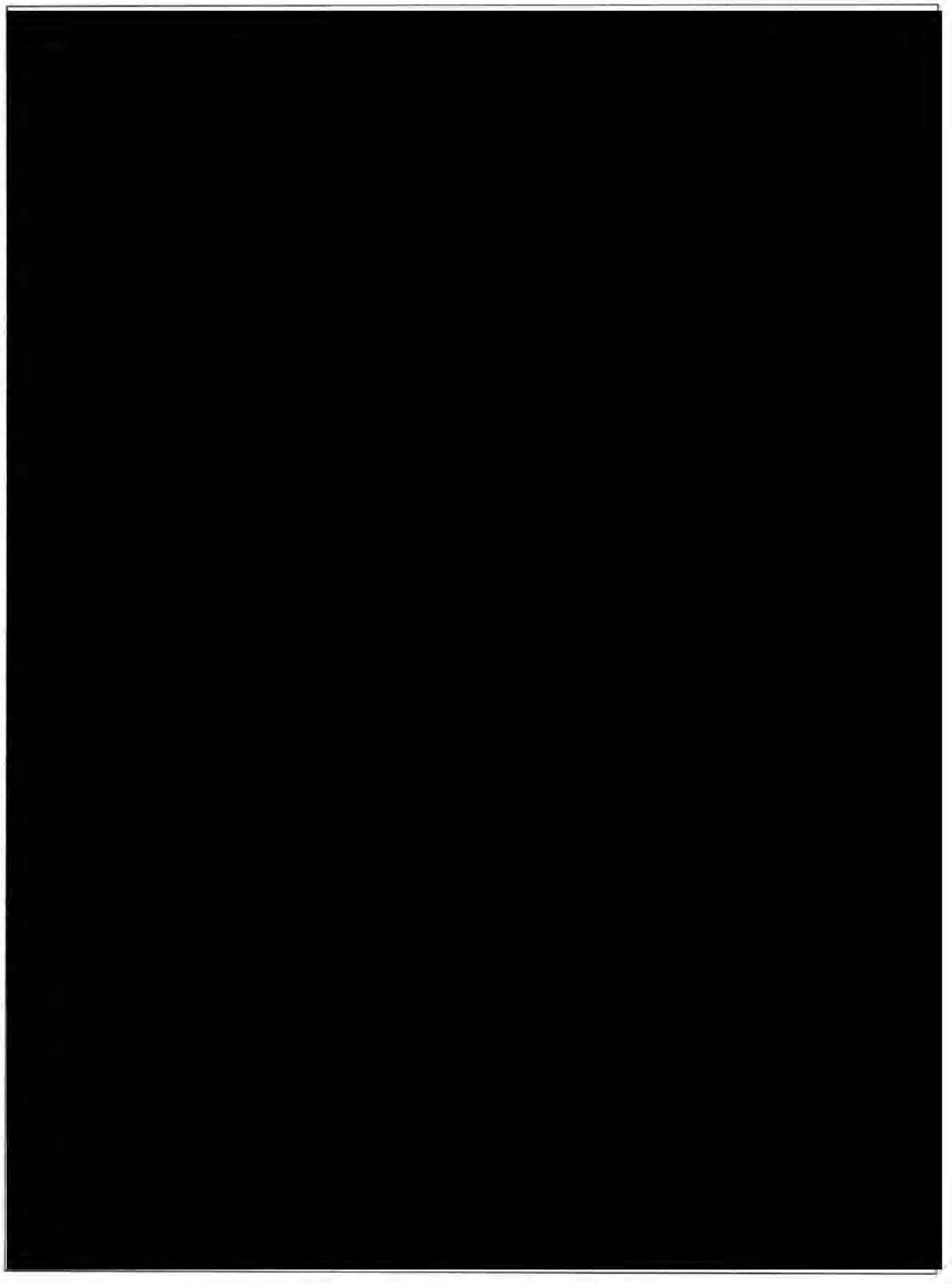












[redacted]

Q Okay.

And when did you leave? When did you stop working at Booneville? When abouts?

A I'm wanting to say it was last year sometime.

Q Okay.

A (Inaudible) year, I'm wanting to say. But I'm not a hundred percent sure.

Q Okay.

[redacted]

[redacted]

Q Okay.

And why did you leave? Why did you stop working at the Booneville facility?

A The higher ups. I didn't really -- it -- they don't know how to run a facility.

Q Okay.

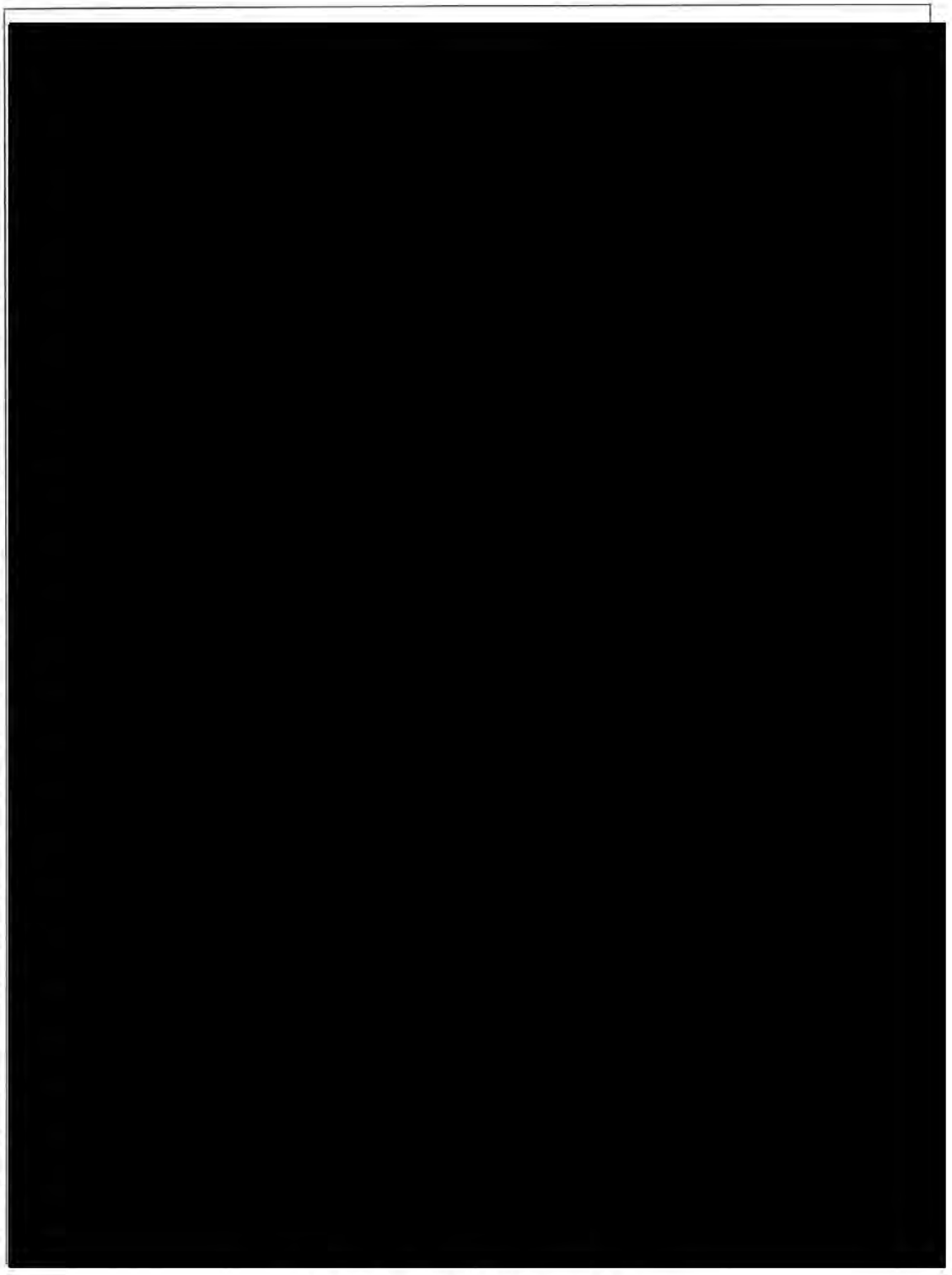
A In my opinion anyways.

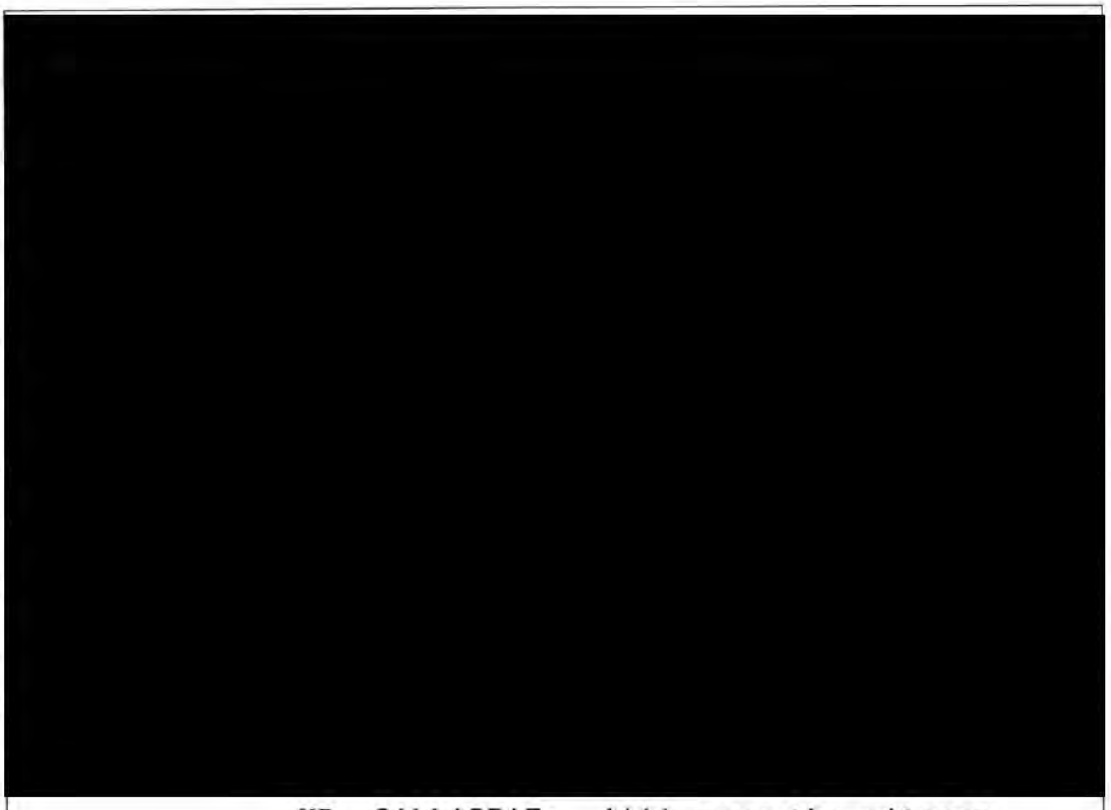
Q Okay. Did you quit? Were you -- there's no wrong answer here.

But did you quit? Were you terminated?

A I quit.

[redacted]





MR. GILLISPIE: I'll pass the witness.
Thank you, Johnathan.

CROSS EXAMINATION

BY MR. ROSEN:

Q Thank you, Mr. McCutcheon.
I'm Rich Rosen. I represent the Department of Human Services. I'm just going to ask you a few questions, some background things, because -- about you.
Are you married?

A No.

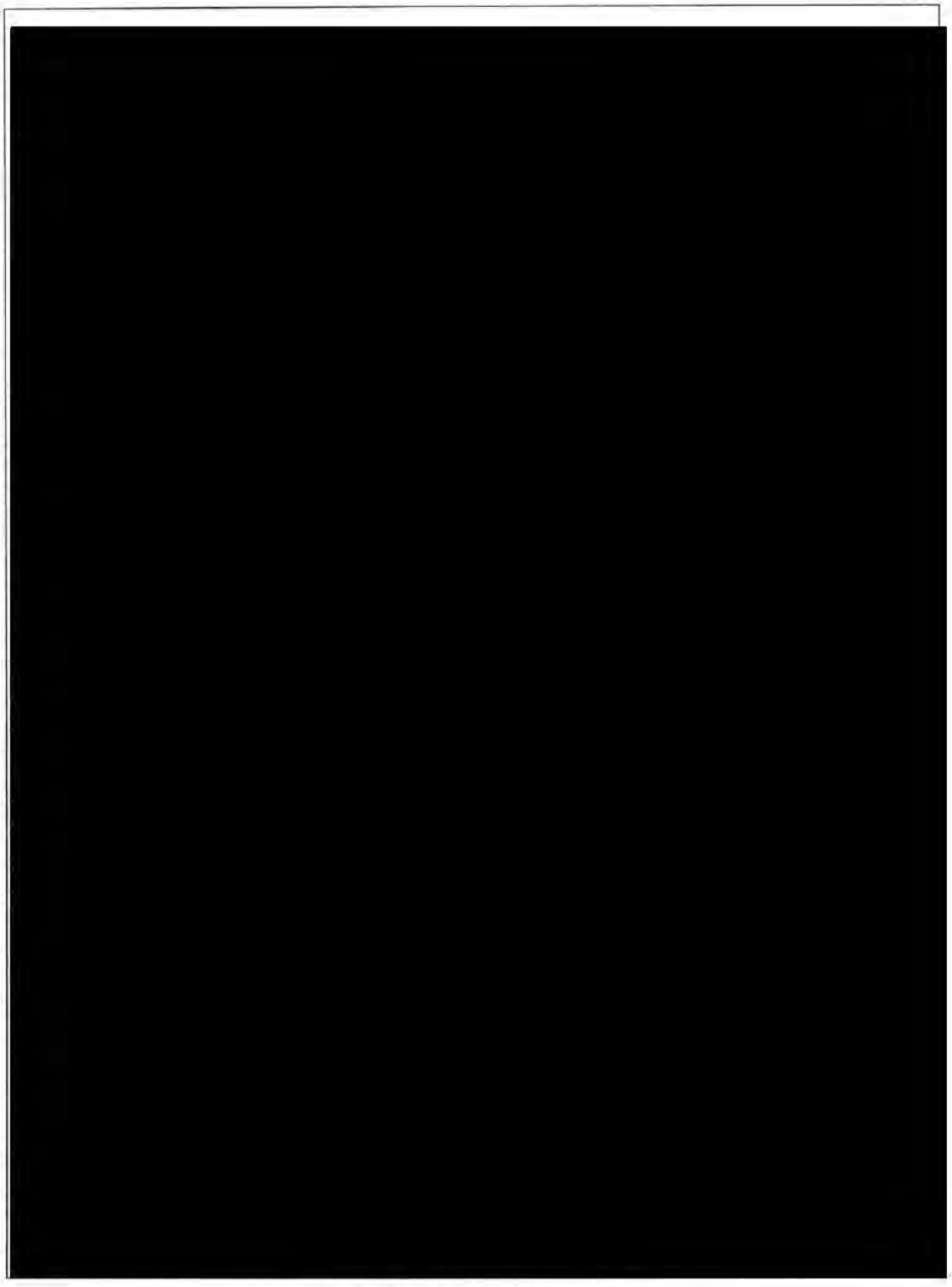
Q What is your -- did you graduate high school?

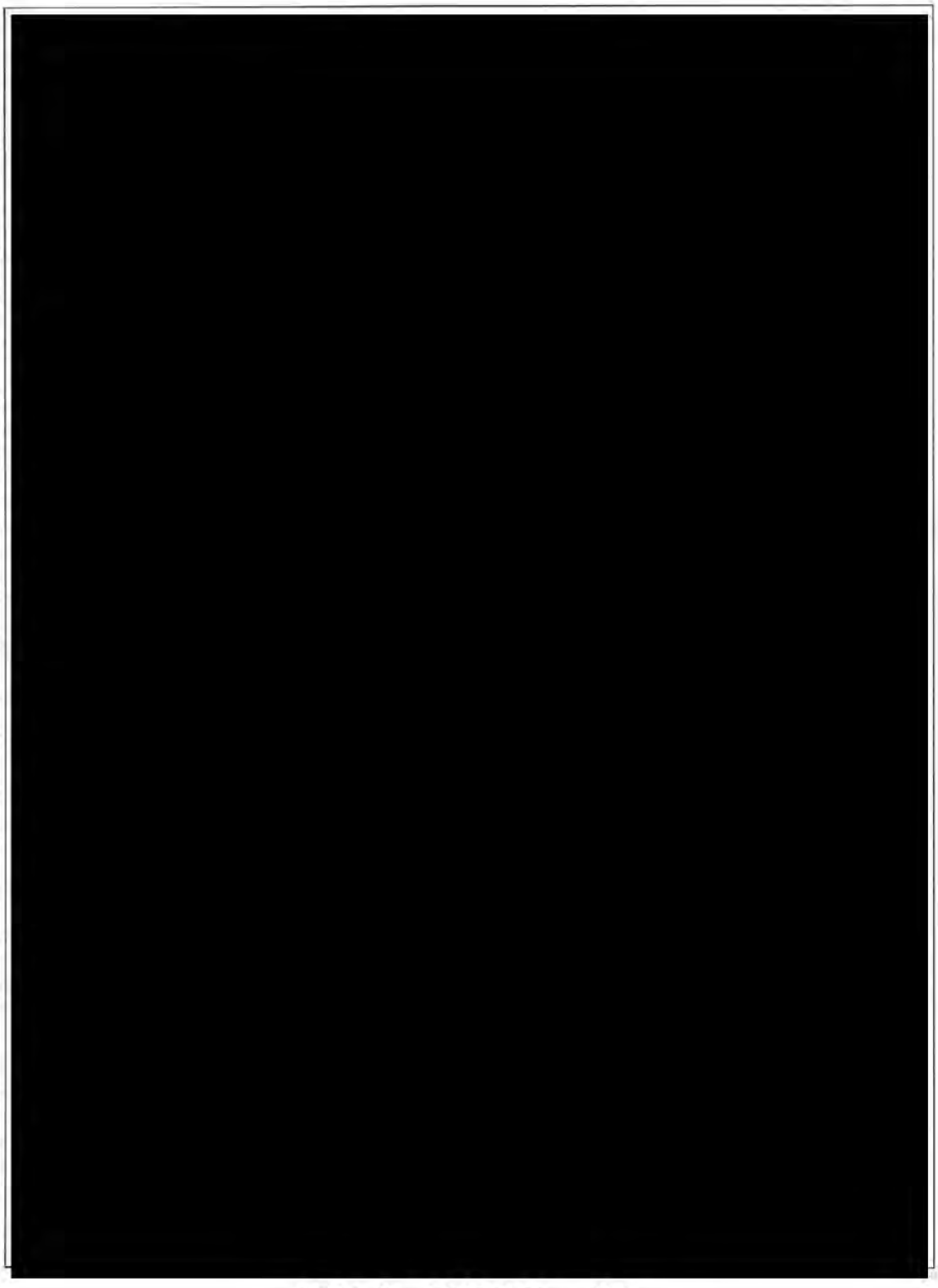
A Yes.

Q Do you have any college?
A No.
Q Are you employed currently?
A Yes.
Q And where are you employed?
A I work at the Tire and Lube at Walmart.
Q Okay. And did you go there, to Walmart, right after you left this job at the Booneville HDC?
A No.
Q Okay. Was there -- did you have employment in between that or was there a period of time you were unemployed?
A I wouldn't really say I was unemployed. I was working with a friend. He owns his own business.
Q Okay. And then you went from -- so is it my understanding, from your testimony, that you quit at the Booneville HDC?
A Yes.
Q Okay. And do you remember exact -- when did you quit? Approximately.
A I'm wanting to say around the middle of the year last year.
Q So mid 20, 2021?
A Yeah.
Q Okay.

A I'm not a hundred percent sure, but I'm wanting to say that's about when.

[redacted]





[redacted]

Q Okay.

MR. GILLISPIE: Form.

BY MR. ROSEN:

Q While you were at the Booneville HDC, did you ever see a resident have a aggressive behavior?

A Yes.

Q In fact, residents with this type of population often would either act out or be aggressive or noncompliant or violent at times; is that right?

A Correct.

Q Okay.

[redacted]

[redacted]

MR. ROSEN: I have no other questions. Thank you.

MR. GILLISPIE: One follow-up, Johnathan.

REDIRECT EXAMINATION

BY MR. GILLISPIE:

[redacted]

[redacted]

Q Thank you, Mr. McCutcheon.

That's all I have.

MR. ROSEN: I have no other questions.

Thank you.

THE WITNESS: Can I ask a question?

MR. ROSEN: No.

MR. GILLISPIE: We can off the record.

MR. ROSEN: We're not -- so we're done,

counsel.

MR. GILLISPIE: Hold on.

Hold on just a second, Cris. Let's go off the record for just a second.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

MR. ROSEN: I object; but at least it has to be on the record.

Go ahead, Mr. McCutcheon, if you want to ask a question.

THE WITNESS: I'm just wondering what [redacted] has to do with any of this.

MR. ROSEN: I don't know what you have to do with this, so this was --

MR. GILLISPIE: I have a follow-up to that, Rich, if you --

MR. ROSEN: This was (inaudible) -- this was not -- I'm here responding and it's Mr. Gillispie -- I didn't call you as a witness.

MR. GILLISPIE: Okay.

I have nothing further, Mr. McCutcheon. Thank you for your time today, sir.

MR. ROSEN: Thank you.

(WHEREUPON, the proceedings were concluded in the matter at 1:24 p.m.)

* * * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Johnathan McCutcheon, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 4th day of November, 2022.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 5-29-20 Living Area Blue - DH

Location of Event Blue Time Started 1405 Time Ended 1410

Print Name/Title of person writing BR Tyler Matthson, RCT (COM)

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ✓ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ___ Involved in work/Training activities
- ___ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials RL TM CT Objects, Own_____

___ Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials_____

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ✓ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area): To (area):
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ✓ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other_____
- ✓ Demand attention
- ___ Inappropriate toileting
- ✓ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other_____

INTERVENTIONS (check all that apply; write details on back)

- ___ Allowed processing time
- ✓ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ___ Medical contacted
- ✓ Supervisory staff contacted
  Name/Title
- ✓ Counseling/instruction
- ___ Ignoring
- ✓ Labeling
- ___ Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other_____
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ✓ Personal restraint 1 min (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Johnson-Miller **Reviewed by** COM/RS

EXHIBIT
tabbies
27

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

DC arrived from Schedule on mobile crim, and screaming, TA Rick Libby told me he for no reason slapped him, I went outside to get him after mobile called saying they needed him, I went outside and asked him to come in to take a shower relax, DC complied, but when we got inside he began screaming and tried to pull the fire alarm, I removed him from that area, when he got into the blue he began screaming more and attempted to smack me. I put him in personals for 1 minute, he seemed, to calm down and went to his room. [signature] RCY TM 5-29-20.

JUN 01 2020

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Craig Date 5-29-20 Living Area Blue - DH

Location of Event Blue Time Started 1445 Time Ended 1455

Print Name/Title of person writing BR Tyler Mathes, RCT

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ✓Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials KH Objects, Own_____

___Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self_____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials_____

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ✓Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area):_____ To (area):_____
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ✓Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other_____
- ✓Demand attention
- ___Inappropriate toileting
- ✓Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____

INTERVENTIONS (check all that apply; write details on back)

- ___Allowed processing time
- ✓Graduated guidance
- ___Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ✓Supervisory staff contacted
  Name/Title
- ✓Counseling/instruction
- ___Ignoring
- ✓Labeling
- ___Redirection
- ___Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other_____
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ✓Personal restraint 5min (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ___Excess behavior stopped; client calmed
- ___Other
- ✓Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Johnson-Miller **Reviewed by** COM/RSS

CM 000734



BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

The nurse kelly King called for DC for meds, DC went down there, soon after he began screaming at the nurse, threatening to throw a thermometer at her. I ran down there as I was in the aid station because I was the only on the floor. When I got down to her I immediately put him in personals for about 3 minutes, I asked to go to his room to relax, he was calm the rest of the day. Tm [illegible] 5-29-20

JUN 0 1 2020

Behavior Report Revised 2019.9.26 CM 000735 __QIDP __Medical __Psychology __Social Services __Living Area

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains **Date** 8-20-20 **Living Area** Blue - DH

Location of Event Room **Time Started** 1550 **Time Ended** 1555

Print Name/Title of person writing BR Tyler Mattson RCM

What happened immediately *before* the problem behavior occurred? (check all that apply)

____Arrived at area	____Involved in work/Training activities	____Physical aggression by another
____Change in client's routine	____Transitioning different setting	____Verbal aggression by another
____Contact with family (phone call, visit)	____Meal time	____Personal space invaded
____Desired object present but out of reach	____Medication administration time	____Preferred activity interrupted
____Difficult / Non-preferred task presented	____Moving from one activity to another	____Request refused
____Environment loud or hectic	____Other clients receiving attention	____Snack time
____Involved in grooming/hygiene activities	____Had seizure	____Request made of client
X Involved in leisure activities	____Toileting accident	____Other client displaying problem behavior
____Involved in off-campus activity	____In bed	
____Other		

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials TM Objects, Own laundry basket COM

____Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self Biting, Right and left hand.
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials TM

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

____Pacing	____Fidgety	X Demand attention
____Confused/disoriented	____Not responding to cues	____Inappropriate toileting
____Had another's property	____Personal space violation (non-sexual)	X Screaming/shouting.
____Noncompliance	____Putting inedible items in mouth	____Meal refusal
____Throwing self in floor	____Wet or soiled (unintentional)	____Inappropriate sexual behavior
____Day sleep	____Disrupting programming/environment	____Awake during sleep time
____Medication refusal	____In another's bedroom	____Instigating conflict
____Stomping	____Lying	____Snack refusal
____Repeating self	____Other_____	____Other_____
____Left functional control From (area):		To (area):

INTERVENTIONS (check all that apply; write details on back)

X Allowed processing time	X Counseling/instruction	____Distraction
X Graduated guidance	____Ignoring	____Implemented BTP
____Time out to calm	X Labeling	____Restitution
____Separate from setting up to 30 minutes	X Redirection	____Reinforcer withheld
____Separate from activity up to 30 minutes	X Verbal intervention	X ~~Personal restraint~~ 4 min (time) COM
____Medical contacted	____Mechanical restraint (form completed)	____~~Suicide precautions~~ started
____Supervisory staff contacted	____Other_____	

Name/Title

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

____Client complied with request	____Client was successfully redirected
X Excess behavior stopped; client calmed	____Excess behavior stopped; client still agitated/angry
X Other	

If Personal Restraint was used: QIDP notified Carole Johnson **Reviewed by** COM/RSM

Behavior Report Revised 2019.9.26

EXHIBIT
29

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

I was walking through the hall and heard banging, I went to see what it was and it was DC kicking his laundry basket, I walked in and asked him whats wrong and he needed to relax, he said "no bitch" and tried to spit and swing on me. I applied personals to him and he continued to fight and resist, calling me a bitch. I continued personals he began to apologize and say he was calm I told him to relax and let him up, he apologized and behavior ended. [signature] Mat[illegible] 3-20-20 [illegible]. 4 minutes of personals. Time of behavior 1550.

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In The Matter Of:

Christine McAuliffe v.
Arkansas Department of Human Services

Kris Stewart
November 9, 2022

Grigsby Reporting Services

[redacted]

Original File 11-09 Kris Stewart.prn
Min-U-Script® with Word Index



BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE McAULIFFE, as
Special Administrator of
the Estate of DAVID CAINS — CLAIMANT

VS. NO. 220374

ARKANSAS DEPARTMENT OF
HUMAN SERVICES — RESPONDENT

ORAL DEPOSITION OF

KRIS STEWART

NOVEMBER 9, 2022

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CAPTION

ANSWERS AND ORAL DEPOSITION OF KRIS STEWART, a witness produced at the request of the Respondent, taken in the above-styled and numbered cause on the 9th day of November, 2022, before Faith Grigsby, Arkansas Supreme Court Certified Court Reporter #686, at 1:50 p.m., at the Department of Human Services, 700 Main Street, Little Rock, Arkansas, pursuant to the agreement hereinafter set forth.

* * * * * * * * * * *

PROCEEDINGS

MR. ROSEN: This is the deposition of Kris Stewart of Disability Rights Arkansas, also known as DRA, in the matter Before the Arkansas State Claims Commission, Christine McAuliffe, as Special Administrator of the Estate of David Cains versus DHS, Claim Number 220374. This is also pursuant to a Subpoena and a Notice of Deposition.

THEREUPON,

KRIS STEWART,

THE WITNESS HEREINBEFORE NAMED, having been first duly cautioned and sworn by me to testify to the truth, the whole truth, and nothing but the truth, testified on her oath as follows, to-wit:

EXAMINATION

MR. ROSEN:

Q Ms. Stewart, hi.

A Hi.

Q My name is Rich Rosen, and I'll be asking some questions today, and if you answer the question, I'm going to assume you understood the question. If you just need me to rephrase it, which happens often, I'll

be happy to do so. If you need to take a break, as long as there's not a question pending, just let me know and we can take a break. If you have a question and need to talk to your attorney, as long as there's not a question pending, okay?

A Okay.

MR. ROSEN: I'm going to introduce as DHS Exhibit 1 the Notice of Deposition.

Counsel, do you want a copy?

MR. LOWTHER: I'm fine without it.

(WHEREUPON, Respondent's Exhibit 1 was marked for identification and is attached hereto.)

Q (By Mr. Rosen) Please state your name for the record.

A Kristina Stewart.

Q And, Ms. Stewart, are you employed?

A Yes.

Q And where are you employed?

A Disability Rights Arkansas.

Q Is that also known as DRA?

A Yes.

Q And if I refer to it as DRA, you'll know who I'm talking about?

A Yes.

Q What do you do over at DRA?
A I am an advocate.
Q What does that mean?
A I monitor facilities for abuse and neglect.
Q And what is monitor? What do you mean by monitor?
A We physically go out and monitor facilities, speak to clients and staff that work there.
Q How long have you been doing this for DRA?
A For DRA, six years.
Q So, I guess you went there in about 2016 or so?
A Yes.
Q What did you do before you were at DRA?
A I was a case manager at ICF, in our group home.
Q At where?
A It's the Intermediate Care Facilities for people that are developmentally disabled.
Q No, I understood that.
A Yeah.
Q But then you said something at the end I didn't catch. Where was that?
A I was in New Mexico at that time.
Q I see. And how long were you there?
A Six years.
Q And, so, you moved, apparently, to Arkansas somewhere in 2016?

A Yeah.
Q And what's your educational background?
A I have a bachelor's degree in Social Work.
Q From where?
A Southern Illinois University Edwardsville.
Q And what year was that?
A 1995.
Q So, you're an advocate for DRA.
A Yes.
Q So, I know what the word -- what does the word "advocate" mean to you?
A To advocate for someone when your rights are violated.
Q And, so, is there some type of certification or licensure for advocates?
A No.
Q So, anybody could be an advocate.
A I mean, I don't know if that's true.
Q Well, I mean -- so, there's no state board. There's no test or training that you need to be employed as an advocate, is there?
A I can't speak to, you know, any place outside of DRA.
Q Well, let's talk about DRA, then.
A We -- we get training. Yeah. No, there's no board

certification or anything, that I'm aware of.
Q So, DRA trains you?
A Sure. Yes.
Q Did they train you before you started working there or train you after you started working?
A There is training that you do the first week that you're there.
Q What's that?
A They have general on-boarding training, and then we had our case management manual that we go through.
Q So, the on-board training, what's included in that is what I'm asking.
A Well, it's been --
Q What subject areas?
A I can't remember exactly everything that they covered, so I don't know if I can answer that, you know, correctly.
Q Well, I mean, I don't want you to answer incorrectly. But, I mean, do you recall any of it? And if you don't know the answer to a question, it's okay to say I don't know.
A I mean, I don't know. I would be -- I would be guessing at this juncture.
Q Do you hold any licenses issued by any state boards?

A No.
Q Do you hold any certifications issued by any agency, company, or state?
A No.
Q Or the federal government?
A No.
Q So, you're not certified by any Arkansas board, commission, or agency of any type?
A No.
Q And, so, not being certified, other than your employer, you're not subject to any regulations in your duties at the DRA, as an advocate.
A I don't understand that question.
Q I'm just trying to see if there's any -- you're only reportable to your superior employer at DRA as opposed to some type of professional organization dealing with advocates.
A Correct.
Q So, there is no regulatory entity over "an advocate," right?
A Correct, that I'm aware of.
Q That you're licensed or certified by.
A Right. Correct.
Q Tell me, have you ever met Christine Cains McAuliffe?

A Met?
Q Yes, in person.
A No.
Q Have you ever spoken to her on the telephone?
A Yes.
Q Have you ever had communications with her through electronic or written communications of any sort?
A Yes.
Q Tell me, when did they -- tell me about those communications. When was the first one?
A I don't know the exact date.
Q Approximately.
A I believe that the intake call came in for him July of 2020, so it would have been shortly thereafter the intake.
Q So, she called you.
A She didn't call me.
Q Who did she call?
A We have an intake department that takes --
Q So, eventually --
A -- our calls.
Q -- it got filtered to you, I take it.
A Yes.
Q And that's when you spoke -- did you then speak to Ms. McAuliffe?

A Yes.
Q And did you have communications with her after that?
A Yeah, I spoke to her more than once. Yeah.
Q And did you speak at all with Charlene Robinson?
A No.
Q Did you have any communications with Charlene Robinson?
A Through Ms. McAuliffe. Through her.
Q What do you mean, "through her"?
A Well, the mom, she was, I think, acting for the family.
Q Well, I'm actually asking, maybe -- I'm asking whether you had any written or verbal communications directly with Charlene Robinson.
A No.
Q Did you have any written or verbal -- do you know Mr. Gillispie? Let me ask you that.
A I have not met him before today.
Q Have you ever spoken or communicated with Mr. Gillispie before today?
A I haven't.
Q Has anybody at DRA, to your knowledge, spoken or communicated with Mr. Gillispie before today?
A I don't know.

Q Has anybody told you that they have?
A No.
Q Is there any -- have you reviewed any written or electronic communications between DRA representatives and Mr. Gillispie?
A I don't think so.
Q What do you mean? You don't recall or you don't --
A I mean, I get a lot of e-mails, so I'm not -- I can't say that -- you know, his name didn't ring any bells for me.
Q Well, let's talk about in context of the David Cains case. Have you had -- does that ring a bell as to whether you communicated with Mr. Gillispie or not?
A I have never communicated with him.
Q Well, what about anything at DRA?
A Anything at DRA?
Q Have anything at DRA indicated to you that there were such communications?
A I mean, because this has come about, yeah.
Q Well, that's what I'm asking you about.
A Okay. Well --
Q So, what communications are you aware of between anybody at DRA and Mr. Gillispie?
A DRA and Mr. Gillispie? When I got the subpoena, our legal director explained to me what this was about,

and that Mr. Gillispie was representing the family.
Q So, I'm asking about communications, though. So, do you know whether your legal director had communications with Mr. Gillispie?
A I assume.
Q So, if there were, do you know anything about them?
A No.
Q Have you seen anything that would indicate what they were about?
A No, other than the subpoena.
Q Well, the subpoena was from my office.
A Right. But that's what brought up Mr. Gillispie.
Q Now, did you author a letter to the DDS director dated October 22, 2020, with regard to David Cains?
A Yes.
Q Do you believe that you thoroughly investigated the circumstances of David Cains' death?
A Yes.
Q Well, let me ask you the first question. Did you investigate it?
A Yes.
Q And do you believe it was a thorough investigation?
A Yes.
Q Who from DRA worked on this investigation?
A Reagan Stanford.

Q That's an attorney, right?
A Right.
Q She's an attorney.
A Uh-huh.
Q Is that a yes?
A Yes, sorry. Sorry.
Q And, so, it was just the two of you.
A Yeah. We did the investigation.
Q So, who drafted the October 22, 2020 letter?
A Well, we both did, but she actually is the one that typed it.
Q Well, when you mean "typed it", you mean drafted it?
A That's -- when you say "draft", that's what that means to me.
Q So she wrote it.
A We wrote it together, but she typed it.
Q So, whether it was typed or not, I'm asking you, kind of, who drafted the substance of the letter?
A You don't believe two people can work on a letter together and --
Q Well, no, that's what I'm asking about.
A Yeah, we both did.
Q So, it's a combined effort is what --
A Yes.

Q -- you're saying?
A It's a combined effort.
Q Do you recall which parts you contributed?
A Not specifically.
Q Did anybody else assist in the drafting of that letter?
A No.
Q Did you speak to others at DRA about the letter before it went out?
A Our legal director looked at it before it went out.
Q And what's his or her name?
A Thomas Nichols.
Q And did Mr. Nichols make any changes to the letter?
A Not that I'm aware of.
Q And, so, why was it sent to the legal director of DRA before it went out?
A That's just what we do for something that -- you know, kind of a death investigation. I -- I wouldn't send something out without having his approval.
Q So, he approved it.
A He approved it and it was sent out. Yeah.
Q And did anybody -- I might have asked this a second ago. But did anybody -- or who edited the letter?
A Reagan and I edited the letter several times while we were creating the letter.

Q And did Tom Masseau review the letter?
A Not that I know of.
Q Is it the regular routine for -- and who was Tom Masseau?
A He's the executive director.
Q And is it the practice of DRA that the executive director review position papers or letters that go out?
A I don't think so.
Q You're not aware that he did.
A No. Yeah.
Q Yeah. Did Mr. Masseau play any role, to your knowledge, in this letter?
A No.
Q Did Mr. Masseau play any role in your investigation?
A No.
Q Are you aware of the DRA position with regard to the closure of the Booneville Human Development Center?
A Our position?
Q Yeah. What's your position with regard to whether it should be closed or not?
A My personal?
Q No, your -- well, yeah, your opinion.
A I -- I don't think it should be closed. I don't think any of them need to be closed.

Q Do you know whether DRA had a position with regard to the closure of the Booneville Human Development Center?
A I don't know.
Q Now, when you started your -- who did the actual investigation? Who went to the facility, you or Ms. Stanford?
A We didn't go to the facility. That was at the height of COVID, so we weren't -- I'm pretty sure we weren't even allowed in the facilities at that time.
Q So, you didn't go -- when you issued the letter, were you aware that the Booneville Human Development Center had already investigated the circumstances of David Cains' death before DRA did?
A Yes, from what the family had told us.
Q Were you aware that the state regulatory agency over at ICF/IIDs had also investigated David Cains' death before DRA got involved?
A It was unclear to us if they had or had not. That was, you know --
Q Who is the regulator for ICF/IIDs?
A Office of Long Term Care handles complaints about restraints and things like that.
Q Well, they handle all complaints, because they are the regulatory agency for ICF/IIDs, right?

A Yeah, but DPSQA -- I can't -- I can't -- I remember somehow DPSQA plays a role.
Q Do you know whether OLTC is within the office of DPSQA?
A I'm trying --
Q And that's D --
A Yeah, I can't remember what it stands for. They're separate from my --
Q It's D-P-S-Q-A.
what is your understanding?
A That they're two separate entities. Sometimes one doesn't know what the other is doing, so --
Q So, are you saying they're independent of each other?
A They're a state facility, but I believe they are independent of each other.
Q I'm not sure what you mean by facility -- state facility.
A I mean, they're -- they're all -- it's a state agency, but they're not -- I believe they're two separate entities.
Q Autonomous.
A Yes.
Q So, are you aware that OLTC surveyors are certified and federally trained?

A Yes.
Q And they're federally trained in investigations, right?
A I don't know.
Q So, what are they federally certified and trained in?
A I know that there's a CMS manual that they have to be trained in, in order to monitor the facilities.
Q And they do inspections or, what we call, surveys, right?
A Correct.
Q And OLTC sends these federally trained and certified investigators/surveyors out to determine whether a facility is compliant with the federal and state regulations governing it, correct?
A Correct.
Q And did you call or speak to anybody from the Office of Long Term Care, the state regulators, to determine whether they had already conducted an investigation by their certified and trained investigators?
A Yes, I did.
Q Who did you speak to?
A Cecilia Vinson.
Q And what did she tell you?

A She was not sure if they had completed a death investigation.
Q And did you follow-up on that and determine whether they had or not?
A She was supposed to get back to us and she did, eventually.
Q And what did she say?
A That she -- they had completed one, and we found it to be lacking.
Q Who found it to be lacking?
A We did. DRA. Myself.
Q I got you. So, what was the outcome of the state regulators' survey of the facility into whether there was a failed facility practice regarding David Cains?
A What was the outcome of their --
Q Yes.
A What we received was, I believe, two papers that had some boxes marked. There was no detail as to what they did or did not do, if they even went out and --
Q Well, what was the outcome --
A -- spoke to --
Q I'm sorry.
A The outcome, I'm sure, had no facility -- facility failure.
Q Did you see the paper?

A Yeah. I have --
Q So --
A I have a copy.
Q So, I think they used the word unsubstantiated or unfounded. I can't remember. It's something like that?
A Right.
Q And what does that mean?
A It means they found that there was no fault in their investigation.
Q And did you speak to any of these surveyors -- these long-term care state regulators?
A I spoke to Cecilia. I didn't --
Q What's --
A I did not speak to the person that did the investigation.
Q Cecilia Vinson didn't do the investigation --
A No.
Q -- right?
A No.
Q That's a correct statement, right?
A Correct.

MR. LOWTHER: Let him finish his question before you start your answer. He'll extend the same courtesy to you.

THE WITNESS: Sorry.

Q (By Mr. Rosen) So, the actual surveyor you never spoke to.
A Correct.
Q So you don't know the basis for his or her findings, do you?
A Based on, we received the entire investigation that that person did, and reviewed it.
Q And you're saying that was two pages?
A No. The notes -- we had to go to -- the two pages of the -- that was unfounded was two pages of boxes, but there were surveyor notes that we asked for and we were able to get those.
Q I assume that's what you mean by what they based their decision on.
A Correct.
Q Now, what does an investigation mean to you? Can you define that for me, how you interpret that term?
A Well, I'm going to investigate the matter at hand, which would be, you know, in this specific -- it's different for every kind of investigation that we do.
Q Well, what does the word investigate mean to you is what I'm asking.
A That's such a -- I don't know. Inquire. I don't know.
Q Now, in your letter of October 22, 2020, you

identified what was reviewed as part of your "investigation", right?
A Right.
Q And from what I can tell, it was adult maltreatment reports; is that correct? Well, tell me what you reviewed.
A Well, like is in the letter, the adult maltreatment report, all the witness statements that DHS collected, the DPSQA complaint investigation, EMS, hospital, coroner's report.
Q And did DRA or did you interview anyone?
A Yes.
Q Who did you interview?
A I would -- I -- I was in all of the interviews of, like, the coroner. We interviewed the staff from the facility. Also, the EMS people that worked on him that day.
Q And who at Booneville Human Development Center did you talk to?
A We talked to Jeff Gonyea, Sandy Evans, the people involved in the restraint, the staff there.
Q Did you speak to the maltreatment investigator?
A Yes.
Q The Booneville one.
A Sandy Evans is what we -- who we spoke to.

Q And all that's identified in that letter, right?
A Correct.
Q And that is what consisted of a DRA investigation; is that correct?
MR. GILLISPIE: Object to the form.
MR. LOWTHER: You can answer.
A It's not -- it's -- it's not all of the investigation, but yes.
Q (By Mr. Rosen) Tell me what the other part of the investigation that's not identified there was.
A Well, we did go back and review restraint positions and things when we spoke to the person that does the restraint training at the facility, so I went back and, you know, refamiliarized myself with those.
Q With restraint positions?
A Yeah.
Q What does that mean?
A So, they use -- so, because the restraint was, you know, involved in this -- I've been certified in these restraints, but it was a long time ago, so I just went back, you know, online to familiarize myself with them so I knew, when we spoke to the person that does the restraints, you know, that I had a good understanding of --
Q So, what did you review?

A There's online materials and handbooks when you purchase these programs, like Handle With Care or CPI.
Q That's what I'm asking about. So, what did you --
A We have those books in the office.
Q You have NCI books?
A We have -- not an NCI book. The Handle With Care was something that we reviewed.
Q I don't know what that means. That's a business that produces -- what is it? Handle With Care?
A It's their restraint.
Q Whose restraint?
A Whose restraint?
Q I'm not sure why this is funny, but --
A I'm looking to see if here if I -- it's not funny. I'm just -- Handle With Care is a -- it's an example. I'm giving you examples of types of restraints that we deal with. Not specifically here, but we have booklets on different kinds of restraints that different facilities use. So, a lot of times we can pull those and use them for reference.
Q Does the Booneville HDC use the Handle With Care restraint procedures?
A I don't know if they were. We were told that they didn't take anyone to the floor for restraints, so that's what we were looking at.

Q I'm really just -- I understand that you're jumping a little ahead of me, but I'm just asking. You had mentioned that there was a -- Handle With Care, I guess, is a certain type of restraint protocol.
A Uh-huh.
Q Is that yes?
A Yeah.
Q That you reviewed to get familiar with how restraints work.
A I reviewed a lot of different restraints. Not the ones that they did here, but we review a lot of them because of prone positions, to make sure -- to see who's using prone positions and what.
Q And, again, you're getting a little ahead of me. I just want to -- I'm trying to identify what protocols that you reviewed during your investigation. So, we know that it was the -- Handle With Care was one. What else did you review?
A All of it. I looked at CPIs.
Q CPI? Which one, because, as you know, there's --
A Yeah.
Q -- several.
A Yeah, CPI. Just the verbal de-escalation part, I believe.
Q So, verbal de-escalation was the only protocol that

you reviewed from CPI.
A Right.
Q You understand that CPI has a whole host of other --
A Yes. They have different -- yeah.
Q Let me finish my question.
MR. LOWTHER: You need --
A I'm sorry.
MR. LOWTHER: You have to let him finish his question --
THE WITNESS: Sorry. Sorry.
MR. LOWTHER: -- before you answer.
Q (By Mr. Rosen) So, they have a host of others that include more -- well, they have a host of different protocols in different situations and how far somebody wants to get involved with the behavior, right?
A Correct.
Q But you just looked at the verbal de-escalation, right?
A Correct.
Q What else?
A I don't know of anything else.
Q So, when you were doing this investigation, did you apply these standards and these protocols to what you were expecting how the Booneville Human Development

Center staff would respond?
A No.
Q So, what was the purpose of looking at these different protocols?
A Just to refamiliarize myself with restraints and what's being used out there.
Q And you were previously trained on what type of protocols?
A The Mandt System.
Q Can you spell that?
A M-A-N-D-T.
Q M-A-N-D-T --
A Yeah.
Q -- System. And that's -- I know there are a lot of different ways of handling situations. So, that's what you looked at. That's what you were trained on. So, did you go back and review that one, or you already knew that one?
A No, I didn't go back. That was -- that training was probably ten years ago.
Q So, just to be clear for my understanding, during the course of your investigation into David Cains' death, you looked into Handle With Care and CPI verbal de-escalation protocols, and those were the only policies/rules/guidance that you reviewed during the

investigation.
A No. I can't say that those are the only things that we reviewed.
Q So, I have those two. So, what else did you review?
A I don't know. I don't remember.
Q Well, do you remember that you reviewed anything else?
A I'm sure we did.
Q Well, is that speculation or you just -- and there's no right answer here. I'm just trying to find out what you reviewed so I can ask you about it.
A It was two years ago, so -- we put a lot of time into this, so I think it's safe to speculate that we reviewed more than two or three --
Q But you --
A -- restraint methods.
Q But you don't have any recollection sitting here today as to what restraint methods or protocols that you reviewed and applied to this case.
A We reviewed Booneville's.
Q Well, that's what I'm asking you. So, you reviewed Booneville. So, what did you review?
A The restraint system that they use.
Q And is that mentioned in your report?

A I don't know. Let me see. Yeah, the type -- you're talking about the type of restraints?
Q Whatever you reviewed is what I'm asking you. What did you review, and was it mentioned in the report?
A We reviewed the NCI CPI.
Q You've already mentioned that. That's the CPI verbal de-escalation, right?
A Yeah. Uh-huh.
Q Is that yes?
A Yes.
Q And, so, that's what you -- that's it. So, those two things is what I can see and -- or that you mentioned, right?
A The two things that what?
Q Those are the two protocols that you reviewed during the course of this investigation.
A No, we reviewed their -- the things that they use for restraint.
Q Well, that's what I'm asking you --
A Right.
Q -- is --
A I mean, that's what you're asking.
Q Yeah. I'm asking what protocols, what policies, what papers did you review as part of your investigation, and you mentioned Handle With Care, CPI,

verbal de-escalation.
A Uh-huh.
Q Now you're saying you reviewed the Booneville HDC policies, but I'm asking you where that's mentioned in here -- in the report.
A Let's see. Well, we do -- on Recommendations Number 4 we mention the 9-1-1 policy.
Q That's not a --
A That's a --
Q That's a policy.
A -- BHDC policy.
Q What else, if anything else?
A I know that -- I don't know the specifics, you know, but we did a record request on the policies --
Q But --
A -- from the facility. I know that the 9-1-1 was a concern. The CPR and --
Q CPR?
A Yeah, CPR protocol.

[redacted]



Q Did DRA review David Cains' 2019 Individualized Program Plan, or IPP?
A Yes.
Q That's not listed in here as one of the documents that you reviewed, is it?
A Where? Here?
Q In the letter.
A In the front page or --
Q Yeah.
A -- in the letter at all?
Q It says what you reviewed, and it doesn't mention that, does it?
A Let's see here. We did review.
Q You have specific recollection even though it's not

mentioned here that you reviewed it, or you're just assuming that you did?
A No. I mean, we asked for it. That's just something I would normally ask for and review. That's how I found out about his choking risk. That's where it was first mentioned. And then there's a separate report that the -- I don't know if it's that OT does or the speech pathologist.
Q And, so, when you looked at the IPP, then you became aware of David Cains' behavioral issues, right?
A Correct.
Q Because they're extensively detailed in there, are they not?
A Correct.
Q In fact, the IPP authorized various forms of restraint, did it not?
A Correct.
Q And is DRA on the IPP treatment team?
A No.
Q Do you know who is?
A It would be his interdisciplinary team, like Case Manager, Psychologist --
Q And physician.
A -- Social Worker. I don't -- I mean, I guess.
Q Well, I'm not asking you to guess.

A I don't know. I know that you're going to have a -- I don't know if they have a 24-hour physician there that participates in IPPs.

Q So, you're saying you reviewed the IPP --

A Right.

Q -- but you don't know whether the physician contributed to or was on the treatment team.

A They have nurses that do.



Q But DRA was aware of David Cains' behavioral outbursts and aggression, correct?

A Correct.

Q And violence, correct?

MR. GILLISPIE: Object to the form.

A Violence? I --

MR. GILLISPIE: Object to the form.

MR. LOWTHER: You may answer the question.

THE WITNESS: Answer?

A The only -- I don't know. I mean, I wouldn't categorize him as violent. I don't know.

Q (By Mr. Rosen) Well, if somebody has hit people in the past, would that be violent?

A Yeah, I guess. Yes.

Q If they've thrown fire extinguishers at people, would that be violent?

A Yeah.

Q If they destroyed a television, would that be violent?

A Yeah.

Q Now, if they -- what did the IPP state with regard to the television in David Cains' room?

A I have no idea right now. That was two years ago.

Q It's not mentioned in this report, is it?

A No, it's not.

[redacted]

Q But you didn't talk about his behavior in there,

did you?
A No. I mean, we did. Page 2, that first paragraph.
Q Well, you're identifying what was stated in the staff written statements and interviews, correct?
A Yeah.
Q So, you're reciting what the staff told you there. What I'm asking is, you didn't take anything from the IPP and put it into the report about David Cains' behavioral episodes, did you?
A No.
Q And why was that?
A It wasn't relevant. We didn't -- yeah.
COURT REPORTER: Can we take a quick break?
MR. ROSEN: Yes.
(WHEREUPON, after a break was taken, the proceedings resumed as follows, to wit:)
Q (By Mr. Rosen) So, we were talking before the break about David Cain's behavioral episodes and the portions of the IPP dealing with his behavioral management issues and how to deal with that, which would include restraints and a host of other things. None of that's in the report, is it?
A No.
Q And, so, DRA didn't think that was relevant?
A I -- that -- well, if it's not in here, I can't

speak to why it's not in here.
Q And, so, I think we've talked, also, about the -- were you aware of any protocols in the IPP regarding David Cain's TV set in his room?
A I don't remember anything about a TV.
Q You don't recall that it had to be behind a plexiglass screen to keep him from destroying it?
A To be fair, all the TVs in those facilities are like that.
Q All of them are?
A Yeah.
Q Now, you don't know anything about the fact that it used to not be that way before David Cains -- well, do you know that David Cains destroyed the TV?
A If it was in his IPP, I read it two years ago, but it's not --
Q None of that --
A -- fresh in my mind.
Q None of that came in to here as being a relevant fact about his behaviors, right?
A No.
Q What about the DVD or CD player in David's room? Anything unusual about that, that you are aware of that happened to it?
A No.

Q Do you know who the EMT -- the emergency technician who responded spoke with when he arrived at the scene on June 13, 2020?
A I don't know off the top of my head. Whoever was on the report, I'm assuming.
Q So, in your report you mentioned, I guess, one of the DRA concerns is that information was not given to the emergency room doctor about the restraint before Mr. Cains vomited.
A Correct.
Q So, what I'm asking then is, do you know -- did you investigate to see who the EMT spoke with to get the information that he relayed to the doctor?
A We did interview the EMT.
Q What did he tell you who he spoke with?
A I can't remember.
Q It's not noted in here, is it?
A I don't know.
Q So, if he spoke to somebody who responded subsequently, and all they knew was that David Cains was on the floor and he had stopped breathing, that's all that can be reported -- and had vomited, obviously, that's all that could be reported, right? Is that yes or no?
A Yes.

Q So, if he spoke to a person who came along later, such as a nurse or someone else who didn't know all the facts that had happened previously, then he could only report what was reported to him by a person who only knew certain facts, correct?

MR. GILLISPIE: Object to the form.

A I suppose. Yes.

Q (By Mr. Rosen) So, if he spoke to the wrong -- if the EMT spoke to the wrong person to find out what happened, he would not get fully updated information, would he?

MR. GILLISPIE: Object to the form.

A No.

MR. GILLISPIE: Calls for speculation.

MR. ROSEN: It doesn't call for speculation.

Q (By Mr. Rosen) Do you know whether the EMT spoke to the right person who could give him all the details or spoke to somebody who only knew part of the details?

A He spoke to the nurse that met -- the nurse -- I guess, the nursing people go to meet the EMT. They were there.

Q So, that nurse, whoever that -- do you know who that nurse was?

A It's -- it's probably in our notes.

Q Well, I mean, who is it?
A I don't know off the top of my head. I don't know the name. It says here on Page 2 that the medical staff are the first call. That's the policy. And there was an LPN that was there, that we refer to her witness statement.
Q So, let's deconstruct that, because you know from your investigation that the LPNs were not present when David Cains was restrained, vomited, or choked, right?
A I don't -- they arrived while that was going on.
Q Did they arrive -- well, why did they arrive, according to your investigation?
A They had to call the nurse.
Q Who called the nurse?
A The staff.
Q Why?
A Well, because he was on the floor unresponsive.
Q Well, that's what I'm asking. So, after he choked and stopped breathing, somebody called the nurse, right?
A Yes.
Q And, so, those nurses responded, correct?
A Yeah.
Q You know that from your investigation --
A Right.
Q -- don't you?

A Yeah.
Q And, so, from what you just told me, the emergency EMT person who responded spoke to one of those nurses, right?
A Yeah, I believe so.
Q That's what your -- well, is that what your investigation uncovered?
A I would have to go back and look at all of my notes and statements. I can't say, without bringing all my stuff in here, without a doubt who they spoke to and which nurse it was. Three or four nurses arrived.
Q But wouldn't that be relevant information to put in an investigative report?
A No.
Q No? So, if the EMT spoke to the nurse and the nurse said he vomited, and he's on the floor, and he's unresponsive and, apparently, he choked, that would be the information that the EMT then would give to the emergency room doctor, right?
A The EMT would give whatever information I'm assuming he was given by whoever. Yeah.
Q And, so, then in this instance I'm sure your investigation revealed that the emergency room, or the hospital then told the coroner what that story was.
A Correct.

Q So, in your investigation, did the emergency room physician or the coroner call the Booneville HDC to get additional facts?
A No, they didn't.
Q And in an emergency situation -- well, have you ever been in an emergency situation?
A Yeah.
Q In an emergency situation when somebody's trying to save somebody's life and somebody else comes along, is it unusual not to have every detail of every fact mentioned?
MR. GILLISPIE: Object to the form.
MR. LOWTHER: Answer, if you can answer the question.
A I don't know where -- ask me --
Q (By Mr. Rosen) Let me reword it. So, would it be reasonable, in your opinion as the advocate in this case, that the nurse spoke to the EMT and relayed information to him based on what she knew and observed, even though it might not have been all the information that happened before she came along?
A Sure.
Q So, when you report in there that -- in your letter of October 22, 2020, when you talk about that the information about the restraint was not relayed to the

emergency room physician or the coroner, that could be the reason is that they spoke to the wrong person, correct?

MR. GILLISPIE: Object to the form.

A I suppose. Yeah.

Q (By Mr. Rosen) Well, if they didn't speak to one of the -- well, do you know whether they spoke -- did your investigation uncover whether the EMT spoke to any of the RCTs, the aids who --

A They did not.

Q Now, with regard to -- I think you even note in here that this incident, when you spoke to the -- during your investigation there was mention that this happened at 11:30 in the morning that day, on June 13, 2020; is that correct?

A Yeah.

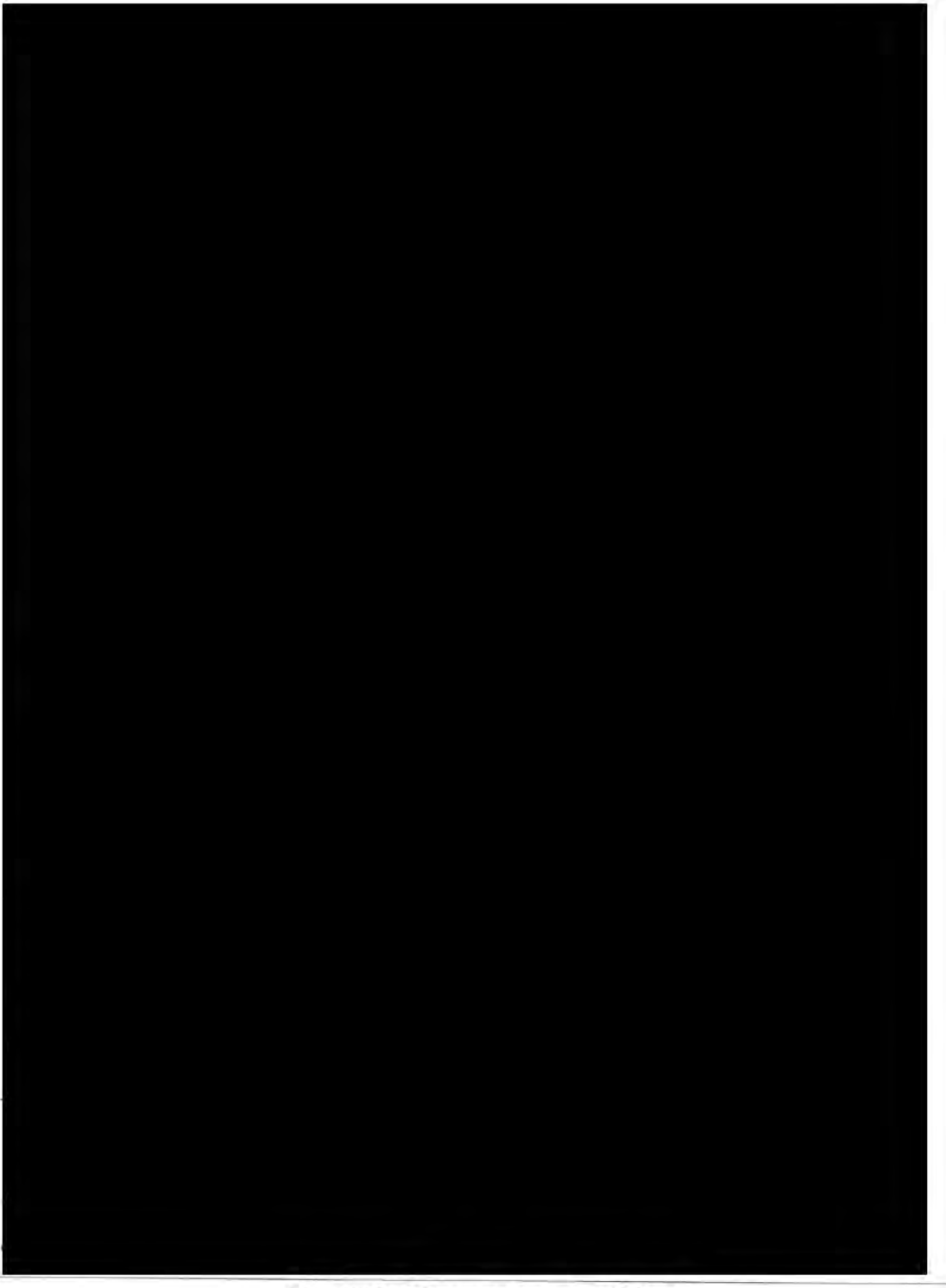
Q And I think you even note in there somewhere that that was just a time estimate from the people asked about what happened, right?

A That we mention 11:30 because that's what one of the RCTs, Tyler, said he thought that that was about the time that it happened.

Q Yes. But you even mention in there, there's no visible clocks --

A Right.

Q -- on the -- let me finish the question.
A Sorry.
Q There were no visible clocks in the commons building lobby, was there?
A That's what staff reported to us. We asked them.
Q And, so, did you ever follow-up as to whether there was or not?
A No.
Q So, do you have any reason to disbelieve staff that there were no clocks in the lobby?
A No.
Q So, when they gave the 11:30 time, I think even it's noted in the report, that's an estimate, right?
A Yeah, he didn't -- he didn't have a watch on.
Q So, we don't -- what does the word "estimate" mean to you?
A About. Close to.
Q Approximation?
A Yeah.
Q It doesn't mean exactly, right?
A Correct.
Q Is there any doubt that was uncovered in your investigation that -- strike that question.
During the course of your investigation, were you able to ascertain whether the RCTs, the aids, and,



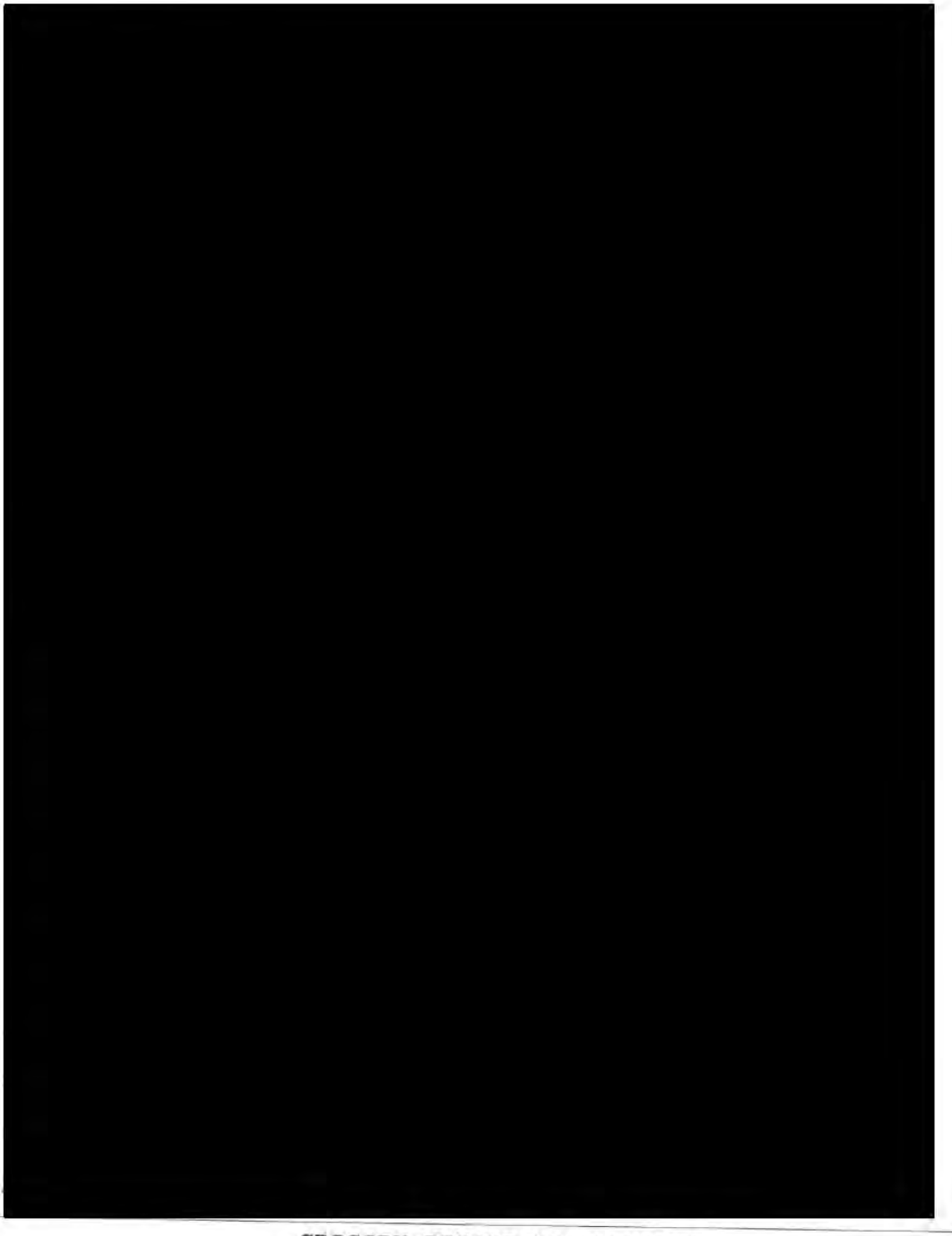
Q I see what you're saying. So, what did your investigation uncover?
A What do you mean, what did it uncover?
Q Whether -- well, let me ask it this way. Did your investigation reveal that the appropriate procedures were performed on David in an attempt to save his life?
A I would say -- did our -- I don't believe that we made a statement to that in this letter, right?
Q Wouldn't that be relevant here?
A Where?
Q In your investigative report.
A What do you mean, wouldn't it be relevant?

[redacted]

Q And it was unsuccessful, right?
A Yeah.
Q And, so, when the EMT was called, do you know how long it took them to arrive at the Booneville Human Development Center?
A We have the time of arrival I believe we put in there from the report. Let's see. They got there at 11:50.
Q And the call was at 11:37, right?
A Right.

Q So, it took them 13 minutes to get there, right?

A Yeah.





Q During your investigation, was DRA able to ascertain any de-escalation protocols that were implemented to calm David down?

A No.

Q No, you weren't able to identify or there were none?

A Are you asking if it's in this letter?

Q Yeah.

A On the second page we discuss, you know, what happened when he came out of the bathroom.

Q And what happened?

A Apparently, he started ripping paper off the wall, and the staff told us that he applied a person restraint.

Q So, what happened right before that?
A He was in the bathroom.
Q And when he came out of the bathroom, according to your investigation, did anything else happen?
A No. I mean, he just -- from what the -- he was irritated and immediately began ripping paper off the wall is what --
Q So, he --
A -- the staff said.
Q So, he comes out of the bathroom and, according to your investigation, he's immediately irritated and rips things off the wall and has a behavioral episode.
A Well, I mean, that would be the behavioral episode, ripping things off the wall.
Q Is that the only thing he did, according to your investigation?
A It said he was attempting to hit staff.
Q And are we talking about Tyler Mattson there?
A Yeah.
Q So, he attempted to hit him.
A Uh-huh.
Q Is that a yes?
A Yes.
Q Did he lunge at him?
A I don't have that in my report.

Q Do you know? What did your investigation uncover?
A I know what -- he attempted to hit Tyler. That's the only thing I have in front of me right now.
Q So, if he lunged at Tyler or did anything else -- well, strike that question.
So, during your investigation, were you able to ascertain exactly where this behavioral incident -- where this happened?
A Yeah.
Q And, I mean, in more detail than just in the lobby of the commons building.
A Yeah, I know. I mean, I've been in the building, so I know.
Q So, you're aware that this was on the second floor.
A Right.
Q And on the second floor of that building there's a -- you're aware that there's a staircase in the middle of it, right?
A Yeah.
Q And between the staircase and the walls on either side there's a half-wall with an opening down to the floor below, correct?
A I think so. Yeah.
Q Do you recall or not? If you don't recall --
A I was just out there last month. I can't remember

that part. I know, like --
Q So, during the course of your investigation, were you able to pinpoint how close this happened to that half-wall with the drop to the staircase below -- the floor below?
A Well, the bathrooms are further back and, so, there are billboards up closer to the stairs, but if he came out of the bathroom -- I mean, I don't have -- they didn't have cameras or -- you know, so we couldn't get an exact location. So, I don't know how far back from the bathroom, you know, that he came out.
Q But you said he ripped things off the wall. What types of things did he rip off the wall?
A I think it was, like -- there was a billboard that had things up on it, but I'm not 100 percent.
Q And that's closer to the half-wall in the front by the steps, right?
A I know there's one billboard there. I don't know if there's another back by the bathroom.
Q And I just want to -- just to summarize it, your investigation and your recollection that went into this report is that David Cains went into the bathroom, came out and started ripping things up, and tried to hit Tyler Mattson, who is the aid.
A Correct.

Q And nothing happened in between that?
A Not that --
Q I'm just asking.
A Not that I can remember.
Q And David Cains' IPP, in the course of your investigation, do you recall or not recall whether there is anything in there about the use of restraints?
A Yeah, there's stuff in there about restraints.
Q And would trying to hit somebody and ripping things off the wall be an occasion for a restraint?
A I'm not sure if it specifically outlines specific incidents to justify a restraint. I'm not sure.
Q Let me just -- that might be all I have. Hold on. That is all I have. Thank you.

EXAMINATION

BY MR. GILLISPIE:

Q Ms. Stewart, while it's fresh on your mind, I want to go back to the time that you were given as to when this restraint incident that ultimately led to David Cains' death began. The time that was given to you -- am I correct that the time that was given to you by Tyler Mattson was 11:30 a.m.? And what I mean by that is, is that the numbers as they represent time that were spoken to you by Tyler Mattson?
A Correct.

Q Did Tyler Mattson ever say it might have been 11:31?
A I can't remember.
Q Do you recall any other times (11:31, 11:32, 11:33) that were ever given to you by anyone?
A We looked at witness statements, so it's possible they could have had different, you know, times.
Q If there had been other times given to you -- other start times -- and when I say "start time," I'm talking about the beginning of the incident. If there had been other start times given to you, isn't that something that would have been important enough to put in the report?
A Yeah, because of -- because the times were -- we were hitting on the times because the staff are not allowed to call 9-1-1.
Q I understand that.
A They have to go through the nurses.
Q Did Tyler Mattson or any other staff specifically say to you, "This time I'm giving you is an estimate," or is this mentioned in the report that times are estimates as there were no visible clocks, or was that something that you sort of came to on your own? And I can restate that for you if you need.
A Yeah. Can you restate it.

Q Sure. Did you recall Tyler Mattson or any other staff member ever specifically saying, "It was 11:30, but that's an estimate?"
A No.
Q But you do specifically remember, as I think you just said, being given the time of 11:30 a.m.
A Correct.
Q And do you have any reason to believe Tyler Mattson didn't have a cell phone on him?
A Oh gosh. I don't know.
Q But my question is, do you have any reason to believe he didn't have a cell phone on him?
A No.
Q Do you have any reason to believe that any of these staff members weren't carrying around their cell phones, which are also clocks, just like all of us do?
A No.
Q And, again, the only time -- I mean, time as represented in numbers. The only time you specifically recall being given by anybody was 1-1-3-0; is that correct?
A Correct.
Q I want to back up just for a moment here. And I believe you touched on this a little bit with Rich, but could you just, while we have you here, tell me about

your experience working in this field.
A I graduated in '95 with a Social Work degree. I worked a total of probably about 12 years in two different HDCs, like Booneville, in Missouri and Tennessee as a case manager.
Q Are you saying you worked as a case manager in a human development center in another state?
A Two of them. Yes.
Q For 12 years.
A Six each. Yeah. So, as a case manager. And during those duties we -- I also did investigations for abuse and neglect on those campuses, as well, and did some incident management roles. And then I --
Q Did you become familiar -- during that time, did you become familiar with NCI, Nonviolent Crisis Intervention?
A Not during that time. That was Mandt training back in the day.
Q I'm sorry to interrupt you.
A And then I worked for Department of Mental Health.
Q In which state?
A St. Louis, Missouri.
Q How long did you do that?
A Six -- six years.
Q What did you do for the Department of Mental

Health?
A I was a case manager there. So, we had people that lived in the community that needed case management services to keep them able to maintain --
Q In your role as a case manager at the two HDCs that you worked at in Missouri, what was your job duties as a case manager at those HDCs in Missouri?
A So, write IPPs, assist with, you know, inputting on behavioral support plans. If you worked with staff and clients one-to-one on a daily basis.
Q And even though it wasn't called NCI, there was a form of restraint training that you and the other staff members at these facilities were trained in at the time?
A Correct.
Q And am I correct to assume that Human Development Centers in Missouri are largely identical to human development centers here as far as what they do and who they cater to?
A At that time, yeah. They don't have any now, so --
Q But Missouri --
A Yeah.
Q But at the time, their human development centers were also long-term care facilities for adults with developmental disabilities?
A Uh-huh. Dual diagnosis.

Q And did the great majority of the individuals living at those places you worked in Missouri have behavioral issues and aggression issues, at times?
A Correct. Yeah.
Q And, so, after you left the Department of Mental Health for the State of Missouri in St. Louis, what did you do after that?
A I moved to New Mexico and I worked for Easterseals, and I did the group homes.
Q What does that mean, exactly?
A So, it's the same population as an HDC. They just live in the community in smaller group homes. About 15 people per home.
Q But, again, you were working with adults with developmental disabilities.
A And mental health issues.
Q How long did you do that?
A I was in New Mexico for six years.
Q And did you work for Easterseals the whole time?
A No. For a year I worked for Humana, the insurance company, as a care coordinator.
Q And how about after New Mexico?
A I've been here since '16.
Q Since 2016?
A Yeah.

Q And have you worked for Disability Rights Arkansas since 2016?
A Yes.
Q And is your job title now the same as it was in 2016?
A Yeah, we just say advocate. Yeah, pretty generic.
Q Sure. When you came to work for Disability Rights Arkansas, which we'll call DRA, were you required to undergo any training?
A Yeah.
Q Could you describe that, please.
A We had a week's worth of training that, you know, went through procedures and stuff, case management manual.
Q Did you find that much of your extensive experience working in HDCs and with developmentally disabled individuals in other states translated well to your job with Disability Rights Arkansas?
A Yeah, I did.
Q Were you able to use many of the techniques and knowledge and tools that you learned in those jobs with this job?
A Yes.
Q Did you receive training or -- were you provided any training or guidance of any sort on how to conduct

investigations of this sort?
A We have guidelines, yeah, that -- that we follow.
Q And are you able to -- I realize you don't have them in front of you, and I don't expect you to be able to just have everything memorized, but can you kind of generally, maybe, say what that consists of?
A So, you know, where you would first start off would be the records request, and so we have a thing that describes and gives examples of what kind of records you would request. And, so, I did investigations for other places, not just HDCs. So, obviously, there would be, you know, forms that -- or, like, IPPs, you know, DYS doesn't have that, so you adjust it accordingly to wherever you're doing your investigation.
Q So, you investigate private facilities that cater to those individuals with developmental disabilities, as well?
A Any place where a person with a disability lives and works --
Q Regardless of --
A -- we're able.
Q Regardless of whether it's state operated or not?
A Correct.
Q And as far as the guidelines on conducting these investigations, you said you request records. Can you

recall any other specifics about what steps -- things that you're always required to do in conducting these investigations?

A Like, with the HDCs, for death you should always have what they call, like, an IRIS report, so those things, and then to interview --

Q And when you say IRIS report, you're talking about the report that, I believe, is generated by OLTC?

A The facility reports to OLTC when somebody dies.

Q Thank you. That's right.

A So, we review those kinds of things. And then, you know, you're going to interview people, witnesses. Things like that.

Q Do you review relevant policies of the facility in question?

A Yes.

Q Do you review policies -- would you have reviewed policies such as DDS policies that would have been applicable to that facility?

A Yes.

Q And you still have a copy of the letter, right?

A Yeah.

Q Turn to the first page for me, please.

A Okay.

Q This third paragraph down, is that a pretty good

concise summary of what all steps you took, and work that you and Ms. Reagan Stanford put into this investigation?

A Yeah. Yes.

Q And you described it as an extensive investigation into his death, correct?

A Correct.

Q Am I correct that this states that the investigation involved reviewing the maltreatment investigation report, all witness statements, the DPSQA complaint investigation report, EMS report, hospital records, and the coroner's report?

A Correct.

Q Am I correct that this reflects that you interviewed BHDC, Booneville Human Development Center, staff, including Tyler Mattson, Amy (Mandy) Jones, and Ryann Campos, the individuals who restrained David; as well as Sandy Evans, the adult maltreatment investigator; Jeff Gonyea, the superintendent; and Mark Hines, the NCI instructor?

A Correct.

Q Additionally, am I correct that your office interviewed the Emergency Medical Services provider, so it would be EMT paramedic Samuel Scow, as well as the coroner?

A Yes.
Q Tyler Mattson, as reflected on Page 2 of this document -- am I correct that -- and I'm at the top of Page 2 here. Am I correct that Tyler Mattson told you that -- during your interview with Tyler Mattson, he told you that David Cains began -- came out of the restroom, begun screaming, ripping paper off the wall, and attempting to hit Tyler.
A Correct.
Q Now, do you have any recollection of Tyler ever telling you that, in addition to David attempting to hit him, that David also, sort of, charged at him like a bull and attempted to either wrap his arms around Tyler or push Tyler off of a ledge?
A No.
Q Do you have any recollection whatsoever of Tyler ever mentioning to you that he was in danger of being pushed off of a ledge or falling off of a ledge?
A No.
Q Am I correct to assume that, had that information been relayed to you, it's something significant enough that it would have made it into this report?
A Yeah.
Q Am I correct that Tyler Mattson, in his interview, told you that he applied personals to David, meaning

personal restraints to David, by grabbing his arms and that they ended up falling over?

A Yes.

Q And he also told you that David landed on his face; is that correct?

A Correct.

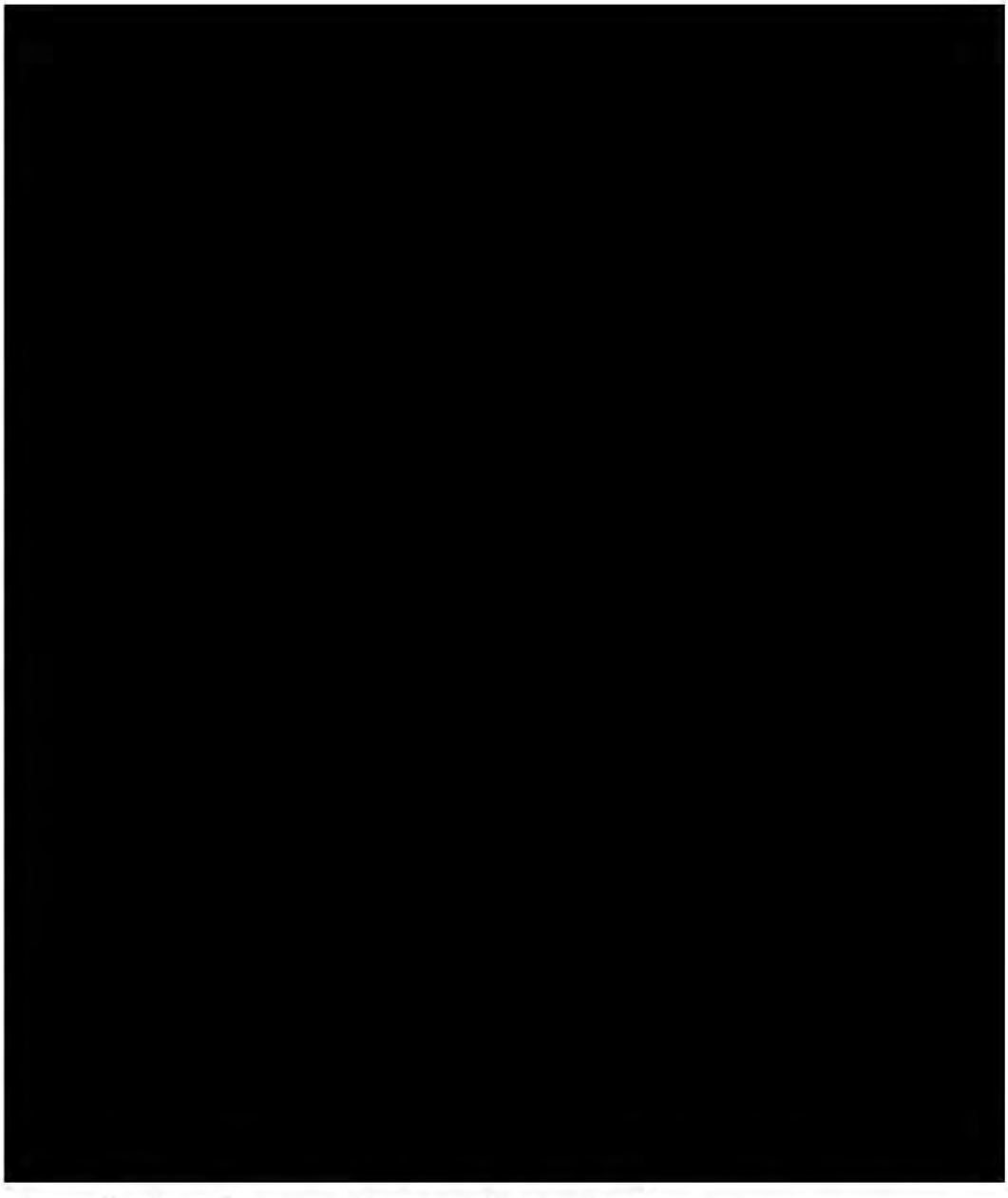
Q And I want to be completely clear about this. There's no doubt in your mind that Tyler Mattson told you that David landed on his face.

A There's no doubt.

Q Am I correct that you also interviewed -- well, you've already said that you did. But you interviewed Samuel Scow, the paramedic. Am I correct that Samuel Scow gave you a specific account of what was communicated to him by Booneville staff?

A Yes.

[redacted]



Q Yeah. The very bottom here of this same page -- not the very, very bottom, but almost. Down here at Footnote 7, this pertains to the 9-1-1 policy. How about I ask a question. Were you told by, I believe,

everyone you interviewed that the Booneville Human Development Center had a policy that forbade non-medical staff from calling 9-1-1 during a medical emergency?

A Yes.

Q And am I correct that even Superintendent Gonyea acknowledged that this policy was the policy?

A He did.

Q Did anyone ever explain to you why this was the policy, or where this policy came from, or whose brilliant idea this was?

A I'm not sure where it originated from. It's an actual policy. We have the policy. They were -- Jeff had mentioned that they were worried that people would call 9-1-1 kind of haphazardly, that didn't have training, you know, maybe for things that weren't a 9-1-1 emergency.

Q Did that make sense to you?

A No.

Q In your years of experience -- no offense, but many years of experience in this field, have you ever come across such a policy?

A No.

Q Were you surprised that this was a policy?

MR. ROSEN: Objection; relevance. I mean, that's not a relevant question.

MR. LOWTHER: You can answer.
A Surprised, yes.
Q (By Mr. Gillispie) Did Mr. Gonyea or anybody else give any other explanation other than what you just told me?
A No.
Q And what you recall him saying was that they were worried that -- I'm sorry. Would you say it again.
A That people would call 9-1-1 unneeded, you know, like, for things that weren't 9-1-1.
Q And did he tell you that the harm that could be caused by that outweighed the harm that could be caused in, say, a situation like this?
MR. ROSEN: Objection; form of question.
A No.
Q (By Mr. Gillispie) Next page, Kris, Subparagraph a states here that -- and this subparagraph of your letter concerns the statement provided you by Ms. Ryann Campos, who was one of the three direct care staff involved. Am I correct that Ms. Campos told you that Amy, who goes by Mandy -- Amy (Mandy) Jones was holding David's head during the restraint?
A Yes.
Q And the explanation for that, that she gave you was so that he wouldn't spit?

A Correct.
Q Then down under Subparagraph c, which pertains to Tyler's statements --
MR. ROSEN: I'm going to object, because I don't see anything about Mandy or Tyler in either of those, a or c. Where does it say that?
MR. GILLISPIE: I'm on physical Page 3.
MR. ROSEN: Yes.
MR. GILLISPIE: And little a paragraph, the last sentence, actually, Mandy came.
MR. ROSEN: Can I --
MR. GILLISPIE: Can we go off the record for a second.
(WHEREUPON, after a break was taken, the proceedings resumed as follows, to wit:)
MR. GILLISPIE: Do you now have an unredacted copy?
MR. ROSEN: No.
COURT REPORTER: Are you going to make this an exhibit, also?
MR. GILLISPIE: Yes. This is the exhibit that I'm going to make.
MR. ROSEN: I don't know how you got an unredacted copy but, okay, that's fine.

MR. GILLISPIE: I mean, I know DHS obviously has one.

MR. ROSEN: Is that unredacted? Well, I don't know that. Does it have a Bates stamp on it?

MR. LOWTHER: No.

MR. GILLISPIE: Yes. The unredacted one has a Bates stamp on it. That's how I got it. That's from you. And the reason you have a redacted one is because, that's the only one I could have produced to you, did produce to you, in discovery.

MR. ROSEN: Can you tell me --

MR. GILLISPIE: Because that all I had at the time.

MR. ROSEN: -- real quick what the --

MR. GILLISPIE: Yes.

MR. ROSEN: -- Bates stamp is.

MR. GILLISPIE: Page 1 is 4523.

(WHEREUPON, Claimant's Exhibit 1 was marked for identification and is attached hereto.)

Q (By Mr. Gillispie) Subpart c on this same page, Ms. Stewart, am I correct that, according to your -- that during your investigation and your interview with Mr. Mattson you found that he deviated from his written

statement; is that correct?
A Correct.
Q And, specifically, am I correct that the deviation was that, while it's not in his written statement, what he told you in his interview was that Amy (Mandy) Jones was holding David Cains' head on the side?
A Correct.
Q Keeping close to ground but not pushing on it, because David was trying to bite --
A Correct.
Q -- correct? And, so, am I correct that the deviation is that, while he told you about Mandy holding David's head close to the ground in his statement to you, it was not contained in the written statement you'd been provided?
A Correct.
Q And am I correct that while Ryann Campos' explanation for why Ms. Jones was holding David's head was so he wouldn't spit, Tyler's explanation for the same thing was so that David wouldn't bite?
A Correct.
Q And that is, in itself, another discrepancy.
A Right.
Q Moving down to the next section of this same page. Were you provided a written timeline -- during your

investigation, was DRA provided a written timeline by Booneville Human Development Center concerning this event?

A Yes.

Q And am I correct that that timeline completely omitted the restraint having occurred?

A Correct.

Q Next page, fourth paragraph. Am I correct that during your investigation you interviewed the coroner, a Mr. Chrisman?

A Yes.

Q And do you recall, was it you and Reagan that first informed him about the restraint having occurred? In other words, the fact that David had been restrained was news to this coroner.

A Correct.

Q Did he make any statements in response to learning about the restraint?

A We asked him if he would have done anything differently knowing that he had been restrained and he said that he would have if he had had --

Q And what would he have done differently?

A -- that information. He said they would have likely requested an autopsy.

Q Did he give any other color to that or was that

kind of, mainly, what you remember?
A That's what -- I mean, they would have probably done more investigating than --
Q Did your investigation also uncover information about the type of notification David's mother and family were provided about his death?
A Yes.
Q And did your investigation reveal that, similarly to Mr. Scow, the paramedic, and the coroner, David's mother and guardian were also told that David died after simply choking on his lunch?
A Yes, that's what they were told. Yeah.
Q And did your investigation also uncover that David Cains' family did not even find out that the personal restraint had occurred until June 22nd, which was nine days after David had died and three days after he was buried?
A Correct.
Q Moving on to the next page. The question I'm about to ask now pertains to the third paragraph under Practice of Restraints at BHDC. You learned in your -- or you became aware at some point, anyways, whether in this investigation or by prior dealings with Booneville, that Booneville staff are given -- that the restraint training given to Booneville staff is NCI; is that

correct?
A Correct.
Q And at the time that you conducted this investigation and helped draft this report, were you familiar with NCI?
A I don't know if I was familiar with it before this or not.
Q Did you become familiar with NCI during your investigation into this case?
A Yes. We -- we also interviewed the guy that does the NCI training.
Q You talked to Mark Hines
A Yes.
Q And in speaking to Mark Hines, as I have, did you learn that the ground restraint used on David Cains was not a method that NCI approves for use?
A Yes.
Q And it is not, in fact, something even taught or authorized by Booneville, is it? Strike that.
It's not something that's taught or authorized by Mark Hines, who does the training.
A Correct.
Q And it's your understanding that Mark Hines is in charge of providing the restraint training to the direct care staff, such as the ones involved in this restraint,

correct?
A Yes.
Q And you were, maybe, about to get into this. But did you also learn during this investigation that, while they formally train staff in NCI, that staff are also regularly using methods of restraint that conflict with NCI training?
A Yeah. Yes, we were told. Direct care staff said they take clients to the floor often in restraints.
Q Is Tyler Mattson one of the persons who told you that?
A Yes.
Q But am I correct that he stopped short of admitting to taking David to the ground in this particular case, but rather --
MR. ROSEN: Objection to that question. There's no evidence of that.
MR. GILLISPIE: Let me finish the question.
Q (By Mr. Gillispie) Am I correct that Tyler Mattson stopped short of admitting that he took --
MR. ROSEN: Objection to "stopped short." I don't know what that means.
Q (By Mr. Gillispie) Stopped short of taking him to the ground and, instead, they --
MR. ROSEN: He either said it or he didn't

say it.

MR. GILLISPIE: Objection noted. I'll ask the question.

MR. ROSEN: Well, you're leading the witness to give a particular response, so I object to that. Just ask her what he said. You're characterizing it in such a way.

MR. LOWTHER: He can ask his question. You can object. If you understood his question, go ahead and answer it. He hadn't got through his question.

MR. GILLISPIE: Allow me to get through the question, Rich, then you can say whatever you want to say.

MR. ROSEN: Well, the objection is the same, if it's the same question.

A Could you repeat it.

MR. GILLISPIE: I need to get through the question, though. So, I will on the record here say that your objection is noted and applies to the question I'm about to ask, but I do need to get through the question, please.

Q (By Mr. Gillispie) Ms. Stewart, am I correct that, while Tyler Mattson admitted to you that he and other staff members often take clients to the ground, he did

not admit that that is what he did here but, rather, said that they fell over together?
A Correct.
Q Did you come across anything or have any -- scratch that.
Was there any other restraint methods that were told to you were commonly used that conflict with NCI, that you can recall?
A I kind of -- I have a recollection, but I'm just not so sure about the floor -- the floor ones. It wasn't a -- Mark Hines wasn't teaching it, but I think there was someone else that would teach them a different set of restraints if they had to go to the floor, but they didn't have -- they couldn't tell us what the restraint technique was, like was it Mandt or --
Q Could they offer you any documentation concerning any of this?
A I don't know.
Q Do you recall who told you that there was -- who would have told you that?
A No.
Q But is it fair to say that whatever that was that you're kind of remembering would have been among those things you describe in this report as not evidence-based and, when practiced, conflict with NCI?

A That's in -- yeah, it's in our recommendation. That's Number 3, the physical restraint, if you look under that paragraph.

Q And, next, moving on to the findings, these bullet points. I'm just going to go through a few of these -- highlight a few of these, rather. You noted in your -- you determined -- am I correct that you determined in your investigation that Mr. Cains suffered from GERD and was supposed to have remained upright for one hour after eating?

A Correct.

Q And am I also correct that your investigation uncovered that this restraint incident occurred very shortly after his lunch?

A Correct.

Q Am I correct that your investigation revealed that, once David was on the floor, the staff continued to restrain him rather than just releasing him and allowing him to calm down?

A Yes.

Q And did you determine that to be not in keeping with the NCI training and other policies that you reviewed?

A Can you repeat.

Q Scratch the question. Bad question.

Did you determine in your investigation that staff failed to use less intrusive interventions such as NCI/CPI, for which they are trained --

A Yes.

Q -- prior to restraining him on the ground?

A Yes.

Q Did you determine that staff failed to leave him on the floor unrestrained until he was calm, after he was on the ground?

A Yes.

Q And is it fair to say, you determined those things to be in violation of what was supposed to have -- in violation of policy; is that correct?

A I think with that particular bullet point, if he fell to the floor, we weren't sure why he just didn't leave him there and, you know, let him calm down rather than turn into a restraint.

Q Well, you said you reviewed the policies governing this sort of thing. Is one of the policies you reviewed DDS Policy 3011, which dictates that in emergency situations -- while personal restraints can be used in emergency situations, it must be the least restrictive form of intervention --

A Yes.

Q -- that can reasonably --

A The last resort.
Q And the least restrictive --
A Right.
Q -- and for the least amount of time, correct?
A Correct.
Q And was it fair to say, then, that you determined that the least restrictive thing -- scratch that.

Is it fair to say that your investigation determined that continuing to hold him on the ground -- restrain him on the ground after he was already on the ground was in violation of that 3011 policy?
A That's how we interpreted it. Yeah.
Q Thank you. Did you determine in your investigation that this restraint likely, either directly or indirectly, led to David's death?
A Yes.
Q Did you determine that the facility failed to properly communicate the circumstances of this incident to emergency responders?
A Yes.
Q Did you determine that there was no evidence that the Booneville facility properly communicated the circumstances of this incident to the Arkansas State Police, the Logan County Sheriff's Office, or any other law enforcement agency?

A Yes.
Q Did you determine that Booneville Human Development Center's investigation failed to resolve discrepancies in statements from witnesses?
A Yes.
Q Did you determine that NCI/CPI does not endorse or instruct any maneuver that involves physically restraining an individual on the floor?
A Yes.
Q And I believe -- can you recall specifically -- scratch that.
Did you determine that Booneville Human Development Center could not articulate what kind of restraint technique is being taught to staff?
A Yeah, in relation to taking people to the floor.
Q And who did you ask and who failed to be able to articulate that, or was it everybody other than Mark Hines?
A Staff, when we interviewed them, you know, they talked about taking people to the floor. They didn't know what it was -- was called.
Q Did they appear to not even know that it was considered an improper technique?
MR. ROSEN: Objection; relevance.
A I can't say. I don't know.

Q (By Mr. Gillispie) Did you conclude that the conclusion from Superintendent Gonyea failed to find that anyone violated any policy or procedure and inexplicably failed to find that any policy or procedure might need review and modification?
A Correct.
Q And, finally, did you determine in your investigation that Booneville Human Development Center failed to adequately inform David's family of the circumstances surrounding his death?
A Yes.
Q Did you also determine, as it appears to be reflected you did in Paragraph 2 under Recommendations -- did you also determine that all staff at Booneville needed to be retrained because NCI/CPI does not endorse the use of restraint while an individual is lying on the floor, and that the very fact that NCI is touted as the intervention strategy implemented by Booneville, and yet this individual was restrained on the floor long enough to aspirate and die means that NCI was either ignored or forgotten?
A You're asking --
Q Yeah. It's meant to be a yes or no question. Let me --
A Okay.

Q -- rephrase. Did you determine that all staff at Booneville needed to be retrained in NCI?
A Yes.
Q And I'm just calling it NCI because, technically, NCI is a program owned by CPI, which is Crisis Prevention Institute. So, for purposes of today, NCI/CPI, it's all NCI.

So, you determined that all staff needed to be retrained in it. And is part of the reason you made that determination that they needed to be retrained because of the conflict you uncovered between Booneville touting NCI as their go-to intervention strategy -- the conflict between that and the fact that David was restrained on the floor long enough to aspirate and die, and the fact that other staff told you that they commonly take people to the floor?

MR. ROSEN: Objection; relevance.

MR. LOWTHER: You can answer.

A I'm sorry. Can you ask me again.
Q (By Mr. Gillispie) Yes. Is part of the reason you determined that staff needed retraining because of the conflict that you uncovered between Booneville touting NCI as what they use, the conflict there with the fact that they're also restraining people on the ground and taking them to the ground?

A Yes.
Q Why were you at Booneville last month?
MR. ROSEN: Objection; relevance.
MR. LOWTHER: You can answer.
A Our usual monitoring.
Q (By Mr. Gillispie) How long -- what is your usual monitoring?
MR. ROSEN: Objection; relevance.
MR. LOWTHER: You can answer.
A It just depends. We monitor all the HDCs, so we try to hit them all.
Q (By Mr. Gillispie) And does that typically mean personally visit?
A Yes.
Q Have you ever personally been involved in any other investigations into Booneville regarding injuries to the residents caused by restraints?
MR. ROSEN: Objection; relevance.
MR. LOWTHER: You can answer.
A No.
Q (By Mr. Gillispie) Do you know of any other DRA investigations of that sort?
MR. ROSEN: Objection; relevance.
A I think there had been some before my time.
Q (By Mr. Gillispie) The last thing I need to do is

have you take a look at a document that we've marked as Claimant's Exhibit 1. Ms. Stewart, you've been looking at this same document for hours now, correct, --

A Right.

Q -- during this deposition? Is the document in front of you that we've been using to question you, is that a true and correct copy of the October 22, 2020, report/letter that you and Reagan drafted and sent to the director of DDS?

A It is.

Q Did you also say that this report was you and Reagan investigated it and drafted it, but Mr. Thomas Nichols reviewed it and approved it?

A Yes.

MR. GILLISPIE: And I'd like to make that our sole exhibit and I'll pass the witness.

FURTHER EXAMINATION

BY MR. ROSEN:

Q I have a few follow-up questions. Tell me, what does the term, as used in this report, "likely" mean to you? What does the word "likely" mean?

A Probably that it happened. Likely, I guess.

Q And, so, are either you or Raegan Stanford a medical doctor?

A No.

Q So, tell me what training either you or Reagan have in determining the likely cause of a person's death.
A Well, I don't know. I haven't been to med school, so I don't know.
Q And that determination that you put in your findings of likely, DRA didn't even say that was the direct cause of death. You have a caveat on there, it likely was, possibly, an indirect cause of death, correct? That's what --
A Correct.
Q -- it says, right?
A Yeah, that's what it says. Yeah.
Q And that's not to a reasonable degree of medical certainty, right?
A No.
Q Now, also on the findings in the exhibit that Counsel introduced it's -- well, let me ask you this. Strike that question.
During the course of your investigation, I think you told me you believe that you looked at the IPP, correct?
A Correct.

[redacted]

[redacted]

Q That's what your investigation uncovered? Simple question.

A I mean, I'm sure. Yes.

Q Now, what does -- in your investigation and after review -- did you review David Cains' IPP?

A Yes.

Q So, then, you know that, despite Counsel's questions to you, that the CPI or NCI restraint procedures are not the only ones allowed at the Booneville HDC, right?

A That's what we were referring to in our --

Q As a matter of fact, from your review of the IPP, other restraint methods are authorized at the Booneville HDC with regard to David Cains; isn't that correct?

A I'm not 100 percent sure, but --

Q Well, you don't recall the IPP and the doctor's orders looking at authorizations for chemical --

A Yeah.

Q -- restraints and mechanical restraints?

A Yeah, he got -- he got plenty of chemical restraints. I do remember that.

Q And he got mechanical restraints, right?

A Right. Yeah.

Q So that would conflict with NCI, right?

A Yeah.
Q So, would that leave you to conclude that NCI is not the sole and only method that is used at the Booneville HDC?
A And we say that in our report.
Q So, you --
A Yes.
Q -- would agree with that statement.
A Yes.
Q So, when Counsel questioned you about the NCI or CPI, I think he referred to it, being the methodology that's taught at the HDC, that's not the only restraint methods being taught at the HDC; isn't that correct?
A They could not clarify for us what the restraint techniques were.
Q I didn't ask you that question.
A Well, that was the point we were trying to make in our report.
Q I understand that's the point you're trying to make. But I'm asking you, what was authorized for David Cains?
A Sitting right here without his IPP and his behavior support plan, I can't tell you specifically.
Q But you would agree that it authorized something more -- what does NCI stand for?

A I don't know. Non-Crisis Intervention, I believe.
Q So, that's just one of several methods of restraint that was authorized for David Cains in his IPP; is that correct?
A They don't take people to the floor in NCI. So, no, that would not have been what was approved for David in this instance.
Q So, let me ask you this. First of all, you told me that they fell over.
A Yeah, they did fall over.
Q So, what does "taken to the ground" or "taken to the floor" mean?
A He's restraining someone on the floor, so the staff still had to get down there to restrain him. They don't -- NCI does not do restraints like that.
Q So, in your investigation into this, "taking to the ground" means restraining on the ground?
A That's what the staff said. That's their words.
Q So, it doesn't mean making him go to the ground. It means restraining him on the ground, according to your --
A No.
Q -- investigation. No, that's not what it means?
A No. Staff say here that they take -- this is their words. They take people to the ground a lot for

restraints.
Q So, what does that mean to you as to what that means?
A That means they take a person from a standing position and they get to the floor. However, they get there, I don't know.
Q But in this instance that's not what happened, according to your investigation, right?
A No. I didn't determine that that's what was happening. That's what Tyler says happened -- I'll find it -- I believe, they fell over.
Q But you don't have any evidence that they didn't topple over, right?
A I don't -- I find it hard to believe.
Q Well, I didn't ask you that.
A Yeah, I don't have any evidence. You're right.
Q You're an investigator. You base it on evidence, right? You didn't base --
A Yeah, but, you know, it's -- there's so many inconsistencies in these guys' statements.
Q So, let me ask you about that. As an investigator, would you expect everybody's statement to be identical?
A No.
Q So, the small discrepancies here and there show that it's not rehearsed, right?

A I wouldn't call them --
MR. GILLISPIE: Object to the form.
A -- small discrepancies. If you can't remember whether you're holding someone's head to prevent them from spitting or biting, I mean, those are not small. Times, yeah. Small, no.
Q (By Mr. Rosen) So, time you agree, but the holding --
MR. GILLISPIE: Object --
Q (By Mr. Rosen) -- the head -- so, this all happened pretty quickly, right?
A I don't -- I suppose, yeah.
Q Well, you investigated --
A About ten minutes is what it looks like.
Q Well, you investigated it, right?
A Yeah, we did.
Q So you would know, wouldn't you? If you did a proper, extensive investigation, you would know.
A I don't --
MR. GILLISPIE: Object to the form.
A It depends on what you mean by pretty fast. It started at 10:30. He left the facility by 12:10. So --
Q (By Mr. Rosen) Now, --
A -- yeah. I mean, I guess that's fast.
Q And this isn't being reported as it's happening

simultaneously. An emergency -- is that correct? It wasn't --
A I don't understand the question.
Q So, there's not somebody there documenting when who was doing what before -- strike that question.
There was nobody there -- like, in an emergency room there would be, typically, a person recording what the doctor's doing, what time it's happening, who's doing what, to document it all for the medical record. Would you agree with that?
A Yeah. I don't believe they had, like, a person standing in there documenting.
Q So, everybody is -- and, so, these people knew David Cains, right?
A Yes.
Q They cared for him, didn't they?
A I don't know.
Q Well, I mean, they were his caregivers.
A It doesn't mean they cared for him. I can't answer that.
Q I meant --
A Oh. You mean as a title?
Q They were his -- they cared for him. They took care of him.
A Yeah.

Q So, they knew him for a long time, right?
A I don't know how long they knew him.
Q Well, this would be pretty upsetting to even a stranger, let alone somebody who they knew, right?
A It should be. Yeah.
Q Well, you would expect that.
A Yeah.
Q Did you ask them that?
A Yeah.
Q What did they say?
A Tyler seemed upset.
Q Yes. What about the other two, Mandy and Ryann? Did you ask them whether they were upset?
A One -- I can't remember. The two -- I get them -- the two females I get confused. One seemed a little shook-up and the other one just didn't seem bothered at all.
Q Well, did you ask them whether at the time they were upset?
A I don't know. Tyler --
Q No, I asked --
A I don't know. I mean, I know --
Q You don't know whether you asked them.
A No. I don't know, but I know Tyler came across that he was upset.

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Q So, while this is happening it's probably pretty upsetting to them and shocking and they're trying to save somebody's life at the time, right?

MR. GILLISPIE: Object to the form.

A I assume.

Q (By Mr. Rosen) That would be reasonable, would it not?

A Yeah.

Q So, then they're asked to go back and reconstruct and state to you and to others what happened, sometimes even months later, right?

A They were -- their statements were taken that day.

Q Did you not speak to --

A The written statements.

Q Did you not speak to them later?

A Yes, we did.

Q So, it wouldn't be unusual for me to -- just like I'm asking you right now about your investigation. Some of it you remember. Some of it you don't; is that right?

A Yeah. Two years later, yeah.

Q And, so, you expect them -- when did you interview them?

A We got the case in July and we interviewed them, I'd say, probably a couple months after. I don't have a

date on here.
Q So, you expect them to remember every detail?
A Well, since it was such a significant event, I think I would remember it. Yeah.
Q Was this investigation a significant event to you or DRA?
A Yeah.
Q So, you would remember every detail.
A I have a file this big full of stuff so, no, I can't remember everything out of that file.
Q So, it's a different standard?
A Well, because they were actively physically trying to save someone's life, I would think it's different than memorizing an IPP.
Q So, did you review your record before you came here today?
A No. I reviewed this letter. That's it.
Q But you didn't see it fit to go back and get more information that supported this, did you?
A I feel like the document speaks for itself.
Q And I don't recall, but correct me if I'm wrong, the document doesn't even mention the IPP, does it?
A It -- there's -- I don't know what the IPP -- what your -- you know, the significance is to you.
Q Well, that's his --

A We read it. We looked at it and we got information out of it that we put in here, so yes.
Q But you don't think the IPP is relevant?
A We did, but you just keep saying it's not mentioned. It is. It's just not mentioned that we got this information from the IPP.
Q Well, you didn't mention in there anything about the NCI training being not the only --
A Yes, we did, back here --
Q Where?
A -- when we discuss --
Q Where is it?
A -- that they couldn't name the restraints when they went -- took them to the floor.
Q Now --
A They couldn't tell me what those were called. We couldn't --
Q Well --
A They couldn't tell us who was trained in it/who was teaching it.
Q Well, that's not my question, though. The question is --
A Well --
Q -- the mere fact that there's -- there's a mechanical restraint allowed. That's not mentioned in

here, is it?
A No.
Q And the chemical restraints were authorized for David Cains. That's not mentioned --
A Well --
Q -- in here, is it?
A We should have mentioned it, because they had given him a lot of chemical restraints. That was our bad. We should have mentioned that.
Q And, so, what one would conclude was, as Counsel has asked you, that it would appear that, if you don't follow NCI, you're not doing it right.
A That is not -- you are -- no. Chemical restraints are never the same as physical. They are two different things. He's asking me about physical restraints. He never asked me about a mechanical or a chemical restraint.
Q Now --
A That is why I answered the way I did.
Q So, a mechanical restraint would require the person to be on the ground, would it not?
A No.
Q So, how would it --
A There's different types of mechanical restraints.
Q Tell me what your understanding is -- and in this

instance the mechanical restraint used at the Booneville Human Development Center at that time was a papoose board. Do you know what that is?
A It wasn't used for this.
Q I know it wasn't used, but I'm asking you. Do you know what --
A I know what a papoose board is. Yes.
Q And, so, how would one get a person onto a papoose board?
A Quite dangerously. They should be banned.
Q In fact, you recommended that.
A Mechanical restraints, putting people in a papoose board could easily lead to an injury.
Q Yes. And that's not what happened here, right?
A Right. No.
Q And, so, you would have to be taken to the ground to get to a papoose board, would you not?
A Yeah.
Q And, so, in this instance they fell over and -- well, for the record, she's making a face, so I want to ask you. What evidence do you have that they didn't fall over?
A What evidence do I have that they did?
Q Well, you're the investigator. I mean, I assume you go on evidence.

A I feel like my -- so, in investigations you have hunches. You kind of -- right? It's -- it's odd to me. I've been doing investigations about abuse and neglect. It's odd to me that he talks all about taking people to the floor and he -- it's just like he would not ever say that he restrained him -- that they fell and, so, it was -- it was odd. The whole thing seemed odd but --

Q So --

A -- he says he fell, so he did, but my -- you know, we stick with, if he fell, he was already on the floor. Just back away. He wasn't a danger to you anymore if he's on the floor.

Q How do you know that?

A If he's on the floor and you're -- how is he a danger to you?

Q If I fell on the floor right now -- if I was threatening you and I fell on the floor, and hitting you and fell on the floor, could I not get up and hit you again?

A Couldn't you just get up and get away from him?

Q Well --

A That would be the least restrictive measure to take.

Q Now, they fell on the floor. There was a -- they were touching each other. I mean, they were trying to

be restrained, according to your investigation.
A He said that they -- let's go back and see exactly what Tyler told me. He applied personals by grabbing his arm. So, Tyler grabs him, okay, and he says they end up falling over. David lands on his face but, then, Tyler is still able to roll him onto his side. So, my point is, if you're able to get up and gain physical whatever over this guy and roll him on his side, you're probably just as able to be able to walk away and give him some space to see if he calms down.
Q What if he didn't calm down?
A Well, he didn't get a chance to.
Q So, was Tyler, when they were on the ground, still attacking -- excuse me, was David Cains --
A No. He was on his face.
Q Well, let me ask you that. That's --
A That's what he says.
Q Did he hit his head?
A He told us that he landed on his face.
Q And during the course of your investigation, did David Cains have any injuries to his face?
A I don't know. There were no photos taken of him.
Q So, you don't know --
A There were no photos taken of him. There were no photos taken of where it happened. There was no report

that they --
Q Who would take photos of him?
MR. LOWTHER: Let her finish the question.
Finish your answer.
Q (By Mr. Rosen) Go ahead.
A What?
Q Finish your answer.
A I don't even know where --
Q Who would photo?
A They photograph injuries, right? Like, the HDCs photograph injuries all the time.
Q Wasn't he taken away by ambulance?
A Right.
Q So, who was going to photo him?
A Hospital personnel. The coroner. I don't know.
Q Well, that's what I'm saying. So, that wouldn't be the HDC.
A You're asking me if he had a bruise on his face. I'm telling you, how would I know. I mean --
Q Did you --
A -- they didn't have photos.

[redacted]



Q So, let's change gears a little bit. So, I think you said that you were a case manager in an HDC similar-type situation in Missouri and Tennessee; is that right?

A Yeah.

Q And did any -- what were the names of those facilities?

A Bellefontaine Habilitation Center is in St. Louis and Clover Bottom Developmental Center is in Nashville, or it was.

Q And while you were there, did they allow the use of restraints?

A They did. They didn't use -- they didn't use mechanical restraints.

Q So, they had personal-type restraints --

A Yeah.
Q -- for safety?
A Uh-huh.
Q Is that yes?
A Yes.
Q And, so, you were a case manager developing the IPPs, I think you said, for these people.
A Correct.
Q So, you're familiar with that restraints are used in these types of facilities; is that correct?
A Correct.
Q In fact, you're the ones who came up with the -- developed the IPP that allowed them in those facilities.
A Well, Behavior Analysts had a different --
Q It's a treatment team.
A Right. So, they did that.
Q I didn't mean it was just you.
A Yeah. I -- yeah. I wasn't --
Q And, so, during the course of your employment at these similar-type human development centers in other states, did you ever see a resident restrained?
A Yeah.
Q Were they acting out?
A The only time they were restrained is if they were being physical to hurt someone else or staff --

Q And --
A -- or, like, running into traffic. Something like that.
Q Sure. And were those required for the safety of the resident and others around the resident?
A Sure.
Q So, I think I asked you this before. But you agree that sometimes restraints are necessary in these facilities for --
A Yeah.
Q -- this population.
A Sure.
Q Now, you also said that as a case manager, I think, that you did internal abuse and neglect investigations.
A Yeah.
Q For those facilities?
A Yes.
Q And, so, as an internal investigator for the facility into abuse and neglect of the facility residents, or possible abuse or neglect of facility residents, were you able to conduct the investigation in a fair and an objective way?
A As long as they didn't assign me anyone that was over the cottage I was in, because this was not going to be a good idea --

Q So, if a --
A -- if I work with those people.
Q Yeah. So, if an abuse investigator at the HDC in Booneville wasn't a supervisor of the individuals or work in the cottage with them, they could do it in a -- you wouldn't have any objection to them doing it in a fair and impartial way, would you?
A Yeah, I would. I mean, it depends on how long they'd been there, what roles they'd been.
Q But you did it yourself, so is that not hypocritical?
A I told you, as long as it wasn't people that I had to deal with or work with.
Q Did you investigate into Ms. Sandy Evans as to whether she worked with these people who were --
A She's been there for 20 years, so it seems like, you know, she probably has had a lot of --
Q So, you never worked or knew any of the people in the facilities that --
A No. I knew who they were, but I had a cottage I was responsible for these clients, so if there was anything that happened in my cottage, I wouldn't be the one that would be investigating that.
Q So, to your knowledge during the course of your investigation, was Sandy Evans the investigator at the

Booneville Human Development Center assigned to the cottage that David Cains was --
A They -- that's not their total job. I do know that I believe she does some social service things on the side.
Q But she didn't have any supervisory or --
A I don't know.
Q Well, I'm asking. Let me --
A No, I really don't know.
Q -- finish the question. So, you didn't --
A I don't know if she -- what her relations, you know, were with those three people; if she supervised them, per se.
Q You said you mentioned you worked for Easterseals in another state; is that correct?
A Yeah.
Q And did you live in the home with these people?
A No.
Q Now, tell me, Counsel asked you during his examination of you some odd question about being pushed off a ledge. Do you know where that came from?
A That's the first I heard of it.
Q Now, Counsel asked you about calling 9-1-1. And in this instance I think you told me in your earlier testimony that the EMTs were there for at least 20

minutes and they couldn't clear the airways either.
A I don't think I told you that.
Q Well, how long were they there?
A If you look back, it says that the EMTs got there at --
Q Well, it says they got there, according to your report/your investigation --
A -- 11:50.
Q -- at 11:50.
A Right, 11:50. And they left --
Q And they left --
A -- at 12:10.
Q Is that 20 minutes?
A I don't know. Yeah.
Q So, you agree it's 20 minutes.
A Yeah. I mean, yeah.



Q So, if there was a delay in a few minutes in

calling 9-1-1, how would that impact the result, or the outcome here?

A Well, I think that if you are not allowed to call 9-1-1 when someone is on the ground and obviously in dire straits -- you know, they're out in Booneville in the middle of nowhere, so I think every minute counts. It takes them a long time to get there, and that was part of our argument.

Q So, it took them at least 13 minutes to get there, and then they were there for 20 minutes, according to your investigation. So, 12 and 20 is 32 minutes. So, if they were called 3 minutes earlier, would that have changed the outcome, based upon your investigation?

MR. GILLISPIE: Object to the form.

A Maybe so.

Q (By Mr. Rosen) Tell me how.

A I would just -- I know that when you're having a medical emergency, as soon as you can get 9-1-1 and EMS there, wouldn't that increase anybody's chances in a heart attack, in a stroke, in any life -- I mean --

[redacted]



Q I only have two more questions. Now, let me ask you. Do you have a cell phone with you?
A Yeah.
Q Where is it?
A It's in my purse.
Q Can you tell me right now without looking in your purse what time it is?
A It's turned off.

Q I just want to know whether you can tell me --
A I'm in a court thing, so it was turned off because that seemed like the right thing to do, so no. If my phone was sitting here, I could tell you.
Q But your phone is not sitting there.
A Right.
Q So, it's --
A In my purse.
Q -- in your purse.
A Right.
Q So, if we had an emergency situation now and you had to respond to something, would you take the time and look in your purse to see what time it was?
A Well, I'd have it in my pocket if I wasn't in here, so I don't know.
Q And you would take -- instead of saving somebody's life, you'd look at the clock, right? Is that what you're telling me?
A That's not what I'm telling you.
Q So, that's what I'm just trying to figure out, because Counsel asked you some questions about, I guess, that Tyler Mattson or the other people trying to save David Cains' life somehow were amiss because they didn't stop to look at their telephone and their watch -- I mean, in their pocket.

A What's your question?
Q So, do you think that they should have stopped their life-saving procedures to look and see what time it was by looking at their cell phone, if it was in their pocket?
A No.
Q Do you even know that they had a cell phone with them on their person at that time?
A No. That's what I answered to him. I don't know.

MR. ROSEN: I have no other questions. Thank you.

MR. GILLISPIE: Thank you, Ms. Stewart.

MR. LOWTHER: You are through. She will read and sign.

(WHEREUPON, the deposition was concluded at 4:32 p.m.)

(WITNESS EXCUSED)

* * * * * * * * * * *

CERTIFICATE

STATE OF ARKANSAS)
)ss
COUNTY OF PULASKI)

I, Faith Grigsby, Certified Court Reporter for the state of Arkansas, do hereby certify that the witness was duly sworn by me prior to the taking of testimony as to the truth of the matters attested to and contained therein; that the testimony of said witness was taken by me through the use of the voice-writing method and was thereafter reduced to typewritten form by me or under my direction and supervision; that the foregoing transcript is a true and accurate record of the testimony given to the best of my understanding and ability.

I FURTHER CERTIFY that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was taken; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested, or otherwise, in the outcome of this action; and that I have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original deposition transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties to the action.

WITNESS MY HAND AND SEAL this 27th day of November, 2022.

_____
FAITH GRIGSBY, CCR 686

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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS — **CLAIMANT**

VS. — **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES — **RESPONDENT**

Notice of Deposition

PLEASE TAKE NOTICE that pursuant to Rules 3.3 and 8.1 of the Rules and Regulations of the Arkansas State Claims Commission, the Respondent, the Arkansas Department of Human Services, Booneville Human Development Center, by counsel, will take the deposition of the **Kris Stewart** of the Disability Rights Arkansas (a/k/a DRA), on the date and time and at the place identified below. The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date & Time: **Wednesday, November 9, 2022 at 1:30 p.m.**

Place: **Arkansas Department of Human Services**
700 Main Street, Second Floor Conference Room
Little Rock, Arkansas 72201

Respectfully Submitted,
Arkansas Department of Human Services

By: ***Richard Rosen***
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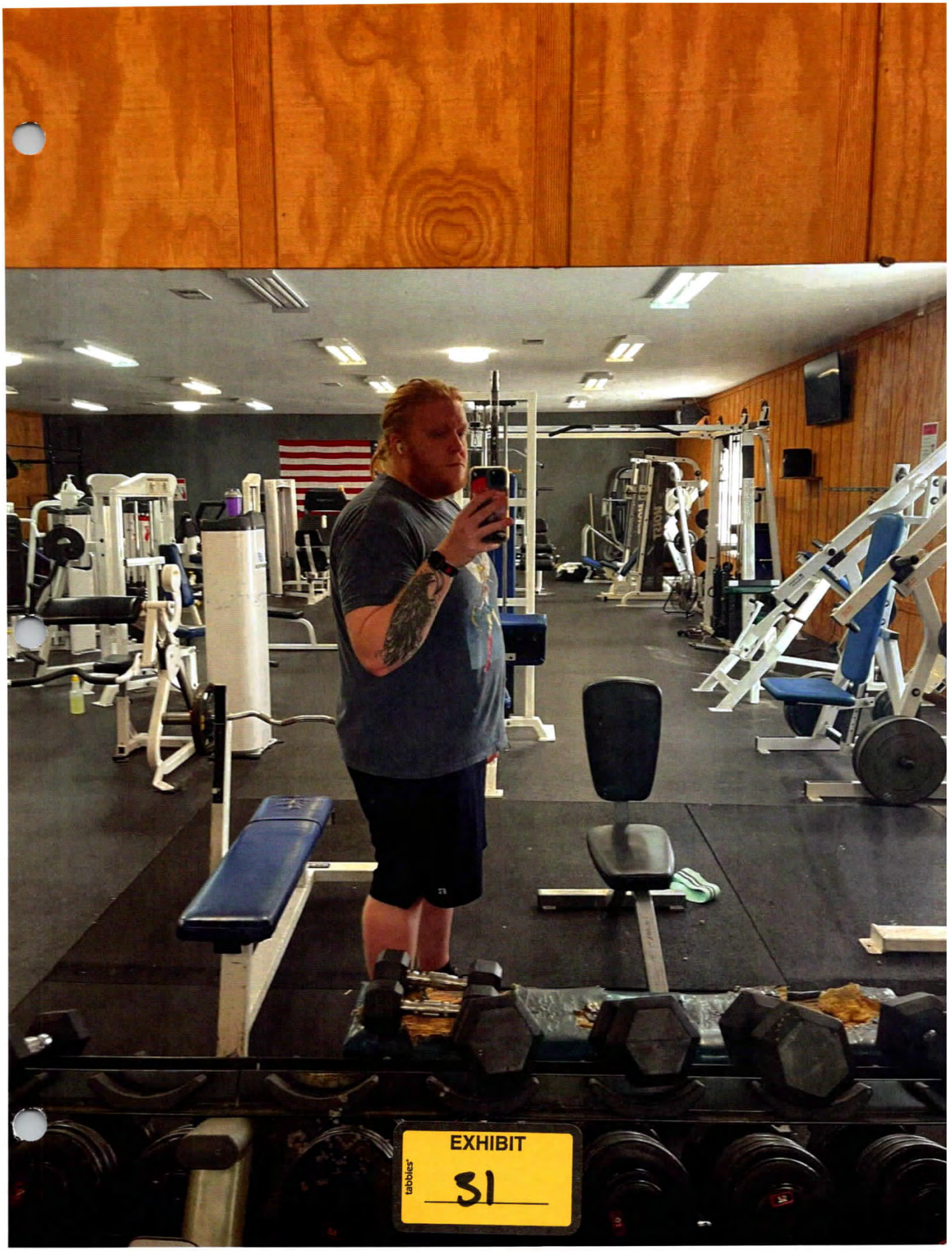
Certificate of Service

On October 11, 2022, a copy of the above notice was served via electronic mail and mailed to:

Joshua D. Gillespie, Esquire
GREEN & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, AR 72214

josh@greenandgillispie.com

Richard Rosen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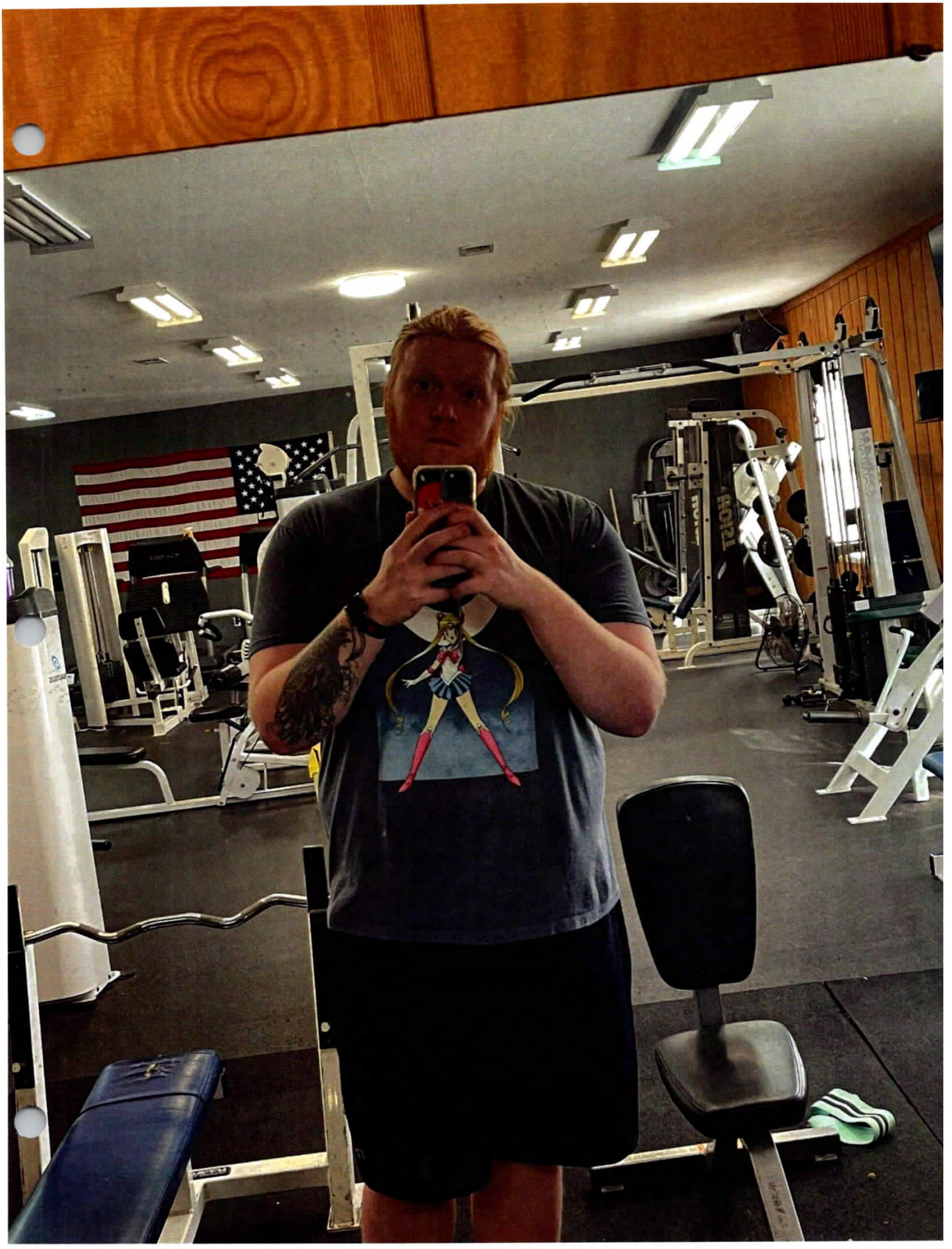


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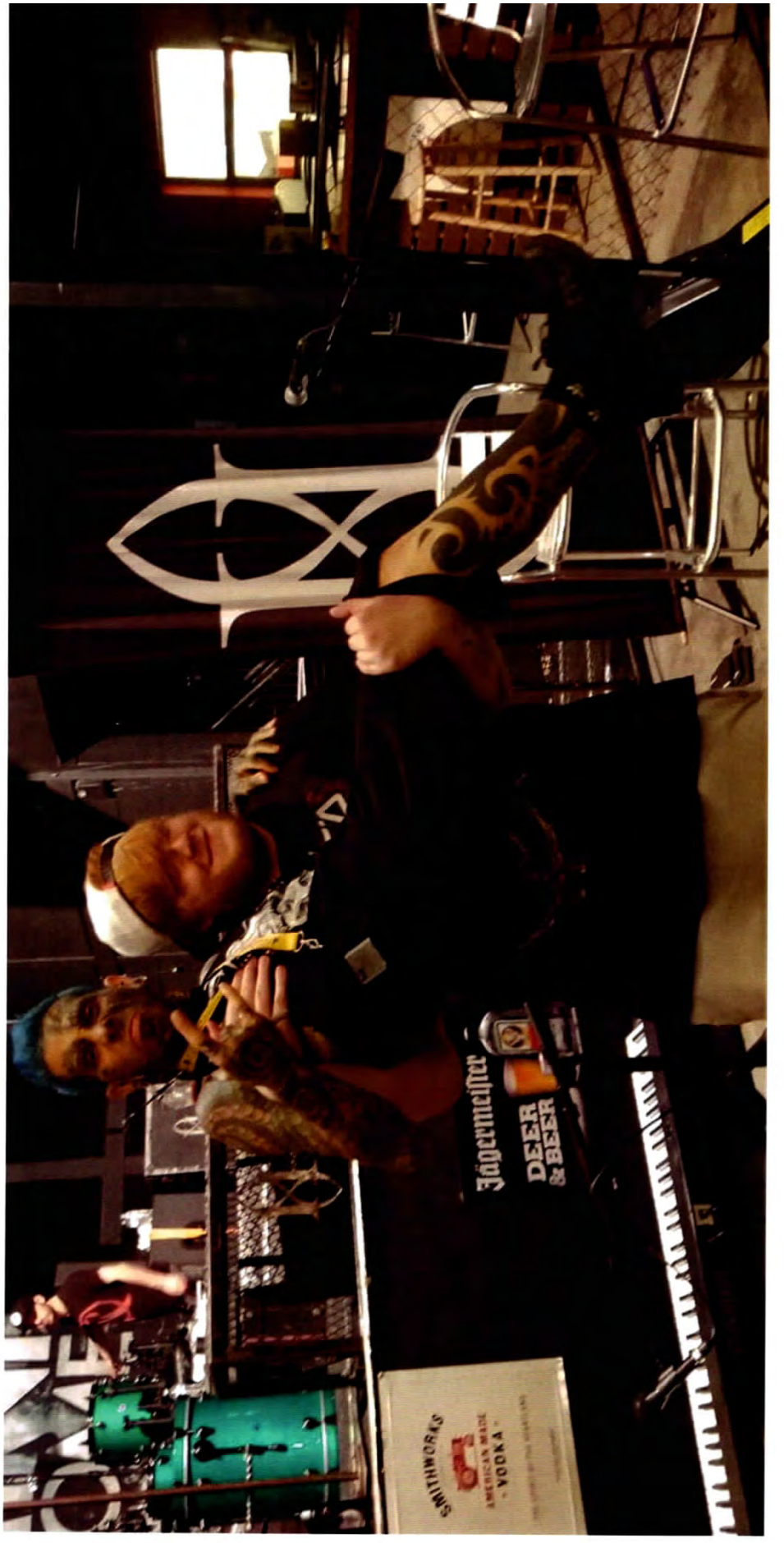
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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

VIDEO DEPOSITION OF

MELISSA WEATHERTON

January 10, 2023, at 9:40 a.m.

CRIS M. BRASUELL, CCR
ARKANSASCOURTREPORTER.COM



A P P E A R A N C E S

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I N D E X

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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Melissa Weatherton produced, sworn, and examined at the office of Arkansas Department of Human Services, 700 Main Street, Little Rock, Arkansas, commencing on January 10, 2023, at 9:40 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

PROCEEDINGS

VIDEOGRAPHER: We are on the audio and video record. Today's date is January 10th, 2023. The time is approximately 9:40 a.m.

This is the videotape deposition of Melissa Weatherton in the case of Christine McAuliffe, et al, versus the Arkansas Department of Human Services, et al.

The claim number is 22-034 [sic] in the Claims Commission of the State of Arkansas.

My name is Randy Schoening. I'm a videographer from Little Rock, Arkansas.

Will counsel please introduce themselves for the record.

MR. GILLISPIE: Josh Gillispie on behalf of the claimant.

MR. GREEN: Chad Green on behalf of the claimant.

MR. ROSEN: Rich Rosen for the Department of Human Services.

VIDEOGRAPHER: Will the witness please be sworn.

(WHEREUPON, Melissa Weatherton was duly sworn to tell the truth, the whole truth, and nothing but the truth and gave the following

testimony to wit.)

VIDEOGRAPHER: You may proceed.

DIRECT EXAMINATION

BY MR. GREEN:

Q All right. Good morning, Ms. Weatherton.

I almost had to check to see if it was morning or afternoon. I was in court morning and afternoon yesterday and kept getting it backwards, so forgive me.

My name's Chad Green. I know you're an attorney, so you understand what a deposition is and how that works.

But just a couple of basic things. If you don't understand a question I ask, will you let me know right away?

A I will.

Q And, if you can't hear me, will you let me know right away?

A I will.

Q Okay. And I don't think today will take horribly long. It's certainly not a marathon; so, if you need a break, at any time, please let me know.

I just ask, that if there's a pending question, that you answer it before we take a break. Is that okay with you?

A I understand.

Q All right. So first, Ms. Weatherington --

Weatherton. Sorry. I'll try --
A You're fine.
Q -- not to make that mistake too many times.
MR. GILLISPIE: My fault.
BY MR. GREEN:
Q Where are you employed? And what is your title and position?
A I am employed at the Arkansas Department of Human Services. I'm the division director of developmental disabilities.
Q And how long have you been in that position?
A Seven years.
Q Okay. And what was your position prior to that?
A Deputy director.
Q And before that?
A I was in office of chief counsel.
Q Okay.
What year did you graduate law school?
A 2005.
Q Did you immediately come to work at DHS or did you --
A I did.
Q All right. In your role as director, can you briefly describe what are some of your responsibilities? Especially with respect to the human development centers.

A The division oversees any service that Medicaid pays for, for people with developmental disabilities, intellectual disabilities, or delays.

So we oversee community programs and then we oversee facility-based programs. We administer lots of programs. Early intervention day treatment centers, adult day treatment centers.

We operate two waiver programs, oversee a managed care program called the PASSE.

Q How do you spell that?

A P-A-S-S-E.

Q Okay.

A We oversee occupational therapy, speech therapy, physical therapy, applied behavioral analysis therapy, day habilitation services.

We run two federally-funded grant programs and we operate five intermediate care facilities for people with IDD; and they're called the human development centers.

Q Okay. Where are those five human development centers located?

A Booneville, Jonesboro, Arkadelphia, Conway, and Warren.

Q All right. I'm going to first ask you about the Booneville facility. When was it first established?

A It was established as a tuberculosis center. It's

our oldest facility. I don't know the exact date of when it was opened as a tuberculosis center or as the HDC.

Q Okay. Do you know how many -- do you call them clients or patients that stay there and live there?

A We refer to them as clients or residents. There's -- on average, it hovers around a hundred at Booneville.

Q So averages around a hundred total clients that Booneville; is that correct?

A In a given day.

Q All right. Can you give just a general overview of the types of persons that would reside there?

Not any specific individual's information, but just generally, the types of disabilities they may suffer from.

A Uh-uh. So, in order to receive services at any intermediate care facility, you have to meet institutional level of care and be deemed intellectually disabled.

And there's five qualifying diagnoses. Epilepsy seizure disorder, down syndrome, autism, cerebral palsy, and then a generalized intellectual disability prescribed by a physician.

And then you also have to have some deficits in your daily living skills.

Q Okay.

Are you familiar with David Cains?
A I read David Cains' case several years ago.
Q Okay.
A When his death happened.
Q Did you -- had you ever met him in person?
A I had not.
Q Okay. So then everything you know would be from what you've read or heard?
A Yes.
Q Okay. And do you know what his particular disabilities were?
A I do not.
Q Okay. Do you know what particular protocols were in place with respect to his care or other treatment?
A I do not.
Q Okay. So there's about a hundred at Booneville; correct?
A (Witness moves head up and down.)
Q And the other four, what's the total, approximately, in the other four?
A We have, on average, around 900 clients across the five centers any time.
Conway is our largest. It's usually around 425 clients at Conway. The rest are between 90 and a hundred.

Q Okay. And would you agree with me that the individuals, the clients in these facilities, have rights to dignity?
A **Yes.**
Q Rights to be treated just like any other person with respect toward their life?
A **Yes.**
Q Okay. And, in fact, that's a goal that you all strive to accomplish; correct?
A **With all our clients.**
Q Right.
Are you familiar with the restraint methods that are used at some of the different facilities?
A **I have some understanding of it, yes.**
Q Okay. And I'll -- I think they do vary from place to place, so I'll just ask about Booneville.
What's your knowledge and understanding of the restraint procedures and policies before June 13th of 2020 at Booneville?
A **Can you be more specific?**
Q Sure. Do you know what types of restraints were allowed? And, again, when I'm asking about these, I'm asking on or before the date that our client died. Not changes that may have occurred.
So do you know what restraints were used or allowed?

A So I don't know the all-encompassing list. I will tell you I know that they were allowed to do physical restraints and chemical restraints and mechanical restraints.

And, at Booneville, they utilized a papoose board. But I do believe they had other types of mechanical restraints.

Q Okay. Do you know what types of physical restraints they were permitted to use?

A Well, a physical restraint is any time you have your hands and you're restraining someone, so I don't really understand that question.

Q All right. Yeah, that's fine. Do you understand that there are certain federal guidelines that regulate the types of care and treatment and restraints that can be used on clients in these facilities?

A Yes. The Center for Medicare and Medicaid sets guidelines.

Q And I know I'm asking questions that seem silly; because I know you know and I --

A You're fine.

Q I have to ask for the record, you understand.

A You're fine.

Q Okay. But you're not intimately familiar with the specific guidelines with respect to the restraints; is

that correct?
A That's just a really broad question. So we have policies around restraint usage that are in compliance with federal and state law.
Q Okay. Do you know if restraining -- well, let me back up.
What would be an example of a situation, again, before June of 2020, where a physical restraint would be allowed or permitted?
A We utilize restraints if a resident is being a harm to himself or herself or others and the -- and there's no other de-escalation technique that has work.
Q Okay. So do you require de-escalation techniques to be employed first?
A De-escalation techniques are part of the training that all of our staff go through.
Q Okay. But is that some -- are they trained to try those de-escalation techniques first?
A Yes.
Q Okay. And do you know if they're also trained on specific ways to block individuals that may be more aggressive?
A I have not been through the CPI training --
Q Okay.
A -- so I can't get into detail.

Q That's totally fine. So if they -- tell me if I'm getting this wrong.

But what I heard was if a -- if a client presents a risk of danger to themselves or other, then they're able to be restrained. Is that your understanding?

A For safety.

Q For safety. Okay. And do you know, is there some hierarchy of what level of restraint is supposed to be used?

A No. It's individualized.

Q Okay. So the individual staff member would have flexibility to choose what restraint to use in the moment?

A Well, in accordance with that resident's behavior management plan.

Q Okay. Would you agree though that they're supposed to use the least restrictive means possible?

A I don't think I could answer that without seeing the behavior management plan for that client.

Q Okay. But you don't know if there's a federal policy or regulation that mandates that you are to use -- and when I say you, I don't mean you personally.

A I know.

Q That Booneville is to use the least restrictive method possible when it comes to restraints, you're not

aware of any federal rules or regulations to that effect?
A No. I know, federally, we can do restraints based on safety.
Q Okay. But you're not aware of any federal rules or regulations that state an escalation? You're not aware of that?
A Do you have a federal rule you could show me that you're referring to?
Q No. I'm just trying to find out what you have a knowledge of. And, of course, the other attorney can show you anything he needs to.
All right. When did you first learn that there was an incident that occurred in June of 2020 involving Mr. Cains?
A I don't know the date. It was two years ago.
Q Okay. Do you know if it was the same day?
A I don't.
Q Okay. I guess one thing I would ask is, before your deposition today, did you review any documents in preparation?
A I did not.
Q Okay. And I'm not going to be asking you any confidential discussions you may have had that could fall within an attorney-client privilege potentially, but did you discuss the nature of the case, the facts of the

case, with anyone else that's not -- that wouldn't have a privilege?

A I did not.

Q Okay.

All right. What is your understanding of what happened with Mr. Cains that day?

A My understanding is Mr. Cains was having lunch and that he went to the restroom and came out agitated and there was a fall and he started to aspirate.

Again, I read the case probably two years ago.

Q I understand. You have access to all of those reports and reports; correct?

A I do. Uh-huh.

Q Okay. Is this any particular reason you didn't take a look at that before today?

A I did not have time.

Q Okay. I understand.

All right. Do you recall that he had been restrained prior to aspirating?

A No.

Q Okay. So you don't have any recollection that he was restrained before he aspirated?

A No.

Q Okay.

I want to ask you about the Arkansas Disability

Rights of Arkansas. Are you familiar with them?
A I am.
Q Okay. Can you tell me what kind of organization they are, what their general purpose is?
A Federally, we're required in Arkansas, when you have a developmental disabilities division, you're required to have a three-pronged organizational structure in your state.

So Disability Rights fills one of those three prongs along with my division and the University of Arkansas at Fayetteville. They are a federal advocacy organization that's been designated by the state to be the advocacy organization here in Arkansas.
Q Okay. So they're -- I want to make sure I get this right.

They're a federally-designated agency that the State of Arkansas has required to be, for lack of a better word, a watchdog over these types of facilities or to at least be involved?

And, if you don't like my word watchdog, you can characterize it however you want.
A Yeah, I think the intent of Disability Rights Arkansas is to advocate for people with intellectual and developmental disabilities.

Your term of watchdog, that's -- I don't think

that's the intent of their organization.
Q Fair enough. But they are impowered to conduct investigations when there's alleged maltreatment of someone or there's a death; correct?
A They have certain authorities, federally, to come in, if they meet the requirements.
Q Okay. What requirements do they have to meet?
A Well, there's a lot of requirements, if someone has a guardian, what they can and can not ask for.
Q Okay. Can you explain to me what they can and can not get if there's a guardian?
A I would have to get -- to pull up the federal regs; because I go through them every time we get a request.
Q Okay.
A So, no. If you could just hand them to me, I could read them and paraphrase it.
Q That's all right. If you don't know, you don't know.
All right. But you would agree that they are mandated to be involved, I think you said, in the three, there's you, U of A, and then Disability Rights of Arkansas; correct?
A There's a three-prong requirement under --
Q Three-prong --
A -- the DD Act.

Q Okay. So their involvement, on some level, is required by law?
A Yes.
Q Okay. And would you agree that Disability Rights Arkansas has, as one of its primary missions, to try to protect the rights of those who have disabilities?
A Yeah. I mean, I think that would be -- I think that is probably part of their mission.
Q Okay. And would you agree with me that it's important that they are there to be one of the three prongs of involvement?
A I think it's always important to have conflict-free types of situations where other organizations are looking out for clients.
Q Okay. So Disability Rights Arkansas, they fill that organization of not having a conflict and being able to be involved to advocate? Is that what you're saying?
A I don't know if they have a conflict or not. I'm not saying that. I'm just saying it's important for other people to have their eyes on clients. But I'm not speaking directly to DRA.
Q Well, you had said conflict free when I was --
A Uh-huh.
Q -- questioning them, so I just -- what did you mean when you said conflict free?

A Well, I think it's important to have organizations that are conflict free. I did not say DRA was conflict free.
Q Okay.
A They're federally required to be one of the three prongs. That doesn't mean they're conflict free.
Q Okay. Do you think they have some conflict of interest in coming in and investigating maltreatment?
A I think that they do have some special interest in what they investigate and what they don't.
They're very little -- very small involvement with clients outside of facilities is always concerning to me.
Q Okay. So they're not maybe as involved with clients that are not in a facility that maybe reside at home?
A Which is thousands of clients.
Q Many more in the homes?
A Many more.
Q Right. Okay. They don't ever investigate any of those allegations?
A It's very minimal.
Q Okay. All right.
MR. GREEN: I'm going to mark this document Exhibit 1.
(WHEREUPON, the document was marked for identification as Exhibit No. 1 and is attached

hereto.)
BY MR. GREEN:
Q I want to let you take a look at it. And I'm going to provide one to your attorney.
A Thank you.
Q Would you take a -- just look at that document and then let me know once you've had a chance just to kind of look over it and let me know if you recognize it and can identify it.
A I do recognize it. Tom Masseau sent me this, I think, via e-mail. It might have been a different format but the content is the same.
Q Yeah, I think there may be some reductions in this particular company.
But who did you say sent it to you?
A Tom Masseau.
MR. GILLISPIE: Can we take a quick bathroom break?
BY MR. GREEN:
Q Can you spell his name real quick for me though?
A I'll just read it from here. M-a-s-s-e-a-u.
Q Okay. That way the court reporter --
VIDEOGRAPHER: We are off the record at 10:02 a.m.
(WHEREUPON, the record was suspended

momentarily and the proceedings resumed as follows, to wit.)

VIDEOGRAPHER: We are back on the record at 10:10 a.m.

BY MR. GREEN:

Q All right. Ms. Weatherton, you understand you're still under oath; correct?

A I do.

Q All right.

I want to go back to Disability Rights of Arkansas because I just want to make sure I understand if you believe they have any conflicts of interest, bias; especially with respect to investigating incidents at human development centers. Particularly, Booneville.

A I do think they have bias.

Q Okay. In what way?

A They have made it very clear that they want to close all of the human development centers. That's been their stands for the last, I would say, at least ten years.

Q All right. And I'll talk about some of the things about that.

Do you know what some of the reasons are that they've stated they want to close the human development center?

A I would say that the director just has a --

fundamentally, does not believe clients should live in a congregate setting and they should be out in the community.

Q Okay. Has he written any publications to that effect that, in general, he doesn't believe in the group settings? Do you know of anything he's ever written, any speeches he's given?

A Yes.

Q Anything like that where --

A Yes.

Q -- he has said --

A He is very open about it.

Q Okay. All right. And was this a publication? Was it a speech?

A I don't know if there's anything that's been published. But he -- he's not scared to say it.

He says it at public events, he says it on phone calls, he says it in group meetings.

Q That he thinks every human development center should be closed?

A Yes.

Q Across the entire country?

A I don't know. Mine are called human development centers, they're called ICFs in other --

Q Correct.

A Right? But I would say, specifically, yes, human development centers in Arkansas.
Q Okay.
Do you think that Disability Rights of Arkansas has something of value to add to your organization?
A Yes.
Q Okay. So, even though there's a bias, you believe, you still do value some of their input; correct?
A I value their role as a, as a protection and advocacy group. I wish it was spread across all of our clients and it wasn't so focused.
I wish there wasn't a bias when they come in to my HDCs. I think, if they advocated and protected all of my clients, I'd have more respect for them.
Q All right. Have you ever addressed that with -- and I'm not going to pronounce his name correctly, probably, but Mr. Masseau? Or how do you pronounce it?
A Masseau.
Q Masseau?
A Yes. I have -- we have had lots of discussions over the years.
Q Okay.
I think you said earlier you have about five to six hundred clients in the human development center; is that right?

A No, it's about 900.
Q Nine hundred? Okay. I misheard.
A That's okay.
Q I don't take a ton of notes because that's what we've got --
A Right?
Q -- a court reporter here for.
And I know it's many, many more, other client and other people you provide services for. Like, for instance, in homes, approximately how many -- and I'm not trying to get you pinned down on a number.
A Yeah.
Q But approximately how many aren't in the human development centers?
A We have approximately -- probably 5,500 that receive services through a 1950-C waiver program that's called community employment supports.
We've got 180 kids who receive services through a waiver called the autism waiver. We've got 70,000 kids that receive OTPT speech, right under a thousand who receive autism services, 32,000 who go to our day treatment programs. Thousands.
Q And that is -- am I correct in assuming that is quite an expensive endeavor for the state?
A Medicaid --

Q For medicaid --
A -- in general, yes. Medicaid, in general, across the nation, it's -- some of their highest spend is for specialty populations. Physically disabled, aging, behavioral health, and intellectual developmental disabilities.
Q Right. And it's -- in Arkansas, at least, there's a larger expense for those that are not in the human development center just because of the sheer numbers? Would I be correct in assuming that?
A I mean, yes. We -- we pay a lot of money for our programs because of the -- more recipients.
Q And Disability Rights of Arkansas, do you know how they're funded?
A You know, I don't.
Q Okay. Do you know if they're funded through the government?
A I assume they're funded through the federal government.
Q Okay. And, with any kind of government, you'd agree with me, there's limited budgets, you're always having to fight to get every extra dollar with the legislature or congress; right?
A Right. Yes.
Q Yeah.

A You're always trying to --
Q That's part of your --
A -- take care of your own.
Q Okay. And do you have any idea how many people are on staff at Disability Rights of Arkansas?
A I don't.
Q Okay.
And correct me if I'm wrong; but, at some point toward the end of 2022, did you or some others from DHS at a hearing in front of the legislature talk about, you know, shortages, not having enough funds to be able to provide all of the things that you would like to be able to do, so that family members would be able and eligible to get certain payments to take care of some of their family members at home with disabilities?
A No.
Q Okay. I may have misread the article.
So are you telling me that DHS, in your division, is fully funded to take care of all of the thousands and thousands that are not in the human development center?
A We are.
Q Okay. All right. Now --
A In fact, what you might have seen was the legislature giving me the funding so I could release more slots so more people could be served under our waiver

program.
Q Yeah, I think -- I thought I read something that you could give funds to family members because you didn't have enough staff.
A Oh, so what you were thinking of -- so there's restrictions in federal waivers and you get to decide whether or not family can be employees.
Q Uh-huh.
A And, because of COVID, and we are experiencing staffing shortages across the nation, I went in and unmarked that restriction.

So now a mom or a dad or a legal guardian can be hired by a Pathfinders or a Easter Seals, a Medicaid provider, and they can be trained, drug screened, background checked, and they can be employees of that provider and be paid to provide for their own children or adults. And, before that, was the restriction.

So we actually just did that because we are releasing 3,000 more slots.
Q All right.
A So we're adding on 3,000 clients.
Q And you say employees, they're not actually employees of your agency?
A Private.
Q Correct.

A Private providers.
Q Right. And I think you just said your agency and other agencies across the country have experienced shortages in being able to provide full levels of care; and that's part of the reason for --
A Family.
Q -- this family program?
A Yes.
Q Okay.
So you've told me about their bias, you think Disability Rights of Arkansas would like to shut them all down, all of your human development centers.
But you also said they do provide some value. So can you tell me how they contribute and provide value to your organization?
A I mean, it's a -- because they're so focused on the human development centers, it is contentious at times with that organization.
Q Okay.
A I -- I actually can't think of anything right this second. Maybe come back to it.
Q Okay.
Well, yeah, let's talk a little bit more about restraints. So I know you talked a little bit about that. You don't know all the details about the

restraints.

But would you agree with me that it's a goal of your organization to reduce restraints as much as possible?

A Absolutely.

Q And is that because, whenever someone has to be restrained, it increased the risk of danger to that client and to staff and to potentially others?

A Yes.

Q And, in fact, am I correct that y'all have had annual reviews to try to reevaluate restraint policies?

A I wouldn't call them annual reviews.

So we have a committee that meets regularly. Of course, we track restraints. We have groups at each HDC who track restraint usage.

I would say, since COVID, we've renewed our effort on reducing restraint usage. We actually had a meeting yesterday and our restraint usage is down 50 percent at my Arkadelphia Human Development Center. I only know that because the superintendent mentioned it on the phone.

I have not received the percentages from the other HDCs.

Q Okay. And there are different types of restraints; correct?

A Uh-huh.

Q Like there's mechanical?
A (Witness moves head up and down.)
Q Can you explain what a mechanical restraint would be? Give examples?
A I can. So a mechanical restraint is when a device is utilized.
So an example would be the papoose board that we talked about earlier at the Booneville HDC or a wrap device that's wrapped around the client to keep them from harming themselves.
Q Okay. Those are mechanical restraints?
A Those are.
Q Okay. So are there -- what are some of the nonmechanical restraints that are used?
A So nonmechanical, like so there's not -- so --
Q Something that's not in the mechanical category.
A Okay. So there's -- there's physical holds --
Q Uh-huh.
A -- and then chemical restraints.
Q Okay. And does your agency keep statistics as far as how many restraints are used at each facility --
A We do.
Q -- on an ongoing basis?
A We do.
Q Okay. How long have you been keeping those

statistics for both the mechanical, and I'm going to say nonmechanical, but the holds and the chemical?
A I would say those were being reported prior to me taking my job.
Q Okay. Was there a period of time after you took your job in 2016 where the agency wasn't tracking the -- again, what I'm going to refer to -- you know what I mean when I say nonmechanical restraints; correct?
A We just don't refer to it as that.
Q What do you refer to it as? I'll use your words.
A Physical restraints, mechanical, or chemical.
Q Okay. So was there a period of time after you became the director in 2016 where only the statistics related to the mechanical restraints were being kept and the others were not being kept up?
A No. So you can go back -- so we have a constitutionally appointed board that oversees the HDCs in addition to me. And chemical and mechanical restraints are reported in board minutes each quarter.
Q Okay. What's the name of that board?
A The Developmental Disability Services Board. It's in the statute.
Q And do you know who all's on the board?
A I do. And I knew you were going to do this. We just got new board members. I can get you a board list.

Suzanne McCommon is the president of the board right now.
Q Okay.
Back to this Disability Rights of Arkansas list that I gave you, I think it's approximately seven pages and it gives an accounting of their findings related to Mr. Cains' death. You had read this before; correct?
A I read it when it was sent back in 2020.
Q Okay.
A I responded to it.
Q And -- yes. And we'll get to that in a minute.
Tom Masseau, is he --
A Masseau.
Q Masseau.
A You're fine.
Q Okay. I'm going to think of it like Nasau.
A That's how I remember it. Yes.
Q Tom Masseau.
A No, I think you're right. I think you said it right that time and I didn't the first time.
Q He's still the executive director; correct?
A He is.
Q Do you know how long he's been the executive director?
A He was there when I took my job.
Q Okay. And, this report, it looks like, at the end,

it's also signed off on by Kris Stewart, who apparently is an advocate for Disability Rights of Arkansas, and Reagan Stanford, one of the attorneys at Disability Rights of Arkansas; correct?

A **It looks like it.**

Q Okay.

All right. I'm going to show you what I'm going to mark as Exhibit No. 2.

(WHEREUPON, the document was marked for identification as Exhibit No. 2 and is attached hereto.)

THE WITNESS: Thank you.

BY MR. GREEN:

Q Will you take a minute to look at that and let me know when you can identify it?

A **I do. This is a response that I sent to Tom.**

Q Okay. So this would have been your response dated November 13, 2020 to Tom in response to what I put forth as Exhibit No. 1; correct?

A **Yes.**

Q All right. And, in this letter, I think you point out that you're not responding to argue about the report and that -- I think you mentioned in here, from time to time, y'all have disagreements, but you do tell him that you appreciate his involvement with the behavioral

consultation committee; is that right?
A Yes.
Q What's the behavioral consultation committee?
A So that's the committee I was referring to, I think, earlier.
Q The statutory committee?
A It's not a statutory committee.

We -- we were concerned when COVID -- well, COVID -- when COVID first hit in March of 2020, we were very concerned that more clients were going to be placed in institutional settings because of the fear that was going around.

You know, nobody understood how it was spreading at the beginning and there were no vaccines; and so we were receiving more client referrals.

And then there was national articles being published at the time of increased restraint usage nationally. Because, the more clients you have in congregate settings and during COVID -- so we started the committee. And it's made up of clinical staff at the Human Development Centers and then there's outside stakeholders on it, so private Medicaid providers.

And then we asked Disability Rights to be a committee member.

Q Okay. And I'm going to jump back to something I

mentioned a minute ago. You agree that the goal is to reduce restraints?

A It is.

Q Would it be to eliminate them if that were ever possible? It may not be, but is that the ultimate goal, ideally, to not have to ever use a restraint?

A Yeah.

Q Okay. And would you agree with me that that's not just your agency's position, that's kind of the general position of most organizations that either take care of people with disabilities or advocate for them across the country, to try to reduce restraints as much as possible?

A That's a common theme.

Q Okay. And certainly Disability Rights of Arkansas believes in that pretty severely; correct?

A They do.

Q All right.

Now, the behavioral consultation committee, was that formed at the beginning of COVID, like beginning of 2020, or was that in existence before COVID?

A It wasn't. It was formed right around the time of this letter, so maybe the end of the summer in 2020 when the -- when we started seeing the articles coming out about increased restraint usage in other countries -- in other states.

Q Okay. And who -- were you in charge of setting up that committee?
A I was.
Q Okay. So did you select the persons to be on the committee?
A I did.
Q Okay. And in your letter -- I'm going to say Tom because I keep --
A That's fine.
Q -- butchering his name. If I say a name and you're not sure what I mean, please let me know.
A I will.
Q If I say Booneville, I mean Booneville Human Development Center.
A Right.
Q But Tom, you tell him that you appreciate the feedback that he gave you, ensuring all recommendations were included in subcommittee projects, and then there's several different goals and things listed throughout the pages.

I'm not going to go over every single word of this. One of the goals, it appears, on page one, is to develop a plan and a timeline of recommendations for collection use of data to inform restraint practices as well as consistent and effective use of that data to restraint.

So is that improved data collection and use of that data to help reduce restraints?

A It is; because, even though, you know, we tell each one of the five centers we'd like you to collect certain data points, inevitably, you know, they hear it a little different and they're tracking things a little differently.

So we're always having a renewed effort on really nailing down those metrics. And that's what that was talking about.

And some of my centers were not collecting personal restraint data. Because, like I said, what we've been reporting to the board has been mechanical and chemical restraints. So trying to get some consistency on how the HDCs that were reporting, each one of those, including personal restraints.

Q Okay. So there's mechanical restraint, you've explained chemical restraint, I'm not going to ask you to explain; I can imagine.

And then you just said personal restraint, is that like --

A Yeah. And I said physical before; and, I'm sorry --

Q Is that like --

A -- I used the wrong word. It's personal.

Q As long as we understand what we're talking about --

A Yeah.
Q -- it's okay. But some of your centers were not reporting the personal restraints?
A At least not on the data that was being put in the board book, booklets.
Q Okay. And that would have been as of the date of this letter in 2020?
A (Witness moves head up and down.)
Q Correct?
A Correct.
Q And you were wanting that to be improved?
A Yeah. I was wanting that to be added as one of the things that we report to the board and -- as well as making sure that we were all using the same terminology and putting restraints in the right category, as well as -- honestly, under chemical, my staff were telling me chemical restraints; and, when you hear that terminology, I -- I think about some sort of sedative. And it came out at the beginning, oftentimes, this is just Benadryl.

So I was -- so we -- you know, just down to that kind of level of what are we -- what are we actually talking about here; right?

What type of medications are we talking about. Just trying to get some consistency across all five. It's a constant work in progress.

Q I guess I'll ask you, since you mentioned a little bit about chemical restraints, what are some of the chemical restraint that are used?

You said medications that can include Benadryl, what are some of the other chemical restraints that you're aware of?

A I can not even guess at the names of those pharmaceuticals. But it's all prescribed by the doctor or the APRN or the psychiatrist that we have on staff.

Q Is there -- and I'm not asking for this question about the time of my client's death or before.

I'm just asking if, even today, is there a uniform policy for all of the Human Development Centers as far as what type of chemical restraints to use and what dosages and what criteria?

A Not that I'm aware of.

Q Okay. Do you know any reason why there's not?

A Because drugs interact with people's bodies differently and they're all unique and they're all on different types of medication usually for their intellectual disabilities and their behavioral needs.

So I can't imagine you can have any kind of uniform policy on dosage and types that, you know, that would mix with the medicines they're already on.

Q Is there even a standardized list of approved

medications that can be used for restraints?
A Not to my knowledge. I mean, they're only prescribed by physicians, so we -- you know, they go to school for that.
Q Well, I know there's lots -- and I'm not telling you something you don't know. There are lots and lots and lots of regulations that you guys have on you.
So there's just no uniform policy as to what's allowed at this facility versus this, it's left to the discretion of the physician?
A That's my understating.
Q Okay. And -- all right.
So one of the questions I was going to ask you about the physical restraint, since you sent this letter at the end of 2020, have your human development centers started keeping up with that data and reporting it?
A They have.
Q Okay. And are they reporting the chemical and the mechanical restraints as well as the personal or physical?
A They do.
Q Okay. Whenever -- let me back up.
I think it was implied when you said what you do, but in your position, you oversee the human development centers; correct?

A There's two staff below me that oversee them directly. I'm over the whole division.
Q Right. And I know you have lots of other responsibilities but I'm just focusing on the human development centers. So who are your two staff below you that also have supervision --
A I have a pretty large executive team. But I have a deputy, Thomas Tarpley. And then, underneath Tommy is an assistant director, Tammy Benbrook who oversees my human development centers.
Q Okay. But, ultimately, for lack of a better word, you are the boss over those two --
A I am.
Q -- and the facilities? Okay. And -- all right. With respect to -- we've talked about chemical restraints.

With respect to personal restraints or mechanical restraints, do you know what type of policies govern the use of those? Are you familiar with, let me make sure I get all my acronyms correct, CPI/NCI?
A I am. I am familiar with CPI, yes.
Q And can you just briefly explain what that is?
A That's a nationally recognized training curriculum that we put all of our staff through to learn deescalation techniques and proper use of restraints.

Q Okay. And that is the training that has been authorized to be used for your staff at your human development centers; correct?
A **Yes.**
Q Okay. And staff at your human development centers are supposed to only follow the training they've received; correct?
A **They have a lot of training in different areas; but yes, they're supposed to follow with the training.**
Q I mean, they're not supposed to just wing it and come up with something different. You expect them to follow their training and the policies that you've put in place; correct?
A **Yes.**
Q Okay. Are you familiar with Mark Hise, H-i-s-e --
A **I'm not.**
Q -- at Booneville Center?
A **No, sir.**
Q Not familiar with him at all?
A **Hu-uh.**
Q Do you know who does the training at your human development centers of the CPI/NCI stuff?
A **We have different trainers at each center. I don't know them.**
Q Okay. So is it true, that at each center, there's

an employee of your agency that's tasked with the responsibility with being one of the people in charge of that training and making sure that it's in compliance?

A Yes.

Q Okay. You don't know if Mark Hise is the individual that does that at Booneville?

A I don't. I have 1,900 staff. So I just --

Q I understand. I understand. All right. If -- let me back up here.

Who is the superintendent at Booneville?

A Jeff Gonyea.

Q Okay. And does he have an assistant?

A Jennifer Berry.

Q Okay. If they had represented that Mark Hise is the expert on the CPI/NCI for that facility, would you have any reason to disagree with that?

MR. ROSEN: I'm going to interpose an objection as to your representation. She's here to talk about facts, not your representations.

MR. GREEN: Okay. Well, she can answer the question and you've objected.

BY MR. GREEN:

Q If they were to have represented that, would you have any reason to doubt them?

A That's a weird way to ask it. I don't -- I don't -- I already said I don't know who he is. And this is probably going to hurt his feelings that I don't know who he, if he is who he says he is, when he sees this.
Q Do you trust Mr. Gonyea and Ms. Berry to provide accurate information about --
A I do.
Q -- the way their facility is run?
A Yes.
Q Okay. So if they've made a statement about him, you would have expected them to give truthful statements about him?
A I would.
Q Okay. That's good enough.
Do you know who Sandy Evans is?
A I don't.
Q Okay. All right.
You still got Exhibit 2 there in front of you?
A I do.
Q And just a little bit lower down, I think you -- let's see. It's the third paragraph that starts at this response isn't intended to argue.
But, later in that, you state that you agree with Tom that people with disabilities, whether they live at the facility or out in the community, deserve the best

possible care; correct?
A Correct.
Q And you're saying Tom, Tom believes that as well?
A I'm responding to his letter, so there must have been something in his letter that referenced that.
Q Because you said you agreed with him; correct?
A This is a letter in response to his letter. I'd have to go back and read his letter.
Q Okay. And you say you agreed that we need to renew our effort to actively reduce restraints. I am committed with your help and other members of the behavioral consultation committee to change the culture and significantly reduce the restraint usage; correct?
A Correct.
Q So I know you've said you wanted to reduce it and you needed help from other partners and Tom and DRA. I'm going to abbreviate Disability Rights of Arkansas as DRA, if that's okay.
A Okay.
Q And you want them to be on the committee and contribute ideas to that as well; correct?
A I do.
Q All right.
And so you wouldn't have put them on the committee if you didn't think they had some value to add to the

committee; correct?
A They're federally and state -- my PNA, when we have committees, they're a member.
Q okay. So are you saying you don't value the input they give you? I know -- I'm not -- let me rephrase the question.
I'm not asking if you agree with everything they tell you. But do you listen to what they have to say, give it consideration, when forming your policies?
A Yeah, of course. I listen to -- I listen to what -- all input --
Q Okay.
A -- and consider it when I'm doing policies.
Q Okay. And so their input at least provides some level of value in that way; correct?
A I do listen to their input, yes.
Q Okay.
A And take it into consideration.
Q And would you agree that sometimes they have an idea that you may agree with?
A I think Tom and I both agree that we need to -- I say reduce, he says eliminate. I don't disagree with his sentiments on, on that statement.
Q Okay. You said to change the culture. Were you referring to the culture specifically at the Booneville

facility?
A No, I wasn't.
Q What did you mean when you said change the culture?
A I use that phrase a lot when I'm doing training with my staff.
When you have almost 2,000 staff, it's like moving the Titanic when you try to do policy changes. And policy changes don't work if you don't have buy-in. And that buy-in from that many people takes a lot of effort.
Q Okay. And so you're wanting to change the culture from restraints at a certain level to less restraints? Would that be fair to say?
A Yes.
Q Okay. And, as you said, you're over a large number of people, it's important to have written policies that are clear, easy to understand; correct?
A Correct.
Q All right. And whenever -- do your facilities, the human development centers, each have their own set of policies in addition to your overriding policies?
A They do. And that's -- that's due to the office of long-term care.
Q Okay.
A The more we try to standardize, inevitably long-term care, each -- you know, when they go out, they say you

need another policy on this or on that. So, you know, we try to standardize.

But, under the regs, it's very hard when we're told to, to deviate.

Q I understand. So if, for instance, the Conway Human Development Center wanted to change one of their regs, what's the procedure they would follow to do that?

Are they allowed to just, on their own, autonomously do that? Do they have to run it up to you or one of your deputies for approval? How do they --

A Are you talking about --

Q -- change their policy?

A So there's -- you know, there's definitely a difference between policy and procedure.

Q Okay.

A So there's a very outlined way to do policy that's promulgated under the APA; and that takes my approval.

Q Okay. So if they're going to change a policy, you expect them to follow the APA?

A If it's promulgated.

Q Okay. And then, but if it's a procedure, they would not need your approval?

A They need Ms. Beenbrook's approval.

Q Okay. And can you give me an example of something that would be a procedure but not a policy?

A Well, a policy, under the APA, is a -- you know, there's a distinct definition of things that affect the public at large and the procedures are internal process.
Q Okay. All right.
A So how you would -- how you would deposit funds, for example, maybe is just a process. It would not be promulgated, although it probably is because we're the state. That's a bad example.

MR. ROSEN: I'm just going to -- I mean, you're asking her about legal issues that really are in the statute.

MR. GREEN: Yeah, I'm asking her knowledge of how rules are -- policy and procedures are implemented at her facilities.

BY MR. GREEN:
Q So I'm just trying to understand.
For instance, restraint use, would that be something that would be a procedure or a policy that would need to be approved through the APA?
A It's my understanding that we have a promulgated policy on some of the restraint usage. There's federal requirements, state requirements that falls under long-term care. That would go up through me.
Q Okay. Great.
And, again, I know we -- some of these, I know the

answers to, you know the answer to, but I still have to make the record.

All right. Okay. And, at your centers, are the staff given regular training updates, refresher courses?

A **Absolutely.**

Q Okay. Is that a uniform policy across all of them, that they get a cert -- they each, each facility gets a certain refresher each year or is it up to each facility to determine what they do?

A **No, that's standardized, how they're trained and how they're annually re-upped on training.**

I will say, when long-term care comes out, if there's a complaint or an investigation, staff are often immediately retrained on site based on what was found. So there's training going on probably right this very second at all five of them.

Q Something is always happening; right?

A **Something is always being trained.**

Q And -- okay. Is there a -- I understand, if there's an instance that has happened, you will do immediate training; is that correct? Is that what you're saying?

A **It depends on what long-term care.**

Q Okay.

A **So our regulatory --**

Q Ah, all right. But is there a standard, once a

year, we have training, whether anything has happened or not?

A Yes. We have annual training.

Q Is that annual training conducted the same time of the year each year? Spring, fall? Is it just scheduled depending on year to year, what all is going on? Do you know?

A I don't know.

Q Okay. Is the training provided by employees at each different facility?

A Yes.

Q Is the training uniform across all of the different facilities?

A I don't know.

Q Okay.

On your letter that you sent back to Tom, I just want to make sure I understand because there's different plans and goals and I want to make sure I understand what, what are your plans and goals and what are not.

On Page Two, at the top, it says action number three, action number four, and then it says DRA recommendation, action five, ensure the use of restraint is regularly monitored including carful evaluations and scrutiny of the recent staff utilized restraint, alternatives to restraint, and follow-up actions in

response to restraint.

This includes requiring the clinical and senior administrative staff to be more involved in the day-to-day activities of residents to ensure the individualized treatment or behavior plans are effective and the adequate act of treatment is provided. The process for this oversight should be included in the project plan.

Did you agree with that recommendation?

A Well, you see how I worded that recommendation. So ones that just say action in front of them were recommendations that came out of my department.

This one is a DRA recommendation and I took down word for word what they recommended.

Q Right. So -- but my question is -- I understand that's the recommendation. But my question is, do you agree with that recommendation?

A Let me reread it.

Q Sure.

A I agree with that.

Q And, if it doesn't say DRA recommendation and it says action number four, action number three, that came from your department; is that right?

A It did.

Q Okay. Would it be safe to assume that you agree

with those because they came from your department? If it doesn't say DRA or (inaudible) --

A No, I'm just saying those are more our words.

When it says DRA recommendation, I just took down exactly what was sent in by them.

Q Right. I'm just trying to understand, for instance, action number four, develop a template, action number three, update incidents, your agency came up with that?

A We did.

Q Do you agree with those actions?

A Oh, yes, I do.

Q Okay. So you wouldn't put an action in there that you wrote if you didn't agree with it and intend to try to implement it?

A Right. And, just remember, this all came out of the committee and there's other stakeholders on the committee.

Q Sure.

A I don't remember at the time, I'd have to go back and look at my e-mails, but Disability Rights wanted their exact language in the plan.

What we did with all these is we put together a behavioral consultation plan that we published and put online. And they asked for their exact words to be used and for -- you know, rather than paraphrase like I had on

the others.
Q Right. Yeah. And I understand completely, if it says DRA, you may not agree with that.
A Right.
Q I'm just trying to confirm --
A On the rest.
Q -- if, on the rest that you all drafted, it seems like an obvious question, but you agree with what you drafted and put in --
A I did.
Q -- with actions one and two -- okay.
A Right.
Q I'm not trying to trick you. I just want to make sure. I know you don't necessarily agree with all of the DRA recommendations.

On the next section where it talks about preferred restraint and communication options, excuse me, it says develop a project plan is the goal, timeline of recommendations for implementing the best devices, including communication devices.

What does that mean? Implement communication devices.
A It can mean a wide variety. You know, we have -- we have clients that cannot communicate at all. We have clients that utilize sign language. We have clients that

need various either technology pieces or different methods in order to be able to communicate their needs, wants.

And so it's -- it's kind of self explanatory in terms of like go back and reevaluate and make sure that our clients have the most comprehensive communication device they can so they can communicate the best they can.

Q I understand your answer. My confusion was -- and I get your answer is you're talking about communication devices to help assist those clients and being able to better communicate with staff.

A Yes.

Q I didn't know if the communication devices meant communication among staff or -- so I was just trying to --

A Oh, no.

Q -- delineate, so that was my question.

A Okay.

Q DRA's recommendation and action was to ban the use of the papoose board as a form of restraint. Do you agree with that as a goal or not?

A We've done that.

Q Okay. Y'all have already implemented that?

A We did.

Q Okay.

On the last page where your signature's at, at the top, it says external advocate recommendations and it says Tom is the chair. So he was the chair of the external advocate group of the committee; is that right?

A **Yes.**

Q Okay. I don't want to get the terminology wrong. All right. And I'm assuming these goals and actions -- well, I don't want to assume. Let me ask you.

Underneath where it says that he is the chair -- and you had designated him in the chair; correct?

A **I think he volunteered, but, yes.**

Q I mean, it was your decision; right? You could have said no?

A **I try to be polite, but, yes.**

Q All right. But you wouldn't put him on there if you didn't -- never mind.

I assume you don't put people in positions that are not competent to be able to handle the position, generally.

A **Well, I mean --**

Q Right?

A **I can't speak for all situations.**

Q Well, sometimes people turn out not to be competent, but you don't know any (inaudible); right?

A That's true.
Q It has a goal and then it has actions listed. Were those actions that you all agreed with? Or were those DRA actions that agreed with some, not others?
A I was trying to read through them really quickly.
Q Yeah. Take a minute.
A Yeah.
Q I'm not trying to rush you. We can take a break. Whatever you need.
A All but number five. I agree with actions one through four. I agreed to research independent investigators, but there's a lot of complications around that. And Tom and I had a lot of discussion.

We already have so much oversight that I disagreed that we needed a fourth, you know, entity to come in and do investigations when we already do one ourselves, we already have adult protective services, we already have office of long-term care, we have the attorney general's office.

And, you know, that's a lot of people investigating our facilities and I -- so I did disagree with action five that we need yet another investigative agency.
Q Okay. You said it quick, and I was trying to write this down.
A Oh, yeah.

Q You said their adult -- that the investigators you deal with are adult protective services, long-term care, the attorney general, I mean --
A Child protective services, DCFS.
Q Okay.
A And then we do our own investigations as well.
Q DHS or DD --
A DDS on behalf of long-term care. We do one, initial for reporting.
Q That's one, two -- yeah. You said five.
All five agencies wouldn't necessarily investigate every incident; correct?
A No. Only if child abuse or maltreatment is suspected. Only if adult maltreatment or abuse is suspected would they be called in.
Q Right.
A The AG's office, it's their discretion, whether or not they come in and do an additional investigation. But they are notified.
Q All right. So, if it's an adult in adult protective services, do they automatically come in and do one or do they have to be requested?
A We automatically have to -- we're mandated reporters. We automatically notify. I don't know -- I haven't represented them in many years.

Q Okay. Gotcha. And, long-term care, do they automatically come in and do an investigation or do they have to be requested --

A They automatically do investigations, yes.

Q Okay. And do they draft a separate report, each of these different entities?

A They do.

Q Okay. What about the attorney general?

A They're always notified.

Q Okay. And, obviously, if it's not a child, you would notify Child Protective Services.

A Right.

Q Okay. And then, DDS, you all do your own investigation?

A (Witness moves head up and down.)

Q Okay. And then, to a certain extent, DRA does some, but they have a limited information; correct?

A Yes. If they -- they pick and choose, but, yes. Like in this case, clearly, they have put out some sort of investigative report.

Q Okay. And -- but these other agencies that you mentioned, they would have full access to all the records; correct?

A Yes.

Q All right.

THE WITNESS: I'm sorry. I really need to use the restroom.

MR. ROSEN: Let's take a break.

VIDEOGRAPHER: We are off the record at 10:59 a.m.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

VIDEOGRAPHER: We're back on the record.

BY MR. GREEN:

Q Ms. Weatherton, you understand you're still under oath?

A I do.

Q All right. You said something earlier and I think I -- I'm not sure if I wrote it down correctly.

When I was asking about the different five agencies that do investigations and also about training, that sometimes there's training after an event, but you always have an annual training.

And the training after an event, did you say if long-term care deems that it's necessary or --

A (Witness moves head up and down.)

Q Okay.

A Or if we do -- because we do an investigation. We do a preliminary when we report it, so --

Q Okay.
A -- retraining is a big part of our curriculum.
Q Okay. So, if something's happened, either you all might put some training in immediately or long-term care?
A Correct.
Q Okay.
All right. I'm going to show you what I'm going to mark as a No. 3.
(WHEREUPON, the document was marked for identification as Exhibit No. 3 and is attached hereto.)
BY MR. GREEN:
Q Let me know once you recognize that document.
A I recognize it.
Q It says it's a DDS behavior consultation committee report summary from April 2022; is that right?
A That's right.
Q And this is the same committee we were talking about earlier that you appoint the members of; is that correct?
A That's right.
Q Okay. And I know this report was generated in April and there's certain objectives.
MR. ROSEN: And I just want to ask, this is -- April of 2022 is the date on the report.
MR. GREEN: Uh-huh.

MR. ROSEN: I mean, is there a relevance to this claim?

MR. GREEN: Yeah. Yeah. I'm going to --

MR. ROSEN: Okay. Well --

MR. GREEN: -- ask a couple of questions that will make it relevant.

MR. ROSEN: Okay. I mean, based on --

MR. GREEN: I'm not going --

MR. ROSEN: -- public policy by the State of Arkansas, about any, anything that has happened since this, I don't know how -- I object to the relevance. Let's put it that way.

MR. GREEN: Okay. I gotcha. I'm not going to --

MR. ROSEN: And I don't know what your questions are.

MR. GREEN: Yeah, yeah. I'm not going to go through page by page.

MR. ROSEN: And so I'll just have a standing objection to each one. I might interpose and additional objection on anything in this report would be not relevant to the claim that is being put forth in front of the claims commission since this is two years

later.

MR. GREEN: And I have no problem treating it as a continuing objection.

MR. ROSEN: Thank you.

BY MR. GREEN:

Q Really, what I wanted to just double check, there's objectives, I won't go through all of those since those objections were formed afterwards.

The very last page lists committee members. And I know that you formed this committee, I think you said, around the time you wrote the letter back to Tom in November of 2020; is that right?

A Yeah. It was a few weeks or months prior to. I just can't remember the exact date.

Q That's okay. I'm not to holding you to an exact month. I'm just trying to get a general idea.

And you're obviously on the committee; and I then I see where the outside partners, Dr. Charlie Green from Pathfinders, Tom from DRA, Reagan Stanford's from DRA, Josh Wilson, I don't know how to say to Dr. Evans' first name.

A Syard.

Q Syard.

A Uh-huh.

Q Were these the committee members, at least the

outside partners, that were on it when you first formed it?
A Yes.
Q Okay. So those outside partners have been on it since you created it?
A Yes.
Q Okay. Are they still serving on the committee?
A You know, we had a meeting yesterday and I don't remember seeing Dr. Wilson or Dr. Evans on the Zoom. I -- so I don't know if they were invited and didn't, weren't able to come, or if they're not on it anymore.
Q Sometimes committee members miss a meeting occasionally?
A Yes.
Q All right. I know, that from reading the documents, that at the time of Mr. Cains' death, there were no cameras at the Booneville facility; is that correct?
A Yes.
Q Okay. In my understanding, the other four human development centers did have cameras; is that correct?
A Somewhat. Not everywhere and the quality was very poor.
Q Okay.
A We're in the process of redoing all five cameras at all five.

Q Okay. So the other four had cameras not covering every square inch and not the greatest quality, but had cameras?
A That's a fair statement.
Q Okay. Have any cameras been installed at Booneville?
A You know, I don't know. We've been working on this camera project for quite a while now.
Q Okay.
A We had to do fibers and internet connectivity and all kinds of stuff to get ready; and I don't know where we are in the process.
Q Okay.
Whenever there is a restraint that has to be used -- well, let me back up.
Would you agree that using a restraint should be an option of last resort if the other deescalation and other things that your staff have been trained have not been successful?
A I think we already talked about this. I didn't answer that because I really don't.
It's so case specific and it's based on that person's behavior plan and I'm just not comfortable answering.
Q Okay. That's fine. That's a perfectly fine answer.

All right. So, when there is a restraint event, I'm going to call it that -- and if I use a word or a phrase that's not the lingo that you guys use, let me know. And I'll try to use your wording.

But, if there is an incident where someone is restrained, what happens after that, as far as your agency?

Is there any automatic investigation? Is it evaluated? Or, you know, what do you do? I know you collect the data, but what is done? And I'm not asking you to disclose anybody's individual information.

A It's my general understanding, so there are -- there's paperwork that the staff members have to complete when any type of restraint is performed. That is routed to the centers human rights committee into the leadership team at HDCs; and then it's also notated on statistical reports.

And, from where I sit, I get statistical data.

Q Okay. Is there anyone -- so you get the statistical data. Is there anyone, one of your deputies or anyone at the actual center, that in addition to taking the reports, actually evaluates to determine the appropriateness of it, what things might need to be changed, or if it was compliant or if there could be other suggestions to help reduce it?

A Uh-huh. So that is my -- that is the role of the human rights committee at each one of the human development centers.
Q Do those committees have a standardized protocol or process that they go by?
A I don't know.
Q Okay. So each one might have different criteria they use in going about it?
A I'm really not sure.
Q Okay.
I'm going to ask you some questions about incidents that have occurred specifically at Booneville but maybe at some of the other centers. In no way, shape, or form, by any of my questions, am I asking you to disclose any names of any persons or any other confidential information.
I'm going to ask you about some things, some occurrences, that were reported in news media that's public information. Just a few questions.
Were you aware of an incident in Booneville that occurred in 2019 where a client had an arm broken by a staff member?
A No.
Q You're not aware of that at all?
A I can't articulate enough the amount of staff that I

have, the amount of clients we serve. I am not into that kind of granular level on an incident in 2019.

Q Okay. What if one of your staff members were to be charged and convicted with a felony in relation to that? Would that be something that would rise to your level?

A We've had staff that have over the years; but I'm not familiar with the exact incident that you're talking about.

Q Okay.

All right. Are you aware of an incident in January of 2019, also in Booneville, where a client lost consciousness based on a choke hold that they were placed in by a staff member?

A No.

Q Okay.

Do you have an opinion as to whether or not a choke hold around someone's neck that rendered them unconscious would be appropriate?

A I'm not going to give an opinion on something I don't know about it.

Q Okay. So you don't know about the proper restraint as dictated by the CPI/NCI? You have other people that train that and teach that; correct?

A Yes. And you prefaced this with saying in the media; so, if the media paraphrased it as a choke hold,

that does not mean that's what occurred.
Q Okay. You're correct.
I can show you this newspaper article, if you'd like to see it, because you actually were quoted in it. Would you like to see it?
A Is that the 2017 -- what was that?
Q This is the 2019. Those two incidents I just mentioned. I've got -- I'm not going to make -- well, if you want me to make an exhibit --
MR. ROSEN: It's your deposition, so --
MR. GREEN: Okay. Sure.
MR. ROSEN: -- however you choose to proceed, and I'll respond appropriately.
MR. GREEN: Is this number four? This will be marked as a No. 4.
(WHEREUPON, the document was marked for identification as Exhibit No. 4 and is attached hereto.)
BY MR. GREEN:
Q And you have to look at the very, very back page where it says the article was contributed by Eric Besson at the Arkansas Democrat Gazette. This was an article that appeared in the Arkansas Democrat Gazette.
MR. ROSEN: Well, let's take a few minutes. It's a four to five page document.

MR. GREEN: Yeah, I'm not -- I'm not asking about the merits.

MR. ROSEN: Oh.

BY MR. GREEN:

Q At the top, it says September 14th, 2020. Take a minute.

MR. ROSEN: Do we want to go off the record or no?

THE WITNESS: Do I need to read this? Are you going to ask me questions?

MR. GREEN: I'm going to ask you specific question if -- and

MR. ROSEN: Then we need to read it then.

MR. GREEN: If I ask -- okay. Yeah.

MR. ROSEN: Okay. So let's take a few minutes. Let's take another five-minute break and read it.

VIDEOGRAPHER: We are off the record at 11:24 a.m.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

VIDEOGRAPHER: We are back on the record at 11:46 a.m.

BY MR. GREEN:

Q All right. Ms. Wetherington, I know I keep asking, but I have to, you understand you're under oath?
A **Yes.**
Q Have you had to look over what's marked as number -- Exhibit 4 and 5?
A **Yes.**
Q Okay. I just have a couple of quick questions.

Exhibit No. 4 was the news article that I had referenced about the broken arm in 2019 and loss of consciousness due to a choke hold that same year.

There was also something about the Conway Human Development Center that I did not mention. But, on page two -- your last name used to be Stone; correct?
A **Correct.**
Q It says that Director Melissa Stone said the events described in the documents were self reported by the centers. In other words, the centers reported these incidents; correct?
A **Yes.**
Q And that you describe them as isolated incidents that should be categorized as abuse, not a personal restraint gone wrong. Was that your quote?
A **Yes.**
Q Was that an accurate quote of yours, as far as you can remember?

A Yeah. Like I said earlier, I just don't remember the exact -- I just don't remember the facts around these cases; but, yeah, I mean --
Q Yeah. And I'm not asking you to remember the facts --
A Uh-huh.
Q -- and I don't want to get into other personal data, but just the general -- is the general idea -- is your belief still that those incidents like that or those incidents were isolated and were not a personal restraint gone wrong but were actually abuse?
A It's my understanding we found that the -- both of these incidents that you mentioned were -- we found abuse. That the employee abused the clients and they were terminated.
Q Correct. And it also has you quoted as saying what happened was not in compliance with our training and we consider the behavior maltreatment of our clients.
It says that you wrote that in an e-mail. Of course, they could be lying. But if, if the actions of staff were not in compliance with the training and it's considered maltreatment and abuse, does that sound like your belief?
A Staff are terminated, yes.
Q Okay. Because you told me earlier you expect them

to follow the training they've been given; correct?
A Right.
Q And, if they fail to follow that training, that can cause abuse?
A I mean, they -- abuse can be caused, you know --
Q I don't mean exclusively.
A Right.
Q But failure to follow proper training can cause abuse; correct?
A Correct.
Q On page -- I guess it's the third page of the article, under the section that begins reducing use, going to third paragraph down, cites to a government report from 2003 that restraints, that seclusion care is a risk of serious injury and death.

I think, earlier, you said restraint increases the risk of danger to injury to clients and the staff; correct?
A Yes. This is referring to a federal mental health agency report. Not anything that we put out.
Q Right. Not anything you've put out. But you're not changing your earlier statement that restraints -- when someone has to be put into a restraint, it increases the danger of harm to clients and staff; correct?
A Yes. It's weighed, you know? They're already a

danger to themselves or others or they wouldn't be going in, so --

Q Okay. Also under that section reducing use, one, two, three, four, five, six, seventh paragraph down, where it says she added, and it's referring to a statement you made in the previous paragraph about having a plan updated annually to reduce restraint use, which you already I think testified about, but it says that staff is trained de-escalation techniques and that a committee was created in 2017 in response to reports of excessive restraint use at Booneville led by a psychologist.

That was different committee than the one we've been discussing earlier that you said you formed in 2020; correct?

A Yes. And you notice that's not in quotes. I don't know what they took from what I said to write that.

Q Fair enough. But it's definitely not the one we've been discussing earlier, if it was one, they may have misquoted you?

A The consultation committee that we've been talking about was enacted in 2020.

Q Okay. Perfect. That's just what I wanted to clarify.

The next page over says criminal convictions. And

did you read the portion that stated the staff member who broke the resident's arm at Booneville pled guilty to a second-degree felony battery?

A The second paragraph under criminal convictions?

Q Yes, ma'am.

A Yes, that's what it says.

Q Okay. And it talks about some abuse at Conway but I'm not going to ask about that.

All right. That's all I'm going to ask you about No. 4.

(WHEREUPON, the document was marked for identification as Exhibit No. 5 and is attached hereto.)

BY MR. GREEN:

Q No. 5 is another Arkansas Democrat Gazette article. At the top says published January 31, 2021. Did you have time to read that earlier?

A I did go through it; but, if you'll point out where your -- what you're asking, that would help.

Q Oh, yeah. I'm not -- I'm not going to just ask you to tell me what it means.

A Okay.

Q Just a few very specific questions. This article, while I don't believe it names Mr. Cains by name, was it obvious to you in reading this that this refers to Mr.

Cains?
A Yes.
Q Okay. It references Booneville, that he liked the Monkees, the band. Those were some characteristics of Mr. Cains; correct?
A Yes.
Q Okay. On the second page, and it's -- I hate to say paragraph because some of these are just a line, but --
A Right.
Q -- the one, two -- on the second one down, where it says his death not revealed in news reports, do you see that paragraph?
A I do.
Q Okay. It said that -- it states that provides new context for the state's division of developmental disabilities services' promise in September to review the use of physical restraints and restraining devices in its five human development centers.

And is that -- would that have been September 2021? I mean, I'm sorry. 2020. Because this was published in January 2021. I misspoke.
A I don't know what, what she's saying there.
Q Okay.

And, earlier, you said that this committee that we talked about that was formed in 2020, you first -- you

said it was around the time you wrote that letter in November 2020, that you said it could have been a couple of months before, and that was certainly formed to review the use of restraints and see what could be done to help minimize those; correct?

A It was.

Q Okay.

Do you see where, one, two, three, I believe it's the fourth one down, that says Stone stopped short of saying?

A I did see that. I again don't know what she's referring to.

Q Yeah. And I'm not going to ask about the trigger language. This reporter said that the state was influenced by restraint data assessment that officials undertook during the pandemic lockdowns to see if the isolation effected residents. And then, in quotes that are attributable to you, the quote is those numbers were high, she said, we need to reengage ourselves in this.

Do you -- does that sound like something you would have said or believed at the time?

A This is referring to what you and I talked about earlier which is, during the pandemic, we were concerned nationally and here in Arkansas, we were receiving more clients and the isolation was affecting restraint

increases.
Q Okay. That's what I thought. I just wanted to make sure.
Let's see. I know it's been a little while since you reviewed the actual documents related to David's death but -- I know you just saw this article.
Do you recall, that when emergency medical arrived on the scene, they were not told that there had been any restraint leading up to the vomiting and the aspiration?
A I do remember looking at some of the reports, but -- I wish you had them so I could relook at them; because it's been two-and-a-half years.
Q Okay. But you recall that was not disclosed?
A I don't remember what the witness statement said.
Q Okay. Do you think it would have been important for your staff to tell emergency medical personnel that arrived on scene as much detail as they can about the circumstances leading up to an emergency event, a medical event?
A That's really speculating. I don't know -- I don't feel comfortable answering about this case when I haven't reviewed it in so long.
Q Okay. But just, in general, if an ambulance shows up on the scene, would you agree that it's important that someone that was a witness to whatever occurred that

caused an ambulance to get there would tell the ambulance as much as they know about what happened?
A If I remember correctly, in this case, he was unfortunately choking and the paramedics were very aware he was choking and were actively trying to remove it from his throat.
Q Yeah, and I'm not asking about this case.
I guess my question is, would you agree with me that it's better to provide more information to medical personnel about all of the circumstances that led up to a medical event?
MR. ROSEN: I'm going to object.
A I just don't know how to answer that.
BY MR. GREEN:
Q So you have no opinion? Or don't know how to answer it?
A I don't.
Q Okay.
A I don't know how to answer that.
Q All right. That's fine.
I think I know the answer to this but I just want to make sure it's on the record. I know you're over all of these centers. I take it you didn't personally call any member of David's family to talk to them about the incident; correct?

A No, I did not.
Q Okay.
I think, in the article, you're quoted as saying that cameras -- if there had been cameras at the facility in Booneville, which had none, it would have helped to make the situation, quote, black and white to you.
Does that sound like something you would have said or believed at the time?
A I am a big believer that we need to have high quality cameras across our facilities.
Q Okay. And this is page -- sorry they're not numbered.
Page three, second paragraph down; and, again, this is a quote attributable to you and it's in quotes. It says it's very clear that a personal restraint did occur leading up to him passing away, referring to Mr. Cains, but I've looked at every document, I've looked at Disability Rights Arkansas' report, I've looked at hospital reports; I've not been given any kind of documentation that says personal restraint did or did not lead to the passing of that client, she said.
Do you recall making that statement or something along those lines?
A Again, I -- I have not looked at this case. I mean, I'm not doubting that she's quoting me, so I'm not going

to argue with what I said.

But I'm sure I had looked at this case in -- before I responded to this interview.

Q If there's a death at one of your centers, you -- you personally do get involved in reviewing the materials --

A I do.

Q -- correct? Okay. And so --

A Well, not every death. We have a lot of clients that pass away that are older age, that it's very clear they've had a heart attack. There's a -- natural causes death.

So we have a lot of people, as you can imagine, over the years, that pass away just because they've been with us a very long time and it's their time. So I don't review every death. I just want to be clear.

Q No. And that's fair. That's fair.

A I did review this death.

Q Obvious natural deaths, you don't. Do you have -- is there a certain criteria that gets applied that would make a death rise to the level that you need to look at it?

A Not necessarily. No.

Q On a case-by-case determination?

A Yes.

Q Okay. But you did look at these materials you referenced here?
A I did.
Q Okay.
A I would have looked at them, especially before I responded to a newspaper reporter.
Q Okay. And, at least according to this, at the time, it's reported that you said that you didn't see anything in those documents that said the restraint did or did not cause this death. Is that still your position? You don't know if it did or did not?
A I don't; because I -- honestly, I don't. It's been so long, I don't remember what the statement said at this point.
Q Okay.
My understanding is, that after all of the investigation was done into this matter involving Mr. Cains, that there was a finding that all of the staff acted properly and provided the appropriate standard of care; is that correct?
A Correct.
Q Okay. Did you approve that final determination? Or was that your determination?
A I don't make that. That's the office of long-term care.

Q Okay. What about -- I think you said that you all have your own people that do your own internal investigation. Did you review that?
A I did. So the internal investigation is only to gather enough information so that we can make a report to our federal reporter, federal investigators.
So that information would have been sent to the office of long-term care and the attorney general's office.
Q Okay.
A Who -- it's my understanding -- I don't know the AG's office ever got involved. I can't remember. But OLTC cleared of any wrongdoing.
Q Okay. So you're saying OLCT cleared of any wrongdoing?
A Yeah.
Q Okay. All right. But you didn't review this and come to any conclusion of your own? You just relied on their conclusion; correct?
A I don't owe verbal investigations of long-term care. That's way outside my scope.
Q Okay.
A They're an independent agency.
Q Understood. So then I guess you don't have an opinion as to what caused this death based on what you

just said. Is that correct or am I not correct?
A I rely on the -- I rely on a federal investigative agency. I read the documents and I found that I -- I agreed with their outcome.
Q Okay.
A But, again, you know, I wasn't there. I wasn't on site. I didn't do any interviews. I mean --
Q Is it your position that Mr. Cains was responsible for his own death?
A I didn't say that.
Q I didn't say you did. It's a question I have to ask.
A No.
Q Okay.
A No, of course not.
Q Again, I just had to ask.
All right. You mentioned long-term care and this will be the last time I ask about this. And I think I'm done with this article almost completely done.
I think your testimony earlier was, if there's an incident, if the office of long-term care finds something wrong, y'all will do training right away or if you all determine that training should be done right away, it would be done right away; is that right?
A That's fair, yeah.

Q What kind of criteria do you all apply to determine whether or not training, immediate training, is necessary?
A I would have to defer to the superintendents on this. That's way down -- I have no idea.
Q Okay. So there's no uniform criteria if certain types of events automatically trigger it; correct?
A Correct. I don't -- I don't know what that would be.
Q Okay.
A They determine disciplinary actions. It's run by legal, so. . .
Q All right.
Let me show you what I've marked as No. 6.
(WHEREUPON, the document was marked for identification as Exhibit No. and is attached hereto.)
THE WITNESS: Thank you.
MR. GREEN: I think this is going to be my last exhibit but --
THE WITNESS: Okay.
MR. GREEN: -- don't hold me to that. If I have one more, I apologize. But I think -- we'll have to take a break in a second.
BY MR. GREEN:

Q This document I've handed you, at the top, it says first aid guidelines. It was provided to us in discovery. It's date stamped at the bottom.

Do you -- do you know what this document is?

A I don't.

Q Okay. Have you ever seen it before?

A I don't recall.

Q Okay. At the top, it says first aid guidelines and it also, in the upper right, says Booneville HDC Policy 4-B-10.

That policy, 4-B-10, what do you all call those policies that the development centers have? Are those policies? Are those procedures? Are they --

A You know, I would have to see. It looks like this is a procedure that's for Booneville. I'd have to get on the Secretary of State to see if this is actually promulgated. I highly doubt it.

Q Okay.

A Just by the way it looks.

Q And if this was a procedure and not a policy, would Mr. Gonyea have been able to just put this in place without any approval from someone at your staff, the executive staff?

A I don't know. I see on there that it was enacted on 3/13 of '15, so that was before I was the director.

Q Well, once you became director, if -- because I know you distinguish between policies and procedures; and I'm just trying to clarify.
A Uh-huh.
Q Policies, we know, go through the APA. A procedure doesn't necessary -- doesn't have to.
But I guess my question is, are the superintendents given the authority to determine and set their own procedures for each individual center or do they have to get approval from someone else higher up, perhaps in your office, for their procedures?
A You know, ideally, all these would run through Tammy Benbrook. Again, she wasn't in place when any of this, when this procedure policy was dated. So I can't tell you the process this went through.
Q And I'm not asking about this particular one.
Just in general, today, if Booneville wanted to change this policy again -- not policy. I'm sorry.
A It's okay.
Q If it's a procedure, a procedure, would you expect Mr. Gonyea to be able to change it on his own without any approval from your staff or would you expect your staff to have reviewed procedural changes at the facilities?
A I would expect this to get sent through someone in my office.

Q Understood.
A The only difference would, you know, if long-term care comes out and they say, immediately, you need to put this policy in place -- which is why these policy manuals at the HDCs get so large and deviate from each other.
If they come out on site and say we need you to put a policy in place, then that would never come through us. We'd hear about it after the fact.
So that's why you feel my hesitancy. It's like I don't -- I can't say a hundred percent that this stuff gets run anywhere.
Q Yeah. And I'm not trying to trip you up and ask you about this specific one. I'm just trying to get the general -- generally, do you expect a procedure at one of your facilities, by facility I mean human development center, if they want to change a procedure, do you expect them to just handle it themselves or to have someone that is up at your office review it and approve it? It sounded like you said you would normally expect that, but I --
A Yeah. I would assume that. But I don't know, you know.
Q Understanding that -- I'm not asking what happened here. And I do understand that long-term care may dictate. And, if they did, you would be told about it

after the fact; right? Or someone in your office --
A Somebody would.
Q Yeah. Someone in your office; is that right?
A Someone would be told. I don't know who. I don't know.
You're asking me to make some very specific statements about stuff that's very different on a case-by-case basis.
Q Well, I'm just trying to understand how your organization works. And, if a human development center, which you oversee ultimately, wants to change a procedure, how would they go about doing that?
A I think it would depend on what the procedure is. And I -- like I said, there's a lot of factors on how the procedure's being pushed on us or if we're changing it ourselves.
If we're changing it ourselves, then I assume, you know, there's a lot of -- there's discussion and it moves up through Tammy, in some form or fashion.
Q Gotcha. And I know Tammy wasn't there in 2015. Do you know who would have been in the equivalent of her position?
A Before Tammy, it was Forrest Steele.
Q I'm sorry?
A Forrest Steele.

Q Do you know if it's S-t-e-e-l-e?
A It is.
Q Okay.
And this procedure -- what did we mark it as, 6? Is that what it is? Yeah, 6.
This Booneville procedure from 2015, you said you haven't seen it before today?
A It doesn't look familiar. But, I mean, you've seen how many procedures and policies each facility has.
Q Oh, I know. I know. It's quite a bit.
A Yes, it is.
Q I'm going to ask you just a couple of questions about it. Do you want me to ask those questions or do you want to take a minute to read it?
A No, you can ask me.
Q Okay. These guidelines state, that on number two, in all cases in which a serious medical injury or illness is expected either to clients or staff, a call to the medical department should be made. It should be the first call so medical staff can respond immediately to the situation. Do you see that?
A I do.
Q Okay. And it specifies what should be told to medical as far as the caller's name and where the location is and all of those things.

But number -- sub section three of number two says medical will assess the situation and call an ambulance if appropriate. Do you see that?
A I do.
Q Okay. So just on its face, from looking at this policy, would you agree with me that it appears, if there is a serious medical injury or illness, the first call should be to medical, and then medical will make a determination whether to call an ambulance?
A That appears to be what this says.
Q Okay.

MR. GREEN: Can we just take five minutes? And I'll probably have five more minutes.

MR. ROSEN: Yeah.

VIDEOGRAPHER: We are off the record at 12:15 p.m.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

VIDEOGRAPHER: We are back on the record at 12:25 p.m.

BY MR. GREEN:
Q Ms. Weatherton, were you able to understand all the questions that I asked you today?
A I was.

Q Okay. Were you able to hear me clearly?
A I was.
Q Are there any of your answers that you would like to change?
A No.
Q Okay. All right.

CROSS EXAMINATION

BY MR. ROSEN:
Q I do have one question.
A Okay.
Q With regard to Claimant's Exhibit No. 5, which purports to be a newspaper article, if you would take a look at that, and there's a picture on the front of it with a small caption underneath that -- what is that caption? What is that a picture of?
A It's someplace in Lakewood, Washington.
Q It has nothing to do with Booneville Human Development Center, does it?
A No.
Q Okay.

MR. ROSEN: No other questions. Thank you.

MR. GREEN: Let me look at my No. 5. I don't think I --

THE WITNESS: It's right here, if you want

to take mine.

REDIRECT EXAMINATION

BY MR. GREEN:

Q Okay. While the picture has nothing to do with Arkansas, you'd agree the article is in reference to the incident that occurred in Arkansas with Mr. Cains; correct?

A I think part of it. I think -- I don't remember if this is some of the national stuff in here too, but part of it, yes.

Q And, certainly, your quotes that it had related to the incidents in Arkansas, not incidents in other parts of the country; correct?

A Yes.

Q All right.

MR. ROSEN: We'll read.

VIDEOGRAPHER: We're off the record.

(WHEREUPON, the proceedings were concluded in the matter at 12:27 p.m.)

* * * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Melissa Weatherton was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

In accordance with the rules, review of the transcript was requested by the deponent and provided to Mr. Rosen thereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 25th day of January, 2023.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

Disability Rights Arkansas

Dignity. Respect. Advocacy.

Tom Masseau, Executive Director

October 22, 2020

Director
Division of Developmental Disabilities
Arkansas Department of Human Services
700 Main Street
Little Rock, AR 72203-1437

Director

Disability Rights Arkansas (DRA) is the designated federal Protection and Advocacy System ("P&A") for individuals with disabilities in Arkansas. One of DRA's core functions is to investigate the deaths of persons with developmental disabilities in facilities that provide services to people with developmental disabilities. DRA has authority under federal law to thoroughly investigate deaths occurring in any public or private entity that provides care, services, treatment, or habilitation to individuals with disabilities.

As you are aware, resident David Cains of Booneville Human Development Center (BHDC) died on June 13, 2020. His death occurred while three BHDC staff restrained David on the floor outside of the cafeteria. David's family contacted DRA and requested we investigate his death and the circumstances surrounding it.

DRA completed an extensive investigation into David's death. Our investigation involved reviewing the Adult Maltreatment Investigation Report, all witness statements, the DPSQA Complaint Investigation Report, the EMS report, hospital records, and the Coroner's report. Our office interviewed BHDC staff, including , , and , the individuals who restrained David; , the Adult Maltreatment Investigator; , the Superintendent; and the NCI instructor. Our office also interviewed the Emergency Medical Services provider, , who provided emergency services that day, as well as , the Deputy Coroner who was assigned to David's case.

Summary

[redacted]

According to the BHDC Staff written statements and interviews with DRA staff:

EXHIBIT
1

On June 13, 2020, David ate his lunch in the cafeteria at the Commons Building. After finishing his meal, David put his tray away, asked to go to the restroom, and was accompanied to do so by . According to , David seemed irritated, asked to sit in the lobby to calm down after exiting the restroom, and then began screaming, ripping paper off the wall, and attempting to hit .

stated that he, "applied personals[1] by grabbing [David's] arms and ended up falling over."[2] David landed on his face and then rolled him to his side.[3] believes that this restraint began at 11:30 a.m., although all times are estimates as there are not any visible clocks in the area where the restraint occurred, according to all staff interviewed. arrived shortly after David was brought to the ground and assisted in the restraint. According to all written witness statements, David was resisting the restraint at that time. arrived sometime later and began holding David's legs. Within seconds of arriving noticed that David had defecated on himself and she

[redacted]

From EMS Report and BHDC Staff written statements:

[redacted]

This entire event took place on the floor while three people were holding David by his legs, torso, and head. A fact that was omitted in reports to EMS, the hospital, the Coroner, and the family.

During our investigation, we noted several unresolved discrepancies between written statements, subsequent interviews, and investigative conclusions:

1) There is not a consensus between the employees involved regarding the positioning and

---

[1] during his interview, acknowledged that this is a restraint.
[2] OLTC Witness Statement, , Page 2 of 3
[3] Interview of by DRA staff on July 29th.
[4] OLTC Witness Statement Page 1 and 2
[5] OLTC Witness Statement, , Page 2 of 3
[6] OLTC Witness Statement, , LPN
[7] BHDC Policy IV-B-10 states that on-site medical should be the first call and that "medical will assess the situation and call an ambulance if appropriate." All persons interviewed, including Superintendent , interpreted the policy to prohibit non-medical staff from calling 911 in response to a medical emergency and confirmed that as the BHDC practice.
[8] Logan County EMS patient record.
[9] *Id*
[10] *Id*

actions of each employee, information pertinent to identifying not only potential wrongdoing, but also possible missteps to be avoided in the future.

a. written statement and subsequent interview by DRA staff were consistent with one another. She states that when she arrived David was on the ground on his left side, was on his knees facing David and holding his wrists, and David's hands were by his sides. "came to assist to position David's head so he wouldn't spit"[11] and then attempted to assist by holding David's ankles when he began to kick.

b. stated that when she arrived, "David was on his left side with his arms held up with his elbows bent slightly."[12] She states she assisted by holding David's hands so that he could not strike who was positioned behind David. denied ever holding David's head during the restraint.

c. According to written statement he was "squatted over him, not putting [his] weight on him during any of this, holding his shoulder and sides,"[13] assisted by "grabbing his hands," and held his legs down. During our interview, deviated from his written statement, stating "she was on his side behind him, holding his head on the side, keeping close to ground but not pushing on it"[14] because David was trying to bite. He also clarified his positioning as being behind David, who was laying on his left side and "spread out T-style"[15] with his left arm on the ground. was holding his right arm (not) and trying to get it to the ground. David's arms were never above his head.

d. Adult Maltreatment Investigation Report #5-2020, completed by , fails to resolve discrepancies regarding the placement of David's hands and whether a staff member was holding his head in place during the restraint.

e. Cameras at the facility would have been immeasurably helpful in resolving the discrepancies and ultimately understanding the circumstances surrounding David's death.

2) A timeline of events included in two separate documents we received completely omits any reference to a restraint having occurred.

a. The DHS Incident Report includes a timeline of events provided by RN/DON, who does not appear to have been at the scene of the incident at any time.

i. According to the timeline at "11:30 a.m. – Immediately after lunch, David Cains headed to common area kicking, yelling, and biting. and attempted to settle client. Suddenly started vomiting and turning cyanotic."

1. and written statements and interviews with DRA indicate that did not arrive until Mr. Cains was already on the ground and being restrained by , in conflict with the assertion here.
2. There is no evidence of either staff member attempting to "settle" David.

b. A similar statement is included in a "Timeline of Events" that appears to be a word document included in David's medical file. The statement is not attributed to anyone in this document.

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[11] OLTC Witness Statement Form, , Page 1 of 2
[12] OLTC Witness Statement Form, , Page 1 of 4.
[13] OLTC Witness Statement Form, , Page 2 of 3
[14] Interview of by DRA staff on July 29th.
[15] *Id*

When DRA interviewed Emergency Services Worker, , he stated BHDC staff never informed them that David had been in a personal restraint prior to or during this incident. stated that they were told that David was found in the hallway, unconscious, and staff attempted abdominal thrusts prior to CPR. They were told that he had choked on his lunch. EMS relayed the same information to the ER staff at Mercy Hospital in Booneville.

[redacted]

The same misinformation was passed on to the investigating coroner, Deputy Coroner leading him to list the cause of death as respiratory arrest, due to food aspiration, and cardiac arrest. Mr. stated:

[redacted]

When our office interviewed Mr. , he stated he had no knowledge that David was restrained prior to or during this incident. He confirmed that his office would have further investigated had they received that information and would likely have requested an autopsy.

When BHDC staff contacted David's mother, they told her that David choked on his lunch and that the family would need to contact the hospital for any additional information. When the family called Mercy Hospital, they were informed David was deceased. David's family did not find out about the personal restraint until June 22nd – nine days after David passed away and three days after David's funeral. By the time the family learned of the circumstances surrounding his death it was too late for them to request an autopsy.

This was a tragic event. Any time an individual passes away while in the custody and care of the state a meaningful, critical evaluation of the policies and practices that led to that incident should be required. In this case, that evaluation included: (1) an investigation by an individual who is employed by the BHDC, working alongside those who she is charged to investigate; (2) a review and endorsement of that investigation by the superintendent who hired or who is ultimately responsible for the actions of those employees investigated; (3) the suppression or omission of relevant, if not crucial facts from agencies who would further investigate the circumstances of this gentleman's death.

The BHDC review of this death, endorsed by Superintendent , concluded that no individual involved in this incident did anything wrong; therefore, nothing could have been done differently to prevent it and nothing can be learned from it. To date, we have not been informed whether BHDC has reviewed or revised their restraint policies or practices following this event.

At some time after the internal investigation concluded the Division of Provider Services and Quality

[16] Logan County Coroner Report.
[17] *Id*

Assurance (DPSQA) investigated David's death and the circumstances surrounding it. Very little information could be gleaned from the DPSQA Complaint Investigation Report reviewed by DRA. Despite the ability to attach narratives of staff interviews, none were found or made available upon our request. Ultimately, the DPSQA investigation concluded similarly to the internal investigation conducted by BHDC with no description of the events or statements from witnesses.

Practice of Restraints at BHDC

In 2012, DDS retained H&W Independent Solutions, who are self-described "skilled trainers and workshop facilitators on a wide range of topics pertinent to organizations supporting people with disabilities." In April of 2012, BHDC participated in a training survey with H&W to evaluate and improve the quality of care to the residents. During the evaluation of BHDC, H&W found that significant improvement was needed due to, in part, the BHDC staff's reliance on emergency restraint.

Nearly four years later, in January 2016, our office issued a report regarding the use of restraint at BHDC. We warned that risks associated with restraint include physical injuries, significant trauma, and death. We pointed out that the overuse of restraint could cause physical and emotional trauma to both the residents and the staff at BHDC. We recommended that BHDC retain an independent expert to implement evidence-based alternatives aimed to reduce or eliminate the use of restraint at BHDC.

NCI/CPI trains staff to respond to crisis by intervening in non-violent ways to prevent escalation and offers programs to certify staff in this skill. At the same time BHDC certifies its staff in the use of NCI/CPI, BHDC also trains its staff to restrain residents using methods that require no certification, are not evidence-based, and, when practiced, conflict with NCI/CPI training. It is concerning that BHDC staff are then left to choose between non-violent crisis intervention and physically/emotionally traumatizing physical restraint.

Findings

- [redacted]
- Instead of releasing David when he was lying down on the floor, David was restrained on the hard floor by three BHDC staff after finishing his lunch.
- Prior to the restraint, Staff failed to use other less intrusive interventions such as NCI/CPI, for which they are trained.
- Staff failed to leave him on the floor, unrestrained, until he was calm.
- [redacted]
- This restraint likely either directly or indirectly led to David's death.
- The facility failed to properly communicate the circumstances of this incident to EMS.
- We found no evidence that the facility properly communicated the circumstances of this incident to the Arkansas State Police, the Logan County Sheriff's Office, or any other law enforcement agency

- BHDC's investigation failed to resolve discrepancies in statements from witnesses.
- It is not the policy or practice of BHDC to permit direct care staff to call 911 in an emergency.
- NCI/CPI does not endorse or instruct any maneuver that involves physically restraining an individual on the floor.
- During interviews, BHDC direct care staff reported that they, "take people to the floor often."
- BHDC could not articulate what kind of "restraint technique" is being taught to staff.
- The conclusion from Superintendent failed to find that anyone violated any policy or procedure and inexplicably failed to find that any policy or procedure might need review or modification.
- No corrective actions were made or recommended by BHDC or DHS - Division of Provider Services and Quality Assurance.
- BHDC failed to adequately inform David's family of the circumstances surrounding his death.

Recommendations

1. ***Install video cameras on campus***. Video cameras on campus would greatly assist investigators in determining whether maltreatment has occurred. Presently, we have differing statements from individuals regarding a restraint on the floor that led to an individual's death.
2. ***Retrain all staff in NCI/CPI.*** NCI/CPI does not endorse the use of restraint while an individual is lying down on the floor. The very fact that NCI/CPI is touted as the intervention strategy implemented by BHDC, and yet this individual was restrained on the floor long enough to aspirate and die means that NCI/CPI was either ignored or forgotten.
3. ***Reevaluate the use of restraint in all forms and employ evidence-based, nonviolent methods of crisis intervention.*** A greater problem that exists is the overall reliance on restraint at BHDC. It is a culture of compliance that we see often in prisons. When individuals are not compliant, they are made to comply. If DHS does not address restraint and physical, mechanical, and chemical intervention as a system-wide problem, the culture cannot be meaningfully changed. Further, the physical restraints BHDC employs are not based on any professional training or sanctioned method.
4. ***Clarify or Modify policy to permit staff to contact 911 in response to emergency medical situations.*** Staff must have permission to identify and respond in an emergency. BHDC is a large campus in a rural area of the state. While it is comforting that nursing staff is available to respond to medical issues, the current policy forces staff to ignore what many first aid/CPR certification programs insist is the first step in responding to a crisis – calling 911.
5. ***Engage qualified, independent investigators to complete thorough, meaningful investigations on ALL deaths.***

a. *Utilize investigators that are completely independent of the Human Development Centers they investigate.* While it is important that BHDC review incidents internally for quality improvement and staff oversight, there must be a truly independent investigation by a disinterested third party. At one time, DDS employed an attorney whose role was to investigate deaths at any HDC. We are unaware whether or why such a position no longer exists. Anyone DDS authorizes to investigate serious incidents should have no connection to the Human Development Centers they investigate. Investigators should be informed regarding the requesting of an autopsy and empowered to make such a request when warranted.

b. *Ensure all investigations are reflective of the gravity of the circumstances investigated.* Death investigations must be both thorough and critical. Investigations that lack specificity in their investigative processes and findings, do not include interviews of all involved parties, and by design can only substantiate maltreatment or declare nothing could have been done differently undermine confidence in the process. When a family is left to gradually learn new information regarding the death of their loved one, including that the coroner was not accurately informed of the circumstances surrounding the death, what else are they to be left with other than suspicion and anger? Instead, the trauma surrounding the death is amplified and revisited with each new fact they learn. That is not closure; that is not justice.

DRA requests a response, delivered electronically, to this letter by October 31, 2020.

Sincerely,

Kris Stewart, Advocate
Disability Rights Arkansas

Reagan Stanford, Attorney
Disability Rights Arkansas

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Developmental Disabilities Services
P.O. Box 1437, Slot N501, Little Rock, AR 72203-1437
P: 501.682.8665 F: 501.682.8380 TDD: 501.682.1332

November 13, 2020

Mr. Tom Masseau
Executive Director
Disability Rights Arkansas
400 West Capitol Avenue, #1200
Little Rock, AR 72201

Mr. Masseau,

I'm writing to formally respond to an investigation conducted by Disability Rights Arkansas that you provided me on October 23, 2020. As I stated in my initial email response that day, I do appreciate you sending the report and including additional recommendations that can be applied across all five Human Development Centers. I also appreciate your involvement with the Behavioral Consultation Committee and your attendance at the meeting held on November 5, 2020. I also appreciate the feedback you provided me yesterday ensuring that all recommendations were included in the subcommittee projects.

I reviewed your investigation surrounding the death and then went back and read through the internal reports, witness statements, hospital records, and his social and medical history. When a death occurs, the records not only detail the death but you also get to read about the person. He had lived at Booneville for thirteen years. He liked the Dukes of Hazard. He liked listening to music by the Monkeys. He didn't like to be alone. He had a mother and a sister and I am sorry for their loss.

This response isn't intended to argue with your report or point out discrepancies. I agree with you that people with disabilities, whether they live at a facility or out in the community, deserve the best possible care. I agree that we need to renew our effort to actively reduce restraints. I am committed, with your help and other members of the Behavioral Consultation Committee, to change the culture and significantly reduce restraint usage. Below I have included the four focus areas for the subcommittees that we will tackle over the next several months. I think we can bring about real change.

Behavioral Consultation Committee Subcommittee Project Plans

Data-Informed Practices

Co-Chairs: Dr. Julie Howard and Dr. Jeremy Thompson

Goal: Develop a project plan, timeline and recommendations for the collection and use of data to inform restraint practices, as well as, consistent and effective use of the data to reduce restraint usage

Action #1: Review and update how we report, categorize and define restraints

Action #2: Review current metrics and methods used for tracking personal, mechanical and chemical restraints, as well as entire episodes involving individual clients.



Action #3: Update how incidents involving restraints are tracked on the HDC Statistical Report. Improve the report's restraint tracking methodologies and terminology.

Action #4: Develop a template for collecting, reviewing and utilizing data that will be utilized throughout the strategic process.

DRA Recommendation and Action #5: Ensure that the use of restraint is regularly monitored, including careful evaluation and scrutiny of the reasons staff utilized restraint, alternatives to restraint, and follow-up actions in response to restraint. This includes requiring that clinical and senior administrative staff be more involved in the day-to-day activities of residents to ensure that individualized treatment or behavior plans are effective, and that adequate active treatment is provided. A process for this oversight should be included in the project plan.

Preferred Restraint and Communication Options while working to reduce restraint usage

Chair: Shannon Roberts

Goal: Develop a project plan, timeline and recommendations for implementing the best devices, including communication devices.

Action #1: Review current mechanical restraint devices used at each human development center.

Action #2: Research and recommend improved devices.

Action #3: Develop action plan for phasing out obsolete devices while implementing improved, standardized devices.

DRA Recommendation and Action #4: Ban the use of the papoose board as a form of restraint at the HDCs.

Restraint Reduction Methods

Chair: Dr. Carl Reddig

Goal: Develop a project plan, timeline and recommendations for reducing the use of restraints. *will need incorporate items from Dr. Howard and Dr. Thompson's project plan.

Action #1: Identify and recommend alternative tools and intervention methods for reducing restraint use.

Action #2: Review client behavioral support plans and identify minimal language required to allow restraint usage as a last resort.

Action #3: Develop an action plan for reviewing and modifying all client behavioral support plans. Ensuring specific restraint language is removed, all support plans have all intervention methods, and support plan templates do not revert back to having specific restraint language.

DRA Recommendations and Action #4: evaluate mental health and other treatment service for clients at each HDC and make recommendations on needed services.

External Advocate Recommendations

Chair: Tom Masseau, Disabilities Rights Arkansas

Goal: Develop a project plan and timeline for implementing recommendations made by Disabilities Rights Arkansas not included in the project plans listed above.

Action #1: Research the use of independent experts with expertise in working with facilities to develop and implement current evidence-based best practices to significantly reduce and/or eliminate the use of restraint at the facility. Outline appropriate options that includes how an expert would be utilized.

Action #2: Research the best comprehensive training on person-centered and trauma-informed, recovery-oriented, evidence-based services and supports. Outline recommendations on who should be trained, including frequency.

Action #3: Develop a plan to increase the frequency of NCI/CPI training with all staff, while incorporating, where appropriate, the comprehensive training recommended in Action #2.

Action #4: Clarify or Modify policy to permit staff to contact 911 in response to emergency medical situations. Staff must have permission to identify and respond in an emergency.

Action #5: Research the use of independent investigators to complete investigations on all deaths.

Thank you for agreeing to lead the External Recommendations Team. You and I may not always agree but I know that we both want people with disabilities to be safe and respected and live their best possible life.

Sincerely,

Melissa Stone, Director
Division of Developmental Disabilities Services
Department of Human Services

April 2022

DDS Behavioral Consultation Committee Report Summary

EXHIBIT 3
PENGAD 800-631-6989

Overview

The Arkansas Department of Human Services (DHS) Division of Developmental Disabilities Services (DDS) set out in the fall of 2020 to conduct a thorough review of the restraint practices at the state's five human development centers (HDC) and develop a comprehensive approach with the help of clinicians and advocates to significantly reduce the use of restraints on developmental and intellectually disabled clients living at the HDCs.

This report outlines what is done today and recommendations made by the DDS Behavioral Consultation Committee, which was tasked with reviewing restraint usage and implementing new strategies to reduce the frequency of using restraints to ensure the safety of clients and nearby individuals, including staff.

Objectives

1. Develop a plan to better use data to inform restraint-related practices and to ensure the State has accurate and comprehensive restraint data.

2. Identify preferred restraint and communication options to be used while working to reduce restraints.

3. Develop a comprehensive approach to reducing restraint usage.

4. Seek and implement additional recommendations from external advocates.

Reporting and data collection

Today, each HDC collects restraint data, and the Developmental Disabilities Services Board reviews it regularly. The long-standing Behavioral Consultation Committee provides a clinical review of restraints. This review became even more important during the public health emergency because we wanted to monitor for increased usage due to the stress of the pandemic, which we did not find.

Restraint practices

Today, all five human development centers use restraints to ensure the **safety** of clients and staff when a client experiences an unsafe behavioral issue. The types of restraints differ depending on the facility and client needs, but can include personal holds, mechanical restraints (such as the blanket wrap), chemical restraints, and less common a papoose board. All staff are trained to de-escalate situations involving unsafe behavioral issues with the goal of not needing a restraint. However, reviews of restraints, client files, and data show that restraints are sometimes included in a client's behavioral plan and are used quickly during an unsafe situation rather than as the last resort. That is something we are working to change.

Existing restraint reduction efforts

DDS leadership has emphasized the need to reduce the number of restraints, and ideally eliminate them altogether. In addition to the ongoing Committee reviews mentioned above, DDS provides crisis intervention and de-escalation training through new employee and ongoing training. In the Fall of 2020, DDS also began requiring all direct care staff to become certified nurse assistants (CNAs), which increases their care skills. The number of restraints have gone down over the last few years, but we believe that with a more intensive focus on restraint usage we can reduce the numbers even more.

External review

Many recommendations outlined in this report summary are listed as "on hold" because DHS is in the process of hiring an independent expert to review restraint-related policies and processes across all five of the human development centers. The review should provide us important information we can use to address the recommendations that are on hold.

RECOMMENDATIONS

Recommendations listed as on hold are pending because DHS is in the process of hiring an independent expert to review restraint-related policies and processes.

Objective 1

Develop a plan to better use data to inform restraint-related practices and to ensure the State has accurate and comprehensive restraint data.

The committee reviewed and discussed current restraint reports and definitions, methods and metrics for tracking restraint usage, and incident tracking.

✓ 1. Select and define common language to be used in reports across all the human development centers:

- Chemical Restraint - the oral, rectal, intramuscular, or subcutaneous administration of a medication to aid the client in calming to ensure the safety of the client and/or others; must be ordered by a physician and administered by a licensed nurse.
- Personal Restraint - the actual physical holding of a client by staff using manual methods that restrict the free movement of the client or restrict movement of or access to a portion or portions of the client's body until the client reaches a state of calm and cooperation, signaling the dangerous behavior has ended and safety no longer is at immediate risk.
- Mechanical Restraint - a device that restricts the free movement of a client or restricts movement of or access to a portion or portions of the client's body until the client reaches a state of calm and cooperation, signaling the dangerous behavior has ended and safety no longer is at immediate risk.

✓ 2. Review and realign current personal restraint policies with new uniform restraint use policy for all HDCs.
✓ 3. Create uniform restraint use policy.
◯ 4. Continue tracking restraints and conducting retrospective analysis.
✓ 5. Create and implement new HDC Quality Assurance Report and HDC Restraint Analysis report for restraint usage at all HDCs.
✓ 6. Amend the existing HDC Statistical Report to combine subcategories and automatically calculate rates.
◯ 7. Review reports to make data-driven decisions related to restraint usage.

✓ Complete ◯ Ongoing/In process ◑ Partially Complete ⊖ Not moving forward with recommendation ▮▮ On hold pending external consultant review

RECOMMENDATIONS

Objective 2

Identify preferred restraint and communication options to be used while working to reduce restraints.

Committee members reviewed existing HDC restraints as well as commercial and customer mechanical restraints on the market. They determined that the commercial restraints are new models of the restraints already used by HDCs. Additionally, members reviewed research and training curriculum related to effective de-escalation communication techniques that can prevent aggressive/harmful behaviors.

↻ 1. Hire an independent consultant to review the types of restraints used at the HDCs and to identify the best restraints to ensure the health, safety, and comfort of clients.

▮▮ 2. Expand communication strategy options for individual clients being restrained, including adding sign language, gestures, timers, visual schedules, etc.

▮▮ 3. Create, implement, and train staff on new manual of available communication strategies and devices for case managers to ensure interdisciplinary teams have access to current, effective practices.

▮▮ 4. Provide supplemental training to all client-facing staff on effective communication strategies.

⊖ 5. During restraints, require staff who are most familiar with client to monitor for safety due to potential limited communication options.

Note: This was highly recommended but is not achievable because familiar staff may not be available.

▮▮ 6. Ban the use of the papoose board.

Note: Recommendations listed as on hold are pending because DHS is in the process of hiring an independent expert to review restraint-related policies and processes.

✓ Complete ↻ Ongoing/In process ◑ Partially Complete ⊖ Not moving forward with recommendation ▮▮ On hold pending external consultant review

RECOMMENDATIONS

Objective 3

Develop a comprehensive approach to reducing restraint usage.

The committee reviewed alternative safety interventions and client behavioral support plans, and identified language that could be used to ensure that restraints were employed as a last resort for safety reasons.

↻ 1. Intensify staff training of positive behavior supports and de-escalation techniques.
↻ 2. Establish routine staff training on individual clients' behavioral health and safety plans.
⊖ 3. Establish a statewide review committee to offer consultation and assistance with clients who are repeatedly restrained.
Note: Human Rights Committee, interdisciplinary teams, and psychiatric teams already review every incident and make recommendations.
▮▮ 4. Identify behavioral health service gaps for individual clients at each HDC, what is needed to address those gaps, and metrics to evaluate mental health and service needs.
▮▮ 5. Establish a group to review all behavioral support plans to ensure removal of restraint-specific language.

Note: Recommendations listed as on hold are pending because DHS is in the process of hiring an independent expert to review restraint-related policies and processes.

✓ Complete ↻ Ongoing/In process ◑ Partially Complete ⊖ Not moving forward with recommendation ▮▮ On hold pending external consultant review

Objective 4

Seek and implement additional recommendations from external advocates.

DDS has worked closely with Disability Rights Arkansas and asked the executive director to provide additional recommendations for changes he thinks the HDCs should implement related to restraint usage.

◑ 1. Hire an independent expert to implement best practices related to restraints at all Arkansas HDCs to significantly reduce or eliminate use of restraints.

✓ 2. Require HDC senior administrative, clinical, and direct care staff to undergo comprehensive training on person-centered and trauma-informed, recovery-informed, evidence-based services and supports. Conway HDC is partnering with Arkansas Building Effective Services for Trauma (ARBEST) within the Department of Psychiatry at UAMS in hosting a conference focusing on trauma-informed care education in August 2021.

↻ 3. Ongoing staff development efforts at each HDC.

✓ 4. Require HDC senior administrative and clinical staff to develop a strategic plan to transform the facility to one that adopts current, best practice philosophy, vision, and values.

↻ 5. Require HDC staff undergo extensive training on de-escalation best practices and ongoing monitoring.

↻ 6. Install video cameras on campus.

Camera status at each HDC:

- Booneville HDC - cameras being purchased, installation plan submitted for approval
- Arkadelphia HDC - cameras in place - planning to upgrade and increase coverage
- Conway HDC - cameras in place - planning to upgrade and increase coverage
- Jonesboro HDC - cameras in place - planning to upgrade and increase coverage
- Southeast Arkansas HDC - cameras in place - planning to upgrade and increase coverage

↻ 7. Retrain all staff on non-violent crisis intervention strategies.

✓ 8. Clarify and reinforce medical emergency policies requiring staff to call on-site medical staff with the option of calling 911, if necessary.

⊖ 9. Engage qualified independent investigators to investigate all deaths.

Note: DHS investigators are trained and certified by Labor Relations Alternatives, Inc.

Note: Recommendations listed as on hold are pending because DHS is in the process of hiring an independent expert to review restraint-related policies and processes.

✓ Complete ↻ Ongoing/In process ◑ Partially Complete ⊖ Not moving forward with recommendation ▮▮ On hold pending external consultant review

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DDS would like to thank each member of the subcommittees for their time and attention on this topic. Your insight and research were helpful and provided a framework for this report and DDS's approach to restraints usage moving forward.

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Reports describe misuse of restraints at 2 state-run homes

Facilities' clients hurt in some cases by Kat Stromquist | September 14, 2020 at 7:15 a.m.

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The Conway Human Development Center is shown in this undated courtesy photo.

Before covid-19 outbreaks threatened two state-run homes for people with disabilities, records show regulators flagged the centers for endangering clients while using physical restraints -- a controversial yet common practice to defuse tense situations.

An ongoing Arkansas Democrat-Gazette review of documents from Conway Human Development Center and Booneville Human Development Center found five cases in which inspectors said facilities violated federal standards when staff members restrained clients, with some cases amounting to abuse.

A client at Booneville suffered a broken arm when a staffer restrained him in July 2019, and another lost consciousness in January that year when a staff member placed him in a "choke hold," inspectors said in reports.

A staff member at Conway threatened to restrain a female client all night if she didn't "shut up," an October report said.

Department of Human Services, police and prosecution reports obtained under the state's public-records law provide a window into facilities entrusted with the welfare of vulnerable Arkansans. They show recurring issues in cases involving both personal and "mechanical" restraints, such as a board with straps called a papoose board.

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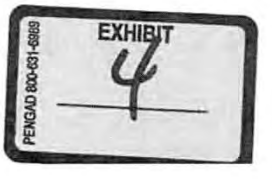

Sometimes, the facilities broke rules meant to limit restraint use in care facilities that receive federal payments from the Medicaid program, inspectors wrote in their reports. At other times, they didn't meet standards meant to protect clients from abuse during events involving restraints.

Division of Developmental Disabilities Services Director Melissa Stone said the events described in the documents were "self-reported" by the centers. She described them as "isolated incidents" that "should be categorized as abuse not a personal restraint gone wrong."

"What happened was not in compliance with our training and we considered the behavior maltreatment of our clients," Stone wrote in an email. "Maltreatment of clients is never OK, and individuals involved in the cases were immediately placed on administrative leave and all were terminated as I understand it."

Four of the five incidents the newspaper reviewed drew inspectors' most serious citation, "immediate jeopardy," which is for events that put clients "at risk for serious injury, serious harm, serious impairment or death."

On Friday -- after the newspaper reached out to the Department of Human Services about its findings -- Stone wrote to the head of an Arkansas disability-rights watchdog describing "additional steps" the state will take to assess restraint usage, including tracking personal restraint and reviewing treatment plans and devices.

About 880 people live in five state-run residential treatment centers for residents with developmental disabilities and, sometimes, other health or mental-health issues. Conway Human Development Center is the largest, with 460 residents.

Like other long-term care settings, the centers have drawn scrutiny this year because of the risk of quick viral spread in group living environments. Conway and Booneville endured the largest outbreaks, with 142 and 89 total resident cases, respectively, Arkansas Department of Health data from Sept. 4 show.

A 66-year-old client of the Southeast Arkansas Human Development Center in Warren died of covid-19 in August, coroner's records show, the facilities' first such death.

Inspectors visiting Conway Human Development Center in June for a review prompted by the pandemic gave the facility good marks for its infection control practices but noted a problem for one client, who was strapped to a papoose board during the visit.

The client was "quietly looking" at a staff member, the inspector wrote. When asked how long the client had been restrained, the employee replied: "Thirty minutes. She still has twenty minutes to go."

That breached federal standards about releasing clients from restraints "as quickly as possible," an inspector wrote. And it ignored internal policy about when residents should be released from restraining devices -- "when calm," the inspector wrote.

Records suggest a pattern of similar infractions that stretches back at least 18 months, including three since 2019 that led to criminal convictions.

Twelve months of state data -- from August 2019 through July -- also shows the five human development centers aren't consistent in their use of restraints, even when considering population sizes.

At Conway, which has a bit more than four times the population of the Jonesboro center, mechanical restraints including a restraint chair, the papoose board and a restraining wrap were used 1,074 times compared to Jonesboro's 92 times, data shows.

An analysis over a different yearlong period provided by the Department of Human Services showed a rate of use at Conway that is nearly five times that of the Arkadelphia center, though others were closer.

Across all five facilities, mechanical restraints were used on residents 148 times in July as the pandemic surged, according to state data: four times at Jonesboro, eight times at Booneville, 12 times at Warren, 14 times at Arkadelphia and 110 times -- or more than three times a day -- at Conway.

Documents and data reviewed by the newspaper weren't comprehensive and did not include documents from each individual use of restraints.

Personal restraints, which involve a staff member's hands or body only, haven't been consistently tracked by the centers, and this review by the newspaper did not extend to "chemical" restraints including antipsychotic and other drugs.

The state watchdog group, Disability Rights Arkansas, noted similar issues with restraints at Booneville in 2015 and 2016, including them in a 23-page report that called for reforms to correct a "culture" of "excessive" restraint.

Its director, Tom Masseau, said in an interview that he thinks the public sometimes doesn't understand what it means when restraints are used at the human development centers, including in cases where residents were injured or otherwise harmed.

"If that happened in your own home, to your kid or your loved one, you would be under investigation. But if it happens to somebody in an institution, we just sweep it under the rug and call it a behavioral issue," he said.

"We really haven't gotten down to the bones of, why do we allow this to continue?"

Witnesses to the July 2019 incident at Booneville told an inspector that they'd seen a resident with an intellectual disability and schizophrenia begin hitting a staff member. The staff member allegedly responded by twisting the resident's arm behind his back in an "emergency personal restraint."

"You're not gonna hit me. I'll [expletive] your world up," the staff member reportedly told the resident. Witnesses heard a "crack" or a "pop," they said.

An X-ray later showed the resident's arm was broken.

REDUCING USE

Restraints are permitted in many care settings, including intermediate care facilities such as the human development centers, but experts and advocates have questioned their continued use, citing the danger of injury, inconsistent data collection and scant evidence of their therapeutic usefulness.

As early as 2003, a federal mental health agency issued a "call to action" to reduce the use of restraints and seclusion. (The latter practice of isolation isn't allowed at intermediate care facilities, a Centers for Medicare and Medicaid Services spokesman said.)

A government report from that same year says both restraint and seclusion carry "risk for serious injury or death, re-traumatizing people who have a history of trauma, loss of dignity, and other psychological harm" and should only be used as a "last resort."

Current Centers for Medicare and Medicaid Services guidelines say intermediate care facilities must develop policies around restraint use and provide "active treatment" to "reduce dependency" on the tools, as well as on "unnecessary drugs" to manage clients' behavior. They also must make sure their use of restraints doesn't violate mandates to keep residents safe from abuse and neglect.

Some states have enacted more stringent standards than the federal guidelines on restraint use. Arkansas has not.

Stone said the state has a plan, updated annually, to reduce restraint use, and provided each facility's restraint policy to the newspaper. Restraints at the human development centers are "not used therapeutically," but in "emergency" situations where clients may harm themselves or others, she said.

She added that staffs are trained in deescalation techniques and that a committee was created in 2017 in response to reports of excessive restraint usage at Booneville. Led by a psychologist, the group conducts a quarterly review of restraint data, she said.

"In general, it is a small group of the same clients who are restrained," she wrote in an email, noting that some clients have "complex behavioral and mental health issues."

Nationwide, restraint remains "ingrained in the environment" at many sites, said Deborah M. Kennedy, a vice president and head of the abuse investigation unit at Chicago-based disability advocacy group Equip for Equality. She added that initiatives to reduce its use often incur pushback, sometimes out of care workers' fear of losing a tool in the "toolbox."

"Provider settings don't take the time and the effort that needs to be undertaken to make that switch in the culture of the institution," she said, which moves "staff away from looking at individuals in terms of 'You are trouble, you are a problem,' to 'How can I help you?'"

Ellen Blair, a clinician who studied methods of reducing restraint use in psychiatric care settings, said the goal in almost any setting should be to curtail restraint use as much as possible. People who have been restrained often describe it as psychologically traumatic, she said.

When restraints are used, facilities should "drill down" on what happened and conduct a formal debriefing with staff members, clinicians and others, including incorporating feedback from the person who was restrained, she said.

"I think we all have to strive for zero, and treat every [use of restraints] as a very important incident," said Blair, the director of nursing at Hartford HealthCare Institute of Living in Connecticut.

CRIMINAL CONVICTIONS

Since the beginning of 2019, records show restraint use was involved in three incidents that led to criminal convictions for staff members of the Booneville and Conway centers. Three people were sentenced to probation, and at least two were fined.

That included the episode that broke a resident's arm at Booneville. The staff member later pleaded guilty to second-degree felony battery.

Roughly six months earlier, a Booneville resident lost consciousness when a staff member placed the client with an intellectual disability and schizophrenia in a "choke hold," according to a report. Red marks were visible on the client's neck and shoulders.

In a separate incident at Conway last September, an inspector wrote that video showed a staff member "kicks [Client No. 1] in the back then continues dragging the client, on his back, by his arm and shirt, on the floor backwards," before strapping the client to a papoose board, a report said.

Another staff member who was present at the time didn't move to intervene. Neither of the two present appeared to follow protocols outlined in the client's "safety plan" when he became agitated, a report said.

"To aid calming ask [the client] to take deep breaths and 'Breathe like Luther'. Luther is a horse he used to ride," that plan said.

In addition to prosecutions of staff members involved, the Conway and Booneville centers responded to those and other incidents by taking several measures outlined in written plans, including retraining, checking other clients for harm and monitoring other staff members.

All the incidents discussed in this report were documented through a complaint process. But two of the three that led to criminal convictions may not otherwise have appeared in state data because a mechanical restraint was not used.

Stone, the Division of Developmental Disabilities Services chief, said the agency will work to establish new tracking and metrics for personal restraint use. Those "should be" tracked, she wrote in an email.

"We believe that tracking personal restraint usage, and tracking when that usage leads to a mechanical restraint will be helpful to provide us an overall picture of restraint episodes," she said in her Friday letter to Masseau.

The Chicago investigator, Kennedy, said facilities that don't document those types of restraints "don't have any control" over how they're used. A physical hold "can be as dangerous" as a mechanical restraint, she said.

Documents on restraint use also demonstrate the stakes when advocates and family can't visit people in long-term care facilities, as was true earlier in the pandemic.

Some limited visits to the human development centers have resumed. Experts in long-term care say contact with family members plays an important role in safeguarding residents.

Limited interaction with the public is part of a problem with institutional care more broadly, said Serena Lowe, interim executive director of Washington, D.C.-based TASH, a disability-rights advocacy group.

Clients who live in institutions are "really in a very segregated existence. That's where abuse happens, when nobody's looking," she said.

Information for this article was contributed by Eric Besson of the Arkansas Democrat-Gazette.

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Files: Site's resident died after restrained

June case preceded state's decision to review use of controls at care centers *by Kat Stromquist | January 31, 2021 at 4:42 a.m.*

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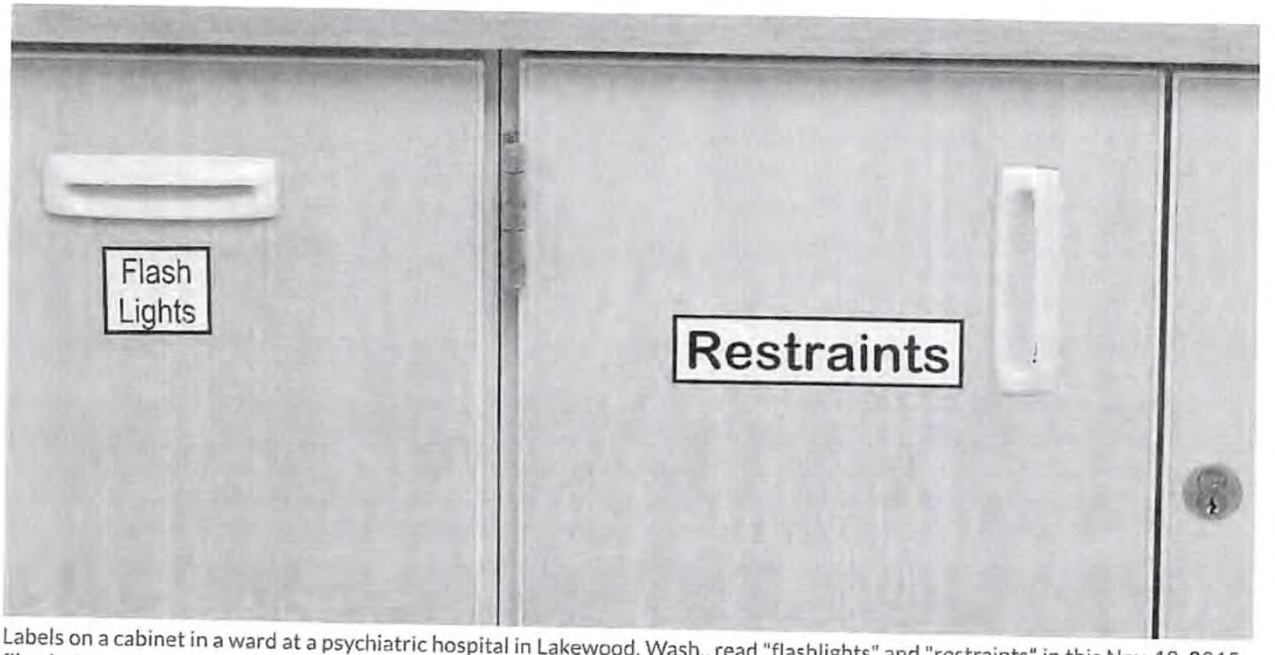

Labels on a cabinet in a ward at a psychiatric hospital in Lakewood, Wash., read "flashlights" and "restraints" in this Nov. 18, 2015, file photo.

A man who lived at an Arkansas-run center for people with developmental disabilities died last summer after three staff members restrained him, just a few months before state officials pledged to review physical restraint use at the sites.



The resident died June 13 after having a medical emergency while restrained by Booneville Human Development Center staff members, according to documents that the newspaper obtained under Arkansas' public records law.

He'd been "brought to the ground" as workers grabbed his arms and then "began holding" his legs, a report from a watchdog group to state officials said. The staff noticed he wasn't breathing "approximately

one minute" after he was restrained.

The man, 42, died at a hospital about an hour after the restraint incident began, files show.

His death, not revealed in news reports until now, provides new context for the state's Division of Developmental Disabilities Services' promise in September to review the use of physical restraints and restraint devices in its five human development centers. The devices include padded boards, restraining chairs and wrist wraps.

Committees at work on the policies are scheduled to meet again Feb. 11. Thus far, the state plans to bring in a consultant to observe and interview staff members, begin more robust data tracking, add camera coverage across the facilities and take other steps, the division's director Melissa Stone said in an interview.

Stone stopped short of saying the death was a "trigger" for the review, while explaining that she did not want to downplay the event. The state was influenced by a restraint data assessment that officials undertook during pandemic lockdowns to see if the isolation affected residents.

"Those numbers were high," she said. "We need to reengage ourselves in this."

The review was made public last fall as the Arkansas Democrat-Gazette reported on an apparent pattern of harmful restraint use at two of five centers housing hundreds of people with intellectual and other disabilities. Among them were incidents at the Booneville site in 2019 that broke one resident's arm and caused another to faint when he was placed in a "choke hold," records show.

Records detailing the 42-year-old man's death last summer raise fresh questions about how Arkansas investigates restraint incidents that hurt people in the care centers. Some of those people cannot speak or walk, and many don't have family members who visit or advocate for them, current and former employees say.

In an Oct. 22 report sent to Stone, a Disability Rights Arkansas attorney and advocate described the man's death and offered what amounted to a scathing critique of the state's response. The group is a federally-designated monitor and advocate for people with disabilities.

Writing from medical records, interviews and state files, the seven-page report alleges that first responders and a physician weren't informed that the man was physically restrained, and were instead told that he "was found in the hallway" and had "choked on his lunch" before he was pronounced dead at Mercy Hospital-Booneville.

The man's mother did not learn that he was restrained by the staff until nine days after his death -- "too late for them to request an autopsy," the report said.

Stone responded to the Disability Rights Arkansas report on Nov. 13 with a three-page written proposal to form new committees to "inform restraint practices" used for human development center clients. Her response "isn't intended to argue with your report or point out discrepancies," she wrote to advocates.

In an interview this month, she said cameras in the facility -- the Booneville site had none -- would have helped make the situation "black and white" to her.

"It's very clear that a personal restraint did occur leading up to him passing away -- but I've looked at every document, I've looked at [Disability Rights Arkansas]'s report, I've looked at hospital reports. ... I've not been given any kind of documentation that says the personal restraint did, or did not, lead to the passing of that client," she said.

Disability Rights Arkansas director Tom Masseau wrote in an Oct. 23 email to Stone that the state's initial probe, which did not lead to any findings of wrongdoing by the staff, was "unacceptable." The man's death was a "tragedy that arose from a dangerous and barbaric practice and never should have occurred," he wrote.

State employees who first looked into the death were not asking "the tough questions. ... Your reports are only as good as the person conducting the investigation," he later told the newspaper.

"You want to know what events led to [a death], and what could be done to prevent it."

FOR 'SAFETY'

An ongoing investigation by the newspaper has shed light on problems at the state-run human development center sites, as well as restraint issues. Records show:

- Staff members didn't wear masks or quarantine sick residents in facilities with covid-19 outbreaks.
- Residents with the eating disorder called pica swallowed batteries and latex gloves.
- An "unsupervised" resident, prescribed a "pureed" diet, died after choking on cake.

More than 800 people live at the centers. Many have behavioral health or other health issues in addition to developmental disabilities, and facility workers say it's not unusual for clients to remain in the centers for years.

Generally, the care system for Arkansans with disabilities appears "woefully behind" other states, University of Minnesota Institute on Community Integration Director Amy Hewitt has said. She said many other states have entirely phased out their large institutions that offer "less choice and autonomy and self-determination."

The newspaper has identified the man who died after being restrained last summer, but is not naming him in this article because a family member declined to comment on the record about the incident. An attorney for the family also declined to comment.

After lunch the day he died, the man "headed to the common area kicking, yelling and biting," according to a Sept. 24 report from a state Department of Human Services committee that reviews all deaths of human

development center residents. Three staff members restrained him for "safety," so he was "lying on the floor on [redacted] left side," the report said.

He suddenly started throwing up "and turning cyanotic," meaning his skin became blueish from lack of oxygen, documents show.

A report describes the man's transport via ambulance to the small hospital where he died. Committee members wrote at the time of their report that his official cause of death was "currently unknown," and determined that the "standard of care" was met by the staff.

The man's obituary describes him as a 13-year resident of the Booneville Human Development Center. He loved singing to the Monkees band, taking trips to Walmart and KFC, and participating in the Special Olympics. He graduated from a Pope County high school.

A Logan County deputy coroner listed the man's cause of death as "respiratory arrest" because of "food aspiration, cardiac arrest" in a June 13 report.

The man "was eating lunch at the Booneville Human Development Center where he lived, when some food became lodged in his throat. The Human Development Center staff tried to dislodge what was stuck but were unable to," a narrative portion of the coroner's report reads.

The coroner's report does not mention restraints.

CHANGES WEIGHED

No staff members were disciplined or terminated in the June incident because "there was no finding of inappropriate use of a personal hold/restraint" and life-saving measures were implemented, Stone said in a written statement last week.

She said she cannot "speak to or verify" what information was provided to first responders, but social services staff members who first notified the man's family have "limited information" about incidents, which could have happened just moments before.

Potential changes in investigative practices in the centers are on the table as part of the policy review.

Their eventual goal, state officials say, is to eliminate restraint use at the centers. Interim plans include modernizing outdated cameras at four centers and installing cameras at the Booneville facility for the first time, in part to deter "bad actors," Stone said.

"You can train people all day long, but you can't train people to be kind, and you can't train them to be respectful," she told a reporter. The staff should "understand that you can't hurt these people, because they can't defend themselves."

The overhaul also is likely to remove mentions of restraints as strategies in individual care plans and further train the staff to lessen reliance on restraints as a behavioral tool.

Masseau, the advocate, has worked closely with the state on the changes and said he felt encouraged by the direction of the review. One likely change will allow human development center staffs to call 911 in medical emergencies without seeking approval from administrators, shaving off crucial moments of response time.

He said "follow through" will be most important.

"There has to be a huge cultural shift," he said. "If there is buy-in from the [administrators], but it doesn't get down to staff, it's not going to do any good."

TRIED BEFORE

This is not the first time Arkansas has tried to change restraint usage in its human development centers. A plan aiming to reduce restraints is updated annually, Stone said in September.

In 2016, Disability Rights Arkansas published a report claiming "excessive" restraint use at the Booneville Human Development Center, which advocates said put residents and the staff at risk. Residents "sustained injuries ranging from scrapes and scratches to large, multiple bruises and even broken bones," the group wrote at the time.

Later that year, the state announced further training on restraint usage for staffs and banned the use of an isolation room at the Booneville facility, according to previous reports. An outside consultant also worked on that review, but did not make site visits or speak in depth with the staff, as is planned this year, Stone said.

The state's latest moves to change its practices arise as restraint use in care settings draws attention nationwide. Michigan health regulators announced a ban of several types of restraints in July after a Black teenager had a heart attack while being restrained at a Kalamazoo care center and died, reports said.

Guy Stephens, director of the Maryland-based group Alliance Against Seclusion and Restraint, says restraint use is a civil rights issue that's most likely to impact people with disabilities and people of color.

Research shows that being restrained can make behavior problems worse, he says, by triggering brain activity and trauma that make people more likely to lash out in the future.

More often than not, he added, the interventions are not being used "for life-or-death danger, but rather for situations of noncompliance, disrespect."

In July 2018, Arkansas inspectors cited the Arkadelphia facility when staff members placed two residents in restraints for "staff convenience" when the residents refused to go to work.

They were then "forcibly" taken to a job site, an Office of Long Term Care inspection report said.



Melissa Stone, director of the Division of Developmental Disabilities services at DHS, speaks Thursday August 27, 2020 in Little Rock during a press conference at the state Capitol to announce that DHS is moving 700 families off the wait list for disabilities services. (Arkansas Democrat-Gazette/Staton Breidenthal)



In this file photo Disability Rights Arkansas director Tom Masseau, right, speaks during the Youth Justice Reform Board meeting in downtown Little Rock. At left is fellow board member Paul Kelly. (Arkansas Democrat-Gazette file photo)

Restraint events end in injuries

These are four harmful restraint incidents at Arkansas Human Development Centers of at least 10 identified by the newspaper since 2018. Inspectors said each incident could have physically or emotionally harmed residents



1. Resident's arm fractured after being twisted behind back by staff member in "inappropriate personal restraint hold." 07/31/19

2. Resident with brittle bone disease breaks arm after being "unnecessarily restrained" by staff member. 11/05/19

3. Staff member kicks resident, drags him down a hallway and straps him to restraining board. 09/12/19

4. Staff member holds a resident's wrist and arm in place to restrict him from getting off a treadmill, causing him to fall and injure his knees. 08/17/18

NOTE: Dates are report dates, not incident dates. Arkansas Democrat-Gazette
SOURCE: Department of Human Services inspection reports.

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FIRST AID GUIDELINES

POLICY STATEMENT: First Aid Guidelines are available for use in each of the Aide Stations in each living area. This will permit appropriate and immediate attention to medical conditions of sudden onset, including injuries and choking.

PROCEDURES:

1. The First Aid Guidelines have been approved by the staff physician for the Booneville HDC.

2. In all cases in which a serious medical injury or illness is suspected, either to clients or staff, a call to the Medical Department should be made. This should be the first call so Medical staff can respond immediately to the situation.

   A call to Medical at 1422 should be made and the following information should be given:

   1. Caller's name and title
   2. Victim's name, location, situation and condition of the victim (alert, unconscious, etc.)
   3. Medical will assess the situation and call an ambulance if appropriate.

3. All staff members are trained in first aid, CPR, and abdominal thrust for choking so, that if necessary, emergency rescue measures can be initiated before Medical staff arrives.

4. Choking is a serious and potentially life-threatening situation and the following guidelines should be followed:

   a. Staff will supervise clients during meal times and nursing staff will be available by phone at all times;
   b. emergency equipment including oxygen and suction machine will be kept in the dining room for use as needed;
   c. All staff will receive annual training in abdominal thrust and choking precautions.

5. First Aid kits, disaster kits, and first aid guidelines will be kept in all areas. Medical will do monthly inspections on first aid kits, and every 6 month inspections on disaster kits, and refill appropriately. If living area staff notice supplies are low, Medical is to be notified and supplies will be replenished.

APPROVED: _____ Superintendent

Supersedes BHDC Policy IV-B-10, dated 03/13/15, in its entirety.



REVIEWED: 11/27/19
VERSION: 12/29/17

CLIENT RIGHTS

1. The right to due process
2. The right to be fully informed of their rights, responsibilities, and any rules they are expected to follow.
3. The right to be fully informed of services available in the facility and of related charges for those services.
4. The right to be fully informed by a physician of their health and medical condition unless the physician documents in their medical record that such information is contraindicated.
5. The right to receive rehabilitative and restorative therapies when needed.
6. The right to refuse treatment.
7. The right to refuse to participate in experimental research.
8. The right to receive medical care, nursing care, and dental care in a safe and clean environment.
9. The right to participate in planning their total care and treatment to the level of their capabilities.
10. The Right to exercise all constitutional and legal rights, including the right to vote and to marry.
11. The right to voice grievances and recommend changes in policies and services.
12. The right to express individual preferences.
13. The right to confidentiality
14. The right to privacy during treatment and care of personal needs.
15. The right to associate, communicate, and meet privately with persons of their choice in an appropriate place and manner
16. The right to be free from mental and physical abuse, and threats of punishment or deprivation.
17. The right to be free from chemical and physical restraints, except when properly authorized for a specific behavior and limited period of time or to protect them from injury to themselves or others.
18. The right to the protection of a qualified guardian if needed for their personal well-being and interest.
19. The right to considerate and respectful treatment.
20. The rights to obtain, retain, and have access to their personal clothing, possessions, and toilet items as space permits.
21. The right to have access to their personal money and to direct the management of their financial resources.
22. The right to productive work or other meaningful activities.
23. The right to a pattern of daily living which follows a normal rhythm of life and which reflects personal choice.
24. The right to participate in activities of social, religious, and community groups of their choice.
25. The right to refuse to participate in activities.
26. The right to be free from retaliation for making a complaint, turning in abuse or maltreatment for investigation, or for filing an appeal.



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11/27/19
12/29/17

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An Investigation into the Physiological and Psychological Impact of Supine and Side Lying Physical Restraint Techniques

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Abstract

This research investigated the physiological and psychological impact of supine and side lying physical restraint (PR) positions which have been suggested as safer alternatives to prone restraint positions. Twenty adults participated. From baseline Forced Vital Capacity (FVC) reduced by 10.4%, 10.4% and 14.6%, and FEV1 reduced by 7%, 7%, and 12% for supine arms low (SPR-AL), supine arms high (SPR-AH), and Side Lying restraint (SLR) respectively. SLR imposed the greatest Thoracic Weight bearing Pressure (TWP) at 116.1 (±17.5) mmHg, which was ~17% more than SPR-AH, and ~23% more than SPR-AL. HR was unaffected. Comfort was perceived to be greatest for SPR-AL, with SPR-AH being 6.7% less comfortable and SLR being 45% less comfortable. Anxiety was greatest in SLR, with SPR-HL and SPR-AL being 36.5% and 48.1% less anxiety inducing respectively. Breathing limitation was greatest in SLR, with SPR-AH and SPR-AL being 44.4% and 46.3% less limiting respectively. Compared to baseline all three restraint positions reduced respiratory measures ($p = 0.001$), with SPR-AL and SPR-AH being similar but differing from SLR ($p = 0.001$), and resulted in perceptions of discomfort, anxiety, and breathing limitation, with SLR being the most negatively impactful position tested. These findings are in keeping with our previous research which showed variance in the physiological and psychological impact of different restraint positions. All restraint positions possess the ability to negatively impact an individual both physiologically and psychologically but that impact is not homogenous, with some positions clearly possessing a lower level of risk than others.

Keywords: Physical Restraint; Supine; Side Lying; Physiology; Psychology

Introduction

This research will be of interest to those who work in, commission or regulate settings where staff are trained to use restrictive physical interventions (manual restraint). Physical Restraint (PR) is a manual, hands-on method of containing or immobilising individuals by limiting their freedom to move to prevent or reduce their ability to harm themselves or others [1,2]. PR remains contentious, not only because of the potential breaches in human rights if misused or abused, but also due to its ability to cause anatomical, physiological and psychological harm including death [3].

The Human Rights Act 1998 [4] created legal obligations for the protection of rights and applies to all public authorities, determining the legal duties of staff to respect and protect everyone's human rights. As such the use of restraint must be lawful and rights-respecting. Article 2 requires *'all reasonable steps to be taken to protect a person's right to life'* and therefore can include intervening with PR to protect a person from harming themselves or others; as well as stopping the use of PR if it is likely to result in harm. Article 3 prohibits *'torture, and inhuman and degrading treatment or punishment'* which may include different types of assault on human dignity and physical integrity, including acts of unjustified suffering and acts which inflict sufficient severity of pain especially if undertaken deliberately. Therefore, the use of any PR must not cause unnecessary or intended harm (including negligent acts or failures to protect) which amounts to degrading or ill-treatment. When deciding if any intervention is a breach of Article 3, consideration should be given to the severity and intensity of suffering inflicted to an individual based on an assessment of factors including duration, physical and psychological effects, sex, age, gender and health of the person, as well as the manner and execution of the intervention. Furthermore, Article 8 protects a person's right to be consulted and involved in decision making. With respect to the use of PR, staff should ensure that the use of any restrictive practice is transparent and part of a recovery-based, person-centred plan which fully involves the individual.

EXHIBIT
tabbies
35

Our previous research [5,6] quantified the pressures imposed on the anterior chest wall, the concomitant reduction in ventilatory capacity and the psychological impact of prone restraint. Although research is lacking into the physiological and psychological impact of alternatives to the prone restraint position recent standards to improve training to eliminate or minimise use of PR and make practice safer have recently become law [7,8]. This recent change in legislation follows on-going social, professional and political campaigns in which seated, supine and side lying restraint has been advocated as "safer" alternatives, with a common perception that restraint-related adverse events arise solely from the use of the prone restraint position [1,2,7-13]. This current study investigated the physiological and psychological effects of three floor positions which may be used as alternatives to prone PR; they were two positions of supine PR, where individual's arms were either held close to the body at 60° of shoulder abduction (Supine Restraint arms low - SPR-AL) or held further from the body at 100° of shoulder abduction (Supine Restraint arms high – SPR-AH). The third position was right side lying (Side lying restraint -SLR). By increasing our understanding of the impact of PR positions current practice can be improved by advocating which positions create the least adverse impact and therefore maximise the level of safety and minimise the level of harm to those subject to PR. The null hypothesis was stated as there would be no difference in physiological or psychological measures between any of the physical restraint positions tested.

Materials and Methods

Ethical issues

Ethical approval was granted by the School of Health and Rehabilitation Ethics Committee (Keele University, Newcastle-under-Lyme, United Kingdom). Prior to data collection participants were reminded of their right to withdraw from the study, and signed consent and health screening questionnaires. No incentives were offered or given to participants.

Participants

Twenty adults (Male = 10, Female = 10) with no known health problems were recruited and none were excluded. All participants were free from current neuro-musculo-skeletal injuries and cardio-vascular-respiratory risk factors. Age ranged from 18-23 years, mean 20 years (± 1.3). Height ranged from 158.6-197.1 cm, mean 176.1 cm (± 11.2). Weight ranged from 53.4-102.8 Kg, mean 73.8 Kg (± 13.5). BMI (kg/m^2) ranged from 19.3-27.8, mean 23.6 (± 2.5).

Equipment

HP Cosmos Pulsar treadmill; 4 Carefusion MicroLab Spirometer; Disposable Spirometry Mouthpieces; Polar H10 heart rate monitor; Stabilizer™ Pressure Biofeedback unit (Figure 2); Seca 761 weighing scales and 220 Standiometer; Goniometer; Alcohol wipes, 10cm Visual Analogue Scale, and a metric ruler. Equipment was freely available from the school of Health and Rehabilitation, Keele University, UK.

Conduct of the study

All participants were tested individually. Before each data collection all equipment was calibrated and cleaned. Before sitting for five minutes participants' height (cm) and weight (Kg) were measured. Whilst sitting the experimental procedures, spirometry technique (without nose clips) and visual analogue scale were explained to each participant after which resting heart rate was measured. Estimated heart rate maximum (HRM) (220 – age) and resting HR were then used to calculate 90% of Heart Rate Reserve (HRRes) (HRM – HR rest x 0.9). Baseline spirometry measures were then taken including Forced Vital Capacity (FVC) and Forced Expiratory Volume in one second (FEV1) (best of three). Next, participants mounted the treadmill and commenced a ramped treadmill protocol which aimed to raise HR to 90% HRRes within five minutes. Once target HR was achieved participants dismounted the treadmill and were restrained by professional instructors in the Management of Actual or Potential Aggression (MAPA) (Figure 1) in the allocated position determined by Triple Latin Square randomisation.



Figure 1: Physical Restraint Positions Investigated **(A)** Supine arms below 90^0 (SPR-AL); **(B)** Supine arms above 90^0 (SPR-AH); **(C)** Side Lying on the right (SLR) ***(Green lines indicate position/angle of arms relative to the body)***

After one minute of PR spirometry measurements (FVC, FEV1) were taken, and after the PR position had been held for a total of five minutes PR was stopped. Before participants commenced their five minute self-paced recovery walk thoracic weight bearing pressure (TWP) was measured (Figure 2) at the posterior chest wall for SPR-AL and SPR-AH, and at the lateral chest wall for SLR using a pressure biofeedback unit.

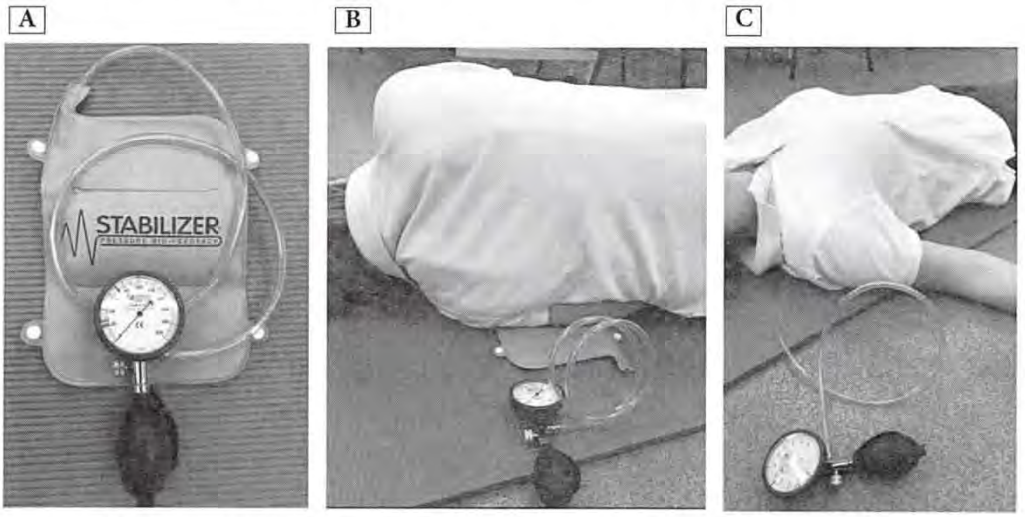

Figure 2: Measurement of Thoracic Weighbearing Pressure: **(A)** Pressure Biofeedback unit; **(B)** Measuring Thoracic weight bearing pressure in side lying; **(C)** Measuring Thoracic weight bearing pressure in supine

Recovery between testing in the second restraint position was 45 minutes in duration, as supported by Winter *et al.* [14]. The third position was tested seven days later as three tests in one day was deemed excessive. Finally, participants completed 10cm Visual Analogue Scales (VAS) that explored their experiences of each position in relation to comfort, anxiety, and breathing limitation. Participants also gave free text responses in relation to their experiences of PR.

Statistical Analysis

The data collected was analysed using Statistical Packages for the Social Sciences Statistics (IBM Corp. version 24.0, Chicago, Illinois, USA). Normal distribution of data was confirmed (Shapiro-Wilk test) and subsequently descriptive and inferential (Paired Sample t-test) statistical analysis was undertaken, with significance set at $p < 0.02$ following Bonferroni correction to reduce the chance of type 1 error as multiple t-tests were performed.

Results

Results of the physiological and psychological measures taken can be seen in Table 1.

Position	FVC (Litres) Mean (SD)	FEV1 (Litres) Mean (SD)	Heart Rate (bpm) Mean (SD)	TWP (mmHg) Mean (SD)	Comfort (scale 0-10) Mean (SD)	Anxiety (scale 0-10) Mean (SD)	Breathing Limitation (scale 0-10) Mean (SD)
Baseline	4.8 (±1.1)	4.2 (±0.8)	66 (±11)	NA	NA	NA	NA
SPR-AL	4.3 (±1.0)	3.9 (±0.8)	137 (±9)	89.1 (±14.1)	6.0 (±2.01)	2.7 (±1.30)	2.9 (±0.92)
SPR-AH	4.3 (±1.0)	3.9 (±0.8)	136 (±9)	96.1 (±13.0)	5.6 (±1.57)	3.3 (±1.92)	3.0 (±1.37)
SLR	4.1 (±1.1)	3.7 (±0.9)	136 (±9)	116.1 (±17.5)	3.3 (±1.25)	5.2 (±1.79)	5.4 (±1.51)

Table 1: Research measurements: Forced Vital Capacity (FVC), Forced Expiratory Volume (FEV1), Heart Rate, Thoracic Weight Bearing Pressure (TWP), and perceptions of restraint (Comfort, Anxiety, Breathing Limitation) at baseline and in positions of restraint

FVC was recorded as 4.8 (±1.1), 4.3 (±0.99), 4.3 (±1.04), and 4.1 (±1.05) litres for baseline, SPR-AL, SPR-AH, and SLR respectively, with SPR-AL and SPR-AH showing a 10.4% reduction from baseline and SLR a 14.6% reduction. FEV1 was recorded as 4.2 litres (±0.8), 3.9 (±0.78), 3.9 (±0.81), and 3.7(±0.85) litres for baseline, SPR-AL, SPR-AH, and SLR respectively, with SPR-AL and SPR-

AH showing a 7% reduction from baseline and SLR a 12% reduction. The results of this study demonstrate that ventilatory capacity as measured by spirometry was reduced in all restraint positions tested compared to baseline ($p = 0.001$) with the greatest reduction seen in SLR which was statistically significantly different ($p < 0.02$) to both SPR-AL and SPR-AH. HR did not differ between the positions tested. SLR imposed the greatest TWP at 116.1 (±17.5) mmHg and was statistically different to both SPR-AL and SRP-AH ($p<0.000$). Pressure exerted in SPR-AH was 96.1 (±13.0) mmHg, which was ~17% less than SLR, and SPR-AL pressure was 89.1 (±14.1) mmHg, which was ~23% less than SLR. In relation to psychological measurements the SPR-AL position was the most comfortable with a VAS score of 6.0 (±2.06), followed by SPR-AH VAS 5.6 (±1.57) which was a 6.7% reduction in comfort, and SLR being the least comfortable VAS 3.3 (±1.25) a comfort reduction of 45% compared to SPR-AL. Ratings for perceived Anxiety were 2.7 (±1.30), 3.3 (±1.92), and 5.2 (±1.79) for SPR-AL, SPR-AH and SLR respectively showing SLR to be the most anxiety inducing with SPR-AH and SPR-AL being 36.5% and 48.1% less anxiety inducing respectively. Ratings for perceived Breathing Limitation were 2.9 (±0.92), 3.0 (±1.37), and 5.4 (±1.51) for SPR-AL, SPR-AH and SLR respectively showing SLR imposed the greatest breathing limitation with SPR-AH and SPR-AL being 44.4% and 46.3% respectively less inducing of breathing limitation perception. Free text responses revealed several themes relating to decreased blood flow to the upper limbs with participants complaining of pins and needles, numbness, "dead arm", and "blood supply felt cut off" (SLR = 8, SPR-AH = 7, SPR-AL = 5). Limitation in breathing described using words such as feeling "squished", "trapped", "suffocated", and "it was harder to breathe" were most frequently reported in SLR (n=8), then SPR-AH (n=2), and least reported in SPR-AL (n=1).

Discussion

Our findings were in keeping with our previous work [3,5,6] in that the effect of the PR positions tested were non-homogenous, and that all PR positions tested reduced ventilatory capacity and resulted in negative psychological perceptions for comfort, anxiety, and breathing limitation. The SLR position was found to impose the greatest pressure to the thorax, the greatest ventilatory restriction, and was perceived to be the most anxiety inducing, the least comfortable and the most limiting to breathing when compared to the two supine positions. Barnett *et al.* [5] reported pressure exerted on the anterior chest wall during unsupported prone restraint (arms abducted) at 102.56 (+24.29) mmHg resulting in a 16% reduction in FVC from baseline, which when in supported prone (arms supporting anterior chest) reduced pressure to 72.74 (+16.9) mmHg, with FVC dropping 11% from baseline. In this current study SLR exerted greater pressure on the thorax (116.1 ±17.5) than did unsupported or supported prone restraint, and reduced FVC by 14.6% compared to 16% for unsupported prone, and 11% for supported prone, therefore the recommendation for the use of SLR as a safer alternative to both prone and supine restraint to minimise the risk of adverse restraint-related outcomes [14] should be challenged.

The reductions in ventilatory capacity seen in the current study were proportional to the extent of the restriction imposed by the restraint position, but did not reach clinical significance, and the perceptions of anxiety, discomfort, and breathing limitation were experienced in an experimental setting. However, PR adverse events occur due to sequelae of cumulative risk factors and it is not known to what extent the ventilatory reductions seen may prove harmful and in what confluence of circumstances risks may occur in a 'perfect storm' scenario [3,16] resulting in adverse outcomes. That said, best practice in PR should seek to risk assess each technique / position used so that the safety of the individual is maximised and any potential harm is minimised by seeking to ameliorate as many risks as possible.

This study has shown that the SLR position was perceived to be more psychologically stressful and imposed more pressure on the thorax than both the supine restraint positions investigated. The negative and potentially adverse psychological and physiological effects observed were similar to those induced by unsupported prone restraint [5,6] and support the findings of Parkes *et al.* [17] suggesting it is erroneous to assume alternatives to prone restraint are homogeneously safer. All restraint positions have the potential for adverse consequences meaning that, regardless of position, PR should always be considered an emergency with the potential for physiological and psychological complications including psychological distress, anatomical injury, physiological compromise and even death.

Methodological strengths of this study included the use of four professional restraint trainers to consistently apply the restraint techniques, and the use of a stringent protocol that covered the procedure of testing and data collection using the same researchers throughout. The use of goniometry and spirometry followed routine clinical practice guidelines, and the construction and use of VAS scales to determine participant perceptions was as suggested by Scott and Huskisson [18] and McCormack *et al.* [19]. Furthermore, all participants achieved 90% of HRRes by running on the treadmill before being restrained to simulate the exertion of PR. Limitations of this study would be that participants did not struggle against their restraint once restrained, due to ethical considerations, and neither did they possess known risk factors for adverse events occurring during PR.

Conclusion

Our on-going research has demonstrated the potential for negative anatomical, physiological and psychological consequences of several PR positions, by investigating the physiological and psychological impact of supine and side lying PR positions which are often perceived to be safer alternatives to prone PR. All PR positions tested reduced respiratory capacity and resulted in perceptions of discomfort, anxiety, and breathing limitation compared to baseline. SLR was found to possess a significantly greater degree

of negative physiological and psychological impact than supine restraint positions. Current guidance suggests avoiding prone restraint where possible however the alternatives are not free from negative physiological and psychological perceptions and as such supine and side lying alternatives should be selected carefully, monitored continuously, and regularly reviewed, with all applications of PR being considered as potential medical emergencies. Further research is required to identify and rank other PR positions and techniques in terms of risk so that staff is better able to make informed decisions during the use of PR in order to maximise safety and minimise harm.

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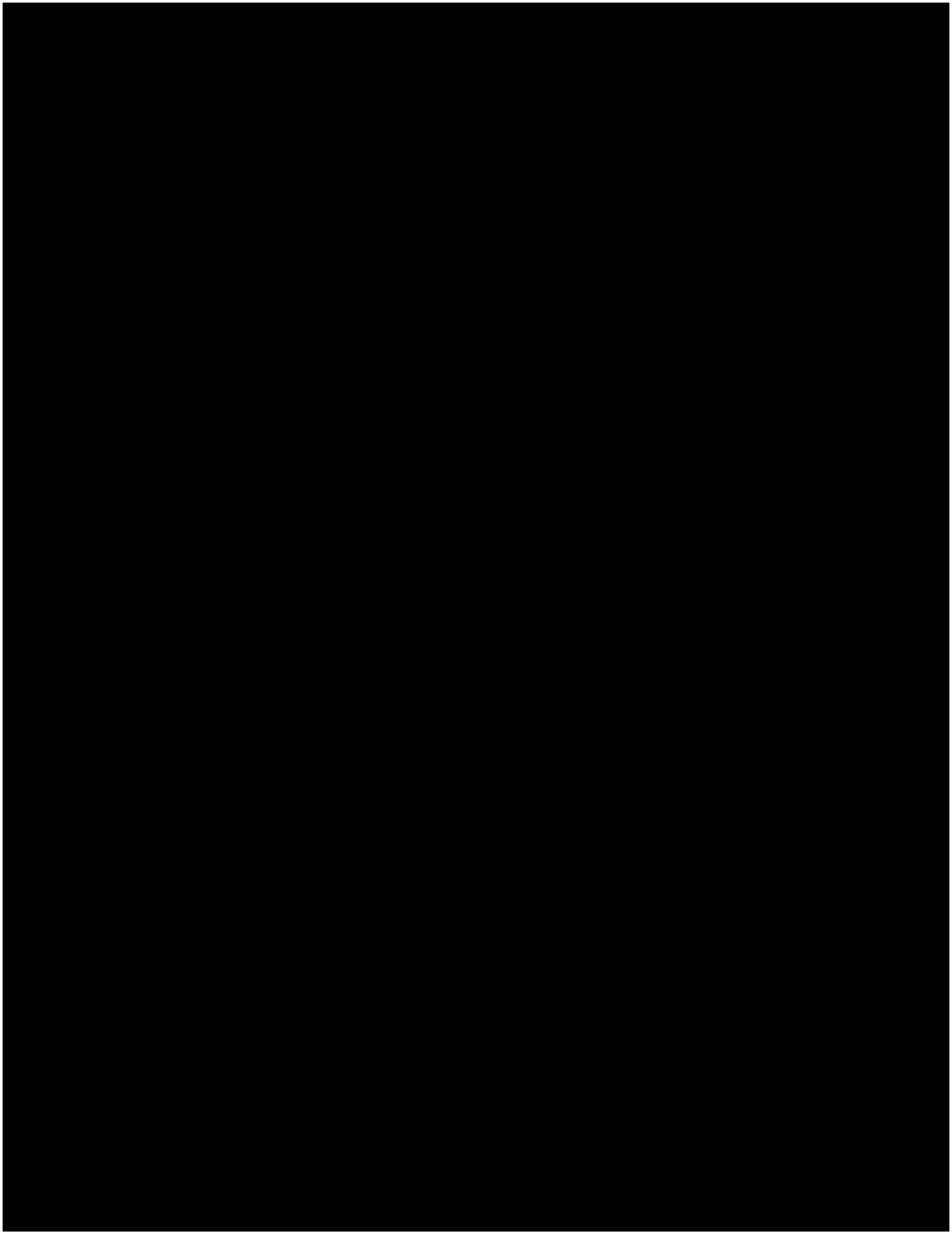

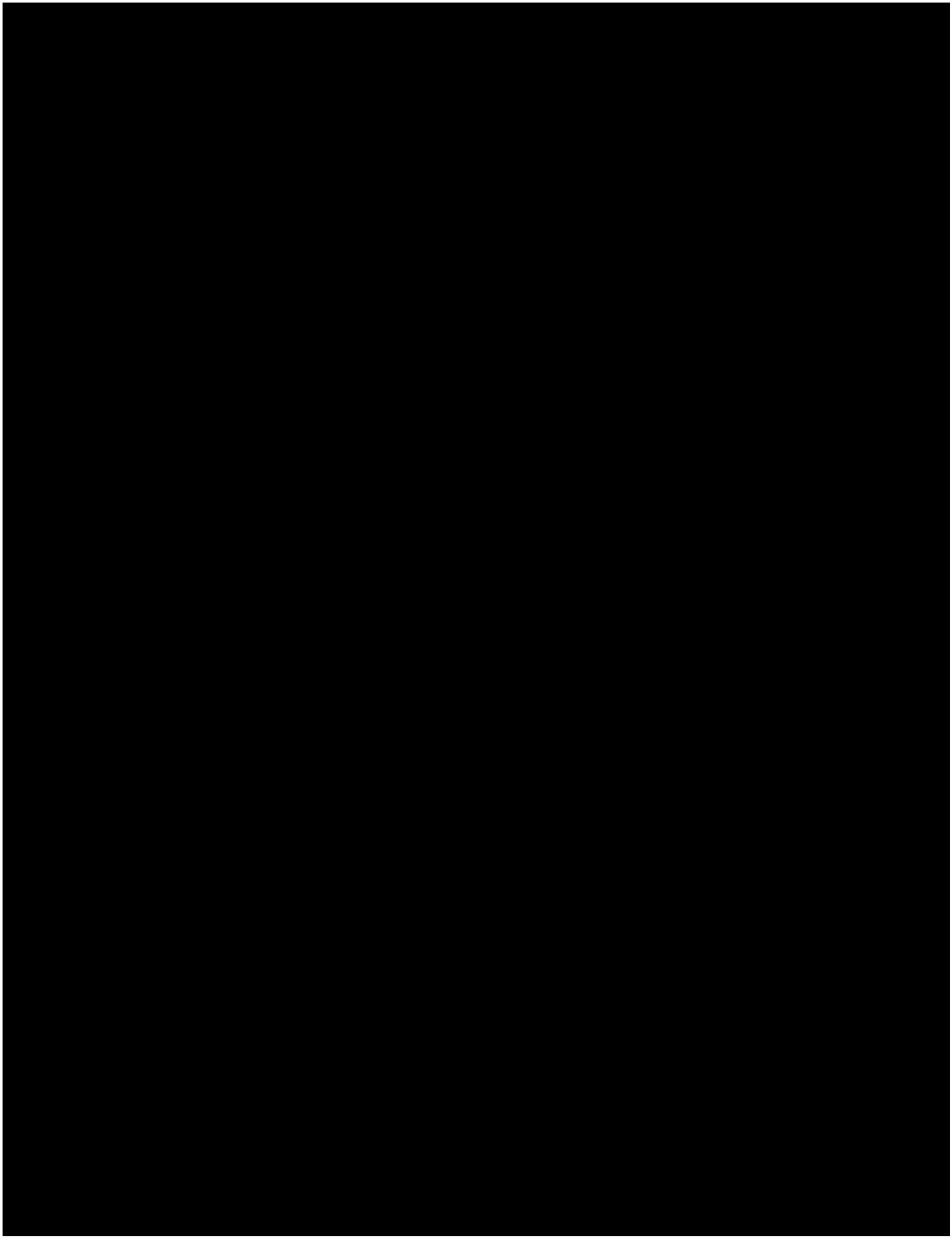

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National Alliance for the Mentally Ill: Gloria Huntley Award
to NASMHPD-OTA Faculty, 2008
D.A.R. Outstanding Volunteer Service Citation, 2012
Historic Salem, Inc. Leadership Award, 2004 & 2005
NASMHPD - NTAC Founding Faculty Award of Appreciation, 2003
Manuel Carballo Governor's Award for Excellence in Public Service, 2002
DMH Commissioner's Recognition Award & Pride in Performance Award, 2002
Northampton Ctr. for Children and Families, Inc. Citation of Appreciation, 1998
Charles River Health Management IRTP Award of Appreciation, 1997
DMH North East Area Award of Appreciation, 1995
DMH Commissioner's Recognition Award, 1995, 2013



PROFESSIONAL EXPERIENCE

May 2012 – 2016	**Co-leader, Delaware Department of Services for Children, Youth and Their Families; Division of Prevention and Behavioral Health Services*: Residential System Evaluation, Transformation Planning & Reprocurement Project.*** Comprehensive review of existing residential programming and strategic action planning process in order transform existing services.
July 2011 – 2014	**Co-leader, New Hampshire Division of Children, Youth & Families & Division of Juvenile Justice: *Youth Transitioning to Permanency Project*** Interagency project working with leading residential provider organizations to facilitate the adoption of promising and best practices, youth and family driven care, permanency, and successful community living for youth returning home from residential treatment in New Hampshire
Feb. 2012 – present	**Co-applicant, Study Grant:** *Restraint Reduction in a Forensic Setting: Testing an Organisational Model for Implementation in the UK, National Health Service: National Health Institute for Health Research for Patient Benefit Programme, Lancashire Care NHS Foundation Trust*
April 2011 – present	**Co-applicant, Feasibility Study Grant:** *Using a Comparative Case Study Design to Test the Feasibility of Implementing a Restraint Reduction Model in a Medium Secure Mental Health Unit in the UK,* National Health Service: National Health Institute for Health Research for Patient Benefit Programme, Lancashire Care NHS Foundation Trust
September 2010 – September 2011	**Facilitator, New York Office of Mental Health, Office of Quality Management Teleconference Learning Collaborative** with thirteen residential treatment facilities in New York state. Leading bi-monthly (2/month) consultation and technical assistance teleconferences with 75 participants on restraint and seclusion reduction/prevention. Provided technical assistance, identification of national resources, and topic-specific consultation/presentations.
2008 - present	**SAMHSA Seclusion and Restraint Matrix Work Group Consultant; White Papers, Issue Papers & Issue Briefs author; Co-developed seclusion and restraint (S/R) prevention web-based toolkit for leaders.** Consultation, participation, and task prioritization in drafting a two-year action plan for this SAMHSA priority area. Authored the Business Case of S/R Reduction White Paper, Issue Brief and Issue Papers and co-authored the Use of S/R in Schools Issue Brief and Paper. Authored the Alternatives to S/R White Paper, Issue Paper and Issue Brief. Developed a S/R resource toolkit for SAMHSA's web-site to assist health care leaders interested in pursuing organizational/practice change.
2004 - 2010	**SAMHSA State Incentive Grant (SIG) Monitor & Consultant, National Association of State Mental Health Program Director's Office of Technical Assistance – Alexandria, VA.** Lead monitor for S/R SAMHSA SIG Grant implementation in: Louisiana, Maryland, Missouri, Hawaii, Indiana, New York and Virginia. Lead/co-lead and organized teams of nationally-recognized S/R Reduction experts, conduct scope of implementation assessment, tour state facilities/programs and provide written synopsis and report of federal S/R SIG grant progress and compliance.

2002 - present

Co-author of National Curriculum, Founding & Teaching Faculty, National Association of State Mental Health Program Directors' Office of Technical Assistance – Alexandria, VA. Co-author & developer of a national training curriculum and resource manual, *Creating Violence Free and Coercion Free Mental Health Treatment Environments*, recognized as an evidenced-based practice by NREPP (2012) and included in SAMHSA's database of nationally recognized evidenced-based practices and interventions.

Member of a specialized faculty team created to provide international, national, regional and state-specific trainings *(National Executive Training Institutes)* and technical assistance to state Departments of Mental Health, Child Welfare, Juvenile Justice, Medicaid and health care organizations and residential provider agencies.

NASMHPD – OTA: *National Experts Meeting on Principled Leadership for State Hospital Administrators / CEOs* - March 16-17, 2009
NASMHPD – NTAC: *National Experts Meetings on Seclusion and Restraint Reduction and Creating Violence Free, Coercion Free Environments of Care*, 2002 & 2006

2013 - present

Director of System Transformation, The Massachusetts Department of Mental Health (DMH), Central Office - Boston, MA
Responsible for oversight and development of DMH Child Youth & Family Statewide programs (inpatient, secure high intensity, and community-based services) for youth. Leadership role of transformational projects including but not limited to: adult system restraint/seclusion prevention effort; Caring Together residential services (community-based services for youth and families); the Interagency restraint/seclusion prevention initiative; and Express Yourself (creative arts effort). Manage a 30M budget and provide clinical and operational oversight of psychiatric inpatient under 21 funded and rehabilitation option programs.

Executive Producer of *Thirteen Reasons to Fly* (anti-stigma, suicide prevention effort for youth) with DVD and study guide (2018); DMH lead on Isaac's Story (2018) public service anti-stigma campaign for youth. Executive Editor and Author of *Creating Positive Cultures of Care: A Resource Guide, 4th Edition* (2018) for national/international distribution.

1995 - 2012

Director of Program Management, Child/Adolescent Division The Massachusetts Department of Mental Health (DMH), Central Office - Boston, MA
Responsible for oversight and development of 200 bed statewide inpatient and secure residential system of care for children and adolescents. Manage a 26M dollar budget. Director and supervisor of Clinical Team providing leadership, technical assistance and training to field staff throughout the Commonwealth. Facilitate implementation of public managed care initiative within the most intensive sector of the service system. Develop standards of care for different services. Monitor inpatient/IRTP contracts for Joint Commission and state regulatory compliance. Write Request for Proposals (RFP)

and negotiate budgets and contracts for child/adolescent services. Represent DMH at national and state meetings, educational events and local forums.

Executive Producer: *Real Danger: Restraints and our Children* 2010
Co-creator of a documentary film providing historical and contemporary perspectives on the practice of restraint and seclusion across human service and school settings with youth, parent, provider, administrator and journalist experiences and featuring one of the Hartford Courant exposé authors who recounts the beginning of the national initiative in the United States.

Chair or leadership role in key initiatives and planning efforts:

- *DMH – DOC Initiative to Reform Bridgewater State Hospital & Strengthen the Commonwealth's Mental Health System – Co-Chair* 2014 – to date
- *DCF Statewide Advisory Board* 2013 - to date
- *DMH State Facility Core Strategy Implementation Team – Chair* 2013 – to date
- *Interagency Residential Procurement:* System redesign effort to implement national Building Bridges framework for all MA residential services purchased by mental health & child welfare ($260M services) 2009 – to date
- *DMH Redesign Team* 2009 – 2011
- *"Rosie D." Assessment Team* 2005 – 2007
- *New Hospital Planning ~ Adolescent Services* 2004 – 2012
- *SAMHSA SIG Grant Advisory Committee* 2003 - 2008
- *Interagency Child/Adolescent Restraint Prevention Initiative* 2000 – to date
- *Central Office Research Review Committee (IRB)* 1999 - 2008
- *Express Yourself* 1995 – to date
  Creator of strength-focused, multicultural, multi-media professional performing arts intervention with 2000 DMH youth and recognized with the *President's Coming Up Taller Award - 2009*

1993 – 1995

Director of Child/Adolescent Services, North East Area
Massachusetts Department of Mental Health – Tewksbury, MA
Responsible for the ongoing development of a community-based, public managed care mental health service system for children, adolescents, and their families from 52 cities/towns. Managed a 6.5M dollar budget. Created Request for Proposals (RFP) for all levels of service. Chaired Interagency Team established to develop local policies and resolve case disputes.

1991 – 1993

Director of Child/Adolescent Services, North Shore Area
Massachusetts Department of Mental Health – Danvers, MA
Oversight and responsibility for development of mental health service system for child/adolescent population from 26 cities and towns. Implemented statewide managed care initiatives and participatory planning processes: Comprehensive Community Support Systems (CCSS). Clinical/Administrative supervision to Case Management Team (20). Managed a 3.8 M dollar budget.
Created Request for Proposals (RFP) for all levels of child/adolescent services. Program monitoring, planning, development and implementation also

performed.

1989 – 1991 **Assistant Director of Case Management, Beverly Site Office**
Massachusetts Department of Mental Health – Beverly, MA
Responsible for development of child/adolescent Case Management Team to serve 14 cities and towns. Clinical/administrative supervision provided to adult and child/adolescent Case Managers (4). Monitored and co-chaired Quality Improvement Teams reviewing local contracted resources. Clinical decision making performed for potential consumers of all ages referred for long-term services by inpatient facilities, school systems, public/private agencies and families.

1987 – 1989 **Case Management Supervisor, Beverly Site Office**
Massachusetts Department of Mental Health – Beverly, MA
Responsible for clinical decision making and all aspects of mental health service planning for an ongoing caseload of 25 children/adolescents. Represented the Department on Area Team meetings/Case Reviews, Court presentations and Special Education/Treatment Planning meetings. Consulted to other EOHHS child-serving agencies, school systems and families regarding child-specific and generic treatment needs and respective resources.

1985 – 1987 **Case Manager, North Shore Community Mental Health Center**
Massachusetts Department of Mental Health – Salem, MA

EDUCATION

ABPP Diplomate May 5, 2012
Board Certification in Counseling Psychology
American Board of Professional Psychology

Ed.D./Ph.D. Northeastern University 1988
Summa cum laude
Dual concentration doctorate: Leadership: Administration, Supervision & Practice of Counseling Psychology
Internship: Salem Hospital Mental Health Unit (outpatient & inpatient services)
Dissertation: A study of type of day care experience and aggressive behavior among preschool children.

C.A.G.S. Northeastern University 1986
Summa cum laude Counseling Psychology

M.Ed. Salem State College 1984
Summa cum laude Community Counseling

B.A. Salem State College 1983
Magna cum laude Major: Psychology; Minor: Sociology

ACADEMIC AWARDS

Psi Chi National Honor Society in Psychology

Kappa Delta Pi	National Honor Society in Education
Phi Kappa Phi	Multi-Disciplinary National Honor Society
Phi Delta Kappa	National Honor Association for Educators

ACADEMIC APPOINTMENTS

2008 – present	Instructor of Psychiatry, Department of Psychiatry University of Massachusetts Medical School, Worcester, MA

PUBLICATIONS

R Refereed Publications

R: LeBel, J. & Anderson, T. (2021, in press). What's Quality Got to Do with It? A Retrospective Analysis of System Transformation. *Journal of Healthcare Risk Management*

R LeBel, J. & Kelly, N. (2021, in press). Education in extremis: What teachers and teachers-to-be need to know about preventing restraint and seclusion use in the classroom. *Rethinking Schools.*

R Trachtman, H.D., Duckworth, K. & **LeBel, J.** (2021, in press) State leadership and consumer advocacy in culture change. In Elyn R. Saks (Ed.): *Restraints in Context*. New York: Cambridge University Press, Inc.

R LeBel, J. & Urff, J. (2021, in press). Issue brief: *From "Safe Use" to prevention through trauma-informed practices: Seclusion and restraint reform efforts since 1998.* Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

R: Caldwell, B., Lieberman, R., **LeBel, J.** & Blau, G. (Eds.) (2020). Transforming Residential Interventions: Practical Strategies and Future Directions, New York, NY: Routledge.

R: LeBel, J., Galyean, L., Nickell, M., Caldwell, B., Johnson, K., Rushlo, K., & Blau, G. (2018). The changing role of residential intervention, *Residential Treatment for Children & Youth, 35*:3, 225-241, DOI: 10.1080/0886571X.2018.1437376

LeBel, J. (2017, December). Leading innovation outside the comfort zone: The Seneca Family of Agencies Case Study. Building Bridges Initiative Case Study. Retrieved from http://www.buildingbridges4youth.org/index.html

R LeBel, J., Caldwell, B., Martone, W., Levison-Johnson, J. & Collins, J. (2017, July*). Implementing effective short-term residential interventions: A Building Bridges Initiative Guide.* Retrieved on July 24, 2017, from http://buildingbridges4youth.org/sites/default/files/BBI%20Short%20Term%20Residential%20Intervention%20Guide.pdf

LeBel, J.L. (2016, Dec 1). [Review of the book Behavioral challenges in children with autism and other special needs: The developmental approach, by Diane Cullinane, MD] *Psychiatr Serv, 67*(12):e19-e20.

R Huckshorn, K. & **LeBel, J.** (2015). Restraint and seclusion. In A. Tasman, J. Lieberman, J. Kay, M. First & M. Riba (Eds.), Psychiatry (4th edition) (pp. 2487-2491). New York: Wiley-Blackwell.

R LeBel, J., Duxbury, J., Putkonen, A., Sprague, T., Rae, C., Sharpe, J. (2014). Multi-national experiences in reducing and preventing the use of restraint and seclusion. *Journal of Psychosocial Nursing and Mental Health Services, 52*(11): 22-29.

R LeBel, J., Huckshorn, K. A. & Caldwell, B. (2014). Preventing seclusion and restraint in residential programs. In G. M. Blau, B. Caldwell, & R. E. Lieberman (Eds.), *Residential interventions for children, adolescents and families: A best practice guide* (pp. 110-125). New York, NY: Routledge.

R LeBel, J., & Kelly, N. (2014). Trauma-informed care. In G. Blau, B. Caldwell, & R. E. Lieberman (Eds.), *Residential interventions for children, adolescents and families: A best practice guide* (pp. 78-95). New York, NY: Routledge.

LeBel, J. (2014, June 5). *Courage is, as Courage does.* Weblog posting for Grafton Integrated Health Network. Available at: http://graftonblog.com/courage-is-as-courage-does

R LeBel, J, Huckshorn, K.A., & Jacobs, H.E. (2014, May 5). An organizational approach to reducing and preventing restraint and seclusion use with people with acquired brain injury. *NeuroRehabilitation.* Epub ahead of print 2014 May 5; DOI:10.3233/NRE-141073

R LeBel, J. (2014, May). Book Review [review of the book *Treatment of complex trauma: A sequenced, relationship-based approach. Psychiatric Services, 65*(5) - e4. ePublished at http://ps.psychiatryonline.org/data/Journals/PSS/930050/e04.pdf

R LeBel, J. (2014). *First randomized controlled-trial research on seclusion and restraint reduction achieves intent. Evid Based Ment Health (epub: 19 March 2014*, p. eb-2014-101717v1); 17(2):40-41.

R Huckshorn, K.A. & **LeBel, J.** (2013). Trauma informed care. In D. Svendsen & K. Yeager (Eds.), *Textbook of modern community mental health work: An interdisciplinary approach (62-83).* New York, NY: Oxford University Press, Inc.

R Chan, J., **LeBel, J**. & Webber, L. (2012). The dollars and sense of restraints and seclusion. *Journal of the Law and Medicine,20,* 73-81.

LeBel, J. & Wentworth, R. (2012, July). Massachusetts interagency restraint and seclusion prevention initiative: Partnering across systems to avoid trauma and support positive outcomes for youth. *Common Ground, 26(1),15-19.* Washington, DC: U.S. Department of Health and Human Services.

LeBel, J. & Lim, A. (Eds.) (2012, May 3). *Creating positive cultures of care: A resource guide,* (3rd edition), Boston, MA: Massachusetts Department of Mental Health.

R LeBel, J., Nunno, M., Mohr, W.K., & O'Halloran, R. (2012). Restraint and seclusion use in U.S. school settings: Recommendations from allied treatment disciplines. *American Journal of Orthopsychiatry, 82*(1), 75–86.

R LeBel, J. (2011). Restraint and seclusion prevention in the USA: Core strategies to reduce use and sustain gains. *Proceedings of the Seventh European Congress on Violence in Clinical Psychiatry,* Amsterdam: Kavanah, Dwingeloo, & Oud Consultancy, p. 440-443.

LeBel, J.L. (2011, July). In reply: Coercion in treatment: Researchers' perspectives. *Psychiatric Services 62*(7), 806-807.

R LeBel, J.L. (2011, May). Taking issue: Coercion is not mental health care. *Psychiatric Services, 62*(5), 453.

R LeBel, J. (2011, March). *Promoting alternatives to the use of seclusion and restraint: Issue paper: Making the business case*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

R LeBel J., Huckshorn K.A., & Caldwell B. (2010) Restraint use in residential programs: Why are best practices ignored? Child Welfare League of America, Washington, D.C. *Special Issue: Residential Services, 89*(2), 169-187.

R Mohr, W.K., **LeBel, J.**, O'Halloran, R., & Preustch, C. (2010). Tied up and isolated in the schoolhouse. *Journal of School Nursing, 26*(2), 91-101.

R LeBel J., & Champagne, T. (2010, June). Integrating sensory and trauma-informed interventions: A Massachusetts state initiative, part 2, *American Occupational Therapy Association Mental Health Special Interest Section Quarterly, 33*(2), 1-4.

R Caldwell, E., & **LeBel, J.** (2010, March/April). Reducing restraint and seclusion: How to implement organizational change. *Children's Voice*, *19*(2), 10 – 14.

R LeBel, J. (2010, March). *Promoting alternatives to the use of seclusion and restraint: Issue Brief #4: Making the business case*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

R LeBel, J., Champagne, T., Stromberg, N. & Coyle, R. (2010, March). Integrating sensory and trauma-informed interventions: A Massachusetts state initiative, part 1, *American Occupational Therapy Association Mental Health Special Interest Section Quarterly, 33*(1), 1-4.

R LeBel, J. (2009). Building the business case for reducing restraint and seclusion ose. *Proceedings of the 6th European Congress on Violence in Clinical Psychiatry* (299-301). Amsterdam: Kavanah, Dwingeloo, & Oud Consultancy.

LeBel, J. (Producer) & Galvin, M. (Director). (2010). *Real Danger: restraints and our children* [educational film]. (Available from the Commonwealth of Massachusetts, Department of Mental Health, 25 Staniford Street, Boston, MA 02114)

R Huckshorn, K.A. & **LeBel, J.** (2009). Improving safety in mental health treatment settings: preventing conflict, violence, and the use of seclusion and restraint. In S. Sharfstein, F. Dickerson & J. Oldham (Eds.), *The textbook of hospital psychiatry* (253-266). Arlington, VA: American Psychiatric Publishing, Inc.

R Huckshorn, K. & **LeBel, J.** (2008, May/June). New monitoring requirements for the use of seclusion or restraint with children and adolescents: A step forward or two steps back? *American Academy of Child and Adolescent Psychiatry News, 39(3), 107-109.*

R LeBel, J. (2008, February). Regulatory change: A pathway to eliminating seclusion and restraint or "regulatory scotoma"*? Psychiatric Services, 59*(2), 194-196.

R LeBel, J. (2007, December 19). Regulatory, clinical, and educational approaches to eliminating restraint and seclusion. In *BioMed Central Psychiatry, Vol. 7*, WPA Thematic Conference Proceedings: *Coercive Treatment in Psychiatry: A Comprehensive Review*, (suppl 1): Pages/record No.: S133

LeBel, J. (2007, July 11). Reply to: Restraint ruling, Society Guardian, UK

R LeBel, J. (2006, Summer). Success in reducing restraint and seclusion in the USA. In *Turkish Journal of Psychiatry, 17(2).* WPA International Congress Proceedings, *Psychiatry: Uniqueness and Universality.* (suppl.1): 123.

LeBel, J. & Huckshorn, K.A. (2006, April). Reply to: Elimination of seclusion and restraint: A reasonable goal? *Psychiatric Services, 57,* 577-578.

R LeBel, J. (2006, January/February). Rediscovering pathways to compassionate care. *American Academy of Child and Adolescent Psychiatry News, 3*(1):17-18, 51.

R LeBel, J. & Goldstein, R. (2005, September). The economic cost of using restraint and the value added by restraint reduction or elimination. *Psychiatric Services, 56,* 1109-1114.

R LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., Harper, G., LaFlair, L., & Sudders, M. (2004, January). Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(1):37-45.

LeBel, J. (1988, March 14) *A study of type of day care experience and aggressive behavior among preschool children.*(Unpublished doctoral dissertation). Boston, MA: Northeastern University.

EXTERNAL / PEER REVIEWER

Journal of Psychosocial Nursing: 2020 – to date
Africa Education Review: 2017 – to date
Journal of the American Psychiatric Nurses Association: 2017 – to date
Psychiatry Research: 2016 – to date
Residential Treatment for Children and Youth: 2015 – to date
SAGE Open: 2014 – to date
Children & Youth Services Review: 2013 – to date
Child: Care, Health & Development: 2013 – to date
Administration and Policy in Mental Health and Mental Health Services Research: 2012 – to date
International Journal of Mental Health Nursing: 2011 – to date
American Journal of Psychiatry: 2011 – to date
Journal of School Nursing: 2010 – to date
Journal of Child and Family Studies: 2009 – to date
American Journal of Orthopsychiatry: 2008 – to date
Psychiatric Services: 2006 – to date

DOCTORAL DISSERTATION COMMITTEE OR DISSERTATION DISCUSSANT

Kevin Ann Huckshorn	Reducing the Use of Seclusion and Restraint in Mental Health Settings: A Qualitative Study of Leaders' Experiences	
Capella University		August, 2012
Nancy Macias-Smith	Restraint Reduction in Public Schools	
Massachusetts School of Professional Psychology		July 12, 2012
Jocelyn Thomann, Psy.D.	Factors Contributing to Restraint Reduction in Residential Facilities	
Massachusetts School of Professional Psychology		April 30, 2009

EXPERT WITNESS / CONSULTATION

Jane Doe vs. Kootenai Hospital District / Kootenai Behavioral Health – Youth Acute, et al, Coeur d'Alene, ID. Case No. 2:20-cv-00423-REB, June 2021 – January 2022. Expert Witness, restraint and seclusion injury/malpractice, medical record review, deposition review, videotape review for ongoing litigation. Case being settled out of court; significant monetary settlement (not disclosed) and non-monetary changes in policy.

Disability Rights Maine, Expert Consultant (restraint/seclusion practice and youth residential programming: operations, policies, procedures, incident reports, and medical record review), May 2019 – to date.

Disability Rights Nebraska, Expert Consultant, restraint and seclusion practice and medical record review and testimony for ongoing litigation, RC v. Lincoln Regional Center et al. Case No. 4:16-cv-3140, February 2, 2018 – July 26, 2019. Case settled out of court; significant monetary settlement (not disclosed) and non-monetary changes in policy.

Ohio Legal Rights Service & Modell Consulting Group, LLC, Clinical Consultant (forensic interviewing curriculum development: Project FIND), November 2017 – to date.

Michigan Protection & Advocacy Services, Inc., Telephonic clinical consultation regarding child/adolescent treatment programming and the use of seclusion and restraint, March 2017.

Disability Rights Iowa, Clinical Consultant, (record, policy and protocol reviews and analysis of restraint and seclusion documentation), August 2013 – to date.

U.S. Department of Justice, Civil Fraud Division, Clinical Consultant (record review and analysis of psychiatric inpatient and residential treatment facility documentation) and Lead Expert Witness for trial, August 2012 – July 25, 2019. Case settled for $127M.

Ohio Legal Rights Service, Clinical Consultant (record, policy and protocol reviews and analysis of restraint and seclusion documentation), September 2012 – October 2015. Case settled out of court, fall 2015, settlement not disclosed.

U.S. Department of Justice, Civil Rights Division, Clinical Consultant, U.S. v. State of Ohio. Expert Witness, seclusion affidavit and testimony for ongoing litigation, February 2014 – April 2014. Case settled out of court in April 2014.

U.S. District Court: So. District of FL, Case No: 10-80473-CIV-Marra/O'Sullivan, JPM, RGM and CM v. Palm Beach County School Board. Expert Witness. Case settled out of court, spring 2013, settlement not disclosed.

Estate of Troy Geske v. State of Colorado: Colorado Mental Health Institute, Expert Witness. Case settled out of court on June 21, 2012 for $750,000 with remedy stipulations.

ON-SITE & REMOTE CONSULTATIONS

2005 – to date On-site consultation provided to:
Far West LHD, Broken Hill Hospital, NSW, AU (remote)
Sydney Children's Hospital Network: Saunders Unit, Randwick & Hall Unit, Westmead Children's Hospital, NSW, AU (remote)

Nepean Blue Mountains LHD, Nepean Hospital, NSW, AU (remote)
New South Wales Health, Sydney, AU (remote)
Good Shepherd Services, NY, NY
Brattleboro Retreat, Brattleboro, VT
Bay Pines Center, Escanaba, MI (remote)
Shawono Center, Grayling, MI (remote)
Vermont Psychiatric Care Hospital, Berlin, VT
Methodist Children's Home Society, Redford, MI (remote)
Wolverine Human Services, Vassar, MI (remote)
Devereux Advanced Behavioral Health – Mapleton / Malvern, PA
Ridge View Youth Service Center, Watkins, CO
Children's Home of Wyoming, Binghamton, NY
Strategic Behavioral Center, Wilmington, NC
New Directions Youth & Family Services, Randolph, NY
Four Winds Hospital, Katonah, NY
Sally & Anthony Mann Center, Hawthorne, NY
August Aichhorn RTF, Brooklyn, NY
August Aichhorn RTF, Manhattan, NY
Excalibur Youth Services, Greenville, SC
Avalonia Group Homes, Marietta, SC
New Hope Treatment Center, Rock Hill, SC
Marshall I. Pickens Residential Treatment Program, Greenville, SC
Gill Montague Regional School District, Turners Falls, MA
Holyoke Public School System, Holyoke, MA
The William R. Peck School, Holyoke, MA
Bridgewater State Hospital, Bridgewater, MA
Vermont Psychiatric Care Hospital, Montpelier, VT
Rutland Regional Medical Center, Rutland, VT
Sequoyah Adolescent Treatment Center, Albuquerque, NM
Massachusetts Hospital School, Canton, MA
PARC Place, Chandler, AZ
Silver Lake Residential Treatment Center, Middletown, DE
Brenford Place Residential Treatment Center, Dover, DE
Terry Children's Psychiatric Center, New Castle, DE
Henry Ittleson Center, Residential Treatment Facility, Bronx, NY
Jerome M. Goldsmith Center Residential Treatment Facility, Hawthorne, NY
Linden Hill Residential Treatment Facility, Hawthorne, NY
Spaulding Youth Services, Tilton, NH
Nashua Children's Home, Nashua, NH
Becket Family of Services, Campton, NH
JPS Health Network, Ft. Worth, TX
Boys Town, Omaha, NE
North Carolina Juvenile Justice System, Raleigh, NC
Osterlen Services for Youth, Springfield, OH
Parmadale Institute, Parmadale, OH
Nebraska Division of Behavioral Health, Lincoln, NE
The Manor, Jonesville, MI
Western NY Children's Psychiatric Center, West Seneca, NY
BryLin Hospitals, Buffalo, NY
The Keys of Carolina, Charlotte, NC
Richmond State Hospital – Youth Service Program, Richmond, IN
Evansville Psychiatric Children's Center, Evansville, IN

Central State Hospital, Petersburg, VA
Commonwealth Center for Children & Adolescents, Staunton, VA
SCO Family of Services, Briarwood, NY
Arizona State Hospital, Phoenix, AZ
Dorothea Dix Psychiatric Center, Bangor, ME
Utah State Hospital, Provo, UT
New York City Health & Hospitals Corporation facilities:
Elmhurst Hospital Center, Jacobi Medical Center, & Coney Island Hospital
South East Louisiana State Hospital, Mandeville, LA
Central Louisiana State Hospital, Pineville, LA
New Orleans Adolescent Hospital, New Orleans, LA
Spring Grove State Hospital, Catonsville, MD
John L. Gildner Regional Institute for Children and Adolescents, Rockville, MD
Regional Institute for Children and Adolescents, Baltimore, MD
Fulton State Hospital, Fulton, MO
Queens Medical Center, Honolulu, HI
St. Elizabeth's Hospital, Washington, D.C.
Comprehensive Psychiatric Emergency Program, Washington, D.C.
New Jersey Department of Mental Health, Trenton, NJ

On-site international consultation provided to:
NSW Health, Sydney, AU
Novalis Trust, Stroud, UK
Niuvanniemi Hospital, Kuopio, Finland
Dept. of Communities, Disability Services & Juvenile Justice Services, Brisbane, Queensland, AU
MH-Kids, Department of Health, Sydney, AU
PsycHealth Centre, Health Sciences Centre, Winnipeg, Manitoba, CA
Dept. of Human Services, Disability Services, Melbourne, Victoria, AU
St. Joseph's Healthcare, Hamilton, Ontario, CA
Centre for Addiction and Mental Health, Toronto, Ontario, CA
Te Whetu Tawera, Auckland District Health Board, Auckland, NZ
Counties Manukau District Health Board, South Auckland, NZ

SELECTED PRESENTATIONS/PAPERS

Reducing Risk and Preventing Violence, Trauma, and the use of Seclusion and Restraint, NH Dept of Health & Human Services, 4-part webinar series, 10/26/21-11/16/21 (remote)

Restraint & Seclusion Use: Another Bastion of Inequality? McLean Hospital Grand Rounds, Belmont, MA April 1, 2021

The Six Core Strategies: An Organization Approach (keynote address) & ***Well, That was Easy: Making Culture Change and Moving Away from Restraint Use*** (workshop)**,** BILD Restraint Reduction Network Annual Conference, Bristol, UK November 12-13, 2019

Transformation with a Massachusetts Twist: Where have we Been? Where are we Going? (keynote address), Cutchins Programs for Children & Families Inaugural Annual Conference. Smith College, Northampton, MA May 4, 2018

Preventing Violence, Trauma, and the use of Seclusion and Restraint in Mental Health Settings. Vermont Cooperative for Practice Improvement and Innovation, Waterbury, VT April 24-25, 2018; June 04, 2021-July 02, 2021 (remote)

Building Bridges Initiative: Overview and Family & Youth Guided Care. South Carolina Partnership Towards Positive Outcomes, Bill Rogers Community Center, Columbia, SC April 20, 2018

The Neurobiological and Psychological Effects of Trauma and Trauma Informed Care. Correct Care Recovery Solutions 2018 Safety Summit, Deerfield Beach, FL, April 12, 2018

Trauma Informed Care: An Overview of Fundamental Concepts, Presentation to First Lady Lauren Baker and The Wonderfund, Boston, MA January 9, 2018

The Six Core Strategies: An Overview and **Regaining Perspective When the Going Gets Tough.** Rutland Regional Medical Center Conference, Franklin Howe Center, Rutland, VT November 29, 2017

Overview of National Building Bridges Initiative/Highlights of BBI Work across the Country and Youth-Guided Care, Magellan Residential Partnership Training, Giant Community Conference Center, Willow Grove, PA October 24, 2017; Texas DHHS Symposium January 27-29, 2019

Short-Term Residential Practice Models for Engaging & Supporting Families with Complex Challenges in their Homes & Communities Plenary Speaker, Building Bridges Initiative National Training Event, Andover, MA, October 4, 2017

Everything you Wanted to Know About the Department of Mental Health Statewide Programs ... Parent Professional Advocacy League Statewide Meeting, Framingham, MA, September 12, 2017

Building Bridges: A National Initiative Overview and Youth Guided Care. Kentucky System of Care Academy, Louisville, KY, June 19, 2017

Where the Rubber Hits the Road: Pitfalls and Pragmatics to Successful Implementation, (keynote address), Third International Restraint Reduction Network™ Conference, Aston Conference Centre, Birmingham, UK, October 16, 2016

Advocating for Trauma-informed Care: Moving from Construct to Reality, (keynote address), Trauma Talks 2016, Women's College Hospital, University of Toronto, Toronto, Ontario, CA June 10, 2016

Violence Prevention and the Link to Trauma-informed Care, Virginia Department of Behavioural Health and Disability Services, state-wide webinar with the National Council, June 1, 2016

Creating Environments that Help and Support Individuals: *Moving from Theory to Practice,* (keynote address), CT R/S Prevention Initiative Partnership Conference, Central CT State University, New Britain CT September 11, 2015

Preventing Traumatic Experiences with Creative Approaches to Help Students Thrive at School, (keynote address), Department of Elementary and Secondary Education Annual Conference, Norwood, MA September 1, 2015 and SEEM Collaborative Conference Keynote Address: Student Mental Health: Roles, Responsibilities and Resources, Middleton, MA August 18, 2015

Caring Together: **Strengthening Children and Families Through Community-Connected Residential Treatment**, NACBH Policy Summit, Baltimore, MD July 17, 2015

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Restraint and Seclusion Use: The Problems and the Remedies, National Disabilities Rights Network Training Webinar, April, 2015

What's Trauma Got to do with it and Why do we Need to be Informed? Mental Health Courts: Principles, Practices and Growth, College of the Holy Cross, Worcester, MA April 1, 2015

Moving Forward: Building Bridges Toward Systems Transformation and Making Trauma-Informed Care Real, Rhode Island Disability Council Conference, Rhode Island College, Providence, RI March 9, 2015

Trauma Talks and Talks and Talks: But What do we Hear and What do we Do? (keynote address). Grafton Integrated Health Network First Annual Symposium, The National Conference Center, Leesburg, VA October 21, 214

REsTRAIN Yourself: Implementing the Six Core Strategies UK to Reduce Harm as a Result of the Use of Physical Restraint. 2-day workshop sponsored by the University of Central Lancashire, Salford Innovation Forum, Salford, UK June 23-24, 2014

The Six Core Strategies: *What are They? Why Should You Care? Do they Only Work in a Hospital?* Western MA Department of Mental Health Grand Rounds, Northampton, MA April 17, 2014

What Have we Learned about Restraint and Seclusion use with Children? (keynote address) at Prevention of Restraint and Seclusion in CT's Schools: Putting Principles into Practice: An Educational Forum for Policymakers, Educators, and Parents, Legislative Office Building, Hartford, CT January 23, 2014

Massachusetts: A Legacy of Restraint and Seclusion Prevention. Grand Rounds presentation at Worcester Recovery Center and State Hospital, Worcester, MA October 8, 2013

Everything you Wanted to Know about the Six Core Strategies© but Were Afraid to Ask. Department of Mental Health Statewide Leadership Forum, Worcester, MA October 3, 2013

Trauma-Informed Care: A Change in Perspective and **Strategies for Moving from Control to Collaboration** (keynote address). Easter Seals conference, Manchester, NH September 17, 2013

From Seclusion to Inclusion, From Restraint to Empowerment ... *Where is DMH Going?* (keynote address). Department of Elementary and Secondary Education Statewide Professional Development Meeting, Norwood, MA September 3, 2013

Creating Positive Cultures of Care, Sequoyah Residential Treatment Center, Albuquerque, NM August 1-2, 2013

Advocating for Trauma-Informed Care: Making Theory a Reality. National Disability Rights Annual Conference, San Antonio, TX June 5, 2013
The Neurobiological and Psychological Effects of Trauma. Geocare: So. Florida State Hospital Conference. Pembroke Pines, FL March 22, 2013

What is Trauma and Why Must we Address it? The Up Center Annual Conference. Ted Constant Center, Old Dominion University, Norfolk, VA January 31, 2013.

Healing the Mind and the Body: Integrating Trauma Informed Care and Sensory Intervention (keynote address). Center for Human Development Annual Conference: Trauma and Attachment Informed Care Innovations. Springfield, MA November 9, 2012

Looking Toward the Future: Incorporating Trauma Informed Care and Reduced Seclusion & Restraint in our Mental Health System (keynote address). Ontario Shores Centre for Mental Health Services 4th Annual Mental Health Thought Leadership Forum, Toronto, Ontario, Canada September 20, 2012.

***What's Trauma Got to do With It?:* Understanding the Brain & Behavior in Context** (keynote), and **Transforming Care: Moving Away from all Things Coercive** (workshop). Texas Network of Youth Services Annual Conference, San Antonio, TX August 16, 2012

The Business Case for Reducing Restraint and Seclusion in Public Schools. Federal Department of Education's Region One Parent Technical Assistance Center Annual Conference, Buffalo, NY June 6, 2012

Leading to Positive Cultures of Care by Preventing Restraint & Seclusion and Full Inclusion of Youth & Families: One State's Experience. Leadership Summit for MH-Kids / New South Wales Health Department, Sydney, AU March 12, 2012

Creating Positive Cultures of Care. Two 2-day symposium/presentations for all NSW child/adolescent inpatient services. Clifton's, Sydney, New South Wales, AU March 13-16, 2012

Creating a Culture of Care: Implementing Trauma-Informed Practices

to Reduce Seclusion & Restraint. Two 2-day trainings for Texas residential providers, sponsored by the Hogg Foundation & Texas Network of Youth Services; Houston & Austin, TX January 9-12, 2012

Making Trauma Informed Care Real: Leading, Planning & Raising Standards of Practice. Magellan of Nebraska Annual Symposium, Lincoln, NE December 13, 2011

Restraint & Seclusion: The National Prevention Effort & Core Strategies to Change Practice; and **The Neurobiological and Psychological Effects of Trauma** and **Sensory Interventions to Promote Healing;** and **The Business Case for Restraint & Seclusion Prevention.** TASH: No Excuses! Annual Conference, Atlanta, GA December 1, 2011

Restraint & Seclusion Prevention in the USA: Core Strategies to Reduce Use and Sustain Gains, 7th European Congress on Violence in Clinical Psychiatry, Prague, Czech Republic, October 21, 2011

Preventing Violence, Trauma, and the Use of Seclusion and Restraint in Mental Health Settings, 2-day training, Niuvanniemi Hospital, Kuopio, Finland, September 22 & 23, 2011

Emerging Consumer Roles in Massachusetts, Substance Abuse Mental Health Services Administration conference: Effective Use of Peer Programs to Prevent the Use of Seclusion and Restraint. Boston, MA, August 9, 2011

Congressional Briefing & Testimony (H.R. 1381: Keeping All Students Safe Act) regarding restraint and seclusion use and economics: The Business Case for Reducing Restraint and Seclusion Use. B-338 Rayburn House Office Building, Washington, D.C., June 28, 2011

National Seclusion and Restraint Reduction Efforts and Psychosocial Rehabilitation Applications, National United States Psychiatric Rehabilitation Association Conference, Boston, MA, June 14, 2011

Optimizing Treatment: Developing the Talent Within. New York Office of Mental Health Lessons Learned Conference. Poughkeepsie, NY, May 25, 2011

Transformation of Care & Sensory Interventions and Crisis Prevention Planning. Contemporary Forums, National Psychiatric Nursing Conference, Philadelphia, PA, March 24 & 25, 2011

The Business Case for Restraint & Seclusion Reduction & Trauma Informed Care for Adolescents with a Disability, Division of Health Services, Treasury Theatre, Melbourne, Victoria, AU, February 9, 2011

Neurobiological and Psychological Effects of Trauma, Delaware Health and Social Services, Division of Substance Abuse and Mental Health, Summer Institute on Substance Abuse and Mental Health, Newark, DE, July 26, 2010

Preventing and Reducing Restraint and Seclusion Use: Massachusetts Moves *Forward*, State Health Research and Policy Interest Group Meeting, AcademyHealth, Hynes Convention Center, Boston, MA June 26, 2010

Moving Away from Restraint and Seclusion: Addressing Violence, Trauma & Fiscal Realities. AACRC Annual Conference, Waltham, MA, April 28, 2010

Core Strategies to Prevent Restraint and Seclusion; & Connecting the Mind and the Body: Moving thru Crises with Sensory Interventions. Contemporary Forums Psychiatric Nursing Conference, Las Vegas, NV, April 22 – 24, 2010

Massachusetts Child/Adolescent Statewide Program Restraint/Seclusion Prevention Journey, SAMHSA Recognition Ceremony, Rockville, MD, March 31, 2010

Addressing Violence and Trauma in Children's Services: How Cultures of Care are Changing, Robert F. Kennedy Action Corps. Leadership Institute, Westford, MA, October 27, 2009

Building the Business Case for Preventing and Reducing Seclusion and Restraint, Sixth European Congress on Violence in Clinical Psychiatry, Stockholm, Sweden, October 21-24, 2009

Setting the Stage for Change: The Statewide Restraint and Seclusion Prevention Initiative, Executive Leadership Forum, Hoagland-Pincus Conference Center, Shrewsbury, MA, May 29, 2009

Preventing Violence, Trauma, and the use of Seclusion and Restraint in Mental Health Settings, Crestwood Behavioral Health, Sacramento, CA February 25-26, 2008; Centre for Addiction and Mental Health, Toronto, Canada April 29-30, 2008; Northeast Mental Health Centre, North Bay, Ontario, Canada October 8-9, 2008; Centre for Addiction and Mental Health, Toronto, Ontario, Canada March 25 – 27, 2009; St. Joseph's Healthcare, Hamilton, Ontario Canada May 11 – 13, 2009; Ontario Shores Centre for Mental Health Services, Whitby, Ontario, Canada September 16, 2009; PsycHealth, Winnipeg, MB, Canada March 14-15, 2011; Ontario Shores Centre for Mental Health Services, Whitby, ON, Canada September 18-19, 2012; Health Science Center, Winnipeg, MB, Canada March 24-27, 2014; Vermont Cooperative for Practice and Innovation, Fairlee, VT October 9-10, 2014; Vermont Cooperative for Practice and Innovation, Rutland, VT November 16-17, 2015; Novalis Trust Stroud, UK January 31 – February 1, 2017; MH-Kids, Sydney, NSW, AU May 8-12, 2017; Bridgewater State Hospital, Bridgewater, MA September 25-26, 2017; Waterbury, VT April 24-25, 2018; Raleigh, NC May 21-22, 2018; Novalis Trust, Stroud, UK 12/15-21/19; Newton-Wellesley Hospital, Newton, MA March 4-5, 2020; *Remote trainings:* MI DHHS October 30, 2021, NY OCFS NY, NY, February 23, 2021; Community Health Network, Indianapolis, IN March 2-22, 2021; SalusCare, Ft. Myers, FL April 5-26, 2021; Vermont VCPI June 4-25, 2021; AU NSW Health, June 8-June 25, 2021;

The National Initiative to Eliminate Seclusion & Restraint, Wisconsin Department of Health Services, Mendota Mental Health Institute, Madison, WI November 16, 2008

Understanding Trauma: Prevalence, Effect & Treatment, Maimonides Medical Center, Brooklyn, NY November 12, 2008

A Future Without Restraints, 18th World Congress IACAPAP, Istanbul, Turkey, May 3, 2008

Letting Go of Seclusion and Restraint: Local, State & National Perspectives, Boston University Center for Psychiatric Rehabilitation Conference: From Innovations to Practice, Cambridge, MA April 15, 2008

Latest International Developments in Seclusion and Restraint Use; Prevention & Customizing Care Using Best Practice Knowledge, Hogg Foundation Conference, Implementing Seclusion and Restraint Reduction: Sharing the Experience, Austin, TX June 22, 2007

Regulatory, Clinical, and Educational Approaches to Eliminating Restraint and Seclusion, World Psychiatric Association, Dresden, Germany, June 8, 2007

National Forums to Create Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint, government-sponsored conference presentations to mental health leadership in Brisbane, QLD (Bardon Conf. Ctre.) and Melbourne, VIC (Telstra Dome) Australia February 19-23, 2007

Implementing and Sustaining More Compassionate Care for Children, Florida Statewide Inpatient Psychiatric Provider Conference, Tampa, FL December 6, 2006

Preventing Trauma through the Reduction and Elimination of Seclusion and Restraint, Symposium presentation with Gregory Smith, PA State Hospital System, Kevin Huckshorn, NASMHPD-NTAC, American Psychiatric Association 58th Institute on Psychiatric Services, New York, NY October 5-8, 2006

Seclusion & Restraint: Creating Violence-Free Environments of Care – State and National Perspectives, Symposium presentation, World Psychiatric Association, International Congress, Istanbul, Turkey July 12-16, 2006; Conrad Day Speaker, McLean Hospital, Belmont, MA December 1, 2006

Crossing the Population Chasm: Learning Together to Prevent Seclusion and Restraint, Keynote Speaker, Wyoming Developmental Disabilities Division Statewide Conference, Thermopolis, WY June 21-22, 2006

National Forums to Create Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint, conference presentations in Sydney, Australia and Auckland & Wellington, New Zealand, weeks of March 6 & 13, 2006, respectively.

19th Annual Research Training Center for Children's Mental Health Conference, Efforts by State Mental Health Agencies to Improve Residential Care and Eliminate Seclusion and Restraint, paper & poster presentation, Tampa, Florida February 23 & 24, 2006

Reducing the Use of Seclusion and Restraint, National Disability Rights Network, National Skills Building Training, San Diego, CA January 10, 2006 & Washington, D.C. June 15, 2006

Restraints and Seclusion 2005: Where We've Been and Where We're Going, NAMI National Convention, Austin, Texas June 21, 2005

Cents & Sensibilities: The Economic Cost of Restraint and the Value Added by Restraint Reduction, Examining the safety of high-risk interventions for children and young people: An international symposium for researchers, policy makers, advocates and intervention system providers, Cornell University, Ithaca, NY June 3, 2005

It Shouldn't Hurt to be a Kid in Treatment: How MA is Replacing Restraint and Seclusion with Strength-Based Care, Deborah Janssens Memorial Grand Rounds, U. MA Medical School, Worcester, MA May 5, 2005

Trauma-Informed Care: Understanding the Profound Impact of Violence and Victimization & Moving from Control to Collaboration
Uta Halee Girls Village/Cooper Village 4th Annual Symposium, Omaha, NE April 28 – 29, 2005

Learning How to Apply Sensory Approaches to Psychiatric Inpatient Treatment, 20th Annual Psychiatric Nursing Conference, Contemporary Forums, New Orleans, LA April 16, 2005

Promoting Strength-Based Care to Reduce Restraint and Seclusion: A Statewide Initiative, 20th Annual Psychiatric Nursing Conference, Contemporary Forums, New Orleans, LA April 15, 2005

A National Training Model for the Reduction and Elimination of the Use of Restraint and Seclusion, National Association for Children's Behavioral Health Mid-Year Technical Meeting, Delray Beach, FL December 9 - 10, 2004

Measuring, Sustaining and Advancing Restraint Reduction/Elimination Success, a Symposium Presentation with Charles Curie, SAMHSA Administrator, Kevin Huckshorn, NASMHPD-NTAC, Ross Greene, Mass. General Hospital at the American Academy of Child & Adolescent Psychiatry 51st Annual Meeting, Washington, DC, October 19 - 24, 2004

National Executive Training Institute, National Association of State Public Mental Health Directors: Creating Violence Free and Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint: South Florida State Hospital, Pembroke Pines, FL February 4 - 7, 2003; Philadelphia, PA April 29 - May 1, 2003; St. Louis, MO May 26 - 29, 2003; Las Vegas, NV August 12 -15, 2003; State of Florida Inpatient and Residential Treatment System, November 16 - 18, 2003; Las Vegas, NV June 9 – 10, 2004; Columbus, OH July 22 – 23, 2004; Seattle, WA January 10 – 12, 2005; Baltimore, MD March 13 – 16, 2005; Newton, MA July 14 – 15, 2005; New Orleans, LA August 25 – 26, 2005; Honolulu, HI September 14 – 16, 2005;

Farmington, CT October 5 – 6, 2005; Baltimore, MD November 7 – 9, 2005; Cedar Grove, NJ November 17, 2005; Tampa, FL December 15 - 16, 2005; Farmington, CT January 22 – 23, 2006; Pembroke Pines, FL February 21, 2006; Newton, MA March 22-23, 2006; Westboro, MA May 11-12, 2006; Columbus, OH June 8-9, 2006; Atlanta, GA July 31, 2006; San Antonio, TX September 20-22, 2006; Springfield, IL October 25, 2006; Fulton, MO November 2-3, 2006; St. Petersburg, FL November 29-30, 2006; Towson, MD June 25-26, 2007; New York, NY July 24-25, 2007; Baltimore, MD April 1-2, 2008; Staunton, VA September 4-5, 2008; Williston, VT October 27-28, 2008; Mt. Laurel, NJ September 2-3, 2009; Worcester, MA December 1-2, 2009; Louisville, KY October 4-5, 2011

Cents & Sensibilities: What Leaders Should Know, State of Connecticut, Riverview Hospital, Middletown, CT, May 24, 2004; New York Office of Mental Health, Best Practices in Residential Care conference, Albany, NY June 7, 2004; Foundations Behavioral Health consultation, Doylestown, PA August 6, 2004

Collaboration in Care: Use of Personal De-escalation Tools in Psychiatric Settings, Contemporary Forum's 19th Annual National Psychiatric Nursing Conference, Jersey City, NJ April 30, 2004

Reducing the Use of Restraint & Seclusion in Child & Adolescent Inpatient Programs, Contemporary Forum's 19th Annual National Psychiatric Nursing Conference, Jersey City, NJ April 30, 2004

The Cents & Sensibilities of Restraint Reduction/Elimination, SAMHSA CMHS One-MHSIP Spring 2004 Meeting, Boston, MA April 21, 2004

Key Elements in Preventing Restraint and Seclusion, Westboro State Hospital Grand Rounds, Westboro, MA April 6, 2004

Cents & Sensibilities: What Leaders Should Know, Massachusetts Department of Mental Health Leadership Forum, Metro West Medical Center, Natick, MA March 30, 2004

Cents & Sensibilities: Substantial Savings Through Systematic Restraint Reduction/Elimination, National Association of State Mental Health Program Directors Research Institute Conference on Services Research and Evaluation: Dollars and Sense: Using the Knowledge Base to Inform Decisions and Practices in a Time of Limited Resources, Arlington, VA February 9, 2004

Reducing Restraint/Seclusion use in Child/Adolescent Inpatient Treatment New Jersey Department of Mental Health, Trenton, NJ October 7 - 8, 2003

Human Service Integration: Considering Child/Adolescent Restraint Reduction Across Agencies, Suffolk University, Boston, MA August 4, 2003

The Massachusetts Child/Adolescent Restraint Reduction Initiative Coalition for the Legal Rights of People with Disabilities Annual Conference Suffolk University, Boston, MA October 22, 2002

Using Evidence to Evaluate Practice: The Massachusetts Department of Mental Health Child/Adolescent Restraint/Seclusion Reduction Effort, Convergence of Data Initiatives: Working Together on Data Infrastructure and Promoting Effective Use of Data, Conference on Mental Health Statistics, SAMHSA, Washington DC May 28 – 30, 2002

Innovative Practices and Lessons Learned: A Forum on Restraint and Seclusion: Best Practices to Improve Safety, Massachusetts Medical Society, (October 2001, November 2001), Waltham, MA

Strength-Based Care in the Treatment of Children and Adolescents; Reducing/Eliminating the Use of Restraint & Seclusion:
(Jan., Feb., May, June, Oct., Nov., 2001
Jan., Feb., March, June, Sept., Oct., Nov., Dec. 2002
Jan., Feb., March, April, May, June, July, August, Sept., Oct., Nov., 2003)

INTERESTS

Board Chair & Trustee ~ Grafton Integrated Health Network ~ Winchester, VA
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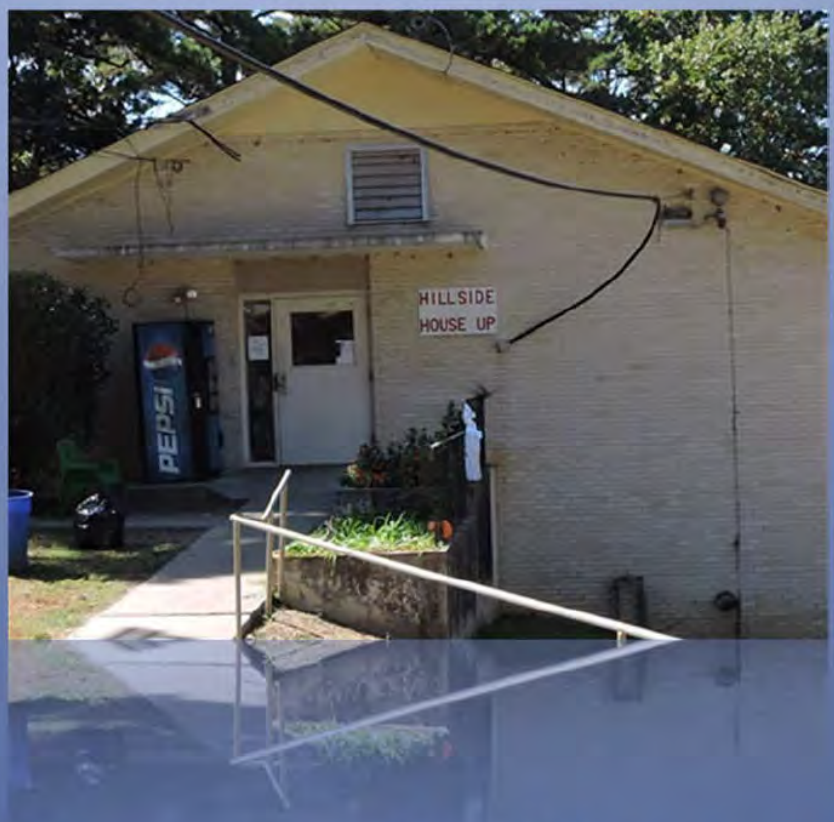

Booneville Human Development Center Death Investigation January 2016

Disability Rights ARKANSAS

Booneville Human Development Center Death Investigation

A public report by

Disability Rights Arkansas, Inc.

January 2016

Acknowledgements

Disability Rights Arkansas, Inc. (DRA) is the federally authorized and funded Protection and Advocacy System and Client Assistance Program for individuals with disabilities in Arkansas. DRA is authorized to protect the human, civil, and legal rights of all Arkansans with disabilities consistent with federal law.

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Executive Summary

In January 2015, Disability Rights Arkansas, Inc. (DRA) issued a report concerning the Booneville Human Development Center (HDC), a state owned and operated ICF/IID at which approximately 121 individuals with developmental disabilities reside. In the monitoring leading up to that report, DRA determined that there was excessive mechanical and chemical restraint of residents at the facility. DRA included information about this in its January 2015 report.[1] DRA found that the use of restraints was unreasonably high when compared with the other similarly-sized Human Development Centers located in Arkansas. DRA recommended that the Arkansas Department of Human Services take steps to determine the root causes of the excessive use of restraint at this facility and pay particular attention to the behavior plans of those residents who are frequently restrained.

DRA followed up its January 2015 report with further investigation and review of restraint practices at the Booneville HDC. DRA issued a second report on January 2016 regarding the excessive use of restraint at the facility.[2] DRA found that, in the months following the January 2015 report, the use of mechanical and chemical restraints at Booneville HDC was excessive, was not consistent with the facility's policies, and was not the product of thorough behavior analysis and programming.

As part of the investigation done for the January 2016 report, DRA reviewed restraint information and identified residents who were repeatedly restrained on a regular basis and for excessive amounts of time at Booneville HDC. DRA then sought further information about those residents. One of these residents was Jane, a 24 year old female who had been placed at the Booneville HDC in 2008 when she was 18 years old, after she briefly resided at the Conway Human Development Center.[3]

Jane was an individual with Mild Intellectual Disability and several mental health diagnoses, including Bipolar Disorder. Part of Jane's treatment and habilitation needs included services to address her emotional and behavioral

[1] A copy of this report can be found at http://disabilityrightsar.org/wp-content/uploads/2015/11/BHDC-Final-Report-January-2015.pdf.
[2] A copy of this second report can be found at http://disabilityrightsar.org/wp-content/uploads/2016/01/DRA-Booneville-Report-January-2016-1.pdf.
[3] DRA will identify the decedent by the name "Jane" in order to protect her anonymity. In addition, the names of the other parties involved have been redacted.

functioning. Jane was assigned to a Special Treatment Program housing unit at the Hillside House at Booneville HDC for most of her time at the facility.

On April 23, 2015, DRA went to the Booneville HDC to meet Jane and talk with her about her experiences with restraint at the facility. DRA wanted to interview her because from January 2014 to February 2015, Jane had been physically restrained more than 40 times for a total of 36 hours and 49 minutes. DRA was not able to interview Jane. Upon arriving at the facility, DRA learned that Jane had died on February 26, 2015, as a result of choking to death on food.

Due to concerns about the treatment of residents generally and the treatment of Jane specifically, DRA conducted an investigation into the circumstances surrounding her death. DRA's investigation revealed that not only was Jane the victim of excessive restraint, she also was the victim of dangerous "treatment" that led to the development and implementation of a behavior treatment program that ignored serious medical concerns, including Jane's known risk of choking and history of seizure episodes that included falling, jerking, and vomiting.

There were both choking and seizure precautions ordered for Jane in the years preceding her death. Those precautions were meant to ensure her safety around food to avoid choking incidents and to provide appropriate action in the event of choking or seizure. Yet these precautions were ignored when a tragic and dangerous decision was made to implement a Behavior Treatment Program that emphasized ignoring any behavior that resembled a seizure because it was believed that Jane was deliberately engaging in the seizure-like episodes to garner attention.

The Behavior Treatment Program for Jane was fatally flawed because it did not acknowledge the conflicts between the choking and seizure precautions required for Jane's safety and the directive that staff ignore her seizure-like episodes. The Behavior Treatment Program was implemented despite concern expressed by direct care staff to the facility's Director of Nursing that the Program caused direct care staff to act outside of their qualifications. Ultimately, Jane choked to death because of a disregard for choking and seizure precautions.

Although Jane's death was not due to a restraint, she did die as a result of the outdated and primitive responses to behaviors used at the Booneville HDC that dangerously combined with a lack of coordination in medical and behavioral

care that left her, and continues to leave other residents, at risk of injury and death. Jane was victim to a dangerous Behavior Treatment Program that ignored serious medical issues and punished her for seeking attention, a normal human need. She was left in the care of direct care staff who were in the untenable position of being instructed to not pay attention to Jane during seizure-like episodes in which she had a heightened risk of choking.

Moreover, as with the excessive use of restraint, the State system charged with oversight and monitoring the treatment and deaths of individuals at the Booneville HDC took only a cursory look at the circumstances leading to Jane's death, thus failing her in death as in life.

DRA urges the Arkansas Department of Human Services and its Division of Developmental Disabilities Services to immediately take the following actions as a start toward ensuring better care for Booneville HDC residents and avoiding unnecessary deaths of residents like Jane:

- immediately hire an independent expert or group of experts to review and assist in evaluating and improving the treatment and habilitation services provided to Booneville HDC residents;
- obtain an independent, expert evaluation of each Booneville HDC resident to make comprehensive recommendations for their treatment and habilitation needs, including coordination of medical and psychological treatment and safety;
- implement a more rigorous, independent review of treatment decisions, practices and incidents, including deaths; and
- implement the recommendations contained in DRA's January 2016 report.

Jane's death at 24 years old was an avoidable tragedy. It is also a warning. Without both adequate collaboration and meaningful review of the practices at Booneville HDC, the unreasonable risks to the safety of the residents will persist.

Tom Masseau, Executive Director
Disability Rights Arkansas, Inc.

Death Investigation Report

On February 26, 2015, Jane, a 24 year old resident of the Booneville Human Development Center (Booneville HDC), was pronounced dead at Booneville Mercy Hospital. Earlier that evening, Jane collapsed, began having seizure-like activity, and vomited on the floor of the TV room of her living unit. By the time she was assessed by medical staff, Jane was lying in her own vomit and spilled cereal and was accompanied by staff members who were ordered not to look directly at Jane while she was experiencing seizure-like activity. Mercy Hospital reported her cause of death as cardiac arrest, seizure, and choking due to food in the larynx. The Arkansas State Crime Laboratory conducted an autopsy and ruled that Jane's cause of death was "[a]sphyxia due to airway occlusion by food bolus." In other words, Jane's airway was blocked by food, and she choked to death.

Disability Rights Arkansas[4] (DRA) undertook an investigation into Jane's death pursuant to our federal authority under 42 U.S.C. §§ 15041-15045 and 42 U.S.C. § 10801 *et seq.*[5] DRA's investigation revealed several serious areas of concern that lead us to conclude that Jane's death was both avoidable and resulted from the deviation from the standard of care expected of a facility of this type in significant ways.

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[4] Disability Rights Arkansas, Inc., is the federally authorized and funded nonprofit organization serving as the Protection and Advocacy System (P&A) for individuals with disabilities in Arkansas. As part of its responsibility under federal law, Disability Rights Arkansas monitors and investigates where persons with disabilities reside to determine whether treatment and resources are fair and humane, including whether residents have been subject to abuse and neglect. Disability Rights Arkansas has not only the authority, but also the obligation to investigate and report these abuses pursuant to: (1) Part C of Title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the DD Act), 42 U.S.C. 15041-15045; (2) the Protection and Advocacy for Individuals with Mental Illness Act of 1986 (the PAIMI Act), 42 U.S.C. 10801 *et seq.*; and, (3) the Protection and Advocacy of Individual Rights (PAIR) Program of the Rehabilitation Act of 1973, 29 U.S.C. 794e.

[5] Disability Rights Arkansas' investigation included a review of all available records regarding Jane's residency and treatment at the facility, applicable policies, procedures and standards, interviews both with Booneville HDC staff and DDS Assistant Director for Quality Assurance, and consultation with a medical expert.

The failures of the facility that combined to cause this tragic event include the following:

- The facility failed to initiate any safe, evidence-based interventions or plans to address Jane's behavior. The Behavior Treatment Program developed for Jane placed her at increased risk of choking, thereby further jeopardizing her safety; the intervention recommended in that Program directly led to her death.
- There was a lack of adequate communication or careful consideration among medical, psychological, and psychiatric personnel at the facility when recommending a Behavior Treatment Program. Jane's Behavior Treatment Program required staff to ignore a dangerous situation, exposing her to increased choking risk during seizure-like activity.
- The facility failed to initiate or follow appropriate, adequate choking precautions while Jane was eating cereal. The failure of the staff to follow these precautions as well as the inability of the staff to identify and respond appropriately to a choking incident, led to Jane's untimely death.
- The Booneville HDC and Arkansas Human Development Center Death Review Committee both conducted reviews of the circumstances of Jane's death; however, the reviews by both Booneville HDC and the Arkansas Human Development Center Death Review Committee were superficial and concluded without complete information or adequate scope.

This report summarizes DRA's findings, conclusions, and recommendations based on information obtained as a result of its investigation.

Findings

1. On July 9, 2008, Jane, at eighteen years old, was admitted to the Booneville Human Development Center (Booneville HDC) on a respite basis and was made a permanent resident on July 24, 2008. Before this, Jane was placed at the Conway Human Development Center for less than one year. Booneville HDC Social Services Department, Social History Narrative, December 17, 2014.

2. Shortly before her admission to the Booneville HDC, the Reynolds Intellectual Assessment Scales (RIAS) was administered to Jane and resulted in an IQ score of 44, which was determined to be in the moderate range of intellectual disability. The Vineland Adaptive Behavior Scales, Second Edition (VABS-II) was administered to assess Jane's adaptive behavior functioning, which resulted in adaptive behavior functioning determined to be in the mild range of intellectual disability. Booneville HDC Psychological Evaluation, [redacted], M.S., Psy. Ex. II, July 14, 2008.

3. Based upon the RAIS and VABS-II results from July 2008, Jane's functioning was determined to be in the *mild range* overall. *Id.*

4. At the time of her admission to the Booneville HDC, Jane had been diagnosed with the following: Bipolar I Disorder, Manic; Enuresis; and Mild Mental Retardation. Booneville HDC Medical Review, December 16, 2014.

5. For most of her time at the Booneville HDC, Jane resided in the Hillside House Special Treatment Program housing unit. Individual Program Plan Annual Review, January 27, 2014.



Hillside House Entrance

6. Individuals in a Special Treatment Program

must meet certain admission criteria, including a psychiatric disorder that significantly impairs functioning and a history of challenging behaviors. Booneville HDC Special Treatment Program Description, Revised February 10, 2012.

7. The Special Treatment Programs at the Booneville HDC utilize a differential reinforcement of other behavior (DRO) framework, which is intended to reinforce appropriate behavior as defined by the facility. *Id.*

8. Residents in the Special Treatment Program earn points for positive behaviors and are awarded reinforcement from one of three levels if meeting the point level required. *Id.*

9. Residents are eligible for discharge from the Special Treatment Program after meeting exit criteria and are considered for transfer to a lesser restrictive environment at that time. *Id.*

10. Jane passed away on February 26, 2015, after an incident at the Booneville HDC in which she choked to death. Arkansas State Crime Laboratory Autopsy, 7.

11. At the time of her death, Jane had been a resident at the Booneville HDC for roughly seven years.

12. The Booneville HDC Death Summary identified Jane's diagnoses as "Mild Intellectual Disability; Antisocial Personality features; Bipolar 1 Disorder, Moderate, Most Recent Episode Manic; Factitious Disorder; Enuresis, Nocturnal and Diurnal; Sinus Tachycardia; Astigmatism; Hyperlipidemia; Constipation; Seasonal Allergic Rhinitis; History of Possible Pseudo Seizures; Anemia of Chronic Disease; Contraception." Booneville HDC Death Summary, p. 1.

13. The Death Summary identified Jane's medications as Ativan (prolonged seizure activity); Clozapine (antipsychotic); Haldol (Bipolar Disorder); Multivitamin (Nutritional Supplement); Desmopressin (Enuresis Diurnal); Diastat (prolonged seizure activity); Depakote (mood stabilizer/Seizures); Colace (stool softener), Ferrous Sulfate (Iron Supplement); Lithium

(antipsychotic); Loestrin FE (birth control); Loratadine (Claritin); Nasacort AQ (Seasonal Allergic Rhinitis); Inderal (to decrease her fast heart rate); Simvastatin (Hypercholesterolemia); and, Polyethylene Glycol (bulk laxative). *Id.*

Choking Precautions

14. "Choking Risk Assessments" identify the residents' likelihood to choke and provide guidance for precautions that aid in ensuring the safety of the resident from choking.

15. On April, 27, 2011, Jane received a modified barium swallow study due to having scored above 50% on a previous Choking Risk Assessment. Booneville HDC Dysphagia Disorder Survey, January 10, 2014.

16. On April 26, 2012, Jane had a repeat barium swallow study. *Id.*

17. Both the 2011 and 2012 barium studies indicated Jane had a delayed swallow with premature spillover. *Id.*

18. On December 3, 2013, Booneville HDC nursing staff assessed Jane for choking risk by utilizing the Choking Risk Assessment form, which assesses risk based on ten categories. Choking Risk Assessment, December 3, 2013.

19. At this time, Jane's choking risk was assessed at 60% based on:

a. dysphagia diagnosis;
b. medication side effects;
c. mealtime actions and behaviors;
d. rate of spooning and drinking; and
e. excessive size mouthfuls. *Id.*

A score of 60% identified Jane as a "High Risk" for choking. Booneville HDC Medical Annual Review, January 2014; Booneville HDC Dysphagia Disorder Survey, January 31, 2014.

20. As a result of the choking risk assessment, choking precautions were ordered for Jane, which included chopping all of Jane's foods, monitoring all meals and snacks, and utilizing weighted utensils and other adaptive

equipment. *Id.* Choking Precautions had been ordered since at least 2013. Physician Order Form, December 20, 2013; *see also* Death Summary, p. 3.

21. On January 10, 2014, a speech pathologist administered a Dysphagia Disorder Survey Screening to Jane. Booneville HDC Dysphagia Disorder Survey, January 31, 2014.

22. The Dysphagia Disorder Screening identified Jane's eating risks and issues to be taking bites and sips that were too large, being distractible while eating, and slumping. The Screening resulted in a recommendation that choking precautions be continued. Booneville HDC Dysphagia Disorder Survey Narrative Summary, January 31, 2014.

23. On January 13, 2014, direct care staff conducted an Annual Review of Jane and identified Jane as a "choker" who gets distracted at meal times and who is monitored for choking. Direct Care Assessment Annual Review, January 13, 2014.

24. On January 31, 2014, the speech pathologist drafted an eating and dining plan to address Jane's choking risk that included:

a. monitoring of Jane during all meal times;
b. ensuring that she sit upright at 90 degrees;
c. ensuring that she take small bites and sips while eating;
d. using adaptive equipment, such as a weighted cup, weighted spoon, and wrist weights; and
e. informing medical staff of any signs or symptoms of aspiration.

25. On December 8, 2014, Booneville HDC nursing staff re-assessed Jane for choking utilizing the same Choking Risk Assessment form used on December 3, 2013. At this time, Jane's choking risk was scored at 30% based on dysphagia diagnosis, medication side effects, and excessive size mouthfuls. Choking Risk Assessment, December 3, 3013.

26. The December 2014 Risk Assessment did not consider the previous issues that the 2013 Choking Risk Assessment and the 2014 Dysgraphia

Disorder Survey Screening had identified that would put Jane at higher risk for choking, namely mealtime actions, mealtime behaviors, and rate of spooning and drinking. Choking Risk Assessment, December 8, 2014.

27. Furthermore, neither the 2013 nor 2014 Choking Risk Assessments reflect knowledge of or information about Jane's seizure activity when both identifying and assessing choking risk, though that information is requested as part of the assessment. *Id.* This was a significant omission due to the amplified risk to Jane of choking.

28. The Death Summary reiterated that Jane's "choking risk was 30% as a result of medication that could affect swallowing, mild Dysphagia disorder and taking excessive size mouthfuls at times," based on evaluations completed on December 8, 2014. Booneville HDC Death Summary, p. 3.

29. Despite failure to identify seizure activity as part of the choking risk assessment, choking precautions were ordered for Jane and remained in effect until the time of her death. Booneville HDC Medical Review, December 16, 2014. Physician's Orders, renewed by Dr. [redacted] on January 2, 2015.

Seizures

30. Jane had a history of seizure-like symptoms that presented as jerking and shaking. Death Summary, p. 2.

31. These episodes were, at times, accompanied by vomiting, urination, falling, and catatonic features. Seizure Report, September 29, 2014; Behavior Reports 2014-2015, discussed individually below.

32. Since at least 2009, Jane had been placed on seizure and choking precautions that included, but were not limited to staff informing the Team RN if any coughing or gurgling sounds occur after eating, as well as if staff observed a wet gurgling sounding voice or any other signs/symptoms of aspiration. Dysphagia Disorder Survey, Narrative Summary, January 10, 2014; Dining Plan, January 31, 2014; Physician's Orders, January 2, 2015.

33. Jane had been seen by a neurologist since at least January 24, 2011. Neurology Progress Note, February 26, 2013.

34. In the months leading up to her death, Jane suffered injuries due to falls that occurred during seizure-like activity, resulting in lacerations to the head, face, and knees:

> *August 23, 2014*: Scraped knee due to seizure activity. (Injury Report, August 23, 2014).
>
> *September 3, 2014*:
>
> Lacerated lower lip and chin after falling down stairs, attributed to a seizure. (Injury Report, September 3, 2014).
>
> *November 8, 2014*:
>
> Abrasion to the back of the head from falling during a seizure. (Injury Report, November 8, 2014).

35. Jane suffered additional falls during 2014 that resulted in injuries, though those falls were not attributed to seizures by direct care or nursing staff:

> *December 9, 2014*:
>
> The Behavior Report states that Jane "had a sudden jerking movement and fell, re-opening an old abrasion on her knee" (Behavior Report, December 9, 2014)[6] The Injury Report accompanying the fall does not document the injury as seizure-related. (Injury Report, December 9, 2014). Jane continued to experience "jerking" and falling, which staff characterized as "attention-seeking." (Behavior Report, December 9, 2014).

[6] A Behavior Report completed on December 9, 2014, describes Jane making "jerking motions" and falling to the ground, with no attempts to break her fall. This Behavior Report states that this happened four times and that "staff could feel the muscle type spasms in her arms." Due to the jerking motions, the Behavior Report states that most of Jane's lunch was spilled or ended up on the floor. Medical was notified and made two visits to check on her. (Behavior Report, December 9, 2014). The Injury Report that coincided with the Behavior Report mentions that Jane falls, but makes no mention of jerking or spasms. (Injury Report, December 9, 2014).

July 25, 2014:

Staff reported that Jane's whole body would jerk while she was getting medications from nursing staff. Staff responded to the jerking by telling Jane to stop because staff "thought it was a behavior." (Behavior Report, July 25, 2014).

- Shortly thereafter, Jane arrived at class, and staff members were told about the previous jerking behavior and were asked to observe for that behavior. Staff stated that, during observations, Jane was jerking. While eating a cracker, Jane's body jerked causing her cracker to hit the floor. As Jane was later walking to mobile (the van used by the facility for transport), she began jerking. She jerked hard and fell to the ground. Staff stated that she was jerking hard and fast. Jane also began vomiting and breathing heavily at that time. (Behavior Report, July 25, 2014).
- The Injury Report completed for treating Jane's scraped knee does not document the injury as seizure-related. (Injury Report, July 25, 2014).[7]

36. From July 2014 until February 2015, Booneville HDC staff reported more than twenty incidents in which Jane had seizure-like activity. There were 9 such incidents in the month preceding Jane's death.

July 25, 2014:

Jane had been exhibiting "jerking" during mealtime. Later, as she was walking to mobile, she began to jerk hard and fell to the ground, vomiting and breathing heavily (Behavior Report, July 25, 2014).

[7] There were additional Injury Reports completed where Jane's injuries were attributed to falls, but no Behavior Reports were provided to know the circumstances surrounding those falls.

August 23, 2014:

Jane had a seizure lasting at least four minutes, which was accompanied by vomiting (Nurse's notes, August 23, 2014).

August 25, 2014:

Jane had a seizure lasting between four and twelve minutes, which also included vomiting and urine incontinence (Nurse's notes, August 28, 2014).

August 29, 2014:

Jane was "jerking" during breakfast (Behavior Report, August 29, 2014).

August 29, 2014:

Jane "jerked' and fell to the ground while working. She was stiff and jerking around on the floor. She then vomited, urinated on herself, and became unresponsive. The incident lasted for twelve minutes (Behavior Report, August 29, 2014).

September 11, 2014:

Jane jerked while carrying her tray and fell to her knees (Behavior Report, September 11, 2014).

September 11, 2014:

Three similar incidents happened right after while Jane was carrying her second tray of food and while she was attempting to eat and drink (Behavior Reports, September 11, 2014).

September 11, 2014:

Jane was observed "jerking" on and off for a ten minute period while in the training area (Behavior Report, September 11, 2014).

November 29, 2014:

Jane was "jerking" while eating, which caused her to spill her food onto the floor. The report notes that another "jerking" incident had occurred earlier (Behavior Report, November 29, 2014).

December 9, 2014:

Jane experienced a "sudden jerking movement" that caused her to fall and re-open an old wound. The Injury Report does not list the injury as seizure-related (Behavior Report, December 9, 2014. Injury Report, December 9, 2014).

December 9, 2014:

Jane was walking to lunch when she made a "jerking motion" and fell to the ground. This happened a total of four times. Staff noted that Jane did not attempt to stop her fall at all. Staff also noted that they were able to feel "muscle type spasms in her arms." Jane's jerking motions were so bad that staff noted most of her lunch ended up in the floor (Behavior Report, December 9, 2014).

December 10, 2014:

Jane displayed what staff characterized as "unusual behavior," consisting of slumping to the floor and jerking (Behavior Report, December 10, 2014).

December 10, 2014:

Jane stumbled and fell a number of times while walking to receive medications and made several "jerking" movements. Medical staff instructed her to "stop," but she continued. Jane continued to stumble while walking to her training area. She fell near her work table. During lunch, she was unable to eat or drink due to jerking movements. She eventually vomited and was taking to medical for observations (Behavior Report, December 10, 2014).

December 10, 2014:

Jane exhibited "jerking" and what staff characterized as attempts to fall down (Behavior Report, December 10, 2014).

February 6, 2015:

Jane was having lunch when she started "jerking." Staff asked her to stop and clean the floor (Behavior Report, February 6, 2015).

February 17, 2015:

Jane was "jerking" and "twisting" so much that the nursing staff had a difficult time taking her blood pressure (Behavior Report, February 17, 2015).

February 19, 2015:

Jane began "jerking," which resulted in her dropping food while at lunch. Staff marked Jane's DRO card for demanding attention/disrupting others (Behavior Report, February 19, 2015).

February 21, 2015:

Jane was "jerking" while eating breakfast, which resulted in her food and drink spilling. Staff marked Jane's DRO card for demanding attention (Behavior Report, February 21, 2015).

February 23, 2015:

Jane was "making jerking motions," which made food spill. Staff ignored her. She continued jerking until she "realized staff was ignoring her and she stopped" (Behavior Report, February 23, 2015).

February 23, 2015:

Jane was "jerking" at supper and again during her bath. It was noted that staff ignored the jerking both times (Behavior Report, February 23, 2015).

February 25, 2015:

Jane was at work and "began to appear to have seizures." She later fell out of her chair and into the floor where she refused to move until the class took a break (Behavior Report, February 25, 2015).

37. On June 3, 2014, Jane saw a neurologist, Dr. [redacted]. According to the Death Summary, the neurologist noted that Jane's seizures were well controlled in the past year and recommended that Jane continue with AED (anti-epileptic drug) regimen. Booneville HDC Death Summary p. 2.

According to Booneville HDC staff, the neurologist was not given Jane's entire behavioral record; thus, she would not have had access to Behavior Reports, which gave a more thorough and accurate picture of Jane's seizure episodes.

38. On August 28, 2014, Jane's seizure-like activity was discussed at a Special Team Meeting. At this meeting, the Team determined that *all suspected seizure activity must be documented on a Seizure Report "in order for the neurologist to be fully informed,"* and that Jane would see the neurologist the next time she was at the Booneville HDC. Special Team Meeting, August 28, 2014 (emphasis added).

39. According to Registered Nurse [redacted], who provided RN approval for Jane's Behavior Treatment Program, a seizure report must be completed by a staff member for every documented seizure. This system is in place in order to ensure that the facility has an accurate and complete clinical picture for its residents. According to the Registered Nurse, if a staff member describes an incident as a "seizure" in a behavior report, then there must be a seizure report completed as well.

40. Booneville HDC staff did not follow the directive to document all suspected seizure activity on a Seizure Report form for Jane. For the twenty episodes of jerking or suspected seizure activity described above, staff completed only three seizure reports for Jane. *See* Seizure Reports, August 29, 2014; September 3, 2014; September 29, 2014.

41. On October 28, 2014, Jane had an Electroencephalogram, (EEG). The EEG report stated as follows:

> No epileptiform activity was seen (although its absence does not necessarily exclude the presence of an underlying clinical seizure disorder). The presence of mild intermittent slowing of the background may also represent a mild encephalopathic process although this particular finding was very subtle and mild. Further clinical correlation is recommended.

Death Summary, p. 2.

42. On November 4, 2014, Jane saw the neurologist again. According to the Death Summary, the neurologist "noted a history of seizures, most of the

jerking reported sound like pseudo seizures, continue present AED regimen approach jerking episodes with non-attention [...]." Death Summary, p. 2.

43. Following the EEG, the neurologist recommended continuing Jane's anti-epileptic drug regimen. Death Summary, p. 2-4.

44. Jane continued to have physician orders for at least two medications to be administered during seizures lasting longer than five minutes. Medical Review, December 16, 2014; Physician's Orders, October 1, 2014.

45. Jane's mother does not recall being told that Jane was somehow faking seizures to gain attention. She said that she was frequently called by facility staff and told that Jane had a seizure. She was aware that Jane frequently fell down, sometimes hurting herself, and that this was reported to her as the result of seizures.

46. Jane's mother was concerned about the cause of the seizures that her daughter was having. She requested that the facility consider *reducing* the amount of medication that Jane was taking, due to concern about whether the medications were causing seizures.

47. Orders for Jane continued to include "Seizure and Choking Precautions." Death Summary, p. 2.

48. Jane's records include research regarding each medication and interactions between medications. Several of Jane's medications, either alone or in combination with other medications prescribed to her cause "loss of seizure control or symptoms such as tremors, poor muscle coordination, increased seizures, and changes in behavior." Other combinations cause "confusion, fainting, fast heart rate, drowsiness, drooling, difficulty breathing, [. . .] dizziness, lightheadedness, fainting, and/or changes in pulse or heart rate." *See* Drug Interaction Report, Received by BHDC Records Room December 17, 2014.

49. On December 12, 2014, Jane saw a psychiatrist, Dr. [redacted]. According to the Death Summary, the psychiatrist reported "[s]tate somewhat

improved, Jerking episodes likely pseudo seizures, possible side effect from meds orthostatic hypotension- decrease Clozapine [...] and added diagnosis for Factitious Disorder." Death Summary, p. 2.

50. According to the DSM-V Manual, there are four diagnostic criteria for Factitious Disorder:

a. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
b. The individual presents himself or herself to others as ill, impaired, or injured.
c. The deceptive behavior is evident even in the absence of obvious external rewards.
d. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.[8]

51. Unfortunately, it does not appear that there was investigation into the underlying cause of the identified problem for Jane. Instead, the seizure activity for Jane was assumed to be attention seeking misbehavior to be ignored. Causes of nonepileptic seizures can include migraines, panic attacks, sleep disorders, or psychologic distress, according to the American Academy of Family Physicians.[9]

The Behavior Treatment Program

52. Jane had a history of significant behavioral symptoms as part of her disabilities. Since at least March 2012, Jane had some form of Behavior Treatment Program. *See* Behavior Treatment Program, March 12, 2012.

53. The primary behavioral symptoms that Jane's Behavior Treatment Program indicated needed to be monitored were "Physical Aggression,"

[8] *Diagnostic and Statistical Manual of Mental Disorders*, American Psychiatric Association, Fifth Edition, 2013.
[9] Alsaadi, Taoufik, M. and Marquez, Anna Vinter, Psychogenic Nonepileptic Seizures, *Am. Fam. Physician*, 2005 Sep 1; 72(5): 849-856.

"Demanding Attention/Disrupting Others," and "Noncompliance." Behavior Treatment Program, March 12, 2012.

54. The Behavior Treatment Program noted that Jane "thrives on personal attention." *Id.*

55. Over the years, Jane's Behavior Treatment Program consisted primarily of Differential Reinforcement of Other Behavior that allowed Jane to earn rewards from a Reinforcement Menu. *Id.*

56. DRA initially encountered Jane's case in conjunction with examining the restraint practices of Booneville HDC as a whole. Jane was frequently restrained by staff, spending over 36 hours in restraints over the course of the thirteen months preceding her death.

57. A few of the behavioral incidents that DRA reviewed for Jane were:

- In September 2014, after Jane was restrained for 1.5 hours on a papoose board, a staff member recommended weekly formal counseling for Jane to help her cope with personal issues. Behavior Report, September 18, 2014. There is no record of Jane ever receiving the counseling recommended by the staff member.
- In November 2014, Jane was administered a dose of Haldol for chemical restraint without any explanation. Although there is a chemical intervention checklist (provided to the physician for evaluation of whether chemical intervention should be permitted) there was not an accompanying behavior report. The intervention checklist states that the client *did not* present a clear and present danger to others at that time, *nor did* the client present a clear and present danger in the hour preceding the evaluation. Nevertheless, the facility administered the dose of Haldol. Chemical Intervention Checklist, November 19, 2014.
- In December 2014, Jane was cited for "non-compliance" when she was yelling that she wanted her mommy during class and acting like she was asleep. When staff told her to work, she swung at

staff and tried to kick or stomp on the staff members' feet. She was restrained on a papoose board for a half hour and told staff afterwards that she would "be good tomorrow and not listen to the voices she was hearing in her head and she misses her mom." Again, no recommendations were provided by staff to prevent future restraints. Behavior Report, December 8, 2014.

- In January 2015, Jane was strapped to a papoose board after refusing to eat her dinner. Staff encouraged her to eat and she left the room. When staff tried to get her back to the dining room, she became aggressive. It was not until after Jane had been restrained for just under an hour that staff gleaned from her that her grandfather had recently died and she missed him. When staff reviewed Jane's restraint on this date, they determined that there were no recommendations to prevent a restraint from occurring in the future. Behavior Report, January 18, 2015.

58. There is no indication that Jane's treatment was altered to address the September 2014 recommendation for formal counseling or that Jane had a formal plan for professional psychological counseling in the year preceding her death.

59. On December 17, 2015, Jane's Interdisciplinary Team requested changes to the Behavior Treatment Program to include interventions for Factitious Disorder symptoms. Behavior Treatment Program, January 6, 2015, p. 1.

60. On January 6, 2015, the Behavior Treatment Program was modified to provide that:

> Factitious Disorder is a condition where Jane purposely feigns illness or causes injury to herself. The methods of illness falsification can include exaggeration, faking, and actual self-harm. Her symptoms include jerking, twitching, shaking to the point where food falls off eating utensils, stumbling, and falling down. The primary functions of the symptoms appear to be avoidance of tasks and

> attention seeking. Jane has verbalized that she had a seizure, then later stated she had faked it. Jane has fallen down without attempting to catch herself, and injured herself. Jane may also demonstrate physical aggression towards others, tantrum behaviors, verbal aggression, noncompliance, running out of an assigned area, and argumentativeness.
>
> *Even though her pseudo seizure symptoms may be attention seeking, with high risk behavior there is always the potential for accidental self-harm.* Jane usually begins this behavior by jerking or twitching. When attention is given, the behavior typically escalates to increased motor movements, stumbling and/or falling to the ground. If Jane makes any threats, gestures or actions to hurt herself, follow BHDC Suicide Precautions Policy or Increased Supervision Policy.

Behavior Treatment Program, January 6, 2015, pp. 2-3 (emphasis added).

61. Jane's Behavior Treatment Program went on to describe Factitious Disorder Interventions as follows:

> This serious illness requires a delicate balance of providing appropriate intervention, but not reinforce the symptoms. Staff should ignore jerks and twitches and monitor these behaviors using peripheral vision (avoid watching her directly). Jane may continue this behavior despite planned ignoring. If Jane is working in a training area and attempts to stand up, or walk off, direct Jane to sit back down. If she complies, provide praise for following staff instruction. Should she refuse to comply and runs, or continues walking, escort her back to a seated position. If Jane complains of an inability to engage in a task due to pseudo seizures, redirect her attention to something positive or about expectation with active treatment tasks. This redirection may serve to provide Jane with the attention she is seeking in a positive manner and reduce her tendency to seek negative attention.

Behavior Treatment Program, January 6, 2015, p. 3.

62. The Behavior Treatment Program recognized that there was a "*serious potential for self-harm [...] when Jane is exhibiting pseudo seizure*

behaviors" and required interventions such as, "*ignore jerks and twitches and monitor these behaviors using peripheral vision* [. . .] instruct her to get up and continue to her destination." Behavior Treatment Program, January 6, 2015, pp. 3-4 (emphasis added).

63. On January 8, 2015, the modified Behavior Treatment Program was approved by Booneville HDC Superintendent [redacted] and [redacted], RN. Behavior Treatment Program Approvals for January 2015 Behavior Treatment Program.

64. On January 30, 2015, Jane's guardian provided consent to the modified Behavior Treatment Program. Consent for Behavioral Treatment, January 30, 2015.

65. The January 2015 Behavior Treatment Program required staff to ignore Jane's seizure-like activity due to the diagnosis of factitious disorder. *See* Behavior Treatment Program, January 6, 2015; Physician's Orders, January 2, 2015.

66. Physician's Orders for Jane continued to require seizure and choking precautions to be followed. There was a significant conflict between the Behavior Treatment Program and Physician's Orders that was not reconciled before Booneville HDC staff were required to implement the new Behavior Treatment Program.

67. For Jane's January 2015 Behavior Treatment Program, [redacted], Psychological Examiner, (Examiner) provided training for eleven staff members on February 12, 2015, and followed with training for approximately fifty more staff members on February 13, 14 and 17, 2015. A video of the February 12, 2015, training was then played for approximately 150 more staff for training purposes.

68. The training provided by Examiner consisted of her sitting at a table and reading the Behavior Treatment Program to staff and briefly discussing its contents. The video was then played for other groups who were not present for the initial training. The training did not include any discussion

of how to resolve the conflict between the Behavior Treatment Program's requirement to ignore seizure-like activity and the seizure or choking precautions.

69. In an interview with Examiner, DRA asked about the incidents in which Jane vomited during seizure-like episodes. Examiner told DRA that she did not know that Jane had ever vomited during seizure-like activities and would have included such information in the Behavior Treatment Program if she had known.

70. DRA consulted with Dr. Kevin Ann Huckshorn, an expert in facility practices.[10] Dr. Huckshorn expressed grave concerns regarding both the implementation and maintenance of the Behavior Treatment Program adopted by Booneville HDC.

71. Dr. Huckshorn identified a need for qualified personnel to identify not only the behaviors for the Program to address but also whether the Program is effective. In Jane's case, seizure-like activities increased after implementation of the Program, signifying to Dr. Huckshorn that the Program was not effective and should have been discontinued. The ineffectiveness of the program was either not reported to the persons charged with evaluation of the Program's effectiveness or was reported and not properly evaluated.

72. Finally, Dr. Huckshorn cited a significant deviation in the standard of care in requiring direct care staff to assess Jane's seizure episodes and distinguish between a behavior that mimics a medical emergency and an actual medical emergency, all of which are outside the scope of their training, education, and experience.

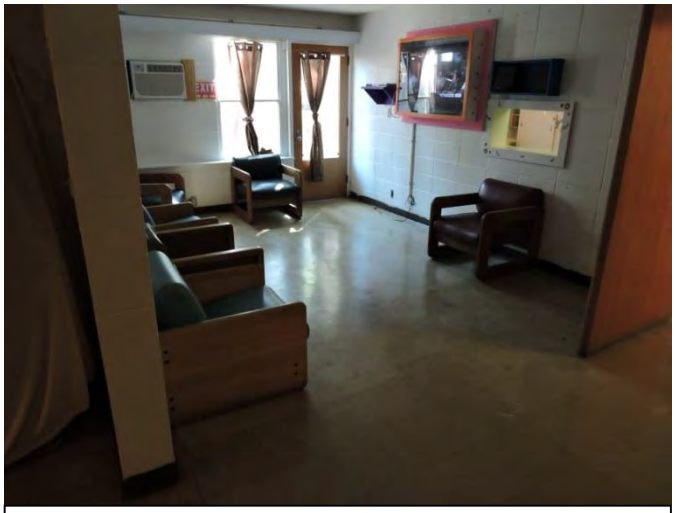
Jane's Death

73. Jane was pronounced dead at 9:14 p.m. on February 26, 2015. The events leading to her death are as follows:

[10] Dr. Huckshorn is a licensed and certified mental health nurse and substance abuse clinician with 36 years of experience working in a variety of public and private behavioral health organizations. She has published on topics including violence, treatment adherence, trauma-informed care, and workforce development and has co-authored a book with William Anthony, PhD, titled "Principled Leadership in Mental Health Systems and Programs" (2008).

February 26, 2015, 7:30 p.m.:

Jane was in the TV room of the Hillside House Down having an evening snack of Fruit Loops cereal and milk.[11] Residential Care Shift Supervisor [redacted] (Supervisor) saw Jane "in the TV room eating her snack [when] all of a sudden she jerked really big with her whole body, spilling her cereal."[12]



TV Room at Hillside House Down

Supervisor later said that Jane spilled her cereal and milk before eating any cereal.[13]

Supervisor responded to Jane by asking her "to clean up her mess."[14] She advised Jane to do this because this was Supervisor's understanding of Jane's modified Behavior Treatment Program to address behavioral symptoms of Factitious Disorder.[15] Jane then walked down the hallway to a linen closet to get a towel.[16]

Supervisor initially reported that Jane, after returning to the TV room, "got down on her hands and knees and fell over in a big jerking movement."[17] Supervisor later reported that Jane "got down on her hands and knees and began wiping up her mess."[18] She also reported that Jane asked if she could

[11] Supervisor Statement February 28, 2015 (Supervisor 2), p. 1.
[12] Supervisor Statement February 26, 2015 (Supervisor 1), p. 1.
[13] Supervisor 2, p. 1.
[14] Supervisor 1, p. 1.
[15] Supervisor 2, p. 1.
[16] Supervisor 2, p. 1.
[17] Supervisor 1, p. 1.
[18] Supervisor 2, p. 1.

have another snack, and when Supervisor told her that they were not going to discuss this at that time, Jane "jerked really big again and fell over."[19]

Supervisor asked Jane to get up and sit in the chair, which she did. At that time, there were several other residents in the TV room.[20]

7:33 p.m.:

Supervisor left the TV room to call the nurse to get some pain medication for another resident.[21] [redacted] (LPN), the LPN who took Supervisor's call for medication, reported this call from Supervisor as 7:35 p.m.[22]

When Supervisor returned to the TV room, "Jane was in the floor, her whole body jerking as if in a seizure."[23] Supervisor again asked her to get up and sit in the chair.[24] Jane did not respond and "only kept jerking."[25] Also, at that time, Jane "started throwing up liquid/flem [sic]."[26]

Supervisor then "left Jane alone but kept watching her."[27] Supervisor later stated that she did not leave her alone in the TV room but "stood watching/monitoring her actions."[28]

After about 30 seconds, Supervisor yelled down the hall for another staff member, [redacted], Residential Care Technician (Technician), who was in

[19] Supervisor 2, p. 1.
[20] Supervisor 2, p. 1.
[21] Supervisor 1, p. 1.
[22] Statement of LPN, February 28, 2015 (LPN 2), p. 1.
[23] Supervisor 1, p. 1.
[24] Supervisor 1, p. 1.
[25] Supervisor 1, p. 1.
[26] Supervisor 1, p. 1.
[27] Supervisor 1, p. 1.
[28] Supervisor 2, p. 2.

another resident's room.[29] She asked Technician to stay with Jane while Supervisor went to call Medical.[30] Technician does not mention this event at all in her statement.[31]

"At this point Jane's eyes were still open. She had finished vomiting, and she had stopped jerking. She was breathing loud raspy breaths…."[32] This was something that Supervisor had witnessed at least two times when she previously witnessed Jane having a seizure.[33]

7:39 p.m.:

Supervisor called Medical a second time and spoke to LPN.[34] In her first statement, Supervisor reported that she told LPN that Jane "had fell out into a *seizure* and that she was throwing up."[35] In her second statement, Supervisor reported that she told LPN that Jane "was having a *pseudo seizure* and that she had thrown up liquids."[36] Supervisor was not sure if LPN "needed to check [Jane.]"[37]

LPN confirmed that Supervisor told her that "we need you to come check Jane after her seizure."[38] LPN reported that "Jane has pseudo seizures as determined by medical staff and protocol mandates observing client and providing safety for client."[39]

[29] Supervisor 2, p. 2.
[30] Supervisor 2, p. 2.
[31] Statement of Technician, February 26, 2015.
[32] Supervisor 2, p. 3.
[33] Supervisor 2, p. 3.
[34] See Supervisor 1, p. 1; Supervisor 2, p. 3.
[35] Supervisor 1, p. 1.
[36] Supervisor 2, p. 3.
[37] Supervisor 2, p. 3.
[38] LPN Statement February 26, 2015 LPN 2, p. 1.
[39] LPN 2, p. 1.

Supervisor reported that LPN told her that she would be over to check Jane in a few minutes.[40] LPN reported that she left for Hillside House Down immediately.[41]

Supervisor then returned to the TV room[42], sat in a chair and watched Jane who was lying on the floor.[43] At this time, Supervisor believed Jane was still breathing because she could see her stomach moving up and down.[44] Jane's eyes were open.[45]

Supervisor wiped the vomit from Jane's face, nose, and hair.[46] She also checked Jane's mouth to "to ensure there was nothing in it."[47] She rolled Jane over onto her back and shook and called out to her.[48] Jane did not respond.[49] Supervisor "assumed she was ignoring me because that's the way she did after every other pseudo seizure event" Supervisor witnessed.[50] Supervisor got up and sat in a chair, leaving Jane on the floor on her back.[51]

Supervisor was not certified to perform CPR on the date of Jane's death. In fact, her certification lapsed more than one year prior, on February 22, 2014.

---

[40] Supervisor 2, p. 3.
[41] LPN 2, p. 1.
[42] Supervisor's hand-drawn diagram of the scene in which these events took place is attached as Appendix A.
[43] Supervisor 2, p. 3.
[44] Supervisor 2, p. 3.
[45] Supervisor 2, p. 3.
[46] Supervisor 2, p. 3.
[47] Supervisor 2, p. 3.
[48] Supervisor 2, p. 3.
[49] Supervisor 2, p. 3
[50] Supervisor 2, pp. 2-3.
[51] Supervisor 1, p. 2.

7:42 p.m.:

LPN arrived at the TV room in Hillside House Down.[52] She did not check on Jane first but instead gave another resident medication.[53] All the other residents left the TV room, leaving only LPN, Supervisor, and Jane.[54]

LPN checked on Jane, who was still lying on the floor in the middle of the TV room on her back with her head to the right side.[55] Meanwhile, Supervisor was sitting in a chair "directly across" from Jane.[56]

LPN checked Jane's mouth and did not find any foreign objects or vomit in her mouth; however, she saw "clear vomitus" around Jane.[57] She also saw whole dry cereal on the floor.[58]

LPN "observed [Jane] per protocol following seizure like activity."[59] LPN at first thought that Jane was breathing based upon "feeling [Jane's] breath on [her] hand."[60] Jane's eyes were open.[61]

LPN sought more information from Supervisor. LPN reported that Supervisor told her "Jane had her cereal in hand and began throwing up."[62] Supervisor also told LPN that "Jane had one of her seizures [sic] like episodes and fell

[52] Supervisor 1, p. 2.
[53] LPN 2, p. 1.
[54] LPN 2, p. 1.
[55] LPN 2, pp. 1-2; LPN 1.
[56] LPN 2, p. 1.
[57] LPN 2, p. 1.
[58] LPN 2, p. 1.
[59] LPN 1.
[60] LPN 2, p. 2.
[61] LPN 2, p. 2.
[62] LPN 2, p. 2.

forward dropping her cereal."[63] LPN asked Supervisor whether any cereal had been eaten.[64] Supervisor reported none had been eaten.[65]

While LPN was talking with Supervisor, Jane's breathing ceased.[66] LPN "got on the floor beside [Jane] to check for her pulse and indications of breathing."[67] Jane did not have any blood pressure or pulse.[68]

LPN began chest compressions.[69] After around 30 compressions, LPN asked Supervisor to take over with chest compressions so she could call for an ambulance, and Supervisor started chest compressions.[70] LPN then took over chest compressions while Supervisor called for assistance from additional staff.[71]

7:50 p.m.:

Residential Care Technician [redacted] (Technician2) was upstairs at Hillside House when he heard someone scream for help and ran downstairs.[72] Technician2 reported that he was asked by LPN to call by radio for an Automated External Defibrillator (AED) which he did.[73] This was at the same time that Technician was trying to call by radio for an AED.[74]

[63] LPN 2, p. 2.
[64] LPN 2, p. 2.
[65] LPN 2, p. 2.
[66] LPN 1.
[67] LPN 2, p. 2.
[68] LPN 1.
[69] LPN 2, p. 2.
[70] LPN 2, p. 2.
[71] LPN 2, p. 2.
[72] Technician2 Statement February 26, 2015 (CD).
[73] CD.
[74] Supervisor 2, p. 5.

7:52 p.m.:

LPN called [redacted], (LPN2), and requested additional medical assistance at Hillside House Down because Jane was "down and non-responsive."[75] After she called for LPN2, LPN again took over doing chest compressions on Jane.[76] After she did another 30 compressions, LPN then retrieved the breathing mask for rescue breaths.[77] When she did this, she noticed that there was no rise in Jane's chest or return of breath.[78] LPN again checked for obstructions but did not find any.[79]

7:57 p.m.:

Residential Care Assistant, [redacted], (Assistant), a First Responder, brought a portable suction devise to the TV room and attempted to suction without success.[80]

7:58 p.m.:

LPN2 arrived; LPN observed LPN2 call for an AED.[81]

8:00 p.m.:

Residential Care Staff [redacted] (Staff) arrived at the TV room with an AED.[82] Assistant proceeded to place the AED pads on Jane; however, the AED never

[75] LPN2 Statement dated February 26, 2015; *see also* LPN 2, p. 2.
[76] LPN 2, p. 2.
[77] LPN 2, p. 2.
[78] LPN 2, p. 2.
[79] LPN 1.
[80] Death Summary, p. 4.
[81] Statement of LPN2, February 26, 2015; *see also* LPN 2, p. 2.
[82] Statement of Staff, February 26, 2015 (KR), p. 1.

provided an instruction to shock "because the heart rhythm showed asystole."[83]

Various staff members continued to do CPR and chest compressions while waiting for the ambulance to arrive.[84]

8:20 p.m.:

The ambulance arrived at the Booneville HDC.[85] EMS were informed that "the patient was eating and started having a seizure and fell to the floor and went into cardiac arrest."[86] EMS personnel took over care, continued chest compressions, and transported Jane to Mercy Booneville Hospital.[87]

9:14 p.m.:

Jane was pronounced dead by Dr. [redacted], Booneville HDC's staff physician.[88]

Post-Mortem

74. On the night of Jane's death, a Booneville HDC staff member called her mother at about 9 p.m. Jane's mother was told that her daughter had died earlier that night. Her mother was upset and shaking, trying to understand what she was being told. She remembers that she was told that her daughter was eating cereal during snack time, had a seizure, fell to the floor, and choked to death on the cereal.

75. Jane's mother later asked if there was any "tape" or recording of what happened to Jane. There are no video cameras at the Hillside House

[83] Death Summary, p. 4.
[84] Statement of Assistant, undated.
[85] Logan County EMS Record, p. 3.
[86] Logan County EMS Record, p. 1.
[87] Logan County EMS Record, p. 1.
[88] Death Summary, p. 4.

where Jane was at the time of the incident. Booneville HDC did not advise her mother of any investigation into Jane's death and did not provide her with additional information, including the death investigation report.

76. The final diagnosis from the Hospital was "Cardiac arrest, Seizure, Choking due to food in Larynx." Death Summary, p. 4.

77. On March 1, 2015, the State Crime Laboratory issued an autopsy report on Jane's death. The conclusion of the report was that the cause of death was "Asphyxia due to Airway Occlusion by Food Bolus." Autopsy Report, p. 1.

78. The Autopsy Report noted that Jane's "stomach contained approximately 200 mL of partially digested food fragments and tan liquid. There was [sic] large food fragments present, some measuring up to 3 cm in greatest dimension." Autopsy Report, p. 3.

79. The Autopsy Report's Findings included, among other things, the following:

> II. Clinical history of dysphasia
> A. Witnessed choking episode
> i. Large food bolus removed from airway reported by emergency medical personnel
> ii. Microscopic food particles present in lungs

Autopsy Report, p. 7.

80. The Autopsy Report's Opinion was as follows:

> This 24 year old female, [Jane], dies due to asphyxia due to airway occlusion by food bolus.
>
> According to investigative reports provided by the Logan County Sheriff's Office and the Booneville Human Development Center, [Jane] was witnessed to be consuming a bowl of cereal when she had a pseudo seizure associated with choking and vomiting. Emergency services were summoned and a large food bolus was removed from [Jane] airway. She was transported to a local hospital where she was pronounced dead.
>
> Autopsy revealed a well-developed, well nourished, adult female with no internal or external evidence of traumatic injury. There was no evidence of significant natural disease.

> At the time of autopsy, there was some freshly masticated food fragments within the airway, but the airway was not occluded at autopsy. Microscopic examination of the lung tissue revealed the presence of food fragments with no evidence of actual inflammatory reaction.

Autopsy Report, p. 7 (emphasis added).

Review of Jane's Death by Booneville HDC and DHS

81. Jane's death was investigated by Booneville HDC. Upon learning of the possible death at 8:18 p.m. (two minutes before the ambulance arrived), [redacted], the administrator of Booneville HDC, ordered [redacted], (Investigator) the on-call Social Service Worker to begin taking statements. *See* Report of Investigator, March 5, 2015.

82. Investigator's investigation involved questioning each of the witnesses, including follow-up with Supervisor and LPN after having received their written statements. Investigator noted that "[t]he only inconsistency I found in the [Behavior Treatment Program] is when it specifies behaviors to expect, and vomiting is not mentioned." Investigator concluded that staff followed the plan, and she did not scrutinize the care Jane received beyond that conclusion. She did not acknowledge or note the choking precautions Jane was under, nor did she consult with a physician regarding whether a patient who exhibits vomiting during seizure-like activity should be ignored.

83. Investigator was also the Social Service Worker on duty at Booneville HDC the day prior to Jane's death. That day, Investigator recorded an incident wherein Staff told Investigator that Jane said that the voices in her head were telling her to kill herself. After consulting with Examiner, they planned to put Jane on suicide precautions, involving "enhanced supervision and 15 min. documented checks," to continue through the next morning. Jane's mother wanted to call Jane and check on her after learning about Jane's suicidal comments, but Booneville HDC staff told her to only speak with staff. Case Notes, February 25, 2015.

84. The Arkansas Department of Human Services Office of Long Term Care appears from their records to have only investigated the incident by reviewing the Investigator's report. There is no meaningful review of the events prior to Jane's death.

85. Arkansas Department of Human Services is required to convene a Human Development Center Death Review Committee (Death Review Committee) for the purpose of reviewing all deaths at HDCs to determine (1) the circumstances surrounding the death; (2) the appropriateness of the medical and nursing care rendered by the HDC; and (3) any HDC system issues that may require review and resolution for quality improvement and quality assurance. The Death Review Committee is charged with ensuring that the HDCs operate in compliance with conditions and standards imposed by the Arkansas Medical Assistance Program.

86. Death Review Committee members are given packets upon which they base their review. The packets are required to contain:

a. Interdisciplinary discharge summary including medical discharge summary;
b. A copy of the incident (IRIS) report of the death and any incident reports prior to the death that were related to the death;
c. Nursing notes for one month prior to the date of death;
d. Physician orders and progress notes for one month prior to the date of death;
e. Most recent MAR and lab reports within the last month, prior to death;
f. Most recent physical examination;
g. Medical diagnostic reports (X-ray, CT scan, MRI, etc.) within the month prior to death;
h. Most recent Individualized Program Plan;
i. Death Certificate; autopsy report, if available; and
j. Verification of guardianship.

87. Although they are charged with scrutinizing the policies of the HDCs to determine whether there should be a policy change, the HDC Death Review Protocol does not require the HDC to forward the written policies to the HDC Death Review Committee.

88. According to the Assistant Director for Quality Assurance within DHS, while it is not a written policy or part of the protocol, the Death Review Committee saves no account of what was received or reviewed by the committee, other than a single "Conclusion Statement" detailing their findings.[89] Every other record of what the Death Review Committee received or reviewed from the HDC is promptly destroyed following the meeting of the Death Review Committee. Thus, there is no opportunity for meaningful review of their decision.

89. In Jane's case, the "Conclusion Statement" consists of a single page. There is no mention of the conflict that existed between the choking and seizure protocols and her Behavior Treatment Program. In fact, there is no mention of her Behavior Treatment Program at all in the HDC Death Review Committee Report; accordingly, there is no way to verify whether the order to ignore Jane during seizure activities was ever considered by the Death Review Committee.

90. There also is no indication that the Death Review Committee reviewed the policies of the Booneville HDC as part of its review of her death.

Critical Information Not Considered as Part of Booneville HDC or the Death Review Committee

91. DRA interviewed some of the employees who were present during Jane's death and during the implementation of Jane's Behavior Treatment Program.

92. Supervisor reported concerns about Jane's Behavior Treatment Program to the Director of Nursing[90] prior to Jane's death. According to

[89] A copy of this Conclusion Statement is attached hereto as Appendix B.
[90] The Director of Nursing mentioned in this report is no longer employed by Booneville HDC.

Supervisor, the Director of Nursing told her that all of Jane's seizures are faked behaviors and that she should ignore them as directed unless it is a medical emergency. Supervisor was uncomfortable having to distinguish between a medical emergency and seizures that she was told were behaviors.

93. LPN, who was the first medical assistance to arrive at the TV room in response to the call for help, suspects that Jane was already deceased when she arrived on the scene. She believes that, in retrospect, she was probably mistaken regarding her immediate assessment that Jane was breathing when she arrived, as there was a large food bolus that prevented her from breathing. The LPN reported that LPN staff are not notified of the specifics of patients' Behavior Treatment Programs, as they do not have the constant contact with the patients that the direct care staff have.

94. Examiner, who wrote the 2015 Behavior Treatment Program for Jane, blamed the psychiatrist and neurologist for the suggestion of ignoring Jane's seizures. When asked whether she considered how to distinguish between seizures that coincided with vomiting and those that did not, she reported that she knew of no incident in which Jane exhibited vomiting as part of a seizure activity, and would have included such a distinction in the Behavior Treatment Program if she had known.

95. Examiner indicated that the medical staff had the opportunity for input in that area and did not note a conflict. However, she confirmed that Behavior Treatment Programs do not rescind medical orders. Yet the January 2015 Behavior Treatment Program for Jane contradicted longstanding medical orders for her, including both choking precautions and a seizure protocol.

96. The Behavioral Treatment Program was developed without comprehensive medical, psychological, and behavioral information about Jane and without adequate coordination of care between disciplines. The resulting inconsistency between reaction to choking or seizures versus reaction to factitious disorder created an unreasonably dangerous environment for Jane.

97. Inconsistent and contradictory treatment directives passed down from medical and psychology staff created an environment where direct care staff members were left in the untenable position of having to make judgment calls which they were not qualified to make. There is no evidence that members of Jane's direct care staff were given instruction on how to reconcile these two contradictory directives. This demonstrates a lack of communication and coordination between departments in client programming.

98. "Ignoring" is overused at Booneville HDC. Dr. Huckshorn notes that the overuse of "ignoring" implies permission for the staff to fail to engage residents who they deem to be misbehaving. Further, ignoring escalating behavior is not best left to staff who do not have the education, training, or experience to know when to respond to an emergency, as opposed to ignore a behavior.

99. The practice of internal investigation of colleagues is not a productive or meaningful practice within the HDC. In this instance, Investigator was only charged with the duty of ensuring that staff followed the directions that were in place. Thus, there was neither an effort to scrutinize the directions nor to inquire into the conflict that existed between the Behavior Treatment Program and Physician's Orders. Investigator even acknowledged the valid point that vomiting is not mentioned in the Behavior Treatment Program, and yet further investigation on this point was quickly dismissed.

100. The HDC Death Review Committee is required to investigate and examine (1) the circumstances surrounding the death; (2) the appropriateness of the medical and nursing care rendered by the HDC; and (3) any HDC system issues that may require review and resolution for quality improvement and quality assurance.

101. The HDC Death Review Committee process and review of Jane's death was superficial. It does not appear that the HDC Death Review Committee goes beyond review of the facts of the sentinel event. In this case, the Death Review Committee did not indicate whether they reviewed Booneville

HDC policies, the apparent conflict between the Behavior Treatment Program and the Physician Orders, or the requirement that the direct care staff act outside of their education, training, and experience in implementing the Behavior Treatment Program.

Conclusions

1. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to ensure comprehensive neurological evaluation and the type of clinical correlation recommended for Jane to ensure adequate assessment of her seizure-like episodes.

2. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to comprehensively or completely assess Jane's choking risk by not considering her seizure-like episodes in the 2013 or 2014 choking assessments.

3. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to ensure that medical needs related to Jane's risk of choking and required choking precautions were addressed in her 2015 Behavior Treatment Program, thus creating an unreasonably dangerous plan for Jane that led to her death.

4. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to assess and determine the impact of the multiple medications administered to Jane, several of which include seizures or seizure-like activity as a side effect.

5. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to ensure comprehensive psychiatric and/or psychological evaluation of and treatment for Jane to determine and treat the underlying causes for the Factitious Disorder diagnosis.

6. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to ensure that Jane had a Behavior Treatment Program that could be safely implemented by direct care staff, thus creating an unreasonably dangerous plan for Jane that led to her death.

7. It does not appear from the evidence in the records that there was meaningful collaboration in developing Programming for Jane at Booneville HDC. While the departments are all represented at interdisciplinary meetings, the events leading to Jane's death signify a lack of meaningful collaboration.

8. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC failed to provide Jane with the active treatment required, including the failure to conduct an adequate or comprehensive assessment of her behavior, and to use evidence-based methods to address her behaviors and their causes.

9. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC adopted a punitive approach to Jane's needs, including her identified need for attention, and overreliance on "ignoring" as a behavioral intervention at the facility.

10. The State of Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and the Booneville HDC otherwise failed to adequately or appropriately address Jane's behavior needs by allowing for the overuse of mechanical and chemical restraints in response to her behaviors.

11. The State of Arkansas Department of Human Services and its Division of Developmental Disabilities Services have failed to ensure that there was an adequate or meaningful investigation into Jane's death, and that a system is in place to ensure such investigations. The failure to examine the medical and psychological treatment, as well as the omissions, in the development of the Behavior Treatment Program led to a cursory, superficial review of Jane's death.

Recommendations

1. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should immediately hire an independent expert or group of experts to review and assist in evaluating and improving the treatment and habilitation services provided to Booneville HDC residents, including coordination of medical and psychological treatment and safety.

2. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should provide improved direct (as opposed to video) training and support for direct care staff.

3. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should retain an independent expert with expertise in working with facilities to implement a more rigorous, independent review of treatment decisions, practices, and incidents, including deaths.

4. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should provide and require participation of Booneville HDC's senior administrative, clinical, and direct care staff in comprehensive training on person-centered and trauma-informed, recovery-oriented, evidence-based services and supports.

5. The Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and Booneville HDC's senior administrative and clinical staff should be required to develop a strategic plan to transform this institution to one that adopts current, best practice philosophy, vision, and values. This plan should be updated monthly and reviewed quarterly by the state office or an external entity.

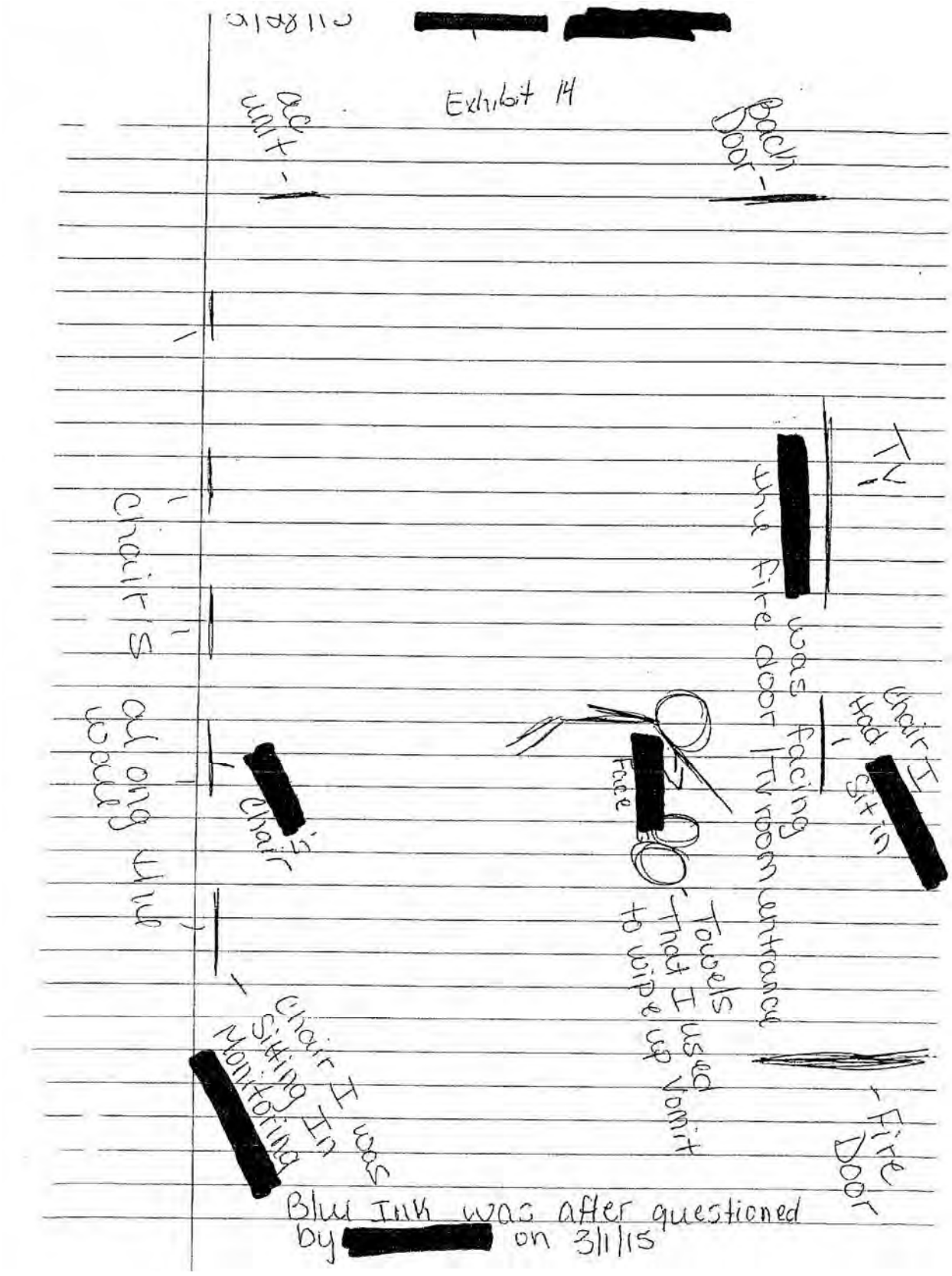
6. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ensure that residents of Booneville HDC have access to active treatment, including the provision of mental health and other treatment that supports residents in addressing their challenging behaviors in ways that do not include coercion or punishment.

7. The Arkansas Department of Human Services and its Division of

Developmental Disabilities Services should implement the recommendations included in DRA's January 2016 Report.

[redacted] [redacted]

Exhibit 14



Blue Ink was after questioned by [redacted] on 3/1/15

Arkansas State DHS Mortality Review Committee

RE: Conclusion Statement from 06-25-15 Committee Meeting

[redacted] was admitted to Booneville Human Development Center (BHDC) on July 23, 2008. She was residing at Hillside House Down, ext. 1486, until her demise on February 26, 2015 at Mercy Boonville Hospital.

[redacted] had diagnoses of mild intellectual disability; Antisocial Personality features; Bipolar I Disorder, Moderate, most recent episode Manic; Factitious Disorder; Enuresis; Nocturnal and Diurnal; Sinus Tachycardia; Astigmatism; Hyperlipidemia; Constipation; Seasonal Allergic Rhinitis; History of possible Pseudo Seizures; Anemia of Chronic Disease; Contraception.

On 2/26/15, [redacted] LPN received a call at 7:39 p.m. from the living area staff reporting, [redacted] was about to eat her snack of cereal, Fruit Loops, and started having seizure like activity. They needed a nurse to come check her. [redacted] LPN arrived to find [redacted] with her head turned to the side, clear emesis/vomitus surrounding client and no seizure activity. The nurse checked [redacted]'s mouth for foreign object/vomitus, her mouth was clear of foreign object. [redacted] was breathing at this time.

[redacted] LPN observed her per protocol following seizure like activity. [redacted] became still, breathing ceased. Staff attempted to obtain pulse and blood pressure with manual Bp cuff but could not get either pulse or blood pressure. The nurse and staff began CPR. Staff members continued compressions while the nurse called for an ambulance at 7:50 p.m.

[redacted], a direct care staff member, who is also a First Responder, responded with a portable suction device and attempted to suction without success. [redacted], LPN checked [redacted]'s mouth for obstruction again due to not being able to force a breath, nothing was visualized. The nurse called for assistance of the other nurses, [redacted], LPN and [redacted] LPN at 7:52 p.m. Staff continued to attempts to give breaths and do chest compressions.

At 8:00 p.m., the Program Supervisor arrived with the AED and it was placed on [redacted]. The AED did not instruct to prepare for shock because the heart rhythm showed asystole, staff continued CPR.

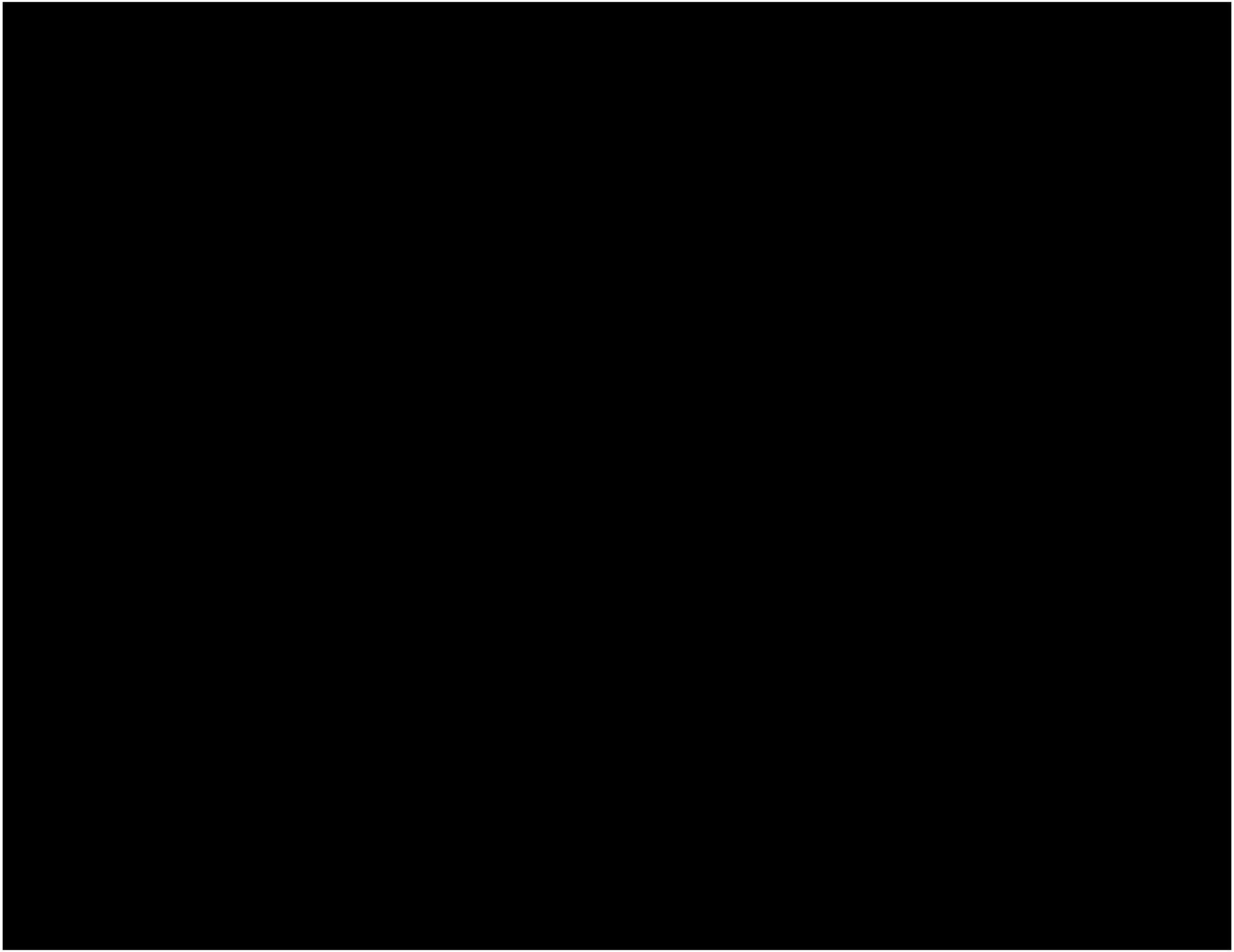
Logan County Sheriff's office reports, the EMS arrived to BHDC at approximately 8:25 p.m. and took over care and continued chest compression, transporting her to Mercy Booneville Hospital. Code Blue was run/CPR continued. She also was intubated. Dr. [redacted] and nurses, [redacted], RN and [redacted] RN arrived at the hospital at 9:10 p.m.

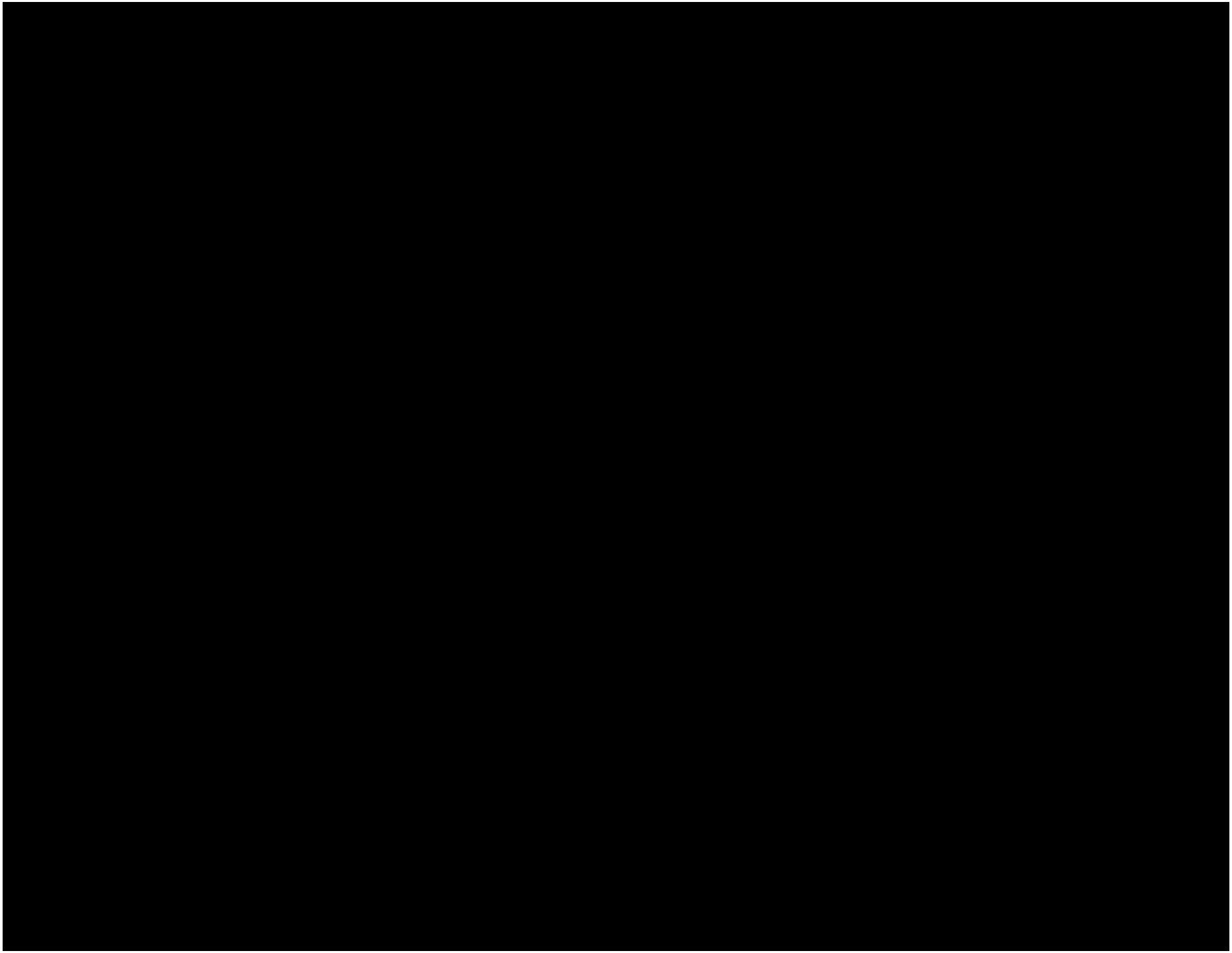
[redacted] was pronounced dead at 9:14 p.m. The Final Diagnosis from the hospital was Cardiac arrest, Seizure, and choking due to food in the Larynx. At 9:50 p.m., Dr. [redacted] and the nurses returned to BHDC and notified [redacted] family of her death.

After review of the information submitted by Booneville Human Development Center, it is the consensus of the committee that standard of care was met at BHDC. There are no recommendations.

Respectfully submitted,

LaToya Bankhead-Sims, DHS/DDS HDC Liaison, QA
Date of Committee Approval: 8/27/15





BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF

SAMUEL SCOW

May 5, 2022, at 9:11 a.m.

CRIS M. BRASUELL, CCR
BREPORTING@GMAIL.COM

A P P E A R A N C E S

ON BEHALF OF THE CLAIMANT:

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EXHIBITS IDENTIFIED

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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Samuel Scow, produced, sworn, and examined via Zoom, commencing on May 5, 2022, at 9:11 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

P R O C E E D I N G S

WHEREUPON, Samuel Scow was duly sworn to tell the truth, the whole truth, and nothing but the truth, and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Okay.

Sam, could you please state your full name for the record.

A My name is Samuel Eric Scow.

Q Okay.

A S-c-o-w.

Q All right. And, Sam, you're an EMT for Logan County EMS; correct?

A I am a paramedic.

Q Paramedic.

A For Logan County EMS.

Q Okay. All right. And what's the different between an EMT and a paramedic?

A Oh, standard of care, level of care.

I have a two-and-a-half-year education. I guess, if you look at -- if you're familiar with a CNA and an RN --

Q Uh-huh.

A -- and the difference between the two, that's an EMT

to a paramedic.
Q Okay.
A **-- transfer of care in the State of Arkansas to an RN.**
Q Oh, okay. Okay. Excellent. I wasn't aware of that. So a paramedic is a higher level --
A **A higher level of care.**
Q -- emergency care worker than an EMT. Okay.
A **Yeah.**
Q Perfect.
And you responded to an emergency call at the Booneville Human Development Center on June 13th of 2020; is that right?
A **Yes, sir.**
Q Okay. And I have here what's going to be an exhibit, our Exhibit 1, and that's simply the Logan County EMS patient care record.
A **Yep.**
Q And it's a seven-page document. And do you have a copy of that as well?
A **I have the copy you sent me and a printed copy we pulled out of archive.**
Q Oh, okay. That you got from archives? Okay.
A **Yep.**
MR. GILLISPIE: Eric, do you want a second

to pull that up?

MR. COLLINS: Yeah. I have a copy here somewhere. You can continue. I'll find it.

MR. GILLISPIE: Okay.

(WHEREUPON, the document was marked for identification as Exhibit No. 1 and is attached hereto.)

BY MR. GILLISPIE:

Q Okay.

Sam, I'd like to go to Page Three of this document.

A All righty.

Q And I just want to confirm a few things that this appears to indicate.

According to this document, the 9-1-1 call came in at 11:37 a.m.; correct?

A Yes. At the bottom right-hand, yeah. The (inaudible) dispatch notified, call received, and dispatched 11:37. That is when my dispatch received the call.

Q Okay. And then --

A Yeah. I did document that --

Q -- you were in route -- and then you got in route at 11:38?

A Yes.

Q And there's an electronic record of these calls

coming in; is that correct?
A Correct. Yeah. Dispatch logs it and records it and they're all available for -- to be pulled.
Q Okay.
And, according to this document, when you arrived at the -- well, first of all, when you arrived at the scene, the patient, David Cains, what were you told -- I'm sorry. Strike that question.
When you arrived at the scene, did you speak to staff present and interview them about what had happened?
A Yes.
Q Okay.
A But I do that as I work.
[redacted]

Q They found him in a hallway?
A **In the hallway and a -- which was right there at the lobby, so --**
Q Okay. And nobody said a word to you about him having been restrained by staff members?
A **No, sir.**
Q You were never told that he was held on the ground and started aspirating while on the ground?
A **No.**
Q You were never told anything about any sort of behavior incident or emergency incident that required him to be restrained?
A **No, sir.**
Q You were specifically told that this patient was simply found on the floor in this hallway and that he had choked on his lunch?
A **Yes.**
Q Okay. And you probably don't remember specifically who you talked to, do you?
A **I do not. That was a pretty -- I know that it was a pretty hectic scene and I just kind of interview as I'm trying to do my interventions.**
And I don't always get to look at who's speaking in the eye or get their name, so --
Q Do you remember that it -- can you say whether --

was it men, women? Do you have any memory of that?
A I remember, besides myself and my partner, there was three women. And I remember that there was one man that was sent to be kind of the gofer to run and get things and do things as we needed them.
Q But the only people you spoke to were these three women?
A Yep. Or my partner.
Q Okay. You didn't speak to any men about what had happened?
A Nope.
Q Okay.
Do you happen to remember, do you have any idea whether these women were nurses or direct care staff? Can you say one way or another?
A No, ma'am. Or no, sir.
Q Okay.
A No, sir.
Q But to be clear, your report here -- and you completed this report; right?
A Yes, sir. This is all done by me.
Q Your report indicates that eight minutes of time lapsed between when the patient stopped breathing and when 9-1-1 was called; correct?
A Correct.

Q And how -- okay. And that's correct?
A **Correct.**
Q Okay. And could you briefly tell us, you know, how you came to that conclusion?
A **So the estimated CPR and time of collapse was a -- so it was a witness collapse.**

[redacted]

Q Okay.
A **And -- so we have a -- I think that's on page -- witness time of collapse, I think that's Page Four. It could be.**
Q Take your time.
A **Yes. So page -- actually, Page Three. The second box, specialty patient, CPR.**

Under the time of call, you see the rest witness by layperson.

Q Okay. And you were specifically told that that was 11:30?
A **Yes.**
Q You wouldn't have just guessed at a time? You would have --
A **No, sir. No, sir.**

Q Okay.
A **No, sir. You know and -- so, I -- you know, I -- this question is always asked, you know, it's important for patient treatment and care and understanding of patient report to the hospital and condition, so --**
Q And what did you report to the hospital about -- well, strike that question.
Did you relay to the hospital the same things you were told by the folks you spoke to at the scene here?
A **Yes. Yes. I relayed everything as witnessed and directed in my patient narrative.**
Q Okay.
A **And they get a copy of this, you know, as soon as I complete it and lock it. It faxes over to them.**
Q Okay.
A **So --**
Q Okay. And so you stand by everything in this report?
A **I do.**
Q Okay. And, again, you were told that he was -- that a witness -- you were specifically told, by somebody on the scene, that a person witnessed him collapse in the hallway choking on his lunch and --
A **Yes.**
Q -- stop breathing; correct?

A Yes.

Q Okay. And you were told nothing, at any point, about a physical restraint performed on this or applied to --

A No, sir.

Q -- this patient?

A No, sir. And there -- you know, part of my evaluation, upon patient assessment initial, is do I see any restraints or anything on the patient. I did not see any restraints on the patient.

Q Okay.

Had you known, had you been told that this patient had been in a physical restraint whereby he was being held down on the ground when he began going into cardiac arrest, that's certainly something you would have put in your report and made sure that the hospital knew about it; right?

A Yes. Yes. And it's really -- that is pertinent information.

[redacted]

[redacted]

Q Yeah. Okay. And I know that -- let me ask it this way.

Based on this document, the hospital waited how long between the time this patient stopped breathing to call 9-1-1?

A The hospital or the facility?

Q The facility.

A Or is HDC considered a hospital? Okay.

Q I'm talking about BHDC.

A Okay. All right.

So, from what was stated as 11:30 CPR initiation, the time of call is seven minutes. And then our scene time to the scene is 13 minutes.

Q Okay. And, if they're performing CPR, that means he's not breathing; right?

A Right. You do not -- unless it's a pediatric patient, nobody performs CPR on a -- on somebody who's breathing.

Q Is it possible that, had 9-1-1 been called

immediately, is it possible at least that you could have -- that the outcome here could have been different?

A I can't give any specific like certainty. But I can say that, yeah, time is tissue.

[redacted]

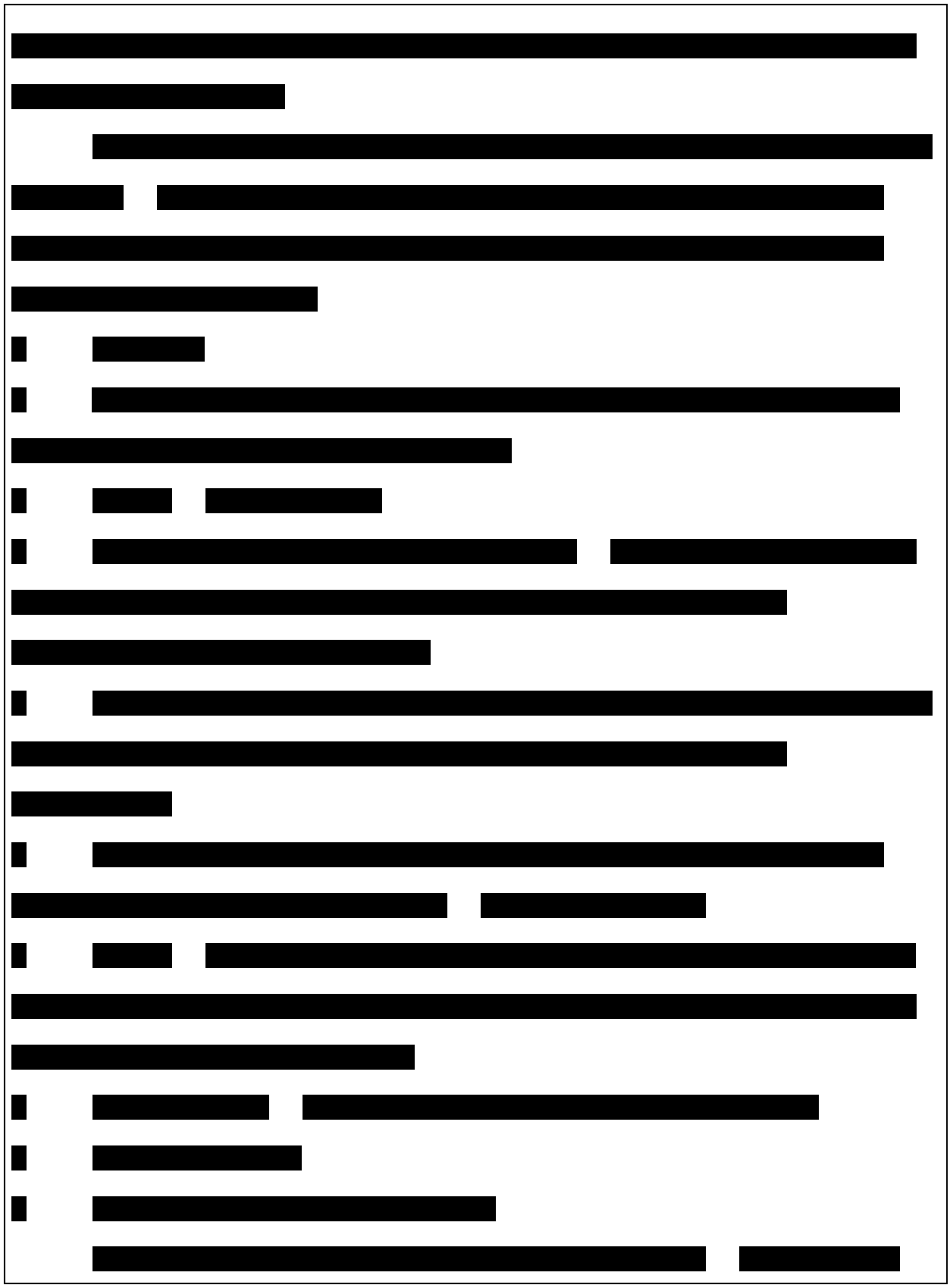
Q Okay.

A You know, that -- you know, time is a variable. So, if you adjust variables, you can have different outcomes.

Q And is one of those outcomes at least in the realm of possible that he could have lived?

A Sure.

[redacted]



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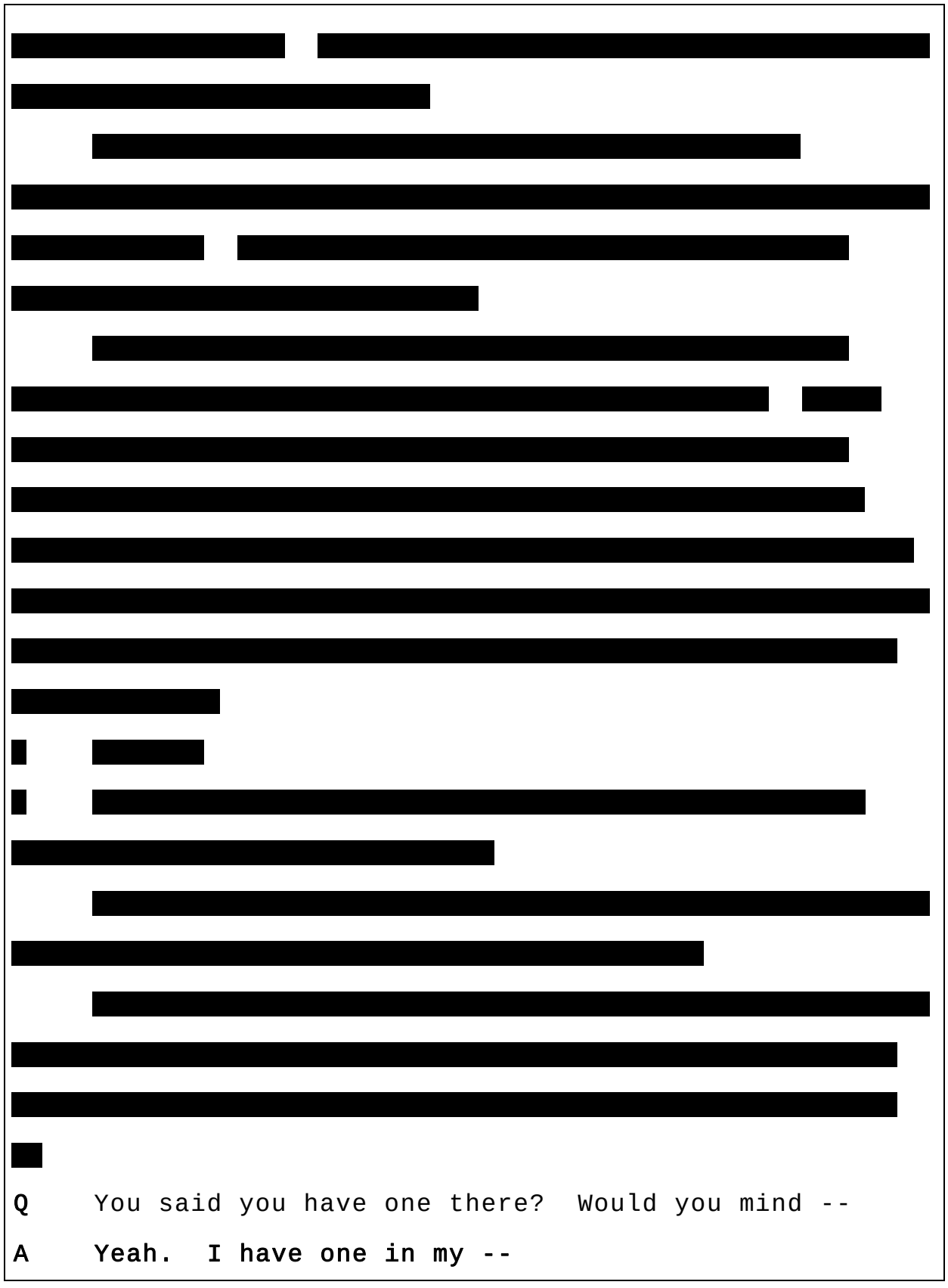


Q You said you have one there? Would you mind --

A Yeah. I have one in my --

Q Would you mind grabbing it real quick? Thanks.

MR. GILLISPIE: You want to go off the record for a second, Cris?

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

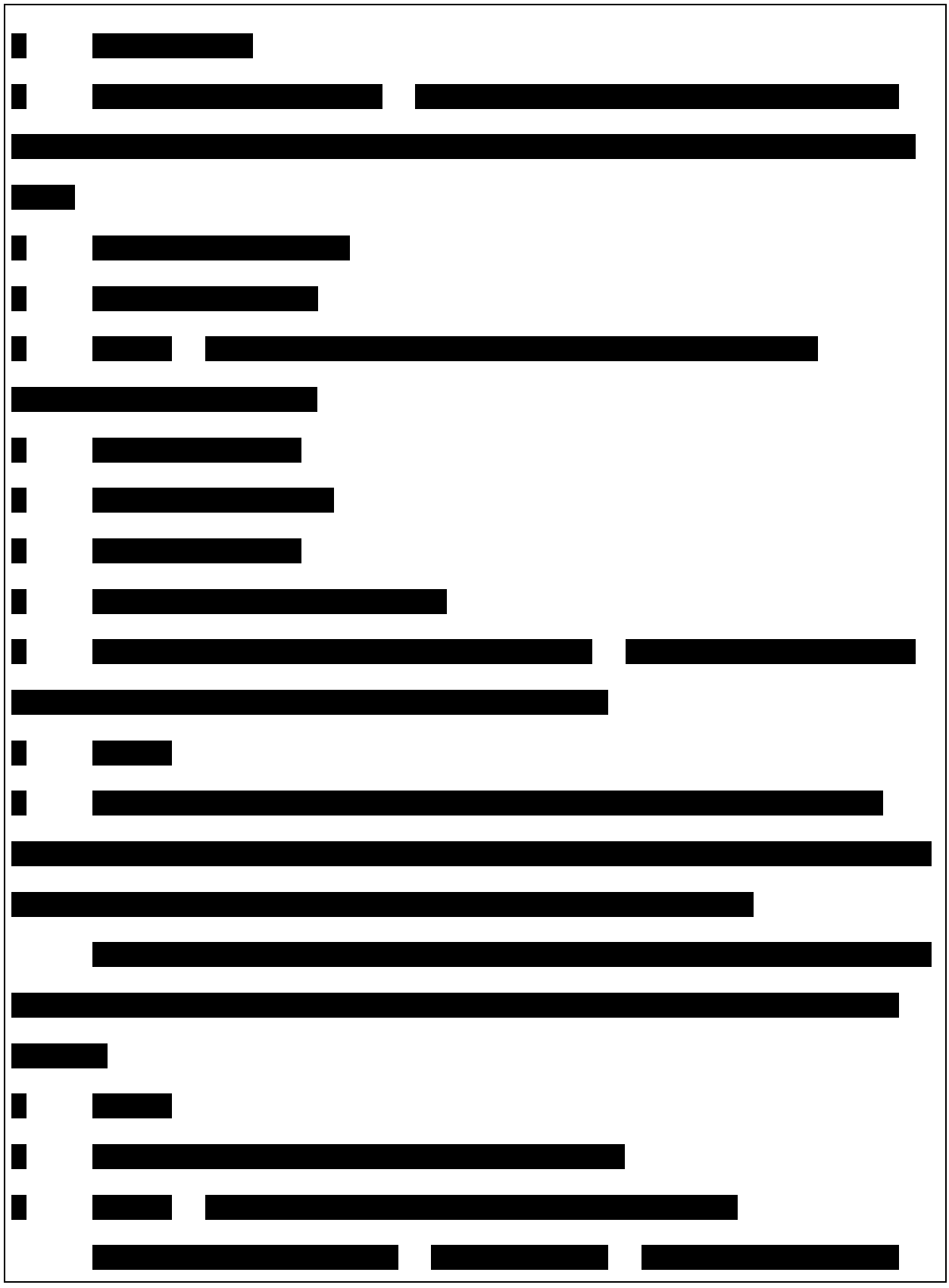
A Well, I can't find my tube.

BY MR. GILLISPIE:

Q Okay. That's okay.

A One of my kids got into it.





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[redacted] I mean, it's --

Q Okay. And --

A **National registry standard, so that's --**

Q Okay. And --

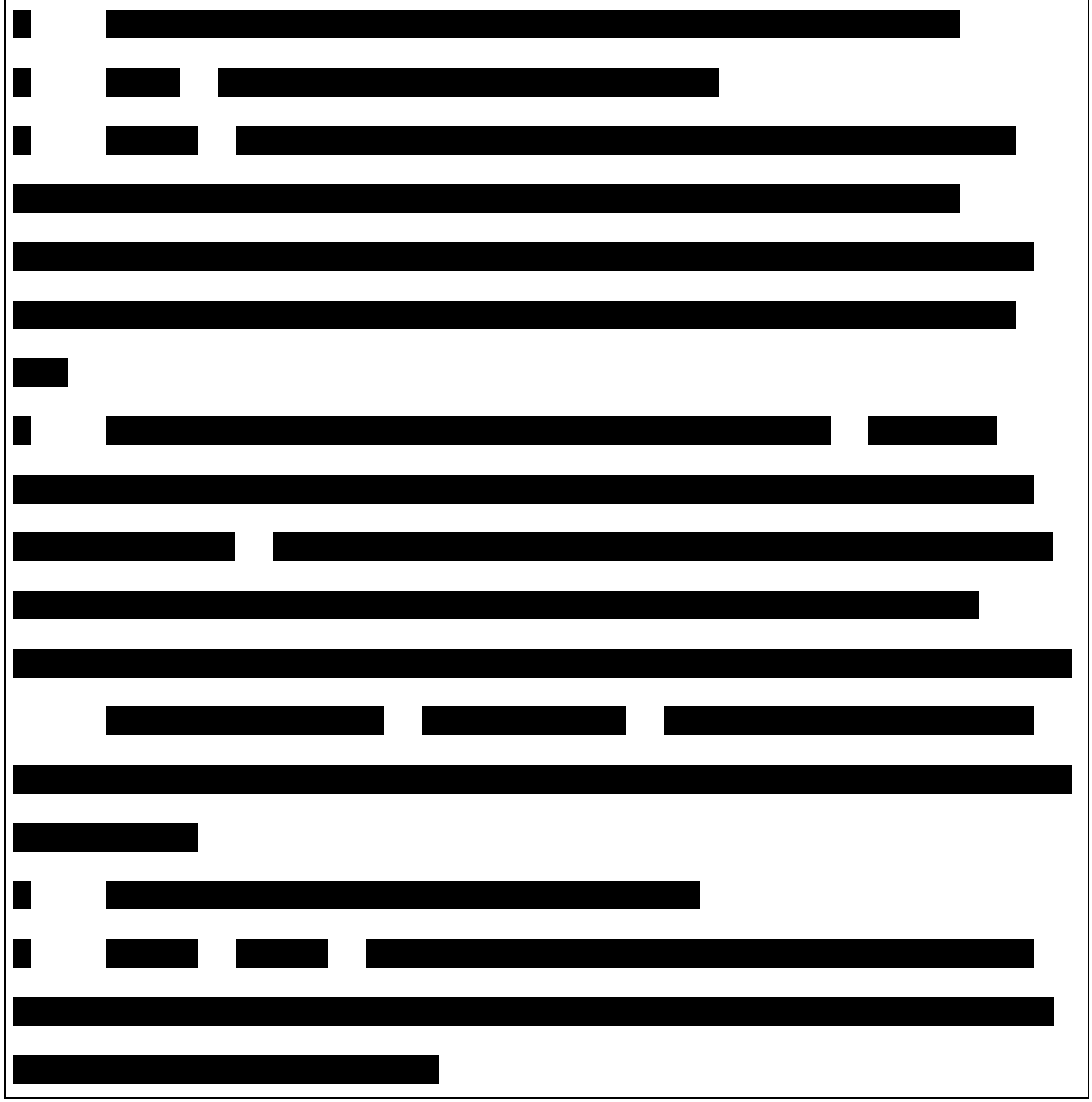
A **That's -- yeah. Go ahead.**

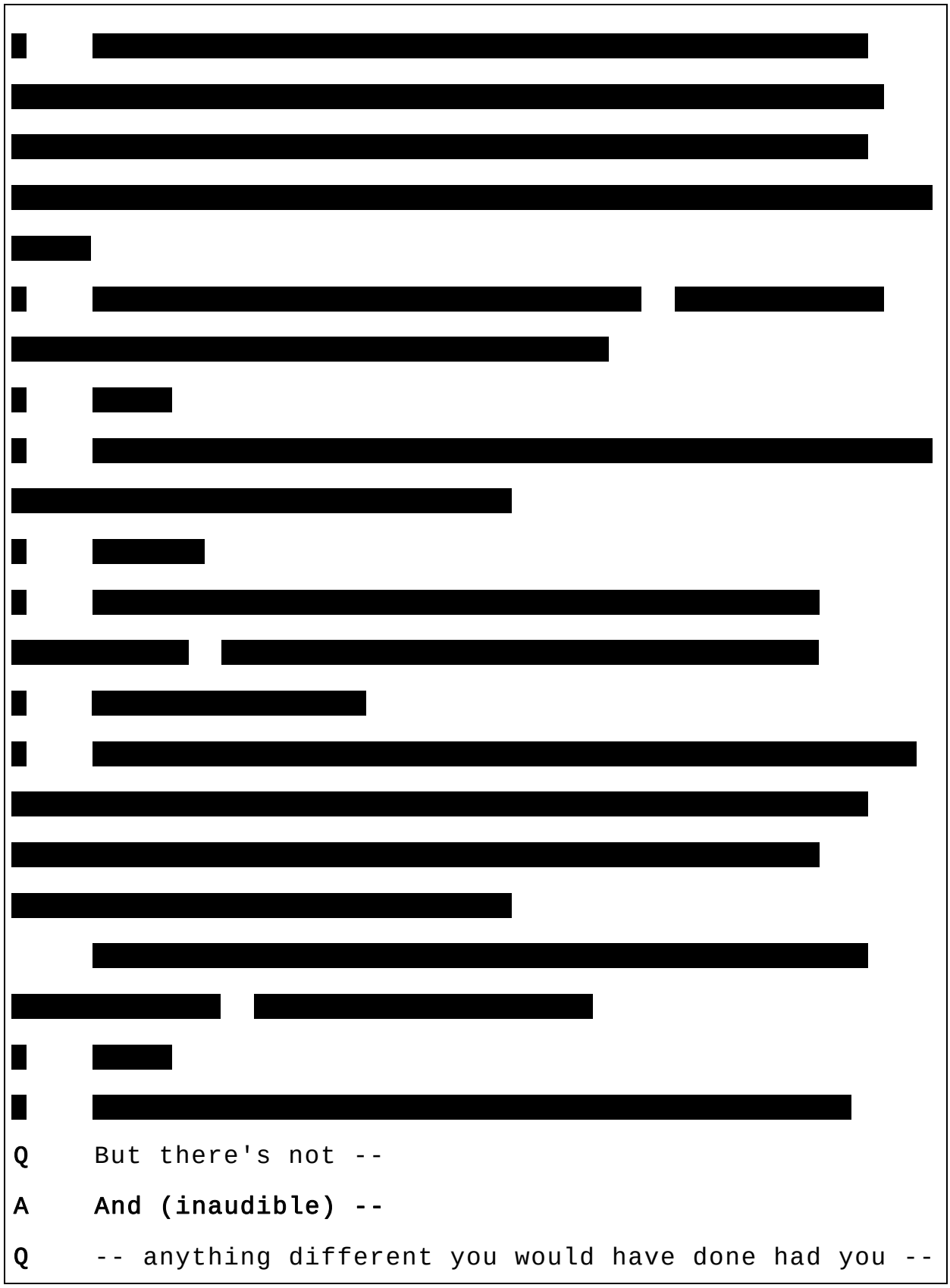
Q What's the different between -- if you're able to, what's the difference between aspiration and choking on your lunch?

A **It's the same thing, man. Aspiration is an inhaled**

-- is an inhaled object. It's just a medical term to say that you have food or an obstruction in your airway.

And the same -- in this case, it's the same thing as choking on his lunch. His -- he's got food in his airway and around his airway obstructing his ability to create gas exchange.





Q But there's not --
A And (inaudible) --
Q -- anything different you would have done had you --

A No. No. (Inaudible) --
Q -- seen (inaudible) --
A -- (inaudible) -- yeah. Same outcome. Aspiration is aspiration, no matter what the root cause is.
Q Okay. And so you would have used the same techniques and the same equipment?
A Yep.
Q Okay.

[redacted]

So this is a -- this is obviously not sized for an adult. This is sized for my children.
Q Uh-huh.
A But this is a BVM.

Q Okay.
A This connects to the oxygen or we can go to room air. This fills with oxygen.
This goes on the patient's face, I squeeze this, and I create positive pressure ventilation.
Q Okay.
A So I'm forcing air into the patient.
Q Okay. And that's know as a BVM?
A Yes. BVM is the non-brand specific term.
Q Bag ventilation mask?
A Yeah.
[redacted]

[redacted]

Q And was this an easy place -- was this an easy facility to get to?

Meaning, when you pulled up in the ambulance, was the door just right there and you were able to just immediately get in there and get to him?

A So access wasn't the greatest.

I remember having to carry our power cot, which is like 200 pounds, and all my equipment on myself or strapped to the cot up the foyer steps. And they are old and stone and it was a lot to move.

And then, when we left, that was one of the problems that my partner worked while I was -- once we got to a point where he could.

And we ended up -- they cleared out the cafeteria and we used the cap -- he moved the ambulance, you know,

300 meters down the driveway and we went to the cafeteria and used a ramp they had there when we left. Because there was no physical way to move that patient safely down those steps.
Q Okay.
A So we just, you know, we worked that problem at the end.
Q Okay. But getting in there took a little bit of time because there were fairly steep steps you had to go up?
A Yep. The steps and just the total amount of equipment to move.
Q Okay.
A So -- yep.
Q Okay.
Any other equipment that y'all had with you that we haven't talked about?
A We talked about my cardiac monitor. That's pretty self-explanatory. Monitor pads or the sticky pads that I -- I can monitor a patient heart rhythm and deliver shocks as needed.
Q Okay. So you talked about a way to deliver shocks?
A Yes. I have a way to defibrillate my patients.
Q And that -- okay. So you had a defibrillator?
A So my cardiac monitor is more than just a

defibrillator. But, yes, it's one of the -- the deal -- I can actually interpret cardiac rhythms, monitor blood pressure and vitals, stuff like that.

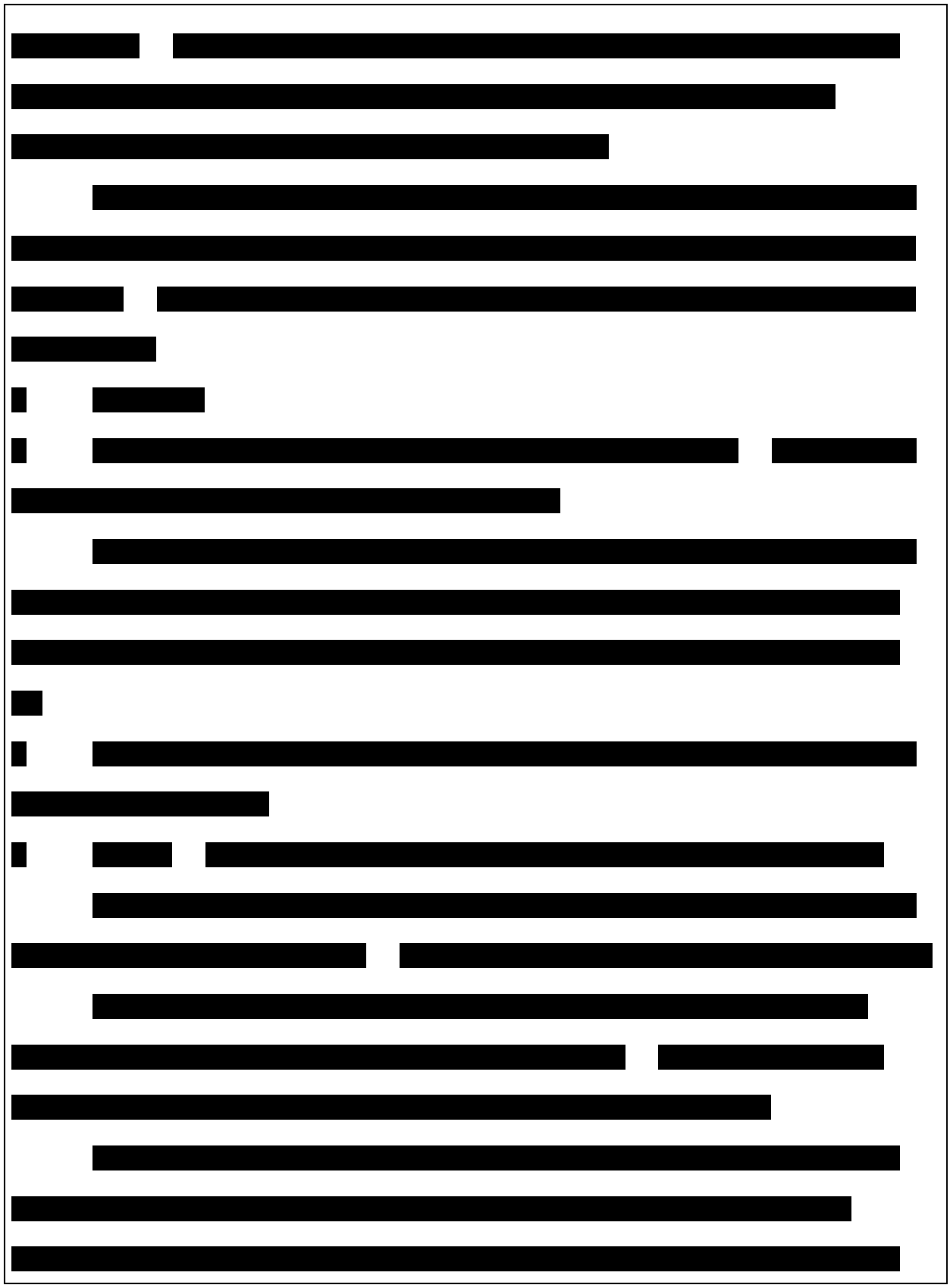
Q Okay.

A So -- let's see.

[redacted]

Q I guess -- hold on just a second. Let me rephrase this question better.

[redacted]



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[redacted]

Q Okay.

Let's see. Were you questioned about this incident by anyone afterwards?

A Yes. At some point, we were contacted and -- by the -- I think someone at the Department of Health.

Q Uh-huh.

A And I remember being pulled into my boss's office and there was a speaker phone conversation. And I basically said everything I've said right here.

You know, whatever's in my narrative -- because it was -- I think it was over a year --

Q Yeah.

A I don't think -- that wasn't a -- that was probably shortly after; because that investigation happened right

after.
Q Were you asked if you thought that -- were you asked if you felt like everything was, you know, done the proper way, copasetic, or were you asked anything like that?
A I was asked if I had any opinion and like as far as what I saw when I walked in about what was being done and resources. I said there's more people there than there usually is when I'm at any other facility.
BHDC is pretty good about having hands there --
Q Uh-huh.
A -- that I can direct. So that's all I could tell. I was like there was three women working the patient when we showed up. It's better than --
Q Yeah.
A -- just one person, so --
[redacted]

[redacted]

Q Last question here. I believe you said earlier time is tissue.

A Yes.

Q What does that mean?

A Time is tissue is kind of a catch all, that the longer you go without gas exchange, the longer you go without oxygen being delivered to your venous and arterial system, your capillaries, to all your organs and perfusing, you have breakdown.

So you don't have oxygen going to your brain, you have brain damage. You don't have oxygen in a heart attack being included in coronary arteries through blood profusion, you end up with dead tissue in your heart, you know, or scar tissue.

Q So time is everything in these situations?

A Yes. Time -- time is a critical component of any healthcare in a critical setting.

Q And this facility waited eight minutes from the time they knew he wasn't breathing to the time 9-1-1 was called, according to what you were told?
A **Yes.**
Q Okay. And, when I say told, according to what you were told by the people on the scene?
A **Yes.**
Q Okay.
All right. That's all. That's all I have. Thank you.

CROSS EXAMINATION

BY MR. COLLINS:

Q Hi, sir. How are you doing?
A **Good. How are you, man?**
Q Not too bad. You know, I appreciate your testimony so far, so I'm just kind of going to go back, I guess from the beginning.
So I saw on this note, the dispatch note that you had, that you were the lead of the team; is that correct?
A **Yes, sir. I am the -- we -- at the time, we had a paramedic EMT team. So I am the -- I'm the patient care lead.**
Q Okay. And you're the paramedic; correct?
A **Yes.**
Q Okay. And your other individual, was he driving the

vehicle that day?
A Yes. He was driving in my assistant. Yeah, he operates at a very basic level. Basic EMT, so --
Q Okay. And, when you guys got the call, where were you stationed at?
A I want to say we were in -- I have to look. I wonder if this even tells me what station I was at.
We have three stations in the county, two in Paris, one in Booneville. And -- I have to look. I don't see my dispatch (inaudible) on here.
We had to be in Booneville with a 13-minute scene time. So, whether we were at one of the other stations or -- but we -- we post in Booneville when Booneville goes out on a call. So we were in Booneville for that, so.
Q Okay.
A We could be at any station but we were at Booneville.
Q Gotcha. So you got the call, you guys drove over to the BHDC. Once you got to BHDC, what occurred?
A What occurred? We had gotten all the information we could over the radio for what was going on. We made the best possible --
(Audio Interference)
BY MR. COLLINS:

Q One second, sir. You're cutting out. You can try again.
A -- hear me?
So we (inaudible) differential (inaudible) for the patient (inaudible) equipment we need. And then loaded it up on the stretcher and then trudged it upstairs and (inaudible).
Q Mr. Scow, I'm still having troubling hearing you.
MR. COLLINS: Cris, are you having trouble hearing him or is it just me?
COURT REPORTER: Yeah, I can't hear him. He's cutting out a lot right now.
MR. GILLISPIE: It's an internet connection thing, I think.
THE WITNESS: All right. Let me (inaudible).
(Brief discussion off the record.)
BY MR. COLLINS:
Q I know we kind of left off with you coming -- I want to back up a little bit.
Because I'm curious to know how you got to the building in question. So were you led in the gate? Were you led in -- how did you find the building?
A So, usually, my partner handles that, as far as what building, because he's driving.

Usually, we're informed through dispatch at such and such building. A lot of those buildings are named, so we know which building to roll up to. And part of that is just he's working that area and that -- for, I think, eight years, so he knows the building names. I don't.
Q Okay.
A So I don't know the building names to save my life.
Q Okay.
A But he does, so that's usually how we know.
Or he'll ask on the radio in route for more clarification for which building and which -- dispatch would contact them and that would get worked out over the radio.
Q Okay. So you guys didn't have any confusion finding the building?
A Not that I'm aware of.
Q Okay.
So how long have you been a paramedic?
A Now or at the time? Now I've -- going on almost five years.
Q Five years. And were you an EMS before that or did you have any other kind of background doing this?
A EMS for -- I was an EMT for like two years, I think, before that. And then four years in an ICU as a tech. Then, I think, what, a year and a half as a mortician's

apprentice.
Q Okay.
A Yeah.
Q In your experience kind of, you know, responding to these situations, are you always given the most accurate information by the people on the ground or is it hectic?
A It's -- so -- yeah. No.
Radio reports aren't always reliable whether it's from a skilled professional at a nursing home or this facility or someone's cousin who found grandma.
Nothing's ever set in stone or specific and I take it all with a grain of skepticism.
On scene, when we're doing patient care, if it's a hectic environment, you take what information you can get and you try to get as clear as -- clearest picture of what you can get when you're asking questions and interviewing while you're doing your work at the same time, so -- yeah.
It's -- it's not always the most accurate but --
Q Okay. And you said you can't identify who was there but you know there were at least three women and one man?
A Yes.
Q Do you know which of those you spoke to? Was it a woman or a man?
A I spoke to the women. I remember the man being

there and he was sent off to go do something and I didn't see him ever again.

Q Okay. And do you know if the women were nurses?

A No.

[redacted]

Q Oh, we have a different -- hold on.

MR. COLLINS: Well, maybe, Josh, I'm working from a different document than you guys are.

MR. GILLISPIE: No, mine says that.

MR. COLLINS: Oh, does it? Okay.

MR. GILLISPIE: Yeah. It's right under -- it's hard -- it's like the very top sentence where -- right under the word --

THE WITNESS: This is a -- you guys have got a different narrative than what I've got from work. Sorry about that.

This must be -- what lock number do you guys -- let's see. One second, guys.

MR. GILLISPIE: Sure. And you have the one I sent you that --

THE WITNESS: Yeah. That's the one I'm looking at now. Let me see other versions.

MR. GILLISPIE: So it's Page Three at the very top under --

THE WITNESS: Right. So I'm looking at it. We have -- all right.

So I guess that looks like the only change that I had in my narrative.

So I've got a different -- I guess this is the final form of my charting.

MR. GILLISPIE: How is yours different?

THE WITNESS: So mine says -- the first paragraph that you're discussing, upon arrival, [redacted]

[redacted]

MR. GILLISPIE: So the time --

THE WITNESS: This is a --

MR. GILLISPIE: The numbers and the times are all the same?

THE WITNESS: Yeah.

MR. GILLISPIE: Okay.

MR. COLLINS: Would it be possible to get a copy of that regardless? Just so we --

THE WITNESS: Oh, the one I've got?

MR. COLLINS: Yes.

THE WITNESS: Yes. I can make sure this comes to you, bud.

MR. COLLINS: Okay. Thank you.

THE WITNESS: You may actually have to reach out to -- I mean, I'll let them know. But you'll have to let the office know, the building office. Or just call EMS station and they'll get it over to you.

MR. COLLINS: Okay.

Well, I guess I'm going to go back a little bit. So I know you're saying you don't have a copy of this one?

MR. GILLISPIE: He does. He has it.

THE WITNESS: I do. I jumped over to y'all's now.

MR. COLLINS: Okay. Sounds good.

BY MR. COLLINS:

Q Did you write this copy?

A Yes. Both copies have been written by me.

Q Okay. So you're the one that the nurse is unable to clear the patient's airway?

A Right. And then it looks like I changed that to staff, basically, and just gave more elaboration on what the -- the intervention the patient -- nurse did.

Q Okay.

So what I'm kind of getting at here is I'm trying to identify the people that you were speaking to. Was your understanding --

A Yeah.

Q -- (inaudible) that you wrote nurse here, that they were in fact nurses?

A Yeah, I guess. Or there was -- yeah.

Q Or is this a reasonable --

A Yeah. It's a -- yeah. It's a reasonable inference

or that -- that I deal with nurses enough that I was like -- that I went back and I wasn't sure and I changed the name to staff. But -- yeah.

If I put nurse, then -- at the time of typing that one, before the edit, I assumed they were a nurse.

Q Okay. So you were speaking to these ladies.

You said you walked up, they were doing CPR, you're speaking to them as you are working?

A Yes.

Q Okay. Then you ask them, if I recall correctly, how they found him?

A I said -- let's see. I asked -- my usual questions would be like how did he get here, how long has he been down or in this condition, what have you done, any patient history.

Like those are all questions just -- you just rattle off as you're going to try to build a picture with more definition.

Q Gotcha. Okay.

Obviously, you're really busy with Mr. Cains. Did you notice any clocks in the room or anything along those lines?

A No.

Q No? Okay.

A No.

Q You also said --
A **I didn't --**
Q Go ahead.
A **Go ahead. No, the only clock that I will say that I had available is my watch, so --**
Q And you said that you didn't see any restraints on his person?
A **Did not.**
Q Okay. But you said that would have been pertinent information? Normally, you check for those things?
A **Correct. Well, it's just one of those things that you do, a head to toe like eye scan.**

You look for any signs of trauma or restraint or, you know, a weed whacker wrapped around their leg. You know, just you look for -- for obvious signs.

[redacted]

Q Let's say, for instance, you did see a restraint on him. What would you have done?
A **I would have just asked for more clarification while I was working.**

At that point, them restraining the patient has no outcome. [redacted]

[redacted]

And the knowledge just helps me to pass that on or paint a picture when I go to the hospital. And for my narrative.

But, otherwise, like if we was restrained, that all has an issue with what led up to the problem and I'm dealing with what's after the problem. The problem after, so it just paints a picture.

Q And you previously stated, that the longer you go without gas exchange, the larger of a problem you have.

A True.

Q How long -- and, obviously, every patient is different, every situation is different. You probably can't give a one size fits all answer.

But, in general, at what period of time after someone stopped breathing is the chance of resuscitating them significantly declined?

A Significantly declined? That depends on which -- which material and studies you go with.

You know, some people and services have a protocol at 30 minutes, no CPR, you don't do anything.

As far as at asystole, as soon as you stop gas exchange, you start having the clock ticking. So, I mean, I've had patients come back from ROSC at 30 minutes, but they never left the hospital, you know, upon

follow up. Patient died in the hospital.

So I can't ever say a patient lived. I can say I've gotten ROSC but I can't say that the patient had a positive outcome and walked out.

But, yeah, it's -- it's patient dependent. It's based on -- for example, how efficient is their body with the oxygen exchange, gas exchange. Do they have COPD, CHF, do they smoke, do they have lung tissue damage from tuberculosis or another pathogen.

So all those things play into how efficient they can -- how long they go without gas exchange do they start having negative effects.

You know, grandma who smoked three packs a day for 60 years versus you who looks like he hasn't smoked a day in his life, you know, if you sat there and held your breath, you're going to hold your breath longer than she does because she's going to panic CO2 retention and oxygen.

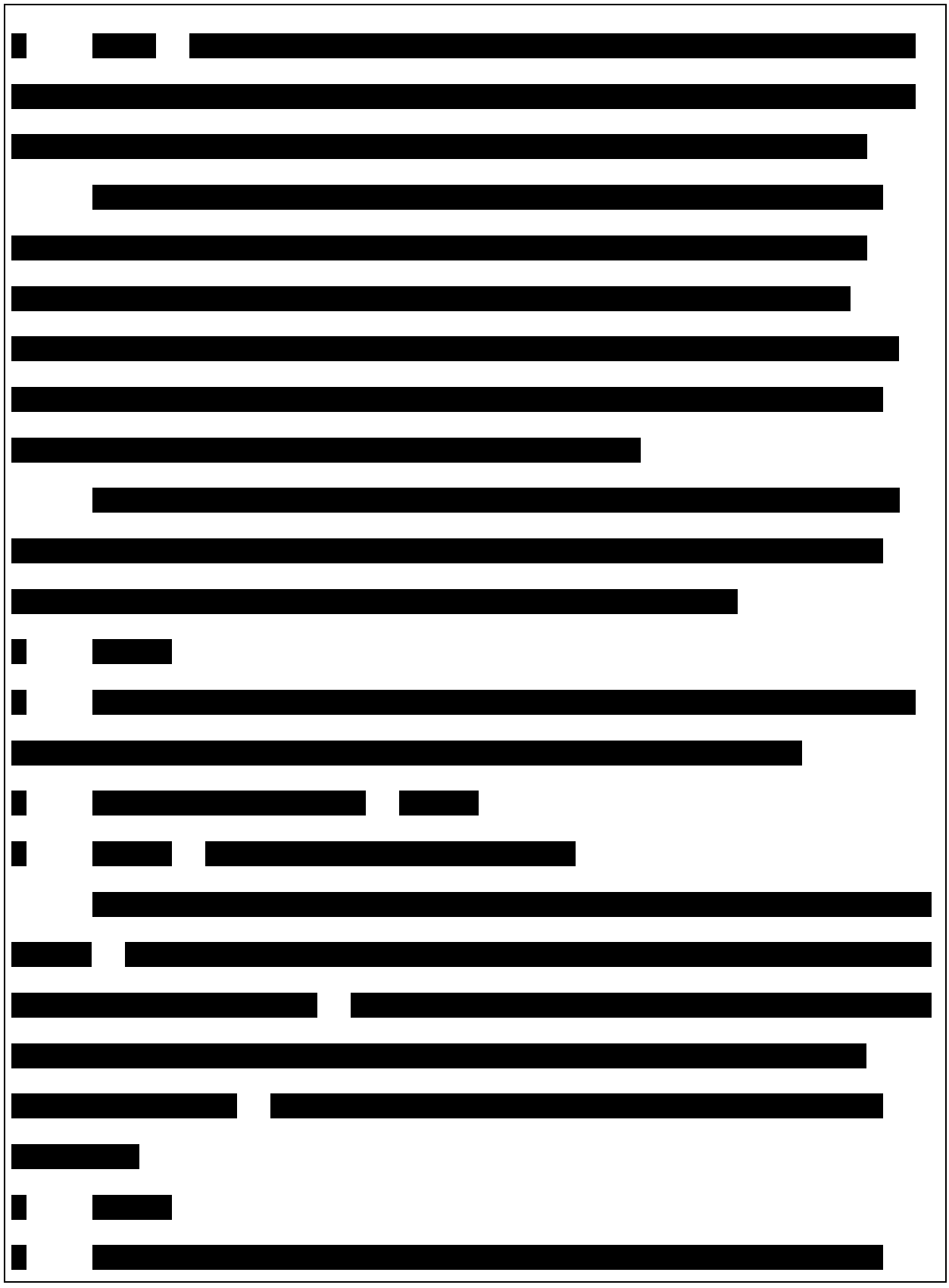
So, you know -- and you can have worse outcomes. She would have worse outcomes, so --

Q Okay.

A That's just very -- that's such a big patient variable. It's based on patient history; right?

Q Okay.

[redacted]



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[redacted]

Q Okay.
A So --
Q You said that the most important thing was CPR; correct?
A At post -- I want to be clear. In a --
MR. GILLISPIE: Object to the form of that. Go ahead.
A To be clear, which I tried to clarify with you, sir, was, in a post cardiac arrest situation, CPR is hands down has the largest impact on getting ROSC.
As far as him having an obstructed airway, clearing that airway is the most important aspect.
So you -- you know, if he was standing there choking, I'd walk up there while he was still standing, I'd do the Heimlich and try to physically, or like doing abdominal thrusts, try to clear that airway; right?

While he's still breathing. But, once he's down, then you got to start that -- that heart pumping.

BY MR. COLLINS:

[redacted]

Q Okay. I probably only have one or two more questions for you.

You said your time on call to the scene was 13 minutes?

A Yeah. Looking at my, let me see, my time sheets. Yep, looking like -- let's see. Eleven --

Q I don't need the exact time. I mean, I trust that it was what you're saying --

A I just want to make sure. Yeah. So I got it written down here. I'm just double checking.

Yeah. So it looks like, from my time of call, was roughly 13 minutes to scene. And then looks like a minute or two to at patient. And roughly 20 minutes on scene and eight minutes from destination from leaving the departure to destination.

Q Okay. That's kind of what I was wanting to get at.

When you're saying time to scene, are you talking to Booneville HDC and then it took you an additional two minutes to get to Mr. Cains?

A Yes. Yes. So what you're seeing on Page Three,

you'll see that on scene means like, hey, I just pulled up at your front door; right? And at patient means I have eyes on you, I'm right there; right?

Like now I'm taking -- I'm starting my treatment and assessment modality with you.

Q Okay.

A With your loved one or whatever; right.

And so there's always that -- you know, like there's always going to be a split in time unless the guy's lying in the road, so --

Q Okay. So the time from the call until the time you put a finger on the patient was 15 minutes?

A Looks like it. Yeah.

Q Okay.

MR. COLLINS: One second, please.

All right I have nothing further.

REDIRECT EXAMINATION

BY MR. GILLISPIE:

Q Just real quick, Sam. On Page Four of the document, top right-hand corner --

A Yes, sir.

Q -- you see where it has on scene and then at patient? You see that?

A Yeah. Yeah.

Q Okay. So on scene 11:49 a.m.; right?

A Yes.
Q And does that mean right at the closest possible place you can get the ambulance to the building?
A That's when we put it in park. That's when we call the -- we call the -- so this is -- I'll clarify.
I don't make these times up. These are times where -- like the on scene is we get on the radio, we say to our dispatch, squad one is on scene. And they say ten-four, 11:49.
Q So that would mean you're right in front of the building at 11:49?
A Yes.
Q And then at patient, 11:50?
A Yes.
Q So that means it took you about one minute to get --
A (Inaudible) and unloading --
Q -- everything up those stairs and to the patient?
A Yeah. It's all like right there. It's all -- so it's all piled up. So I just pull it up and grab it.
My -- at patient for me is not finger on patient. That is visualization of my patient. I am seeing -- because that is the start of my patient assessment and treatment, so --
Q So then, if you got the call at 11:37, you were in route at 11:38, you arrived --

A Right.
Q -- at the patient where you could see the patient at 11:50, that means it was roughly -- that means it would have been either 12 minutes from -- 13 minutes from the time of the call to the time you had the patient visually in front of you?
A Yeah.
Q Yes?
A Yes.
Q Okay.
A If that's what the numbers say, yeah.
Q Okay.
A But those are all times that are documented and then handed to me at the end.
Q But it took you a full minute, probably because of those stairs, to get from the parked ambulance to the scene?
A Yeah. Pull the equipment out and get up the stairs, yeah.
Q Okay.
A And the doors are right there. He was like in full view of the doors.
Q Yeah.
A So.
Q But, because of those stairs and just the layout of

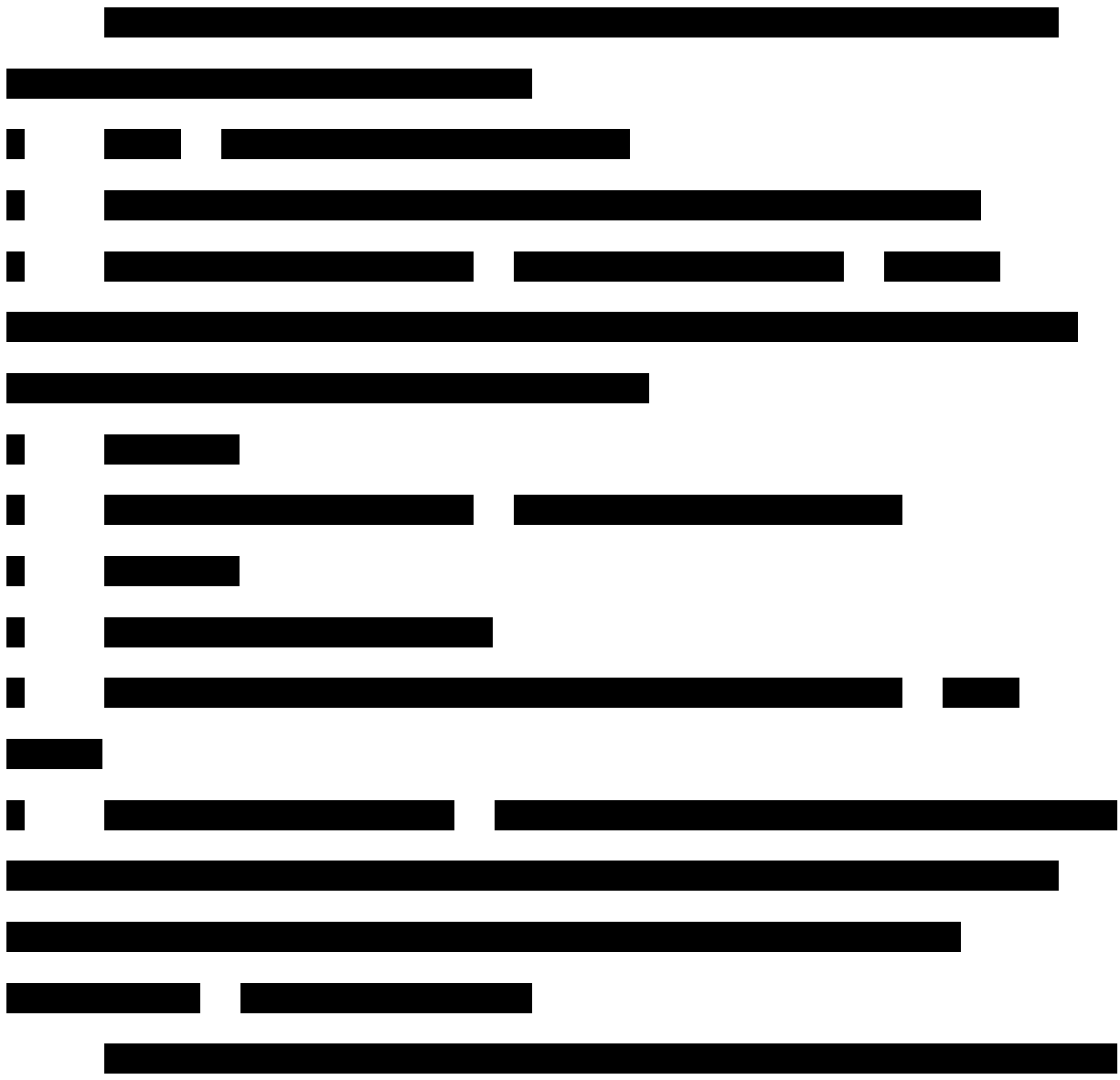
the place, it still took a minute to get from the ambulance to the location of the patient?

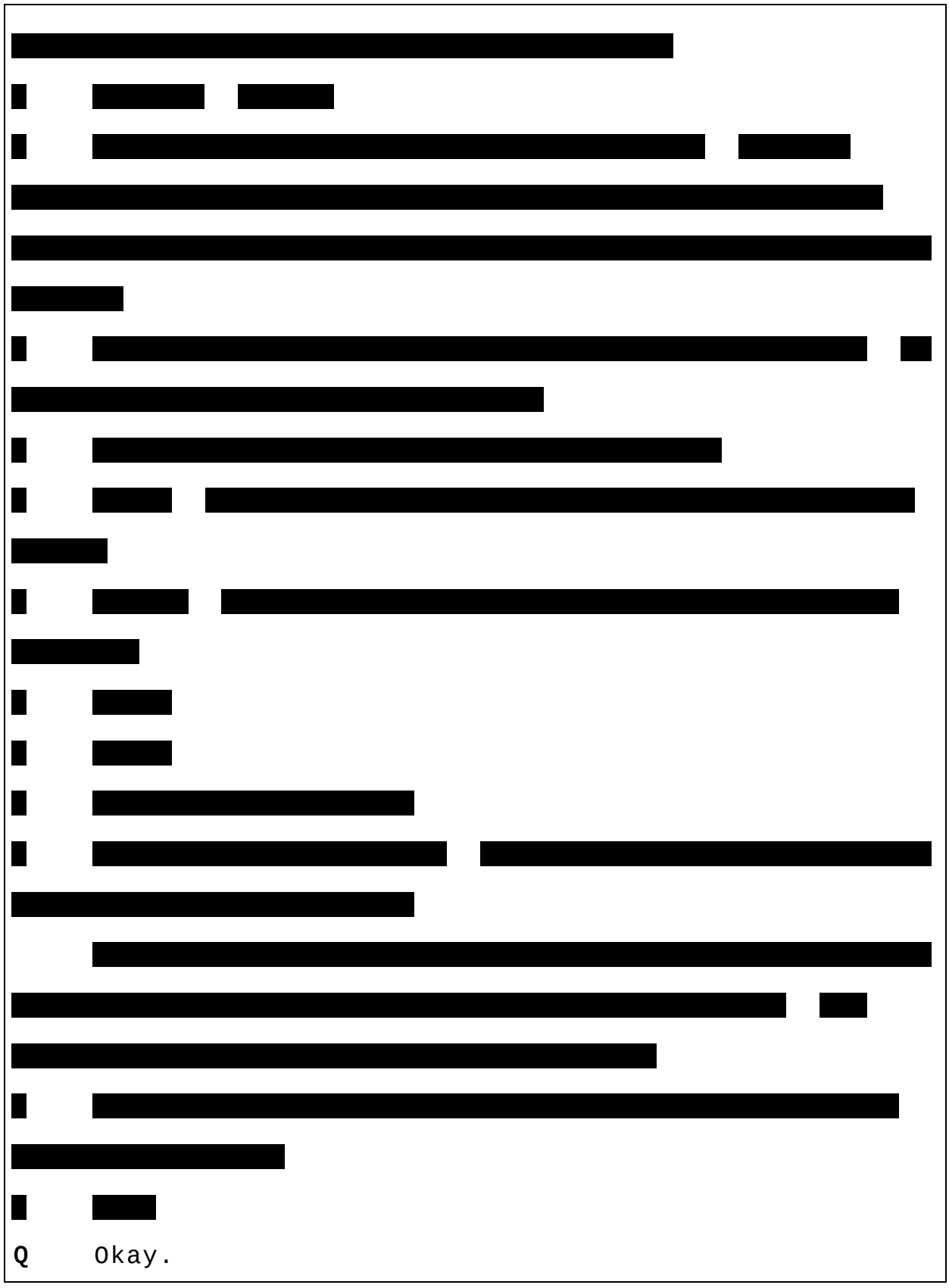
A Yes.

Q Okay. And you were parked right tin front of the building as well; right?

A Yes. We were parked right there at the stairs.

Q Okay.





Q Okay.

[redacted]

Q Okay. And last question.

Mr. Collins asked you about whether you can always rely on the information that you're given at the scene in hectic situations.

I just want to follow up on that real quick and confirm that you were in fact specifically told that this guy had -- this patient had collapsed and --

A **Was a (inaudible) --**

Q -- was unable to breathe since 11:30; correct?

A **Yes. Yes. They -- I asked --**

Q And do you have any specific reason -- in this case,

do you have any specific reason to think that the person that told you that was lying or wrong?

A Nope.

[redacted]

Q Okay. All right. That's all I have. Thank you.

MR. COLLINS: I just have a quick follow-up.

RECROSS EXAMINATION

BY MR. COLLINS:

Q This will take two seconds. I just want to clarify a few things.

You said you parked right in front of the building and you could see him from the door of the building at least. What was the (inaudible) --

A (Inaudible) --

Q Didn't you testify that --

A I'm sorry. What?

Q -- once you -- I guess, my understanding of your testimony is, once you crossed the door or got into the

door, you could see Mr. Cains; is that correct?
A Yeah. There's farther steps inside the door; but, yeah, I could see Mr. Cains laying on the floor. Yeah.
Q Okay.
I'm just wondering if you can -- obviously, you're going to be guessing to a degree, the distance from where you parked to where Mr. Cains was laying. How many feet do you think that was?
A Twenty or 30 feet from like the vertical height of getting up the stairs.
Like I said, we had everything on the cot already and so it was just pull the cot up which is an auto load thing so it's just like that. It's on rails. And then just hefted it up the stairs.
As we hefted it up the stairs, I can see as their -- from the doorway, the patient, [redacted]
Q Okay. I just want to clarify real quick. Obviously, you wouldn't do this, but let's say you decided not to take any of your equipment with you, you just got out of the ambulance and just ran up to there.
How long do you think it would have taken you to get there?
A Thirty seconds? Generally, we -- I don't run because running leads to injury. And, if I'm hurt, I

can't help my patient.

But I -- I walk with a sense of urgency. So if you mean like with a sense of urgency and mindful of the environment, yes, it'd be about 30 seconds that -- to summit those stairs without any equipment.

Q Okay. And I'm sure this is on both your form, our form, and the one you received from Mr. Gillispie.

All these times that are noted that you say you call in, I notice they're all rounded off. Do you know the standard practice for how you guys determine what time to round off to?

A I don't.

Q Okay. So you don't know if they're rounding to the nearest minute or if they're just looking up what the minute is and calling that minute out?

A Yeah. So like all I know is, on my end, I'll say, hey, or my partner usually manages the radio and say, you know, squad one is on scene. And they'd say 10-4, 11:49.

Or if they're busy -- this does happen. Because, like I said, they manage our law enforcement guys as well. There's usually only one dispatcher.

They'll mic click us and let us know, acknowledge us, but they're tied up on something else. And then they'll come back to us later.

And they email and then they report the times and

then I get the times also.

So there is like human error and what not on their side of it that I'm not in control of, so --

Q Okay.

I have nothing further. Thank you.

MR. GILLISPIE: Me neither.

Thank you so much, Mr. Scow.

THE WITNESS: Thanks, guys.

(WHEREUPON, the proceedings were concluded in the matter at 10:18 a.m.)

* * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

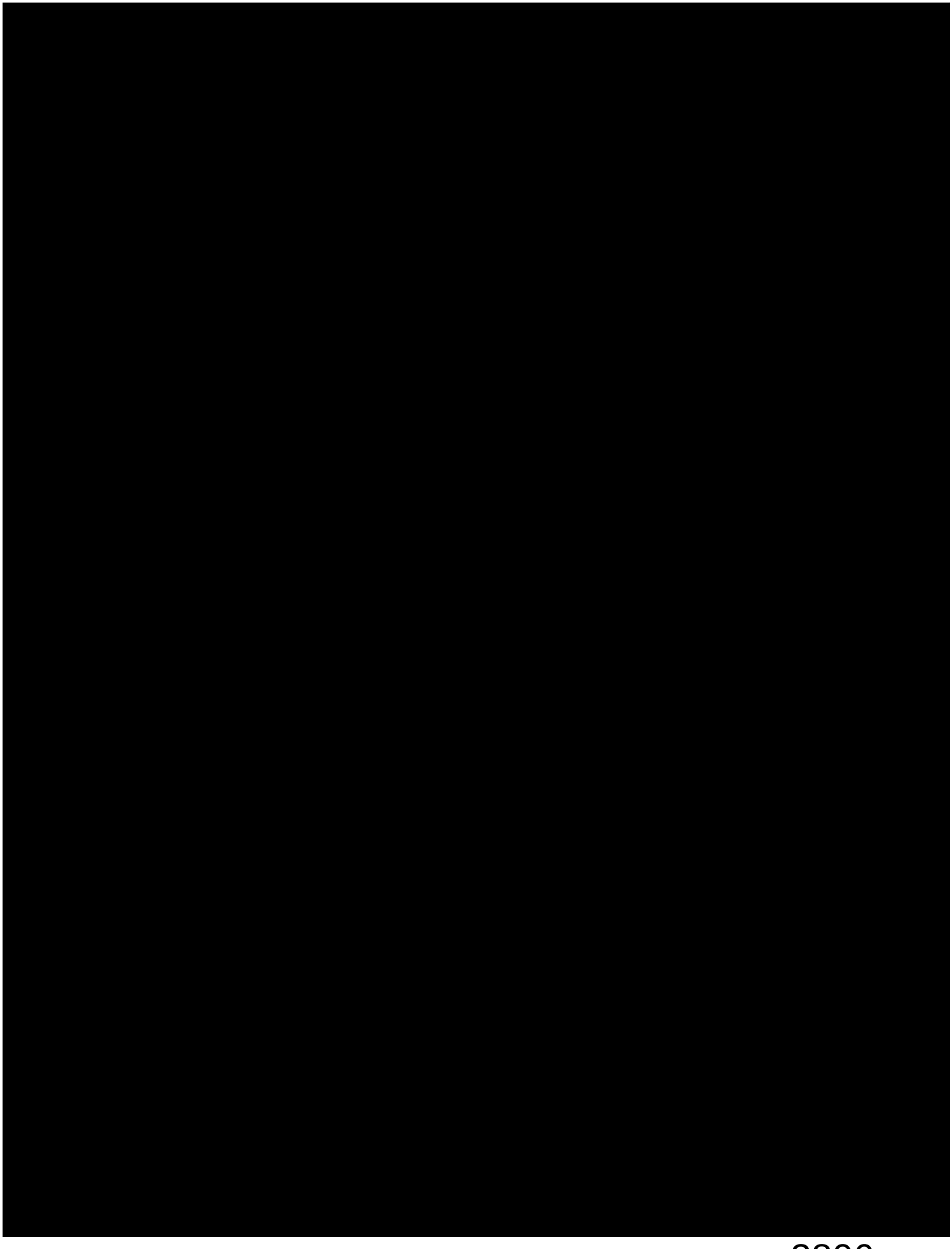
I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Samuel Scow, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

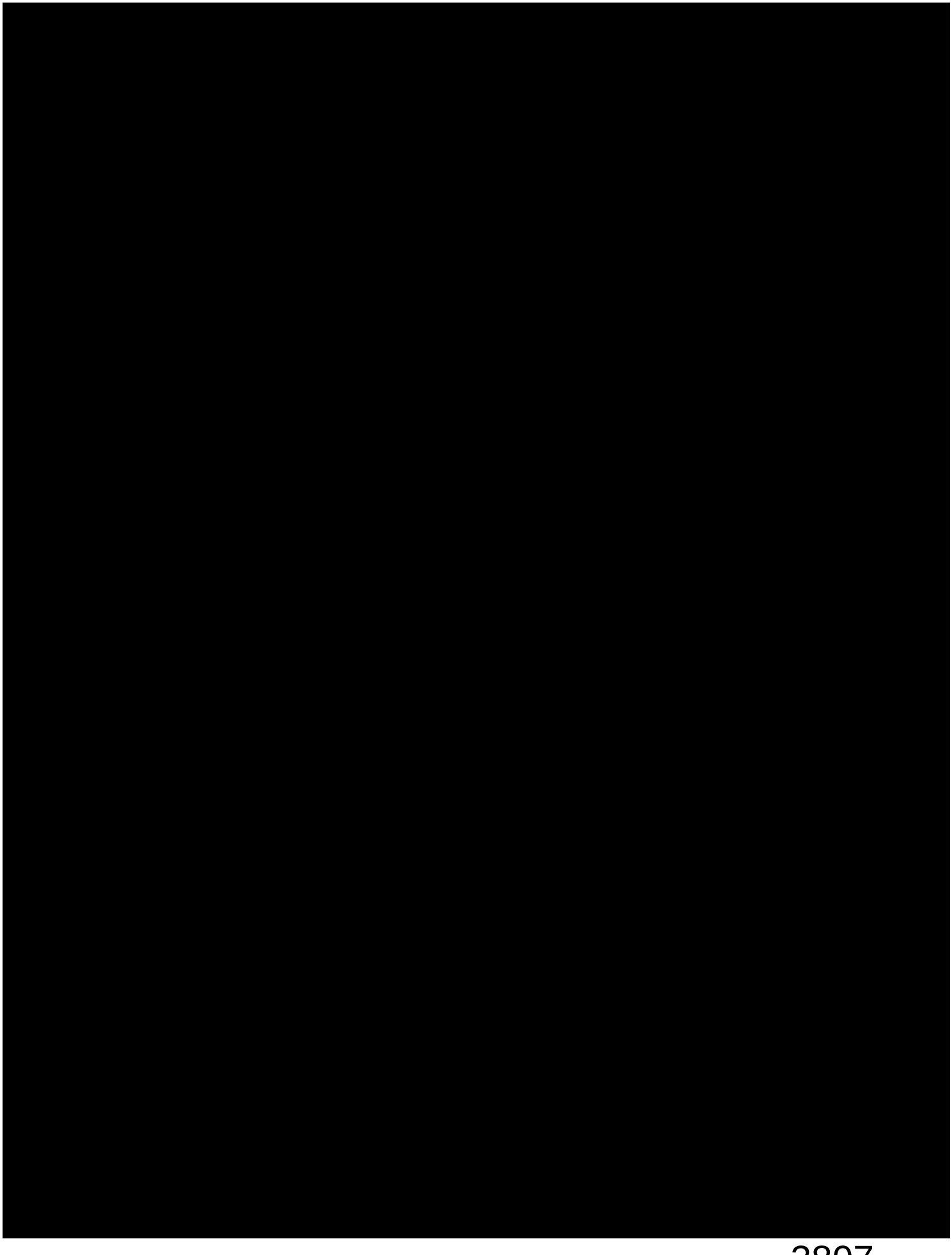
I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

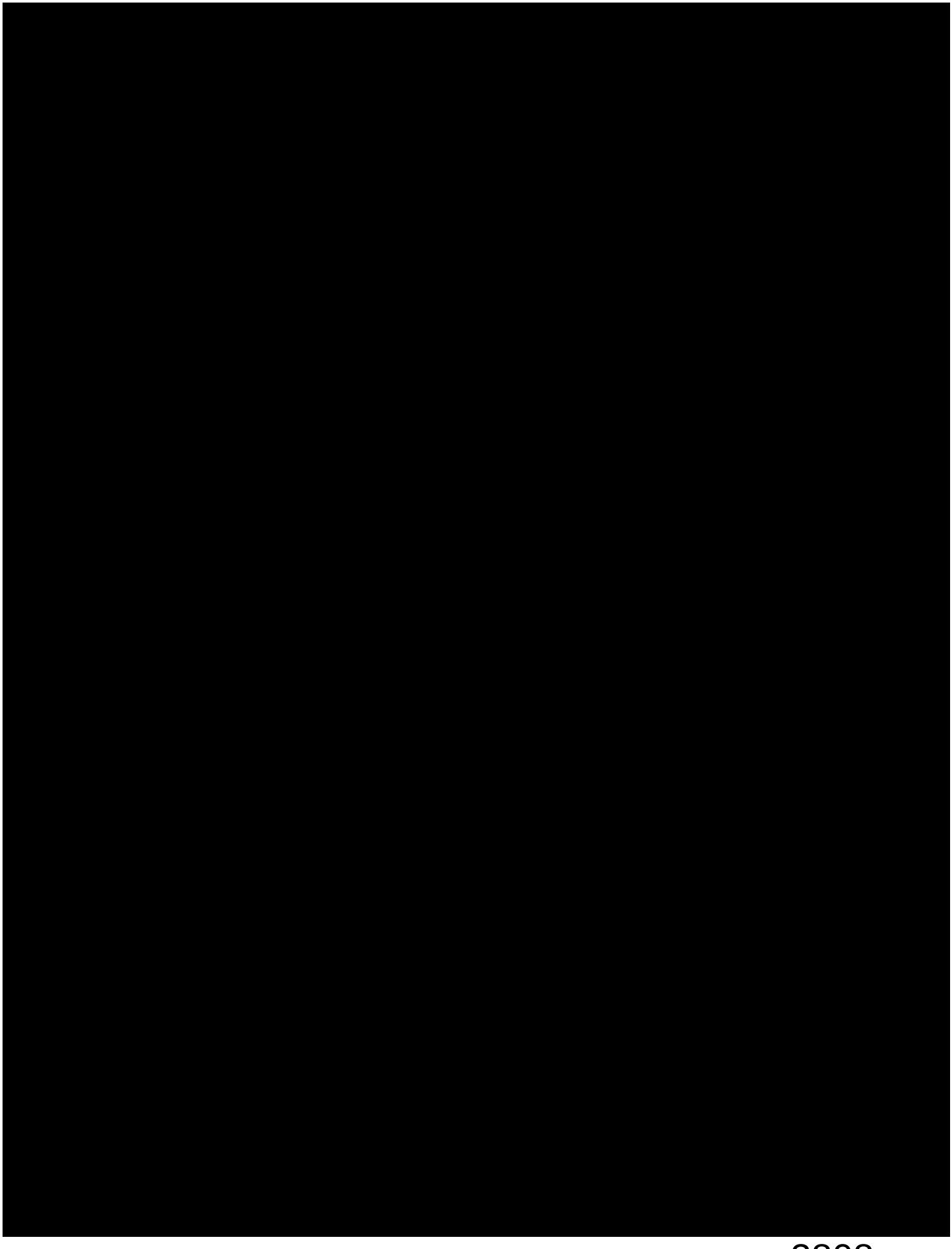
WITNESS MY HAND AND SEAL this 19TH day of May, 2022.

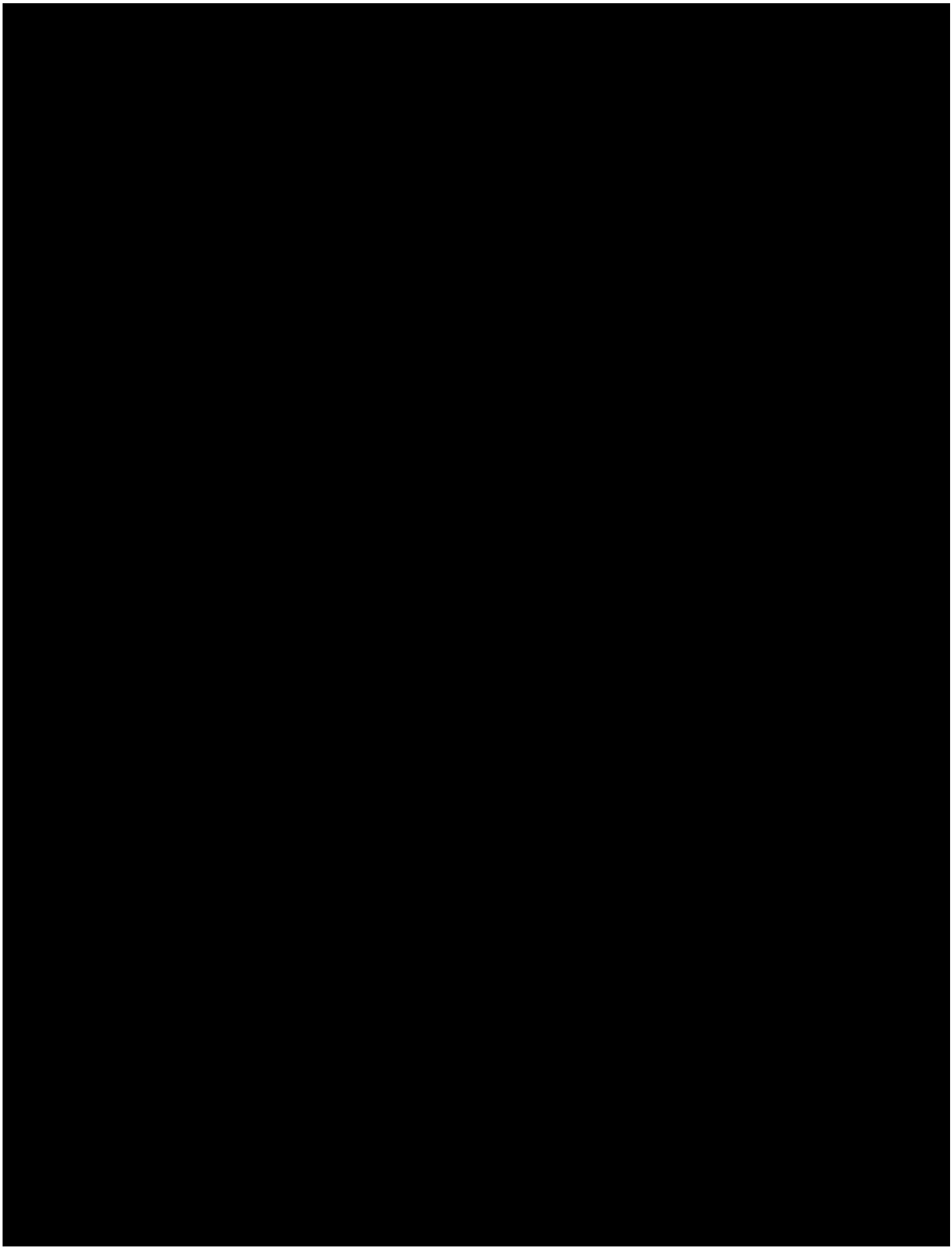
Cris M. Brasuell
CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

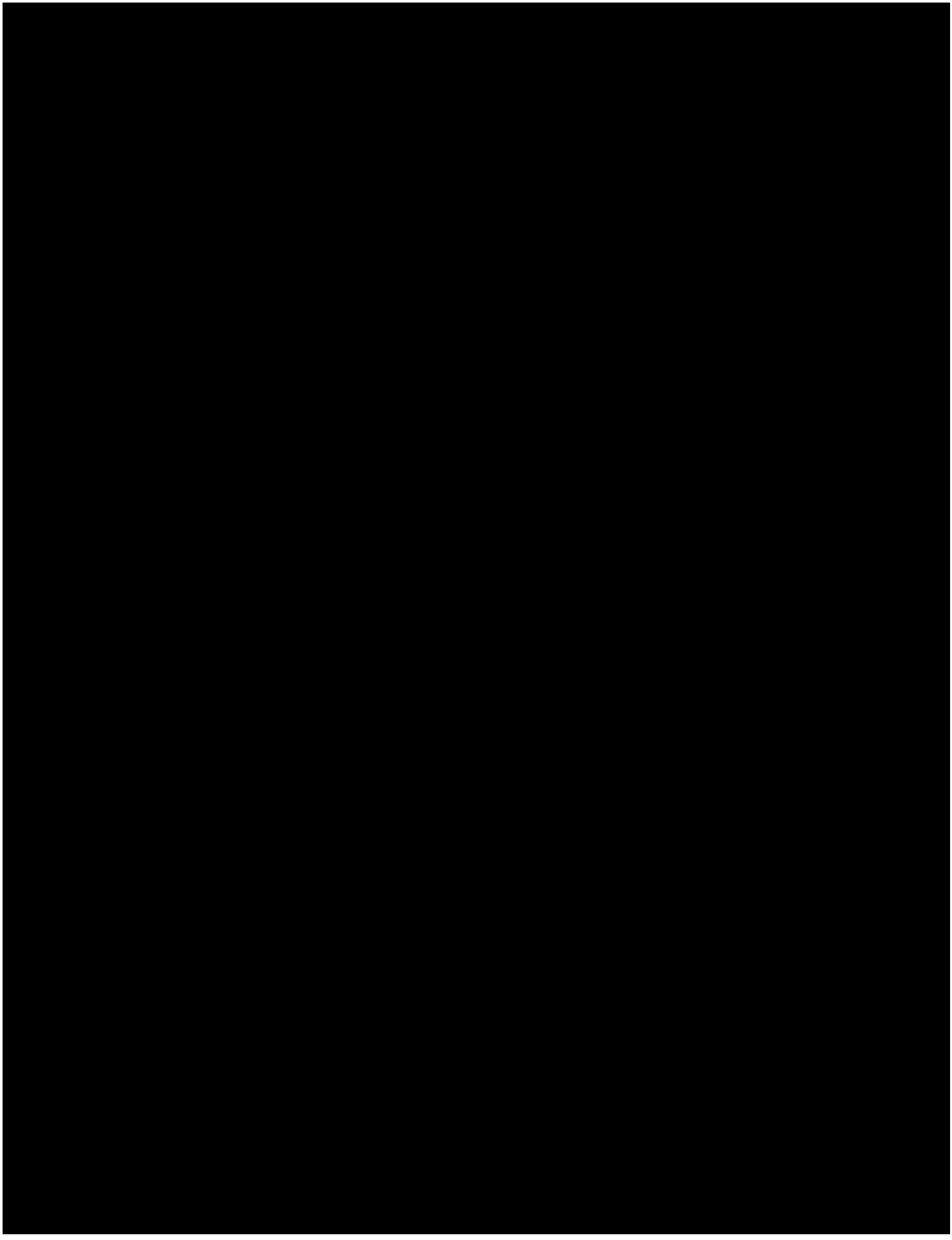
My Commission Expires:
August 16, 2031

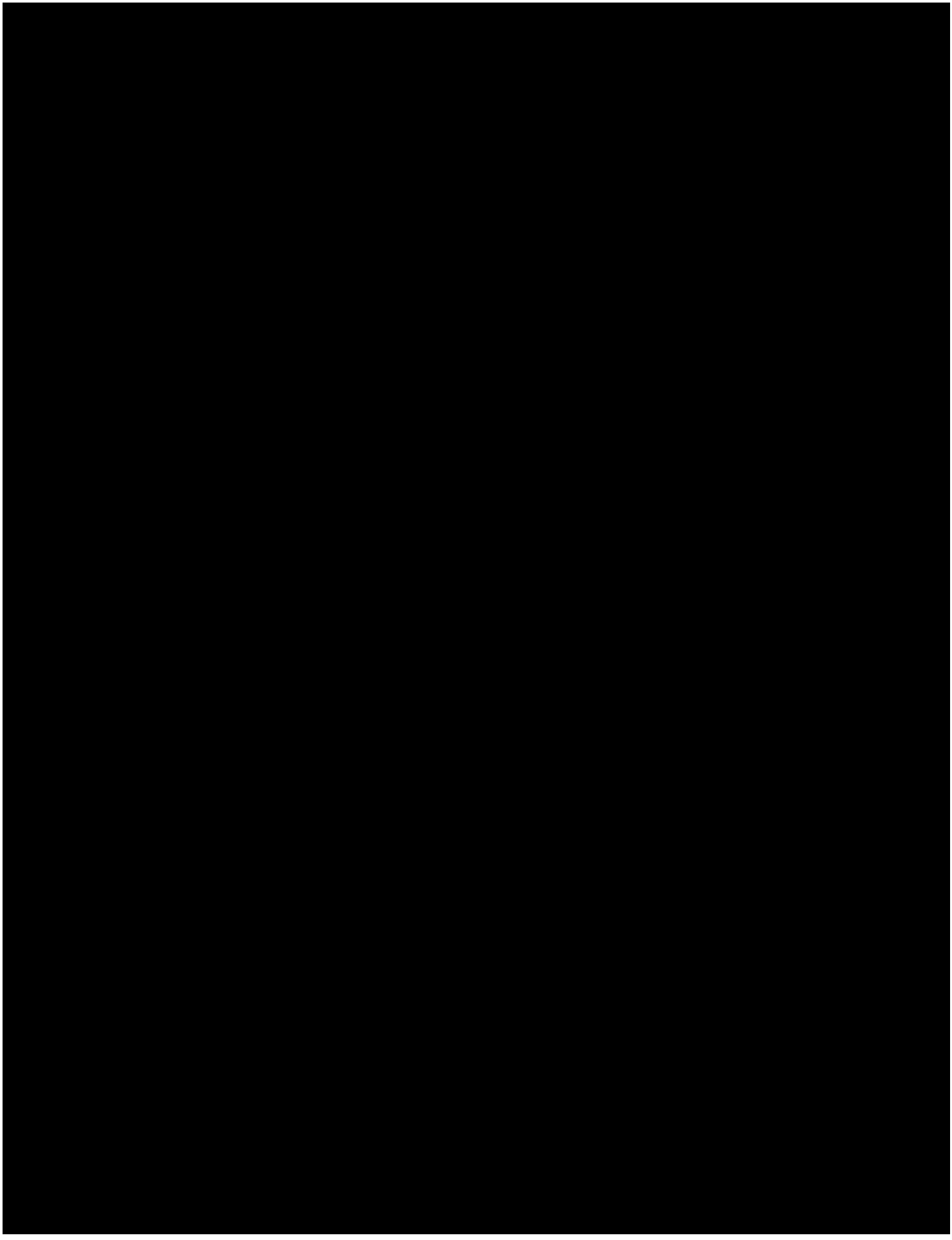


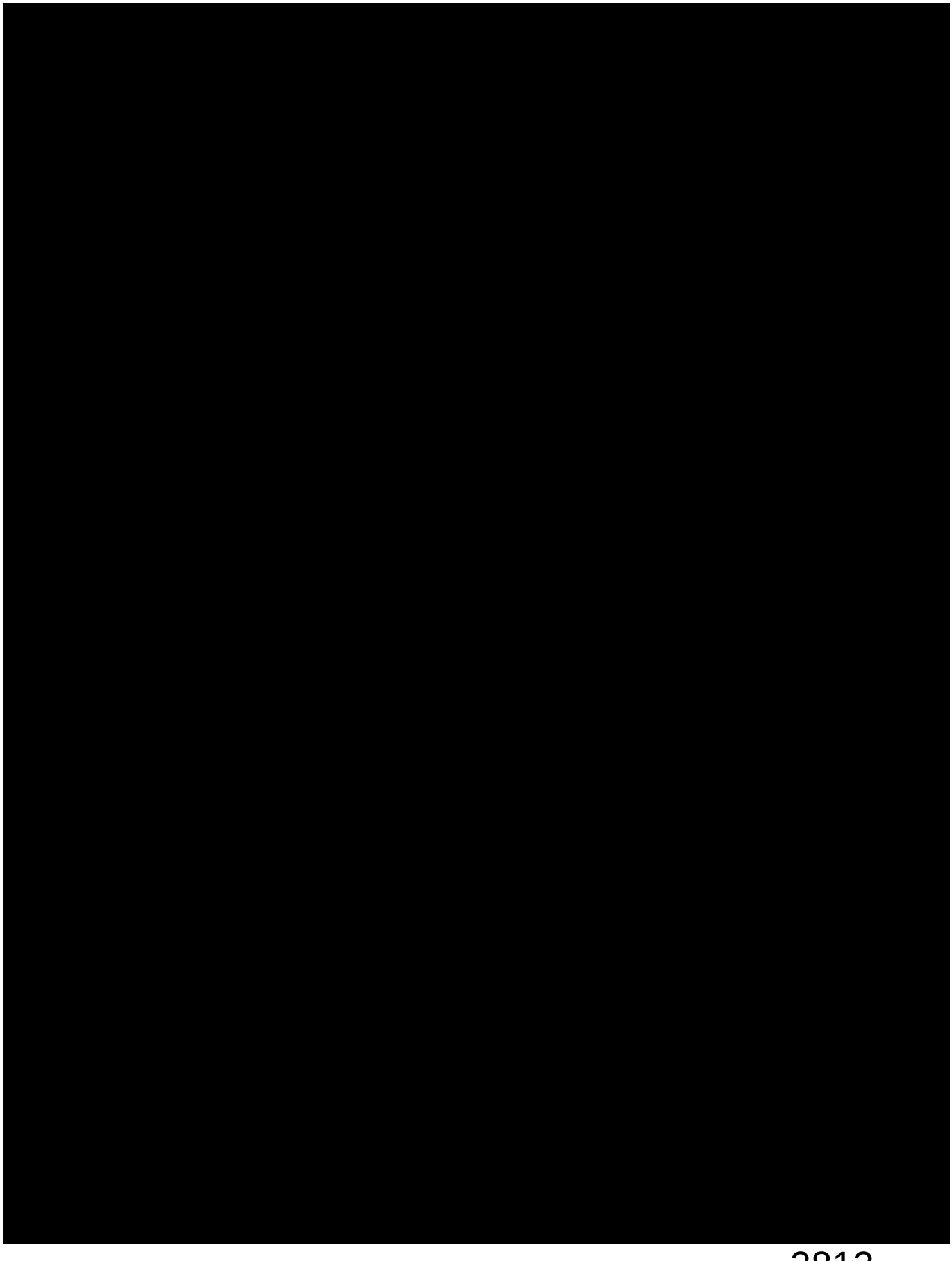


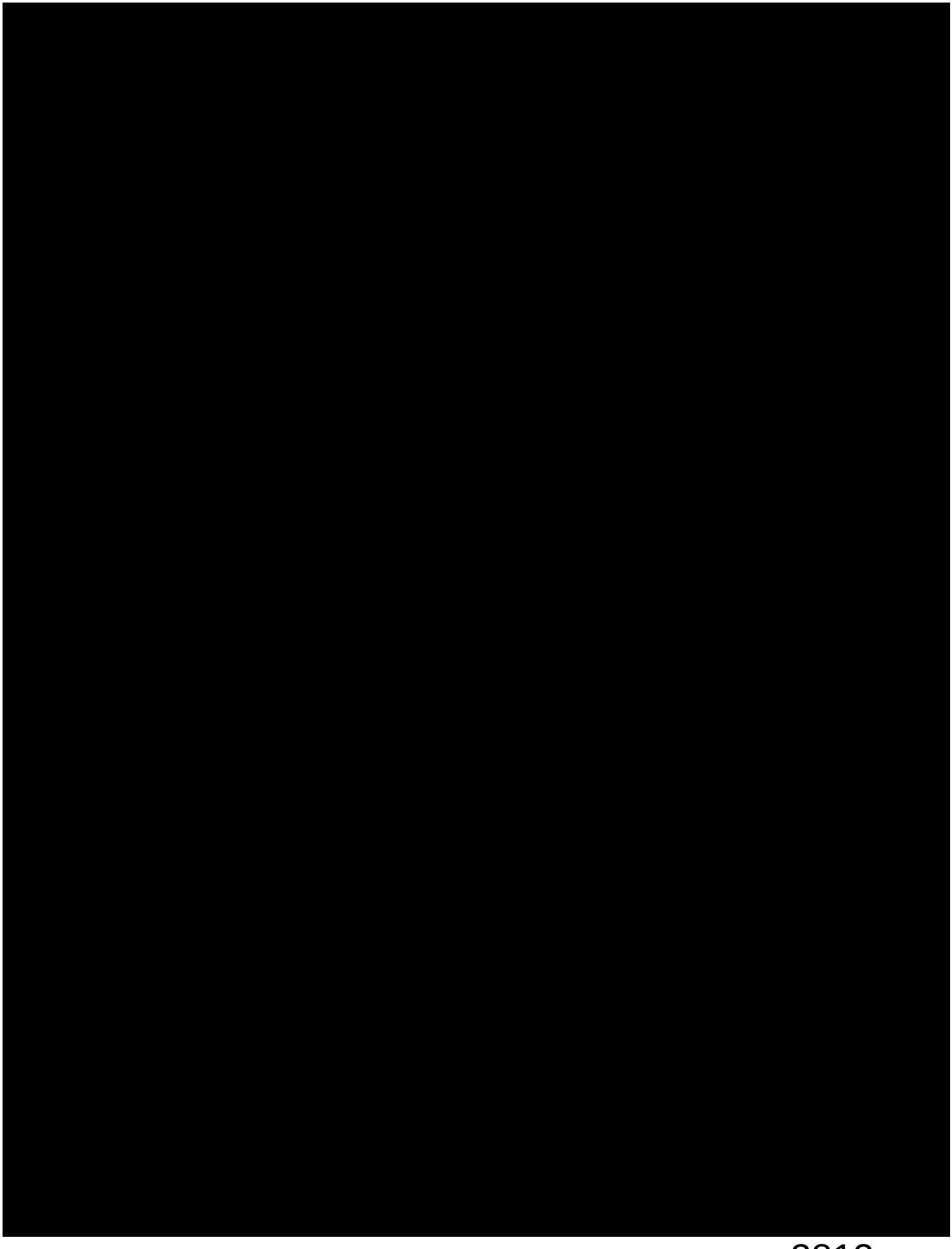


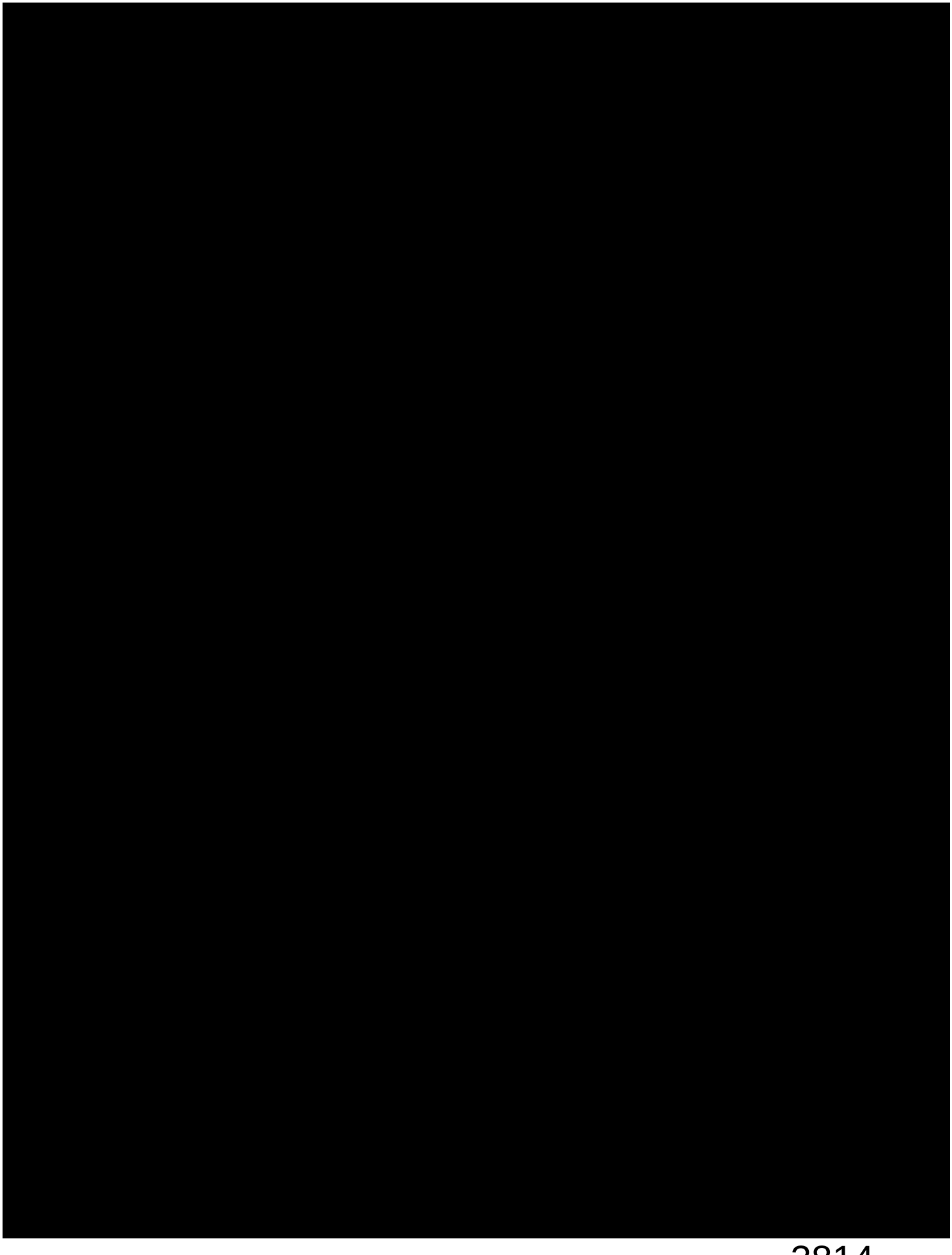


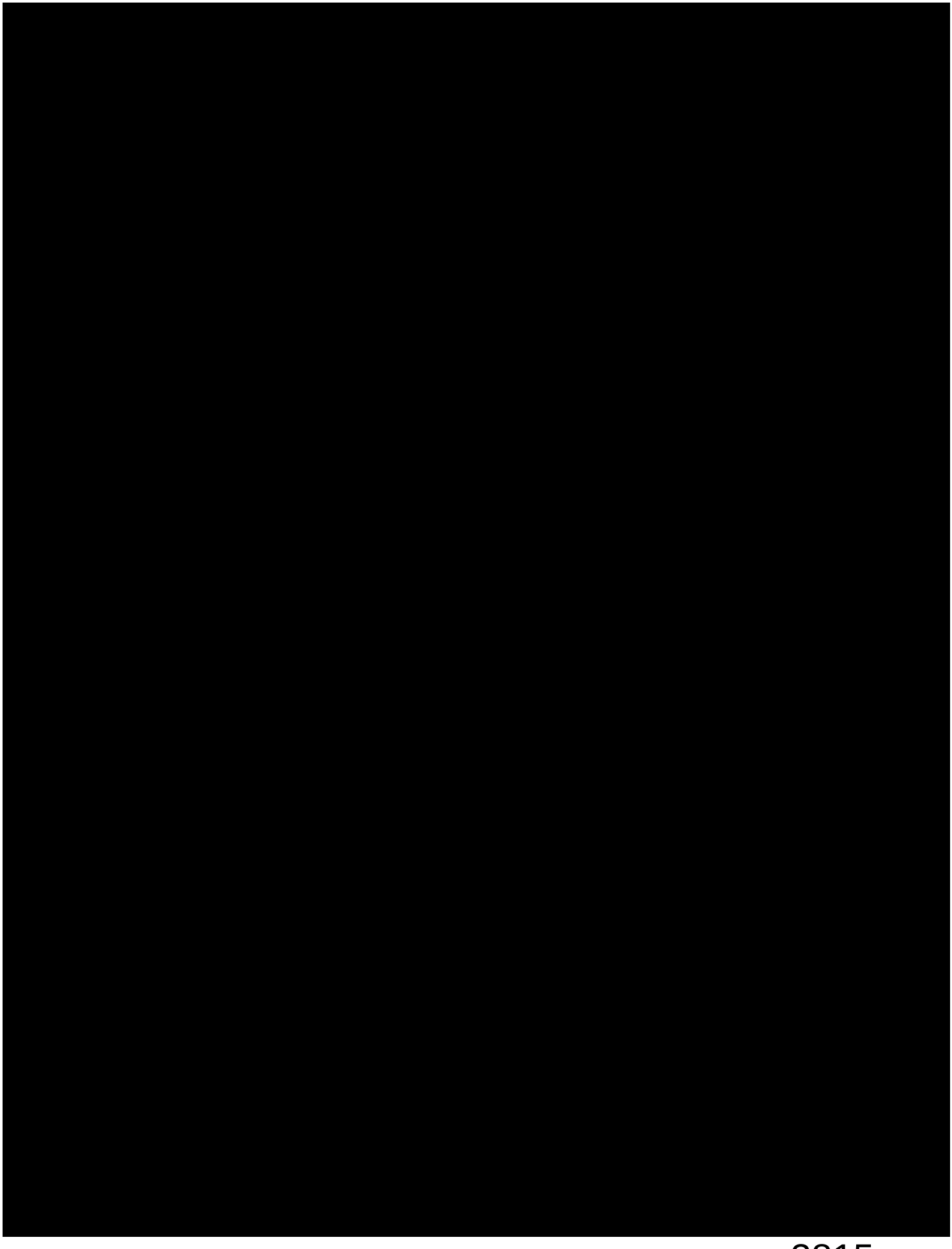


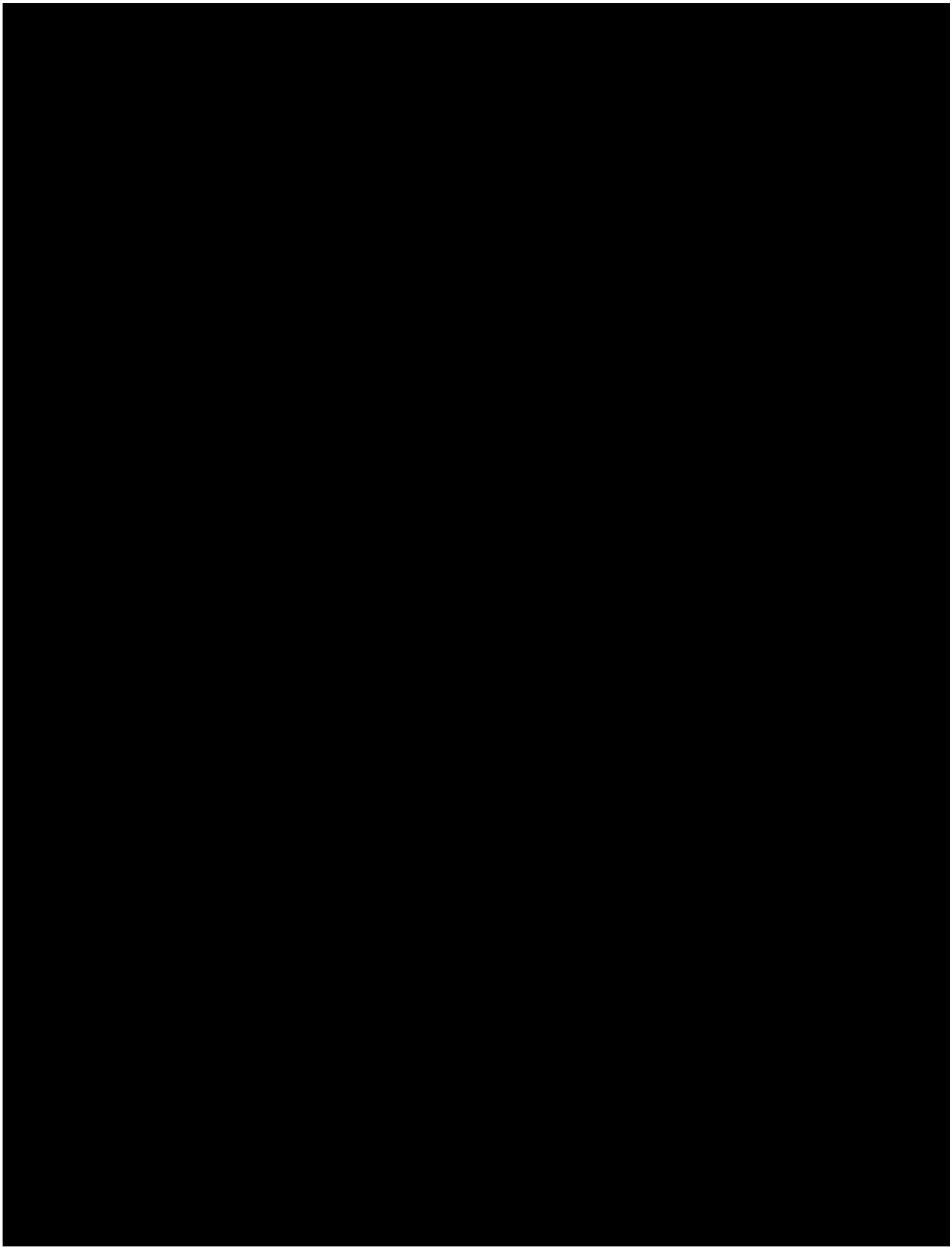


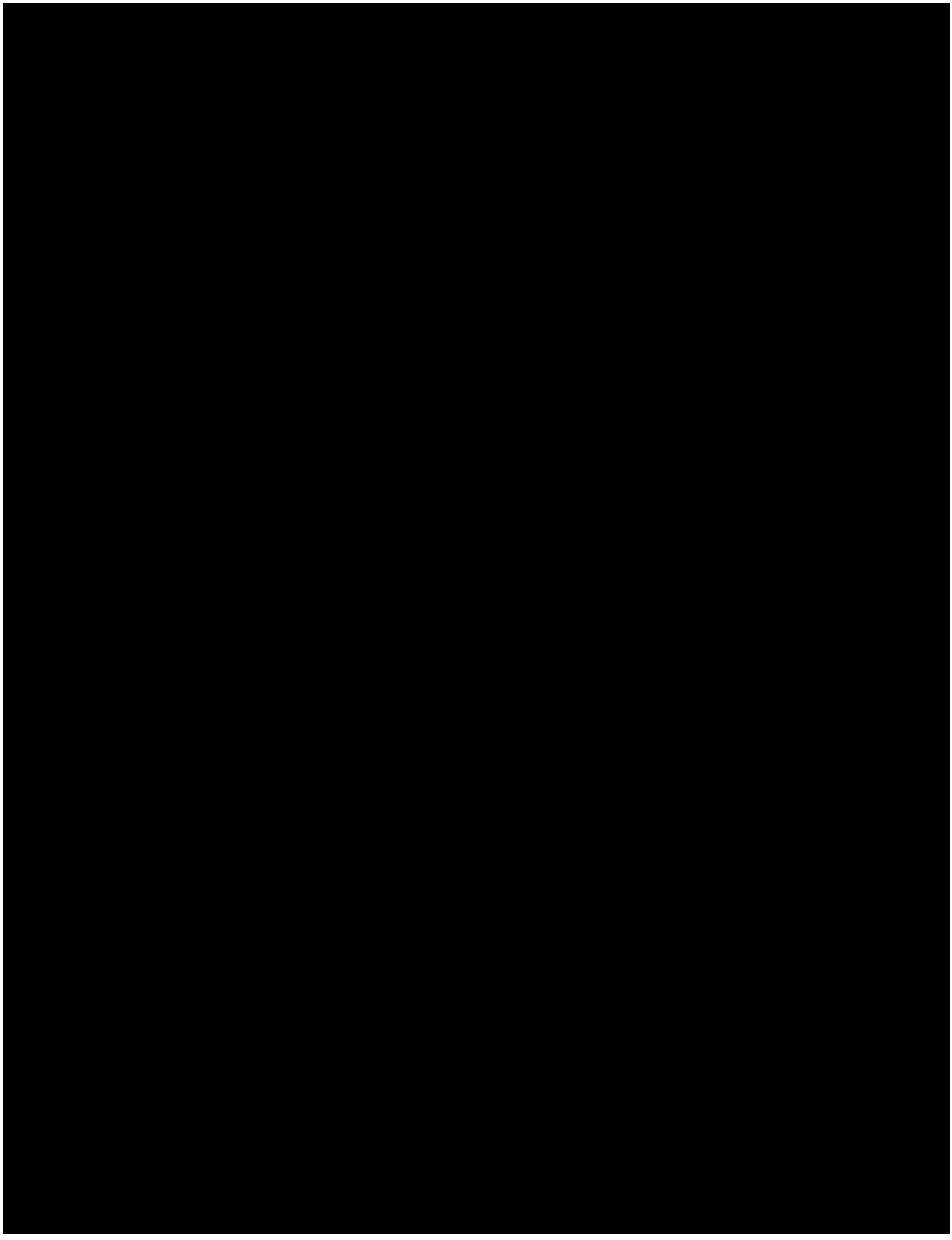


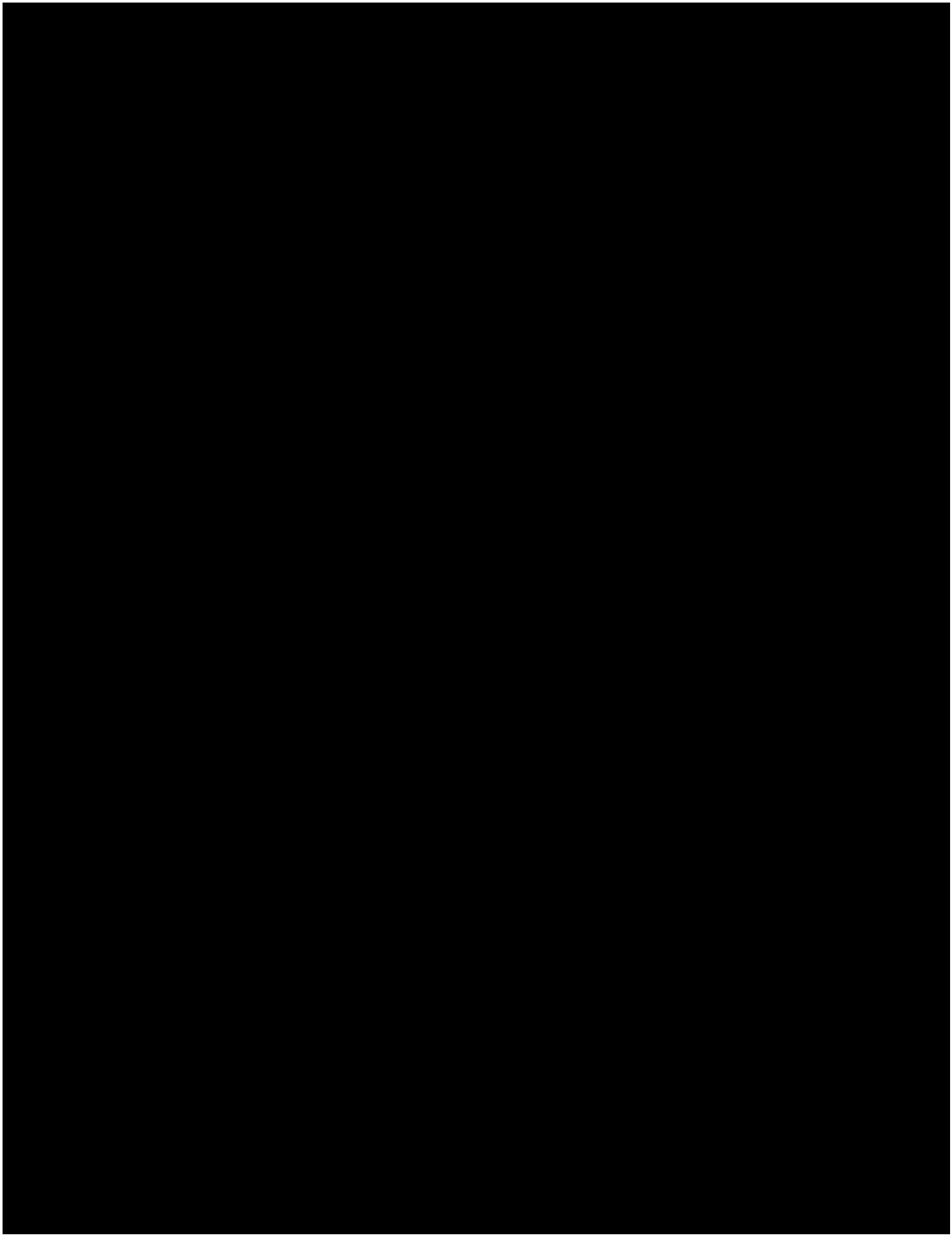


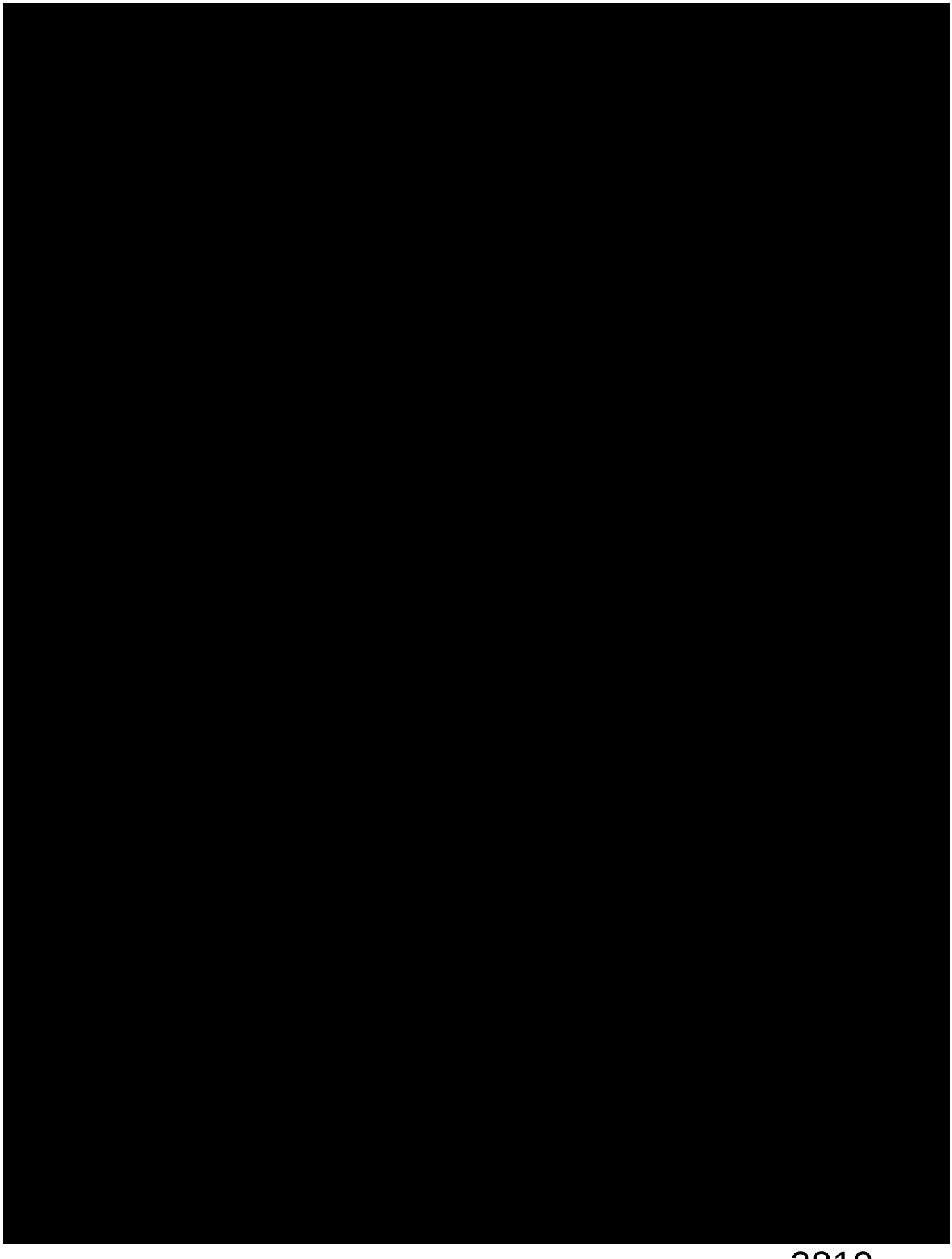












BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

ZOOM DEPOSITION OF

DR. RICKIE BROWN-FORESTIERE

October 21, 2022, at 9:35 a.m.

A P P E A R A N C E S

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I N D E X

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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Dr. Rickie Brown-Forestiere, produced, sworn, and examined via Zoom, commencing on October 21, 2022, at 9:35 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

P R O C E E D I N G S

THEREUPON, Dr. Rickie Brown-Forestiere was duly sworn to tell the truth, the whole truth, and nothing but the truth and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Dr. Brown, thanks for being here today. Could you state your name for us for the record.

A **Dr. Rickie Brown-Forestiere.**

Q All right.

And, before we get into the case, I wanted to get a little bit of information about your background and expertise on this issue.

If you could just talk a little bit about your background and what it is that allows you to provide an expert opinion in a case like this on causation.

A **Sure. So I am a board certified emergency physician. So that means I went to medical school. I had a three year emergency medicine residency and have passed all my qualifying boards to become a board certified physician.**

In terms of training and the specifics of this situation, multiple different areas are of importance. Initially, I would say the most important is that we are

experts in resuscitation; meaning, people in their most emergent and critical settings, that is where we are experts to take care of these patients. So we see people in all different settings.

But, in this scenario, [redacted], which is what the patient suffered, is something that we do on a daily basis. And we're highly trained and we're definitely the experts for that. We're called in all over the hospitals for our expertise on that.

In addition, in regards to restraints, we have extensive training in how to use chemical and physical restraints safely; as we, you know, occasionally need to use those in the emergency department.

And we also have extensive training in how to deal with situations that come from physical restraints not being done properly and when we need to take care of someone for that.

Q Okay. And as an emergency room physician, do you encounter choking pretty frequently?

A Yeah. It's -- unfortunately, yes, we do, for multiple different reasons. People have natural choking where they choke on their food.

People -- we have many people who, unfortunately, from an altered mental status, whether it be something like a stroke or a drug overdose, will have an induced

vomiting and choking.

And then we also deal with people with strangulation, suffocations, drowning. These are all different forms of suffocation leading to cardiac arrest.

Q Okay. And, as an emergency room physician who's graduated from medical school, gone through residency, worked in an emergency room as a physician for several years, is it true to say that you have seen your fair share of choking emergencies in your emergency room?

A **Yeah. Absolutely.**

Q Okay.

And you've received some training over the years specific to -- you talked about specific to restraints and specific to resuscitation, obviously.

But I assume there's also specific training that you've received, either in medical school or throughout residency or otherwise, specifically relating to choking and suffocation?

A **Absolutely.**

Q Okay.

A **It's a very -- it's a very unfortunately seen thing and we have very specific training for it.**

Q Okay.

All right. And is it -- would it even be possible for you to estimate how many, how many choking

emergencies that you've provided treatment for in the emergency room over the years?

A Oh, my gosh. Honestly, I don't think I'd be able to count.

I can tell you that it's definitely within every week of working; and sometimes multiple times a day. It just depends on the day. Our -- we're in the emergency room. That's where everyone (inaudible) --

Q That's one of the more common things you see in an emergency room, in other words?

A What's that?

Q It's one of the most common things you see in the emergency room?

A It's pretty common. Yeah. It's one of our most common --

Q Okay.

A -- (inaudible) as traumas.

Q Okay.

And, Dr. Brown, you've reviewed some documents and records related to this case in preparation for giving an opinion here today; correct?

A Uh-huh. Yep. Many.

Q Okay. What materials have you reviewed that you intend to or that have informed the opinion you're going to give today?

A So first, I did some research on David. And so we -- I took a look at the dysphasia survey and choking assessment. These are all part of his IPP.

Also his physician orders, his diet orders, to see if there were any sort of special circumstances that needed to be, you know, taken into account.

Also, I then looked at depositions for Tyler Mattson, Ryann Campos, Amy Jones; and then the LPNs, Kelly, Amanda, and Debbie.

I also looked through the OLTC statements from Jones, Mattson, and Campos. And then I reviewed the paramedic's deposition, Samuel and also looked at his paramedic reports from the day, from the event.

Q Okay. And then I assume you, of course, looked at the coroner's report and the ER records as well?

A Yes. Yes. Those as well.

Q Okay. And then you also looked at the deposition, did you also look at the deposition of Dr. Hamid.

A Dr. Hamid, yes. The other -- yes, that as well. Sorry.

Q Okay. And, finally, did you also review the report, the written report, that Disability Rights of Arkansas released on this case?

A Yes.

Q Okay.

And, in reviewing David's records and all of these other documents, were you able to form a medical opinion as to precisely how David Cains died?

A Yes. So --

Q And are you able to say within a reasonable degree of medical certainty what caused his death on this day?

A Yes. It's -- it's -- well, I won't call it simple --

MR. ROSEN: Well, hold on. I'm going to make an objection; because the -- in the information provided to us in the first, second, or third supplemental responses to DHS, there was no opinion stated as to a reasonable degree of medical certainty.

That opinion has not been submitted to us in the reports. And I'm specifically looking at the report of what Dr. Brown would be testifying to in -- which was provided to DHS in Claimant's Third Supplemental Responses to discovery.

MR. GILLISPIE: Uh-huh.

MR. ROSEN: So we're going to make an objection to that, because that is not an opinion that was provided to us, despite numerous requests for updates.

MR. GILLISPIE: Well, the opinion that I believe she's going to give is the same opinion that you've seen.

Now, I may have neglected to include that actual language in the response; but, as you know, any expert that -- any medical expert that gives an expert opinion in a case in Arkansas must do so within a degree of -- you know, that's the standard.

So, by the very fact that she's, you know, my expert tells you that she's going to be testifying within a reasonable degree of medical certainty, but --

MR. ROSEN: No, I would -- I would disagree with that. I mean, we can continue on, but I'm --

MR. GILLISPIE: Sure.

MR. ROSEN: -- objecting to it because --

MR. GILLISPIE: All right.

MR. ROSEN: -- it was not provided to us. And that's an essential part of the opinion. Go ahead.

MR. GILLISPIE: Well, that's noted.

BY MR. GILLISPIE:

Q Dr. Brown, go on ahead with what you were going to

say as far as your opinion, again, that you're giving within a reasonable degree of medical certainty.

MR. ROSEN: And I assume that, Counsel, you're going to be asking that question and to the extent that you -- it's an ongoing objection. So I don't have to keep making that?

MR. GILLISPIE: Sure. Yeah. I agree to a continuing objection on that issue, Rich.

A Okay.

[redacted]

BY MR. GILLISPIE:

Q Okay.

And, Dr. Brown, are you also able to say within a reasonable degree of medical certainty what caused Mr. Cains to vomit?

A Yeah. I -- I think that I can. So there's a lot of physics to this. I'll try -- I'll do my best to make it in easy to understand terms.

So, when someone is struggling in this scenario that's been described by all the participants, someone who is struggling has what's called a fight or flight response, meaning they're -- have adrenaline surges and they are fight -- essentially fighting for their life.

Their muscles constrict to fend off what they feel is an attack. They -- so their muscles constrict, their breathing increases, (interference) set of physiological (interference) leads to increased (interference) pressure which is the pressure in your chest.

And it also constricts the abdomen which increases the intra-abdominal pressure. Both of these are cavities in the body where the stomach is.

The inferior or superior aspect on top of the stomach is the diaphragm in the chest above that, and just below it, the abdomen. And increased pressure on both of these does place increased pressure on the stomach and from the sides.

Obviously, there's a definitive end to the body and

how far it can stretch. And also his left side being on the floor is another definitive mechanical block as to where it can expand.

So, if you think of the stomach as a cube, it's having pressure from all different angles for -- because of the struggle and the position and the increased pressures. And it caused him to vomit.

[redacted]

Q Okay. So if I'm hearing you correctly, Dr. Brown, and in my very nonmedical layman's terms, intense struggle that produces a fight or flight reflex and adrenaline can, is itself, increases the likelihood of triggering vomiting; is that correct?

A In this scenario, it would, yes, due to gravity.

Q And being on his left side increased the likelihood that the pressure, intrathoracic pressure and gravity, would --

A Yeah.

Q -- trigger vomiting?

A Yeah. Unfortunately, the stomach -- and the stomach's on the left. So it means everything in the body and all the pressures above him were pressing down onto the stomach; which was butting up against the ground, essentially.

Q Okay.

And the fact that he had -- if I'm hearing you correctly, the [redacted]

Q Okay.

And do you have any opinion as to after he began vomiting while he was on his left side, do you have any opinion or does what happened next, what staff did next, play into your opinion at all?

[redacted]

[redacted]

Q Is it fair to say, that once he started vomiting while on his left side in the restraint, that placing him, quickly placing him onto his back, was essentially the worst thing that they could have done?

A **Yes, unfortunately.**

The very first thing that is taught is to turn them onto their side if there's any sign of vomiting.
Q Okay.
A That is absolutely the just very unfortunate wrong thing.
Q Okay.
MR. GILLISPIE: And, Rich and Cris, back up just a second.
I meant to introduce her CV as Exhibit 1. It's going to be my only exhibit. Do you have any objection to that, Rich?
MR. ROSEN: Is that the one that was provided with the discovery?
MR. GILLISPIE: It's -- yes.
MR. ROSEN: Number two --
MR. GILLISPIE: Yes.
MR. ROSEN: -- number -- second supplemental?
MR. GILLISPIE: Yes, sir.
MR. ROSEN: Okay.
MR. GILLISPIE: The only CV of hers that I've ever -- that I have, yes.
MR. ROSEN: Yeah. No, I don't have any objection to that.
MR. GILLISPIE: Okay. Thanks. And I'll

just have to e-mail you that later, Cris.

(WHEREUPON, the document was later received and marked for identification as Exhibit No. 1 and is attached hereto.)

MR. ROSEN: And, just fort court reporter, just make sure that's attached to the copy of the deposition that I get, if you would.

THE COURT REPORTER: Absolutely.

MR. GILLISPIE: Sure.

BY MR. GILLISPIE:

Q Okay. Just a few more questions, Dr. Brown.

I wanted to see if you could describe kind of what happens when somebody -- well, let me phrase that differently.

When a person vomits and chokes on their own vomit and they end up suffocating to death, could you just describe kind of medically what happens there and what that -- what that's like --

A Sure.

Q -- as best you can?

A Sure. So, when someone chokes and their airway is closed off, obviously, they can no longer receive oxygen or expel CO2.

This quickly induces kind of what we would call a terror fight or flight response, similar to a drowning

victim. They start fighting with everything they can.

Unfortunately, as the airway is blocked, CO2 which is -- turns into a toxic substance, which is an acid, builds up in their body, their muscles fighting against and are unable to expel the lactic acid they build up.

So, essentially, you're not only suffocating, but it's a feeling of burning. Your lungs begin burning, your whole body, because of the acid build up.

And the struggle -- and eventually you become unconscious and -- and your body continues to struggle until it no longer can.

Q Is it a painful death?

A It's probably the -- one of the most painful deaths there could be. That and I assume burning to death.

But strangulation or suffocation and burning are the -- are known as the two most awful ways to die.

Q Okay. Thank you.

I know that you testified that you reviewed the -- you reviewed the depositions of the three LPNs --

A Uh-huh.

Q -- and the three staff members, Tyler, Amy, and Ryann. And you reviewed the deposition transcript of Samuel Scow, the paramedic who arrived at the scene --

A Uh-huh.

Q -- correct?

A Correct.
Q And you reviewed records and testimony that state that there was a gap of eight minutes between when Mr. Cains began suffocating and when 9-1-1 was called; correct?
A Correct.
Q Are you able to give any opinion with regards to whether the outcome for Mr. Cains could have been different had paramedics arrived eight minutes sooner than they did?

MR. ROSEN: Objection. That also was not an -- any opinion on that, which would have been asked, which was asked for, for expert opinion.

It was not provided in any of the first, second, or third supplemental responses to interrogatories as to the facts and opinions and substance of any expert's testimony. So that is a surprise to us --

MR. GILLISPIE: Okay. Thank you.

MR. ROSEN: -- and was not provided previously. So we object.

MR. GILLISPIE: Okay. Noted. Thank you.

BY MR. GILLISPIE:
Q All right. Dr. Brown, go ahead.

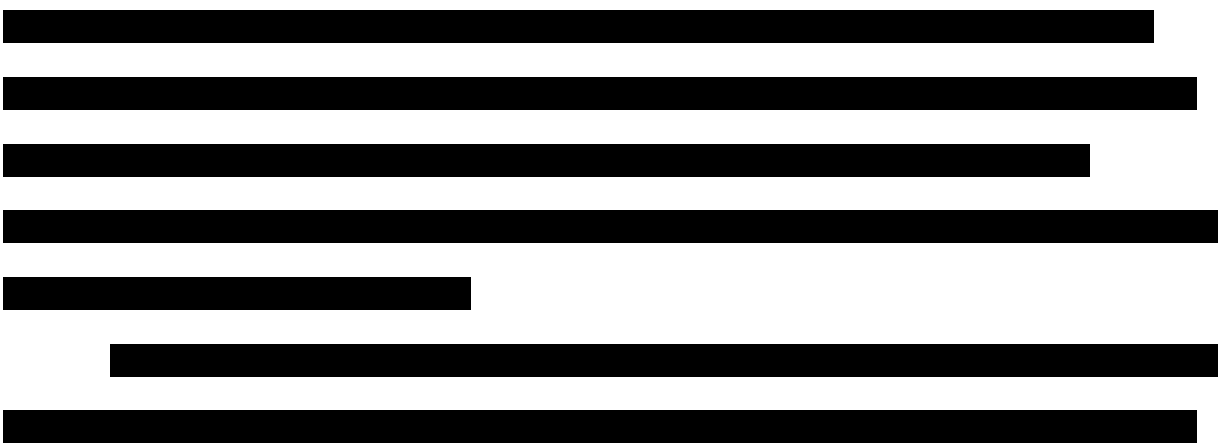
A So I did take a look. And, based on the facts from all the different documents that there was an eight minute duration before 9-1-1 is called, I can give you the facts on a resuscitation.

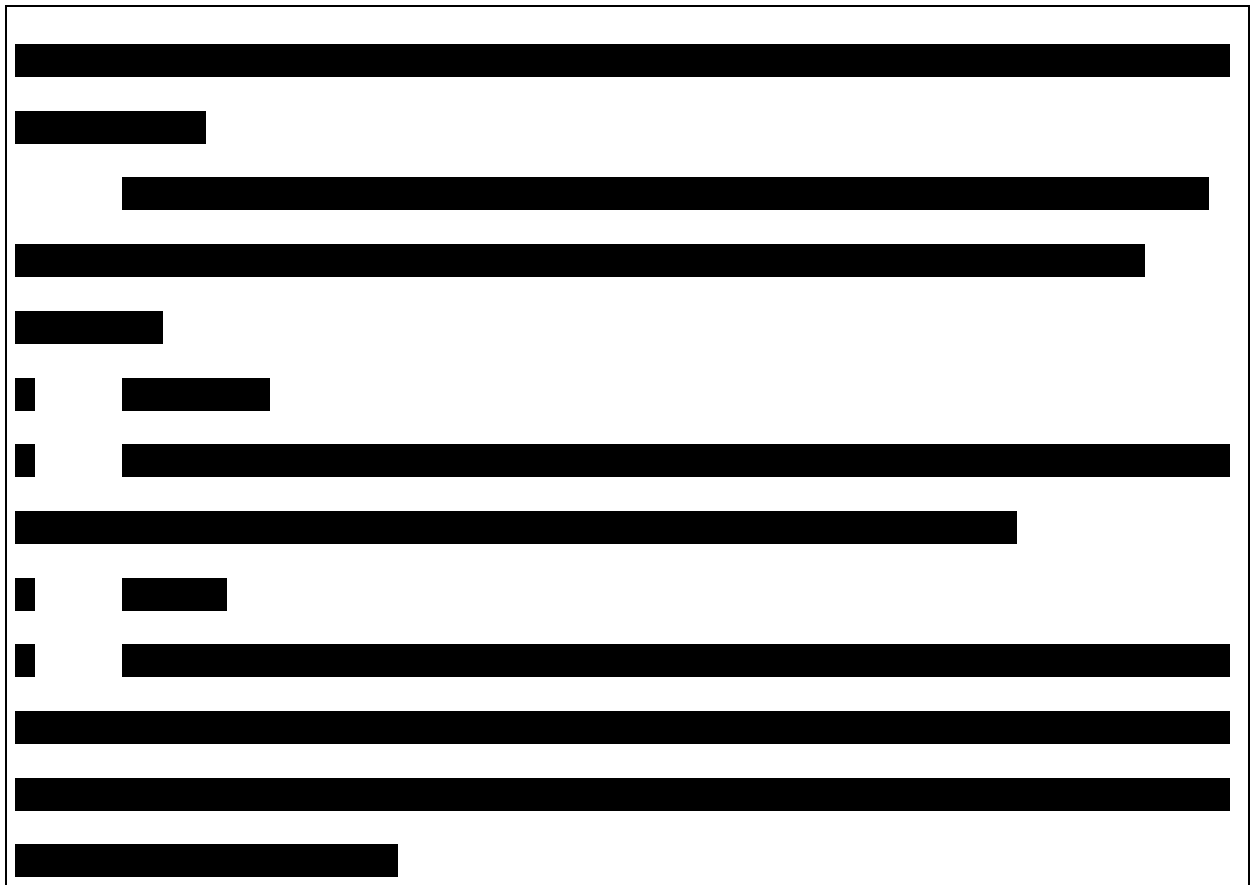
Without any intervention, someone who suffocates will likely die within five minutes. If there is a resuscitation, meaning the CPR that was immediately started for him, that leads into a resuscitation time.

Our research, and it's plentiful in emergency medicine, shows that a resuscitation past 20 minutes drastically drops the possibility of a meaningful outcome; meaning not only that we can revive the body but also the brain.

So, yes, it is very unfortunate. Those eight minutes, honestly, in my opinion, I think that it could have had a very large impact.

It did take the paramedics 13 minutes to get there. And review of Samuel's deposition discusses the fact that





They're very well trained. They have all of the medications and the tools needed to do so. They would have been able to do much more sophisticated resuscitation.

And, in an absolute dire emergency like this, they also can place what's called a surgical airway. If it is blocked from above and he was unable to clear it, they can cut through the neck and place a tube into the trachea --

Q Okay.

A -- to allow for gas exchange.

Q Okay.

A Many different ways that could have helped.

I can't say for sure if it would have changed whether he died or not, but I can definitely tell you that there would have been a much better chance had it been done earlier.

Q Okay. And am I correct that a paramedic such as Mr. Scow, the training and the equipment that they brought to the scene, is much greater than what your typical LPN would be able to provide?

A Oh, absolutely. An LPN is the -- one of the very lowest medical certifications in regards in the nursing world it -- as the lower end.

And, even an RN, which is above an LPN, would not have been able to have the tools or administer the type of treatments or procedures that a paramedic can.

They're very highly trained. So they -- they have quite a few tools at their disposal and knowledge to use them.

Q Okay. This is my last question.

I don't know if you came across the -- and I can't recall if you would have come across this in the materials you read, but there have been one or two witnesses, staff members, who have testified at deposition that they believe that Mr. Cains had the ability to intentionally vomit when agitated.

Assuming that you came across that, do you have any -- can you provide any opinion as to whether you think that that could have happened here?

MR. ROSEN: And I'm going to object again to the extent that this doctor is going to render any opinion on that question. That is an expert opinion on that question that has not been provided to DHS despite numerous requests and three supplemental responses to interrogatory. So there's -- that's not something that's subject to this deposition.

MR. GILLISPIE: Well, I'm asking her for the -- for the first time here, Rich. So I -- I just want to hear if she has an opinion on it.

BY MR. GILLISPIE:

Q Go ahead, Dr. Brown.

A I did come across that information. It was in Tyler Mattson's OLTC and I believe in another area as well.

I cannot imagine a scenario in where someone who's fighting for their life would have the wherewithal to intentionally vomit. I don't see any evidence from the three -- from Ryann and Amy and Tyler that gave any description that would be consistent with someone intentionally vomiting.

It's a physically demanding thing to do and quite a difficult one. I -- I don't see how -- of course, I cannot give you a 100 percent certainty, and no one can, but I think that it is probably one of the least possible things that I could imagine.

Q Okay.

MR. GILLISPIE: Let me go off the record for just a couple minutes here and review my notes, Cris.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. GILLISPIE:

Q Dr. Brown, my last question is, would you mind, just so we all know exactly what it is you're saying, would you mind one more time just kind of recapping your expert opinion or re-summarizing your expert opinion as to how David Cains vomited and then choked on his vomit and suffocated to death?

MR. ROSEN: I'm going to object. That's been asked and answered.

MR. GILLISPIE: (Inaudible) that.

MR. ROSEN: I think that the doctor's opinions was quite clear; and so giving her a second opportunity to clarify anything or to

change her testimony would be inappropriate.

I think the question is --

MR. GILLISPIE: I'm -- I'm --

MR. ROSEN: -- what -- does the doctor think she was quite clear? Because I think she was quite clear.

MR. GILLISPIE: I do as well.

MR. ROSEN: Then there's no need for the question.

BY MR. GILLISPIE:

Q Dr. Brown, I'm certainly not asking you to -- Dr. Brown, I'm certainly not asking you to -- certainly not intending to give you a chance to change your opinion and nor do I expect you to change your opinion at all.

My question is -- I'd simply like for the record -- we only get one shot with you here.

So, for the record, I'd just like to hear it one more time and maybe even in simpler terms, because you did such a great job, as Rich said, describing it in medical terms, maybe in simpler terms, what it is that happened here.

MR. ROSEN: I --I object --

MR. GILLISPIE: Your objection's noted. Your objection's noted.

MR. ROSEN: Irrelevant and asked and

answered. She's already stated it. I think the question is that, the first -- there's a lack of --

MR. GILLISPIE: Richard, your objection's noted. Your objection's noted.

MR. ROSEN: Well, I just want to put it on as a lack of foundation as well. Because she hasn't -- you know, unless she says that she's been unclear in her statements previously --

MR. GILLISPIE: Yeah --

MR. ROSEN: I don't think that it's necessarily.

MR. GILLISPIE: Well, I'm -- I'm not going to pull the question. I want -- I want to hear this answer and then you'll have your chance.

BY MR. GILLISPIE:

Q Go ahead, Dr. Brown.

A I -- I'll just give a quick recap. I think that that's -- that's fine and there's nothing that will change in it.

So Mr. Cains was on the floor being restrained by three people in three different locations of his body.

There was a struggle, fight or flight, patient just struggling, adrenaline pumping, causing a lot of constriction of muscles and things of that nature.

If you think -- in simpler terms, if you think of the stomach as a water balloon, essentially, it had pressure coming from every single direction; and the water balloon, eventually the tie at the top, broke. That would be the lower esophageal I was talking about.

The tie at the top broke and all the water was released and, unfortunately, the water was a solid substance and it then --

Q And his balloon tie is weaker than most because of his [redacted] correct?

A Correct.

MR. ROSEN: I'm objecting because she wasn't done with her answer that -- to the question that you asked her before there was an interruption. And so I would ask that she be --

MR. GILLISPIE: Okay.

BY MR. GILLISPIE:

Q Go ahead, Dr. Brown.

MR. ROSEN: -- allowed to answer the question that you asked her.

A Sure.

Yeah, so balloon, weaker tie, breaking, everything coming up. Those are solid substances. He was on his left.

They then turn them on his back, allowing the vomit to rest in his throat closing off his air pipe and closing off gas exchange.

He then suffocated. And the suffocation cut off oxygen to his body and that eventually causes the heart to stop, which is what happened, and that's how he died.

BY MR. GILLISPIE:

Q Thank you very much, Dr. Brown.

MR. GILLISPIE: I'll pass the witness, Rich.

CROSS EXAMINATION

BY MR. ROSEN:

Q Thank you, Dr. Brown. Let me just finish taking my notes of what you just said.

MR. GILLISPIE: I'm going to grab my coffee while you do that.

MR. ROSEN: Okay. I'll wait for you.

MR. GILLISPIE: All right. I'm back, as you can see.

MR. ROSEN: Okay. Yes.

MR. GILLISPIE: Hard to miss me.

BY MR. ROSEN:

Q All right. And I'm ready to go.

Just on one thing that I just -- and I have a lot of questions based upon what you've asked, or excuse me,

testified to. But that last statement or one of the statements is that I think everybody agrees that he was -- that David Cain was on his side, whether the right side or left side --

A Uh-huh.

Q -- that might be -- but everybody agrees that he was on his side when he started vomiting.

A Uh-huh.

Q Would you agree with that?

A Sounds like what I read.

Q Okay. And that they turned him over after they noticed that he had choked and stopped breathing?

A After they noticed that he had vomited, choked, and stopped breathing, yes.

Q Okay.

Now, I want to get into a little background here and then we'll get back to the substance of your opinion.

I'm looking at your resume, which was introduced by counsel in this case, and you graduated from medical school in 2018; right?

A Yep.

Q And that was -- what's the name of the medical school?

A University of Science, Arts and Technology, USAT.

Q And that's in Montserrat, West Indies?

A Uh-huh.
Q And so you -- oh, so you went to medical school in the West Indies? I mean, that's what school is?
A Uh-huh.
Q Is that a yes or a no?
A Yes. Sorry.
Q Okay. And is that an accredited medical school?
A Sure is.
Q And who is it accredited by?
A Oh, gosh, I don't remember the accreditation board of the -- you know, the NIH has an accreditation board. I don't quite recall the acronym. It's got a couple letters in there.
Q Well, I'm familiar with West -- with the Caribbean Medical School.
A Uh-huh.
Q And I know there's a Caribbean accrediting agency for schools, medical schools. There are numerous medical schools in the Caribbean.
A Uh-huh.
Q And had it -- and is that -- is that agency accredited?
A Not entirely sure I understand your question, but --
Q Well, let me -- we'll walk through it again. Okay.
A Sure.

Q So it's your understanding that you're -- I mean, to me, it's a very simple question as to whether the school I went to or didn't go to was accredited.

A **Yeah, it was.**

MR. GILLISPIE: Well, I'll object there. It's -- she -- it's -- she an -- she answered that right away.

MR. ROSEN: Okay. Well, okay. So let's --

MR. GILLISPIE: So, yes, it's accredited.

BY MR. ROSEN:

Q So, as counsel has said, tell me -- because I just want to get through this. I just kind of want to know kind of your training, a little background.

A **Sure.**

Q So you graduate in 2018 from the Montserrat Medical School of Science --

A **Sure.**

Q -- Arts and Technology; right?

A **Uh-huh.**

Q Is that a yes?

A **Yes. I'm sorry.**

Q You're a -- Doctor, you're going to have to say yes or no because --

A **Yeah. Sorry, I forgot about that.**

Yes, that's true.

Q I mean, I knew what you were talking about, I just --

A I gotcha.

Q The court reporter might not.

A I got it.

Q So you started the school in what year?

A Oh, man. I've got to think back on this one. Let's see, it would be four years, so '14, I believe.

Q Okay. In '14, so let's start in 19 -- in 2014.

Was the medical school that you went to in Montserrat West Indies an accredited medical school program?

A Yes.

Q Okay. Can you tell me the name of the accrediting agency?

A Sorry. I'd have to look it up, honestly. I'm not in the business of accrediting medical schools.

So -- but I know it's accredited by the American Board that accredits schools.

Q Well, would you disagree with me then when I read just the other day that that medical school is not an accredited medical school?

A That's not true. That was accredited at the time I went there.

Q Okay.
A **I believe they have since had some financial struggles.**
Q Okay. Do you -- are you saying, that when you graduated, it was an accredited medical school program?
A **Correct. Correct.**
Q And is it accredited medical school program today?
A **I have no idea.**
Q And you don't -- to recap, you don't know who accredited it, do you?

MR. GILLISPIE: Object to the form. That's -- that is -- that's not what -- that's not what she said. She said she'd have to look it up. Obviously, it's --

MR. ROSEN: Well, I --

MR. GILLISPIE: -- an accredited medical school. She's board certified.

MR. ROSEN: No, you --

THE WITNESS: You can't be board certified without an accredited medical school.

MR. ROSEN: Well, let me get there; because I would tend to disagree with both you, Counsel, and you, Doctor.

BY MR. ROSEN:
Q So is it accredit -- is the -- hold on.

Are you aware that the University of Science, Arts and Technology website today states on their website at U-S-T, excuse me, USAT.edu/aboutus/ under, quote, listings and accreditations, quote, under that title, quote, we are currently in the process of applying for accreditation, unquote. Are you aware of that?

A No. I do know that they had some financial struggles and some things they had to reorganize. And I believe it was mostly paperwork --

Q Are you aware --

A At -- at the time that I was there, it was 100 percent certified.

You can't get into a residency without a 100 percent certified program. It's not possible. You can't even apply to get into residency without that.

Q Well, let me follow up on my question.

Okay. So, here in Arkansas, we have the University of Arkansas for Medical Science College of Medicine which is accredited by the Liaison Committee for Medical Education of the Association of American College of -- American Medical College, also known as AAMC.

To your knowledge, was the medical school that you went to accredited by AAMC at any time that you were there?

A I believe so. I -- and, honestly, whatever the

accrediting board is -- and, again, I'm happy to look it up. But I don't know the actual acronyms of the boards that certify medical schools.

What I do know is that my medical school was -- was certified at the time I went to it. And, again, you cannot get into -- you cannot even to apply to ERAS, which is the program that gets you into residency without an accredited medical school. They won't accept your application. So it's kind of a moot point. You can't do it without it.

Q Well, I mean -- and currently, right now, would you agree that the -- that through 2018, graduates of your medical school could get into that, could do a residency here?

A Actually, I know that they can through 2019; because one of my classmates came to my program right after me, so --

Q Well --

A They were 2019.

Q -- let me ask you, so the Caribbean Accreditation Authority for Education and Medicine and other professionals known as CAAM-HP is the accrediting body for medical schools and other programs in the Caribbean; right?

A Probably.

MR. GILLISPIE: Objection. Asked and answered. She doesn't --

A I don't know the acronyms. I'm sorry.

BY MR. ROSEN:

Q Well, do you know -- forget about the acronym.

What about the Caribbean -- have you ever heard of the Caribbean Accreditation Authority for Education and Medicine and other Health Professions?

MR. GILLISPIE: Same objection; asked and answered.

MR. ROSEN: I don't know what the answer is.

A The answer is I --

MR. GILLISPIE: She doesn't either. That's the point. That's the answer. She's not sure.

A I don't know the accrediting boards that are in charge of these things.

I know that I went to an accredited medical school and could not get into a residency; nor could I be board certified without it.

BY MR. ROSEN:

Q The university you went to, excuse me, the medical program is a privately owned school; correct?

A As are most private schools.

Q Okay. And it's a for-profit institution, is it not?
A **Don't know.**
Q You didn't check into this when you went to -- when you applied?
A **I mean, I have no idea whether a program is for, for profit or not. I know that most private schools are for profit.**
Q Have you ever heard of --
A **(Inaudible) hospitals and they're all allowed.**
Q Well, here in Arkansas, the University of Medical Science, College of Medicine is not a for-profit agency --
A **Yeah, it's a university.**
If you want to go through all the medical schools, we can go through a lot of them, such as Harvard and Stanford and all the rest of them, all private medical schools.
Q Okay.
Now, have you ever heard of the Education Commission for Foreign Medical Graduates?
A **Yes.**
Q And they're the ones that --
A **ECFMG. And I'm certified by them as well.**
Q Yes. That I know, you are certified by them.
A **Uh-huh.**

Q Okay. But that doesn't certify the medical school that you went to, does it?
A **Actually, it does.**
Q No, it doesn't. Okay.
A **You can't get certified by them if they don't approve of your education. I'm sorry. That's not true.**
Q It is, but okay.
Let's talk about -- are you a licensed physician in Arkansas?
A **No.**
Q Have you ever lived in Arkansas?
A **No.**
Q Okay. Did you do any training in Arkansas?
A **Nope.**
Q Have you ever visited even Arkansas?
A **Many times. My husband's from Arkansas. I go to the Hot Springs Derby every year and his family's in Pine Bluff. And my husband went to medical school there.**
Q Okay. And so did you perform a rotation here --
A **No.**
Q -- or any training, medical training, here whatsoever?
A **Not at all.**
Q Have you ever been to -- you're going to have to excuse me for a second. There's an alarm going on. I

don't know if you can hear it.
A I can.
Q Let me finish my questioning. I might have to leave the building. So it usually only takes a few minutes, if that's the case.
Have you ever been to Booneville, Arkansas?
A I'm sorry, where?
Q Booneville, Arkansas.
A I have not.
Q Okay. Logan County, Arkansas, you ever been there?
A I don't know.
Q Okay.
A I've been a couple places there with my husband. Not sure.
Q Do you know -- have you ever -- did you ever meet David Cains?
A No.
Q No? Is that --
A No.
Q Okay. Did you ever treat David Cains?
A No.
Q Do you know the population mix at the Booneville Human Development Centers or the differences in the populations that at the several Arkansas Human Development Centers?

A I do not.
MR. GILLISPIE: Object to form.
MR. ROSEN: I'm sorry, Counsel?
MR. GILLISPIE: I object. Object to form of the question.
MR. ROSEN: Well, I don't know -- this is cross examination, so I don't know what the form would be.
MR. GILLISPIE: Well, it's a -- it's a broad compound question that --
MR. ROSEN: All right.
MR. GILLISPIE: -- asks for multiple answers.
MR. ROSEN: Let me break it down.
BY MR. ROSEN:
Q Do you know the population mix at the Booneville Human Development Center?
A I do not.
Q Do you know the populate or any differences in the population mixes from the other Human Development Centers in Arkansas?
A I have not specifically reviewed them in Arkansas, no.
Q Are you aware, do you have any information that Booneville Human Development Center population includes a

large mix of behavioral management population?
A Behavioral management population?
Q In other words, population with people who have behavioral problems.
A I gathered this much from the training that the -- Mattson and all of them completed, that they probably had to deal with that.
Q Let me ask you -- okay. So since you didn't treat him and you didn't -- you really -- you weren't trained here, you -- you're in Florida; right?
A Uh-huh.
Q Is that a yes?
A Yes. Yes. Sorry.
Q Okay. And you're licensed in Florida?
A Correct.
Q Okay. Not licensed in Arkansas; right?
A No.
Q Do you know Mr. Gillispie or any people in his firm personally?
A No.
Q Have you met him before this case?
A No.
Q Have you ever spoken to him before this case?
A I don't believe so, no.
Q Okay.

And where -- I see on your resume that you're employed at a hospital in Florida.

A At two hospitals, yes.

Q Okay. And where are they?

A Brandon and Lakeland.

Q Where's that? What's it near?

A Tampa.

Q Okay. So you're -- is this in Tampa or --

A Between Tampa and Orlando.

Q Okay. So you're out -- you're in between. All right.

A Uh-huh.

Q How is it that you came to be hired as an expert physician in this case by Mr. Gillispie or people of his -- in his firm?

A I was recommended to him.

Q By?

A Through mutual friends.

Q Okay. So then -- and who were the mutual friends?

A Through my husband and his -- much of his colleagues and friends --

Q Okay.

A -- I was recommended to him.

Q Your husband knew Mr. Gillespie? Is that what you're saying?

A Yes.
Q Okay. And so, your husband, what type of physician is he?
A He's a trauma surgeon.
Q Oh, but is he licensed here in Arkansas?
A No. But his father is.
Q Okay. Is his father still practicing?
A Yes, he is. And he trained at UAMS.
Q Okay. So what I'm asking then is why did -- but they didn't come to testify in this case, you did; right?
A They're not emergency medicine physicians.
Q Okay. But they're physicians --
A They don't deal with these emergencies. I do.
Q All right.
A They're traumas surgeons.
Q Are you listed or enrolled with any organizations that refer expert witnesses to plaintiff's counsel?
A No.
Q You've never been a like -- like kind of like a headhunter for what expert witnesses?
A No, sir.
Q Okay. When were you actually retained in this case?
A I will have to -- I would have to go review my records --
Q Approximately.

A -- for if there's a date for my retainer check. I honestly --
Q Don't --
A -- don't remember. I got to think --
Q Okay. I mean, approximately, what month was that? What year and what month?
A Well, it was this year. Yes, it was this year. Gosh. I would have to check my records. I honestly don't recall.
Q Okay.
So would you -- was it in the winter of this year? In the spring of this year? In the summer of this year?
A Well, I live in Florida, so they're all the same. But I don't recall -- I can very easily pull up my retainer fees and my retainer contract. But I --
Q Okay. Well --
A -- don't have them on me.
Q Well, let me ask you that. So has -- have you -- so you were retained, right, by --
A Right.
Q -- counsel; is that right?
A Uh-huh. Yes.
Q Yes? Okay.
A As all witnesses are, I believe.
MR. GILLISPIE: Unfortunately.

BY MR. ROSEN:
Q Okay.
Now, how much have you been paid to date?
A I don't recall. I would have to review my records.
Q Do you do this a lot, these expert witnesses?
A I'm training in them and doing them often.
Q So you are? You testify a lot in these types of cases?
A I'm beginning to, yes.
Q Okay. How many do you think you've testified in?
A Today is my first official deposition with -- in this scenario.
Q So -- but -- so this is the first one, but you -- but you don't know how much you've been paid to date?
A No, sir, I do not.
Q All right.
A I would have to check my records. I don't actually keep those things in my brain.
MR. GILLISPIE: Rich, I'll -- I'm happy to provide you all that. I'm happy to provide you --
MR. ROSEN: Okay.
MR. GILLISPIE: -- all that information.
MR. ROSEN: But I'm still going to ask the question. So -- but I would ask that you would

provide it.

BY MR. ROSEN:

Q Are there any outstanding bills or invoices regarding the work you've done on this case?

A **Not at this time.**

Q Not at this time? Everything's paid to date?

A **Yes, it is.**

Q And are you paid directly by the claimant or counsel or through an agency? Or an intermediary?

A **Through a law firm, the law firm.**

Q Mr. Gillespie's law firm?

A **Correct.**

Q All right.

Now, you said earlier that you -- that you were familiar with the -- Mr. Cains' IPP; correct?

A **Uh-huh. Correct.**

Q Okay. And before I -- since the warning, the alarm is still going off, I don't know if you can hear it or not, but --

A **Oh, I can hear it.**

Q Okay. I'm going to -- let's take a, say, five or ten minute break before we start talking about the IPP just so I can see what's going on.

And I promise I'll come back and tell you whether there's a fire in the building or it's a drill. And I

apologize, but it's beyond my control. So --

MR. GILLISPIE: No problem.

THE WITNESS: Very clearly.

MR. ROSEN: If we can just take about -- it's 10:30, about -- reconvene at 10:40.

THE WITNESS: Okay.

MR. GILLISPIE: Sure.

(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)

BY MR. ROSEN:

Q Okay. I apologize for that. And we were starting talking about review, your review of the IPP, the --

A **Correct.**

Q -- individual program plan for Mr. Cains.

A **Uh-huh.**

Q So, Doctor, you -- you've reviewed that IPP and you're aware of Mr. Cains' behavioral aggression and violence issues; is that correct?

A **I did not --**

MR. GILLISPIE: Object to form. That assumes evidence not in the record.

A **I did not see anything in regards to him being violent.**

BY MR. ROSEN:

Q Okay. You didn't see anything in the IPP about his aggressive behaviors and his care plan for how to handle aggressive behavior?
A **I heard irritable behaviors that were to be handled with care.**
Q And you read the -- I think you testified that you read the depositions of Mr. Mattson, Ms. Campos, and Ms. Jones; is that correct?
A **Correct.**
Q Okay. So then, at least from Ms. Jones, you're aware that he had -- that David Cains had violent tendencies and outbursts of aggression that -- where he would try to hit, he would throw, he would have violent --

MR. GILLISPIE: Same -- same objection. The word aggressive is used in his care plan. But violent -- in fact, almost everybody that's been deposed couldn't even think of time he hurt a single person.

So violent is not a word that I ever recall seeing anywhere. So same objection, assuming evidence not in the record.

BY MR. ROSEN:
Q Well, I'm going to -- if you can answer the question, because violence could mean -- and there are

evidence, if you read the record -- at least this Jones deposition carefully, you would have seen where he did hear -- hurt people and he did have outbursts where he destroyed things. And he did --

A I read things about him --

Q -- (inaudible) -- huh?

A Sorry. I read things about him ripping a paper off of a wall.

Q Uh-huh.

A I heard things that he did have word outbursts which are not violent. And that was about it.

I don't recall hearing anything that -- about him striking anyone or causing any bodily injuries to anyone.

Q Do you recall anything about a fire extinguisher being thrown?

A I don't. I'm sorry.

Q Do you know anything about him attacking people or trying to hit people?

A I actually remember reading the opposite, that he would have aggressive yelling outbursts, but that he was not known to have ever attacked anyone.

Q Okay. So that's part of that -- part of your opinion is based upon the fact that he's never attacked anyone or tried to have anyone, he just had verbal outbursts; is that correct?

MR. GILLISPIE: I'm going to object --
MR. ROSEN: I'm asking the doctor.
MR. GILLISPIE: Her opinion is about his cause of death. It has nothing to do with his history of aggression or lack thereof.
MR. ROSEN: Well, I mean, I'm just -- I'm asking her about the IPP upon which you asked her whether she formed an opinion based upon all those documents she reviewed. So I'm just following up.
A I'm -- you know --
MR. GILLISPIE: What's the question? What's the question then?
BY MR. ROSEN:
Q The question is, so is it your testimony that your opinion formed in this case had nothing to do with that there was -- you saw no evidence of any aggression or violence or throwing of fire extinguishers or trying to hit people in the records and transcripts that you reviewed?
MR. GILLISPIE: Object to form.
THE WITNESS: Okay. Do I still answer?
BY MR. ROSEN:
Q Yeah.
A Okay.

So, no, actually, my medical opinion has absolutely nothing to do with his personal -- whether he had personal aggression or not.

My interest in the forums of his medical records and IPP was much more so to his physical, any physical conditions, in regards to if he had any diet specifics that made -- would have made him more of a choking risk and -- which he didn't, and if he had any special considerations and conditions in regards to eating; [redacted]

[redacted]

Outside of that, my opinion is purely medical and scientifically driven and does not take into account whether he was a violent person or not. It has no bearing on whether he died from suffocation from choking.

Q Okay. So if he had a violent outburst at the time right before -- or at -- during this incident, is it your opinion, since you testified about restraints and I guess it's based upon your personal training of restraints -- well, let me ask it this way. Strike that question.

Are you familiar with the training on restraints and what authority there is to restrain David Cains in the Human Development Center?

A In the Human Development Center, I do not believe I read specifics on --

Q Okay.

A -- their particular protocols.
I recall them talking about it, but I don't see -- I did not see a specific protocol.
Q Okay. Fair enough. And so you base -- based upon -- you base your opinion based upon your own training on restraints; is that right?
MR. GILLISPIE: Object. Object to the form. Object to the form again. That assumes evidence not in the record.
Her -- whatever restraint training she had, as she's already said, has nothing to do with her opinion of how he died. The medical cause of his death --
MR. ROSEN: Okay.
MR. GILLISPIE: -- which is her purpose.
BY MR. ROSEN:
Q Well, I heard earlier and I think I made an objection to it, in fact I know I did, about her being -- about Dr. Brown, I'm sorry, Dr. Brown being an expert and test -- in restraint and testifying that they, that they -- you have extensive training on how it's used in your emergency rooms. Isn't that what I heard?
A Yes.
Q Okay.
A I have extensive training in chemical and physical

restraint.

Q Okay. And that's the type of training that you have in your emergency room; right?

A **They're not specific to institutions. They're generally state and federal laws on how restraints can be used.**

Q Okay. All right. Well, are you -- so but you're not aware of what -- are you aware of what the laws are or the policies or rules regarding restraints in Human Development Centers in 2020?

A **I am not.**

Q Okay. Fair enough. So your opinion has nothing to do with whatever was authorized in the IPP or allowed in Arkansas in HDCs at that time?

A **Correct. It is not.**

Q Okay. Fine.

Now, so I want to -- I'm a little confused by your testimony, including your recap, as to -- is it your testimony that David Cain was restrained on, I think you said left side, and then put on his back and -- and on his left side, started vomiting, and then put on his back? Is that your testimony?

MR. GILLISPIE: It's --

MR. ROSEN: It's to the doctor. Not to the counsel.

MR. GILLISPIE: Well, I -- I -- my objection is, yeah, it's her testimony, but it's --

MR. ROSEN: I didn't ask that.

MR. GILLISPIE: -- everybody's testimony. He was on his left side.

MR. ROSEN: Mr. Gillispie, I didn't -- well, it's not, but -- well, that he was on his side.

MR. GILLISPIE: It absolutely is. It absolutely is.

MR. ROSEN: Mr. Gillispie, I really -- my questions are directed towards Dr. Brown and her testimony and her recollection.

MR. GILLISPIE: Well, I just want to make sure you understand the case, Rich.

MR. ROSEN: I --

MR. GILLISPIE: He was on his left side.

MR. ROSEN: I understand the case. So --

MR. GILLISPIE: Well, you seem to be confused about whether it was his right side or his left side.

MR. ROSEN: Well, no, I'm not. Okay? I'm trying to ask a question to probe a response to see what Dr. Brown knows.

MR. GILLISPIE: Okay.

BY MR. ROSEN:

Q First of all, Dr. Brown, you weren't there, were you?

A **No, of course, I was not.**

Q Okay. And you didn't see it. There was no picture that you saw of David Cain being restrained on the ground on that June day in 2020, is there?

A **No, sir.**

Q Okay. So you're getting -- you're formulating your opinions based upon the depositions and the records that you testified earlier to in your testimony; right?

A **Correct.**

Q Okay. Now --

A **The only available forms of account of what happened, as far as I'm aware.**

Q Okay.

So what I'm asking about is, we all agree that he was -- that when he was restrained, that he was on his left side, right? Correct?

A **Correct.**

Q Okay. And that would be a proper type of restraint to protect against vomiting. You would agree with that; correct?

MR. GILLISPIE: Object to the -- object to

the form. She has already testified she doesn't know what the -- what was allowed and what wasn't allowed, as far as restraints go at this facility.

She's not researched it. She's not researched the laws in Arkansas on what's allowed and what isn't. So she's already testified that she can't -- you know, she can't say whether that type of restraint was appropriate, allowed under Arkansas law, or not.

We have a different expert for that very thing.

MR. ROSEN: I'm asking from -- let me -- let me back up and make it more simple. Okay?

BY MR. ROSEN:

Q You had said earlier on, as I recall, that it was -- that you would want somebody to be -- who is vomiting to be placed on their side and not on their back --

A Correct.

Q -- is that correct? Okay.

And we all agree that David Cains, on that day, was placed, was on his side when he started vomiting.

A Correct.

Q Okay. Fine.

Your testimony that I'm getting, going to ask you about, is I recall you saying, that he was then -- after he started vomiting, he was then at some point in time placed on his back.

A Correct.

Q Okay. And that's where you have your concerns; is that right?

A One of my concerns.

Q Okay. So let's talk about this one concern. Okay?

A Uh-huh.

Q Do you know when he was placed -- when he was turned from his side to his back, after he had vomited, do you know whether he was breathing at that point in time or not?

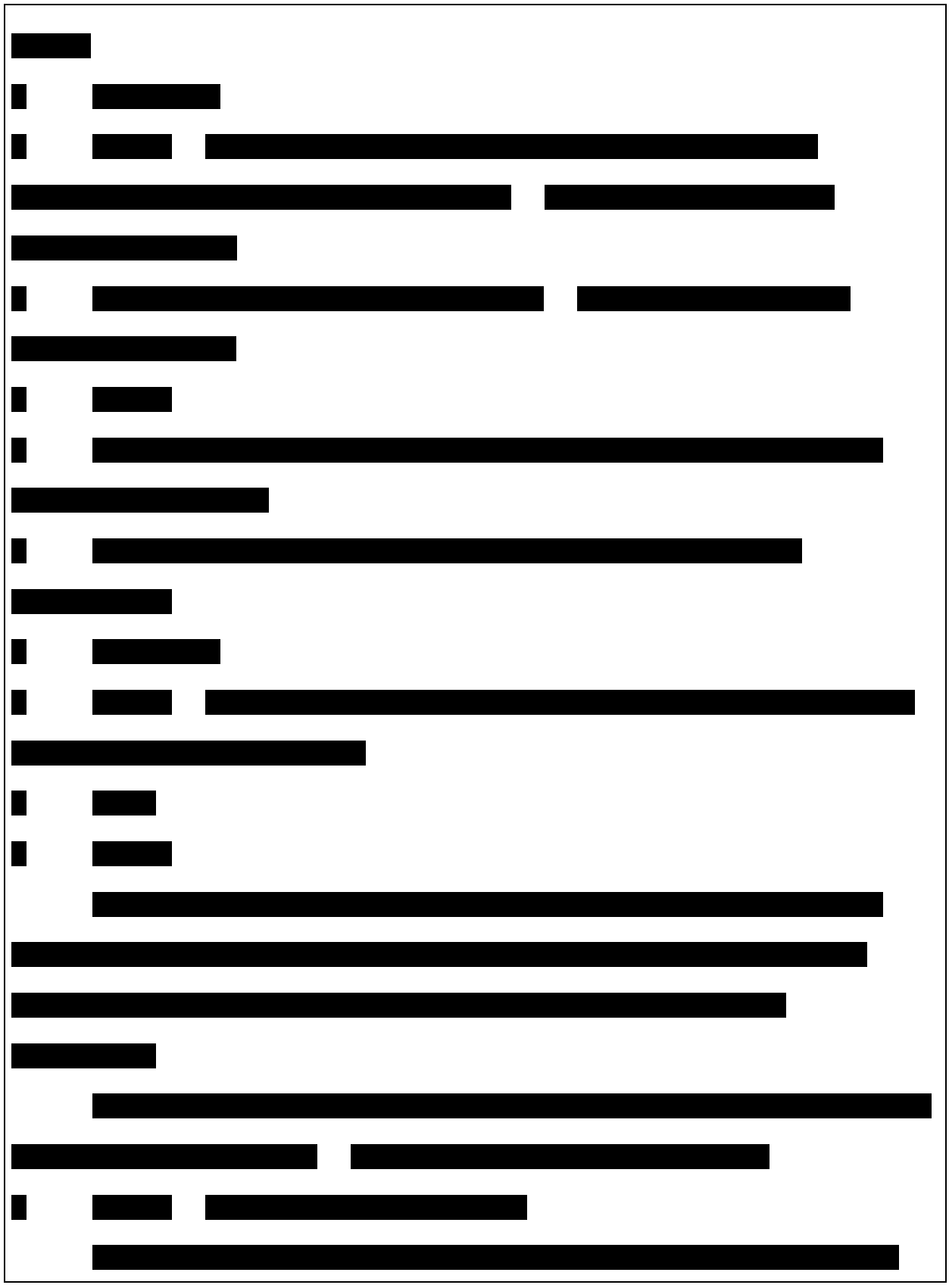
A I only have -- I personally was not there. No, I do not know. I have what I -- what were the accounts.

Q Okay. And what accounts -- so based upon your understanding of the facts, was he breathing or not breathing when they turned him from his side to his back?

A I believe they said that he had choked and they did not think he was breathing.

Q Okay.

[redacted]



[redacted]

Q Okay.

A **Typically.**

Q So if he was on his left side and vomited and then they turned him on his back and did abdominal thrusts, would you conclude that they believed or had reason to believe that he was choking?

A **I can't comment on what they thought. I'm sorry.**

Q Well, so I mean, on your opinion, your opinion is that he was on his left side and vomited and then they turned him on his back and put pressure on his stomach and somehow, it -- that's when he choked. Is that your

opinion?

A My opinion is that he choked from vomiting when he was on his left side.

[redacted]

MR. GILLISPIE: Objection. Objection. Object to the form with regards to the part of your question, the comment that said that completely unresponsive.

There was no -- there's no -- I don't believe that he was completely unresponsive at that point. But there's not been testimony that he was completely unresponsive when he was turned over; only that he was choking on his vomit.

BY MR. ROSEN:

Q Now, Doctor, I see you're looking down. Are you reading something?

A No.

Q Okay.

[redacted]

Q Oh, so you're thinking that he should have been pulled on his stomach?

A **No, not on his stomach.**

Q Okay. So how would you do back thrusts if he's laying down?

A **Actually, the proper way to do that at that point would be to lean someone over a chair if they are unable to stand and do back thrusts.**

Q But that -- so you're saying -- it's your testimony here today, as a medical expert in the emergency room resuscitation, that abdominal thrusts in the stomach to pop out an obstruction in the esophagus, in the airways, is not an appropriate procedure?

A **It is not the appropriate procedure.**

It is the idea that they had to try it, from what I can see. But, unfortunately, that is not the teaching.

The teaching is quite clear that laying someone on their back occludes their airway and it is never the teaching to lay them on their back --

Q Okay.

A -- unless you happen to have a device that can then remove things from the airway.



Q Taught to whom?

A To experienced resuscitation team --
Q Do you know whether it was taught at the HDC to these (inaudible) --
A I have no idea whether it was taught there or not. But I can tell you that it's not the correct approach to a choking patient.
Q Okay.
So if somebody -- and, in your opinion, what would be the correct response in a unresponsive choking patient who is laying on the ground?
A In a situation where you have no tools?
Q Yes.
A Again, you should do your best to get them up onto a chair, a chair being at their diaphragm, and doing back strikes. Or you can put them over your knees and do back strikes.
Q Okay. And what would be the purpose of that?
A To use gravity for you, not against you.
If you put them on the back, the food falls into the back of the oropharynx and blocks the trachea. If you put them facing down, they -- and have area to -- for things to fall out of their mouths -- so if you put them just on his stomach, he would just have vomited and gone to the floor and cause another mechanical obstruction.
If you put them over your knees and have a space in

between and strike on the back, you're trying to dislodge something and also give it space to move from the oropharynx.

Q Would not the abdominal thrusts also be an attempt to dislodge it through -- just using through pressure?

A **Well, the only problem with that is that you would dislodge it and cause it to fall right back into the oropharynx, so it --**

Q Do you know whether that happened or not?

A **-- dislodge -- I'm sorry?**

Q You know whether that happened or not?

A **I have no way of knowing whether that --**

Q Okay.

A **-- happened or not.**

Q But you -- so -- okay.

A **You asked me what the techniques are supposed to be per protocol; and that is not it.**

Q Now -- hold on. I'm just looking at my notes.

A **That's fine.**

Q Earlier, you talked about a struggle and fight, fight and flight. And those are terms we all learned a long time ago in grade school. Okay?

A **Correct.**

Q And so what -- how do you know or do you -- did you form an opinion on the intensity of this, quote/unquote,

struggle, unquote?
A I mean, form an opinion, I don't know if it's a direct opinion or just a typical instinctual reaction.
Your body instinctually fights as hard as it possibly can to survive when it feels that it may be dying. Regardless of your mental state, your body fights, so --
Q Are you --
A -- I would assume that it would be a very intense struggle, given your death being the alternative.
Q Well, I mean, initially, there was a behavioral incident of aggression and the aid, Mr. Mattson, attempted to restrain Mr. Cains for -- to keep him from harming himself and others. Okay? Would you agree with that?
MR. GILLISPIE: Object to -- object to the form.
MR. ROSEN: (Inaudible.)
MR. GILLISPIE: That's definitely not anywhere in the evidence.
MR. ROSEN: And I wish that Mr. Gillispie would stop testifying and try and coach the witness.
BY MR. ROSEN:
Q But I would ask, Dr. Brown, you read the -- you read

the -- you read all these documents.
A Can you ask the question again?
Q This incident occurred when Mr. Cains, during a behavioral episode where Mr. Cains lunged at Tyler Mattson, and they -- Tyler Mattson put him in an emergency hold authorized by the IPP, would you agree with that statement?
A I did not see anything documented about lunging at someone.
Q Oh, you didn't? Okay.
Now, if it turns out that Mr. Cains lunged at Tyler Mattson, which is the reason for the restraint, would -- would that change your opinion?
A No.
Q Would it change your opinion if you knew that there were steps right by there and a half wall that went down to the lower level?
A I don't -- I don't see how that would change anything.
Q Okay. That's fine.
So is it your opinion from a medical expert -- well, that you're -- just to allow somebody to -- well, was Tyler Mattson supposed to allow, in your opinion, Mr. Cain to just attack him or --
MR. GILLISPIE: Object to the form. She

didn't -- object.

She didn't give any opinion on any of this, Rich. So what do you cross --

MR. ROSEN: Well, she gave an opinion that --

MR. GILLISPIE: She didn't give any opinion on this.

MR. ROSEN: -- this, this was an intense struggle due to a fight or flight. And I'm asking questions about that and how she knows that. Okay? That's --

MR. GILLISPIE: She knows there was a struggle when they went to the ground.

MR. ROSEN: Okay.

MR. GILLISPIE: It was a struggle, he had to be restrained by three people. Obviously, that's --

MR. ROSEN: And, Counsel, I appreciate that. But I'm not asking you the questions. I'm asking her the questions.

I want to know what how she formed her opinions that she's giving here today and whether she had all the information that she really needed to have in order to make a valid medical opinion. So that's what I'm asking.

BY MR. ROSEN:

Q So, Doctor, when you say that this was a -- is it your opinion this was an intense struggle --

A **It is.**

Q -- or do you not know whether it was an intense struggle?

A **I -- I would assume that it is. But, no, of course, I have no way of knowing exactly how intense it was.**

Q Okay. Well, I think that answered the question. Thank you.

Let's talk about, it's your opinion, and I saw it and it's all in the record, in the -- in the responses to interrogatory, third supplemental responses, that's kind of your opinion that we were notified of at our request to the plaintiff.

And you state, and as you stated today, that this pressure on the stomach, on the laying on the left side, caused increased pressure and caused him to vomit; which, ultimately, he choked on.

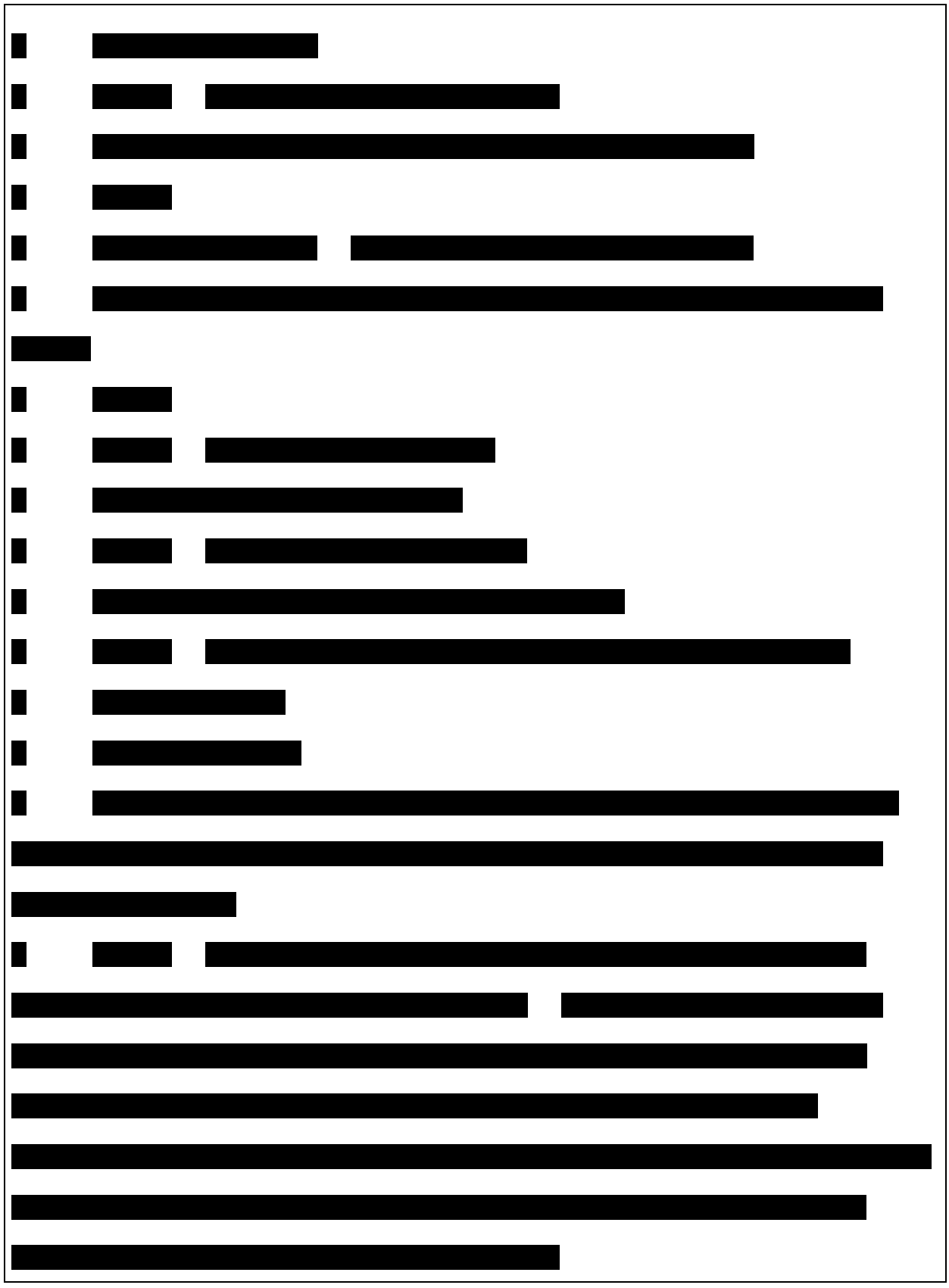
That's just a quick recap. Would you agree?

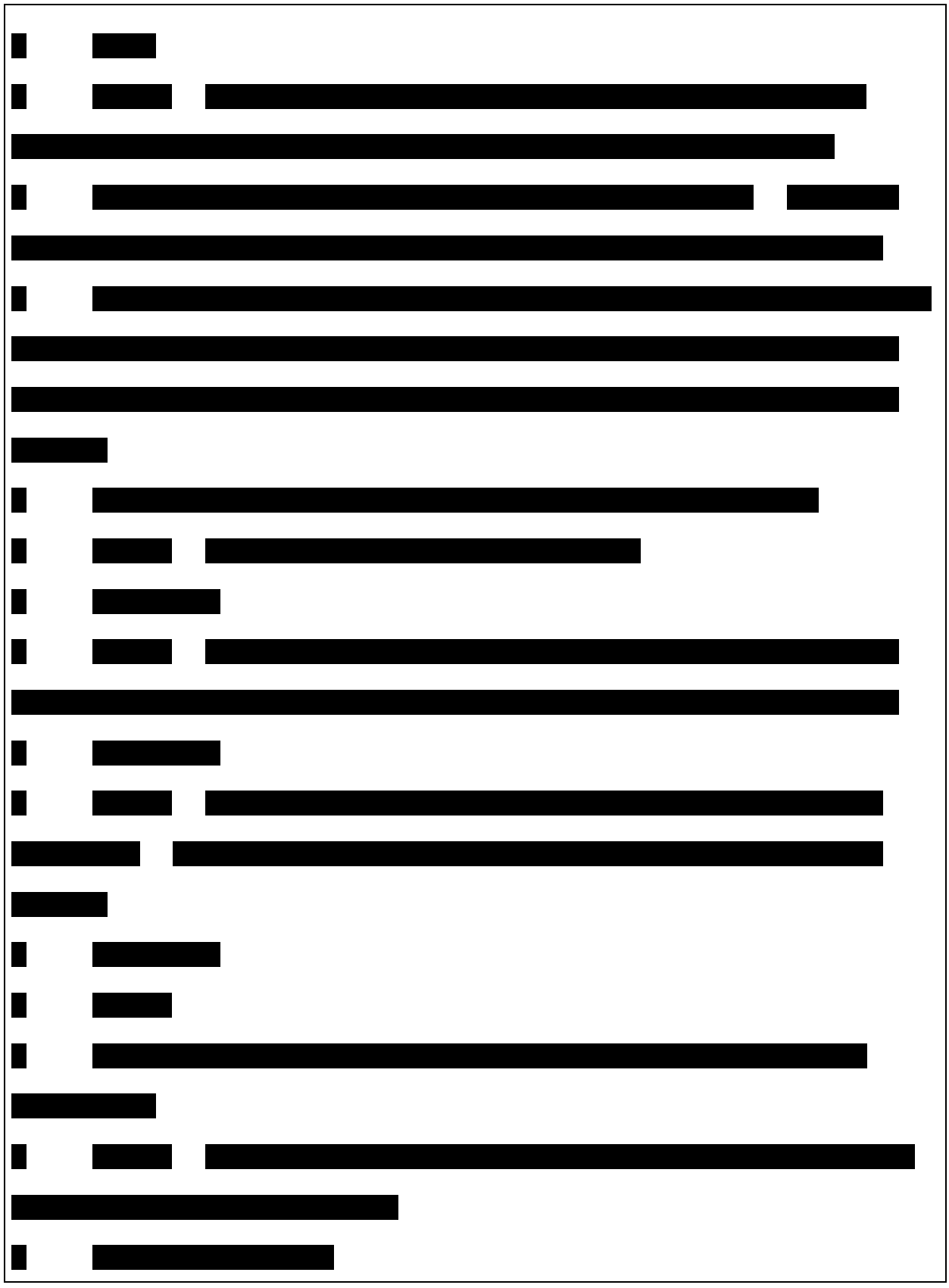
A **Quick recap is, yes. There was multiple avenues of pressure that could have caused the stomach to erupt in vomit, yes.**

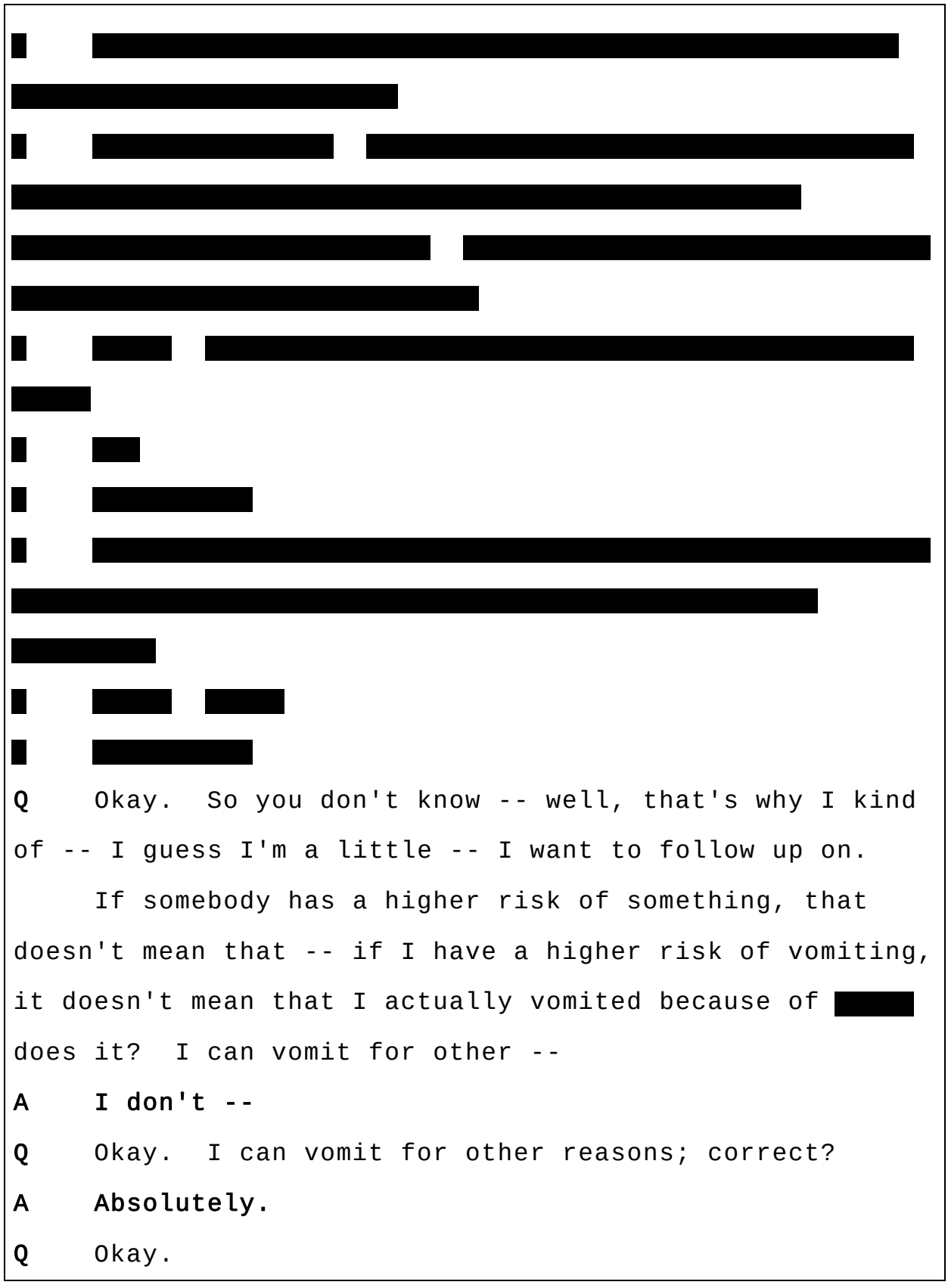
Q Okay. Did you rule out any other causes?

A **Of what?**

Q Of him vomiting.
A **I'm not sure exactly what type of causes you're talking about.**
Q Any cause. I mean, you've reached this conclusion. Did you consider other reasons that he might have vomited?
A **Absolutely.**
Q What were they?
A [redacted]







Q Okay. So you don't know -- well, that's why I kind of -- I guess I'm a little -- I want to follow up on.

If somebody has a higher risk of something, that doesn't mean that -- if I have a higher risk of vomiting, it doesn't mean that I actually vomited because of [redacted] does it? I can vomit for other --

A I don't --

Q Okay. I can vomit for other reasons; correct?

A Absolutely.

Q Okay.

Now -- and that goes back to my earlier question to you about what was ruled out, if anything.

A There was no evidence suggesting any other injury had occurred.

Q Okay. Do people have a -- what if he had an upset stomach?

A I can't say. I wasn't able to ask him.

Q Okay. So you don't -- you weren't able to rule that out, were you?

A I was not able to rule out whether he had an upset stomach or not. Although he was not vomiting when he was standing, per report.

Q But you realize, a few minutes earlier, he had gone to the restroom? Did you know that?

A I'm sorry. Say it one more time.

Q Did you know, that a few minutes before this episode occurred, he had gone to the restroom?

A Yes.

Q Okay.

A That's in the record.

Q And were you able to rule out, and if so, how, his voluntary ability to vomit?

A If in this scenario if he was able to voluntary -- well, let me back up.

Tyler's description of the bathroom visit, which is

only thing that we were able to go off of, states very specifically that -- that he did not hear any noises that were -- that he could say sounded like vomiting, intentionally vomiting, or otherwise.

He's heard no abnormal sounds that indicated vomiting. So I think that's the only piece of evidence we all have in regards of what happened in the bathroom.

Q Okay.

A So --

Q And that's what --

A -- there was no indication that he had an upset stomach. Only that he went to the bathroom.

Q But you -- but you didn't rule -- you weren't able to definitively rule out any of this, were you?

A No one can.

Q Okay.

A The only thing I can rule in is that a struggle often induces vomiting.

Q Okay. You don't know how intense the struggle here was?

A If you're fighting for your life, I think it's without question that it's going to be --

Q Well --

A -- an intense fight.

Q Well, I mean, so when the -- when the restraint

started, there was a behavioral episode. Was he fighting for his life then?
A What he thought was a fight for his life and when it came down to that, I can't say.
Q Do you --
A But, I mean --
Q -- is it your opinion --
A -- I imagine being restrained at all would be very intense.
Q So -- but you -- you saw that it will -- well, strike that question.
Do you know -- I mean, what's your idea of how he was restrained? What do you base your opinion on?
A The reports.
Q Okay. Tell me the facts that you based your opinion on about --
A From both depositions and the OLTCs. There was Ryann at the feet, Tyler behind, and Ms. Amy at the head.
I think there was a question whether she was holding the head or the arms. I don't know if that was ever completely delineated, but that -- I know that those were the three people there. And they came in at various times --
Q Okay.
A -- and various locations.

Q And so they were just -- if they were holding his arms and his feet, what -- is it your opinion that somebody was on top of him?
A I -- no. I didn't say that either.
Q So he wasn't pinned to the floor --
A I believe that --
Q -- (inaudible)?
A -- Tyler had his hand on his waist holding him on the ground. He said he was holding him there but did not place his weight on him.
Q Okay.
A That was his description.
Q Okay. So I ask you again, is it -- did you formulate an opinion that he was, that Mr. Cain was somehow pinned to the floor?
A Hard to say. I know that he had a restraint at the shoulders, at the waist, at the either arms or head, and at the feet.
And I don't think that you can get up on the floor, if your feet are restrained --
Q And so --
A -- and your hands restrained.
Q Okay. And so I know that you have said that you do restraints in your emergency room.
A Yeah.

Q And that's to protect the individual from hurting himself, him or herself or, and for -- to protect the staff and other people in the surrounding areas; isn't that correct?
A **Yes.**
Q Would you have any reason to differ that that was the situation here?
A **That they were restraining him for his own protection or theirs?**
Q Yes.
A **I -- I -- you would have to ask them. I don't know their reasons for doing things.**
Q Okay.
A **I do know, that in our training, the first thing to do is verbal de-escalation so that you can avoid restraints. And it does not appear that that happened.**
Q It didn't appear to you that they tried to de-escalate it?
A **I heard that he was given a chance to go to the bathroom and sit down.**
Q And was the sit down a calming mechanism?
A **I don't know.**
Q As a matter of fact, the reason he sat down was to calm down, was it not?
A **That might have been what it was directly --**

Q So, in other words, there was a de-escalation or a calming before this outburst?
A Not what I would call the traditional, but potentially the way they thought of it, maybe.
Q Okay.
A It's not my training in de-escalation for -- to use those particular methods.
Q Now --

MR. GILLISPIE: And again, I --

MR. ROSEN: Is there an objection?

MR. GILLISPIE: I just -- that she's not giving -- she didn't -- I didn't ask her to give any expert opinions on de-escalation or physical restraints --

MR. ROSEN: Well, no --

MR. GILLISPIE: -- (inaudible) --

MR. ROSEN: -- I'm just following up -- I understand, Counsel.

But I'm following up on her fight or flight struggle opinion. And this is part of that. And she did mention about there was no de-escalation that she saw.

I'm just reminding her that there was. Okay?

BY MR. ROSEN:

Q So, Doctor -- and I don't have too much longer. Okay?

A **You're fine.**

Q I'm just -- your opinions here today that you have said, and I think counsel asked you, that they're based upon a, I guess your medical education and your training and your four years of experience as an emergency room doctor; is that right?

A **Yes.**

Q Okay. You wouldn't expect -- I mean, some of the -- I -- I saw your -- the statement in the third supplemental responses where you explained it and it was kind of -- and I think you were today, used the word today, intrathoracic pressure increased.

And the -- and you're explaining of the obstruction to the left side of the stomach, in your opinion.

I've been a lawyer for 39 years. Okay? I'm not a physician. I don't know -- I wouldn't be expected to know what you said. And that's why you're here today; is that correct?

A **I'm -- I'm not sure, but --**

Q Okay, let me reword it. Okay?

This increase of intrathoracic -- as a lawyer or as just a layperson, I wouldn't know what -- you wouldn't expect me to understand until you explain it or somebody

else explains it, what intrathoracic pressure is, would you?
A Correct. I would not expect that you knew what that meant.
Q So your opinion about the how Mr. Cain, why he choked, the medical reason for that, you wouldn't expect me to know that, would you? Without you -- that's why we're here today; right?
A I would not to expect you to know how he died?
Q Yes.
A In the -- in medical terms, no. I would --
Q Okay.
A -- expect in medical terms.
Q Or the -- I mean, I know how it -- looking at -- we know what happened. He choked on vomit.
A Correct.
Q That's the lay version of it; right?
A Absolutely.
Q I think your -- in your opinion, the way it was laid out to me in the interrogatory answers was you're giving the reason, in your opinion, it happened.
A Yes. The physiologic response of an -- of your body.
Q And you wouldn't -- the cause, so to speak?
A Correct.

Q Okay. And you wouldn't expect me -- and again, I'm not medically trained to know that without asking you; is that right?

A **Yes.**

Q Okay.

Only a few more questions. Actually, I want maybe a few more -- maybe a few, few more, but not too many. And a lot of these, I've already asked you a lot of questions. I'm just going back to my notes, so --

A **You're fine.**

[redacted]

Q Okay. And, if the person was totally blocked and no air was going in and no air was coming out, mouth to mouth resuscitation would not be of any use, would it?

A Most likely, it would be futile, yes.

[redacted]

Q Okay. And you don't -- and that was appropriate, in your opinion; right?

A **Yes.**

Q And that was an attempt to save David Cains' life, was it not?

A **Yes, it was. As far as I can tell.**

Q And so do you -- were you -- you're aware that this is a rural community in Booneville?

A That it's a rural community?
Q That it is a rural -- well, were you aware of this was a rural, this happened in a rural community?
A No one had used that terminology, but it sounded like it.
Q Okay. And so do you -- I don't know if where you live is a rural community or not. But is it?
A Where I live is not a rural community --
Q Where you --
A -- some of where I practice is a bit rural.
Q Okay. Well, this is rural Arkansas. And Logan County is in the western part of the state.
A Uh-huh.
Q And do you have any experience in emergency responses and the timeframes in rural areas?
A I do.
Q Okay. So you know then, that while in the city, it probably takes four to six minutes for an ambulance to respond; in a rural area, it could take an hour?
A Absolutely. I have trained and practiced in multiple rural settings. And I've done EMS work as well.
Q Okay. So then you're familiar with the situation, the reality on the ground, so to speak --
A Absolutely.
Q -- in rural areas with emergency responders. Okay.

Now, I think, in this instance, you mentioned that it -- it took eight minutes before that, from your understanding, before, I guess, 9-1-1 was called; right?
A That's what I read.
Q Is that what your understanding is?
A That is my understanding.
Q Okay.
Now -- and you're aware that a call -- when this happened, when the -- when the aids, Mr. Mattson and the other people, realized that this -- something had happened and Mr. Cains had stopped breathing, that they called the medical team at the --
A Yes. That's what I read.
Q -- facility? Yes. And those were the LPNs that responded; correct?
A Correct.
Q And do you know how long it took them to respond after that call came?
A I believe they said it was one to two minutes, but I am not positive.
Q Okay. So they arrived within one to two minutes, according to your understanding. That's faster than any ambulance would be there; correct?
A Yeah.
Q Even in a city?

A Yeah.
Q Okay. And they responded and at that -- when they responded, about one to two minutes after this happened, 9-1-1 was called; correct?
A Not sure that's the exact timeline, but --
Q Okay. Well, what's your understanding of the timeline?
MR. GILLISPIE: Rich --
A I just know there was a total of eight minutes in --
MR. GILLISPIE: Rich --
A -- (inaudible) time.
MR. GILLISPIE: I'm sorry to interrupt. I just want to clarify just one brief objection.
I understand your line of questioning. I just want to clarify that nobody's conceding that it took one to two minutes for the nurses to get there or that they got there that fast.
That's what she -- that's what these -- that's what some witnesses testified to, but just I don't -- want to make that clear. Nobody's conceding that that's -- that it only took them one to two minutes to get there.
MR. ROSEN: Well, appreciate your -- your -- I understand why you are making these statements.

But this is really a question between me and Dr. Brown and what her understanding is from the records. Because she said she read all those depositions and I believe that she read all those depositions.

So I really would appreciate if Counsel would stop trying to steer the witness and let the witness just answer the question.

MR. GILLISPIE: I --

MR. ROSEN: You can ask a follow-up question if you want.

MR. GILLISPIE: And I appreciate that, Rich. And I'm not trying to -- I would rather not have to interrupt you. And I'd rather not have to object.

It's just that you're asking questions that keep assuming evidence that's not in the record or contested issues.

MR. ROSEN: There's no contested about it. There's no -- there's no --

MR. GILLISPIE: Okay.

MR. ROSEN: -- dispute about that, as far as I saw. And this is just based upon what Dr. Brown reviewed.

MR. GILLISPIE: Okay.

MR. ROSEN: Those depositions that she reviewed are undisputed. Everybody says that, including the people that -- the nurses who responded. Okay?

MR. GILLISPIE: Go ahead. Go ahead.

MR. ROSEN: So I'm asking for what you read about.

MR. GILLISPIE: Go ahead.

MR. ROSEN: It's not about whatever you want to argue, just what she read. Okay.

BY MR. ROSEN:

Q So, you read one to two minutes, I think, was your testimony; right?

A I believe so. I -- I would have to look back, but I believe I read that.

Q Okay. And so that is -- so they called the medical station and they were there within one to two minutes.

And, when they got there, you read, I'm sure -- well, do you recall that they -- somebody directed that one of the aides call 9-1-1?

A Yes, I recall that.

Q Okay. And they did right away; right?

A I don't know. I wasn't there.

Q Well, according to the records that you read --

A According to the records, it looks like two

different people had -- had to call.
Q Okay. And so the call went out.
And so we know that the call went out, according to what you read, about one to two minutes after the problem happened; right?
MR. GILLISPIE: Object to the -- what -- object to the form.
A I don't --
MR. ROSEN: I don't know what form there would be --
MR. GILLISPIE: Well, you're -- one or two minutes after the problem.
MR. ROSEN: Okay.
MR. GILLISPIE: If you're talking about the problem being --
MR. ROSEN: Okay.
MR. GILLISPIE: -- the choking, it's eight minutes. We know that because --
MR. ROSEN: No, we don't know that.
MR. GILLISPIE: -- the ambulance records say eight minutes.
MR. ROSEN: Okay. Yeah.
And, Counsel, I appreciate you're trying to give the witness a hint. But I --
MR. GILLISPIE: I'm not -- you just -- you

just asked if, if the ambulance was called one or two minutes after the problem started.

MR. ROSEN: Okay. And the problem being the choking.

Now, you're -- and this is -- I really would appreciate, Counsel, if you would just wait and hold your questions for the witness until later.

MR. GILLISPIE: How can I not object to that question? We all know it's --

MR. ROSEN: What's objectionable? It's not -- what you're saying is not true. That's your classification of it. And I get to ask the questions to the witness.

And -- because this witness may or may not know some facts. And, actually, this witness doesn't know the facts, only knows what she read. Okay? And I want to get her understanding of --

MR. GILLISPIE: All I would ask is --

MR. ROSEN: -- her opinion. Okay.

MR. GILLISPIE: I appreciate that. Just -- just ask it in a way that doesn't mischaracterize the evidence. That's all I ask.

MR. ROSEN: Okay. Counsel, there is no evidence -- there's your statements. And your statements are not evidence. Okay?

MR. GILLISPIE: The ambulance records, that's evidence --

MR. ROSEN: Let me --

MR. GILLISPIE: -- (inaudible) --

MR. ROSEN: We're going to need to -- Counsel, you --

MR. GILLISPIE: -- (inaudible) --

MR. ROSEN: -- can -- you can follow up with Dr. Brown all you want. Okay?

But, at this point in time, in my experience, during cross examination, I'm allowed to ask my questions. Okay?

You can make an objection. I don't even mind you making some limited speaking objections. But giving -- trying to steer the witness is inappropriate at this time, because you don't know what my follow-up questions are going to be. And it might be on that line. Okay?

BY MR. ROSEN:

Q Now, let's back up a little bit.

Dr. Brown, in an emergency room situation, which is,

I would assume, is somewhat chaotic but probably more controlled than in most emergency situations -- well, let me strike that.

In the emergency room, is there a clock on the wall?

A Yes.

Q Okay. And, often in an emergency, is there somebody documenting times and orders and events that happen in an emergency room?

A Yes.

Q Okay. When somebody has a car accident and they're injured and somebody says it happened at 12:30, do you know whether that is a total accurate a time or -- accurate time or is that often an estimated time?

A I have absolutely no idea.

Q Okay.

In your experience, when somebody said something happened at 12:30 or one o'clock, does that mean that it happened exactly at that minute?

A It is my practice to take a patient at their word --

Q Okay.

A -- for when things happen, because I don't have any evidence showing me otherwise --

Q Okay.

A -- unless there are other participants who can give me other information.

Q Okay. So then you read, in Tyler Mattson's deposition, that they didn't look at the clock; right?

A **The -- I read multiple times that it was eight minutes.**

Q Okay. Well, that's somebody's conclusion. And this is where I'm going at.

So, in the emergency room, when you're doing something and administrating, administering a drug or calling out an order for someone else to do something, often there's somebody documenting and looking at the clock to see -- and because I know it will say what time to the minute; right?

A **Yeah.**

Q In an emergency room; right?

A **Correct.**

Q Okay.

Now, were you aware that in the lobby of the commons building where this choking incident happened on June 13th, 2020, there was no clock?

A **I did not know one way or another, no.**

Q Okay. So when the call -- when somebody says the call went out at 11:30 to the medical and they said that I'm estimating because I didn't look at the clock, would you expect that to be at exactly 11:30 or would you expect it to be around 11:30?

A If they don't have an exact time that they did it, then we would have to assume it's an approximation.
Q Exactly. And particularly if they said, this is an approximation; right?
A I -- I think we're getting a little semantic in this scenario. I -- but I'm just commenting --
Q (Inaudible) --
A -- on what I read, which is --
Q Okay.
A -- eight minutes --
Q Okay.
A -- multiple times in multiple forms. That's all.
Q Yeah. But you did read that in Tyler Mattson's and everybody else that this was an approximation, because -- because there was no clock and nobody looked at the watch; right?
A Yes.
Q You recall that; right?
A Uh-huh.
Q Is that yes or no?
A Yes. Sorry.
Q Okay.
A Yes.
Q So -- but we do know that it took one to two minutes from the call to the, what we call Judge Hill, which is

the nurse's station, to respond to the -- to the commons lobby where David Cains was. That took one to two minutes from that call.

MR. GILLISPIE: Object to form.

BY MR. ROSEN:

Q Do you -- would you -- that's your -- that's what you read; right?

A **I -- I believe so.**

Q Okay. Now, and then when -- once the nurses got there and saw what was happening, they had had one of the aides call 9-1-1. Is that your recollection?

A **Called medical, yes.**

Q Okay. And so then, after that, after that call, and that call was registered at 11:37, correct, according to the EMT reports? Do you recall that? And, if you don't recall, it's okay.

A **Yeah. I mean, I can pull it up, but --**

Q Okay.

A **If I need to, but --**

Q Okay.

A **-- whatever the time (inaudible) --**

Q Okay.

According to the reports, it was at 11:37. And we know that that call came in, that call went out rather, one to two minutes after the choking incident from the

testimony of --

MR. GILLISPIE: Object to the form.

BY MR. ROSEN:

Q -- everybody else; right?

MR. GILLISPIE: Object to the form.

BY MR. ROSEN:

Q Is that what you would conclude?

A **I conclude the same thing I've concluded 12 times. It's my understanding it was eight minutes from the --**

Q But I --

A **-- initial onset of the situation to when the phone call was made.**

Q Okay.

A **And how they concluded that timeline is not up to me. I just read it.**

Q Okay. And, when you say from the beginning of the, of the incident, you talking from the time that he choked or from the time that the incident started?

A **You would have to ask the people involved. I was not there.**

Q Okay. So fair enough. Fair enough. You don't know?

A **I -- I was given the information, same as you, that it took eight minutes.**

Q Okay.

A That's all we can all comment on.
Q And if --
A Because none of us were there.
Q Okay. But we do know that the call went out to 9-1-1 at 11:37, because we know that from Logan County EMS, which does document times, and -- and it's all sequenced in their own system. I mean --
A Yes.
Q -- their watch in there -- you know, they know when it came in; right?
A Yeah.
Q Okay. And so it came in 11:37, and they were dispatched en route at 11:38, according to this.
Do you have any recollection of that?
A Yes. They're all -- yeah. That's generally the case of EMS. They're dispatched immediately.
Q And do you know -- and just for your -- they arrived at 11:50, according to these documents. Is that your understanding?
A Yes, it is.
Q Okay. So it took them 13 minutes to arrive at the building or to arrive -- to arrive at the building; right?
A Uh-huh.
Q Is that yes?

A Yes. Sorry.
Q And we know from the E -- and you read Mr. Scow's, if I'm pronouncing it right, the EMT's deposition, that he took one to two minutes to assess the situation before he jumped in. Do you remember that?
A I believe his terms were that he assessed while talking to them.
The -- so he started working on the patient while -- while he was assessing the situation.
Q Well, that's not -- okay. Well, is that your understanding of the timeline?
A Yes.
Q Okay. Now, if that understanding is wrong, does that do anything to your opinion?
A If my understanding is wrong on what?
Q That before he touched the patient, he waited one to two minutes.
A It -- no. It doesn't change my opinion as to how --
Q Okay.
A -- Mr. Cains died.
Q Okay. I'm not asking how he died, as to the timeline as far as what happened here.
A No.
[redacted]

[redacted]

Q Okay.

Now, was there ever a time that the EMTs, according to your understanding, and I'm not a doctor and I don't know what half of this means --

A **Sure.**

[redacted]

[redacted]

Q Okay. So we have, say, from the time 9-1-1 was called at 11:37 and not even go out en route until 11:38, until about -- I think they transported -- they arrived at the hospital at -- destination at 12:18.

They weren't -- it's your understanding they weren't able to clear?

A **Twelve -- so -- sorry. The timeline you were saying was?**

Q It looks like, according to this document, and I'm looking at the Logan EMS records -- and I'm assuming -- I think this is one of the records that you stated that you read; is that right?

A **Yes.**

Q Okay. And it said -- it says, at patient 11:50, I think we're all in agreement on that --

A **Uh-huh.**

Q Depart scene at 12:10 and -- and arrive at destination 12:18. And I'm -- would you agree with that or --

A **Yes.**

Q Okay. And I assume the destination is the local hospital; is that right?
A **I would assume so.**
Q Okay. Now, I don't know the distances, but it took eight minutes to get there in -- by ambulance.
[redacted]
Q All right. Few more questions. I know -- I promise to wrap up soon.
Oh, let me ask you this because I'm not a CPR expert. But the chest compressions, if you do -- are you supposed to do 30 sets of chest compressions three times? Is that a standard?
A **It depends on how many people are working on the person.**
Q Okay. So it would -- so would that be an acceptable thing to do or would that be a recommended thing to do?
A **Not in the scenario they were in.**
In the scenario -- if you're talking about the paramedic, they would have done continuous compressions for two minutes until pulse check.
[redacted]

[redacted]

Q Okay.

And as I didn't ask a question, did this thought come back to you or did somebody contact you versus -- and say in an instant message to tell you that?

A **No one contacted me in an instant message.**

Q I --

A **I was thinking about the fact that I may have been making -- we may have been having difference of semantics and particularly terminology.**

Q Okay.

So I just -- I just want to follow up in your opinion that you said today and in your third supplemental responses to the claimant's third supplemental responses to interrogatory that included your opinions, at least some of them that you said here today, you mentioned about laying on the left side, on your left side, and a mechanical obstruction to the

stomach, which is kind of what I didn't -- I never would have known that but for you telling me that.

Is that -- is -- what does that mean?

A Let me see if -- how I can explain it. So --

Q What does the mechanical obstruction mean?

A Oh, okay. A mechanical obstruction is -- so I'm going to just show you here.

So saying my -- my fist here, this is the stomach and this is the floor on the left side --

Q Okay.

A -- you only go as far as this will allow. It's not a flexible surface.

So the mechanical obstruction would be something that you cannot pass due to mechanical physics, that this is a solid ground, you cannot move through it.

Q And you were indicating a fist and kind of the other hand was the floor and just saying that --

A Uh-huh.

Q So it's not as flexible, I guess, is what you're saying?

A Correct.

Q Okay.

A It's an inflexible --

Q Because I -- I have to say, and maybe I need to act differently, but I mean, I would think that -- I know I

do.

But I would think that a lot of people, after they eat, go to their couches and kind of lounge on it and lay down on their left side and watch TV or read or play with the dog.

Are you saying that's something they should not do?

A No, I'm not saying that at all.

Q Okay.

A I'm simply commenting on a physics, that he was on the floor and that's a --

Q Okay.

A -- that is a mechanical stop to the end of the flexible surface, is the floor. That's all.

Q Okay. So but when I -- if I were to eat and lie down on the floor, there would be a mechanical obstruction on the left side of my stomach; right?

A There would be -- if you were on a couch, it'd actually be soft, so probably not. But --

Q Well, I have animals and I'm often on the floor playing --

A I'm sorry about that.

Q Okay. And so is -- I mean, I -- would I then too have a mechanical obstruction?

A I think -- I think you're misunderstanding my terms.

Q Okay.

A All I'm commenting on is that that was the end of the level, because this is the floor, this is how he was laying down.

It's not about a mechanical obstruction that could cause vomiting of -- if you were not in this scenario.

I'm talking about a box, a cube if you will, and the different areas of pressure that were being applied based on the various physical restraints of gravity, frankly.

Q Okay.

And, in your opinion, when you say that there was pressure, Tyler Mattson put pressure on Mr. Cains' stomach, you're talking about when he was doing the abdominal thrusts; is that correct?

A On both the abdominal thrusts, he did do -- put pressure there. And then also from restraint.

I mean -- but, however, he didn't -- however minimal his physical pressure was, if he was restraining him, there was at least some level of pressure coming from his arm.

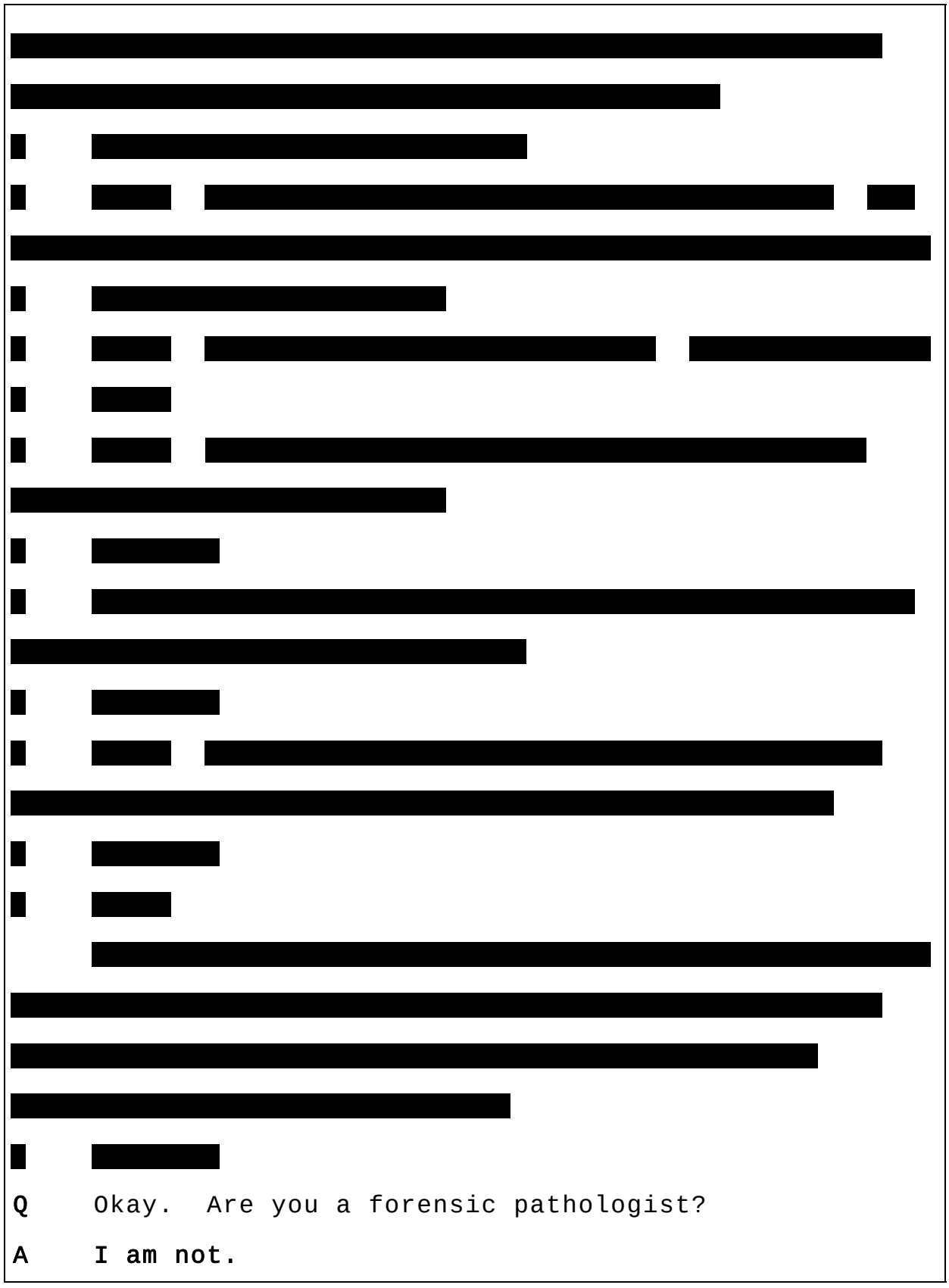
Q You not being there, you don't know how what level that is; correct?

A Nope. I do not. I know that any pressure is some.

Q Almost done here.

A You're fine.

Q [redacted]



Q Okay. Are you a forensic pathologist?

A I am not.

Q Okay. And.
You didn't treat David Cain or know his condition before you were approached to testify in this case; right?
A **Not at all.**
Q Okay.
I think I have no other questions. Thank you.
A **Thank you.**
MR. GILLISPIE: Okay. Give me a couple minutes. I may not have any further questions. Give me a couple minutes, if that's all right.
MR. ROSEN: That's fine. I'm going to stretch, so --
MR. GILLISPIE: Go ahead.
MR. ROSEN: I was going to say, five minutes?
MR. GILLISPIE: Five.
MR. ROSEN: Okay. Sounds good. Thank you.
(WHEREUPON, the record was suspended momentarily and the proceedings resumed as follows, to wit.)
MR. GILLISPIE: Okay. Rich, no redirect. So thank you, Dr. Brown.
THE WITNESS: Thank you.

MR. ROSEN: All right.

Thank you, Dr. Brown.

(WHEREUPON, the proceedings were concluded in the matter at 11:45 a.m.)

* * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Dr. Rickie Brown-Forestiere was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 4th day of November, 2022.

Cris M. Brasuell
_____
CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031

Ricki Brown-Forestiere, MD

[redacted]

EMPLOYMENT

1/2022-Present	Lakeland Regional Hospital Emergency Medicine Physician Department Chair: James Melton, MD	Lakeland, FL
8/2021-Present	HCA - Florida Brandon Hospital Emergency Medicine Physician Supervising Faculty - Emergency Medicine Residency Department Chair: Victor Sasson, MD	Brandon, FL
7/2018-6/2021	Brandon Regional Hospital Emergency Medicine Resident Program Director: Anthony Furiato, DO	Brandon, FL
1/2015-4/2017	Acute Care Solutions Providence Hospital, Emergency Department Physician Assistant, PRN Department Chair: Nicholas Steinour, MD	Waco, TX
6/2013-9/2014	Dell Seton Medical Center at The University of Texas Physician Assistant, Orthopedic Trauma Surgery Department Chair: Drake Borer, MD	Austin, TX

EDUCATION/TRAINING

7/2018-6/2021	Brandon Regional Hospital - University Southern Florida Emergency Medicine Residency	Brandon, FL
9/2014-4/2018	University of Science, Arts and Technology Doctor of Medicine	Montserrat,West Indies
7/2009-11/2011	Touro University Master of Science, Physician Assistant Studies	Henderson, NV
5/2005-12/2007	Northeastern Illinois University Bachelor of Science, Biology and Chemistry	Chicago, IL
8/2003-6/2005	Oakton Community College Major: Biology	Niles, IL
8/2001-5/2002	Michigan State University Major: Theater	East Lansing, MI

Ricki Brown-Forestiere, MD

[redacted]

HONORS

04/2018	Graduated *Magna Cum Laude* Department of Medicine, University of Science, Arts and Technology	Montserrat, West Indies
12/2007	Graduated *Summa Cum Laude*, Department of Science Northeastern Illinois University	Chicago, IL

BOARD CERTIFICATION

2022	American Board of Emergency Medicine ID: 77688
2018	Educational Commission For Foreign Medical Graduates ID: 09658394
2012	The National Commision on Certification of Physician Assistant ID: 110245

CERTIFICATIONS

ATLS, ACLS, PALS, BLS, USMLE I, USMLE 2CK, USMLE 2CS, USMLE 3

LICENSURE

4/21-Present	DEA: FB0133330
2/2021-Present	Florida Medical License ID: ME149105
7/2018-6/2022	Florida Training Physician Medical License ID: TRN27408
10/2017-12/2018	California Physician Assistant Board ID: 54991
8/2012-2/2018	Texas Medical Board; Physician Assistant, ID: PA07947

RESEARCH EXPERIENCE

2020	Brown-Forestiere R, Furiato A, Foresteire N P, et al. (May 11, 2020) Acute Appendicitis: Clinical Clues and Conundrums Related to the Greatest Misses. Cureus 12(5): e8051. DOI 10.7759/cureus.8051
2005-2007	Synthetic pathways and variations in feedstock for production of Biodiesel Ana Fraiman, PhD, Veronica Palmer, PhD, Northeastern University, Chicago, IL
2006-2007	Effects of Melatonin on rapidly dividing, HPV+ cervical cancer derived HeLa cells Terrance Puryear, PhD, Northeastern Illinois University, Chicago, IL

ABSTRACT PRESENTATION

2007	**Brown R**, Anderson M, Stoyan A, Puryear T, PhD. "Effects of Melatonin on rapidly dividing, HPV+ cervical cancer derived HeLa cells. Poster & Podium at Northeastern Illinois University Student Research Symposium, Chicago, IL. April 24, 2007

LEADERSHIP

2022	ACEP Leadership & Advocacy Conference -Lobby senators: Physician and patient centered policy -Political Affairs Focus Groups	Washington DC
2021-Present	Supervising faculty - Emergency Medicine Residency	Brandon, FL

Ricki Brown-Forestiere, MD

[redacted]

LEADERSHIP

2019-2021	Brandon Regional Hospital - Emergency Residency - Resident Mentor	Brandon, FL
2013-2018	University of Science, Arts and Technology - Student Mentor	Montserrat, West Indies
2013-2015	Central Texas Physician Assistant Society - Physician Assistant Student Preceptor	Waco, TX
2009-2011	Touro University - Student Council: Class President, Physician Assistant	Henderson, NV
2005-2007	Northeastern Illinois University - Student Council: Treasurer	Chicago, IL
2006-2007	Northeastern Illinois University - Student Council: Volunteer Event Coordinator	Chicago, IL
1999-2001	Niles West High School - Gymnastics Team Captain	Skokie, IL

TEACHING EXPERIENCE

2022	Brandon Regional Hospital -Emergency Medicine Residency Faculty lecture: -July 2022: EM Advocacy "What are you fighting for"	Brandon, FL
2020	Brandon Regional Hospital EMS: Fundamentals, Fellowship, Future	Brandon, FL
2018	Brandon Regional Hospital Toxicology Lecture: Cocaine and Other Sympathomimetics	Brandon, FL
2018	EM Clerkship Podcast Episode Summary Guide	
2016	University of Science, Arts and Technology Anatomy Lab Assistant	Miami, FL
2014	University of Science, Arts and Technology Renal Lecture: Renin Angiotensin Aldosterone System Renal Lecture: Diuretic Pharmacology	Dallas, TX
2005-2007	Northeastern Illinois University Organic & Inorganic Chemistry Biweekly Review Lectures	Chicago, IL
2005-2006	Northeastern Illinois University Organic Chemistry Lab Assistant	Chicago, IL
2004-2005	Oakton Community College - Inorganic Chemistry Lab Assistant	Chicago, IL

ADMINISTRATIVE

2016	University of Science, Arts and Technology - University Web Design Team: Content	Montserrat, West Indies
2010-2011	Touro University - Student Clinical Coordinator	Henderson, NV

Ricki Brown-Forestiere, MD

[redacted]

2009-2011	Touro University - Curriculum Develop Committee	Henderson, NV

VOLUNTEER

2013	Balinese Women's Higher Education Fund - Founder	Candidasa, Bali
2012-2013	Livestrong Cancer Research Challenge	Austin, TX
2012	Gedong Gandhi Ashram Urgent Care Clinic	Candidasa, Bali
2010-2011	Multiple Sclerosis Society - Bike MS 150	San Diego, CA
2010	Justin Timberlake PGA Shriners Children Hospital	Henderson, NV
2010	Susan G. Komen Breast Cancer Walk	Las Vegas, NV
2010	Adolescent Heart & EKG Screening	Henderson, NV
2009-2010	Boys and Girl Club - Health Fair Coordinator	Henderson, NV
2009-Present	Visual Impact - Coordinator & Pediatric Vision Screening	Los Angeles, CA
2005-2007	Red Cross Blood Drive	Chicago, IL
1996-2001	March of Dimes - Finish Line Food Distributor	Chicago, IL

PROFESSIONAL ORGANIZATIONS

2018-Present	Physician's for Patient Protection
2019-Present	National Emergency Medicine Political Action Committee (NEMPAC)
2015-Present	American College of Emergency Medicine (ACEP) -Physician Member -Former Resident/Student Member
2018-Present	Emergency Medicine Residents Association (EMRA) -Former Resident Member
2013-Present	Educational Commission for Foreign Medical Graduates -Certified Physician Member - Former Resident Member
2013-Present	Central Texas Physician Assistant Society - Physician Assistant Student Preceptor - High School Student Observation Preceptor

HOBBIES: Patient advocacy, Emergency physician advocacy, Yoga, National Parks, International Travel

REFERENCES

1) Victor Sasson, MD
   Emergency Department Chair, HCA Brandon Regional Hospital, Fl
   [redacted]

2) Anthony Furiato, DO
   Residency Program Director, HCA Brandon Regional Hospital, FL
   [redacted]

Ricki Brown-Forestiere, MD
[redacted]

3) Kelly Grabbe, DO
Residency Assistant Program Director, HCA Brandon Regional Hospital, FL
[redacted]

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

Prevention of Choking and Aspiration

Arkansas
State Claims Commission
FEB 16 2023
RECEIVED



Choking Hazards

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

The Office for People With Developmental Disabilities (OPWDD) recognizes that individuals with developmental disabilities present a high risk for dysphagia (difficulty swallowing) which can lead to both choking and aspiration.

This online course reviews preventative measures to decrease the risk of choking and aspiration.



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COURSE EXPECTATIONS

In this course, you will review the following:

- Definitions of choking and aspiration
- Common issues that people with developmental disabilities face when eating or drinking
- Identification and reduction of hazards through observation of the person and their environment
- Interventions to reduce the risk of choking and aspiration
- Appropriate first aid responses to an incident

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DEFINITIONS

CHOKING

Choking is the blocking of the airway by foods, liquids or foreign objects.

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DEFINITIONS

ASPIRATION

Aspiration is the inhaling of foods, liquids or foreign objects into the lungs. This is also known as "going down the wrong pipe".

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COMMON ISSUES - 1 of 3



For people with developmental disabilities, common issues exist that place a person at risk for Choking and Aspiration:

- The person has decreased muscle coordination and/or tone which is causing problems with their chewing or swallowing
- The person has difficulty holding their head up or sitting up straight
- The person has impaired mobility which leaves them unable to properly position themselves for adequate swallowing

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COMMON ISSUES - 2 of 3

- The person has been diagnosed with Gastroesophageal reflux disease, commonly referred to as GERD or acid reflux
- The person has dental concerns or problems
- The person takes medications that affect the muscles of the throat or mouth and cause delayed swallowing

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COMMON ISSUES - 3 of 3

- The person has poor self-eating skills and is prone to food stuffing or rapid eating
- The person has difficulty swallowing anything with inappropriate fluid or food consistencies
- The person is assigned a staff team member who has not been trained in supporting people with their eating/drinking

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PREVENTION IS CRITICAL

- Some incidents are completely preventable
- Mealtime can be pleasurable for some and a difficult time for others
- If we identify problems and develop interventions early, we can ensure the health and safety of individuals and make eating and drinking a pleasant experience

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YOUR CHALLENGE!!



- The greatest error made by most treatment teams is failing to identify the source of the real eating/drinking problems
- Treatment Teams should routinely consider a wide range of potential causes
- Intervention and prevention strategies should be identified and noted in the ISP, CFA, any risk assessments and Dining Plans
  - How a person eats should be discussed during the Interdisciplinary Service Planning session, and, if risks are present, a good plan of prevention should be discussed, written down, and shared with all staff that support the individual including day program staff

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OBSERVATION



Observation is the greatest incident prevention tool you have. When helping an individual eat or drink make sure your attention and focus stays on the individual.

What to observe:

- Does someone else put food or fluid into this person's mouth?
- Does this person cough or choke during or after finishing their food or beverage?
- Does food fall (or fluid drool) out of this person's mouth?

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OBSERVATION



- Does this person regularly refuse liquids?
  - Answer "yes" if, for example, they will not drink for certain staff or if they like drinks that are only thick or only thin
- Does this person regularly refuse food?
  - Answer "yes" if, for example, they will not eat for certain staff or they do not like certain consistencies

Important:
If an individual's eating or drinking pattern changes please notify the nurse or supervisor immediately

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OBSERVATION



- Does this person have a medical condition such as cerebral palsy, acid reflux, difficulty swallowing or hiatal hernia?
- Does this person have chronic chest congestion, frequent pneumonia, rattling when breathing, persistent cough or does this person chronically use cough or asthma medication?
- Does this person complain of chest pain or heart burn or have small, frequent vomiting (especially after meals) or frequent or wet burping?
- Does this person eat or drink too rapidly or stuff food into their mouth that may cause choking?

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OBSERVATION

- Does this person have extreme food seeking or liquid seeking behavior that may cause injury to them?
- Does this person engage in pica behavior?
  - Some persons with developmental disabilities have a condition called pica that causes them to eat non-edible items such as rubber gloves, batteries, cigarette butts, or paper. It is very important to pay close attention to the environment of the home if there is an individual with pica living there.

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INTERVENTIONS are methods to help reduce the risk of choking and aspiration

- Know the individual's written Dining Plan
- Prepare the appropriate food texture and liquid consistency per physician's order
- Only trained staff are to assist with eating
- If there are swallowing difficulties consult with a nurse or supervisor immediately
- Carefully stop the individual from eating if the person coughs, chokes, or gags
- Call for help and apply first aid, if needed, to ensure the safety of the individual

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INTERVENTIONS

- Maintain a slow pace of eating and decrease the size of bites
- Be sure individual is seated for meals and snacks in proper sitting position to encourage safe swallowing
- Do not engage in power struggles with persons that have behavioral issues when eating
- Maintain a calm environment while eating and drinking

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SUPERVISION



- Supervision is critical for choking prevention
- Supervise all individuals when they are eating and/or drinking at meals, snack time, medication administration, in program or in the community:
  - movies
  - picnics
  - ball games
  - restaurants

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TRAINING PROTOCOLS

- Staff should be trained in prescribed food and liquid consistencies
- If there is any possibility a person is choking, do not wait, call 911 or activate the Emergency Medical Services (EMS) and assist the individual immediately by applying choking interventions per your First Aid training
- If a person is assigned to one-to-one staffing, staff must follow the one-to-one protocol
- Staff should be trained in the Dining Plan for each individual they support

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Universal Sign for Choking

- Call for Help
- Use your first aid training
- Seek medical treatment



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COURSE REVIEW QUESTIONS

Your training is nearly complete, however, to ensure you take away the most important points you will now test your knowledge with review questions.

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QUESTION 1 of 4

1. If there is any possibility a person is choking:

- A. Call 911 or activate EMS
- B. Assist the individual immediately
- C. Wait for the individuals to ask for help
- D. Both A & B are correct
- E. None of the above

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QUESTION 2 of 4

2. Walking around while eating can increase the risk of choking.

- True
- False

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QUESTION 3 of 4

3. Any time a person with a developmental disability is eating, you should (choose all that apply):

- ☐ A. Leave the room if they ask for privacy
- ☐ B. Be sure they are seated while eating
- ☐ C. Allow them the freedom to eat how they wish
- ☐ D. Ensure that their food is cut up properly
- ☐ E. Encourage them to eat slowly

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QUESTION 4 of 4

4. If a person's eating or drinking pattern changes you should do the following:

- ○ A. Cut their food into smaller pieces
- ○ B. Offer the person additional fluids
- ○ C. Notify the nurse or supervisor immediately
- ○ D. Spoon feed the person to complete the meal

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ACKNOWLEDGMENTS

We acknowledge The Division of Developmental Disabilities at the Arizona Department of Economic Security for allowing us to adapt their e-learning course to develop the course that you just completed.

Ricki Brown-Forestiere, MD

[redacted]

EMPLOYMENT

1/2022-Present	Lakeland Regional Hospital Emergency Medicine Physician Department Chair: James Melton, MD	Lakeland, FL
8/2021-Present	HCA - Florida Brandon Hospital Emergency Medicine Physician Supervising Faculty - Emergency Medicine Residency Department Chair: Victor Sasson, MD	Brandon, FL
7/2018-6/2021	Brandon Regional Hospital Emergency Medicine Resident Program Director: Anthony Furiato, DO	Brandon, FL
1/2015-4/2017	Acute Care Solutions Providence Hospital, Emergency Department Physician Assistant, PRN Department Chair: Nicholas Steinour, MD	Waco, TX
6/2013-9/2014	Dell Seton Medical Center at The University of Texas Physician Assistant, Orthopedic Trauma Surgery Department Chair: Drake Borer, MD	Austin, TX

EDUCATION/TRAINING

7/2018-6/2021	Brandon Regional Hospital - University Southern Florida Emergency Medicine Residency	Brandon, FL
9/2014-4/2018	University of Science, Arts and Technology Doctor of Medicine	Montserrat,West Indies
7/2009-11/2011	Touro University Master of Science, Physician Assistant Studies	Henderson, NV
5/2005-12/2007	Northeastern Illinois University Bachelor of Science, Biology and Chemistry	Chicago, IL
8/2003-6/2005	Oakton Community College Major: Biology	Niles, IL
8/2001-5/2002	Michigan State University Major: Theater	East Lansing, MI

Ricki Brown-Forestiere, MD

[redacted]

HONORS

04/2018	Graduated *Magna Cum Laude* Department of Medicine, University of Science, Arts and Technology	Montserrat, West Indies
12/2007	Graduated *Summa Cum Laude*, Department of Science Northeastern Illinois University	Chicago, IL

BOARD CERTIFICATION

2022	American Board of Emergency Medicine ID: 77688
2018	Educational Commission For Foreign Medical Graduates ID: 09658394
2012	The National Commision on Certification of Physician Assistant ID: 110245

CERTIFICATIONS

ATLS, ACLS, PALS, BLS, USMLE I, USMLE 2CK, USMLE 2CS, USMLE 3

LICENSURE

4/21-Present	DEA: FB0133330
2/2021-Present	Florida Medical License ID: ME149105
7/2018-6/2022	Florida Training Physician Medical License ID: TRN27408
10/2017-12/2018	California Physician Assistant Board ID: 54991
8/2012-2/2018	Texas Medical Board; Physician Assistant, ID: PA07947

RESEARCH EXPERIENCE

2020	Brown-Forestiere R, Furiato A, Foresteire N P, et al. (May 11, 2020) Acute Appendicitis: Clinical Clues and Conundrums Related to the Greatest Misses. Cureus 12(5): e8051. DOI 10.7759/cureus.8051
2005-2007	Synthetic pathways and variations in feedstock for production of Biodiesel Ana Fraiman, PhD, Veronica Palmer, PhD, Northeastern University, Chicago, IL
2006-2007	Effects of Melatonin on rapidly dividing, HPV+ cervical cancer derived HeLa cells Terrance Puryear, PhD, Northeastern Illinois University, Chicago, IL

ABSTRACT PRESENTATION

2007	**Brown R**, Anderson M, Stoyan A, Puryear T, PhD. "Effects of Melatonin on rapidly dividing, HPV+ cervical cancer derived HeLa cells. Poster & Podium at Northeastern Illinois University Student Research Symposium, Chicago, IL. April 24, 2007

LEADERSHIP

2022	ACEP Leadership & Advocacy Conference -Lobby senators: Physician and patient centered policy -Political Affairs Focus Groups	Washington DC
2021-Present	Supervising faculty - Emergency Medicine Residency	Brandon, FL

Ricki Brown-Forestiere, MD

[redacted]

LEADERSHIP

2019-2021	Brandon Regional Hospital - Emergency Residency - Resident Mentor	Brandon, FL
2013-2018	University of Science, Arts and Technology - Student Mentor	Montserrat, West Indies
2013-2015	Central Texas Physician Assistant Society - Physician Assistant Student Preceptor	Waco, TX
2009-2011	Touro University - Student Council: Class President, Physician Assistant	Henderson, NV
2005-2007	Northeastern Illinois University - Student Council: Treasurer	Chicago, IL
2006-2007	Northeastern Illinois University - Student Council: Volunteer Event Coordinator	Chicago, IL
1999-2001	Niles West High School - Gymnastics Team Captain	Skokie, IL

TEACHING EXPERIENCE

2022	Brandon Regional Hospital -Emergency Medicine Residency Faculty lecture: -July 2022: EM Advocacy “What are you fighting for”	Brandon, FL
2020	Brandon Regional Hospital EMS: Fundamentals, Fellowship, Future	Brandon, FL
2018	Brandon Regional Hospital Toxicology Lecture: Cocaine and Other Sympathomimetics	Brandon, FL
2018	EM Clerkship Podcast Episode Summary Guide	
2016	University of Science, Arts and Technology Anatomy Lab Assistant	Miami, FL
2014	University of Science, Arts and Technology Renal Lecture: Renin Angiotensin Aldosterone System Renal Lecture: Diuretic Pharmacology	Dallas, TX
2005-2007	Northeastern Illinois University Organic & Inorganic Chemistry Biweekly Review Lectures	Chicago, IL
2005-2006	Northeastern Illinois University Organic Chemistry Lab Assistant	Chicago, IL
2004-2005	Oakton Community College - Inorganic Chemistry Lab Assistant	Chicago, IL

ADMINISTRATIVE

2016	University of Science, Arts and Technology - University Web Design Team: Content	Montserrat, West Indies
2010-2011	Touro University - Student Clinical Coordinator	Henderson, NV

Ricki Brown-Forestiere, MD

[redacted]

2009-2011	Touro University - Curriculum Develop Committee	Henderson, NV

VOLUNTEER

2013	Balinese Women's Higher Education Fund - Founder	Candidasa, Bali
2012-2013	Livestrong Cancer Research Challenge	Austin, TX
2012	Gedong Gandhi Ashram Urgent Care Clinic	Candidasa, Bali
2010-2011	Multiple Sclerosis Society - Bike MS 150	San Diego, CA
2010	Justin Timberlake PGA Shriners Children Hospital	Henderson, NV
2010	Susan G. Komen Breast Cancer Walk	Las Vegas, NV
2010	Adolescent Heart & EKG Screening	Henderson, NV
2009-2010	Boys and Girl Club - Health Fair Coordinator	Henderson, NV
2009-Present	Visual Impact - Coordinator & Pediatric Vision Screening	Los Angeles, CA
2005-2007	Red Cross Blood Drive	Chicago, IL
1996-2001	March of Dimes - Finish Line Food Distributor	Chicago, IL

PROFESSIONAL ORGANIZATIONS

2018-Present	Physician's for Patient Protection
2019-Present	National Emergency Medicine Political Action Committee (NEMPAC)
2015-Present	American College of Emergency Medicine (ACEP) -Physician Member -Former Resident/Student Member
2018-Present	Emergency Medicine Residents Association (EMRA) -Former Resident Member
2013-Present	Educational Commission for Foreign Medical Graduates -Certified Physician Member - Former Resident Member
2013-Present	Central Texas Physician Assistant Society - Physician Assistant Student Preceptor - High School Student Observation Preceptor

HOBBIES: Patient advocacy, Emergency physician advocacy, Yoga, National Parks, International Travel

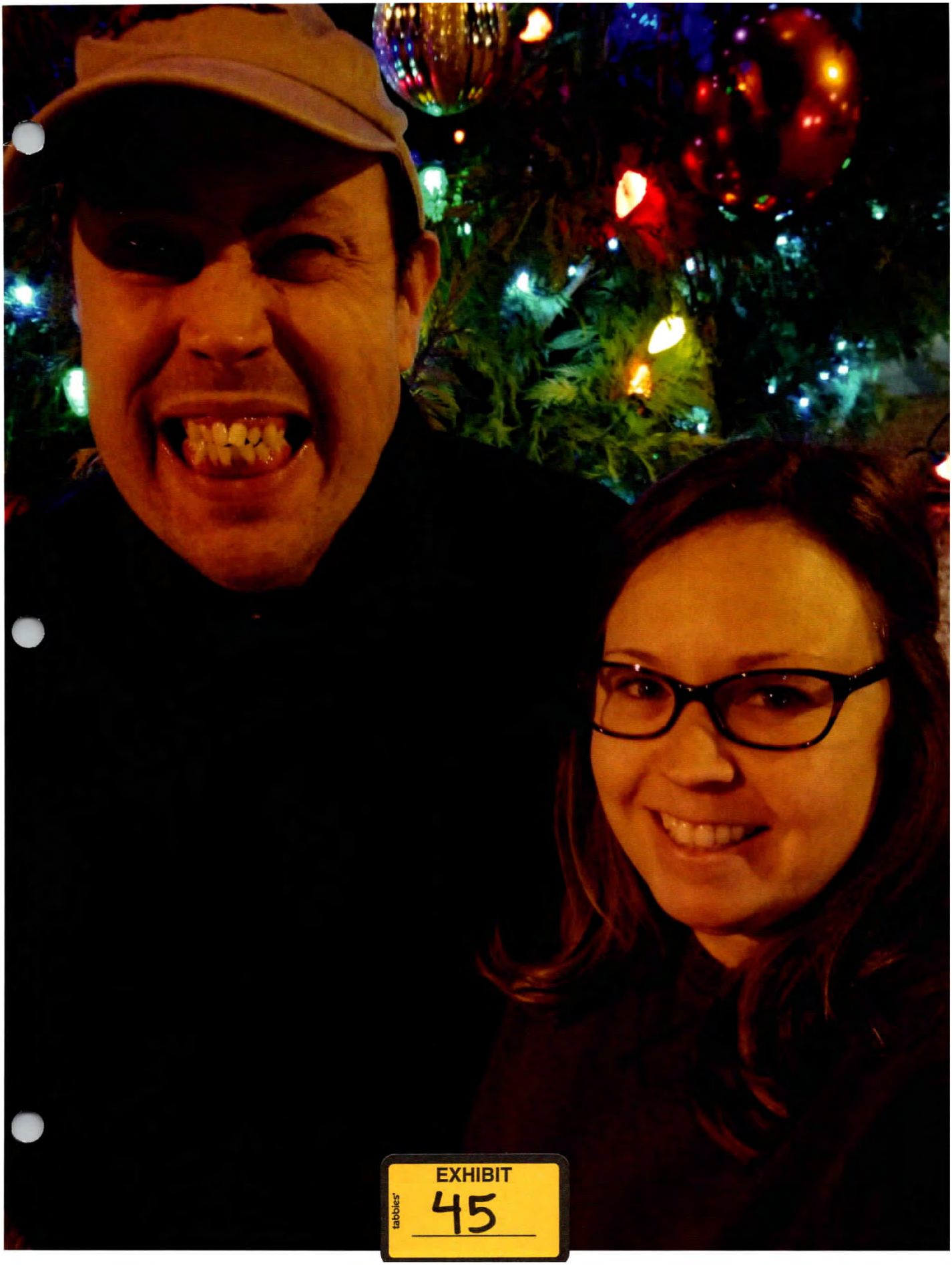
REFERENCES

1) Victor Sasson, MD
   Emergency Department Chair, HCA Brandon Regional Hospital, Fl
   [redacted]

2) Anthony Furiato, DO
   Residency Program Director, HCA Brandon Regional Hospital, FL
   [redacted]

Ricki Brown-Forestiere, MD
[redacted]

3) Kelly Grabbe, DO
Residency Assistant Program Director, HCA Brandon Regional Hospital, FL
[redacted]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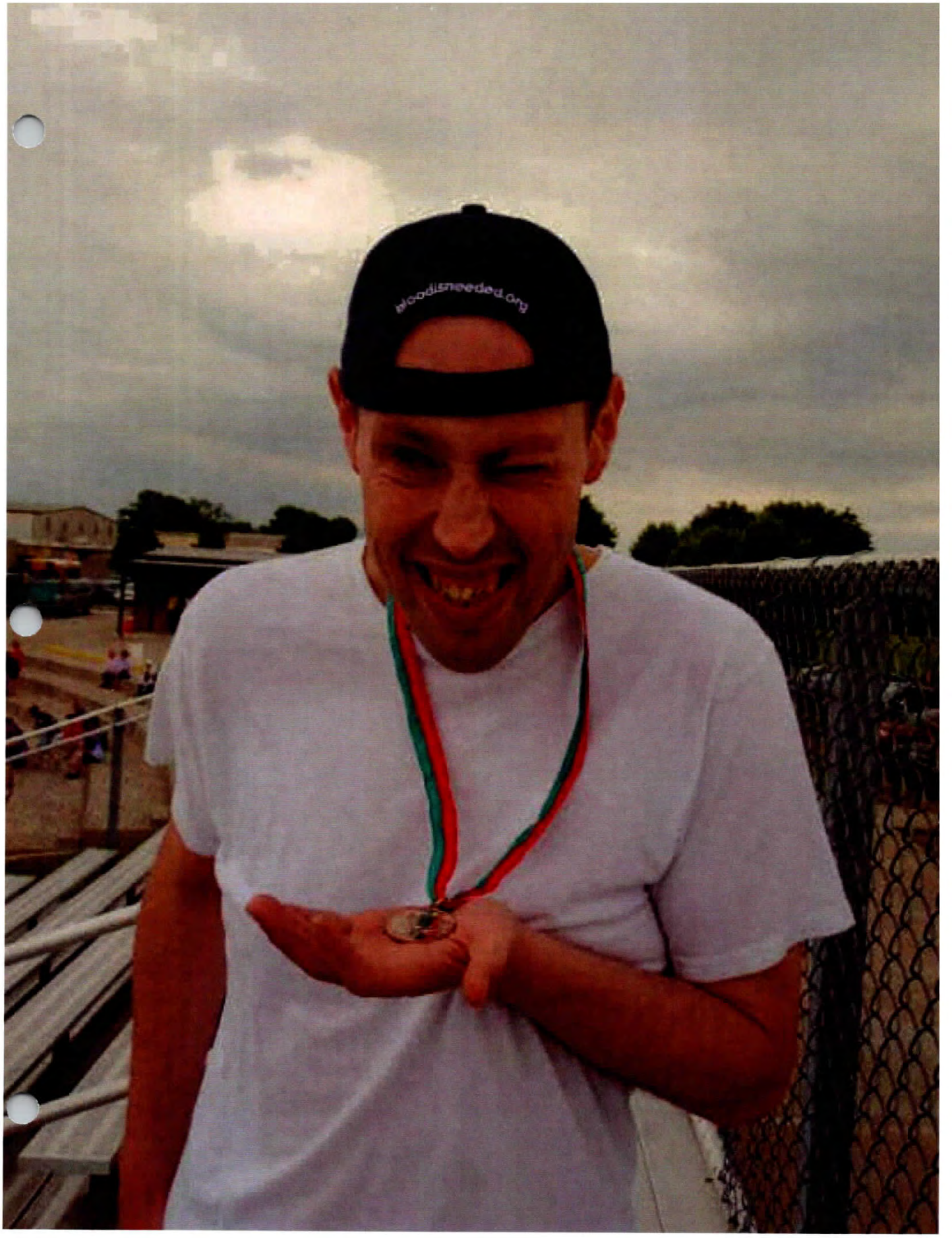
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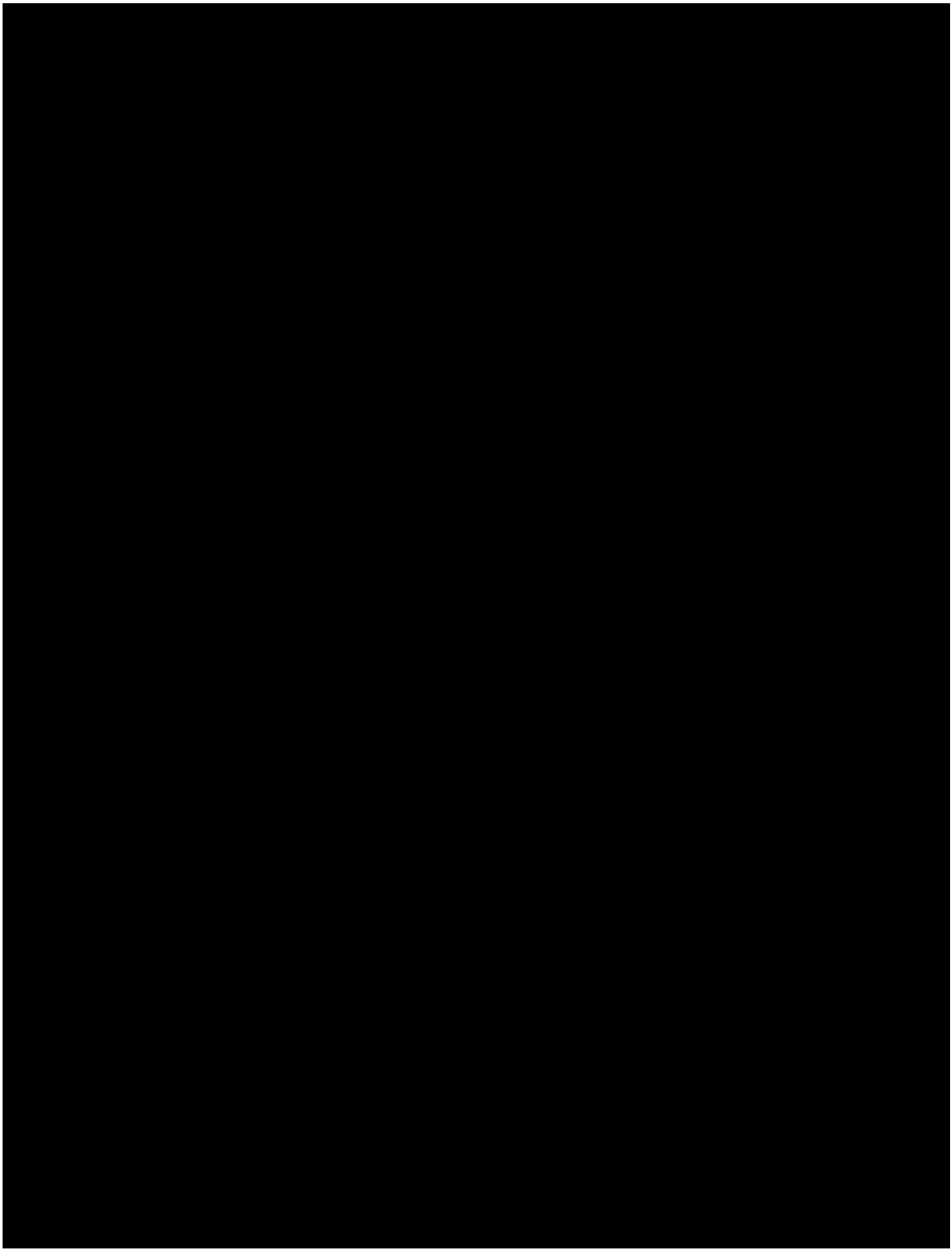

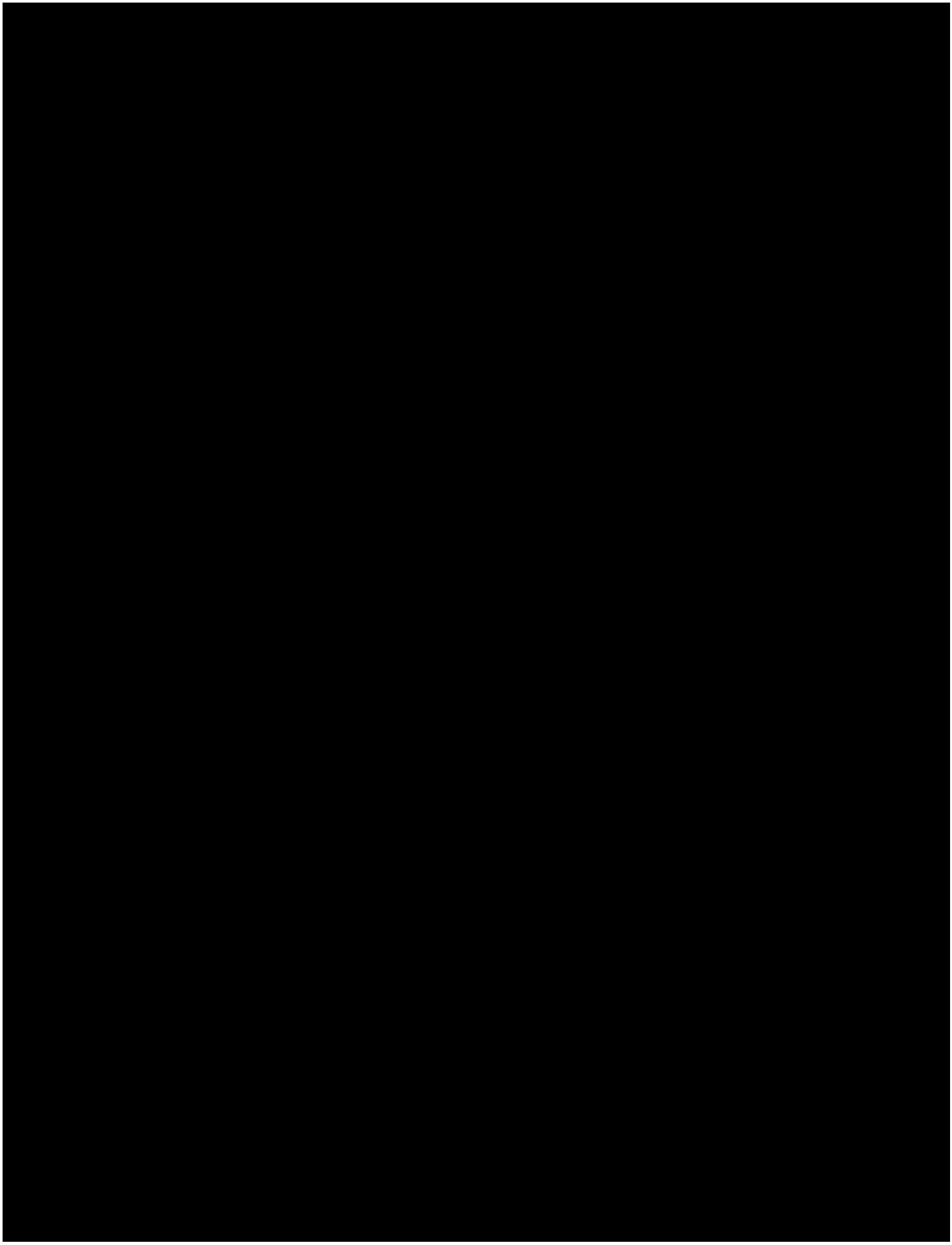

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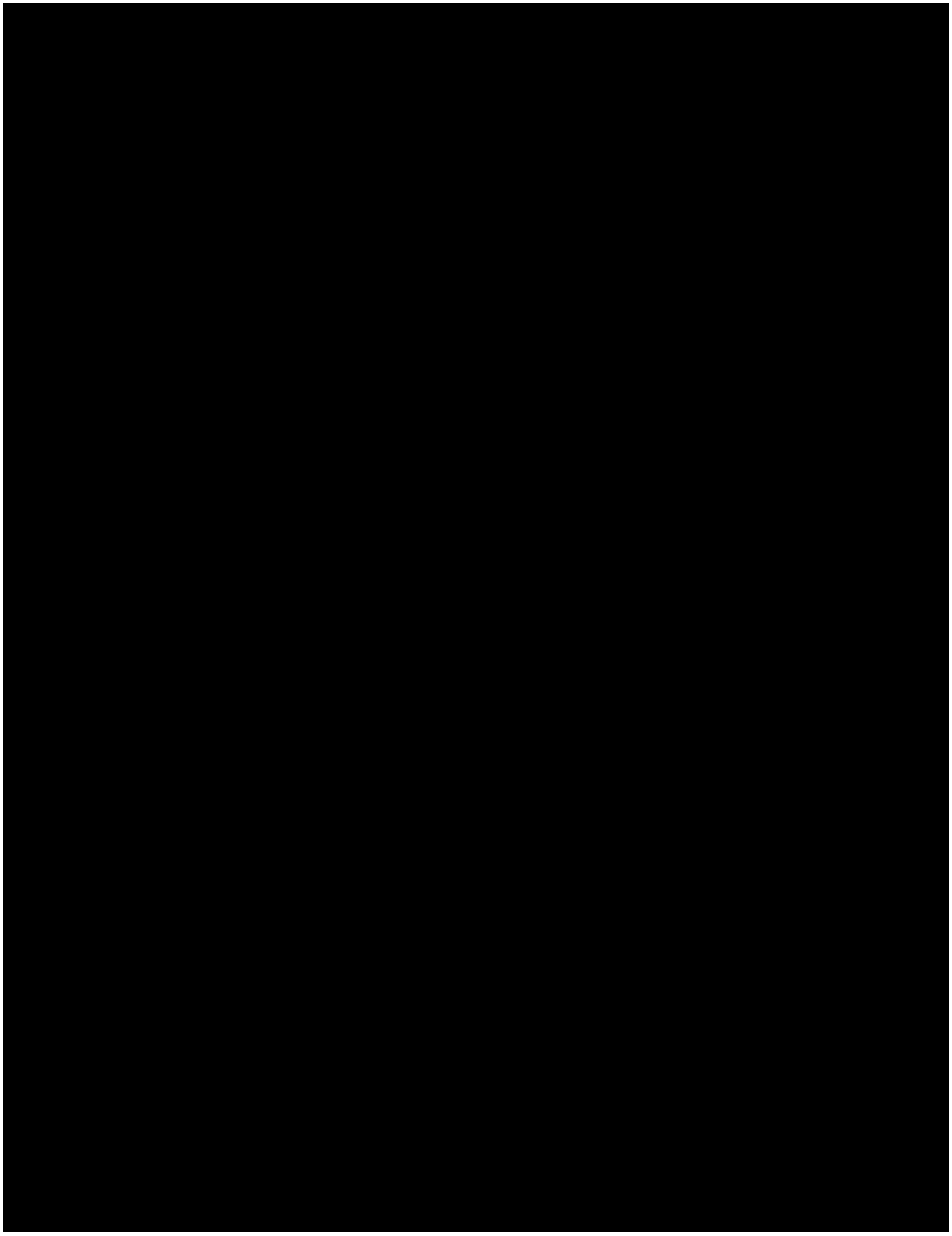

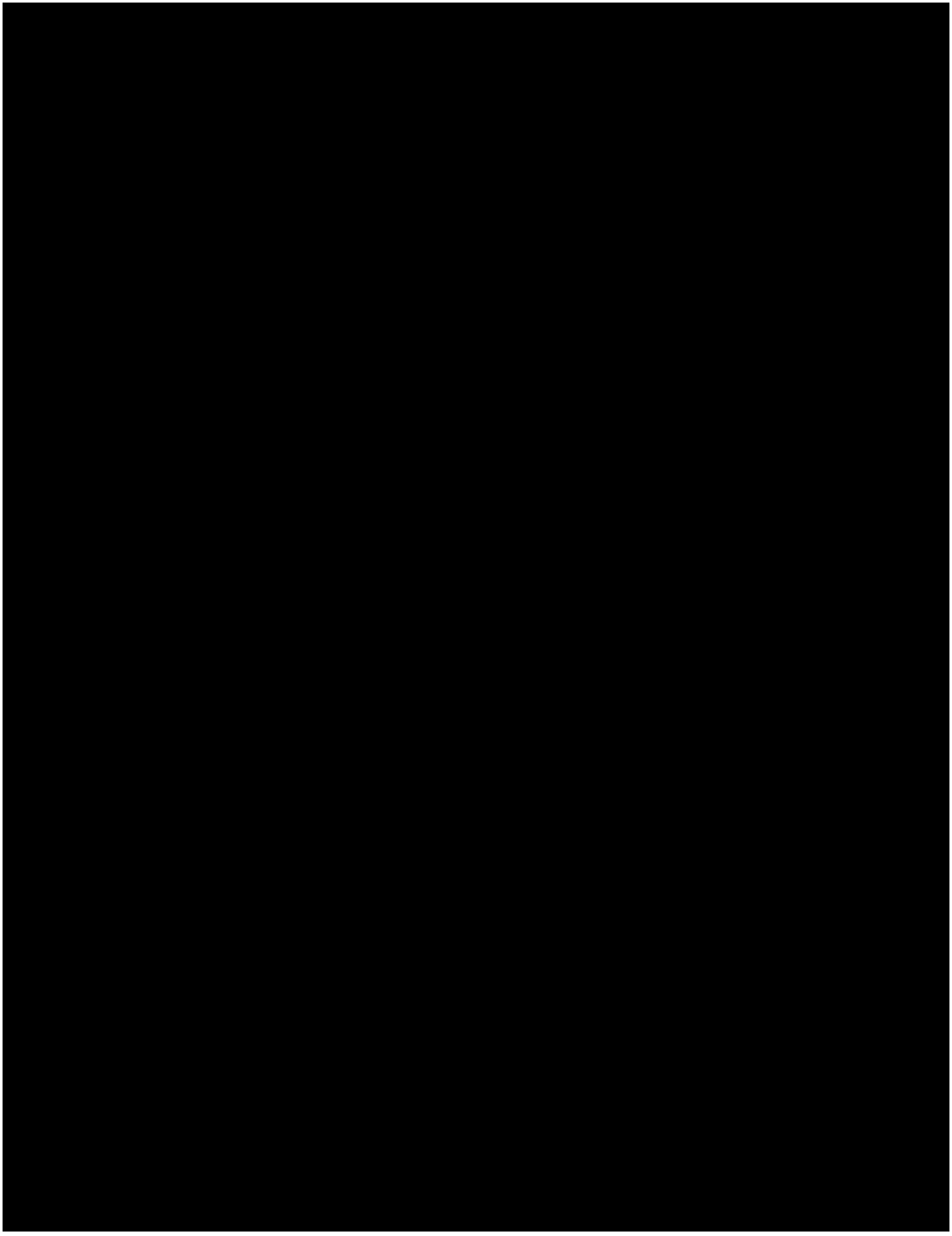

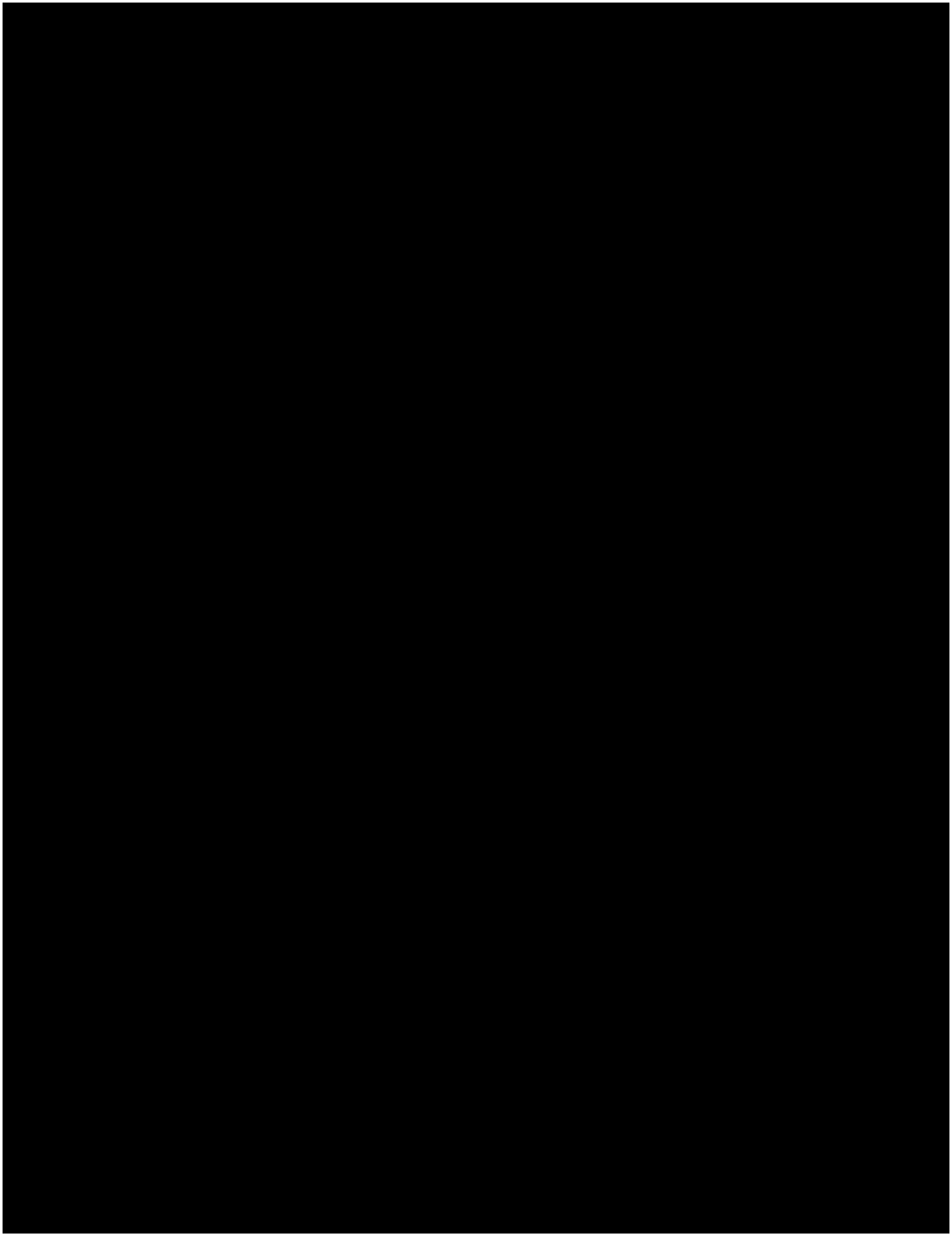

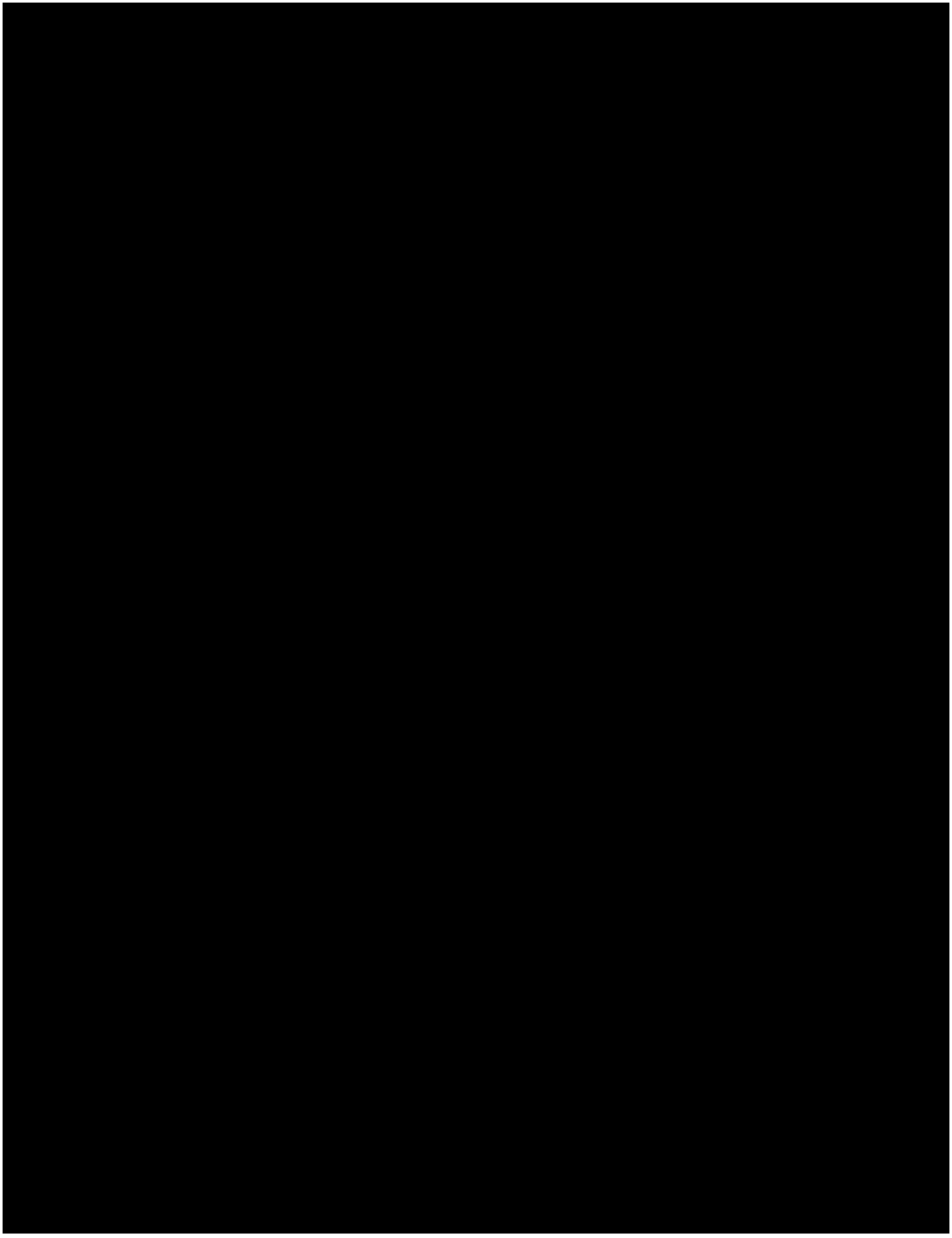

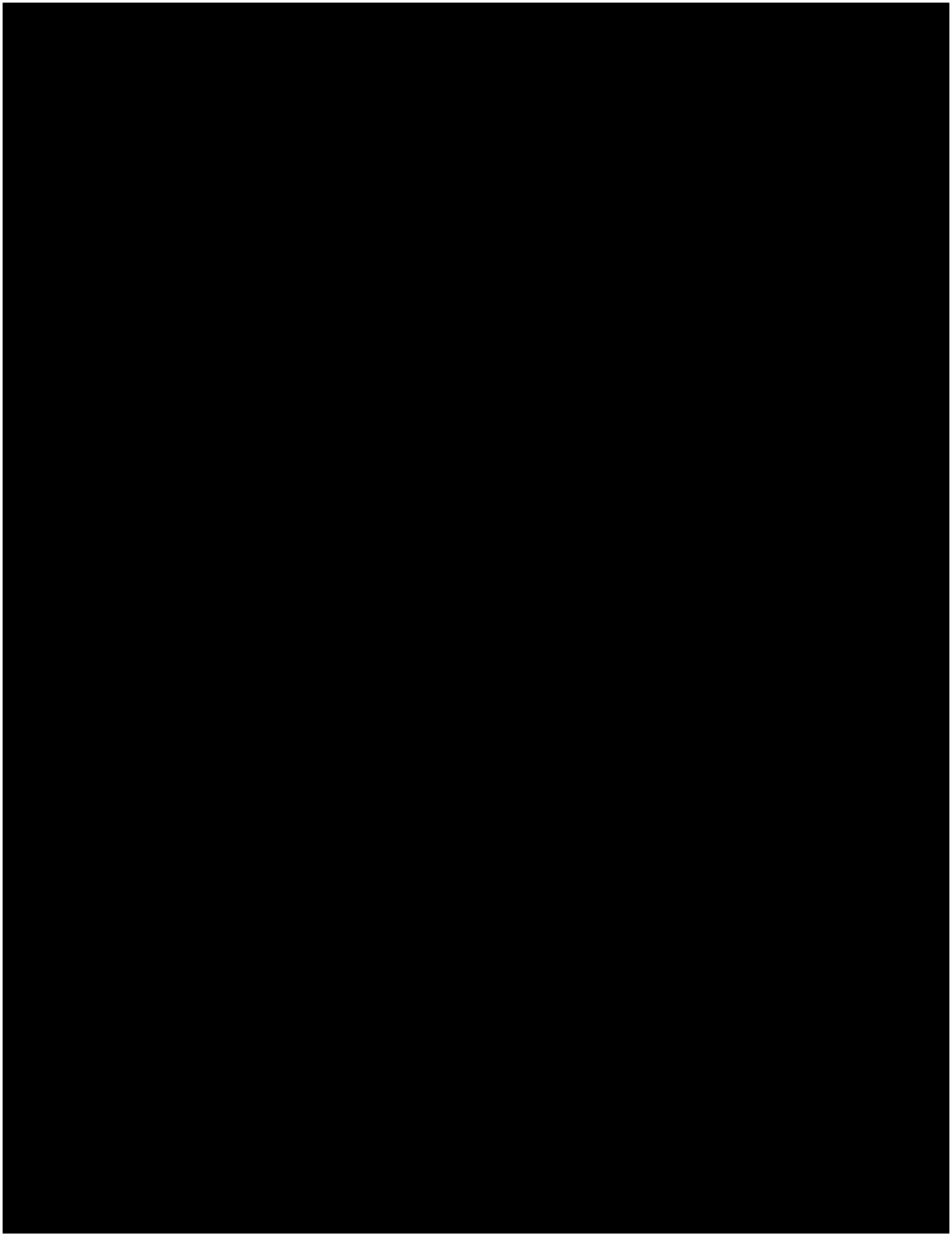

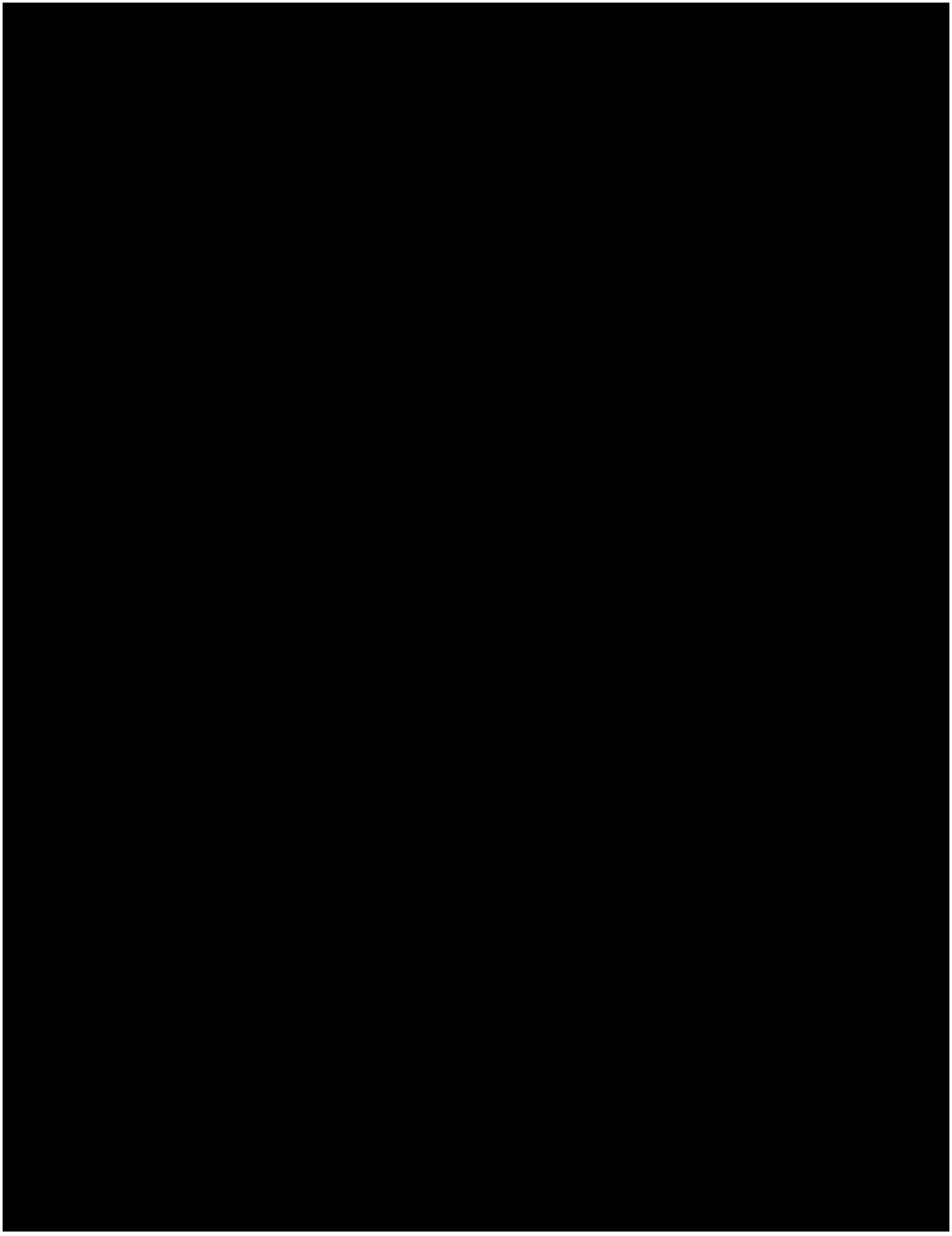

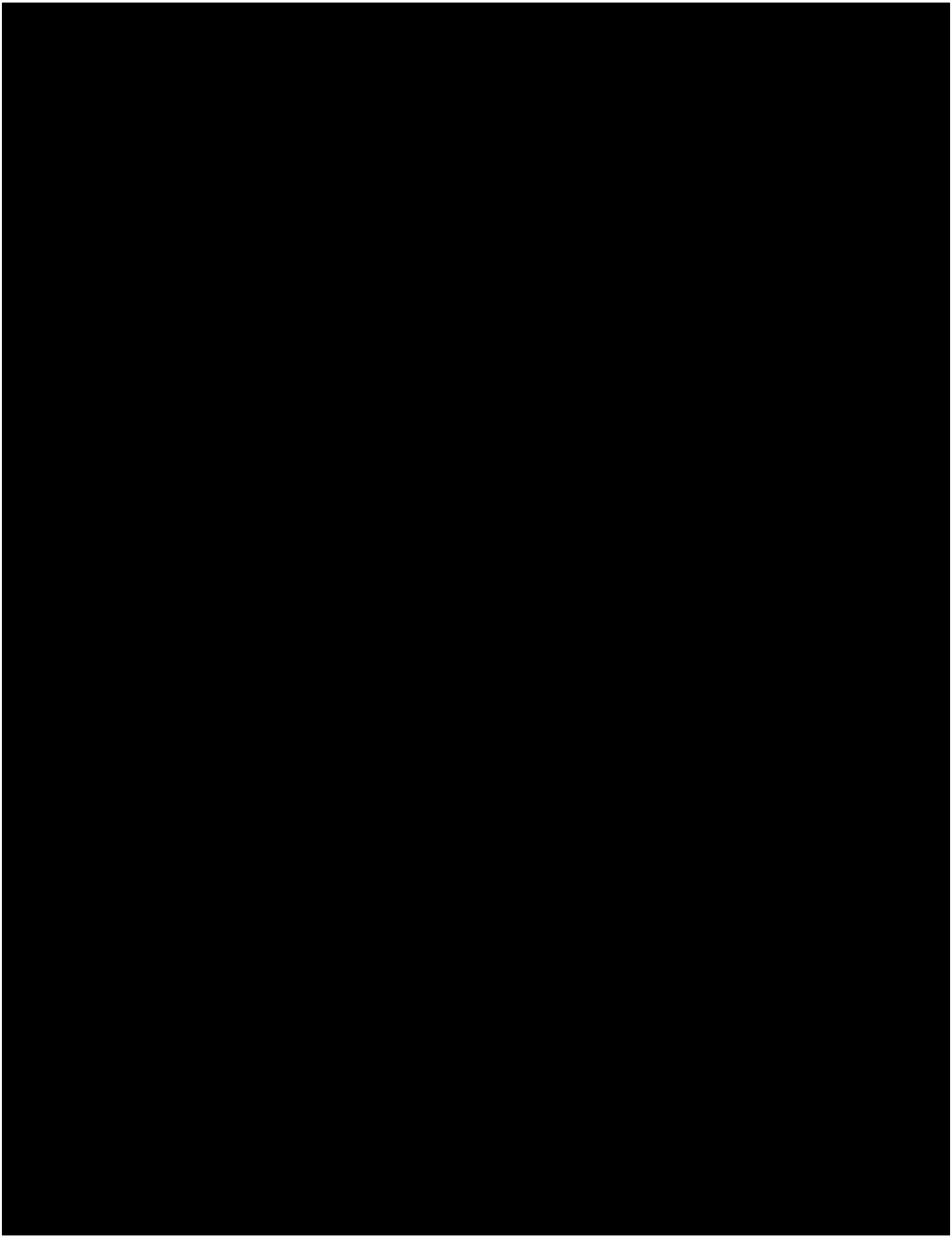

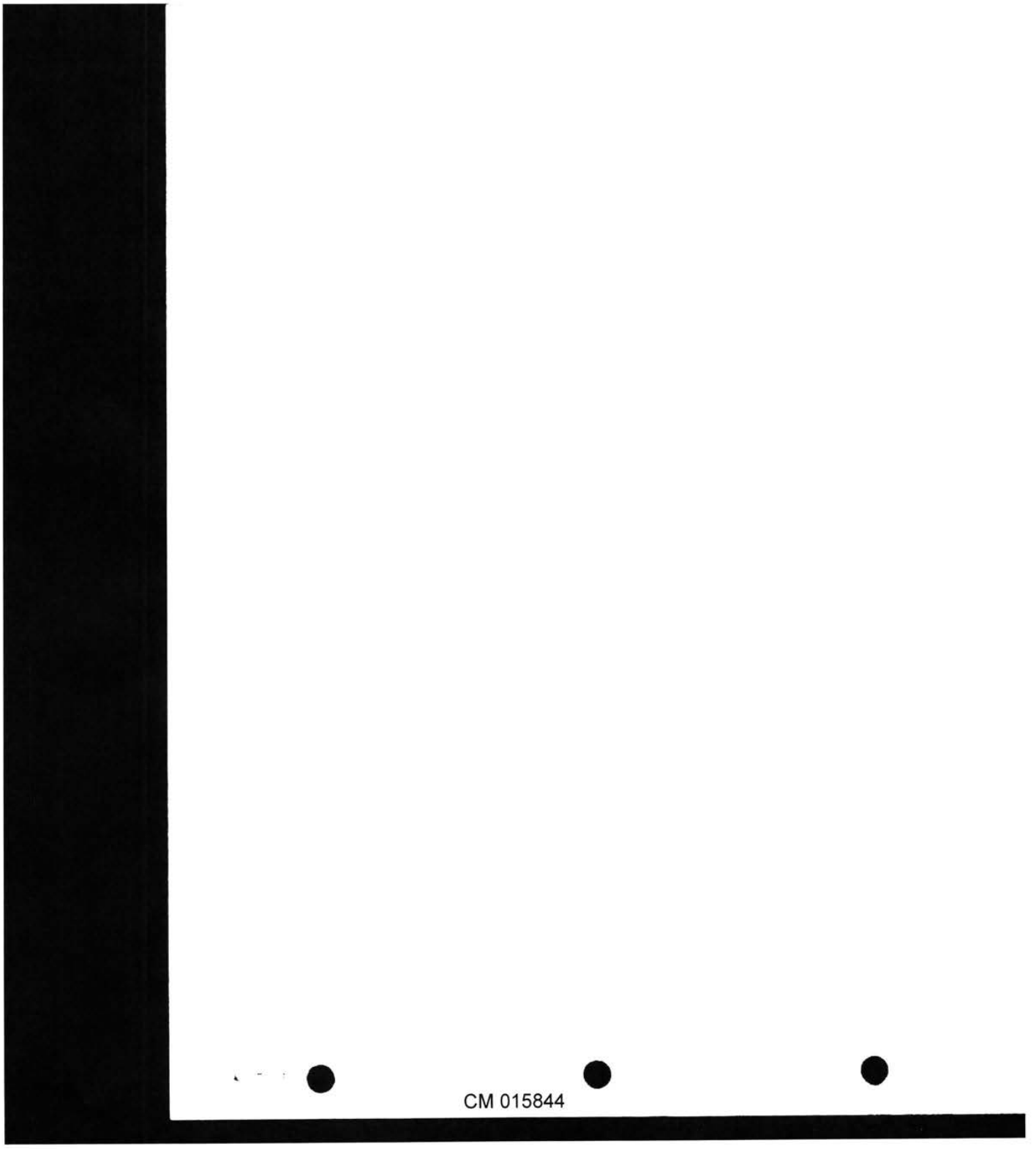
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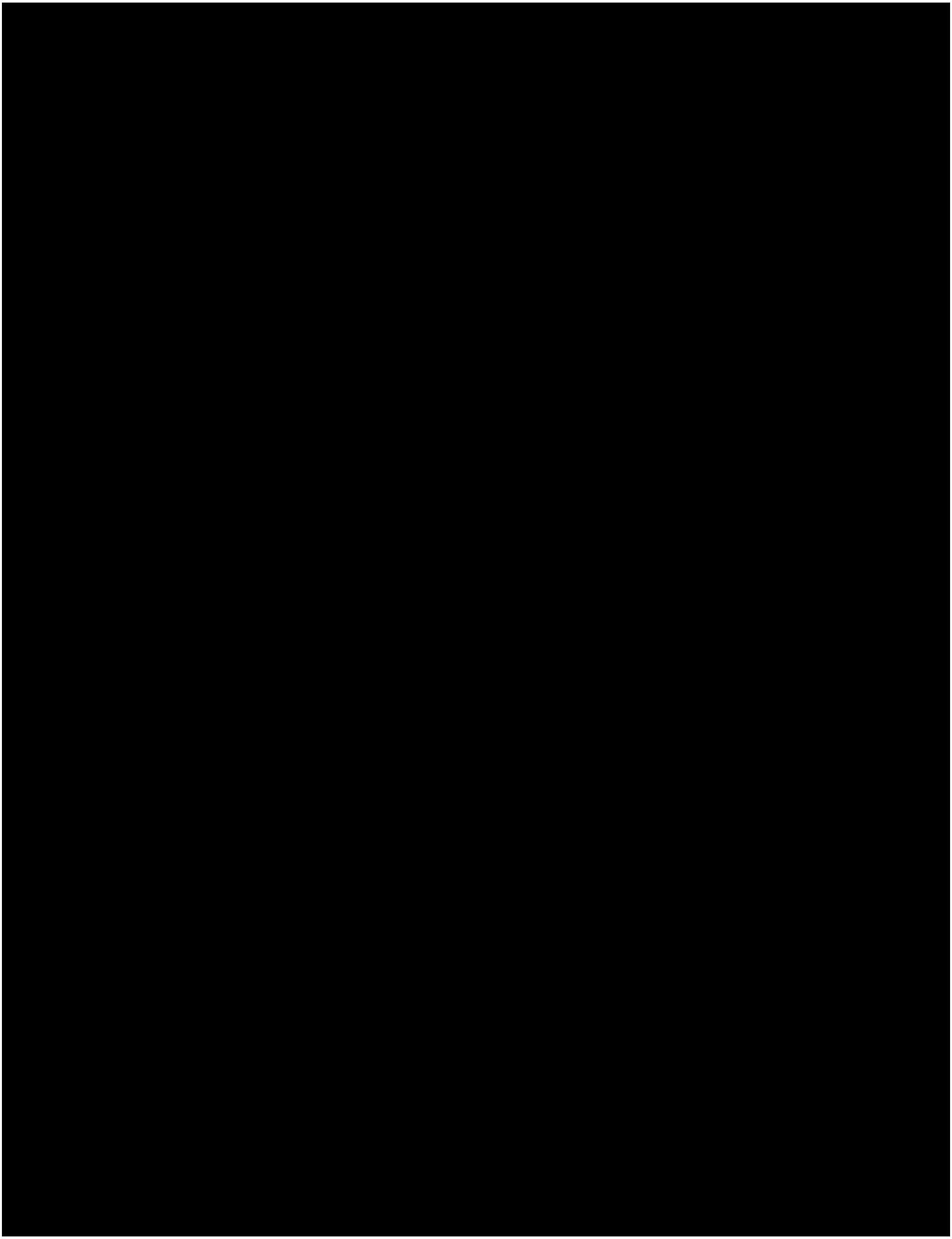

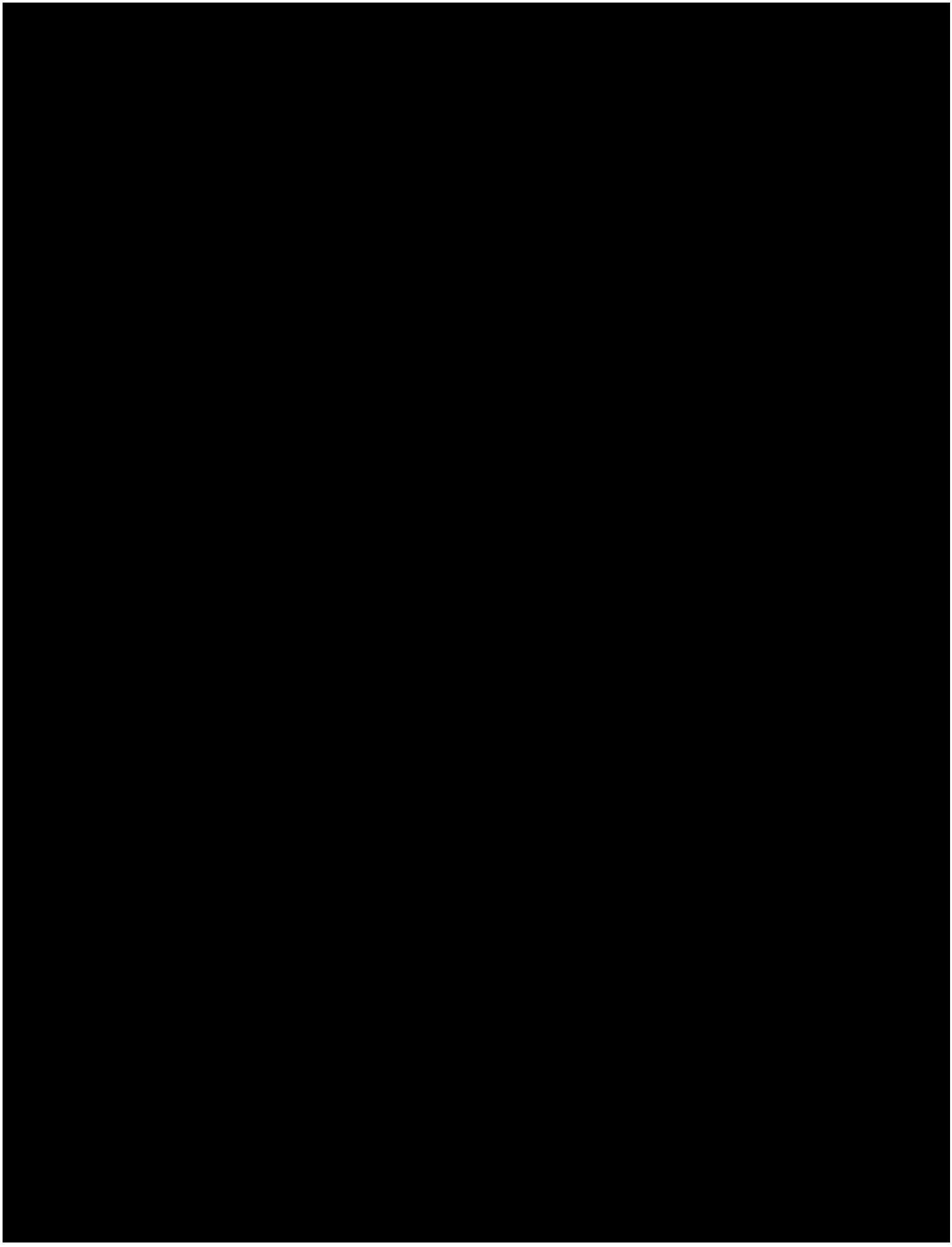

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS — CLAIMANT

VS. CLAIM NO. 220374

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) — RESPONDENT

ORAL DEPOSITION

OF

RHONDA HARRIS

(Taken July 21, 2022, at 2:04 p.m.)

APPEARANCES

(ALL APPEARANCES VIA VIDEOCONFERENCE)

ON BEHALF OF THE CLAIMANT:

JOSHUA D. GILLISPIE, ESQUIRE
GREEN & GILLISPIE
ONE RIVERFRONT PLACE, SUITE 605
NORTH LITTLE ROCK, ARKANSAS 72114
501-224-0700

ON BEHALF OF THE RESPONDENT:

ERIC COLLINS, ESQUIRE
ARKANSAS DEPARTMENT OF HEALTH
4815 WEST MARKHAM
LITTLE ROCK, ARKANSAS 72205
501-661-2000

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EXHIBITS

(NONE MARKED)

CAPTION

ANSWERS AND ORAL DEPOSITION OF RHONDA HARRIS, a witness produced at the request of the Claimant, taken in the above-styled and numbered cause on the 21st day of July, 2022, before Kristina R. Gray, Arkansas Supreme Court Certified Court Reporter #725, at 2:04 p.m., via Zoom videoconference, pursuant to the agreement hereinafter set forth.

* * * * * * * * * *

STIPULATIONS

IT IS STIPULATED AND AGREED by and between the parties through their respective counsel that the oral deposition of RHONDA HARRIS may be taken for any and all purposes according to the Arkansas Rules of Civil Procedure.

P R O C E E D I N G S

WHEREUPON,

RHONDA HARRIS,

Having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. GILLISPIE:

Q You are Rhonda Harris, right?

A Yes.

Q And you used to work at the Booneville Human Development Center as a residential services-prevocational trainer or teaching assistant, right?

A Yes.

Q And you would encounter David Cains from time to time or fairly regularly in the Stone building; is that right?

A Yes. We got him in the afternoons, yes.

Q Oh, okay. And how many years were you there at the same time David was there? David was there from 2007 until his death in 2020. What years did you work there? Can you hear me?

A Can you hear me?

Q Well, I think we got a connection issue for a second.

A No, it's storming at my house. Sorry.
Q Oh, okay. I'll make it real quick. What years did you work at Booneville?
A Like for the whole time I worked there or just down there at the work area?
Q Just in that work area.
A I would say probably five, six years because I worked up there ten all together, so probably between five and six roughly.
Q David probably would have been there the whole time you were there, right?
A Yes.
Q And you'd see him every day after lunch?
A Yes.
Q Because he would come to work in your building?
A Well, yes, but I wasn't always on the Stone building. There's three different buildings down there that we would work in. We would have to rotate between buildings, but the majority of the time, 80 percent of the time, yes.
Q Okay. I wanted to talk to you about a -- so if you know, as you know, this case has to do with personal restraints and I understand that in -- I believe it would have been in maybe April of 2020, there was a behavioral incident in the Stone building

in the classroom that involved David Cains and you and then a man named Don Carter; is that correct?
A Yes.
Q And does April of 2020 sound about right?
A Yeah. I mean, that's been a while ago. I mean, it was -- I mean, yeah.
Q And my understanding is that during this incident, David had just gotten back from lunch. He was in a bad mood and he was kicking chairs. And then at one point, he got up and picked up one of those combination chair desk deals like children have and threw it.
A Yes.
Q Is that right?
A Yes.
Q And then it didn't hit anybody, but at that point -- it didn't hit anybody, correct?
A Correct.
Q But at that point, you intervened with -- my understanding is that you and Mr. Carter performed a successful intervention, personal hold that did not result in any sort of harm to anybody; is that correct?
A That is correct.
Q And my understanding is that you took him to the ground and then you guys restrained him on the ground for about five minutes until he calmed down.

A Yes.
Q And then you were able to -- he calmed down and y'all were able to let him up and he was fine, right?
A Yes.
Q Could you describe kind of how you guys were able to take him to the ground?
A Well, when he threw the chair, you know, we just come up and like I had him, you know, like by one arm, you know, and he was still swinging the other one, and he was like, "I'm calm, I'm calm, I'm calm," you know, I'm done. And he just like collapsed to the ground and laid -- I mean, he would lay on his belly. So he laid down and I just held his arms like by his wrists down on each side, you know, with him laying flat down and his arms was down by his waist and I would just -- you know, I restrained him by his wrists, you know, got beside him, and Don, you know, was on his knees and just like held his legs down. We let him lay there for a few minutes and he kept saying he didn't feel good, and so I told him, you know, get up, you know, we'll set you back in your chair, and we will contact the nurse, you know, to come evaluate you and check you out. And that's what happened.
Q So in this particular instance, you initiated a personal hold and then he went to the ground himself?

A Yeah. I mean, we didn't force him to the ground or nothing else. I had him by the wrist and like my hand back there on his back, you know. And when he went down, I just -- the hand that was on his shoulder, I took that hand off and grabbed his other wrist, you know, from behind him as he was, you know, on the ground. That way he couldn't flail his arms to try to hit somebody or anything. And I held his wrists while he held his -- and I want to say he held him like by the calves, you know, just like had his arm across his calves down there.

Q Don held him by the calves?

A Yeah. So that way he wouldn't flail.

Q And you told me that whenever you would have to restrain David on the ground, you would try to put him on his stomach?

A I always did. And it's knowing your clients, you know, because like I told you, you know, he could throw up, you know, I mean, on the spot. He didn't give you any warning when he was, you know, going to have a behavior either. I mean, it was a split second. But you've got to learn him. We always made sure that we put him facedown. That way, you know, if he did have any issues, you know, he was already facedown.

Q And that's specifically because he was a known

vomiting threat?
A Yes. He had medical issues going on. I still to this day don't know if the nurses ever found out what exactly was wrong with him, but everybody that worked around him knew that, you know, so you always -- we always -- where I worked, you know, we had the understanding, you know, if you ever took him down, make sure he was facedown. That way if he started to, you know, vomit -- because I don't know -- at first, we thought he just was like -- you know, he could do it, you know, on his own, like just make himself throw up, but then it's become like it happened, you know, regularly, you know, where we were constantly calling the nurses, you know, or medical to have them come evaluate him because that's not normal, you know, for anybody to do. I know they'd send him for some tests and stuff, but, you know, they don't tell us what they find or anything. But just from us every day of being around him, you know, you just learn how to deal with him the best you can to keep anybody, them or yourselves or another client or somebody, from getting harmed.
Q So everybody that was accustomed to David or had been around David and knew David was aware that there was a risk of him vomiting?

A Yes.
Q I think you said at first, you know, you couldn't tell if he was doing this on purpose.
A Yeah, purposefully or not, but, you know, as time went on, you know, and it continued -- and I'm telling you it was months, you know, of this, that he was doing this. They sent him to the doctor, you know, to have tests run and stuff like that, you know, to figure out what was causing him.
Q You eventually determined that this is more likely some sort of medical thing that's going on with him?
A Yeah, because anytime he would drink red -- you know, anything with red in it, he would throw up. You know, within a little bit after that, he would be vomiting.
Q And so that's why you would be very careful to make sure he was laying facedown whenever you used a ground restraint?
A Yes, sir.
Q I assume there were other times where you had to do this where he didn't just initiate going to the ground on his own where you had to kind of gently put him on the ground, right?
A Right. Well, yeah. I mean, there's a few times of that, yeah.

Q And when you would have to --
A But there was always -- you know, there's several people that work down there, so there was always two of us, you know, and you just like -- what we normally do is you grab like -- grab up underneath their arm with your arm on their shoulder, you know, and then you just kind of go down to the ground with them. You just go to the ground. And a lot of times we would do it on their back, and then once we'd get them on their back, then we would roll him over, you know.
Q And then he would just kind of hold there until he calms down?
A Yes.
Q Okay. And Don told me that was a -- in his experience, that was the thing that seemed to work best for David, I think Don said.
A Oh, yeah, because as long as he could see you, you know, I mean, he would still be -- you know, he would be still wanting to fight, but if you would roll him over, you know, where he was facedown and he would just lay his head down for a minute, you know, it would help him, you know, on calming down.
Q Do you recall ever talking with anybody, any nurses or doctors or administrators or really anybody about the vomiting issue?

A Yeah, we talked to the nurses all the time about it.
Q What did they have to say about it? Do you recall? I take it not good?
A Yeah, not good.
Q Tell me.
A They told us for a long time, you know, that it was, you know, him purposely doing it, you know. I mean, this went on for a while before -- we just got to where we would call them every single day, you know, because, I mean, it turned into at least three, sometimes four times a week that he would throw up because we would always get him after he had just freshly ate lunch, you know. And he did not like crowds of people, you know, and that cafeteria is full and we tried for a long time, you know, to have him where he would -- you know, after he left his work area that morning, you know, to go back to his living area and eat there, you know, and then send him down to us. And they wouldn't go for that either because they said once they sent him back to the dorm, you know, then it was a fight to get him out of there to go back to work, so they didn't want to start that.
But yeah, I mean, we just got to where, you know, every afternoon we would -- you know, when he would



place up there, like you can -- you know, we see them and deal with them every single day on a daily basis. And you go to one of them and tell them like something's not right and they look at you like they're crazy. Well, they're just faking it. They're just faking it. No. You know, when you see these people every single day, you know, and they like look different or they're acting different than normal, something's wrong somewhere, you know, and that is a big deal with that up there, you know, is -- I mean --

Q And the nurses just didn't take this seriously in your opinion?

A No, not at all. Not at all. And I'm sure if I was still up there, it would be the same way, but, I mean --

Q Do you happen to remember specifically which nurses you're talking about?

A No. There were so many of them, I can't recollect exactly like -- I mean, I'm trying to think off the top of my head, but . . .

Q I know there's an Amanda Schmidt, a Deborah Noah, a Kelly King, Angie Nelson. And it's okay if not. I just wondered if any of those -- you had any specific memories of any of them.

A Well, them -- I mean, them are three -- now that

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]





know that he wasn't feeling good. And it become more frequent, so we just got to where we would, you know, contact the nurses. And they would say it was a behavior.

Q We kind of covered this a little bit. I want to go back into how you play into this. So you're over one of the training areas or the job areas; is that correct?

A Yes, I was.

Q What did you guys do in that job area?

A We tore books. You know, we got around recycling because we're the recycling center. We go as far as like Russellville and surrounding counties and we pick up like their textbooks when they get new ones or whatever and we let them tear books. Some of them sort. You know, we get bags of like paper, you know, where they would recycle it and we would let them sort the color from the white. And then other clients that's higher-functioning, they shred that paper and then we take the paper down and put it in a baler and we bale it up and they sell it.

Q Okay. Did you guys do that in the mornings and the afternoons or just in the afternoons?

A No. We did it morning and afternoons, but we have different clients in the mornings and different clients

in the afternoons. I mean, there's a handful that we would have all day, but, you know, he went to Hamp in the mornings and then he would come to us after lunch.
Q Are you aware of him having any issues throwing up after breakfast?
A Yeah.
Q How are you aware of that? Have you seen it yourself or what's your understanding of that issue?
A Well, whenever I worked -- before I worked as the training area, I worked in direct care and I worked at the dorm at the green when he lived at the blue.
Q Okay. I'm asking did you see it yourself or did somebody tell you?
A I mean, I've seen it myself, but, you know, a lot of times if he was throwing up in the afternoons, we would contact, you know, somebody that served breakfast down there and ask them, you know, if he had issues, you know, at breakfast, you know, just to kind of compare if it was something that's been going on, if that was the second time he had thrown out, because once you throw up three times, you know, we're -- I mean, we're supposed to contact medical, you know, but we were trying to keep an eye on it, you know, to see if it was an ongoing issue or not.
Q Okay. And so when you contacted those people from

the morning job, they would say that he had been throwing up?
A Some days he would. Some days he wouldn't.
Q And you previously mentioned that you tried to get him to go eat in his dorm room; is that correct? That's something you guys told him?
A Yes.
Q And they said no because once he got there, it would be really hard to get him to come back out and go to work?
A Yes, they would have a behavior, you know, trying to get him back on the van to come back to work.
Q So he didn't enjoy going to the work site?
A Sometimes he would. I mean, it varied. It depended on how he felt that day. Sometimes he was happy to go and sometimes he wasn't.
Q You also said that nurses didn't take it seriously. Do you recall that?
A Yeah, I do.
Q But you're also saying that BHDC apparently sent him to get checked out with the doctor?
A I can't hear what you're saying. You're breaking up real bad.
Q Okay. I'm saying you also testified that Booneville HDC eventually sent him to the doctors to

have tests done?
A Yes, eventually. Yeah.
Q How long do you believe that took for that to happen?
A Do what?
Q How long do you believe that took for that to happen?
A Several months probably. At least two or three.
Q Thank you. I have nothing further.

FURTHER EXAMINATION

BY MR. GILLISPIE:
Q Real quick. Rhonda, the vomiting, you would mainly notice it after lunch; is that right?
A Yes. That's when I had him. That's when he would come to where we were at, you know, or we'd be in the dining room. You know, he would be sitting there eating, you know, sometimes, you know, and he would get up, you know, and they were taking him out to go to the bathroom, you know, because he was getting sick.
Q And you said that it started happening and it happened pretty regularly and kind of got worse over a period of months. Are you talking about -- would that have been 2020, the months leading up to his death?
A I'm trying to think. Yeah.
Q He died in June of 2020. I'm assuming you're





memos, you know, and e-mails that goes to like my supervisor. When we come in the morning, he would have them laid out on the table, you know, and everybody has to initial it. You know, all the staff that works in that area, you know, we all had to initial at the bottom, you know, that we read, you know, the memo of what it was.

Q Those were e-mails that would come from supervisors?

A No, like medical. You know, on something like that, medical. Like Stacy would send out an e-mail, you know, to all the supervisors, you know, and then the supervisors would make sure that all their staff, you know, read it and then you initialed it at the bottom, you know, letting them know that you read it, so you were aware.

Q Do you recall there being a memo from Stacy on this issue that we're talking about?

A Yeah, I believe there was.

Q Do you have any recollection of what it might have said?

A Well, I knew, you know, with the vomiting, it was, you know, like keeping an eye on him, you know, and this and that, I believe. Then they had come out with one, you know, saying that -- where they had found out





A Well, I worked -- like Audra Delay. I don't know if you talked to her.
Q No, I haven't. The name's come up, but . . .
A Yeah, she was -- I mean, David loved her. She was his like -- he hollered all the time that was his girlfriend. He was going to marry her one day.
Q When you said we realized this was a medical issue and they need to do something about it, is Audra one of the staff members that --
A Yeah, her, Lori Franklin. I mean, everybody that worked at the Stone building.
Q Okay. All right. Well, thank you for your time today, ma'am.
A You're welcome.

(WHEREUPON, the proceedings were concluded in the matter at 2:33 p.m.)

* * * * * * * *

CERTIFICATE

STATE OF ARKANSAS)

)ss

COUNTY OF PULASKI)

I, Kristina R. Gray, Arkansas Certified Court Reporter #725, do hereby certify that the facts stated by me in the caption on the foregoing proceedings are true; and that the foregoing proceedings were reported verbatim through the use of the voice-writing method and thereafter transcribed by me or under my direct supervision to the best of my ability, taken at the time and place set out on the caption hereto.

I FURTHER CERTIFY that in accordance with Rule 30(e) of the Rules of Civil Procedure, review of the transcript was not requested.

I FURTHER CERTIFY that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested, or otherwise, in the outcome of this action, and that I have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original deposition transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties to the action.

WITNESS MY HAND AND SEAL this 31st day of July, 2022.

Kristina R Gray
_____
Kristina R. Gray
Arkansas State Supreme Court
Certified Court Reporter #725

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Files: Site's resident died after restrained

June case preceded state's decision to review use of controls at care centers *by* ***Kat Stromquist*** *| January 31, 2021 at 4:42 a.m.*

3

Follow



Labels on a cabinet in a ward at a psychiatric hospital in Lakewood, Wash., read "flashlights" and "restraints" in this Nov. 18, 2015, file photo.

A man who lived at an Arkansas-run center for people with developmental disabilities died last summer after three staff members restrained him, just a few months before state officials pledged to review physical restraint use at the sites.



The resident died June 13 after having a medical emergency while restrained by Booneville Human Development Center staff members, according to documents that the newspaper obtained under Arkansas' public records law.

He'd been "brought to the ground" as workers grabbed his arms and then "began holding" his legs, a report from a watchdog group to state officials said. The staff noticed he wasn't breathing "approximately

one minute" after he was restrained.

The man, 42, died at a hospital about an hour after the restraint incident began, files show.

His death, not revealed in news reports until now, provides new context for the state's Division of Developmental Disabilities Services' promise in September to review the use of physical restraints and restraint devices in its five human development centers. The devices include padded boards, restraining chairs and wrist wraps.

Committees at work on the policies are scheduled to meet again Feb. 11. Thus far, the state plans to bring in a consultant to observe and interview staff members, begin more robust data tracking, add camera coverage across the facilities and take other steps, the division's director Melissa Stone said in an interview.

Stone stopped short of saying the death was a "trigger" for the review, while explaining that she did not want to downplay the event. The state was influenced by a restraint data assessment that officials undertook during pandemic lockdowns to see if the isolation affected residents.

"Those numbers were high," she said. "We need to reengage ourselves in this."

The review was made public last fall as the Arkansas Democrat-Gazette reported on an apparent pattern of harmful restraint use at two of five centers housing hundreds of people with intellectual and other disabilities. Among them were incidents at the Booneville site in 2019 that broke one resident's arm and caused another to faint when he was placed in a "choke hold," records show.

Records detailing the 42-year-old man's death last summer raise fresh questions about how Arkansas investigates restraint incidents that hurt people in the care centers. Some of those people cannot speak or walk, and many don't have family members who visit or advocate for them, current and former employees say.

In an Oct. 22 report sent to Stone, a Disability Rights Arkansas attorney and advocate described the man's death and offered what amounted to a scathing critique of the state's response. The group is a federally-designated monitor and advocate for people with disabilities.

Writing from medical records, interviews and state files, the seven-page report alleges that first responders and a physician weren't informed that the man was physically restrained, and were instead told that he "was found in the hallway" and had "choked on his lunch" before he was pronounced dead at Mercy Hospital-Booneville.

The man's mother did not learn that he was restrained by the staff until nine days after his death -- "too late for them to request an autopsy," the report said.

Stone responded to the Disability Rights Arkansas report on Nov. 13 with a three-page written proposal to form new committees to "inform restraint practices" used for human development center clients. Her response "isn't intended to argue with your report or point out discrepancies," she wrote to advocates.

In an interview this month, she said cameras in the facility -- the Booneville site had none -- would have helped make the situation "black and white" to her.

"It's very clear that a personal restraint did occur leading up to him passing away -- but I've looked at every document, I've looked at [Disability Rights Arkansas]'s report, I've looked at hospital reports. ... I've not been given any kind of documentation that says the personal restraint did, or did not, lead to the passing of that client," she said.

Disability Rights Arkansas director Tom Masseau wrote in an Oct. 23 email to Stone that the state's initial probe, which did not lead to any findings of wrongdoing by the staff, was "unacceptable." The man's death was a "tragedy that arose from a dangerous and barbaric practice and never should have occurred," he wrote.

State employees who first looked into the death were not asking "the tough questions. ... Your reports are only as good as the person conducting the investigation," he later told the newspaper.

"You want to know what events led to [a death], and what could be done to prevent it."

FOR 'SAFETY'

An ongoing investigation by the newspaper has shed light on problems at the state-run human development center sites, as well as restraint issues. Records show:

- Staff members didn't wear masks or quarantine sick residents in facilities with covid-19 outbreaks.
- Residents with the eating disorder called pica swallowed batteries and latex gloves.
- An "unsupervised" resident, prescribed a "pureed" diet, died after choking on cake.

More than 800 people live at the centers. Many have behavioral health or other health issues in addition to developmental disabilities, and facility workers say it's not unusual for clients to remain in the centers for years.

Generally, the care system for Arkansans with disabilities appears "woefully behind" other states, University of Minnesota Institute on Community Integration Director Amy Hewitt has said. She said many other states have entirely phased out their large institutions that offer "less choice and autonomy and self-determination."

The newspaper has identified the man who died after being restrained last summer, but is not naming him in this article because a family member declined to comment on the record about the incident. An attorney for the family also declined to comment.

After lunch the day he died, the man "headed to the common area kicking, yelling and biting," according to a Sept. 24 report from a state Department of Human Services committee that reviews all deaths of human

development center residents. Three staff members restrained him for "safety," so he was "lying on the floor on [redacted] left side," the report said.

He suddenly started throwing up "and turning cyanotic," meaning his skin became blueish from lack of oxygen, documents show.

A report describes the man's transport via ambulance to the small hospital where he died. Committee members wrote at the time of their report that his official cause of death was "currently unknown," and determined that the "standard of care" was met by the staff.

The man's obituary describes him as a 13-year resident of the Booneville Human Development Center. He loved singing to the Monkees band, taking trips to Walmart and KFC, and participating in the Special Olympics. He graduated from a Pope County high school.

A Logan County deputy coroner listed the man's cause of death as "respiratory arrest" because of "food aspiration, cardiac arrest" in a June 13 report.

The man "was eating lunch at the Booneville Human Development Center where he lived, when some food became lodged in his throat. The Human Development Center staff tried to dislodge what was stuck but were unable to," a narrative portion of the coroner's report reads.

The coroner's report does not mention restraints.

CHANGES WEIGHED

No staff members were disciplined or terminated in the June incident because "there was no finding of inappropriate use of a personal hold/restraint" and life-saving measures were implemented, Stone said in a written statement last week.

She said she cannot "speak to or verify" what information was provided to first responders, but social services staff members who first notified the man's family have "limited information" about incidents, which could have happened just moments before.

Potential changes in investigative practices in the centers are on the table as part of the policy review.

Their eventual goal, state officials say, is to eliminate restraint use at the centers. Interim plans include modernizing outdated cameras at four centers and installing cameras at the Booneville facility for the first time, in part to deter "bad actors," Stone said.

"You can train people all day long, but you can't train people to be kind, and you can't train them to be respectful," she told a reporter. The staff should "understand that you can't hurt these people, because they can't defend themselves."

The overhaul also is likely to remove mentions of restraints as strategies in individual care plans and further train the staff to lessen reliance on restraints as a behavioral tool.

Masseau, the advocate, has worked closely with the state on the changes and said he felt encouraged by the direction of the review. One likely change will allow human development center staffs to call 911 in medical emergencies without seeking approval from administrators, shaving off crucial moments of response time.

He said "follow through" will be most important.

"There has to be a huge cultural shift," he said. "If there is buy-in from the [administrators], but it doesn't get down to staff, it's not going to do any good."

TRIED BEFORE

This is not the first time Arkansas has tried to change restraint usage in its human development centers. A plan aiming to reduce restraints is updated annually, Stone said in September.

In 2016, Disability Rights Arkansas published a report claiming "excessive" restraint use at the Booneville Human Development Center, which advocates said put residents and the staff at risk. Residents "sustained injuries ranging from scrapes and scratches to large, multiple bruises and even broken bones," the group wrote at the time.

Later that year, the state announced further training on restraint usage for staffs and banned the use of an isolation room at the Booneville facility, according to previous reports. An outside consultant also worked on that review, but did not make site visits or speak in depth with the staff, as is planned this year, Stone said.

The state's latest moves to change its practices arise as restraint use in care settings draws attention nationwide. Michigan health regulators announced a ban of several types of restraints in July after a Black teenager had a heart attack while being restrained at a Kalamazoo care center and died, reports said.

Guy Stephens, director of the Maryland-based group Alliance Against Seclusion and Restraint, says restraint use is a civil rights issue that's most likely to impact people with disabilities and people of color.

Research shows that being restrained can make behavior problems worse, he says, by triggering brain activity and trauma that make people more likely to lash out in the future.

More often than not, he added, the interventions are not being used "for life-or-death danger, but rather for situations of noncompliance, disrespect."

In July 2018, Arkansas inspectors cited the Arkadelphia facility when staff members placed two residents in restraints for "staff convenience" when the residents refused to go to work.

They were then "forcibly" taken to a job site, an Office of Long Term Care inspection report said.



Melissa Stone, director of the Division of Developmental Disabilities services at DHS, speaks Thursday August 27, 2020 in Little Rock during a press conference at the state Capitol to announce that DHS is moving 700 families off the wait list for disabilities services. (Arkansas Democrat-Gazette/Staton Breidenthal)



In this file photo Disability Rights Arkansas director Tom Masseau, right, speaks during the Youth Justice Reform Board meeting in downtown Little Rock. At left is fellow board member Paul Kelly. (Arkansas Democrat-Gazette file photo)

Restraint events end in injuries

These are four harmful restraint incidents at Arkansas Human Development Centers of at least 10 identified by the newspaper since 2018. Inspectors said each incident could have physically or emotionally harmed residents



1. Resident's arm fractured after being twisted behind back by staff member in "inappropriate personal restraint hold." 07/31/19

2. Resident with brittle bone disease breaks arm after being "unnecessarily restrained" by staff member. 11/05/19

3. Staff member kicks resident, drags him down a hallway and straps him to restraining board. 09/12/19

4. Staff member holds a resident's wrist and arm in place to restrict him from getting off a treadmill, causing him to fall and injure his knees. 08/17/18

NOTE: Dates are report dates, not incident dates. Arkansas Democrat-Gazette
SOURCE: Department of Human Services inspection reports.

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A public report by

Disability Rights Arkansas, Inc.

January 2016

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Introduction

The State of Arkansas operates five Human Development Centers (HDCs),[1] which are institutional facilities that provide 24-hour residential, medical, and habilitative services to individuals with developmental disabilities.[2] The five HDCs are located in Arkadelphia, Booneville, Conway, Jonesboro, and Warren. As of September 2015, 908 individuals with developmental disabilities reside in the State's HDCs.

Booneville HDC is the oldest property of the five HDCs. The facility is located in Logan County at the former site of the Arkansas Tuberculosis Sanatorium; it is a large facility on 900 acres with many buildings that are almost 100 years old.[3] Booneville HDC has 138 licensed beds for residents and has approximately 300 employees. The facility's annual budget was $16 million for Fiscal Year 2014; however, millions of additional dollars are needed to address the aging physical plant conditions at the facility.[4]

In January 2015, Disability Rights Arkansas (DRA) released a report expressing concerns regarding both the physical plant conditions and the high number of restraints at the facility.[5] DRA recommended closure of Booneville HDC due to the conditions and the excessive use of restraint at the facility. These concerns are in addition to DRA's general concern that Arkansas continues to rely on restrictive institutional care for individuals with disabilities in violation of the integration mandate of the Americans with Disabilities Act as articulated by the United States Supreme Court in *Olmstead v. L.C*, 527 U.S. 581 (1999),[6] while thousands of Arkansans are unable to access services that would allow them to live in their communities.[7]

There is controversy within the State about the continued existence of Booneville HDC, and there has been no movement toward closing the facility. Nevertheless, if the State continues to rely upon Booneville HDC for the care of individuals with developmental disabilities, it must take steps to ensure that the individuals who reside in the facility are free from the unnecessary use of restraint and have access to treatment that eliminates the need for restraint.

Since publication of our January 2015 report, DRA has continued to monitor and review the use of restraints at Booneville HDC. In an effort to evaluate the extent of the restraint activity, DRA reviewed all restraint reports for a sixteen month period and HDC reports, which are submitted quarterly to the Developmental Disability Services Board.[8] DRA talked with facility staff and administrators to discern not only the extent and type of restraints used in the facility but also the efforts to provide programming to reduce restraint incidents. DRA also consulted with an expert in facility practices, including reducing the use of restraint in facilities.[9]

DRA has concluded that the restraint practices at Booneville HDC are both contrary to currently recognized best practices regarding restraints and puts residents and staff at risk of physical and emotional harm. Furthermore, DRA has concluded that the restraint practices at Booneville HDC will not be eliminated without serious scrutiny and comprehensive changes within the facility.[10]

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Regulations and Policies Governing Use of Restraints

Intermediate care facilities for individuals with developmental disabilities, such as Booneville HDC, must meet certain federal standards in order to receive Medicaid reimbursement.[11] The Centers for Medicare and Medicaid Services regulations govern these types of facilities and provide requirements for compliance in order for those facilities to maintain their Medicaid funding. Within those regulations are specific criteria regarding the use of restraints at institutions such as Booneville HDC.

Facilities must "[e]nsure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints."[12] Physical restraints are only allowed as part of an individualized program intended to result in less restrictive means of managing a specific behavior, on an emergency basis if required to protect the resident or others from injury, or as prescribed by a physician to be used during specific medical or surgical procedures, or while a medical condition exists.[13]

Written policies and procedures regarding the management of any inappropriate behaviors must be developed so that these types of interventions are done on a continuum; the least restrictive means of managing a behavior must be attempted first before resorting to more intrusive methods.[14] These policies and procedures are intended to ensure that a resident's human and civil rights are protected and that restraints are not used "for disciplinary purposes, for the convenience of staff, or as a substitute for an active treatment program."[15]

The Division of Developmental Disabilities Services (DDS) within the Arkansas Department of Human Services (DHS) has developed a policy related to behavior management that the HDCs are required to follow.[16] This policy notes that the agency's philosophy is to use positive approaches to behavior management before utilizing more restrictive approaches.[17] It also recognizes that "[e]fforts at positive programming prove to be successful with the majority of maladaptive behaviors."[18]

> *"The goal is to eliminate the use of seclusion and restraint in behavioral health, as the use of seclusion and restraint creates potential physical and psychological dangers to the persons subject to the interventions, to the staff members who administer them, or those who witness the practice."* [19]

Restrictive methods, including restraints, which are used as part of an individual's behavior program, should be limited to those "individuals who repetitively engage in *dangerously aggressive* behavior and for whom other interventions have not been effective."[20]

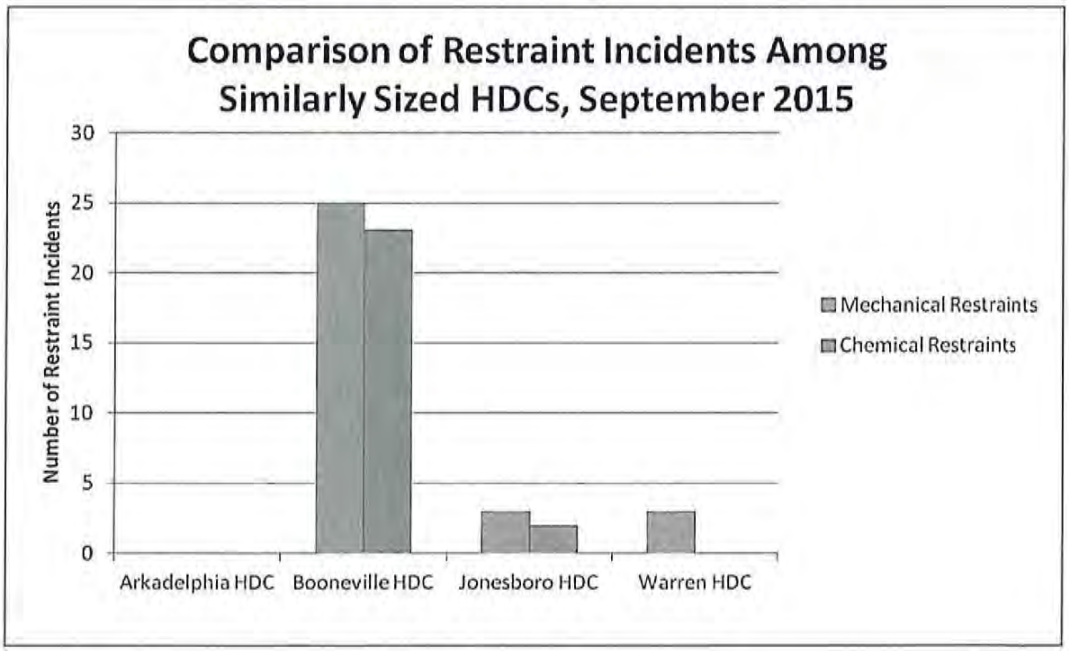
Restraints must also include documentation that other, less restrictive methods of addressing behavioral issues have previously been tried and failed. The program should be carefully reviewed and monitored by professionals and revised if the interventions are proving ineffective.[21] Regardless of how they are labeled, restraints, both personal and mechanical, should only be used to prevent personal injury or serious property damage.

Booneville HDC also has an internal policy and procedure for managing behaviors that recognizes that it is not effective to control behavior by coercion[22] and that personal or mechanical restraints for behaviors should only be used in emergency situations.[23] Emergency restraints are only to be used when a behavior is *severely aggressive* or *destructive* and never for punishment or convenience.[24] Emergency mechanical restraints are only to be used when all other means of behavior control have been exhausted and when the individual is "*so* aggressive that restraint is necessary to prevent *imminent* physical harm to themselves, others, or property."[25]

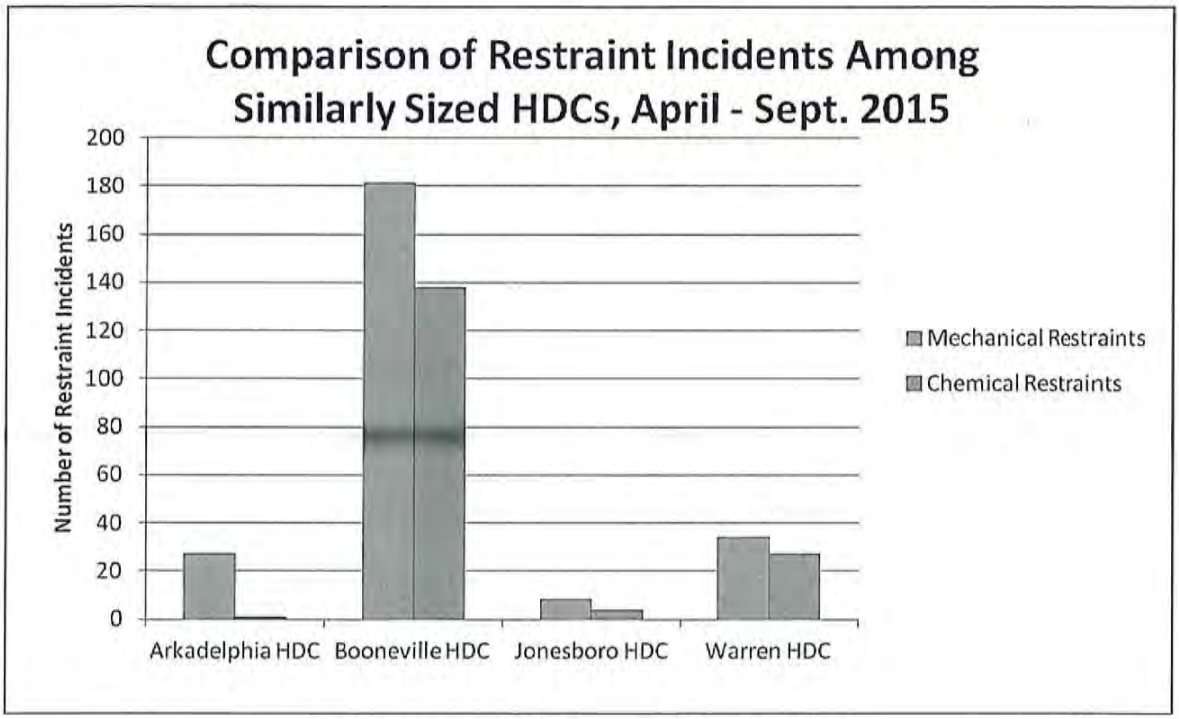
Booneville HDC Has A Significantly Higher Number of Restraints than Similar HDCs

As part of examining the use of restraint at Booneville HDC, DRA compared the frequency of restraint use at that facility with the three other similarly sized HDCs, which are in Arkadelphia, Jonesboro, and Warren.[26] Booneville HDC continues to have more restraints, in relation to population, than the other similar HDCs.[27]

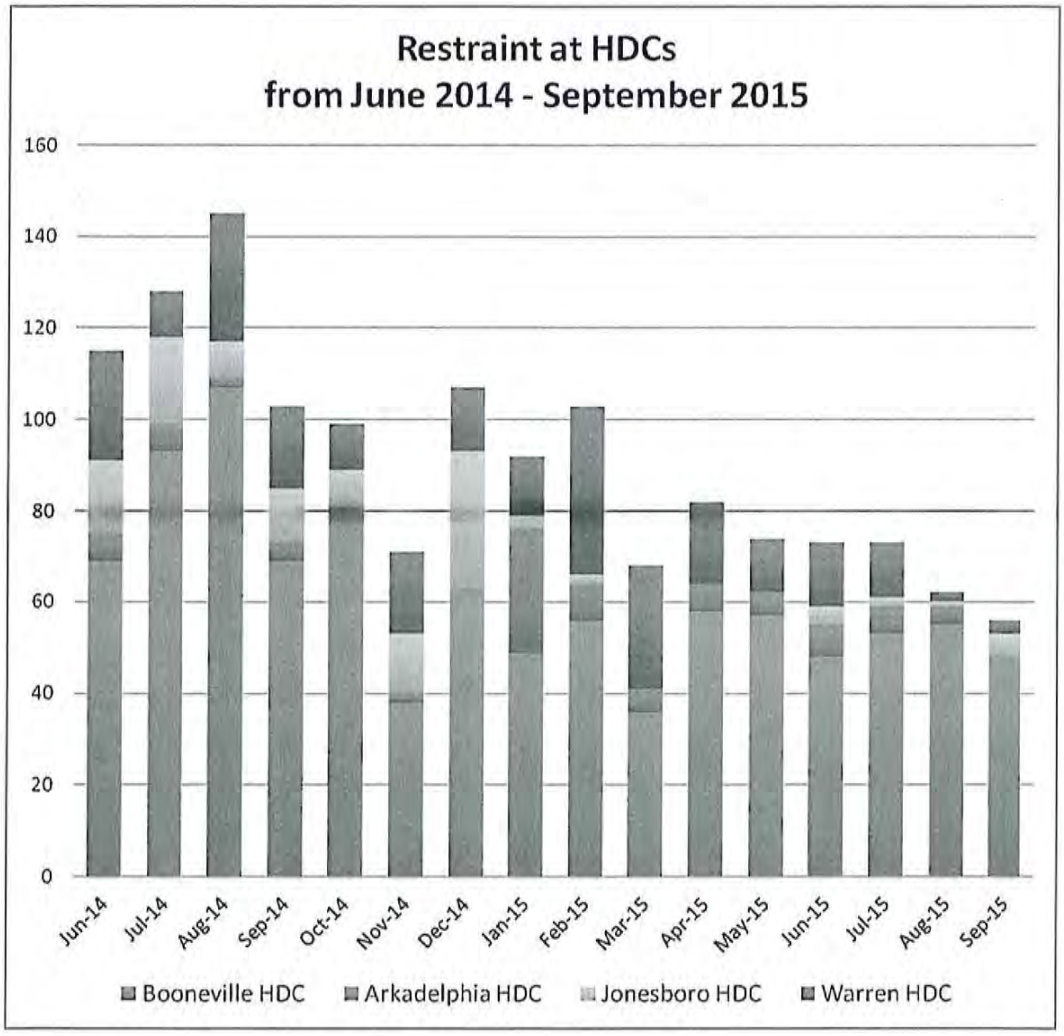
In September 2015, Booneville HDC's population was 122 residents, and it reported 25 mechanical restraints and 23 chemical restraints.[28] By comparison, Arkadelphia HDC's population was 117 residents, and it reported no restraints. For further comparison, Jonesboro HDC's population was 104 residents, and it reported 3 mechanical restraints and 2 chemical restraints. Warren HDC's population was 92 residents, and it reported only 3 mechanical restraints and 0 chemical restraints.



The September 2015 results are not an anomaly. Restraint numbers reported for the preceding six months yielded the same result—Booneville HDC has consistently higher incidents of restraint when compared with other HDCs of similar size and character. From April through September 2015, Booneville HDC reported a total of 181 mechanical restraints and 138 chemical restraints. Arkadelphia HDC reported 27 mechanical restraints and 1 chemical restraint. Jonesboro HDC reported 8 mechanical restraints and 4 chemical restraints during that same reporting period. Warren reported 34 mechanical restraints and 27 chemical restraints during that same period.



Each month over a sixteen month period from June 2014 to September 2015, Booneville HDC consistently utilized more restraints than any of the other comparable HDCs *combined*.[29] While Booneville HDC has reduced the number of restraints occurring at the facility, the average number of restraints is still approximately twenty-five times higher than the average number of restraints at other HDCs.



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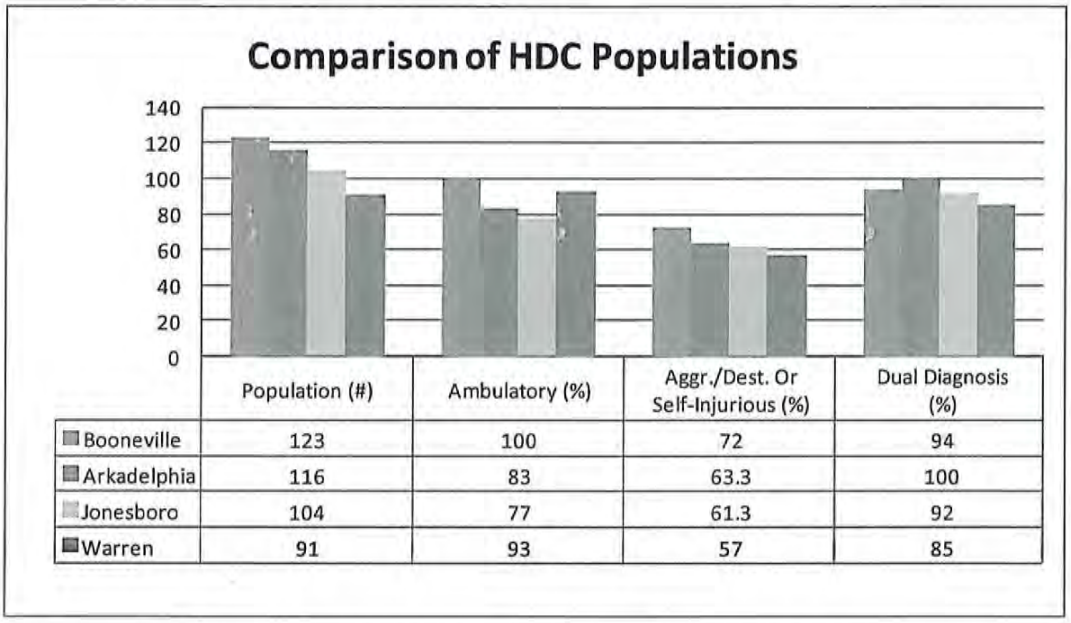
As shown in the graph below, the remaining HDCs (Arkadelphia, Jonesboro, and Warren) are comparable in not just the raw number of residents but also in the percentage of residents who (1) have a dual diagnosis, (2) have been identified as exhibiting aggressive/destructive or self-injurious behavior, and (3) are ambulatory.[30]



	Population (#)	Ambulatory (%)	Aggr./Dest. Or Self-Injurious (%)	Dual Diagnosis (%)
Booneville	123	100	72	94
Arkadelphia	116	83	63.3	100
Jonesboro	104	77	61.3	92
Warren	91	93	57	85

These particular characteristics were chosen for comparison because the Department of Human Services has explained the higher number of restraints at Booneville HDC, stating: "the number of times restraints are used at Booneville tends to trend higher than other HDCs, and we believe that relates to the fact that Booneville specializes in serving only intellectually or developmental disabled, ambulatory individuals with severe behavioral challenges [. . .]"[31] Therefore, DRA compared the number of HDC residents reported to have a dual diagnosis, which means a resident has both a developmental disability and a mental health diagnosis. The HDCs have nearly even numbers of individuals with dual diagnoses.[32] In fact, according to recent reports from the HDCs, Arkadelphia HDC has the highest number of residents with a dual diagnosis among the HDCs compared.

DRA also compared the percentage of residents who have been identified as having "aggressive/destructive" or "self-injurious" behaviors according to reports from the HDCs. While Booneville HDC has a marginally higher percentage of residents who exhibit these identified behaviors, the other HDCs have a significant number of residents with these same types of behaviors.[33] This difference in the number of residents who have been identified as having "aggressive/destructive" or "self-injurious" behaviors does not justify the uncommonly high number of restraints at Booneville HDC.

Finally, DRA compared the percentage of ambulatory residents and found some difference.[34] All of the residents at Booneville HDC are ambulatory, which is necessary due to the inaccessibility of its campus for persons with mobility impairments. However, there are significant numbers of ambulatory residents at the other HDCs as well. The small disparity in the number of ambulatory residents at Booneville HDC does not explain the large discrepancy between the number of restraints at Booneville and at the other HDCs.

Restraint is Inherently Dangerous

Concern over the high number of restraints used at Booneville HDC comes from the inherent dangers associated with these types of interventions. Published studies and articles have discussed the risks associated with restraints, which can include physical injuries, significant trauma, and death.[35] Due to these recognized risks, numerous institutions across the country providing services to individuals with mental health or developmental disabilities, or training professionals to do so, have worked to eliminate the use of restraints. They have done so due to the potential for serious physical and psychological harm, both to the individual restrained and to the staff implementing the restraint.[36] Many organizations across the country have also agreed that restraint should be a last resort and used only in instances where serious injury is imminent.[37]

Booneville HDC's Restraint Incident Debriefing Form acknowledges the danger of restraints to both staff and residents, noting that the "use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used." However, restraints routinely occur at Booneville HDC where, based on documentation of the incident, the risk of serious injury was not imminent. As a result of restraint use, residents at Booneville HDC have sustained injuries ranging from scrapes and scratches to large, multiple bruises and even broken bones.

> *"The use of physical restraints can cause harm including strangulation, loss of muscle tone, decreased bone density (with greater susceptibility for fractures), pressure ulcers, decreased mobility, depression, agitation, loss of dignity, incontinence, constipation, and in some cases, resident death."* [38]

Types of Restraints at Booneville HDC

At Booneville HDC, there are five approved restraint procedures, techniques, and devices—

1. personal restraints;
2. chemical interventions;
3. protective helmets;
4. papoose board; and
5. wrist restraints.[39]

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Based on our review of documents, the methods used most often are personal restraints, chemical interventions, and the papoose board. Personal restraints are procedures that limit movement by physically holding the hand or limb.[40] However, this procedure can range from a hand on the shoulder to forcing a resident to the ground and forcibly holding him or her there, sometimes with a knee in the resident's back and a forearm across the back of the resident's neck.

Chemical interventions/restraints involve the administration of a drug to restrict a resident's movement or to sedate him or her. The most commonly used chemical interventions at Booneville HDC are Ativan and Haldol.[41] Ativan is labeled as a medication to treat epileptic seizures and to sedate patients before surgery.[42] Side effects can include central nervous system depression, respiratory depression, dizziness, confusion, depression, sobbing, and delirium.[43] Meanwhile, Haldol is used to treat schizophrenia and Tourette's Disorder.[44] Its known adverse reactions or side effects include tachycardia, hypotension and hypertension, impaired liver function, anorexia, constipation, diarrhea, hypersalivation, nausea, vomiting, visual disturbances, insomnia, anxiety, agitation, depression, and "potentially irreversible, involuntary, dyskinetic movements."[45] Chemical restraints are often given in conjunction with a mechanical or personal restraint.[46]

The final method of restraint reviewed for this report is the papoose board. This "mechanical restraint" is a device that limits movement and range of motion.[47] It resembles a padded board with straps to hold a resident tightly to the board in a way that prohibits movement and completely controls a resident's body. Frequently, the term "graduated guidance" is used to describe the method of moving a resident to the papoose board and represents how a staff member must struggle with and force a resident, who does not want to be restrained, onto this restrictive device. The papoose board is used for longer periods of time than personal restraint. At least one resident has been strapped to the papoose board for six hours in a single day, while only being released for mandatory breaks every 55 minutes.



Papoose Board currently used at Booneville HDC

Use of Restraints at Booneville HDC

Booneville HDC's policies require that less restrictive measures be used before resorting to restraints. According to the documentation reviewed by DRA, restraints often occur when a lack of meaningful intervention by staff has led to an escalation in the resident's behavior.

Staff often use restraint when Booneville HDC's policy would dictate a less restrictive intervention. Staff document less restrictive interventions most often in the form of redirection, direction, or sanctions. Redirection routinely takes the form of simply telling an agitated or upset resident to "stop," "calm down," or "go back to work." Residents will also be told that they risk having a privilege taken away. None of these strategies actually address the needs of the resident, or the motives of the behavior, and frequently accomplish nothing but escalation of the resident's behavior.

This is concerning because some of the residents at Booneville HDC are in restraints for extended lengths of time.[48] In the fourteen month period between January 2014 and February 2015, the cumulative time residents were personally or mechanically restrained ranged anywhere from one minute to nearly four full days.[49] The average cumulative time a resident at Booneville HDC spent in either personal or mechanical restraints was over five hours for that period of time.[50]

A few examples from the period of January 2014 through February 2015 illustrate the lengths that residents have been restrained on a papoose board:

- Resident 1 was restrained every month and restrained a total of 59 hours and 17 minutes during this time frame.
- Resident 2, who also was restrained every month, was restrained a total of 64 hours and 51 minutes during this time frame.
- Resident 3 was restrained in all but one month and was restrained a total of 94 hours and 57 minutes during this time frame.
- Resident 4, who was also restrained in all but one month, was restrained a total of 84 hours and 22 minutes.

The restraint documentation also does not provide enough information regarding *why* a behavior escalated, or what occurred before the incident that led to the behavior. Instead, the focus is limited to the resident's actions that led to the restraint, without regard to the reason for the behavior. Resident behaviors and actions are consistently examined in a vacuum, divorced from any context or meaning, and viewed only as compliant or non-compliant. Staff involved in restraint incidents rarely document the reason for a behavior, or suggest any changes to the individual's program as a way to address the problematic behavior. This is true even in instances when a resident's behavior tends to occur in identifiable patterns, frequently taking place at the same time of day, with the same residents, or in the same location.

> *"Seclusion and restraints have no therapeutic value, cause human suffering, and frequently result in severe emotional and physical harm, and even death."* [51]

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Example: Resident was upset that another resident was telling her what to do. Staff intervened in the situation, but they stated it was too late. Staff report that Resident was then engaging in self-injurious behavior and spitting at staff. Staff also report that *Resident asked the staff to restrain her on the papoose board and give her a chemical restraint.* Resident was strapped to the papoose board for 40 minutes. There was no insight regarding program changes or the motivation for the behavior other than agitation by a co-resident.

Identifying the function that a particular behavior serves is one of the most important aspects of modifying a challenging behavior. This important step is relatively nonexistent at Booneville HDC. Instead, the same residents are subjected to repeated restraints with no attempts at providing them with needed therapy and tools for them to use to adapt their behavior.

Most human behavior has meaning. Professional staff, with training to identify that meaning, should be carefully reviewing all restraint documentation and events leading up to a restraint in order to better provide direct care staff with an understanding of what the resident is seeking to communicate with a behavior. For this to occur, staff involved in the restraint must consistently document what happened prior to the escalation of the behavior so that a true understanding of the behavior can take place.

A related issue that is apparent from review of restraint documentation at Booneville HDC is that staff routinely relies on rule enforcement instead of resident engagement. When a resident does not "comply" with a rule, a restraint often follows. This is typically due to a resident's resistance to being directed to do some action that he or she does not want to do at the time. Instead of engaging with that resident to determine why there is resistance, or to find alternate avenues that allow for resident expression, staff often will try to force the resident to comply, which only escalates the situation.

Example: Resident did not want to go to his room for shift change. When staff attempted "graduated guidance" to get him to his room, he started threatening and swinging at staff. One of the staff members fell on Resident, *breaking his collar bone.* Resident was then strapped to the papoose board for 50 minutes. There was no indication that any staff member questioned Resident to see why he did not want to go to his room. When staff asked Resident for his input to prevent future restraints, he replied that he would like to go to either the Arkansas State Hospital or jail as opposed to staying at Booneville HDC.

In fact, non-compliance is frequently used throughout the restraint documentation as justification for why a restraint was used. Non-compliance places the blame and consequences for a behavior on the resident. The focus on non-compliance reflects an outdated philosophy that exists at Booneville HDC and likely contributes to the frequency of restraints. In many similar institutional settings across the country, non-adherence has replaced non-compliance as a best practice. Non-adherence acknowledges a resident's choice in treatment and gives information to the provider that the resident needs to be better engaged in the program.

Example: Resident was asked to take a shower due to having a bowel movement in his pants during a seizure. Resident became upset with staff after they told him several times to take a shower. He swung at a staff member and was promptly strapped to the papoose board for thirty minutes until he agreed to shower. There were no recommendations to help prevent a similar event from occurring again.

Another concern is the frequency with which Booneville HDC staff routinely restrain residents based on behaviors that they classify as "attention-seeking." Restraint documentation revealed that events leading up to a resident being restrained were often due to a resident attempting to gain the attention of staff members. When those attempts were unsuccessful, due to staff either ignoring the resident or trying to redirect their actions, the resident's behavior would escalate, and restraint would result. The use of restraints in these instances is inappropriate and would be unnecessary if staff were provided with training on best practices to enable them to better understand a resident's need for attention and how to appropriately respond to that need.

The record below is an excerpt from a Restraint Incident Debriefing Form.[52] This restraint began with the resident having displayed self-injurious behavior, leading to a personal restraint. She calmed herself enough to have breakfast and take her medications, at which point a nurse announced that she was still going to administer a chemical restraint in the form of a shot. This, according to staff, escalated the resident's behavior. Upon reflection, the staff member filling out the debriefing form recommended that the nurses be more discrete when administering chemical restraints. There is no documentation that explains why staff thought a chemical restraint was necessary after the resident was already calmed.

3. Interaction with Staff: (Was the interaction with this person and the client performed in such a way as to deescalate the situation or a factor in escalating the behavior? Was this person someone whom the client likes or not? Could a different staff person have interacted with the client and avoided the emergency restraint?) Please Describe:
[redacted] calmed [redacted] to the point of taking her meds and have breakfast. The nurse [redacted] stated. I'm still gonna give her that shot and [redacted] threw her water and went to bite herself. and fight staff.

****

6. Recommendations: (Are there any recommendations from the Client, the Intervention Team and/or the Restraint Leader that could help prevent a similar event from occurring again?) Please List:
Have staff not say things like the Nurse said in front of clients. Need to be descreet.

Another important issue is that documentation of a restraint requires the use of multiple forms, which, though intended to capture the entire event, often miss critical pieces required to truly understand what happened. As noted earlier, staff members tend to document the resident's behavior after it has already escalated. There is little attention given to events leading up to the escalated behavior, to effective interventions prior to the use of restraint, or to an analysis of how the restraint could have been avoided.

Furthermore, the Restraint Incident Debriefing Form is often completed or reviewed at a later date, which does not aid in identifying patterns or avenues for reducing the use of restraints for that resident. DRA's review of the restraint documentation revealed that many residents experience restraints repeatedly during the same day, week, or month. Without a prompt review and thorough discussion of the restraint, the resident is subjected to repeated instances of this dangerous, dehumanizing, and coercive intervention that could have been avoided had that review taken place.

> ***Example:*** According to a *Behavior Report*, Resident was restrained for threatening to kill staff and himself, and he relentlessly continued this behavior while restrained on a papoose board for one hour and thirty-five minutes; however, a *Chemical Intervention Checklist* for the same incident states that Resident "was calm until he heard staff talking about how he needed a shot." Yet another document, the *Restraint Incident Debriefing Form,* does not mention the interaction with staff that escalated Resident's behavior.

Residents in institutional settings rely on staff members for all of their basic needs. The majority of their days are spent on the same campus, in the same rooms, with the same individuals. As such, it is simply human nature to seek out attention in a variety of ways. Instead of ignoring or punishing that behavior, staff should be working with residents to better engage them in their treatment programs and in the world outside of the Booneville HDC campus.

> ***Example:*** Resident made a homemade badge and was pretending that he worked at Booneville HDC. He began telling clients what to do. When staff tried to redirect him, he punched a staff member. He was strapped to a papoose board for 35 minutes. When asked to reflect on programmatic issues that could be made to prevent the restraint, the staff member writes, "no changes could of [sic] helped this behavior." No effort was made to transfer Resident's imagined role as a staff member to a purposeful activity before resorting to restraints.

Lack of Meaningful Follow-up

Though restraints are routinely used at Booneville HDC, there is a lack of meaningful follow-up by the facility in order to identify alternative avenues of behavior management. While other institutions across the country seek to eliminate the use of restraints, Booneville HDC has shown marginal movement towards that goal. Review of documentation revealed that the same residents are repeatedly restrained without consideration of ways to avoid the use of restraint.

Booneville HDC uses a "Restraint Incident Debriefing Form" that is to be completed by staff following an emergency restraint.[53] When an incident occurs, a restraint incident leader is to conduct a debriefing session with other staff involved, as well as the resident, to pinpoint the behavior that led to restraint, environmental factors involved, antecedents to the behavior, staff actions that could have kept the situation from escalating, the resident's reaction, and any programmatic changes or resident options that could have prevented the restraint.[54]

While staff members appear to complete the debriefing forms with regularity following a restraint, the documentation frequently does not provide the information that the questions intend to target. Many times the answer is simply "none." The area designated for resident input often does not include information from the resident to better understand the resident's point of view. There is little documentation of ways the restraint could have been avoided.

In addition, staff routinely place the blame for the use of restraints on the resident's "bad behavior," without regard to how the staff's own actions may have contributed to the escalation. Though there is an area that allows staff to put recommendations as to how to avoid restraints in the future, staff members rarely have suggestions. A review of the debriefing forms reveals that direct care staff members involved in administering the restraints do not see any other options and just accept restraint activity as a necessity. This reflects a culture at Booneville HDC where overuse of restraint is the norm.

Lack of Meaningful Oversight

Booneville HDC does have a Human Rights Committee (Committee) that is intended to protect the rights of Booneville HDC residents. The Committee, which is required and established by both the Division of Developmental Disabilities Services and Booneville HDC policies, is tasked with a number of functions, one of which is to review the restraint activity at Booneville HDC.[55] However, the Committee rarely, if ever, questions the use of restraint. The meeting minutes reflect that the Committee routinely approves the use of restraints, even for those residents who are repeatedly restrained during a review period, with no discussion documented as to ways to prevent those restraints in the future. Though the same residents often are included in the review month after month, there appears to be no effort by the Committee to question the course of action or to reduce the use of restraints. Instead, there appears to be acceptance, facility-wide and by the Committee, that the use of restraints is the status quo.

Conclusion

According to the data collected and maintained by Booneville HDC and the State, residents at Booneville live in an environment in which restraint is used excessively, far more frequently than at the Arkadelphia, Jonesboro, or Warren HDCs. Booneville HDC fails to ensure that staff utilize effective tools to de-escalate situations, leading to the use of restraints when other interventions, if implemented sooner, could eliminate the need for restraint. The Department of Human Services and its Division of Developmental Disabilities Services has failed to provide the oversight and training to ensure that residents at Booneville HDC are not subjected to unnecessary and excessive restraints. Residents and staff have already been injured due to the current restraint practice at Booneville HDC.[56]

All HDC residents are entitled to live in an environment in which restraints are used as a last resort after other interventions have failed. The residents at Booneville HDC have a right to be treated with dignity and respect, to not be subjected to unnecessary and harmful restraint, and to receive active treatment based on evidence-based best practices. DRA urges the State to take immediate action to address the culture at Booneville HDC and to instruct Booneville HDC to stop this inherently dangerous practice. The individuals with disabilities residing at Booneville HDC deserve better.

Disability Rights Arkansas, Inc.
"Bound to the Past: The Excessive Use of Restraint at Booneville Human Development Center"
January 2016

Recommendations

DRA recommends that the State take the following steps to ensure that residents at Booneville HDC are protected from excessive and unnecessary restraint:

1. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should retain an independent expert with expertise in working with facilities to develop and implement current evidence-based best practices at Booneville HDC to significantly reduce and/or eliminate the use of restraint at the facility.

2. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should provide and require participation of Booneville HDC's senior administrative, clinical, and direct care staff in comprehensive training on person-centered and trauma-informed, recovery-oriented, evidence-based services and supports.

3. The Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and Booneville HDC's senior administrative and clinical staff should be required to develop a strategic plan to transform this institution to one that adopts current, best practice philosophy, vision, and values. This plan should be updated monthly and reviewed quarterly by the state office or an external entity.

4. The Arkansas Department of Human Services, its Division of Developmental Disabilities Services, and Booneville HDC should ensure that all facility staff immediately receive extensive training and are intensively monitored to ensure that evidence-based best practices are used to avoid escalation of behaviors and the use of restraint. DRA recently learned that Booneville HDC has begun training some facility staff on Nonviolent Crisis Intervention Training. Nevertheless, the number of restraints a Booneville HDC are still much higher than at the other HDCs.

5. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ensure that the use of restraint at Booneville HDC is regularly monitored, including careful evaluation and scrutiny of the reasons staff utilized restraint, alternatives to restraint, and follow-up actions in response to restraint. This includes requiring that clinical and senior administrative staff be more involved in the day-to-day activities of residents to ensure that individualized treatment or behavior plans are effective and that adequate active treatment is provided.

6. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ensure that residents of Booneville HDC have access to active treatment, including the provision of mental health and other treatment that supports residents in addressing their challenging behaviors in ways that do not include coercion or punishment.

7. The Arkansas Department of Human Services and its Division of Developmental Disabilities Services should ban the use of the papoose board as a form of restraint at Booneville HDC and other HDCs.

Endnotes

[1] About DDS, http://humanservices.arkansas.gov/ddds/Pages/AboutDDDS.aspx (last visited Dec. 3, 2015).

[2] Developmental disability is defined as "'an impairment of general intellectual functioning or adaptive behavior' that is a 'substantial handicap to the person's ability to function without appropriate support services, including, but not limited to, planned recreational activities, medical services such as physical therapy and speech therapy, and possibilities for sheltered employment or job training.' It is caused by mental retardation or a closely related condition; cerebral palsy; epilepsy; autism; or dyslexia (difficulty learning to read and spell) resulting from cerebral palsy, epilepsy, or autism. [. . .] The definition also includes 'a functionally retarded person who may not exhibit an intellectual deficit on standard psychological tests, but who, because of other handicaps, functions as a retarded person.'" Gloria Gordon, *DDS Children's Guide*, (2005) (citing Arkansas Code. § 20-48-101 (2015) and Arkansas Act 729 of 1993), http://humanservices.arkansas.gov/ddds/ddds_docs/dds_childrens_guide.pdf.

[3] *Booneville Human Development Center Description of Services and Programs*, Meeting of the Hosp. and Medicaid Study Subcomm. of the Ark. Legis. Council, 89th General Assemb. Exhibit D-2 (Jan. 8, 2014), http://www.arkleg.state.ar.us/assembly/2013/Meeting%20Attachments/080/I12304/Exh%20%20D-2-Booneville%20HDC.pdf.

[4] Ark. Building Authority, *Human Development Centers Condition Assessment Report for Arkansas Department of Human Services*, Developmental Disabilities Services, (2015). According to this Assessment, Booneville HDC requires an additional $79,755,937 in order to modernize the campus, which does not take into account the cost of ADA compliance, code compliance, demolition of unused buildings, or remediating hazardous material present. Therefore, it is reasonable to assume that a detailed assessment including these factors would likely be much higher.

[5] Disability Rights Arkansas, Inc., *A New Approach to Care in Arkansas: Why the Time Has Come to Close the Booneville Human Development Center*, (2015), http://disabilityrightsar.org/wp-content/uploads/2015/11/BHDC-Final-Report-January-2015.pdf.

[6] In *Olmstead*, the United States Supreme Court held that needlessly segregating individuals with disabilities is a form of discrimination that is prohibited by the Americans with Disabilities Act. The Court decision "that unjustified institutional isolation of persons with disabilities is a form of discrimination reflects two evident judgments. First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life...Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment." *Olmstead*, 527 U.S. at 600-01 (citations omitted). *Olmstead* directed states to serve individuals in the most integrated setting appropriate to meet their needs. *See e.g.*, United States Department of Justice Civil Rights Division, Olmstead: *Community Integration for Everyone*, http://www.ada.gov/olmstead/index.htm (last visited Dec. 28, 2015); United States Department of Health & Human Services Office of Civil Rights, *Serving People with Disabilities in the Most Integrated Setting: Community Living and* Olmstead, http://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html (last visited Dec. 28, 2015); Judge David L. Bazelon Center for Mental Health Law, *The* Olmstead *Decision*, http://www.bazelon.org/Where-We-Stand/Community-Integration/Olmstead-Implementing-the-Integration-Mandate/The-Olmstead-Decision-.aspx (last visited Dec. 28, 2015).

[7] *See* United Cerebral Palsy, *The Case for Inclusion 2015*, (2015), http://cfi.ucp.org/wp-content/uploads/2015/07/UCP_2015_CaseforInclusion_FINAL.pdf. According to this report, Arkansas is one of the worst states in the country for providing alternatives to institutional care, ranking number 49, and has consistently ranked as one of the worst states since United Cerebral Palsy's first report in 2007.

[8] The Developmental Disabilities Services Board (DDS Board) is charged with the oversight of the services provided to Arkansans with developmental disabilities. Arkansas Act 348 of 1985 reorganized DHS, placing the Division of Developmental Disabilities Services (DDS) under its authority, and designated control and administration of the HDCs under the management and direction of the DDS Board. The mission of DDS and the DDS Board includes a commitment to the positive management of challenging behaviors, and protection of the constitutional rights of individuals with disabilities, and their rights to personal dignity, respect and freedom from harm.

[9] DRA consulted with Dr. Kevin Ann Huckshorn, who is a licensed and certified mental health nurse and substance abuse clinician with 36 years of experience working in a variety of public and private behavioral health organizations. She has published on topics including violence, treatment adherence, trauma-informed care, and workforce development and has co-authored a book with William Anthony, PhD, titled "Principled Leadership in Mental Health Systems and Programs" (2008). Dr. Huckshorn is the President and CEO of Kevin Huckshorn & Associates, Inc., a small behavioral health consulting business. She is the former Director of the Division of Substance Abuse and Mental Health in Delaware. She led the development of the evidence-based best practice titled "The Six Core Strategies" and was involved in the successful implementation of a United States Department of Justice settlement agreement in Delaware.

[10] DRA wants to emphasize that these conclusions are not meant as any type of reflection on the community of Booneville and its residents who work at Booneville HDC. DRA's conclusions are intended to address the shortcomings in the State's provision of active treatment and safe care to HDC residents and to encourage the State to take the necessary steps to change the culture at the facility by reducing and eliminating the use of restraint.

[11] Centers for Medicare & Medicaid Services, *Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)*, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/ICFMR_Background.pdf.

[12] 42 C.F.R. § 483.420 (a)(6) (2015).

[13] 42 C.F.R. § 483.450 (d) (2015).

[14] 42 C.F.R. § 483.450 (b)(iii) (2015).

[15] 42 C.F.R. § 483.450 (b)(3) (2015).

[16] Arkansas Department of Human Services Division of Developmental Disabilities Services, Policy No. 3011-D *Behavior Management*, (2003), *available at* https://ardhs.sharepointsite.net/DDS%20Policies/Forms/By%20Policy%20Type.aspx.

[17] *Id.*

[18] *Id.*

[19] 2012 CARF Behavioral Health Standards Manual: Section 2.F. Nonviolent Practices/Nonviolent Crisis Intervention Training Program, (May 2012), https://www.crisisprevention.com/CPI/media/Media/Resources/Knowledge-Base/Carf_alignment.pdf.

[20] *See supra* note 16.

[21] *Id.*

[22] Booneville Human Development Center, Policy No. I-D-2, *Use and Documentation of Procedures to Manage Behavior*.

[23] Booneville Human Development Center, Policy No. I-D-4, *Documentation of and Response to Maladaptive Behaviors*.

[24] *Id.* at (2)(a) (emphasis added).

[25] *Id.* at (2)(f) (emphasis added).

[26] Conway HDC has over four hundred residents (more residents than the other HDCs combined) and serves a population that includes children and medically fragile residents; therefore, it will not be considered for comparison to Booneville HDC, which only has 121 residents. Conway Human Development Center, http://humanservices.

arkansas.gov/ddds/Pages/ConwayHDC.aspx (last visited Dec. 3, 2015) (explaining that Conway HDC has residents ranging from ages 7 to 74).

[27] *Human Development Center Monthly Statistical Reports* provided quarterly to the DDS Board.

[28] *Human Development Center Monthly Statistical Reports*, September 2015.

[29] *Human Development Center Monthly Statistical Reports*, June 2014-September 2015.

[30] Based upon data contained within the *Human Development Center Monthly Statistical Reports*, July 2015-September 2015.

[31] Max Brantley, *State Responds to Report on Conditions at Booneville Human Development Center*, The Arkansas Times Blog (Jan. 5, 2015, 11:40AM), http://www.arktimes.com/ArkansasBlog/archives/2015/01/05/state-responds-to-report-on-conditions-at-booneville-human-development-center.

[32] The average number of residents with dual diagnoses within Arkadelphia, Jonesboro, and Warren HDCs is 92.75%, whereas 94% of Booneville HDC's residents have a dual diagnosis.

[33] The average number of residents who have exhibited self-injurious or aggressive/destructive behaviors among Arkadelphia, Jonesboro, and Warren HDCs is 63.4%. Booneville HDC has 72% of its residents who exhibit those behaviors, which is only slightly higher than the average of the other HDCs.

[34] The average number of ambulatory residents within Arkadelphia, Jonesboro, and Warren HDCs is 88.25%. At Booneville HDC, 100% of the residents are ambulatory.

[35] *See, e.g.*, Stephan Haimowitz, Jenifer Urff, & Kevin Ann Huckshorn, *Restraint and Seclusion—A Risk Management Guide*, (2006), http://www.nasmhpd.org/sites/default/files/R-S%20RISK%20MGMT%2010-10-06%282%29.pdf; United States General Accounting Office, Report to Congressional Requesters, *Mental Health: Improper Restraint or Seclusion Use Places People at Risk*, (1999), http://www.gao.gov/archive/1999/he99176.pdf; United States General Accounting Office, Testimony Before the Committee on Finance, U.S. Senate, *Mental Health: Extent of Risk From Improper Restraint or Seclusion Is Unknown*, (1999), http://www.gao.gov/archive/2000/he00026t.pdf; Stacey A.Tovino,"*Psychiatric Restraint and Seclusion: Resisting Legislative Solution,*" 47 Santa Clara L. Rev. 511 (2007); Equip for Equality, *National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint*, (2011), http://www.equipforequality.org/wp-content/uploads/2014/04/National-Review-of-Restraint-Related-Deaths-of-Adults-and-Children-with-Disabilities-The-Lethal-Consequences-of-Restraint.pdf.

[36] *See supra* note 35.

[37] *See supra* note 35.

[38] Centers for Medicare & Medicaid Services, *Freedom from Unnecessary Physical Restraints: Two Decades of National Progress in Nursing Home Care*, (Dec. 3, 2015), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter09-11.pdf.

[39] Booneville Human Development Center, Policy No. I-D-4(6), *Documentation of and Response to Maladaptive Behaviors*.

[40] *Id.*

[41] Booneville HDC Chemical Intervention Checklists from 2014 and 2015.

[42] *Ativan (lorazepam) Injection*, (2015), http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/018140s028lbl.pdf.

[43] *Id.*

[44] *Haldol (haloperidol) Injection*, (2009), http://www.accessdata.fda.gov/drugsatfda_docs/label/2009/015923s084l-bl.pdf.

[45] *Id.*

[46] Booneville HDC Resident Behavior Reports and Chemical Intervention Checklists from 2014-2015.

[47] Booneville Human Development Center, Policy No. I-D-4(6), *Documentation of and Response to Maladaptive Behaviors.*

[48] *See* Appendix 1, which incorporates data from Human Rights Committee Reports furnished by Booneville HDC for the time period of January 2014 to February 2015. DRA compiled the aggregate times residents were in either personal or mechanical restraints per month.

[49] *Id.*

[50] This average includes residents who were not restrained at all during their time at Booneville HDC. If averaging the length of time in restraints for only persons who were actually restrained at Booneville HDC, the number of hours would be over 9 ½ hours. *See* Appendix 1.

[51] Mental Health America, *Position Statement 24: Seclusion and Restraints*, http://www.mentalhealthamerica.net/positions/seclusion-restraints (March 2011) (last visited December 2, 2015).

[52] *See* Appendix 2.

[53] *See* Appendix 2, which is an actual set of forms from a restraint incident, redacted to protect the privacy of the residents involved.

[54] Booneville Human Development Center, Policy No. I-D-4(2)(f)(v), *Documentation of and Response to Maladaptive Behaviors.*

[55] Booneville Human Development Center, Policy No. I-C-2(1)(a-d), *Human Rights Committee.*

[56] Resident injuries were previously described herein. Several employees at Booneville HDC who were placed on Worker's compensation leave from 2013-2015 were reportedly injured by "client behavior." Booneville Human Development Center, Worker's Compensation Report.

Appendix 1

MONTHLY NUMBER OF MINUTES RESTRAINED PER RESIDENT

	02/15	01/15	12/14	11/14	10/14	09/14	08/14	07/14	06/14	05/14	04/14	03/14	02/14	01/14	Total	Total (hours)
Resident		1.00										55.00		45.00	101	1h 41m
Resident	26.00						75.00		149.00						250.00	4h 10m
Resident								45.00	1.50						46.50	46.5m
Resident			1.00	18.00		323.00									342.00	5h 42m
Resident			25.50						2.00	3.00					30.50	30.5m
Resident							5.00						1.00		6.00	6m
Resident		170.00			123.00				45.00						338.00	5h 38m
Resident												3.00			3.00	3m
Resident					42.00	1.00				55.00				30.00	128.00	2h 8m
Resident		3.00	3.00	25.00				26.50	1.00					34.00	92.50	1h 32.5m
Resident		3.00	45.00	110.50	1.00		8.50	37.00	1.50	74.50		44.00	55.00	30.00	410.00	6h 50m
Resident									15.00				1.50		16.50	16.5m
Resident														30.00	30.00	30m
Resident		37.00	30.00		30.00	15.00					13.00			3.00	128.00	2h 8m
Resident					1.00										1.00	1m
Resident				2.00	145.00	43.00				56.00	5.00	60.00	1.00		312.00	5h 12m
Resident						18.00							5.00		23.00	23m
Resident									2.00						2.00	2m
Resident	35.50	72.00	34.00	104.00	11.00	51.50	112.00	87.00	341.00	110.00	11.00	126.00	87.50	140.00	1322.50	22h 2.5m
Resident							2.00		1.50				20.00		23.50	23.5m
Resident	15.00	13.00	7.00	30.00	43.00		6.00	5.50						22.00	141.50	2h 21.5m
Resident		57.00	150.00	88.00	12.00	109.00	95.00	15.00	96.00	94.00	184.00		7.00		907.00	15h 7m
Resident	23.00	80.00	129.00	111.50	335.00	190.00	214.00	694.00	45.00	215.00	80.00			93.00	2209.50	36h 49.5m
Resident			139.00		50.00			45.00	35.00	35.00	45.00			45.00	394.00	6h 34m
Resident								2.00					2.00		4.00	4m
Resident	53.00	2.00				13.00		90.00			4.00		1.00	11.00	174.00	2h 54m
Resident					15.00	13.00									28.00	28m
Resident											2.00				2.00	2m
Resident	2.00	41.00		85.00	15.00		60.00	52.00	26.00		122.00	8.00	15.00	37.50	463.50	7h 43.5m
Resident		2.00			8.00										10.00	10m
Resident							55.00	45.00	293.00	130.00	40.00	55.00	45.00	55.00	718.00	11h 58m
Resident	210.00	71.00	123.50	11.00	38.00	131.00	431.00	554.00	514.50	270.00	99.00	572.00	3.00	529.50	3557.50	59h 17.5m
Resident					27.00		38.00			30.00		45.00			140.00	2h 20m
Resident								3.00							3.00	3m
Resident		150.00							31.00					4.00	185.00	3h 5m
Resident	26.00				30.00							2.00	2.00		60.00	1h
Resident		57.00	75.00	70.00	85.00		60.00	10.00		83.00		18.00			458.00	7h 38m
Resident		85.00	58.00		365.00	190.00	34.00	3.00	173.00			57.00			965.00	16h 5m
Resident			1.00				22.00								23.00	23m
Resident			56.00									165.00		1.00	222.00	3h 42m
Resident	17.00	4.00						59.00							80.00	1h 20m
Resident								2.00							2.00	2m
Resident			158.00	3.00	119.00	213.00	483.00	231.00	79.50	55.00	628.00	71.00	1.50	365.00	2407.00	40h 7m
Resident									3.00						3.00	3m
Resident	288.00	90.00	425.00		560.00	585.00	240.00	325.00	145.00	832.00	676.00	291.50	161.50	1078.00	5697.00	94h 57m
Resident	54.00	88.00	35.00	73.00	129.00	43.00	61.00	97.00	38.00		15.00	120.00	264.00	165.00	1182.00	19h 42m
Resident	3.00	71.00			30.00	1.00	34.00			80.00					219.00	3h 39m
Resident							36.00								36.00	36m
Resident		4.00	11.00	4.00	1.00	58.00			5.00			3.50		10.50	97.00	1h 37m
Resident	203.00	298.50	475.00	298.00	450.50	169.00	235.00	270.00	319.00	83.00	353.50	424.00	208.00	105.00	3891.50	64h 51.5m
Resident			1.00												1.00	1m
Resident	50.00	86.00		55.00	165.00	314.00	161.00		82.00				65.00		978.00	16h 18m
Resident								52.00	45.00					165.00	262.00	4h 22m
Resident	75.00	120.50	229.50	2.50	166.00		888.00	730.50	213.00	700.50	128.00	857.50	115.00	836.50	5062.50	84h 22.5m
Resident	160.00	4.00	136.00	31.00	73.00	58.00	168.00	165.00	125.00	251.00	80.00	316.00	199.00	241.00	2007.00	33h 27m
Resident			17.00			29.00		46.00							92.00	1h 32m
Resident	3.00		90.00	85.00		20.50	10.00							4.00	212.50	3h 32.5m
Resident												23.00			23.00	23m
Resident				29.00		35.00				20.00	103.00	194.00	55.00		436.00	7h 16m
Resident									4.00						4.00	4m
Resident	1.00				90.00										91.00	1h 31m
Resident		1.00													1.00	1m
Resident	1.00			30.00						24.00	35.00				90.00	1h 30m
Resident			63.00	35.00	64.00	100.00	20.00		20.00	278.00	175.00	115.00	154.00		1024.00	17h 4m
Resident			5.00												5.00	5m
Resident	35.00		1.50												36.50	36.5m
Resident	45.00		223.00		164.00	130.00	195.00	77.00	132.00	49.00	125.00	55.00	157.00	150.00	1502.00	25h 2m
Resident										40.00		170.00			210.00	3h 30m
Resident			4.00		1.00	65.00	8.00		19.00	33.00	124.50		61.00		315.50	5h 15.5m
Resident									27.00			45.00			72.00	1h 12m

Appendix 2

Booneville Human Development Center
RESTRAINT INCIDENT DEBRIEFING FORM
To be completed and turned in with the Restraint Log

The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program), when a very real risk of personal injury or severe property damage is imminent.

INCIDENT:
On [redacted] [redacted] was placed in mechanical restraint
Date *Client name*
as documented on the attached Restraint Log. The reason that the use of restraint was necessary because (describe the behavior):
[redacted] was calm enough to get her meds and then have breakfast. The nurse stated she was still gonna give her the shot and [redacted] threw her water and went to hit herself and fight staff

I. The Restraint Incident Leader was [redacted]
Signature

II. The other members of the Intervention Team were:
[redacted]
Signature
[redacted]
Signature
[redacted]
Signature
[redacted]
Signature
_____
Signature

III. Event Analysis:
The following may be contributing factors to this restraint incident:

1. Physical Environment: (Where did the incident occur, were their anything in the physical environment that may have been a factor in the incident?) Please Explain:
In med pass area

2. Interaction with Peers: (Was another person's interaction with the client a factor in the client requiring restraint?) Please Describe:

Booneville Human Development Center
RESTRAINT INCIDENT DEBRIEFING FORM
To be completed and turned in with the Restraint Log

3. Interaction with Staff: (Was the interaction with this person and the client performed in such a way as to deescalate the situation or a factor in escalating the behavior? Was this person someone whom the client likes or not? Could a different staff person have interacted with the client and avoided the emergency restraint?) Please Describe:
We calmed [redacted] to the point of taking her meds and have breakfast. The nurse [redacted] stated I'm still gonna give her that shot and [redacted] threw her water and went to bite herself. and fight staff.

4. Programmatic Issues: (Were there any programming issues involved in the incident, such as requests to perform assigned tasks such a laundry, room maintenance, going to class, bathing, etc. involved in the incident? Could any programmatic changes be made to prevent similar incidents such as doing laundry at a different time or day, etc?) Please Describe:
None

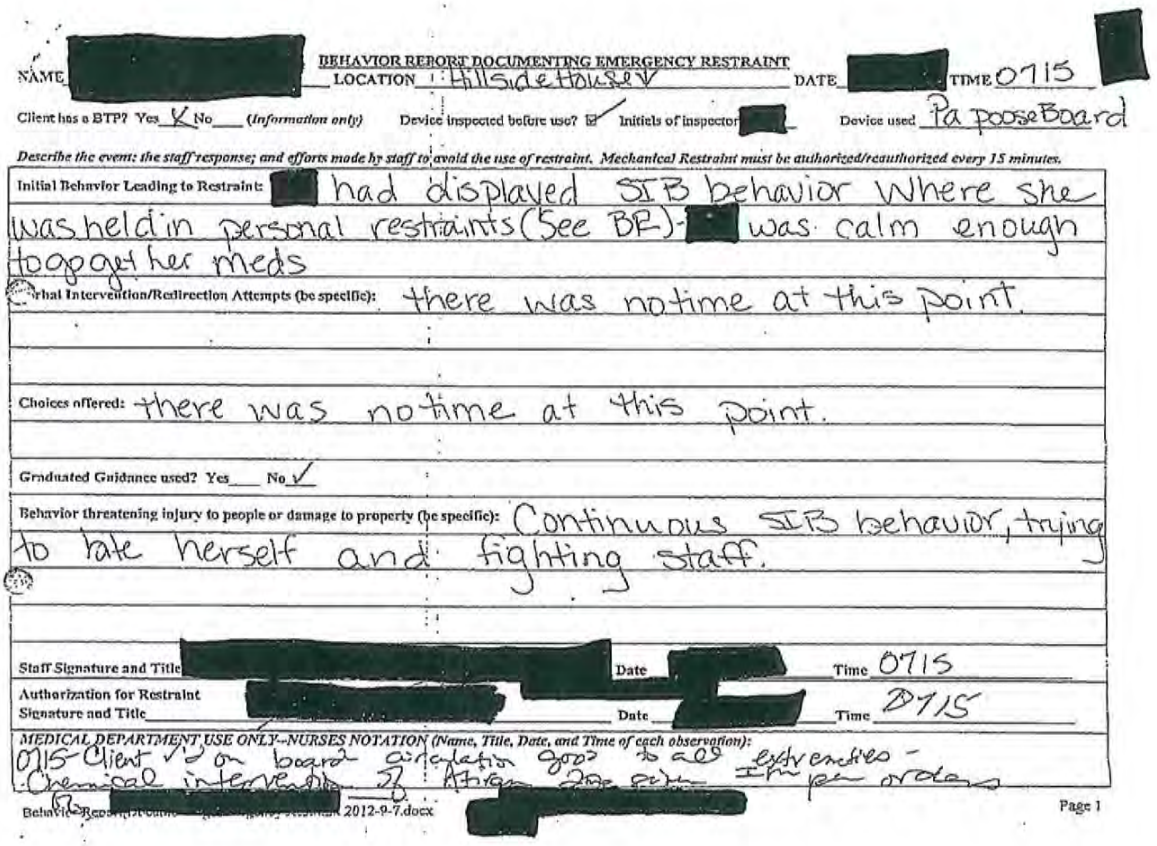
5. Client Input: (Actively seek information from the client as to what could be done to prevent such an incident in the future. Did the client feel that staff overreacted in the incident or did they feel the restraint was justified?) Please Describe:
She ignored staff

6. Recommendations: (Are there any recommendations from the Client, the Intervention Team and/or the Restraint Leader that could help prevent a similar event from occurring again?) Please List:
Have staff not say things like the Nurse said in front of clients. Needs to be descreet.

IV. Reviewed by: [redacted] Date [redacted]
Signature, Title

RECEIVED
[redacted] 2015
RECORDS ROOM
BHDC AR 72927

0000000827



BEHAVIOR REPORT DOCUMENTING EMERGENCY RESTRAINT

NAME [redacted] LOCATION Hillside House DATE [redacted] TIME 0715 [redacted]

Client has a BTP? Yes X No ___ *(Information only)* Device inspected before use? ☑ Initials of inspector [redacted] Device used Pa pooseBoard

Describe the event: the staff response; and efforts made by staff to avoid the use of restraint. Mechanical Restraint must be authorized/reauthorized every 15 minutes.

Initial Behavior Leading to Restraint: [redacted] had displayed SIB behavior where she was held in personal restraints (See BR) - [redacted] was calm enough to go get her meds

Verbal Intervention/Redirection Attempts (be specific): there was no time at this point.

Choices offered: there was no time at this point.

Graduated Guidance used? Yes ___ No ✓

Behavior threatening injury to people or damage to property (be specific): Continuous SIB behavior, trying to bite herself and fighting staff.

Staff Signature and Title [redacted] Date [redacted] Time 0715

Authorization for Restraint Signature and Title [redacted] Date [redacted] Time 0715

MEDICAL DEPARTMENT USE ONLY--NURSES NOTATION (Name, Title, Date, and Time of each observation):
0715 Client ✓'d on board circulation good to all extremities - Chemical intervention of Atiran 2mg [illegible] IM per orders

Behavior Report [illegible] 2012-9-7.docx [redacted] Page 1

BEHAVIOR REPORT DOCUMENTING EMERGENCY RESTRAINT

Time started	15 minute checks	Staff Name, Title	Indicate behavior requiring restraint; whether the dangerous behavior is continuing; and what resulted in release.	Authorization every 15 minutes
0715		[redacted]	attempted SIB and fighting staff Chemical given @ 0720	[redacted]
	0723 Released. Calm			
	55 minutes Release		Was released for fluids, meals, toileting: _____ Initial Ongoing Behavior:	Reauthorized every 15 minutes
	55 minutes Release		Released for fluids, meals, toileting: _____ Initial Ongoing Behavior:	Reauthorized every 15 minutes
	55 minutes Release		Released for fluids, meals, toileting: _____ Initial Ongoing Behavior:	Reauthorized every 15 minutes

RECEIVED [redacted] 2015 RECORDS ROOM BHDC AR 72927

JUSTIFICATION AND AUTHORIZATION FOR MECHANICAL RESTRAINTS

Client response to intervention and alternate behavioral choices: She got up, put his shoes on and went and ate breakfast

Staff debriefing form completed by Restraint Incident Leader? Yes *Restraint Incident Leader Signature, Title, and Date:* [redacted]

Suggested measures to avoid restraint use: Staff needs to be more discreet.

Injury noted upon release ☒NO ☐YES Suggested *measures to insure safety:* Staff needs to be more discreet.

Regulations: Restraint is only used as an emergency procedure to prevent or minimize imminent danger of injury to people or serious damage to property. All efforts must be made to deescalate the incident prior to the use of restraint. The person in restraint must be under constant staff observation, documented every 15 minutes. The person must be released when calm. The person must be released from restraint every 55 minutes for fluids, toileting, meals, or exercise. Restraint use must be authorized; continued use must be reauthorized after 15 minutes.

Behavior Report Documenting Emergency Restraint 2012-9-7.docx Revised September 7, 2012. Page 2

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0000000831

DAVID CAINS

D.O.B.

[redacted]

EXPIRED

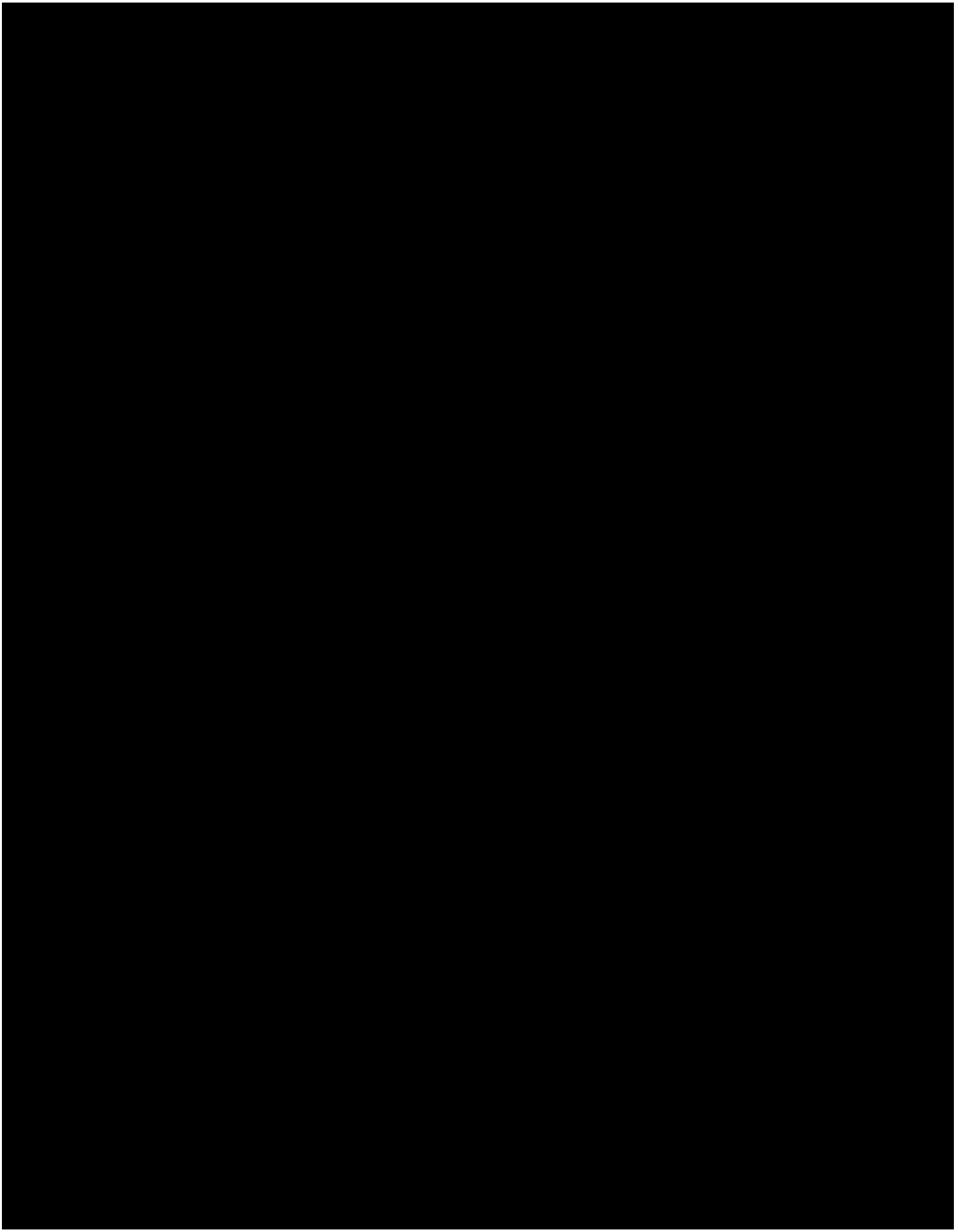
06/13/2020

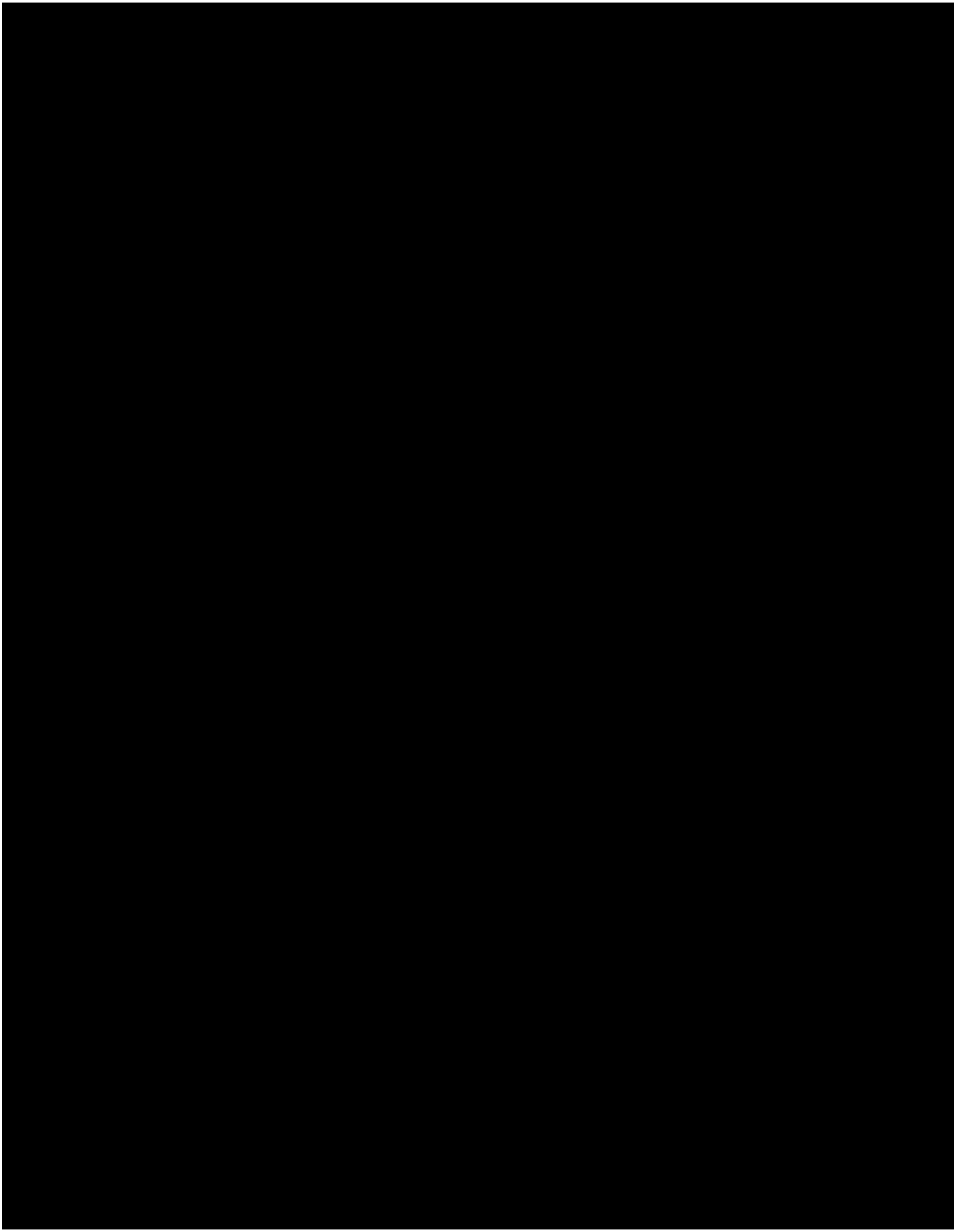
TIME LINE OF EVENTS

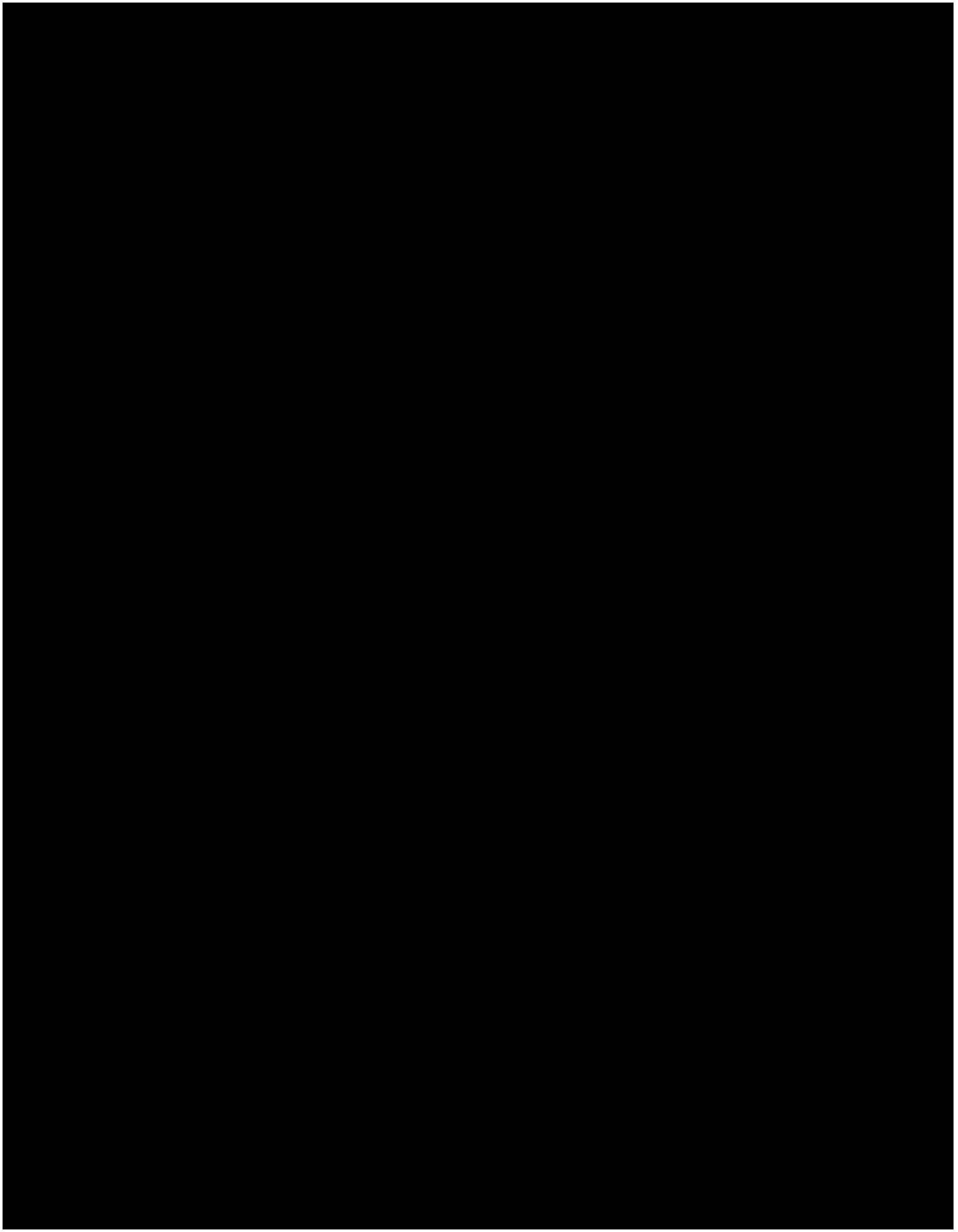
June 13, 2020 **TIME LINE OF EVENTS**

David Cains

TIME	**DESCRIPTION**
1130	Immediately, after lunch, David Cains, headed to common area kicking, yelling, and biting. (Tyler and Mandy) attempted to settle client. Suddenly, he started vomiting and turning cyanotic. Heimlich was attempted numerous times and was unsuccessful. Client became unresponsive and incontinent of bowel.
1133	Ryann called (Debi) at Judge Hill. Amanda Schmitt stated client was down and not breathing.
1134	Amanda S and Kelly K arrived. 911 was called. [redacted]
1148	[redacted]
1156	Jeff Gonyea notified by Amanda Schmitt
1158	Amanda Krigbaum (Social Worker) update given
1200	Dr. Hamid – notified.david cains - 06.13.2020
1200	[redacted]
1202	[redacted]
1205	[redacted]
1221	[redacted]







BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE McAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS, CLAIMANT, VS. ARKANSAS DEPARTMENT OF HUMAN SERVICES, RESPONDENT.	CLAIM NO. 220374

---o---

DEPOSITION

OF

CHARLENE ROBINSON

---o---

FRIDAY, NOVEMBER 4, 2022

---o---

COURT REPORTER:

DONNA K. PETRE, CCR
P. O. Box 1027
Little Rock, Arkansas 72203

A P P E A R A N C E S:

ON BEHALF OF THE CLAIMANT:

JOSHUA D. GILLISPIE, ESQUIRE
Green and Gillispie
1 Riverfront Place, Suite 605
Little Rock, Arkansas 72201

ON BEHALF OF THE RESPONDENT:

RICHARD N. ROSEN, ESQUIRE
Office of Chief Counsel
P. O. Box 1437, Slot S-260
Little Rock, Arkansas 72201

ALSO PRESENT:

RANDY SCHOENING, VIDEOGRAPHER

---o---

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Claimant Exhibit One.....	87
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The deposition of Charlene Robinson was taken before me, Donna K. Petre, Certified Court Reporter within and for the County of Pulaski, State of Arkansas, duly commissioned and acting, on Friday, November 4, 2022, beginning at the hour of 10:01 a.m., at the Offices of Green and Gillispie, 1 Riverfront Place, Suite 605, North Little Rock, Pulaski County, Arkansas.

---o---

THEREUPON, the following proceedings were had, to-wit:

---o---

* * * * * *

P R O C E E D I N G S

* * * * * *

WHEREUPON,

VIDEOGRAPHER: We are on the audio and video record. Today is November 4th, 2022, the time is approximately 10:01 a.m. This is the videotaped deposition of Charlene Robinson in the case of Christine McAuliffe versus the Arkansas Department of Human Services. Case number is 220374 in the Claims Commission of the State of Arkansas. My name is Randy Schoening, I'm a videographer from Little Rock, Arkansas.

Will counsel please introduce themselves for the record?

MR. GILLISPIE: Josh Gillispie for Claimant.

MR. ROSEN: Rich Rosen for the Department of Human Services.

VIDEOGRAPHER: Will the witness please be sworn?

(WHEREUPON, the witness was duly sworn.)

COURT REPORTER: She's sworn.

VIDEOGRAPHER: You may proceed.

MR. ROSEN: Thank you.

WHEREUPON,

CHARLENE ROBINSON,

having been called for examination, and having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. ROSEN:

Q Good morning, Ms. Robinson. My name is Rich Rosen.

A Good morning.

Q And I'm the attorney with the Arkansas Department of Human Services, and I'm going to be asking you questions this morning.

A Uh-huh. (Indicated yes.)

Q Your counsel might -- or, excuse me, Mr. Gillispie may be asking some questions, as well. I'm going to -- when I ask you a question, I'm going to assume, if you answer it, that you understood the question.

A Uh-huh. (Indicated yes.)

Q And if you don't understand it or you need me to repeat it, just let me know and I'll be happy to do so.

A Okay.

Q If for some reason you need to take a break, as long as a question is not pending, just let me know.

A Okay.

Q Okay? All right. I'm going to start out with some

preliminary things, such as, if you could kindly please state your name.

A Charlene Robinson.

Q Okay. And you're going to have to speak up.

A Okay.

Q There's a lot of microphones here and the transcript, but still we're wanting to make sure that we accurately transcribe your testimony.

A Okay.

Q And in doing that, and since we're all present here, a lot of times in communications we nod heads or say "uh-huh". On the record we have to say "yes/no".

A Right.

Q Because we take visual cues and stop, but it doesn't come out on the transcript.

A Right.

Q So, we're going to have -- I might interrupt you and say, "Is that a 'yes' or a 'no'" --

A Okay.

Q -- when you kind of nod your head. Okay?

A Okay.

Q All right. Can you -- Ms. Robinson, can you please state your address?

A I live in [redacted] My physical address is [redacted]

Arkansas.
Q Okay. And how long have you lived at that address?
A 23 and a half years.
Q Okay. And where did you live before that?
A I lived in -- I've lived nowhere but [redacted] since 1970.
Q Okay. So, you all -- you lived in that area?
A Yes.
Q Okay. Now, did you live in that house -- and your relationship to David Cains is what?
A I'm his mother.
Q Okay. And did you live in that house when David Cains was born?
A No.
Q Okay. Where did you live?
A We lived at [redacted]
Q In [redacted]
A [redacted] yes.
Q And when was David born?
A He was born [redacted]
Q And did there come a time -- and how long did you live there with him in that residence?
A In that residence? We moved, he was about three months old.
Q Okay. To another --

A We bought a home.
Q In [redacted]
A Yes.
Q And who lived with him there in the new home?
A In the new home? His father and I.
Q Okay. Was David the oldest child?
A Yes.
Q Did there come a point in time when you had other children?
A Yes.
Q Who?
A Chrissie, Christine.
Q And Christine --
A Was born [redacted]
Q So, she's three years younger, approximately?
A Yes.
Q And Christine is now known as -- what's her current name?
A If I can say it, McAuliffe.
Q Okay. Christine McAuliffe?
A Yes.
Q And did she live in the house with you and David and your husband?
A Yes.
Q Okay. And how long did you live in that house?

A The new house? I lived there from 1977 to 1984.
Q Okay. And who lived there with you?
A Well, part of the time it was my husband and my two children. Then, after, from 1982 on, it was my two children.
Q Okay. So, your husband moved out?
A Yes.
Q And I understand -- did you get divorced?
A Yes.
Q Okay. And what year was that?
A 1982.
Q In 1982. So, did David -- where did David live?
A He lived with me.
Q Okay. Did he go visit his father, did he ever live in his father's house, as well?
A He stayed with his father, yes. He lived with his father. We were -- everything was, you know, nice. We played nice.
Q Well, what I'm asking, so, were you the primary custodian or was your --
A We were -- it was dual.
Q Joint?
A Joint --
Q Okay.
A -- custody.

Q I got you. Okay. So, they would live at your house about half the time and live at his -- at their father's house about half the time?
A Approximately. But, I mean, he didn't live like the first six months and then go the last six months, no. He might -- they might stay there for a week or two or, you know, if I went out of town, of course, then he took care of them.
Q And --I'm sorry. So, that was in about 1982 starting, did you say?
A Starting in 1982.
Q Okay. And so, David would have been approximately five years old or so?
A Yeah, almost.
Q Do you have any other children?
A No.
Q Okay. And so, then, there came -- and you lived in that house until when, approximately?
A Until 1984.
Q Oh. Till '84?
A Yes.
Q And then, where did you live?
A I moved into a rental home for three months, and then I moved into an apartment for seven years.
Q Okay. Until about when?

A I moved into the apartment in 19 -- in November of 1984 -- no, I'm sorry. That was September of 1984, I moved out and then November, the seven.
Q When?
A Of '84.
Q Of '84. Okay. So, after that, where did you live?
A I moved into an apartment in [redacted]
Q Okay.
A And I lived there for seven years.
Q Okay. So, you moved into that apartment in about 1984?
A Yes, that first one.
Q Okay. And how long -- and you lived there seven years?
A Yes.
Q So, that would be until about '91?
A '91, yes.
Q All right. And so, during that seven-year period who lived there with you?
A My two children.
Q Okay. That would be David and Christine?
A David and Chrissie.
Q Did you say Chrissie?
A Yes.
Q Okay.

A Well, that's what we call her. Her name is Christine.
Q Okay. I've got it. I'll probably refer to her as Christine.
A That's fine.
Q And so -- and did this joint arrangement with your former husband at this point in time continue throughout that period?
A Yes.
Q Okay. So, David would spend -- it was basically kind of a shared type of residence?
A Yes.
Q A couple weeks over at one, a couple weeks over at the other?
A In the summer. And like I said, it wasn't necessarily two weeks in a row, but they might spend the whole weekend, or maybe in the summer they might spend a whole week.
Q Okay.
A I mean, he took them on trips once in a while.
Q Okay. And did David go to school?
A Yes.
Q Where did he go to school?
A He began his school in Friendship.
Q What's Friendship?

A Friendship is a school for the developmentally delayed.
Q Okay.
A He was there, and then they moved him to middle school, a regular middle school but a self-contained classroom, and then he went --
Q And what does that mean?
A It means that he didn't go anywhere. They were right there, they taught him everything, especially in his case. Whatever he was going to learn he learned. I mean, he learned how to write. He didn't learn how to read, he couldn't do that. But they would teach him life skills.
Q Okay. So, when you say "self-contained", he didn't move around from class to class?
A No. He went to lunch, you know, obviously, in the cafeteria with everybody else. But as far as going to other classes, no.
Q And so, Friendship was a school for the developmentally delayed?
A Yes.
Q And so, he started that in, what, first grade?
A He was -- no. He started going there when he was four years old.
Q Okay.

A Sort of a pre-school.
Q Okay. And so, he had been diagnosed early on?
A Yes.
Q Is that correct?
A (Indicated yes.)
Q You're going to have to say "yes".
A Yes.
Q Or "no".
A No, be was diagnosed early on.

MR. GILLISPIE: That's because they have to make a record.

THE WITNESS: Right.

MR. GILLISPIE: So, I like to do that as a reminder.

BY MR. ROSEN:
Q And sometimes I might think that you paused and I'll start talking, and this lady will -- she needs to get it down. So, okay. And so, what types of -- was he -- and he was in the school in a class with other children?
A Yes.
Q Okay. And he was in there until about what age?
A He was all in a classroom situation, he might have went to a different school because the elementary, they only had one self-contained classroom. But he actually graduated -- you could say that he ended his schooling

career when he was 17.
Q Okay. And what year was that, approximately?
A He was 17 in 1994.
Q Okay. And so, during this time when he was, you would say in preschool, in that self-contained school was Friendship, I think you mentioned?
A Yeah, that was one of them.
Q Okay. Oh, so, there were other schools?
A Well, yes. He went to Sequoia Elementary -- no, he didn't, he went to Center Valley.
Q I see.
A One of the elementary schools.
Q Was he mainstreamed or was he in special classes?
A No. It was special classes.
Q But it just happened to be in that school?
A Right.
Q Public school?
A Yes.
Q I got it. Okay.
A He never went to anywhere but a public school after he left Friendship.
Q All right. And so, during the time that he was a child, and I guess living in your home, were there any behaviors that you had noticed about him?
A Just your normal, maybe a little temper tantrum

every now and then, but nothing that wasn't ordinary for a child his age, you know.

Q Okay. Give me an example of a temper tantrum.

A He would just lay on the floor sometimes and kick, you know, his arms and legs, and (indicating), he would holler. So, I would redirect him. In fact, I got on the floor with him and did the same thing, and he looked at me like I was nuts. Guess what, it stopped. I mean, you know, it's like if you can't win, join them. But it did help that I got down, I guess, to his level.

[redacted]

Q Oh, they don't do it that early?

A No, they didn't then, because he wasn't even -- at that point in time, he wasn't attending any type of school.

Q Okay. So, that took us to -- you said he stopped school in about 1994?

A Yes.

Q Okay. And you lived in that home, I think you said, until '91?

A In 1994 I was living where I -- let's see. Where was I? Oh, I was living on Marina -- I was living in an

apartment on North Inglewood.
Q Okay.
A Sorry.
Q And so, from -- that was after you left the other location in 1991?
A Yes.
Q How long did you live on the Inglewood apartment?
A Two years.
Q Okay. Well, that would take you to '93, approximately?
A No.
Q I just -- so where --
A '94 to '96.
Q I'm sorry. Okay. So, let's go back a little bit. You moved out of your house in -- I think you said in 1991?
A My house, no.
Q Or your --
A I moved out of my house in 1984. I sold it.
Q Okay. Where were you living, again, in 1991?
A 1991, I was living in the apartment on North Joplin.
Q Okay. That's what I'm talking about.
A Okay. And then, later that year I moved to another apartment.
Q Okay. And so, in these two apartments in '91 and

then later that year, who lived there with you?
A Myself, and my son was living there part of the time also, and my daughter.
Q David, David?
A David, yes.
Q When you say "part of the time", where was he living the rest -- the other part of the time?
A Davie was being taken care of by an individual part of that time, because I had to work. I was working.
Q Okay.
A Sometimes two jobs. So, yeah, he was being taken -- excuse me, taken care of.
Q And when -- by another family?
A He was -- by a young woman and her daughter.
[redacted]
Q Okay. Where did she live?
A She lived in Lamar.
Q Where is Lamar?
A So, he -- Lamar, it's like close to Clarksville, out 64 Highway.
Q Okay. So, about how far from your house?
A Maybe 20 minutes, maybe.

Q All right. And how -- so, this started when, approximately?
A That started in '91 after his father was -- had passed away.
Q Okay. And so, he lived with the [redacted]
A [redacted]
Q And were they friends or family?
A They were friends. I did not know them directly, but I did know that they had worked for -- the services would take him, they worked for the same company I had worked for at one time.
Q Oh. And what company was that?
A I worked for Friendship Services at one time.
Q Okay. So, they went -- you said part-time. So, tell me how the arrangement was. And we're talking in, what, the '91 year?
A '91 he moved in there, I believe. I don't know. I can't remember exactly what month. It was fall. And he stayed there with her till they moved -- she moved to Russellville in '92, and then they lived right around the corner from where I was.
Q Okay.
A And he stayed there until 1993 with her.
Q Okay. And then, what? Then, where did he live?
A He went to live with the [redacted] in Russellville.

Q [redacted]
A They were living in Russellville at the time.
Q And were they family or friends, or did you know them?
A I did not know them, but I knew people that did know them.
Q Okay. And so, when you say he went -- so, he went, basically, to live there full-time?
A Yes.
Q Okay. So, when was the last time that David lived in your home and not just visited?
A That would be 1991.
Q Okay. So, then, the -- so, then, in -- you said that he stayed with the [redacted] and then he switched to the [redacted]
A Yes.
Q And was there a reason he switched?
A The lady just wanted to be -- she was a nurse, and she wanted to go back to nursing.
Q Okay.
A Full-time nursing.
Q And so, did she find the [redacted] or did you find the [redacted]
A No. Friendship.
Q Oh, an organization found the [redacted]

A Yes. Friendship Services --
Q Okay.
A -- found the [redacted]
Q But you didn't know them before he lived with them?
A No, I did not know them, but they were recommended.
Q All right. And then, how long did he live with the [redacted]
A Till March of 2007.
Q So, from about 1994?
A '93.
Q From 1993 to 2007?
A Yes.
Q So, about 14 years?
A Well, almost 14 years, yes.
Q Okay. And where did the [redacted] live, again?
A They lived in Russellville for a while, and then they moved to Fayetteville.
Q And during any of this time from when David moved out, out of your house in 1991 and through like 2007, I think, when you said he lived with the Roberts' through that date, did you visit him?
A Oh, yes.
Q Okay. Did you notice any behaviors that he had?
A No, not anything that I would call out of the ordinary. I mean, he would get upset or --

Q Tell me about when he would get upset.
A Well, he would just -- sometimes he would get upset or frustrated.
Q And what would happen?
A Sometimes he would just cry, or he would say, "Call my sister," you know, so I did, if I could. But, no, he wasn't doing anything -- he was hyper, too. He was hyper.
Q Now, so, I guess when he left your house in '91, he was about 14 years old?
A Yes.
Q Oh. So, when grad -- when he stopped going to school, he -- that was -- he was with the [redacted]at that time; is that right?
A Yes.
Q Okay. What school did he go to at that time?
A He was going to Center Valley -- no. I'm sorry. He was going to the high school, Russellville High School --
Q Russellville.
A -- in a self-contained classroom.
Q Okay. And so, who had custody, legal custody of him?
A Me.
Q Oh. You did?
A Yes.

Q Okay. So, during this time period -- so, the [redacted] moved -- lived in Russellville, then at a point in time they moved to Fayetteville?
A Yes.
Q Approximately when did they move to Fayetteville?
A In 1994, I believe.
Q And did they -- did you ever visit?
A I visited -- I went up there every other weekend, if I could. If I wasn't working, I was up there every other weekend. And he came home for holidays.
Q So, when you went up there for the weekend, did you stay at the [redacted] house?
A No.
Q Oh, you stayed in a hotel or somewhere else?
A I stayed in a hotel. Or sometimes I would just bring him home.
Q Oh. You would run up there and come take him back?
A Yes, yes. Most of the time, I just went up there and took him back so he could see his -- you know, he had grandparents that lived here, you know. And he was very social.
Q And so, when you would run up there and take him back, how long would he stay at your house?
A Anywhere from Friday afternoon to Sunday evening.
Q And about how often did this happen?

A I tried to get up there every other weekend, depending on my work schedule.
Q What did you do during this time period?
A What do you mean?
Q What type of work did you do?
A Oh. In that time period I was working for the Hector School District.
Q Okay. And what type of work did you do?
A I was an aide in a self-contained classroom. I had one person that I actually took care of.
Q Oh, okay. So, this -- is this a school for developmentally delayed?
A No. It's a -- no, no. It's a regular public school. They just had -- just like all the other schools, they just have a specific classroom for individuals.
Q Okay. Who were developmentally delayed --
A Yes.
Q -- or physically?
A Physically and developmentally, it could be, yes.
Q So -- I got it. Okay.
A Yes.
Q So, you're an aide to the teacher in this classroom --
A Yes, yes.

Q -- in Russellville?
A No. Hector.
Q Where is Hector? I mean, is that another county or town?
A No. It's in Pope County.
Q Okay. So, a nearby school district?
A Yes.
Q I got you.

MR. GILLISPIE: Rich is from Virginia.

THE WITNESS: I'm sorry about that.

MR. ROSEN: Yeah, I'm from Virginia. I've only been here 25 years, so I don't know -- I know where most counties are, but I don't know where all these other --

THE WITNESS: It is Pope County. It's Pope County.

MR. GILLISPIE: I couldn't tell you. I couldn't tell you where Hector is if my life depended on it.

THE WITNESS: I couldn't, either, until I started working there.

BY MR. ROSEN:
Q So, you are at -- and so, you took care of a particular --
A I took care --

Q -- developmentally delayed child at that school?
A I had one child. And if she wasn't there, then I helped with other children.
Q Okay. So, was there more than one aide in the classroom?
A Yes.
Q I got it. Okay. And how long did you do that?
A I worked there from the fall of 1992 till the spring of 1999.
Q Okay.
A And I had second jobs, too, during that time.
Q What were your other jobs during this time period?
A I filled in at Friendship, did various -- worked with various people, I worked at --
Q What -- before we go off that, what type of work did you do there?
A I worked with developmentally delayed individuals at Friendship. Just I worked with individuals.
Q I don't know what that -
A That would either be --
Q Can you provide me --
A Well, I worked with an individual that was living at home, or I worked with an individual that was living with a family. I would provide care.
Q Oh, you're a caregiver? Okay.

A Right. And I worked in a facility they had also, I worked in their school. I just filled in, I worked in the --
Q Yeah. But when you say you worked at wherever these various tasks that you did for Friendship, they were -- Friendship is a -- it was all for developmentally delayed people?
A Yes.
Q Okay. And what types of things would you do, just some examples?
A I would take them to a workshop. They had a workshop there. Or I would work in the classroom with somebody. And they had a day care during the summer, I worked there. Just various things. I worked in the group homes.
Q Okay. And you would -- what type of work, supervise care?
A Supervise, maybe make sure they bathed, make sure they ate, you know. We went on trips, like maybe we went to the Christmas parade in Russellville, and we would take them there and I was with them.
Q Okay.
A Or we would take them to the movies, I went.
Q All right. And so, I think you were about to tell me that you also had some other jobs that you did?

A I worked at a nursing home.
Q Okay. Which nursing home?
A Russellville Nursing Home.
Q And what did you do there?
A I was a certified aide, nurse's aide.
Q A CNA?
A Yes.
Q And so, this was all during this '92 to '99 time period, approximately?
A Approximately, yes.
Q Okay. Did you have any other jobs?
A Yes. I worked for the Pope County Health Department. I started that in 1998.
Q Okay. And actually, let me -- in Russellville you were a CNA. And I know what a CNA is. But just for the record, what is a --
A I'm still a CNA.
Q Oh.
A It's a Certified Nurse's Aide.
Q And what is the type of work a CNA does?
A We do things in the home, we help bathing, we do cooking. In the nursing home, it's still bathing, you observe the patient, putting -- you know, like this person seems to be more tired today, or this person is angry today for some reason. You know, we just had to

pay attention to what they were up to.
Q And did you help assist with transfers and ambulation type issues, or not?
A The only thing -- in the nursing home, yes, I would put -- help people get into a wheelchair.
Q Bathe?
A Yes. Or into a geriatric chair, or into a shower chair so they could go, you know, have a shower. Some of them could take themselves down there, but not all of them.
Q Okay. And then, you had said the Pope County Health Department?
A Yes. At one time -- there's 75 counties in Arkansas, but 69 of them had their own health departments, and some shared. So, I did personal -- they had home health, personal care, and hospice care. Well, in 2016, Hutchinson decided to break it up. He sold the license for the personal care, home health, and hospice care.
Q When you say "Hutchinson", you mean the Governor?
A Yes.
Q Oh, okay.
A Now, he left the rest of the Pope -- you know, the Health Department, he left it alone. But he sold it to Kindred, which is a company out of Kentucky. And I've

worked there since 2016 with them.
Q Okay. So, this is a little after the time period of '99?
A Yes.
Q This is all currently?
A Yes.
Q Okay. So, you worked -- I'm sorry. So, who do you work for?
A Well, it's called -- it was called Kindred. They just changed their name to Centerwell.
Q Okay.
A But it's the same --
Q And you do CNA type work?
A Yes.
Q And this is -- do you work certain shifts or --
A I work in people's homes.
Q Oh, you -- okay. You mentioned that.
A Now.
Q So, you go to the home and provide the care?
A Yes, yes.
Q So, without mentioning anybody's names.
A I can't remember.
Q When you go into a client's home who needs these care services?
A Yes.

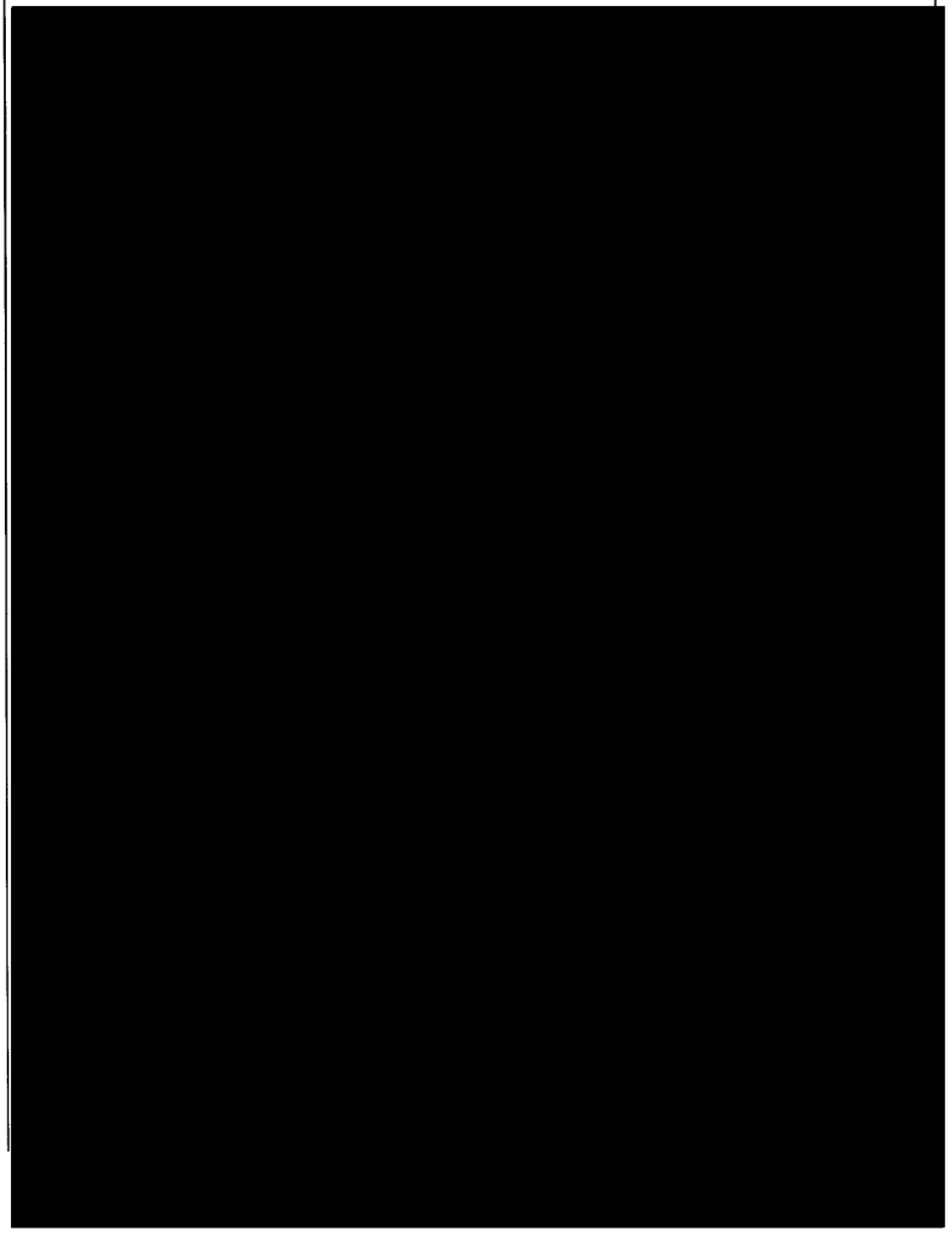
Q You -- what do you do there?
A I help them with their bathing, I may prepare a meal. I do light housekeeping, I do laundry. We're not allowed to transport at all out of the home, but I do assistance in the wheelchair, to their bed, or that type of thing. I observe them for any differences in behavior or health. You know, if they complain of headaches or backaches or any type thing like that, then I report it.
Q Okay. And that started when?
A I started doing that in 1998.
Q Okay. When did you become a CNA?
A In 1994 -- no. '93, '93.
Q Okay. All right. So, we kind of got a little ahead of ourselves.
A Okay.
Q But who is Sarah Ashley?
A She's my children's half-sister, Davie and Chrissie's half-sister.
Q So, subsequent to your first marriage to David's father, you got married again?
A No.
Q Okay. Can you explain that?
A Sarah Ashley is not my daughter.
Q Oh. She's related -- it's through your former husband?

A Yes.
Q Okay. And what is -- I'm sorry, I didn't ask you that, I'm going to ask -- what is Christina --
A It's Christine.
Q Christine McAuliffe's date of birth?
A [redacted]
Q Okay. And Ashley -- Sarah Ashley's?
A [redacted] She was born on Father's Day that year.
Q [redacted]
A Uh-huh. (Indicated yes.)
Q And she's your -- she's your children's half-sister?
A Yes.
Q And is Sarah Ashley her full -- is that her name or is that --
A Her name is Sarah Ashley.
Q Okay. And did she ever live in a home with David Cains?
A No. Now, she was there, you know, maybe on a visit. But, no, they never lived -- actually lived together, no.
Q And who is Shelly?
A Shelly is Ash -- I call her Ashley, but I will say Sarah Ashley's sister.
Q Oh. So, it's the same relation?

A Yeah. They have the same mother.
Q And how old is -- well, do you know when Shelly was born?
A I don't have any idea.
Q I understand. Did Shelly ever live in the house with David Cains?
A Yes.
Q Okay. Where and when?
A When they were living in Pottsville. Oh, gosh, approximately 1988, '89, I guess, until '90. It's like she didn't live there that whole time.
Q Okay. So, this is when -- so, like from '88 to '90 and --
A I believe. I don't -- I mean, she was living somewhere -- living up north, I think. I don't know.
Q Okay. I'm just trying to -- and I understand this was a while ago and she's not your child.
A No. I mean, I've never really --
Q You don't really know her?
A Not really. I know her, but not that well.
Q What I'm getting at is just -- so, during this time, this is before, say, your -- you were no longer married to David's father?
A No.
Q And he had remarried, apparently?

A Yes.
Q And they -- so, this is a time when David lived part-time, I guess is what you're saying, with the father --
A He lived --
Q -- and part-time with you?
A -- there part-time, and then they did move in and stay there a little bit longer because of my work schedule.
Q Okay.
A And he had a business from home. I mean, we were very on -- you know, like I said, dual custody and we supported both of them. And he supported us and I supported him. So, we did get along.
Q Okay.
A And not just for the sake of the children, I mean, we got along.
Q All right. So, we were talking about -- and we got a little out of order. But we were talking about, I guess, David at a certain point in approximately 1994 -- well, at a certain point, David came to live with the [redacted]
A Yes.
Q And again, what year was that?
A 1993.

Q Three. Thank you. And they lived locally and then they moved to Fayetteville?
A Yes.
Q And you would go on up there and would --
A I went up there, yes, and he came home.
Q Okay. And how long did he live with the [redacted]
A He lived there until March of 2007.
Q And then, where did he live?
A That's when he went to Booneville Human Development Center.
Q Oh. So, what happened at that point in time?
A What do you mean?
Q Why did he go to live there?
A Because --
Q Why did he --
[redacted]
Q Oh. That's what I'm asking. Okay.
A Yeah. I don't.



[redacted]

Q Okay. And so, you had seen him at Christmastime in 2006?

A Yes. He came home.

Q He came home?

A Yes.

Q How long did he come home for, do you remember?

A Normally I would pick him up, depending on my work schedule, again, I would have him from the 23rd of December until the 26th or 27th of December.

Q And were there other people in your home?

A My daughter would be there.

Q Which one, Christine?

A My only daughter. Yes, Christine.

Q And so, when you would bring David home when he was at the [redacted] or at the [redacted]-

A [redacted]

Q -- [redacted] did he have any behavioral issues that had to be addressed?

A No, not really.

Q Who is -- is there an Uncle Patrick?

A That's my brother.

Q Okay. Did he ever visit David?

A Oh, yes. He visited him, he would go see him and take him out for lunch or dinner. Sometimes he didn't go

until later.
Q This is -- and I'm going to jump forward a little bit. But did there come a point in time when Uncle Patrick took David, while he was at the human development center, and went into town in Booneville and had lunch at McDonald's?
A Yes.
Q And did something unusual happen?
A Yeah, there was a little behavior. I wasn't there.
Q Did you hear about -- I mean, you're the guardian?
A Oh, of course, I heard about it, yes.
Q So, what happened? What's your understanding of what happened?
A My understanding was Davie, I don't know why, he threw his Coke on him. He didn't do it -- you know, he didn't do anything else, he threw his Coke on him. Because it's a public area, my brother did the right thing and called Booneville Human Development Center.
Q What do you mean? And called Booneville to do what?
A To -- they came and picked him up.
Q Oh. So -- okay.
A Yes.
Q I understand. And what's Patrick's last name?
A Riley.
Q So, he's David's uncle?

A Yes.

MR. GILLISPIE: Pat Riley.

THE WITNESS: Yeah. I call him Patrick, but --

BY MR. ROSEN:

Q Oh, his name is Pat Riley?

MR. GILLISPIE: Yes. He goes by Pat. His name is Patrick.

BY MR. ROSEN:

Q Okay. Pat. All right.

A He goes by Pat, but I call him Patrick.

Q Okay. Well, that's fine. We're talking about the same person; right?

A Yes, we are.

Q And so, Mr. Riley?

A Yes.

Q So, he came -- do you remember when this happened, approximate year?

A I don't remember exactly when that happened, no.

Q But there was a behavioral incident in McDonald's?

A Yes, yes.

Q And so, he had -- so I understand it, he had gone to pick up David and take him into Booneville?

A Yes.

Q And they went to have lunch at McDonald's?

A Yes.
Q And I understand that McDonald's is one of his favorite places?
A Yes, it is.
Q Was?
A One of his favorite.
Q And that, I guess, during this lunch David had a behavior?
A Yes. He threw a Coke.
Q And so, why did --
A He threw the Coke -- I don't know. I mean, I don't know. He just --
Q No, no. I meant, why -- and so, then, Mr. Riley immediately called Booneville?
A He called Booneville Human Development Center to tell them what was happening, and they came and picked him up and took him back. Because when you're in public, you have to be so careful.
Q Okay. Do you know why Mr. Riley didn't just take him back himself?
A I don't know. I believe he didn't -- he just called, in case there was a situation, maybe. I don't know. I mean, I don't know.
Q Do you know whether there were other customers who were alarmed in the McDonald's?

A I don't think so. I mean, my brother did not say anything about that.
Q Was that -- had he ever thrown things, water or anything before, soda before?
A Not that I know of. He never threw anything at me like that.
Q Did he ever swat at you or punch at you?
A No, he didn't punch.
Q Did he swat?
A He would flail his arms a little bit, and if I was in the -- you know, close enough, yeah, I would get, like that. (Indicating.) But, no.
Q Do you know why he would flail --
A He was just upset, you know.
Q Okay.
A I mean, I don't know why. He would just get upset sometimes.
Q So --
A He was anxious. He would -- you know, he had anxiety issues, and sometimes he would -- but it was easy. I just sat him down, or had him go put on his Monkees. If he was at home, I would put him in his room. Tell him -- he would go in his room by himself. He would turn on his Monkees.
Q Okay.

A And then, a little while later he would come out and say, "I feel better." But there was never any --
Q And while he was visiting you or in your house, did he ever throw anything?
A No.
Q Did he ever break anything?
A No, no.
Q You're aware -- are you aware that he threw things later and broke stuff later in life?
A I don't know. I mean, maybe he did it -- I mean, if he had a behavior, obviously, at the human development center, I would find out about it. But as far as anywhere else, no.
Q Okay. Now, when he was -- I guess when he was removed from the [redacted] home in March of 2007 --
A Yes.
Q -- you were the legal guardian; right?
A I was his guardian.
Q You didn't -- he didn't come back to live in your home, though?
A No. Not then, no. It was -- no. They took him to Booneville Human Development Center.
Q Do you know why they didn't take him to your house?
A Because it probably wouldn't -- it would have been too confusing to him. This way, he went there. And, you

know, like I said, I had to work. My schedule was so varied I couldn't -- and he couldn't be left alone.
Q What about Christine, was she in a position to take him?
A Not at that time, no.
Q Did she want to -- did she offer to take him?
A She would have taken him if she could have. But, no. She had a job, she had, you know, responsibilities. She couldn't -- she had to work, too.
Q Were there other family members that lived in Arkansas at the time?
A Yes. But they --
Q They didn't take him?
A No.
Q So, he went to Booneville?
A Yes.
Q And were you familiar with Booneville at the time?
A I knew at one time it had been the sanitorium for people with tuberculosis.
Q Okay. But it wasn't at this time?
A Oh, no, no. Yes, I was familiar -- I knew about Booneville.
Q And when he went to Booneville -- so, actually, and let me just get this straight, were you the legal guardian before he went to Booneville?

A I was his guardian when he went to Booneville, yes.
Q And for the years before that, had you actually gotten legal guardianship over him?
A I was his guardian.
Q Okay. So, you were this whole time?
A Yes, I was his -- the contact, I was the one that made all the decisions.
Q And so, did you decide to put him in Booneville?
A I did decide to -- I had looked at other options. There was one in Dardanelle, but I didn't feel like it would be suitable because they didn't have any type of programs, like work, that type of thing.
Q Tell me why you chose to put him in Booneville Human Development Center.
A Well, that's where they took him. I did go there and I talked to the individuals. They had programs, they had --
Q What do you mean by "programs"?
A Programs, like work.
Q Vocational?
A Vocational programs. He worked. He had life skills programs, they sent him to a life skills class, he was able to have his own room. And, of course, he had friends. And I know at one time he went -- they took some of them, I don't know about all of them, to -- oh,

excuse me -- an aquarium in Oklahoma.
Q So, they do field trips?
A They did field trips.
Q And so, they had recreational social programs?
A Yes. And they had a pool there, which he -- he used the pool for a while, but he got to where he didn't care about it.
Q Okay.
A They had a gym. I know he went to the gym periodically and worked out.
Q And all meals throughout the day; right?
A Yes.
Q And healthcare?
A Oh, yes.
Q They had a medical team; right?
A Yes.
Q Nurses, did you ever meet any of them?
A I met some of the nurses. Yes, I did, because when I would go pick him up, I would have to get his medications.
Q Okay. And so, they all knew David; right?
A Oh, yes.
Q Okay. And David knew them; right?
A Oh, yes.
Q Did David consider the Booneville Human Development

Center his home?
A He did consider it his home, but he also considered my home his home, because he had a room, he had things at my home. He had his own room, his own bed, he had clothes, he had a TV, he had a stereo. I mean, he had everything at my home. But, yes, he did consider -- he enjoyed it. He had friends that he talked to that he would -- sometimes he would share his movies and they would watch them in the TV room, you know, a group of them. But, yeah, he told me all the time how much he liked it.
Q Did he have any friends in the caregivers that were there?
A I believe he had some that he was partial to, yes.
Q Do you know their names?
A I don't know all their names, because, you know, sometimes when I would come, there may be a different one every time I came because of their scheduling.
Q Oh.
A And I normally came on Sunday to see him when I did, so, you know --
Q So, when you would come there on Sundays to visit him at the Booneville Human Development Center, what would you do?
A Well, first of all, of course, I went to the dorm,

and then I would have to go over to Commons to get his medication. He took medicine, his medicine at --

Q Oh, this was to pick him up?

A Yeah. I picked him up at the dorm and then took him to Commons, because that's where they gave out medications for, you know, people who were eating at the cafeteria, I guess.

Q Okay.

A And I would take him and we would go to -- usually we would go to KFC, Taco Bell, or we would go to one of the pizza places, whatever he wanted.

Q And then, what?

A And then, we had to make at least one trip to Wal-Mart. We went to Wal-Mart. And sometimes he didn't buy anything, sometimes he liked walking around. But he would buy CDs or DVDs or Razorback t-shirts, and he would buy something for his sister. It was always usually a candy bar. But after that, sometimes we would go to Sonic because he wanted a milkshake.

And then, we would go back to the dorm for a little while. And anything I bought, because I kept a complete inventory sheet of everything we bought, and marked everything he got and I gave them an inventory sheet. And then, he would want to go to Dollar -- he liked Dollar Tree.

Q Okay.
A And we would go there. Sometimes he went to Dollar General, but I don't think he liked Dollar General. I don't know why. He just walked around, got a bag of chips, and that was it. And then, I always bought him supper before I left.
Q To eat with you or to take back to the --
A No. To take back to the dorm. They would put it up for him.
Q All right.
A And that, we went to McDonald's.
Q And --
A And while we were there, he watched Dukes. I mean, he would --
Q He what?
A Watched the Dukes of Hazzard while I was there.
Q Oh, TV?
A And I would clean out his drawers and his, you know, closet.
Q Would you watch TV with him?
A Yes, I did, sometimes.
Q Would that be -- and I understand that in the dorm or in the cottage, whatever you call it --
A The dorm.
Q -- they would have a TV room. But he also had a TV

in his --
A Oh, yes, he had his own television.
Q Okay. And did you notice that the TV was behind a plexiglass glass screen?
A Yes. I knew it was behind there. It needed to be behind there, because, for one thing, the rooms weren't big enough for anything. And it was -- and also, some of the other residents came in his room and would take things or touch things. So, that's why.
Q Well, do you -- was the TV bolted to the wall?
A I don't know. It had one of those -- I don't know. You can put them on any wall.
Q Okay. But it was behind a TV -- behind a plexiglass screen?
A Yes, yes.
Q Now, the TV in the -- strike that question. And did that have anything to do with him breaking the TV?
A The TV did get broken. I was not there.
Q Okay.
A I did not see it, I just know it got broken.
Q You were informed about it?
A Of course.
Q Okay. And what did he do to the TV?
A I don't know. I wasn't there.
Q Okay.

A I don't know if he pushed it over. I don't know -- I don't know.
Q Okay. Did you ask?
A No.
Q Okay.
A They just told me it was broken.
Q Okay. And so, that -- did it get replaced?
A I replaced it eventually, yes.
Q And so, when it got replaced, they took this precaution to put it behind --
A That's where I -- I also suggested -- in fact, I even bought the thing to put it on the wall. And then they said, "What about to put plexiglass on it?" And I said that would be a good idea. For one thing, nobody else can mess with it.
Q And he wouldn't be able to break it?
A No.
Q Or it wouldn't be as easy to break?
A It wouldn't be.
Q Yes. But he broke it; right?
A I assume he did. Like I said, I wasn't there. They told me it had gotten broken. Now, I don't know who witnessed it. You know, I don't know. I just know it got broken. But he -- it happened.
Q Okay. And he also listened, and I think you

mentioned about DVDs --

COURT REPORTER: She just said something, and I didn't get it.

MR. GILLISPIE: She said, "It happened".

COURT REPORTER: Thank you. Sorry.

THE WITNESS: I said it happened.

BY MR. ROSEN:

Q So, you had mentioned that you would periodically buy DVDs, or David would?

A Yes, he --

Q Or CDs. I don't know what the difference is.

A There is a difference. A DVD is more like a movie, and a CD is music.

Q So, he had a CD player and a DVD player?

A No. You could play CDs on the DVD player.

Q Okay. So, he had a player?

A Yes, he had something to play both.

Q And did they ever get broken?

A No.

Q So, the DVD player never got broken?

A No. He had the same one the whole time he was there. And it was sitting on his --

MR. ROSEN: If we could stop for a second.

THE WITNESS: Okay.

MR. ROSEN: I see that the microphone has

gotten tangled.

THE WITNESS: Oh.

VIDEOGRAPHER: You can pick that up.

THE WITNESS: No, mine is all right.

MR. ROSEN: I told you. That's fine.

MR. GILLISPIE: Does anybody need anything, water or anything? Water?

MR. ROSEN: Okay. We're good. Let's take a break.

VIDEOGRAPHER: You want to go off the record?

MR. ROSEN: Yes.

VIDEOGRAPHER: We are off the record at 10:50 a.m.

(WHEREUPON, a brief break was taken.)

VIDEOGRAPHER: We are back on the record at 10:58 a.m.

MR. ROSEN: Thank you.

BY MR. ROSEN:

Q Ms. Robinson?

A Yes.

Q Just so I understand and the record is clear. So, when did you first become the court-appointed legal guardian of David Cains?

A In May.

Q Of what year?
A 2007.
Q Oh, okay. Okay.
A I've always been his guardian, like I told you. Yes, I was court-appointed at that time.
Q Okay. So, you only became the court-appointed legal guardian in 2007?
A Well, actually, when I got divorced I was considered his legal guardian.
Q Okay. That would be through the divorce papers, presumably?
A Yes. I had --
Q But then, once David turned 18, who was his legal guardian? Did he have a court-appointed legal guardian?
A No.
Q Okay.
A He didn't. I still made all his decisions.
Q Okay. But from a -- but he was an adult at that time?
A Yes.
Q And so, but you didn't become the court-appointed legal guardian until 2007?
A Right.
Q Is that yes?
A Yes.

Q Okay. I'm sorry. And that was about the time that he went into the Booneville Human Development Center?
A Yes.
Q I got it. Okay. So, just before that time when he went in -- in the early -- in the spring of 2007 before he went into the human development center, before he was [redacted] and placed there, did -- and I think we determined that you had seen him around Christmas or December of --
A Yes, I saw him.
Q -- 2006.
A Yes.
Q What about, did Christine or Ashley or Shelly or Uncle -- or Pat Riley ever visit him while he was at the [redacted] in 2007?
A No, not that I know of.
Q Okay. How often -- where did Christine reside at that time?
A In 2007 she was living in Russellville, I believe.
Q Okay. Was she married, was she working?
A No, she wasn't married, but she was working.
Q What type of work did she do?
A She works for -- outages at nuclear plants.
COURT REPORTER: I'm sorry?
THE WITNESS: Outages at nuclear plants.

BY MR. ROSEN:

Q Do you know when the last time she went up there to visit David at -- [redacted]

A No. She saw him at Christmas of 2006, I know that.

Q At your house?

A Yes. She was home at Christmas at my house, yes.

Q Okay. Did she live at your house at that time?

A No.

Q Okay. Do you know how often she went up to visit him in, say, the fall of 2006 and into 2007?

A No, I don't. She saw him whenever I had him at home. I don't know. I don't know. She was an adult, she could do what she wanted. I don't know. I don't know. I don't know.

Q Are you aware of any times that she went up to visit him by herself without going with you or when David came to your home?

A She would go up there, yes, alone.

[redacted]

[redacted]

Q Do you know whether he had been getting his dental care?

A He, I know -- I don't know.

Q Okay. Did you --

A Because Medicare or Medicaid won't pay for dental care after a certain age. I don't know. I don't know.

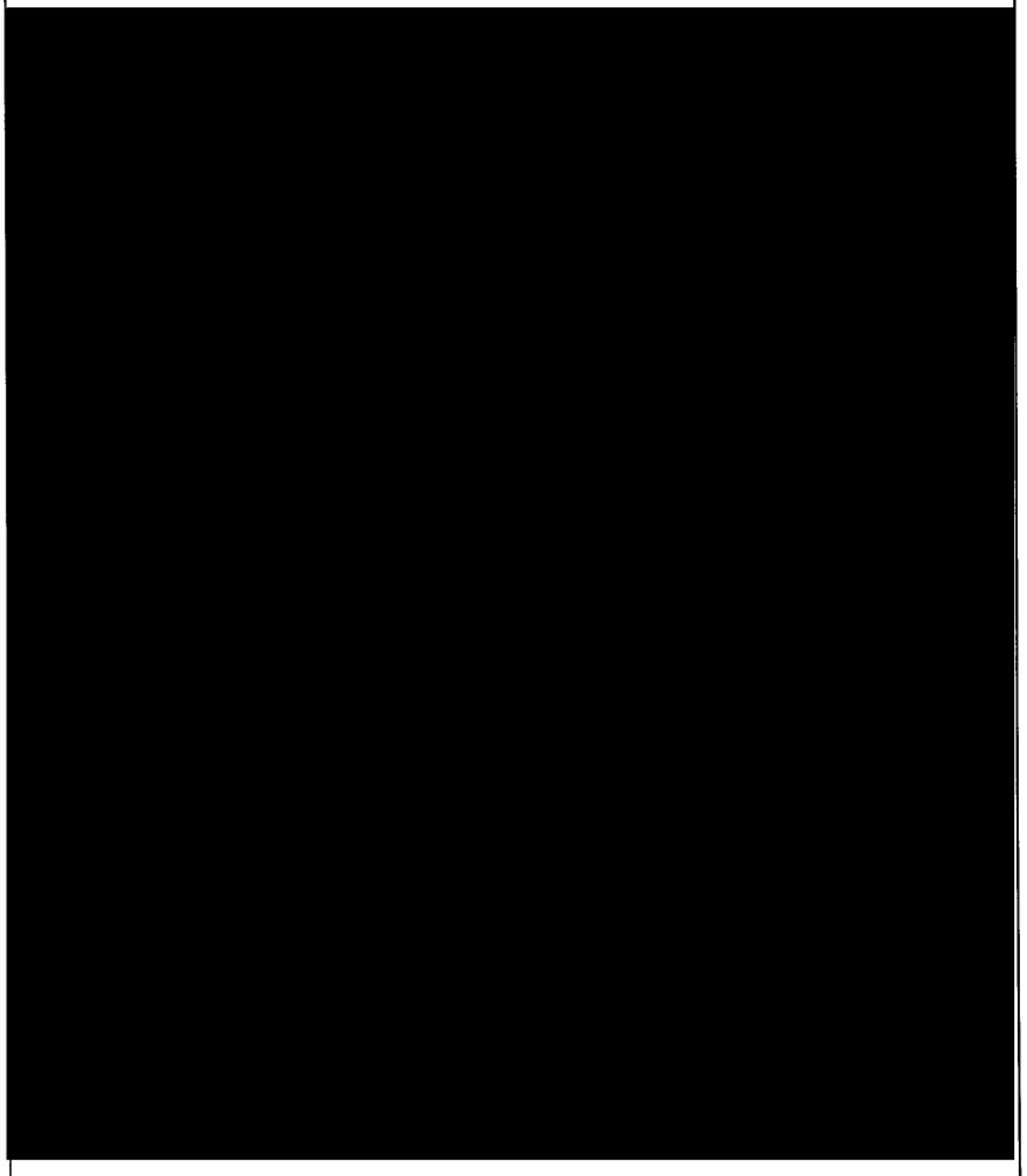
Q So, do you know whether he got dental care or not?

A He got dental care at Booneville.

Q No. Once he got there, I know.

A Yes.

[redacted]



Q Did you go to doctors with David when he had to go to the doctor?

A No.



Q Okay. And as legal guardian of David, once you became legal guardian in 2007, the court-appointed legal guardian, you got to control his placement where he lived; right?

A Yes.

Q Okay. And where did you place him?

A I placed him in Booneville.

Q Okay.

A I left him there. That seemed appropriate, so I left him.

Q And you never removed him from there?

A No.

Q Okay. And you didn't see any reason to remove him, did you?

A No.

Q And so, when he is at Booneville, as his legal guardian, you were actually involved in making decisions on his care and his Treatment Plan, were you not?
A Yes.
Q Okay. And do you know what they call that?
A IPP.
Q IPP?
A Uh-huh. (Indicated yes.)
Q And that stands for Individual Program Plan?
A Uh-huh, yes.
Q And he had one every year?
A Yes.
Q And did you participate every year?
A Yes.
Q And it was a team of people that were on the -- that developed this plan; right?
A Yes, yes.
Q It wasn't just you?
A No.
Q It was -- what type of people were on the plan -- on the IPP?
A His case manager, his supervisor at work, one of the nurses was there.
Q So, there was vocational?
A Vocational, yes.

Q There was medical?
A Yes.
Q There was, I guess, residential?
A Yes.
Q And I guess -- and a host of other ones; right?
A Yes.
Q It was a big team, wasn't it?
A Not big, but it was --
Q About how many people were on it?
A Counting me, maybe seven, I guess.
Q Okay. And they got reports from different areas as to what he needed and what he was --
A Yes.
Q And goals he needed to receive?
A Yes.
Q Okay. And you actually signed off on the care plans; right?
A Yes. I was there.
Q I'm sorry?
A Yes, yes.
Q Okay. Included in the care plan was -- they talked about David's aggression and behavioral problems, didn't they?
A They did talk about his behavior, yes.
Q And what do you remember being talked about,

generally?
A Generally, they said he sometimes was anxious.
Q And what would happen when he got anxious?
A He would sometimes shout, or he would go into his room and turn up his Monkees.
Q Okay. Did he ever have an aggressive outburst?
A Not that I know of. I was never -- I had nothing aggressive reported about him, no. No.
Q Okay. It also in there talked about restraint -- in the IPP it talked about restraint use; right?
A Yes.
Q And as a matter of fact, you would -- you would periodically be advised from the human development center social services staff about his aggressive behaviors, would you not?
A Yes.
Q And that it required the use of a restraint to calm him down or to protect himself?
A Some type, yes.
Q Okay. So, let's talk a little bit about that. Okay?
A Okay.
Q So, there were times -- and I know that generally David was calm?
A Yes.

Q But as we discussed, he would have his moments where things got -- behavioral-wise, got a little out of control?
A Yes, yes.
Q Okay. You would agree with that?
A Well, yes.
Q Okay. And that's why there is a -- it's addressed in the IPPs; right?
A Yes.
Q Do you recall addressing and discussing it in the meetings?
A We discussed certain things, yes.
Q Okay. And what would you discuss?
A We would discuss manners of what they would use to --
Q And why would they need it, though?
A If he got -- if he was going to hurt himself, they would make sure that -- or, you know, like I said, if he was going to hurt himself. If there was something in the way, he would just fly his arms out, he might have hit something.
Q So, it would be a safety issue?
A Yes.
Q I guess for himself --
A For him.

Q -- and for staff and other residents around him?
A For himself.
Q Okay. Not for the staff or other residents nearby?
A I don't believe there were other residents -- I don't know if there were other residents with him involved, if they were even -- sometimes, they would be -- I don't know. They may run into the wrong rooms. I don't know.
Q And so -- thanks. And so, when a restraint was used or necessary for safety, the Booneville Human Development Center, or at least somebody from there, would often call you and tell you what is happening?
A They would call or they would send some type of conversation, or communication of that, yes.
Q And they would talk to you as the legal guardian; right?
A Yes.
Q And Mom?
A Yes, I was his -- I'm his mother.
Q And so, and that would be discussed at the annual meetings for his IPP; right?
A Yes, yes.
Q Okay. So, it wasn't just once a year. You would get calls from, say, the staff about problems in David's behavior?

A No, no.
Q Oh, you wouldn't?
A I did not get phone calls, no.
Q Okay. So, you would have conversations with them?
A I would have conversa -- when I -- no, I didn't have conversations with that staff, no.
Q Okay. I thought you just said you did?
A No.
Q Okay. So, do you know who Jennifer Barry is?
A I don't know.
Q Okay. Did you ever talk to her about David's behavior?
A Not that I can recall.
Q Okay. And in the IPP, the treatment team, which included you at least every year; right?
A Yes.
Q Okay. The development team, I don't know what they call it.
A No, right.
Q But the IPP team that developed it?
A Yes. The team that -- yes.
Q Okay. They found that David's Behavioral Treatment Plan was appropriate each year; correct?
A For certain things, yes.

Q Okay. And that would include you; right? You agreed with it?
A I would approve whatever they presented.
Q Yes. And that would include the use of emergency restraints for safety?
A A papoose board.
Q Okay.
A Yes.
Q What's a papoose board?
A A board that they put him on.
Q Okay. So, you approved that?
A I approved that.
Q Okay. And is that -- that is put on there on the ground, he has got to be on the ground, they would put him on it?
A No.
Q Okay. Did you approve any emergency holds?
A No.
Q Okay. Did you approve -- and we're talking in the IPP.
A I know what you're talking. I know.
Q And did you approve early chemical intervention?
A They did have chemical intervention of some sort, yes.
[redacted]

[redacted]

Q And when would he need that?
A Not very often. I don't know. They did not call me every time he had a behavior and ask me.
Q Well, now, I don't mean every time. I mean, but they would update you periodically, would they not?
A Only if I asked how he was doing, they would answer, yes.
Q Did you ever ask?
A I asked every time I got a phone call from every week when he talked to me. Yes, I asked about him.
Q So, you would ask the staff? That's kind of where I was going.
A No, not the staff.
Q Well, who would tell you about his behaviors?
A Caleb Murray is the person I would talk to directly.
Q Okay. And he -- Caleb, Mr. Murray would tell you about David's behaviors?
A He would tell me if there were any behaviors or something, say, "No, he didn't have any issues this week." I mean, he would inform me what was going on, yes. I knew what was going on with him.
Q Okay. And that's what I'm asking, what was going

on?
A Yes.
Q Because I don't know, so I'm asking you.
A I knew what was going on with him.
Q What? What was going on?
A If he had a behavior, he told me.
Q Okay.
A But there were many times he said, "He has had a good week, he's happy," that type of thing.
Q Sure.
A But I did not get a letter in the mail all the time.
Q Oh, I'm not asking about a letter. I'm just --
A And I did not talk to the staff. It was Caleb.
Q Okay. So, you just spoke to Caleb?
A Yes.
Q Caleb is part of the staff, is he not?
A Yes, but not in the essence of --
Q I mean, he works at the Booneville Human Development Center?
A Yes. But he's the case manager. He does not work in the dorm.
Q Okay. But he would update you about David's behavior problems --
A Yes, he would.
Q Let me finish the question. Okay? Because this

lady has to take it down.
A Okay.
Q So, he would have -- he would update you on David's behaviors and behavioral problems?
A Yes.
Q His good behavior and his bad behavior?
A Yes.
Q And he would update you periodically about that David's behavior required some safety restraints; correct?
A Yes.
Q Okay. In fact, you -- each year, you signed the IPP?
A I signed off. Of course I did, I was there. Yes, I signed.
Q And you found it -- and you and the treatment team all agreed that -- each year that this was -- the Booneville Human Development Center was a good placement for David?
A I believed it was, yes.
Q Okay. Because there were other options; right?
A Yes.
Q Okay. And you had explored them, I think you said earlier?
A I had explored them.

Q Okay. I'm just going to actually introduce a document, and it's not stapled, it's just clipped, and I'm not -- we're not going to go through the whole document. Okay?
A Okay.
Q I just want you to look at it and --
A In a minute.
Q Do you need your glasses?
A Yes.
Q Okay.

MR. ROSEN: And while we're doing that, I'm going to go ahead and introduce the Notice of Deposition as DHS Exhibit One.

(WHEREUPON, DHS Exhibit Number One was marked for identification.)

BY MR. ROSEN:
Q And what I'm going to show you is -- the booklet is labeled "Booneville Human Development Center Individual Program Plan". It says, "Date of identification," it's -- well, this is for 2018?
A Yes.
Q Do you recognize that?
A I have one. Yes.
Q And you can flip through it.
A I --

Q And it's Bates stamped -- and I don't -- CM1346 through 1430 -- 1346 to 1437.
A 1346, where do you get that?
Q On the bottom. It's just page numbers.
A Oh.
Q Okay. And while you're -- I'll let you look through it. But if you would just turn to page -- oh, maybe about the third page of that, which is CM1348.
A Okay.
Q And it has a bunch of signatures on there. About the third page in there.
A Yes.
Q And one of those signatures is yours; right?
A Yes.
Q And what's the date of that?
A August 9th, 2018.
Q Okay. And so, this was the plan for that year; right?
A Yes.
Q Okay. In fact, the -- all right.

MR. ROSEN: We don't need to go through all of that. I'm going to move this be introduced as DHS Exhibit Two.

THE WITNESS: Yes, I see it here. I have seen it.

MR. ROSEN: Counsel, do you want a copy? I know you have it probably.

(WHEREUPON, DHS Exhibit Number Two was marked for identification.)

BY MR. ROSEN:

Q And I'm going to show you what's marked as -- what we're going to mark as DHS Exhibit Three, which is identified as Booneville Human Development Center Individual Program Plan. And it's Bates stamped CM1453 through -- these are the page numbers.

A Yes, I know.

Q CM1544. And this is for 2019. If you could identify that and peruse it? And I'll just ask you one or two questions on it.

A (Witness reviews document.)

Q Okay. And are you still reviewing it?

A I'm just looking at it.

Q Okay.

A There are a lot of blank pages. (Witness reviews document.)

Q Have you read it?

A No, there's all them blank pages.

Q Well, there are some, I guess, forms in the back.

A Blank pages.

Q So, I'm going to -- if you are done, do you

recognize this document?
A I recognize the document, yes, obviously.
Q Okay. And this is the -- according to, on the first page, it says it's for the annual review date of 07-18-19.
A Uh-huh. (Indicated yes.)
Q Is that "yes"?
A Yes.
Q Okay. So, this is the -- this is really just the next year's version of what we just talked about as Exhibit Two; right?
A Right.
Q So, this is Exhibit Three, and this is for the year 2019 into '20; correct?
A Yes.
Q And just turning to page three of the document, that's your signature on there, is it not --
A Yes.
Q -- on 1455?
A Yes.
Q And also, on there it says Chrissie Cains; correct?
A Yes.
Q And that's your daughter?
A Yes.
Q Okay. And everybody signed it on July 18th of 2019;

right?
A Everybody I can see here.
Q Yes. And this has the same type of treatment teams that made recommendations?
A Uh-huh. (Indicated yes.)
Q And discussed the care and treatment; correct?
A Yes.
Q And it also included discussions of David's behaviors and safety precautions, including restraints; right?
A Yes.
Q Okay. And I just want to -- I'm not going to go through the whole document. Just want to point out on page 1463. If you would turn to that?
A (Witness complies.) Okay.

[redacted]

[redacted]

A I never -- he never broke a -- I don't know about the radios and the DVD player.

Q Okay.

A I do know about the television. I don't know anything about a window.

[redacted]

Q And so, if you look at -- well, okay. So, we're going to -- but you signed this, and these issues were discussed at the meeting?

A Yes, they were.

Q Okay. All right.

MR. ROSEN: Introduce that as Exhibit Number Three.

(WHEREUPON, DHS Exhibit Number Three was marked for identification.)

THE WITNESS: I wanted to --

BY MR. ROSEN:

Q I only have a few more minutes.

A Okay.

Q Okay. So, let's change a little course of topics. Okay? And let's talk about, so David Cains passed away, when did he pass away?

A June 13th, 2020, on a Saturday.

Q Okay. And when was the last time that you had visited with him?

A February 16th, 2020, on a Sunday.

Q Okay. And you went to the Booneville Human Development Center?

A Yes, I did.

Q And did you do what -- kind of the routine that we just talked about?

A Yes.

Q The Wal-Mart, type of food?

A Yes.

Q McDonald's?

A Yes.

Q Okay. A day visit?

A Yes.

Q All right. And did you go up there by yourself, did you have somebody with you?
A I was by myself.
Q All right. Now, did you -- before David passed away, were you on any -- were you going to any type of counseling or therapy or having any treatment for emotional or psychological issues?
A No.
Q And after he had passed away, did you undergo any such treatment?
A No.
Q And before David passed away, were you on any antidepression medications?
A No.
Q Any antianxiety medications?
A No.
Q Any type of antipsychotic medications?
A No.
Q And what about afterwards, did you start any such medications?
A No.
Q So, you didn't take any antidepressants, any antipsychotics, or antianxiety pills?
A No.
Q I'm going to ask you -- I know that Christine has a

different name now. So, at some point in time, I assume she got married?
A Yes.
Q Okay. And it's my understanding, she lives in Vermont?
A Yes.
Q Do you know when she moved to Vermont, approximately?
A Approximately -- I don't know. 2015, 2016, I think. I'm not sure.
Q Okay. And she got a job up there?
A Yes. In that area, yes.
Q And so, how often would she come back down to visit you?
A She would come at least once, maybe twice a year.
Q Okay. And when she came to visit you, did she also go to see David?
A Always, yes.
Q So, that would be once or twice a year?
A At least once or twice a year, on average.
Q All right.
A Yes.
Q Do you know who the Disability Rights Arkansas organization is?
A I know what it is.

Q Have you ever spoken to them?
A No.
Q You never spoke to anybody from them or to them about David?
A No.
Q You never spoke to them at the Booneville Human Development Center?
A No.

MR. ROSEN: I think that's all the questions I have. Thank you very much.

CROSS EXAMINATION

BY MR. GILLISPIE:

Q Ms. Charlene, was there -- you said that you had last visited David in February of 2020?
A Yes.
Q Was there a reason that you had not been able to visit him since February, 2020?
A Yes.
Q What's the reason?
A COVID.
Q And could you -- was there -- or was visitation suspended?
A Yes.
Q Mr. Rosen showed you David's IPPs from 2018 and 2019. And those have been introduced as Respondent's

Exhibits Two and Three to your deposition.
A Yes.
Q And did you review -- you took a look at those; right?
A Yes.
Q And he asked you questions about that?
A Yes.
Q As far as you know, is there any mention of ground restraints anywhere in either of these documents?
A No.
Q As far as you know, did anybody at Booneville ever talk to you or tell you that David might be restrained on the ground?
A No.
Q All right. Is there any mention in either of these same documents about a policy that they had whereby only medical staff could call 911?
A No, no.
Q Did you see anything in those documents that mentioned that?
A No.
Q Did anybody ever tell you that there was a policy at Booneville whereby direct care staff could not call 911?
A No.

Q On the day of your son's death, did someone call you to notify you that he had passed away?
A Somebody called me, yes.
Q And how did they tell you he had died?
A The person that called me said he had choked on his lunch.
Q Okay.
A While eating lunch. But they know he has -- you know, that's what I was told.
Q Okay. I'm showing you an envelope here. Take a look at that.
A Okay. (Witness complies.) Yes.
Q That's an original envelope, so there is no copy of it?
A Yes. I must have taped it shut.
Q Okay. You received a letter in this envelope after David's death?
A Yes.
Q Could you tell -- is there a postmark date on that?
A Yes. It appears to be 22nd June '20.
Q Okay. Could you hold that up for the camera?
A Uh-huh. (Witness complies.)

THE WITNESS: You got it?

VIDEOGRAPHER: Yes.

THE WITNESS: Okay.

BY MR. GILLISPIE:
Q And did you receive that letter -- so, it's postmarked June 22nd, 2020. Did you receive that letter either on the 22nd or the 23rd of June?
A Yes, yes.
Q And did that -- and that envelope contained a letter; correct?
A Yes.
Q Let him take a look at it, and then I'll ask you one or two questions about the letter.
A Okay.
Q Now, Ms. Charlene, is this the actual copy, the original letter that you received?
A Yes, yes.
Q Okay. And who is that letter from?
A Caleb Murray.
Q Okay. And who is -- and Caleb Murray is who?
A Program Coordinator/Social Worker. I call him case manager.
Q Is it a letter from the Booneville Human Development Center?
A No, there's nothing on it. It just says -- where is it? It says, "Human Services", which is the department he was in.
Q Okay. Is it a letter from the Arkansas Department

of Human Services?
A Yes, Arkansas Department of Human Services.
Q Okay. And it was written by Caleb Murray?
A It appears to be, yes.
Q Okay. And where did Caleb Murray work?
A He worked at Booneville, and he was in social services.
Q He was David's social services worker?
A Yes, he was.
Q Okay. And I would like you to just read the entire letter.
A Okay. "Reference: David Cains. Dear Ms. Robinson" --
Q Speak up, please.
A Okay. Sorry. My throat is a little dry. "Enclosed you will find a copy of the Final Synopsis of an incident that was reported to you earlier. As always, I appreciate your cooperation and involvement. If you should have any questions or concerns, please do not hesitate to contact me. I can be reached by phone at 479-675-1406 or by email at Caleb" --
Q That's fine.
A You know, I couldn't do that anyway.
Q And this letter came with a Final Synopsis?
A Yes.

Q But it references a Final Synopsis?
A Yes.
Q And is this the Final Synopsis that you received on that day? (Indicating.)
A Yes.
Q Okay. And I won't ask you to read the entire thing.
A Okay.
Q But what did this Final Synopsis contain? What did you learn from this Final Synopsis?
A I learned that he choked while eating lunch. I learned that there was maltreatment of some sort. Well, it says "maltreatment".
Q You had been told he choked while eating lunch?
A Yes, that's what I had been told.
Q But did this Final Synopsis give you new information that you hadn't known previously?
A Only that he was restrained on the floor.
Q Okay.
A Other than that, no.
Q This Final -- does this Final Synopsis reflect that your son had -- there had been a restraint incident related to his death?
A It -- yes.
Q Does it reflect that there was a maltreatment investigation into the people who restrained -- into the

direct care staff that restrained David?
A Yes.
Q Prior to receiving this letter on either June 22nd or June 23rd of 2020, had you ever been informed that there had been a restraint incident that led to his death?
A No.
Q Prior to this letter, had you ever been informed that there was a maltreatment investigation related to your son's death?
A No.
Q Okay. Nobody ever called you and mentioned anything like that to you?
A No.
Q And you -- again, you received this letter on either June 22nd or June 23rd?
A Yes.
Q And your son died on June 13th?
A Yes.
Q Okay. At the time you received this letter, had your son's funeral already occurred?
A Yes.
Q Was he -- what day was he buried?
A June 19th.
Q And was that a Friday?

A Yes, it was.
Q Okay. And you received this letter either three or four days after he was --
A Yes.
Q -- was buried?
A Yes.
Q And again, prior to this letter, you -- and as far as you know, neither you, and as far as you know, nobody in your family had received any notice whatsoever that there had been a restraint incident that led to his death or a maltreatment investigation into that restraint incident?
A No.
Q Okay. If you would, hold the letter up for the camera.
A Like this? (Indicating.)
Q Yes.

MR. ROSEN: Are you going to introduce it?

MR. GILLISPIE: Yes.

MR. ROSEN: Okay.

MR. GILLISPIE: And can you hold up the Final Synopsis?

THE WITNESS: (Complies.)

MR. GILLISPIE: Yes. You got it?

VIDEOGRAPHER: Uh-huh. (Indicated yes.)

BY MR. GILLISPIE:
Q Okay. And I'll introduce the envelope as a --
A I wrote on this one.
Q Well, I'll make a copy of it. But make the envelope Exhibit One, and then we'll make the letter and the attached Synopsis Exhibit Two, because they're one document, really.
A They came together.
Q They came together. And in fact, since this is the original, I'll make copies of the exhibits. I have one.

MR. GILLISPIE: Give me just a moment, please. I'm not sure I have anything else.

MR. ROSEN: Do you want to go off the record?

MR. GILLISPIE: Yes.

MR. ROSEN: You've got to make the copy anyway.

VIDEOGRAPHER: We are off the record at 11:37 a.m.

(WHEREUPON, there was a discussion held off the record.)

(WHEREUPON, Claimant's Exhibit Numbers One and Two were marked for identification.)

VIDEOGRAPHER: We are back on the record at 11:41 a.m.

BY MR. GILLISPIE:
Q Okay. Ms. Robinson, I'm showing you once again the Final Synopsis that you received in the mail on June 22nd or June 23rd of 2020 which has been marked as Claimant's Exhibit Two to your deposition. I would like, if you could, read that first paragraph under "Final Synopsis".
A "I have reviewed the Adult Maltreatment Investigation Report prepared by Sandy Evans, Residential Services Director/Adult Maltreatment Investigator, as well as all supporting documentation. This report concerns David Cains, client, and BHDC facility."
Q Okay. And I would like you to, the next paragraph, read the first three sentences of the second paragraph.
A "On 6-13-20, David Cains purportedly vomited and choked during a behavior incident at the Commons Building at approximately 11:30 a.m. David had physically attacked and he was held in personal restraint on his left side by" --
Q And are there -- there are portions of this that are redacted?
A Yes.
Q The name of the person he allegedly attacked is redacted?
A Yes.
Q And then, the names of the people who, it says,

restrained him on his left side are redacted?
A Yes.
Q Okay.
A There are names redacted.
Q Okay. Now, I would like you to read the last part that says -- starting with, "Based on", and then those two little paragraphs under that.
A "Based on interviews and written statements by BHDC staff, I find: There is insufficient evidence to corroborate maltreatment of David Cains by," and there it's redacted, "and/or," and another redacted. "All staff conducted themselves in an appropriate manner and immediately responded to help David in this crisis. All staff was current on their CPR training and CPI training and followed Mr. Cains' IPP dated 7-18-2019. Therefore, I find there is not sufficient evidence to substantiate a finding of Adult Maltreatment by facility nor staff." And then, redacted, "and," redacted, "will report back to full duty June 18, 2020."
Q And then, what's that?
A "CLOSED".
Q "CLOSED". And did you have any idea what they were -- what this was talking about at the time you received this letter?
A No.

Q This is the very first you had heard of any of this?
A Very first I had heard.
Q Did anybody ever follow up with a phone call and give you some explanation as to what all this meant?
A No.
Q Never?
A Never.
Q Okay. Nobody from Booneville, nobody from DDS, nobody from DHS ever gave you the courtesy of a phone call to go over this incident and the contents of this letter and give you some answers?
A No.
Q Or even to express condolences?
A No. What do you want me to do with this?
Q You can have that.
A Okay.
Q Okay. Do you miss your son, Ms. Robinson?
A Yes. I think about him every day.
Q Could you say that again?
A I think about him every day.
Q What do you think about when you think of him?
A I think about how happy, you know, he was there, about how much fun he had coming home, about his Monkees, and his sister, you know, his sister, he asked about her

all the time.
Q Were they extremely close?
A They were very close, yes.
Q Had they been close their whole lives?
A Yes.
Q What do you -- what are some of the things you miss most about Davie?
A I miss just his bubbly personality. I miss being able to speak to him every week, and we would talk about, you know, what he did for the week. And, of course, he always wanted chicken, that he wanted me to come see him.
Q Did you speak to him every week?
A I spoke to him every week.
Q And what did he talk about, typically?
A Typically, I talked about how he -- I asked him, "How are you doing," "I'm doing good." "What have you been doing," and he would tell me he would go to work or he was listening to his Monkees and watching TV. Of course, during COVID, obviously, things were limited. But he was happy. And when I explained to him I couldn't come up there, he understood.
Q He understood?
A Yes.
Q Is there anything else you would like to share about

David, about who he was and what he meant to you?
A He meant the world to me. I mean, I was his mother, but we were friends, too. We laughed, you know. Yes, we argued, but you argue with your children, you know, and he would -- sometimes when I would take him shopping, he would say I owed him money. He was always using my money. But it was fun, we had very good outings. We went on drives, you know, take a drive. And I just miss him, I miss him, I miss him coming home. He had his own room, his own TV, you know, at my -- or I call it our home. And he was a lot of fun to be around.
Q Did you ever spend time with him at Christmas?
A Always. He was there at Christmas always.
Q Are Christmases without him hard?
A There was one Christmas that we decided not to be with him, and that was due to the weather.
Q Are Christmases, now that he's gone, difficult?
A Yes. I still put the tree up because he loved the tree. I hung his huge stocking that a friend of mine decorated for him, and I put that out by the tree, too, because he --
Q You still put his stocking up every year?
A Yes. And he has a little tree that he decorated for Halloween, and then let those kids -- this is funny, Halloween, you know, decorations, and then turn around

and put Christmas decorations on the same tree with the Halloween.
Q He did that?
A He did that. Because I was going to take them off, "No, no. These are going to stay on."
Q Did he love Halloween, too?
A He liked Halloween, he did.
Q Yes. Would he dress up?
A He did dress up sometimes. They had -- sometimes they would have, you know -- and I know they had cookouts and stuff like that, through the year for different occasions.
Q Yes.
A But, yeah, he would dress up sometimes.
Q Okay.

MR. GILLISPIE: Well, thank you, Ms. Robinson, I don't think I have any further questions for you.

THE WITNESS: Okay.

MR. ROSEN: I have a few more.

REDIRECT EXAMINATION

BY MR. ROSEN:
Q Just a few followup questions for you.
A Okay.
Q What does the word "investigation" mean to you?

A It's investigating the circumstances, what may have happened surrounding an individual or a situation.
Q Okay. So, like an inquiry?
A An inquiry, asking questions, yes.
Q So, investigations take a little bit of time, don't they?
A Normally, yes.
Q So, it wouldn't be unusual, in your mind, would it, for something, an event to happen, whatever it is, and then the investigation to be conducted once that happened would take several days, or even sometimes longer?
A It could take a while, yes.
Q Okay. So, that wouldn't be unusual?
A No.
Q Okay. And you mentioned that -- so, after you received what has been marked as Claimant's Exhibit One, the letter?
A Yes.
Q Did you call anybody at Booneville Human Development Center and ask what it meant?
A No, I did not.
Q Okay. And there were members of the Booneville Human Development Center at David Cains' funeral; right?
A His case manager and his supervisor.
Q Because they're the ones who took care of him on a

day-to-day basis; right?
A Part of them, yes.
Q And they knew him?
A Yes, they knew him.
Q And were they upset?
A Yes.
Q Okay.

MR. ROSEN: I have no other questions. Thank you.

VIDEOGRAPHER: We are off the record at 11:50 a.m.

(WHEREUPON, at 11:50 a.m., the taking of the above-entitled deposition was concluded.)

---o---

DHS Exhibit One:

DHS Exhibit Two:

DHS Exhibit Three:

Claimant Exhibit One:

Claimant Exhibit Two:

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, DONNA K. PETRE, Certified Court Reporter in and for the County of Pulaski, State of Arkansas, duly commissioned and acting, do hereby certify that the above-entitled proceedings were taken by me in Stenotype, and were thereafter reduced to print by means of computer-assisted transcription, and the same fully, truly, and correctly reflects the proceedings had.

I FURTHER CERTIFY that I am not attorney or counsel of any of the parties, nor am I relative or employee of any attorney or counsel or party connected with the action, and have no interest in the outcome or results of this proceeding.

WHEREFORE, I have subscribed my signature and seal as such Court Reporter in the City of Little Rock, County of Pulaski, State of Arkansas, this the 20th day of November, 2022.

_____
DONNA K. PETRE, CCR #125
COURT REPORTER IN AND FOR
PULASKI COUNTY, ARKANSAS

---o---

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS — CLAIMANT

VS. — CLAIM #220374

THE ARKANSAS DEPT. OF HUMAN SERVICES — RESPONDENT

NOTICE OF DEPOSITION

To: CHARLENE ROBINSON

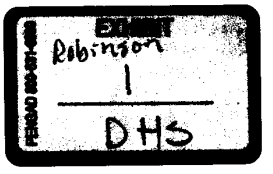
PLEASE TAKE NOTICE that pursuant to Rule 3.3 of the Rules and Regulations of the Arkansas State Claims Commission and the Rule 30 of the Arkansas Rules of Civil Procedure, the Respondent, the Arkansas Department of Human Services, by counsel, will take the deposition of **CHARLENE ROBINSON** on the date and time and at the place identified below.

The examination shall cover all matters, issues and factual allegations raised and/or related to the matters, issues and factual allegations raised in the claim. The deposition shall be taken, under oath, before a certified Court Reporter authorized to administer oaths and shall be used for the purposes of discovery and for evidentiary purposes to the fullest extent allowed.

Date: **FRIDAY, NOVEMBER 4, 2022**

Time: **10:00 a.m.**

Place: **1 Riverfront Place, Suite 605**
North Little Rock, AR 72114



ARKANSAS DEPARTMENT OF HUMAN SERVICES

By: Rich Rosen

Richard N. Rosen, Bar # 97164
Office of Chief Counsel
P.O. Box 1437, Slot S-260
Little Rock, Arkansas 72201
(501) 682-8608

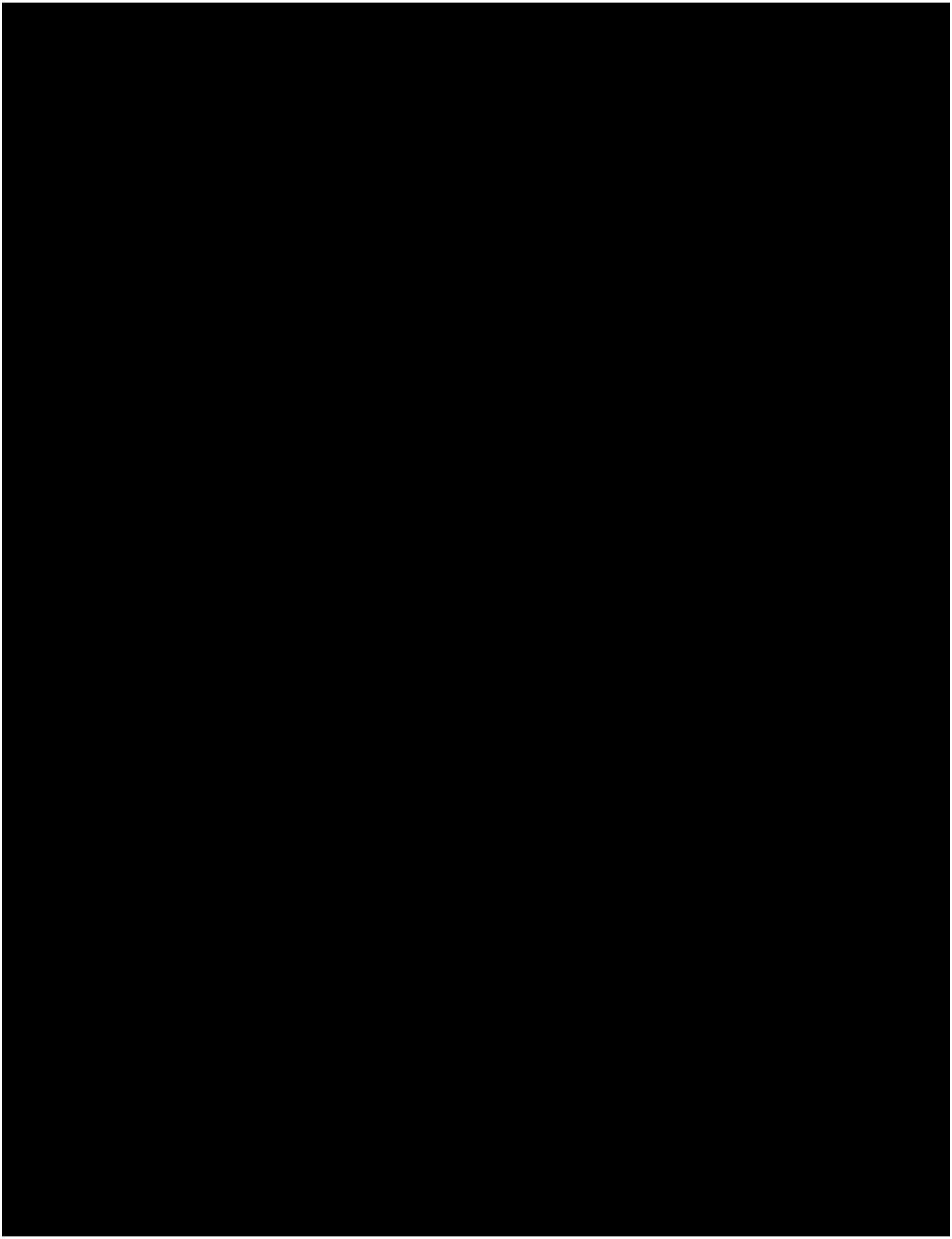
CERTIFICATE OF SERVICE

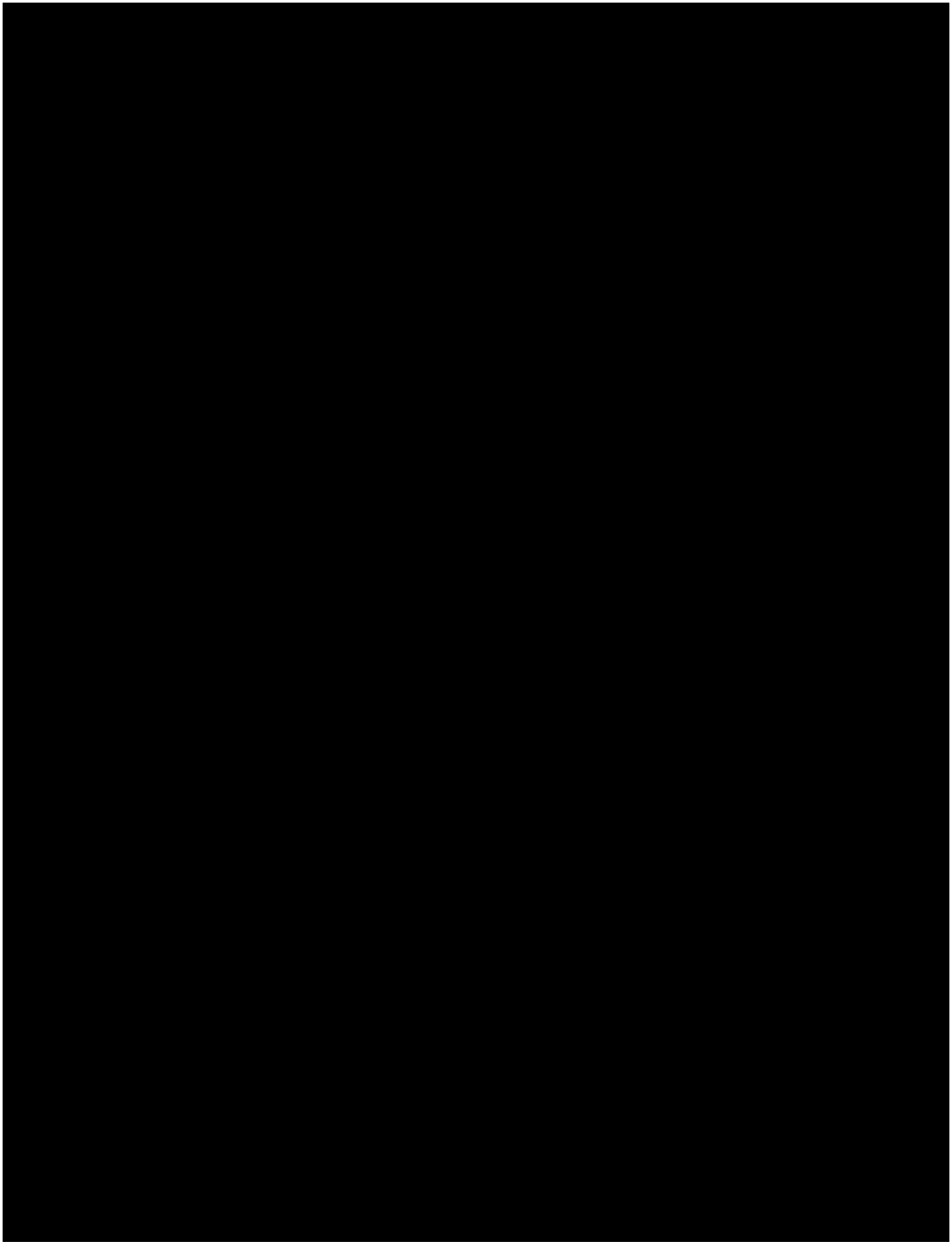
This is to certify that a copy of the foregoing Notice was mailed, postage prepaid, and emailed this 15th 16th (RR) day of September, 2022 to:

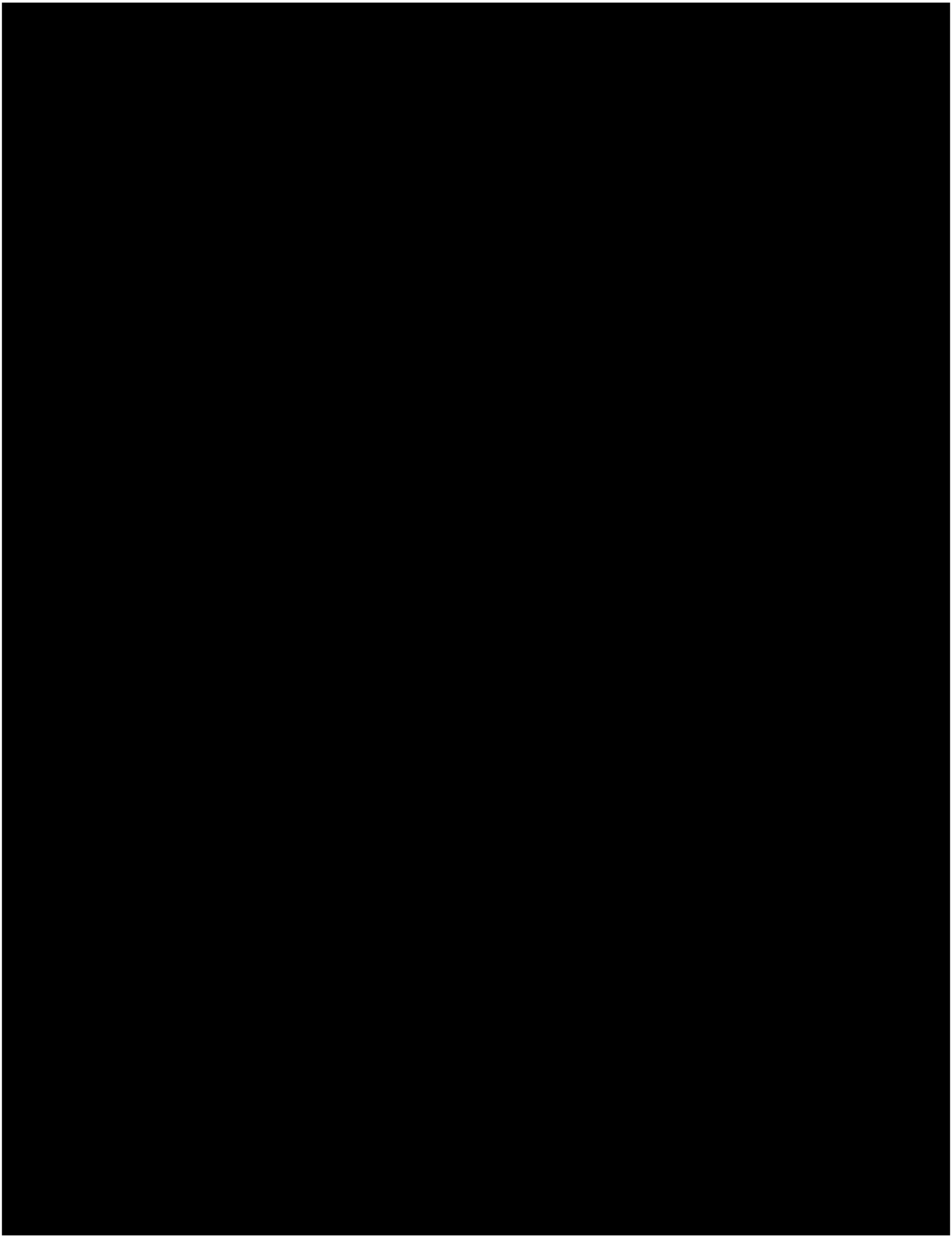
Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114

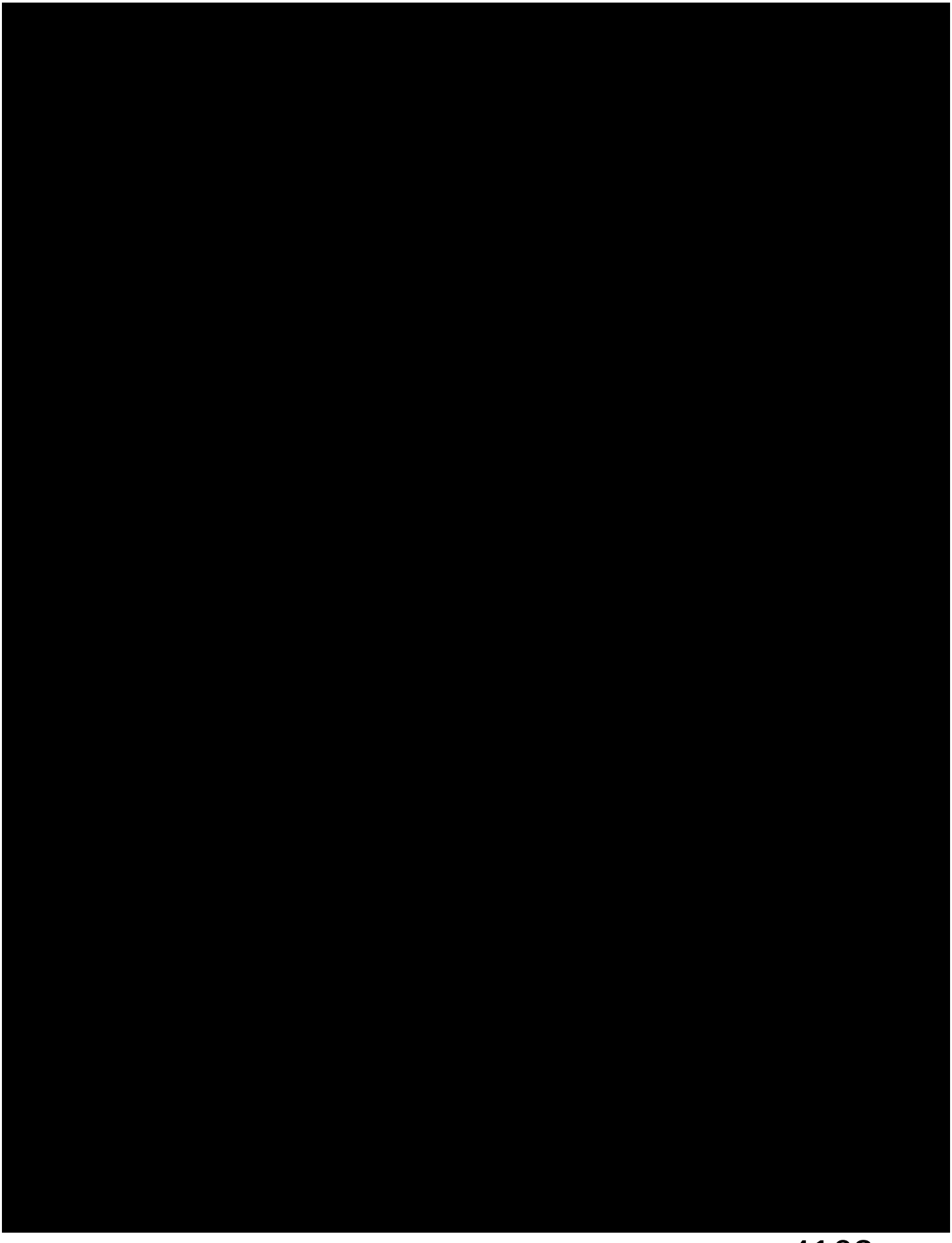
josh@greenandgillispie.com

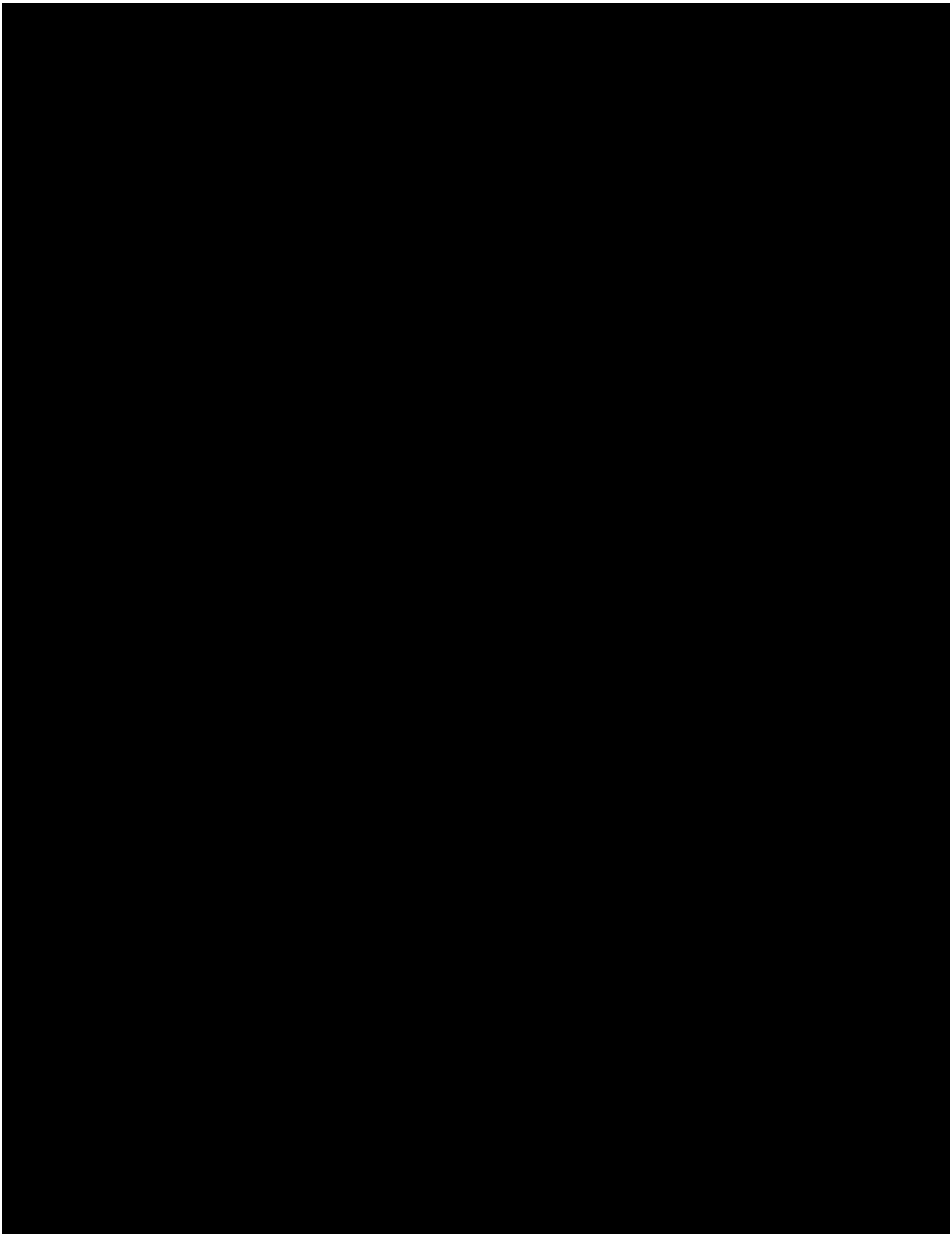
Rich Rosen
Richard N. Rosen

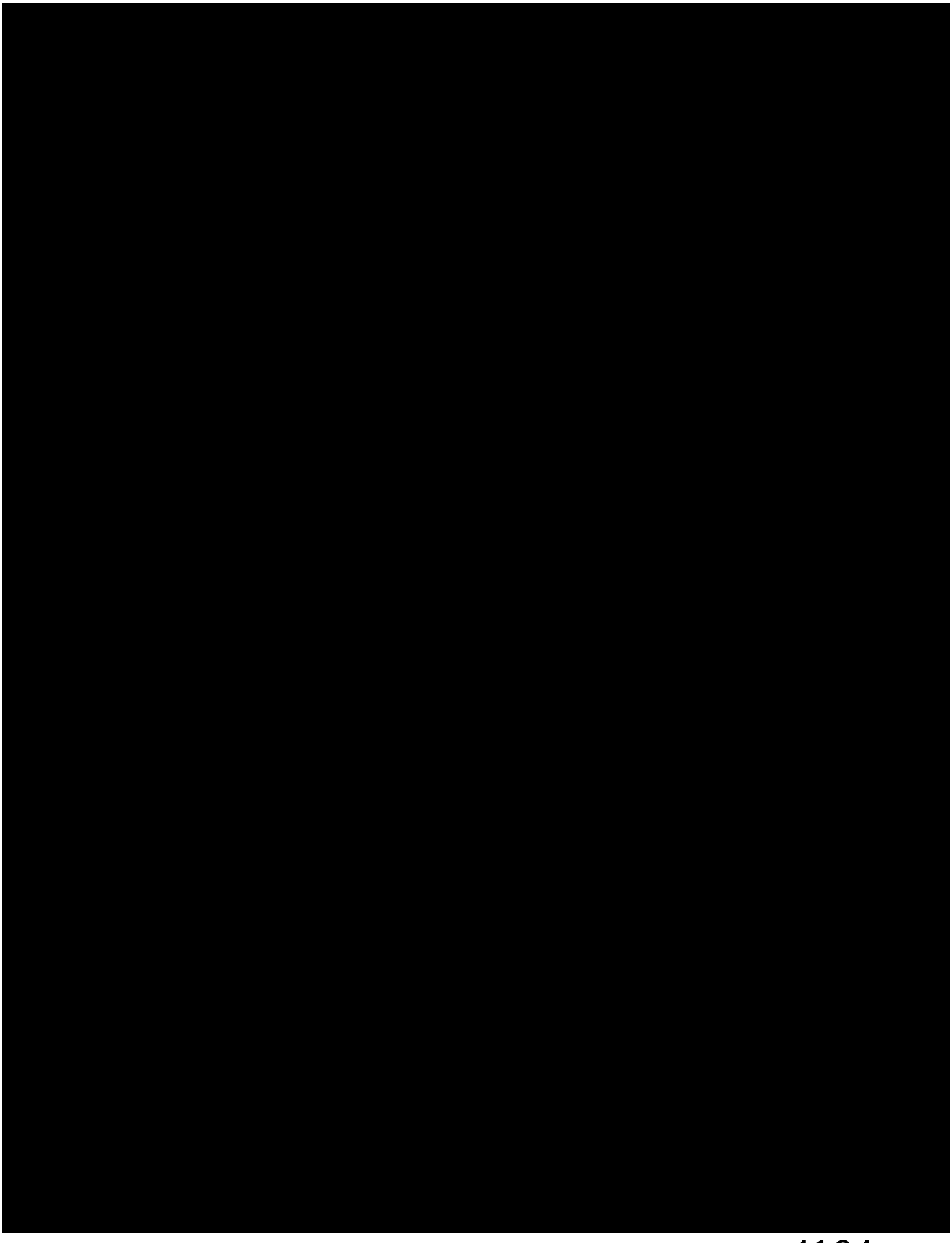


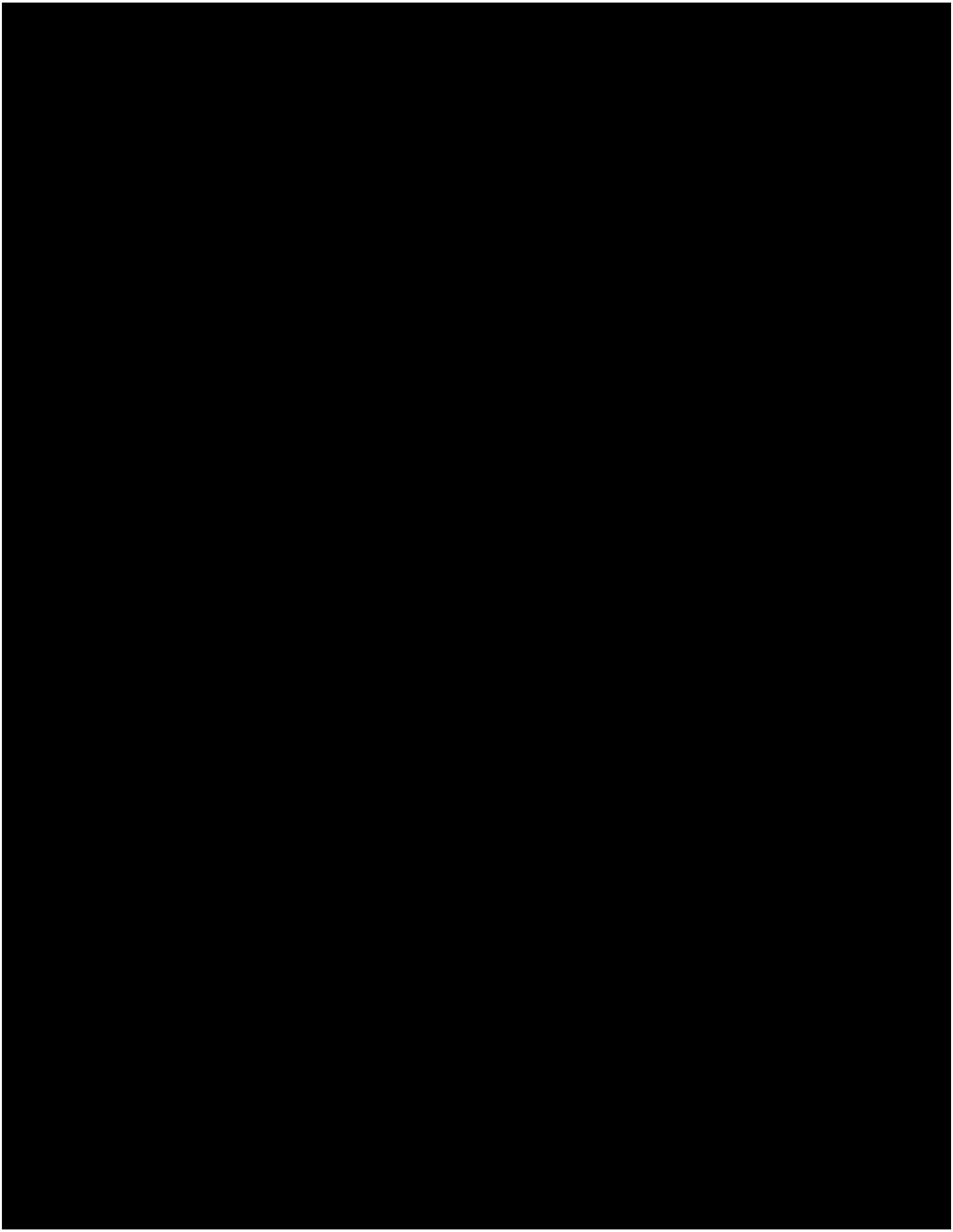


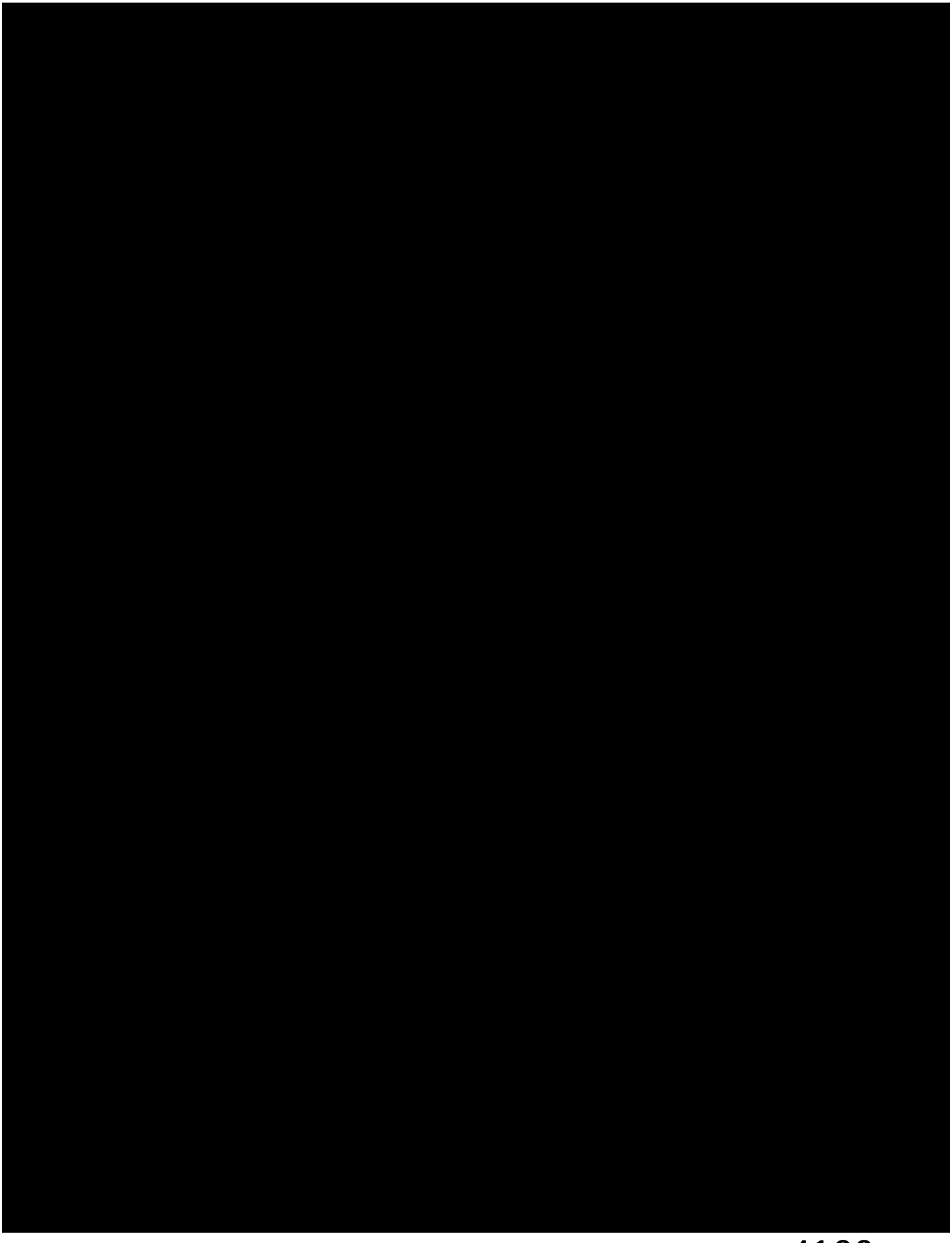


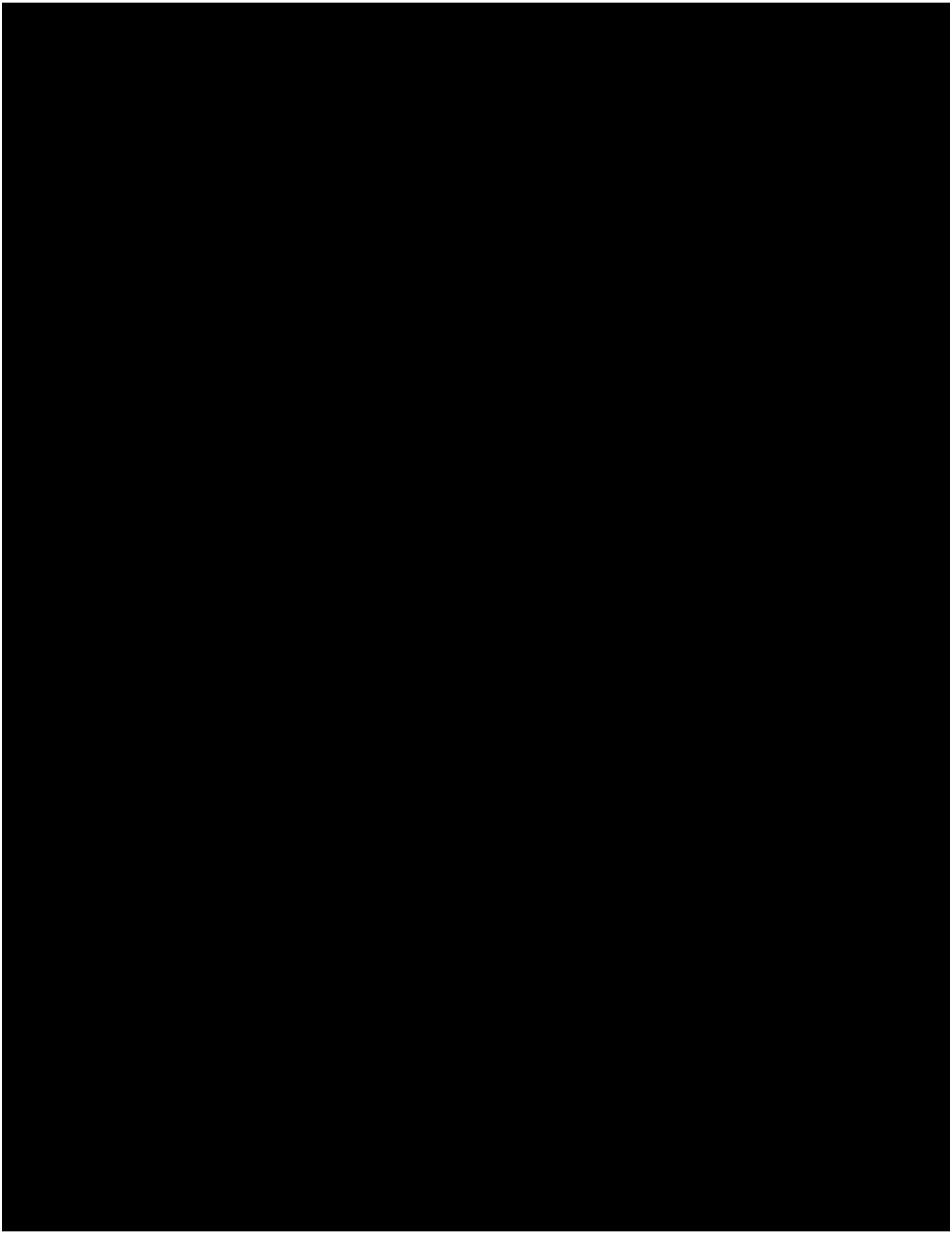


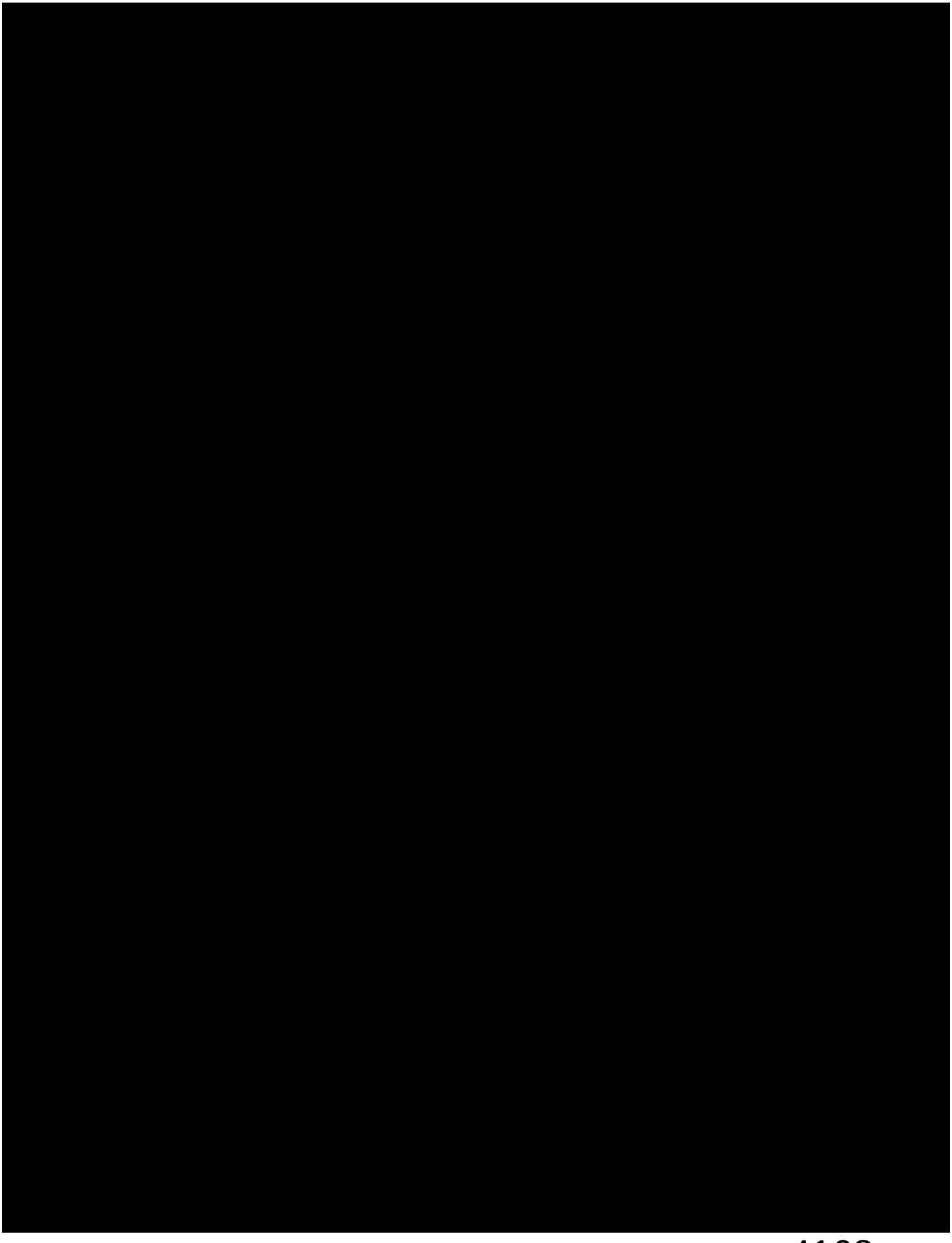


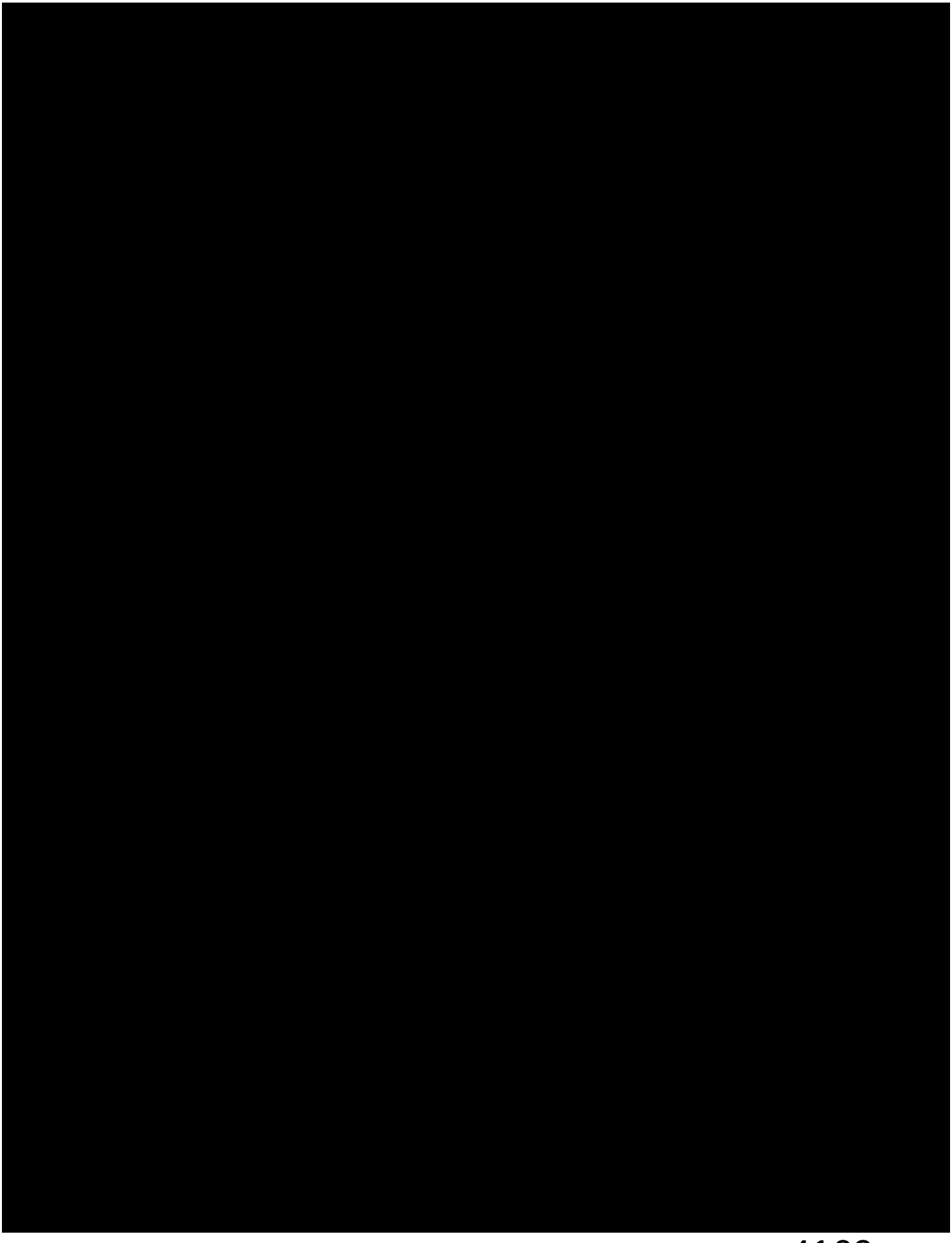


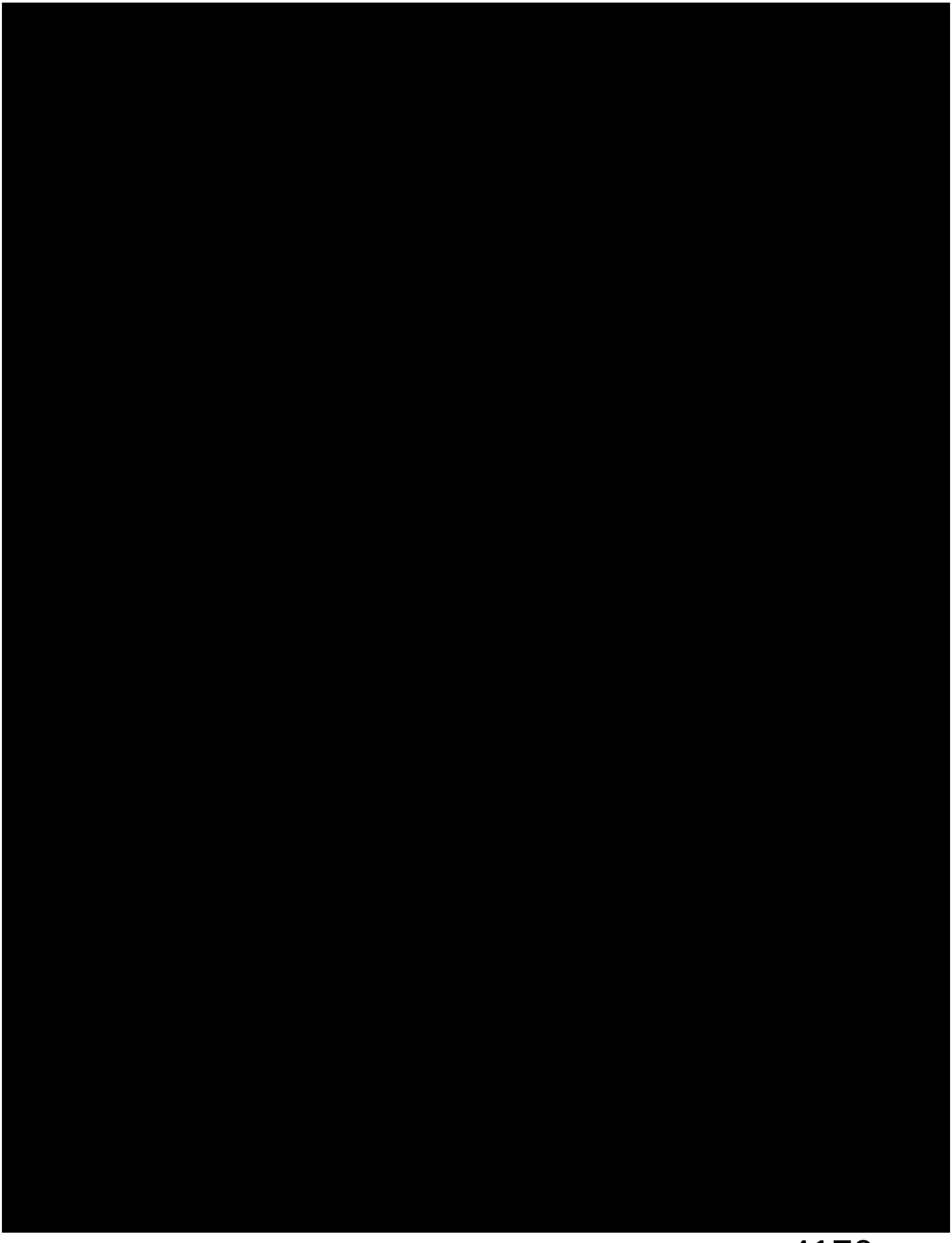


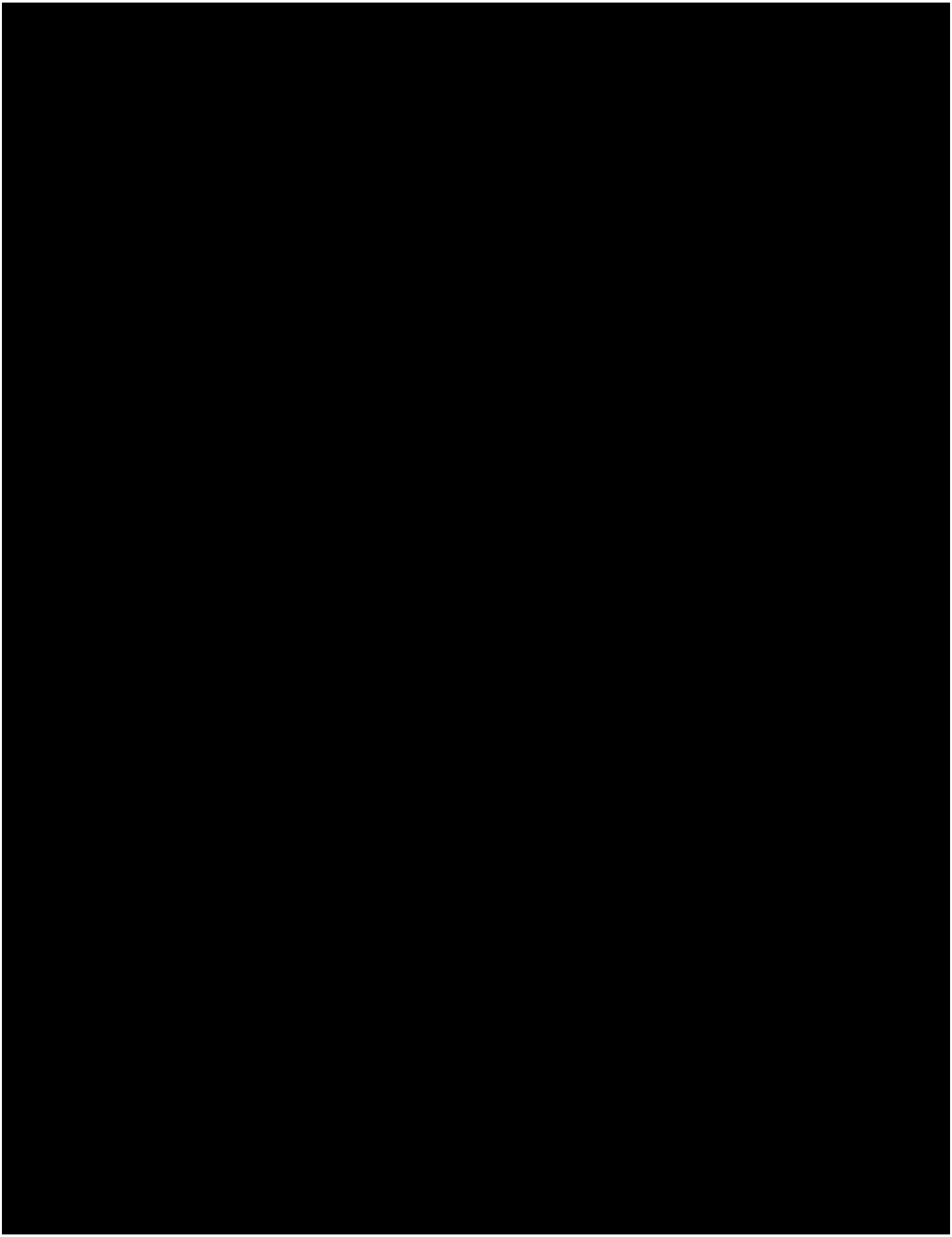


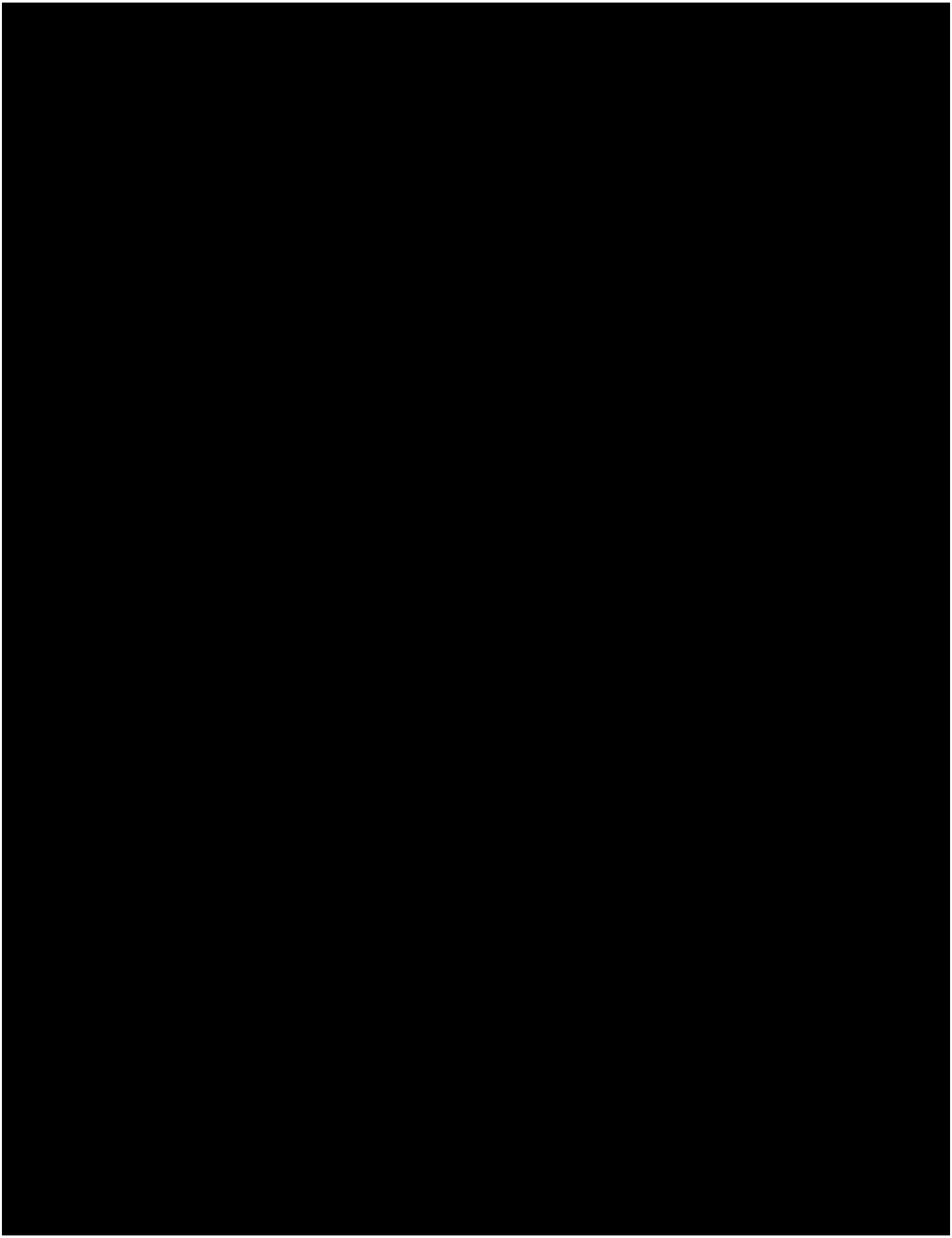


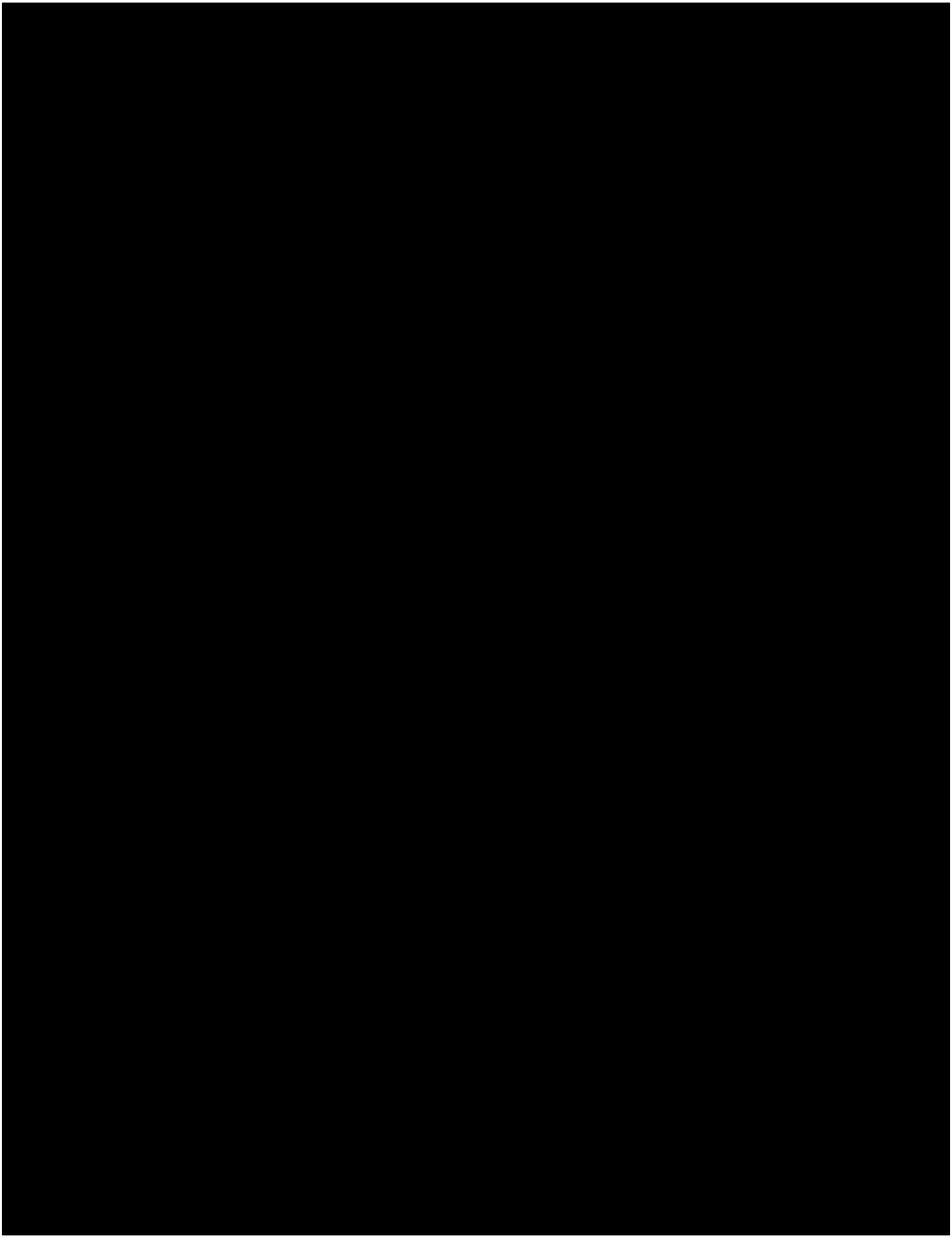


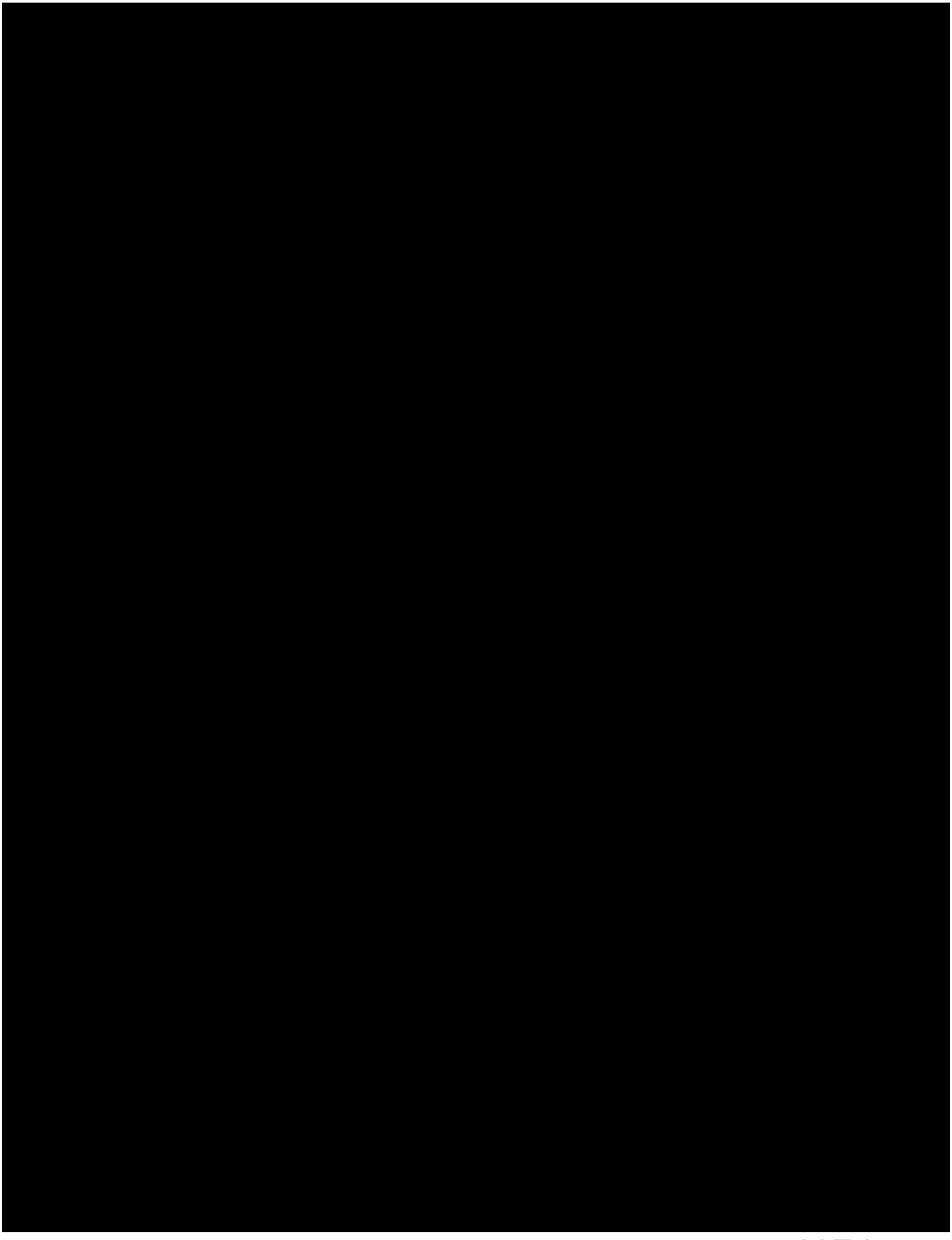


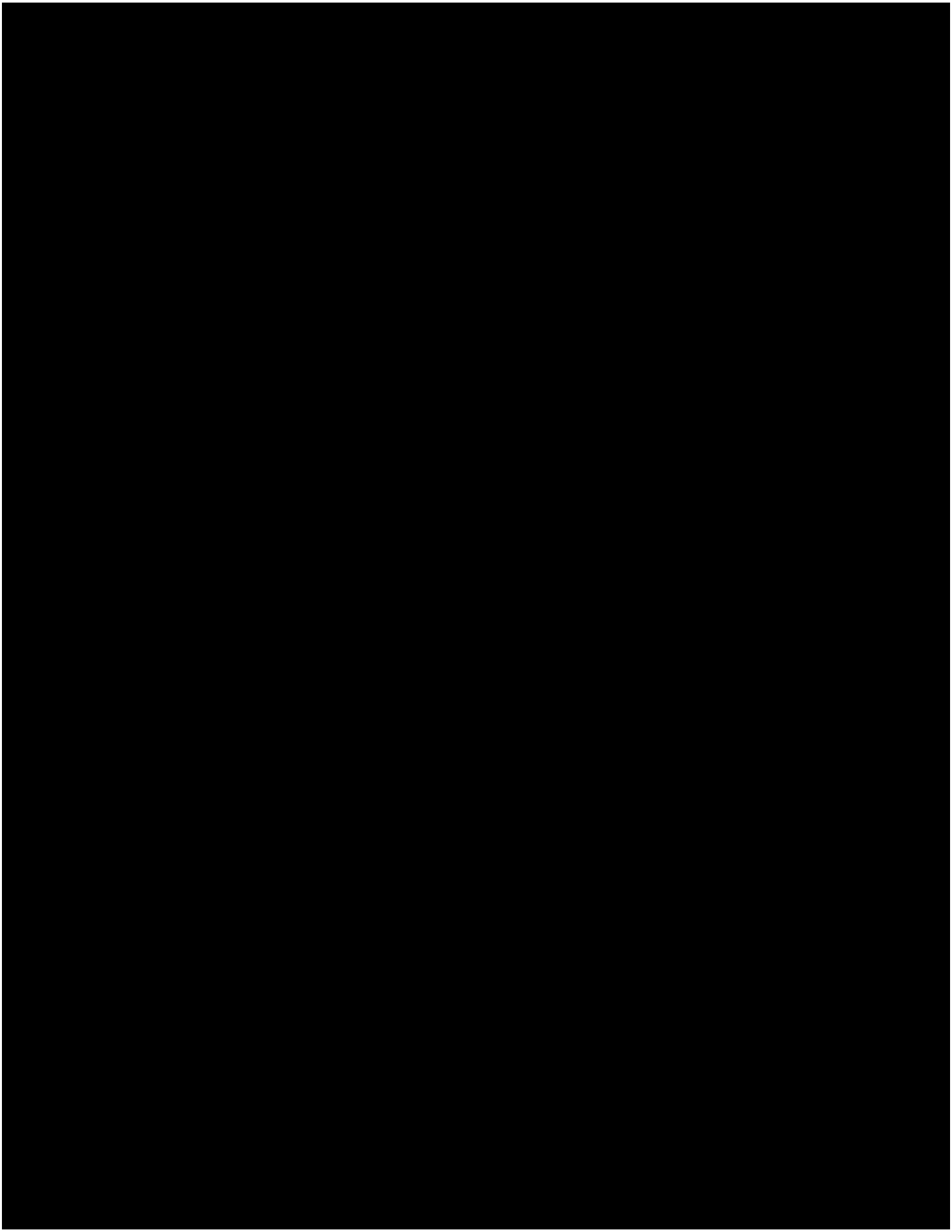


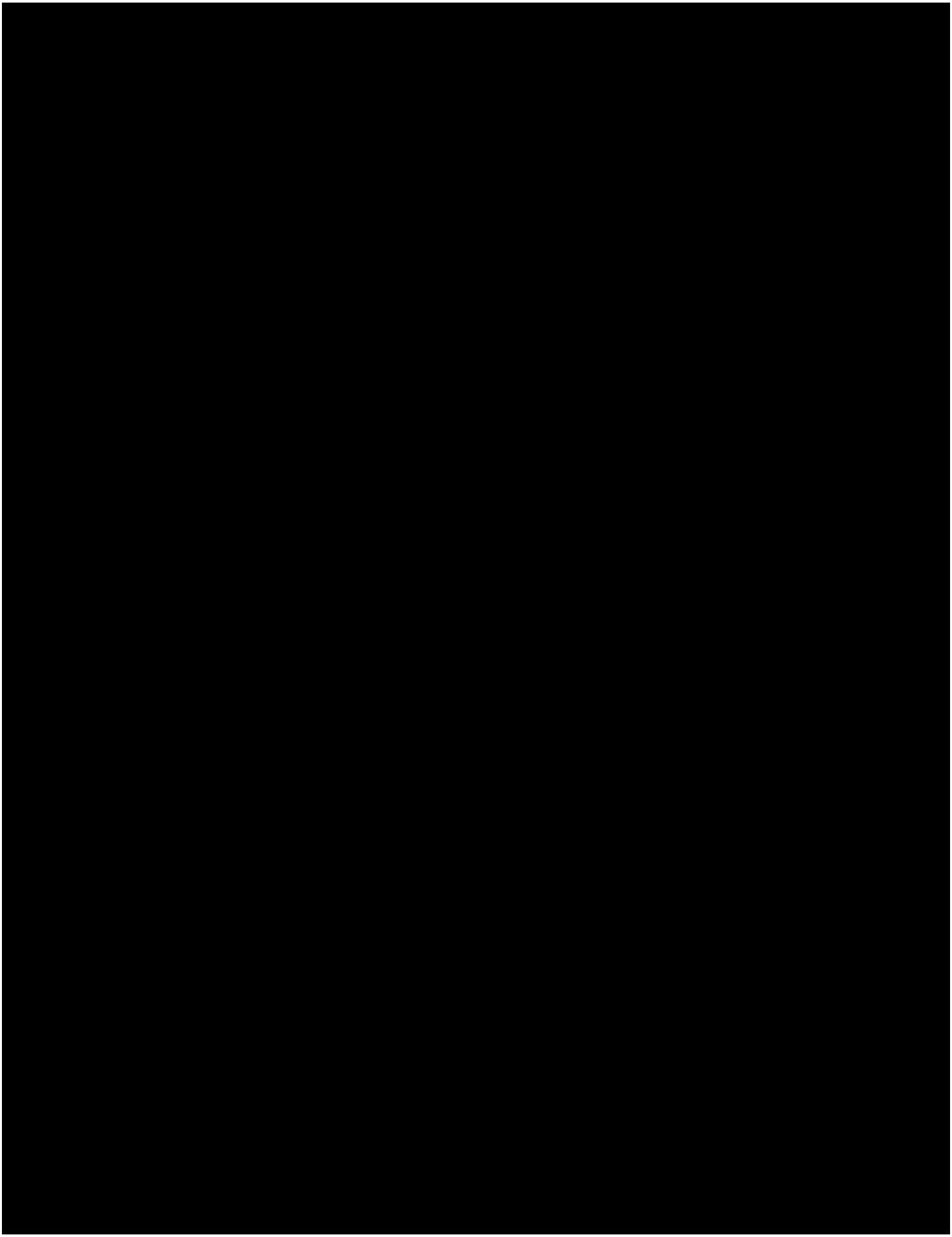


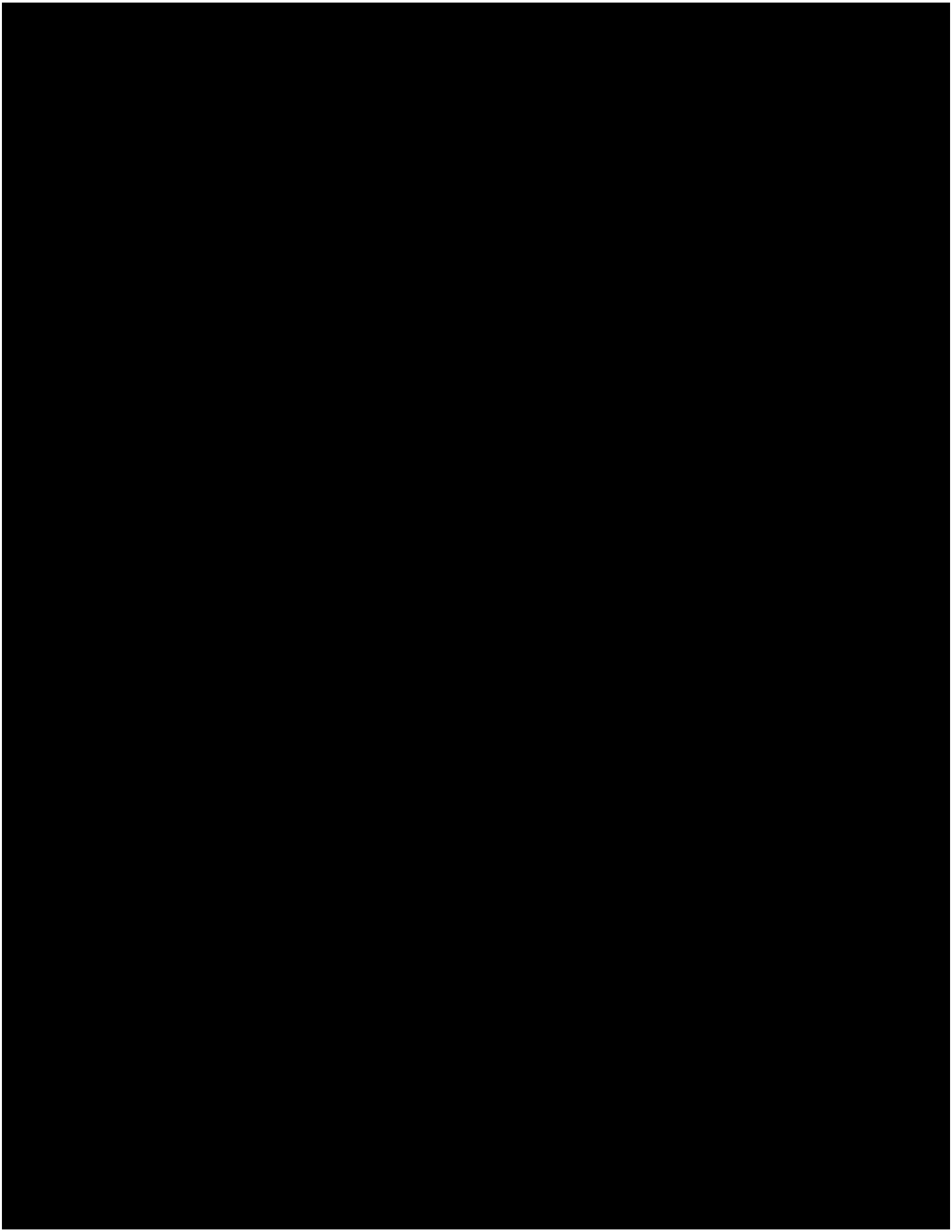


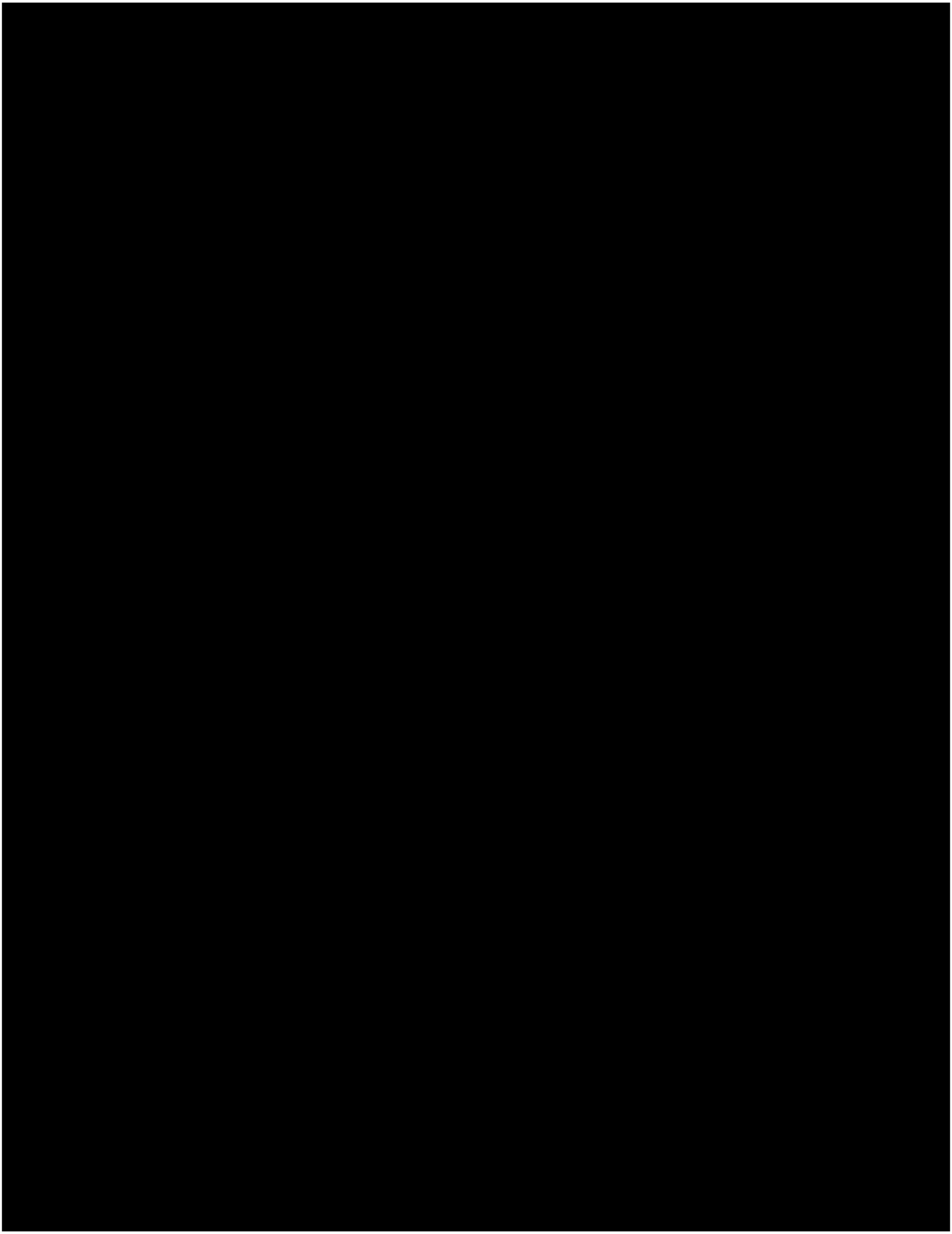


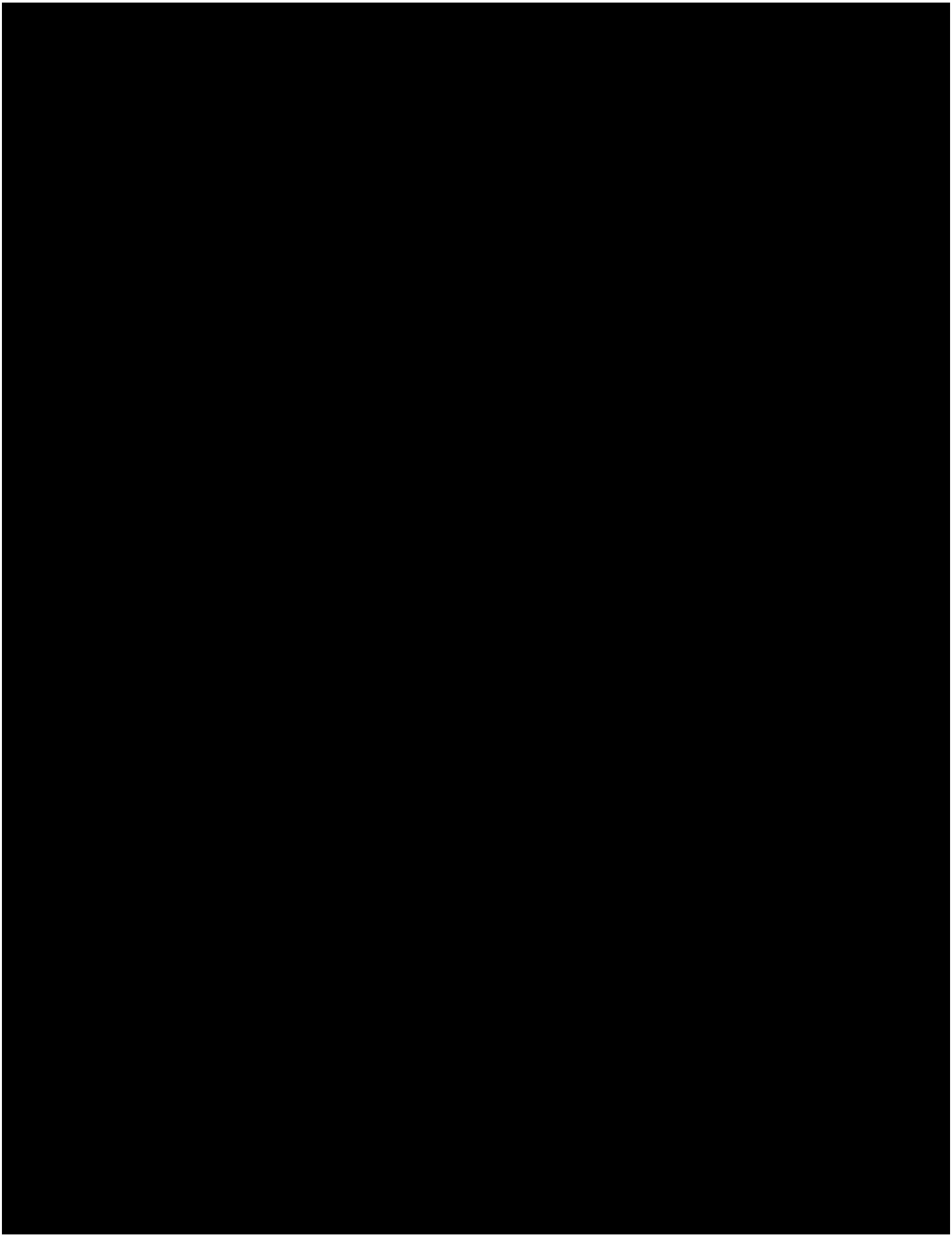


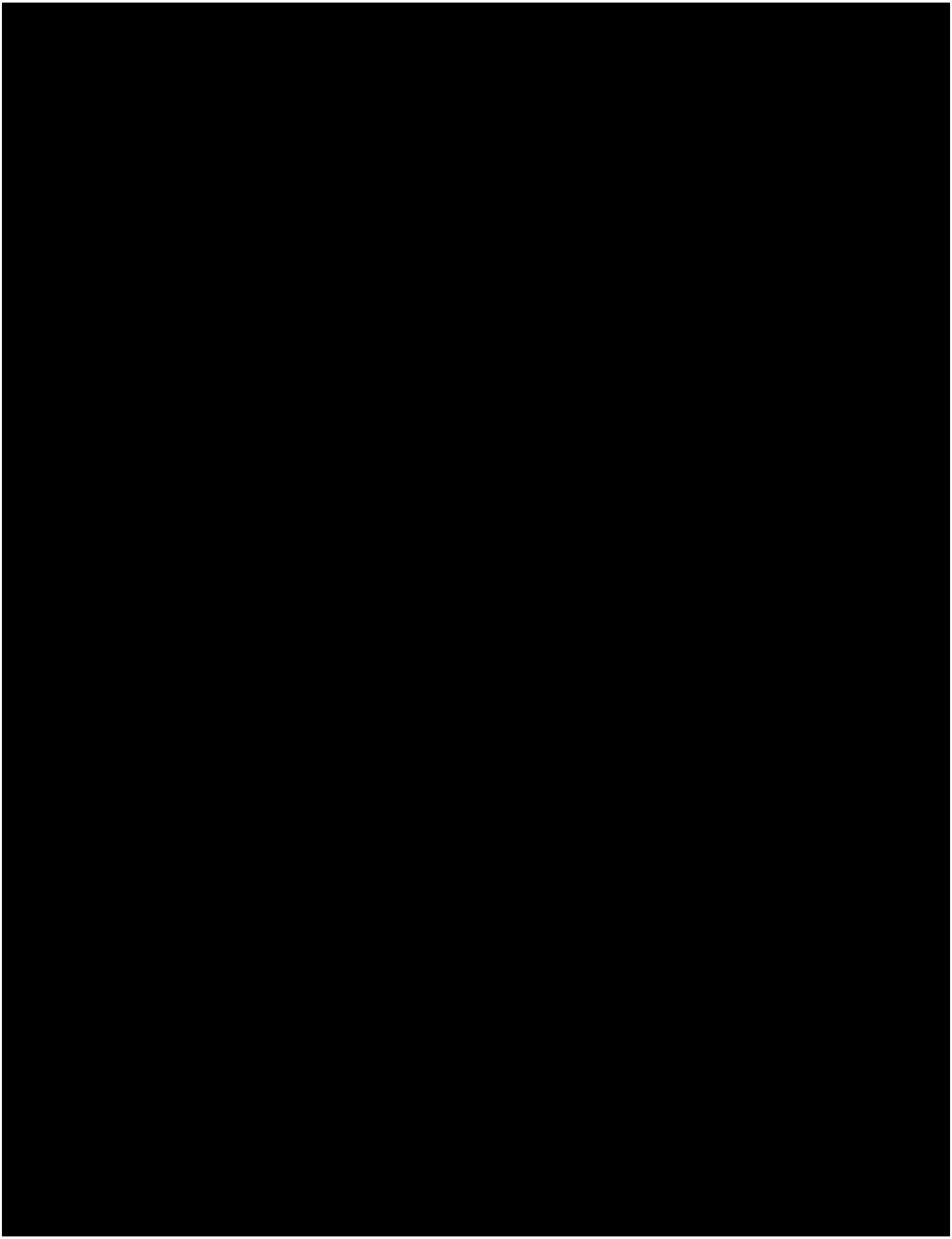


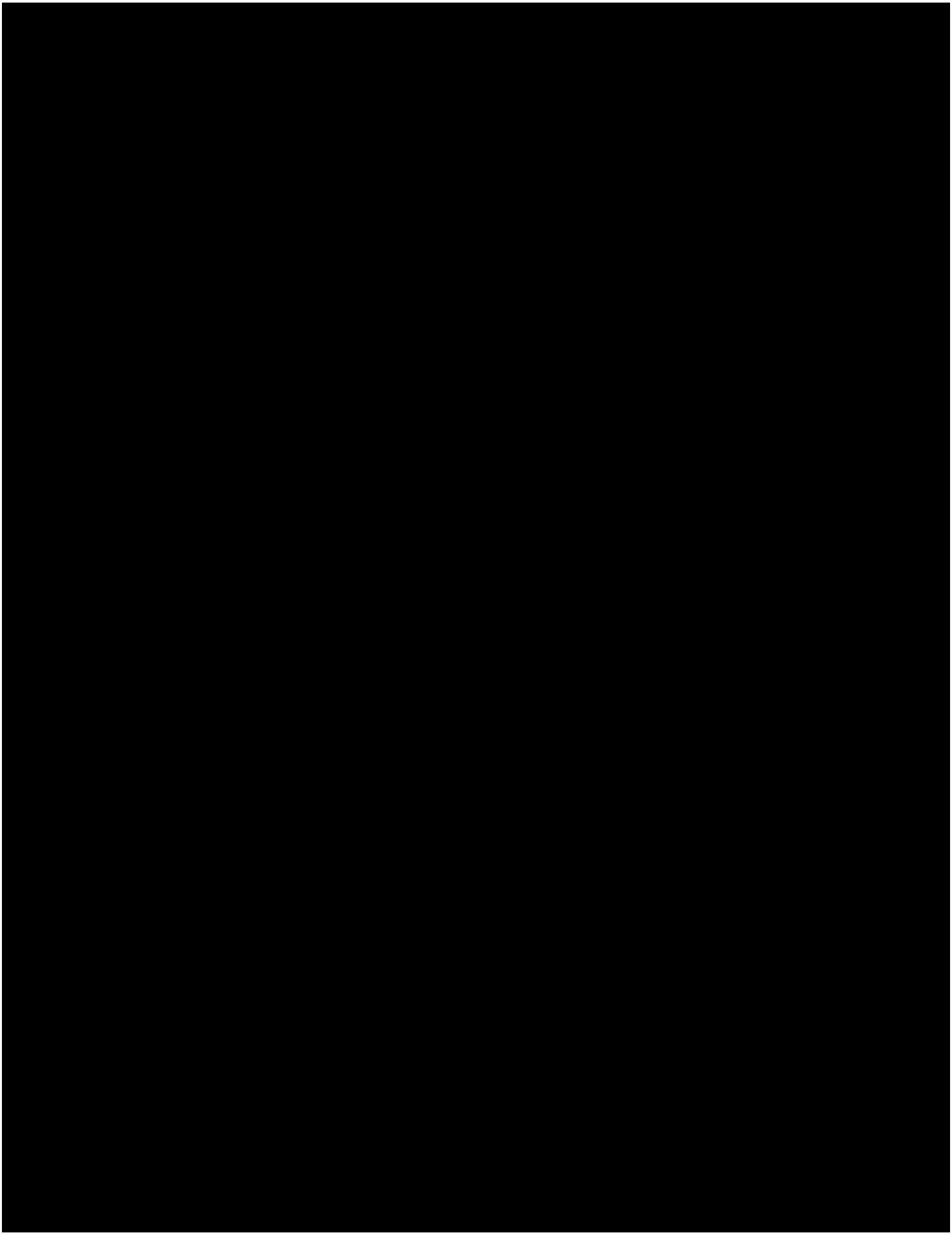


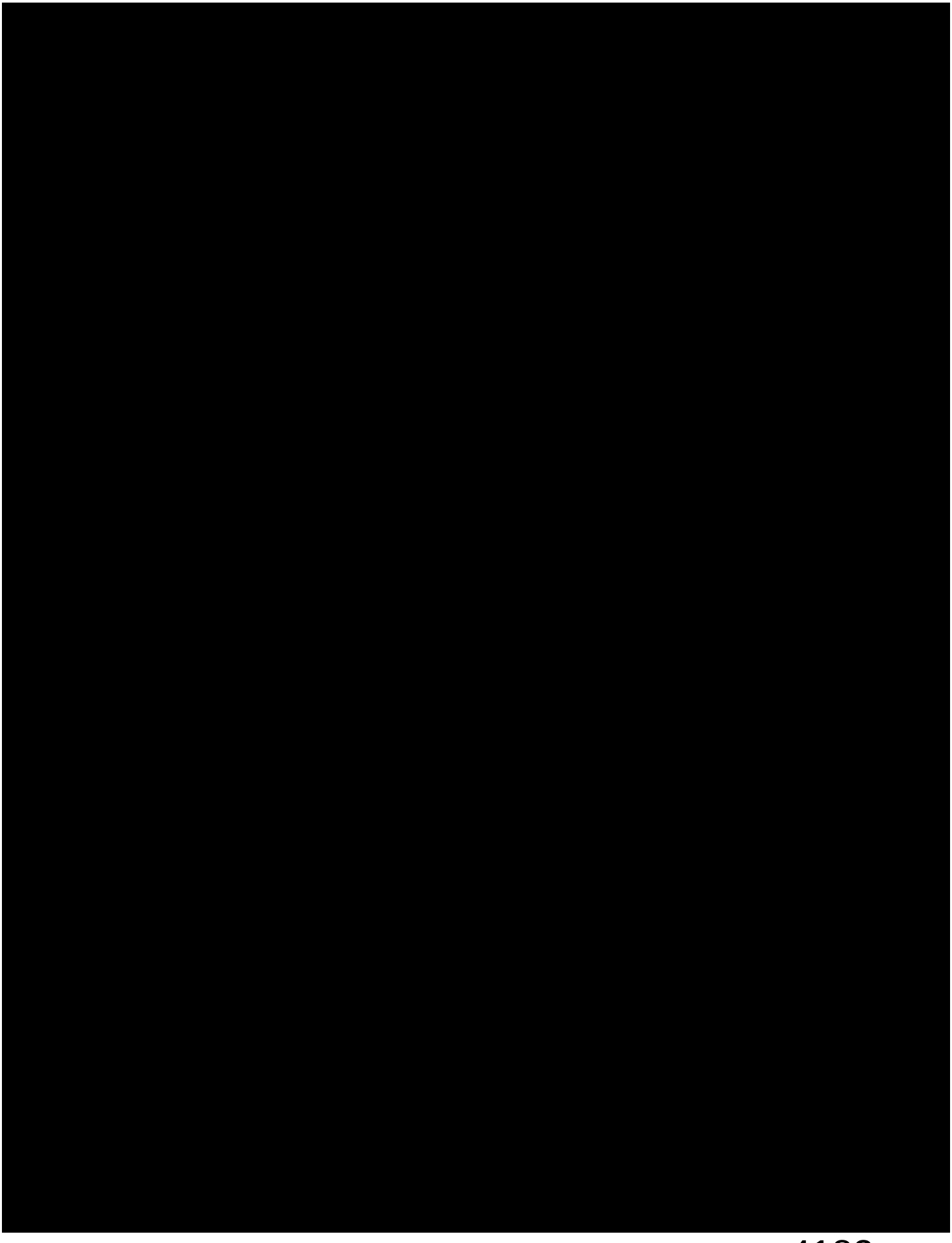


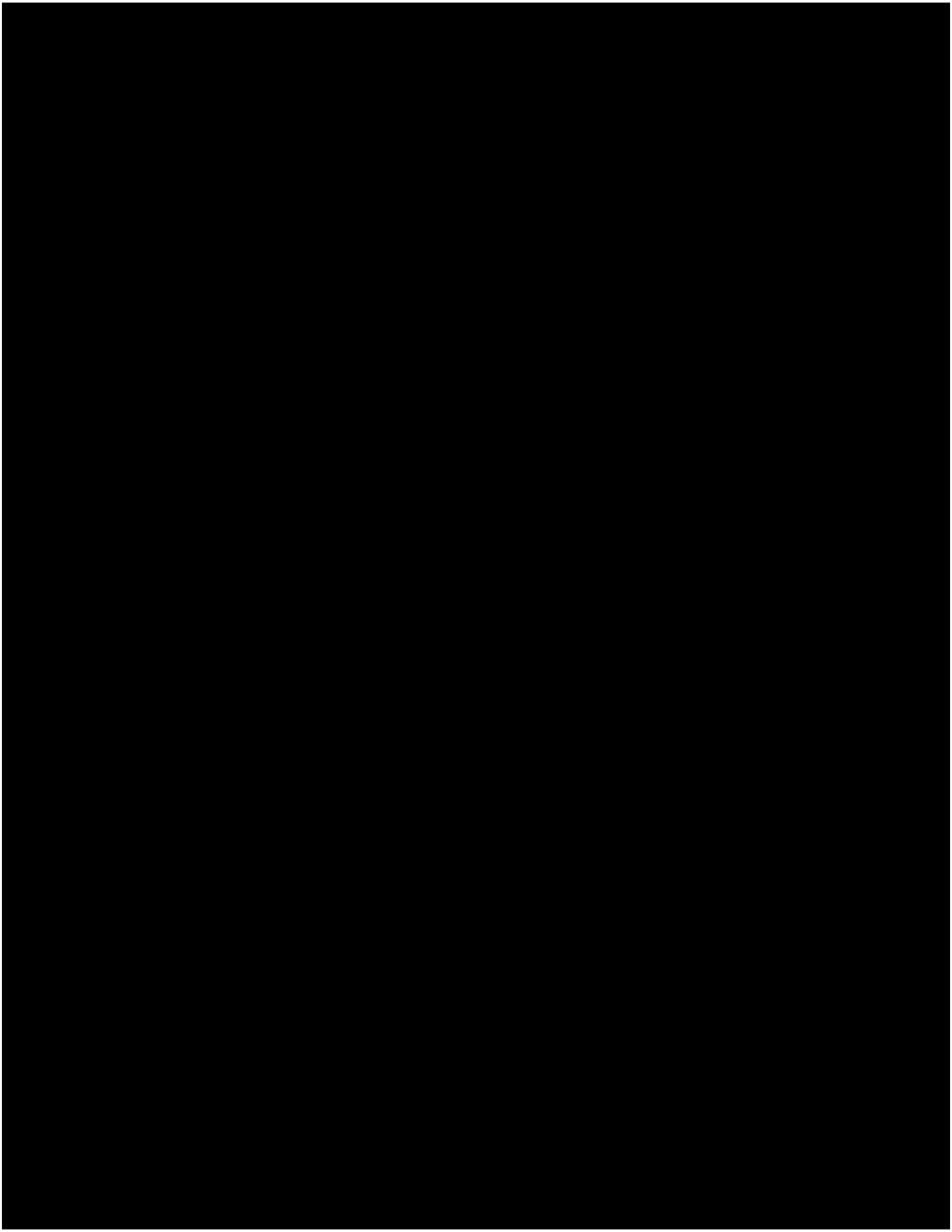


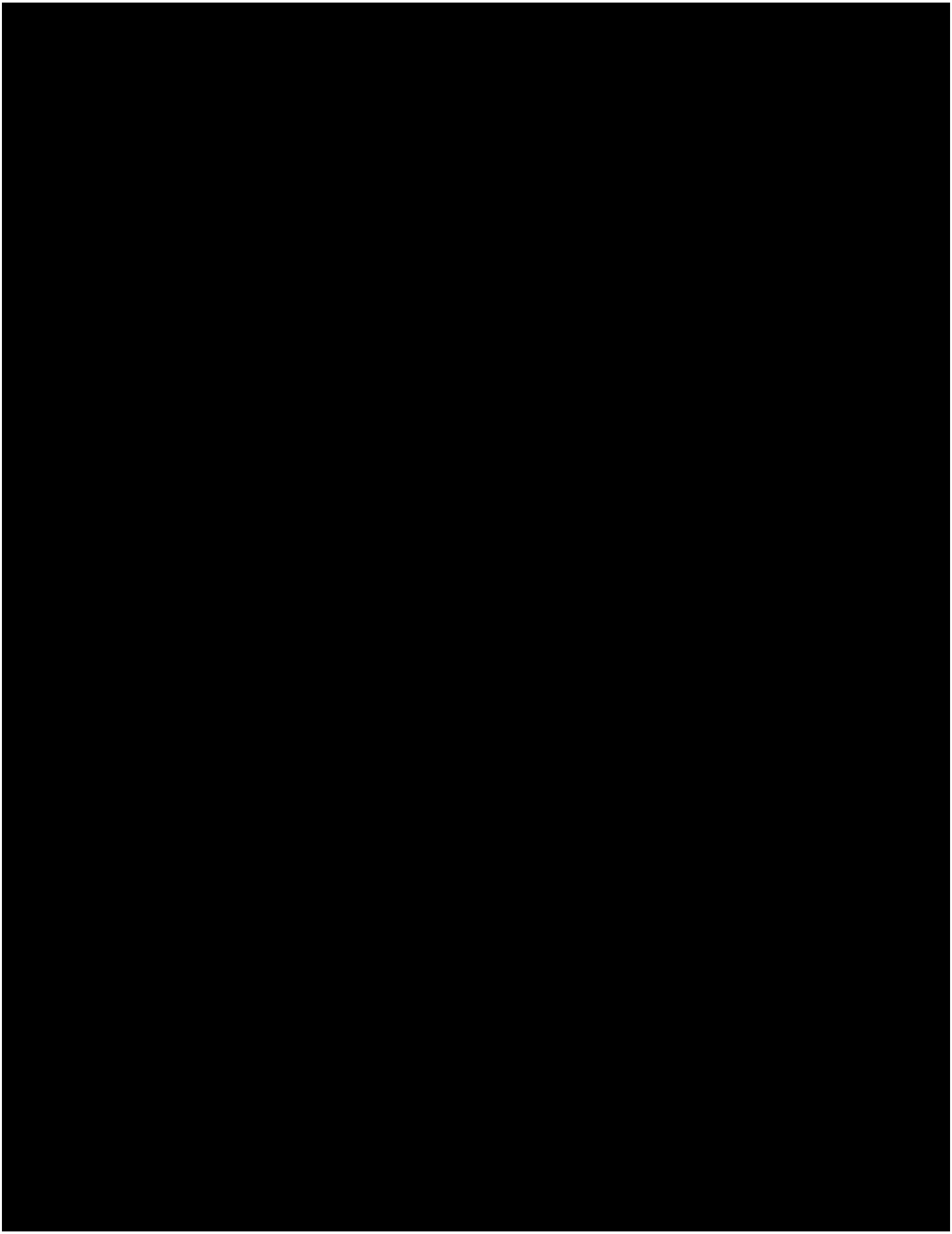


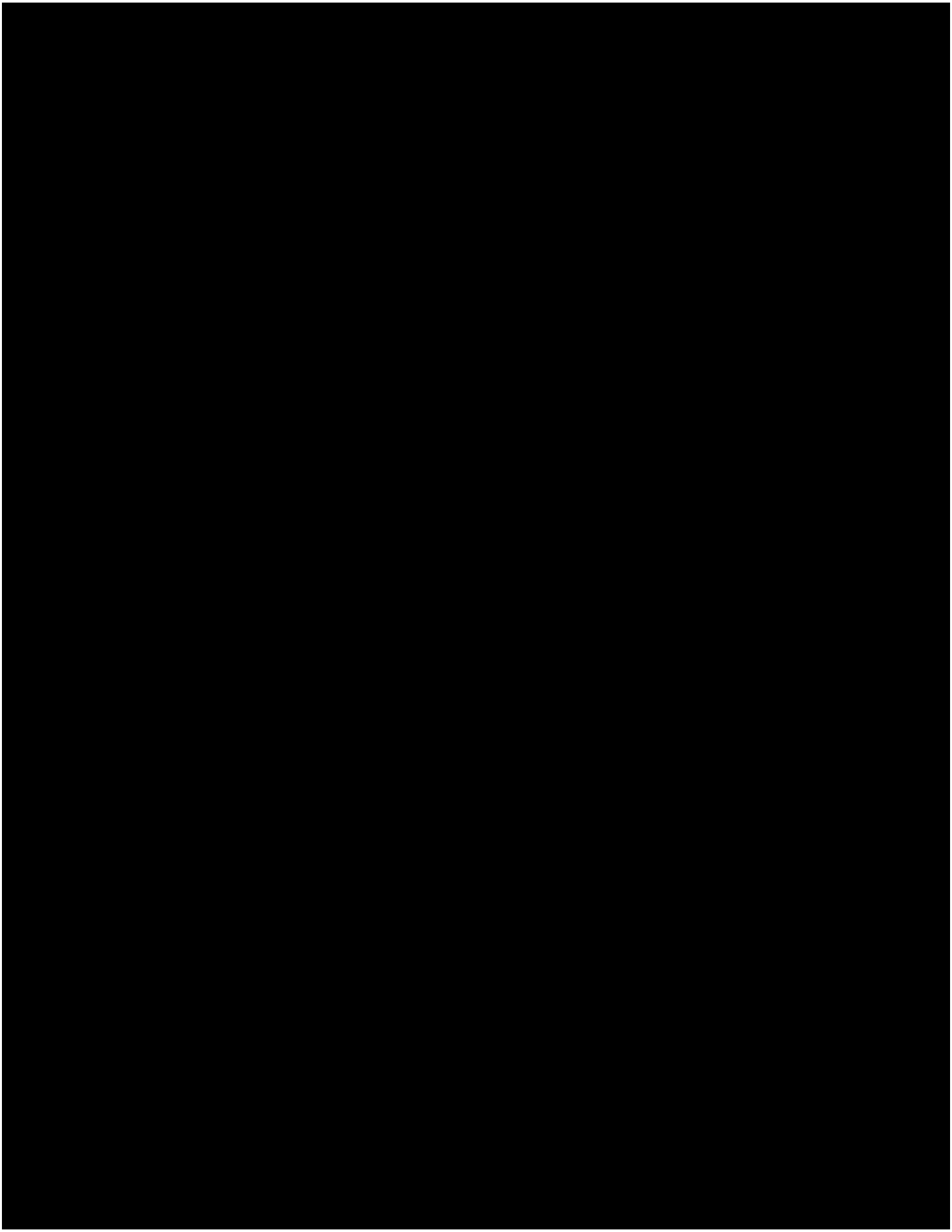


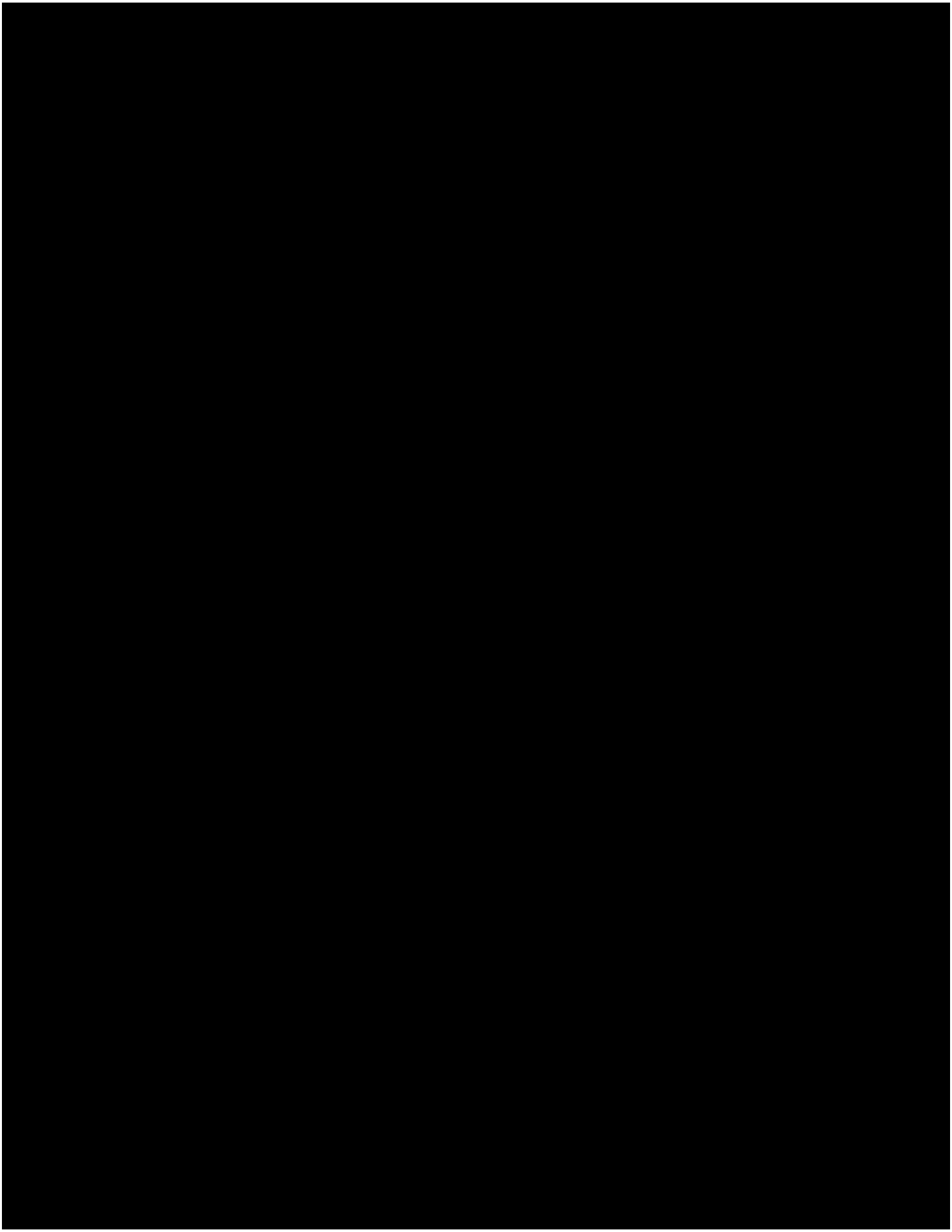


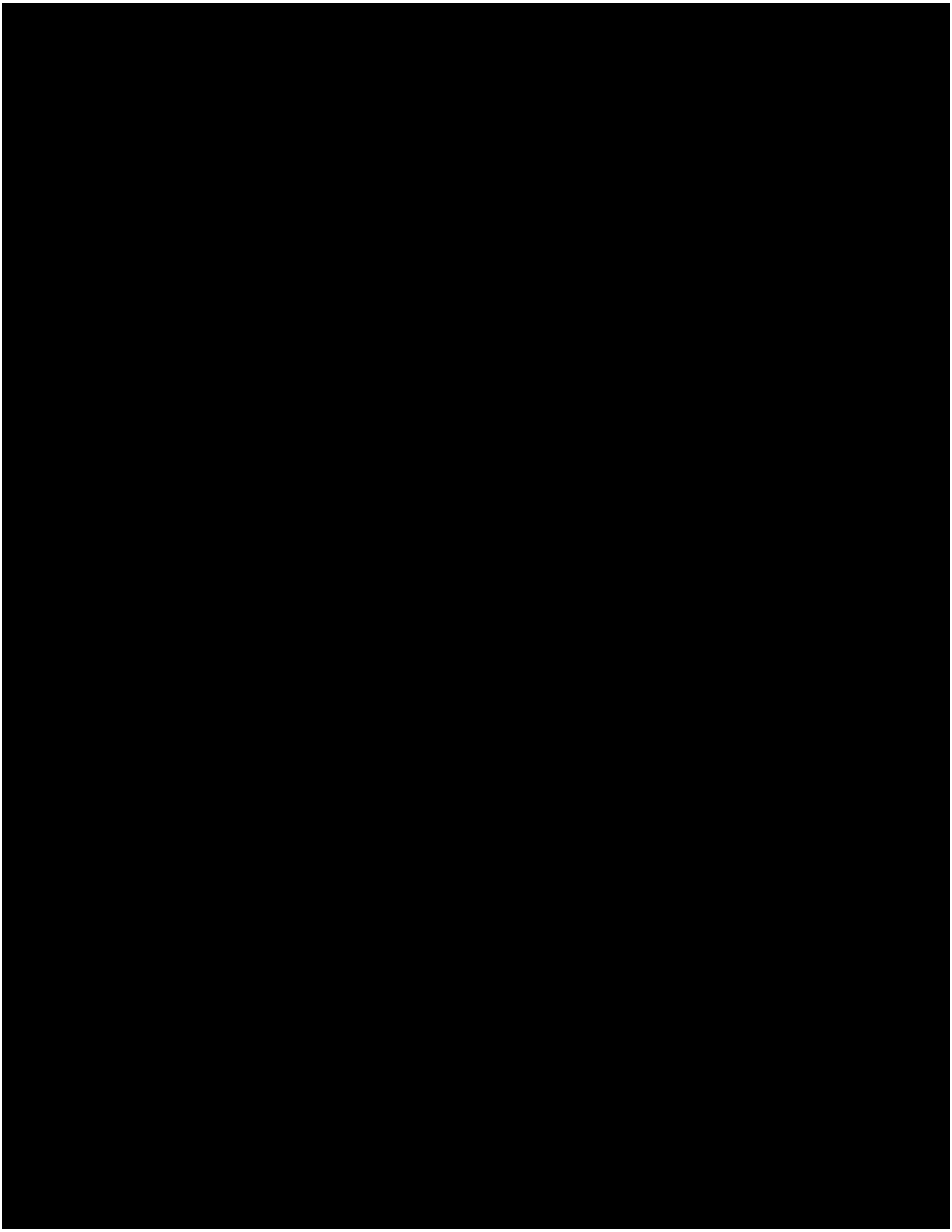


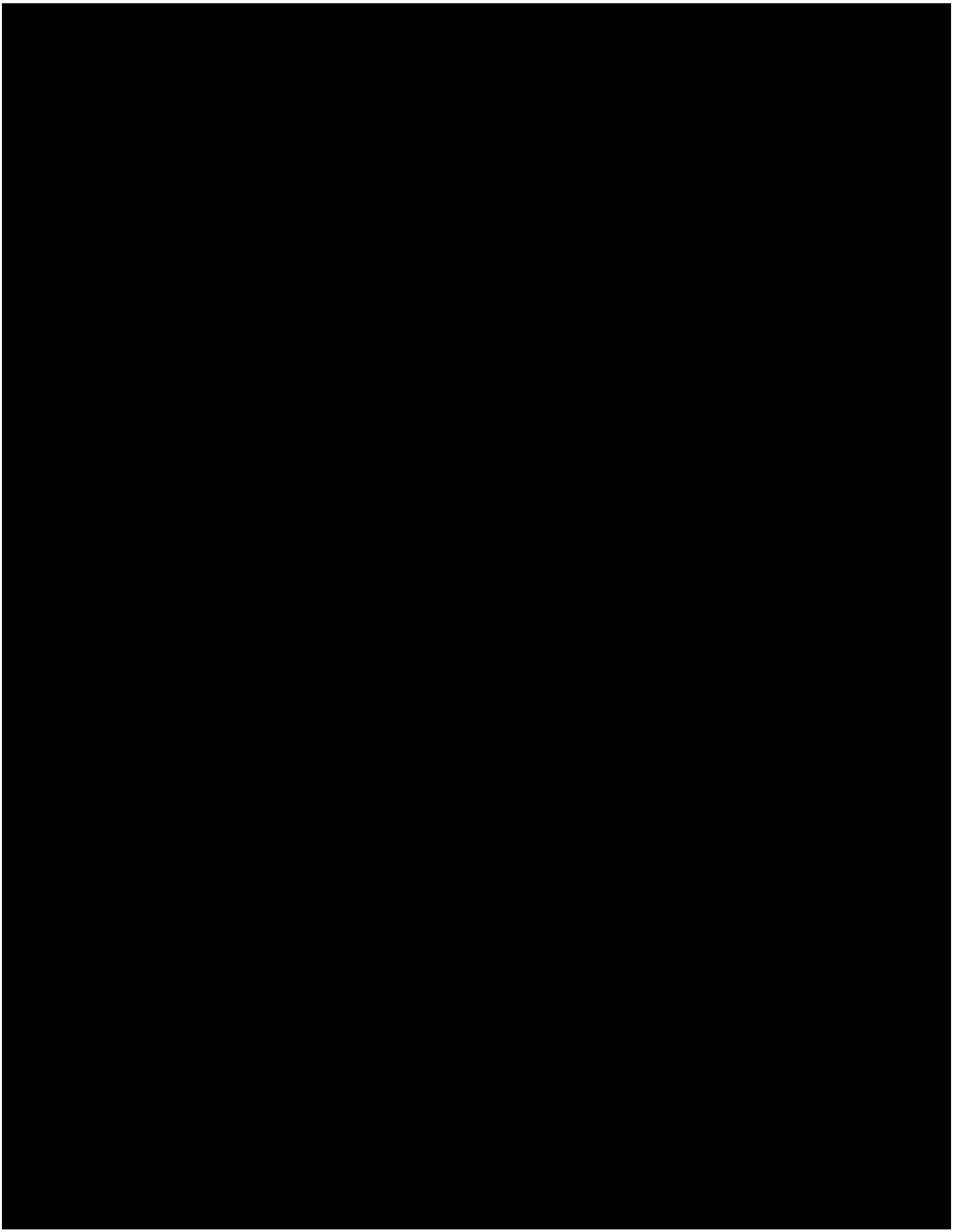


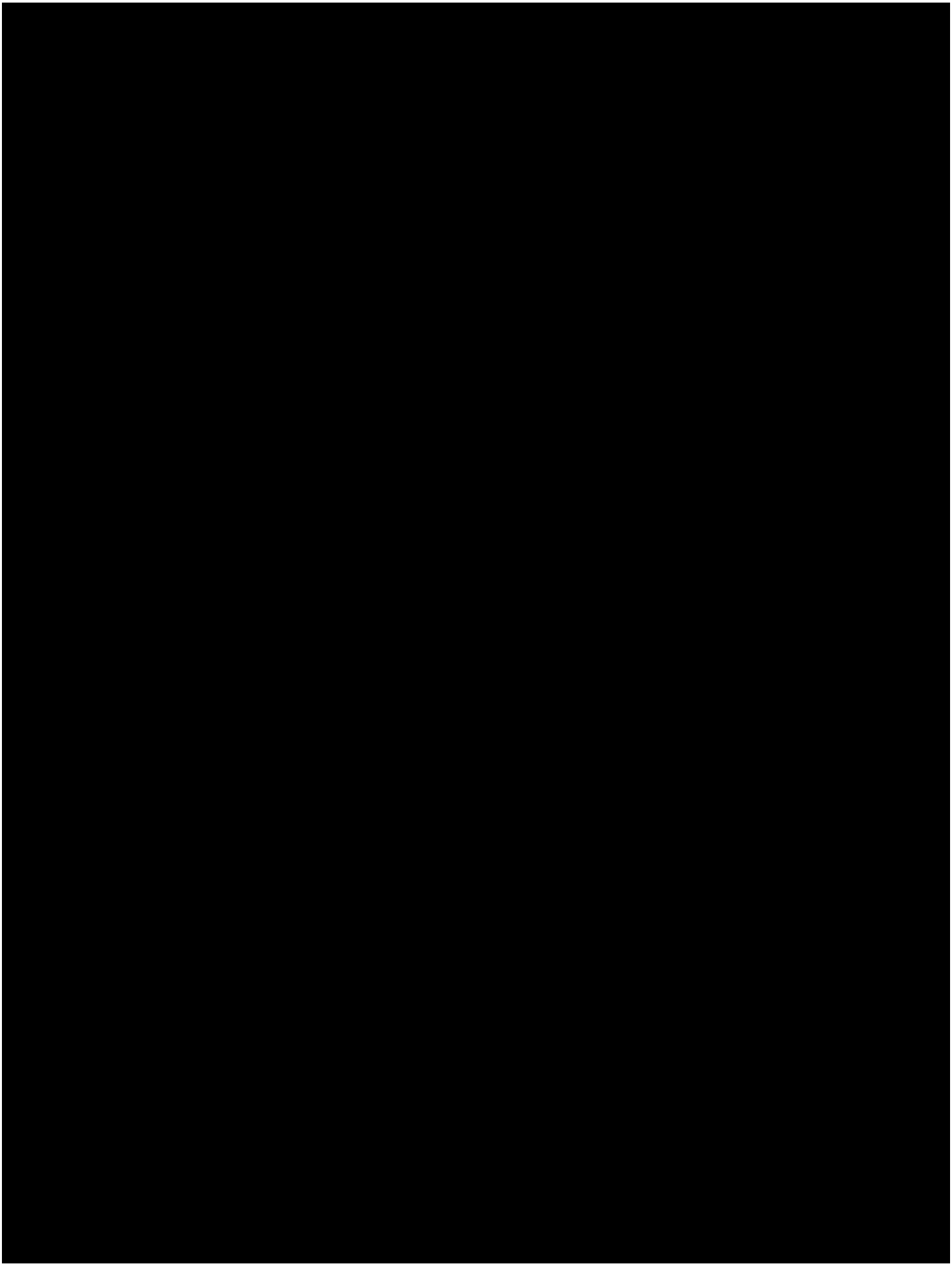


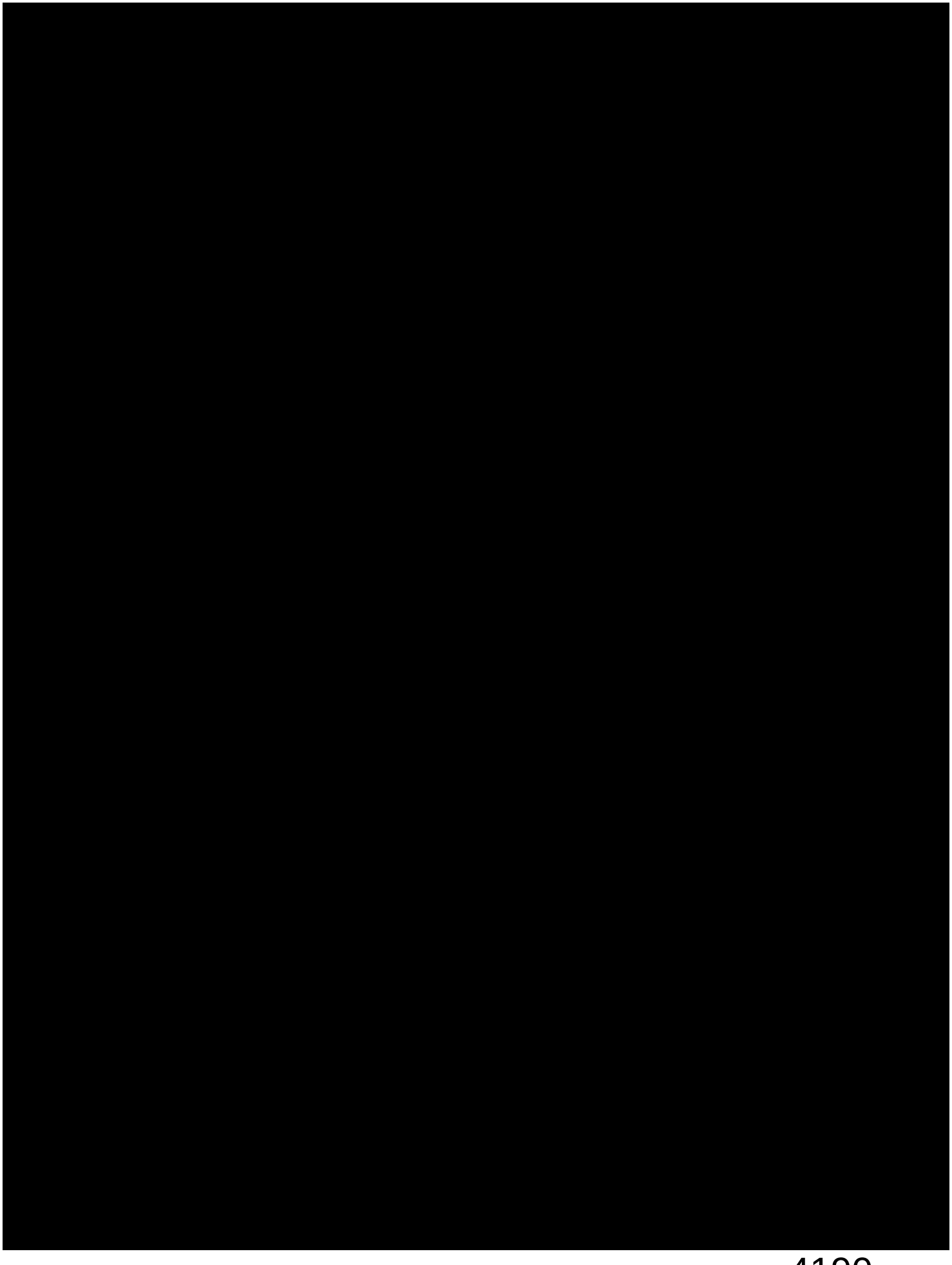


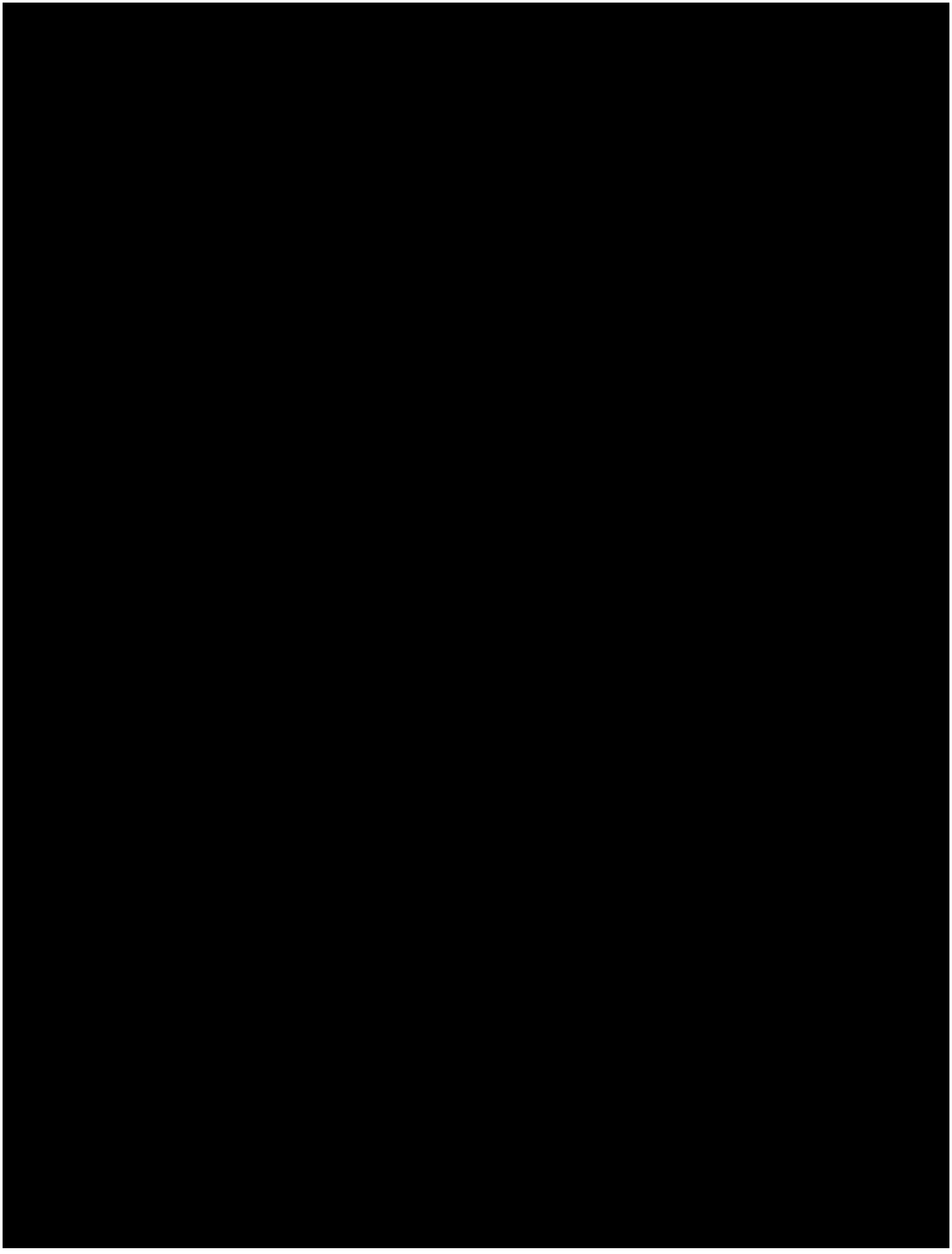


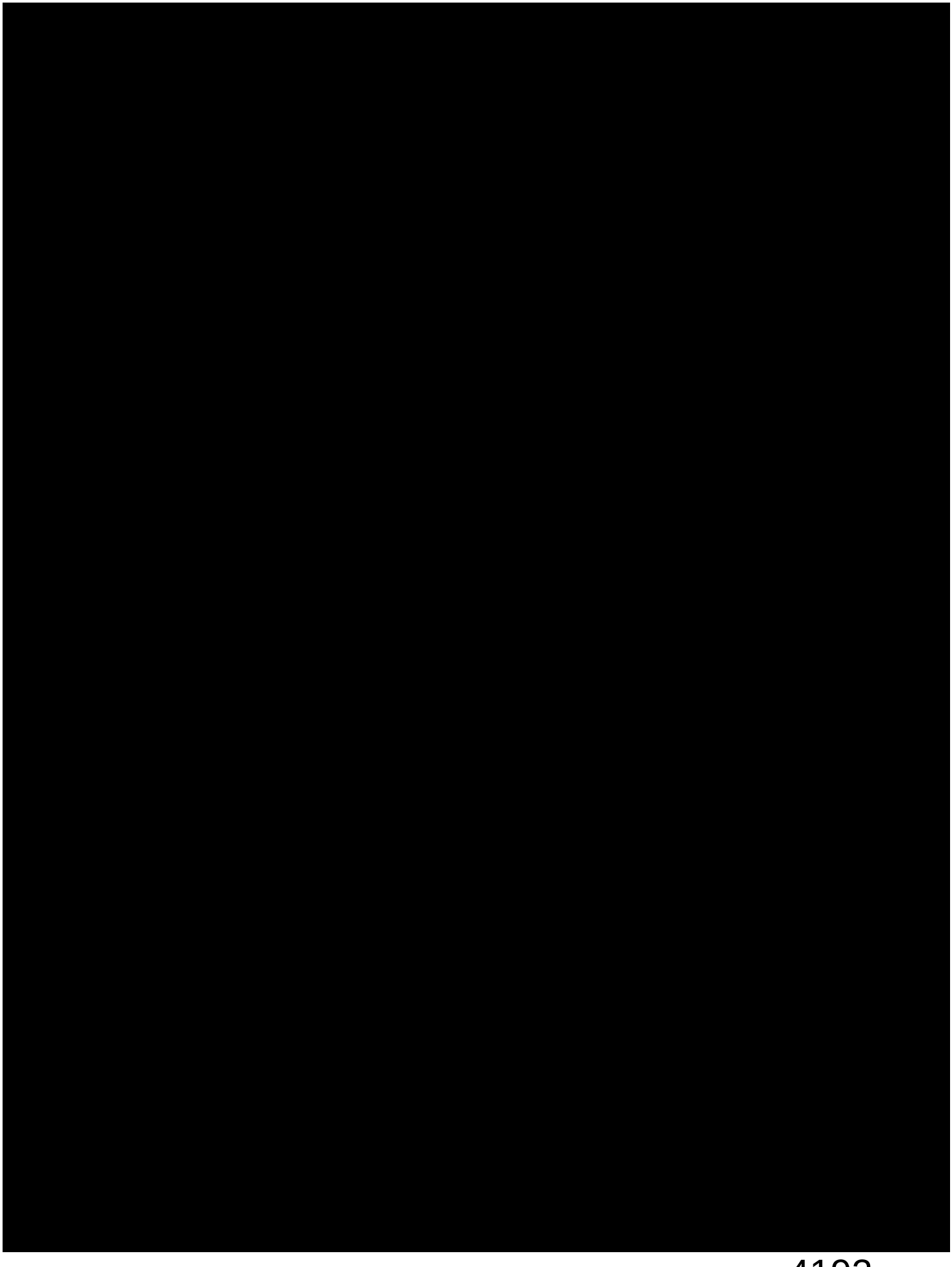


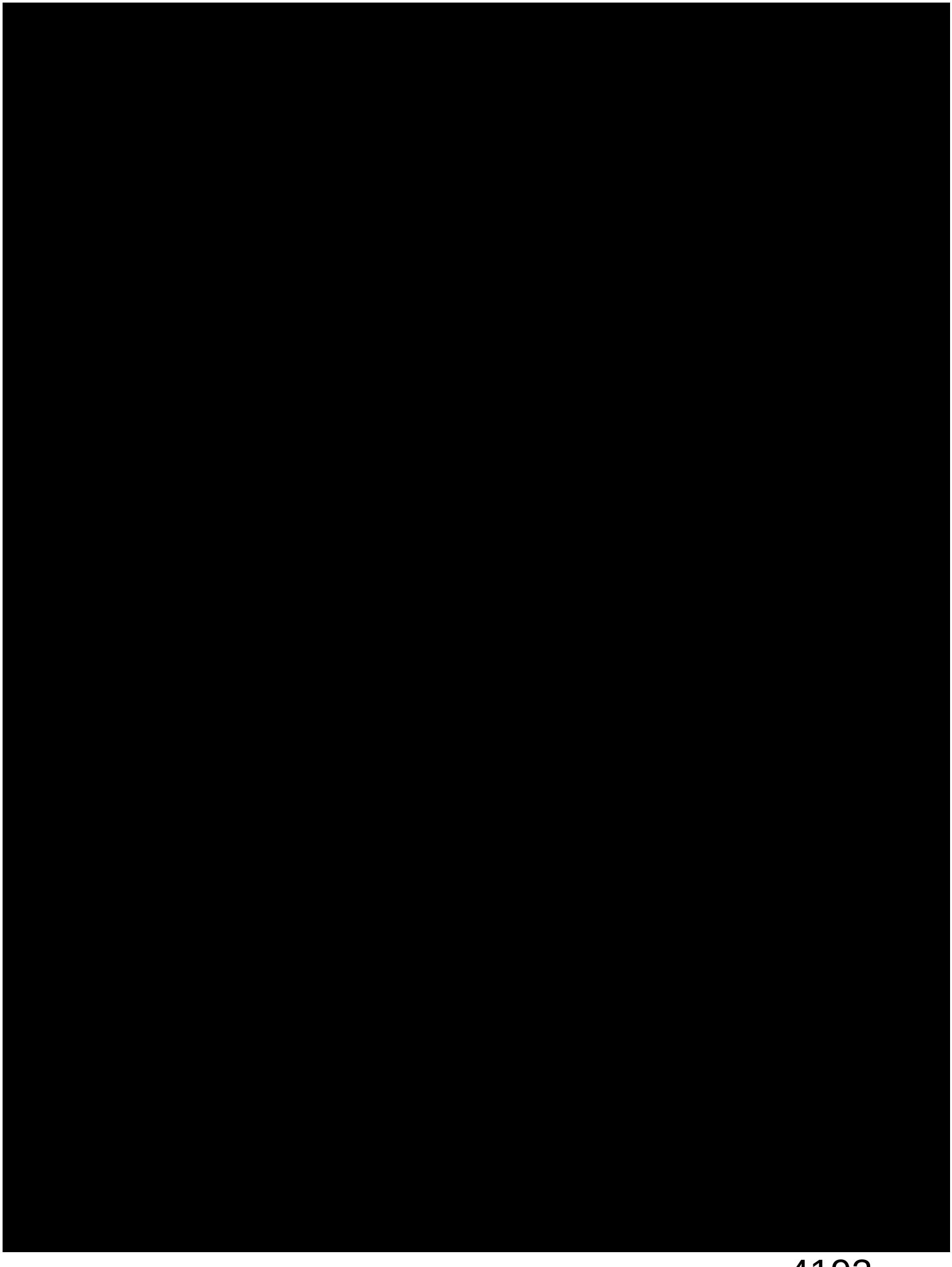


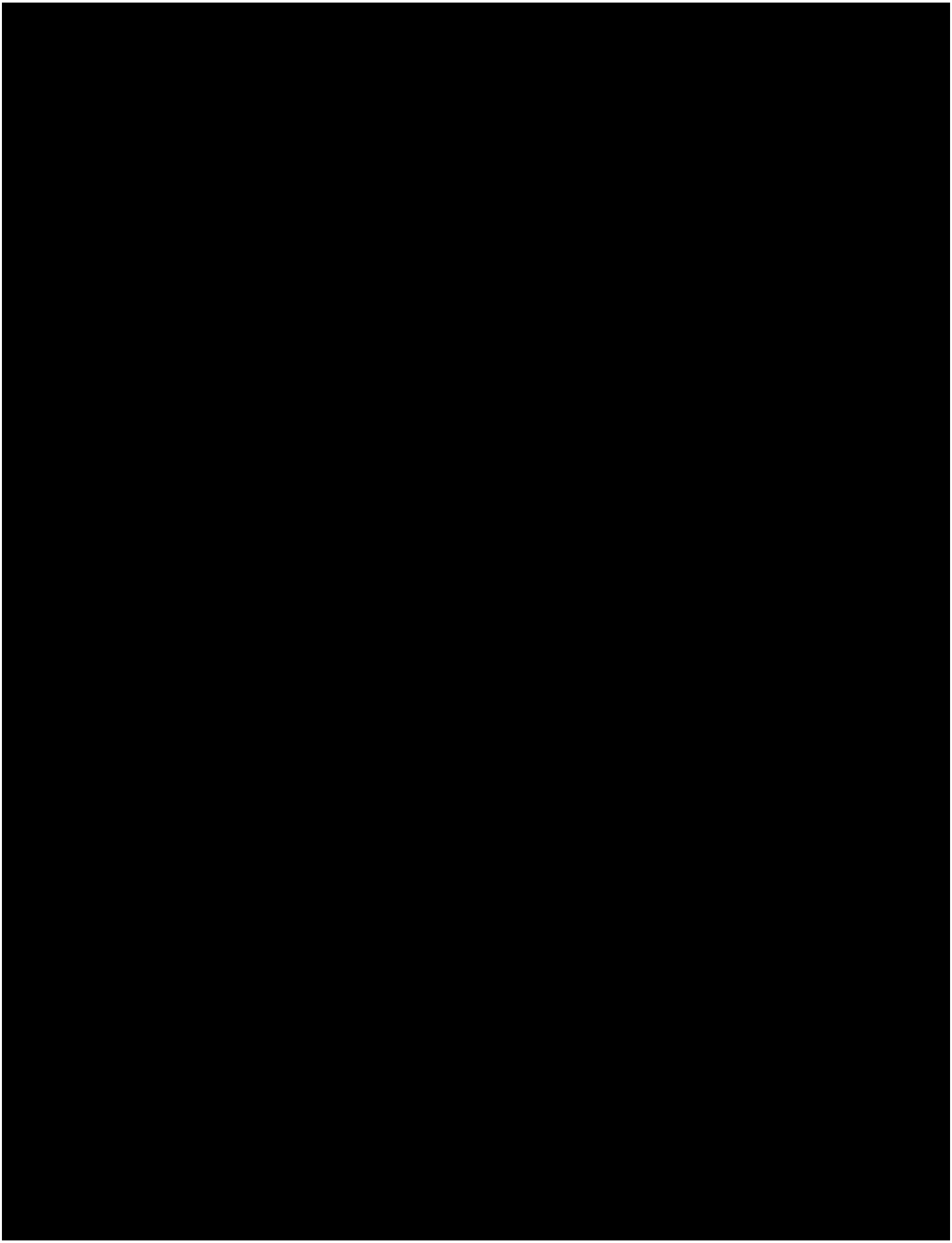


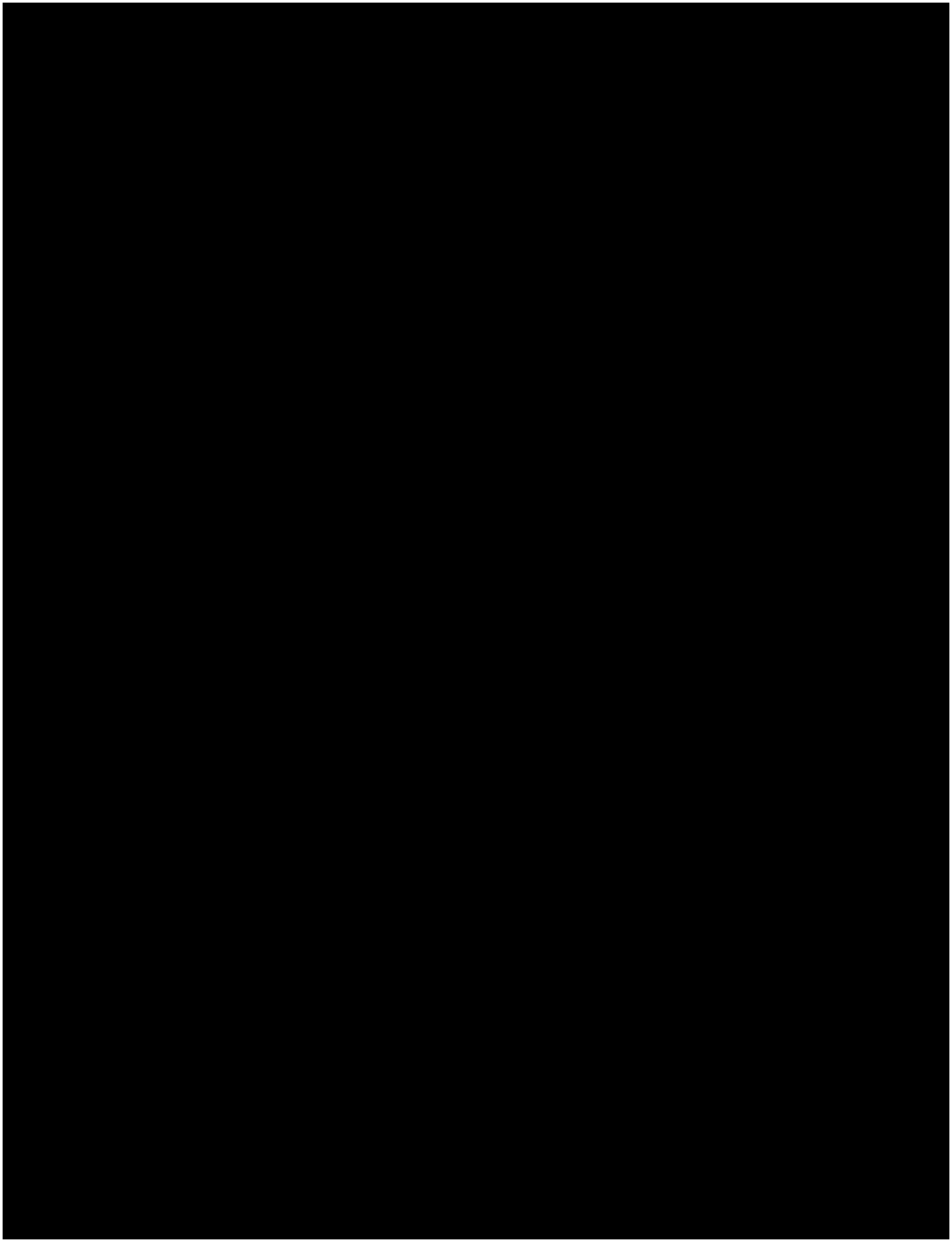


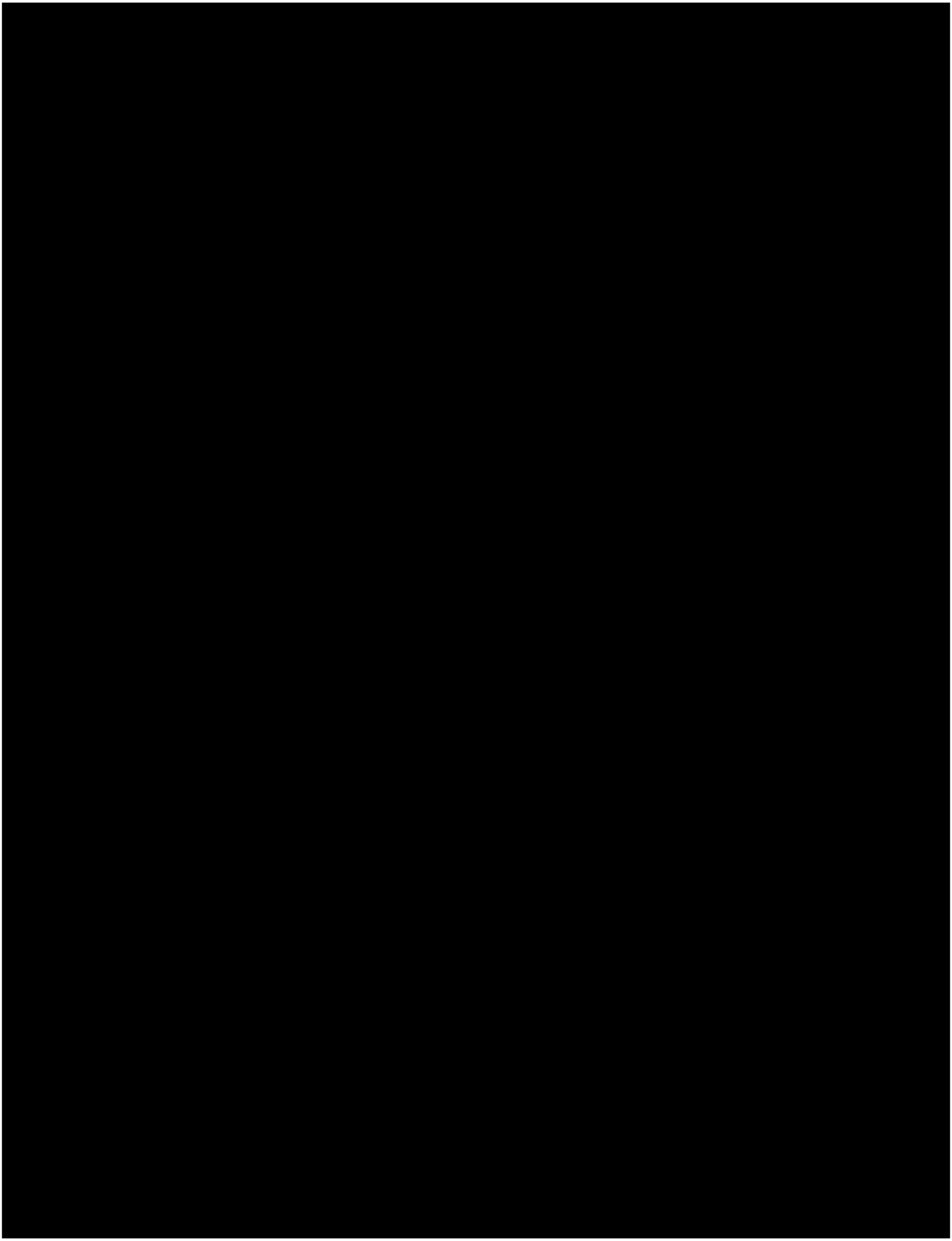


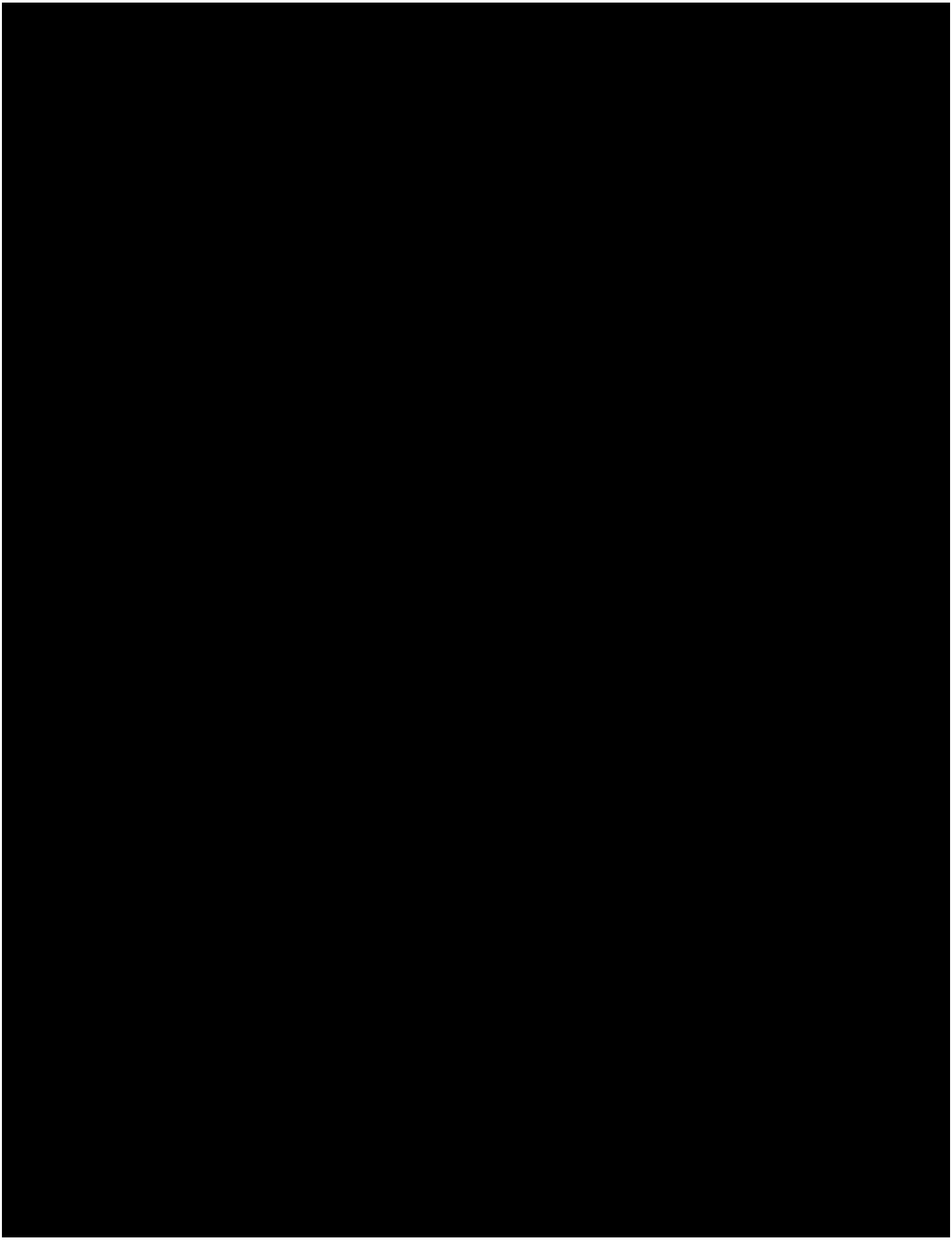


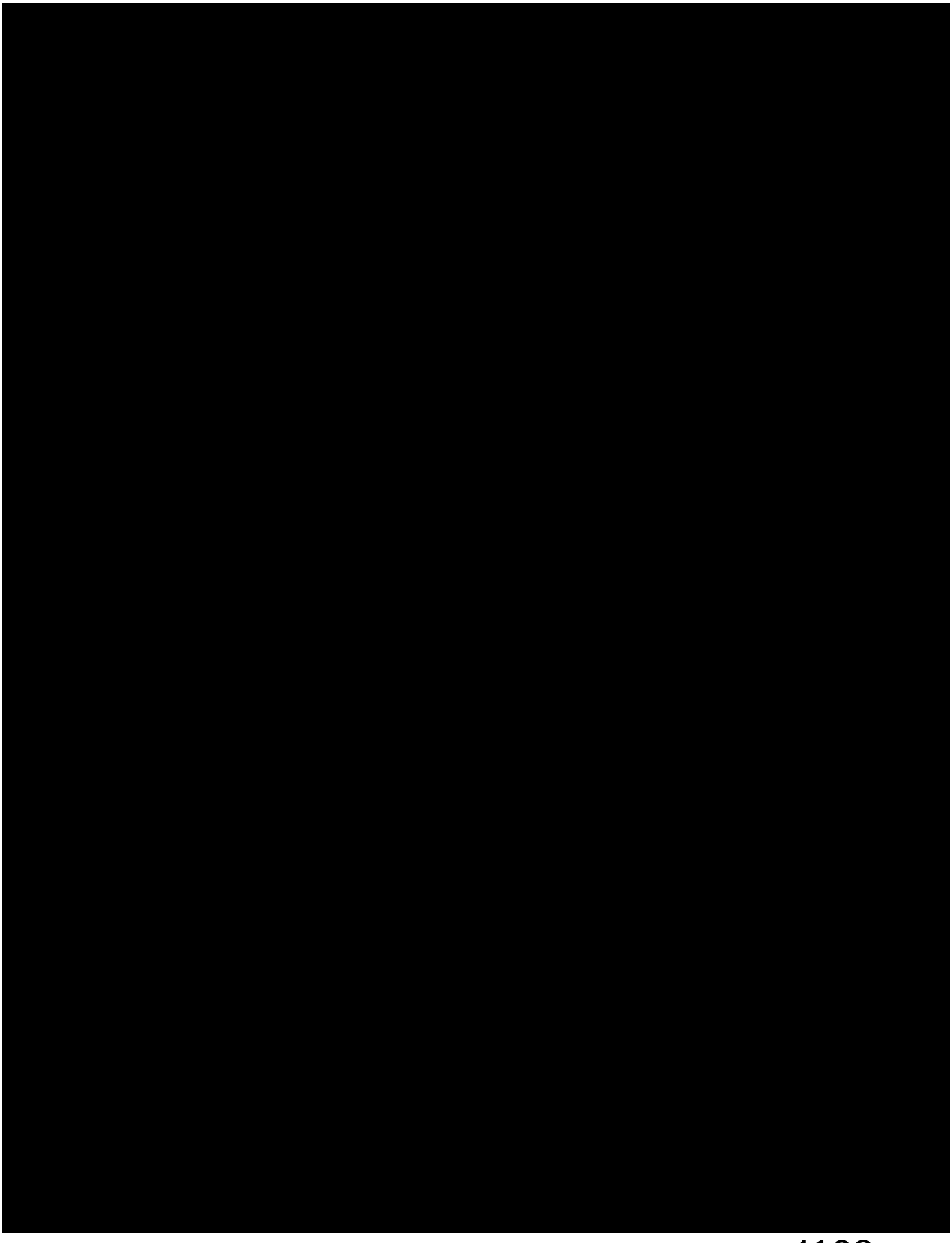


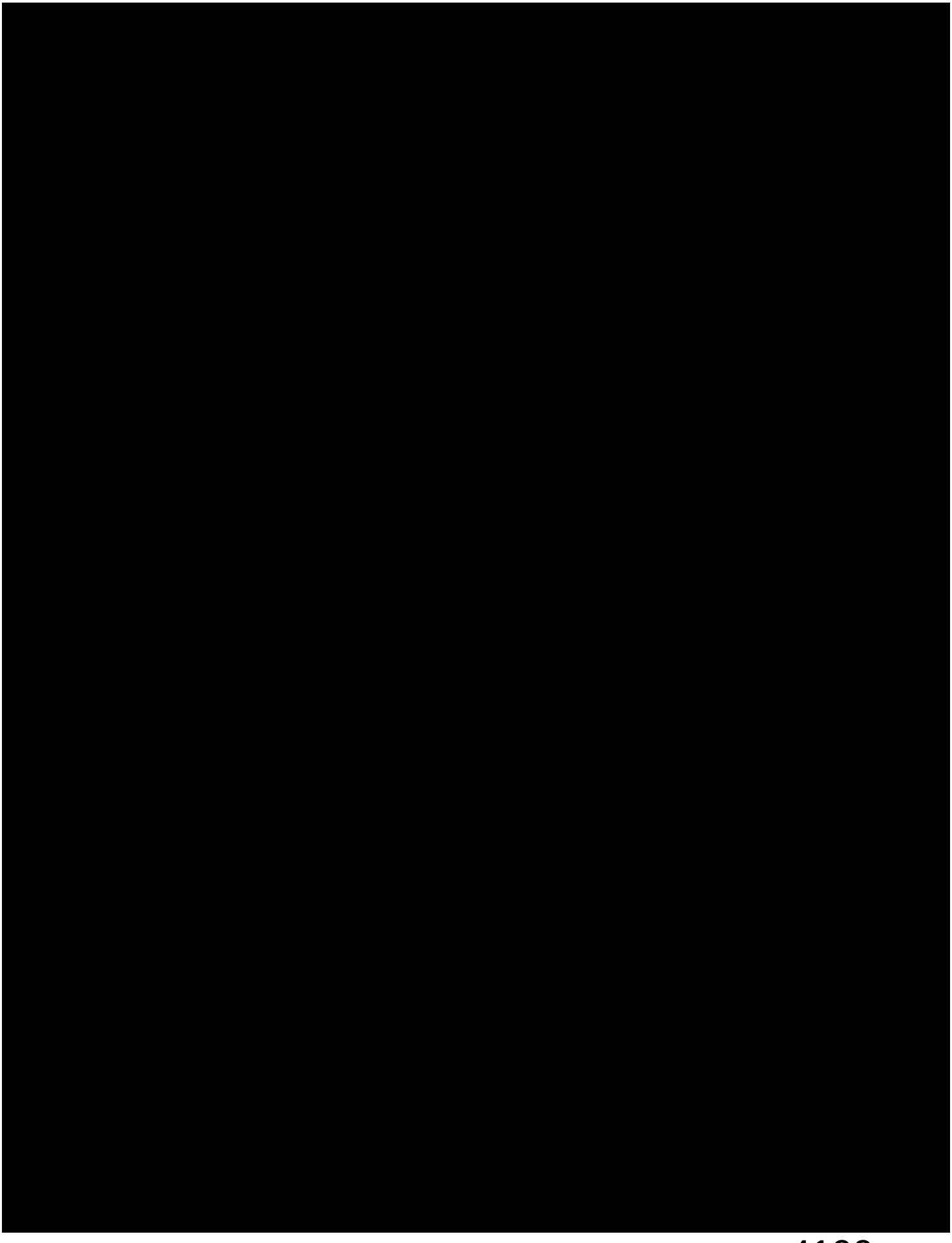


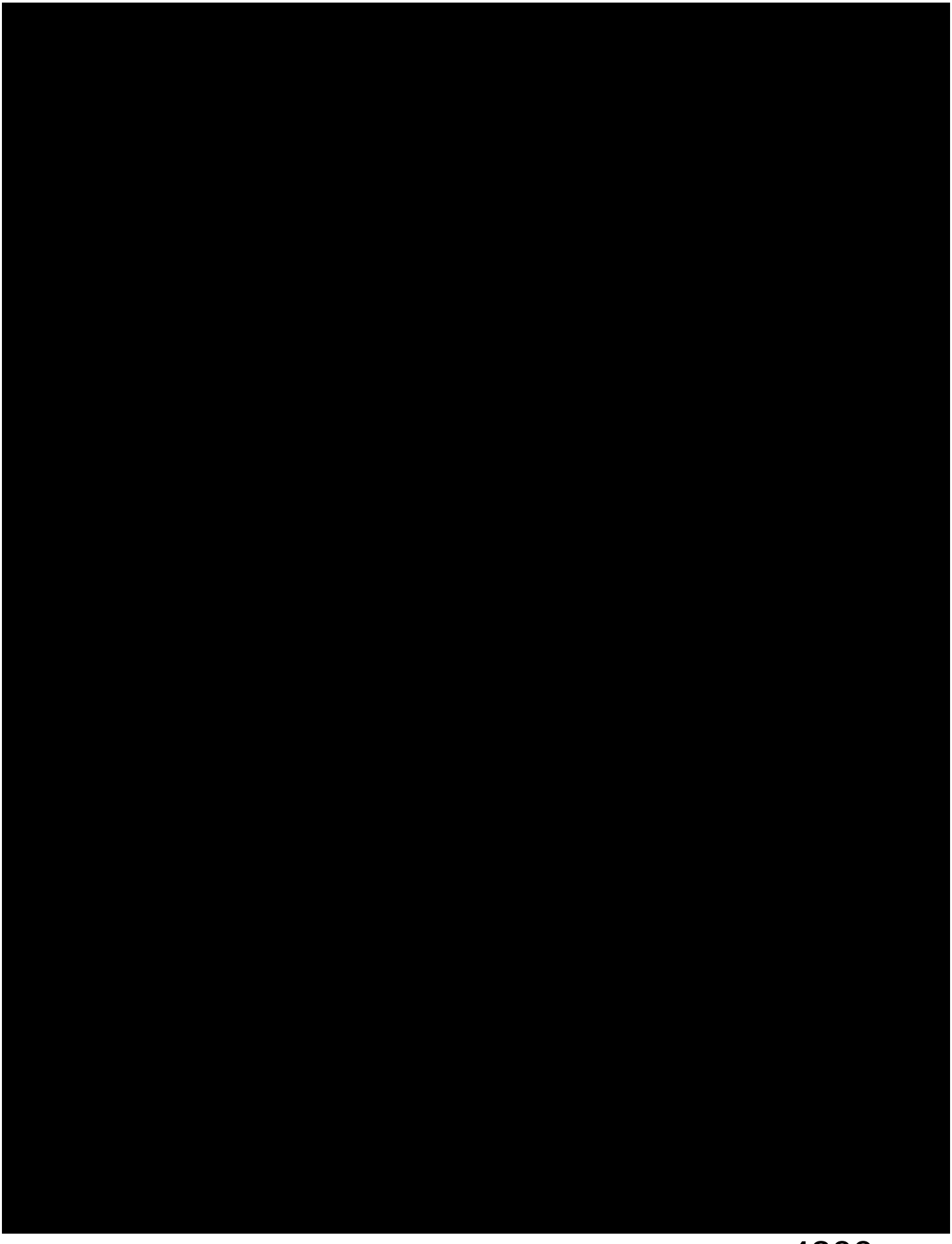


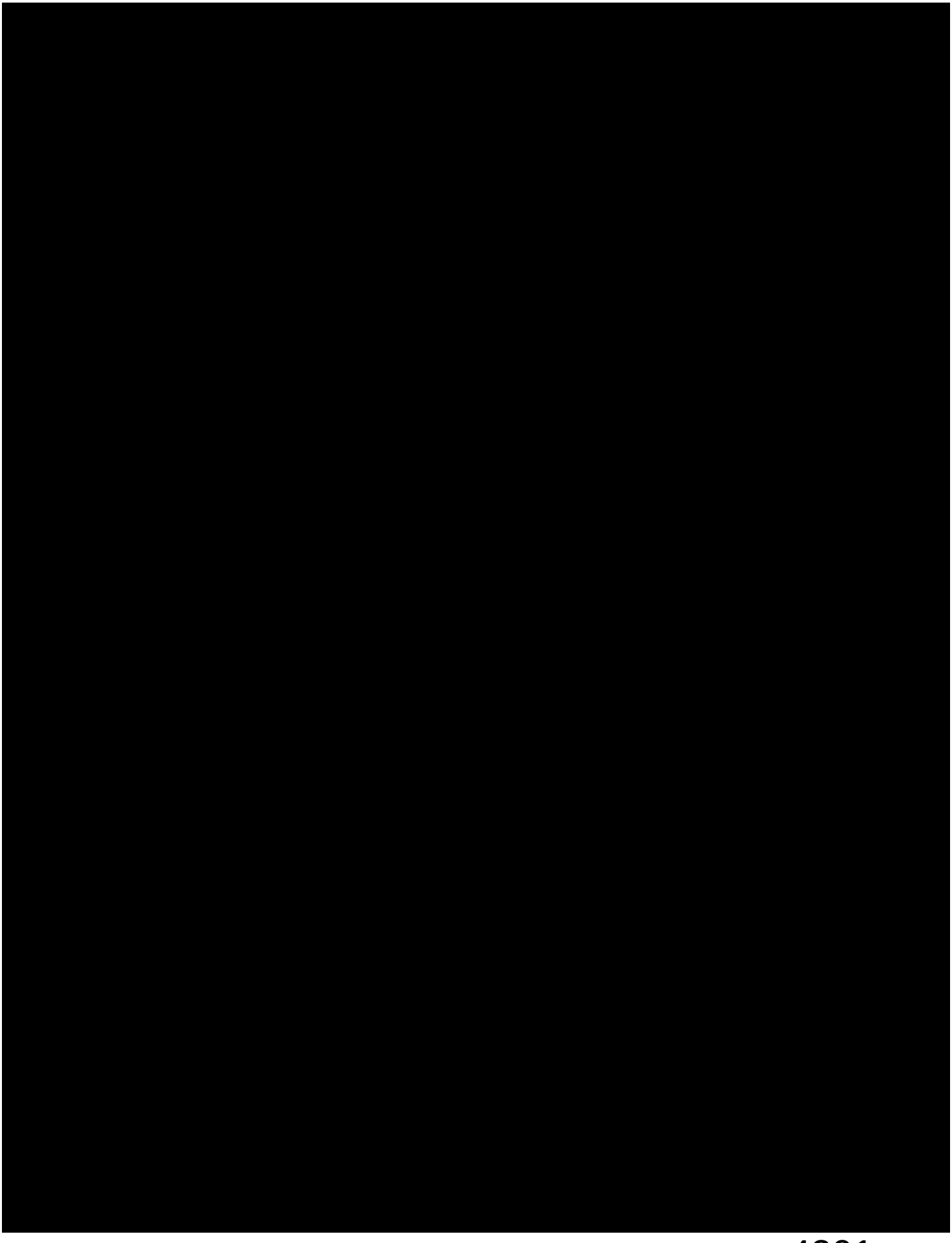


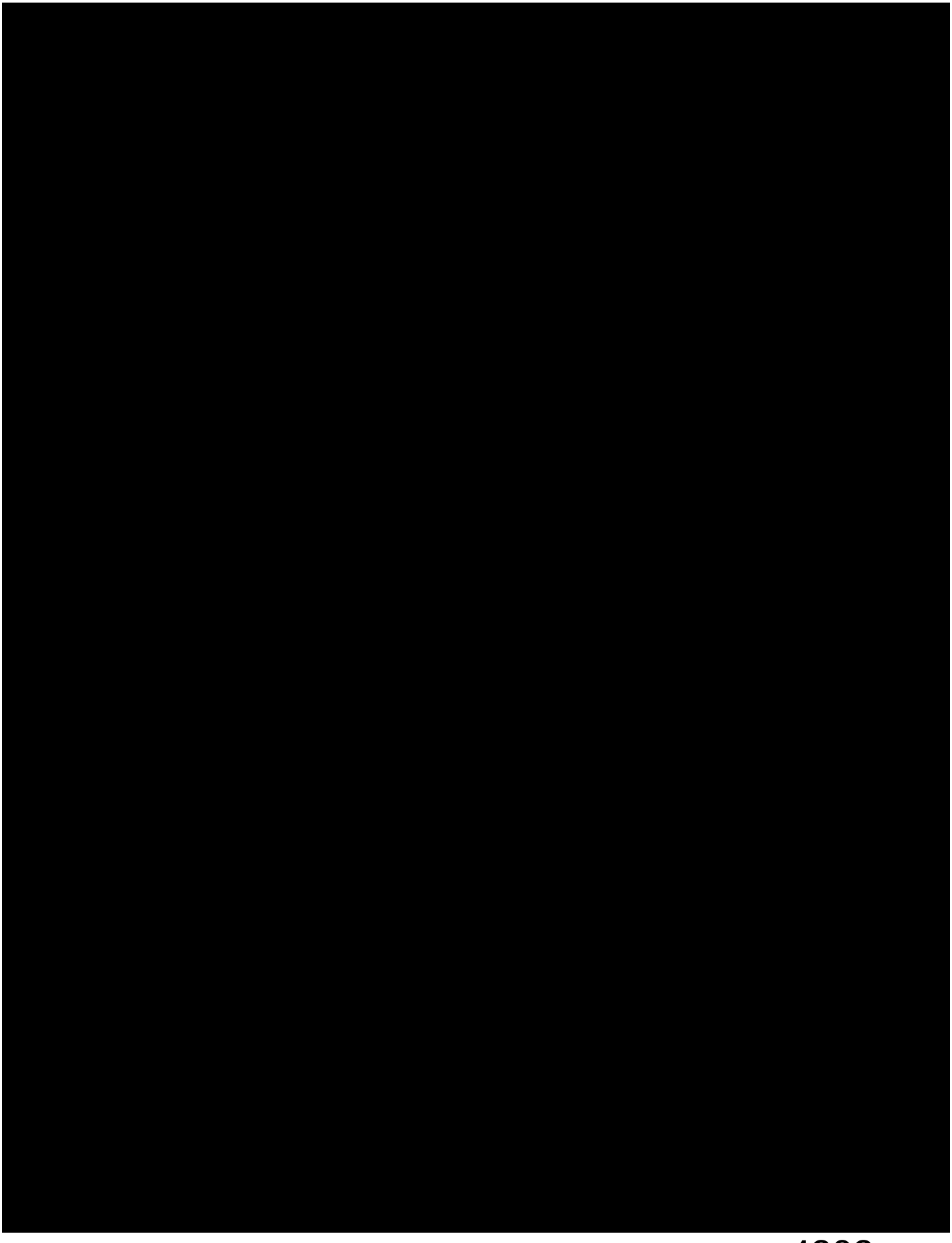


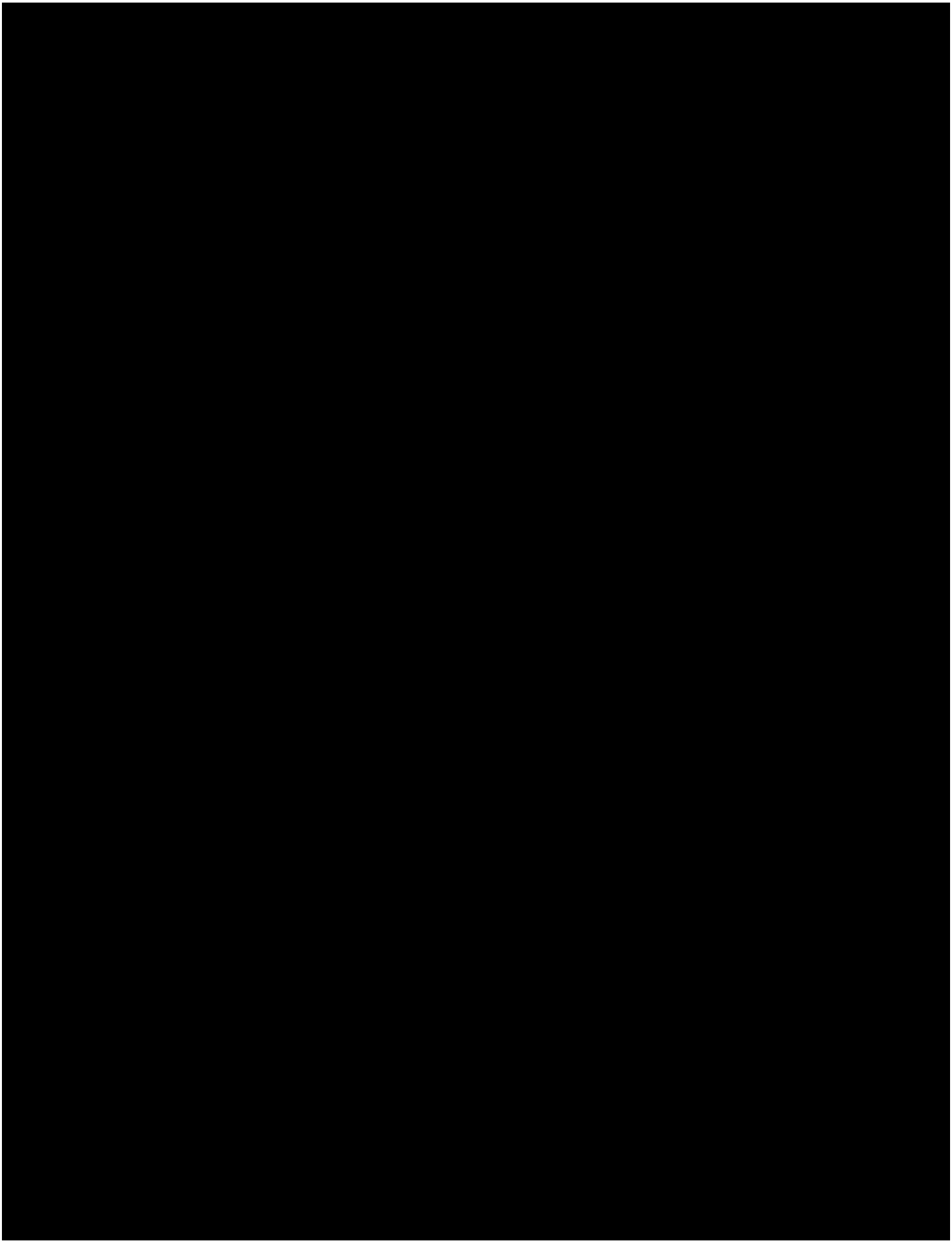


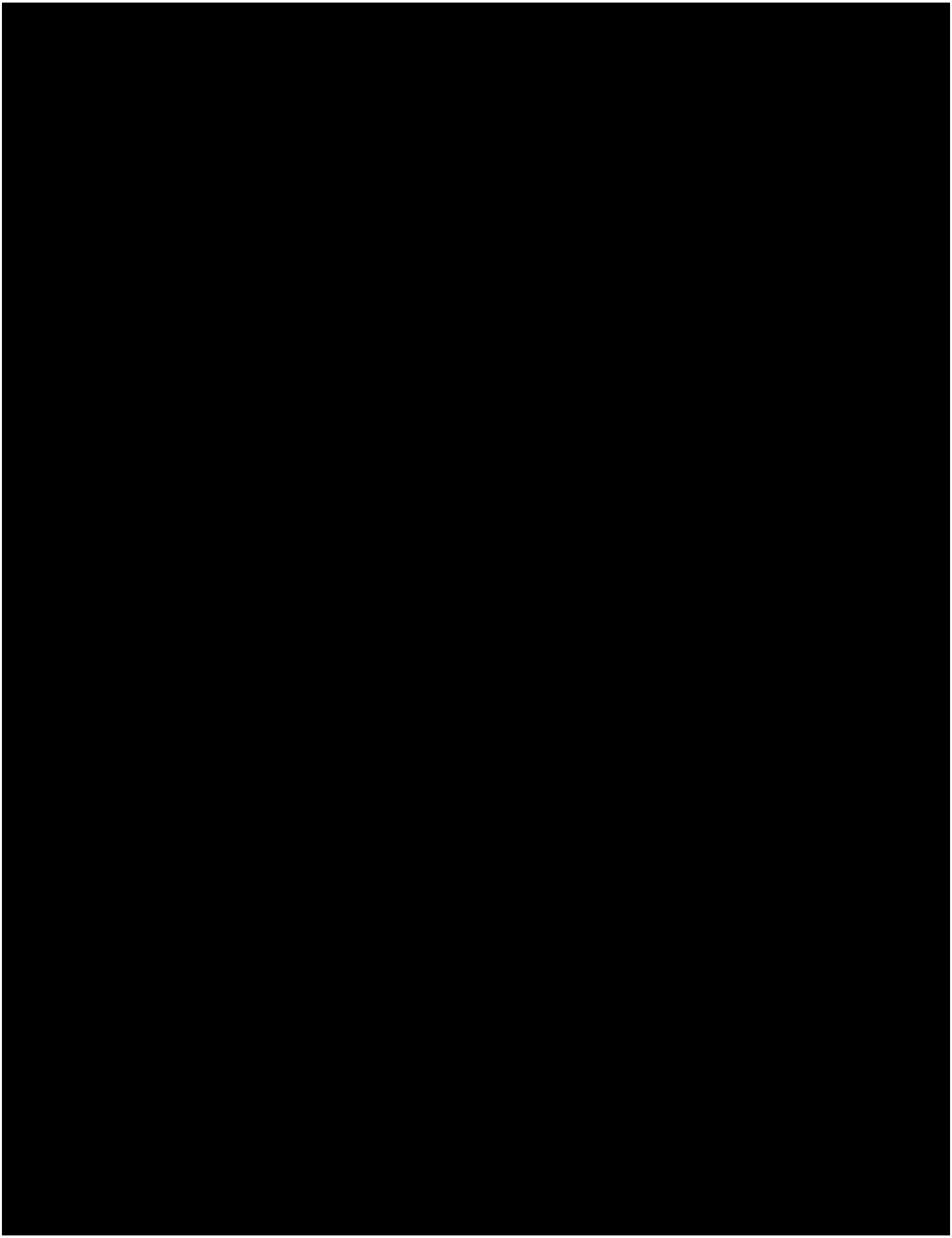


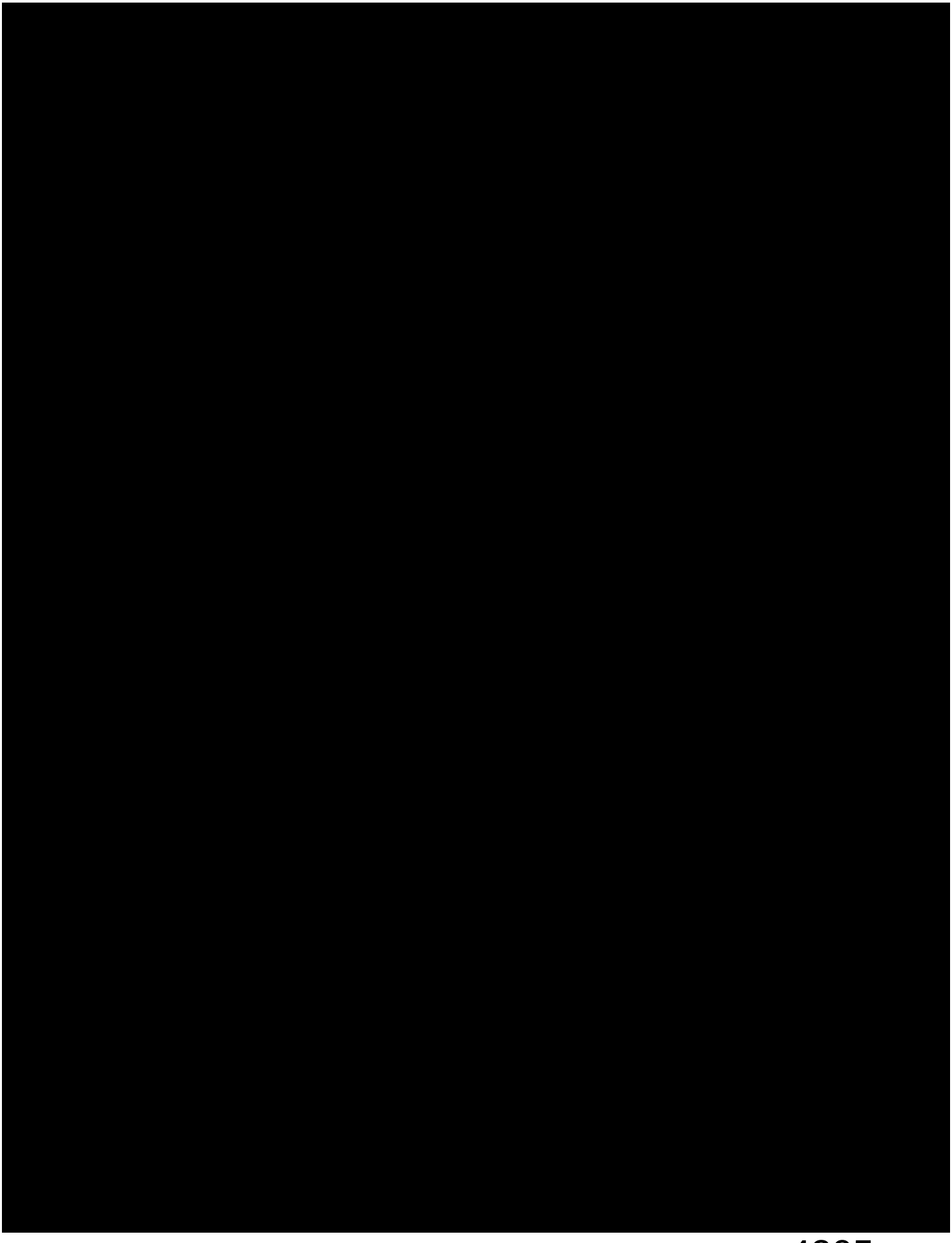


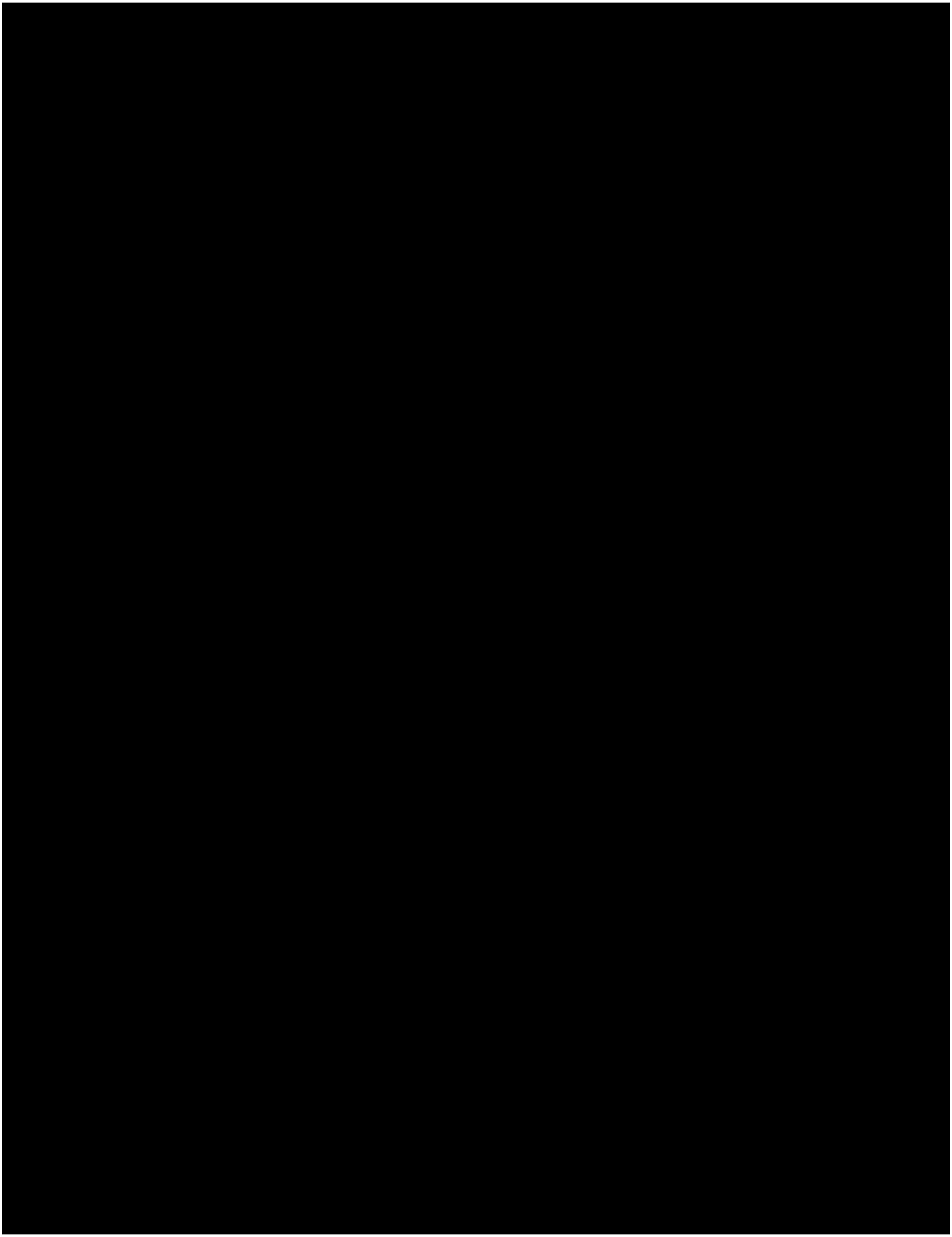


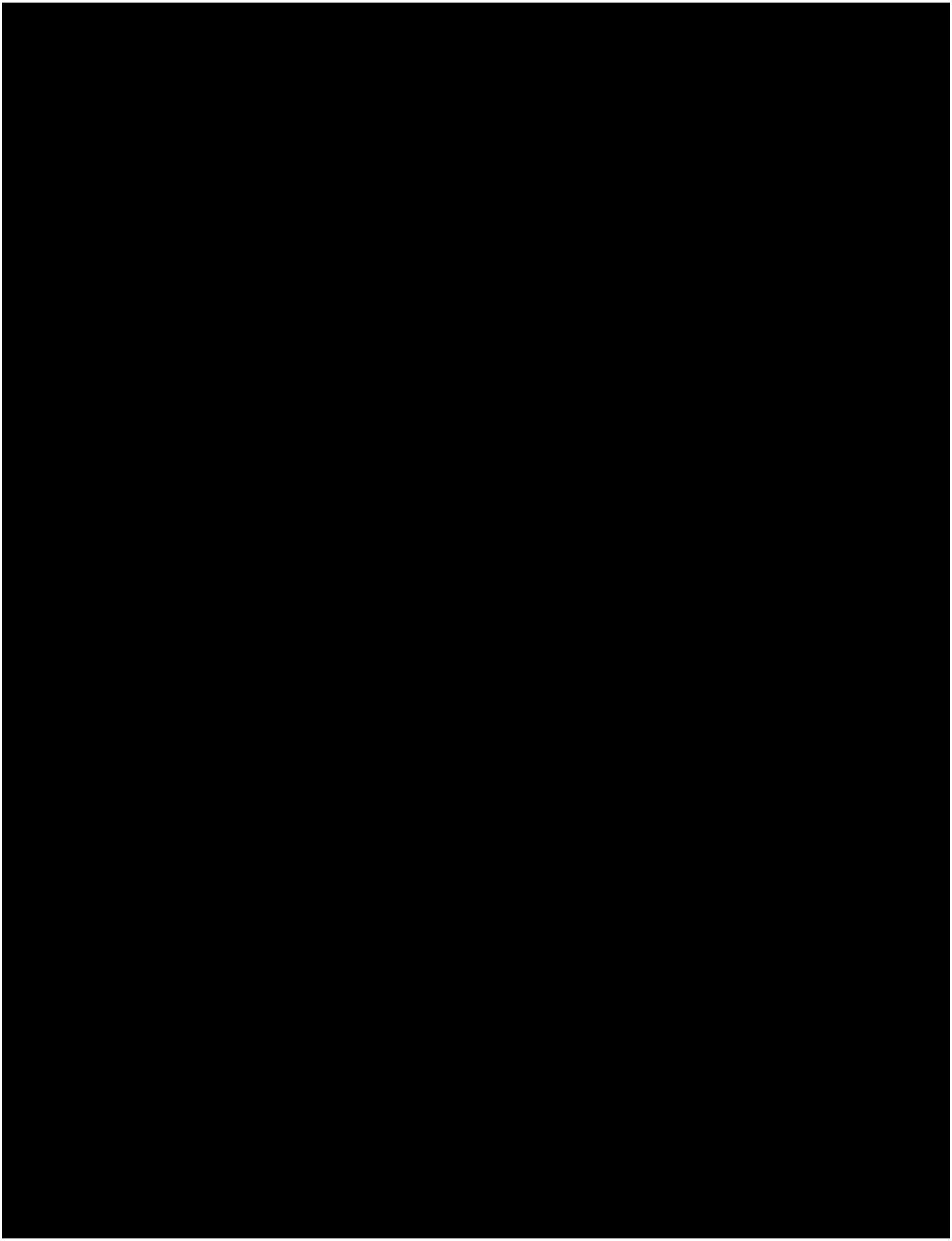


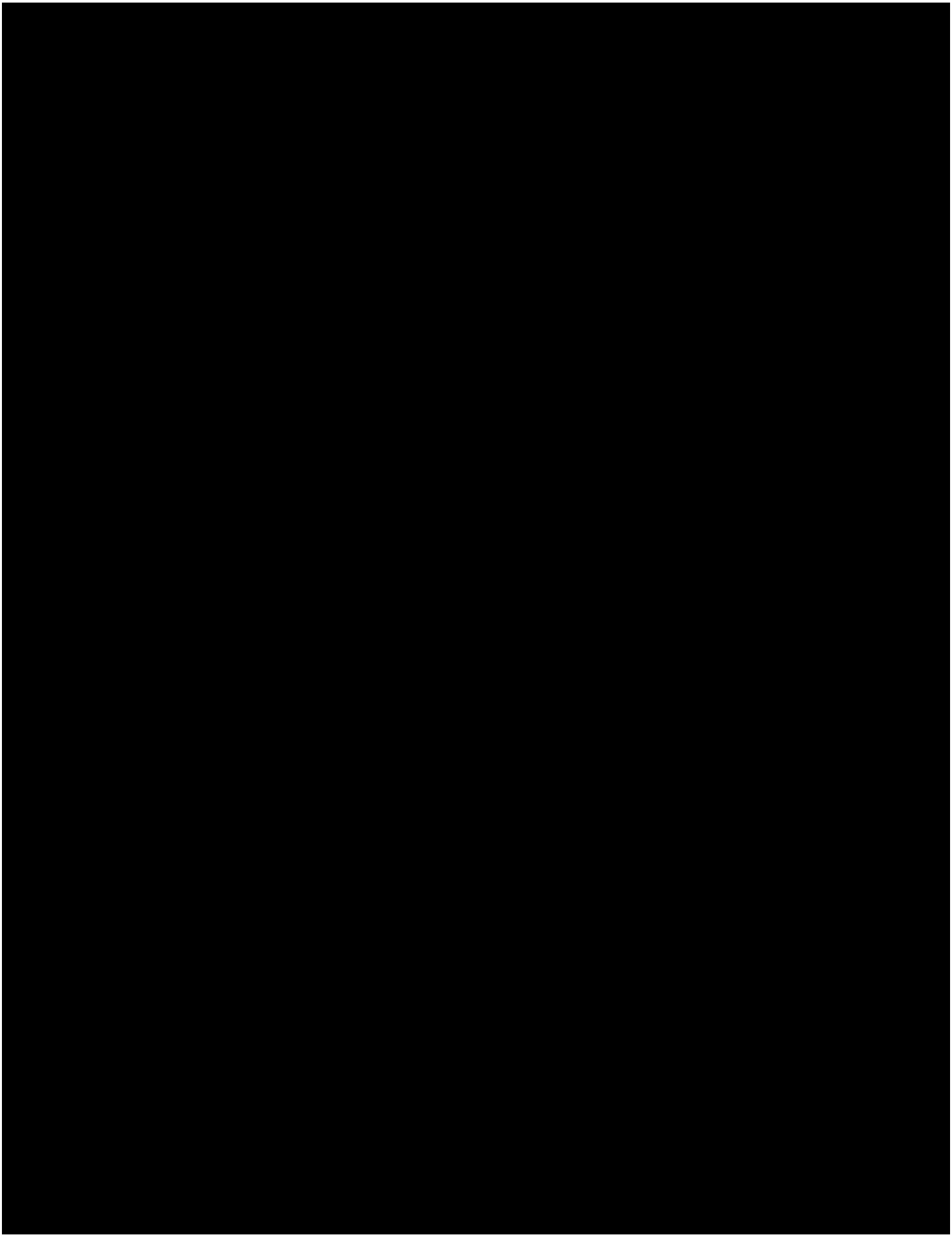


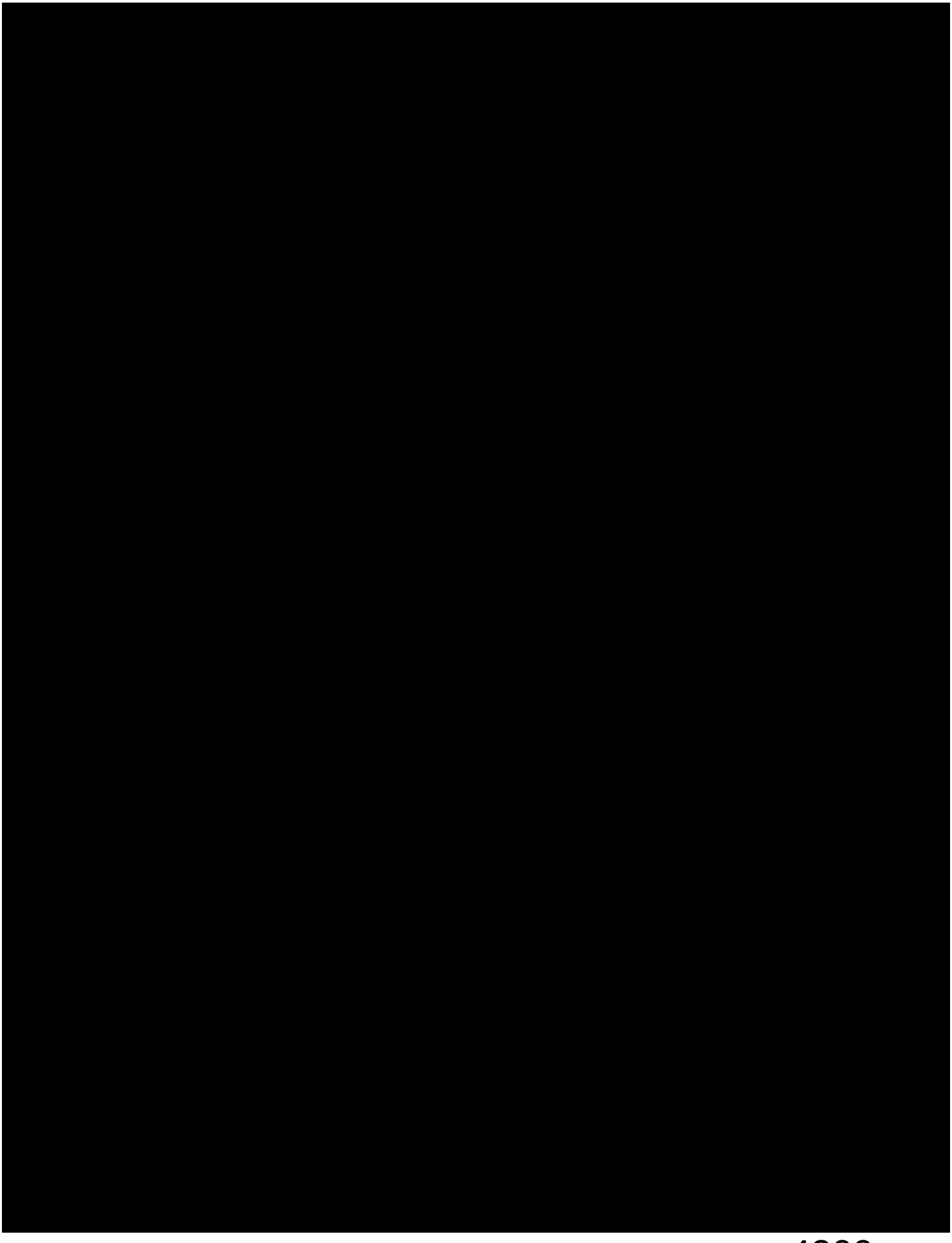


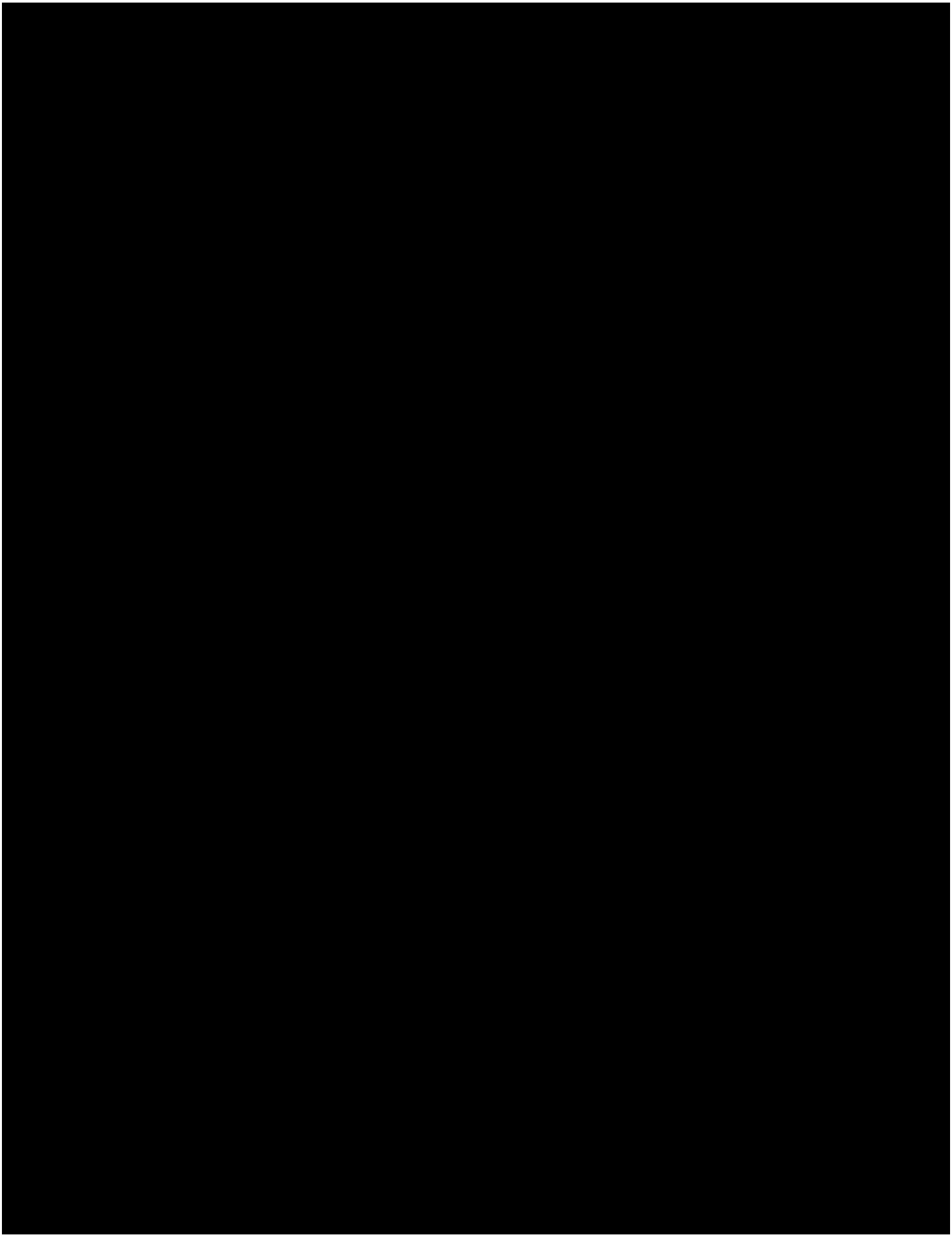


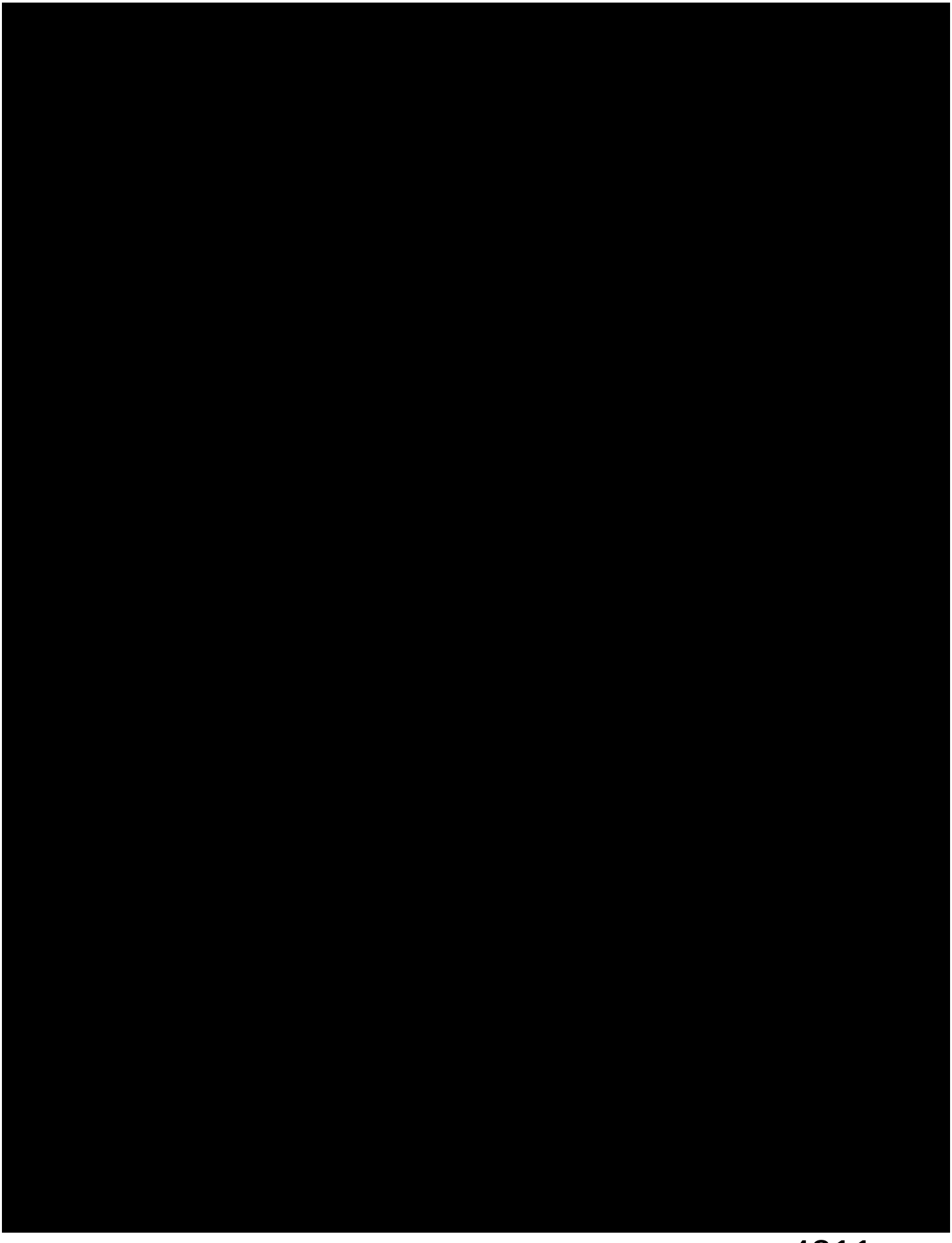


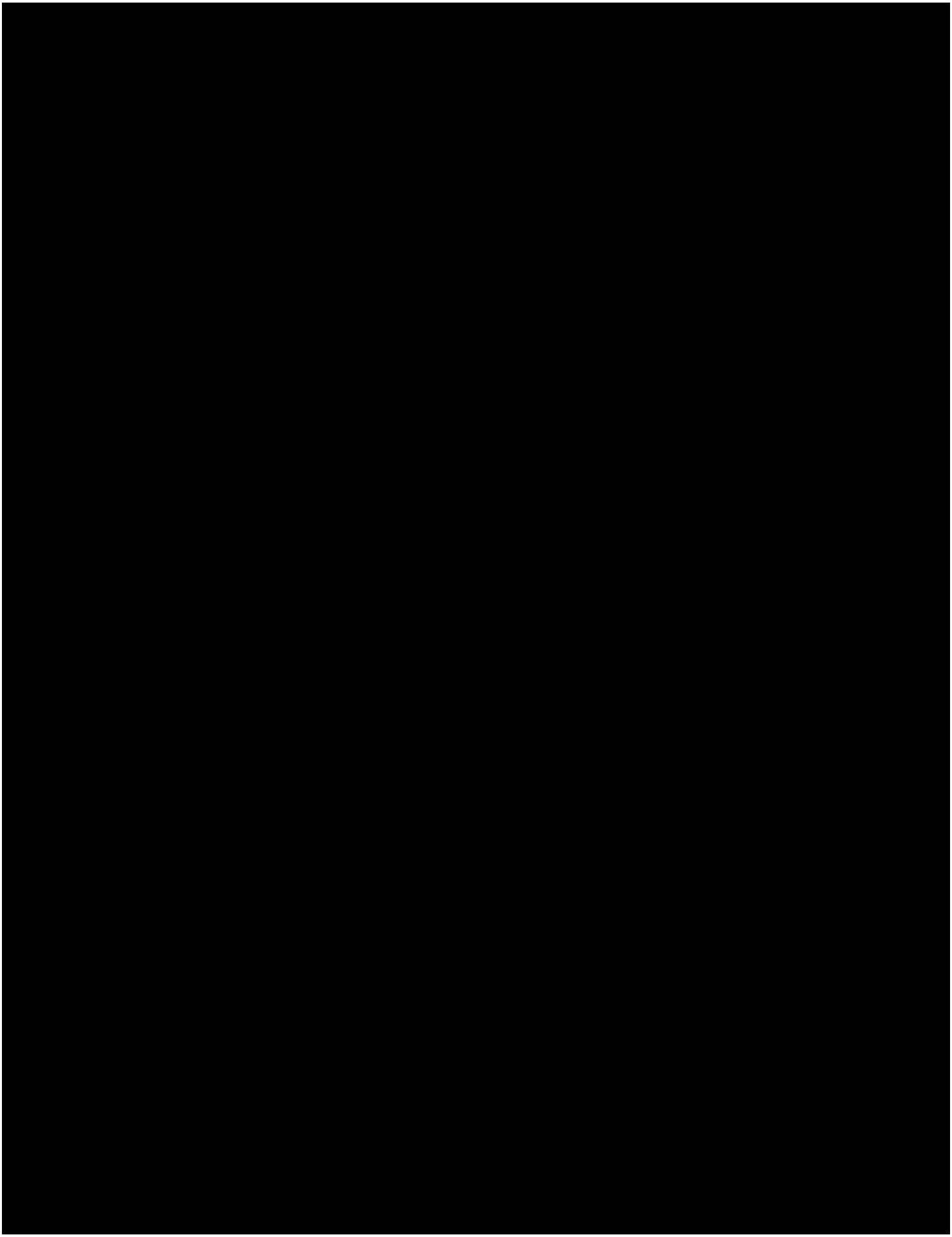


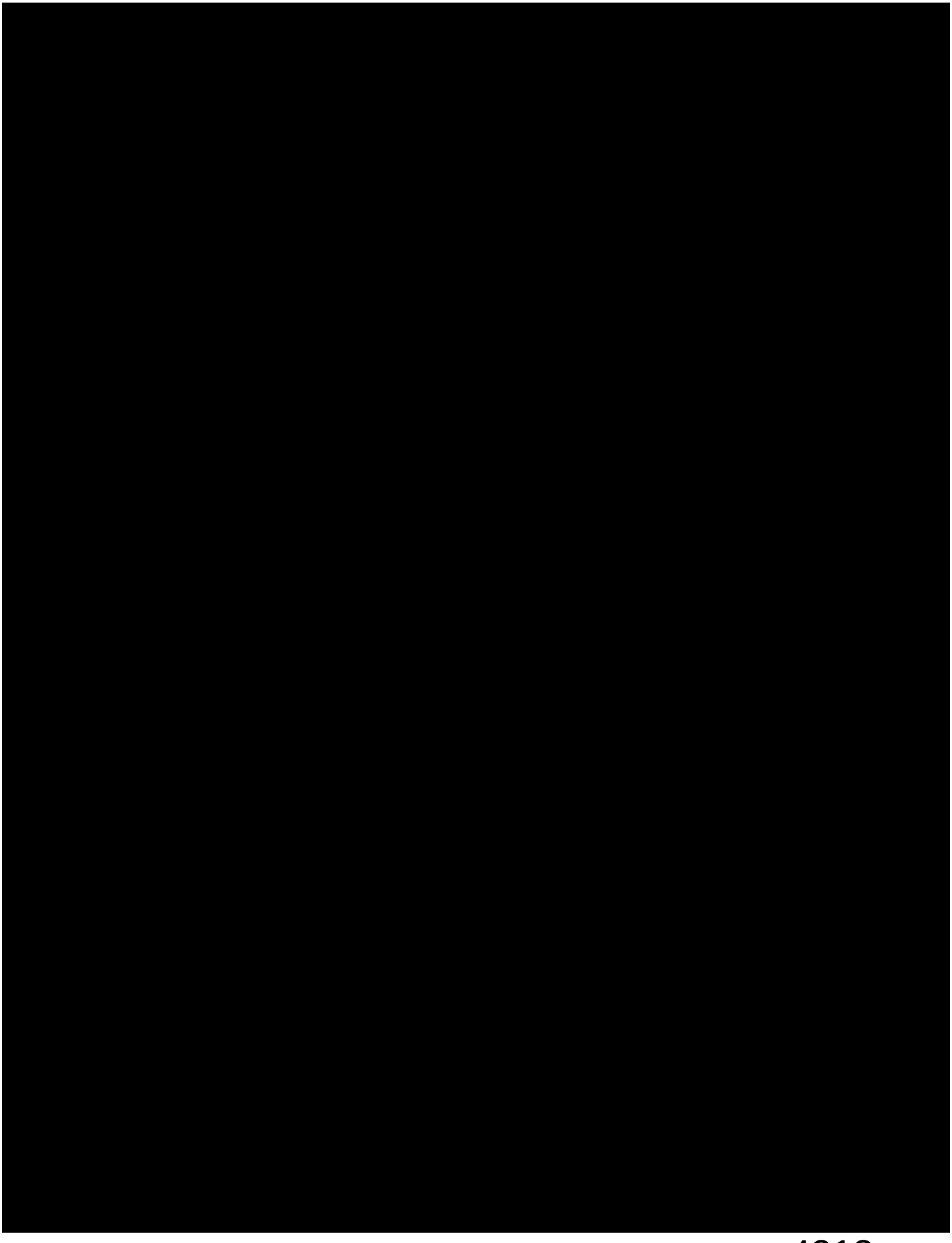


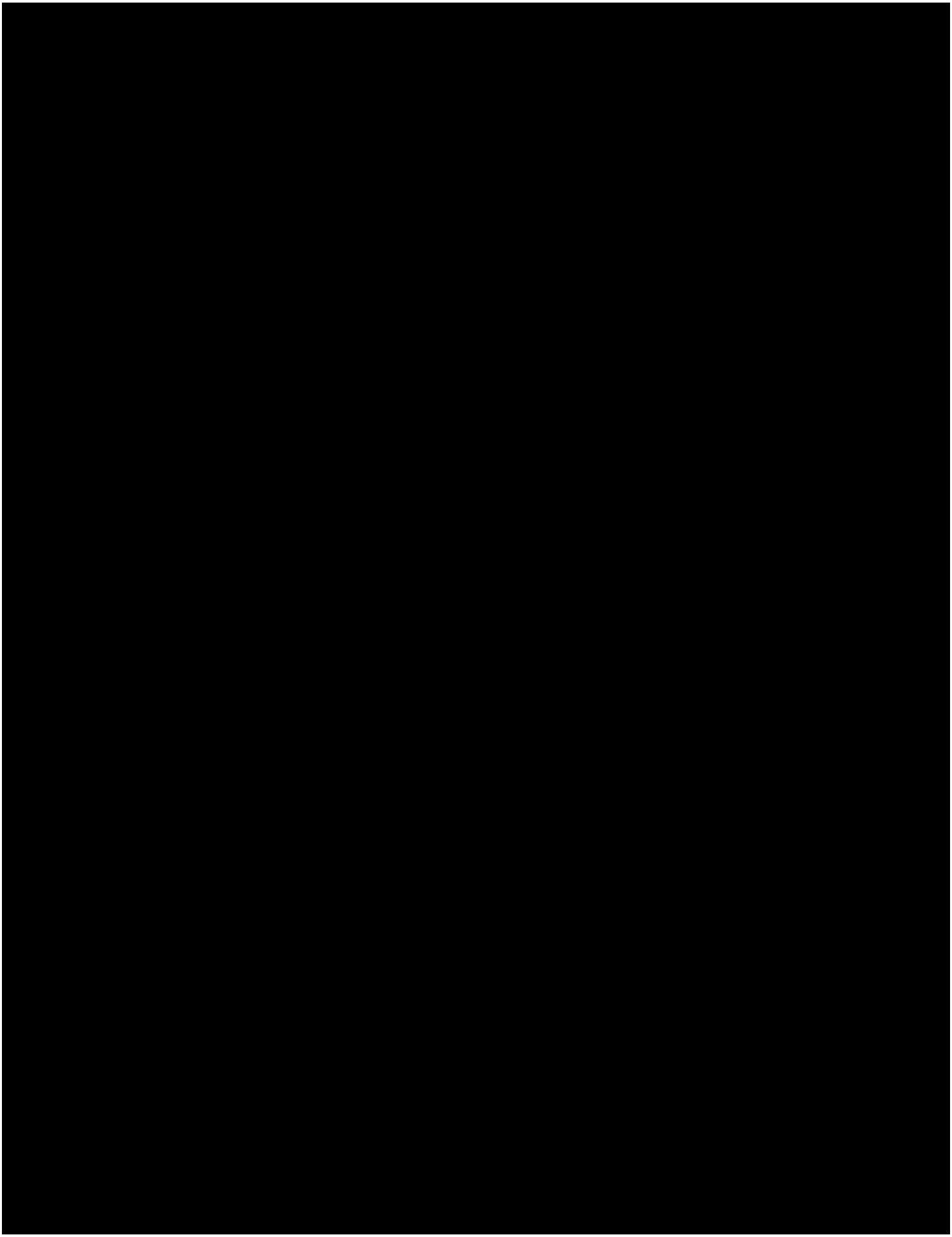


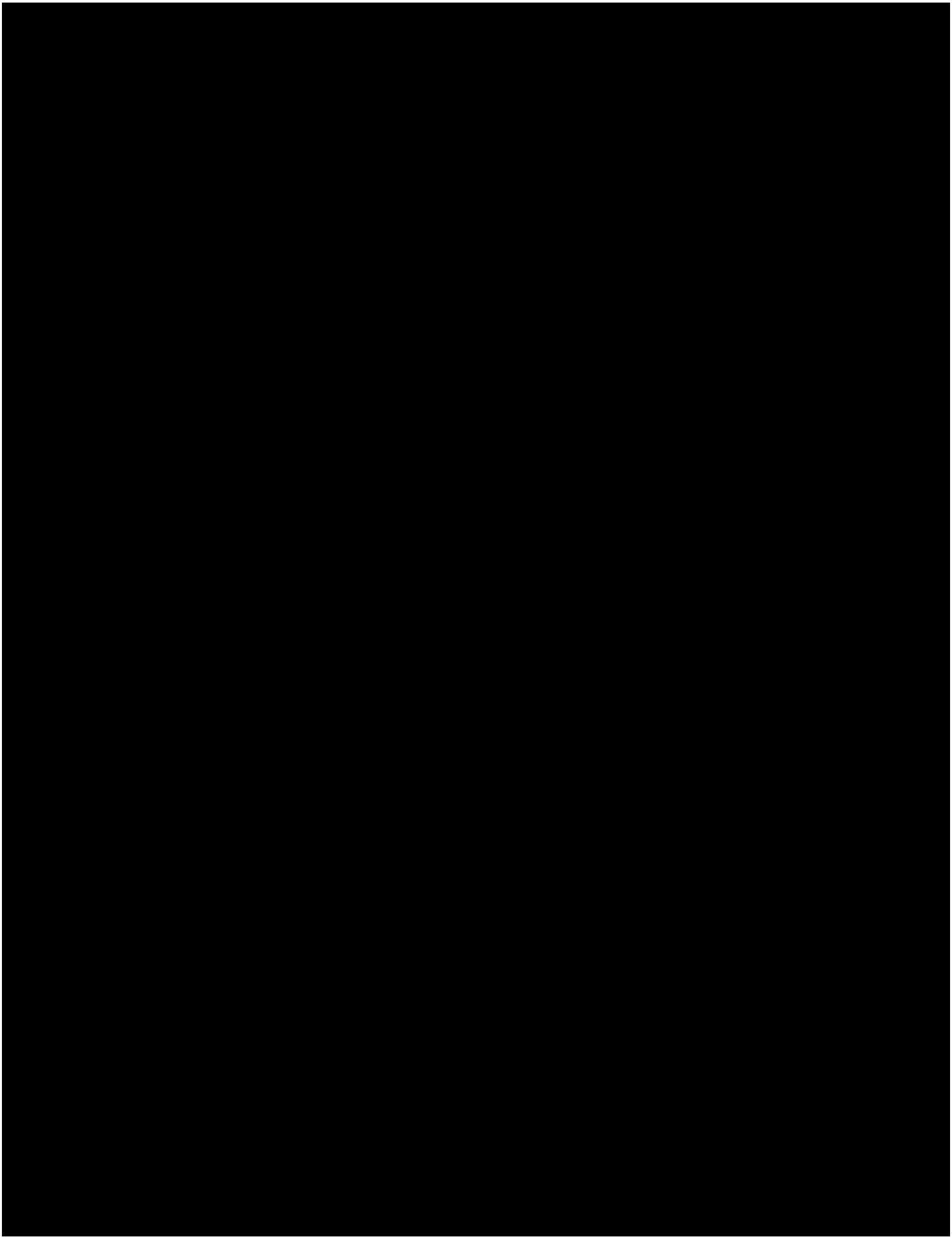


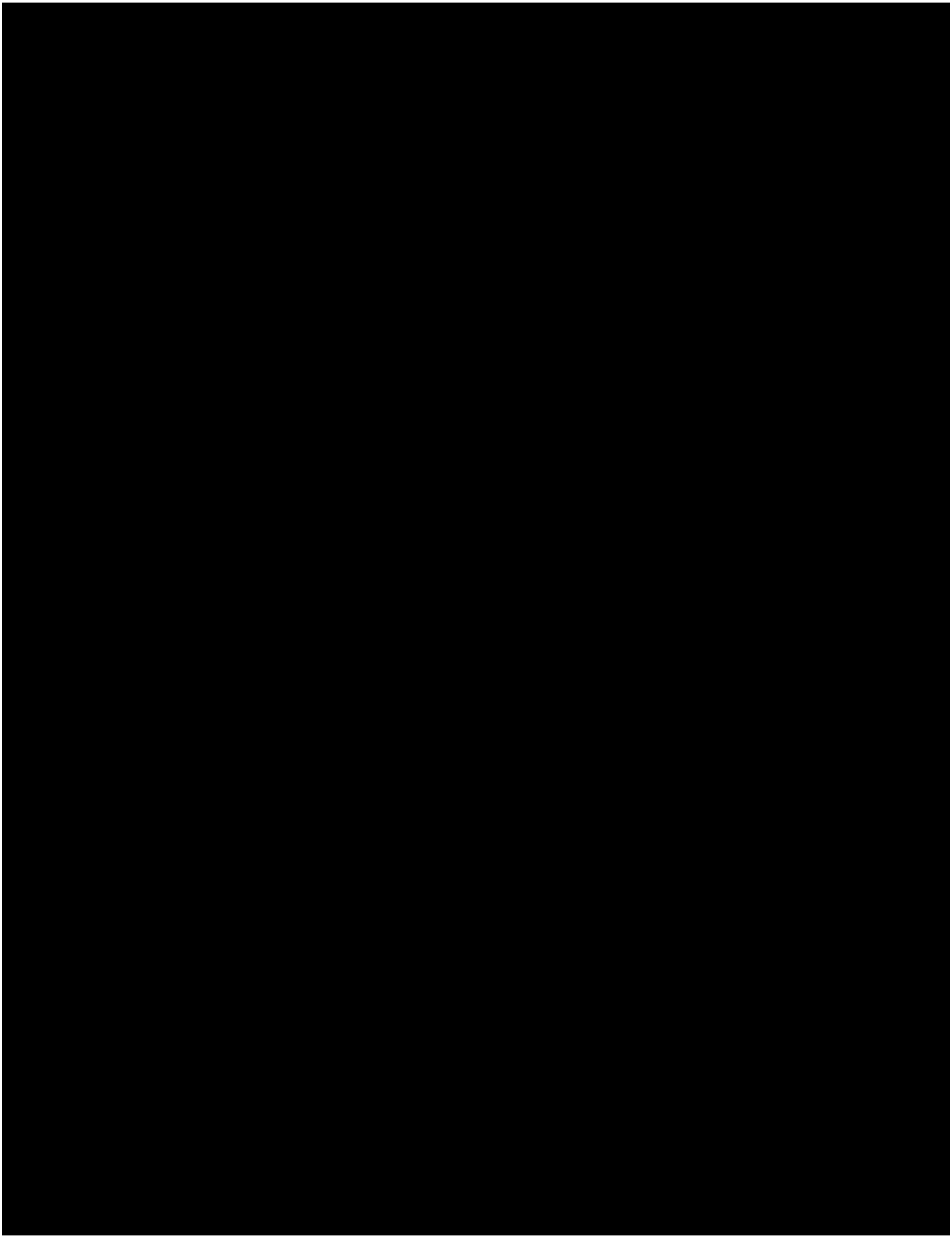


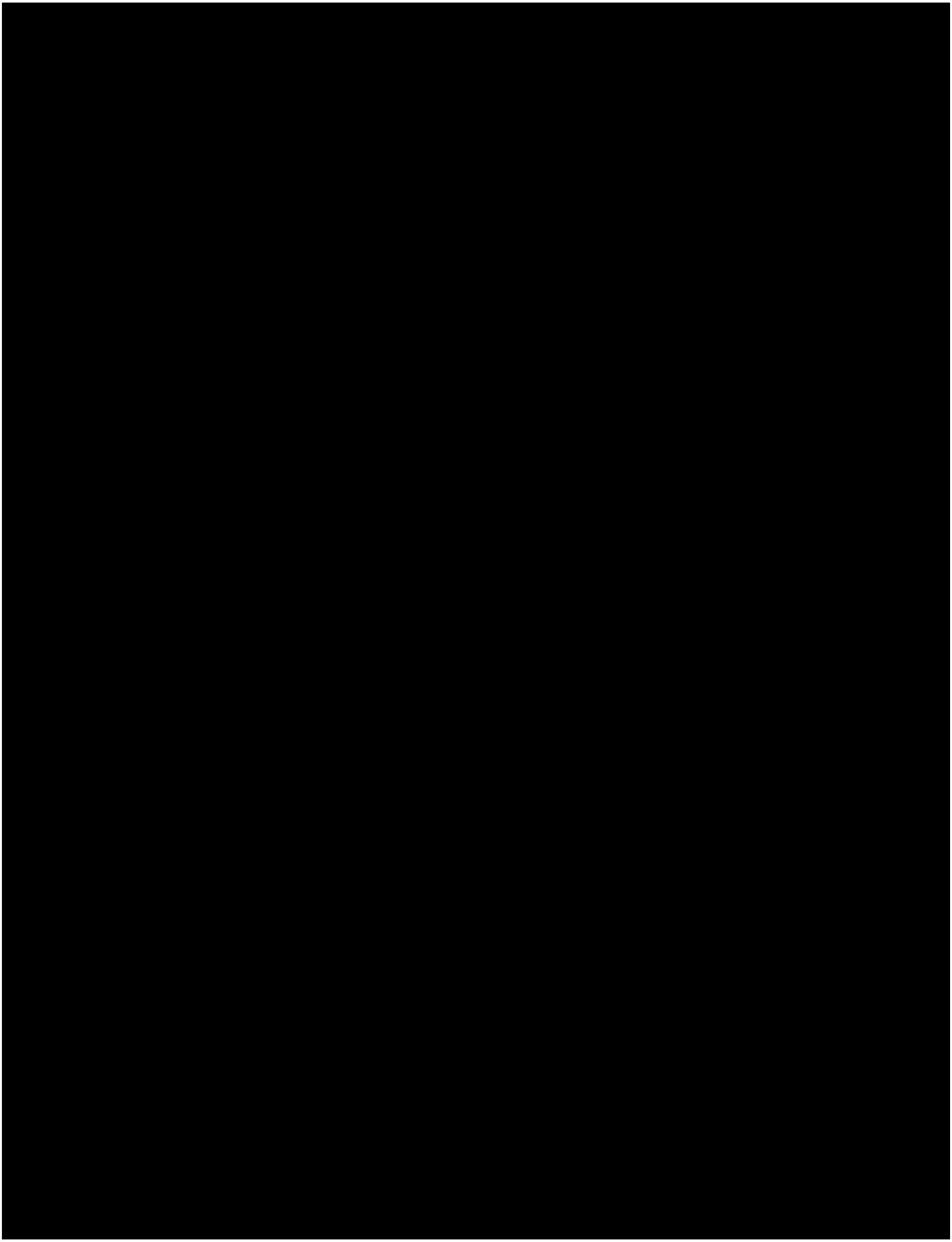


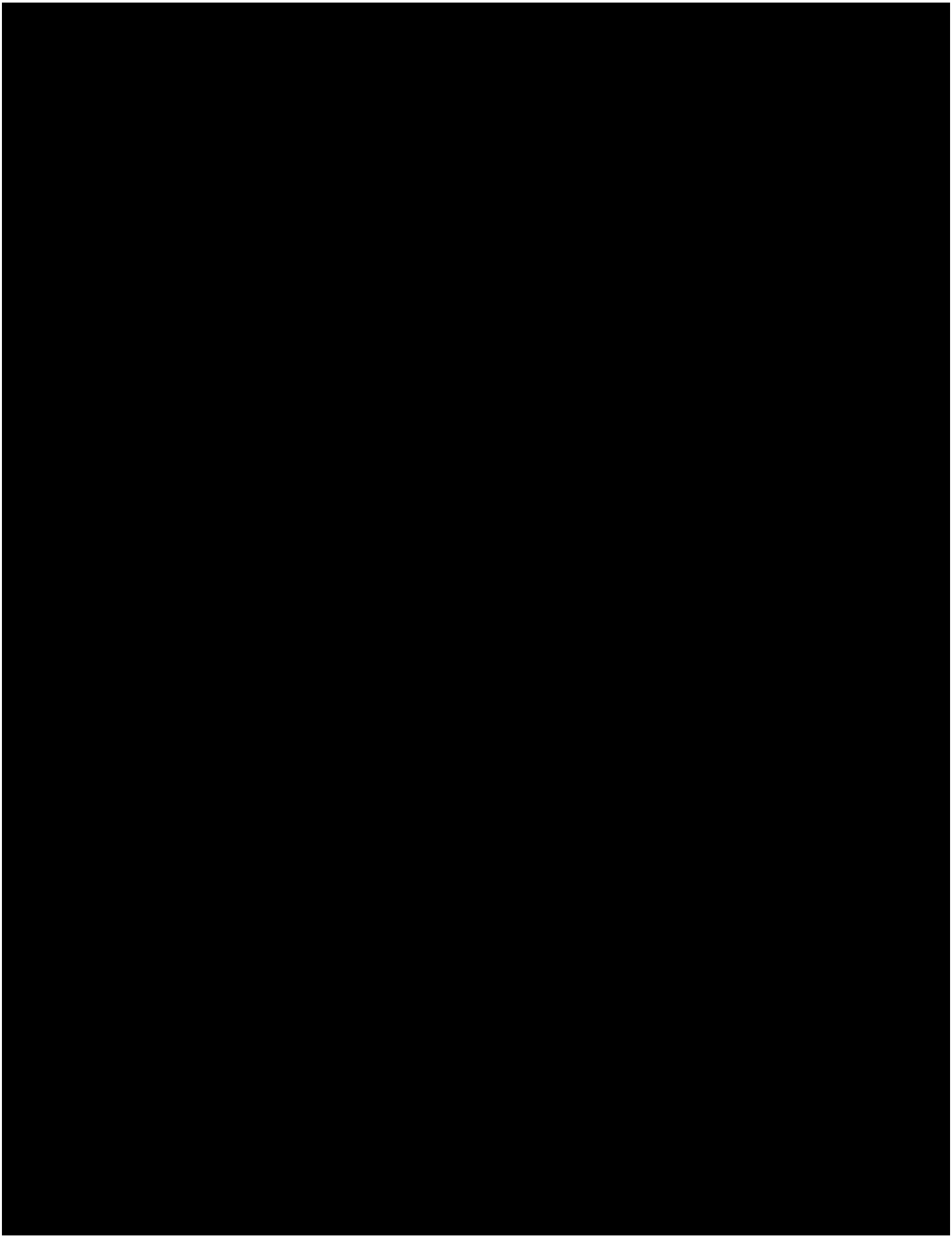


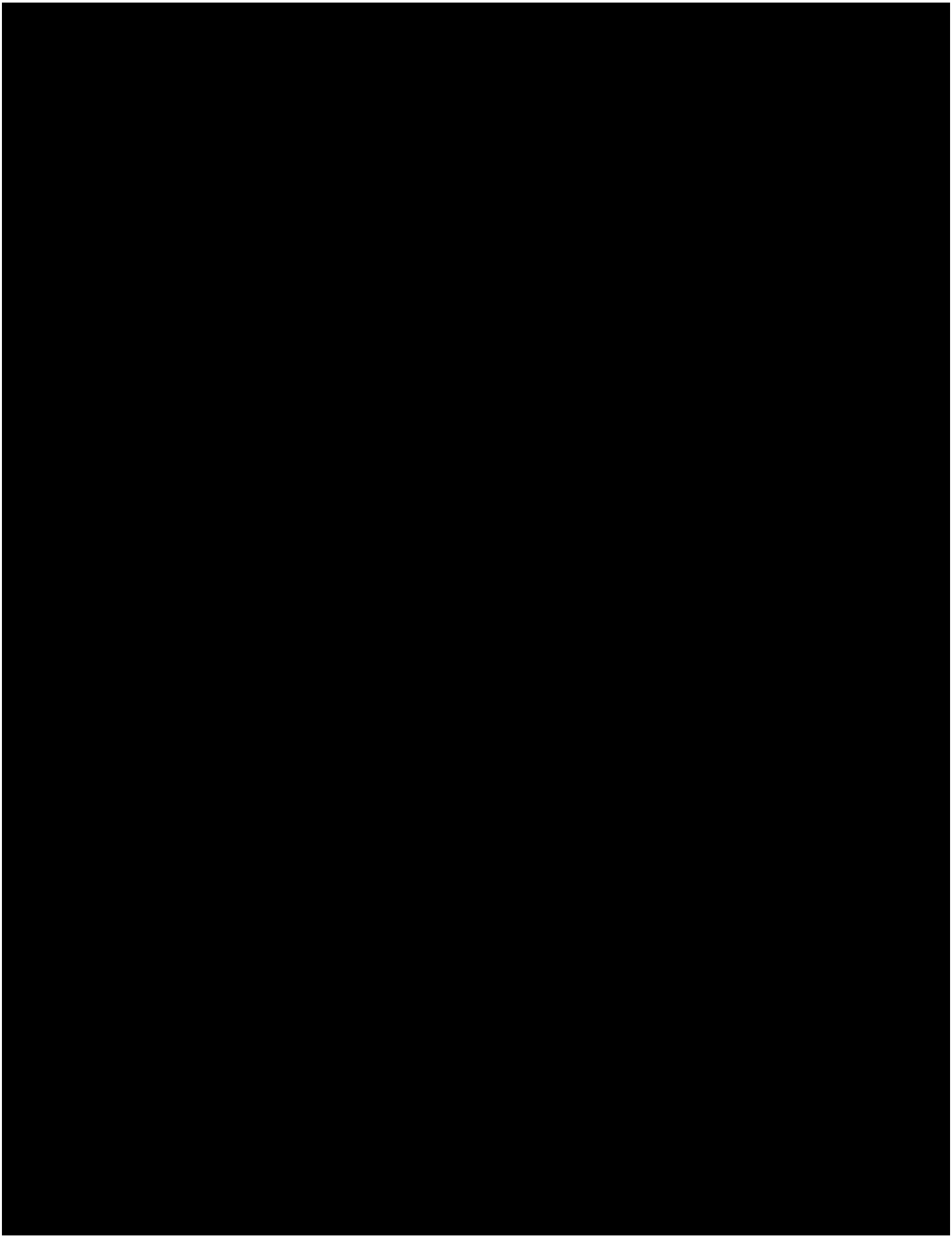


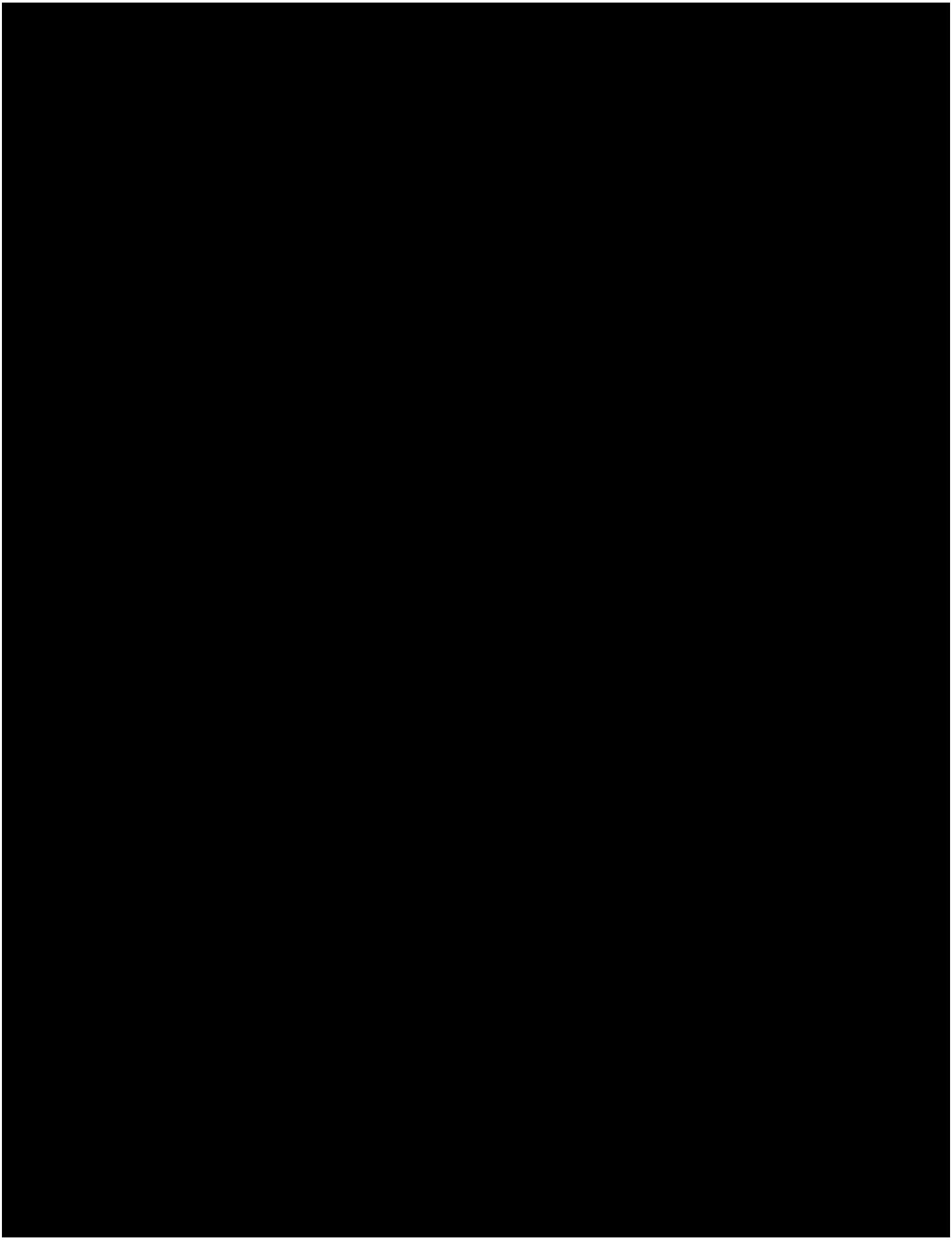


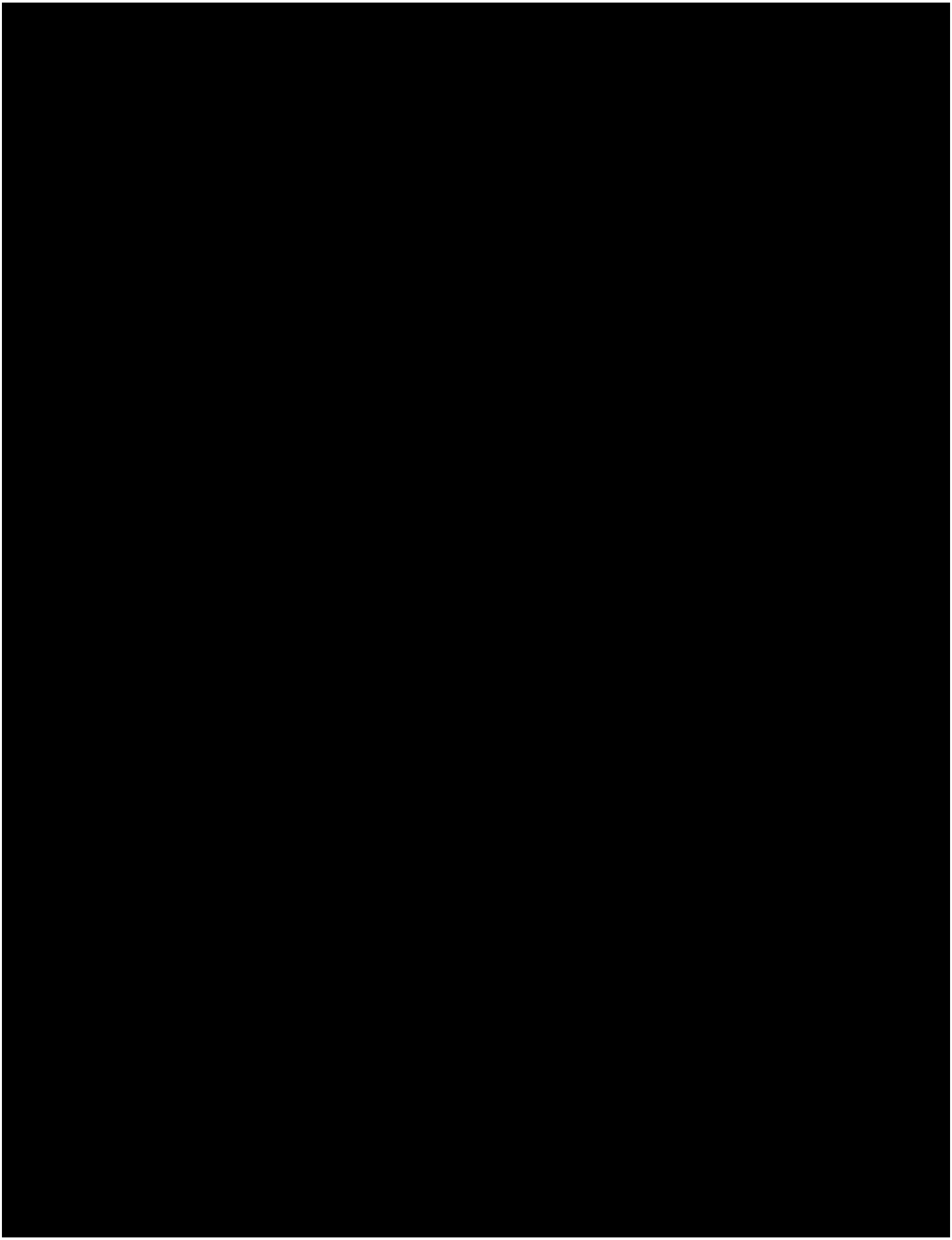


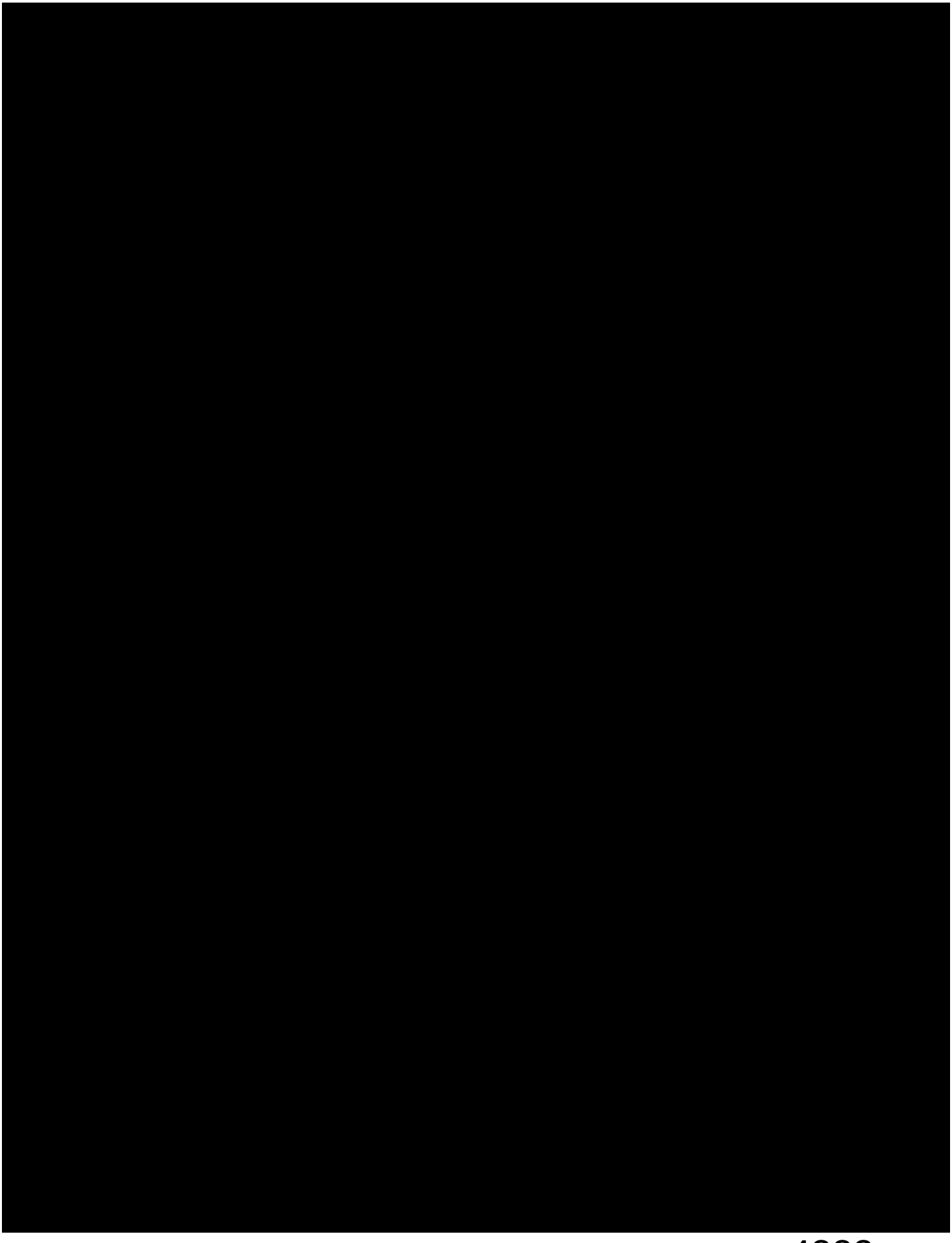


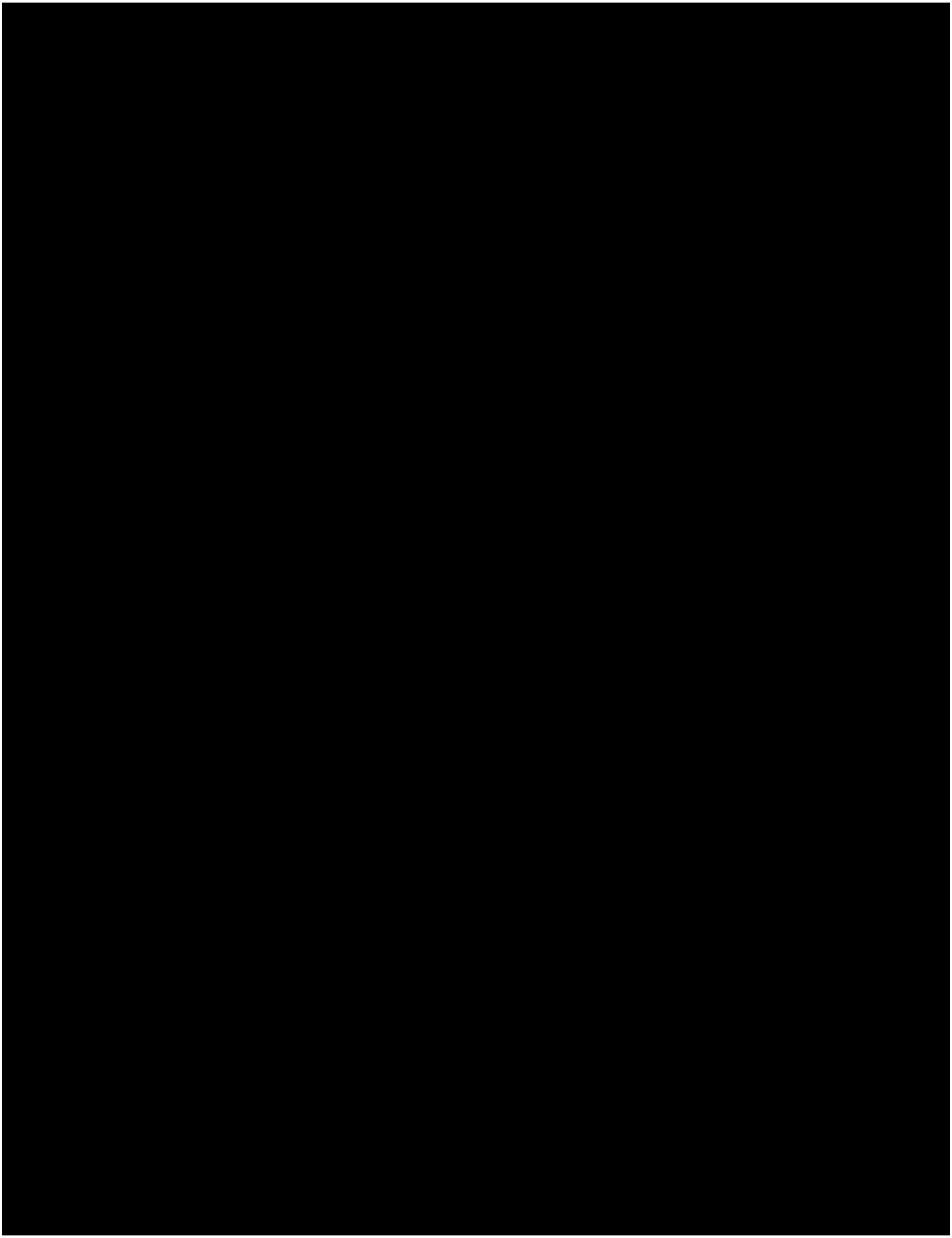


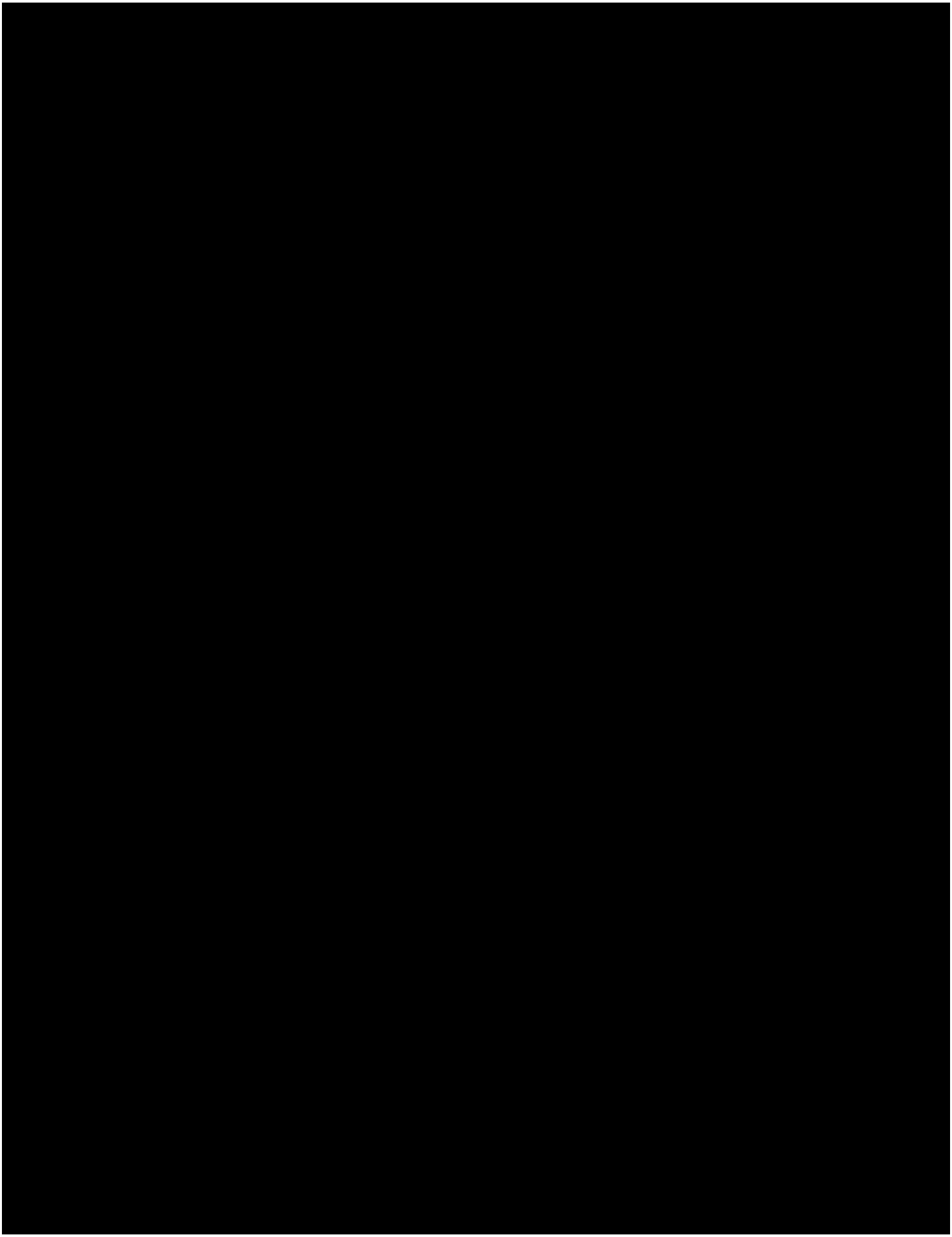


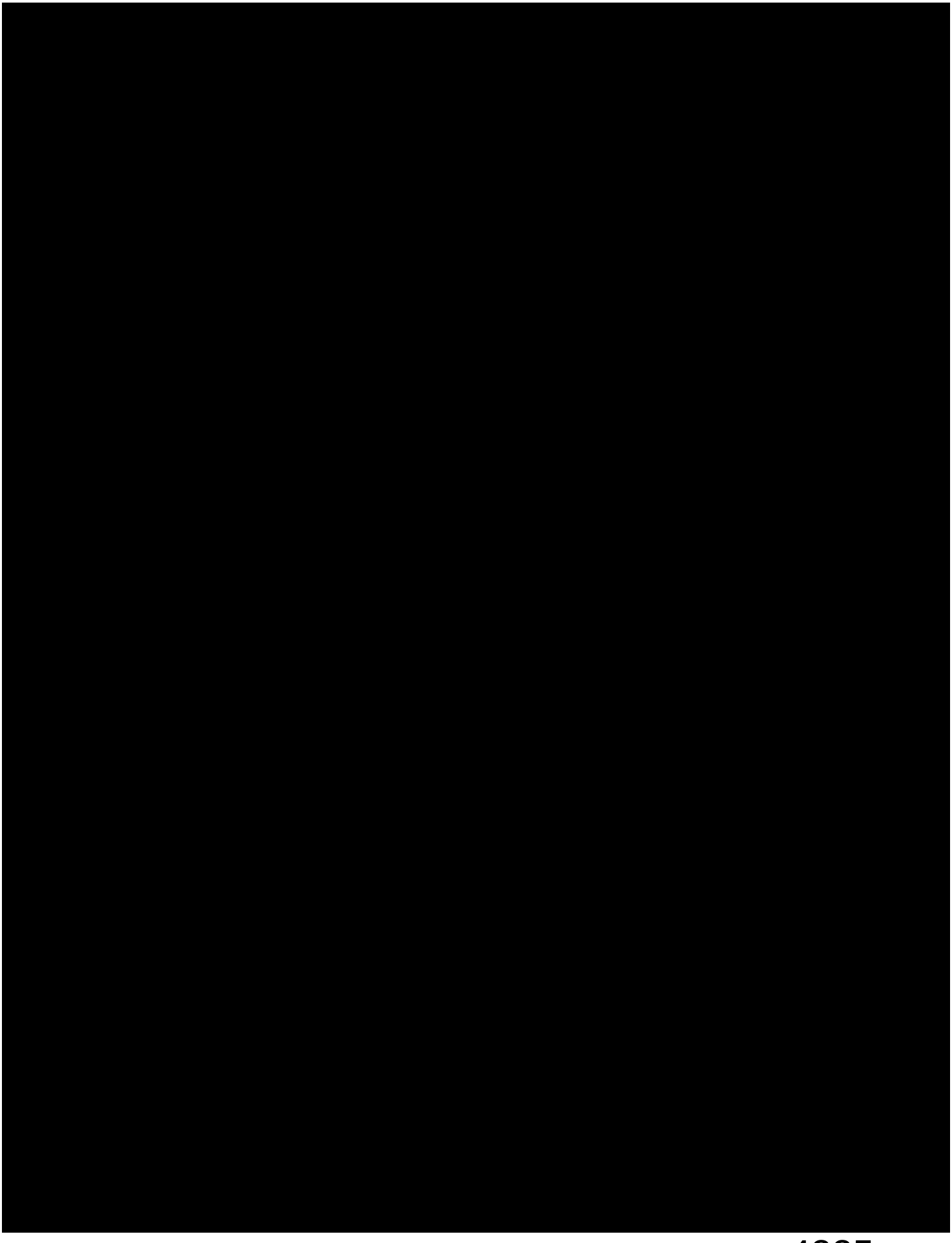


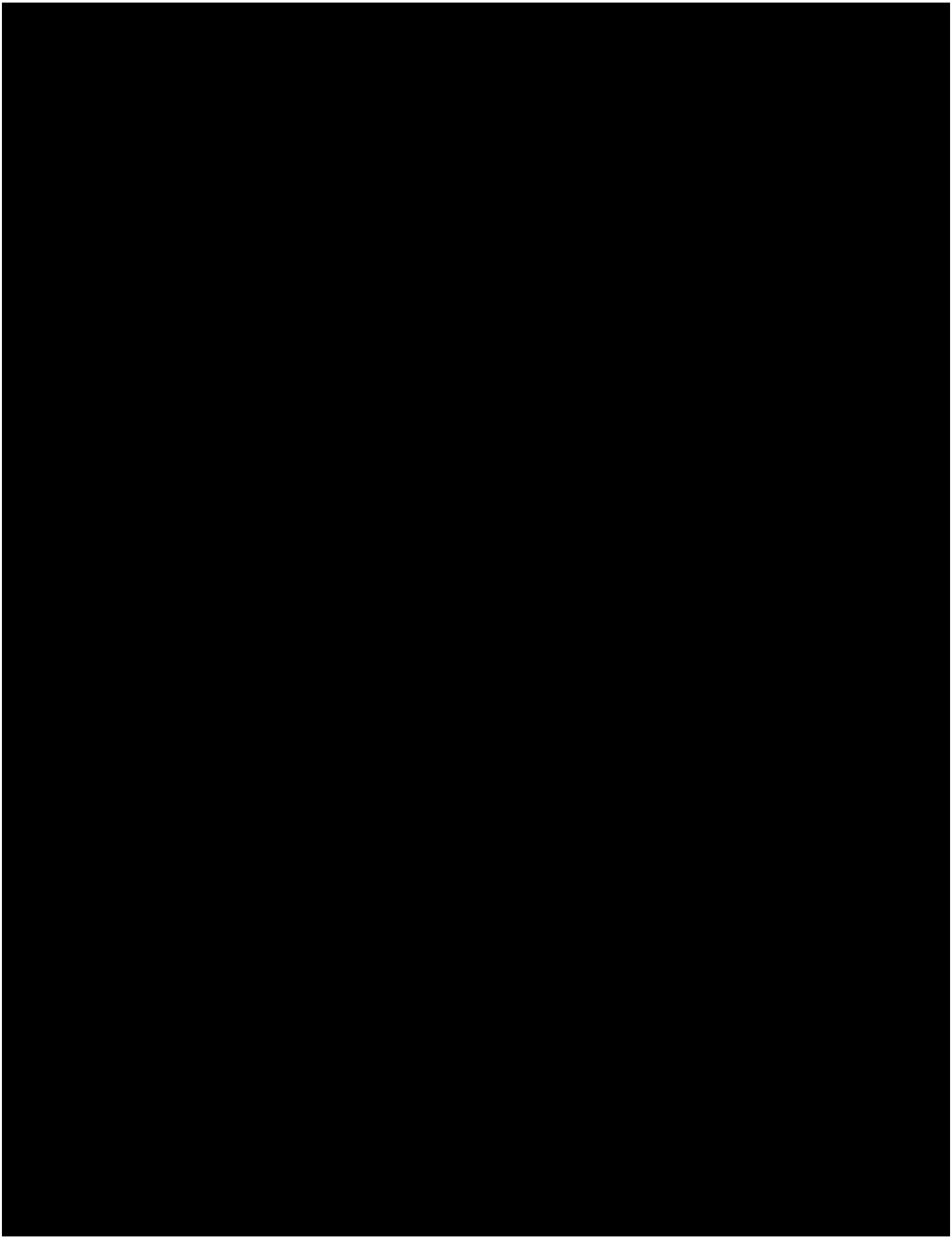


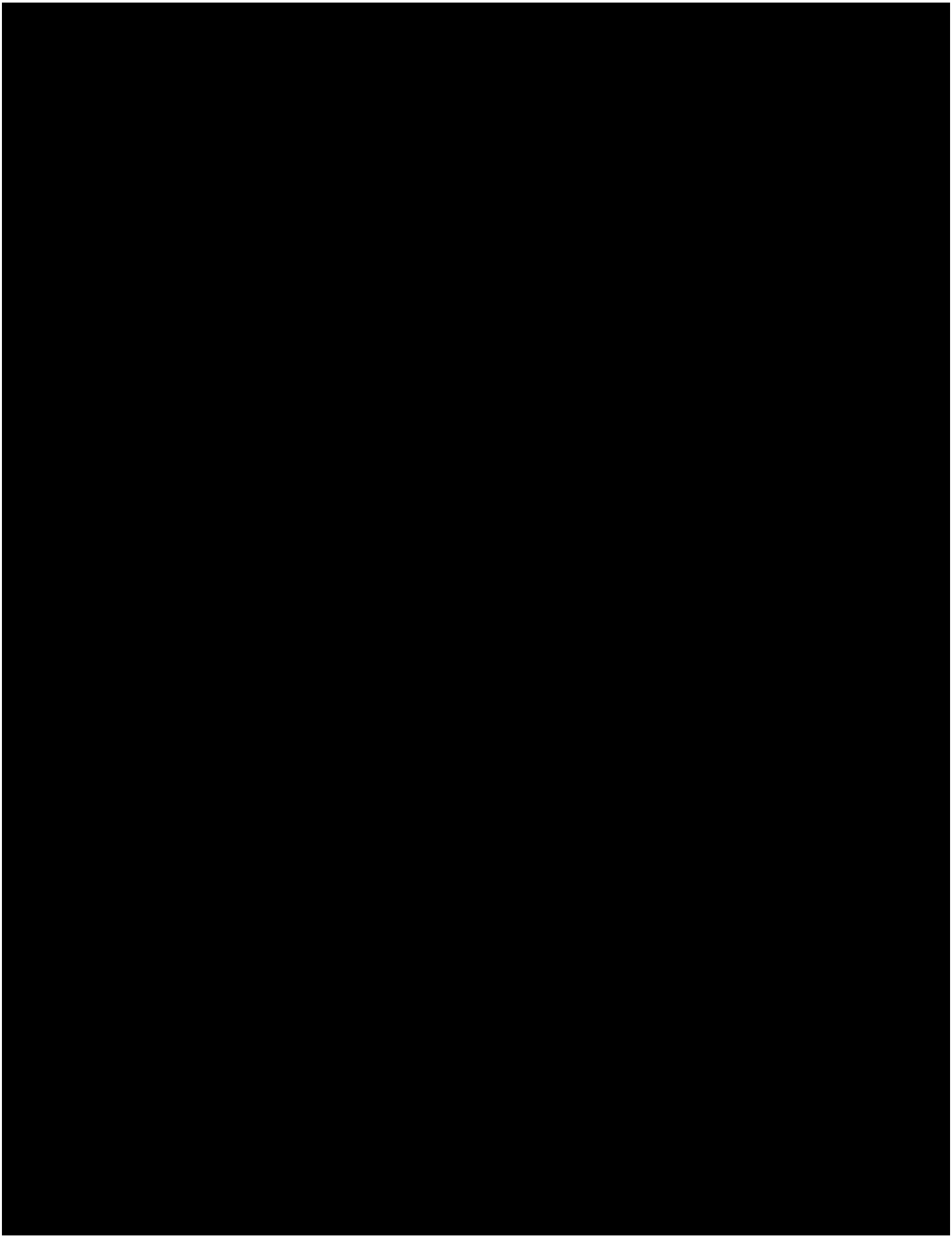


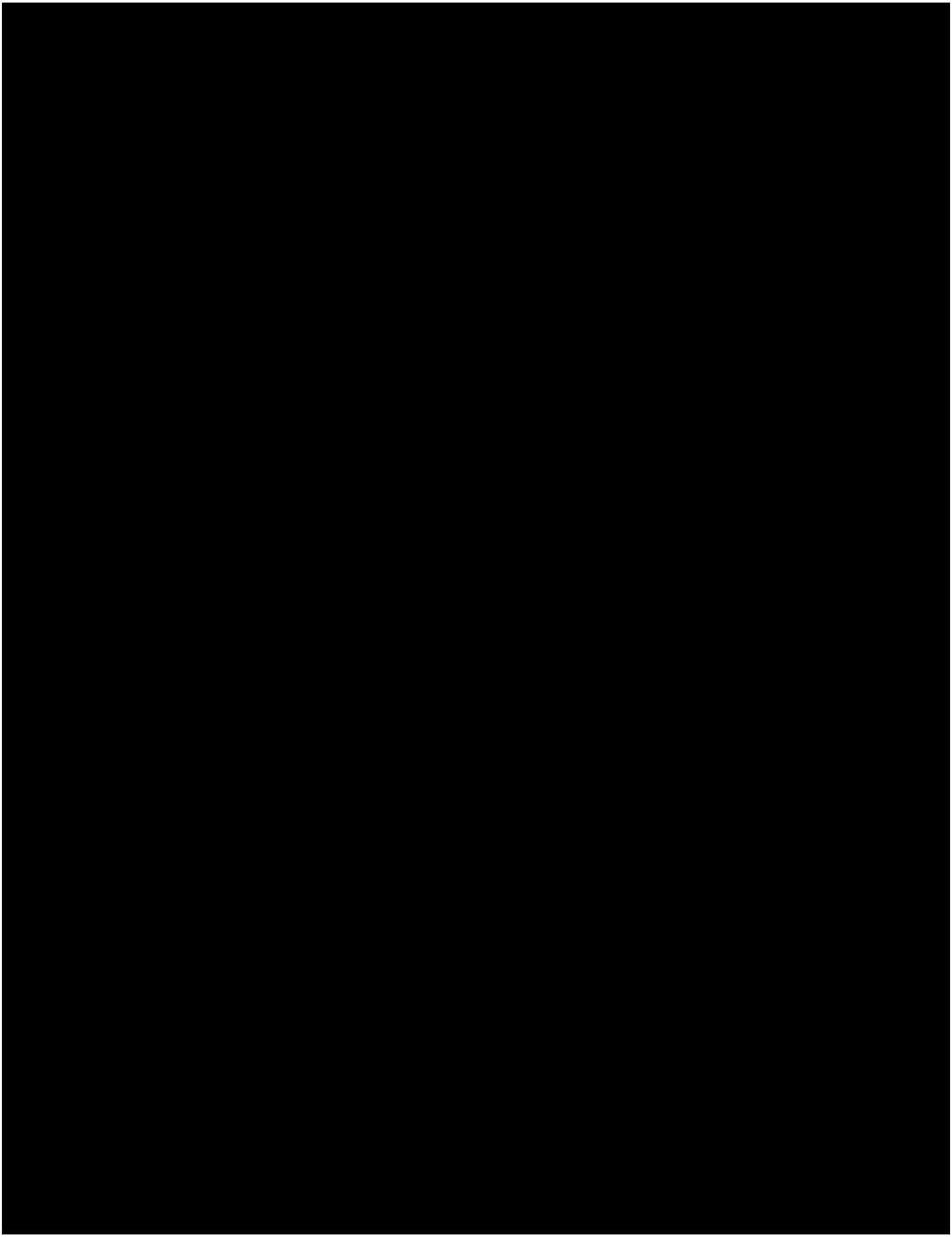


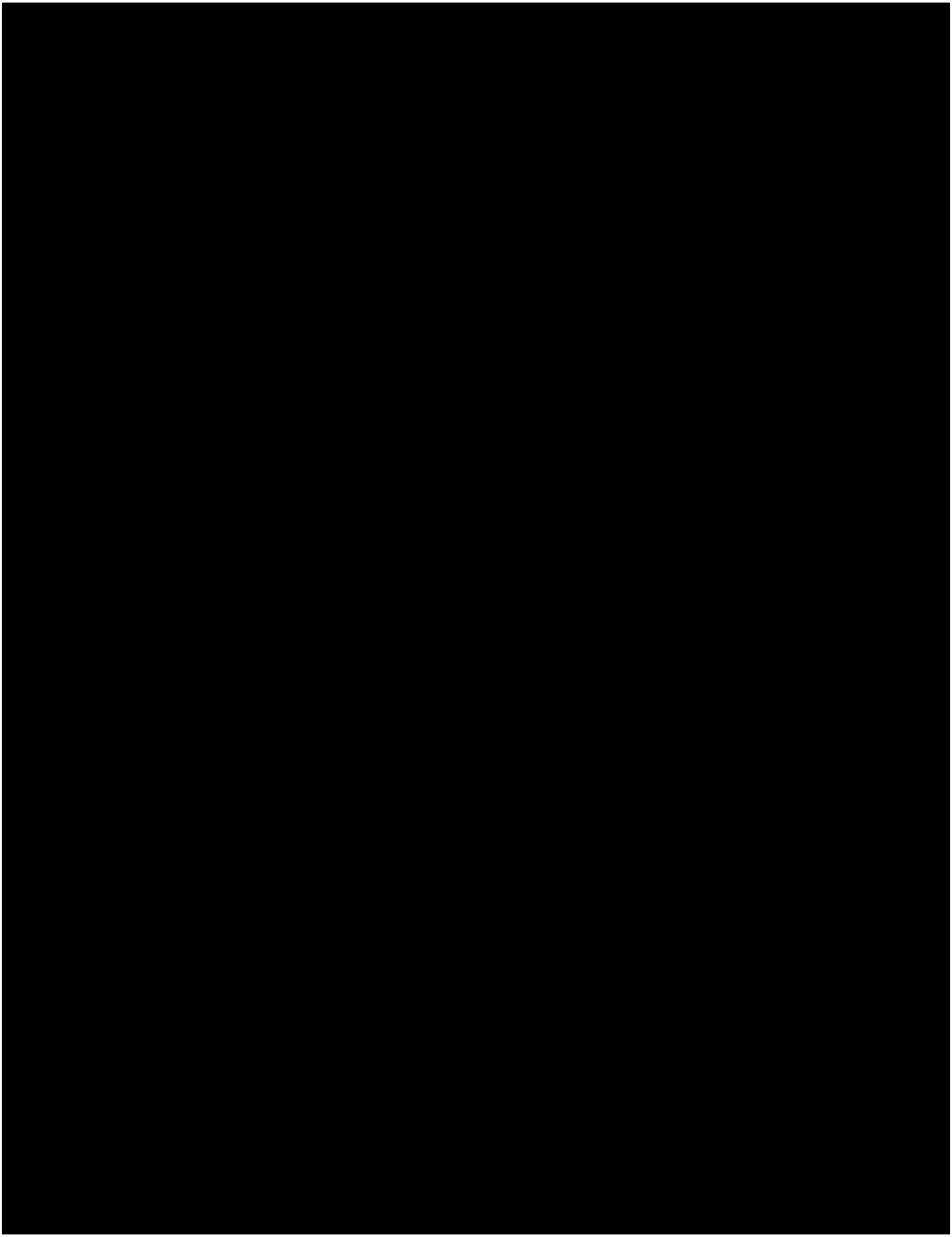


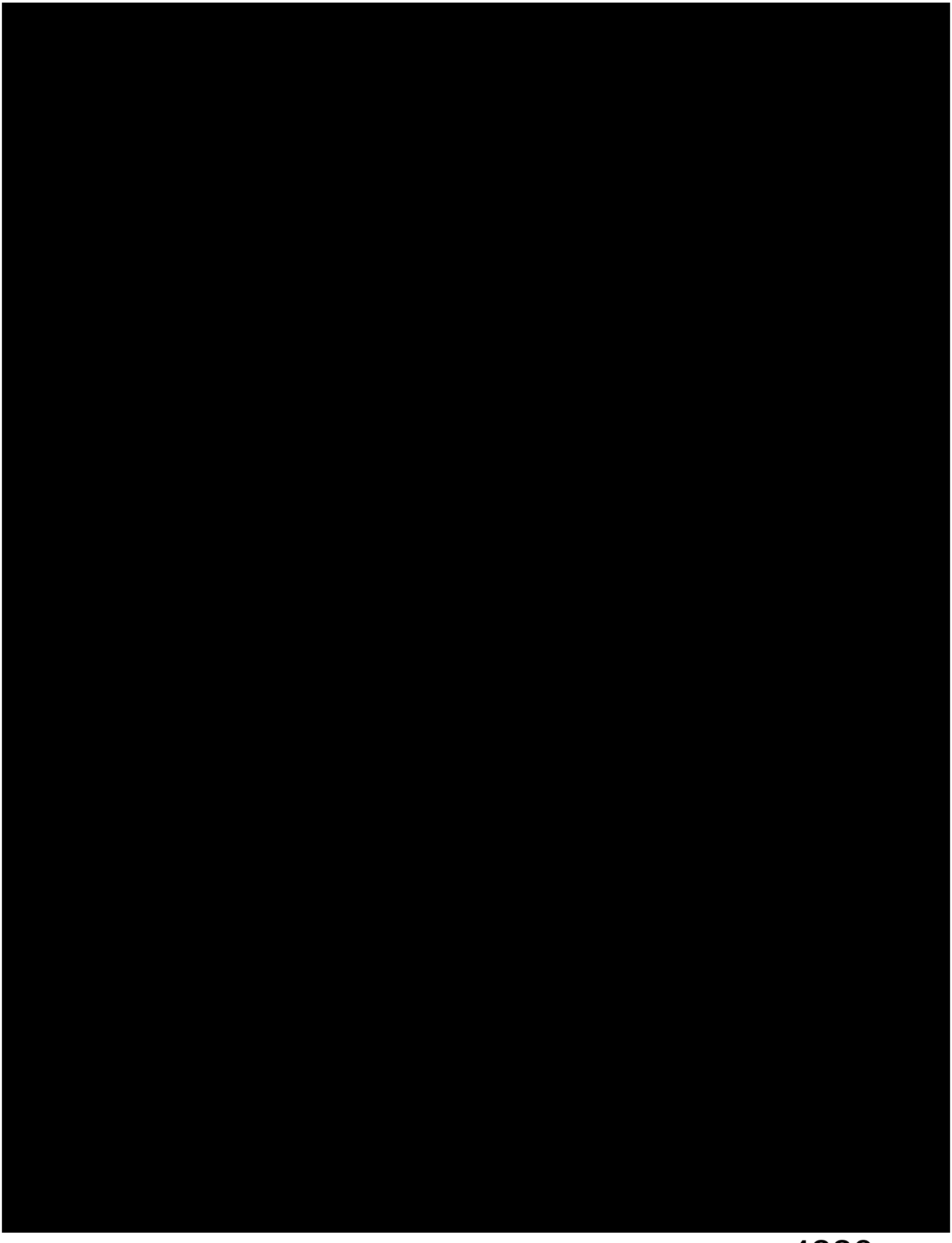


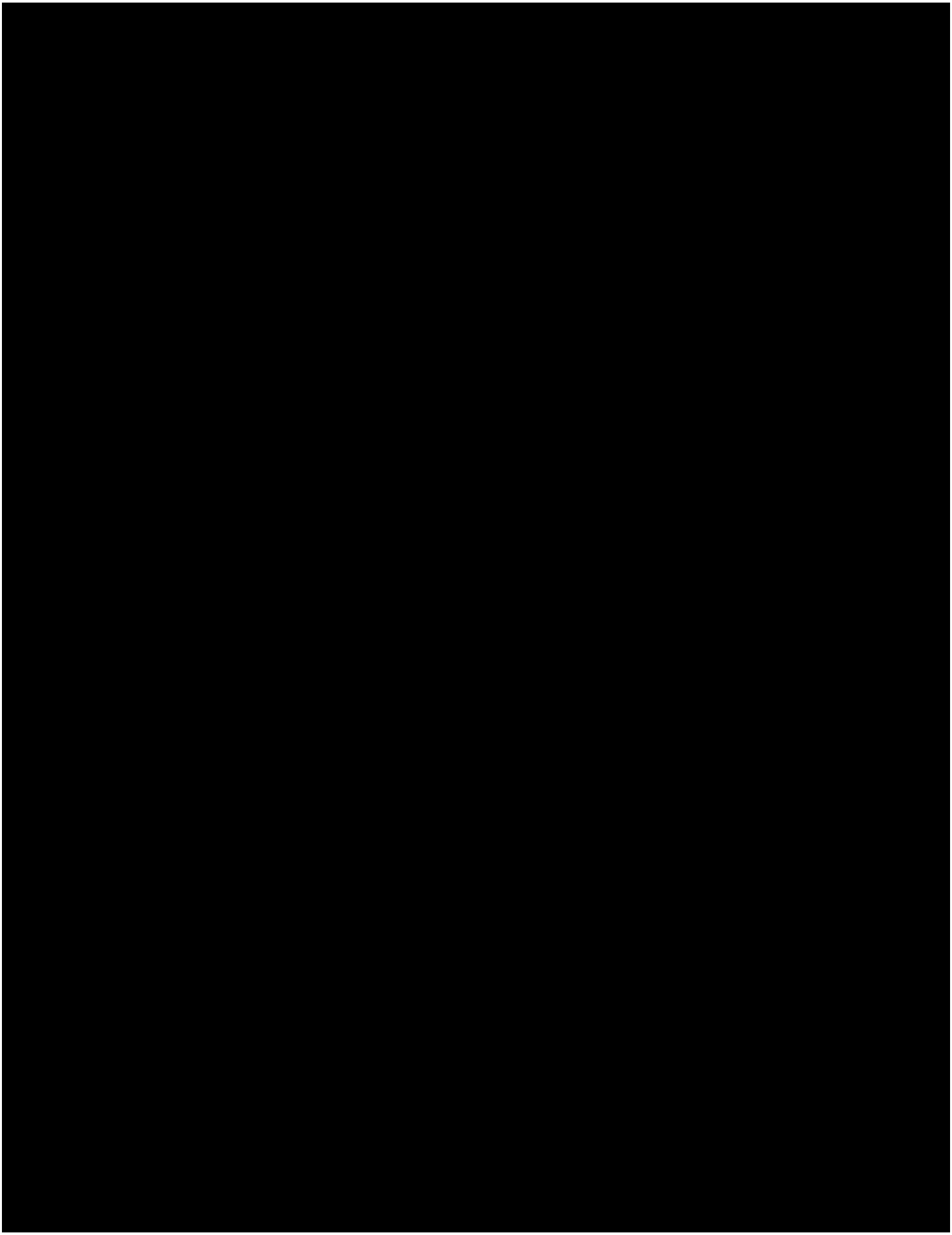


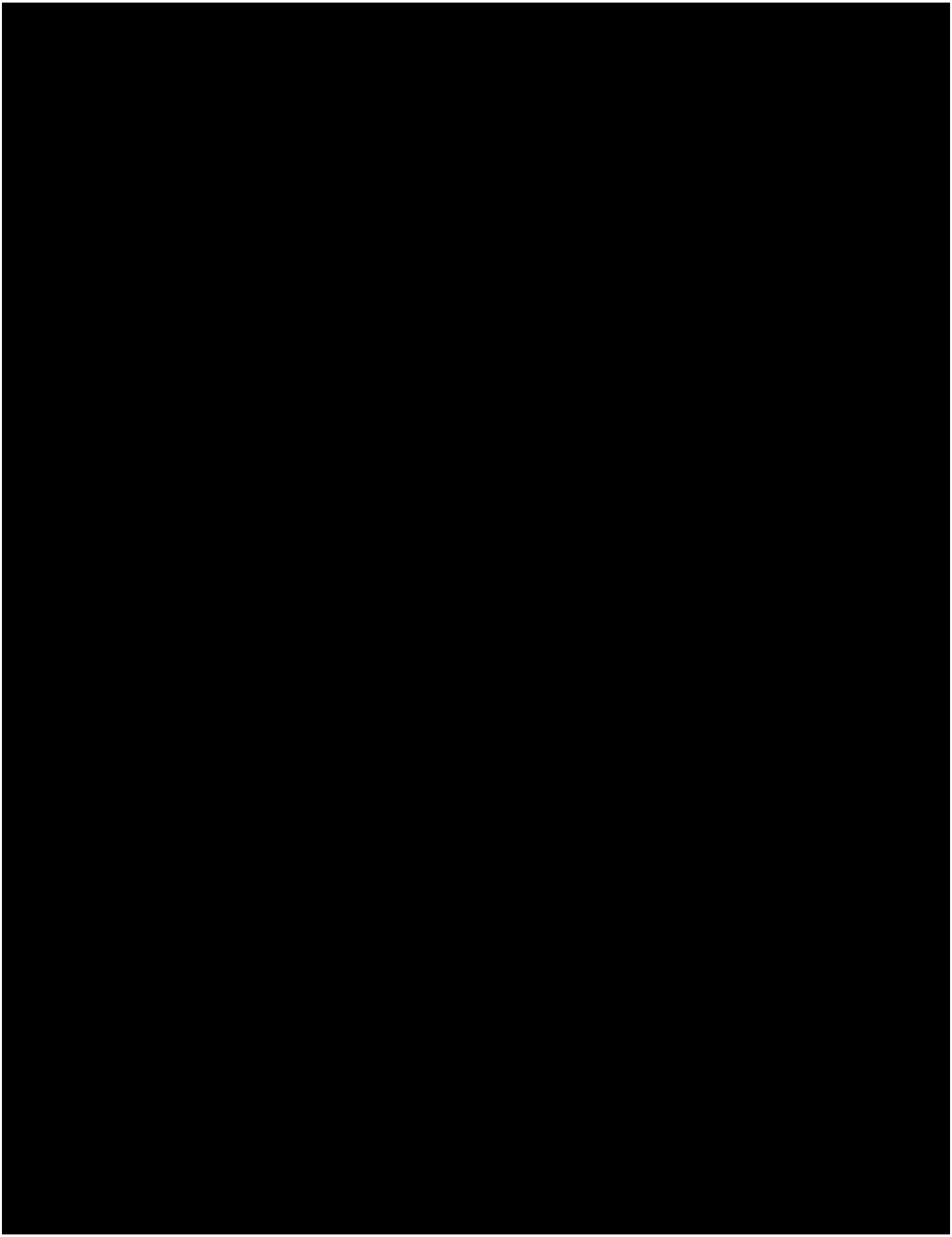


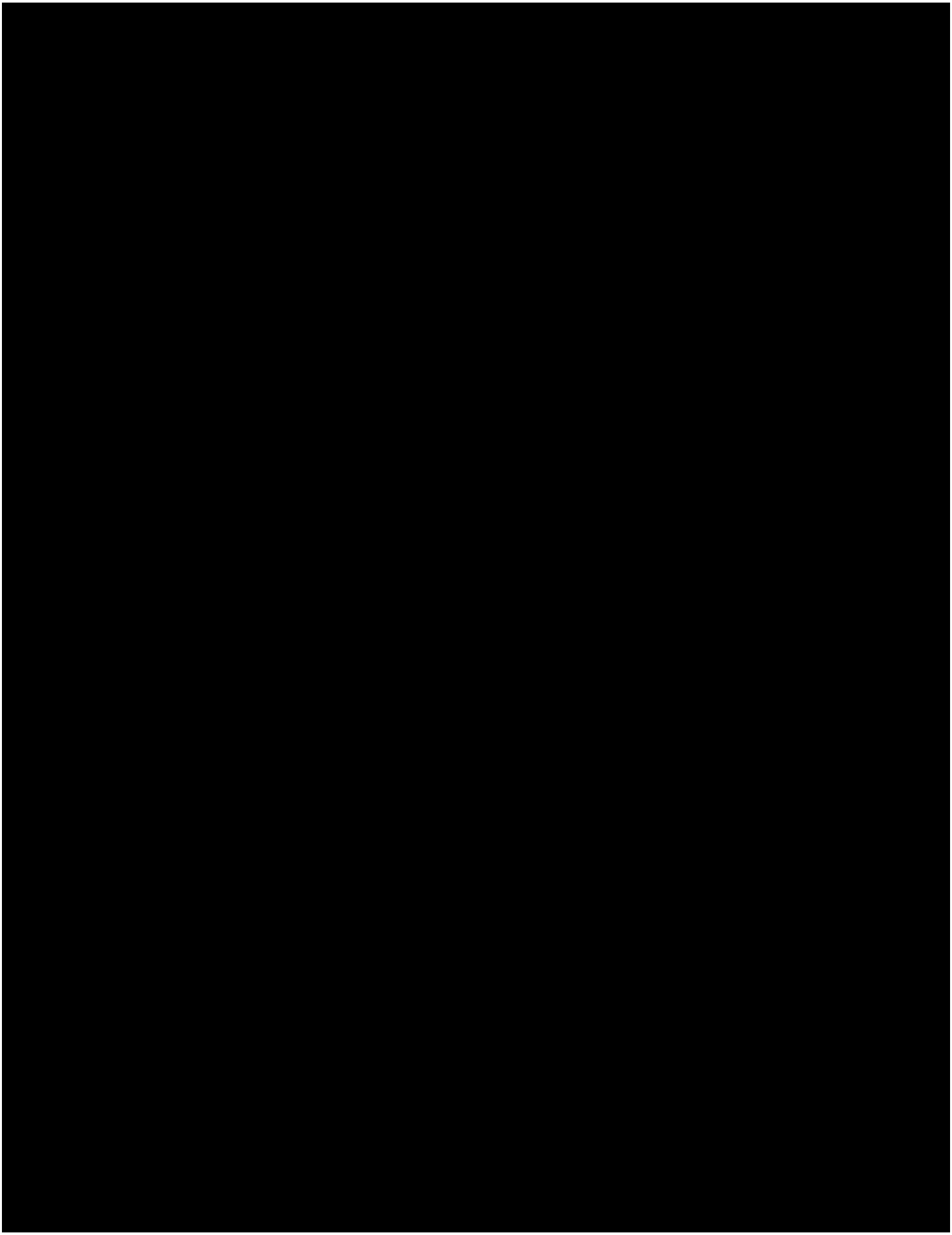


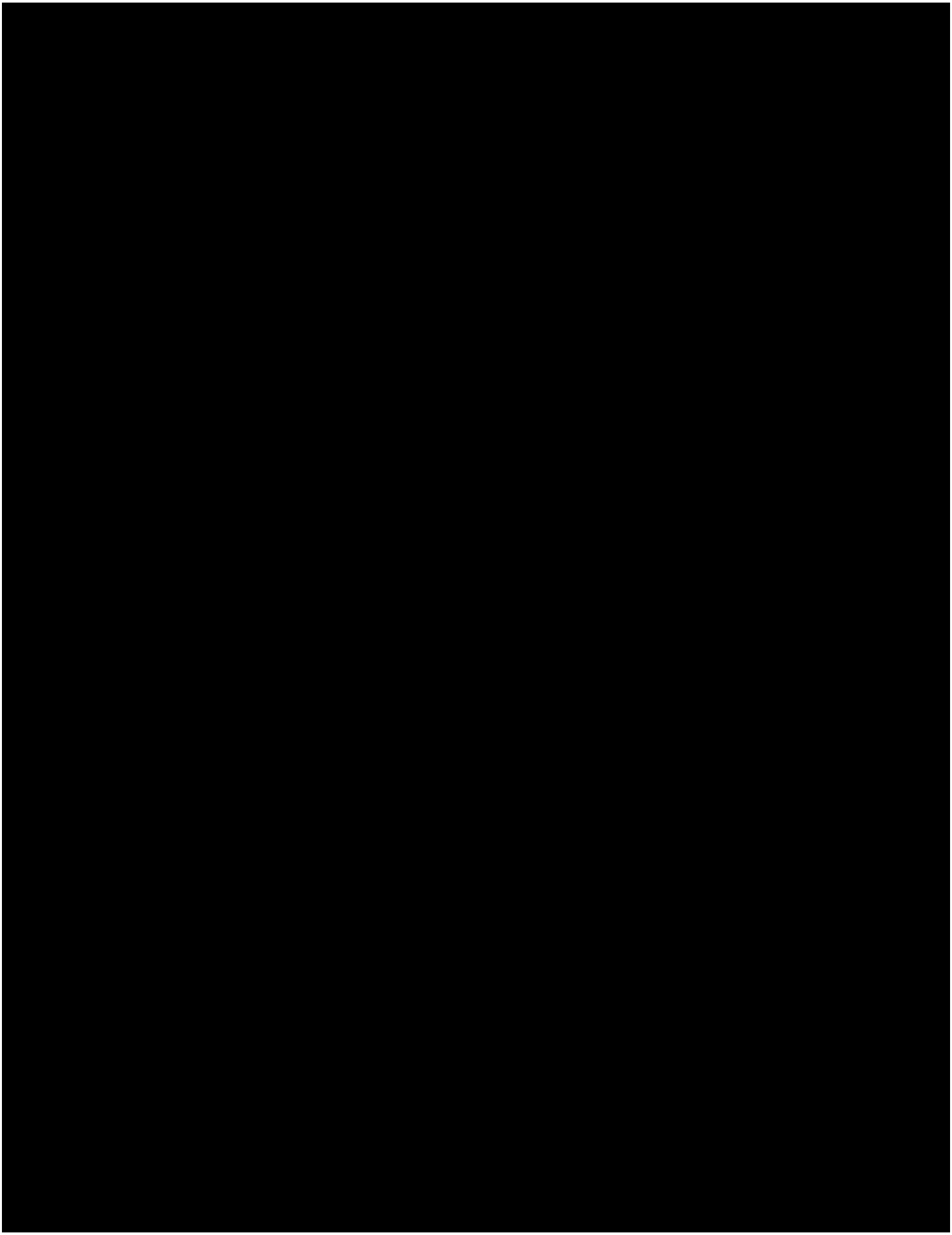


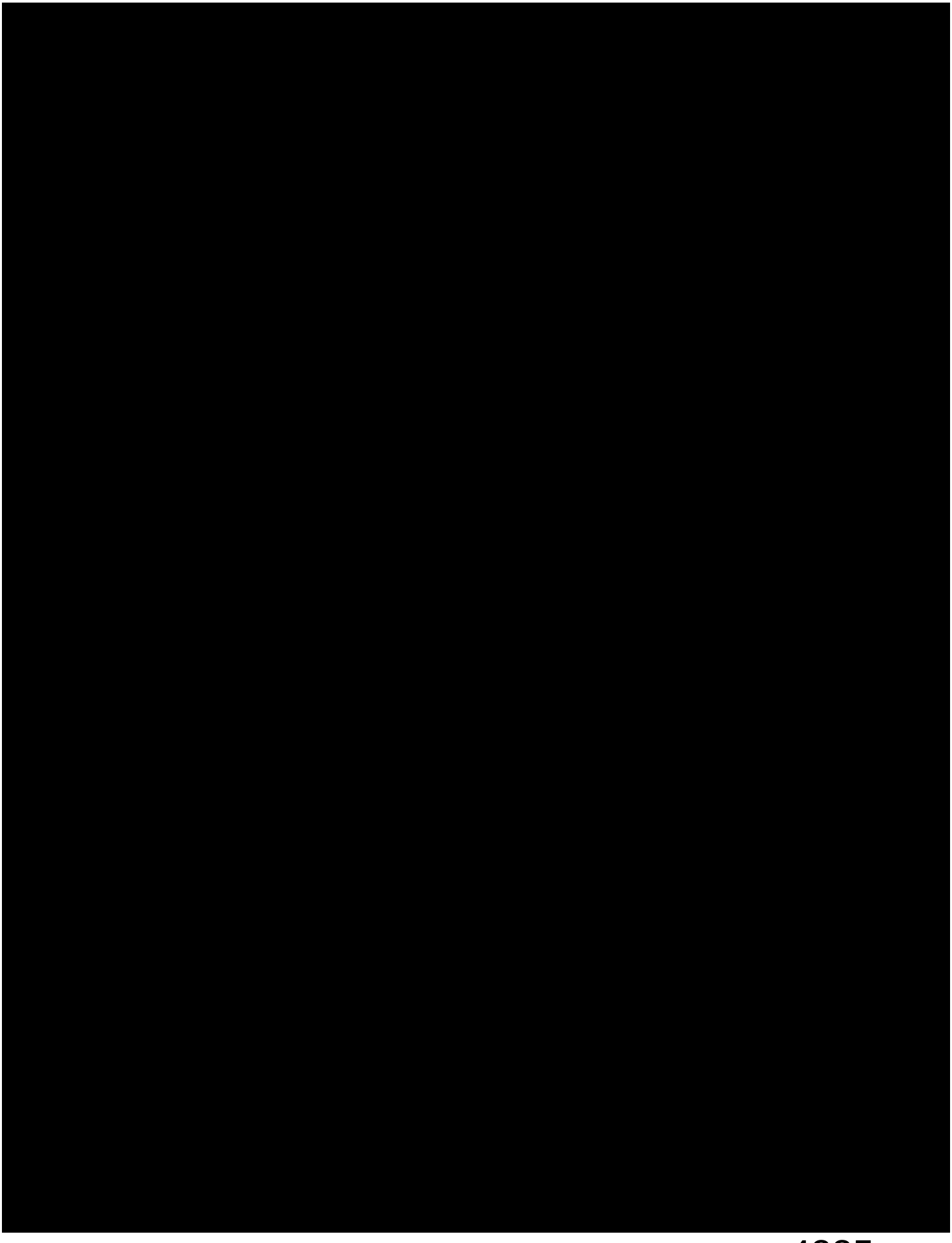


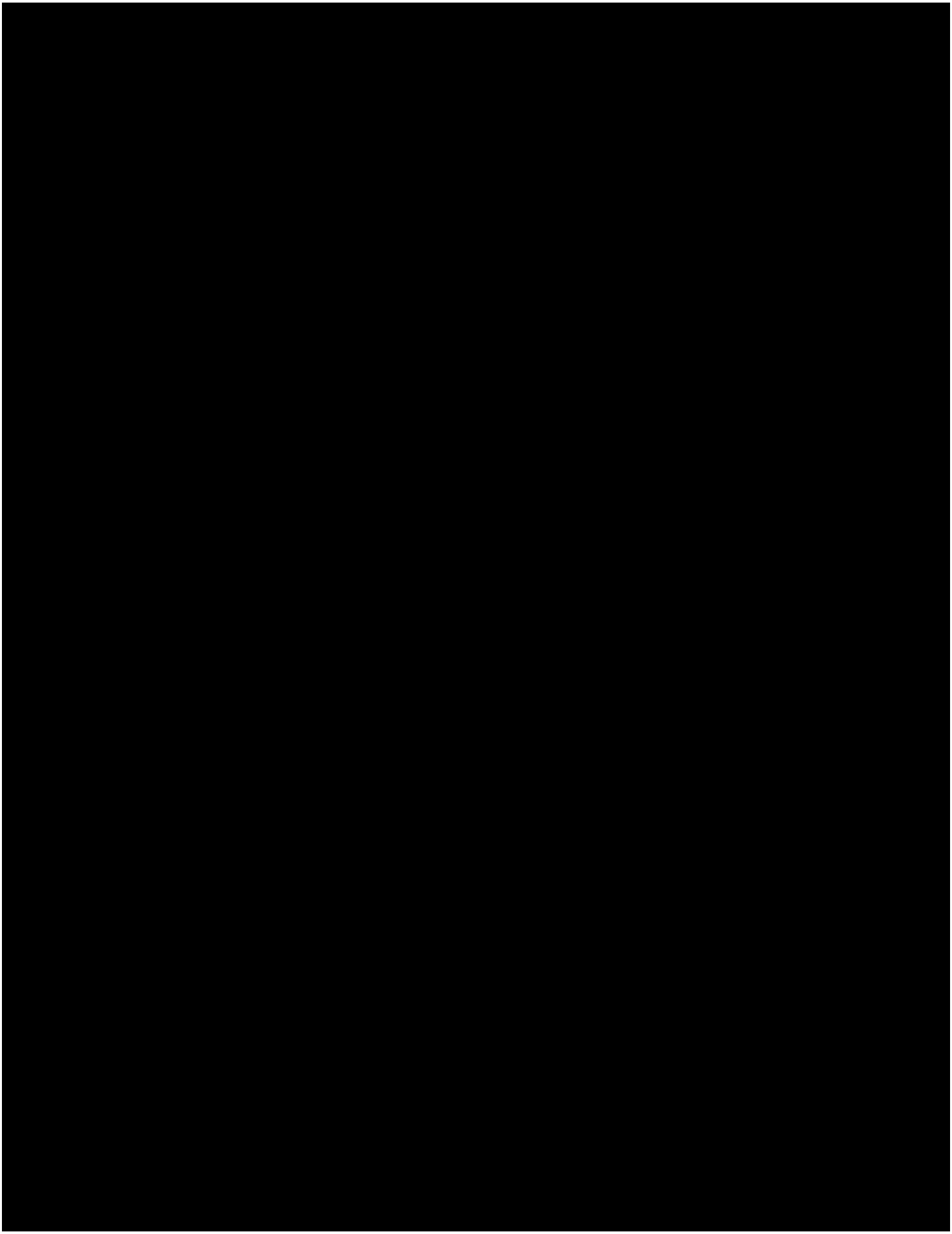


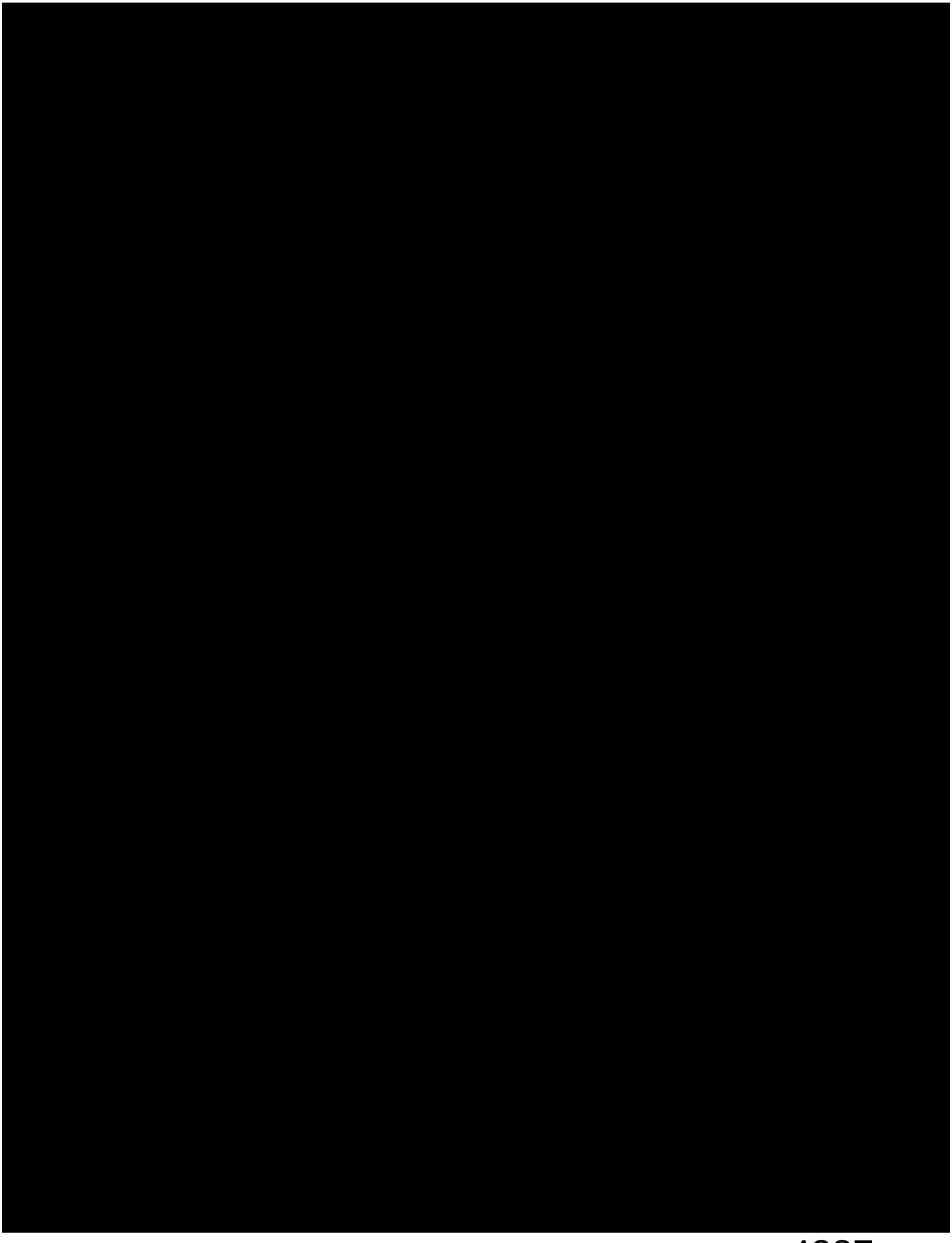


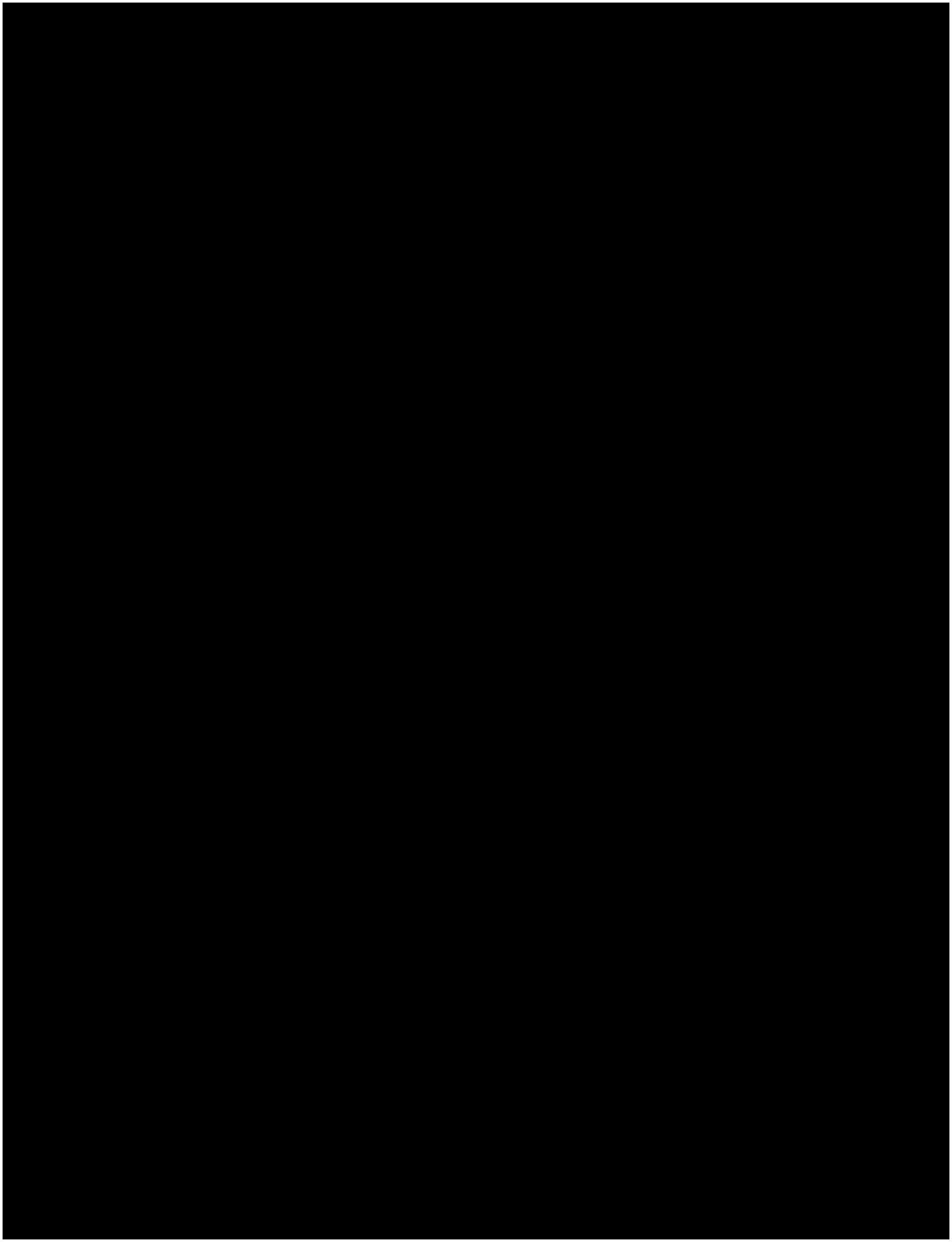


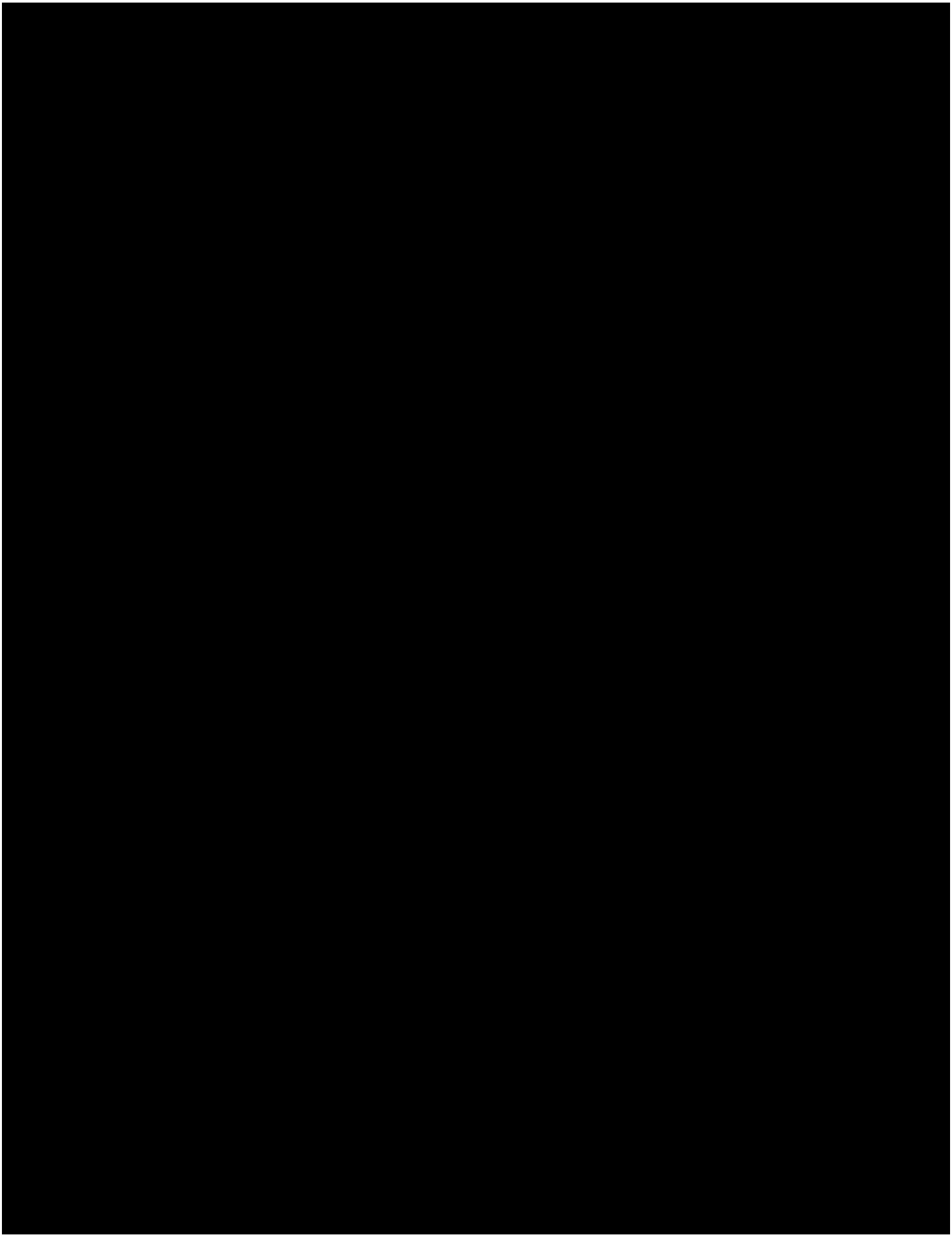


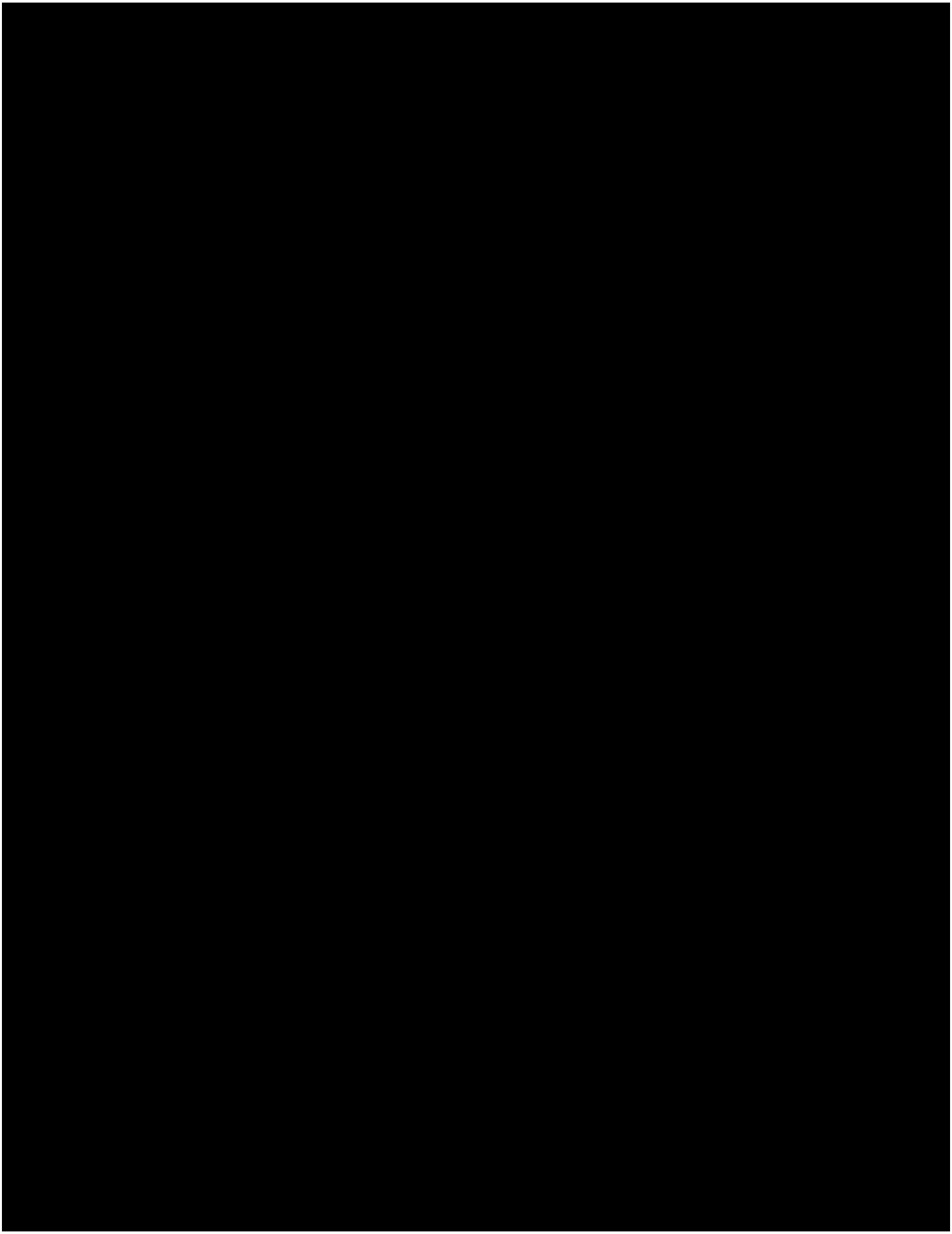


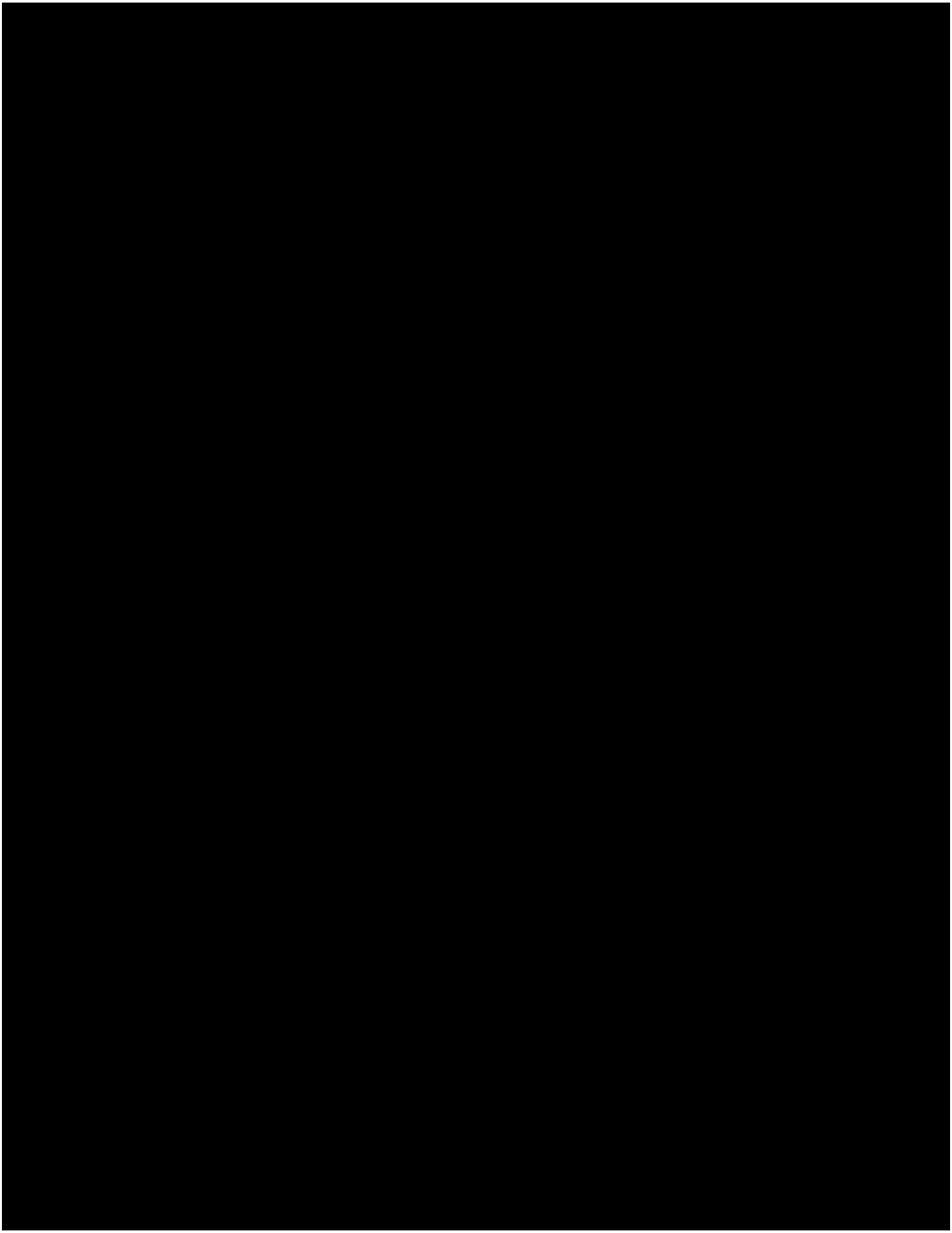


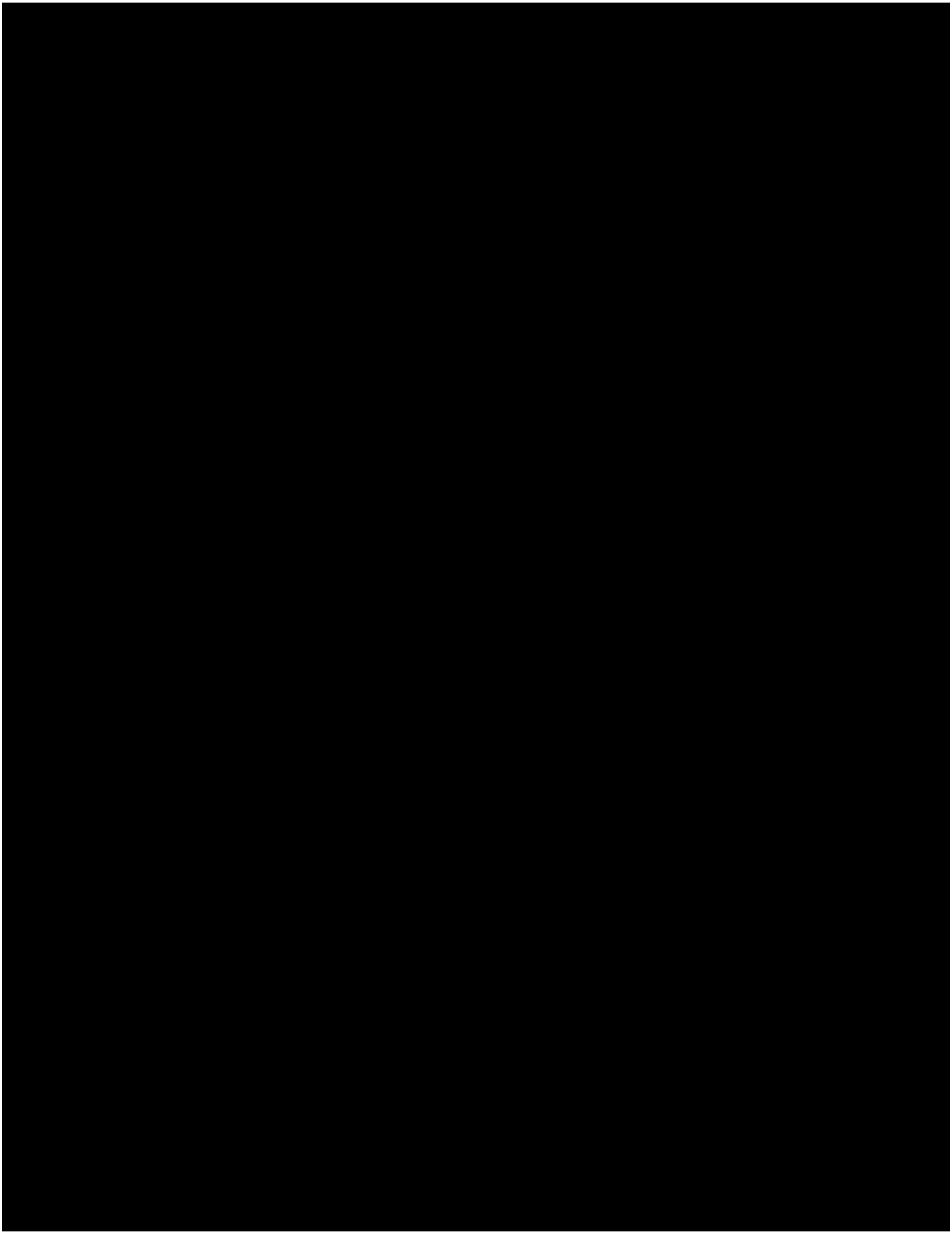


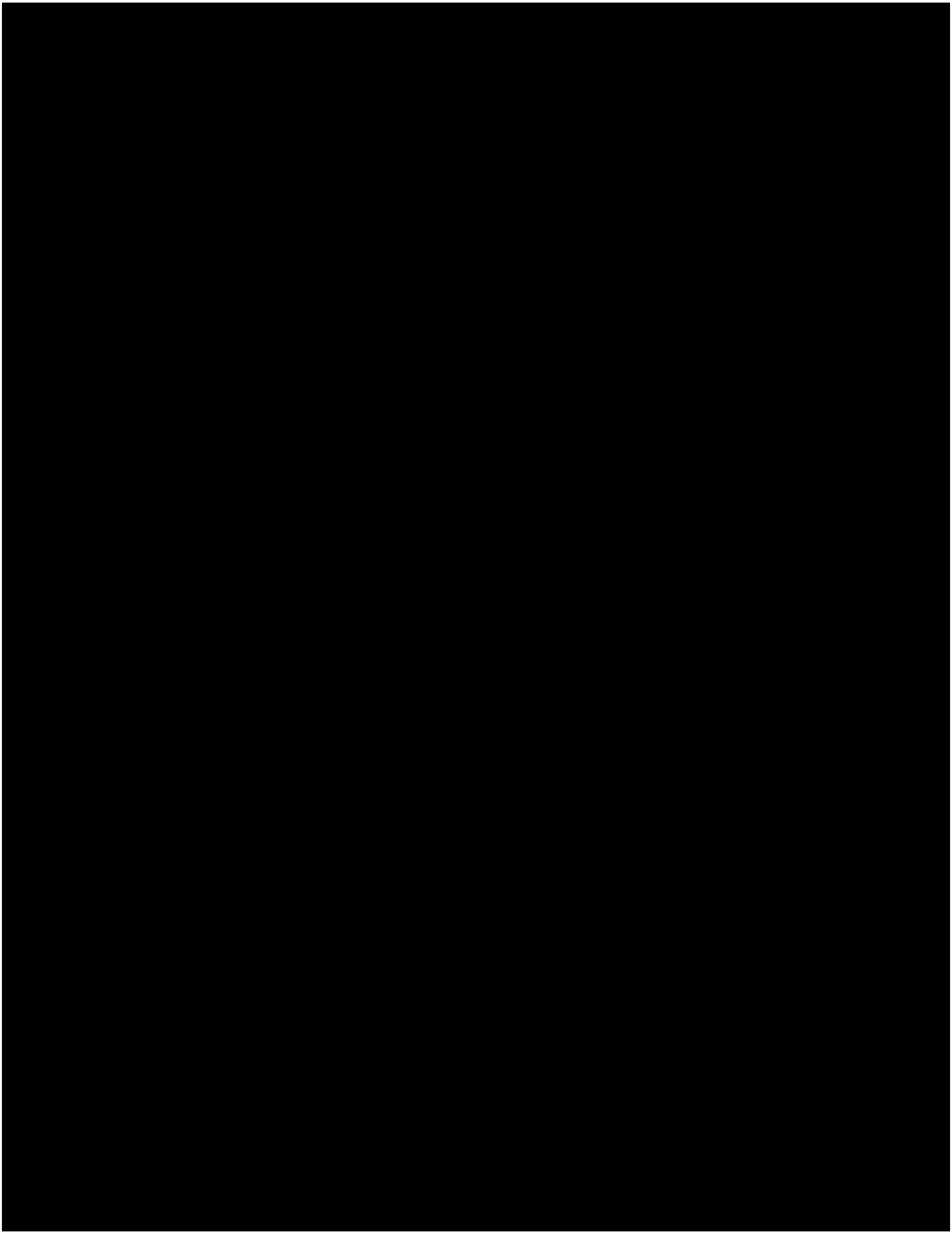


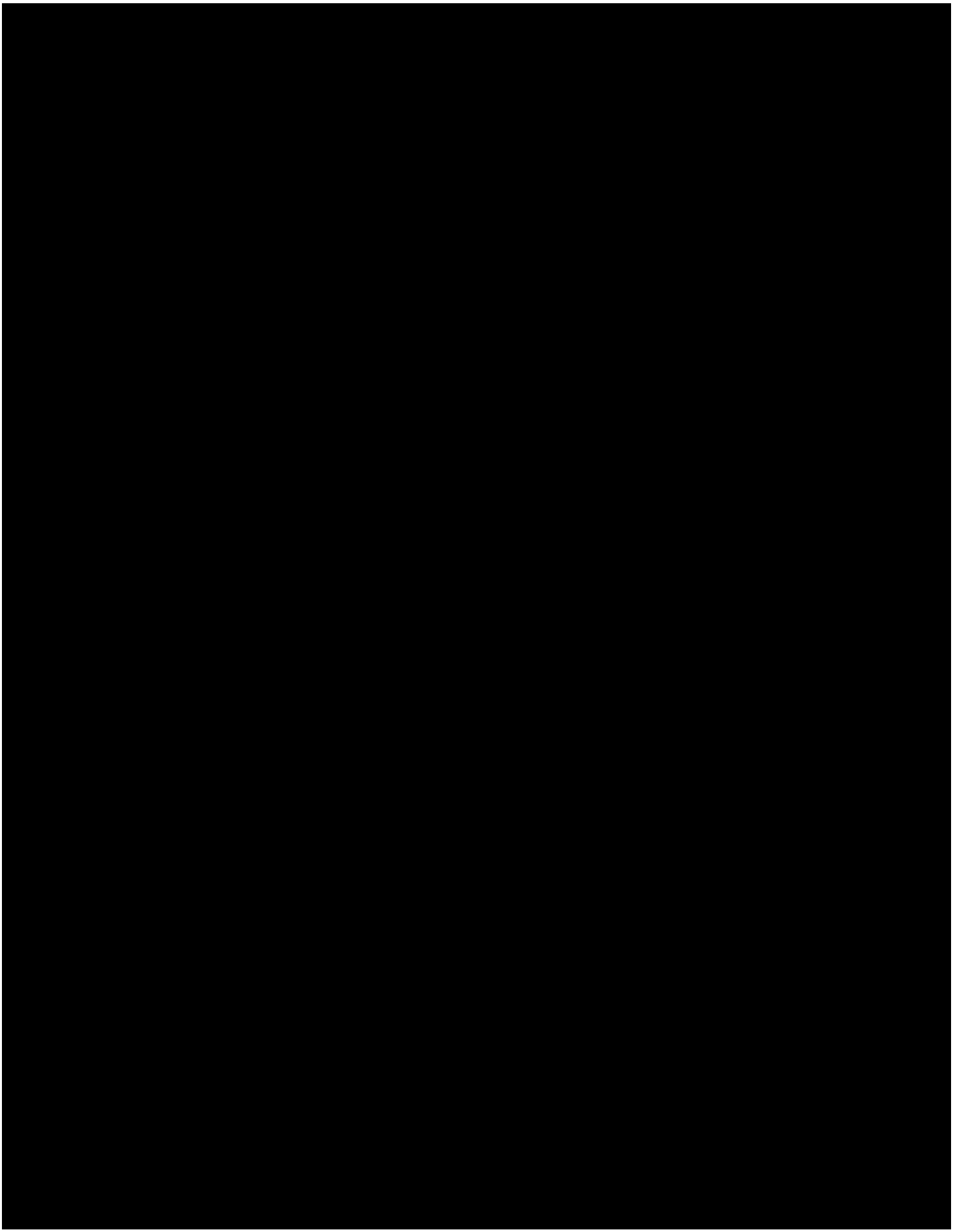


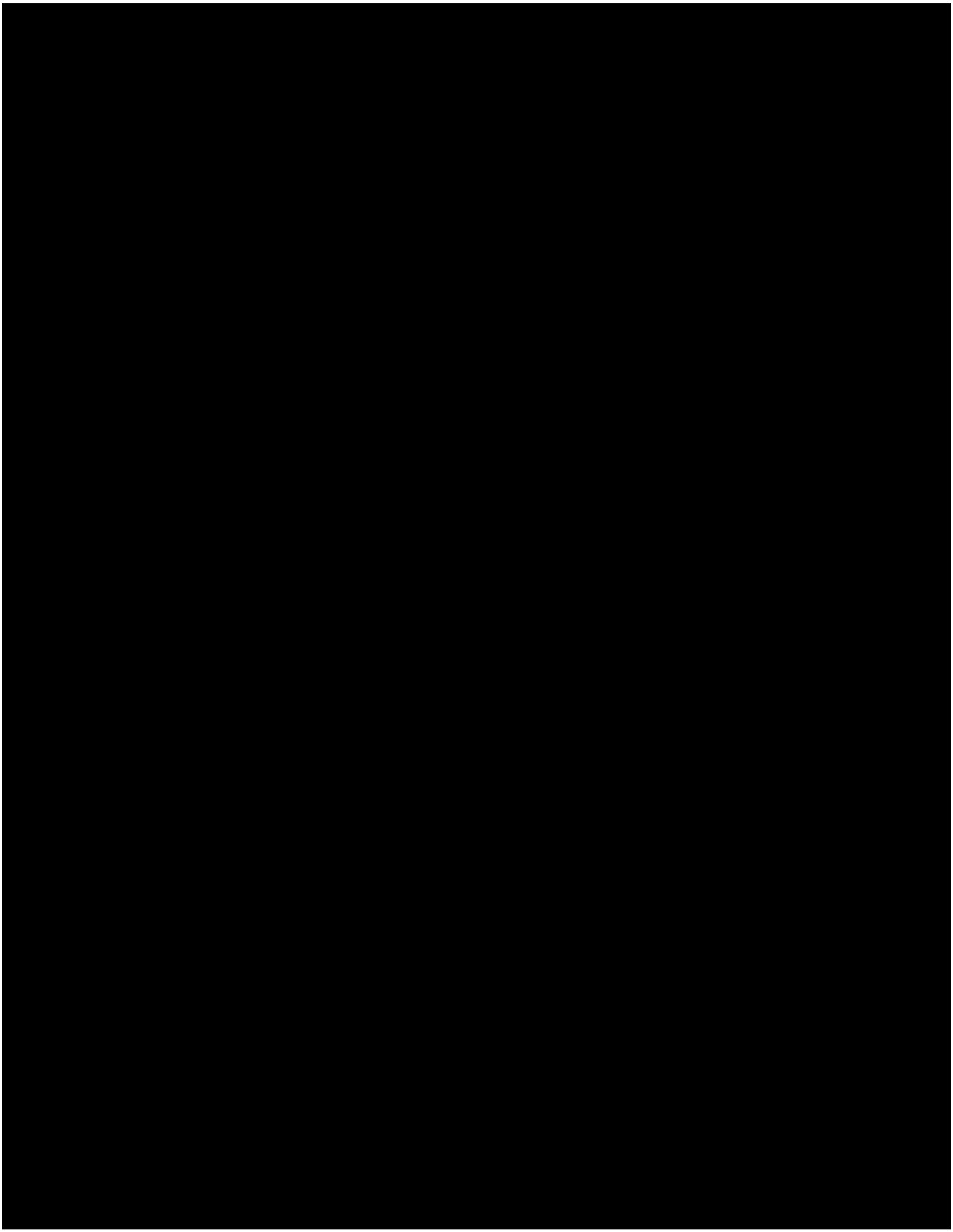


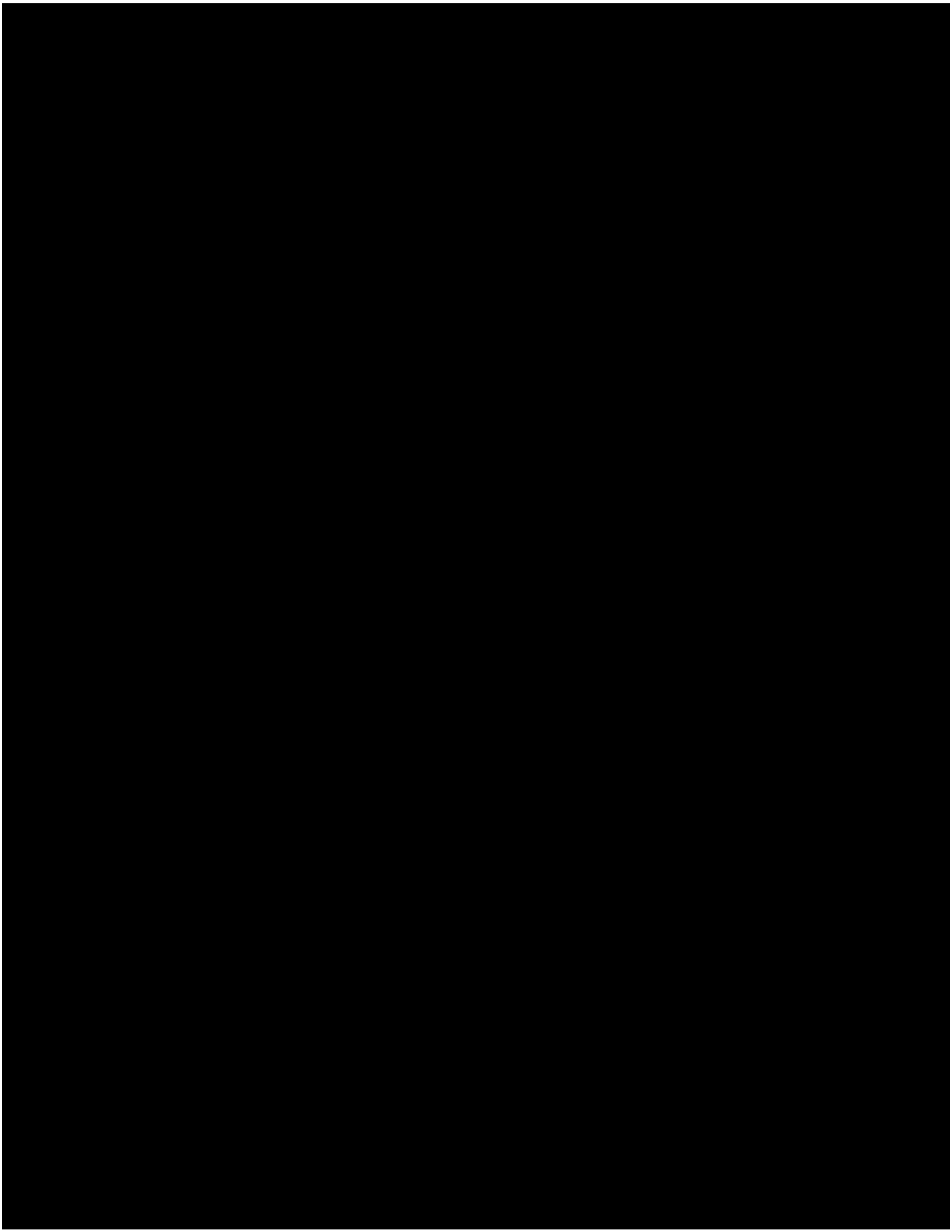


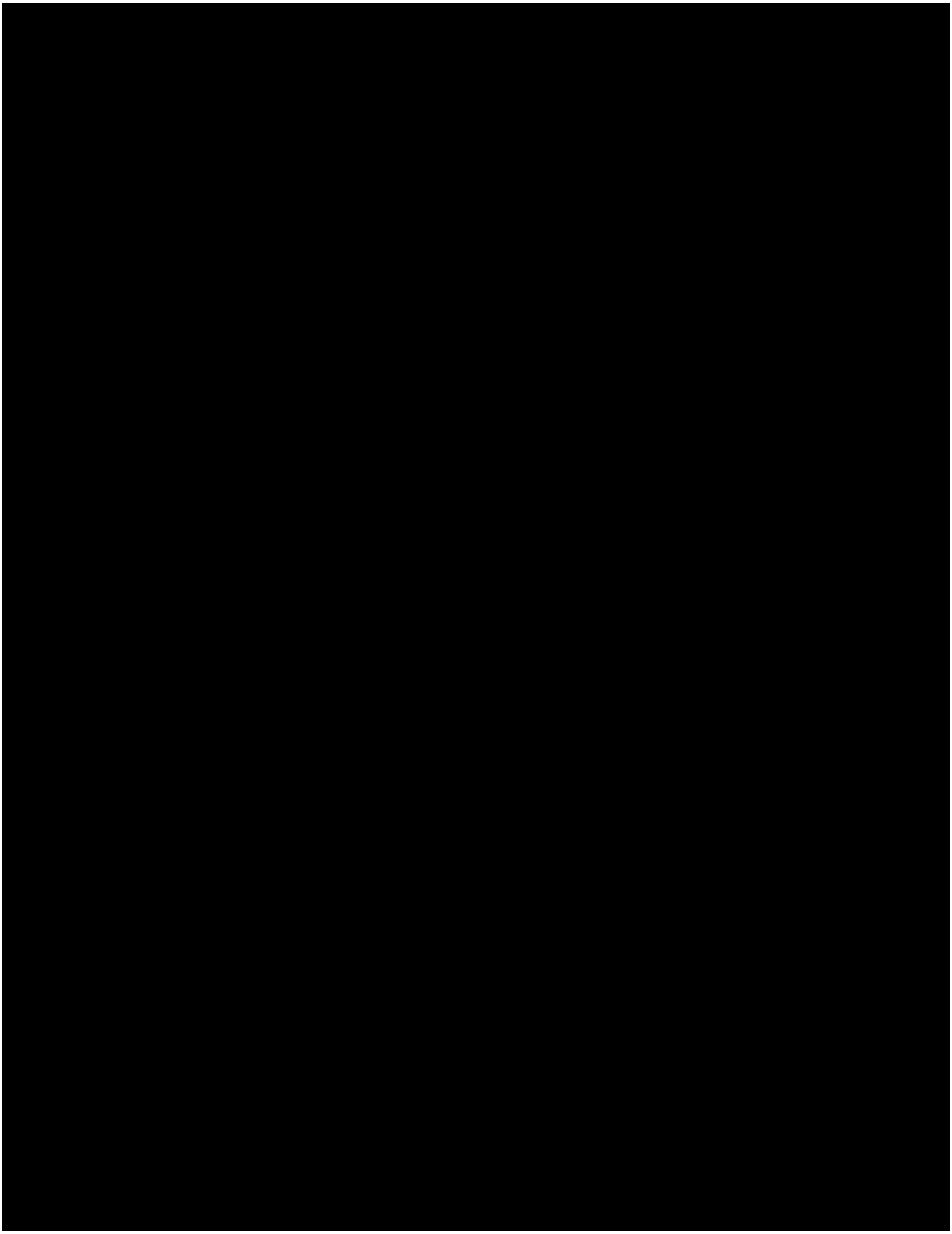












F.1

Arkansas Department of Human Services
Developmental Disabilities Services
Booneville Human Development Center
87 Reed Road
Booneville, AR 72927

Mailed copies to Christie 6/24/20

Charlene Robinson
P.O. Box 1543
Russellville, AR 72811

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US POSTAGE $00.50

ZIP 72927
041L11236314

1 Warrants

72811-154343

4248

Booneville Human Development Center
87 Reed Road
Booneville, AR 72927
P: 479.675.2121
F: 479.675.2518
HUMANSERVICES.ARKANSAS.GOV

ARKANSAS DEPARTMENT OF HUMAN SERVICES

June 19, 2020

Charlene Robinson
P.O. Box 1543
Russellville, AR 72811

Re: David Cains

Dear Ms. Robinson,

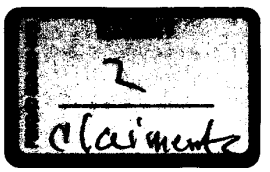
Enclosed you will find a copy of the Final Synopsis of an incident that was reported to you earlier.

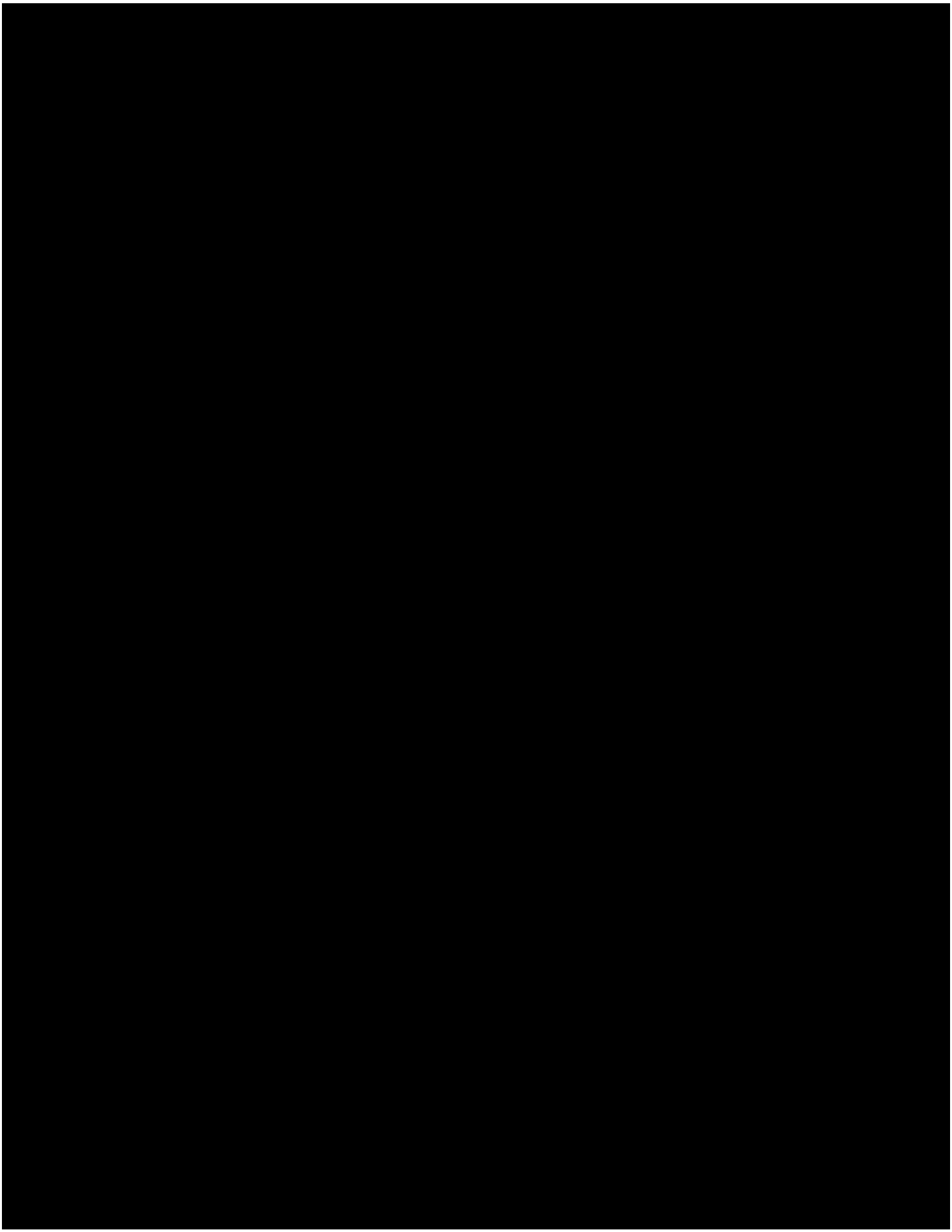
As always, I appreciate your cooperation and involvement. If you should have any questions or concerns, please do not hesitate to contact me. I can be reach by phone at 479-675-1406 or by email at Caleb.Murray@DHS.Arkansas.Gov

Sincerely,

Caleb Murray
Program Coordinator/Social Service Worker

CM/Enclosures CC: Master File





BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE McAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS, CLAIMANT, VS. ARKANSAS DEPARTMENT OF HUMAN SERVICES, RESPONDENT.	CLAIM NO. 220374

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DEPOSITION

OF

SARAH ASHLEY CAINS

---o---

FRIDAY, NOVEMBER 4, 2022

---o---

COURT REPORTER:

DONNA K. PETRE, CCR
P. O. Box 1027
Little Rock, Arkansas 72203

A P P E A R A N C E S:

ON BEHALF OF THE CLAIMANT:

JOSHUA D. GILLISPIE, ESQUIRE
Green and Gillispie
1 Riverfront Place, Suite 605
Little Rock, Arkansas 72201

ON BEHALF OF THE RESPONDENT:

RICHARD N. ROSEN, ESQUIRE
Office of Chief Counsel
P. O. Box 1437, Slot S-260
Little Rock, Arkansas 72201

ALSO PRESENT:

RANDY SCHOENING, VIDEOGRAPHER

---o---

I N D E X

WITNESS: Page

SARAH ASHLEY CAINS

Direct Examination..... 6

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E X H I B I T S

(None marked.)

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Reporter's Certificate..... 21

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The deposition of Sarah Ashley Cains was taken before me, Donna K. Petre, Certified Court Reporter within and for the County of Pulaski, State of Arkansas, duly commissioned and acting, on Friday, November 4, 2022, beginning at the hour of 11:54 a.m., at the Offices of Green and Gillispie, 1 Riverfront Place, Suite 605, North Little Rock, Pulaski County, Arkansas.

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THEREUPON, the following proceedings were had, to-wit:

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P R O C E E D I N G S

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WHEREUPON,

VIDEOGRAPHER: We are on the audio and video record. Today's date is November 4th, 2022, the time is approximately 11:54 a.m. This is the videotaped deposition of Sarah Ashley Cains in the case of Christine McAuliffe versus the Arkansas Department of Human Services. Case number is 220374 in the Claims Commission of the State of Arkansas. My name is Randy Schoening, I'm a videographer from Little Rock, Arkansas.

Will counsel please introduce themselves for the record?

MR. GILLISPIE: Yes. I'm Josh Gillispie on behalf of claimant.

MR. ROSEN: Rich Rosen for the Department of Human Services.

VIDEOGRAPHER: Will the witness please be sworn?

(WHEREUPON, the witness was duly sworn.)

VIDEOGRAPHER: You may proceed.

MR. ROSEN: Thank you.

WHEREUPON,

SARAH ASHLEY CAINS,

having been called for examination, and having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. ROSEN:

Q As I was introduced, my name is Rich Rosen, I represent the Arkansas Department of Human Services in this matter, and I'm going to be asking you a few questions here today.

A Okay.

Q If you answer the question, I'm going to assume that you understood what the question asks. If you don't understand what it asks, just ask me to --

A Clarify?

Q -- repeat it or restate it and I'll be happy to do so.

A Okay.

Q If for any reason you need to take a break during this deposition, as long as there's not a question pending, just let us know.

A Okay.

Q And we're good. Okay. I'm going to start off with the basics. Would you please state your name again?

A Sarah Ashley Cains.

Q And do you go by Sarah or Ashley?

A I go by Ashley.
Q Okay. All right. And what is your date of birth?
A [redacted]
Q And where do you live?
A Gulfport, Mississippi.
Q Okay. Are you employed?
A Yes.
Q And what do you do?
A I work at Bubba Gump Shrimp Company, and I also work at KimCo as a billing clerk.
Q Okay. And the shrimp company, what do you do there?
A I do a daiquiri retail shop.
Q What does that mean?
A I do the retail shop, and we also sell daiquiris.
Q Okay. I like daiquiris. Okay. And how long have you been in Mississippi?
A I've been there since March 2008.
Q Oh, for a long time?
A Yes, sir.
Q Okay. And did you ever live in Arkansas?
A Yes, sir.
Q Okay. So, before March of 2008?
A Yes. My whole life before that.
Q Okay. And what caused you to move to Mississippi?
A My boyfriend, we had a son, and we decided to follow

his family down there.
Q Okay.
A A change.
Q All right. And so, what did you do when you lived here in Arkansas?
A I worked at Dixie Cafe after I graduated high school.
Q Okay. And is this in Pope County?
A Yes.
Q So, did you -- hold on. What's your relationship to David Cains?
A My brother, he was my brother.
Q Okay. And from what I understand, he's -- his mother is different than your mother?
A Yes.
Q Okay.
A We share a dad.
Q Okay. When did you -- and what was your father's name?
A David.
Q And he has passed away since?
A Yes.
Q Okay. And David was your father's name?
A Yes.
Q And so, David, your father, remarried after his

divorce to David Cains' mother; is that right?
A They married after I was born.
Q Yes. Because the names are the same, it's a little confusing.
A Yes.
Q So, let me ask it a different way, just to make sure I understand. Your father -- David Cains is your half-brother?
A Yes.
Q And David Cains, I guess, Senior is your father?
A Yes. We share a father.
Q And so, did -- well, let me ask it this way. Did you ever live in a home with David Cains, Junior?
A Not that I can recall. I was little. I'm sure I did at some point.
Q Okay. But you don't really recall living with him?
A I was little.
Q Yes.
A When our dad passed.
Q Okay. And so, growing up, you didn't -- you don't recall living with David Cains, your half-brother, but did you -- did he ever come visit with you or did you ever visit him?
A Yes, we visited every -- a lot.
Q Okay. I'm sorry. I know I asked you this. But

what year were you born?
A [redacted]
Q [redacted] Okay. And so, [redacted] where was David Cains living, the son?
A In Pottsville with my dad and sister.
Q And where were you living?
A I was just born.
Q Okay. All right. So, you all lived together --
A I'm -- yes.
Q You lived together, you just don't remember it?
A Yes. I was too little. I was too little to remember.
Q All right. Did he live with your father full-time? I mean, do you know?
A At that point, yes.
Q Okay. So, he didn't live -- in 1988, he didn't live with Ms. Robinson?
A I believe, before I was born, they did live together.
Q Okay.
A I am not aware of that.
Q Okay. But in 19 -- there came a point in time where he lived -- after you were born, where David Cains came to live full-time in you and your dad's household?
A I believe, yes.

Q Okay. That's your understanding?
A Yes.
Q Okay. And how long did that last?
A I'm not sure.
Q Okay. And then, there came a point in time, from my understanding, that David Cains, your half-brother, moved away?
A Yes.
Q Okay. Tell me what happened.
A I do not know. I was young.
Q And after -- do you know where he went, David went?
A When he moved?
Q When he moved, do you know anything about that?
A He lived with a family.
Q All right. Do you know anything about that family?
A I just know his name was [redacted]
Q Okay.
A He lived there.
Q [redacted] was the first name or last name?
A His first name.
Q Okay. Do you know his last name?
A No.
Q And what's your understanding, how long did he stay with that family?
A For years, yeah.

Q Okay. And then, did you ever visit David Cains?
A Not at that family. When he would come home, we would visit, at my grandma's or his mother's house.
Q So, let's talk about -- okay. So, when he would come home, where would he come to, to your home?
A No. Charlene's house.
Q To Ms. Robinson's house?
A Yes.
Q His mother's?
A Yes.
Q Okay. And you would come over there --
A And visit.
Q -- and see him?
A (Indicated yes.)
Q Okay. Is that a "yes" or a "no"?
A Yes, sir.
Q I'm sorry. One of the things that --
A Yeah. Sorry.
Q In person we all have nonverbal communications, but it has to be on the record.
A Yes.
Q So, I'm just trying to understand. So, you would simply -- when he would come home from this family that he was living with, when he would go visit his mother, you would sometimes come over?

A Yes.
Q What, for dinner or --
A Dinner, hang out, to visit, see him.
Q I got it. And to see the rest -- I guess you had other siblings, Christine?
A Yes.
Q Okay. So, it wasn't just for David Cains, it was for the family?
A Yes.
Q Okay.
A But we made it a big deal when he came home.
Q Okay. How often would he come home, that you saw him?
A I'm not sure. I was really little at that time.
Q What about later, how long did he live with this other family?
A I'm not for sure.
Q Okay. Fair enough. Do you know, did he stay with that family for -- did he ever go with another family or stay with that family, or do you not know?
A I do not know.
Q And did there come a point in time where he had a different placement, that you're aware of?
A Just the family he was with, and then ADHD -- or ADC.

Q The human development center?
A Yes.
Q I know what you meant, but I needed to --
A Yes.
Q And did you ever visit him there?
A Yes, several times.
Q "Several" being approximately how many?
A I can't put a number on it. I moved shortly after that to Gulfport. So, when we would come visit, we would come see him, or he would come down and we would see him then.
Q So, when you -- I guess what I'm asking is, did you go directly to visit him in the Booneville Human Development Center, or did you go with like other family members to go visit him?
A I went with my sister a few times, mainly with her, and Charlene. But when I lived in Gulfport, I would come visit him probably a couple of times alone with me and my kids.
Q Okay. And so, you were familiar with Booneville Human Development Center?
A Somewhat.
Q Okay. Did he seem happy there?
A Yes.
Q Did it seem a good placement for him?

A He loved it there.
Q That was his home?
A Yeah.
Q Okay. Did you meet any of the staff?
A Just signing in and in passing.
Q Okay. So, you didn't really talk to them?
A Not personally, no.
Q Did you -- were you -- at any times that you were visiting or that you recall -- and I understand you were young when you were in the house -- but with that caveat, were there any behavioral problems, aggression, that you became aware of or noticed?
A No, sir.
Q Okay. Did you ever become aware of any aggression or violence?
A No.
Q Okay. And so, after David became -- after you have your own family and you had moved away, and you had said that you would come up sometimes and you would bring your kids and go visit David. Would that -- tell me about that.
A We would just -- we would go visit him, we would stop at Wal-Mart, buy him the snacks that he liked, bring him his lunch, stayed there a few hours and visit.
Q Okay. What types of things would you do when you

were at -- so, you would visit him at the Booneville Human Development Center?
A Yes.
Q Did they have a room or an area that --
A His room.
Q Oh. Okay.
A Or if we would bring him lunch, we would go sit in the lunchroom.
Q And during those times there were no problems?
A No, sir.
Q And everything looked -- at the human development center, you were satisfied with the care he was given?
A Yes, sir.
Q Anything -- and you went into David's room in the development center?
A Yes.
Q And he had his own room; right?
A Yes.
Q Did he -- did he have a TV?
A Yes.
Q Did you notice anything about the TV?
A No, sir.
Q Did you notice that it was behind plexiglass?
A No, not that I can recall.
Q How many times do you think, after you moved to

Mississippi, that you came up to see the family and eventually David?
A A good handful. I couldn't really put a number on it. But every time we would come home, if he didn't come visit us at his mom's, we would go up there and visit him.
Q And I don't have the name, but Shelly, is that your sister?
A Yes. We share the same mom.
Q Okay. And did Shelly -- where did she live?
A She lives in New York now.
Q Oh. When did she move there?
A Recently. Not even a year ago.
Q Okay. Before that -- before David Cains passed away, where did she live?
A In the house with them in Pottsville.
Q With?
A My mom, my dad.
Q Okay. And your dad passed away in 1991?
A Yes.
Q And then, do you know -- so, where did Shelly live after that, with your mom?
A Yes. And then --
Q Okay. Is that what you're saying?
A Yes.

Q Okay.

MR. GILLISPIE: Don't wait.

MR. ROSEN: We'll wait.

VIDEOGRAPHER: Do you want to go off the record?

(WHEREUPON, a brief discussion was held off the record.)

BY MR. ROSEN:

Q So, were you at David's funeral?

A Yes.

Q Was Shelly at the funeral?

A No.

Q Okay. What's her last name?

A Now?

Q Yes.

A Panulla.

Q Can you spell that?

A P-A-N-U-L-L-A.

Q Was your mom at the funeral?

A No.

Q Was Ms. Robinson at the funeral?

A Yes.

Q Was Christine at the funeral?

A Yes.

[redacted]



Q Are you aware of any behavior -- well, when you were with David, did he have any -- express any frustrations or behaviors that were when he was agitated?

A No.

Q So, when you saw him, everything was nice and calm?

A Yes.

Q In a good mood?

A Yes.

Q And do you still visit with Ms. Robinson?

A When I do come home to visit, I will.
Q Okay. And you saw her today here?
A Yes.
Q Do you stay in contact with her?
A I do.
Q By telephone?
A Yes.
Q Okay.

MR. ROSEN: I don't think I have anything further.

MR. GILLISPIE: I don't have any questions. Thank you very much.

MR. ROSEN: Thank you very much.

THE WITNESS: Thank you.

VIDEOGRAPHER: We are off the record at 12:12 p.m.

(WHEREUPON, at 12:12 p.m., the taking of the above-entitled deposition was concluded.)

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C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, DONNA K. PETRE, Certified Court Reporter in and for the County of Pulaski, State of Arkansas, duly commissioned and acting, do hereby certify that the above-entitled proceedings were taken by me in Stenotype, and were thereafter reduced to print by means of computer-assisted transcription, and the same fully, truly, and correctly reflects the proceedings had.

I FURTHER CERTIFY that I am not attorney or counsel of any of the parties, nor am I relative or employee of any attorney or counsel or party connected with the action, and have no interest in the outcome or results of this proceeding.

WHEREFORE, I have subscribed my signature and seal as such Court Reporter in the City of Little Rock, County of Pulaski, State of Arkansas, this the 26th day of November, 2022.

_____
DONNA K. PETRE, CCR #125
COURT REPORTER IN AND FOR
PULASKI COUNTY, ARKANSAS

---o---

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

PART ONE OF ZOOM DEPOSITION OF

JUSTIN JOBB

April 21, 2022, at 11:45 a.m.

CRIS M. BRASUELL, CCR
BREPORTING@GMAIL.COM

A P P E A R A N C E S

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S T I P U L A T I O N S

IT IS HEREBY AGREED AND STIPULATED by the parties in the above cause, through their attorneys of record, that the testimony of Justin Jobb, produced, sworn, and examined via Zoom, commencing on April 21, 2022, at 11:45 a.m., before Cris M. Brasuell, CCR, pursuant to the terms and provisions of the Arkansas Rules for use as permitted by the Rules; that the questions and answers so given and propounded shall be transcribed by the reporter.

WHEREUPON, there being no further stipulations, the following proceedings were had and done, to wit:

P R O C E E D I N G S

WHEREUPON, Justin Jobb was duly sworn to tell the truth, the whole truth, and nothing but the truth, and gave the following testimony to wit.

DIRECT EXAMINATION

BY MR. GILLISPIE:

Q Hi, Mr. Jobb. Thanks for being here today.

My name is Josh Gillespie. I'm the attorney for the Estate of David Cains.

Would you state your full name for us, please.

A **James Justin Jobb.**

Q Okay.

A **Not job.**

Q Okay. Jobb. Okay. I'm sorry.

A **That's okay. I get it all the time.**

Q If it's possible to either turn up your volume or scoot a little bit closer --

A **Okay. Let me see.**

Q -- I'm having a little trouble -- I can hear you but it's a little quiet.

A **They usually say I'm loud, so this is news to me.**

Q Me too. Easiest thing might just be to get a little bit closer.

A **Okay.**

Q I don't know though.
A **All right. I'll scoot up. Is that better?**
Q Yeah. Sorry about that.
Are you in your office today?
A **Yeah, I am.**
Q Okay. Is anybody else present with you?
A **No, sir.**
Q Okay.
All right, Mr. Jobb. Again, have you ever been -- appreciate you being here.
Have you ever been deposed before, sir?
A **No, sir.**
Q Okay. Well, basically I'm going to ask you some questions. I'm going to try not to take up too much of your time.
The only real rules here are to make sure you can hear me. If you can't hear me, let me know. If you don't understand what I'm asking, ask me to rephrase.
And, because we have the court reporter who has to make a record, it's important to verbalize yes and no as opposed to -- as opposed to that. Because she has to make a record of it.
If you need to take a break, at any point, just let us know, and we can do that. Other than that, we can get started here.

A Okay.
Q All right.
What is your educational background, Mr. Jobb?
A I have a bachelor's degree in history with a minor in historical interpretation.
Q Okay. And how long -- and your title at Booneville is what?
A Well, I'm actually doing double duty at this time. I'm a program coordinator as well as a team leader.
I just hired on as team leader maybe two months ago. But I was -- I've been a program coordinator here for between 12 or 13 years. I worked at BHDC for close to 24 years.
Q Oh, okay. Close to 24 years. All right.
A I've worked in this field for a little over 30 years.
I've worked at different facilities out in Texas as well. Been doing this --
Q (Inaudible) -- I'm sorry. Go ahead.
A No, I just said I've been doing this awhile.
Q Okay.
Where'd you go to college? Where'd you get your degree?
A University of Arkansas in Fort Smith.
Q Okay. And do you have any other -- other than your

bachelor's in history and your minor, do you have any other degrees?

A No, sir. I do not.

Q Okay.

And what was your title at Booneville at the time of David Cains' death?

A Program coordinator.

Q You weren't the QIDP, qualified --

A (Inaudible) --

Q -- intellectual disability professional?

A It's the same thing. It's a QIDP, program coordinator.

Q So those are interchangeable terms at Booneville?

A It is. Yes, sir.

Q Okay.

A I mean, the social workers are also considered program coordinators as well, for whatever reason.

But, yes, Q -- QIDP, slash, program coordinator. It's a long title but. . .

Q Okay.

A Q for short, usually. But program coordinator seems to help people understand actually what I do.

Q Okay. And you were specifically the qualified intellectual disability professional, which we'll call Q for short. You were the Q for David Cains?

A Yes, sir.
Q Okay. Did he have more than one Q or was it just you?
A Just me. Just me at that time.
Q How long had you been his Q at the time of his death?
A Oh -- let's see. I'd say probably -- honestly, I don't know.
Because our caseloads change periodically, so I can't give you a clear answer on that.
Q More than five years?
A Honestly, don't know. Because, like I said, our caseloads -- you know, we had a revolving door of Qs there for a while.
And I had clients added, moved, and just -- we rotated quite a bit. So I know, at the time of his death, I was his Q. I had known him for years though.
Q Can you give me any idea of how long you know for sure you had been his Q at the time of his death?
A I would -- I would just have to guess.
I mean, I've been a Q over that particular living area along with some other living areas. But, over at Davison house, where he resided, the entire time I've been a Q. But I can not put a timeframe on that. I'm sorry.

Q How many clients does each Q have? How many clients is each Q responsible for, at a given time, typically?
A **During my time, it's been anywhere from 22 clients to 38 is about -- I think 38 is probably about the most I've ever had.**
I've probably not had less than 21, 22, at any time. That number goes up and down because this is an intermediate facility, so. . .
Q And could you say how many you had in 2020?
A **No, I can not.**
Q Did you review any documents, review any materials, in preparation for today?
A **I looked at my IPP that I wrote. It's -- it's probably three years old.**
At the time of his death, we were -- we had a scheduled annual review for him that we obviously did not get to conduct. So I just looked at -- that's the big document that I was responsible for; so, yes, I did look over that.
Q And am I correct that the most recent IPP for David had been done in July of 2019?
A **Yes, sir. That's correct.**
Q And I presume that the next one would have been done in July of 2020 had he lived?
A **Right.**

We usually -- those IPPs have to be typed and up for review and posted within 15 working days after the meeting itself, so yes.
Q And that meeting takes place once a year for each client?
A Well, yes. Honestly, it's close to 11 months because we have to have that annual review in and IPP has to be typed, reviewed, and posted before that annual year will lapse. So we'd be out of compliance.
So that gives you time -- really, it's every 11 months on -- you know.
Q Okay.
A Because, at that time -- I mean --
Q But it's an annual thing?
A It's an annual thing, yes. It's a once-a-year meeting.
But it -- it has to be done in a timely manner where we have time to get the meeting and the paperwork done and everything in place. There's a lot that goes with those.
Q And you referred to it as, you know, my IPP. Is that because, as the Q, you're the person, ultimately, in charge of and responsible for the individual program plan for your clients?
A Yes. I wrote that IPP. So it's considered a legal

document and it has my name on it, so. . .
Q I'm just trying to get a sense of if there's any other person that is more ultimately responsible for that IPP than the Q.
A No. I mean, it -- it has to go up for review before we can post it.
And, at this time, our QA director reviews them. That has -- you know, they -- they may look for typos and any kind of mistakes we may have made.
You know, they're sometimes 20 to 28 pages long; there's going to be some typos. So it's just a thing that we go by where they review it and they send it back to us, we correct those mistakes, and then we post it. Or we post it on SHARE, is what we use, so (inaudible). Go ahead.
Q No, I'm sorry. That's another thing about depositions I should have mentioned. I'm going to be careful to try to not speak over you and let you finish your sentence so that it doesn't confuse the record. And you've already been doing a good job at this, but just do the same for me.
I'm probably going to ask questions where you know the -- you seem like a bright guy. You're going to -- there's going to be some questions where you know the answer before I even finish the sentence. Go ahead and

let me finish the sentence anyways --
A Certainly.
Q -- for the record --
A Sure.
Q -- before you answer. And I'll do the same for you.
It's something I -- it's hard for me, particularly. I'm an impatient sort.
A It's not my strength, but I'll do my best.
Q Me either. I come by it honestly though.
As far as documents you reviewed to prepare for today, other than the 2019 IPP, were there any other things that you looked at?
A Just the health and safety plan. But that is within the IPP as well.
That's another document that I type up following that annual review. But it's -- it's included in the IPP.
Q Isn't there a team of folks that are supposed to, at least, give you input on these IPPs?
A Well, yes. Yes.
Q And, if you could, just explain to me that -- would that be the interdisciplinary team?
A Yes, sir.
Q Okay. And if you could -- and I have the policy, the interdisciplinary team. And then I have the one for

qualified intellectual disability professional process.

But how would you describe -- and, again, I'm asking just so I can get a -- make sure I have the best understanding, the clearest understanding possible, of how this process works, with regards to producing the IPP.

So, if you could, explain what this -- with regards to David, what the interdisciplinary team is. What it did; how it then effectuates producing this IPP.

A Okay. The first thing we do is, after the previous years' annual review, we schedule one. Like I said earlier, it's approximately 11 months after that.

Now, leading into the annual review itself, there's various areas at this, on this campus, that provide me with their evaluations. Those -- those people would be his prevocational trainers, his living area supervisor, his registered nurse that's on the team, psychology, social services.

You know, if he were in speech therapy, I'd have a report from the speech therapist. I also -- and there's different reports within the medical, like the nutritional report, the dysphasia, those types of things.

So everybody provides a report. And we like to have those at least one week prior to the meeting. And they post them on the computer, what we call SHARE.

So everyone on the team goes and ideally reviews these reports and then I develop -- I go by the reports. And a lot of them provide me training objectives that -- whether it be domestic skills or personal care skills or the prevocational training, fitness training, those different things.

So I will develop a draft of the training plan. And that training plans is also included in the IPP. But I like to have a draft going into the meeting after I've reviewed everybody's reports. So --

Q Are the people that submit the reports, are those considered the members of the interdisciplinary team?

A Well, we have what is called a core. The core team members would be social services, the guardian, the client, psychology, medical, and a representative. Usually, it's a supervisor in the living area.

Those would be your core team members. Now --

Q And that's --

A Go ahead.

Q I apologize. Go ahead.

A Well, those are your core team members. But there's times where other people will show up.

Like I mentioned before, there might be a speech therapist that shows up. Prevocational trainers show up.

But, see, speech is under medical; prevocational

trainers are under residential services, so we can't stack the deck with the vote because we do a lot of voting at these meetings.

So we only allow the -- we want the core team members to vote.

Q Okay. I'm going to show you a document. I think this must -- tell me this -- okay.

So this is page three of the 2019 IPP. And, at the top, it says the following people attended the annual review, see signature sheet, and then name and title.

MR. GILLISPIE: And this is Bates marked 13908, Eric.

MR. COLLINS: Okay.

BY MR. GILLISPIE:

Q My question is, the people listed under name and title here of these, one, two, three, four, five, six, seven, eight, nine, ten, 11, these 11 folks, would that be the core team for the 2019 IPP?

A They're not all core team members, no. I can point out, if you'd like, the core team members that's listed.

Q Please.

A All those people listed were in attendance at that meeting.

Q Okay. That was my next question, but -- okay.

A Yeah, they were -- those people were in attendance.

Now, there are times where they're on conference calls. But it looks like, in this case, everybody was in person at -- because I will stipulate if it was on a conference call --

Q Okay.

A -- under the same area.

Q But you have this in front of you, so you don't need me to hold it up?

A Well, I couldn't see it anyway. You're about the size of a half-dollar right now. I might have to blow you up over there so. . .

Q Okay. Well --

A Yes, I do have it in front of me.

Q Okay. So who were the core team members for this 2019 IPP?

A Okay. I'll list them off for you.

The first one was Caleb Murray. He is the worker for -- he's the social services worker.

Q Yes, sir.

A Brenda Jo Jarrard is the RN. She's the team RN.

Q Yes, sir.

A The next one, she no longer works here, but her name was Ashton Cobb. She was the living area supervisor that was representing Davison house.

Q Yes, sir.

A The next one is Mike Alvis. He's the psychological examiner.
Q Yes, sir.
A And then David is listed and his mother, as guardian, is also part of that core team.
Q Okay.
A As you can see, there's other people that were at that meeting. The one -- Angela McPhail, the RI, she's from prevo; or was.
Q Yes, sir.
A Jane Ziegler, she was our QA director at the time.
Q Yes, sir.
A She's no longer with us.
But another -- I had another representative from prevocational training, Audra DeLay.
And the sister, Chrissy Cains, was -- is not part of the core; but she was obviously a family member and -- and attended that particular meeting.
Q Yes, sir.
So, to recap, the core team members were Caleb Murray, Brenda Jo Jarrard, Ashton Cobb, Mike Alvis, yourself, and Charlene Robinson?
A Yes. And I -- I always include the client as well.
Q And David. Okay. Okay. Very good.
And the, below that, those are the folks that you

referred to earlier from different areas, from psychology, from medical, from nursing, who may have submitted written input through the SHARE system; is that right?

A That is correct.

Everyone I have listed there had some type of information, whether it was an evaluation or -- a lot of it, I mean, the first few are under medical. And that was included in Brenda Jo Jarrard's medical review.

But some of them -- yes. That is the answer to your question. All of these people, I had some type of report, some information provided to me, prior to that annual review.

Q And I've spoken to Caleb Murray before, but what would you -- Caleb Murray, as David's social worker, in layman terms, how does he function as a core member of this IPP, of this team, that helps you with his IPP?

A Well, he provides the social history report. And, I don't know, they vary but -- and I don't have that one in front of me.

But, you know, they're about five or six pages long. And it includes a lot of the background information, you know, what transpired through his life, how he actually came to our facility, you know, as far as the guardianship, some of the legal terminology and how he

acquired guardianship and those sort of things.

So -- but he's a voting member at my -- there's a few things that we have to vote on.

Q What are those?

A Okay. Well, the first one is we talk about whether we feel this individual client is properly places here at BHDC or should -- does anybody from the team feel like we need to seek alternate placement outside of this facility.

We are an intermediate facility. We are not you live here forever facility. We try to give the individual skills so they can thrive in the community or another setting at some point in their life.

But we have to vote on that. And I actually have them vote on that close to the beginning of my meeting and then before we wrap up the meeting.

Somewhere toward the end, we vote again. And we go around the table and ask the core team members that will say that.

Now, we vote on that particular thing; but the guardian actually has the real say as -- and that's one thing that, in her case, she would have complete say.

We could have everybody on the team say I think he's properly placed. If his mother said, no, I want to seek alternate placement, her vote just vetoes everybody else

in that particular case and we would seek alternate placement for that individual in that case, but --
Q She could have chosen to remove him from the facility at any point?
A At any time. At any time.
Q Whether you wanted her to or not?
A Right. And the team would document that they were opposed to it, if they were opposed to it. And it's happened, you know, so. . .
Q Never with him though?
A No. No. No.
Q All right.

MR. GILLISPIE: I think I forgot to say that I'm going to enter this as Exhibit 1. This is the page. We'll just have to email it around.

(WHEREUPON, the document was marked for identification as Exhibit No. 1 and is attached hereto.)

A Well, I did not finish the other things that we vote on, if you were interested.
BY MR. GILLISPIE:
Q Yeah. I'm sorry. Please.
A You did ask on that.
That was -- that's what we -- we do that at the

beginning and at the end.

But another thing that we have to vote on, and we do at every meeting for every individual we serve is we go down the list of rights restrictions. And, usually, the way I carried that out is I will read to the team what we currently have authorized, and we'll determine as a team if we want to make any type of revisions.

Maybe sometimes -- we really try to do away with restrictions when we can. That's the idea. Sometimes we need -- it's a health and safety plan. So sometimes we need to add things to that particular document to better protect that individual we serve.

So -- but these are all voted on. And we go around the table and majority rules. You know, sometimes you'll have members opposed to it and -- but we will go with the majority and the restriction will be added if the numbers are in that way.

Another thing that we discuss is money authorization. And similar with the health and safety plan, I will -- I will usually say this is what we currently have authorized and does anybody feel like we need to make any type of revisions. And we will go around and vote on that.

So, usually, that's about it. I mean, there's -- there's times where someone will ask, you know, if they

don't feel he's properly placed at that particular setting on campus, so, you know, there are times, if somebody wants to, we'll discuss it.

If they might want him to live in another particular area on campus, we will vote on that, if that's an issue. But, usually, those are the things that I can think of off the top of my head that we vote on during my meeting.

Q And, with regards to David specifically, can you recall any contested votes on any particular issue?

A No. You would probably see it on page five under the professional judgment guardian opinion. That's usually where I would indicate if there were someone that was opposed to it.

In his -- I would have to look at this real quick. But it looks like, in this case, every -- we had a consensus that he was probably placed. And we -- we're not going to seek alternate placement.

Q Okay.

A Looks like we did have a consensus there.

But that would be the area, if there was an opposing view -- and there are times that we do. But not in this case.

Q And am I correct that you were also the Q for his 2018 IPP as well?

A I -- maybe. I'm not certain. But -- you know, if

you had that document -- if my name is on there, I was.
We do list under the name and title and -- but I don't have that one in front of me. I'm sorry.
Q Okay. Let me --
A It's possible.
Q I would just really, if possible, like to figure out, at least get some idea of how long you've served in this, what sounds like, an extremely important role for Mr. Cains.
A Yeah. I'm not even sure how we would acquire that information. I mean, like I said, those caseloads -- I'm sure there's a way. I don't have that information in front of me.
Q So I don't have it printed out. I can't show it to you. But this was produced to me in discovery. I'm looking at it here on my screen.
MR. GILLISPIE: And this is the -- Eric, this is Bates stamped 1350. And this is that same page three that lists the people who attended the meeting except this is for 2018.
BY MR. GILLISPIE:
Q And it does list you, Mr. Jobb, under that, on that list, as QIDP, dash, DDS, backslash, PC.
A All right.
Q So, assuming that I'm not lying to you about what

I'm looking at here, would that indicate you were his Q in 2018 as well?
A Yes. That would be a reasonable assumption. Yes.
Q Okay. And I don't know that I've looked at the one for 2017 or if I have it. So I'm not going to be able to ask you about that.
But, assuming that's true, you were the Q for at least the last two years of his life?
A Yes.
Q Okay.
And what is the RN's role on core team? Brenda Jo Jarrard. We talked about the social worker. What's the RN, Brenda Jo Jarrard's, role on the core team?
A Okay. She provides a medical review. I'm sure you have a copy of her review that's provided.
And she would do those annually prior to the meeting. There's a lot of information. I'd rather her answer it.
But, basically, she's a voting member. She brings any concerns to the table that may need to be addressed. But she kind of -- and I may have failed to mention this. They read their reports at the meeting.
So they -- well, the high points of the report. I'm not going to sit here and say they read word-for-word everything. But they certainly hit the high points of

their report that they provide to me prior to the meeting.

And so she would go over, you know, the medications and some of his doctor appointments he may have had or if there were any certain injuries or illnesses or anything that was addressed over that year.

She would also touch on the psych review. And then, at the end of her report, she would ask if anybody has any questions.

So anybody at the table, whether they're a core team member or not, could ask any question they like.

Q Okay. And then Ashton Cobb, she was the -- tell me that, what her job was again and her --

A She was, basically, the -- one of the dorm supervisors. And there -- we had a different number of supervisors. So each supervisor that we have has a caseload similar to what I would have. So --

Q Is --

A Go ahead.

Q Would Ashton Cobb -- RCSS. You told me earlier what they stood for. What is that?

A Residential care supervisor. Staff supervisor. She -- she supervises the direct care staff.

Q Okay. That's my next question.

So does that mean she was the highest-ranking direct

care staff member for David?
A Honestly, I don't -- I don't know that answer.
You know, like right now -- no, she wasn't. They have different levels of supervision.
But she -- she was the one that had him on her caseload. She provided the report. But, like right now, in my current position, I'm a team leader. I'm still over that same dorm. So, if she were still with us, I would be her supervisor.
Q Okay. Let me --
A And I have supervisors above me, so -- go ahead.
Q Well, first, let me follow up. Who are the supervisors above you?
A Currently, Jennifer Bancroft is my immediate supervisor.
Q What's her title?
A Residential Services Director.
Q Okay. And, in 2020, who was -- was it still Jennifer Bancroft?
A No. No. She's just been in that position about a year.
Q Who was your direct supervisor in 2020?
A My direct care supervisor in 2020. Honestly, I don't know. I could narrow it down for you, but that --
Q (Inaudible) --

A -- (inaudible) -- you know, there was a time -- because they moved us around.

There was a time that Jane Ziegler, that you see there as a QA director, she was -- she was our supervisor for a period. But then we were moved to residential services.

And now we've been moved back to QA. So we kind of bounce around. So it would have either been her or Debby Porter.

Q And when you say we, whatever department Q is part of, gets moved?

A Well, the Q's, there -- currently, there's, I think, five. And, you know, we don't have -- we're currently under quality assurance.

But there was a time that we were under residential services, so --

Q And you can't say which for --

A -- it's gone back and forth two or three times. So it's -- I would just be making it up.

I want to be perfectly honest with you. I can't -- I don't know.

Q But, in 2020, at the time of his death, it most likely would have either been Debby Porter or Jane Ziegler? Depending on if the Qs were under residential or quality assurance?

A It could have been Carey Johnson.
Q Okay.
And then who would be the person over them?
A If he was still with us -- I'm not sure if he was, but Jerry Cravins was in Jennifer Bancroft's position. But he retired around that time.
Q What was his job title?
A Same as Jennifer Bancroft. He was the residential services director.
Q And who supervises the residential services director?
A The superintendent.
Q And there's --
A Jeff Gonyea.
Q Okay.
So the superintendent is the direct supervisor over the residential services director?
A Yes.
Q Okay. And you're not sure who the residential services director was at the time of David's death?
A I can narrow it down for you.
It was either Jerry Cravins or Sandy Evans. They have both retired since. I don't have the date when they retired, but Jennifer -- it was Jerry Cravins then Sandy Evans and then Jennifer Bancroft replaced Sandy.

The other two have retired.

Q Okay. That's fine.

A **We're still hoping for the third one to retire.**

Q No, no. That's fine. And I'm not trying to test your memory. I'm just --

A **Well (inaudible) --**

Q -- trying to get a basic understanding of the hierarchy.

A **I can narrow it down for you. But that's difficult for me to do.**

Q Perfectly sufficient. I appreciate it.

Can you say who would have been -- you know, these three direct care staff who were involved in the restraint that led to David's death being Ryann Campos, Tyler Mattson, and Mandy Jones, my understanding is that Mandy Jones was some sort of, maybe a shift supervisor that day.

But do you know who would have been the immediate supervisor over her and over them at that time?

A **No. I do not have that answer.**

Q Do you know what job title would typically would function in that role, if not the name of the person?

A **In those three roles that you just mentioned, those three staff members?**

Q Right.

A Well, I know the --
Q You've got these three staff members on this date in June of 2020 in the Commons area. They're all direct care staff.
I'm just trying to figure out what -- I know you don't know who the person was. But, typically, what job title would have been the direct supervisor over those three direct care staff?
A Well, it may -- it depends on where they -- you know, it'd probably -- it'd be one of the team leaders. But we have three different team leaders. So it depends on what area they worked on, worked in, or were assigned.
Because sometimes staff are moved around. And I don't know where those three particular staff members were working at that time.
So it really depends on where they were assigned as to who would be their supervisor.
Q (Inaudible) --
A But, ultimately, it would have been the residential service director, would certainly be over all three of those.
Q Okay.
A Yeah.
Q That's fine. That's fine.
Okay. And am I correct that, as the Q, is it fair

to say that you were responsible for overseeing the implementation of this IPP?
A Yes. I would -- like I said, I would provide the draft and then we would initiate it. It's usually initiated within 24 hours of the annual review.
And then, as a Q, you have to do progress notes each month to check the data that's been collected from those various areas. And there's times where you make some modifications on those objectives if they meet criteria and are advancing.
But there's also times where they're not progressing; and, after a certain period of time, we may change the criteria to help them show some type of progression.
Q Okay.
A Because they meet the criteria, the objective, altogether, and it's managed to the best of their ability and it's discontinues and there are times where we add a new objective.
So, yes, it's monitored through the Qs or the program coordinator.
Q And is it fair to say that the IPP, you could call that the treatment program? Are those pretty much interchangeable terms?
A Well, there's a behavior treatment program that's

completely different.
Q Okay.
A It comes out of psychology. But it's just an individual plan for that individual that we serve.
They're all different. I mean, they can look similar on the outside, but we really try to make them as individual as we can.
They -- they're not all working on the same objectives. We just try to meet their needs. And they have certain goals so -- and they have a different list of goals. And that's on page four.
But -- so those objectives would have something to do with each and every one of those goals.
Q And what I'm getting at is just trying to get a full understanding of the responsibilities of the Q, so --
A I can give you a list of some of my duties as a Q --
Q Well --
A -- if that would help.
Q -- let me -- before you do that, when I say implement the IPP, I mean, is the -- am I correct to say -- am I correct, in my understanding, that the Q is ultimately responsible for making sure that the IPP is being implemented properly, that it's integrated, that it's done in a coordinated way so that direct care staff and whomever else are all on the same page about what a

particular client's IPP --
A I think that's fair to say.
Q -- dictates?
A I think that's fair to say, yes.
Now, as far as implementing it, it depends on the area. Like the direct care staff would be implementing their -- and fitness track. And I'll just go down here, the (inaudible) --
Q Right. Right.
A -- IPP. But I just would monitor to make sure --
Q But you make sure -- I know that you don't do the actual, you know -- you don't --
A (Inaudible) --
Q You don't work with him in vocation and you don't actually do the direct care.
But, as the Q, you kind of have to make sure that they know what the IPP says they're supposed to be doing. Is that right?
A That is correct.
Q Okay.
A And there's times where, you know -- as a Q, you visit them in their living area at least once a month and you visit them in their training area at least once a month.
So there are times where you can kind of get an idea

of how they're doing. And then once a month, usually -- I mean, the data's supposed to be posted on the fifth working day of the month. That's not always done; but, ideally, that's what they do.

So then I would go and pull up those members and then I can see if they're progressing or if we need to make any modifications to those objectives.

I mean, sometimes we want to let them go three or four months just to kind of give them an opportunity. But, you know, we don't want to stay on a particular objective of the same criteria if they're not showing any progression. We would want to modify that because we want to assist them in any way we can to progress.

And sometimes they just simply can't do the task assigned and it'll be deleted and we'll come up with another task that would help them.

Q Okay. I'm going to put a pin in that for just a second and go back.

I meant to follow up on your -- real quick, on your background a little bit more, my understanding is that there are certain qualifications, required qualifications, to serve as a Q.

Just briefly tell me, you know, kind of what those are and how you meet those qualifications. I'm not suggesting you don't. I just need to have it on the

record.
A Yeah. They want you to have a bachelor's degree at least with a -- you know, in this field, teaching will suffice.
My particular degree was more focused on teaching at the college level. But what helped me was my experience. I mean, I -- I have, in this particular field, over 30 years experience at four different facilities. And I've been a supervisor at every facility I've worked at.
So the combination with my experience and my -- I mean, you have to have a bachelor's degree.
Q You don't have to have a bachelor's degree in a certain area?
A No.
Q Okay. Anything other than a bachelor's degree required?
A You know, they certainly want you to have experience in the field, you know.
Q Okay.
MR. GILLISPIE: Hey, Eric, can we talk a quick five?
MR. COLLINS: Uh-huh.
MR. GILLISPIE: Thanks.
(WHEREUPON, the record was suspended momentarily and the proceedings resumed as

follows, to wit.)

BY MR. GILLISPIE:

Q Okay.

Mr. Jobb, following up on the qualifications or the required qualifications for serving as the qualified intellectual disability professional, I hate to harp on this. I don't want to harp on this.

MR. GILLISPIE: But I went back and took a look at the state operations manual that y'all provided me. Starting at regulation, 483.30 which is Bates stamped page number 1679, Eric, these are what are labeled as the ICF-IID regulations.

MR. COLLINS: Okay.

BY MR. GILLISPIE:

Q State operations manual Appendix J, guidance to surveyors intermediate care facilities for individuals with intellectual disabilities; so the state operations manual.

So starting on this page here, again, Bates marked 1679, it sort of defines the role of the Q.

It says that each client's active treatment program must be integrated, coordinated, and monitored by a qualified intellectual disability professional who -- would you agree with that statement, Mr. Jobb?

A Yes.

Q Okay.

And then it sort of lays out I think, basically, the same things that you've done an excellent job of already describing to me, but that the Q's responsible for orchestrating all facets of the active treatment effort, including the IDT creation of relevant IPPs tailored to meet individual client needs. Do you agree with that?

A Yes, sir.

Q You'd agree that the Q is responsible for effectively coordinating internal and external program services and supporting, and supports, to facilitate the acquisition of client skills and adaptive behaviors?

A Externally, you know, as far as medical appointments and that sort of thing, that'd be coordinated through the medical department.

Now, I might make sure that those appointments are being seen. But I don't schedule any of those things and I don't -- I would count on my team RN to do that sort of thing.

Q Okay. Other than that, though, you would agree with that statement? That the Q would be responsible for -- to effectively coordinate at least internal services and supports to facilitate the acquisition of client skills and adaptive behaviors?

A I think that's accurate, yes.
Q Okay. And, finally, the Q is responsible to promote or is responsible for the promotion of competent interactions of residential staff with clients in program implementation and behavior management?
A Okay. (Inaudible.)
Q Would you agree that that is your responsibility as the Q?
A Well, I'm not sure that -- I mean, as far as, you know, psychology, they write the behavior treatment programs and they would make any type of revisions.
You know, they might take some input from the team, but they ultimately are responsible for that BTP.
Now, we try to carry it out the best we can in adherence to that program; but I don't -- I don't write that particular program.
Q But that program is part of the IPP, isn't it?
A Not the program. I mean, as far as the target symptoms and the target behaviors, I mean, you can look as far as -- let me see where I mention it.
Q Well, right here on page nine of the 2019 IPP, under [redacted]
[redacted]
A Right.
Q [redacted]

[redacted]

You wrote that; right?

A Yes. I -- I took that entirely from the report or the program that psychology provided.

As you'll see with a lot of the IPP, it's taken directly from the reports or evaluations that I received.

Q But what I'm getting at is one of your roles as Q is to make sure that these interventions that are specifically authorized by the IPP that you wrote are properly being implemented or that they're being integrated into his actual day-to-day care; correct?

A Certainly want to give guidance in that sense.

But, as far as the training, I do not conduct that training, as far as the TACT or the NCI training.

Q Well, let me put it this way.

The literal state operations manual that your organization goes by, it says -- now, if we were in person, I'd show it to you.

It says that the Q is responsible to promote

confident interactions of residential staff with clients in program implementation and behavior management.

Are you saying, as you sit here today, that that is not how it's done at Booneville?

A Well, it's -- I think it's left for interpretation.

Q What is?

A What you just said. I mean, as far -- as I don't write the program. I don't write the BTP program.

I don't do the training on how to conduct those types of interventions.

Now -- and I don't carry -- I mean, our psychology department carries out that training and has the staff sign off on that. I don't do that either, so --

Q But you integrate it into the IPP based on the -- I get that that's their area --

A (Inaudible) --

Q -- but you take their information and integrate it into the IPP; correct?

A It'd be similar.

Let me give you another scenario. Like with the medical department or psychology and the medications that prescribed, I don't give those medications. Do I include it in the IPP, yes. It's part of the program.

But same thing with the behavior treatment program. I don't carry out that program myself.

Q Right.
A **I try to give them guidelines and information so they can carry it out properly.**
Q Right. Right. And we may be just talking past each other and that's my fault. I may be saying this wrong.
I get that you don't administer medication.
A **Right.**
Q I get that you don't administer restraints on clients yourself. I think what I'm simply asking is, is it or is it not the Q's responsibility to make sure that the folks who do do those hands-on things know what they're supposed to be doing as stated in the IPP?
A **I think it's -- it's part of my job as a coordinator to make sure that that particular department is carrying out what they're supposed to be carrying out, as far as the psychology department, and I assist them in any way I can.**
I try to interpret their program and make sure that the proper training is being conducted. But I don't conduct that training.
Q Right. Right. Well, let's just --
A **I just try to give them guidelines to go by and to give them information that they can access and make sure that that information is updated and that they have the appropriate -- even as far as them having the appropriate**

BTP in their living area, that's done by the living area supervisor.

Now, when I'm over there and I happen to see that it might not be the right one, then I would certainly let somebody know.

But there's certain things as a coordinator, I'm just making sure -- I try to coordinate and make sure everybody else is doing their job.

Q Yeah.

A I don't do all their jobs for them.

Q Yeah. You're the overseer of the IPP. And you'd agree --

A Right.

Q -- that no -- direct care staff aren't allowed to perform an intervention, a behavioral intervention, that is not authorized by the IPP; correct?

A Well, that's -- I mean, correct. I mean, as far as interventions are concerned --

Q That's -- no. Are they authorized to do something -- yes or no.

Are they authorized to do something, as far as a physical restraint, that is not authorized by the IPP?

A Only in emergency situations can they carry out any type of restraints.

Q Well, the IPP calls -- the IPP specifically mentions

that, emergency situations.
A 11-D, emergency situations. That's the only -- we do not have -- in anybody's plan, we do not have any type of restraint that's not emergency.
Q Okay.
A Whether it's category one or category three.
It's not part of any behavior treatment program then; it's not part of any behavior treatment program now. Only in emergency situations.
Q Okay. We'll put a flag in that and come back.
I get that. I'm just saying -- and his IPP does authorize the emergency procedures if necessary and TACT procedures. I get that.
I'm simply asking, I mean, am I wrong that things other than what are specifically authorized in this IPP can not be done?
Isn't this document sort of, you know, gospel when it comes to the client's care and treatment?
A Well, it's -- it's one of many pieces. I mean, like the program, BTP program, is an entity on its own.
Q And what is that? Don't use the acronym. Tell me what you're saying.
A I'm sorry. It's the behavior treatment program.
Q Okay. And who's responsible for that?
A The psychology department which is usually a

psychological examiner.
Q And you're saying that the behavioral treatment program operates completely in its own world separately from what you do?
A Well, I touch on that in my report. But, as far as writing that program, I've never written one.
I don't have the background to write one.
Q And so who advises you from behavioral treatment on what to touch on in your report?
A The core team member which is a psychological examiner.
Q Okay. And, in this case, it would have been Michael Alvis?
A That's correct. Yes.
And, during his portion of the meeting, he goes over the BTP and the -- he looks over the previous years and tries to make some comparisons on what may be working and what might not be.
So I include some of that information from his report in my IPP, as I do with everybody's report.
Q Okay.
Would you agree that the Q is required to and responsible for guiding the interdisciplinary team and ensuring that the team decisions comply with established policies as well as ICF regulations?

A I'd say that's accurate, yes.
Q And would you agree the Q is responsible for chairing the interdisciplinary team and completing individual program plans for clients?
A Yes.
Q And would you agree that the Q is responsible for monitoring the implementation of training objectives and the delivery of services for clients on their assigned caseloads as determined in each client's IPP?
A Well, that one, I mean, like I said, as far as these objectives that I put in the training plan, I'm not going to be over there every day monitoring to see if those are conducted.

Now, I will do a monthly check to see if I've got appropriate data being collected. But I put the plan and give the plan to the staff. It's up to them to carry that out, their supervisors to train them properly.

But I'm not -- I don't see them on a daily basis. I do not see these objectives carried out on a daily basis.
Q You do on some basis though. Not daily, but monthly or randomly or weekly or something, don't you?
A Yeah, I just said that. I do the monthly progress notes. And we mentioned that earlier. They usually are posted fifth working day of the month; and so I can go on SHARE and kind of monitor that and make some revisions if

needed.

Or maybe I encourage some of their instructors to consider some revisions.

Q And, in fact, you have to do on-site observations of the clients in their living and training areas at least once a month; right?

A Correct. Yes.

Q Okay.

And so I'm reading from -- and this is Booneville HDC Policy III-A-8 and this is Bates stamped 4386 and then page two is 4387.

And this document is called qualified intellectual disability professional process. So this is Booneville's own policy on the role of the Q.

MR. GILLISPIE: And this is going to be Exhibit 2 for Mr. Jobb's deposition.

BY MR. GILLISPIE:

Q But one of the things it says that you push back on a little bit was that the program coordinator, backslash, QIDP monitors the implementation of training objectives and the delivery of services for clients on their assigned caseloads as determined in each client's IPP.

They do on-site observations, tracking for each of their clients in the living areas and training areas at least once a month.

A Right.
Q They may also observe their clients in other areas. Would you now agree with that passage?
A Well, I agree that we certainly make monthly -- we do check on the individuals we serve in their training areas once a month, in their living areas once a month. We do document that.
Q But you do not agree that you monitor the implementation of the delivery of services?
A I would -- I would agree that I monitor that, at least, on a monthly basis. I don't -- it's not monitored on a daily basis.
Q Would you agree that, as the Q, you are the person that is ultimately responsible for monitoring it, whether it be on a monthly basis or any other basis?
A I think that's fair to say, yes.
Q Okay.
And then you do a monthly plan review every month to summarize information from your observations and record reviews?
A That's correct.
Q Okay.
A It's on a monthly progress note.
Q And the same exhibit, under duties and responsibilities of the Q, Section A, the program

coordinator, backslash, QIDP functions as advocate for the client by assuring he or she receives the maximum benefit of active treatment.

Would you agree that that's your job? To make sure that that your clients receive the maximum benefit of active treatment?

A Yes.

Q What I seem to be getting here is that the Q is the, essentially, may be the most important person to a given client when it comes to that client's care in the facility.

I mean, you're the advocate; is that fair to say?

A Yes. That is fair.

Q And your IPP -- scratch that.

MR. GILLISPIE: Eric, I'm marking that as Exhibit 2.

MR. COLLINS: Okay.

(WHEREUPON, the document was marked for identification as Exhibit No. 2 and is attached hereto.)

BY MR. GILLISPIE:

Q I want to, real quick, go back to the state operations manual, the ICF-IID regulations.

Specifically, Section 483-430(A)(I). This is Bates Stamp 1680. And this is -- these are the state's

requirements for QIDPs.

The first requirement is that the person have at least one year of experience working directly with persons with intellectual disability or other development disabilities.

And I believe you said you had that; right? Before becoming a Q at Booneville?

A That's correct.

Q Okay. Where did you get your experience? And it could have been at Booneville, I suppose, in some other capacity.

But where did you get your one year of experience working directly with folks with intellectual disabilities prior to becoming a Q?

A Well, I worked at the Lubbock State School. Started out there in 1987. Supervised a special treatment unit for about five years.

Q And that involved persons with intellectual disabilities?

A Very -- very similar to the campus I currently work on.

Q Okay.

A Just a little (inaudible).

Q When did you first become a program director or a Q?

A Oh, I would -- I'd have to approximate.

Q That's fine.
A **But between 12 -- around 12 years ago.**
Q Okay. So that's one requirement which you clearly seem to meet.
The second requirement is that the person be either a doctor of medicine or osteopathy or a registered nurse or it can be an individual who holds a bachelor's degree in a professional category specified in B5 of this same document.
And, specifically, that's 483, Section 483.430-B5 Roman Numeral I through 11. And I'm going to go through what those different areas are that you can get a bachelor's degree in.
The first listed in this section is occupational therapy. You do not have a bachelor's degree in occupational therapy; correct?
A **Correct.**
MR. GILLISPIE: Cris?
COURT REPORTER: Lost you for a second. We heard your question, you do not have a degree in occupational therapy, is that correct; and he said correct.
MR. GILLISPIE: All right.
BY MR. GILLISPIE:
Q Okay. And you also do not have a bachelor's degree

in physical therapy, do you?
A No, I do not.
Q Okay. You're not a psychologist; correct?
A That's correct.
Q And your bachelor's degree is not in psychology?
A No, sir.
Q Okay. And you don't have a bachelor's degree in social work?
A No.
Q You don't have a bachelor's degree in speech language pathology?
A No, I do not.
Q How about audiology?
A No.
Q You don't have a bachelor's degree in recreation such as art, dance, music, or physical education?
A No.
Q And you don't have a degree in diet science? You're not a dietician; correct?
A No.
Q And you said your degree is in history, just regular history?
A Yes. History with a minor in historical interpretation.
Q Okay.

But you were never asked about -- you were never required to have any of these other specific degrees, obviously.

A **No. I think it was -- I don't know. My guess is that -- because this facility doesn't dictate who gets the interview or not. That's determined in Little Rock.**

So I -- I would only be assuming that, since it was educational and maybe my experience -- because they certainly don't just let anyone interview for the position, so. . .

Q Sure. And I'm not suggesting you're not qualified. I'm just trying to determine if the, you know, if the rules were followed or not.

MR. GILLISPIE: So we'll mark this as Exhibit 3.

(WHEREUPON, the document was marked for identification as Exhibit No. 3 and is attached hereto.)

MR. GILLISPIE: So I think this is a good stopping point, Eric.

And then we can find a day to finish up. I probably need about another hour or two.

(WHEREUPON, the proceedings were paused in the matter at 1:14 p.m. and continued at a later date.)

* * * * * * * * *

(WITNESS EXCUSED)

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, CRIS M. BRASUELL, Certified Court Reporter and Notary Public do hereby certify the proceedings which appear in the foregoing pages are the proceedings taken by me verbatim through the use of the voice-writing method and was thereafter reduced to typewritten form under my supervision; that the witness, Justin Jobb, was duly sworn by me; that the foregoing pages contain a true and correct record of the testimony given by said witness held to the best of my ability, along with all items of evidence admitted hereto.

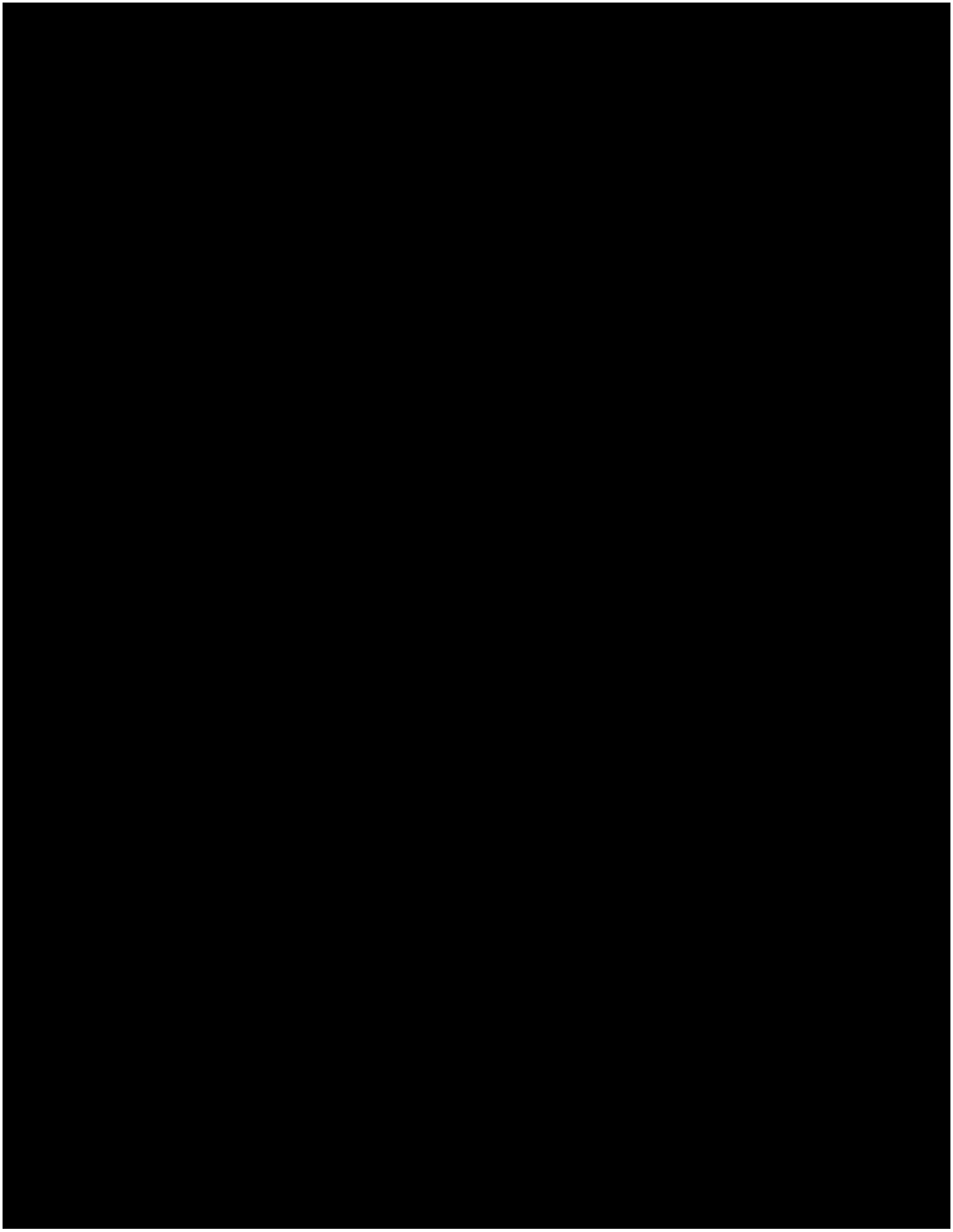
I FURTHER CERTIFY, that I am not a relative or employee of any attorney or employed by the parties hereto, nor financially interested or otherwise, in the outcome of this action, and that I have no contract with any parties within this action that effects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties in the action.

WITNESS MY HAND AND SEAL this 2nd day of May, 2022.

Cris M. Brasuell

CRIS M. BRASUELL, CCR
Arkansas State Supreme Court
Certified Court Reporter No. 742

My Commission Expires:
August 16, 2031



QUALIFIED INTELLECTUAL DISABILITY PROFESSIONAL PROCESS

POLICY STATEMENT: Every client will have an assigned QIDP (Qualified Intellectual Disability Professional), as defined in ICF/IID Regulation 483.430. The Program Coordinator/QIDP has an assigned caseload. They are responsible for chairing the interdisciplinary team and completing Individual Program Plans for clients on their respective caseload.

The Program Coordinator/QIDP monitors the implementation of training objectives and the delivery of services for clients on their assigned caseloads, as determined in each client's IPP. They do on-site observations (tracking) for each of their clients in the living areas and training areas at least once a month. They may also observe their clients in other areas.

The Program Coordinator/QIDP also reviews Monthly Progress Notes and other documentation relevant to each client. They submit Monthly Plan Reviews to summarize information from their observations and their record reviews. Monthly Plan Reviews document monthly observations/tracking and are submitted on a monthly basis. The original Monthly Plan Reviews are filed in the client's master file.

PROCEDURES:

1. PROGRAM COORDINATOR/QIDP ASSIGNMENTS

   a. Each Program Coordinator/QIDP works with an assigned caseload or group of clients. A master list of Program Coordinator/QIDP caseload assignments is maintained on the secure drive.

   b. Each client is assigned a Program Coordinator/QIDP when he/she is admitted to BHDC. Changes in Program Coordinator/QIDP caseload assignments are generally made if a client moves to a different living area, but may be appropriate for other reasons. Team Leaders are responsible for making the caseload assignments.

2. DUTIES AND RESPONSIBILITIES OF PROGRAM COORDINATOR/QIDP

   a. The Program Coordinator/QIDP functions as advocate for the client by assuring he/she receives the maximum benefit of active treatment.

   b. The Program Coordinator/QIDP is chairman of the client's interdisciplinary team. As chairman he/she is responsible for scheduling and conducting 30-day reviews and annual reviews, and for conducting special meetings to discuss various problems or concerns that may occur throughout the year. IPPs are to be completed by the 15th working day after a given 30-day review or annual review. However, an additional requirement is that 30-day IPP's must be completed and distributed within 30 days after admission. Annual review IPP's must be completed and distributed within 365 days after the previous annual review and by the 15th working day following an annual review.



c. The Program Coordinator/QIDP observes actual delivery of services by randomly visiting the living areas, as well as the training areas or work areas each month to observe each client on his/her caseload. These observations, along with any problems noted, are documented on the Monthly Plan Review.

d. If a change of caseload assignment is made, the current Program Coordinator/QIDP completes the documentation for the current month and then forwards that client's file to the new Program Coordinator/QIDP. The majority of the file is available on the secure drive. File information includes the client's IPP and their activity schedule, as well as other information pertaining to that client.

e. The Program Coordinator/QIDP reviews Progress Notes and data posted on the secure drive, monitors progress on objectives, and works with service providers to make any necessary modifications in training objectives and service objectives.

f. The Program Coordinator/QIDP completes the Monthly Plan Reviews, as outlined in the BHDC policy. These reports include documentation of their monthly observations (tracking), follow-up, and/or other significant information. Monthly Plan Reviews for each client are to be completed monthly and are due by the 15th working day after the end of the month.

g. The Program Coordinator/QIDP must guide the interdisciplinary team and assure that team decisions comply with established policies, as well as ICF regulations.

3. INTERNAL REVIEW OF INDIVIDUAL PROGRAM PLANS

Every IPP will be reviewed by Residential Services managerial staff prior to publication/distribution. The reviewer will complete an IPP Proofing Sheet and will include any questions they have, or any corrections that are needed by the Program Coordinator/QIDP. The Program Coordinator/QIDP will make any necessary corrections, post the IPP to the secure drive, and send the original IPP to the master file. A copy with signatures is sent to Social Services for the guardian, with a request for guardian approval or input.

APPROVED: _____
Superintendent

Supersedes Policy III-A-8, dated 10/02/18, in its entirety.

§483.430 Condition of participation: Facility staffing.

(a) Standard: Qualified intellectual disability professional

W159

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who –

Guidance §483.430(a)

The position of qualified intellectual disability professional (QIDP) is unique to the ICF/IID program. This position can be central to the overall responsiveness and effectiveness of an active treatment program. Whether a supervisory or non-supervisory position, the QIDP is responsible to:

- Orchestrate all facets of the active treatment effort, including the IDT creation of relevant IPPs tailored to meet individual client needs;
- Effectively coordinate internal and external program services and supports to facilitate the acquisition of client skills and adaptive behaviors; and
- Promote competent interactions of residential staff with clients in program implementation and behavior management.

Breakdowns in the provision of needed services does not automatically equate with deficient practice with QIDP regulations. Non-compliance with QIDP regulations exist where the facility has failed to provide a QIDP or sufficient numbers of QIDPs to effectively perform these required functions or the QIDP(s) has failed to assertively attempt to integrate, coordinate and/or monitor each client's active treatment program.



Elements of integrating, coordinating and monitoring active treatment programs include:

- Routinely observing clients across settings in program areas to assess effectiveness of program implementation and consistency of training effort to determine effectiveness of IPPs and making timely modifications to facilitate achieving desired skills or goals.

- Routinely interacting with program staff across settings to assist in determining the effectiveness and continued relevance of program plans in meeting identified client needs.

- Determining the need for program revision based on client performance.

- Identifying inconsistencies in training approaches or programs not being implemented as written and facilitating the resolution of these inconsistencies.

- Assures follow-up occurs for any recommendation for services, equipment or programs so that needed services and supplies are provided in a timely manner to meet the client's needs.

The number of QIDPs will vary depending on such factors as the number of clients the facility serves, the complexity of needs manifested by these clients, the number, qualifications and competencies of additional professional staff members, and whether or not other duties are assigned to the QIDP function.

The QIDP function may not be delegated to other employees even though the QIDP co-signs their work.

W160

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(a)(1) Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and

Guidance §483.430(a)(1)

"Experience" means providing professional or direct services, either paid or volunteer, in a setting that serves persons with intellectual disabilities. The experience working directly with persons with intellectual or other developmental disabilities can be obtained prior to or after obtaining the qualifying degree or credentials.

§483.430(a)(2) Is one of the following:

W161

(a)(2)(i) A doctor of medicine osteopathy.

W162

(a)(2)(ii) A registered nurse.

W163

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(a)(2)(iii) An individual who holds at least a bachelor's degree in a professional category specified in paragraph (b)(5) of this section

Guidance §483.430(a)(2)(iii)

The individual must have at least a bachelor's degree in one of the professions listed in §483.430 (b)(5)(i-xi).

(b) Standard: Professional program services

W164

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430 (b)(1) Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.

Guidance §483.430 (b)(1)

The effectiveness of the active treatment effort is dependent on a facility's assembly of a competent team of professional program staff, with knowledge of contemporary care practices in intellectual disabilities specific to their field of expertise, that work cooperatively as members of an IDT. The facility is responsible for the acquisition of professional staff necessary to provide direct and indirect professional services to meet client needs.

Professional program services are those services that meet the needs identified by a client's CFA that must be provided by a member of a vocation founded upon specialized education/training.

Professional staff services also include on-going monitoring of the effectiveness of programs and plans developed by professional staff but implemented by non -professional staff.

Indirect professional staff services also include on-going, technical support to staff implementing these programs as well as timely assessment of the need for modification of the program with appropriate communication to the QIDP and IDT.

The needs identified in the initial CFA, as required in §483.440(c)(3)(v), should guide the team in deciding if a particular professional's involvement is necessary and, if so, to what extent professional involvement must continue on a direct or indirect basis.

Since such needed professional expertise may fall within the purview of multiple professional disciplines, based on overlapping training and experience, determine if the facility's delivery of professional services is adequate by the extent to which clients' needs are aggressively and competently addressed. Some examples in which professional expertise may overlap include, but are not limited to:

- Physical development and health: nurse, dietitian, pharmacist.

- Nutritional status: nurse, nutritionist or dietitian.

- Sensorimotor development: educators, recreation therapists, and occupational therapist, physical therapist.

- Affective (emotional) development: special educators, social workers, psychologists, psychiatrists, mental health counselors, rehabilitation counselors, behavior therapists, behavior management specialists, behavior analyst, and medical staff.

- Speech and language (communication) development: speech-language pathologists, special educators for people who are deaf or hearing impaired, and medical staff.

- Auditory functioning: audiologists (basic or comprehensive audiologic assessment and use of amplification equipment); speech-language pathologists (like audiologists, may perform aural rehabilitation); special educators for clients who are hearing impaired and medical staff.

- Cognitive development: teachers (if required by law, e.g., school aged children, or if pursuit of GED is indicated), behavior analysts, psychologists, speech-language pathologists.

- Vocational development: occupational therapists, vocational rehabilitation counselors, or other work specialists (if development of specific vocational skills or work placement is indicated).

- Social Development: teachers, professional recreation staff, social workers, behavior analysts, psychologists (specialized training needs for social skill development).

Adaptive behaviors or independent living skills: special educators, occupational therapists, behavior analysts, and medical staff.

W165

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(1) Professional program staff must work directly with clients

Guidance §483.430(b)(1)

Examples of professional staff working directly with clients include: performing professional assessments of clients, provision of direct support and services and periodic monitoring by the professional of the client working on the program. The amount and degree of direct care that professionals must provide will depend on the needs of the client and the ability of other staff to effectively work with clients on a day-to-day basis.

For those services that must be provided by a professional due to either law, licensure or registration, the client receives the services directly from the professional. Professionals may deliver services through the supervision and direction of subordinates where provided by law.

W166

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(1) and with paraprofessional, nonprofessional and other professional program staff who work with clients.

Guidance §483.430(b)(1)

Paraprofessionals are persons in various occupational fields who are trained to assist professionals but are themselves not licensed at the professional level.

Examples of "working with" these other staff may include, but not be limited to:

- Modeling the correct technique for interacting with clients or implementing a specific program objective.

- Designing residential activity programs and teaching staff how to implement them.
- Conducting classes on discipline specific topics.
- Answering questions of staff related to program implementation or specific behavioral management issues.
- Monitoring active treatment areas to identify program implementation or staff-client interaction issues.

W167

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(2) The facility must have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

Guidance §483.430(b)(2)

There should be sufficient professional staff in the facility to ensure that:

- needed assessments by professionals are completed timely;
- direct professional services are provided when indicated;
- clients are receiving interventions as specified in the IPP;
- client outcomes are being monitored by the professional;
- assessments and outcomes are being communicated to the IDT; and
- professional staff are available to consult with team members when needed.

W168

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(3) Professional program staff must participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

Guidance §483.430(b)(3)

When a professional does an assessment and determines there are client needs which become incorporated into the IPP, with a current prioritized objective, the professional should actively participate on the IDT. This participation may be through written reports or verbally while attending the IPP meeting or participating via telephone or other electronic means, to provide team members with the opportunity to review and discuss information and recommendations relevant to the client's needs, and to reach decisions as a team, rather than individually, on how best to address those needs.

W169

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(4) Professional program staff must participate in on-going staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

Guidance §483.430(b)(4)

Professional program staff provides various types of training to staff as indicated by the IPP and IDT.

Formal training: a specific training done at the time a program is implemented or updated by the professional, with all staff who works with the client.

Informal training: when the professional observes the staff not correctly implementing a program, the professional provides informal guidance on correct implementation.

Training on programs that apply to multiple clients: when a particular program applies to several clients in a facility, a professional may provide training to several staff on a particular topic that applies to multiple clients (such as safe transfer techniques).

Professional staff of the facility should participate in ongoing training such as conferences and workshops to maintain current standards of practice in the field of intellectual and developmental disabilities as required by their professional licensure or certification.

W170

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5) Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. Those professional program staff who do not fall under the jurisdiction of State licensure, certification, or registration requirements, specified in §483.410(b), must meet the following qualifications:

W171

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(i) To be designated as an occupational therapist, an individual must be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

Guidance §483.430(b)(5)(i)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

The American Occupational Therapy Association is now known as the National Board for Certified Occupational Therapists (NBCOT). There is no "other comparable body."

Eligibility means the professional must have completed a degree in their designated field,

completed all field work required for a license, must meet licensure requirements in the state they are practicing in, and are registered or certified nationally as applicable.

W172

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(ii) To be designated as an occupational therapy assistant, an individual must be eligible for certification as a certified occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

Guidance §483.430(b)(5)(ii)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

The American Occupational Therapy Association is now known as the National Board for Certified Occupational Therapists (NBCOT). There is no "other comparable body."

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in state they are practicing in, and are registered or certified nationally as applicable.

W173

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(iii) To be designated as a physical therapist, an individual must be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

Guidance §483.430(b)(5)(iii)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated filed and are eligible to sit for the national exam.

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in state they are practicing in, and are registered or certified nationally as applicable.

W174

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(iv) To be designated as a physical therapy assistant, an individual must be eligible for registration by the American Physical Therapy Association or be a graduate of a two year college-level program approved by the American Physical Therapy Association or another comparable body.

Guidance §483.430(b)(5)(iv)

If a professional is not nationally certified, they would have to show evidence they completed the degree and field work in their designated filed and are eligible to sit for the national exam.

Eligibility means the professional must have completed a degree in their designated field, completed all field work required for a license, must meet licensure requirements in State they are practicing in, and are registered or certified nationally as applicable.

W175

§483.430(b)(5)(v) To be designated as a psychologist, an individual must have at least a master's degree in psychology from an accredited school.

§483.430(b)(5)(vi) To be designated as a social worker, an individual must--

W176

§483.430(b)(5)(vi)(A) Hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body; or

§483.430(b)(5)(vi)(B) Hold a Bachelor of Social Work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

§483.430(b)(5)(vii) To be designated as a speech-language pathologist or audiologist, an individual must--

W177

§483.430(b)(5)(vii)(A) Be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language-Hearing Association or another comparable body; or

§483.430(b)(5)(vii)(B) Meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

W178

§483.430(b)(5)(viii) To be designated as a professional recreation staff member an individual must have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

W179

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(ix) To be designated as a professional dietitian, an individual must be eligible for registration by the American Dietetics Association.

Guidance §483.430(b)(5)(ix)

If a professional is not nationally registered as a dietician, they would have to show evidence they completed the degree and field work in their designated field and are eligible to sit for the national exam.

W180

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(x) To be designated as a human services professional an individual must have at least a bachelor's degree in a human services field (including, but not limited to: sociology, special education, rehabilitation counseling, and psychology).

Guidance §483.430(b)(5)(x)

Human Services is a diverse field focused on improving the quality of life of clients in communities in which the professional serves. A human services professional works directly with the population being served. Surveyors should see evidence that a human service professional has a bachelor's degree at a minimum.

W181

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(b)(5)(xi) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of paragraph (b)(5)(i) through (x) of this section are not required-

(A) Except for qualified intellectual disability professionals;

(B) Except for the requirements of paragraph (b)(2) of this section concerning the facility's provision of enough qualified professional program staff; and

(C) Unless otherwise specified by State licensure and certification requirements.

Guidance §483.430(b)(5)(xi)

An individual client program may not require that professional staff perform all of the services as outlined by the IPP (e.g. the direct support staff may be trained by the professional to safely and effectively carry out the designed program), however, any specialized therapy must involve evaluation, program development, and re-assessment by the appropriate professional at periodic intervals.

(c) Standard: Facility staffing

W182

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(c)(1) The facility must not depend upon clients or volunteers to perform direct care services for the facility.

Guidance §483.430(c)(1)

The facility must have sufficient staff to provide needed care and services without the use of volunteers or enlisting the help of clients residing in the facility to perform the duties normally performed by facility staff.

The facility may not rely on volunteers in lieu of paid staff to fill required staff positions and perform direct care services. Volunteers are permissible, but must be in addition to the number of paid staff required to carry out a function. Volunteers should have an orientation to the policies and procedures of the facility and oversight is required by facility staff.

W183

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

AVOIDING / DEFUSING VIOLENT BEHAVIORS

Employees are reminded that we must continue to strive to calm upset individuals without injury or damage. The following steps may help defuse or avoid violent behaviors:

1. Know the individual.
2. Breathe slowly and deeply to relax
3. Try to appear calm and relaxed before intervening- even if you are not.
4. Speak slowly and softly, keeping voice low at all times.
5. **Listen.**
6. Keep hands at sides with palms open in a reassuring stance. Do not trap or corner the angry person. Do not double your fist, point your finger, cross your arms, put your hands on your hips, in your pockets, or behind your back.
7. Judge the distance you keep by your knowledge of the individual and your rapport with him/her; allow both of you space and room to escape.
8. Stand if he/she stands; sit if he/she sits. Squat or sit down if the individual is in a wheelchair.
9. Do not ask "Why." Do not argue, threaten, raise your voice, or become judgmental.
10. **Listen.**
11. Let the individual know you are there to help in any way you can, but do not make promises you cannot keep.
12. Keep your face passive and neutral – do not frown, scowl, or laugh.
13. Reassure the individual that you are there to help and you will wait with him/her until he/she works through whatever is bothering them. Let them express his/her fears, frustrations, and accusations without censor.
14. Stay relaxed, keep a monitor on your voice tone, body stance, muscle tension, and breathing so that you present yourself as a source of stability and model of how to remain calm.
15. **Listen.**

NONVIOLENT CRISIS INTERVENTION TRAINING PROGRAM OBJECTIVES (NCI)

Identify behavior levels that contribute to the development of a crisis and choose appropriate staff intervention for each level. This program is used to provide guidance to the acting out individual and the employees that are dealing with de-escalating the behavior.

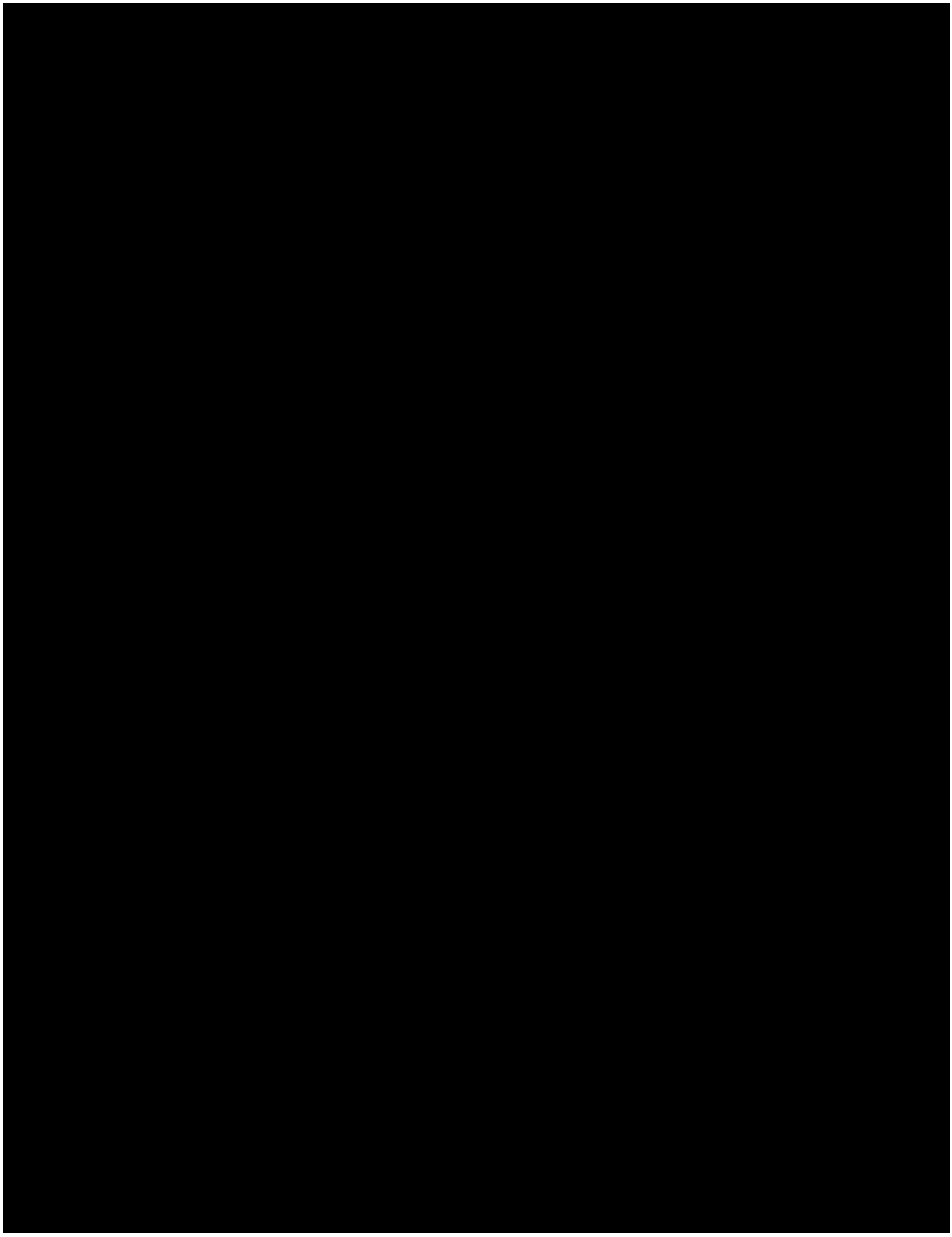
When writing a Behavior Report, be careful not to include any of your personal feelings (opinions) about the incident or behavior. Instead, always rely on the Five 'Ws'- *Who, What, Where, When, and Why.*

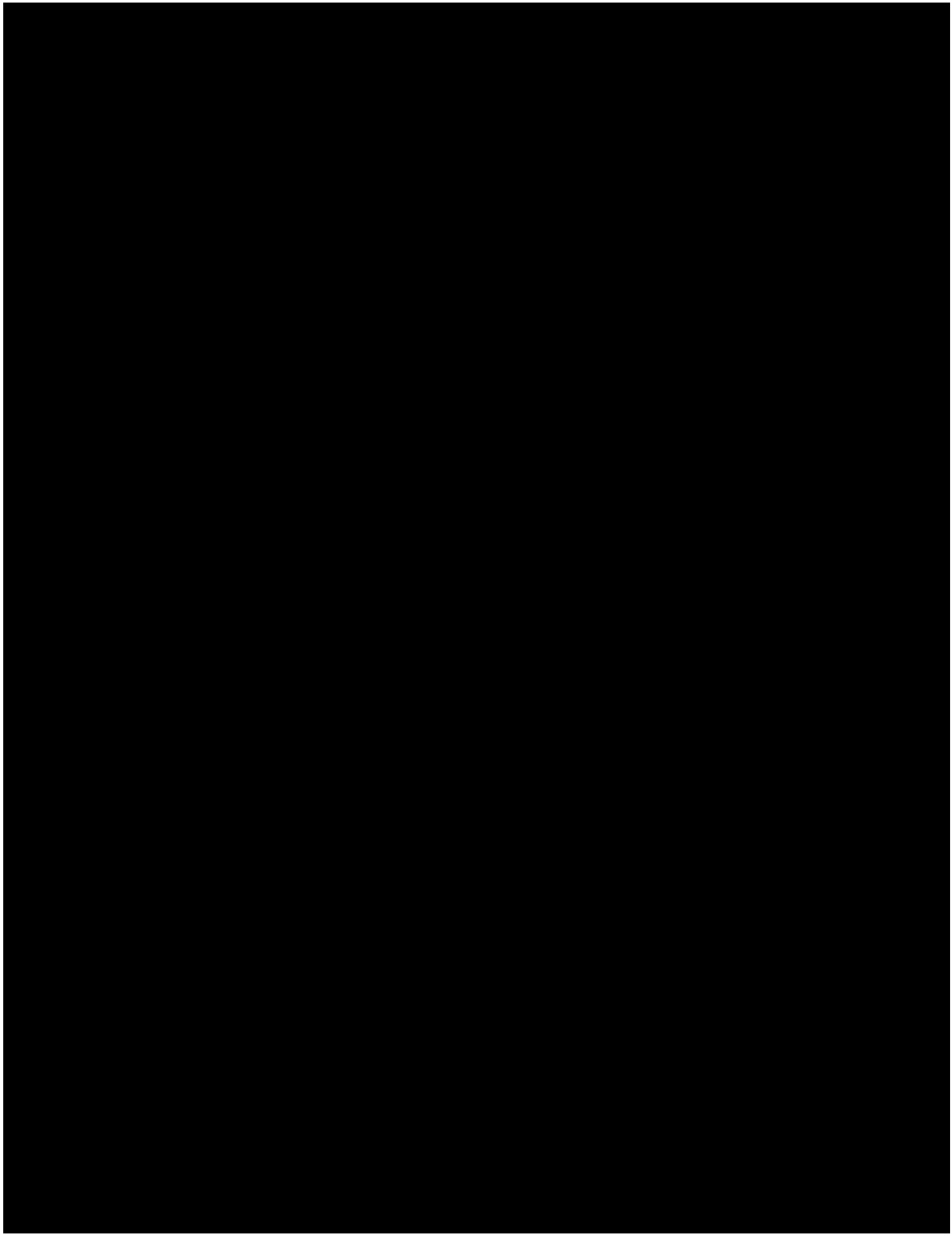
PREVENTION / REPORTING OF MALTREATMENT

BHDC strictly prohibits the maltreatment of clients residing at this facility. Maltreatment is defined as:

- Physical abuse or assault.
- Psychological abuse.
- Verbal abuse.
- Negligence.
- Failure to provide necessary care.
- Exploitation or sexual abuse.
- Misappropriation of personal property or moving furniture or belongings without permission.







5. The client's suitcase is to be examined for bed bugs. If any evidence of bugs are found, it is to be bagged immediately after the clothes are emptied out of it. Contact Custodial so they can spray the suitcase and then re-bag it.

6. All clothes that were taken LOA, and any other possessions he/she brings back with them, are to be placed in the dryer in the living area on high for 60 minutes (i.e. shoes, stuffed animals, books, etc.) Do not overload the dryer or the clothes will not reach the proper temperature. When placing the clothes in the dryer, take them directly from the bag and directly into the dryer, **DO NOT SHAKE THEM!**

7. Examine client's body for evidence of bed bug bites, document, and notify Medical if any bites are found so client can be treated accordingly.

Choking Protocol for a Choking Client

Purpose: To provide guidelines to all staff for client care and evaluations in the event a client has a choking episode.

In the event a client has a choking episode the following steps are to be taken:

1. All choking events will be documented on a Choking Event Data Collection form. These forms will be available in the Food Service Secretary's office, LPN office, as well as in all living areas and training areas.

2. After the client has received care, the staff member witnessing the choking event will immediately take the client with the form to Medical to be evaluated by the LPN. (Forms will be available with LPN if necessary). The staff member that witnessed the choking event will inform the LPN the details of the choking event and complete the first (1st) portion of the **Choking Event Data Collection Form.** If client is **not** able to come to Medical or in the case of an emergency, call for Medical Assistance, Medical Emergency phone # 1422. **After the choking event, the client will be placed on supervision and be monitored during mealtimes/snack times until all observations/evaluations are completed (Dietary Supervision/Monitoring Choking Event – page 4 of 5)** The QIDP and ROM (Residential Operations Manager) will be notified for the need of supervision of the client.

3. The LPN will assess the client, fill out the second (2nd) section of the Choking Event Data Collection form labeled "Nursing Evaluation", notify the Clinic RN, and send the client and all related documentation to the Clinic RN. If Client is in distress and exhibits symptoms of medical discomfort related to the choking event the physician will be notified. The Physician will be given all pertinent information and will make the determination whether immediate medical care is necessary. The LPN will notify **(ROM, QIDP, Dietary, Team Leader, Team Secretary, Living Area Supervisor, Social Service, & Team RN)** by email to insure all direct care personnel on all shifts are aware of the choking event, the need for Dietary Supervision, to provide continuity of care.

4. The LPN will also initiate and generate the Dietary Supervision/Monitoring Sheet which will be used for client until all evaluations/recommendations are completed. The Dietary Supervision/Monitoring Sheet will be initiated by the LPN and given to the Direct Care Staff

member returning with the Client to their living area. The Choking event will be documented in the living area communication log for staff information and need for monitoring when eating. Monitoring of the client while eating will continue until informed by Nurse Manager or Team RN that Dietary Monitoring is no longer necessary. **The LPN will forward the Choking Event Form to the Clinic RN and will leave the Dietary Supervision/Monitoring Sheet in the Living Area to be completed at each meal.**

CHOKING / ABDOMINAL THRUST

1. If a **choking person** is **coughing forcefully**, let him or her try to cough up the object. A person who is getting enough air to cough or speak should be observed. If they continue to cough, call the Emergency Medical Phone, Ext. **1422.**
2. A person who cannot speak, cough, or breath **IS CHOKING**. Give quick upward thrusts to the abdomen, just above the navel, until airway is cleared. Instruct someone to call the Emergency Medical Phone, Ext. **1422**.

CARDIO PULMONARY RESUSCITATION (CPR)

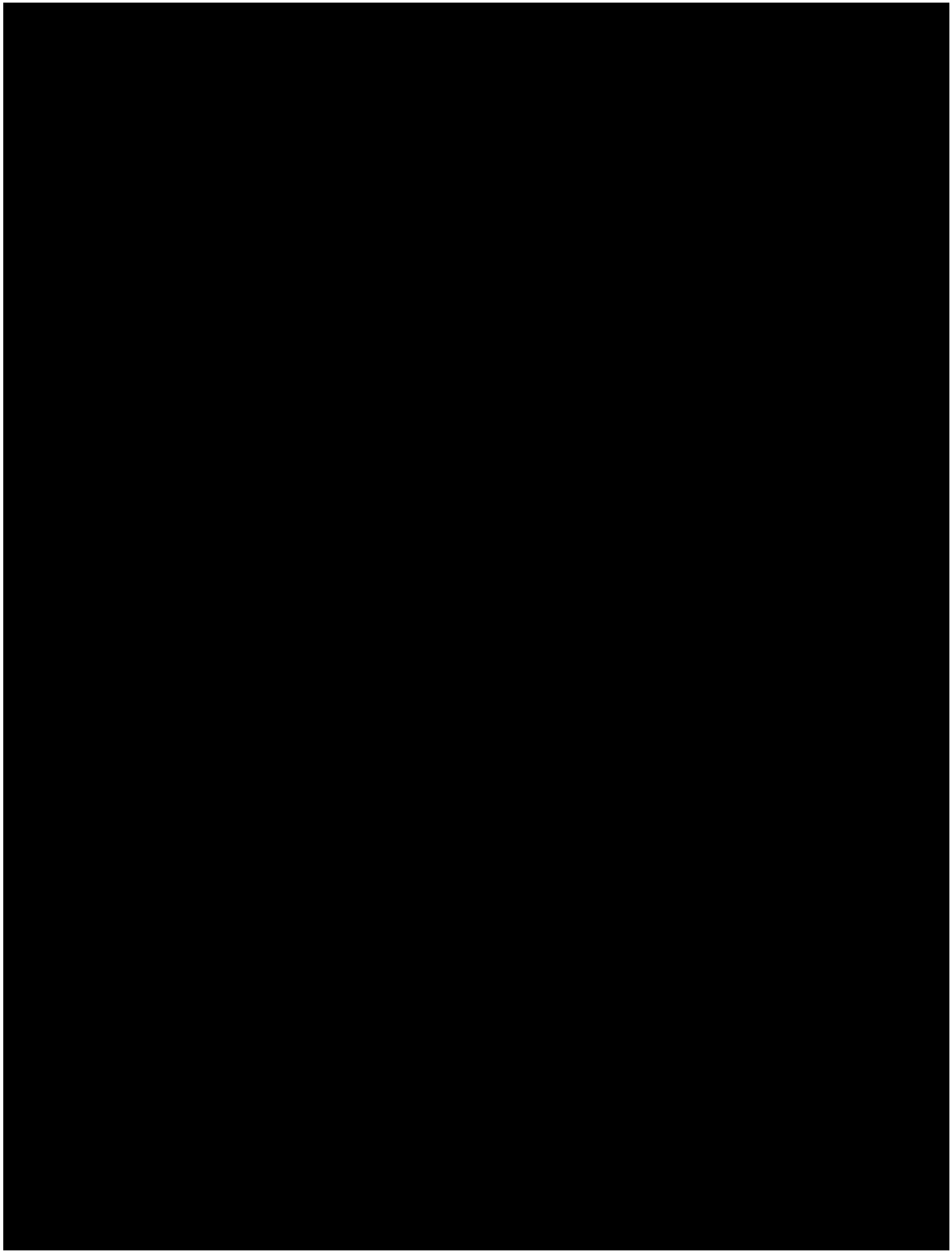
1. When you arrive at the scene, be sure it is safe to go to the victim. As you walk towards the victim, try to look for signs of the cause of the problem.

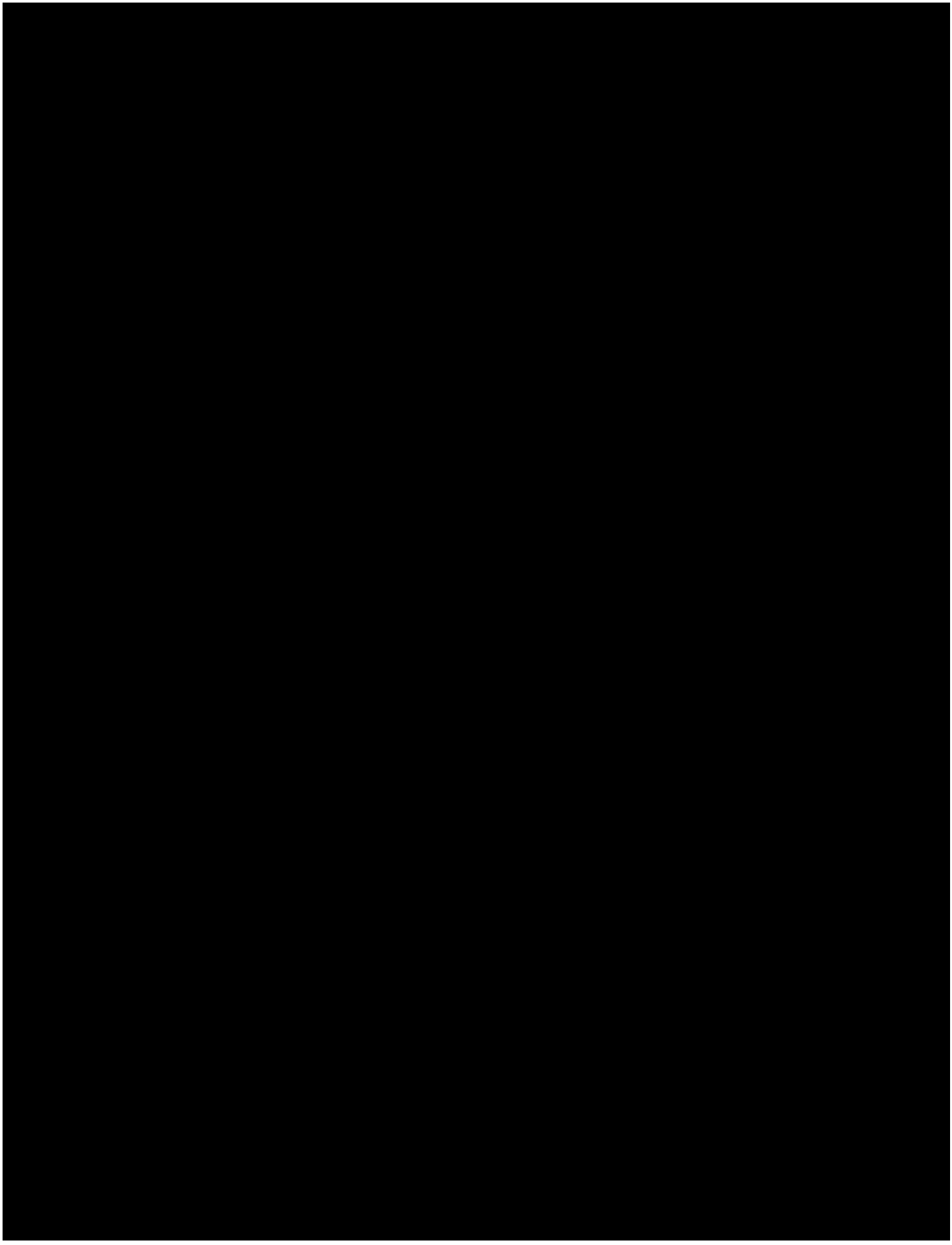
2. Check whether the victim's responsive. Shake the victim firmly and shout "Are you OK?"



3. If victim is unresponsive then you must call for help. Call 911 if the victim is a fellow staff member and if the victim is an individual/client/resident you must first phone the **BHDC Medical Only Emergency # 1422.** If there are other staff members present have them make the call- if you are alone make the call yourself and return to the victim's side.

Remember "CAB'!
Compressions
-AIRWAY –
BREATHING!!!





USE AND DOCUMENTATION OF PROCEDURES TO MANAGE BEHAVIOR

POLICY STATEMENT: The Booneville Human Development Center (BHDC) is an environment that projects an atmosphere of normalization. The most important factor of this program is teaching the clients to accept responsibility for his/her actions using positive, non-aversive techniques whenever possible. Behavior control by dictates, mandates, and coercion is not conducive to helping people learn to make more responsible decisions. It is the responsibility of the staff to set forth a program wherein the client has an opportunity to make decisions for himself/herself. All Booneville HDC staff have the responsibility of being that type of example; whereby the clients can reflect upon and learn through observation. The use and documentation of disciplinary procedures will comply with all relevant ICF/IID regulations and DDS Policy #3011-D.

PROCEDURES:

1. All staff should use positive nonaversive techniques in dealing with client behaviors. When positive, nonaversive techniques fail to produce the desired effect, alternate methods defined in Category I of DDS policy 3011-D may be used:

2. Category I procedures are those which may be used without prior approval of the Human Rights Committee or psychology staff. Frequent use (as determined by Interdisciplinary Team (IDT) of these procedures with a client indicates the need for consideration of the development of a behavior plan by the client's IDT.

   The client must be supervised during these procedures. With the exception of verbal intervention, any use of Category I procedures, whether part of a formal behavior program or not, requires documentation on a Behavior Report, Data Sheet, or other locally used behavior documentation system.

   a. Verbal Intervention: Verbal intervention is utilized to stop an inappropriate behavior in progress and involves telling the client "no" or "stop", identifying the behavior, and redirecting to an appropriate activity. The command is given in a firm but normal tone of voice. Threats, screaming, yelling or issuing repetitive or multiple sets of commands are not considered verbal correction and are inappropriate.

   b. Separation from Activity up To 30 Minutes: The client is prevented from engaging in a reinforcing activity in which he/she has displayed inappropriate behavior. Separation is maintained within the same room or outdoor area where the activity is conducted. This is considered a Category I procedure if compliance by the client can be accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

   c. Separation from Setting up To 30 Minutes: The client is removed from the area where the reinforcing activity is taking place. Separation must occur under observation either outdoors or in a living or training area (bathrooms, storage rooms

and closets do not constitute living/training areas). This is considered a Category I procedure if compliance by the client can be accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

Note: Separation to Allow Calming (STAC) - Also available is the positive procedure of STAC whereby the client is encouraged to move to an area away from the person or situation that upset him/her. At the same time, they are assisted in directing their attention to talking about the problem, listening to music, talking about family, relaxing quietly, going for a walk, etc. The activity should be chosen by the client in need of calming. When sufficiently calm, staff will assist the client in resuming normal activities.

d. Assignment of Additional Chores: The client is assigned additional chores as a consequence for inappropriate behavior. Additional chores may be assigned only if such chores are already a part of the Individual Program Plan (IPP) and are not designed to replace work assignments of housekeeping personnel.

e. Restitution: The client is cued to restore any property damaged, stolen or defaced. If appropriate to the client's level of functioning, he/she may be cued to offer a verbal apology to the offended person. If appropriate to the client's ability to comprehend, monetary reimbursement for the value of the damaged or stolen property may be required if this is a part of the IPP. In lieu of full value, a symbolic portion of the value may be required. Monetary reimbursement requires Human Rights Committee approval and Guardian consent.

Note: The client is not degraded nor put on display while restoring damage. The client is given the same equipment and protection to complete the restitution as would normally be given to a person not responsible for the damage.

f. Withholding Privileges: The client loses a particular privilege following the occurrence of an inappropriate behavior. Privileges include such things as cookouts, going to the recreation room, or on site fishing. Trips off grounds are special and should only be curtailed if problem behavior is anticipated during that trip. Examples of situations where problem behaviors may be anticipated include a problem behavior having already occurred and the person is not fully calm or a problem behavior has not yet occurred, but there are indications that a problem behavior is likely. The curtailing of trips off grounds should be done only after consultation with Psychology Staff or the Program Supervisor if Psychology Staff is not available. Privileges do not include basic living activities, such as meals, habilitation activities, or basic rights afforded all clients.

g. Personal Property Removal (less than one hour): Removal of a client's personal item that is being used in an inappropriate or unsafe manner or location. For example, if a client disturbs others in a common TV room by playing his radio too loudly and will not reduce the volume when instructed, the radio may be removed from that client for

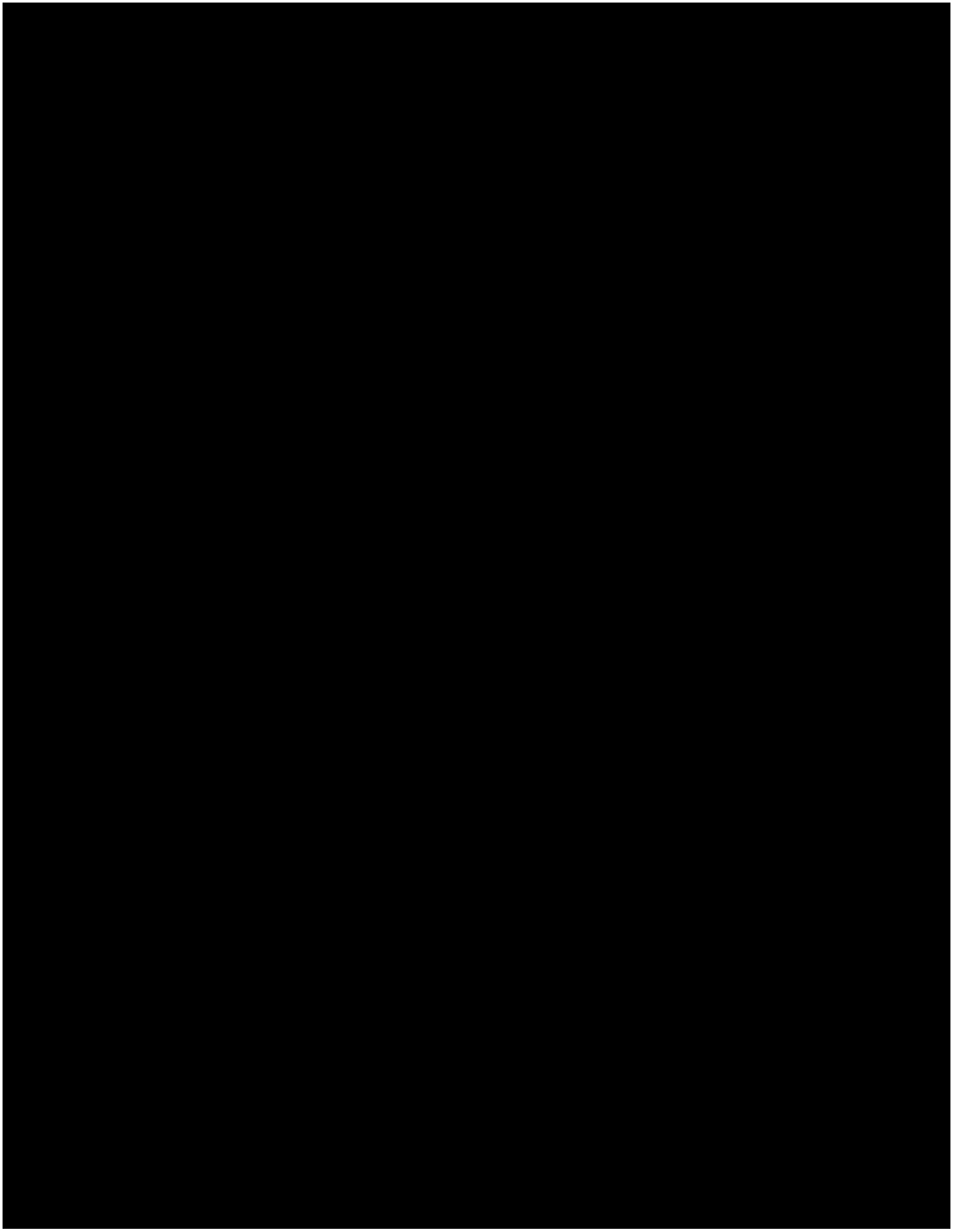
a time not to exceed one hour. The item will be held in a secure area and will be returned to the client's room or to the client directly, as appropriate (See Section 6, Page 8 of 9, DDS 3011-D).

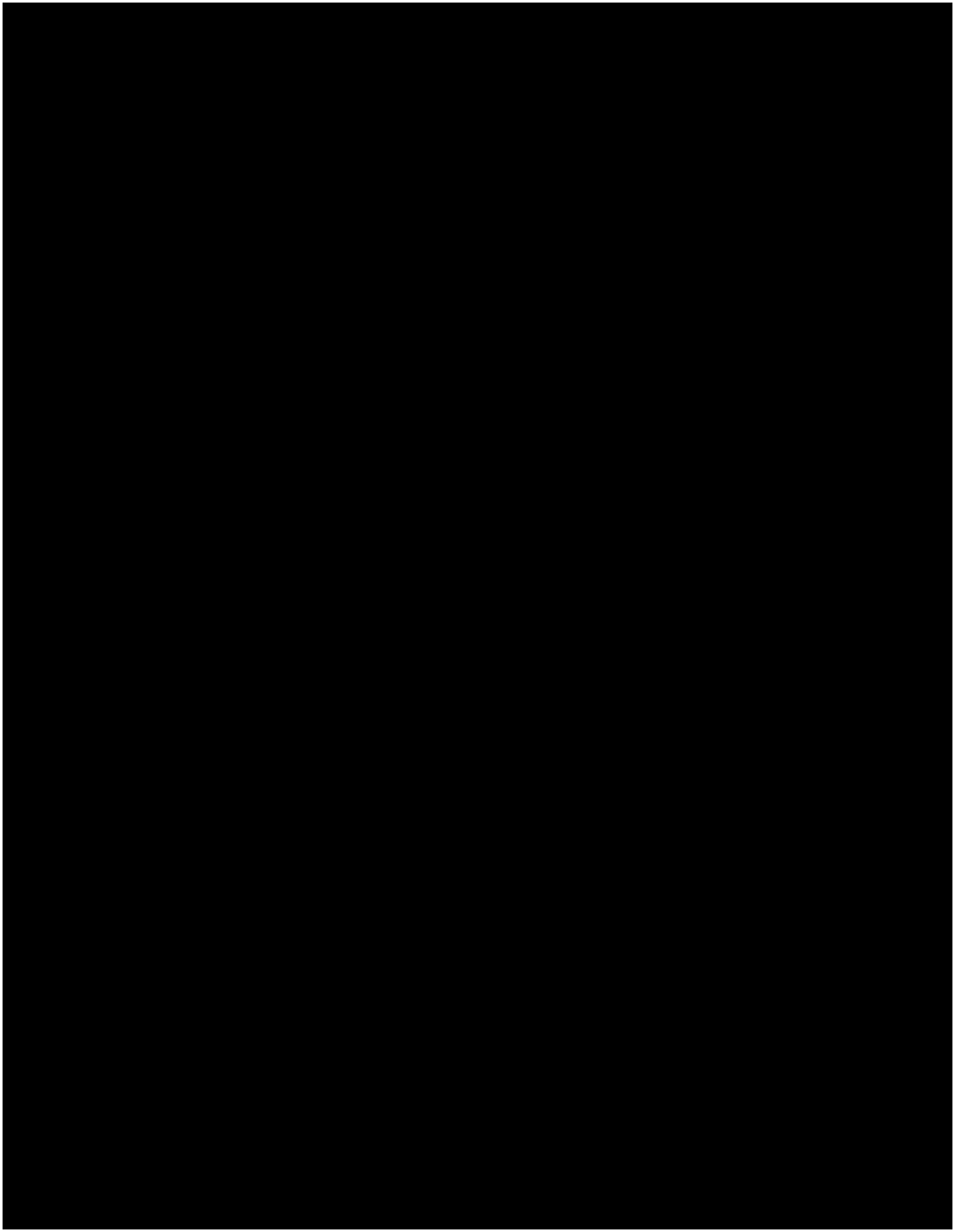
3. If the above measures are needed for dealing with a client on a frequent basis, then the IDT will review the behaviors to determine whether a written behavior modification program is required.

4. A Behavior Report or BTP data sheet (if applicable) shall be completed immediately following any incident in which a procedure except verbal reprimand was applied.

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-D-2, dated 12/10/15, in its entirety.





Consultant Report:
A Review of Restraint Use in Five Arkansas Human Development Centers

A report commissioned by Arkansas DDS based on recommendations of the DDS Behavioral Consultation Committee

Theodore A. Kastner, MD, MS
Kevin K. Walsh, Ph.D.
Robert Bowen

September, 2022

Consultant Report:
A Review of Restraint Use in Five Arkansas Human Development Centers

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Consultant Report:
A Review of Restraint Use in Five Arkansas Human Development Centers

INTRODUCTION

Beginning in 2016 the Arkansas Division of Developmental Disabilities Services (DDS) launched an examination of restraint use in the state's five Human Development Centers (HDCs). A committee "set out in the fall of 2020 to conduct a thorough review of restraint practices at the state's five human development centers" (Committee Report 2021). The committee was known as the *DDS Behavioral Consultation Committee* (hereafter referred to as the Committee). The purpose of the Committee was to:

> "…conduct a thorough review of the restraint practices at the state's five human development centers and develop a comprehensive approach with the help of clinicians and advocates to significantly reduce the use of restraints on developmental and intellectually disabled clients living at the HDCs."

In May 2021 the committee released a report that identified a number of objectives for DDS with regard to the use of restraints in HDCs. These objectives were as follows:

> **Objective 1:** Develop a plan to better use data to inform restraint-related practices and to ensure the State has accurate and comprehensive restraint data.
>
> **Objective 2:** Identify preferred restraint and communication options to be used while working to reduce restraints.
>
> **Objective 3:** Develop a comprehensive approach to reducing restraint usage.
>
> **Objective 4:** Seek and implement additional recommendations from external advocates.

In its May 2021 report, the Committee identified a total of 26 specific recommendations. The report was subsequently revised in April 2022 and now contains 27 specific recommendations. Three recommendations were ultimately rejected by the Committee. Action on six recommendations was deferred and subjected to a review by outside consultants. DDS, in collaboration with various stakeholders, is in the process of implementing the remaining 18 recommendations.

The six specific recommendations placed on hold pending further consultant review, under each of the four Committee objectives, included:

> **Objective 1**: No recommendations placed on hold.

Objective 2:

- Expand communication strategy options for individual clients being restrained, including adding sign language, gestures, timers, visual schedules, etc.
- Create, implement, and train staff on new manual of available communication strategies and devices for case managers to ensure interdisciplinary teams have access to current, effective practices.
- Provide supplemental training to all client-facing staff on effective communication strategies.
- Ban the use of the papoose board.

Objective 3:

- Identify behavioral health service gaps for individual clients at each HDC, what is needed to address those gaps, and metrics to evaluate mental health and service needs,
- Establish a group to review all behavioral support plans to ensure removal of restraint-specific language.

Objective 4: No recommendations placed on hold.

The Committee's recommendations included the engagement of independent experts "to review restraint-related practices and processes across all five of the human development centers" (Committee Report, 2021). The Committee also recommended that the experts review the six recommendations which had been placed on hold.

> "Many recommendations outlined in this report summary are listed as "on hold" because DHS is in the process of hiring an independent expert to review restraint related policies and processes across all five of the human development centers. The review should provide us important information we can use to address the recommendations that are on hold" (Committee Report, 2021).

Our present report describes the engagement and findings of independent behavior experts retained for the purpose of implementing the recommendations of the Behavior Committee. This report also addresses those six recommendations that were placed on hold.

CONSULTATION OVERVIEW

1. Purpose and Definitions

Purpose. The purpose of the consultation was to systematically review restraint usage and practices at five public-operated Human Developmental Centers (HDCs) including Arkadelphia, Booneville, Conway, Jonesboro and SEAHDC (Warren). Consultants reviewed the use of restraints in order to make recommendations for alternatives as needed. This consultation relied on restraint use data collected and aggregated by the Division of Developmental Disabilities Services (DDS) and data provided by each of the five HDCs. This project did not independently assess the quality (i.e., validity) of the data collected and reported by each HDC.

Definition of Restraint. Throughout this document the term "physical restraint" is defined as any manual method, or physical or mechanical device, that the individual cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body. According to regulations, the following definitions are used herein.

"Personal restraints" are a type of physical restraint and refer to the actual physical holding of a client by staff using manual methods that restrict the free movement of the client or restrict movement of or access to a portion or portions of the client's body.

"Mechanical restraints" are devices that restrict the free movement of a client or restrict movement of, or access to, a portion or portions of the client's body. Excluded are physical guidance and prompting techniques of brief duration and mechanical supports as defined in ICF/IID guidelines [§483.440(c)(6)(iv)] relating to providing position or support to an individual. This consultation did not review the use of psychotropic medication or chemical restraints.

2. Consultation Methodology

In order to minimize the risk of Covid transmission to DDS staff members and individuals residing in HDCs, the project was performed remotely using Microsoft Teams and through digitally shared data and documents. The methodology included the following:

1. Initial Meeting: The consultants met with the DDS Director and the DDS Executive Staff to discuss specifics of the data collection process and schedule of meetings with personnel at each HDC. DDS approved the final schedule for the duration of the consultation (see below).
2. Pre-Interview Material Review: Using Medicaid ICF/IID Appendix J regulations on restraint as a source document, the consultants created a data gathering protocol and tool for use at each HDC. The protocol provided guidelines for collecting standardized information set from HDCs as well as standardized interview questions. The scope of the consultation was expanded to include personal control techniques (PCTs) known within DDS as "personal restraints." Review of materials included:
    - Policy and Procedures
    - Restraint Use Types
    - Compliance with Active Treatment Parameters

- Training Programs
- Review and Oversight Mechanisms
- Data Collection and Communication

3. Pre-interview Data Review: Consultants collected raw and/or aggregated data from each HDC for all types of restraint use from 2018 onward.
4. Additional Material Collection: Consultants also collected oversight committee notes, minutes, and deliberations in order to ensure integrity of HDC oversight and review processes. This included the following:
    - Examination of training materials, incident reports, policies and procedures.
    - Examination of notes of Human Rights Committees, Behavior Management Committees and the DDS Behavioral Consultation Committee.
5. HDC Staff Interviews: The consultants gathered information about current practice at each HDC using a standardized protocol/tool as well as using it during interviews via remote meeting technology with the following personnel:
    - Superintendent and/or designee
    - Training Manager
    - Quality Management Manager
    - Clinical Services Administrator
    - Other relevant personnel involved in restraint review process

    DDS staff provided consultants with summary reports and other data as determined during the HDC staff interviews.
6. Compile Information and Interview Responses: Consultants aggregated and analyzed data provided by HDCs and DDS.
7. Submit Report of Findings and Recommendations: Within sixty (60) days of the completion of the final interview, consultants provided DDS a report of findings and recommendations.
8. Follow-up Meeting With DDS: Within thirty (30) days of the submission of the findings and recommendations reports, consultants will participate in one or more meetings with DDS Executive staff to discuss and answer questions about the report.
9. Follow-up Meeting With Each HDC: Consultant will participate in a follow-up meeting with each HDC to assist in finalizing the implementation of any plans developed based upon the consultant's recommendations.

3. Consultation Timeline

The timeline for the consultation was adopted and is shown in Table 1 following:

Table 1. Arkansas Behavioral Consultation Estimated Timeline

	Activity	Completion Date
1	Initial Meeting	3/1/2022
2	Pre-Tour Material Review	4/1/2022
3	Pre-Interview Data Review	4/1/2022
4	Additional Materials Review	4/1/2022
5	HDC Staff Interviews	5/15/2022
6	Compilation of Responses and Data Analysis	7/1/2022
7	Report Submission	9/1/2022
8	Follow-up with DDS	10/1/2022
9	Follow-up with HDCs	11/15/2022

4. Consultant Team

The authors of this report were engaged as a team to carry out this independent review of restraint practices in the HDCs. The consultants are: Theodore A. Kastner, MD, MS; Robert Bowen; and Kevin K. Walsh, PhD. Drs. Kastner and Walsh are familiar with Arkansas DDS and the five HDCs having carried out several contracted behavioral consultations and staff training activities in all five HDCs. Mr. Bowen is a behavioral consultant and trainer with over 40 years' experience in the United States, Canada, and Australia. He was the CEO of a company that taught the prevention and, if needed, use of restraint for 13 years and has provided expert witness reports on the inappropriate use of restraint in the state of Victoria in Australia and the state of Iowa in the US. He is a published author and an internationally-known presenter. Mr. Bowen has been a university professor, and has held several advocacy and professional positions in the field of disabilities. Full listings of the consultants' experience and qualifications relative to this project are shown in **Appendix A.**

5. The Report

In this report we present our finding from the current phase of our review of restraint practices in the five Arkansas HDCs. The contents of this report center around three main activities undertaken to understand and characterize the use of restraints in the HDCs. First, we collected general information pertaining to standing policy and procedures and related them to Medicaid regulations. Second, we collected information from key staff at each HDC consisting of responses to a comprehensive questionnaire/survey document followed up by individual interviews of key staff members at each facility. Third, we collected recent use and outcome data on personal and mechanical restraints in each HDC, subjected them to secondary analyses and report the results herein.

METHOD

1. Information and Data Collection

In February, 2022 a standardized information and data request was sent to each of the five DDS HDCs requesting the following:

- A standardized set of contact and other information and specific data items pertaining to the use of restraints at HDCs
- A standard memorandum providing instructions and time frames on what and how to submit information and data to our team
- A standard *Interview and Questions for Teams* document was used in two ways: first, the document was completed in a group context by selected personnel from each HDC and, second, the group-completed form was used as a basis for individual interviews with six key HDC staff members. The six key staff members from each HDC were designated as follows:

    1. Superintendent and/or designee for this project
    2. Director of Training or Training Manager
    3. Director of Quality Management or QA Manager
    4. Clinical Services Administrator
    5. Restraint Review Committee Chair
    6. Staff Psychologists (for those residents who have been restrained)

All information documents and data files were transferred to a member of our team via email by "data transfer managers" at each HDC.[1] The following list designates the specific materials that had been requested.

1. HDC Staff Member Listing and contact information for the six key HDC staff
2. A resident listing with descriptive information
3. Restraint policies, procedures and reports
4. Restraint training materials (both personal restraints and mechanical restraints)
5. Restraint oversight/review committee materials and unusual incident reports associated with restraint
6. Three years of restraint data and associated reports

When information files were received from HDCs, they were identified as to content and logged into a file log-in system maintained by the consultant team. The initial data collection efforts resulted in the collection of nearly 200 document and data files from all of the HDCs taken together. A small number of additional files were collected from the DDS Central Office. These files constituted the bulk of the materials used by the consultants in their review.

[1] The consulting team wishes to recognize and thank each HDC data transfer manager. All of these individuals were very helpful, fully responsive, and efficient in responding to our requests. In certain cases, these individuals were also part of the team interviewed at the facility. We owe the following individuals a debt of gratitude for their efforts on our behalf: Linda Scales (Arkadelphia); Nakita S. Martin (Booneville); Joseph Price (Conway); Becky Hale and Ann Marie Hatcher (Jonesboro); Dana Harvey and Tekeila Rawls (SEAHDC); and Shannon Roberts (DDS).

2. *Standard Interview Questions for Teams* forms

A standardized data collection form was created to gather initial information from each HDC. This form was titled the *Standard Interview Questions for Teams* form (hereafter: "Standard Interview") and consisted of a multi-page document comprised of a number of questions on restraints in five different sections. A copy of the form is included in **Appendix B**. The sections of the questionnaire form were:

1. Identifying Information
2. Restraint Type, Use, and Training
3. Restraint Review and Oversight
4. Restraint Documentation and Data Collection
5. Compliance with Active Treatment Requirements

The Standard Interview forms were used in two ways. First, copies of the form were sent to each HDC with personnel at the facilities completing them and returning them to our team. We had requested that at least one form be returned for each HDC. At this stage all HDCs returned one completed form (Jonesboro returned two forms from two senior administrators which were nearly identical) representing information from that HDC. A simple consolidated template was created to show the responses to the Standard Interview form of the HDCs into one document. Second, the form was used later in the project as a template and background document to interview the key individuals noted above from each HDC.

The responses from the HDCs were consolidated (from six completed forms because we had two from Jonesboro HDC). These responses were compiled and made available to our two interviewers prior to the individual interviews with HDC staff members. They only served as background material for these interviews. The consolidated responses from these forms are presented in the Results section of the Report.

3. Individual Interviews

Following the collection and consolidation of the HDC responses to the Standard Interview, as noted the completed form from each HDC served as a guide for individual interviews. Several individual interviews were carried out with the key personnel for each of the five HDCs. The key staff members who were interviewed at each HDC:

1. Superintendent and/or designee for this project
2. Director of Training or Training Manager
3. Director of Quality Management or QA Manager
4. Clinical Services Administrator
5. Restraint Review Committee Chair
6. Staff Psychologist

These interviews were open-ended, that is, not tightly-structured interviews, and HDC staff could provide whatever information they thought was relevant. These interviews were carried out one-to-one with each HDC staff member and one of two members of our team (TK or RB); all interviews were conducted via Microsoft Teams.

Two members of our consulting team (TK and RB) carried out all of the individual interviews with HDC staff members. Consultants maintained individual notes from these interviews and

used the consolidated responses from the Standard Interview forms as background information. The interviewers organized their notes and provided written sections on this phase of the project in the Results section.

4. Comparison of Policy to Appendix J

As a basic foundation to other work, one member of our team (RB) carried out a comparison of the DDS and HDC restraint policy statements provided to us with the Medicaid standards as contained in Appendix J of the Medicaid Survey Procedures and Interpretive Guidelines (known generally as "Appendix J"). The comparison was restricted to specific areas of Appendix J regulations. This comparison determined the most fundamental requirements for the system. A separate document/report detailing this review appears in the Appendices to this report (**Appendix E)** and it titled: *A Rule Comparison: ICF/IID Regulations Appendix J and Arkansas DDS.*

To accomplish this comparison, policy and procedure statements and documents pertaining to the use of restraint were collected from HDCs. These were grouped and reviewed in relation to the Medicaid regulations governing ICF/IID facilities in the *State Operations Manual Appendix J – Guidance to Surveyors,* for those regulations related to the use of restraint.

The DDS statewide policies and procedures as well as those specific to each of the five HDCs were reviewed. The comparisons of these policies and procedures with Appendix J Conditions of Participation and regulations were carried out in the following areas:

- Active Treatment
- Assessment
- Replacement Behaviors
- Data Collection / Plan Monitoring
- Committee Requirements
- Informed Consent
- Client Behavior
- Conduct Towards Clients
- Management of Inappropriate Client Behavior
- Use of Aversive Techniques – Hierarchy of Interventions
- Protection of Rights
- Physical Restraints
- Oversight

This review determined that all of the collected policy and procedure statements from DDS and from the individual HDCs demonstrate that all of the facilities are in substantial compliance with ICF/IID regulations.

5. Restraint Data Analysis

We collected various existing data reports on restraints from each HDC. Using these data we carried out secondary or *post hoc* analyses on data provided by each HDC. The goal was to identify overall rates of restraint use and to characterize the average frequency and duration of the restraints based on aggregate data provided by the HDCs.

Data received from the HDCs varied in format, content, and quantity. Analyses proceeded in each HDC dataset to create similar statistics, although due to data limitations, there are certain differences that had to be carried into this report.

One of our team members (KW) concentrated on compiling, comparing, and carrying out analyses on the restraint data submitted from the five HDCs and from the standard DDS Monthly Statistical Reports supplied from DDS Central Office (based on fiscal years). The general goals of these analyses were as follows:

1. Identify standardized and comparable rates of restraint for each HDC
2. Identify comparability problems across HDCs
3. Analyze reporting methods to improve overall utility and comparability across the system
4. Propose standardized methods of data collection for the system (i.e., all HDCs)
5. Identify elements of best practice and make recommendations for approaches to reducing restraint use
6. Make recommendations for data reporting from HDCs to DDS
7. Identify possible future analytic methods to quantify and monitor restraint reduction efforts.

RESULTS

1. Standard Interview Questionnaire Data Results

To achieve comprehensive information on the HDC approaches and current practices with regard to restraint, the Standard Interview form included items that required both short answers (e.g., "yes" or "no") and items that required extended explanation and longer textual answers. These two types of items were segregated for ease of compilation.

A. Short-Answer Items from Standard Interview

The short-answer items for each HDC are shown in Table 2 below. Table 2, for the most part, shows a remarkable similarity across HDCs which no doubt reflects general compliance with statewide guidelines and regulations pertaining to the use of restraint. There are some differences however.

[Table 2 appears on the page following.]

All of the HDCs used "planned restraints" for health limitations (such as mittens, helmets, etc) that are fully reviewed by Human Rights Committees (HRCs) and Restraint Committees. However, Arkadelphia, Booneville, and SEAHDC do not use what might be termed "planned *behavioral* restraints" while Conway and Jonesboro reported using them. These are restraints that are typically written into a resident's personal plan. The statistical reports received from Jonesboro did not make a distinction between planned and emergency restraints and we considered all the data reported to us from Jonesboro under the general rubric of restraints. Further, the Conway data were broken down by type of restraint ("safety" restraints vs. "emergency" restraints); due to the size of the facility and its administrative structure the Conway restraint data presented certain problems for our secondary analyses (see Conroy section later in this report).

All of the HDCs have dedicated restraint review committees, known by different names in the different HDCs (e.g., Arkadelphia is named the QA Committee; others use HRC committees). In extended text response on the form, Arkadelphia laid out a multi-level review process beginning with line supervisor review, a quality assurance committee, psychology review, and various administrative levels up to and including the Superintendent. The other HDCs designated committees to review restraint and produce minutes. [Note: we report on a secondary analysis of a set of such minutes from SEAHDC later in this report.]

All HDCs reported that staff members are trained in both personal and mechanical restraints although there were differences in the time spent in training of staff members to handle behavioral crises.

Specifically, Booneville HDC reported that staff received 600 minutes (10 hours) of training in the prevention of problem behaviors, 600 minutes (10 hours) of training in de-escalation of problem behaviors, and 90 minutes (1.5 hours) of training for implementation of restraint procedures. When queried about the number of hours of training, Boonevillle personnel stated that this included all informal hours of training including peer-to-peer, on-the-job training in addition to formal didactic training. In contrast, the other HDCs identified only didactic training hours in response to the survey. We concluded that the amount of formal and informal didactic

training available to staff at all HDCs was comparable to the amount of training afforded to staff members at the Booneville HDC.

Table 2. HDC Compilation of Standard Interview Short-Items

Items	Arkadelphia	Booneville	Conway	Jonesboro	SEAHDC
1. Are mechanical restraints used?	Y	Y	Y	Y	Y
2. Are mechanicals used without a plan?	Y	Y	Y	Y	Y
3. Are planned mechanical restraints used?	N	N	Y	Y	N
4. Are staff trained in use of mechanical restraints?	Y	Y	Y	Y	Y
5. Is there periodic refresher training (mech)?	Y	N	Y	Y	Y
6. Does the HDC use personal restraints (i.e., holds)?	Y	Y	Y	Y	Y
7. Are personal restraints used without a plan?	Y	Y	Y	Y	Y
8. Are non-emergency/planned restraint holds used?	Y	Y	Y	Y	N
9. Are staff trained in the use of personal holds?	Y	Y	Y	Y	Y
10. Is there periodic refresher training (personal)?	Y	Y	Y	Y	Y
11. Does initial training include "prevention"?	Y	Y	Y	Y	Y
12. Does initial training include "de-escalation"?	Y	Y	Y	Y	Y
13. Total time in restraint training during orientation?	9.5 hrs	7.5 hrs	1.5 hrs	13 hrs	2 hrs
14. How much time is spent on refreshing/re-certifying staff members in the following: a.) Prevention of problem behaviors b.) De-escalation of problem behaviors c.) Implementation of restraint procedures	 a) 60 min b) 60 min c) 60 min	 a) 600 min b) 600 min c) 90 min	 10 min 10 min 10 min	 4 hrs 4 hrs 4 hrs	 45 min 45 min 45 min
15. How often does debriefing occur after restraint?	Each time	Each time	Each tim	Each time	Each time
16. Does a QIDP review restraint data?	Y	Y	Y	Y	Y
17. Is there a dedicated restraint review committee?	Y	Y	Y	Y	Y
18. Does the committee meet on a regular basis?	-	Y	Y	Y	Y
19. Does the committee produce official minutes?	-	Y	Y	Y	Y
20. Are all instances of restraint reviewed?	Y	Y	Y	Y	Y
21. Are review committee members trained in the use of restraints?	Y	Y	-	Y	Y
22. Does restraint review lead to changes in IPP?	Y	Y	Y	Y	Y
23. Are IPP changes followed up by the committee?	Y	Y	Y	Y	Y
24. Are all instances of restraint documented?	Y	Y	Y	Y	Y
25. Is there a process to assess correct use?	Y	Y	Y	Y	-
26. Is there a functional assessment on file for each person who is restrained?	Y	Y	Y	Y	Y
27. If restraint is in IPP, are specific plans on file?	N	Y	Y	Y	Y
28. Have such plans been reviewed by an HRC?	Y	Y	Y	Y	Y
29. Is documentation of such review included in IPP?	Y	Y	Y	Y	Y
30. Less restrictive alternative attempted/considered?	Y	Y	Y	Y	Y
31. For those restrained, are behavior plans in IPP?	Y	Y	Y	Y	Y
32. Are such plans regularly monitored?	N	Y	Y	Y	Y
33. Are such plans made available to restraint review committee?	N	Y	Y	Y	Y
34. Are there clear attempts to reduce restraints?	Y	Y	Y	Y	Y
35. Is there a facility-wide effort to reduce restraints?	Y	Y	Y	Y	Y
36. If yes, is there a written plan?	Y	Y	Y	Y	Y

2. Individual Follow-Up Interview Results

A. Purpose

The purpose of these individual follow-up interviews of key staff member was to provide an opportunity for individuals employed at the HDCs to provide personal responses to the Standard Interview document completed for each HDC or to simply voice their own thoughts on the issues. This part of the project was completed by Mr. Bowen and Dr. Kastner in early to mid-June 2022. Mr. Bowen and Dr. Kastner both participated in the interviews with Booneville staff in order to achieve comparable interviewer approaches to assure reliability. Separately, Mr. Bowen conducted the interviews at Arkadelphia and Jonesboro and Dr. Kastner conducted the interviews at SEAHDC (Warren) and Conway.

The development and use of the *Interview and Questions for Teams* document is described previously in sections 2 and 3 of the Methods portion of this report. As noted earlier, the goal was to have six individuals from each HDC interviewed about the completed *Interview and Questions for Teams* document. Twenty-five such interviews were accomplished, including 26 individuals, in all of the HDCs taken together. These individuals were to represent the following organizational functions:

1. Superintendent and/or designee for this project
2. Director of Training or Training Manager
3. Director of Quality Management or QA Manager
4. Clinical Services Administrator
5. Restraint Review Committee Chair
6. Staff Psychologists (for those residents who have been restrained)

On several occasions, the interviewers discussed behavioral data which had been collected as part of this project and was being subjected to secondary analyses. The responses to these interview sessions are presented below and have not been individualized. Rather, responses have been aggregated as some people answered the same question and while their words were different the responses were similar giving us a high degree of confidence in the authenticity of the responses. We wish to extend our thanks to all the participants in the interviews and to the staff members who are providing what appears to be services and supports consistent with state and federal regulations and best practice standards.

B. Arkadelphia HDC

Following are notes from the follow up interviews with staff members from the Arkadelphia HDC taken on June 22, 2022. The interviews were conducted by Bob Bowen, who transcribed his own notes. The persons interviewed and their roles were:

- Kerry Gambill, Superintendent
- Michael Nelson, Director of Training
- Samantha Tippitt, Director of Quality Management and HRC Director
- Dr. Julie Howard, Psychologist

Linda Scales completed the original questionnaire for the Arkadelphia HDC. The interviews began by sharing some of the findings from the secondary data analysis conducted by Dr. Walsh

which appeared to show that a large majority of the restraints are used by a small number of residents.

Restraint Type, Use, and Training
Section A. Mechanical Restraint

- Mechanical restraints are used only in emergency situations and are part of an individual's Individual Program Plan (IPP) if they are needed in order to provide safety as a last resort.
- Behavior Support Plans and Safety Response Plans are different documents to separate preventative and proactive interventions from responses that are a last resort to address imminent threat of harm to self and/or others.
- All staff members are trained in the prevention, de-escalation and if needed, use of restraints including personal holds, releases, and transitions to the ground.

Section B: Personal Hold Restraints

- These are restraints taught by the Crisis Prevention Institute (CPI) and are used as a last resort if and when the behavior of a client poses an imminent threat of harm to self and/or others.

Section C: Additional Information

- There are video cameras in all common areas in all homes. Footage from these cameras has been used to identify potential triggers, verify allegations and in some cases protect staff from false allegations.
- Understanding the impact of co-existing (dual) diagnoses and the impact of trauma on behavior was discussed by several people.
- A new psychiatrist will be starting work in September at Arkadelphia.

Restraint Review and Oversight

- Debriefing is completed after every restraint.
- Restraint is seen as "treatment plan failure" (consistent with the document "Six Core Strategies for the Reduction of Seclusion and Restraint" by Kevin Ann Huckshorn, 2008).
- Trends are analyzed with information sent to all relevant parties.
- There is a robust process to identify factors that impact behavior such as what staff person is on duty, what foods a particular resident might have eaten prior to incontinence, etc.
- The superintendent requires that unless there is an emergency the physician must authorize all restraints. The superintendent is notified of all restraints.
- Restraint documentation and data collection is carried out.
- Data are analyzed monthly with results sent to the QIDP for each person who was restrained that month.

Compliance with Active Treatment Requirements

- Trauma history, environmental factors such as noise, light and temperature are also considered as potential setting events.
- An active treatment program is in place for each person.
- Identification of replacement behaviors is a priority for the interdisciplinary team for each person who is restrained.

Concluding Remarks and Observations

The consultant concluded that the Arkadelphia HDC is fully invested in the concept of using restraint only as a last resort, and using best practices to find ways to minimize the use of restraint. It appears that the culture established by the leadership of the organization fully embraces the Six Core Strategies for the Reduction of Restraint and Seclusion, developed by Kevin Huckshorn. It should be noted that the use of seclusion is prohibited at Arkadelphia.

C. Booneville HDC

Following are notes from the follow up interviews with staff from the Booneville Human Development Center on June 7, 2022. The interviews were conducted together by Ted Kastner and Bob Bowen with notes transcribed by Bob Bowen. The interviews began later than scheduled due to a power outage at the Booneville HDC. All staff members easily adjusted to the time changes necessitated by the power outage, and during the interviews all personnel were professional, forthcoming, and helpful in the process of following up on the responses to the Standard Interview document. The persons interviewed and their roles were:

- Jeff Gonyea, Superintendent
- Vanessa Wyrick and Mark Hise, Training Department
- Nakita Martin, Director of Quality Management (Ms. Martin completed the initial Standard Interview document)
- Becky Draper, Restraint Review Committee Chair
- Kathy Edwards, Psychology Examiner

We started the interviews by sharing that our secondary data analysis conducted so far showed that the frequency and duration of restraints is declining at the Booneville HDC. It also appears that a large majority of the restraints are used by a small number of residents.

Restraint Type, Use, and Training
Section A. Mechanical Restraints

- Mechanical restraints are used only in emergency situations and are not a part of any individual's Individual Program Plan (IPP).
- All staff members are trained in the prevention, de-escalation and if needed, use of restraints including personal holds, releases, and transitions to the ground.

- The transitions to the ground are not part of the Crisis Prevention Institute (CPI) training protocols, but rather are designed and taught by HDC staff in Arkansas. Their purpose is not to restrain individuals on the ground, but rather to transition from a personal hold to a mechanical restraint.
- The term "papoose board" was noted to be outdated and pejorative. Some staff just refer to it as a mechanical restraint.

Section B: Personal Hold Restraints

- In the written response, restraint was defined as "restraining the arms, legs, head or a combination." It was clarified that in situations of biting the head was not restrained but rather stabilized.
- A soft item such as a pillow was placed between the head and the floor in cases of head-banging.

Section C: Additional Information

- It was noted that many of the resident population has a dual diagnosis (an intellectual disability and a mental health diagnosis), which requires more intensive training.
- A three week staff orientation model is used, and within that time the concepts of prevention and de-escalation of potentially aggressive incidents is covered.
- Refreshers are provided annually, with full re-certification required every two years.

Restraint Review and Oversight

- Debriefing is completed after every restraint.
- Restraint is seen as "treatment plan failure" (consistent Huckshorn, 2008).
- Trends are analyzed with information sent to all relevant parties.
- New approaches to address problematic behaviors are attempted in order to further reduce restraint use.

Restraint Documentation and Data Collection

- Data are analyzed monthly with results sent to the QIDP for each person who was restrained that month.
- It was noted that new residents tend to have restraint used more than existing residents, until staff become aware of triggers and preferred de-escalation methods.
- Very few staff injuries noted, even though the US Department of Labor reports that staff injuries in human service programs are increasing.

Compliance with Active Treatment Requirements

- A Functional Behavior Analysis (FBA) is conducted for all restraints to identify potential triggers.

- Trauma history, environmental factors such as noise, light and temperature are also considered as potential setting events.
- Staff would like specific ideas and contacts to further reduce and perhaps even eliminate the use of restraint.

Concluding Remarks and Observations by Interviewers

It is our impression that the Booneville HDC is fully invested in the concept of using restraint only as a last resort, and using best practices to find ways to minimize restraint use. The use of the papoose board with a chest restraint is considered to be a potential risk, as it is difficult to determine if a person is struggling because they are still behaviorally heightened, or if they are feeling the effects of the restraint on their ability to breathe.

D. Conway HDC

Following are notes from the follow up interviews with staff from the Conway Human Development Center on June 6, 2022. Dr. Kastner conducted the interviews and transcribed the notes. The persons interviewed and their roles were:

- Sarah Murphy, Superintendent
- Stuart Douglas, Education and Instruction Coordinator
- Glenn Gray, Psychological Examiner
- Joe Price, Quality Assurance Manager (Mr. Price completed the initial *Interview and Questions for Teams* document)
- Jennifer Evans, Central Quality Assurance Committee Chair
- Dr. Moore, Chief Psychologist

The Conway HDC operates multiple administrative teams. Data for each team had not yet been analyzed and, therefore, was not shared. Joe Price had completed the Standard Interview for Conway HDC.

Restraint Type, Use, and Training
Section A. Mechanical Restraints

- Mechanical restraints are used only in emergency situations and are not a part of any individual's Individual Program Plan (IPP).
- All staff members are trained in the prevention, de-escalation and if needed, use of restraints including personal holds, releases, and transitions to the ground.
- The transitions to the ground are not part of the Crisis Prevention Institute (CPI) training protocols, but rather are designed and taught by HDC staff in Arkansas. Their purpose is not to restrain individuals on the ground, but rather to transition from a personal hold to a mechanical restraint.

Section B: Personal Hold Restraints

- In the written response, restraint was defined as "restraining the arms, legs, head or a combination." It was clarified that in situations of biting the head was not restrained but rather stabilized.

- A soft item such as a pillow was placed between the head and the floor in cases of head-banging.

Section C: Additional Information

- A three week staff orientation model is used, and within that time the concepts of prevention and de-escalation of potentially aggressive incidents is covered.
- Refreshers are provided annually, with full re-certification required every two years.

Restraint Review and Oversight

- Debriefing is completed after every restraint.
- Trends are analyzed with information sent to all relevant parties through an internal process. Materials are uploaded from a common server.
- New approaches to address problematic behaviors are attempted in order to further reduce restraint use.

Restraint Documentation and Data Collection

- Data are analyzed monthly with results sent to the QIDP for each person who was restrained that month.
- It was noted that new residents tend to have restraint used more than existing residents, until staff become aware of triggers and preferred de-escalation methods
- Very few staff injuries noted, even though the US Department of Labor reports that staff injuries in human service programs are increasing

Compliance with Active Treatment Requirements

- A Functional Behavior Analysis (FBA) is conducted for all restraints to identify potential triggers
- Trauma history, environmental factors such as noise, light and temperature are also considered as potential setting events

Concluding Remarks and Observations by Interviewer

The Conway HDC is fully invested in the concept of using restraint only as a last resort, and using best practices to find ways to minimize restraint use. The use of the papoose board with a chest restraint is considered to be a potential risk, as it is difficult to determine if a person is struggling because they are still behaviorally heightened, or if they are feeling the effects of the restraint on their ability to breathe.

E. Jonesboro HDC

Following are notes from the follow-up interviews with staff from the Jonesboro on June 16, 2022. The interviews were conducted and the notes transcribed by Bob Bowen. The persons interviewed and their roles were:

- Diane Keith, Superintendent
- Ann Hatcher, Director of Training
- Ross Granberry, Director of Quality Management
- Josh Barnes, Psychology Examiner

Originally two Standard Interview documents were submitted by Jonesboro HDC – one by Becky Hale, Program Administrator and the other by Ann Marie Hatcher, Training Project Manager.

Restraint Type, Use, and Training
Section A. Mechanical Restraints

- Mechanical restraints are used only in emergency situations and are a part of an individual's Individual Program Plan (IPP) if they are needed in order to provide safety as a last resort.
- All staff members are trained in the prevention, de-escalation and if needed, use of restraints including personal holds, releases, and transitions to the ground.
- In the responses to the questionnaire, the term "Matt wrap" was used. This term refers to what other HDC's call a "burrito wrap." If this mechanical restraint is needed, the person is transitioned to the floor as it would be dangerous to attempt to implement the Matt wrap standing up.

Section B: Personal Hold Restraints

- A restraint using a chair was described as a process taught by the Crisis Prevention Institute (CPI) in which an individual served sits in a chair and 2 people (one on each side) come up behind them
- Using gentle touch, they begin to attempt to de-escalate the individual. If this is not effective, staff can transition to a CPI restraint if that is the last resort in order to establish safety.

Section C: Additional Information

- There is a perceived need for more training to empower people to actually practice physical restraint, as staff may not have a high enough skill level given the current structure of 1.5 hours for training in physical skills
- There was an emphasis on providing training that would focus more on prevention through creating environments in which restraint cannot occur. This is consistent with the writings of Edward Carr, one of the authors of the initial articles describing what is now known as Positive Behavior Support.
- There was also a recommendation to provide more training on how to communicate more effectively with individuals served.
- There are video cameras in all common areas in all homes. One recommendation was to use these recordings more in order to analyze behavioral incidents, as well as to analyze situations in which staff successfully prevented and/or de-escalated an incident.

- Finding ways to better train what were described as “rotating staff” was also discussed, as was a suggestion that there should be a focus on increasing compassion for the individuals served, and not taking their behaviour personally when it occurred.
- Helping staff understand the differences between reactive and instrumental (or purposeful) aggression was suggested.
- Understanding the impact of co-existing (dual) diagnoses and the impact of trauma on behavior was discussed by several people.
- It was recommended that select staff, such as all people who qualify as QIDP’s, go through a nationally recognized training to become Registered Behavior Technicians. More information is available from https://www.bacb.com/rbt/

Restraint Review and Oversight

- Debriefing is completed after every restraint.
- Restraint is seen as “treatment plan failure” (consistent with the document “Six Core Strategies for the Reduction of Seclusion and Restraint” by Kevin Ann Huckshorn).
- Trends are analyzed with information sent to all relevant parties.
- Factors that impact behavior such as the weather, time of day and functioning level were presented and need to be more widely discussed and known.

Restraint Documentation and Data Collection

- Data are analyzed monthly with results sent to the QIDP for each person who was restrained that month.
- It was noted that new residents tend to have restraint used more than existing residents, until staff become aware of triggers and preferred de-escalation methods.
- Very few staff injuries noted, even though the US Department of Labor reports that staff injuries in human services are increasing.

Compliance with Active Treatment Requirements

- All people who are prescribed psychotropic medication are required to have a Behavior Development Plan, which includes a Functional Behavioral Analysis (FBA) for all restraint to identify potential triggers
- Trauma history, environmental factors such as noise, light and temperature are also considered as potential setting events
- Staff would like specific ideas and contacts to further reduce and perhaps event eliminate the use of restraint

Concluding Remarks and Observations

It is my impression that the Jonesboro HDC is fully invested in the concept of using restraint only as a last resort, and using best practices to find ways to minimize the use of restraint. The need for not only additional training but supports to empower staff to implement the training was a common theme among all the people interviewed.

SEAHD**C (Warren)**

Following are notes from the follow up interviews with staff from the Southeast Arkansas Human Development Center (SEAHDC) on June 6, 2022. Dr. Kastner conducted the interviews and transcribed the notes. Dana Harvey completed the Standard Interview document from SEAHDC. The persons interviewed and their roles were:

- Mark Wargo, Superintendent
- Dana Harvey, Assistant Superintendent
- Tekeila Rawls, Quality Assurance Manager
- Lauren Franklin, Client Training
- Tim Watson, Staff Training
- Dr. Julie Howard (on June 8, 2022)

Behavioral data for the SEAHDC had not yet been analyzed and, therefore, was not shared. However, a quick review indicated that a large majority of the restraints are used by a small number of residents.

Restraint Type, Use, and Training
Section A: Mechanical Restraints

- Mechanical restraints are used only in emergency situations and are not a part of any individual's Individual Program Plan (IPP).
- All staff members are trained in the prevention, de-escalation and if needed, use of restraints including personal holds, releases, and transitions to the ground.
- The transitions to the ground are not part of the Crisis Prevention Institute (CPI) training protocols, but rather are designed and taught by HDC staff in Arkansas. Their purpose is not to restrain individuals on the ground, but rather to transition from a personal hold to a mechanical restraint.

Section B: Personal Hold Restraints

- In the written response, restraint was defined as "restraining the arms, legs, head or a combination." It was clarified that in situations of biting the head was not restrained but rather stabilized.
- A soft item such as a pillow was placed between the head and the floor in cases of head-banging.

Section C: Additional Information

- A three week staff orientation model is used, and within that time the concepts of prevention and de-escalation of potentially aggressive incidents is covered.

- Refreshers are provided annually, with full re-certification required every two years.

Restraint Review and Oversight

- Debriefing is completed after every restraint.
- Trends are analyzed with information sent to all relevant parties through an internal process. Materials are uploaded from a common server.
- New approaches to address problematic behaviors are attempted in order to further reduce restraint use.

Restraint Documentation and Data Collection

- Data are analyzed monthly with results sent to the QIDP for each person who was restrained that month.
- It was noted that new residents tend to have restraint used more than existing residents, until staff become aware of triggers and preferred de-escalation methods
- Very few staff injuries noted, even though the US Department of Labor reports that staff injuries in human service programs are increasing

Compliance with Active Treatment Requirements

- A Functional Behavior Analysis (FBA) is conducted for all restraints to identify potential triggers
- Trauma history, environmental factors such as noise, light and temperature are also considered as potential setting events

Concluding Remarks and Observations by Interviewer

SEAHDC is fully invested in the concept of using restraint only as a last resort, and using best practices to find ways to minimize restraint use. The use of the papoose board with a chest restraint is considered to be a potential risk, as it is difficult to determine if a person is struggling because they are still behaviorally heightened, or if they are feeling the effects of the restraint on their ability to breathe.

3. Appendix J Comparison Results

As noted in the Method section, a review of DDS and HDC policies and procedures surrounding restraint was carried out (see comparison document in Appendix E). There is a basic continuity across both sets of regulations although there are some differences due to the use of both personal and mechanical restraint. Our review of DDS and HDC policy and procedures surrounding the use of restraints suggest that the facilities are all in substantial compliance. We note that the Appendix J regulations on restraint permit the use of restraints in both a planned and an emergency manner. In the questionnaire responses, three facilities (Arkadelphia, Booneville, and SEAHDC) responded that planned mechanical restraints are not used; and one (SEAHDC) added that planned personal restraints are also not used.

Additionally, there is a relationship between the use of restraints and the individual service plan prepared for the individual. Planned restraints (i.e., those with an intended clinical effect) need to be included formally in the person's plan while emergency restraints do not. In our review and in interviews we found the HDCs to be in compliance in this regard as well.

With regard to the distinction in the type of restraints permitted in Appendix J, a certain amount of complexity has been introduced in the use of "safety" plans in some of the HDCs, most notably Conway. We address this later in the following section.

4. Analysis of Restraint Data

Exclusion of Chemical Restraints. Although Medicaid regulations for ICF/IID (i.e., Appendix J) permit the use of chemical restraints we have not reviewed them in detail nor included them in the current report. Chemical restraints are defined as the oral, rectal, intramuscular, or subcutaneous administration of a medication to aid the client in calming to ensure safety of the client and/or others. These restraints require a physician's prescription and must be administered by a licensed nurse. We have limited our review to the external application of restraints because chemical restraints are used, and produce their outcomes, in a different manner than personal and mechanical restraints.

A. Arkadelphia Restraint Data

Data Source and Secondary Analyses. Arkadelphia provided a 21-page *Quality Assurance Indicator Report* that included restraint data for a number fiscal years. The four sections of the report provided restraint data that covered 42 months, from July 2018 to June 2022. Each section of the report divides the restraint data into quarters of the fiscal year; thus, each fiscal year begins with the second half of one calendar year and includes the first half of the next calendar year. Therefore, the first quarter of each year is July – September; the second quarter is October to December, and so on.

Using the data from the HDC report, we extracted the frequency and duration of personal and mechanical restraints for the 14 quarters (representing the entire 42-month period) and calculated *restraint rates* for both types of restraints. Table 3 shows the frequency and duration of the restraints in each fiscal year. The duration row also includes the average duration per restraint in parentheses.

[Table 3 is shown on the page following.]

The restraint rate is presented throughout our report as a *per person per year* rate. Note that this does *not* mean that each individual in an HDC was restrained; rather it is simply a statistical device to produce a standardized rate that can be compared across the HDCs. In fact, in all HDCs only a small minority of individuals account for the vast majority of restraints.

For any given HDC, the *per person per year* (PP/Y) rate statistic is calculated as follows:

$$\text{PP/Y} = \frac{\text{total \# of restraints in a given time frame}}{\text{average census for the time frame}}$$

For Arkadelphia, in any given fiscal year per person per year restraint rates for both personal and mechanical restraints varies. However, across the years that PP/Y rate for each fiscal year has increased from the beginning to the end of the period under question. The PP/Y rates for personal and mechanical restraint for each quarter over the 42 months for Arkadelphia are shown in the large table in Appendix C.

Table 3. Frequency and Duration – Personal and Mechanical Restraints (Arkadelphia)

RATE	FY 2018-2019	FY 2019-2020	FY 2020-2021	2nd Half-2021*
Average Census	116	113	102	102
PERSONAL RESTRAINTS				
Personal Restraints Frequency (Count)	73	114	205	37
Personal Restraints Total Duration - Minutes (Average Duration/restraint)	238 (2.0 min)	402 (3.6 min)	852 (8.4 min)	144 (1.4 min)
MECHANICAL RESTRAINTS				
Mechanical Restraints Frequency (Count)	25	55	125	67
Mechanical Restraints Total Duration - Minutes (Average Duration/restraint)	605 (5.2 min)	1170 (21.3 min)	2711 (26.6 min)	1454 (14.3 min)

*** The frequency and duration of both types of restraint in the last column only represent two quarters; therefore these figures are not directly comparable to the other three years; because the time period is 6 months, it would be reasonable to double the figures in this column for comparison**

The restraint rate for mechanical restraints is less than the rate of personal restraints in all years. In fact, this was true for 12 of the 14 quarters (see Appendix C); the two quarters in which the rate for mechanical restraints exceeded personal restraints were the most recent in the 42-month sequence (i.e., the last two quarters, or the 2nd half of 2021). Overall, there were fewer mechanical restraints and the personal restraints were shorter in duration than the mechanical restraints – both favorable trends (Table 3). Table 4 following extracts the personal and mechanical restraint rates by fiscal year.

[Table 4 appears on the page following.]

It is not clear why previous increases occurred although it is possible that there have been changes in the makeup of the population at Arkadelphia. Although the census has remained somewhat stable over the period (with perhaps a slight decrease) it is possible that the nature of the population has shifted to individuals with more complex and challenging behavioral profiles.

Table 4. Personal and Mechanical Restraint Rates X Fiscal Year (Arkadelphia)

RATE	FY 2018-2019	FY 2019-2020	FY 2020-2021	2nd Half-2021*
Personal Restraint Rate (PP/Y)	.63	1.01	2.01	.36
Mechanical Restraint Rate (PP/Y)	.22	.49	1.23	.66

* This column only represents 2 quarters therefore it is not directly comparable to the other 3 years.

B. Booneville Restraint Data

Data Source and Secondary Analyses. Booneville provided a set of Excel spreadsheets (three tabs) covering the years 2019, 2020, 2021 that presented data on personal holds and mechanical restraints. There are three spreadsheet charts, one on each tab covering a single year. Statistics and per person per year rates were calculated from these spreadsheets for personal and mechanical restraints. Complete data compilations are presented by year in **Appendix D.**

The spreadsheets received from the HDC contain aggregate data and therefore certain statistical calculations were not possible (such as the range of restraint duration by individual; number of restraints attributable to individuals). Note that in Tables 5 and 6 only 9 months of data were available in 2019 for personal restraints (this is when personal restraint data collection was initiated) and therefore, a pro-rated statistic was added to the relevant cells (in parentheses) to show what the full year value might have been had the 9-month rate held for the entire year. Our findings are shown in Tables 5 and 6 following.

Table 5. Frequency and Duration – Personal and Mechanical Restraints (Booneville)

RATE	2019	2020	2021
Average Daily Census	128	121	120
PERSONAL RESTRAINTS			
Personal Restraints Frequency (Count)	702 (936)*	887	575
Personal Restraints Total Duration -Minutes (Average Duration/restraint)	2,181 (3.1 min) (2,908 min)*	3,196 (3.6 min)	2,073 (3.6 min)
MECHANICAL RESTRAINTS			
Mechanical Restraints Frequency (Count)	214	145	135
Mechanical Restraints Total Duration -Minutes (Average Duration/restraint)	8,372 (39.1 min)	6,155 (42.4 min)	4,090 (30.3 min)

*Data on personal restraints were only available for 9 months in 2019; prorated (to 12 months) the figure for frequency would be 936; total minutes would be 2,908; the average would remain 3.1).

Findings. Table 5 shows the frequency and duration of restraints at Booneville during the period 2019 – 2021 and Table 6 shows the *per person per year* rates as described earlier. It is noteworthy that both of the restraint types (personal and mechanical) show reductions year to year. Using the pro-rated figure for 2019 there was a 39% reduction in time spent in personal restraints and a 37% reduction in time spent in mechanical restraints over the time period.

Table 6. Personal and Mechanical Rates X Year (Booneville)

RATE	2019	2020	2021
Personal Restraint Rate (PP/Y)	5.5 (7.3)*	7.3	4.8
Mechanical Restraint Rate (PP/Y)	1.7	1.2	1.1

* Prorated to 12 months from 9 months.

Although individual restraint data were not provided, it was possible to discern from the spreadsheets that the range in the number of individuals across the months of each year dropped slightly from 2019. The range in the percentage of residents restrained during the months of 2019 ranged between 18% and 25%; however the range in the percent of those restrained in the months of 2021 had dropped to between 13% and 23% indicating a smaller percentage of individuals restrained in the later years.

Because the statistics shown in Tables 5 and 6 were derived from aggregate data, it is not possible to determine the number of restraints experienced by specific individuals. Thus, for example, at Booneville in 2021 there were 575 Personal Holds applied to a total number of "195 residents." What can't be determined is the number attributed to any specific individual or group of individuals. It is possible, for example, that 190 of the identified residents had 1 personal hold each and the 5 remaining residents accounted for the remaining 387 personal holds. In the future, it would be a useful statistic to report the number of restrains per individual. This is the practice at the other HDCs.

C. Conway Restraint Data

Data Sources and Secondary Analyses. Unlike the other HDCs, Conway has a system of safety restraints which are planned, but not necessarily designed for clinical behavioral change, and, in addition, the facility employs emergency restraints. We comment on this distinction further later in this section. Additionally, the facility uses a team structure to monitor and report restraint statistics, unlike the other HDCs. Taken together, these two facts greatly complicated our secondary analyses of CHDC's restraint data. The facility supplied our consultant team with a series of 60 20-page Behavior Reports and Restraint Use Summaries ("BR Reports") and 12 sets of Quality Assurance Subcommittee minutes ("QASC Minutes) from 2021 and 2022 consisting of two sets from each of five administrative teams at the facility. The teams included in the BR Reports are as follows:

SLT Sheltered Living Team
IAT Individual Assistance Team
HTT Habilitation & Training Team

TCT Total Care Team
ITT Intensive Training Team

The QASC minutes consist of spreadsheets of individual cases documenting each incident review and individual action taken by the subcommittee. However, there is no aggregation in these minutes because the focus is on the individual incidents; without aggregation these reports were less than useful to our team as they sometimes consisted of over 200 lines each without any aggregation or compilation. We did not have the time or resources to go through these reports to aggregate them in some fashion. Therefore, we relied on the BR Reports.

The 60 BR Reports, totaling approximately 1,200 pages, each contained individual listings of restraint incidents for each team, several tables pertaining to behavior incident reports by day, by residence, etc. (which may or may not include restraints of different types) and an aggregated data table (named Restraint Totals by Team). Again, some of this information however, these was difficult to use by our consultant team's review of restraints because of several disclaimer statements in each BR Report to the effect of: (1) all restraints may not be included ("...these may not include all restraints – only those marked on BR's" because "…some programs do not require a BR to accompany every restraint use"); (2) certain restraint cases including "…any individual who has more than 1,500 minutes of restraint use per month is separated from the team total…" in the reports; (3) "the reports listed…are obtained from the behavior reports only…(t)hey do not include all restraints"; and (4) "the 'time began' and 'time ended' is from the behavior report and indicates when (the) behavior incident began and ended. This time does not reflect actual time in restraints." We were concerned that these disclaimers would render the Conway statistics we computed not entirely comparable with the other HDCs.

Nonetheless, we have examined the aggregated tables named "Restraint Totals by Team" from all of the 60 months supplied to us (2017 through 2021) and have noted that, by far, the majority of restraint takes place in the IAT and HHT teams. Although the picture is somewhat incomplete, we have created five years' of restraint statistics from these tables for these two teams only. The statistics created from these reports are shown in the two tables included below (Tables 7 and 8).

[Tables 7 & 8 are shown on the page following.]

In the IAT it is noteworthy that between 2017 and 2021 for "safety mechanical" restraints (rows 1 – 4) and for "emergency personal" restraints (rows 13 – 16) all of the statistics shown are, more or less, substantially reduced. For example, for safety mechanical restraints (rows 1 – 4) percentage decreases between 2017 and 2021 were large for both frequency (43%) and for duration in minutes (55%). In contrast to these reductions, the statistics shown for "emergency mechanical restraints" (rows 9 – 12) all increased between 2017 and 2021.

We constructed the same set of statistics for the Habilitation and Training Team (HTT) which is the other CHDC team with substantial restraint use. These statistics are shown in the table below. Some of the statistics in the HTT mirrored the IAT, for example the statistics for "safety mechanical restraints" (rows A – D) and "emergency personal restraints" (rows M – P) were all

Table 7. Five Years of Restraint Statistics for IAT (Conway).

Row	Restraint Type/Statistic	2017	2018	2019	2020	2021
	Individual Assistance Team (IAT)					
1	Safety Mechanical Restraint Frequency	561	512	426	282	322
2	Safety Mechanical Restraint Minutes	24,676	22,009	20,732	13,748	11,130
3	Average duration of restraints (minutes)	44.0	43.0	48.7	48.8	34.6
4	Average frequency per month for the year	46.8	42.7	35.5	23.5	26.8
5	Safety Personal Restraint Frequency	7	9	6	15	19
6	Safety Personal Restraint Minutes	57	53	39	141	111
7	Average duration of restraints (minutes)	8.1	5.9	6.5	9.4	5.8
8	Average frequency per month for the year	0.6	0.8	0.5	1.3	1.6
9	Emergency Mechanical Restraint Frequency	11	6	29	374	117
10	Emergency Mechanical Restraint Minutes	86	20	1,217	19,745	4,816
11	Average duration of restraints (minutes)	7.8	3.3	42.0	52.8	41.2
12	Average frequency per month for the year	0.9	0.5	2.4	31.2	9.8
13	Emergency Personal Restraint Frequency	24	252	67	29	5
14	Emergency Personal Restraint Minutes	920	10,552	2,510	247	91
15	Average duration of restraints (minutes)	38.3	41.9	37.5	8.5	18.2
16	Average frequency per month for the year	2.0	21.0	5.6	2.4	0.4

Table 8. Five years of restraint statistics for HTT (Conway HDC).

Row	Restraint Type/Statistic	2017	2018	2019	2020	2021
	Habilitation & Training Team (HTT)					
A	Safety Mechanical Restraint Frequency	7662	4629	651	344	305
B	Safety Mechanical Restraint Minutes	488,683	272,977	31,993	17,278	12,929
C	Average duration of restraints (minutes)	63.8	59.0	49.1	50.2	42.4
D	Average frequency per month for the year	638.5	385.8	54.3	28.7	25.4
E	Safety Personal Restraint Frequency	158	518	129	84	124
F	Safety Personal Restraint Minutes	756	4,629	570	410	364
G	Average duration of restraints (minutes)	4.8	8.9	4.4	4.9	2.9
H	Average frequency per month for the year	13.2	43.2	10.8	7.0	10.3
I	Emergency Mechanical Restraint Frequency	86	129	199	214	209
J	Emergency Mechanical Restraint Minutes	333	579	4,056	10,098	9,665
K	Average duration of restraints (minutes)	3.9	4.5	20.4	47.2	46.2
L	Average frequency per month for the year	7.2	10.8	16.6	17.8	17.4
M	Emergency Personal Restraint Frequency	1620	191	366	68	77
N	Emergency Personal Restraint Minutes	51326	8,319	15,995	299	313
0	Average duration of restraints (minutes)	31.7	43.6	43.7	4.4	4.1
P	Average frequency per month for the year	135.0	15.9	30.5	5.7	6.4

also reduced between 2017 and 2021 in the HTT. Additionally, all of the statistics for "safety personal restraints" (rows E – H) were also all lower in 2021 than they were in 2017. Offsetting these laudable reductions is the fact that all of the statistics for HTT emergency mechanical restraints (rows I – L) increased across the five year period.

Some of the HTT reductions over the period are striking. For example, minutes for "safety mechanical" restraints went from an annual total of 488,683 to an annual total of 12,929 (a 37-fold decrease!). Although minutes for "safety mechanical restraints" were reduced in both the IAT and the HTT, in both teams the number of minutes in these restraints annually remained above 10,000 (with average individual durations of 34.6 minutes in IAT and 42.4 minutes in HTT).

In general, taking just these two teams (IAT and HTT) which account for the preponderance of Conway restraints, there is a bit of a shift over the period (2017 to 2021) toward "emergency mechanical" restraints as the statistics for these have increased in both teams (table rows 9 -12 for IAT and table rows I – L for HTT).

Our secondary analyses of CHDC restraints are not fully comparable to the other HDCs because of the caveats noted above (possible restraint exclusion issues), and the restraint differences across teams at Conway. Therefore, given time and resource constraints, we have not been able to calculate *per person per year* statistics for the entire CHDC center. We could have calculated these for the IAT and HTT, however given the possible missing data and the lack of similar secondary analyses for the other three teams, we refrain from reporting them because they could easily be misinterpreted.

Conway HDC is rather different from the other HDCs in that it relies to a great extent on "safety" restraints compared to emergency restraints. Additionally, the IAT relies far more on mechanical restraints than personal restraints; in our view personal restraints are likely to be considered less aversive and therefore should be favored. This pattern holds for the HTT as well – that is, there are more mechanical restraints than personal restraints, and as in the IAT, the mechanical restraints are far longer. Again, we urge the facility to seek to increase the use of shorter-duration emergency personal restraints instead of longer-duration emergency mechanical restraints.

Safety Restraints vs. Emergency Restraints. We are cognizant of the laudable efforts on the part of CHDC to recognize that certain residents will require the use of restraint and to, in a way, plan for them via "safety plan" restraints.[2] However, our data compilation shows that such safety restraints are used more than emergency restraints (at least in the IAT and the HTT) and that perhaps the concept of "emergency behavioral issues" has been somehow incorporated into the safety restraint system. This may convey that when emergencies arise, for residents that have "safety plans," staff members *should* apply the restraints instead of attempting to avoid them. Our general position is that restraint use is reduced when staff members are constantly reminded that the primary goal in behavioral crisis situations is to

[2] Safety restraints are different than the "planned" restraints permitted in the ICD/IID regulations. "Planned" restraints are intended to be "clinical" in nature – that is, they seek to change behavior. In contrast, the intent of "safety" restraints (also planned in advance) in our understanding is to keep residents "safe" when behavioral acting out presents a danger to self or others.

avoid the use of any restraints unless, and only if, there is a clear indication that danger to the person or others is imminent.

It may be a valuable exercise for DDS to closely review the use of "safety" restraints *viz viz emergency restraints* (or ICF/IID "planned" restraints) based on the current use statistics at Conway. Similarly, we note that in the "safety restraint" category of both teams we reviewed, that the use of mechanical restraints far exceeds the use of personal restraints. Therefore, we further suggest that any such review include the assessment of (less intense and shorter) personal restraints in favor of the use of mechanical restraints.

D. Jonesboro Restraint Data

Data Source and Secondary Analyses. Jonesboro provided a series of yearly restraint reports covering the period from 2018 to 2021 that included individual restraint data by resident. Duration of restraints was not available for 2018 and 2019. We extracted data from these reports and created tables, by year, showing restraint data. As is typical in such data, a small number of individuals accounted for the majority of restraints. For example, for all of the years in our review five or fewer residents accounted for 70% of all personal and mechanical restraints for each year.

Findings. Table 9 below shows the frequency of each type of restraint at Jonesboro over the time period. As noted, the duration of restraints was not included in the 2018 and 2019 data. A slight increase in the number of restraints is shown between 2018 and 2021.

Table 9. Frequency and Duration – Personal and Mechanical Restraints (Jonesboro)

RATE	2018	2019	2020	2021
Average Census	106	105	102	103
PERSONAL RESTRAINTS				
Personal Restraints Frequency (Count)	40	72	76	72
Personal Restraints Total Duration - Minutes (Average Duration/restraint)	-	-	370 (4.9 min)	616 (8.5 min)
MECHANICAL RESTRAINTS				
Mechanical Restraints Frequency (Count)	83	80	66	106
Mechanical Restraints Total Duration - Minutes (Average Duration/restraint)	-	-	3070 (46.5 min)	4481 (42.3 min)

Table 10 following presents per person per year (pp/y) restraint rates as described earlier.

Table 10. Personal and Mechanical Restraint Rates X Year (Jonesboro)

RATE	2018	2019	2020	2021
Personal Restraint Rate (PP/Y)	.38	.69	.75	.70
Mechanical Restraint Rate (PP/Y)	.78	.76	.65	1.03

E. SEAHDC Restraint Data

Data Source and Intensive Study. SEAHDC provided 12 sets of Human Rights Committee (HRC) Restraint Review Meeting Minutes from the period between July 30, 2020 and January 25, 2022. These minutes included the HDC's individual review of restraints that occurred during a 19-month period from June 2020 to December 2021. These meeting minutes were very complete and provided our team with an opportunity to examine a typical HRC review process closely. Using these meeting minutes, we conducted an intensive study of them by first extracting data from each individual meeting minute entry in these minutes. These data were entered into a database we created covering the period; we identified the frequency and duration of both personal and mechanical restraints. During this 19-month period we identified 175 personal restraints and 102 mechanical restraints.

All of the restraints identified in this intensive study were experienced by a total of only 34 unique residents or about 36% of the population of SEAHDC. These residents consisted of 29 males (85%) and 5 females (15%). Of these 34 residents, however, only 11 individuals accounted for 75% of all of the restraint incidents we identified in our study. This is a common finding in reviewing restraint statistics in HDC facilities – that is, a very small number of individuals account for a disproportionate number of restraint incidents.

This study permitted us to evaluate an HDC seeking to reduce the use of restraints over three six-month periods. In the table below we compare statistics for these three periods. Although our database covered 19 months, we have decided to exclude the first month (June 2020, and the restraints during this month) to render the three periods directly comparable. We present the frequency and duration of restraints at SEAHDC in Table 11.

[Table 11 is shown on the page following.]

As shown in Table 11, over this 18-month period there is a clear reduction in the frequency of both the personal and mechanical restraints from the first six month block to the second, but less so between the second and third six month blocks. This is also true for the duration of both personal and mechanical restraints. Note that in the table there is an additional row at the bottom that shows the continuation of mechanical restraints *after* the addition of a chemical restraint. That is, someone who was in a mechanical restraint was then administered a chemical restraint as well, and the duration shown in the table reflects the overall time that restraints continued after that. Therefore, the total duration of mechanical restraints is correctly characterized by the sum of these two rows (i.e., 1,000 min, 643 min, and 486 respectively) which still shows a decline over the 18 month period.

Table 11. Statistics from Three Time Frames Comparing Restraints (SEAHDC).*

STATISTIC	1ST SIX MONTHS (Jul – Dec, 2020)	2nd SIX MONTHS (Jan – Jun, 2021)	LAST SIX MONTHS (Jul – Dec, 2021)
Personal Restraints	83	39	44
Total Personal Restraint Duration	453 min (Average – 5.5 min)	328 min (Average – 8.4 min)	285 min (Average – 6.5 min)
Mechanical Restraints	42	24	29
Total Mechanical Restraint Duration	783 min (Average – 18.6 min)	393 min (Average – 16.4 min)	391 min (Average – 13.5 min)
Additional Mechanical Restraint Duration (Continuing After Implementation of a Chemical Restraint)	217 min (Average – 5.7 min)	250 min (Average – 10.4 min)	95 min (Average – 3.3 min)

***To make each time block six months in length, we eliminated one month Jun 2020 which included 9 personal restraints and 7 mechanical restraints.**

Using the same database, the table below shows the rate statistics that we calculated for each HDC. In Table 12 we calculated these statistics from the database we created directly from the HRC meeting minutes data we included in our created database.

Table 12. Personal and Mechanical Restraint Rates for three 6-month periods (SEAHDC).

RATE	1ST SIX MONTHS (Jul – Dec, 2020)	2nd SIX MONTHS (Jan – Jun, 2021)	LAST SIX MONTHS (Jul – Dec, 2021)
Census (mid-period)	94	91	90
Personal Restraint Rate (PP/Y)	.88	.43	,49
Mechanical Restraint Rate (PP/Y)	.45	.26	,32

Progression of Restraints. The database we created from the SEAHDC Human Rights Committee review minutes permitted us to do a more fine-grained analysis of these restraints that we believe may have implications for the other HDCs as well. This finding was mentioned in at least one other HDC report as well. In general this has to do with the *progression* from one form of restraint to another. In particular the data we collected in the intensive study at SEAHDC shows such progression.

As noted, in the full 19-month period we identified 175 personal restraints and 102 mechanical restraints of which all but 11 of the mechanical restraints progressed from prior personal restraints. This is important when considering whether personal restraints are used in their own right to ameliorate the behavioral outburst, or are used simply as a means to get individuals into mechanical restraints.

Additionally, we identified “progressions” from mechanical to chemical restraints which had the effect of extending the duration of mechanical restraints. Of the 115 chemical restraints that were included in the HRC meeting minutes, 31 of them (27%) were chemical restraints only and were not associated with prior personal or mechanical restraints. We identified 23 chemical restraints (20%) which were preceded by personal restraints. The remaining 61 chemical restraints (53%) were preceded by mechanical restraints (which, in turn, were typically preceded by personal restraint) with the mechanical restraints continuing after the chemical restraint was administered. It is for this reason that we noted that the duration of mechanical restraints needs to include the time in a mechanical restraint *after* a person may have also received a chemical restraint. We strongly recommend caution in the use of chemical restraints while someone is concurrently in mechanical restraints.

Review of chemical restraints is beyond the purview of this report; however, it should be understood that there often exists a *progression* among restraints with the initial personal restraints often giving rise to a cascade of restraints – both mechanical and chemical that may follow.

The short duration of personal restraints (usually just a few minutes) often lead to mechanical restraints of more than 20 minutes. As any part of a policy or plan to reduce the use of restraints needs to take this progression into account, lest personal restraints simply become a “gateway” to additional restraints. In our view, two laudable goals for all HDCs would be to track and study such restraint progressions in their HRC reviews and seek to: (1) *increase* the duration of personal restraints while simultaneously working to *decrease* the duration of mechanical restraints; and (2) work to have personal restraints function as the *only* restraints used when needed. As personal restraints successfully replace mechanical restraints – that is, breaking the “progression” – then the goal can shift to reducing the use of personal restraints as well.

CONSULTANT RECOMMENDATIONS

Before providing specific recommendations based on our findings we want to address the recommendations made by the DDS Behavioral Consultation Committee, specifically those that the committee has placed on hold. We support all of the committee's recommendations so far and make the following recommendations in regard to the "on hold" recommendations. There is a certain amount of overlap in our reiteration of the DDS Behavioral Committee recommendations (#1 below) and our specific recommendations under #2 below.

1. Recommendations Related to the *DDS Behavioral Consultation Committee*

Earlier, in the Introduction herein, we identified the six specific recommendations that the Committee had placed on hold pending consultant input. Below are our recommendations related to the six that the Committee placed on hold. In addition to the recommendations shown under the following headings, some of our specific recommendations made in part 2 of this section may also be relevant.

A. Consultant recommendations in relation to Objective 2: *Identify preferred restraint and communication options to be used while working to reduce restraints.*

1. Expand communication strategy options for individual clients being restrained, including adding sign language, gestures, timers, visual schedules, and similar media.

2. Create, implement, and develop training on a new manual of available communication strategies and devices; target administrative, supervisory, professional and clinical staff members to ensure that interdisciplinary teams have access to current, effective practices.

3. Provide supplemental training to all client-facing staff on effective communication strategies to prevent, and effectively de-escalate behavioral incidents.

4. Discontinue the use of the papoose boards. Note that there is some concern around the use of restraint chairs as well; however, the state's committee (in Objective 2) only addressed the papoose boards. If discontinuance of the use of papoose boards results in an increase in the use of restraint chairs, then Arkansas should consider also banning them.

B. Consultant recommendations in relation to Objective 3: *Develop a comprehensive approach to reducing restraint usage*

1. Identify behavioral health service gaps for individual clients at each HDC, identify what is needed to address those gaps, and adopt metrics to evaluate identified mental health and service needs.

2. Establish a group to review all behavioral support plans to ensure removal of restraint-specific language.

3. Review HDC restraint training and annual follow-up training; seek to standardize curricula and time in training. Enhance training that seeks to *prevent* behavioral

crises before restraint is required. Use existing HDC training teams and procedures to build a DDS "best practice" training standard.

4. Develop and adopt a written plan for restraint reduction of all types. Implement the plan in the same manner in all Human Development Centers. Explore general approaches such as the six core strategies promulgated by the National Association of State Mental Health Program Directors (nasmhpd.org).

5. Utilize the existing elements in HDCs to develop a comprehensive standardized restraint data tracking, reporting, review, and oversight system; apply to all HDCs; develop standardized HRC or similar restraint review and oversight processes; produce standardized oversight meeting minutes; create a standardized reporting format that presents comparable frequency, duration, and standardized rates.

6. Develop and adopt a restraint *data analytic* framework that goes beyond the simple reporting/tracking/graphing of incidents and other data to the actual analysis of data to produce useful information for administrative decision-making that connects with the comprehensive standardized restraint reduction plan. Develop comprehensive metrics (such as standardized rate measures, e.g., per person per year) that can be used to gauge restraint reduction efforts across all HDCs.

2. Additional Consultant Recommendations

1. Review all DDS and local HDC restraint policies and procedures; to the extent possible create a single DDS-state-wide set of restraint policies and procedures that are informed by and meet all ICF/IID regulations (i.e., Appendix J).

2. Because we believe that restraint cannot be reduced simply by creating regulations, we urge the creation of a DDS-wide separate, stand-alone policy/procedure/handbook document pertaining to the reduction in the use of all types of restraints. Include in this a careful examination of the use of "safety" vs. "emergency" restraints as well as the use of "progressive" restraints; e.g., short duration personal restraints followed by longer duration mechanical restraints (with or without chemical restraints added). The consultants are concerned that the current system in both of these cases may inadvertently reduce the effectiveness of any restraint reduction messaging or philosophy.

3. Create a centralized DDS restraint review function that has the capability to: collect annual and/or quarterly reports from all HDCs; create a DDS level annual restraint report that addresses all restraint data; this function may benefit from an interdisciplinary "DDS state-wide" restraint review team. In conjunction with this it may be beneficial to identify a DDS central office position with restraint oversight, training, and analytic capabilities. Although the state may have a centralized reporting function, during our review the only data received from Central Office were Monthly Statistical Reports between 2018 and 2022. These

reports seem to only list the data submitted by HDCs – there was no analytic function evident in these reports.

4. Create an *analytic* approach to the collection, presentation, and reporting of restraint data; currently data collection is uneven across HDCs although in some facilities large amounts of data are collected. The goal of an analytic approach is to "use data to inform practice" (Huckshorn, 2008); at present although some elements of HDCs are awash in data, there is less *information* being extracted from the data to inform practice. Results from this process should be reviewed in light of the standardized restraint reduction documents.
5. Apparently the HDCs have all employed the CPI restraint training system. In some cases there appeared to be disparities in how the CPI program was trained. The goal would be to standardize the basic training program across HDCs if not already completed. If local needs exceed such training then add additional training programs to specific areas. Agree on standardized training formats, content, and time with modifications to same based on local HDC need. Subsequent discussions suggest that the basic CPI training is approximately 7.5 hours and that about 1 hour each is allotted to subsequent topics identified by our team.
6. Closely examine the use of chemical restraints in conjunction (concurrently) with mechanical restraints. Our team urges extreme caution.
7. Employ existing video cameras as restraint data capture elements to provide useful critical review data for informing routine practices.
8. Assure that "rotating shift" personnel are afforded the full restraint training received by regular staff members.
9. If not already available, where needed, create training elements on behavioral acting out during mental health crises; include information on dual diagnosis (MH and IDD).
10. Explore additional trauma-based training. All HDCs acknowledged that trauma-informed perspectives were incorporated into assessment and treatment planning; however, staff members at two facilities (Arkadelphia and Jonesboro) requested additional training.
11. It may be reasonable for selected staff members (such as QIDPs) go through a nationally-recognized training program to become registered behavioral technicians (RBTs) (information can be found at www.bacb.com/rbt.

CONCLUSION

The consultants thank DDS and the HDCs for the opportunity to undertake this review of restraints pursuant to the DDS Behavioral Consultation Committee. We found all of the DDS and HDC personnel to be professional and helpful in our work and we owe them a debt of gratitude for their assistance.

We found the personnel we interviewed to clearly have the best interests of those they care for at heart. We generally found an interest in both the reduction of restraint use and/or the improving of the quality, review and oversight of restraints. We note that some of the populations of HDCs have been shifting slightly with the result that behavioral challenges with regard to mental health concerns are becoming more common.

As is typical in this area, we found that a rather small percentage of complex individuals account for the majority of restraints of all kinds. Nonetheless, there are certain elements in the DDS system in which restraint use is still rather prevalent; these areas are good targets for reduction efforts.

The system, as a whole, would benefit from more standardized approaches including an over-arching philosophy, including related policy and procedures of restraint reduction. It may be timely to review and update all DDS and HDC restraint policies/procedures. Although there is typically ample data in the system we think that an increase of *analytic* treatment of such data to inform practice would be very beneficial.

We think there are some issues that require more intense scrutiny such as: (1) the relationship between safety and emergency restraints; (2) the progression of restraints (i.e., personal restraint as a gateway to more restrictive forms); (3) the continued use of problematic restraint forms (e.g., papoose boards); and (4) the concurrent use of mechanical and chemical restraints. In contrast, with a few exceptions, we also found that in most HDCs and in many areas the use of restraints has diminished in frequency and duration over the past several years. Therefore, the facilities have a very good start and need to re-double their efforts along the path to reduced restraint use.

In general, we are hopeful that DDS and the HDCs can accomplish the reduction in the use of all types of restraint and we hope that the review and recommendations that we have provided will be found useful.

Respectfully submitted:

Theodore A. Kastner, MD, MS
Kevin K. Walsh, Ph.D.
Robert Bowen

September, 2022

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APPENDICES

Appendix A – Qualifications of Consultant Team

Appendix B – *Standard Interview Questions for Teams* form

Appendix C – Arkadelphia Restraint Data Statistics

Appendix D – Booneville HDC Restraint Statistics

Appendix E – *A Rule Comparison: ICF/IID Regulations Appendix J and Arkansas DDS.*

APPENDIX A
QUALIFICATIONS OF CONSULTANT TEAM

Theodore Kastner, M.D., M.S.

Theodore Kastner is a physician board-certified in three specialties – Pediatrics, Developmental and Behavioral Pediatrics and Neurodevelopmental Disabilities. Dr. Kastner completed his training in the care of children and adults with developmental disabilities and handicapping conditions at the Rose F. Kennedy Center of the Albert Einstein College of Medicine in 1986. In addition, in 1997 he received a Master of Science in population health from the University of Wisconsin.

Dr. Kastner is a leading authority on the health care concerns of people with I/DD. In 1998 Dr. Kastner founded and served as the President of Developmental Disabilities Health Alliance, Inc. (DDHA), which grew to become the largest provider of health care services to persons with I/DD in New Jersey. DDHA was nationally recognized for its health care programs for persons with I/DD and received a CMS Health Care Innovations Challenge Award to further its work.

Between 2015 and 2019, Dr. Kastner was Co-Director of the Rose F. Kennedy Center at the Albert Einstein College of Medicine. In that role he also served as Director of the RFK Children's Evaluation and Rehabilitation Center at Montefiore Medical Center and as the Director of the Leadership in Education in Neurodevelopmental Disabilities (LEND) program, a federally-designated training program in neurodevelopmental disabilities. He also served as the Director of the Rose F. Kennedy University Center for Excellence in Developmental Disabilities (UCEDD) a federally funded center for people with developmental disabilities. Additionally, he served as principal Investigator on four federally-funded training programs and half a dozen state and local contracts.

In 2019, Dr. Kastner became Commissioner of the New York State Office for Persons With Developmental Disabilities (OPWDD) where he led an organization with a budget of approximately $10 billion with 18,000 employees serving 121,000 individuals with intellectual and developmental disabilities (I/DD).

Dr. Kastner has been a recipient of more than a dozen awards and honors including the Health Care Professional of the Year Award by The Arc and the Elizabeth M. Boggs Citizenship Award from the United Cerebral Palsy Associations of New Jersey and the Ann Klein Advocate Award from the New Jersey Community Health Law Project.

Dr. Kastner has served as a consultant to innumerable national organizations and agencies including the US DOJ and 14 states. Dr. Kastner has presented at over 200 conferences and training workshops and authored more than 100 publications in the field of I/DD. His research interests are in the areas of primary health care, mental health problems, infectious disease concerns, managed care and public policy issues for people with I/DD.

Kevin K. Walsh, Ph.D.

Kevin Walsh is the founder and president of Kevin Walsh Consulting, LLC, a firm that specializes in the training of techniques to manage behavioral crises including personal control techniques to staff members in the field of intellectual and developmental disabilities

(www.kevinwalshconsulting.com). Dr. Walsh has spent his entire career in the field of intellectual and developmental disabilities in clinical, administrative, and research capacities. In his full-time capacity, he has recently retired as the Director of Quality Management and Research for Developmental Disabilities Health Alliance, Inc. (DDHA) a specialized statewide health care and in-home behavioral support organization. He received his undergraduate degree in developmental psychology in 1972 from Mount Saint Mary's University in Emmitsburg, Maryland and his MA and Ph.D. degrees in Life-Span Developmental Psychology from The University of Akron in Ohio in 1978 and 1981 respectively.

He served for 14 years as a part-time Associate Editor of the journal *Intellectual and Developmental Disabilities* published by the American Association on Intellectual and Developmental Disabilities (AAIDD). Additionally he has served on the boards of directors of the state, regional, and national levels of that organization. He is a past President and current Treasurer of the Arc of Cumberland County having been a member of that board since 1991. Until this past year he also served as a Member-at-Large on the Executive Committee of the board of The Arc of New Jersey, where he began his service in the mid-1990s.

Dr. Walsh has presented widely at conferences and meetings and continues to regularly publish in the field of intellectual and developmental disabilities with over 50 peer-reviewed articles or book chapters to his credit. Dr. Walsh's research interests include clinical practice models of specialized health care for people with disabilities; quality and outcomes research in the field; behavioral approaches; and policy and service system needs for people with intellectual and developmental disabilities.

He has consulted in ten states in addition to New Jersey (ME, MA, CT, PA, MD, FL, WA, AR, WV and OH) and has often served as an expert witness in state-level cases involving developmental and other disabilities and quality of care issues.

Dr. Walsh was a long-time member (since the 1980s) of the New Jersey Division of Developmental Disabilities (NJ/DDD) committee that reviews the behavioral management policies and personal control technique curricula used by agencies under contract with the NJ/DDD. During his tenure on this committee, it has reviewed hundreds of behavior support and behavioral restraint policies and procedures. As the longest-serving non-state member of the BPRC committee, Dr. Walsh has reviewed nearly every personal control technique program proposed for use by any New Jersey organization since the 1980s.

Bob Bowen

Bob Bowen is a behavioral consultant and trainer with Prag Consulting in Melbourne, Australia. He has over 40 years of experience supporting individuals with complex behavioral needs in the United States, Canada, and Australia. He has provided keynote and plenary presentations at conferences in the United Kingdom, Ireland, Norway, Australia, Hong Kong, Canada and the United States. Bob is the developer of The Matrix of Needs, an innovative approach to understanding human needs. he has published over 20 peer and scientifically reviewed articles, three book chapters, and presented hundreds of workshops on the prevention of workplace violence, while improving the quality of life for people affected by disabilities, and the staff who support them.

During his career in human services, Bob has held positions ranging from direct support professional to CEO and almost everything in between. He was the CEO of The Mandt System, Inc., an organization providing training in the prevention and, if needed, use of restraint. In this role he was the primary author of the curriculum used to teach preventative measures, and wrote the chapters on Trauma Informed Services and Positive Behavior Support. He has also served as an adjunct assistant professor of psychiatry at the University of Rochester in New York for eleven years, and also has experience teaching at Walsh University in North Canton, Ohio, and at Hawkeye Community College in Waterloo, Iowa. Additionally, Bob was a field placement supervisor for the Malone University Department of Social Work in Canton, Ohio, and is currently a member of the Department of Social Work Community Advisory Board at Malone.

Bob is a member of the Australasian Society for Intellectual Disability, the Restraint Reduction Network in the United Kingdom, the National Association of Social Workers, the National Organization of Human Services, the Association for Positive Behaviour Support, and the National Association of Qualified Intellectual Disability Professionals. Bob is certified in trauma treatment through the National Institute for the Clinical Application of Behavioral Medicine, and the Trauma Research Foundation.

Appendix B

Standard Interview Questions for Teams form

The Standard Interview document begins on the following page. Because the goal in this appendix is to show the content of the Standard Interview, much of the space provided for personnel to record their answers has been removed. The document was provided to HDCs in both a fill-in MS Word format and in a .pdf format. All forms were acceptable and provided for unlimited space to include textual responses. The abbreviated answer spaces shown in the copy following is for brevity.

Arkansas Human Development Centers

Restraint Review Project

Winter/Spring, 2022

STANDARD INTERVIEW

I. IDENTIFYING INFORMATION

HDC NAME:_____ **DATE:**_____

PERSON COMPLETING FORM (name/title):_____

EMAIL:_____ **PHONE:** _____

OTHER HDC STAFF MEMBERS PARTICIPATING IN COMPLETING THIS FORM (names/titles):

_____

_____

When completed, submit this form to K. Walsh at: email: wallvine.kw@gmail.com.
If mailed, send to: K. Walsh, 2490 Vine Rd, Vineland NJ 08361-2520

Providing support to direct support professionals who are the people charged with implementing physical and/or mechanical restraints is a key part of the role of administrators, managers and/or clinical staff members. These questions are designed to enhance the ability of the various persons, teams and oversight committees at Arkansas Human Development Centers to "*develop a comprehensive approach with the help of clinicians and advocates to significantly reduce the use of restraints on developmental and intellectually disabled clients living at the HDCs*." (DDS Behavioral Support Committee Report Summary, 2021)

FOR OFFICE USE:
Form ID #:_____ DATE
RECEIVED:_____
Information Coded and Entered: ☐ Date:_____ By:_____
NOTES:_____
_____

II. RESTRAINT TYPE, USE, AND TRAINING

NOTE: Medicaid ICF/IID regulations mostly cover mechanical restraint use; however, increasingly facilities are using personal hold restraints (PHR). This section covers both

A. MECHANICAL RESTRAINTS

DOES THE HDC USE MECHANICAL RESTRAINTS?.....
Yes ☐ No ☐

If "no" skip to section B; if "yes" complete section A.

If MECHANICAL RESTRAINTS are used, please list all mechanical restraint devices that are employed:

_____

_____

DOES THE HDC USE EMERGENCY MECHANICAL RESTRAINTS (THAT IS, WITHOUT A PLAN BEING IN THE IPP)?.....Yes ☐ No ☐

NOTES: _____

_____

IS NON-EMERGENCY USE OF MECHANICAL RESTRAINTS USED (THAT IS, "PLANNED" AND INCLUDED IN THE IPP)?.....Yes ☐ No ☐

NOTES: _____

_____

ARE STAFF MEMBERS TRAINED IN THE IMPLEMENTATION OF MECHANICAL RESTRAINTS.....Yes ☐ No ☐

If yes, please list below all training provided to staff who implement mechanical restraints:

_____

NOTE: Materials used to train staff members who implement mechanical restraints have been requested in the separate request for materials from the HDC.

DO STAFF MEMBERS TAKE PART IN A PERIODIC "REFRESHER" CLASS ON THE USE OF MECHANICAL RESTRAINTS?.....Yes ☐ No ☐

If yes, describe: _____

_____

B. PERSONAL HOLD RESTRAINTS

DOES THE HDC USE PERSONAL HOLD RESTRAINTS (PHR)?.....Yes ☐ No ☐

If PERSONAL HOLD RESTRAINTS are used, please list all the types that are employed:

_____

_____

DOES THE HDC USE EMERGENCY PERSONAL HOLD RESTRAINTS (THAT IS, WITHOUT A PLAN BEING IN THE IPP)?.....Yes ☐ No ☐

NOTES: _____

_____

IS NON-EMERGENCY USE OF PERSONAL HOLD RESTRAINTS USED (THAT IS, "PLANNED" AND INCLUDED IN THE IPP)?.....Yes ☐ No ☐

NOTES: _____

_____

ARE STAFF MEMBERS TRAINED IN THE IMPLEMENTATION OF PERSONAL HOLD RESTRAINTS (PHR)?..... Yes ☐ No ☐

If yes, please list all training provided to staff members who implement PHRs?

_____

_____

NOTE: Materials used to train staff members who implement personal hold restraints have been requested in the separate request for materials from the HDC.

DO STAFF MEMBERS TAKE PART IN A PERIODIC "REFRESHER" CLASS ON THE USE OF PERSONAL HOLD RESTRAINTS?.....Yes ☐ No ☐

If yes, describe: _____

_____

C. ADDITIONAL RESTRAINT TRAINING INFORMATION

DURING THE INITIAL STAFF MEMBER ORIENTATION/TRAINING, IS TIME SPENT IN TRAINING STAFF MEMBERS IN THE *PREVENTION* OF BEHAVIORAL INCIDENTS?.....Yes ☐ No ☐

If so, how much time: _____

DURING THE INITIAL STAFF MEMBER ORIENTATION/TRAINING,

IS TIME SPENT IN TRAINING STAFF MEMBERS IN THE *DE-ESCALATION* OF BEHAVIORAL INCIDENTS?.....Yes ☐ No ☐

If so, how much time:_____

HOW MUCH TIME IN TOTAL IS SPENT IN THE TRAINING OF STAFF MEMBERS IN THE IMPLEMENTATION OF RESTRAINT PROCEDURES IN THE INITIAL STAFF ORIENTATION?

HOW MUCH TIME IS SPENT ON REFRESHING OR RE-CERTIFYING STAFF MEMBERS IN THE FOLLOWING:

PREVENTION of PROBLEM BEHAVIORS: _____ minutes

DE-ESCALATION of PROBLEM BEHAVIORS:_____minutes

IMPLEMENTTION OF RESTRAINT PROCEDURES:_____minutes

Additional Notes:_____

_____

HOW OFTEN DOES DE-BRIEFING OCCUR AFTER THE USE OF RESTRAINT (describe)?

_____

_____

WHAT ARE THE CRITERIA FOR DECIDING WHEN TO DE-BRIEF AFTER THE USE OF RESTRAINT?

_____

_____

ADDITIONAL NOTES FOR SECTION II:

_____

_____

III. RESTRAINT REVIEW AND OVERSIGHT

WHO ARE THE PEOPLE IDENTIFIED IN POLICY/PROCEDURE WHO ARE PERMITTED TO AUTHORIZE THE USE OF RESTRAINT? [SEE GUIDANCE §483.450(D)(3)]

_____

_____

DOES THE QIDP REVIEW RESTRAINT DATA?.....Yes ☐ No ☐

If so, how:_____

_____

NOTE: HDC restraint policies and procedures, including oversight and review procedures, have been requested from each HDC in the general information request. However, the goal in this section is to get a brief description of current processes.

DOES THE HDC HAVE A <u>DEDICATED</u> RESTRAINT REVIEW COMMITTEE? **Yes** ☐ **No** ☐

If yes, does the committee meet on a regular basis?
(i.e., monthly or quarterly)?..... **Yes** ☐ **No** ☐

If yes, does the committee produce official minutes that are distributed? **Yes** ☐ **No** ☐

If minutes are produced, to whom are minutes distributed?

_____

_____

If there is NO <u>dedicated</u> restraint review committee, what alternative is used?

_____

_____

WHETHER THERE IS A DESIGNATED REVIEW COMMITTEE OR NOT, DESCRIBE THE RESTRAINT REVIEW PROCESS:

_____

_____

HOW ARE CASES REFERRED TO THE COMMITTEE FOR REVIEW (WHAT IS THE CRITERION?) describe:

_____

_____

ARE ALL RESTRAINTS REVIEWED?.....**Yes** ☐ **No** ☐

If not, is there a cutoff for type, frequency or duration? If so, describe:

_____

_____

HAVE COMMITTEE MEMBERS BEEN TRAINED IN RESTRAINTS AND ON OVERSIGHT MECHANISMS?.....**Yes** ☐ **No** ☐

WHAT IS THE FEEDBACK PROCESS FROM THE COMMITTEE TO THE QIDP, SUPERVISORS, AND STAFF IMPLEMENTING THE RESTRAINTS? Describe:

_____

_____

IS THERE ADDITIONAL ADMINISTRATIVE REVIEW OF RESTRAINTS? (If so, describe):

_____

_____

DOES COMMITTEE OVERSIGHT OR RECOMMENDATIONS RESULT IN *INDIVIDUAL PROGRAM PLAN* CHANGES?.....**Yes** ☐ **No** ☐

If yes, what is the mechanism?

_____

IN SUCH CASES, ARE PLAN CHANGES FOLLOWED-UP BY THE REVIEWING COMMITTEE?.....**Yes** ☐ **No** ☐

If so, how:_____

_____

IV. RESTRAINT DOCUMENTATION AND DATA COLLECTION

ARE ALL RESTRAINTS DOCUMENTED?.....**Yes** ☐ **No** ☐

If YES, how documented:_____

_____

If NOT, why not?_____

_____

WHAT IS THE POLICY AND PROCEDURE FOR COLLECTION OF DATA? Describe

_____

WHAT FACTORS ARE USED TO IDENTIFY PATTERNS OF RESTRAINT USE?

_____

IS THERE A PROCESS FOR ASSESSING WHETHER RESTRAINTS WERE USED CORRECTLY?..... **Yes** ☐ **No** ☐

If YES, describe the process:

_____

DESCRIBE WHAT HAPPENS IN THE EVENT THAT RESTRAINTS WERE DETERMINED TO HAVE BEEN IMPLEMENTED INCORRECTLY (such as re-training, staff discipline, etc.):

_____

_____

V. COMPLIANCE WITH ACTIVE TREATMENT REQUIREMENTS

DOES EACH CONSUMER/RESIDENT WITH WHOM RESTRAINT IS USED HAVE A FUNCTIONAL BEHAVIOR ASSESSMENT ON FILE ADDRESSING THE BEHAVIORS WHICH REQUIRE RESTRAINT USE?

Yes ☐ **No** ☐

IF ANY TYPE OF RESTRAINT IS INCLUDED IN THE IPP (I.E., PLANNED RESTRAINT), ARE SPECIFIC PROGRAM PLANS ON FILE?

Yes ☐ **No** ☐

HAVE SUCH PLANS BEEN REVIEWED BY A HUMAN RIGHTS COMMITTEE?

Yes ☐ **No** ☐

IS DOCUMENTATION OF SUCH REVIEW INCLUDED IN THE IPP DOCUMENTS?

Yes ☐ **No** ☐

ARE LESS RESTRICTIVE ALTERNATIVES ATTEMPTED AND/OR CONSIDERED?

Yes ☐ **No** ☐

FOR CONSUMERS/RESIDENTS WITH HISTORY OF RESTRAINTS ARE BEHAVIORAL OR OTHER INTERVENTIONS INCLUDED IN THE IPP?

Yes ☐ **No** ☐

IF SO, ARE THEY REGULARLY MONITORED?.....

Yes ☐ **No** ☐

Briefly describe how monitoring is carried out:

_____

_____

ARE SUCH PLANS MADE AVAILABLE TO THE RESTRAINT REVIEW COMMITTEE?.....**Yes** ☐ **No** ☐

ARE THERE CLEAR ATTEMPTS TO REDUCE THE FREQUENCY AND DURATION OF INDIVIDUAL RESTRAINT USE?..... **Yes** ☐ **No** ☐

If so, describe how?

_____

_____

IS THERE A FACILITY-WIDE EFFORT TO REDUCE THE FREQUENCY AND DURATION OF RESTRAINTS USE?.....**Yes** ☐ **No** ☐

IF SO, IS THERE A WRITTEN PLAN?.....**Yes** ☐ **No** ☐

HOW IS THE PLAN IMPLEMENTED?

_____

_____

HOW IS THE PLAN MONITORED?

_____

_____

END OF STANDARD OUESTIONS

ADDITIONAL NOTES OR COMMENTS:

_____

_____

THANK YOU FOR YOUR COOPERATION AND PARTICIPATION IN THIS PROJECT. IT IS MUCH APPRECIATED!

End of Document

Appendix C

Arkadelphia Restraint Data Statistics

[Appendix table shown on the page following.]

Arkadelphia Restraint Data

#	Year	Quarter	Date Range	FREQUENCY			DURATION		Avg. Quarterly Census	RATES (per person per year)		
				Personal Restraints	Mechanical Restraints	Chemical Restraints	Personal Restraints	Mechanical Restraints		Personal Restraint Rate (pp/y)	Mechanical Restraint Rate (pp/y)	Chemical Restraint Rate (pp/y)
1	2018	1	Jul - Sep	21	6	1	64	188	116	0.18	0.05	0.01
2	2018	2	Oct - Dec	6	4	2	18	131	116	0.05	0.03	0.02
3	2019	3	Jan - Mar	15	5	0	63	121	116	0.13	0.04	0.00
4	2019	4	Apr - Jun	31	10	7	93	165	116	0.27	0.09	0.06
5			**ANNUAL**	**73**	**25**	**10**	**238**	**605**	**116**	**0.63**	**0.22**	**0.09**
6												
7	2019	1	Jul - Sep	24	13	6	86	271	115	0.21	0.11	0.05
8	2019	2	Oct - Dec	13	4	4	35	130	114	0.11	0.04	0.04
9	2020	3	Jan - Mar	15	13	10	56	258	113	0.13	0.12	0.09
10	2020	4	Apr - Jun	62	25	27	225	511	110	0.56	0.23	0.25
11			**ANNUAL**	**114**	**55**	**47**	**402**	**1170**	**113**	**1.01**	**0.49**	**0.42**
12												
13	2020	1	Jul - Sep	69	35	19	300	593	106	0.65	0.33	0.18
14	2020	2	Oct - Dec	60	20	18	243	408	103	0.58	0.19	0.17
15	2021	3	Jan - Mar	46	37	21	189	969	99	0.46	0.37	0.21
16	2021	4	Apr - Jun	30	33	11	120	741	101	0.30	0.33	0.11
17			**ANNUAL**	**205**	**125**	**69**	**852**	**2711**	**102**	**2.01**	**1.23**	**0.68**
18												
19	2021	1	Jul - Sep	24	38	18	114	778	102	0.24	0.37	0.18
20	2021	2	Oct - Dec	13	29	13	30	676	102	0.13	0.28	0.13
21			**SEMI-ANNUAL**	**37**	**67**	**31**	**144**	**1454**	**102**	**0.36**	**0.66**	**0.30**

Appendix D

Booneville HDC Restraint Statistics

YEAR-OVER-YEAR COMPARISONS (2019 – 2021)

PERSONAL HOLD RESTRAINTS – Booneville HDC

#	Statistic	2019 [1,2]	2020	2021
1	Total number of personal holds applied (2021)	**702 (936)**	**887**	**575**
2	Total number of individuals in personal holds during 2021	**234 (312)**	**235**	**195**
3	Average number of personal hold restraints (per person / per year)	**5.5 (7.3)**	**7.3**	**4.8**
4	Average number of individuals restrained (personal hold) per month (and range)	**26 (35) (23 to 32)**	**27 (21 to 32)**	**22 (16 to 27)**
5	Average number of individuals restrained with a personal holds per month as a percent of census	**20.3% (27.3%)**	**22.3%**	**18.3%**
6	Range in the number of individuals restrained (personal holds) in a month	**23 to 32**	**21 to 34**	**16 to 27**
7	Total minutes in restraint for 2021 (all personal hold restraints)	**2,181 min (2,908)**	**3,196 minutes**	**2,073 minutes**
8	Average duration of personal hold restraints	**3.1 min (3.1)**	**3.6 minutes**	**3.6 minutes**

[1] Data on personal holds only available for 9 months in 2019.
[2] Values in parentheses are 9-month values prorated to 12 months for comparison purposes.

YEAR-OVER-YEAR COMPARISONS (2019 – 2021)

EMERGENCY MECHANICAL RESTRAINTS (EMR) – Booneville HDC

#	Statistic	2019	2020	2021
1	Total number of EMRs applied (2021)	**214**	**145**	**135**
2	Total number of individuals in EMR during 2021	**132**	**102**	**78**
3	Average number of EMR restraints (per person / per year)	**1.7**	**1.2**	**1.1**
4	Average number of individuals restrained (EMR) per month (and range)	**11 (6 to 15)**	**9 (6 to 12)**	**6.5 (3 to 10)**
5	Average number of individuals restrained with an EMR per month as a percent of census	**8.5%**	**7.4%**	**5.4%**
6	Range in the number of individuals restrained (EMRs) in a month	**6 to 15**	**6 to 12**	**3 to 10**
7	Total minutes in restraint for 2021 (all EMR restraints)	**8,372 minutes**	**6,155 minutes**	**4,090 minutes**
8	Average duration of EMR restraints	**39.1 minutes**	**42.4 minutes**	**30.3 minutes**

Appendix E

A Rule Comparison: ICF/IID Regulations Appendix J and Arkansas DDS.

[The appendix begins on the page following.]

A Rule Comparison: ICF/IID Regulations Appendix J and Arkansas DDS

Target Group: Arkansas Human Development Centers, Arkansas DDS

Introduction

42 CFR 483.450 is a "Condition of Participation" related to the behavior of clients and the practices of the facility to address these behaviors positively which the Human Development Centers (HDC's) in Arkansas must meet in order to maintain their certification to participate in Medicaid funded services. When doing surveys to measure compliance with waiver funded expectations, federal surveyors use the ICF/DD regulations as a template to measure the implementation of services addressing health and safety issues. The Interpretive Guidance to Surveyors (Appendix J) states the following Compliance Principles:

"The Condition of Participation of Client Behavior and Facility Practices is met when:
• Individual programs and activities regularly include use of positive techniques, teaching strategies, and supports. Efforts are made to reduce and eliminate use of restrictive techniques with positive results;
• Staff teach and reinforce appropriate behaviors, such as communication skills, social skills, independence and choice-making skills, coping skills, and leisure skills which serve as functional substitutes for inappropriate behaviors; and
• Restrictive techniques are used only when warranted by the severity of the behavior, and result in desired behavioral outcomes.

The Condition of Participation of Client Behavior and Facility Practices is not met when:
• Restrictive, intrusive techniques are used to manage or control behavior in lieu of positive teaching strategies;
• Individuals are physically or psychologically injured or harmed as a result of the use of the restrictive interventions and the facility has failed to adequately monitor the use of the intervention; or
• Restrictive interventions are used when they are not warranted or without first attempting less restrictive/more positive measures."

The Comparison

The Arkansas Department of Human Services, Division of Developmental Disability Services (DDS), has promulgated a series of policies and procedures for state-wide use, and each of the five HDC's has their own set of policies and procedures which contain differences between facility policies and procedures and the Condition of Participation in Appendix J for Client Behavior and Facility Practices.

Following is a more detailed look at the standards contained in the Condition of Participation of the ICF/DD regulations governing ICF/DD programs, compared with relevant sections of Arkansas DDS regulations and HDC policies and procedures. The comparison is divided into the following sections:

- Active Treatment
- Assessment
- Replacement Behaviors
- Data Collection/ Plan Monitoring
- Committee Requirements
- Informed Consent
- Client Behavior
- Conduct Towards Clients
- Management of Inappropriate Client Behavior
- Use of Aversive Techniques – Hierarchy of Interventions
- Protection of Rights
- Physical Restraints
- Oversight

ICF/DD Conditions of Participation	Arkansas HDC Policies and Procedures	Comparison Notes
Active Treatment		
(a) Standard: Active treatment Tag number W195 (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward-- (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. W239 (vi) Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.	In the policies and procedures available for review, the term "Active Treatment" was not mentioned. This does not mean that Active Treatment is not being implemented in the HDC's as the policies and procedures reviewed pertained only to behavioral supports. An example of a policy and procedure which would comply with the Active Treatment standards is from Booneville, and reads as follows: "The Psychology Department recognizes that an enriched environment and individualized instruction help develop adaptive behaviors and are the first basis for preventing and managing maladaptive behaviors." Policy #I-F-5 These and other policies and procedures focusing on enriched environments and improved quality of life are important aspects of positive behavior support. The Arkadelphia HDC policy states that: "It is the philosophy of this agency to focus on reinforcing the development and maintenance of appropriate replacement behaviors." , Policy I-F-5	Active treatment is the backbone of the CMS standards. In numerous surveys, CMS has found that when behavioral issues are not addressed, and are significant enough to show non-compliance with behavioral standards, the Condition of Participation for Active Treatment is also at risk of non-compliance, as the client is not able to function with self-determination and independence due to the negative effects of behavior. This and other policies and procedures meet the expectation of W239.

Assessment		
ICF/DD Conditions of Particpation	**Arkansas HDC Policies and Procedures**	**Comments**
W214 standard: (iii) Identify the client's specific developmental and behavioral management needs; Guideline: Assessment of the behavior assumed to be maladaptive should include analyses of the potential causes, such as lack of exposure to positive models and teaching strategies, lack of ability to communicate needs and desires, lack of success experiences, a history of punishing experiences, presence of a physiological condition, or other environmental or social conditions which may elicit or sustain the behavior.	The policies and procedures appear to meet the standard expectations of a Functional Behavior Assessment, as evidenced by the relevant document from the Conway HDC: "Discuss how the functional assessment was conducted such as the use of a formal assessment, interviews, professional knowledge of person, observations of the person. Structural/Environmental/Physical/Sensory Concerns Person served has migraines, constipation, etc., the person served does not like crowds, has problems with transitions, does not like certain television shows, does not like certain foods, does not like certain clothing, etc. Antecedents/triggers contributing to the display of inappropriate behavior. Identify and discuss the events, times and situations that predict when the problem behavior will and will not occur across the full range of typical daily routines" Policy II-D-16	Assessment is the key to identifying what CMS sees as the root causes of a behavior (and this is critical – "assumed to be maladaptive". In addition to the standard definitions of Functional and Structural assessments, the Condition of Participation is recommending ICF/DD programs also consider the following as potential causes of maladaptive behavior: Lack of exposure to positive models Lack of exposure to positive teaching strategies Lack of ability to communicate wants and needs Lack of success experiences A history of punishing experiences Presence of a physiological condition Other social or environmental conditions which sustain the behavior

Replacement Behaviors		
ICF/DD Conditions of Participation	**Arkansas HDC Policies and Procedures**	**Comparison Notes**
483.440(c)(5)(vi) FACILITY PRACTICES: The training program provides specific information as to how to elicit or strengthen appropriate behavior and what behaviors to teach, reinforce or encourage which would reduce or replace the inappropriate behavior. Replacement behaviors are functionally related to the targeted behavior. (6) The individual program plan must also: W240 (i) Describe relevant interventions to support the individual toward independence.	The Jonesboro HDC policies and procedures on behavior support and management are representative of how the Arkansas HDC's meet this requirement: "The focus of Behavior Support and Management is primarily on reinforcing the development and maintenance of functionally appropriate replacement behaviors and secondarily on the decrease of inappropriate behaviors."	After assessment, CMS expects a program plan that identifies why a person engaged in a specific behavior (what did they want to acquire or escape from), and then a specific training program to help the person get or get away from what they want to get (acquire) or get away from (escape), in ways that do not result in harm or injury to self or others.
Data Collection/ Plan Monitoring		
W252 (1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms		Data is a key factor in assessing how the program is working. In the absence of data, CMS assumes the plan is ineffective.
§483.440(e)(2) FACILITY PRACTICES: Standard: Program monitoring and change. The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which	Policy and Procedure #II-D-16 from the Conway HDC clearly lays out the expectation for review of incidents and desired outcomes of Positive Behavior Support plans.	The word "data" is only used once in the Condition of Participation on Client Behavior and Facility Practices. For this reason, we are looking at the data collection requirements in the Active Treatment Condition of Participation for guidance.

the client- - (i) Has successfully completed an objective or objectives identified in the individual program plan; (ii) Is regressing or losing skills already gained; (iii) Is failing to progress toward identified objectives after reasonable efforts have been made or; (iv) Is being considered for training towards new objectives (2) At least annually,		
Committee Requirements		
ICF/DD Conditions of Participation	**Arkansas HDC Policies and Procedures**	**Comparison Notes**
W261 (3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to- - W262 (i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights; W263 (ii) Insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian; and W264 (iii) Review, monitor and make	Policy #QA-4 from the Jonesboro HDC clearly lays out the expectations of the Human Rights Committee. The policy says, in part, that "the person's program coordinator will serve as an advocate to ensure that rights are understood, affirmed and protected and that this includes the right to refuse services." Procedure #1 goes on to say that the committee should be "by membership and training, a resource for center on rights support and protection." A second committee, the Quality Assurance sub-committee, is designated within the HDC's to review behavioral data. The specific form for reporting the use of any restraint is identified and a clear chain of command is presented.	The policies and procedures of the HDC's and the DDDS Central office are in substantial compliance with the relevant conditions of participation found in Appendix J. Where there are differences between the conditions of participation and relevant policies and procedures, the differences do not appear to be substantive in nature. There appears to be a consistent emphasis on the rights of individuals served and the responsibility of the Human Rights Committee to advocate on behalf of the individuals receiving services.

suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. §483.440(f)(3) GUIDELINES: Depending on its size, complexity and available resources, the ICF/DD may establish one multi-purpose committee to serve it for all advisory functions, or it may establish separate single-purpose committees. The facility§s human rights committee may be shared among other agencies or the ICF/DD may utilize a human rights committee established by another governing body, e.g., a county or a statewide group, as long as all pertinent regulatory requirements are met. The regulation does not specify the professional credentials of the "qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior". There is no requirement that any specific disciplines, such as nurse, physician or pharmacist be members of the committee.	As an example, the Booneville HDC policy and procedure on the Human Rights Committee states, in part: a. HRC will review all psychoactive medications that are prescribed for a psychiatric diagnosis, to help ensure appropriate treatment for psychiatric problems. b. HRC will review and decide whether to approve Category III Behavior Treatment Programs which involve the use of certain restrictive or intrusive procedures. c. HRC will review all rights restrictions at least every six months or more often as determined by the Committee. d. HRC will review documented evidence in cases of alleged maltreatment and/or other situations, if requested by the Superintendent, to determine the appropriateness and adequacy of the investigation (as determined by DDS Policy #3004-I). e. HRC will review human rights issues in regard to any research proposals that would be carried out on site f. HRC will review a summary of the personal holds, mechanical restraints, and chemical interventions that have been utilized during the review period prior to the meeting.	

§483.440(f)(3)(i) FACILITY PRACTICES: Any programs which incorporate restrictive techniques (e.g., restraints, medication to manage behavior, restrictions on community access, etc.) have been reviewed and approved by the committee prior to implementation. The committee periodically monitors restrictive programs to determine if the restriction of rights or risk to protections remains justified.	g. HRC will review other emergency procedures, including Emergency Increased Supervision, Suicide Precautions or other restrictive measures that must be implemented immediately to ensure client safety. h. In certain situations it may be necessary to quickly expedite medication changes. If the Medical Department requests emergency approval of a psychoactive medication, the HRC Chairperson will contact HRC members by phone or email to request the emergency approval and will document that information for the client's Master File.	
Informed Consent		
W263 (ii) Insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian; and §483.440(f)(3)(ii) FACILITY PRACTICES: Written consent is present prior to implementation of any restrictive program. Consent is given by the legally appropriate party.	(H) A facility must ensure that each resident and the resident's legally authorized representative are notified of the DADS rules and the facility's policies related to restraint and seclusion.	

The consent is for the program which incorporates the use of a restrictive technique, rather than the restrictive technique alone. The consent is informed, i.e., the person giving consent is aware of the risks, benefits, alternatives, right to refuse and consequences.		
Client Behavior		
ICF/DD Conditions of Participation	**Arkansas HDC Policies and Procedures**	**Comparison Notes**
W266 483.450 Condition of participation: Client behavior and facility practices. §483.450 COMPLIANCE PRINCIPLES: The Condition of Participation of Client Behavior and Facility Practices is met when: o Individual programs and activities regularly include use of positive techniques, teaching strategies, and supports. Efforts are made to reduce and eliminate use of restrictive techniques with positive results; o Staff teach and reinforce appropriate behaviors, such as communication skills, social skills, independence and choice-making skills, coping skills, and leisure skills which serve as functional substitutes for inappropriate behaviors; and o Restrictive techniques are used only	The policy statements found in relevant HDC and DDDS central office documents appear to meet the expectations laid out in the Conditions of Participation, as evidenced by: "The Arkansas Human Development Centers are committed to managing the dangerous behaviors of clients that place the safety of the client and/or others at risk by using the least restrictive interventions that are effective in managing the behavioral situation. While the elimination of dangerous behaviors is sought using positive behavior interventions and de-escalation techniques, it is acknowledged that clients may not always respond to these interventions and the dangerous behavior may escalate to an emergency situation in which physical and/or chemical restraint may be required to protect the safety of the client and/or others.	While the basics of the Arkansas HDC and DDS central office policies and procedures are consistent with the federal Conditions of Participation, the policies and procedures appear to be focused on using positive behavior supports to prevent restraint use rather having a primary focus of addressing behavioral concerns. As an example, the Conway HDC Policies and procedures state, in part, that "A PBSP is usually written, except in circumstances discussed by the IDT, when a Safety Plan has Restraints. The PBSP, at the very least, addresses the specific issue(s) related to the need to plan for restraints of the person receiving services. The PBSP attempts to expand the skill level of the person served by teaching replacement behaviors such that the need for restraints, are reduced or eliminated. The PBSP may also be written to

when warranted by the severity of the behavior, and result in desired behavioral outcomes. The Condition of Participation of Client Behavior and Facility Practices is **not met** when: o Restrictive, intrusive techniques are used to manage or control behavior in lieu of positive teaching strategies; o Individuals are physically or psychologically injured or harmed as a result of the use of the restrictive interventions and the facility has failed to adequately monitor the use of the intervention; or o Restrictive interventions are used when they are not warranted or without first attempting less restrictive/more positive measures.	Restraints are not considered to be a psychologically therapeutic intervention; rather, they are a facility's response to an emergency situation with the goal of restoring the client to a state of being calm and no longer a danger to self and/or others." Source: Jonesboro HDC Policy and Procedure on Behavior Intervention and Emergencies, BH-3.	teach replacement behaviors in order to reduce or eliminate restrictions."
Conduct Toward Clients		
ICF/DD Conditions of Participation	**Arkansas HDC Policies and Procedures**	**Comparison Notes**
W267(a) Standard: Facility practices--Conduct toward clients. (1) The facility must develop and implement written policies and procedures for the management of conduct between staff and clients. §483.450(a)(1) FACILITY PRACTICES:	The focus of the Arkansas HDC and DDDS policies and procedures appears to be on the prevention of abuse and the methodologies for reporting and investigating allegations of abuse.	Policy 3004-I appears to meet the federal expectations of conduct towards clients. The identified policies state what staff should not do, while the guidance for surveyors found in Appendix J has an added focus on what staff should do in their interactions with clients.

Observed practices regarding the behavior and interactions of staff and individuals served demonstrate proactive assertion of the individual's right to learn to exercise his or her rights. §483.450(a)(1) GUIDELINES: "Conduct between staff and clients" refers to the language, actions, discipline, rules, order, and other types of interactions exchanged between staff and individuals or imposed upon individuals by staff during an individual's daily experiences and which affect the quality of an individual's life. These policies and procedures must- - W268 (i) Promote the growth, development and independence of the client; W269 (ii) Address the extent to which client choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible; W270 (iii) Specify client conduct to be allowed or not allowed; and W271 (iv) Be available to all staff, clients, parents of minor children, and legal guardians. W272 (2) To the extent possible, clients must participate in the formulation of these policies and procedures. W273(3) Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.	The Policy and Procedure on Maltreatment Prohibition, Prevention, Reporting and Investigation (Policy 3004-I) identifies four ways in which the HDC's will ensure proper conduct towards clients: 1. Screening: Screen potential employees for a history of maltreatment, as defined by applicable requirements. 2. Training: Train employees, through orientation and through on-going sessions, on issues related to maltreatment prohibition practices such as: • Rights of clients • Recognition of events that may precede or trigger certain behaviors • Early intervention techniques for positive behavioral support • Approved interventions to deal with aggressive and/or catastrophic reactions • Recognizing signs of staff burnout, frustration and stress that may lead to maltreatment; • Definition of maltreatment, and • Reporting suspected maltreatment. 3. Prevention: Provide clients, families, and staff information on how and to whom they may report concerns, incidents and grievances; and how they may receive feedback regarding the concerns that have been expressed. Identify, correct and	The guidance specifically tasks surveyors to look for "Written policies describe how self-determination, as defined by free choice of one's own acts and decisions without external coercion or direction, to the extent possible and self-management, as defined by control of one's own routine and daily responsibilities, to the extent possible, are incorporated into the development of program plans and daily routines." W269 There may be other documents, such as House Rules, in the HDC's, which would address this section.

	intervene in situations in which maltreatment are more likely to occur. This includes an analysis of: • Features of the physical environment that may make maltreatment and/or neglect more likely to occur, such as secluded areas of the facility; • Failure to recognize and respect client rights. • The deployment of staff on each shift in sufficient numbers to meet the needs of the clients, and assure that the staff assigned have knowledge of the individual clients' care needs; • Inappropriate staff behaviors, such as: • derogatory language, • rough handling, • ignoring clients while giving care, • directing clients who need toileting assistance to urinate or defecate in their beds; and • use of items for staff convenience (i.e., disposable briefs, restraints) • The assessment, care planning, and monitoring of clients with needs and behaviors which might lead to conflict or neglect. 4. Identification: Identify events, occurrences, patterns, and trends, such as bruising of clients, or a change in behavior that may suggest maltreatment.	

ICF/DD Conditions of Participation	Arkansas HDC Policies and Procedures	Comparison Notes
	Management of Inappropriate Client Behavior	
483.450(b)(1) (W 275 – W284). • the use of a functional behavior assessment in the development of behavior management programs; • a hierarchy of least to most intrusive measures; and • incorporation of behavior management programs into the IPP. The facility policy for unexpected behavioral incidents must provide direction for the staff in the utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others. Policies must be implemented to ensure that all restrictive procedures begin at the lowest level of the hierarchy unless there is documented evidence that less intrusive interventions have been tried and have been found to be ineffective. The facility is not required to justify discontinuing the use of a more restrictive technique before initiating a less restrictive technique, since the intent of the	The policy and procedure from the Jonesboro HDC, Policy # BH-3, provides a representative view of how the Arkansas HDC's and DDDS Central Office address the specific expectations in the Conditions of Participation related to the management of inappropriate client behavior. Relevant portions of the policy and procedure are found below: Functional Assessment of Behavior (FAB): A problem-solving process for evaluating client inappropriate behavior(s) that looks beyond the behavior itself and identifies the purpose of the specific behavior(s). The focus is on identifying the primary client-specific social, affective, cognitive, environmental, and/or psychiatric factors associated with the occurrence (and non-occurrence) of specific behaviors Positive Techniques may include but are not limited to the following: - Positive Reinforcement - Redirection Technique used to focus the client's attention to an appropriate activity and away from potential trigger or source of agitation. - Graduated Guidance Technique	Policy and Procedure BH-3 provides a clear structure which meets the expectations of the federal Condition of Participation for the Management of Inappropriate Client Behavior. The definitions of the Functional Assessment of Behavior (FAB in the Arkansas regulations, FBA or Functional Behavior Assessment in Appendix J) are clear and easy to understand. The different methodologies identified to teach replacement behaviours, such as Positive Reinforcement, Redirection Technique, etc. are also clear. The only portion of the relevant Conditions of Participation missing is the requirement for a hierarchy of interventions from least to most intrusive. For the sake of comparison a separate section on the Hierarchy of Interventions follows this discussion.

regulation is to use the most positive, least intrusive technique possible. In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible. All interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy. Examples of positive interventions include, but are not limited to, verbal praise reward systems, and prompting.	- Modeling – a technique used by staff to teach the replacement behavior by demonstrating it for the client. - Differential Reinforcement Technique used to develop and maintain an appropriate behavior by paying attention to and reinforcing the occurrences of the appropriate behavior while ignoring minor occurrences of the inappropriate behavior. - Precision Requests The client is presented a choice and reminded of consequences of the choice as pre determined by the client's IDT. The goal is to help the client learn to consider consequences of their actions and to make the more appropriate choice. - Separation to Allow Calming The client is encouraged to move to an area away from the individual and/or situation that is causing the client to be agitated in order for the client to calm.	

Use of Aversive Techniques – Hierarchy of Interventions		
ICF/DD Conditions of Participation	**Arkansas HDC Policies and Procedures**	**Comparison Notes**
Examples of negative interventions include, but are not limited to, removal of a privilege, implementation of restraint, and/or the use of exclusionary time out. Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior. Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.	The Arkadelphia HDC Policy and Procedure on Behavior Health , #IF-5, provides a representative example of how the HDC's meet this specific portion of the Condition of Participation on the Management of Inappropriate Client Behavior. The policy and procedure lays out three categories of behavioral interventions, from least to most restrictive. They are: **Category 1 Interventions:** These interventions may be used without consent/approvals and without a formal Behavior Support Plan (BSP). With the exception of Verbal Interventions, any use of Category I interventions requires documentation on a Behavior Report (BR) regardless of whether such interventions are part of an implemented Behavior Support Plan. Frequent use of these interventions will be determined by the client's IDT, and the IDT will consider if a formal BSP is needed. **Category 1 Interventions are:** **Separation from Activity up to 30 Minutes** **Separation from Setting/Separation Time Out up to 30 Minutes.** **Assignment of Additional Chores** –	While the Policy and Procedure on Behavior Health does comply with the requirement to utilize a hierarchy of interventions from least to most restrictive, there are significant questions about several of the interventions and the rationale for their inclusion. The identified interventions which should be examined for use in a hierarchy of interventions designed to manage inappropriate behavior are: Assignment of Additional Chores Positive Practice Overcorrection Withholding privileges Response Cost Restitution Overcorrection Contingent Personal Property Removal (up to 24 hours) Sensory Deprivation Personal Restraint There is sufficient evidence in peer reviewed research to call the efficacy of these interventions into question. Personal restraint should not be included in a listing of behavioral interventions as it is clearly identified as an intervention of last resort for the safety of the individual and/or others.

	Restitution of the environment **Financial Restitution** **Withholding Privileges** **Removal of personal property for less than one (1) hour.** **Category II Interventions**: These interventions may only be used as part of a formal Behavior Support Plan (BSP) designed by the client's IDT. Once the client's IDT has identified the target behavior(s), a referral is made to the licensed behavioral health professional (LBHP) for the development of the BSP. The BSP is written by the LBHP and must be consented to and approved by the following: client or guardian, IDT representative (QIDP/Program Coordinator), physician, superintendent, licensed psychologist, and Human Rights Committee. The IDT will document the attendant risks of the intervention and the potential risks of the target behavior if allowed to continue without intervention. Category II interventions are: **Response Cost** **Restitution Overcorrection** **Positive Practice Overcorrection**	

	Category III Interventions: These interventions may only be used as part of a formal Behavior Support Plan (BSP) designed by the client's IDT. Once the client's IDT has identified the target behavior(s), a referral is made to the licensed behavioral health professional (LBHP) for the development of the BSP. The BSP is written by the LBHP and must be consented to and approved by the following: client or guardian, IDT representative (QIDP/Program Coordinator), physician, superintendent, licensed psychologist, and Human Rights Committee. The IDT will document the attendant risks of the intervention and the potential risks of the target behavior if allowed to continue without intervention. **Separation Time Out (Activity or Setting)** **Contingent Personal Property Removal up to 24 Hours Maximum** **Sensory Deprivation** **Physical Restraint**	

	Protection of Rights	
ICF/DD Conditions of Participation	**Arkansas HDC Policies and Procedures**	**Comparison Notes**
W285 - Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.	The Jonesboro HDC Policy and Procedure on Behavior Intervention and Emergencies, Policy #BH3, provides a structure requiring approval of the QIDP or the Supervisor on Duty, integration of restraints into the client's IPP, and approval of the Human Rights Committee with monthly monitoring of each restraint. A debriefing process is in place for all restraints.	The safeguards in the policies and procedures reviewed appear to be consistent with those delineated in the Conditions of Participation.
Physical Restraint		
§483.450(b)(1)(iv)(B) The use of physical restraints; "Physical restraint" is defined as any manual method or physical or mechanical device that the individual cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of an individual's body. Examples of manual methods include therapeutic or basket holds and prone or supine containment. (d)Standard: Physical restraints. (1) The facility may employ physical restraint only- - W295 (i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied; W296 (ii) As an emergency measure, but	The Jonesboro HDC Policy and Procedure on Behavior Intervention and Emergencies, Policy #BH3, lists three types of restraint: **Personal Restraint –** the actual physical holding of a client by staff using manual methods that restrict the free movement of the client or restrict movement of or access to a portion or portions of the client's body until the client reaches a state of calm and cooperation, signaling the dangerous behavior has ended and safety is no longer at immediate risk. **Mechanical Restraint –** restricting the free movement of or access to a portion or portions of the client's body until the client reaches a state of calm and cooperation, signaling the dangerous behavior has ended and safety is no longer at immediate risk.	The federal regulations do not differentiate between physical restraint and mechanical restraint. The Arkansas HDC and Central Office policies and procedures do differentiate between the two types of restraint. This makes tracking the use of different types of restraint easier and results in data that reflects, as closely as possible, the actual use of the different types of restraint. The definition of mechanical restraint does not specify that it uses mechanical rather than human force to accomplish the aims of the restraint. The definition of Preventive Restraint incorporates what the federal regulations define as mechanical restraint.

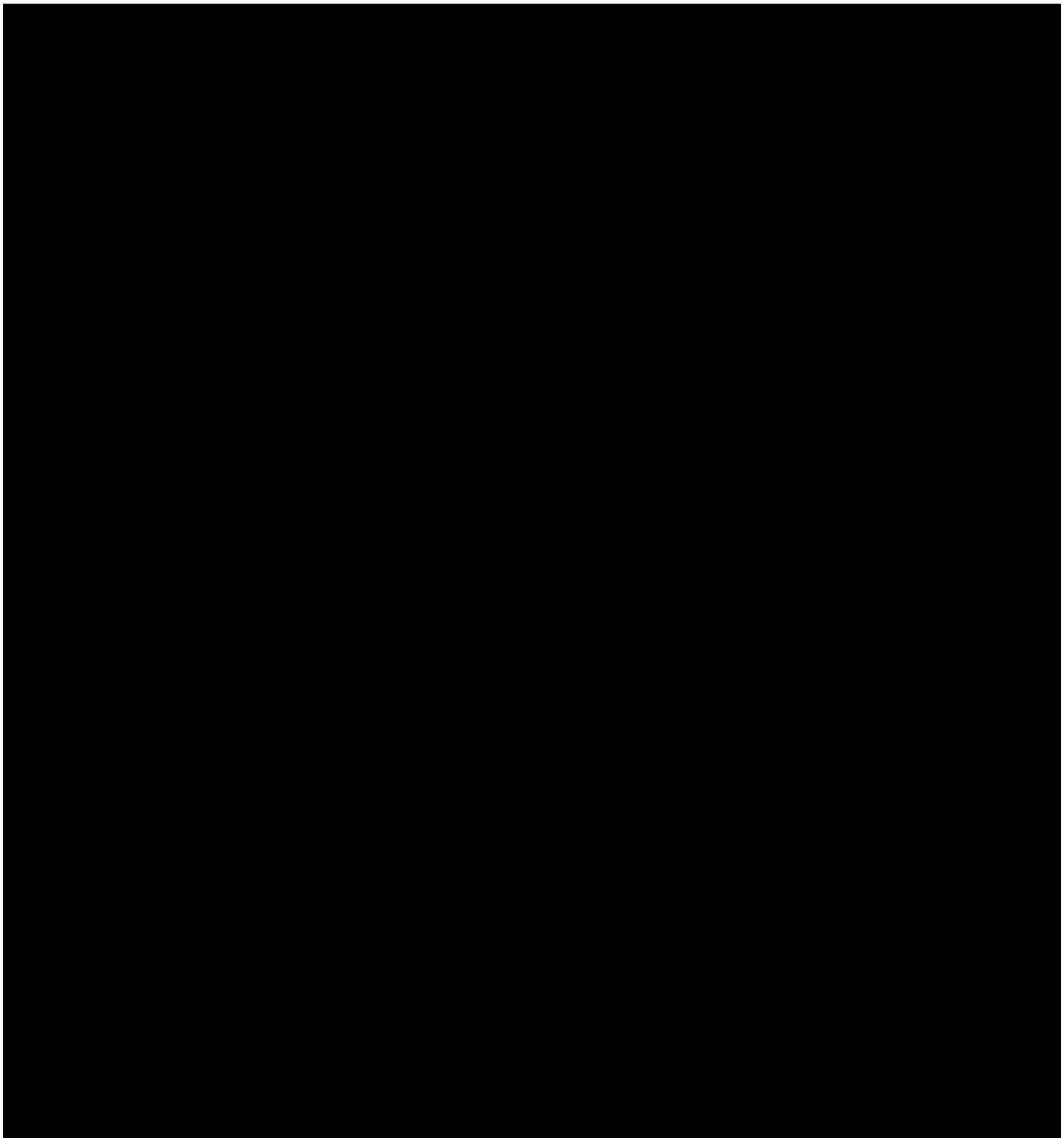
only if absolutely necessary to protect client or others from injury; or W297 (iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists. (2) Authorizations to use or extend restraints as an emergency measure must be: W298 (i) In effect no longer than 12 consecutive hours; and W299 (ii) Obtained as soon as the client is restrained or stable. W300 (3) The facility must not issue orders for restraint on a standing or as needed basis. W301 (4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints W302 released from the restraint as quickly as possible, and W303 a record of these checks and usage must be kept. (5) Restraints must be designed and used W304 so as not to cause physical injury to the client W305 and so as to cause the least possible discomfort. (6) Opportunity for motion and exercise must be provided W306 for a period of not less than 10 minutes during each two hour period	**Preventive Restraint –** primary purpose is to prevent or inhibit maladaptive behavior; while these typically do not restrict movement, they do restrict or limit normal functioning to a portion or portions of a client's body	The Arkansas HDC and DDDS Central Office policies and procedures provide for the face to face monitoring, release and monitoring requirements specified in the federal regulations.

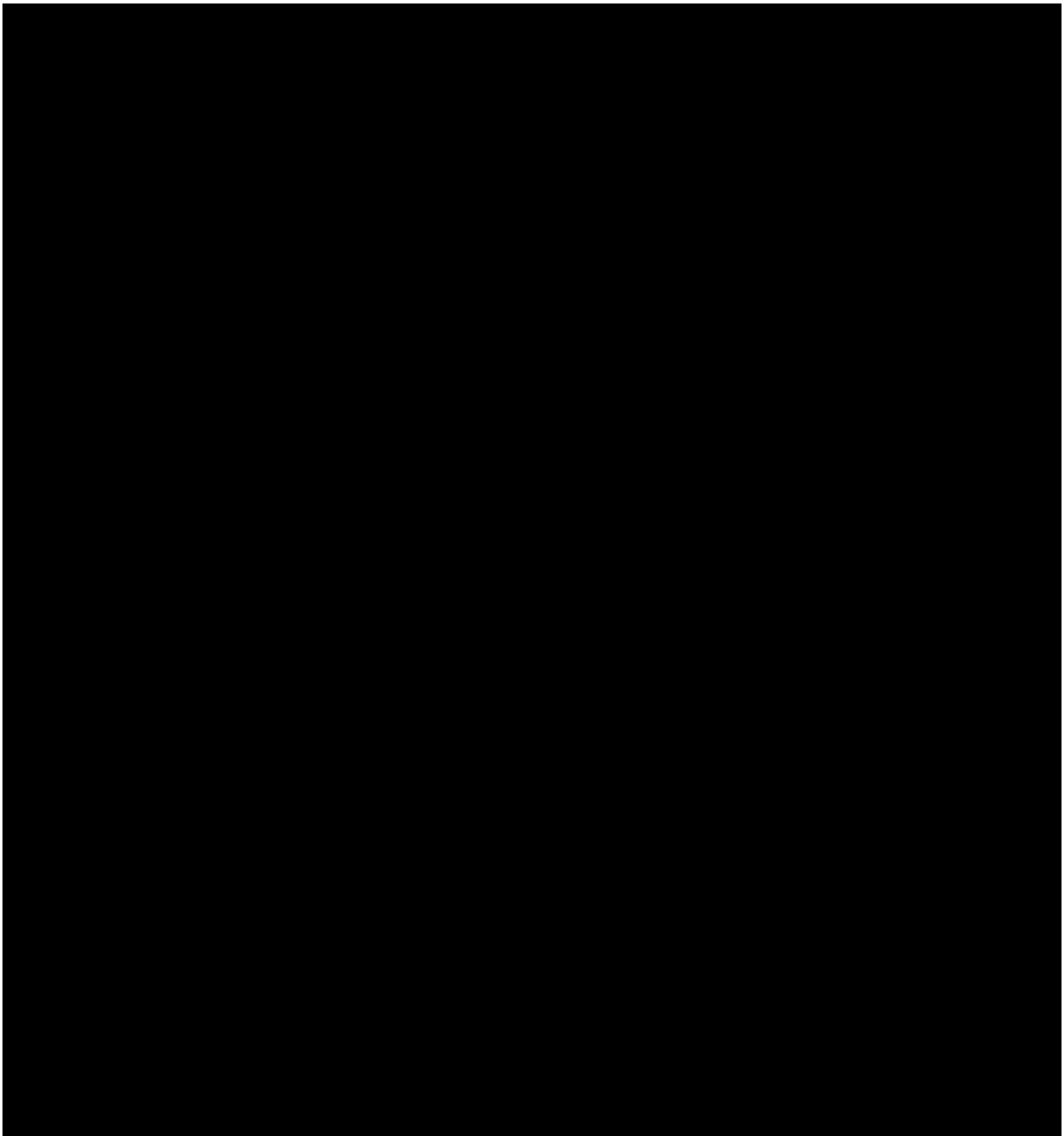
Comments

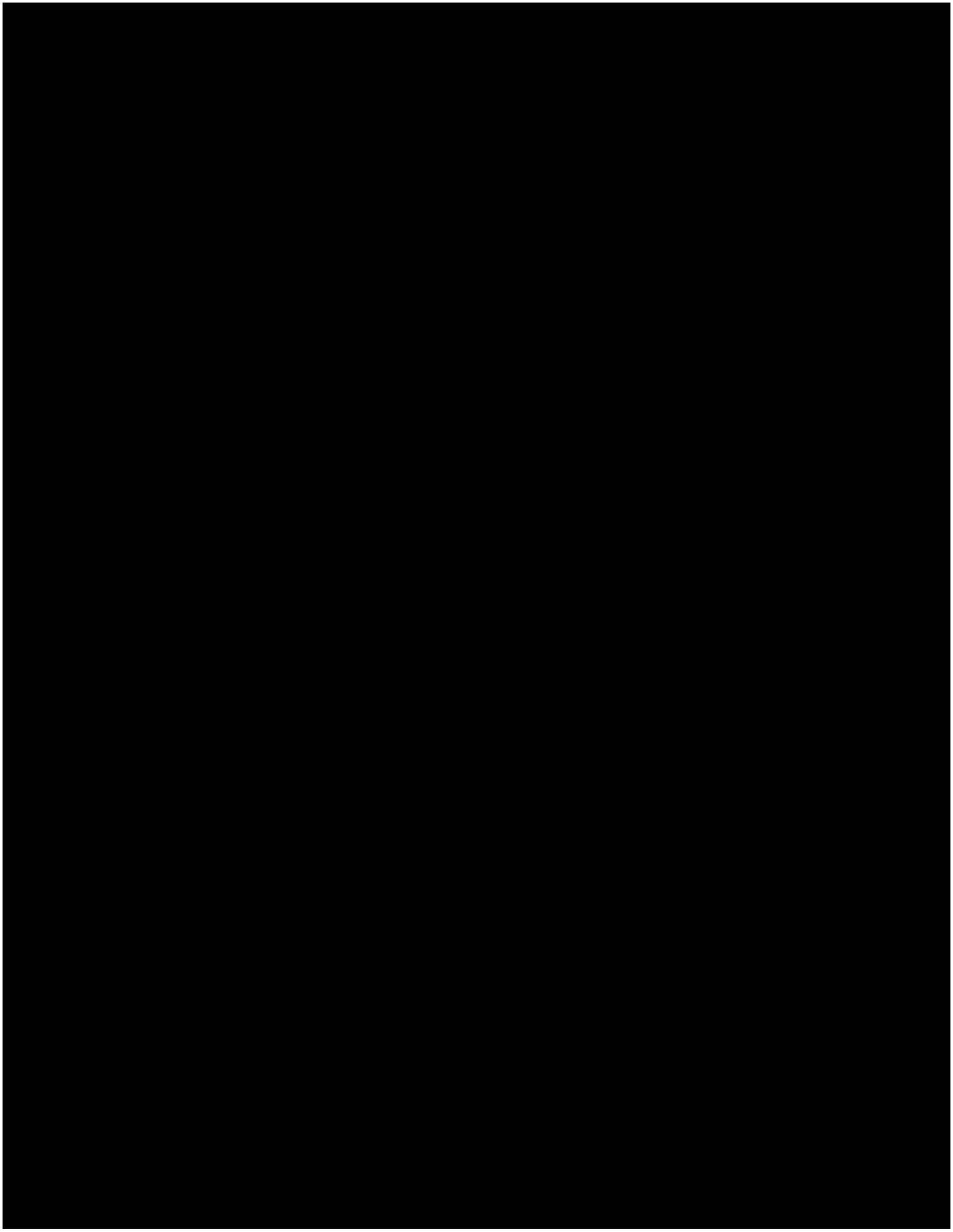
This review of the ICF/DD regulations and the Arkansas regulations governing the use of restraint demonstrate the continuity of both sets of regulations in most instances. The state and local policies and procedures differentiate mechanical restraint from physical restraint, unlike the federal regulations. The distinctions should be made as data collection and analysis is easier when definitions are clear.

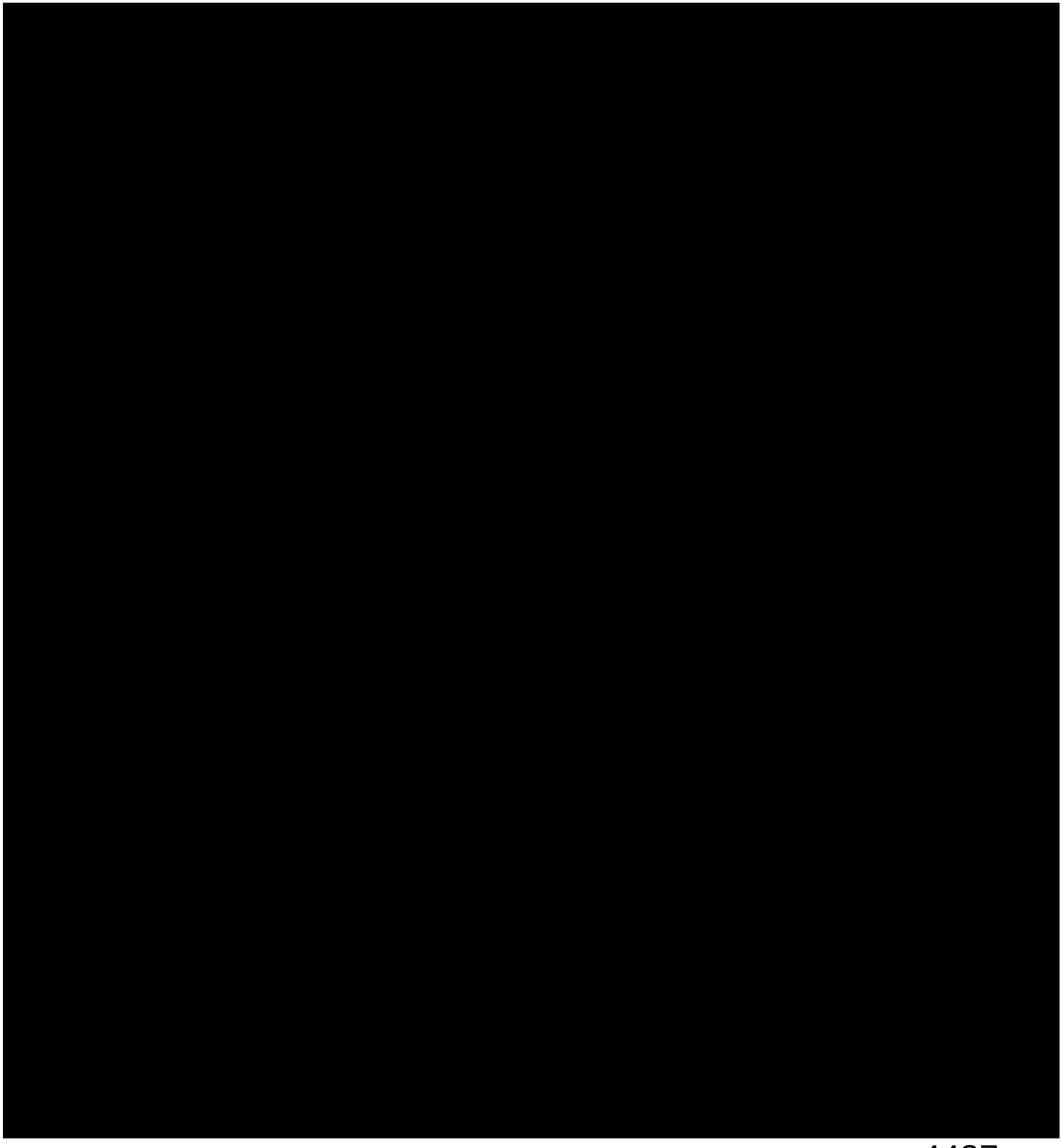
The areas of most concern are the Hierarchy of Interventions, which appear to utilize techniques not supported by current research, and the inclusion of physical restraint as a behavioral intervention.

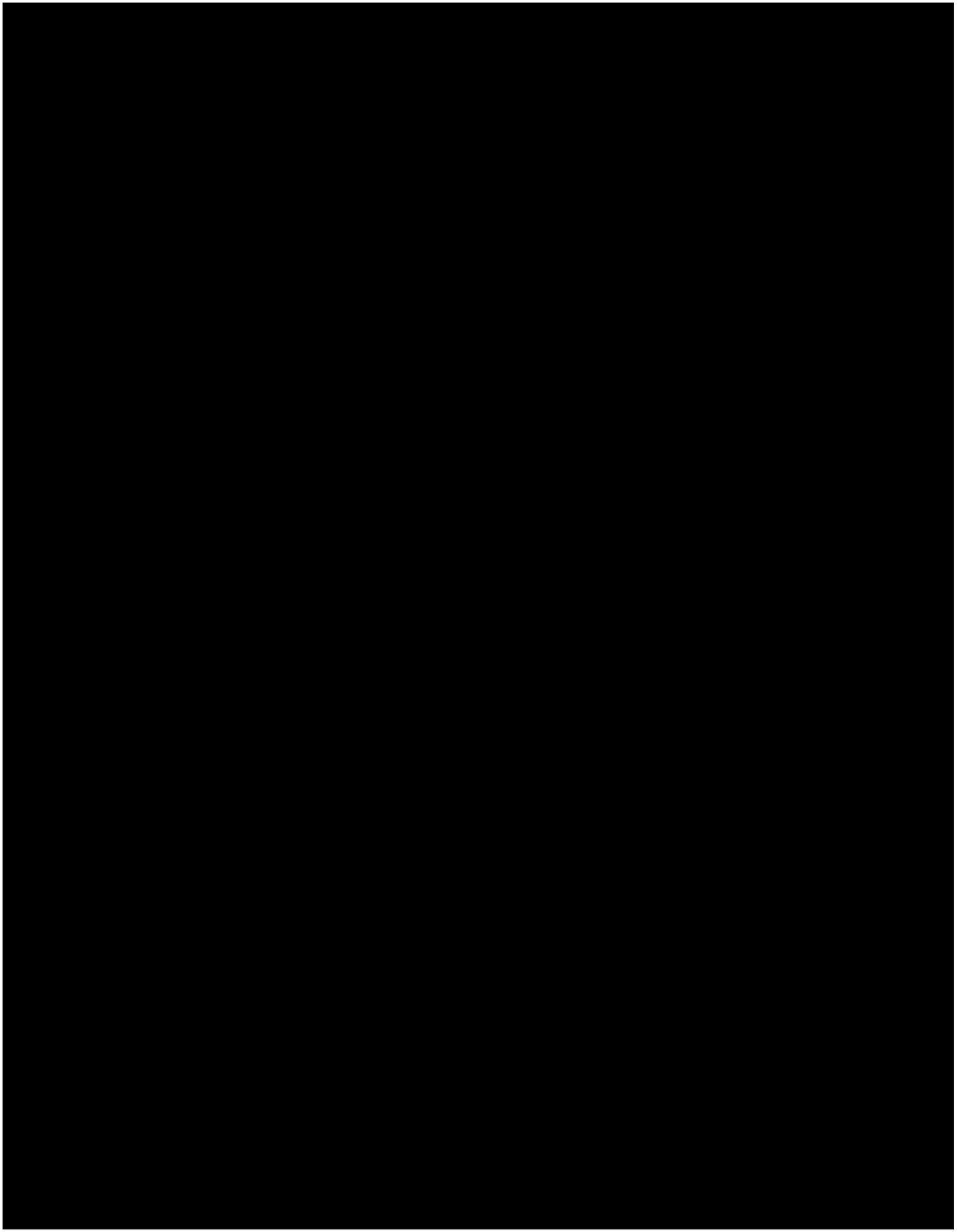
The differences between the various policies and procedures of the five Human Development Centers and the DDDS Central Office should be reviewed. Rather than attempt to update the different policies and procedures, it is recommended that the state and local policies and procedures be updated using Appendix J as a starting point.

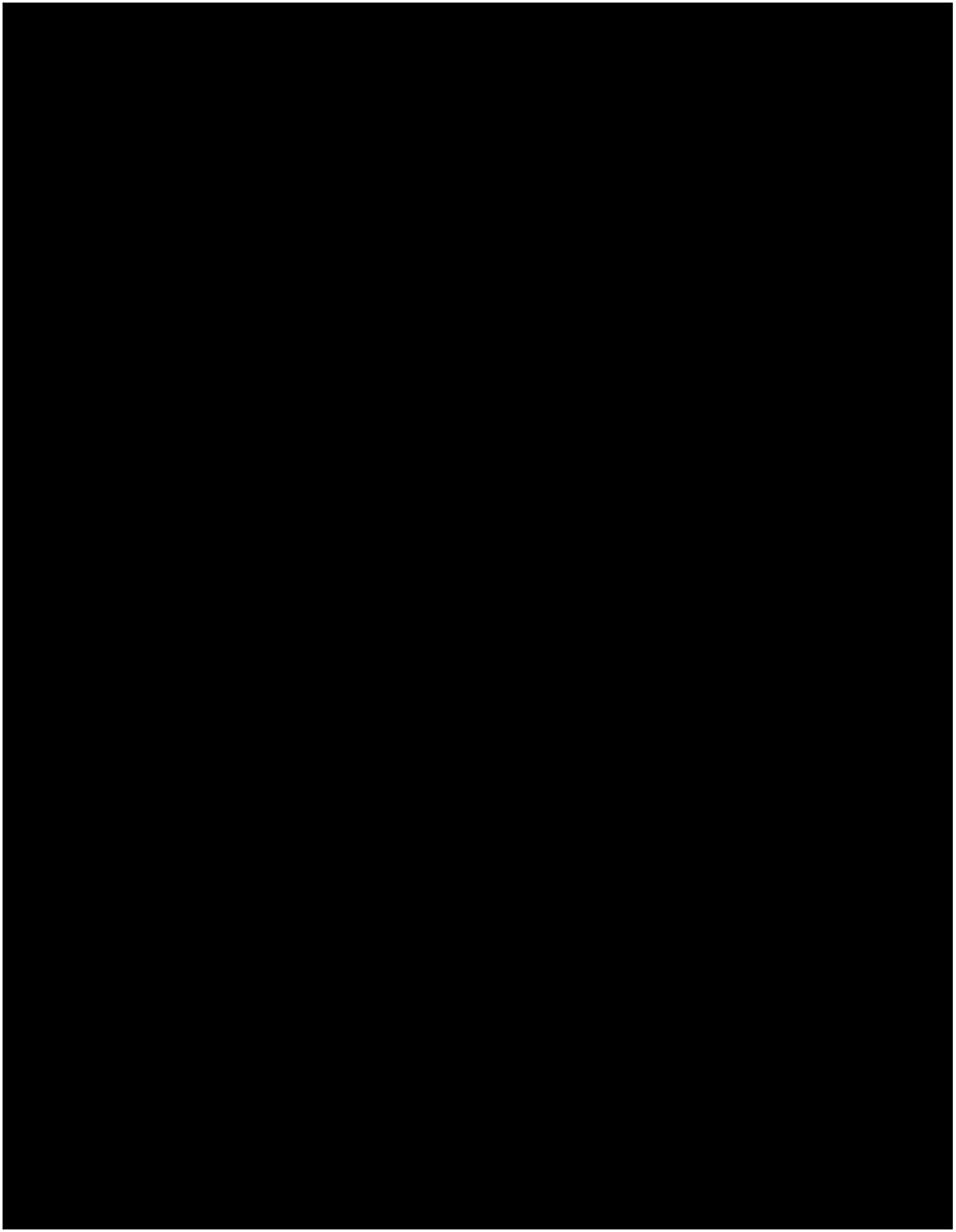


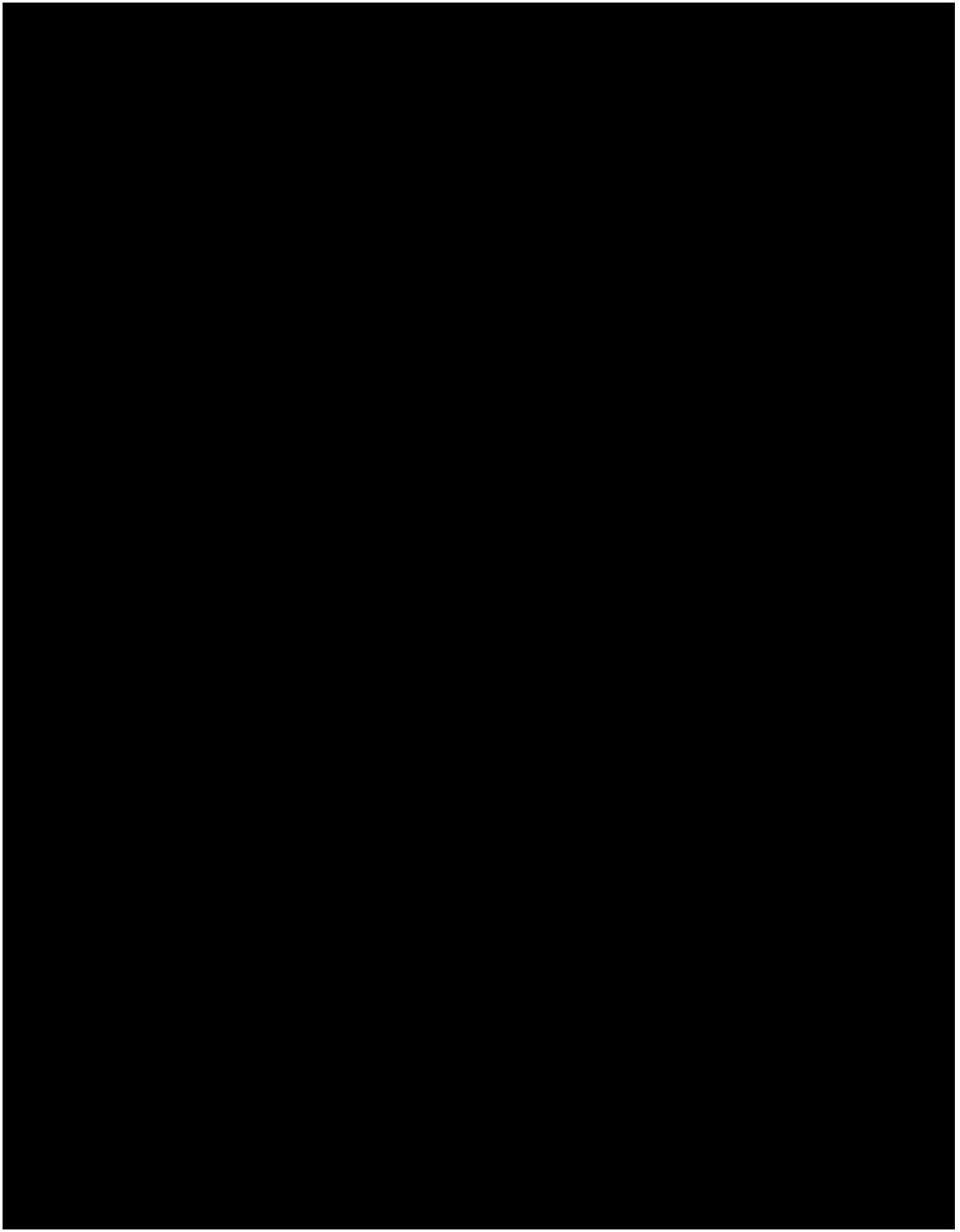


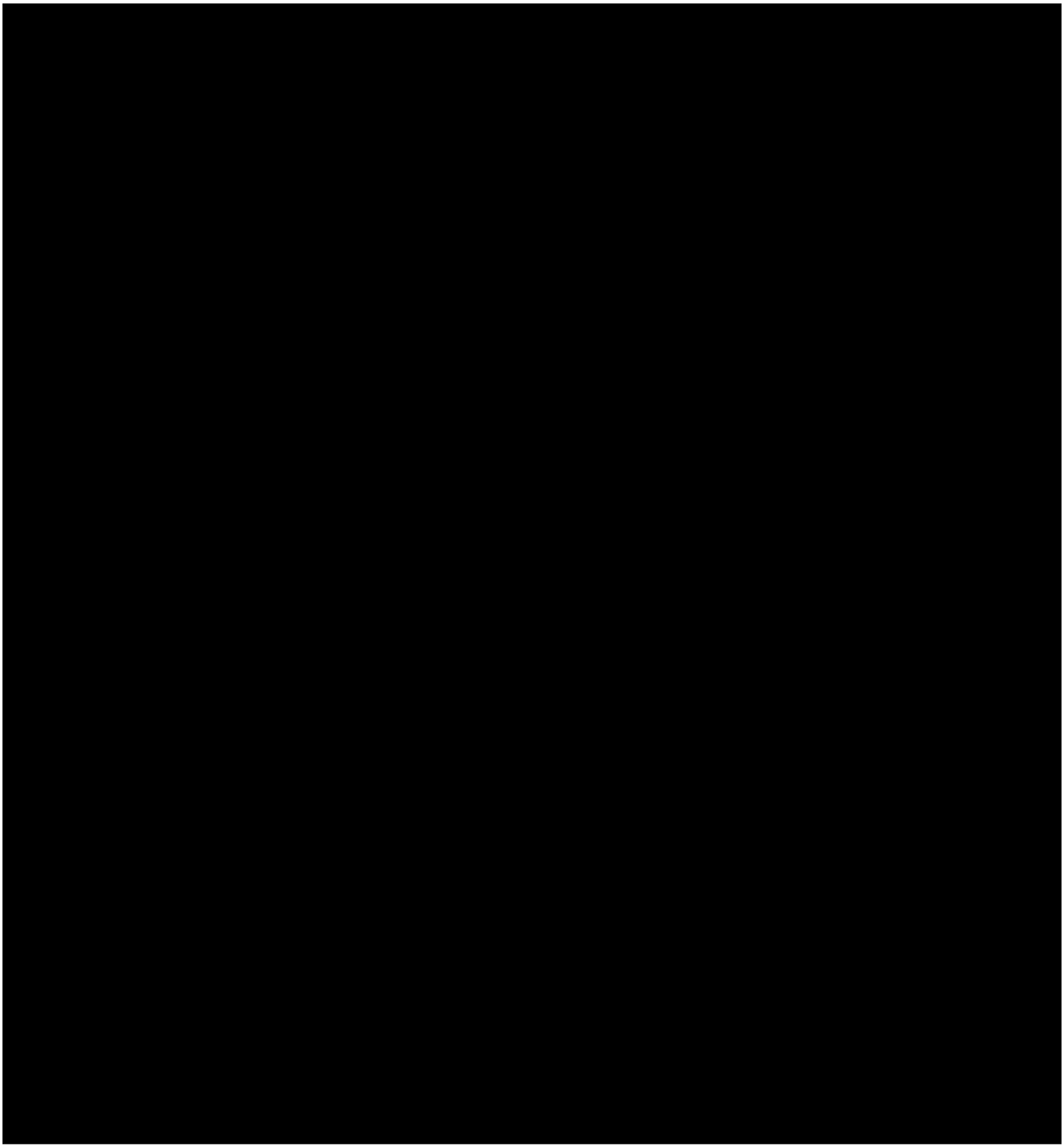


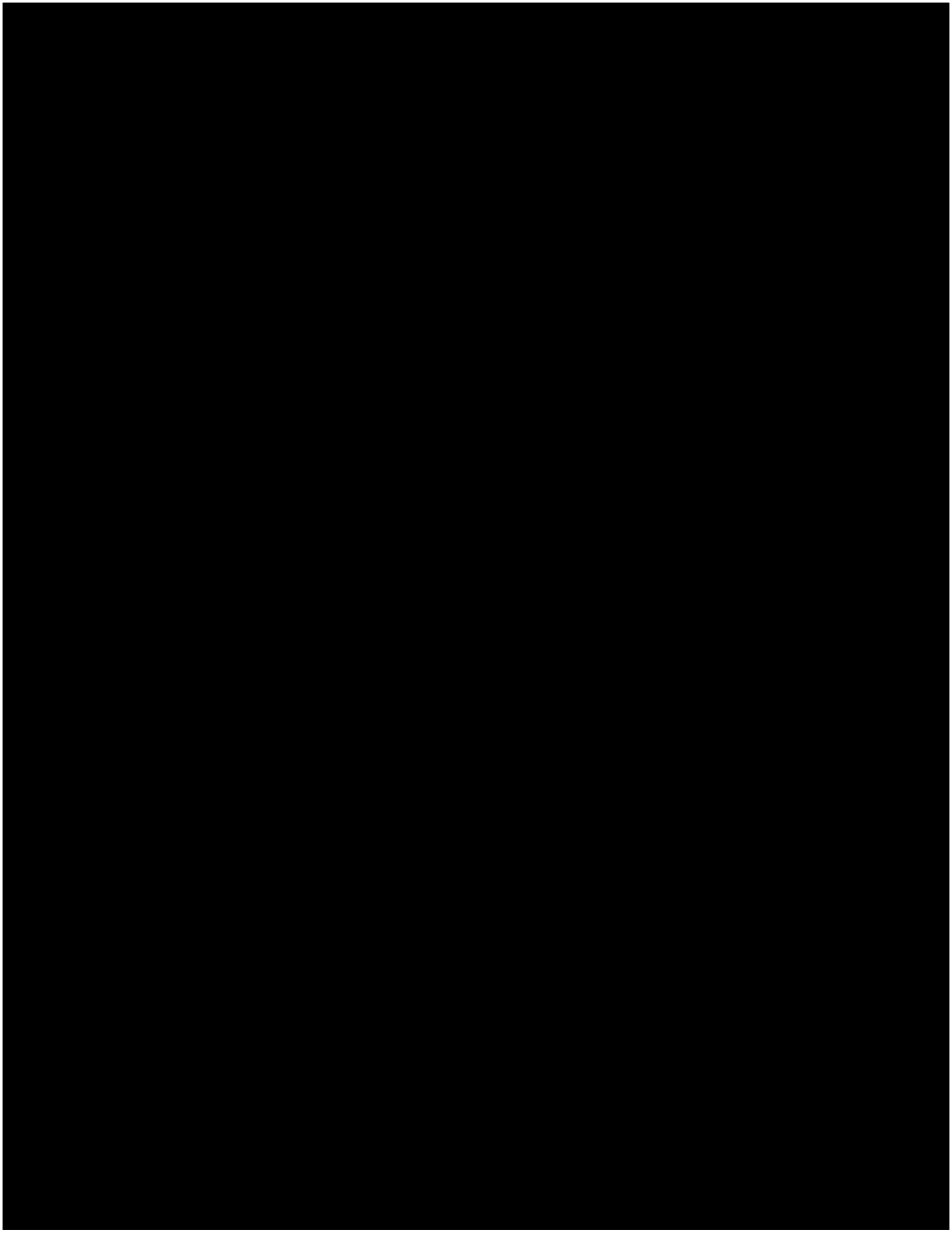


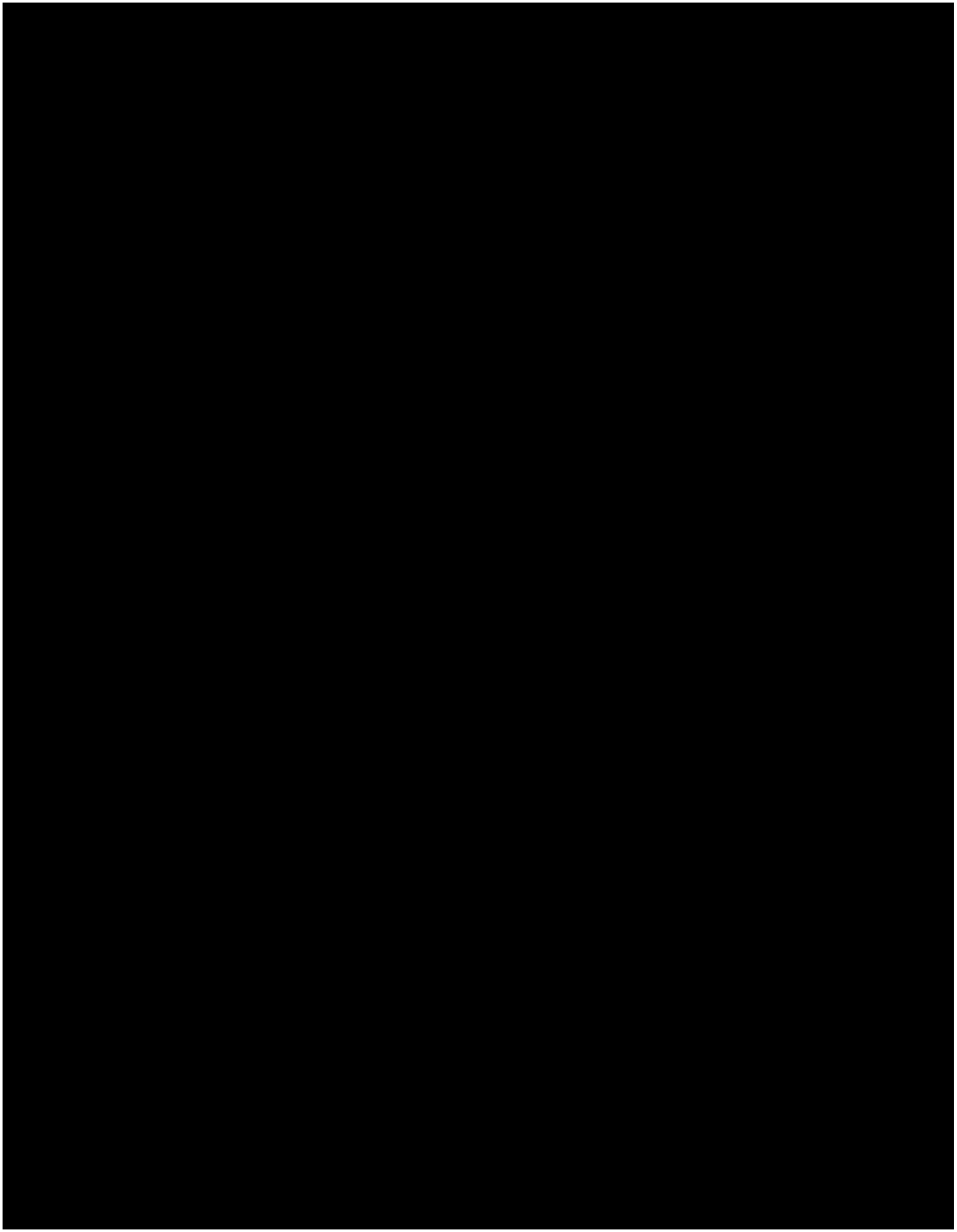


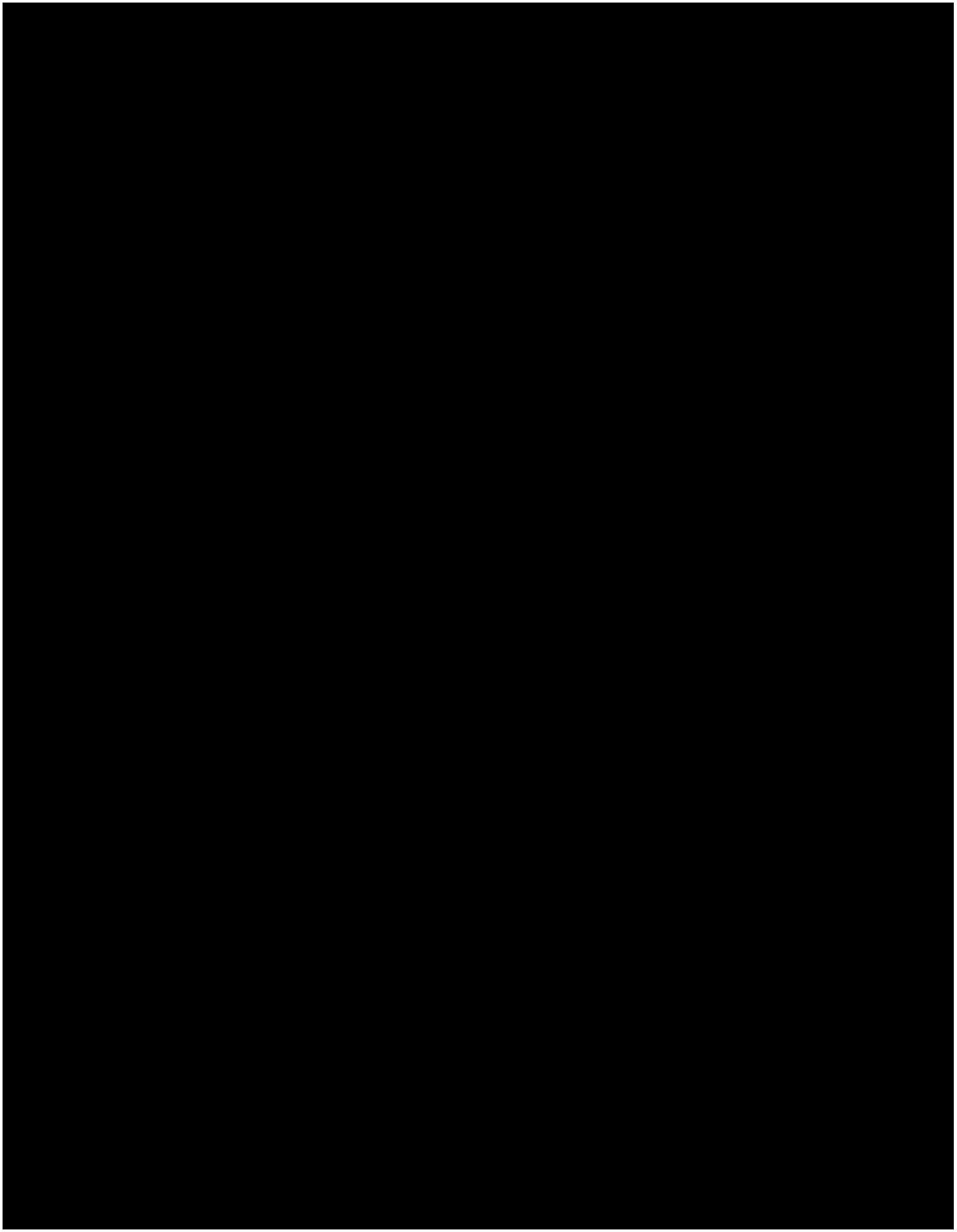


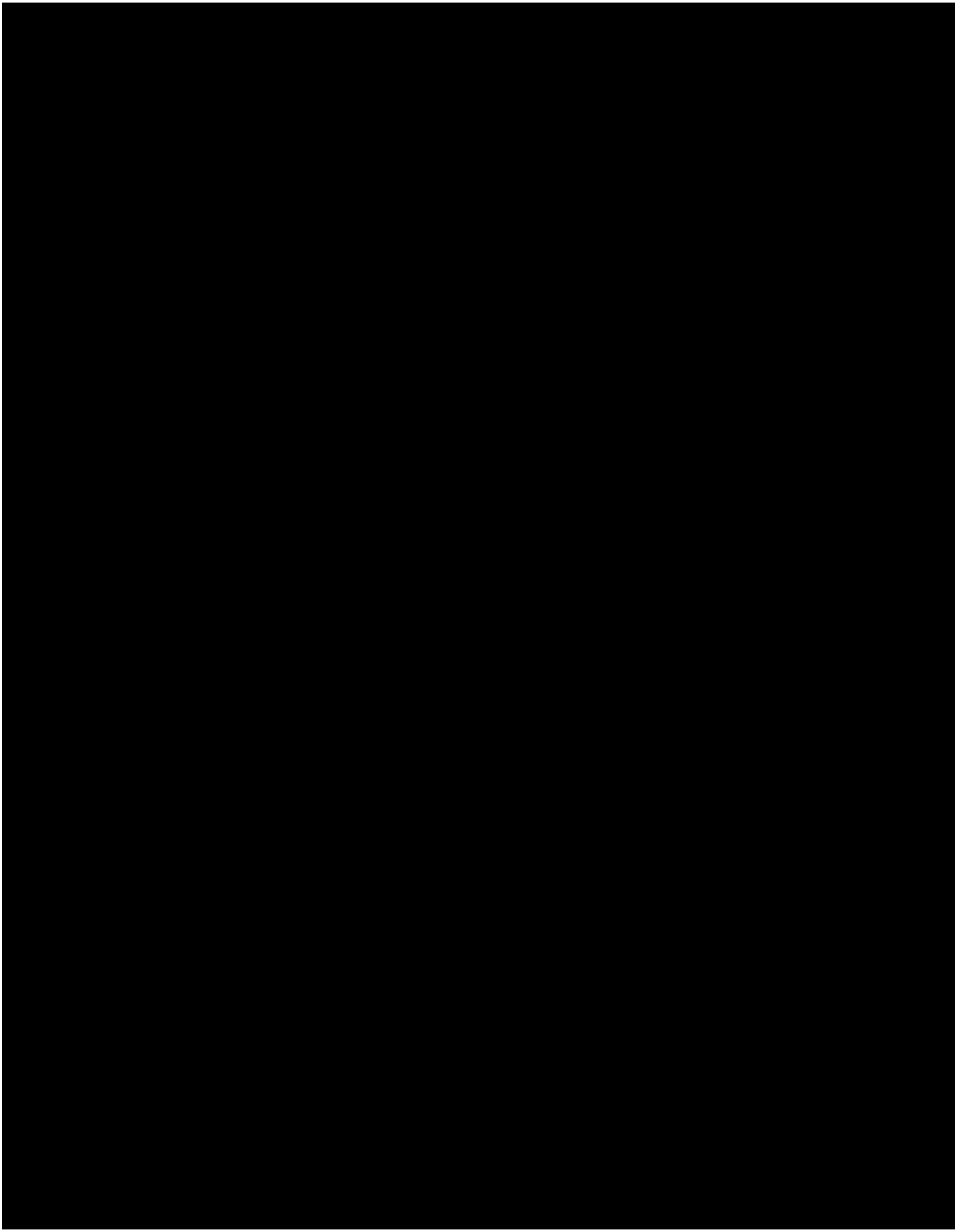


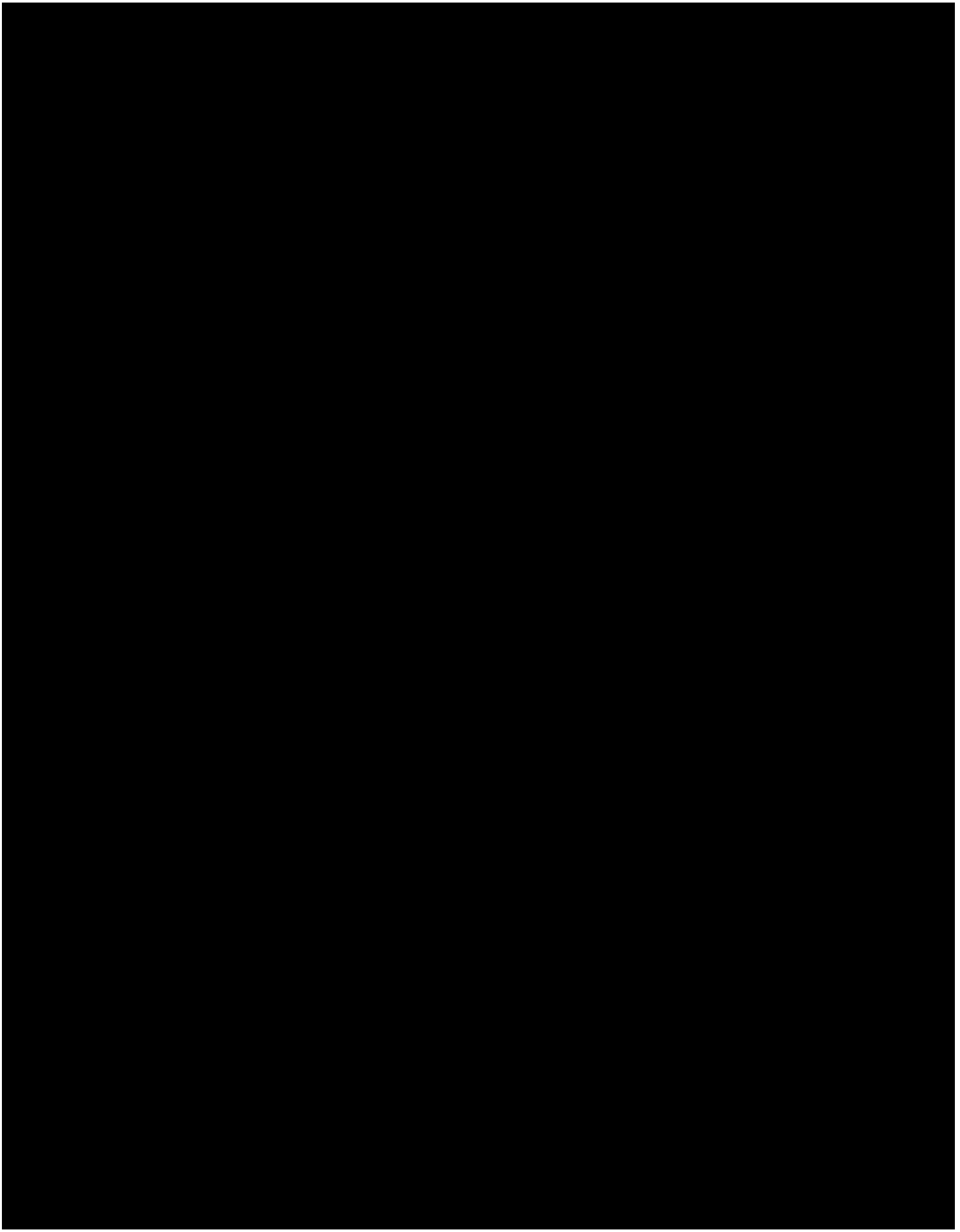


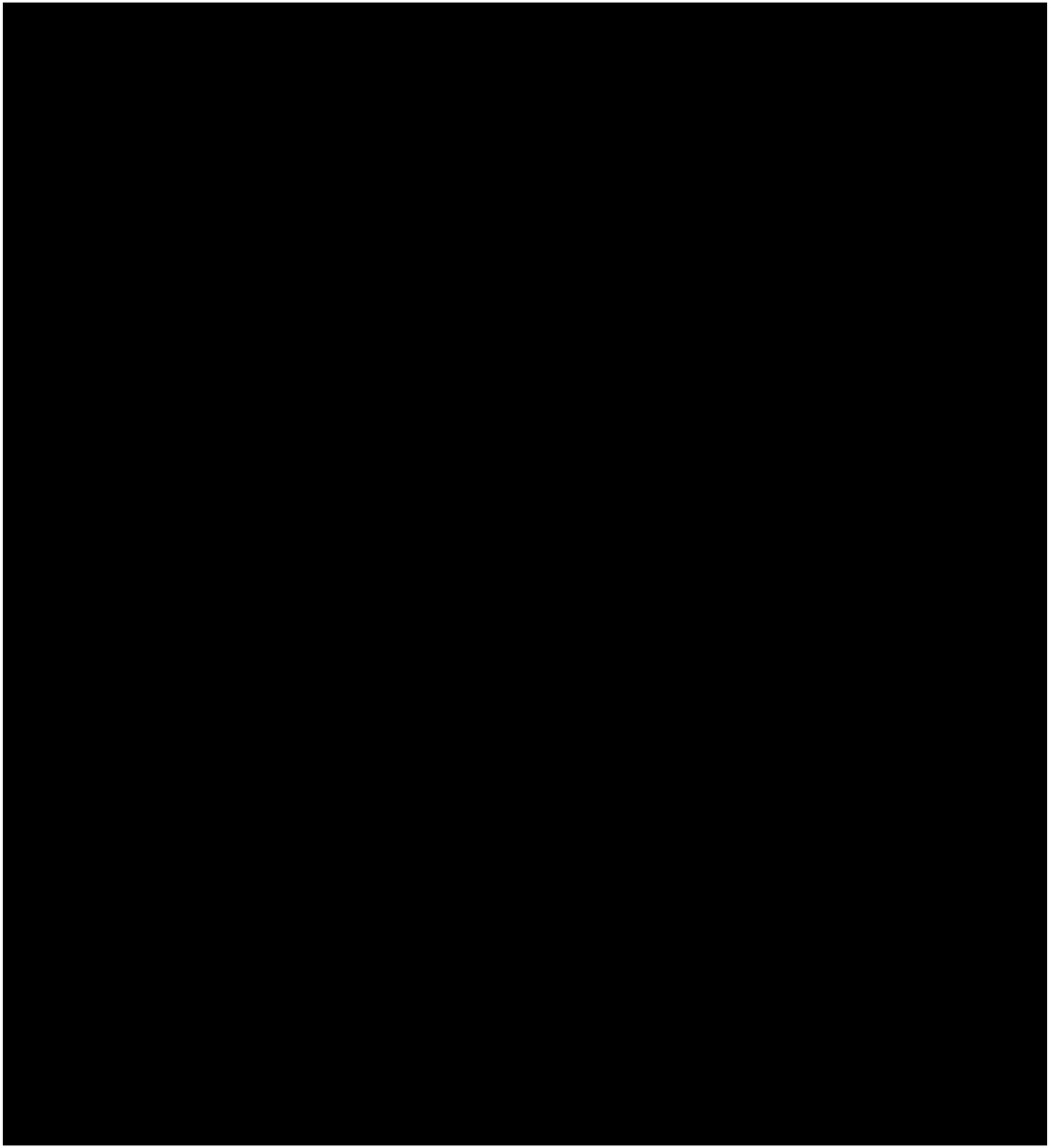


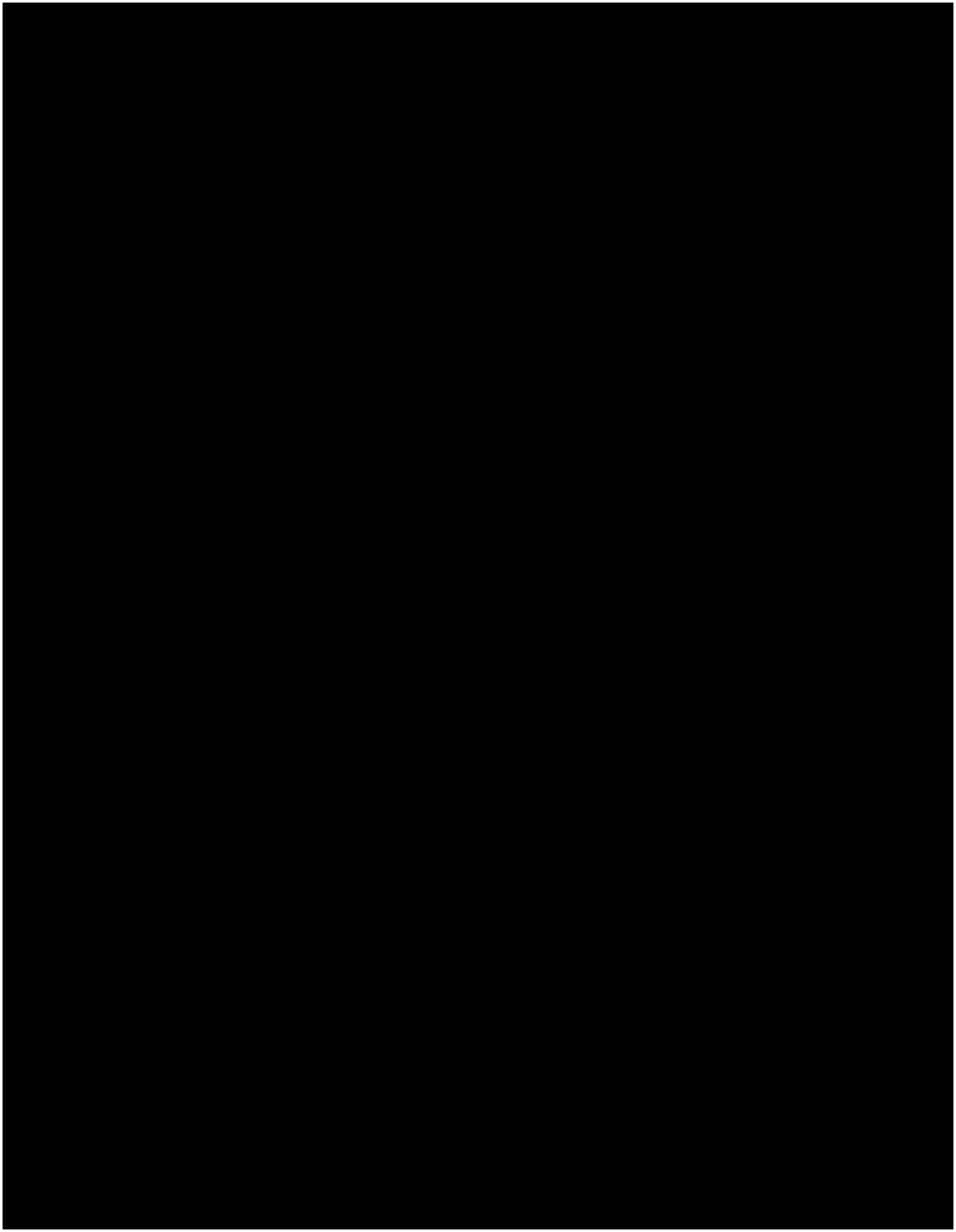


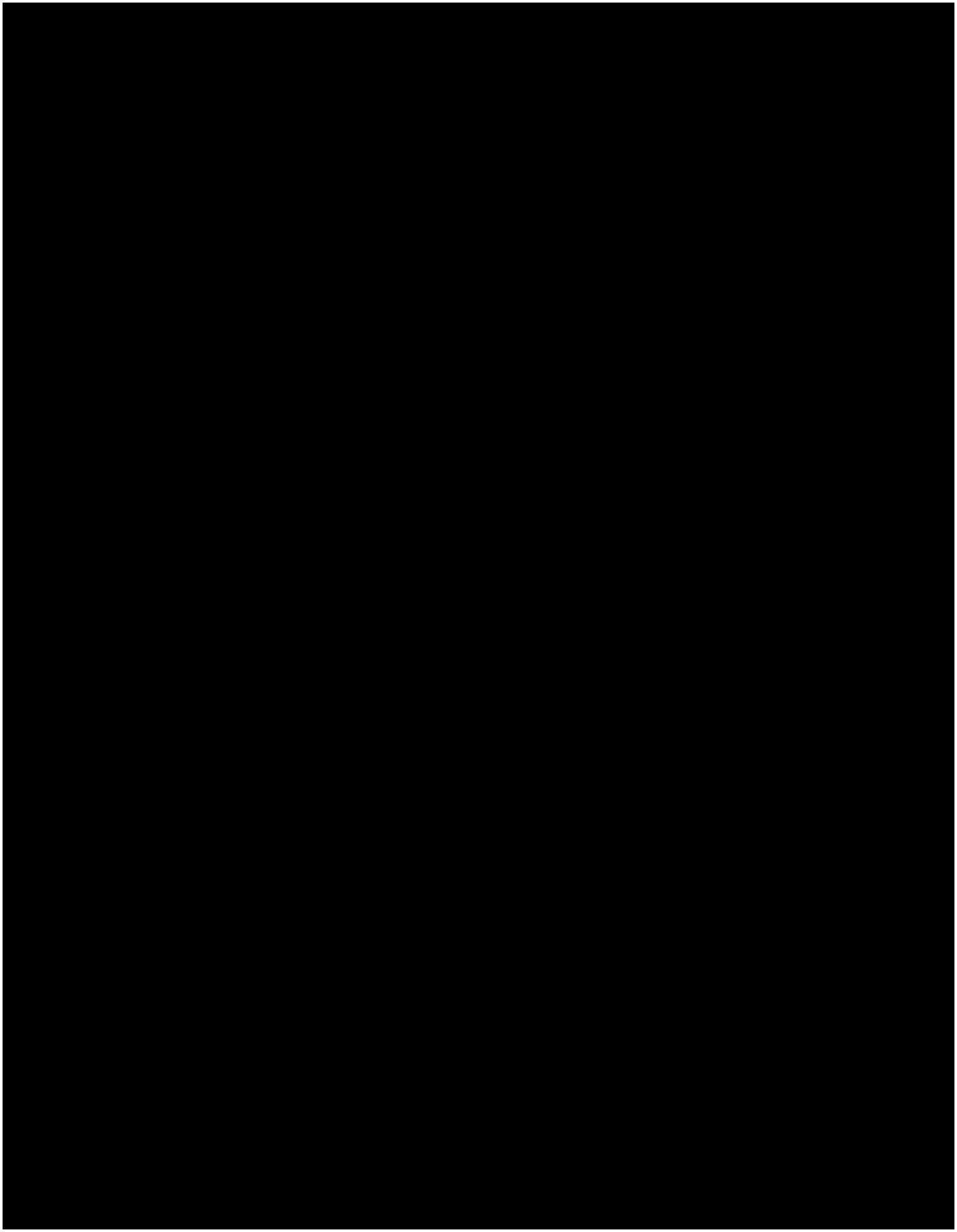


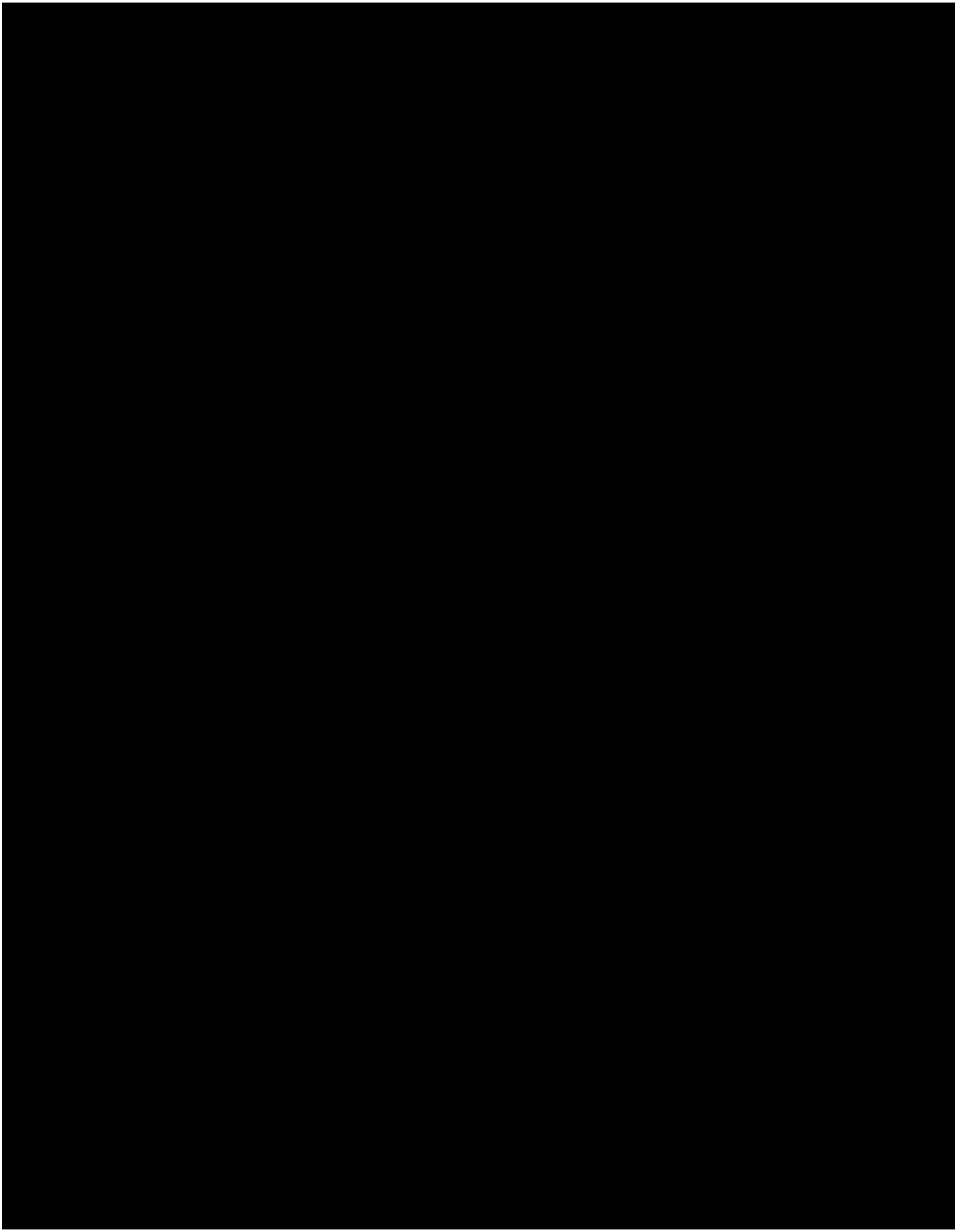


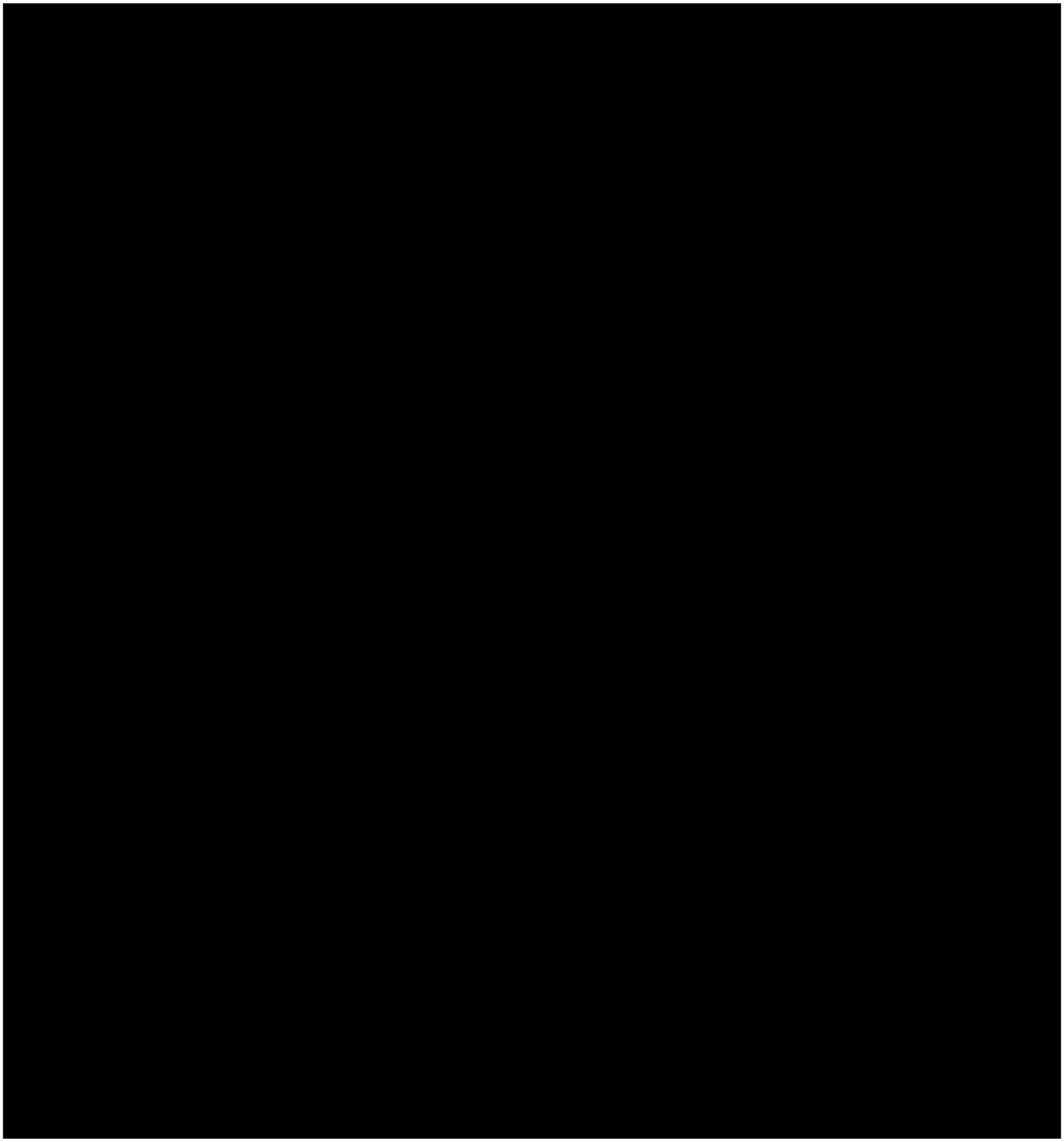


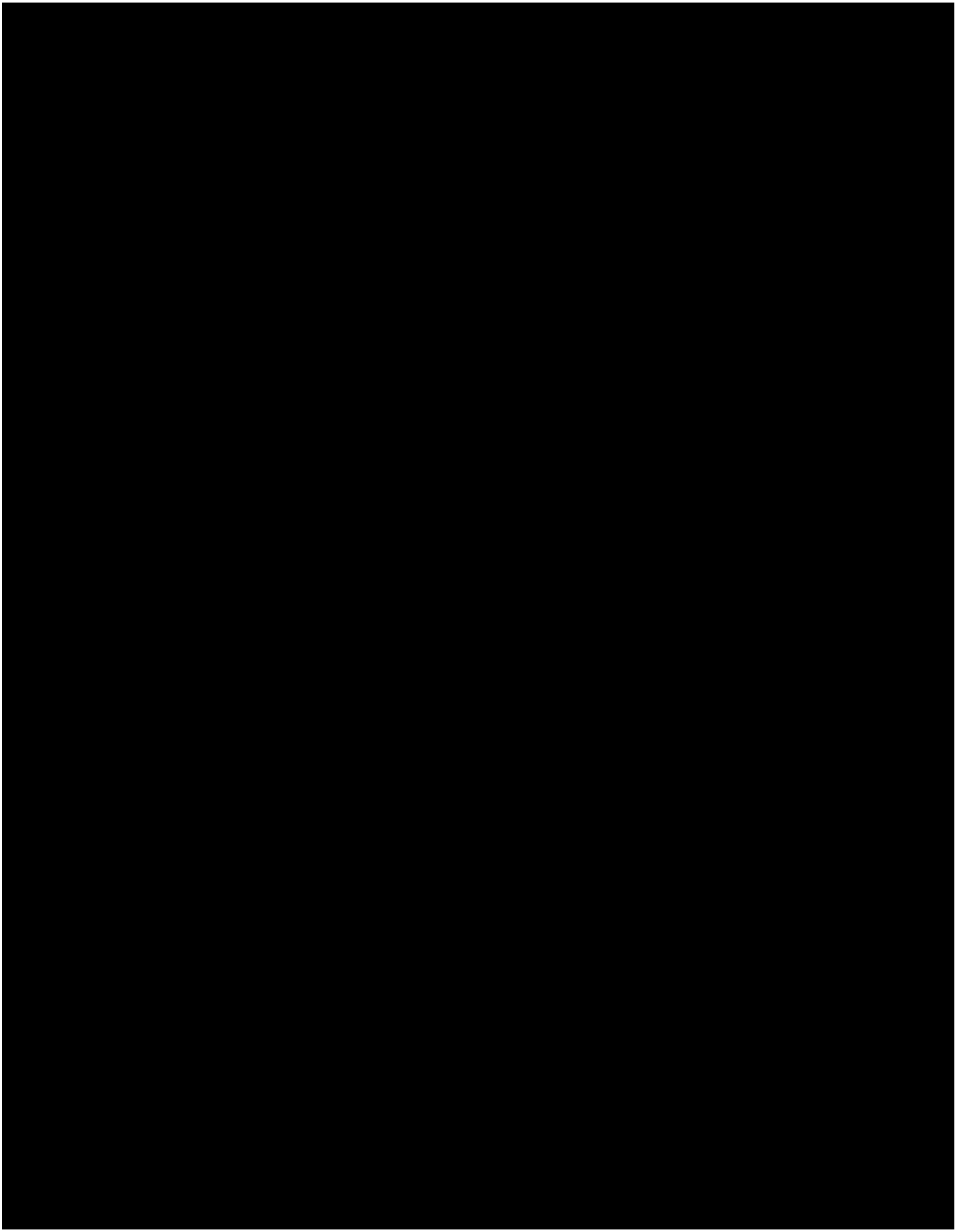


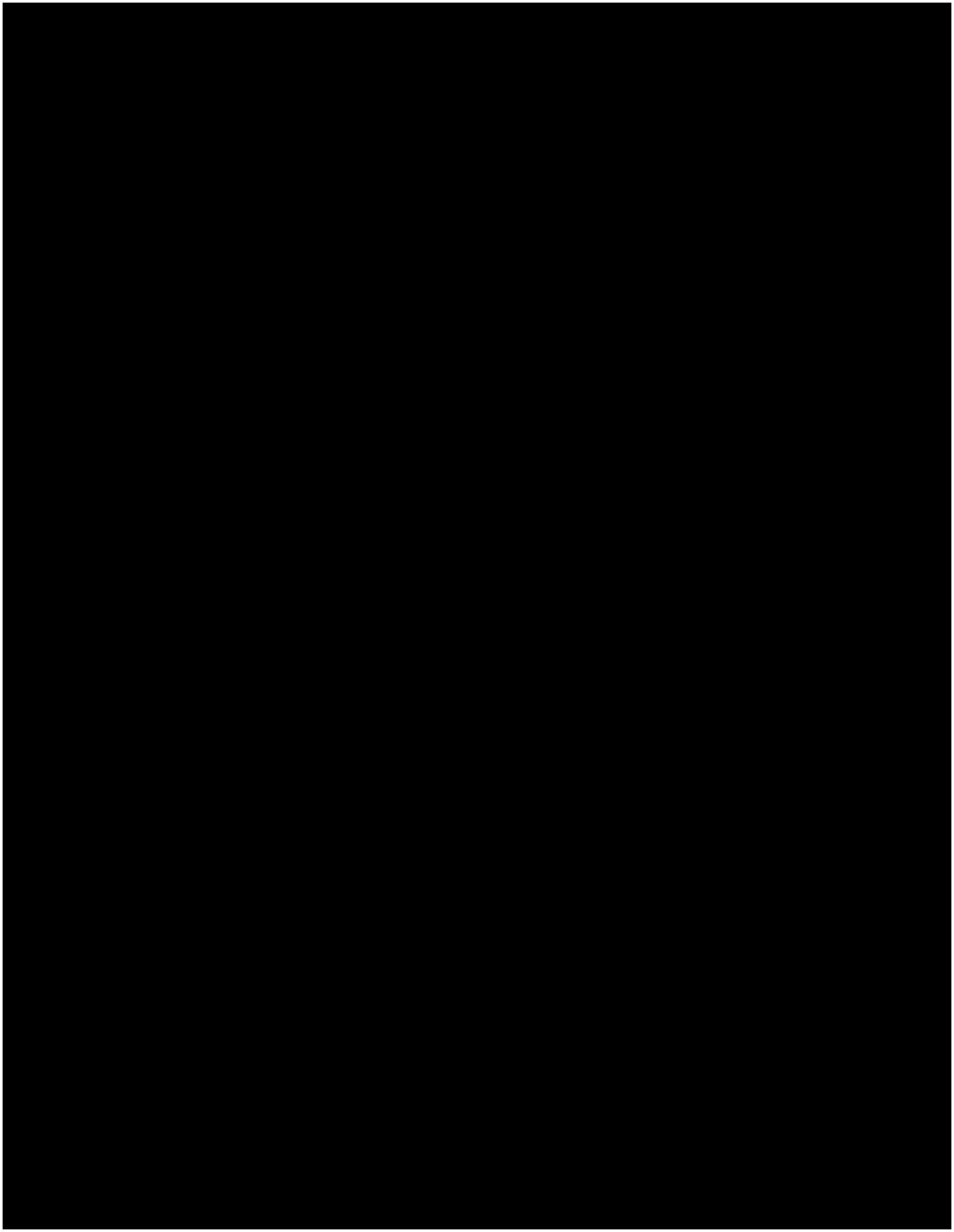


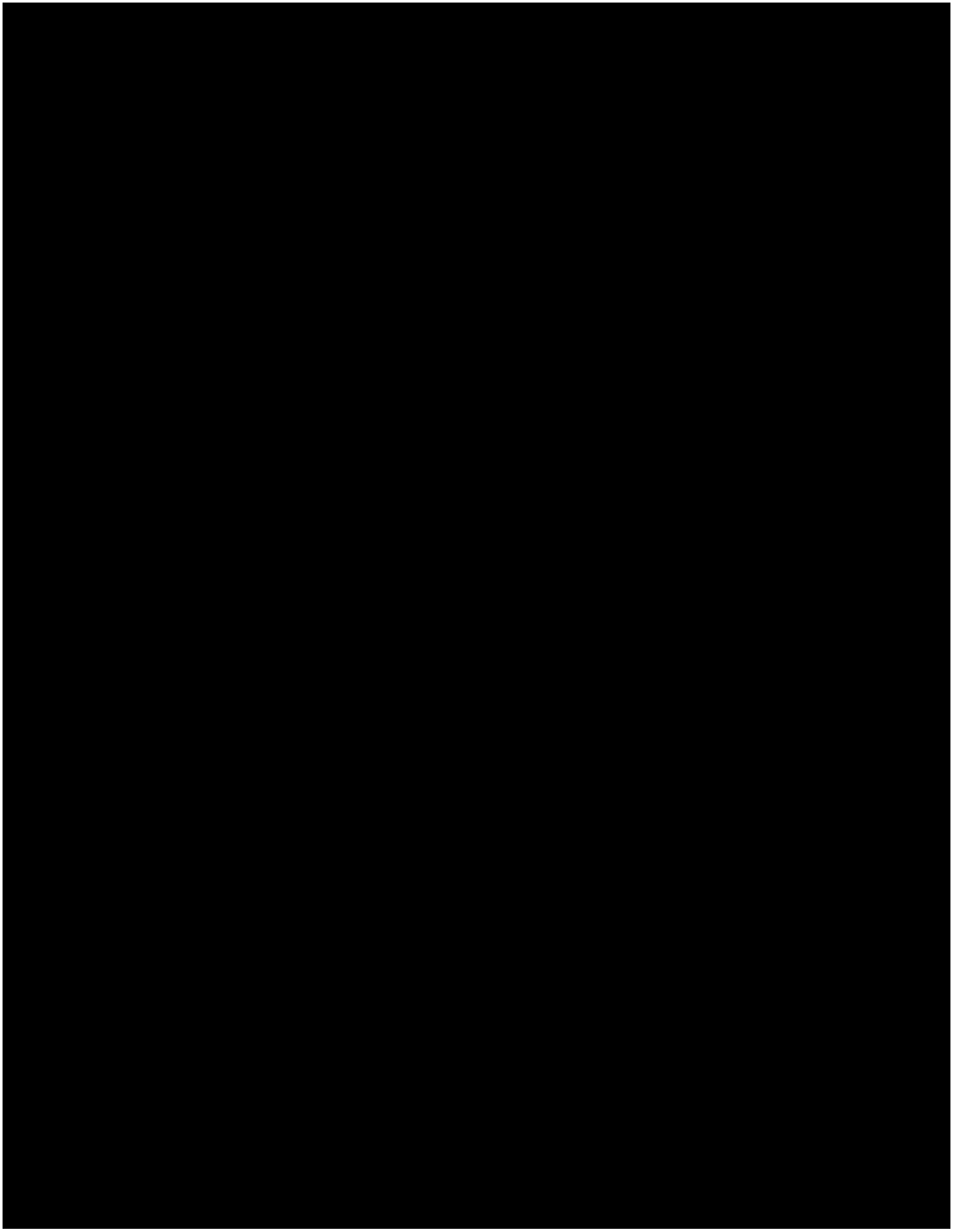


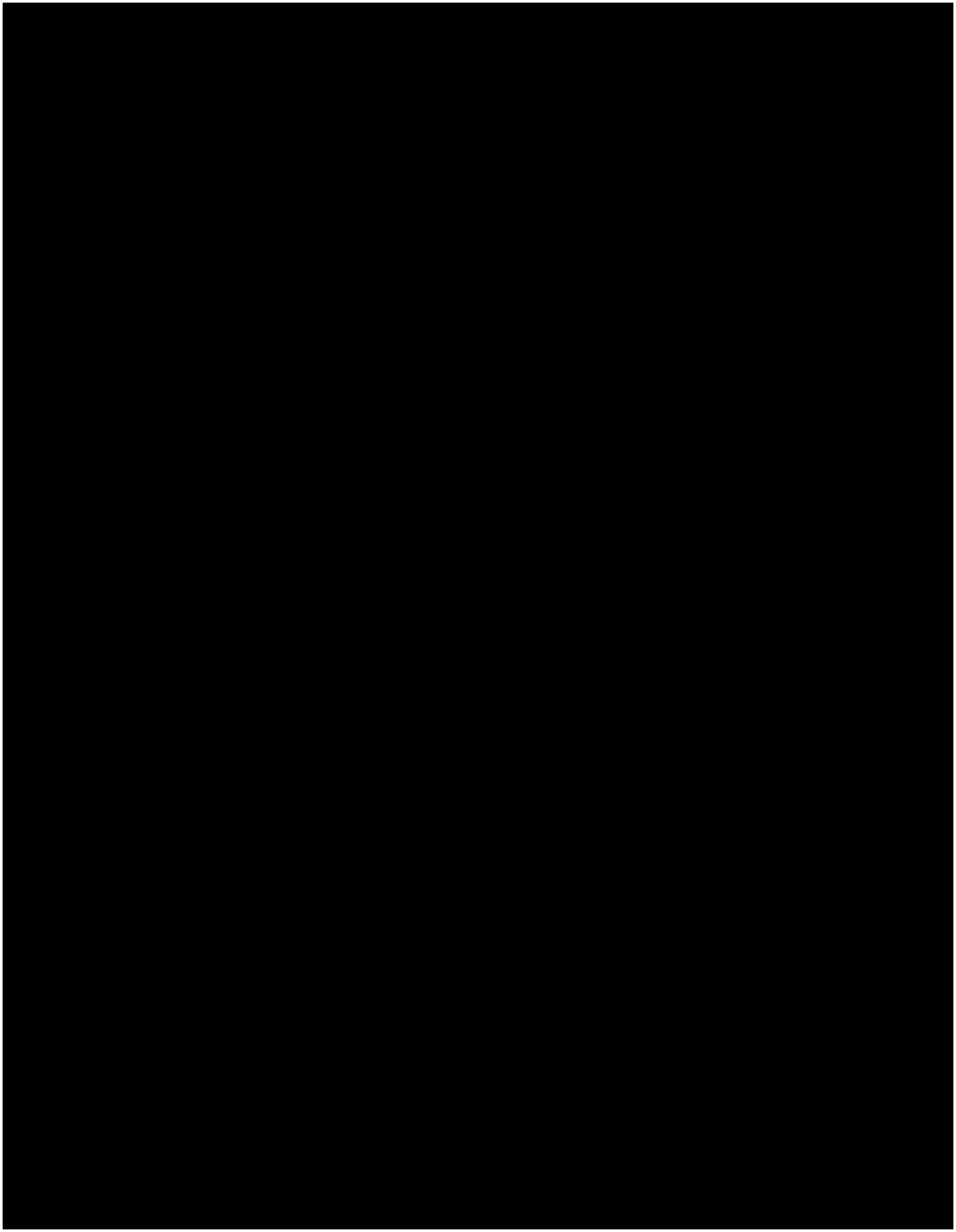


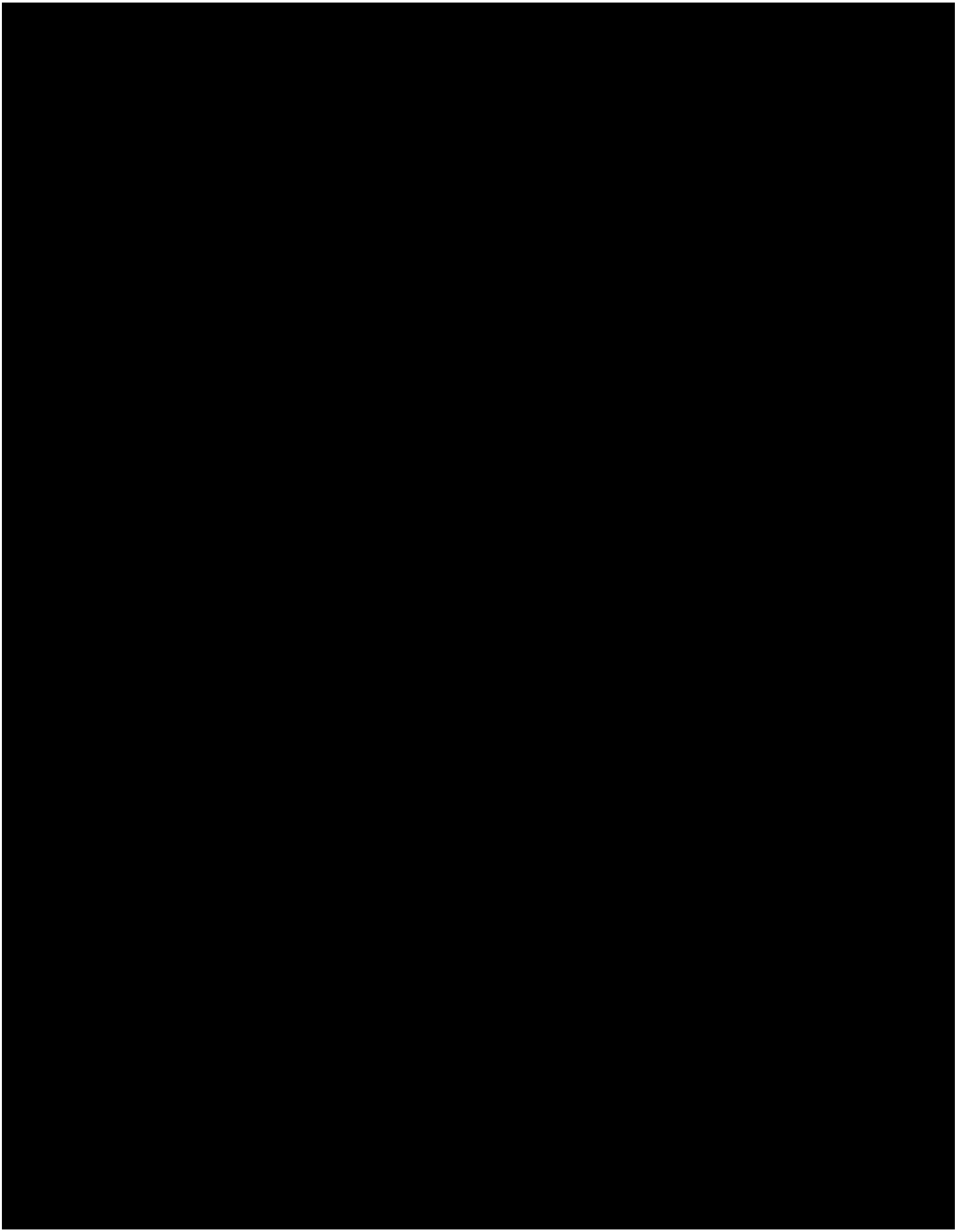


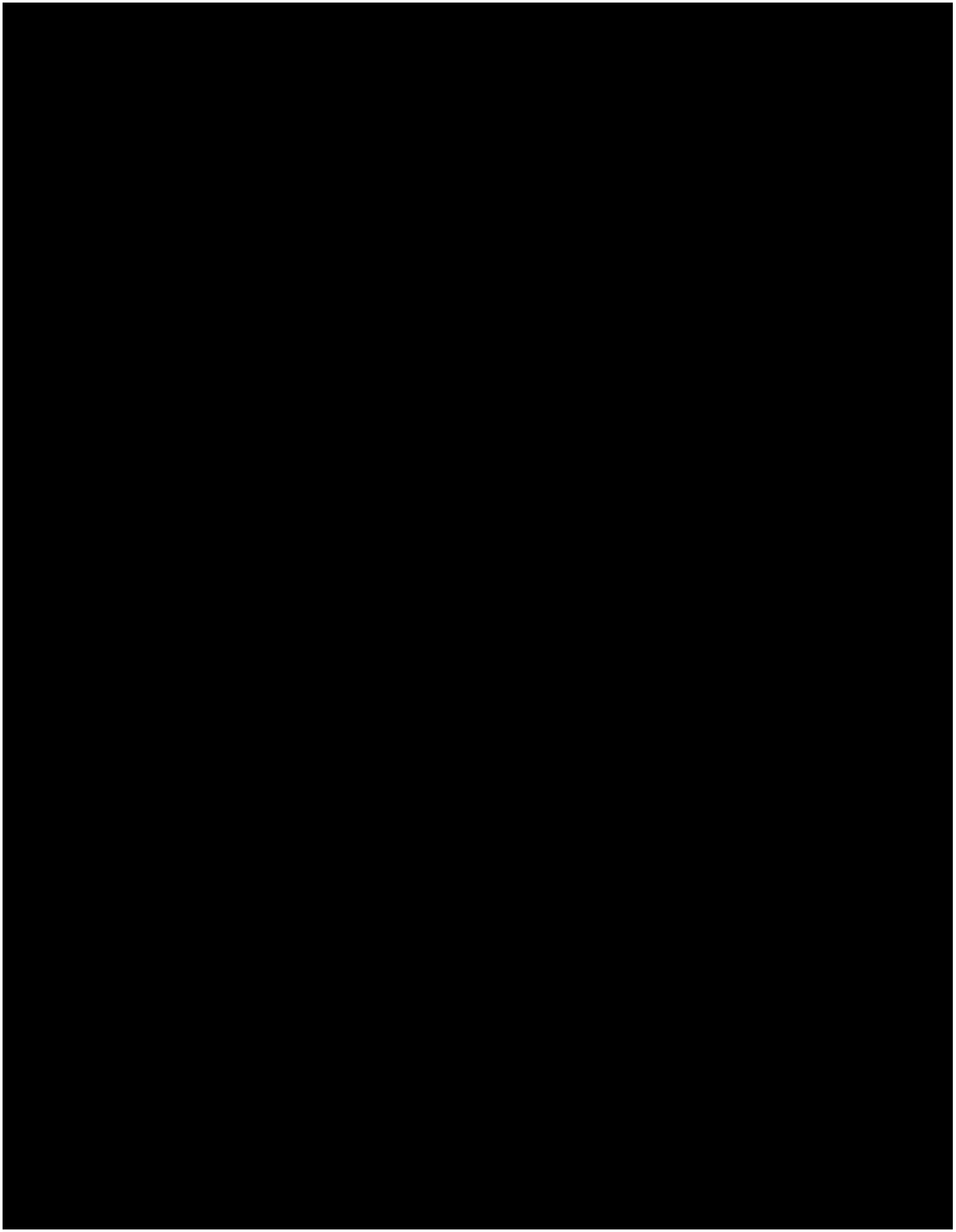


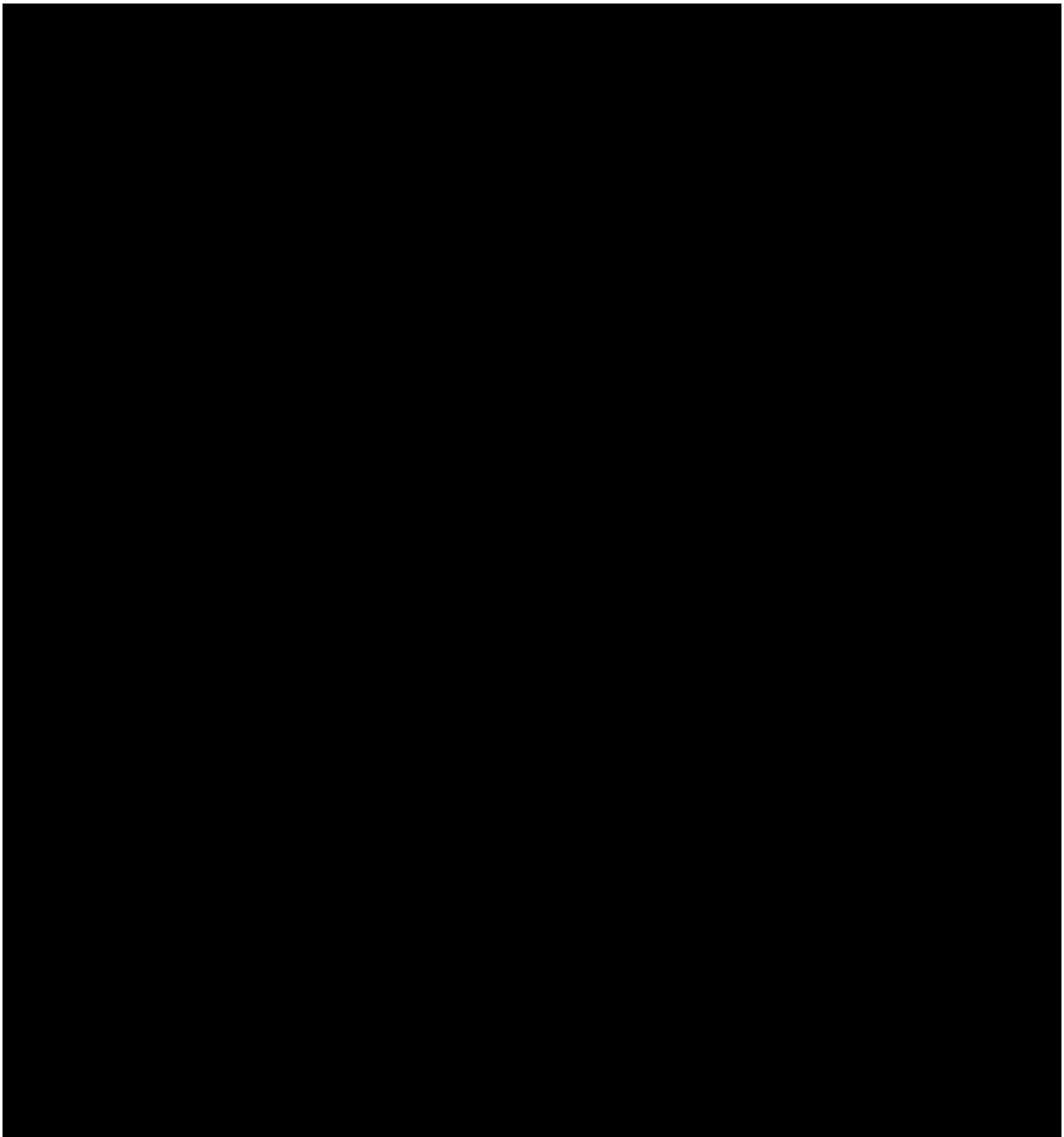


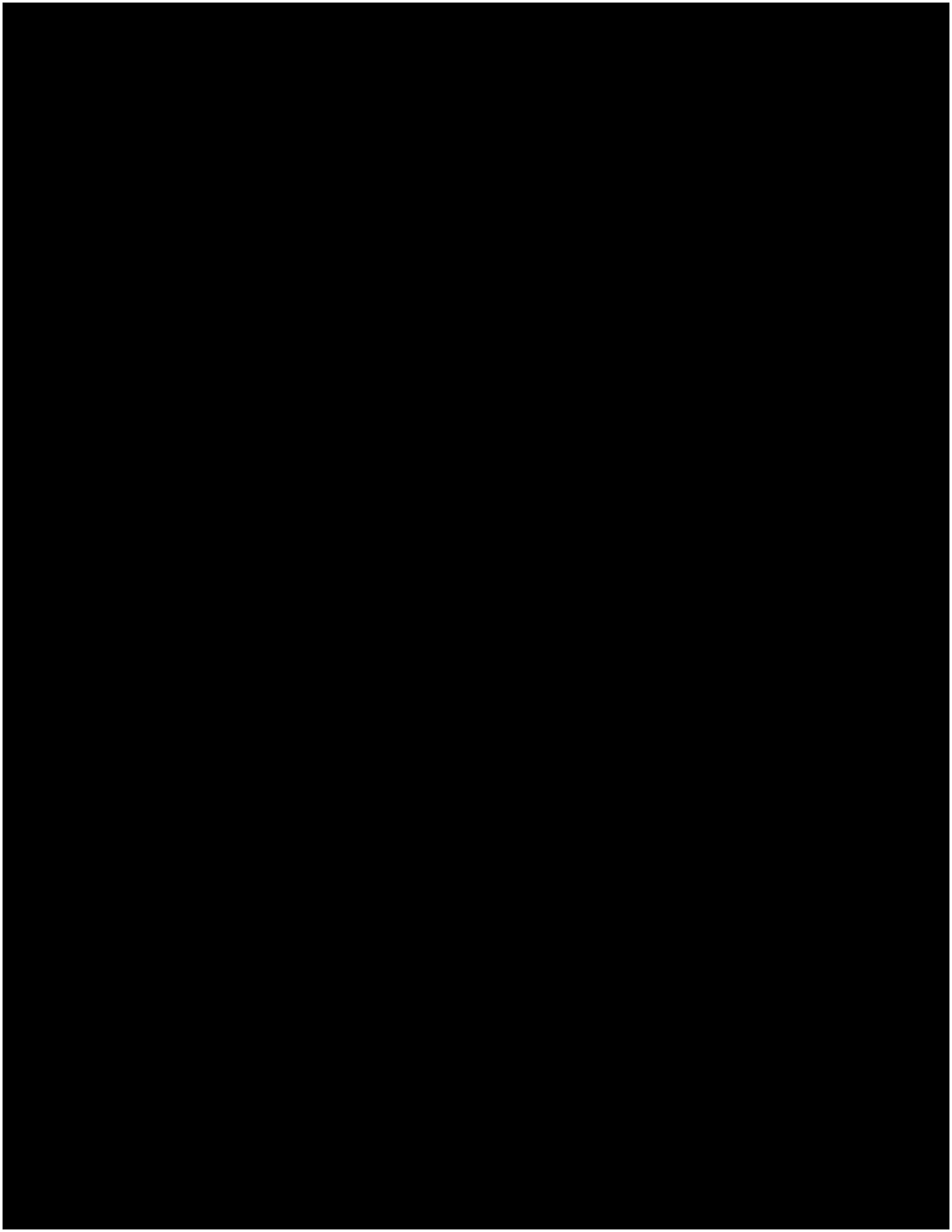


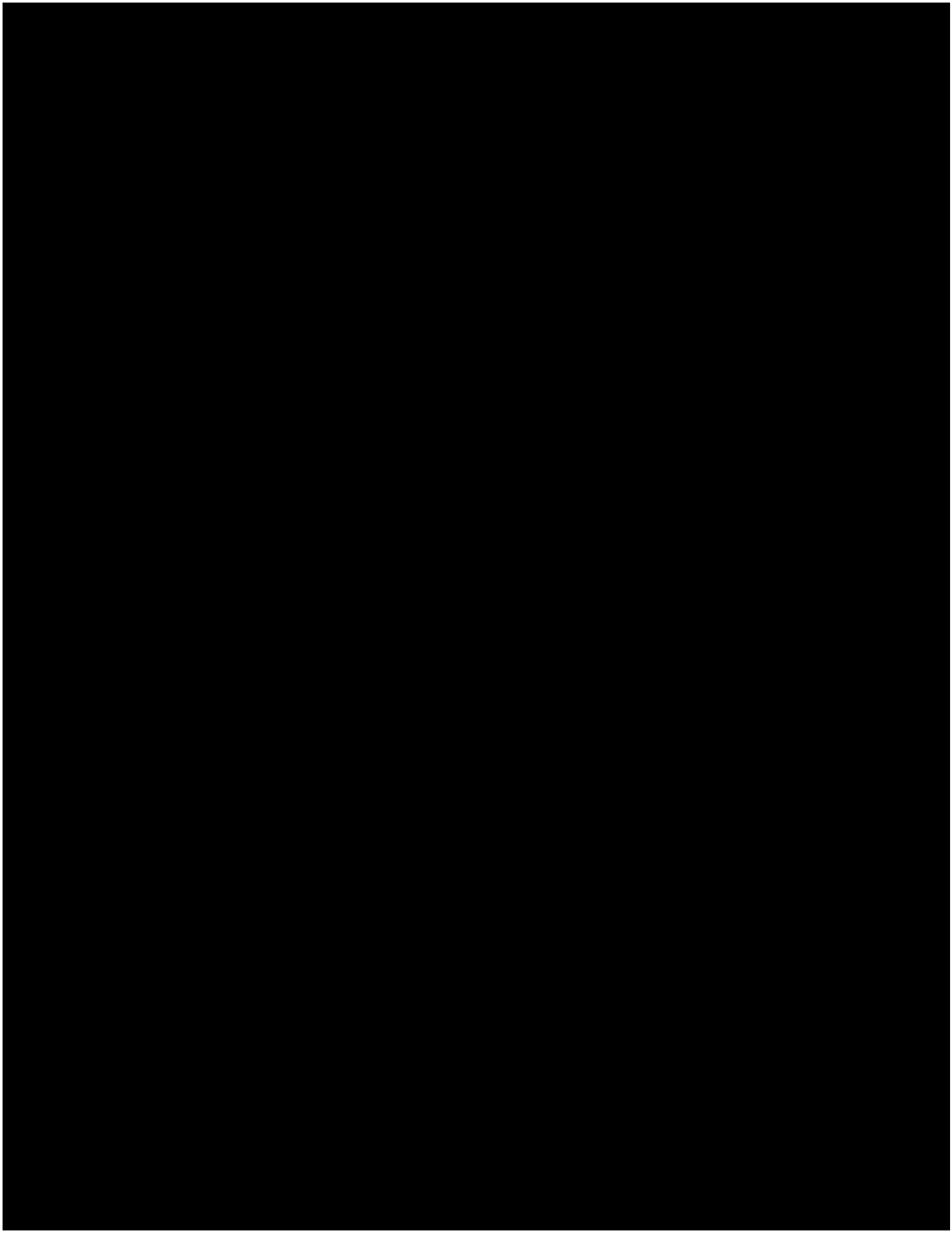


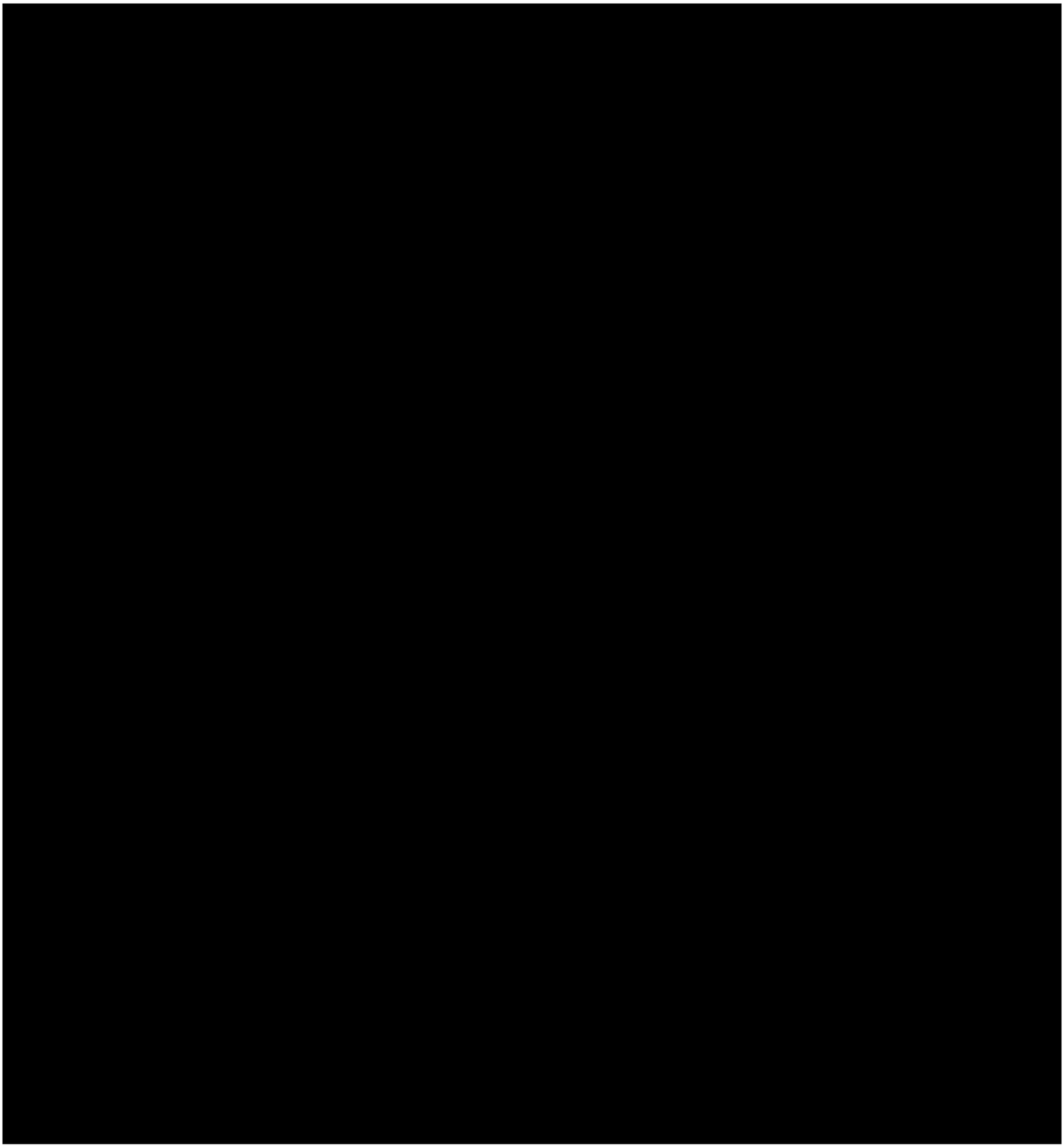


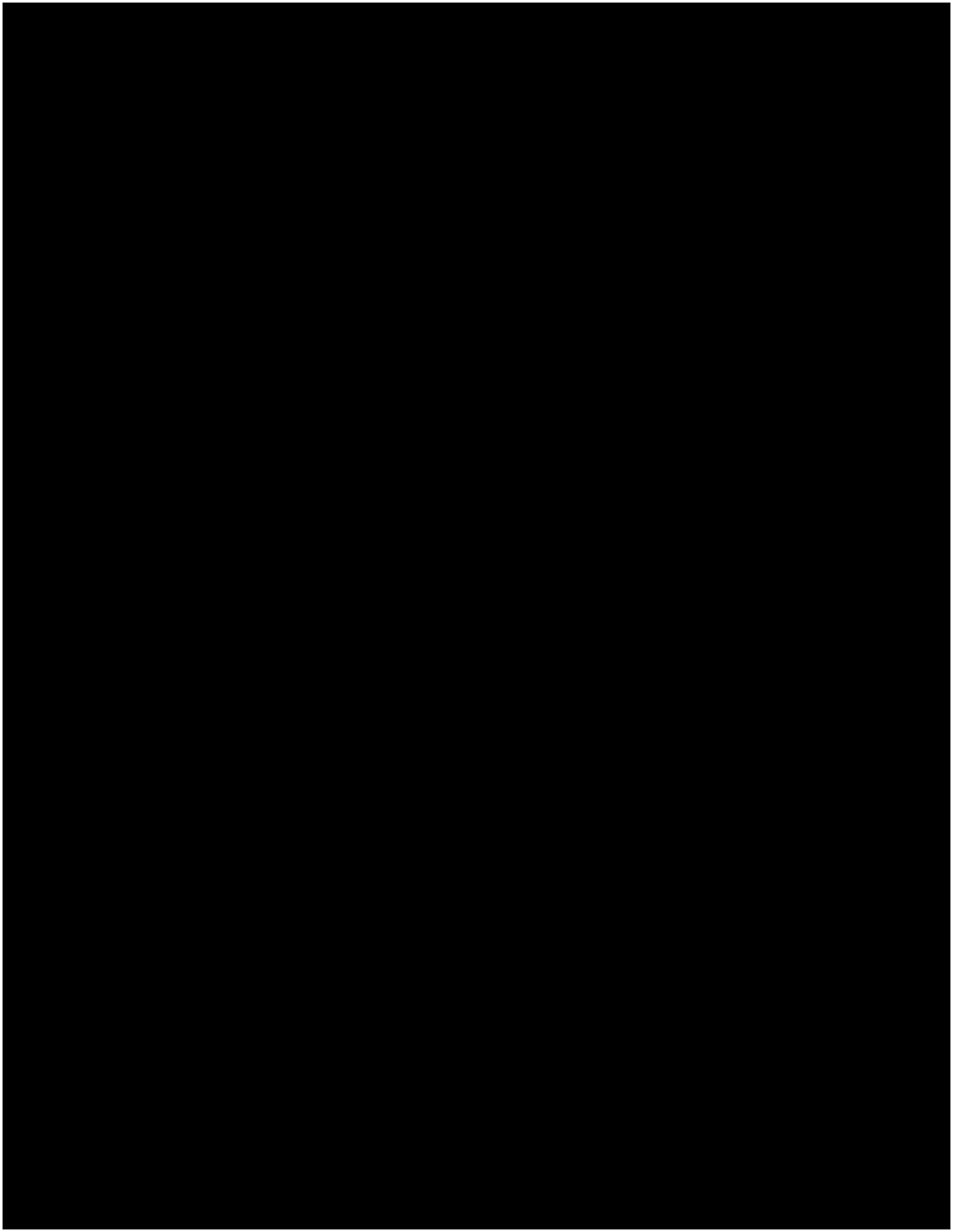


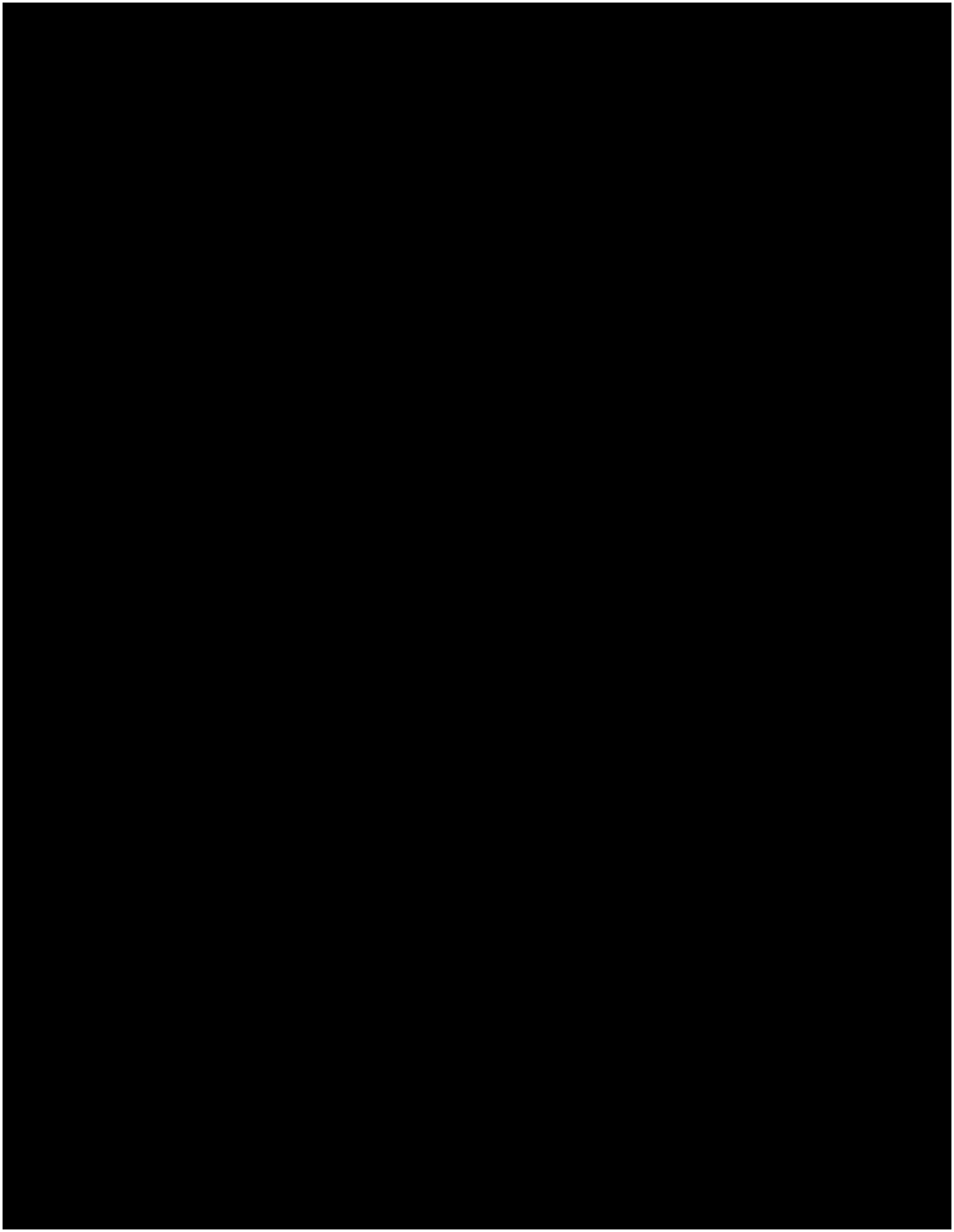


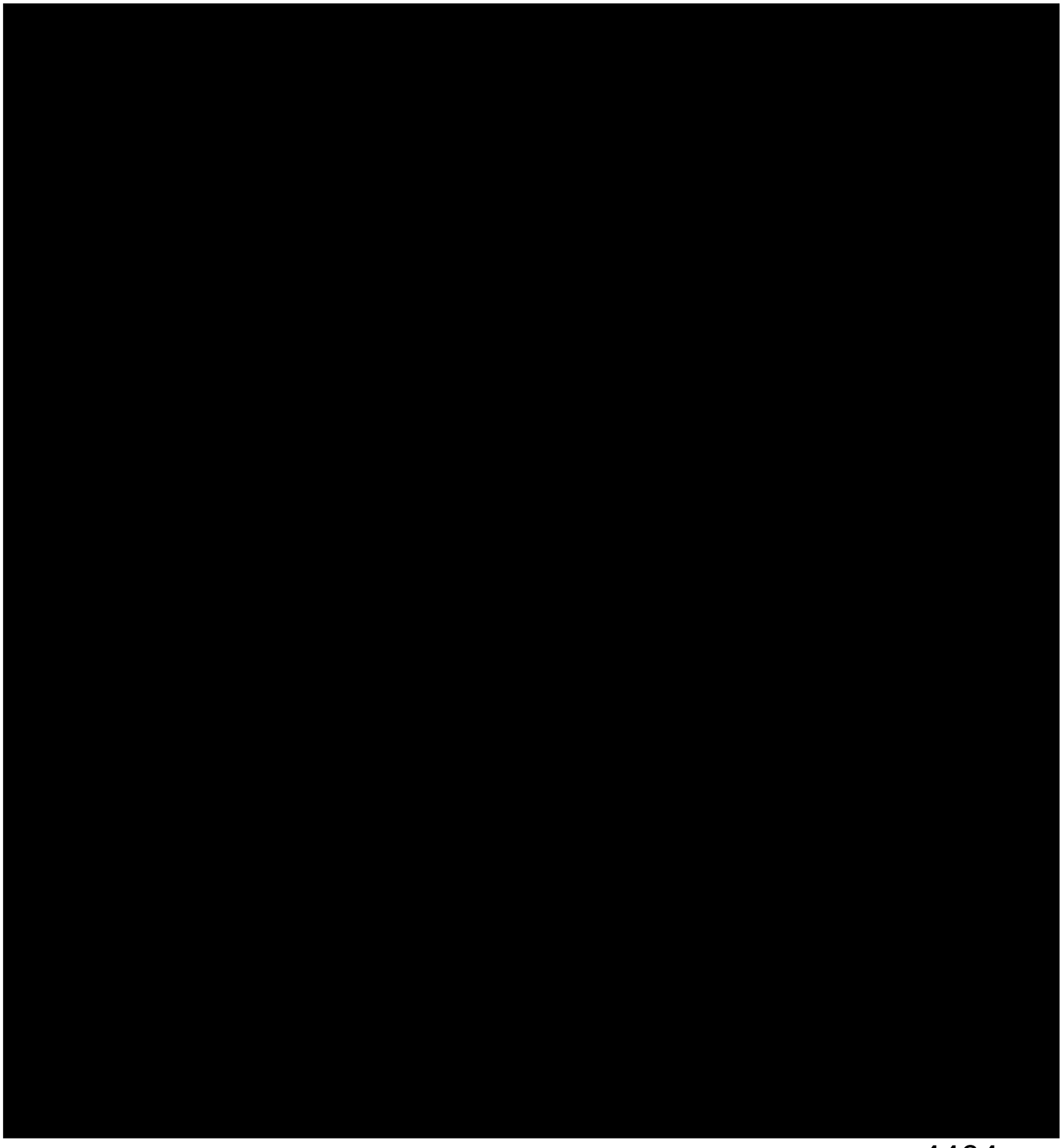


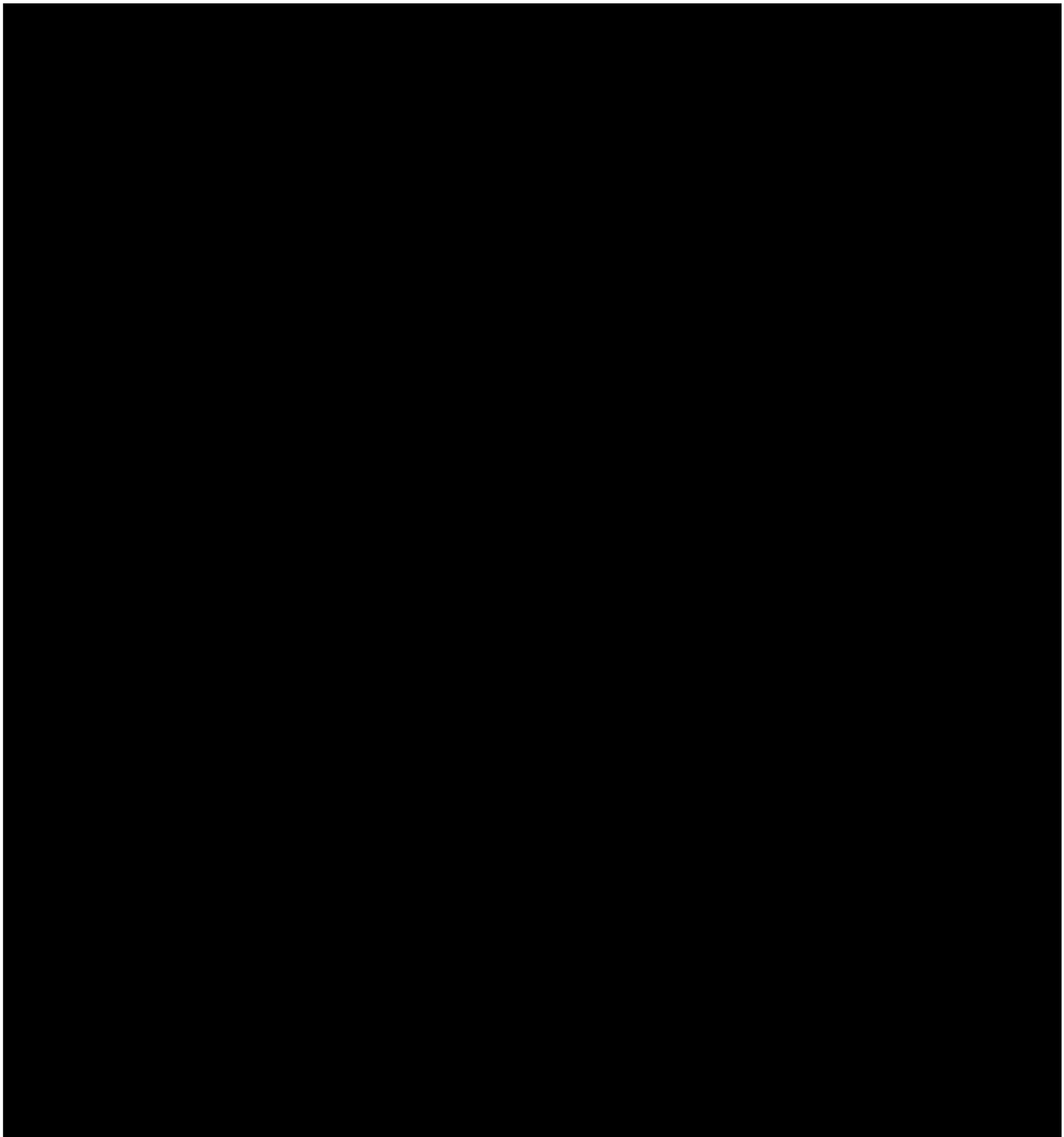


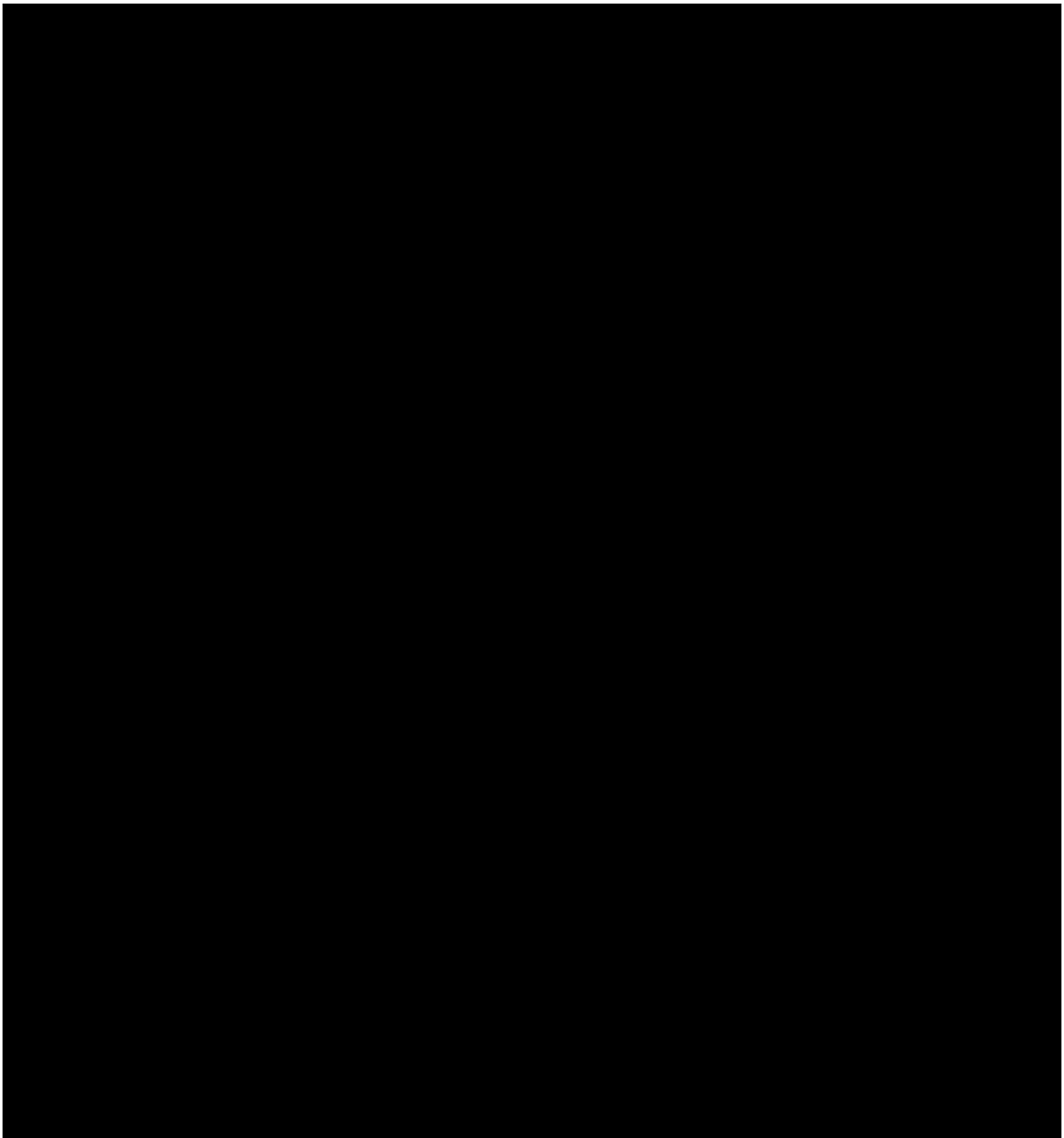


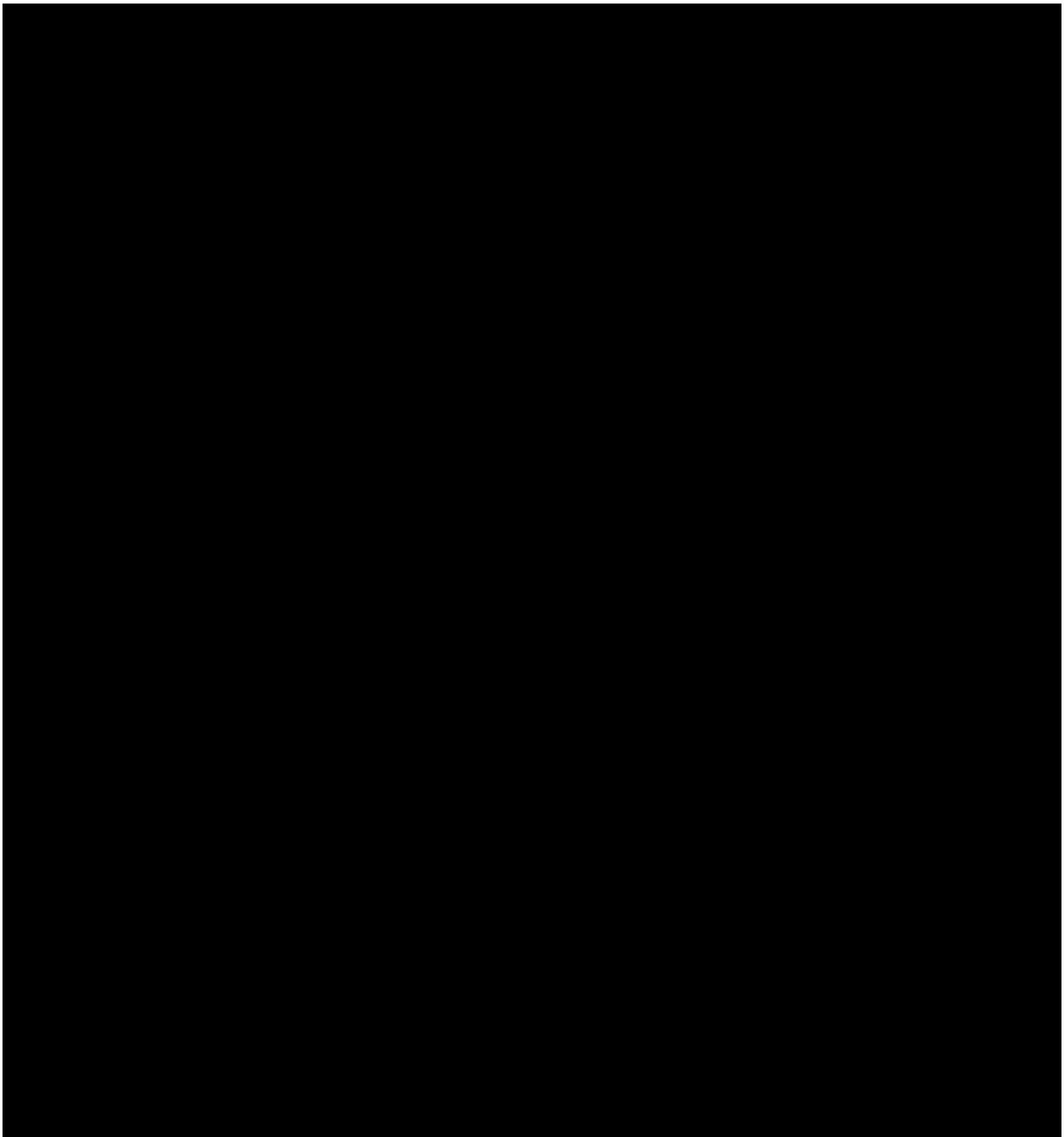


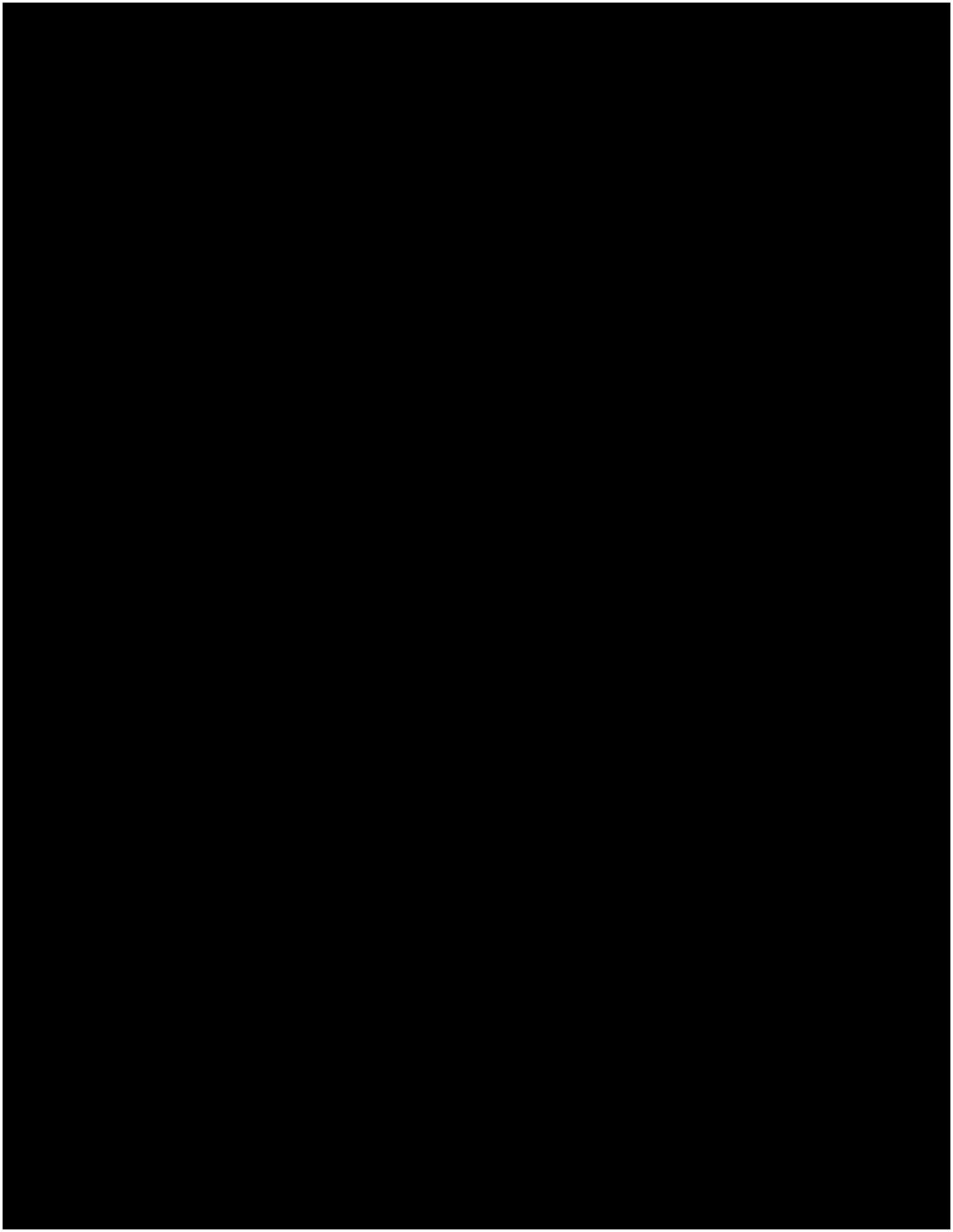


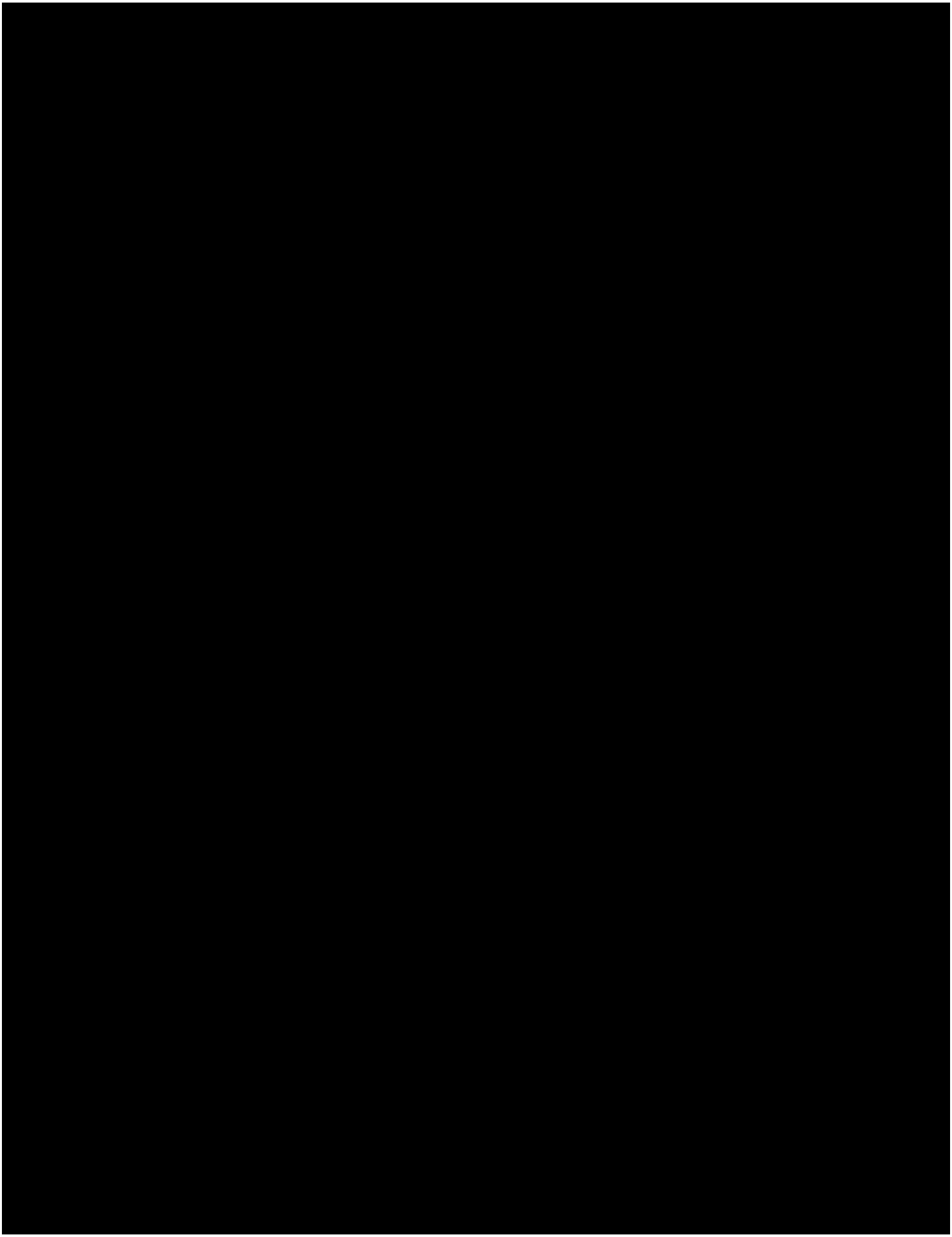


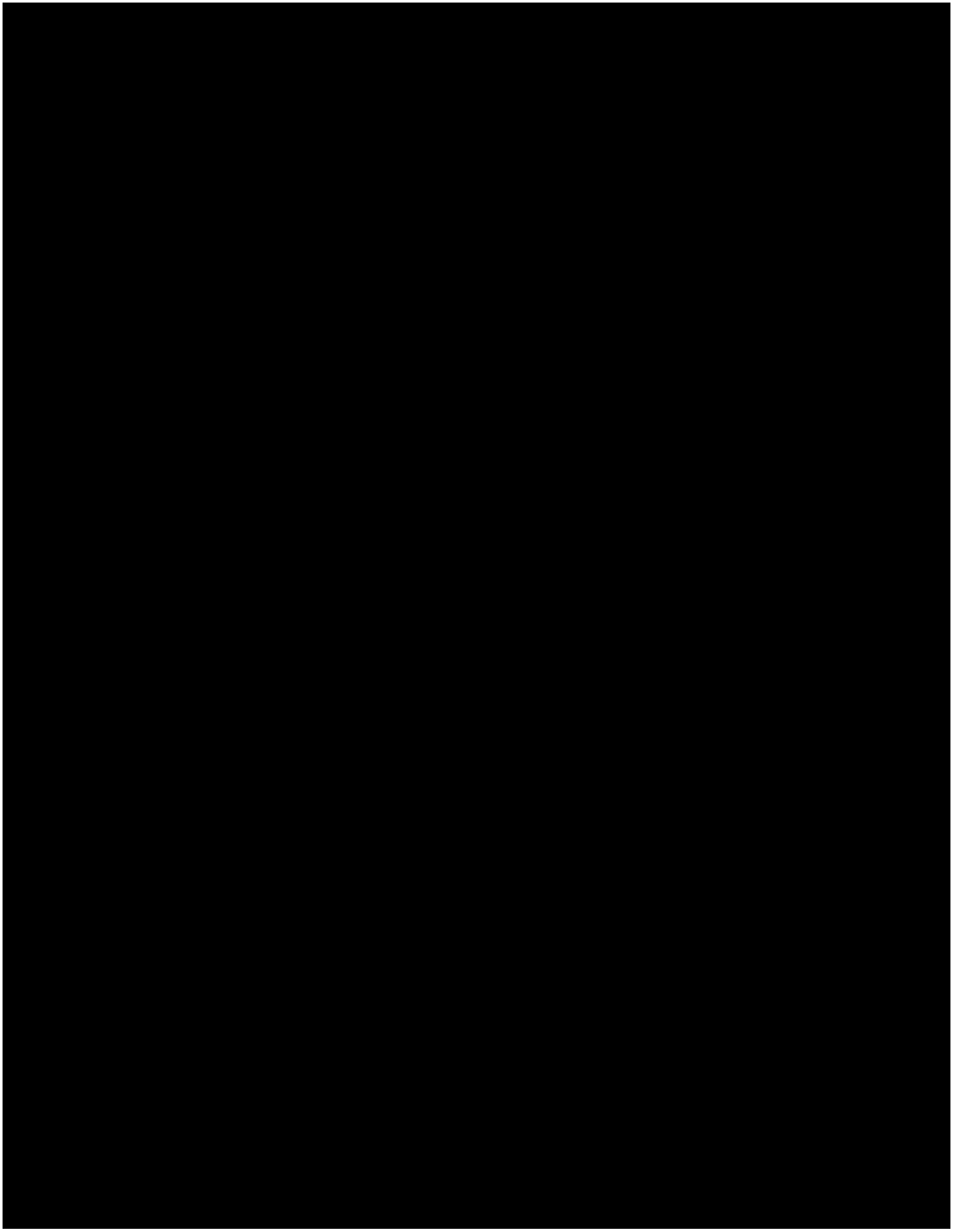


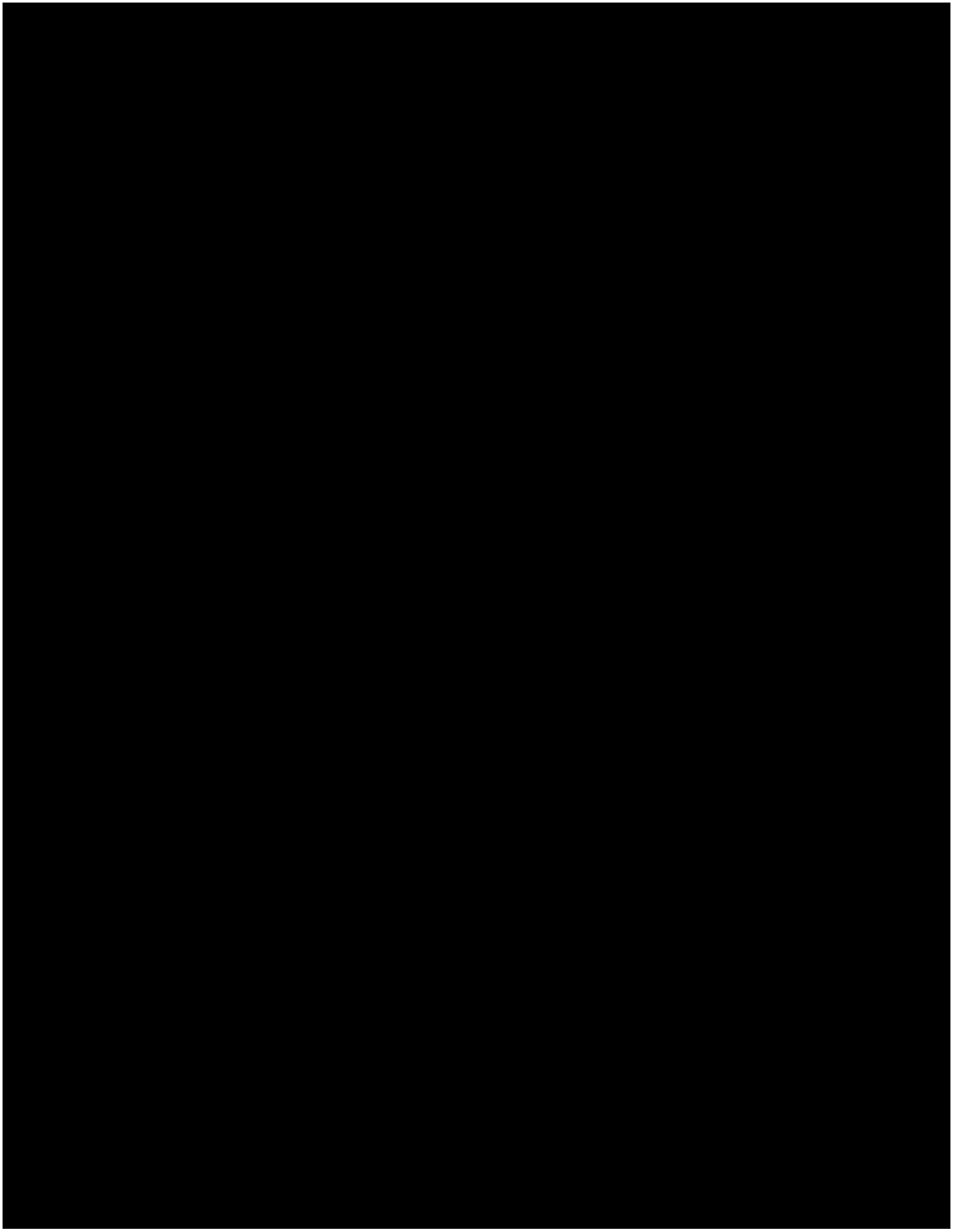


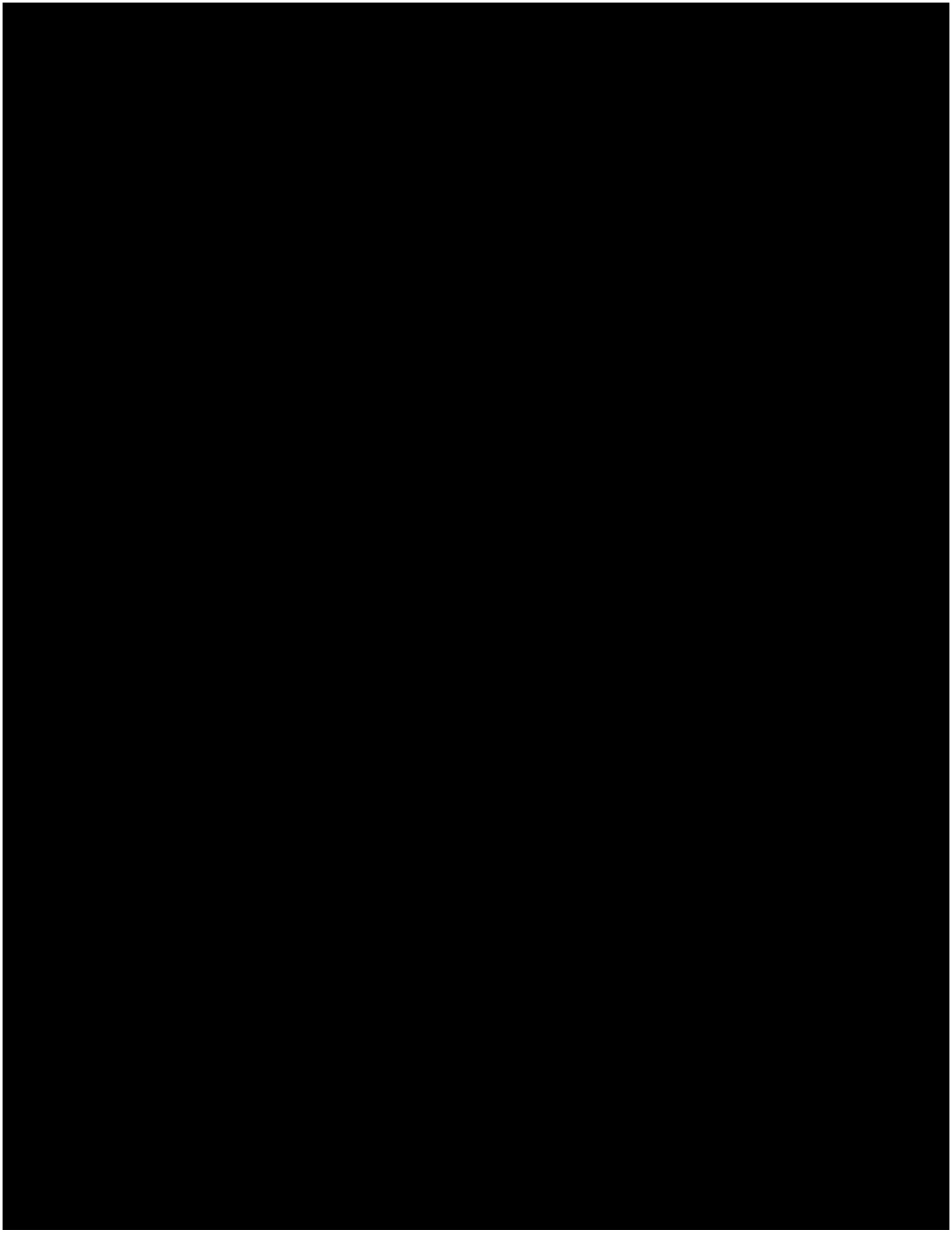


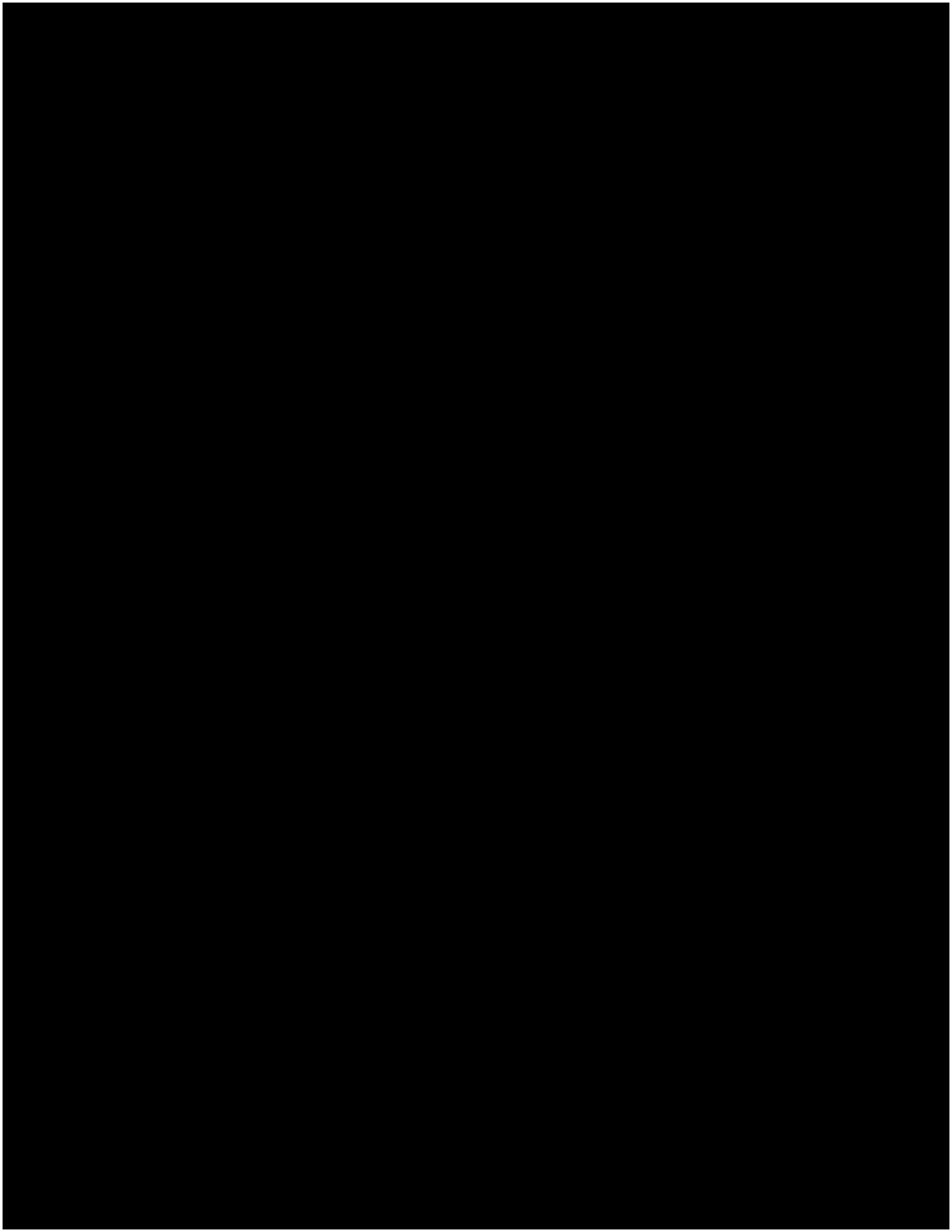


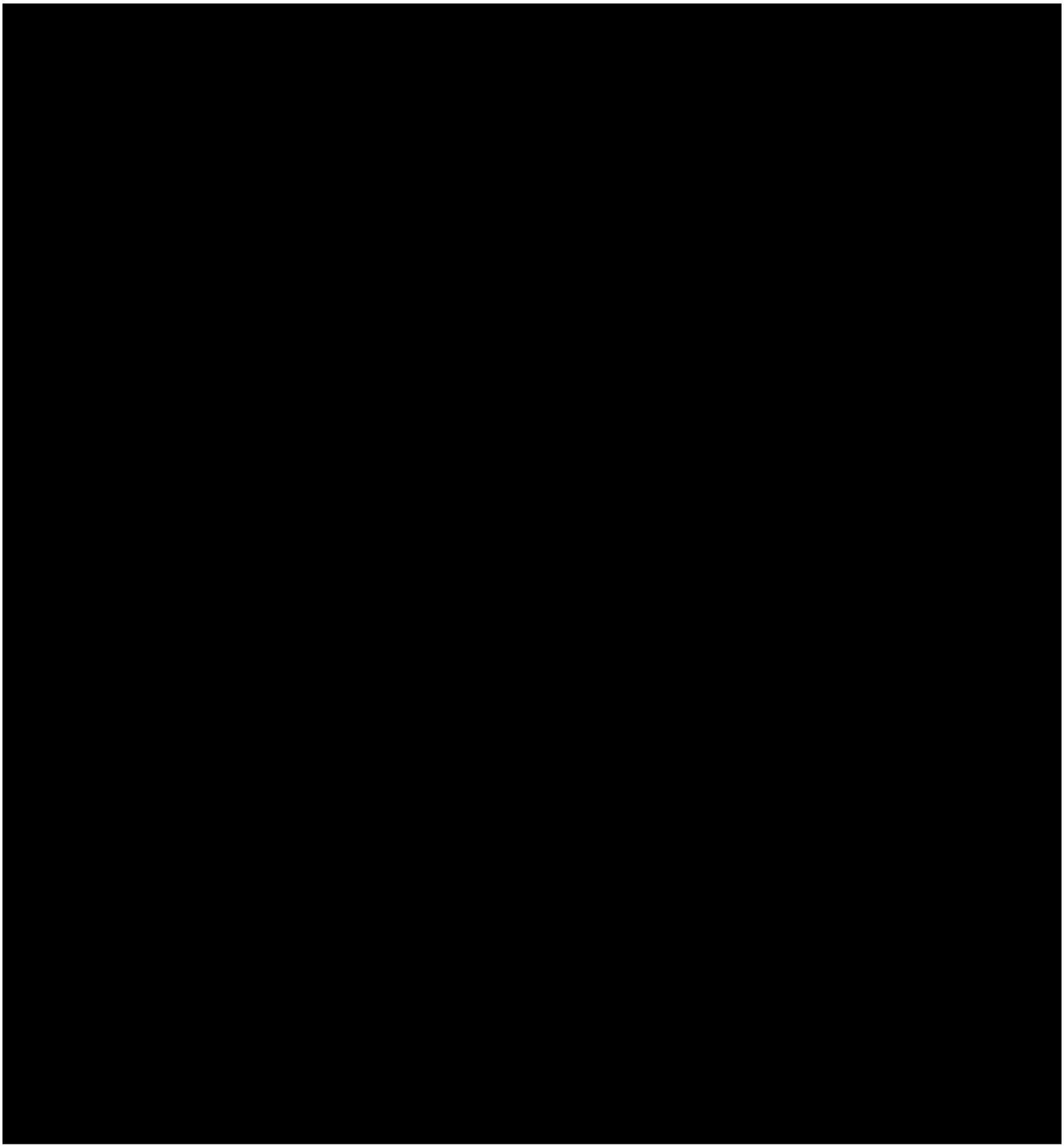


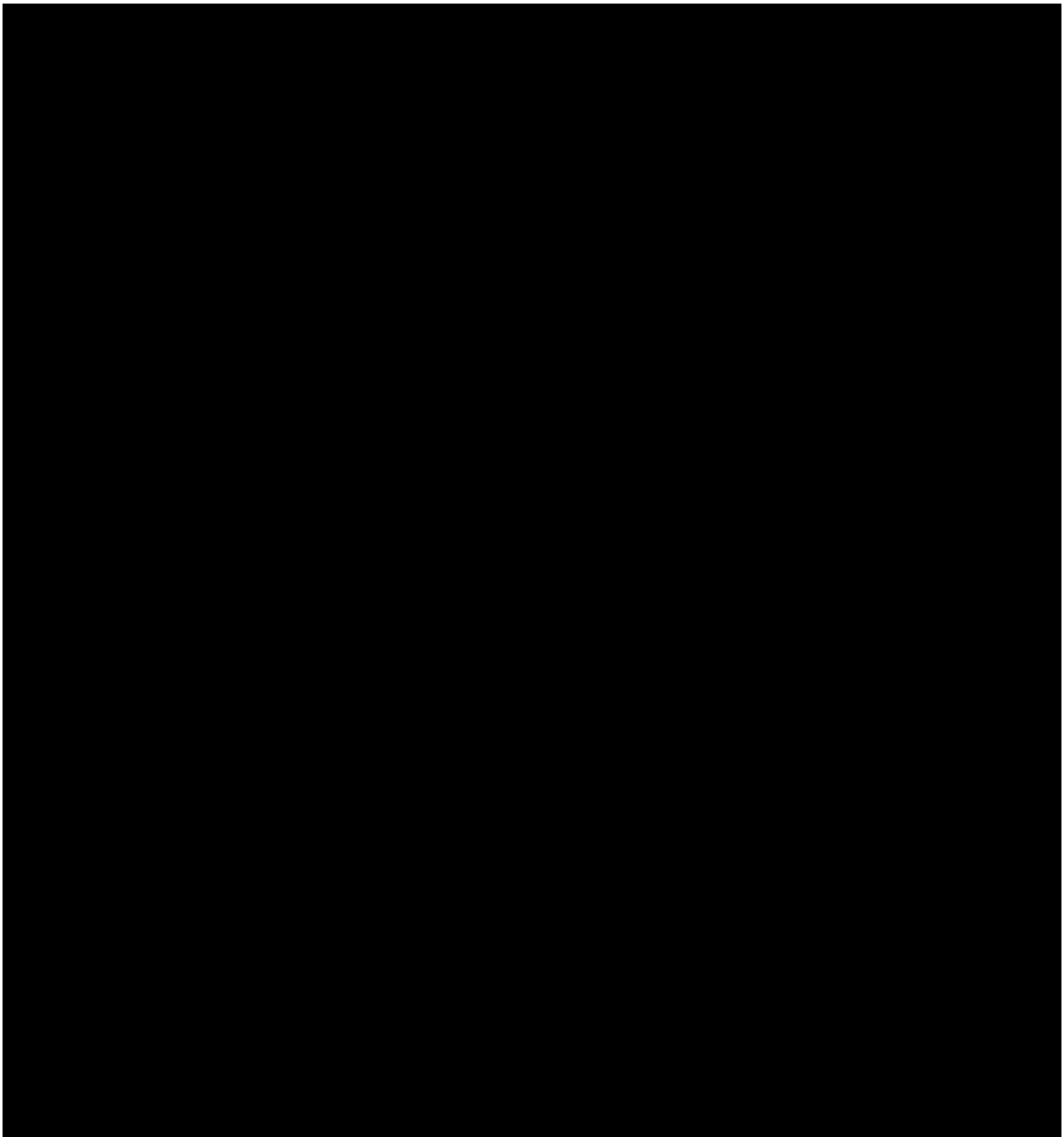


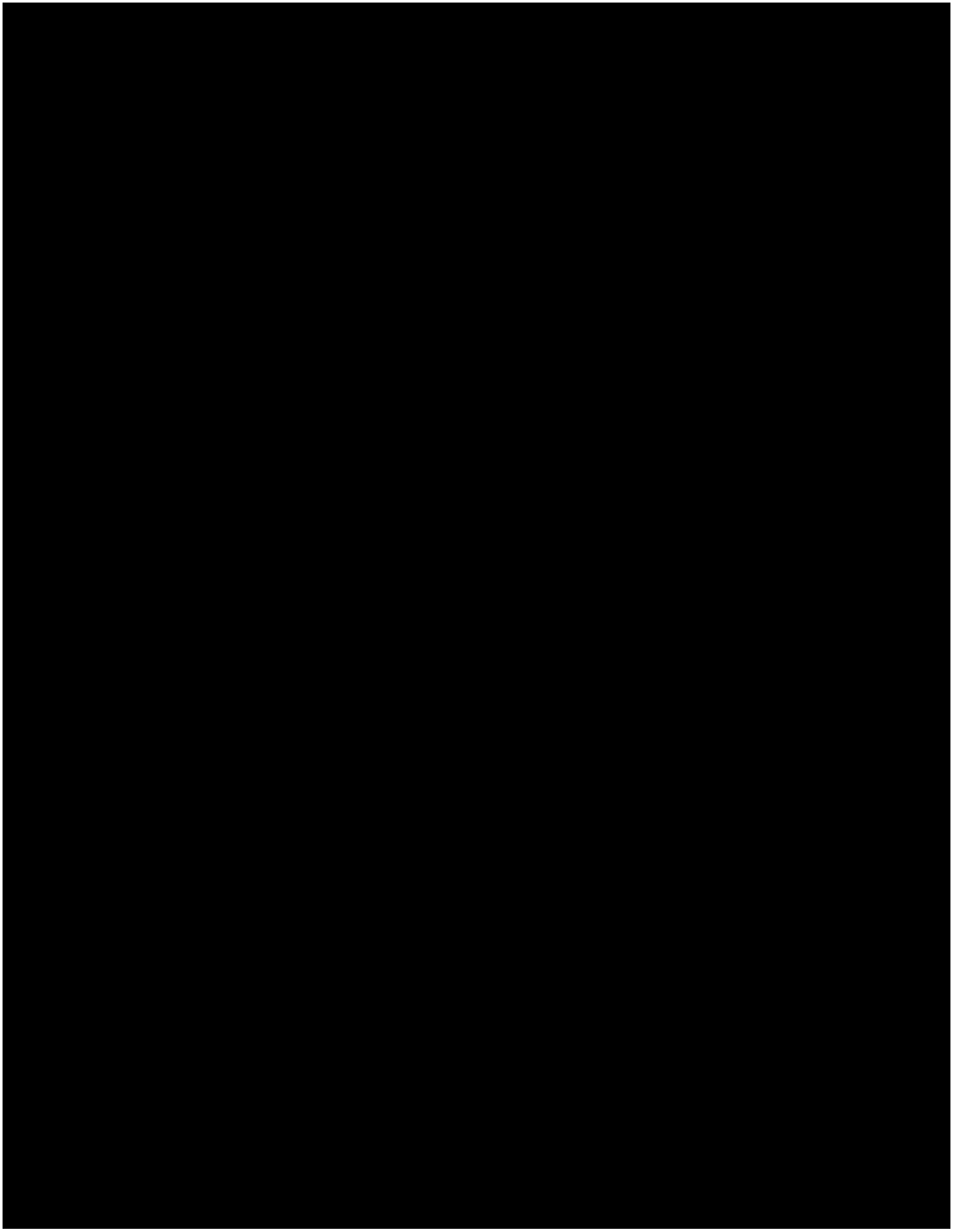


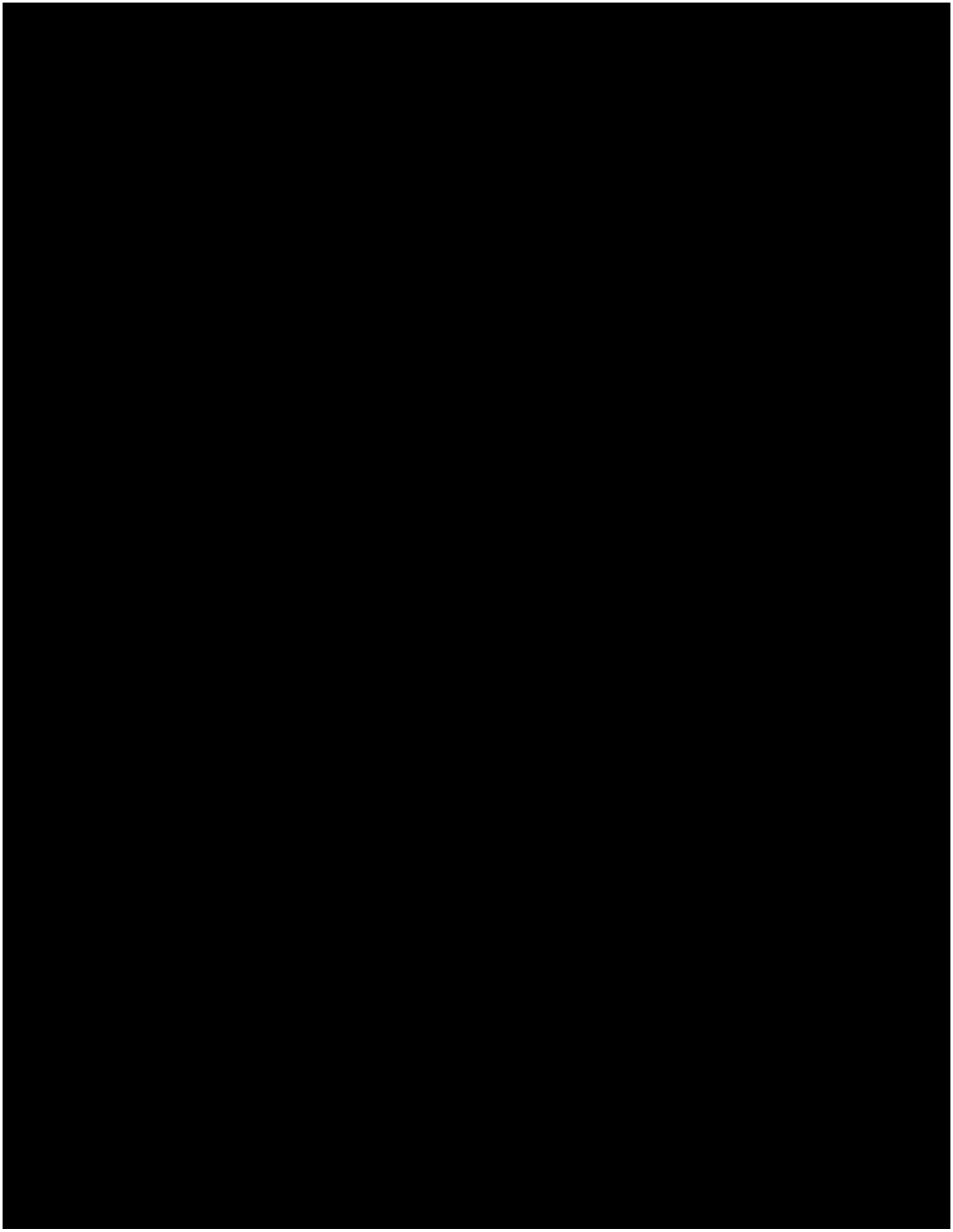


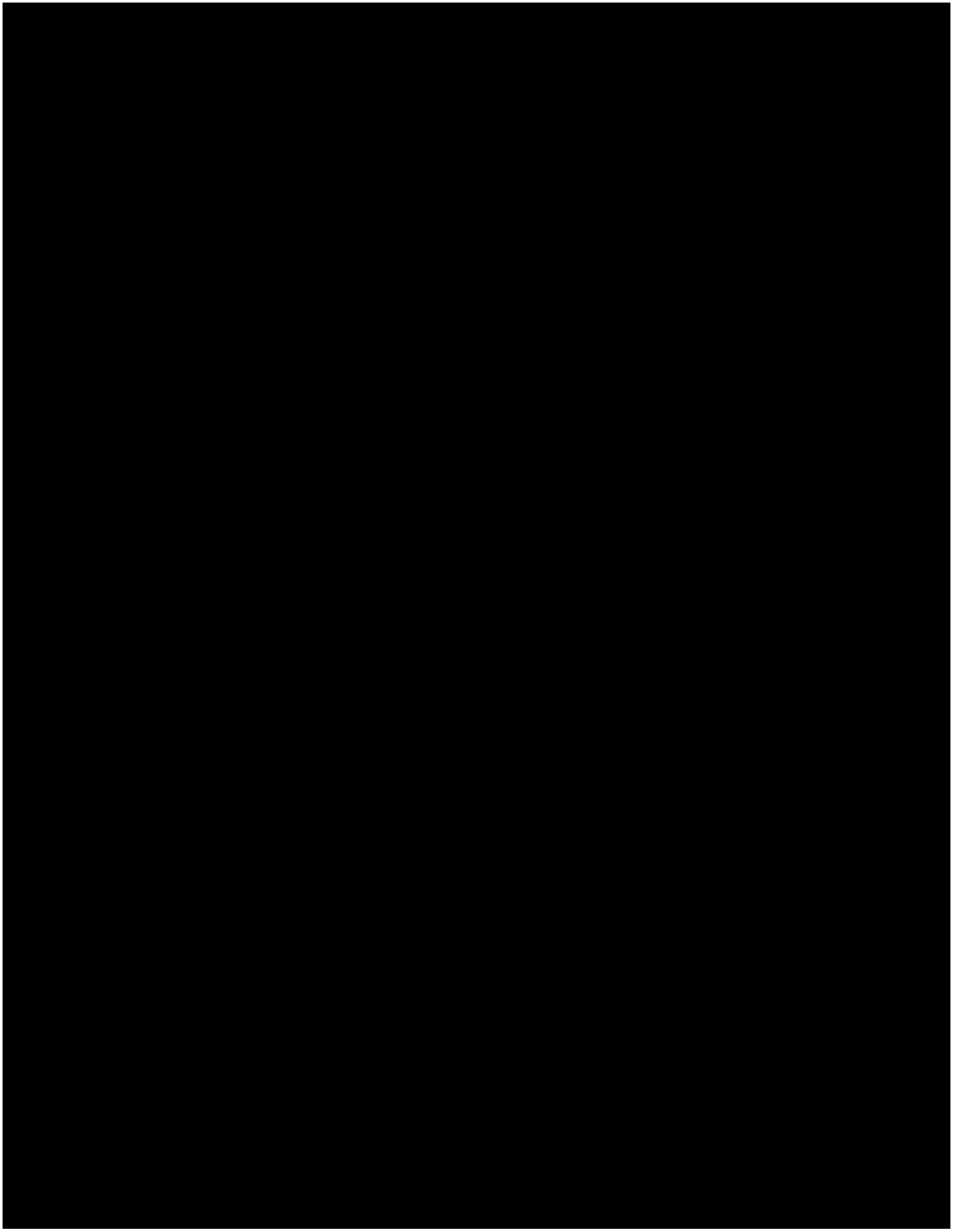


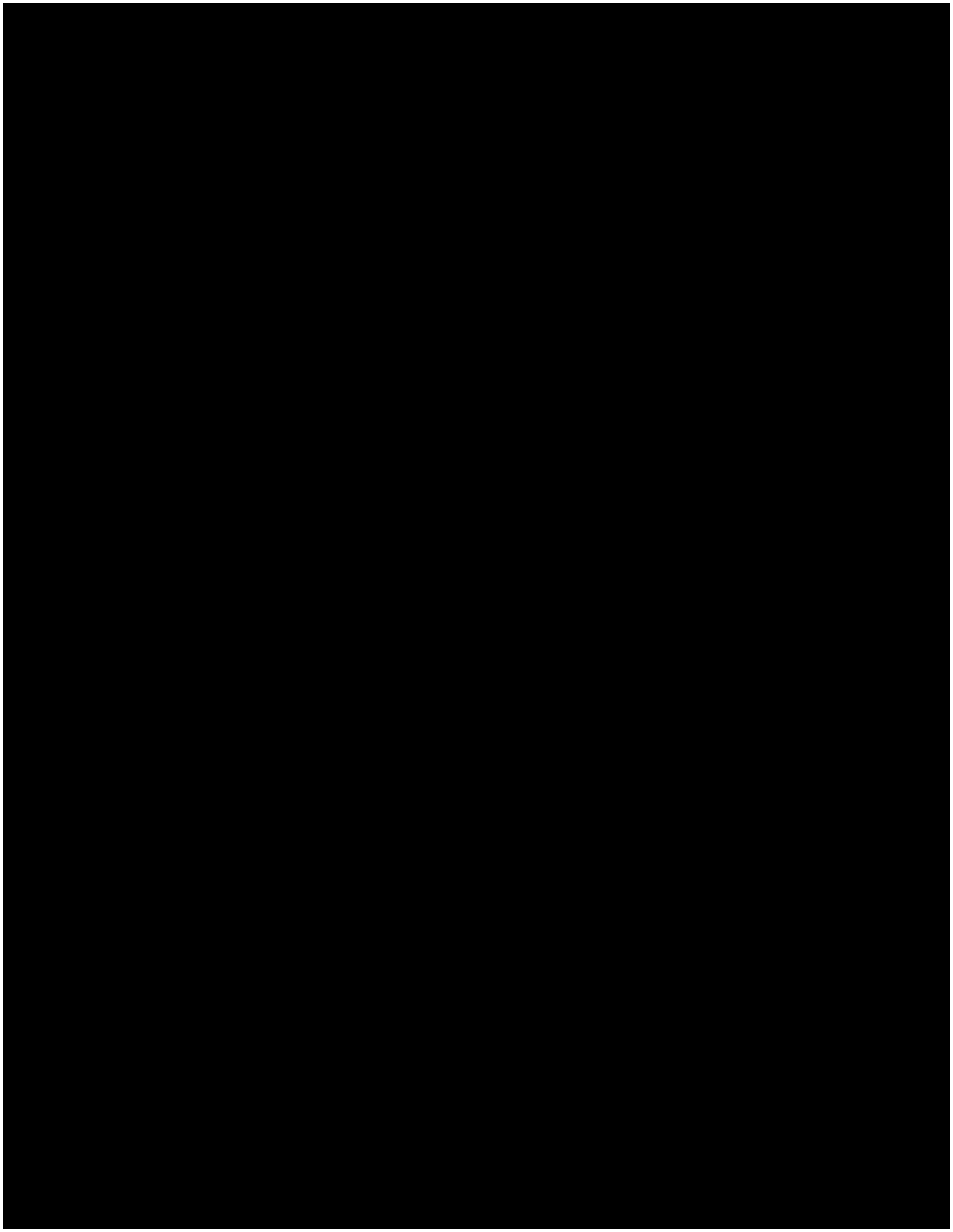












STATEMENT OF PHILOSOPHY

The Booneville Human Development Center (BHDC) is organized as a public institution to serve persons with developmental disabilities in the State of Arkansas under statutory authority of Act 320 of the 69th General Assembly of Arkansas. BHDC is committed to the philosophy of equal rights, human dignity and freedom for all.

The Interdisciplinary Team (IDT) approach to individualized program plan development, and the monitoring of the client's progress is employed. The full participation of clients, parents and advocates in the programming process is encouraged and desired. This participation includes full and open communication and visits to campus.

It is the intent of BHDC to provide active treatment for adults with developmental disabilities. Programming is based on the "developmental model", which is a principle and an awareness of the client's ability to progress toward established goals.

The behavioral model for programming and discipline is used at BHDC. The ultimate aim of BHDC is to foster those behaviors that maximize the human qualities of the client, increase the complexity of his/her behavior, enhance his/her ability to cope with his/her environments and provide opportunities to make choices. This approach will enable the client to grow by experiencing both successes and failures.

It is, therefore, our purpose to:

1. Provide a residential and training environment that will foster the development of the client's physical, intellectual and social capabilities to the fullest extent possible.

2. Provide emotional maturity and to develop skills, habits and attitudes essential for either the return to or successful placement in the community.

3. Provide and protect constitutional rights guaranteed to all American citizens, both staff and clients. Persons with developmental disabilities will be encouraged to exercise the same human and civil rights enjoyed by all citizens. Using due process, these rights, if limited or modified, will be only to the extent necessary based on the client's abilities.

4. Provide each client a comprehensive assessment to identify his/her present developmental level; strengths, abilities and developmental needs; and the conditions that impede development. This includes physical, sensorimotor, cognitive, communicative, emotional and social areas. Based on results of the assessment, an adequate program plan will be established to meet the individual needs of each client as determined by an appropriately constituted IDT.

5. Provide a warm, stimulating atmosphere for living and training which reflects age-appropriateness and respect for the client in the least restrictive environment.



6. Provide a positive programming approach for training skills and adaptive behaviors.

Fulfillment of the above-stated purpose will be provided in an ethical atmosphere as stated in BHDC Code of Ethics (See Attachment # 1).

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-A-1, dated 12/04/15, in its entirety.

BOONEVILLE HUMAN DEVELOPMENT CENTER

CODE OF ETHICS

As an employee of the Booneville Human Development Center (BHDC) I commit to conduct myself in accord with this code and I subscribe to the following statements:

I will uphold and advance the values, ethics, philosophy and mission of BHDC.

I will contribute my knowledge, skills and support to the programs of BHDC and to the clients served.

I regard the welfare of the clients served as my primary obligation.

I will treat clients and other employees with respect, courtesy, good faith, and without bias or prejudice.

I will respect the privacy of the clients I serve.

I will maintain client confidentiality.

I will do no harm to the clients I serve.

I will use appropriate channels to express my opinions.

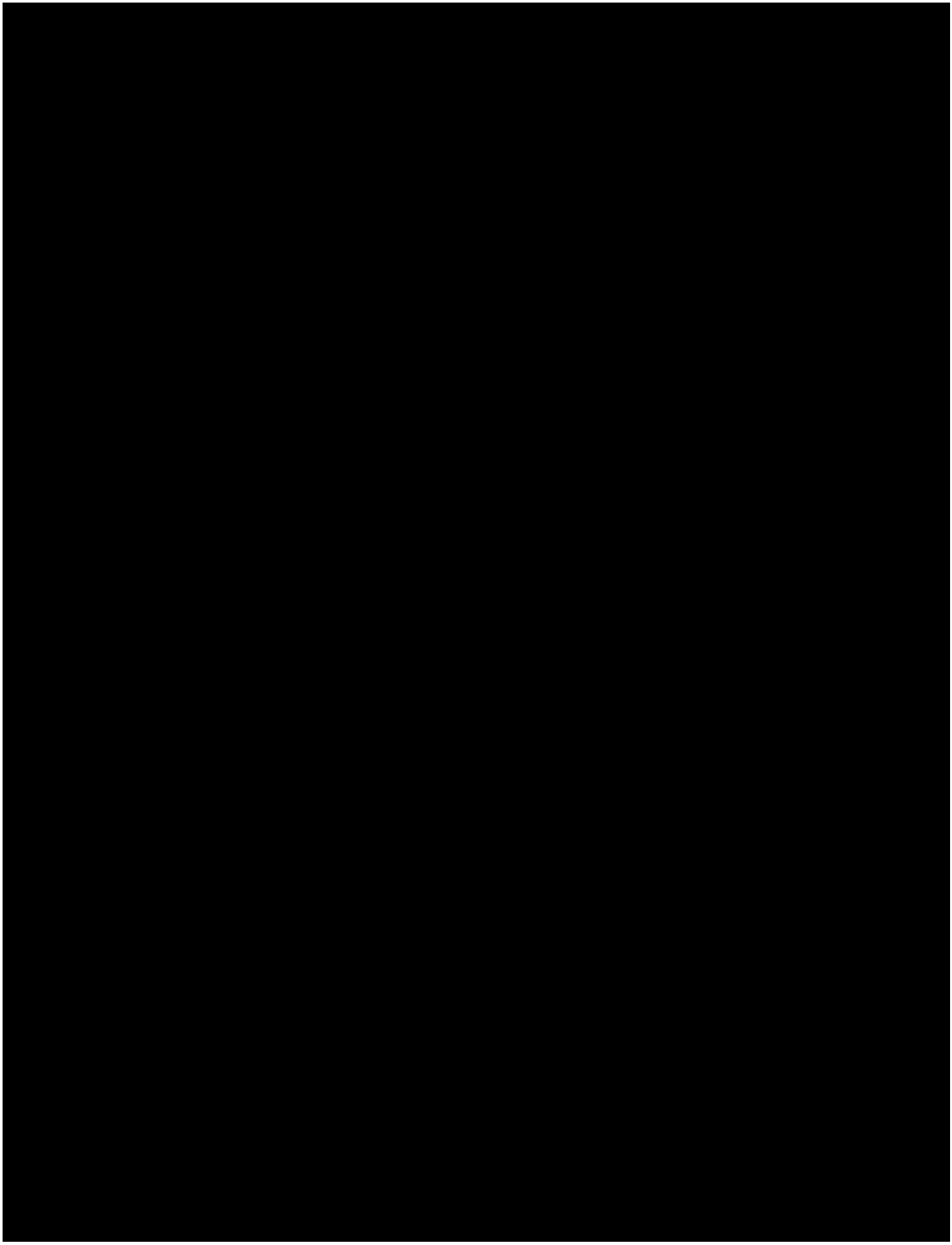
I will accept responsibility to protect BHDC against unethical practice by others.

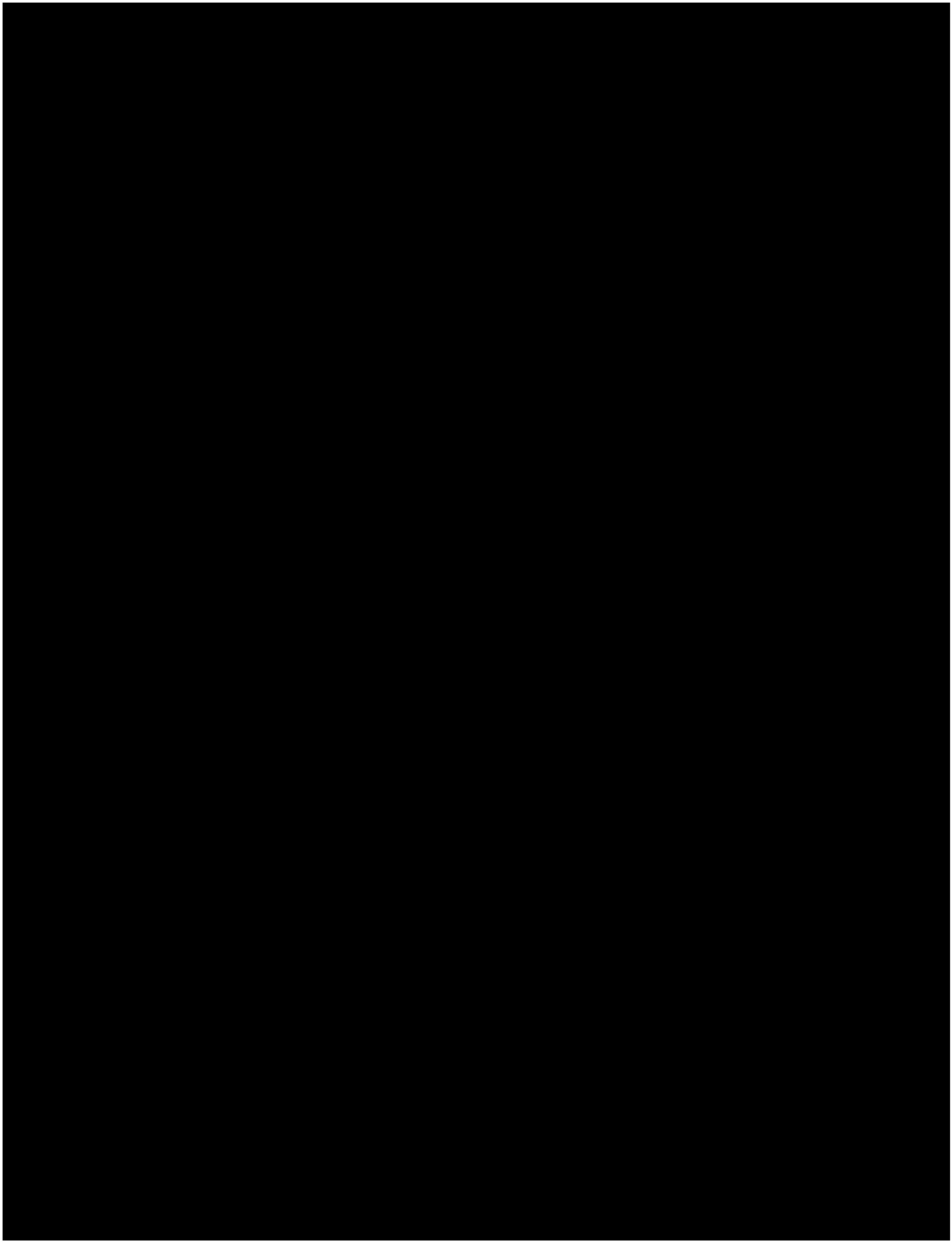
I will distinguish clearly, in public, between my statements and actions as an individual and as an employee of BHDC.

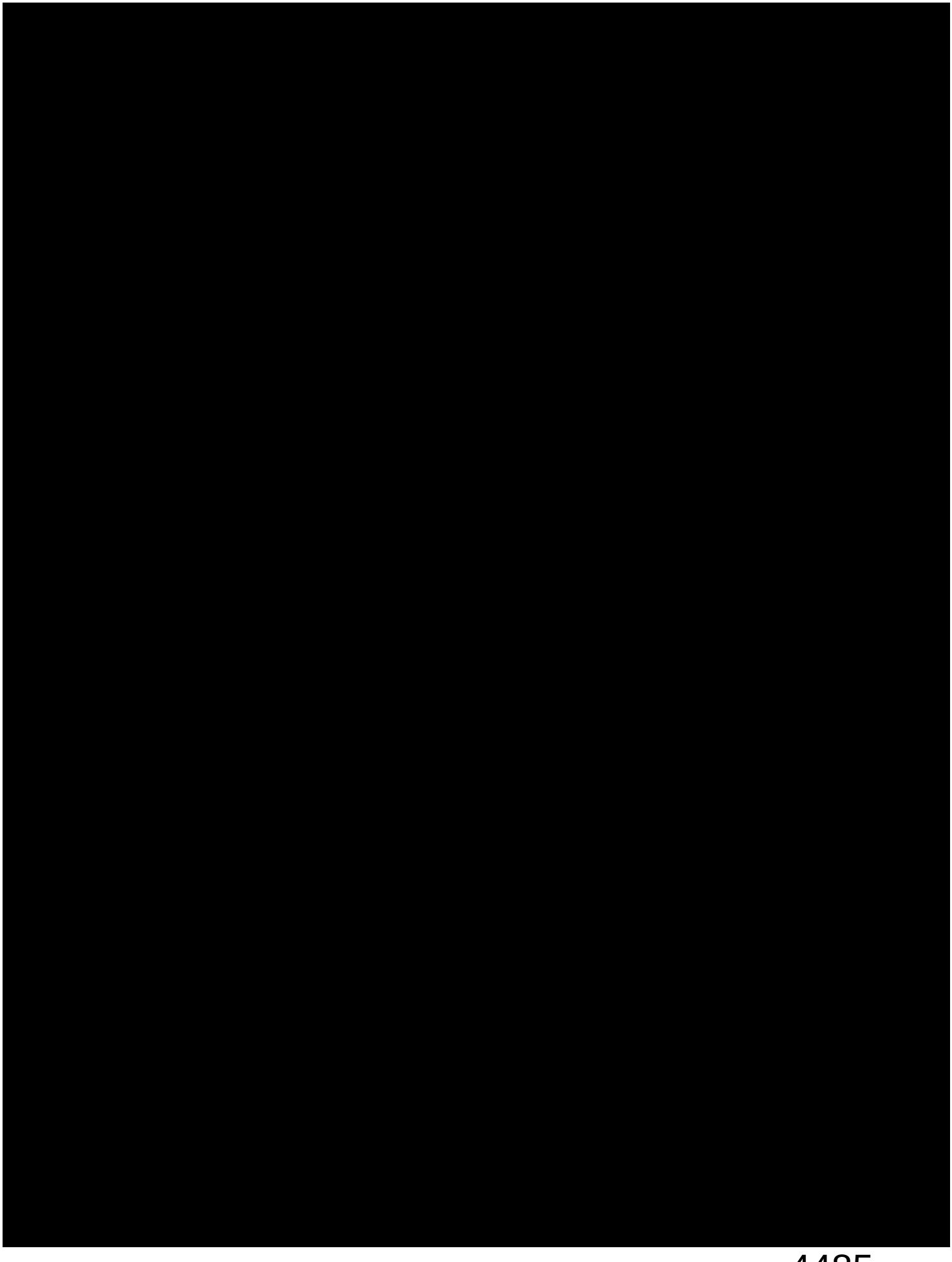
I hold myself responsible for the quality and extent of the duties I perform.

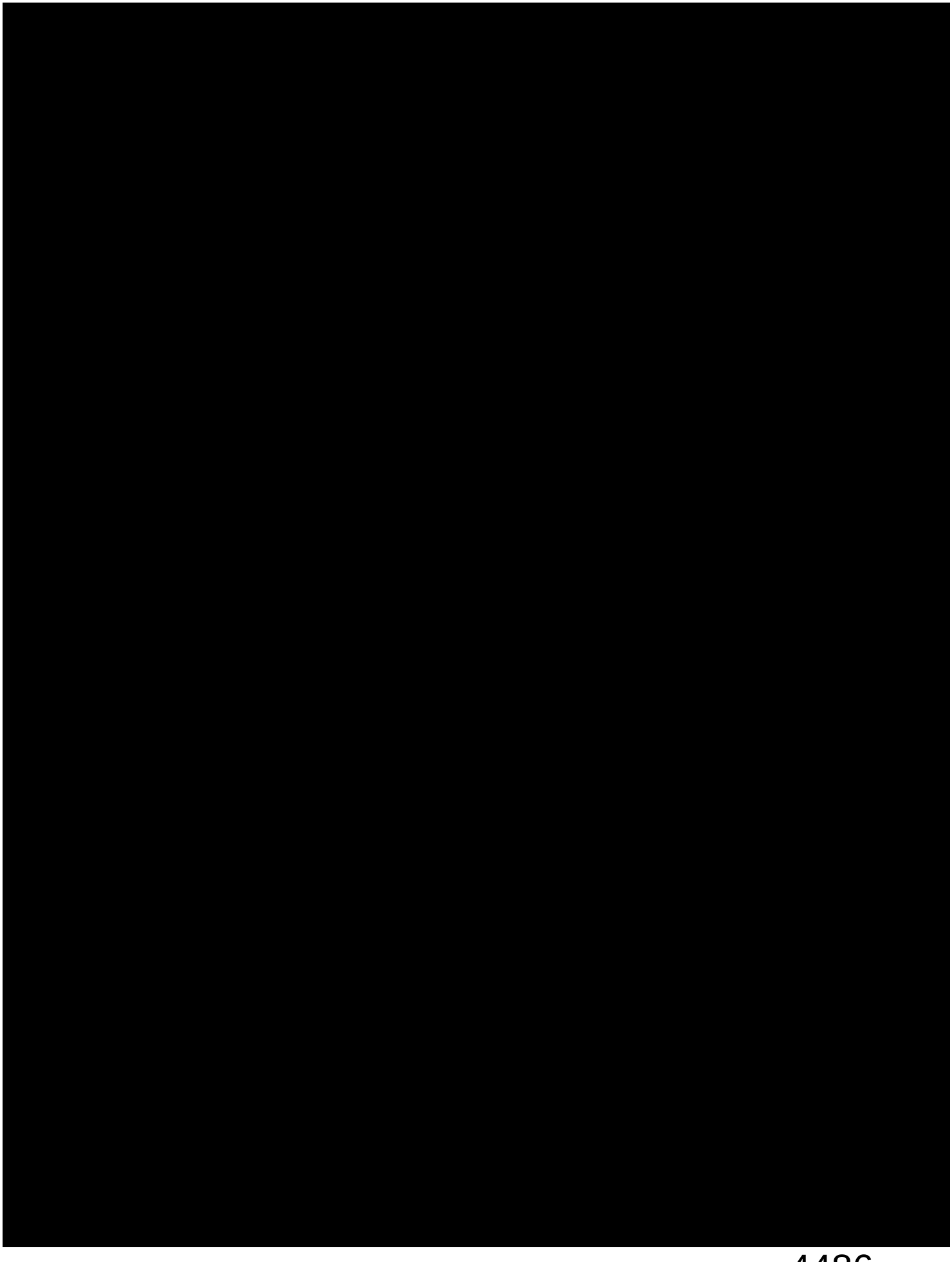
I will perform my job duties proficiently and competently.

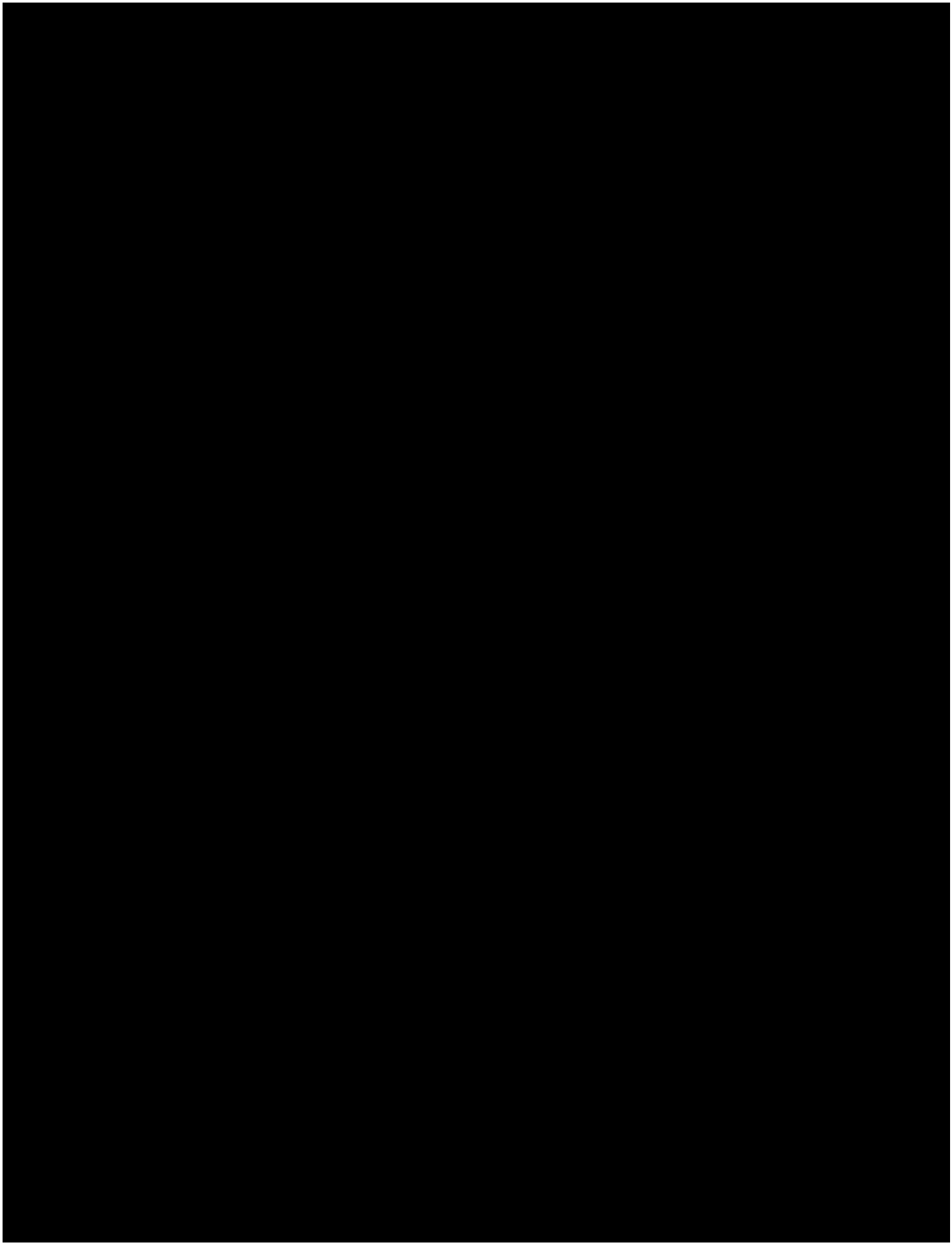
I will stand ready to give appropriate service in emergencies.

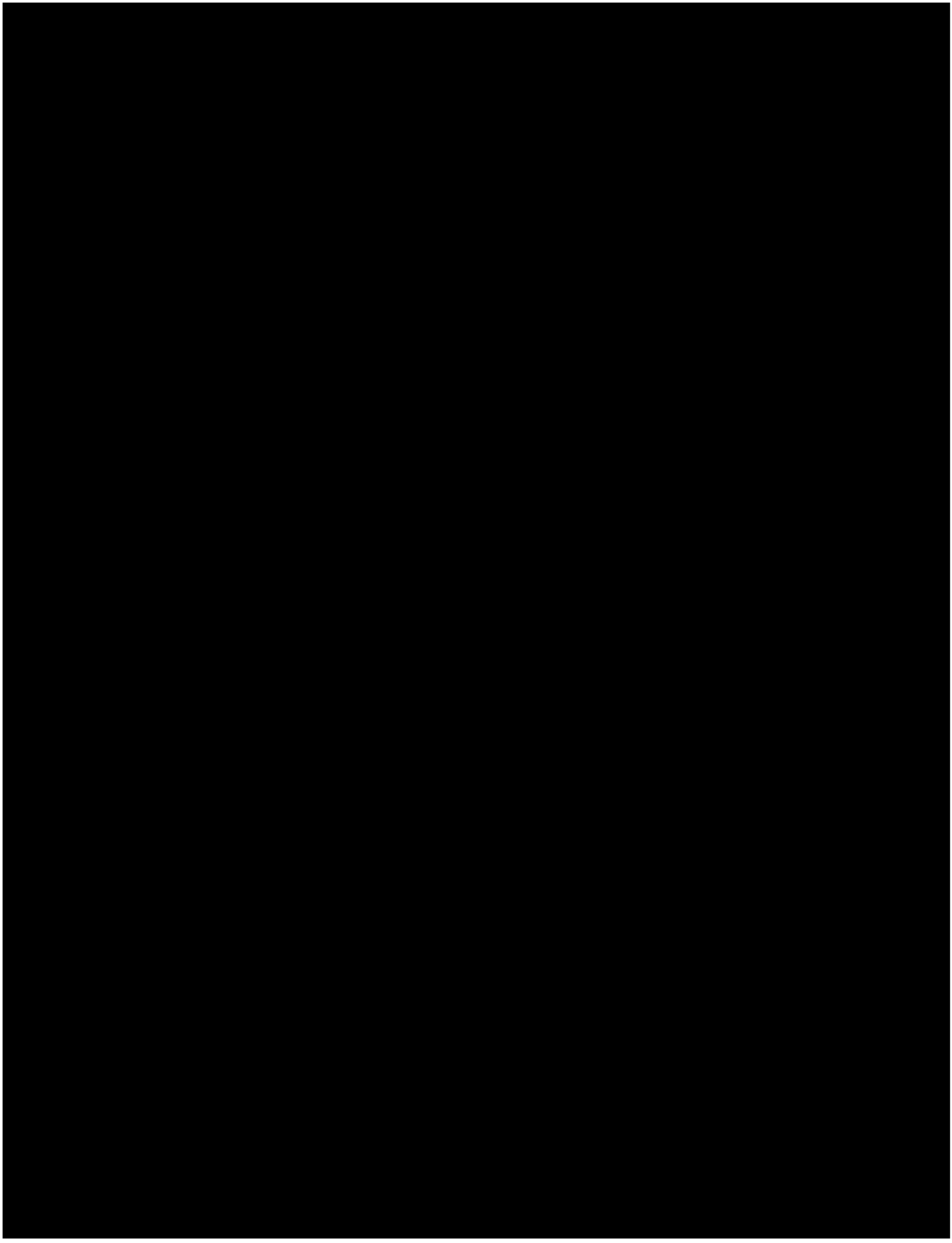


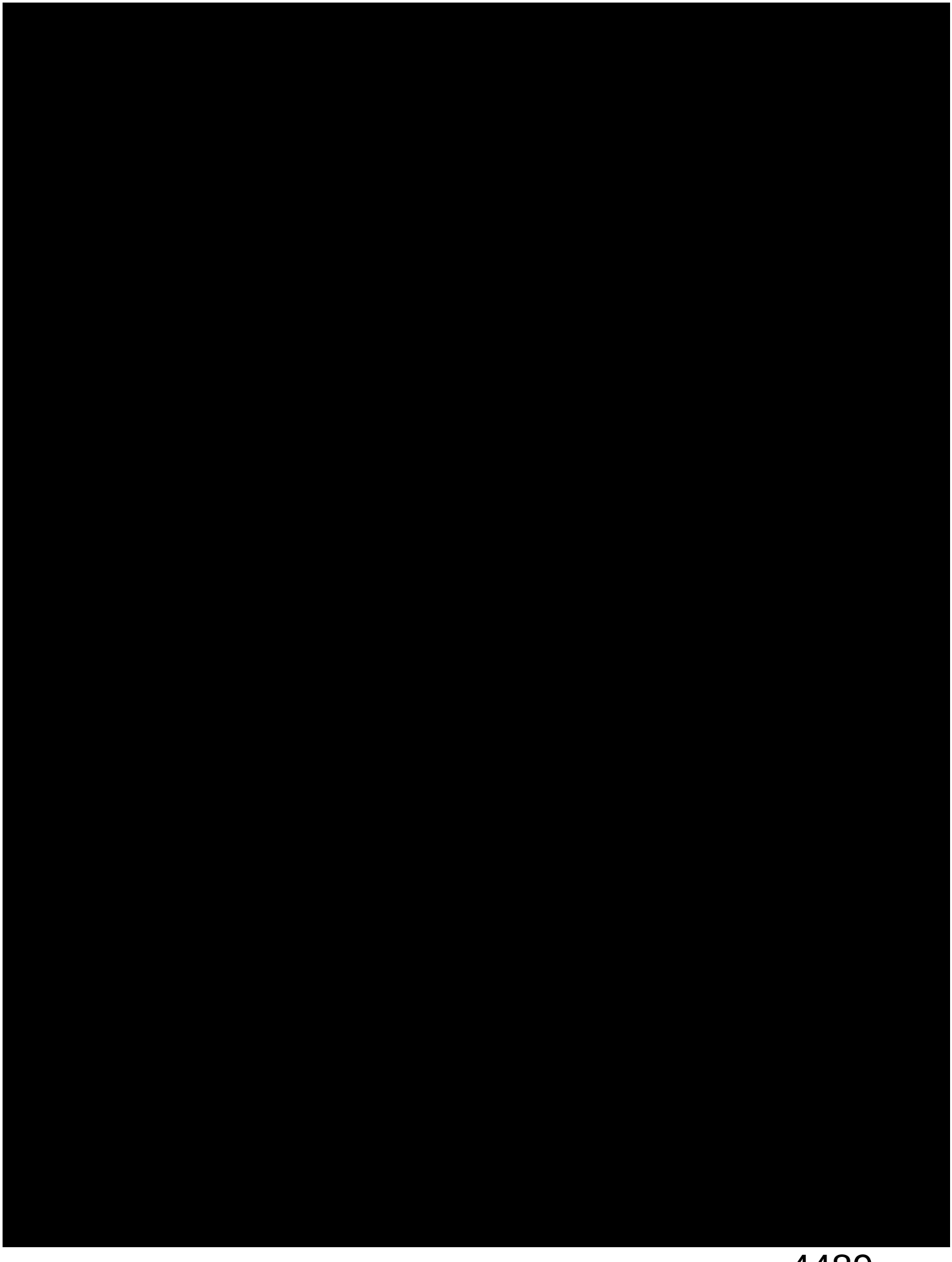


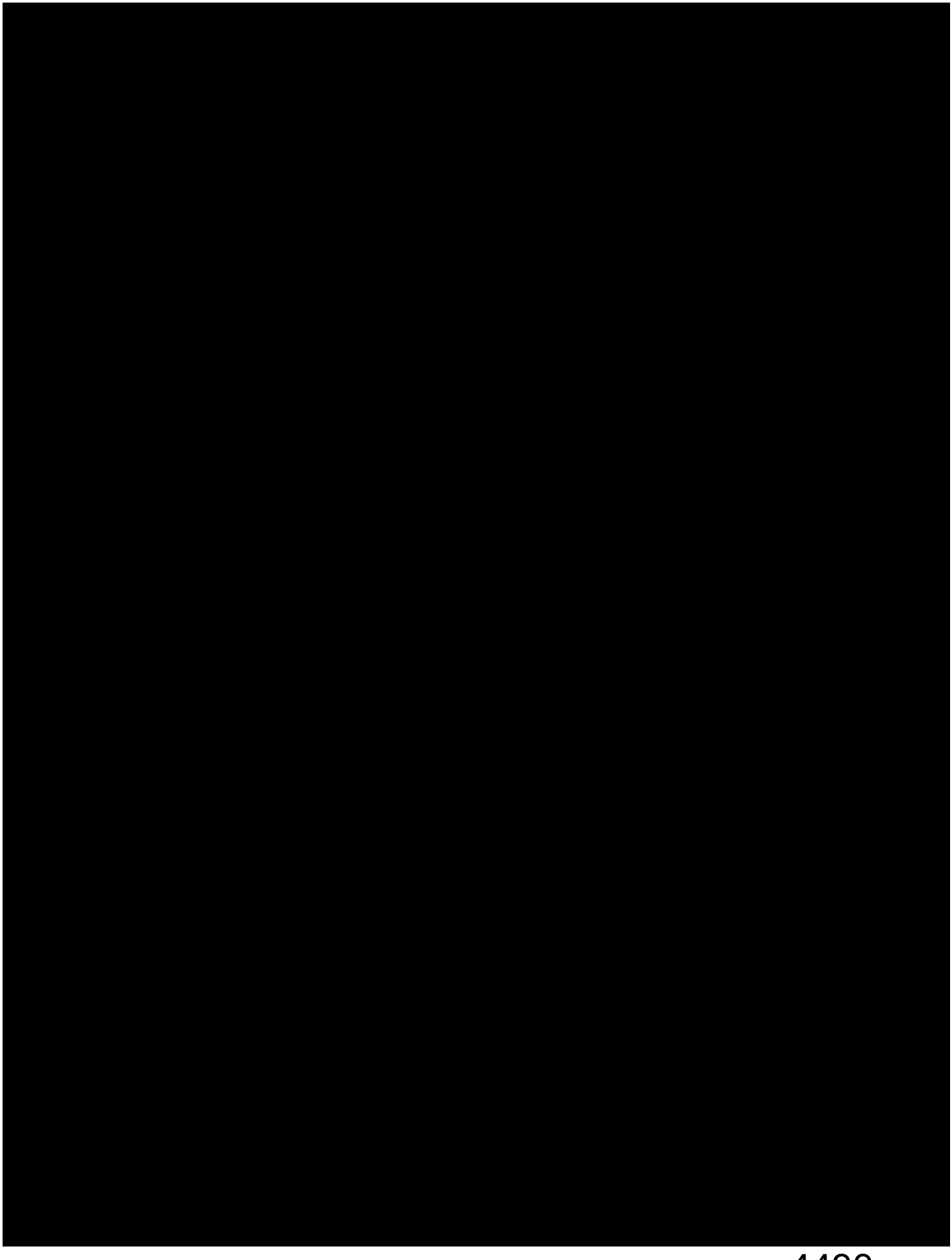


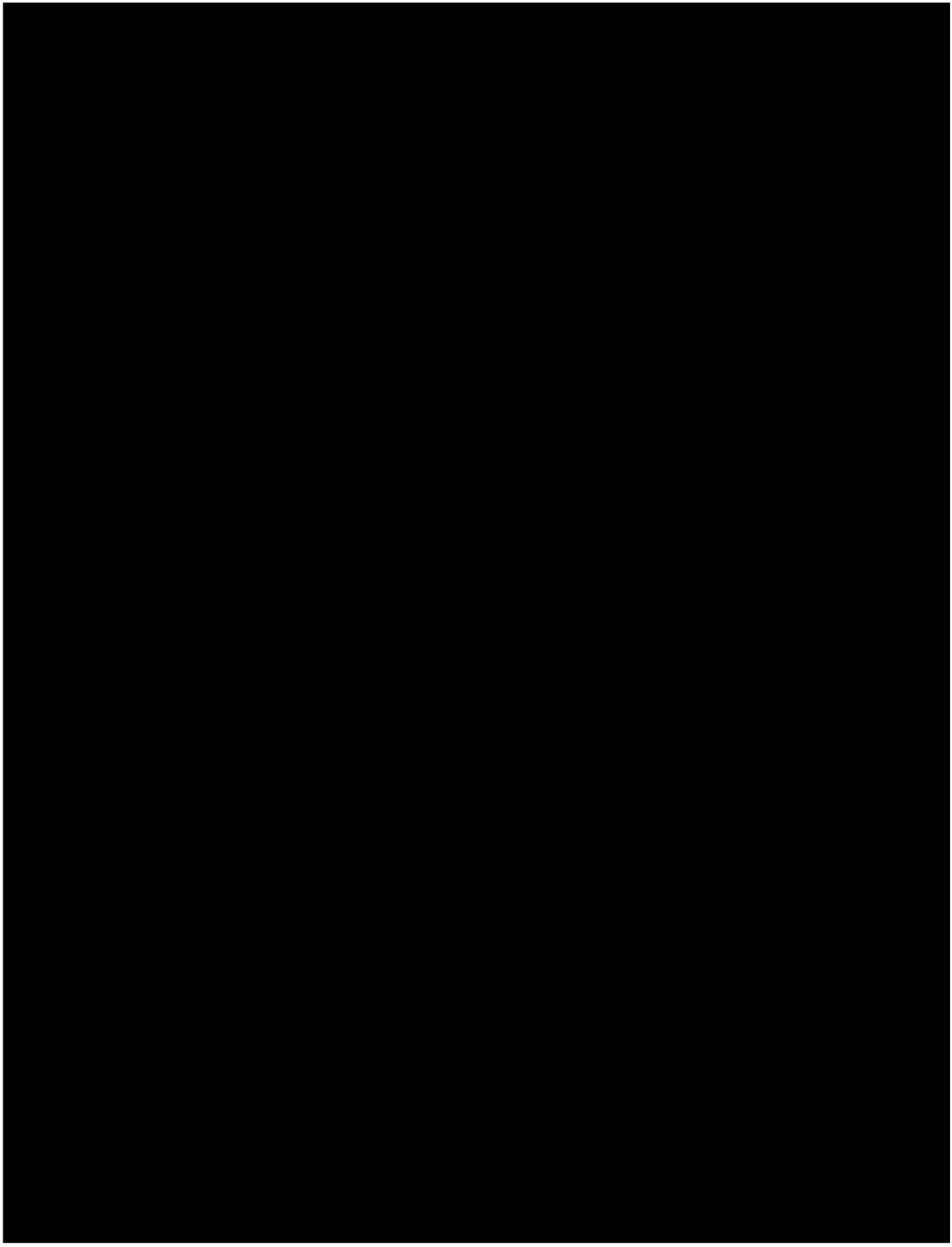


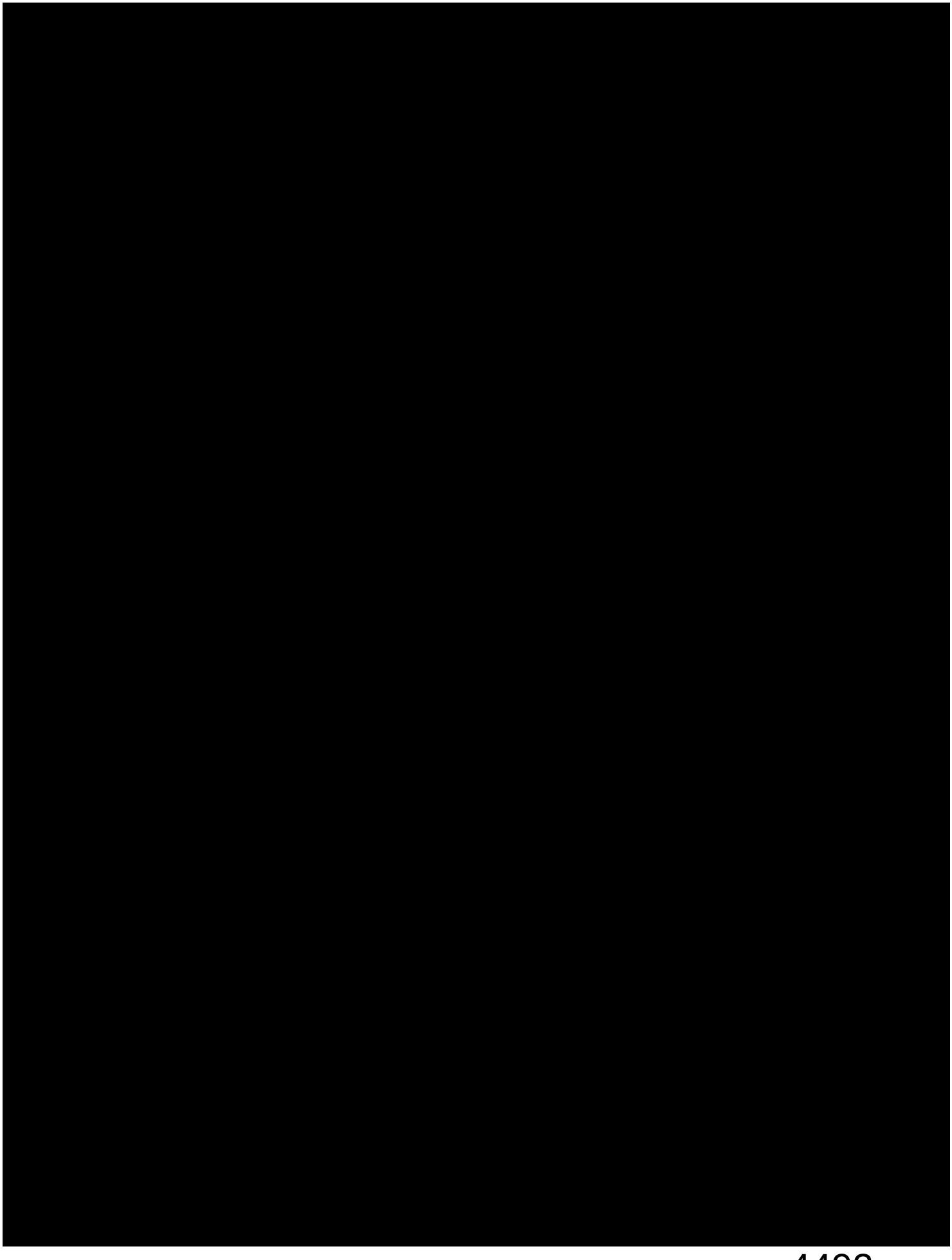


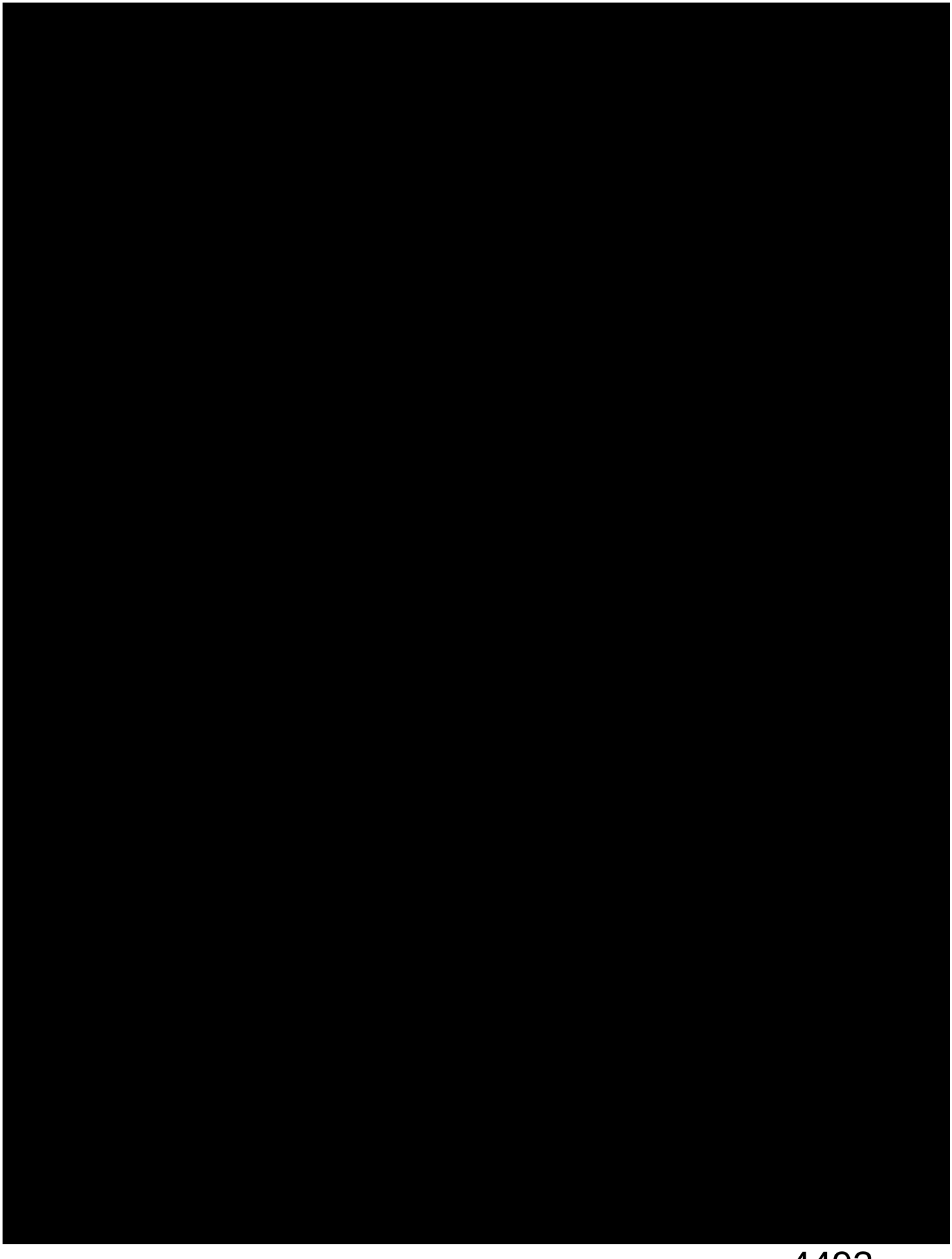


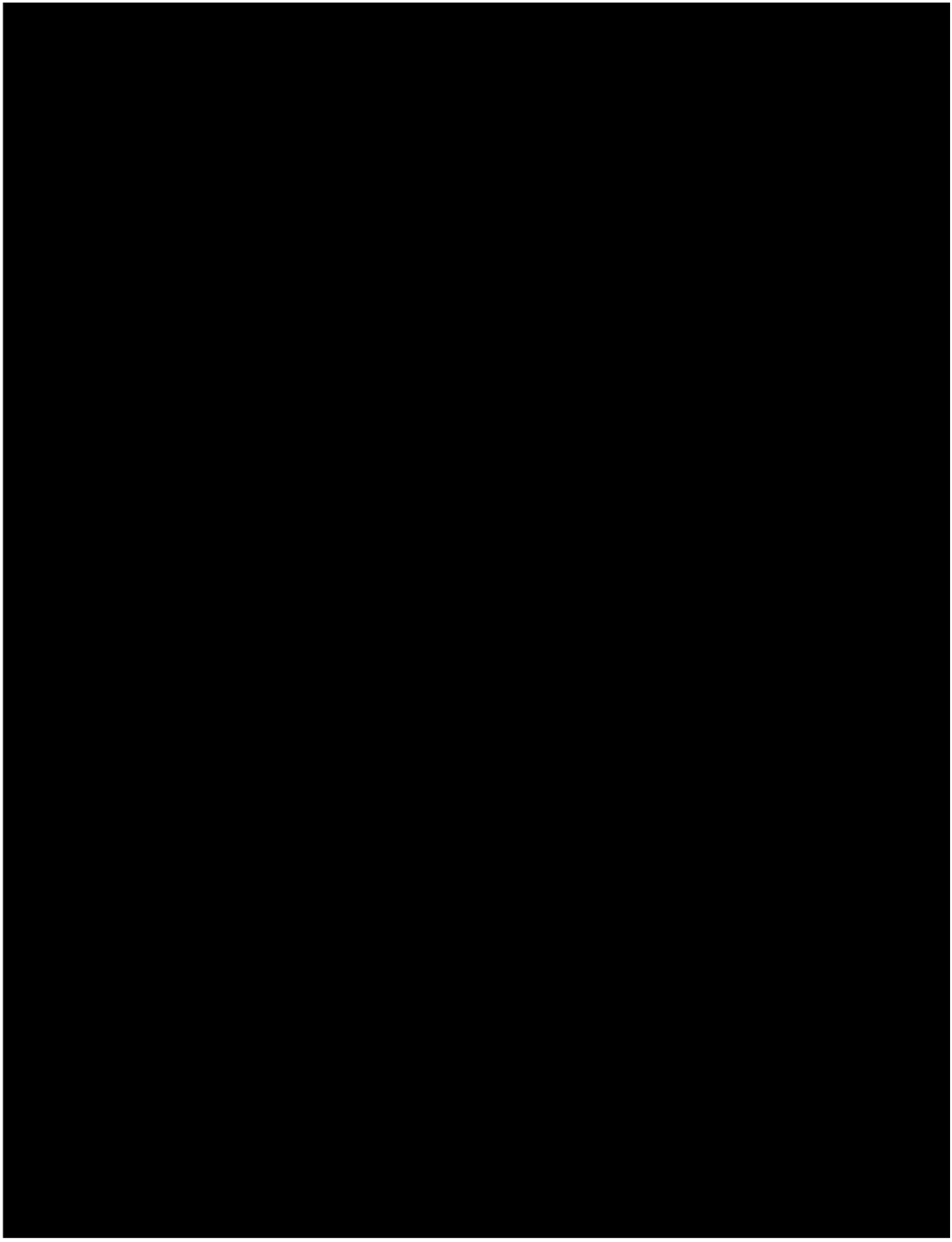


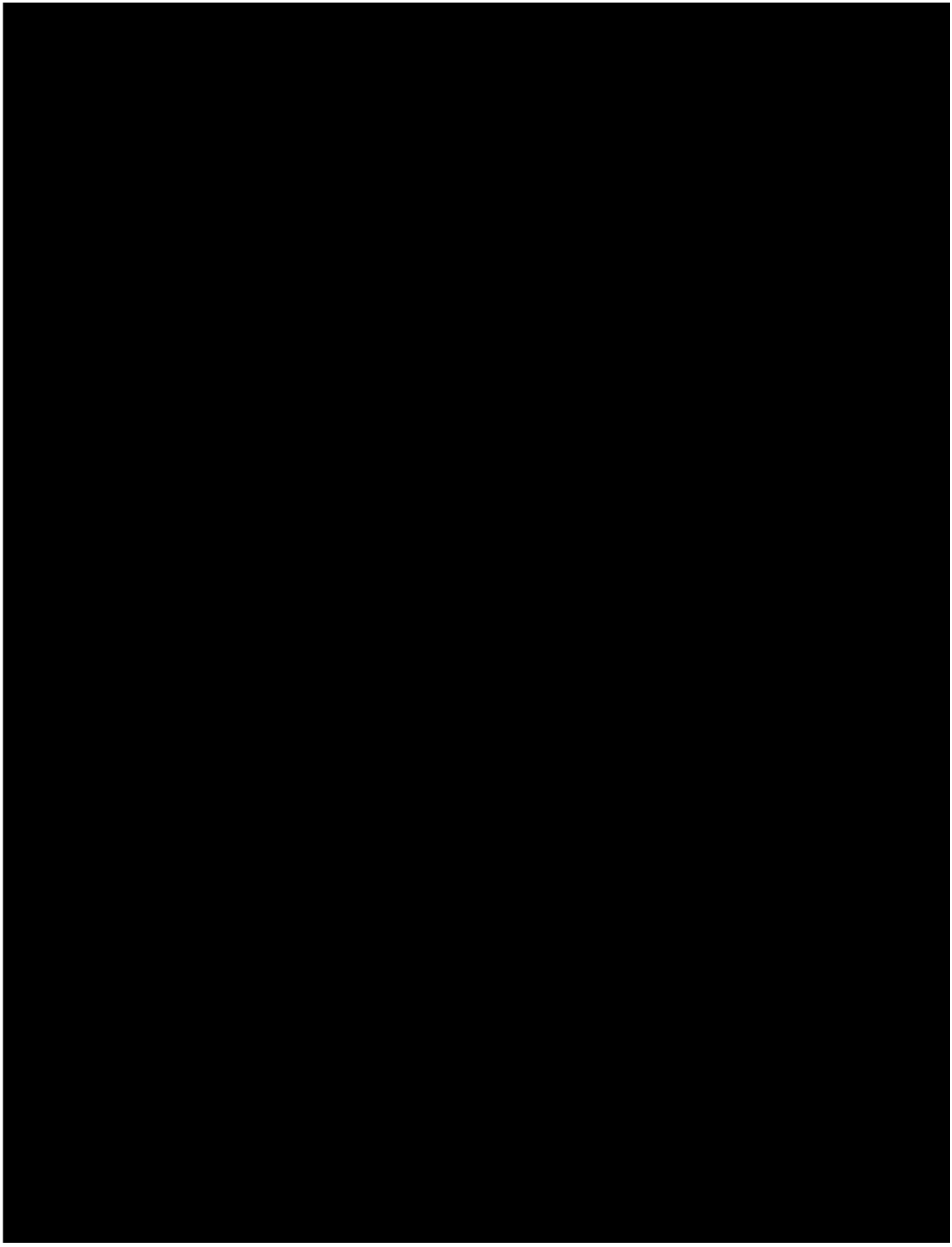


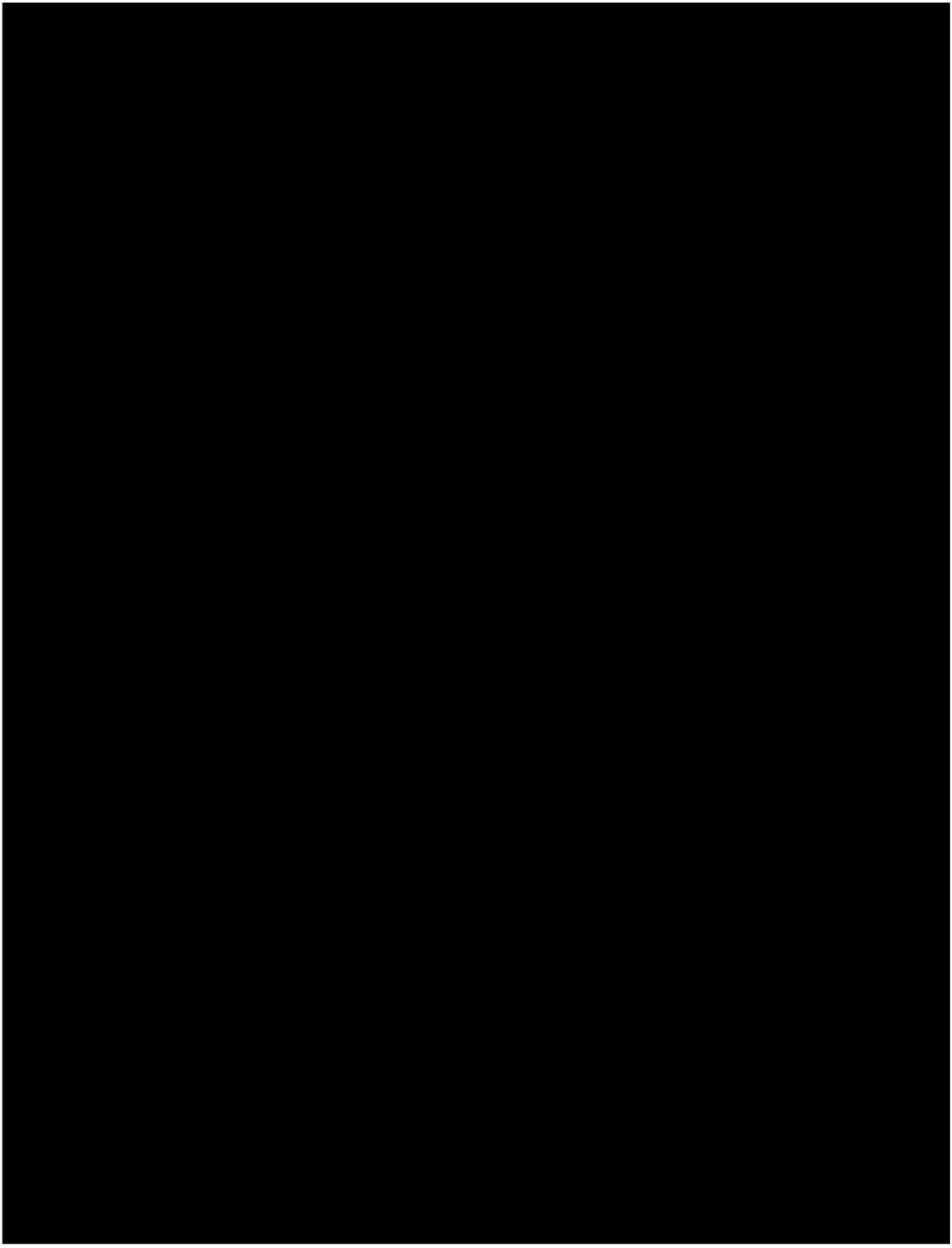


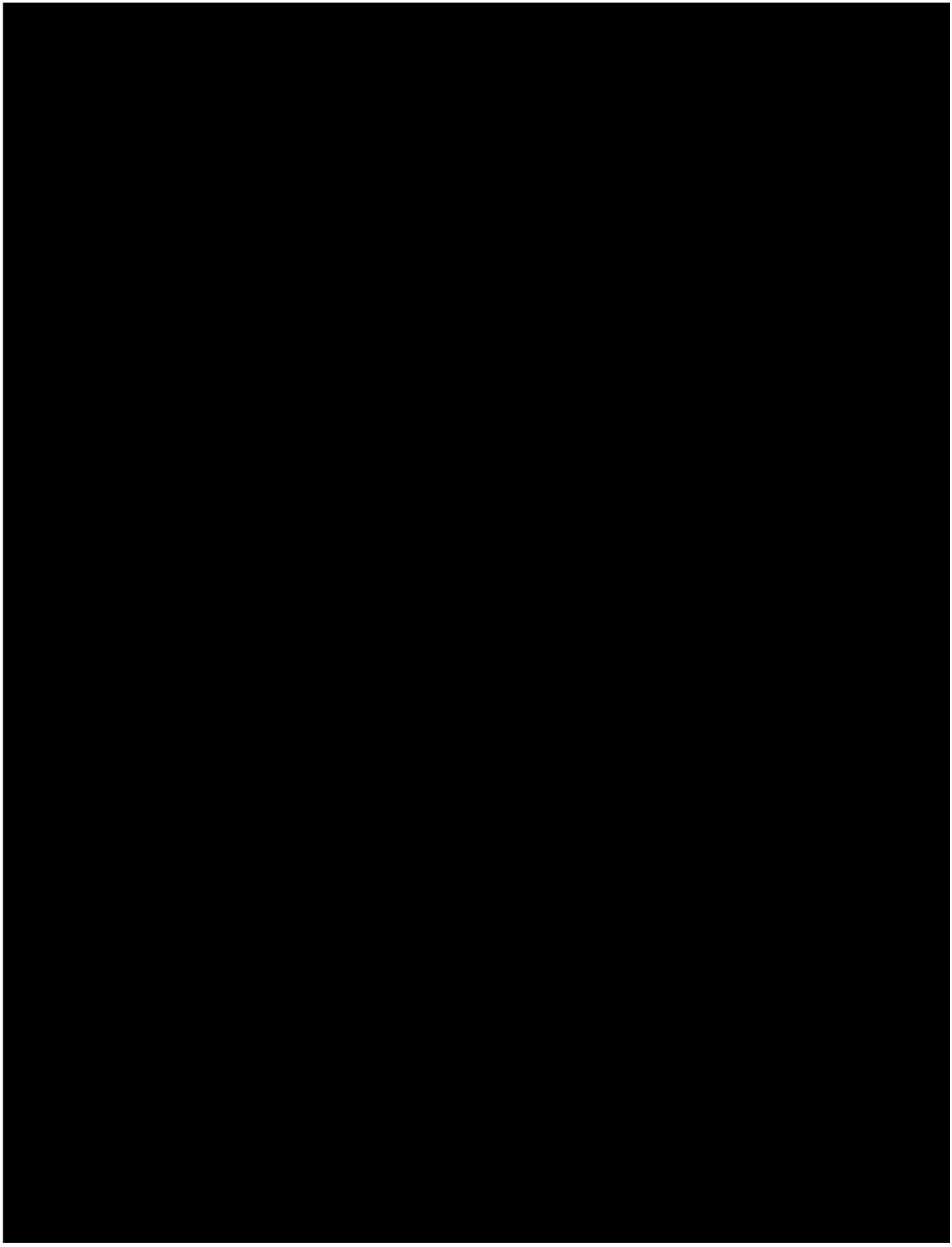


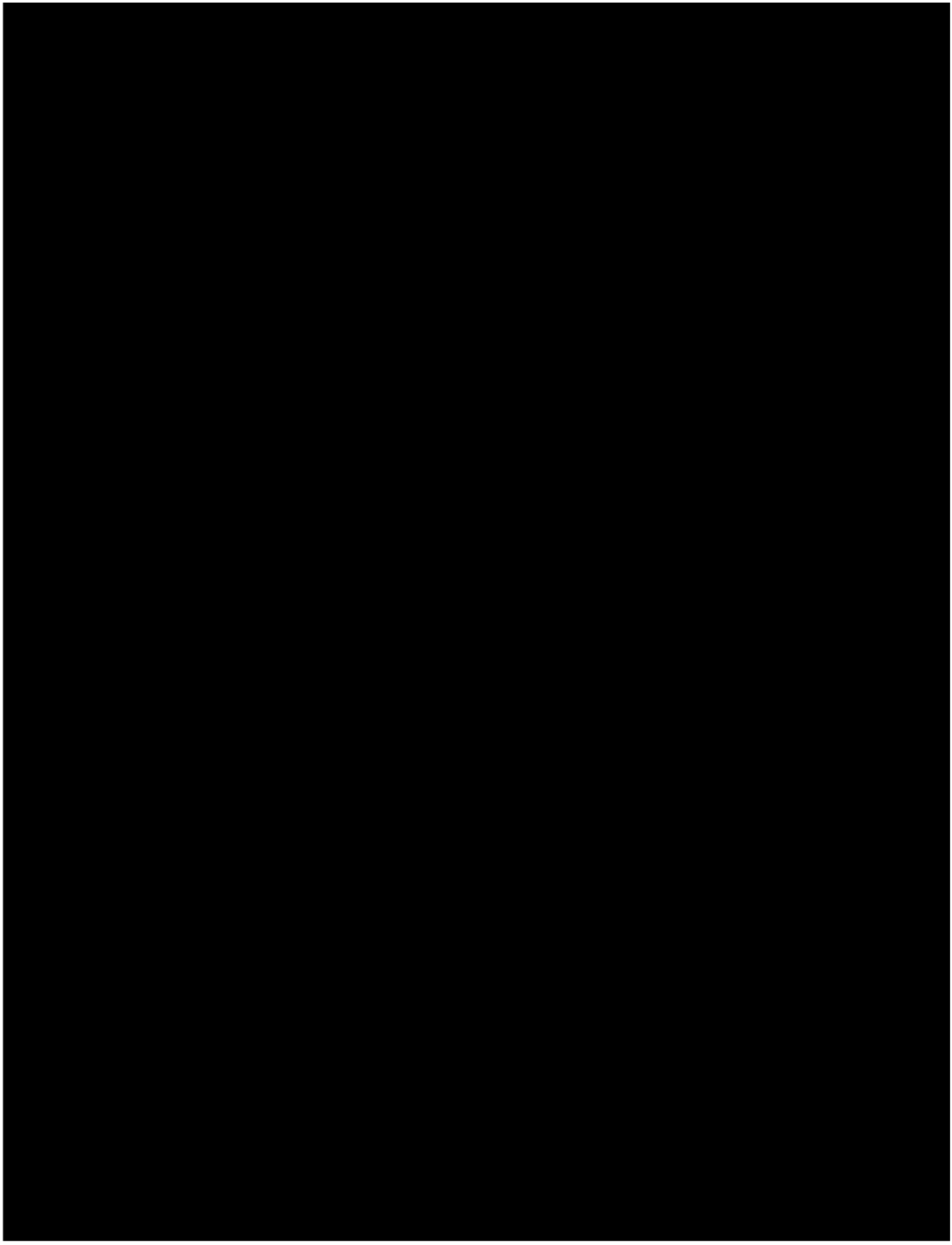


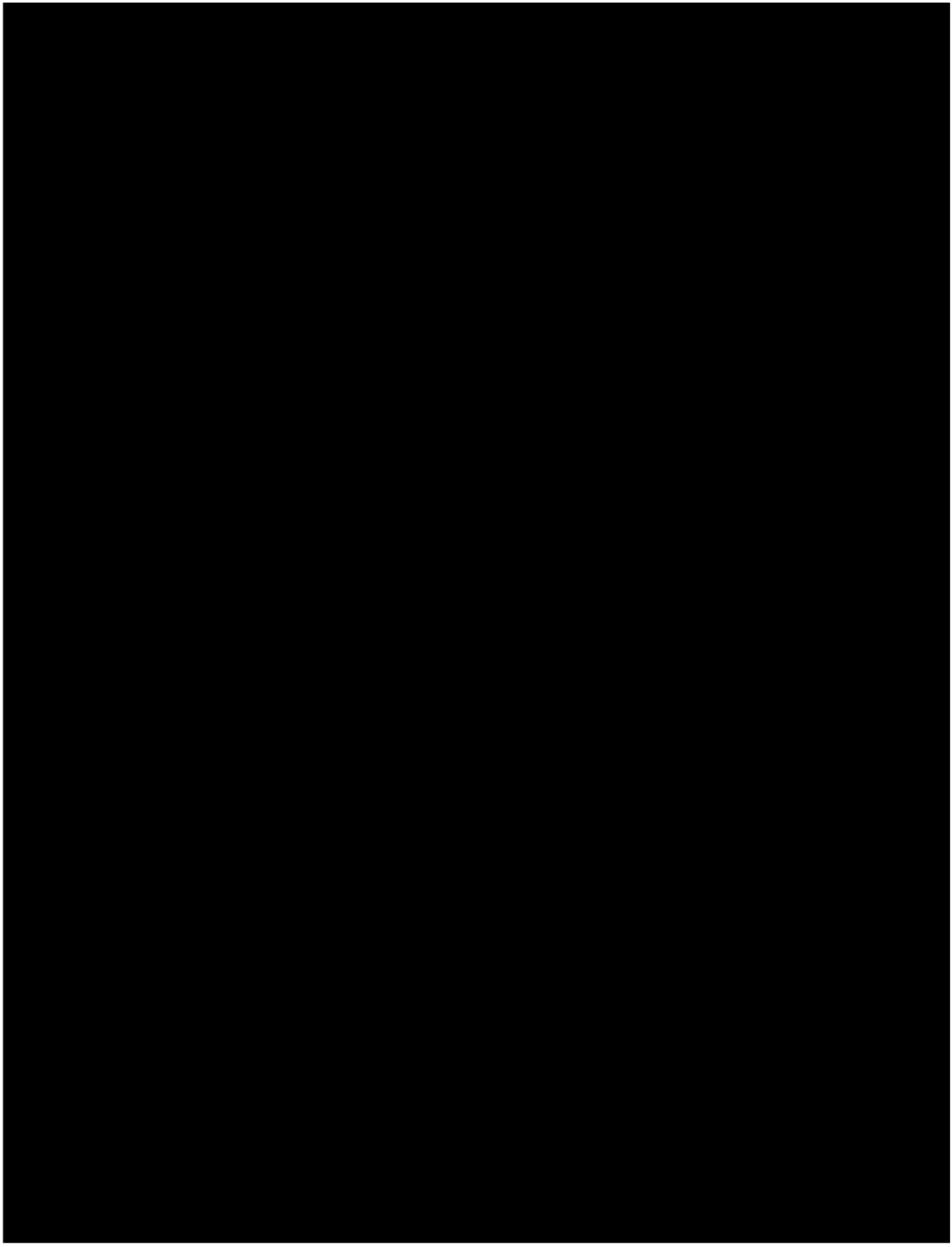


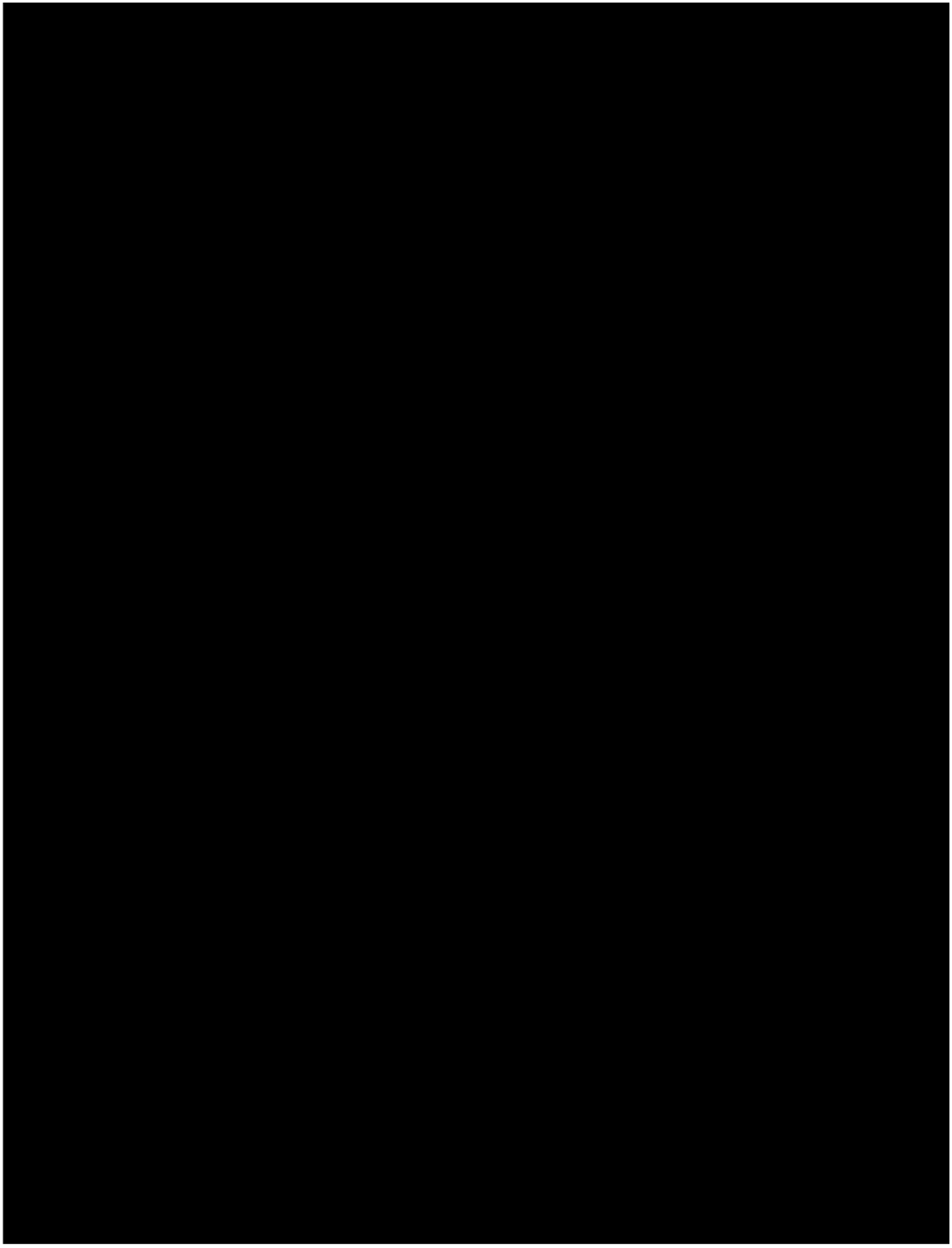


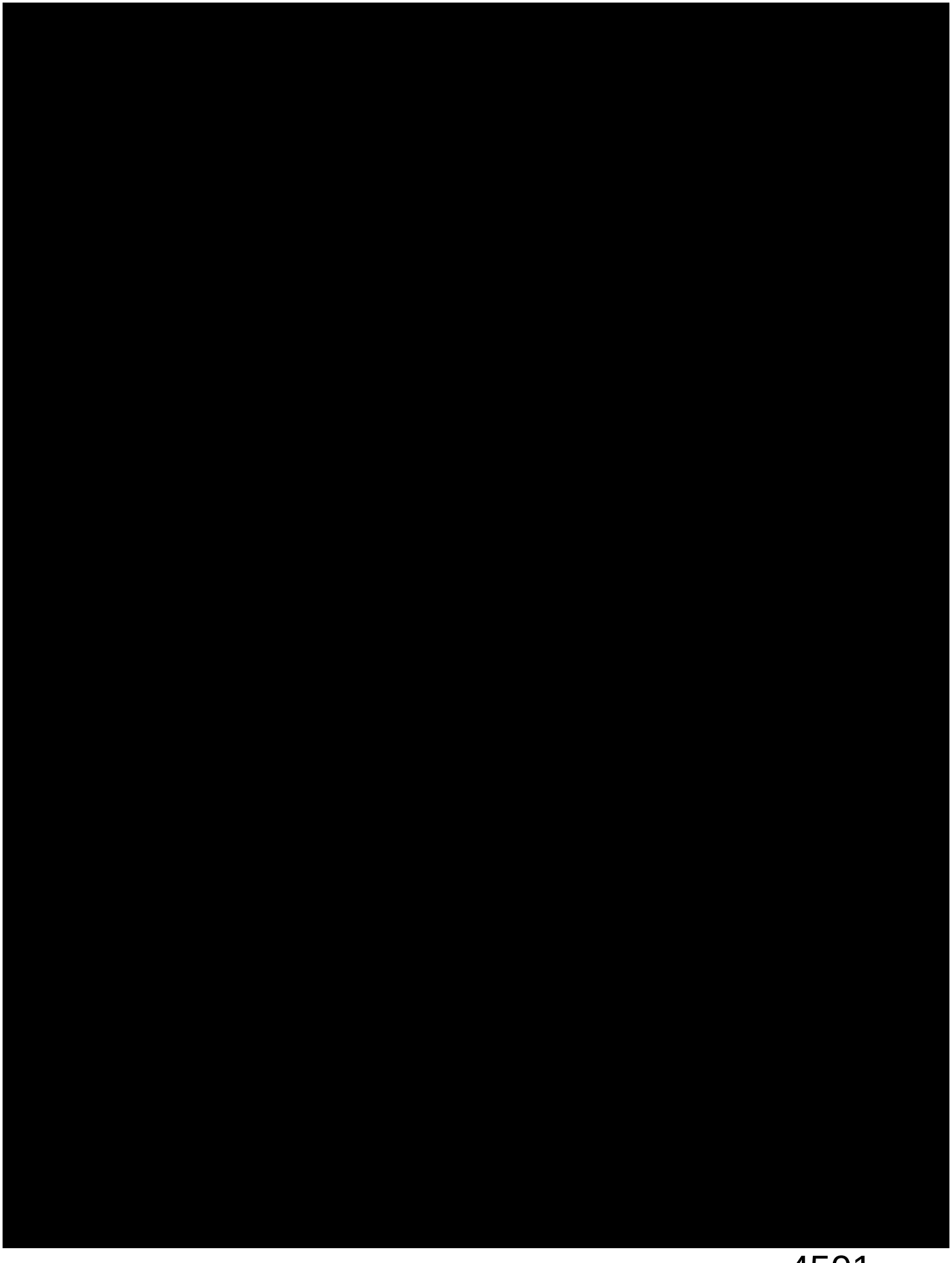


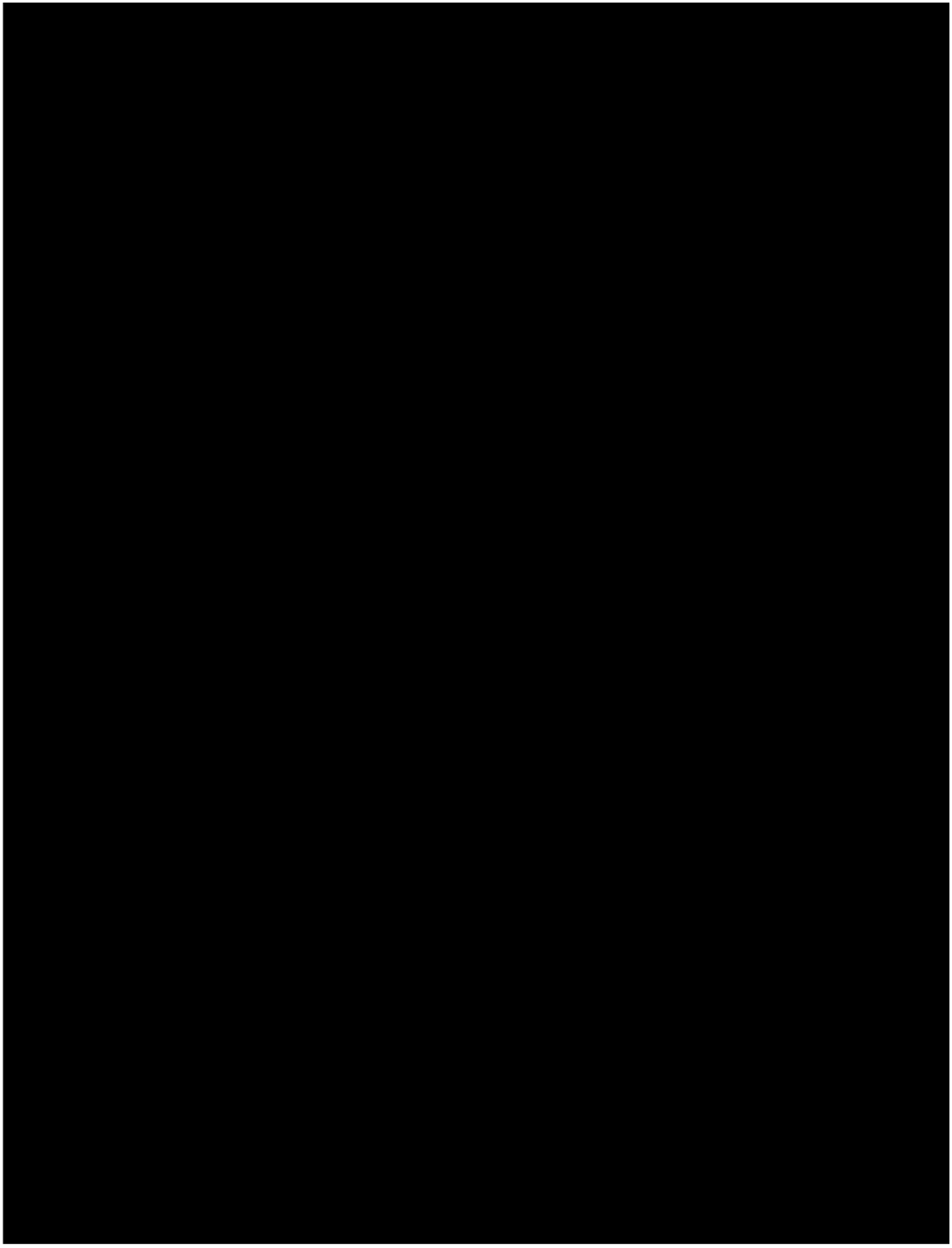


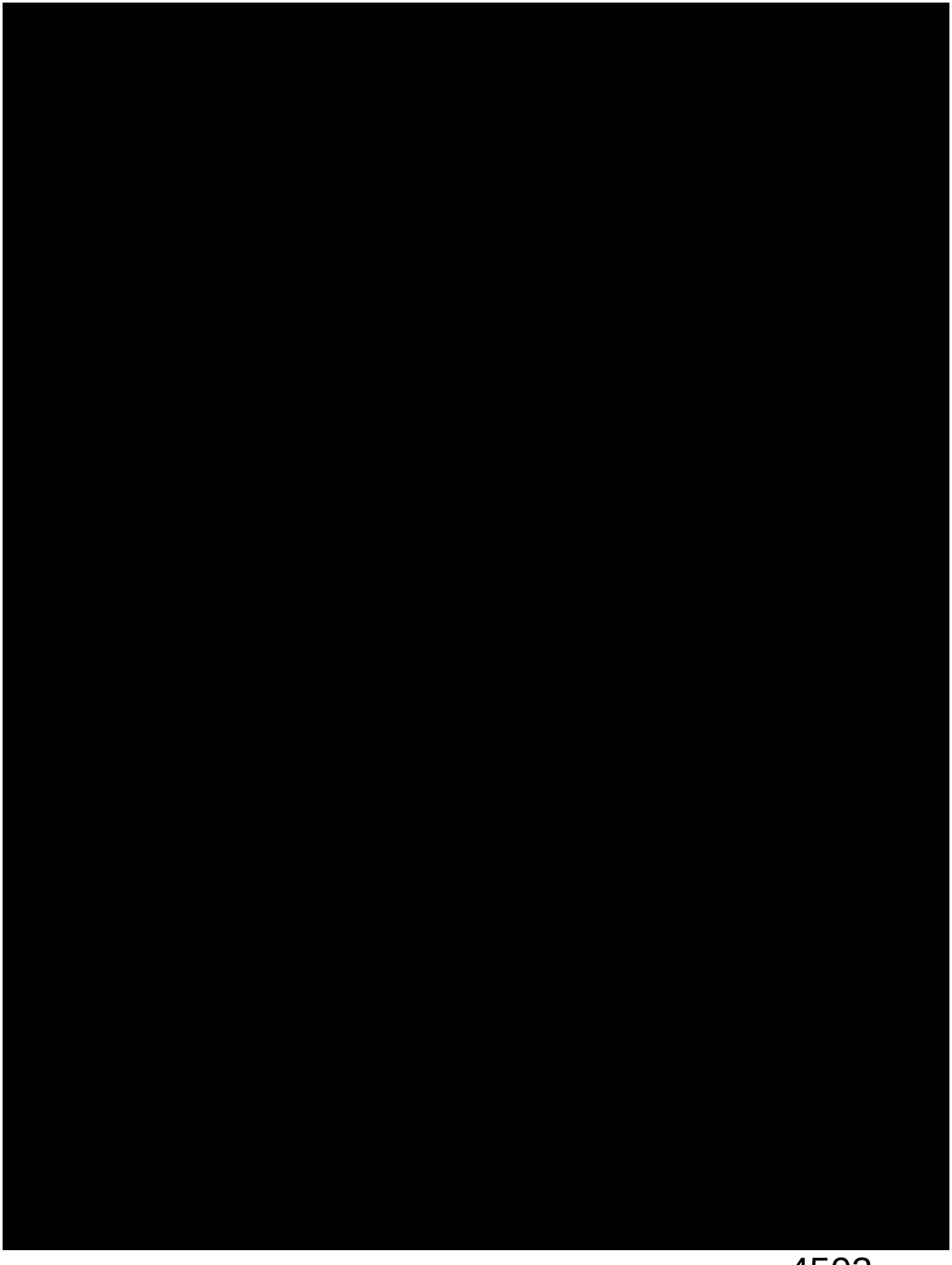


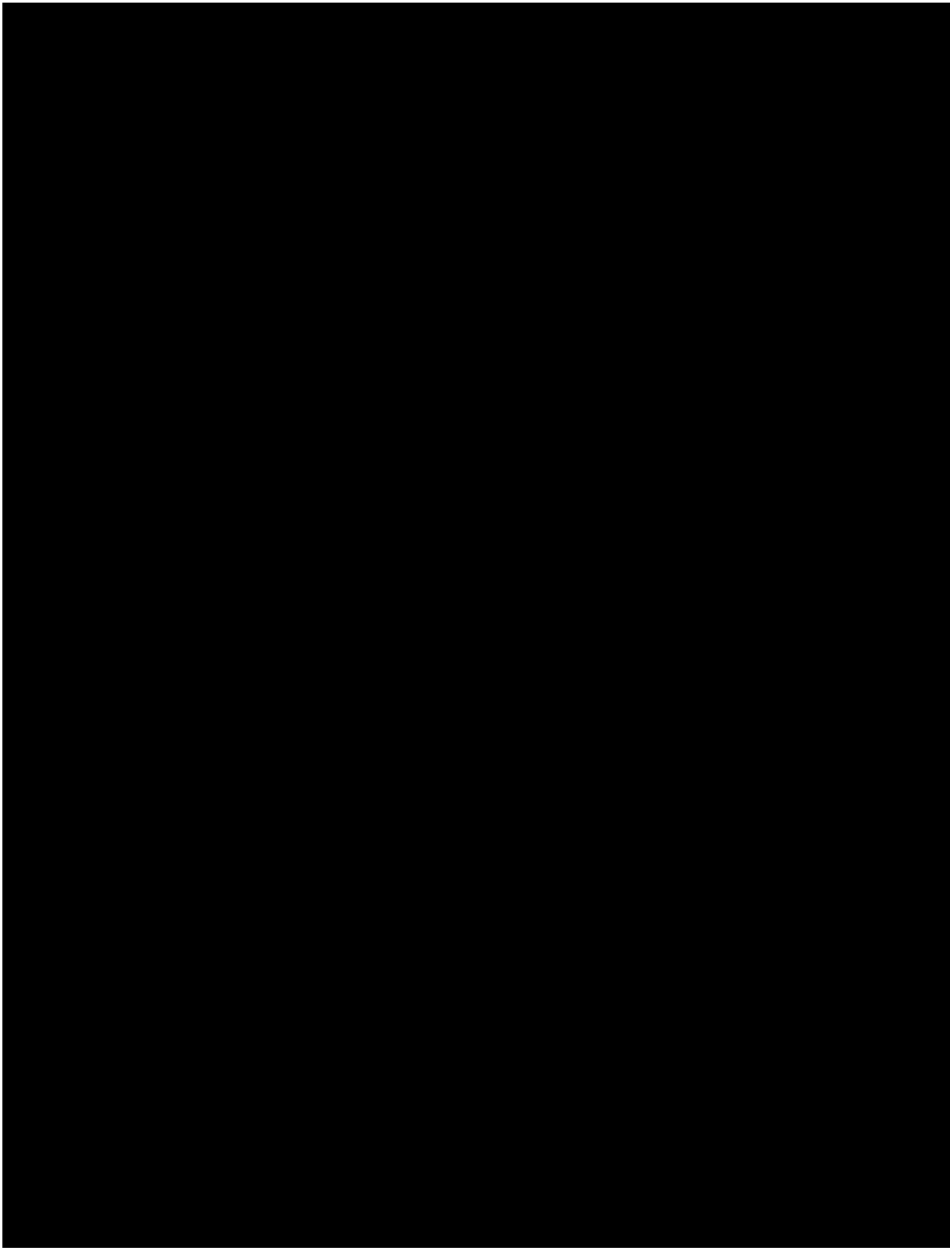


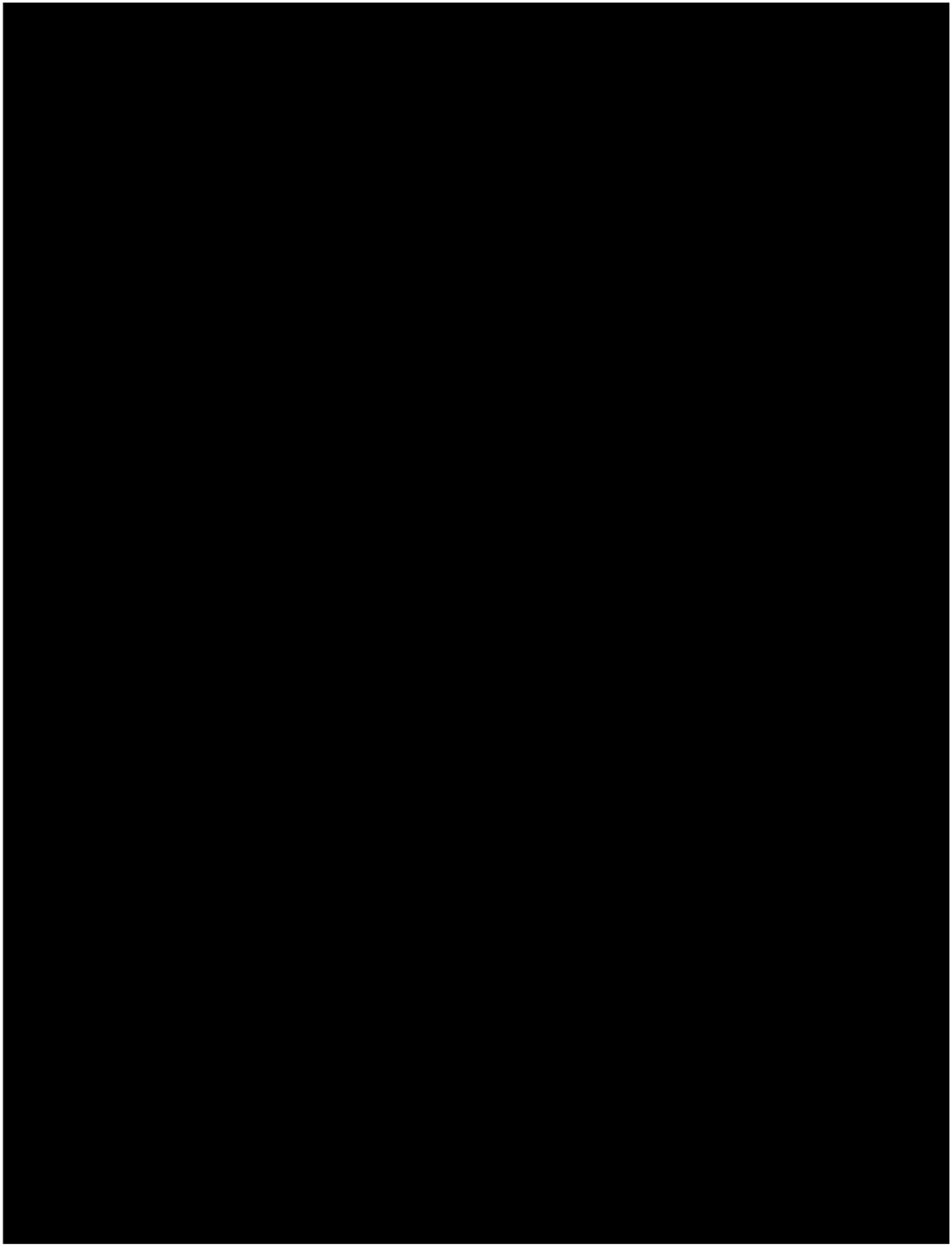


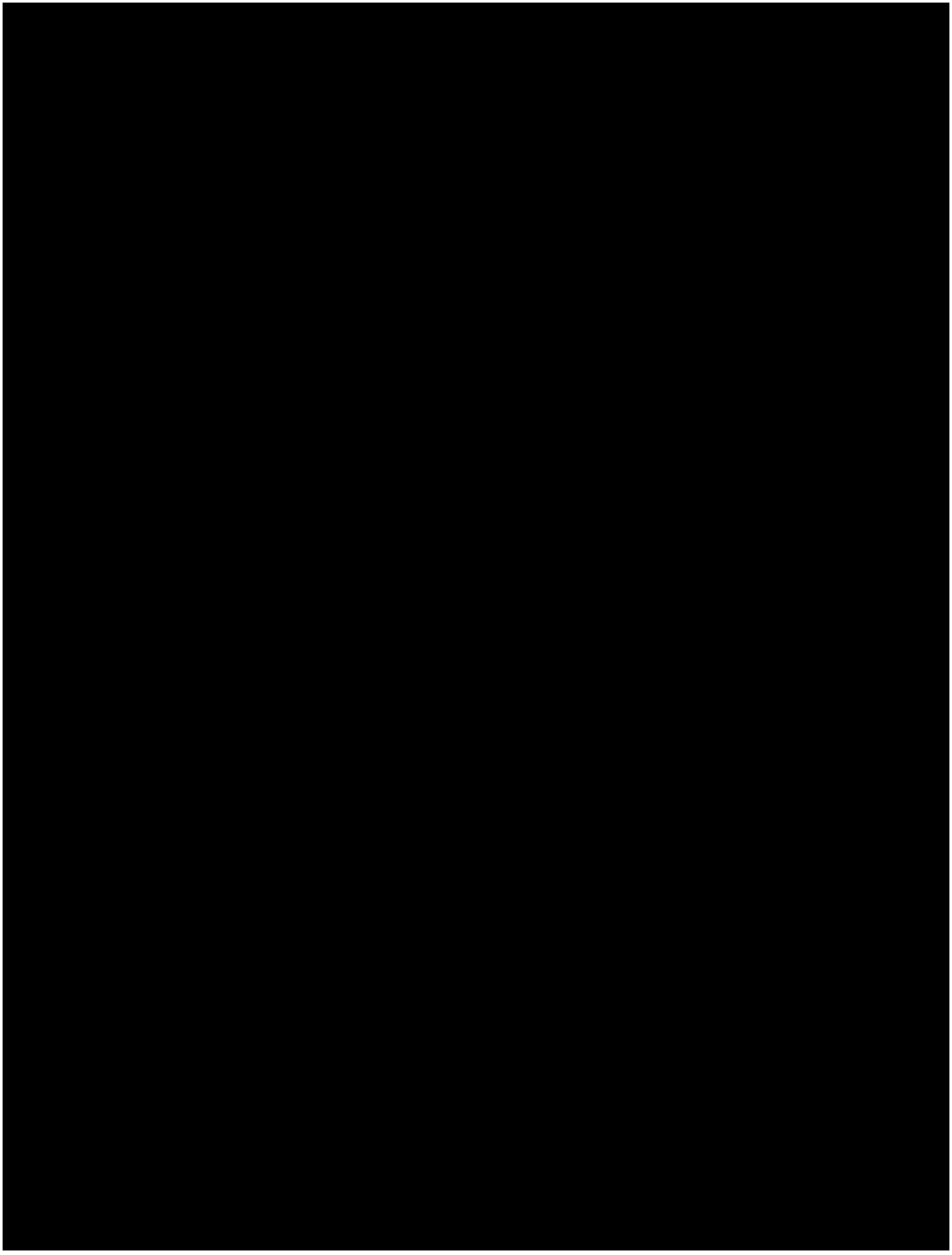


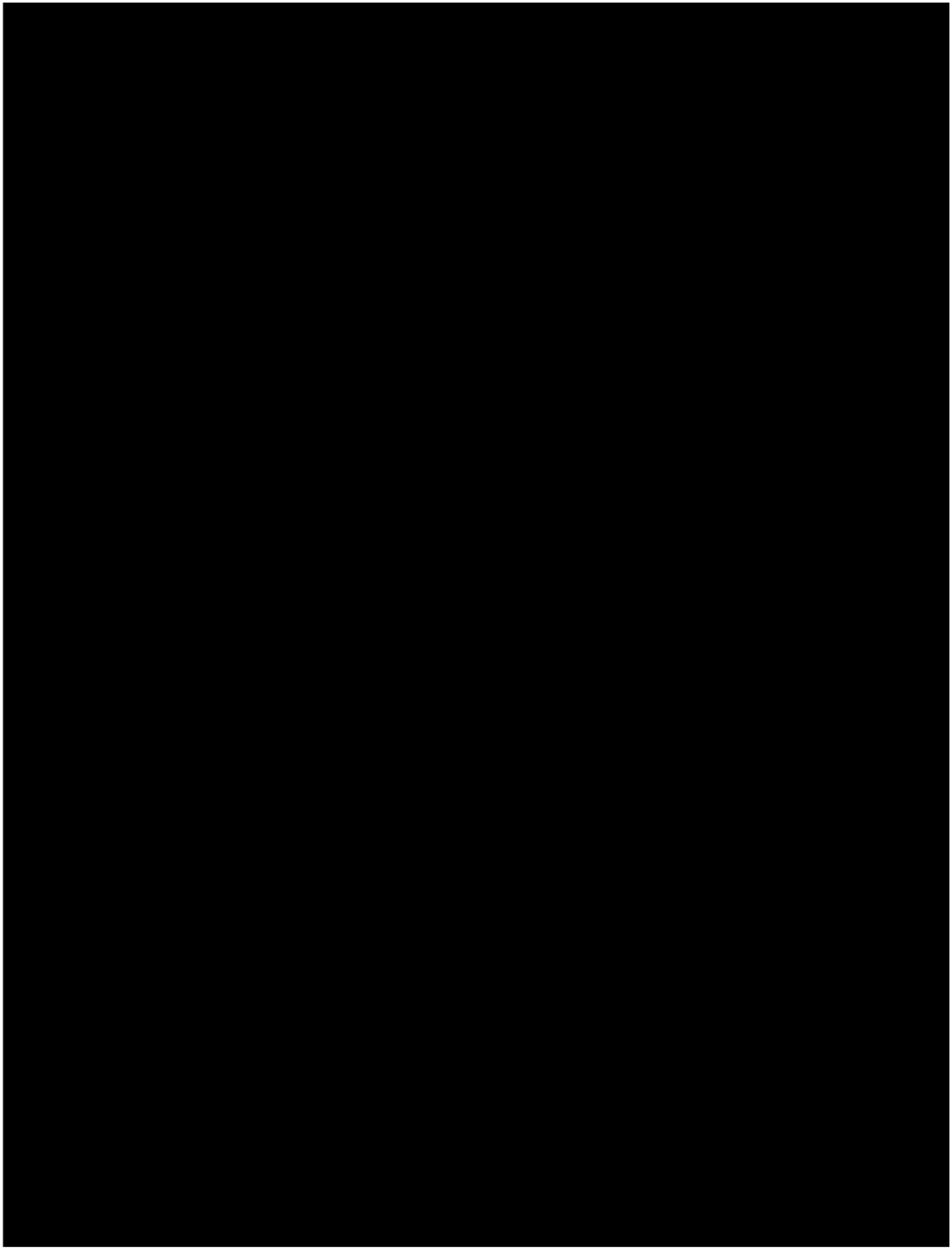


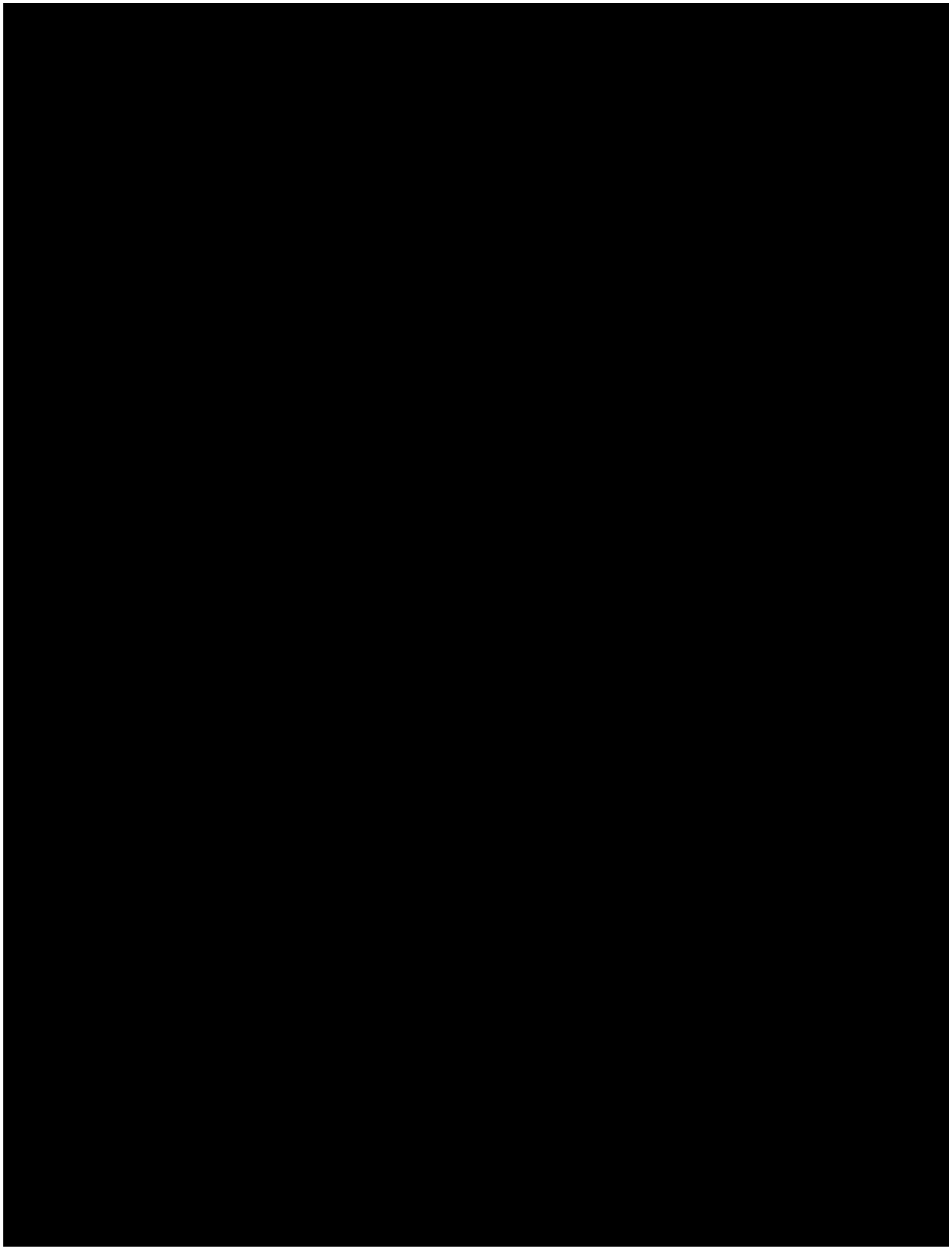


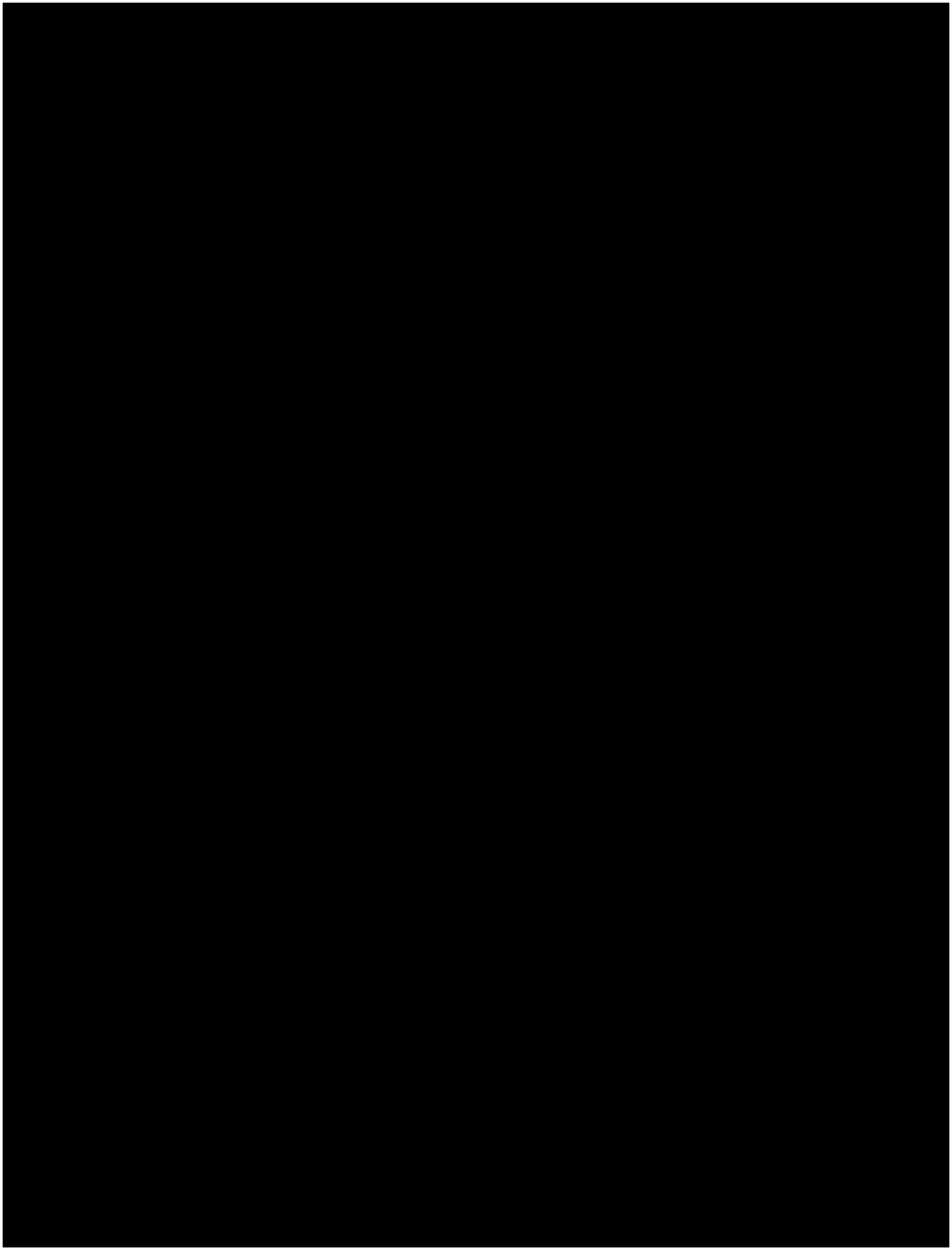


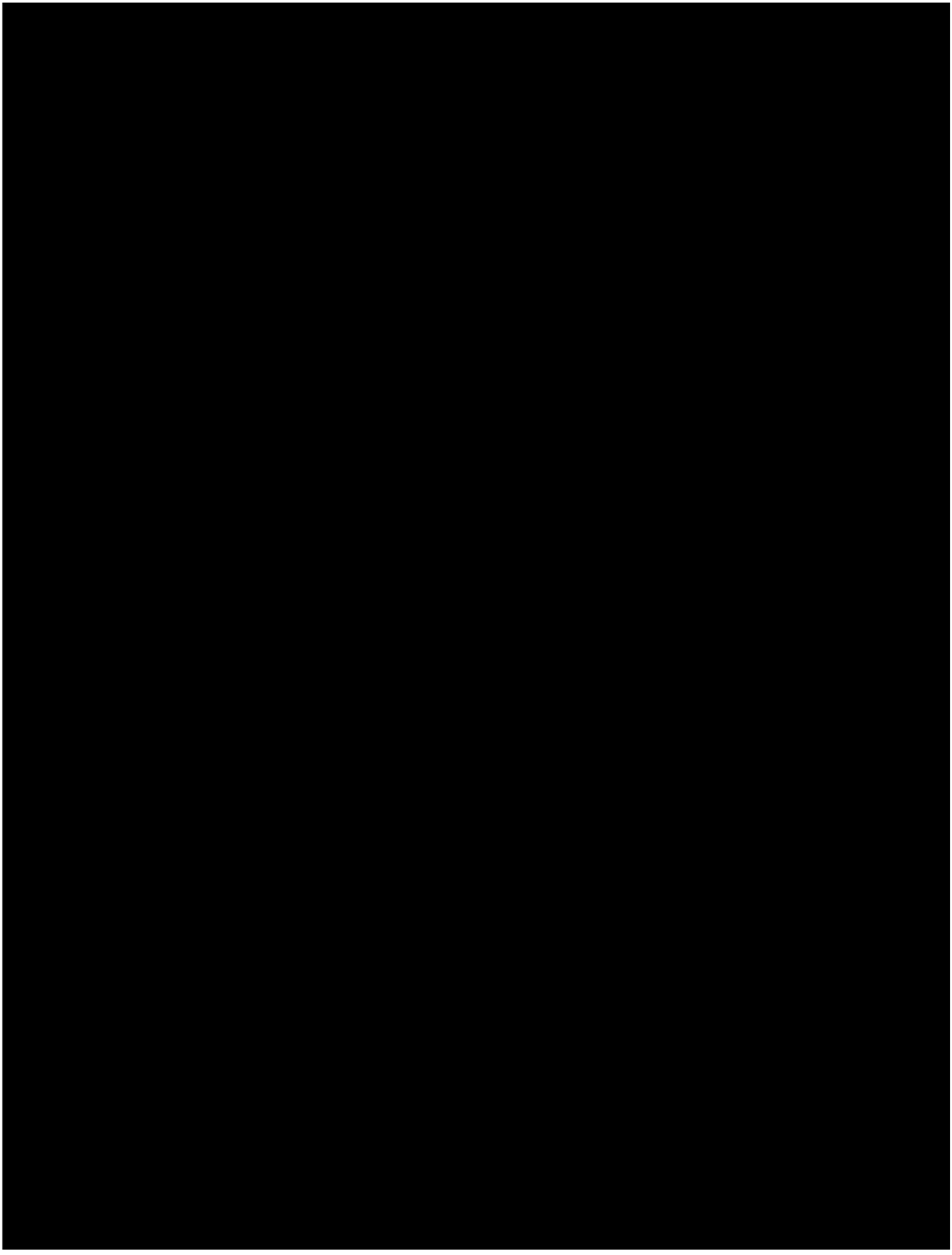


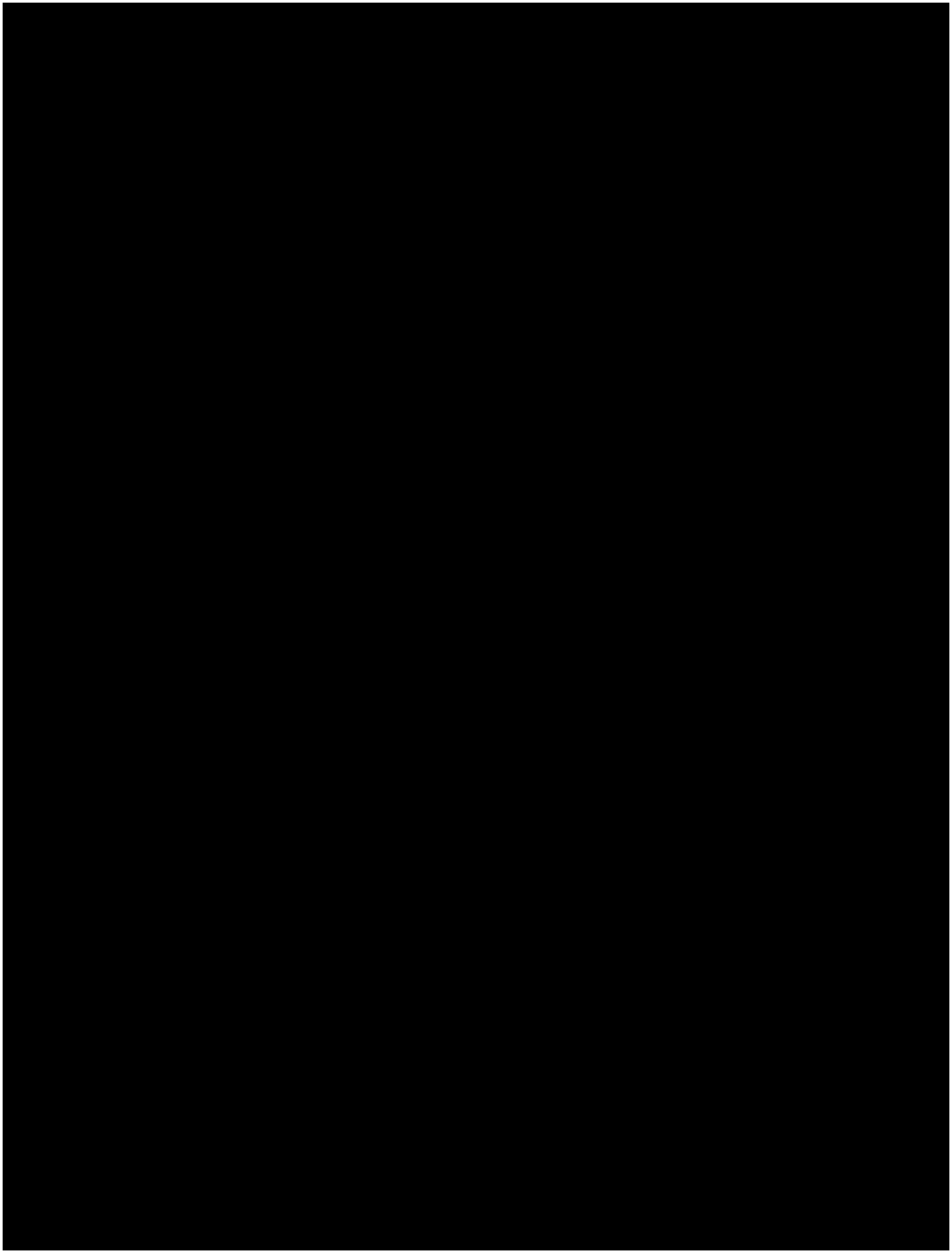


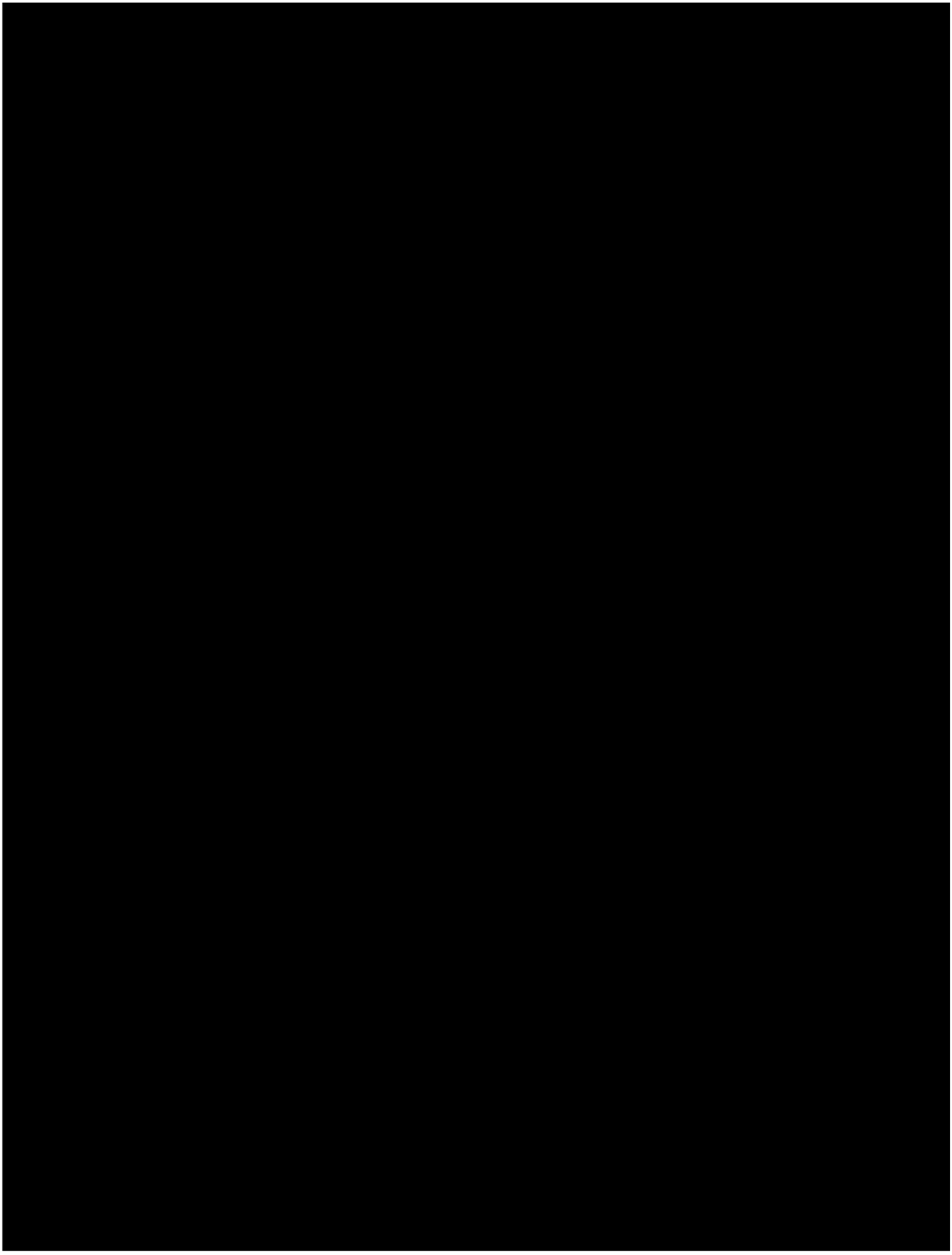


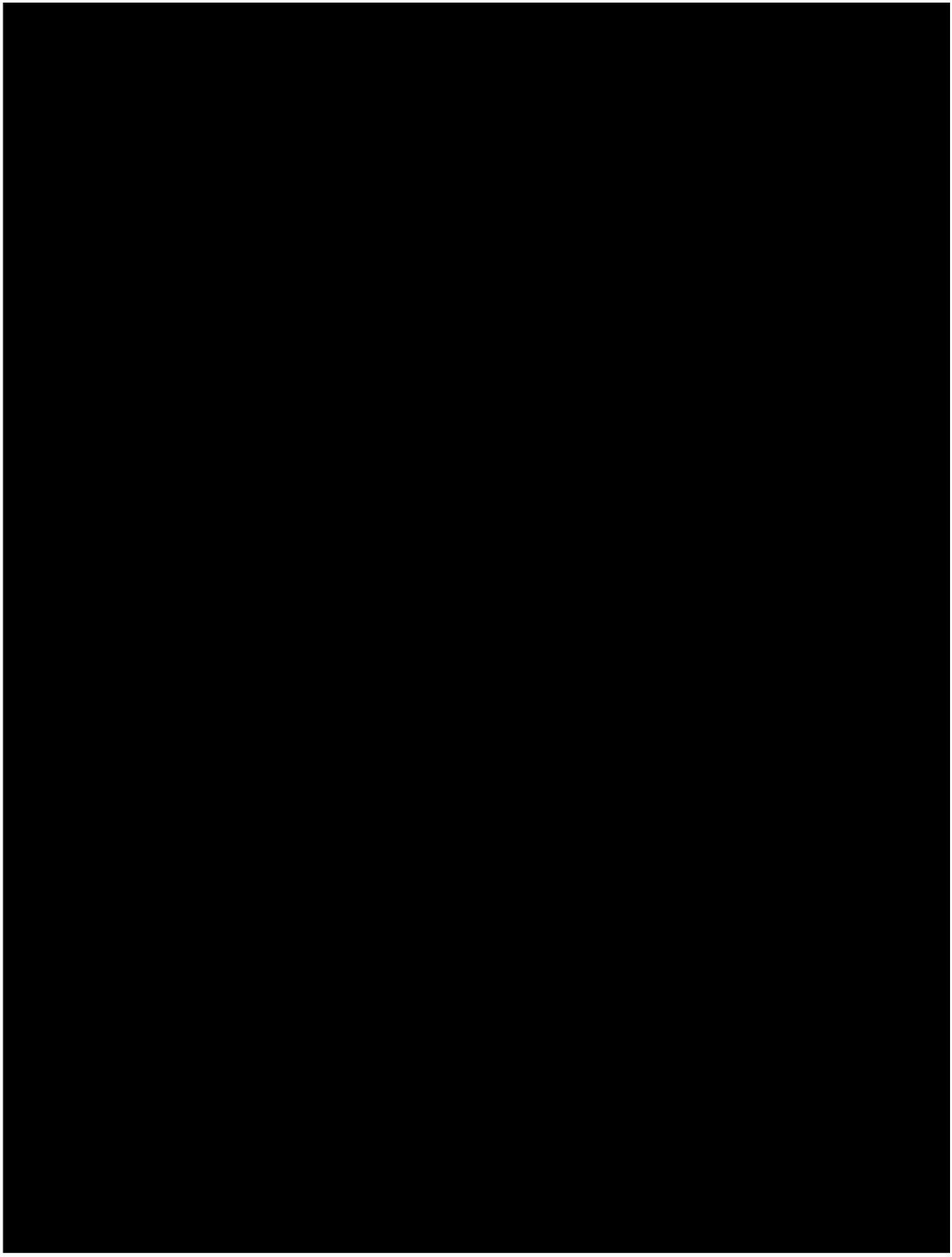


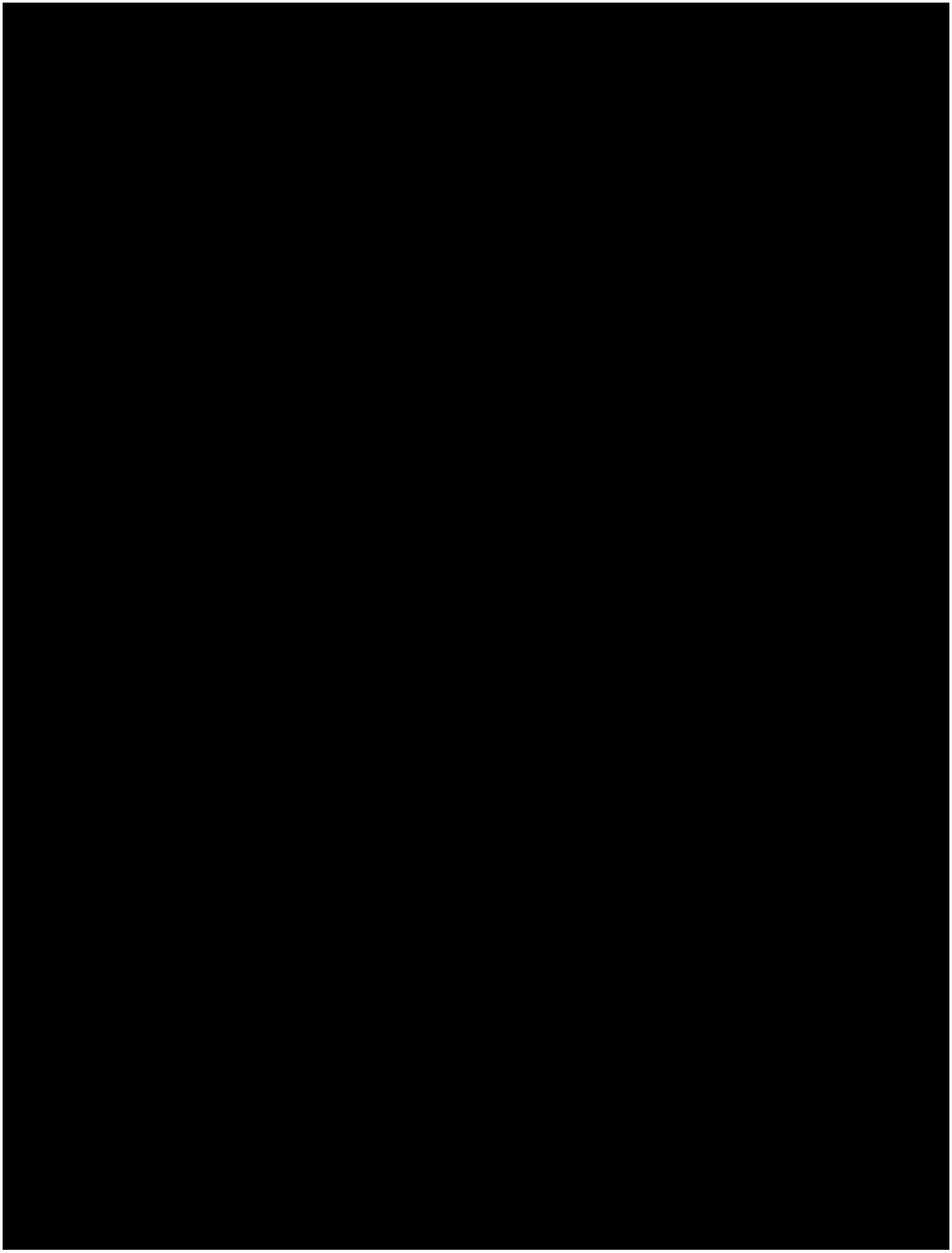


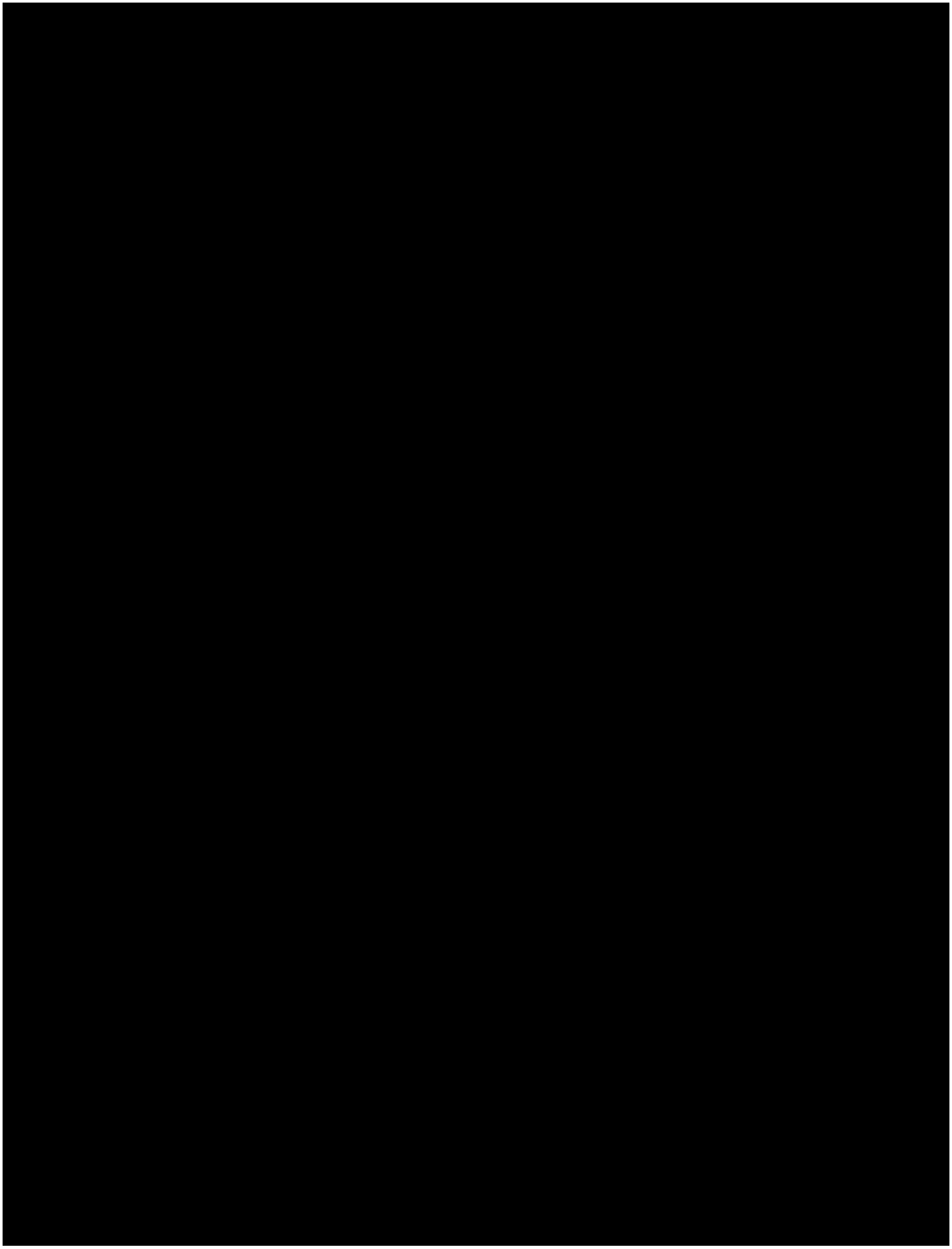


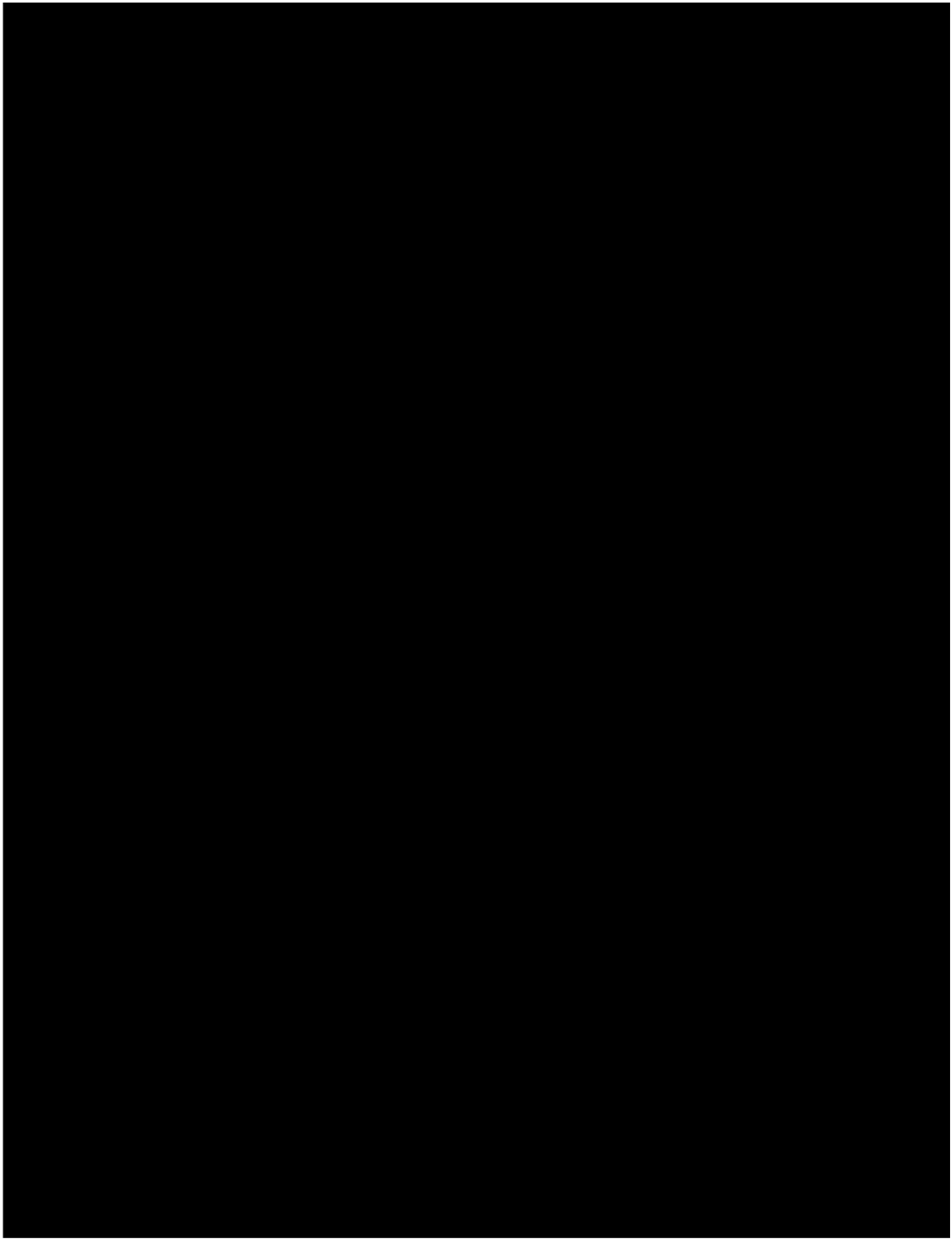












PROHIBITION OF HARMFUL ACTS TO CLIENTS SERVED

POLICY STATEMENT (Philosophy): Each person served by the Booneville Human Development Center (BHDC) has the right to be free from treatment or conduct that is harmful to them physically or psychologically. BHDC strictly prohibits inappropriate treatment in any form or of any nature to individuals receiving services.

REFERENCES: **DDS Policy #3004-I**
Maltreatment Prohibition, Prevention, Reporting and Investigation
DHS Policy #1090
Incident Reporting

1. **Purpose:** BHDC will do everything in its control to prevent inappropriate treatment of those served at the facility and to report, investigate, and address instances of such activity. This policy establishes a protocol and defines responsibilities for reporting and investigating instances where a person served by BHDC is potentially subjected to improper treatment.

   This policy does not replace or remove the legal responsibility of any person or organization to report maltreatment or of any external organization to conduct investigations as required by law. Because of the nature of acts which constitute a violation of this policy, all allegations of harmful acts to clients served at a facility must be reported immediately as possible maltreatment and reviewed as such. Upon completion of the review, investigative findings will be forwarded to the Office of Long Term Care (OLTC) for a determination regarding whether employee actions rise to the level of violating the Arkansas Adult Long Term Care Facility Resident Maltreatment Act and Child Maltreatment Act. A facility review may determine inappropriate conduct or acts that do not rise to the level of maltreatment. Such conduct or acts shall be addressed through a personnel action up to and including termination.

   An OLTC finding is in addition to the facility determination regarding a violation of Department of Human Services (DHS) Policy 1084, Employee Conduct Standards. The OLTC determination is apart and separate from the facility findings, and relates to the question of whether the infraction of policy also constituted a violation of state law. The OLTC finding is not indicative of employee innocence regarding DHS policy and does not impact the facility determination that an action violated policies of the Department of Human Services.

2. **Scope:** Compliance with this policy is the responsibility of all staff, consultants and volunteers at the facility or any other person as determined by the facility administrator. It is the responsibility of the facility administrator to ensure overall compliance with this policy and to take all necessary precautions to prevent the occurrence of harmful acts against residents of a facility. (Persons outside the scope of this policy suspected of harmful acts against a person served at the facility will be reported to the appropriate state protective agencies according to OLTC guidelines.)



REVIEWED: 12/04/19
VERSION: 12/29/17

3. **Definitions:**

Harmful Acts - Actions which include, but are not limited to, inappropriate/harmful physical, verbal, psychological, sexual, or neglectful acts, exploitation, misappropriation of property, and violation of the rights or dignity of individuals receiving services.

Founded charge – A preponderance of credible evidence exists that supports the allegation that a harmful act to an individual by a BHDC employee has occurred.

Facility administrator – The licensed administrator or designee.

A. Prohibition of harmful acts to clients served

The facility administrator is responsible for implementing this policy in a manner to lessen the potential that harmful acts to clients served by the BHDC occur. Implementation measures will include, but are not be limited to, the areas of employee screening/training/prevention.

1. Screening:
Pre-employment screening of potential employees for a history of committing harmful acts to others. Screening includes:
   - Attempting to obtain information from previous employers and/or current employers,
   - Checking with the appropriate licensing boards, registries, and DHS personnel offices, and
   - Performing criminal record background checks.

2. Training:
Training employees, through orientation and on-going educational sessions, on issues related to the prohibition of harmful acts against people served at the facility. Areas of training may include:
   - Rights of clients
   - Recognition of events that may precede or trigger certain behaviors
   - Early intervention techniques for positive behavioral support
   - Approved interventions to deal with aggressive and/or catastrophic reactions
   - Recognizing signs of staff burnout, frustration and stress that may lead to maltreatment
   - Definition of harmful acts and maltreatment, and
   - Reporting suspected harmful acts.

3. Prevention:
Providing the people served at the facility, their families, and staff information on how and to whom they must report concerns, incidents and grievances; and how they may receive feedback regarding the concerns expressed.

Staff should immediately intervene when suspected maltreatment is witnessed to ensure client protection.

Identify, correct and intervene in situations in which harmful acts are more likely to occur. This includes an ongoing analysis of:

- Physical environments
- Supports in place to encourage recognizing and respecting client dignity and rights
- Deployment of staff
- Reports of inappropriate staff behaviors related to harmful acts
- Care planning and monitoring of people served at the facility who have challenges that might lead to conflict or neglect.

4. Identification:
Identify and respond to events, occurrences, patterns, and trends that may suggest harmful acts are being committed against a person or persons served at the facility.

B. Reporting

1. All alleged, suspected, and witnessed harmful or inappropriate acts will be **immediately** reported by **all** persons having knowledge of the alleged incident to the facility administrator.

2. All alleged, suspected, and witnessed harmful acts will be reported as required by policy to the appropriate abuse reporting hotlines by the facility administrator.

   NOTE: Nothing in this policy removes the right and obligation of a person reporting a harmful act to immediately report an incident directly to the appropriate abuse reporting hotline, as well as to the facility administrator.

3. Reporting shall not be delayed for any type of investigation.

4. Incidents shall be reported in accordance with DHS Policy 1090, Incident Reporting.

5. Reports of allegations shall also be made by the facility administrator/designee to local law enforcement and to the individual's parent/guardian/advocate. Documentation of these notifications should be maintained as part of the IRIS/investigative report.

C. Protection of Individuals During Investigations

The facility administrator will ensure staff accused or suspected of committing harmful acts as defined in this policy leave the center campus and have no contact with any

persons served at the facility until an investigation has been completed. Under no circumstances will the subject(s) of an investigation resume regular duties or assume new duties at the facility until investigative results are final. The facility administrator or designee may allow employees who are alleged to have committed harmful acts to be on the facility campus under the supervision of management staff when being interviewed as part of an investigation.

D. Investigations

1. Investigations will begin promptly after an incident is reported and be conducted by a person trained in the area of performing investigations and reviews.

2. The facility administrator shall notify the facility Human Rights Committee of all founded cases of harmful acts and may also request the committee to make recommendations on current investigations.

3. As mandated by statute, the facility administrator will defer investigations to the proper entity (law enforcement, protective service agencies, Office of Attorney General, etc.) when requested. In such cases, however, a completed review of the matter by the facility is still required.

4. Officials outside BHDC who are authorized to conduct/review investigations may request and obtain a copy of relevant documents from the facility administrator.

E. Investigation Reports

1. The facility administrator must submit a report of findings to the Office of Long Term Care (OLTC) within five (5) working days of the facility's knowledge of the incident to comply with OLTC regulations. The submitted report should contain all information collected (photos, witness statements, medical documentation, etc.) during the investigation.

2. If circumstances prevent a findings report from being completed within five (5) working days, a status report must be submitted to OLTC at the conclusion of that five-day period.

F. Discipline

1. Founded charge of harmful acts
The employee is immediately terminated as outlined in DHS Policy 1084, Employee Discipline, and is designated as "not eligible for rehire" by DHS.

2. Failure to report or delay in reporting alleged, suspected, or witnessed harmful acts
The facility administrator will utilize discipline as noted in DHS Policy 1084, Employee Discipline, unless the documented circumstances call for a deviation from the guidelines, due to aggravating or mitigating facts.

The facility administrator will utilize discipline as noted in DHS Policy 1084, Employee Discipline, unless the documented circumstances call for a deviation from the guidelines, due to aggravating or mitigating facts.

3. Other Involvement

An employee alleged to have committed a harmful act and who is not terminated will be required to attend training that at a minimum covers prevention of harmful acts and reporting requirements. The facility administrator will identify, based on factors identified in a harmful act investigation, other staff required to attend retraining. The facility administrator shall specify the training course(s) and ensure that documentation of training is maintained.

G. Record Keeping

BHDC shall maintain in a secure location a copy of all files related to cases of alleged, suspected, or witnessed harmful acts. The following items will be maintained in this file:

- The original incident report and all follow-up reports
- The facility investigation report and findings
- Any correspondence regarding the allegation
- Any documentation of supporting evidence (photos, etc.)
- Documentation of corrective actions taken by the facility administrator

A summary report of investigations of all alleged, suspected, and witnessed harmful acts conducted at the HDCs and subsequent outcomes shall be submitted to the DDS Director by January 15 of each year for the previous calendar year. Individual identifier information shall not be used. Victims shall be identified by case number and staff shall be identified by job title. Investigative files will be maintained at the facility for a minimum of 10 years.

H. Release of Maltreatment Investigative Files

Maltreatment investigative files will not be released without prior consultation with the DHS Office of Chief Counsel.*

*NOTE: When an investigation results in a disciplinary action that is grieved, relevant portions of a maltreatment investigation report will be provided to the grievant through the DHS Office of Equal Opportunity. The names of people served at the facility must be deleted from the record before it is released. Aspects of the report that are prohibited from release by law will not be included in the information submitted.

I. Confidentiality

All aspects of allegations, reports, and investigations of harmful acts to people living at an HDC are confidential. Verified violations of confidentiality will be subject to discipline under DHS Policy 1084, Employee Discipline.

J. Appeals

Employees who have been disciplined as a result of violations of this policy may appeal utilizing DHS Policy 1086, Employee Grievance Procedure.

APPROVED: _____
Superintendent

Supersedes BHDC Policy I-A-5, dated 11/05/15, in its entirety.

QUALIFIED INTELLECTUAL DISABILITY PROFESSIONAL PROCESS

POLICY STATEMENT: Every client will have an assigned QIDP (Qualified Intellectual Disability Professional), as defined in ICF/IID Regulation 483.430. The Program Coordinator/QIDP has an assigned caseload. They are responsible for chairing the interdisciplinary team and completing Individual Program Plans for clients on their respective caseload.

The Program Coordinator/QIDP monitors the implementation of training objectives and the delivery of services for clients on their assigned caseloads, as determined in each client's IPP. They do on-site observations (tracking) for each of their clients in the living areas and training areas at least once a month. They may also observe their clients in other areas.

The Program Coordinator/QIDP also reviews Monthly Progress Notes and other documentation relevant to each client. They submit Monthly Plan Reviews to summarize information from their observations and their record reviews. Monthly Plan Reviews document monthly observations/tracking and are submitted on a monthly basis. The original Monthly Plan Reviews are filed in the client's master file.

PROCEDURES:

1. PROGRAM COORDINATOR/QIDP ASSIGNMENTS

   a. Each Program Coordinator/QIDP works with an assigned caseload or group of clients. A master list of Program Coordinator/QIDP caseload assignments is maintained on the secure drive.

   b. Each client is assigned a Program Coordinator/QIDP when he/she is admitted to BHDC. Changes in Program Coordinator/QIDP caseload assignments are generally made if a client moves to a different living area, but may be appropriate for other reasons. Team Leaders are responsible for making the caseload assignments.

2. DUTIES AND RESPONSIBILITIES OF PROGRAM COORDINATOR/QIDP

   a. The Program Coordinator/QIDP functions as advocate for the client by assuring he/she receives the maximum benefit of active treatment.

   b. The Program Coordinator/QIDP is chairman of the client's interdisciplinary team. As chairman he/she is responsible for scheduling and conducting 30-day reviews and annual reviews, and for conducting special meetings to discuss various problems or concerns that may occur throughout the year. IPPs are to be completed by the 15th working day after a given 30-day review or annual review. However, an additional requirement is that 30-day IPP's must be completed and distributed within 30 days after admission. Annual review IPP's must be completed and distributed within 365 days after the previous annual review and by the 15th working day following an annual review.

c. The Program Coordinator/QIDP observes actual delivery of services by randomly visiting the living areas, as well as the training areas or work areas each month to observe each client on his/her caseload. These observations, along with any problems noted, are documented on the Monthly Plan Review.

d. If a change of caseload assignment is made, the current Program Coordinator/QIDP completes the documentation for the current month and then forwards that client's file to the new Program Coordinator/QIDP. The majority of the file is available on the secure drive. File information includes the client's IPP and their activity schedule, as well as other information pertaining to that client.

e. The Program Coordinator/QIDP reviews Progress Notes and data posted on the secure drive, monitors progress on objectives, and works with service providers to make any necessary modifications in training objectives and service objectives.

f. The Program Coordinator/QIDP completes the Monthly Plan Reviews, as outlined in the BHDC policy. These reports include documentation of their monthly observations (tracking), follow-up, and/or other significant information. Monthly Plan Reviews for each client are to be completed monthly and are due by the 15th working day after the end of the month.

g. The Program Coordinator/QIDP must guide the interdisciplinary team and assure that team decisions comply with established policies, as well as ICF regulations.

3. INTERNAL REVIEW OF INDIVIDUAL PROGRAM PLANS

Every IPP will be reviewed by Residential Services managerial staff prior to publication/distribution. The reviewer will complete an IPP Proofing Sheet and will include any questions they have, or any corrections that are needed by the Program Coordinator/QIDP. The Program Coordinator/QIDP will make any necessary corrections, post the IPP to the secure drive, and send the original IPP to the master file. A copy with signatures is sent to Social Services for the guardian, with a request for guardian approval or input.

APPROVED: _____
Superintendent

Supersedes Policy III-A-8, dated 10/02/18, in its entirety.

[redacted]

Bob Bowen

Guiding Principles

Excellence, effectiveness, enthusiasm and ethical behavior are the guiding principles of my human services career. Having had the experience of being recruited, developed and mentored by great leaders, it is my goal to provide future leaders with the same opportunities to become their best selves professionally and personally. My experiences as an Adjunct Assistant Professor of Psychiatry at the University of Rochester for 10 years, a CEO of an international consulting firm, and experiences in the administration of residential supports for people affected by disabilities give me the ability to integrate my passion for knowledge with compassion for people to close the gap between research and practice, and most importantly improve the quality of life of all people with and for whom I work. Inviting rather than coercing behaviour change is the foundation upon which I enter relationships, seeking ways to eliminate the barriers that prevent full participation in the life of the communities in which we live, learn, work and play.

Current Employment

Prag Consulting: Disability Complex Supports, Balwyn East, VIC, Australia – Independent Contractor as a Senior Associate, Positive Behaviour Support, providing behaviour support services to people with multiple complex support needs, including mental health, inter-personal trauma, and human relations.

Current Projects

The Journal of Aggression, Conflict and Peace Research, published by Emerald Insights, has asked me to edit a Special Issue of the Journal focused on Workplace Violence and Workplace Incivility, to be published in January 2024.

Member of the Organizing Committee for the EuroNursing Conference, Zurich, Switzerland, May 4-6, 2023.

Publications (Partial Listing)

Bowen, B (2022). Autism Spectrum Differences: ASD and an Ordinary Life. *Health*, 14(12): 1267-1273. doi: 10.4236/health.2022.1412089.

Bowen, B. and Bowen, E. (2022) Moving Away from Coercion: Social Justice and Behavior Change in Disability Services. *Health*, **14**, 194-203. doi: 10.4236/health.2022.142014

Bowen, B (2021). The Matrix of Needs: A new way to understand and respond to needs. *Human Services Today*, 2(3): 34-35,

Bowen, B (2021). The myth of attention-seeking behavior: Supporting health and wellness in people with Autism Spectrum Disorders and Intellectual Disabilities. *Health*, 13(12):1452-1459. doi: 10.4236/health.2021.1312103.



Bowen, B (2021). Hope and despair: The healing power of listening. *Health*, 13(5): 591-599. doi: 10.4236/health.2021.135044

Bowen, B. (2021). The Matrix of Needs: Reframing Maslow's Hierarchy. *Health*, 13(5), 538-563. doi: 10.4236/health.2021.135041.

Bowen, B (2021). Hopelessness and hope in human services, *Human Services Today*, 2(2): 20-21.

Bowen, B (2017). The positive practice of safety: Reductions in workplace violence through increases in safety and security at organisational and interpersonal levels. Routledge International Handbook on Forensic Psychology in Secure Settings, Jane L. Ireland, Carol A. Ireland, Neil Gredecki & Martin Fisher, Ed. New York, NY: Routledge

Bowen, B (2016). Creating and sustaining cultures of care: Minimizing aggression by maximizing safety related behaviors. Ian Needham, Kevin McKenna, Odile Frank & Nico Oud (Eds) Proceedings of the Fifth International Conference on Violence in the Health Care Sector, 268-271. Dwingaloo, The Netherlands: Kavanah.

Privitera MR, Bowie V & Bowen B (2015). Translational Models of Workplace Violence in Healthcare, *Violence and Victims*, (30)2, 293-307. https://doi.org/10.1891/0886-6708.VV-D-13-00119

Bowen, B (2015). Risk, gain, liability and hope: Integrating and training family members in the treatment planning and implementation process when aggression history is present. In Patrick Callaghan, Nico Oud, Johan Hakon Bjorngaard, Henk Nijman, Tom Palmstierna & Joy Duxbury (Eds), the Proceedings of the Ninth European Congress on Violence in Clinical Psychiatry, (pp 249-251). Dwingaloo, The Netherlands: Kavanah.

Bowen, B & Kemp, S (2014). Replacing Restraint: Good Practices in North America Human Service Programmes for Persons with Intellectual Disabilities and Autism, in *A Human Rights Perspective to Reducing Restraint Practices*, Sam Karim (Ed): BILD

Privitera M, Bowie V & Bowen B (2014). Translational models of workplace violence in healthcare: Interprofessional applications. In Ian Needham, Mierelle Kingma, Kevin McKenna, Odile Frank, Carol Tuttas, Stuart Kingma & Nico Oud (Eds), Proceedings of the Fourth International Conference on Violence in the Health Care Sector (pp 145-148). Dwingaloo, The Netherlands: Kavanah.

Bowen B, Geels T & Bowie, V (2013). Creating Safety: How Risk Management Leads to Aversive Decisions. *Intellectual Disability Australiasia*, 33(3): 3-6.

Bowen, B & Risser, P (2013). Strengthening the pavement of good intentions: Ethical and legal implications of restraint and seclusion strategies. In Patrick Callaghan, Nico Oud, Johan Hakon Bjorngaard, Henk Nijman, Tom Palmstierna, Roger Almvik & Bart Thomas (Eds), the Proceedings of the Eighth European Congress on Violence in Clinical Psychiatry, (pp122-125). Dwingaloo, The Netherlands: Kavanah.

Bowen B, Privitera MR, & Bowie V. (2011). Reducing Workplace Violence by Creating Healthy Workplace Environments, *Journal of Aggression, Conflict, and Peace Research,* 3(4) 185-198, October 2011, https://doi.org/10.1108/17596591111187710

Bowen, B (2011). Moving Away From Coercion and Enhancing Patient Dignity and Respect in Workplace Violence in the Mental and General Health Care Setting, Michael R. Privitera, MD (Ed), 2011. Boston, MA: Jones & Bartlett.

Bowen, B (2010). Commonalities in Maximizing Safety in Various Human Service Sectors. In the Proceedings of the 2nd International Conference on Violence in the Health Care Sector, Ian Needham, Kevin McKenna, Mirielle Kingma & Nico Oud, editors. Pages 380-383. Dwingaloo, the Netherlands: Kavanah

Bowen, B (2009). The Dance of Aggression: Learning to Follow Instead of Lead, in the Proceedings of the 6th European Congress on Violence in Clinical Psychiatry, Ian Needham, Patrick Callaghan, Tom Palmstiera, Henk Nijman & Nico Oud, editors. Pages 218 - 222. Dwingaloo, The Netherlands: Kavanah.

Bowen, B & Mohr, WK (2009). Measuring the Presence of Coercion in Psychiatric Settings, in the Proceedings of the 6th European Congress on Violence in Clinical Psychiatry, Ian Needham, Patrick Callaghan, Tom Palmstiera, Henk Nijman & Nico Oud, editors. Pages 223-226. Dwingaloo, The Netherlands: Kavanah

Mohr, WK & Bowen, B. (2009) Decreasing Workplace Violence Means Increasing Workplace Safety Through Positive Behavior Supports. the Proceedings of the 6th European Congress on Violence in Clinical Psychiatry, Ian Needham, Patrick Callaghan, Tom Palmstiera, Henk Nijman & Nico Oud, editors. Pages 250-253. Dwingaloo, The Netherlands: Kavanah

Presentations (Partial Listing)

2023 – Maximising Safety, Minimising Risk – Presented to staff of Being Human Assist, Melbourne, VIC, February 7, 2023

2022 – Level III Positive Behaviour Support, Yooralla, Wonthaggi, VIC, staff training provided 25 November, 2022.

2022 – National Organization for Human Services, Symposium, "Social Justice and Behavior Change: Inviting, Not Coercing Behavioral Changes." 2022 Virtual Symposium, October 21, 2022.

2022 – Malone University Ethics Seminar, "Social Justice: the Ethics of Behavior Support vs. Behavior Management, Malone University, October 14, 2022.

2022 - Workshop presentation, "The Matrix of Needs: Supporting Students with Complex Trauma Histories," Lighthouse Ministries, Canton, OH June 2022.

2022 – Workshop presentation, "Autism Spectrum Differences: ASD in a New Light. Co-presented with Elise Muller, virtual workshop in Melbourne, Australia, September 27, 2022.

2022 - Workshop presentation, "The Matrix of Needs: Supporting Adults with Intellectual Disabilities and Trauma Histories," Sacred Ground, Berlin, OH, April 2022

2021 – Positive Childhood Experiences: Using the Matrix of Needs to Structure Resilient System. Workshop presented at the National Organization for Human Services virtual conference October 21, 2021.

2021 – Panel member, The Courage to Practice Ethically, workshop on ethical practices for social workers, Malone University, October 1, 2021.

2021 – Presented "The Matrix of Needs" virtual workshop for the Hong Kong Society for Professional Training, September 10, 2021.

2021 – Presented "The Matrix of Needs: Classroom Applications" for the California School Employees Association, online virtual conference, March 3-5, 2021

2020 – Presented "Trauma Informed Positive Behaviour Support," Easy iCare, Melbourne, Australia, April, 2020.

2019 - Presented "Maximising Safety, Minimising Risk" workshop for FBA Care, Melbourne, Australia, August, 2019

2019 – Presented "Autism Spectrum Differences: Celebrating Differences and Supporting People", Yarraville and Springvale, Victoria, Australia, May 21 and 22, 2019.

2018 – Presented "Supporting People with Complex Behavioural Needs", Bendigo, Victoria, Australia, September 2018

2018 – Presented "Supporting People with Complex Behavioural Needs", Frankston, Victoria, Australia, April, 2018

2016 – Invited Presentation, "Escalation and De-Escalation in Humans and Other Animals," International Society for Research in Aggression, Sydney, Australia, July 2016

2016 – Presented "Quality of Life: Changing Organizational Cultures from the Bottom Up," Central Okanagan Caregivers Society, Kelowna, British Columbia, Canada

2015 – Presented "Trauma Informed Teamwork: Understanding the Dynamics and Trauma Histories of Caregivers," 9th European Congress on Violence in Clinical Psychiatry, Copenhagen, Denmark, October 2015

2015 – Presented "Houses, Hope and Healing" to the Central Okanagan Caregivers Society, Kelowna, British Columbia, Canada, May 2015

2015 – Presented "The Wellness Model: Preventing Burnout of Mental Health Staff", 9th European Congress on Violence in Clinical Psychiatry, Copenhagen, Denmark, October 2015

2014 – Presented "Building Our House Together: Implementing an Indigenous Framework of Wellness to Achieve Safety and Security, 4th International Conference on Violence in Human Services, Miami, FL

2014 – Presented "Preventing the Transgenerational Transmission of Trauma" at the Inaugural Symposium on the Neurosequential Model of Therapeutics, Banff, Alberta, Canada

2013 – Co-presented "Te Whare Tapa Whā: Building Trauma Informed Systems of Care Together." Australian Society for Intellectual Disabilities, Sydney, Australia

2013 – Presented workshop, "Doing What We Know When We Know It: Translating Research to Practice," 8th European Congress on Violence in Clinical Psychiatry, Ghent, Belgium

2013 – Presented Special Workshop, "Corporate Culture Change", 8th European Congress on Violence in Clinical Psychiatry, Ghent, Belgium

2013 – Presented Special Workshop, "Supporting People with Complex Behavioural Needs," 8th European Congress on Violence in Clinical Psychiatry, Ghent, Belgium

2013 – Presented workshop, "Strengthening the Pavement of Good Intentions: Ethical and Legal Implications of Restraint and Seclusion practices, 8th European Congress on Violence in Clinical Psychiatry, Ghent, Belgium

2013 – Presented "It Was For Their Own Good: Coercion, Power, and Ethics in Positive Behaviour Support." British Institute of Learning Disabilities Research to Practice Conference, Brighton, England, May, 2013.

2012 – Presented "Conflict Resolution Strategies" as part of a retreat for the Ulster Project, bringing students from Ulster, Northern Ireland to the US to develop peacemaking and conflict resolution skills.

2012 – Presented "Enhancing Educational Outcomes: The Use of Structural Assessments to Align the goals of Students and Educators." Council for Exceptional Children National Conference, April 2012, Denver, CO

2012 – Presented "The Systemic Roots of Workplace Violence: Understanding How Funding, Regulations, Administration and Quality Assurance Create Toxic Cultures" at the 3rd International Conference on Violence in the Healthcare Sector, Vancouver, BC, Canada

2011 – Keynote presentation, "The Effect of Trauma on Neurological Development" at the Australia Society for Intellectual Disabilities, Sydney, Australia

2011 – Invited speaker, Plenary Session, "Increased Awareness About the Effect of Stress on Cognitive and Affective Behaviour" at Schizofrenidagene (Schizophrenia Days) 2011, Stavanger, Norway

2011 – Presented "Relationship of Equals, Difference of Roles: Non-Coercive Team Leadership" at the 7th International Conference on Violence in Clinical Psychiatry, Prague, Czech Republic

2011 – co-presented with Dr. Jennifer Vanderberg "The Use of Psychiatric Hospital Security Staff in the Prevention and De-escalation of Restraint" at the 7th International Conference on Violence in Clinical Psychiatry, Prague, Czech Republic

2010 – Keynote presentation – Supporting People with Complex Behavioural Needs – at the BILD International Conference on Positive Behaviour Support, Dublin, Ireland

2010 – Presented "Moving Toward the Elimination of Restraint: How Positive Behavior Supports Have Paved the Roads Ahead and One State's Experience with a Statewide Effort," Reinventing Quality, Baltimore, MD

2010 – Presented "Transforming Your Organisation from Toxic to Welcoming", University of Western Sydney, Sydney, NWS, Australia

2010 – Presented "Supporting People, Not Just Their Behaviours", Australasian Society for the Study of Intellectual Disabilities, Brisbane, QLD, Australia

2010 – Presented "Supporting People with Complex Behavioral Needs", University Hospitals Psychiatric Division, Stavanger, Norway

2009 – Presented "Traumagenic Neurodevelopmental Aspects of Positive Behavior Support, Calgary, Alberta, Canada

2009 – Presented "Working with Complex Behaviors", Texas Behavioral Health Institute, Austin, TX

2009 – Presented "Invitational Healing: Applying the Theory of Invitational Practice to Mental Health Settings", International Conference on Invitational Education, Rochester, NY

2008 – Presented "Hospitals, Hospitality, and Healing" at Bellevue Hospital, NYC, NY and five other hospitals operated by NYC Health Corporation.

2008 – Presented "Continually Moving Away From Coercion: The Use of Positive Behavior Support to Create Safe Environments, 1st Annual Conference on Violence in the Health Care Sector, Amsterdam, Netherlands

2007 – Presented "Corporate Culture Change: Reducing the Use of Restraint" for organizations in Toronto and Ottawa, Ontario, CA

2006 – Presented "Supporting People, Not Just Their Behavior" at the International Association for Positive Behavior Support, Orlando, FL

2006 – Presented "A Methodology for the Reduction of Restraint and Seclusion" at the International Symposium on Restraint Reduction, Cornell University, NY

2005 – Presented "Relational Behavior Support" at the British Institute of Learning Disabilities conference, Bristol, England

2003 – Presented a Poster Session, "Establishing Best Practices Standards in Crisis Prevention and Crisis Interaction Programs," First International Symposium on Positive Behavior Support, Orlando, Florida.

2003 – wrote "A Comparison of Ohio's Behavior Support Rule and ICF/IDD Regulations", Ohio Department of Developmental Disabilities Behavior Support Advisory Committee, 2003

2003 – Presented "A Comparison of Behavior Support and Behavior Intervention Strategies" Ohio Provider Resource Association (OPRA), Columbus, Ohio

2002 – Keynote speaker, Utah State Conference on Behavior Supports, American Fork Utah

2002 – Presented "Relational Behavior Support" workshops at Exceptional Persons, Waterloo, Iowa

2000 – presented training throughout Ohio on behalf of the Ohio Department of Developmental Disabilities on proposed revisions to the Ohio Behavior Support Rule.

2000 – Presented "People First – Pushing the Paradigm" at the December TASH conference in Miami, Florida.

Expert Witness Reports

2020 – Provided expert witness report in Sioux City, Iowa. The report was pertinent to alleged severe emotional distress suffered by a 5 year old boy diagnosed with ADHD. The case was filed with the Woodbury County District Court, Case Number SCCV 181827

2018 – Provided expert witness report in Denison, Iowa. The report was pertinent to the inappropriate application of physical restraint with 10 year old boy. The case was filed with the Iowa District Court, Case Number LACV039874.

2013– Provided expert witness report to the state of Victoria Joint Conference of Experts. The report was centered on the inappropriate use of physical restraint with a 16 year old adolescent male. Proceeding No. VID844 of 2010.

Related Experience

2021 – present – Member, Malone University Social Work Department Professional Advisory Committee, Canton, Ohio

2011 – 2021, Adjunct Assistant Professor of Psychiatry, University of Rochester, Rochester, NY. In this role I worked with Michael R. Privitera, MD, MA and, until his death, Vaughn Bowie, MSW, University of Western Sydney ,in researching and writing on the subject of workplace violence in healthcare.

2018 – Present, peer reviewer for the Journal of Humanistic Psychology, the Spanish Journal of Psychiatry, the Journal of Aggression, Conflict and Peace Research.

2017 -2018 – Participated with the New Hampshire Division of Developmental Disabilities as a consultant to revise the Intensive Treatment Services model in the state.

2014 – 2015, Steering Committee member, The Oud Consultancy, Amsterdam, the Netherlands

2001 – 2010, Member, Behavior Support Advisory Committee, Ohio Department of DD, Columbus, Ohio

2002 – 2008, Chairperson, Lighthouse Committee, an after-school tutoring and drop-in center for at risk youth, Canton, Ohio

2003 – Chairperson, Committee on Developing Best Practice Training Standards, National Task Force, Child Welfare League of America

2003 – Participated in National Call to Action: Eliminating the Use of Seclusion and Restraint, sponsored by SAMHSA, Washington, DC

1999 – 2001, member of the Board of Trustees, Ohio Private Residential Association, Columbus, Ohio.
1994 – 1998, active in the Association of Developmental Disability Community Providers in New Mexico. Led efforts to improve the funding of services to community based service providers.

1992 – 1994, Chairperson, ICF/DD Program Director Committee of the Ohio Private Residential Association, Columbus, Ohio.

1986 – 1989 – Volunteer, Pegasus Farms, Equine Therapy program, Hartville, OH

1982 – Chair, Iowa Human Services Training Consortium, facilitated training conferences with Wolf Wolfensberger

Work Experience

07/01/2019 - present Prag Consulting Victoria, AU

Senior Associate, Positive Behaviour Support

- Provide training and education to family members, individuals served and staff to address behavioural concerns and understand the impact of trauma (when applicable)
- Conduct behavioural assessments and develop behaviour support plans

05/01/2016 – Present Followship Solutions, Inc. Canton, OH

Lead Consultant

- Developed The Matrix of Needs, published a comprehensive research article in the journal *Health*
- Provided organizational consulting to human services programs to improve the culture and teamwork of the organization
- Provided training on various topics including autism, trauma associated behavioral needs, organizational culture change
- Provided specific behavioral consultation as requested consistent with HCBS requirements in the United States, and appropriate state and federal regulations in Australia.
- Developed behavior support plans for specific individuals as requested
- Mentoring a person in Australia

09/2000 – April 30, 2016 The Mandt System, Inc. Richardson, TX

CEO, Senior VP for Product Development Work hours – 40+ per week

- 9/2000 to August, 2002, Faculty Member, teaching The Mandt System®
- August, 2002 – July 2014, Chief Executive Officer. Responsible for the overall administration of services provided worldwide.
- Continued responsibility to develop and/or write all materials taught by The Mandt System, Inc. including workshops on autism, complex behavioral needs, organizational culture change, management practices.
- Conducted 1-2 behavioral assessments of individuals served, completion of PBS plans, and staff training per year.
- Taught 15-25 workshops per year in all countries in which The Mandt System® operated.
- Expanded services into Canada, Australia, Hong Kong and the United Kingdom.
- New leadership structure in 2014 with Kevin Mandt as President, assumed role of Senior Vice-President for Product Development.

1999 – 2000 Walsh University North Canton, OH

Instructor, College of Education

Taught classes on the topic of "Differences and Diversity: Preparing teachers to meet the needs of students affected by disabilities who have been "mainstreamed" in elementary and secondary educational settings.

1999 – 09/2000 People Developed Systems, Inc. North Canton, OH

Executive Program Director/QIDP Work hours – 40+ per week

- Responsible for multiple site programs serving individuals affected by developmental disabilities and challenging behaviors.

- Coordinated services in a homeless shelter serving individuals who were homeless due to chronic mental illness.

1998-1999 Dungarvin Illinois, Inc. Rockford, IL

Area Director Work hours – 40+ per week

- Increased the number of individuals served by 200% over a two-year period, raised level of staff training and competencies.
- Developed innovative approach to supporting persons affected by developmental disabilities and behavioral challenges.

1996-1998 Dungarvin, Inc. St. Paul, MN

Regional Director Work hours – 40+ per week

- Responsible for all services provided by Dungarvin in New Mexico and Colorado. Established new services provided by Dungarvin in Oklahoma.
- Interacted with IDD directors in different state and county settings utilizing HCBS waiver programs.

1994-1996 Dungarvin New Mexico, Inc. Albuquerque, NM

Director, Senior Director Work hours – 40+ per week

- Provided leadership to enable to company to grow from serving seventeen individuals in 1994 to sixty-four in 1996.
- Established Supported Employment program for individuals affected by developmental disabilities

1990 – 1994 Molly Stark Hospital Louisville, OH

Program Director/QIDP Work hours – 40+ per week

- Successfully led efforts to empower individuals affected by developmental disabilities to move from this 76 person ICF/IDD to community based homes.
- Utilized Strategic Planning format to teach individuals the skills necessary to choose their service provider from a group of nine providers.

1986-1990 Hartville Meadows Hartville, OH

Program Director/QIDP Work hours – 40+ per week

- During the 4-year period had 2 surveys that were deficiency free
- Empowered one individual to live in his own Supported Living home two years before Supported Living programs were formally available.

1984-1986 Association for the Disabled of Elkhart County Elkhart, IN

Admissions Social Worker Work hours – 40 per week

- Assessed all individuals who requested services from the agency and a neo-natal ICU in South Bend, IN. Social work services provided to families in childhood programs through adulthood for entry into residential services for individuals affected by developmental disabilities.
- Established guardianship and advocacy program to serve individuals affected by developmental disabilities.

1981 – 1984 Hawkeye Community College Waterloo, Iowa

Instructor

Taught classes on Behavior Modification for nurses and psychiatric technicians, direct support and other human services professionals. Taught Level I and Level II courses.

1974 – 1983 Exceptional Persons, Inc. Waterloo, Iowa

Assistant to the Director for Residential Services (1980-1983)

- Supervised community based residential services provided to forty individuals affected by developmental disabilities.
- Wrote software program to monitor financial information for all individuals served by the organization.
- Represented over thirty individuals in appeals of denied Social Security/SSI benefits, all appeals were won.

Caseworker (1978-1980)

- Supported individuals affected by disabilities in supported living and supported employment programs, and provided counseling supports.

Houseparent (1974-1977)

Provided live-in supports at a direct support professional level to 12 women affected by developmental disabilities and co-occurring disorders.

Education

1974 – 1981 University of Northern Iowa Cedar Falls, IA

BA, Social Work, minor in English

- President, Social Work Club

1983 – 1984 Associated Mennonite Biblical Seminaries, Elkhart, IN

Thirty semester hours with a concentration in family therapy

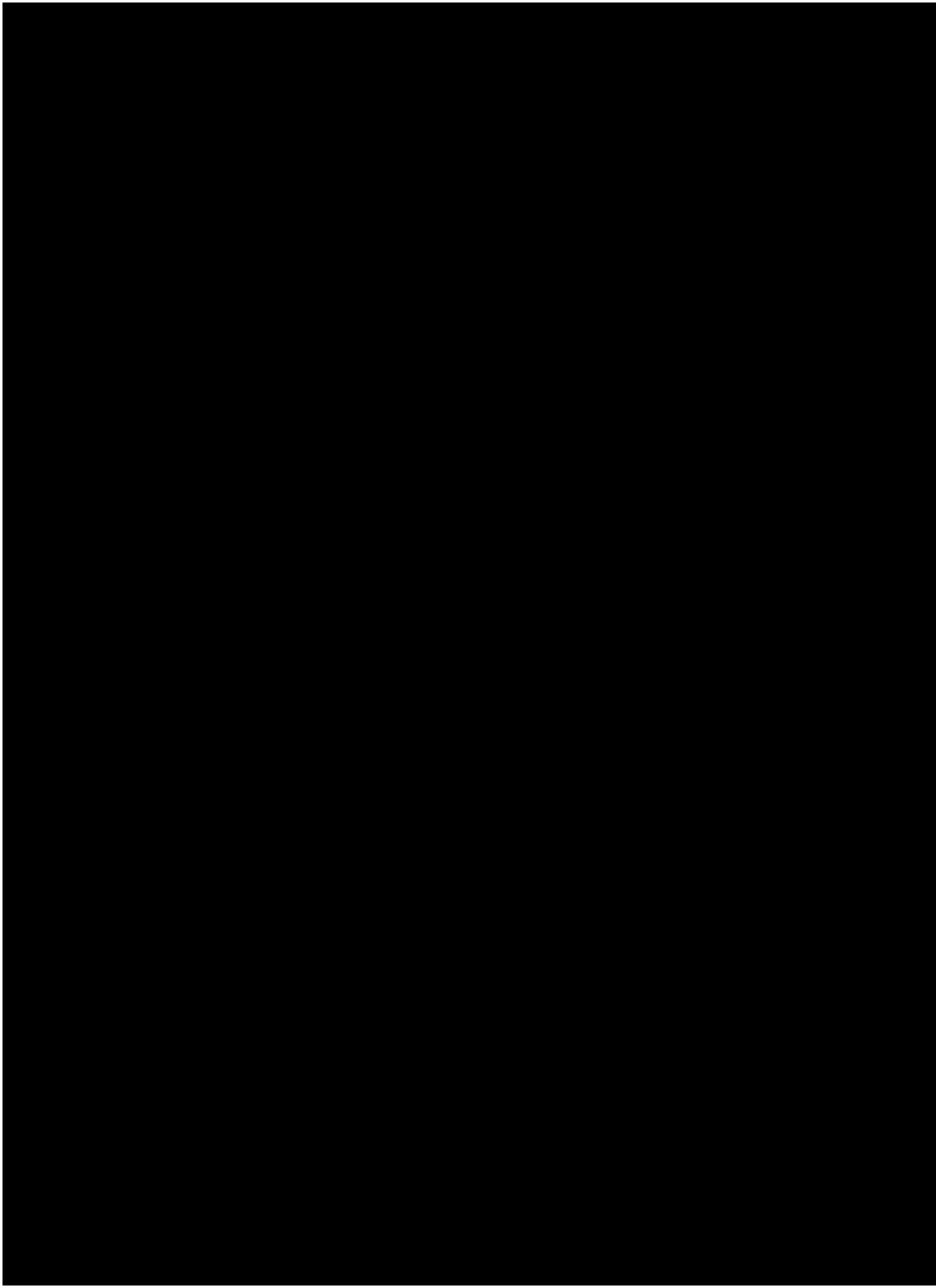
1987 – 1988 Kent State University Kent, OH

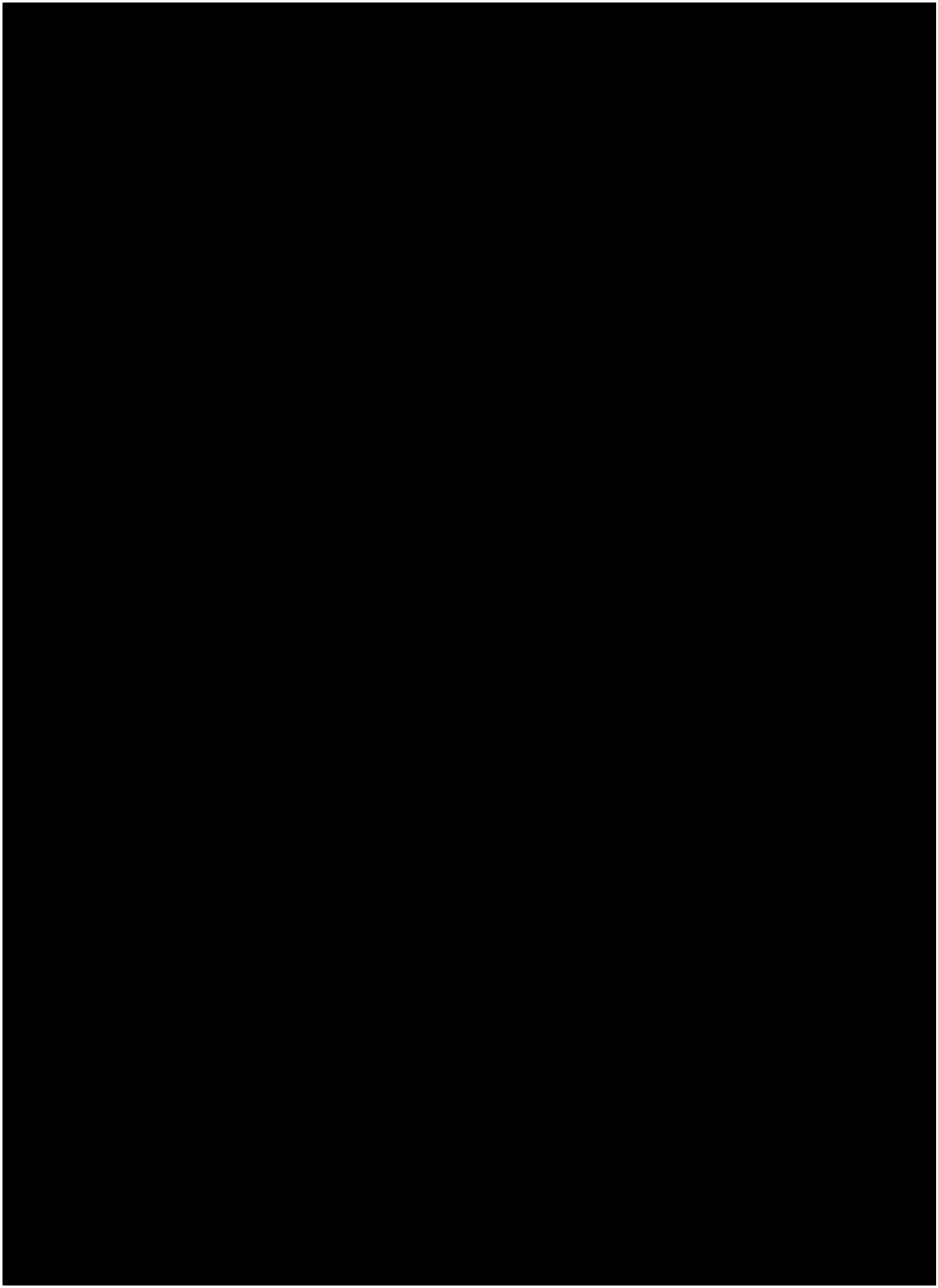
Two courses required for QIDD certification in Ohio

2003 – 2004 University of Phoenix On-Line

16 hours towards Master of Arts in Management

References Available Upon Request





198 F.Supp.2d 25
United States District Court, D. Massachusetts.

Loretta ROLLAND, et al., Plaintiffs,
v.
Argeo Paul CELLUCCI, et al., Defendants.

No. Civ.A.98–30208–KPN.
|
May 3, 2002.

Synopsis
Class of developmentally disabled and mentally retarded individuals in Massachusetts nursing homes, who entered into settlement agreement with state defendants which obligated state to provide specialized services under Nursing Home Reform Act (NHRA), filed motion for further relief concerning specialized services. The District Court, Neiman, United States Magistrate Judge, held that: (1) plaintiff class had a privately enforceable right to specialized services under NHRA; (2) active treatment standard was applicable in measuring state defendants' compliance with settlement agreement; (3) state defendants were not in compliance with their obligations under settlement agreement; and (4) remedy would be designed to ensure that plaintiff class members properly received specialized services in a manner required by law, while respecting defendants' responsibilities to design the particular mechanisms by which those ends would be accomplished.

Motion allowed.

Attorneys and Law Firms

***26** Richard D. Belin, Nima R. Eshghi, Foley, Hoag & Eliot, Boston, MA, Steven J. Schwartz, Center for Public Representation, Northampton, MA, Cathy E. Costanzo, Center for Public Representation, Northampton, MA, Stacie B. Siebrecht, Disability Law Center, Boston, MA, Frank J. Laski, Mental Health Legal Advisors Committee, Christine M. Griffin, Disability Law Center, Boston, MA, Thomas B. York, Dilworth Paxson, LLP, Harrisburg, PA, Matthew Engel, Disability Law Center, Northampton, MA, for Plaintiffs.

Peter T. Wechsler, Attorney General's Office, Boston, MA, Judith S. Yogman, Attorney General's Office, Government Bureau, Boston, MA, H. Gregory Williams, Attorney General's Office, Springfield, MA, Ginny Sinkel, Office of the Attorney General, Government Bureau, Boston, MA, Thomas B. York, Dilworth Paxson, LLP, Harrisburg, PA, for Defendants.

Phillip Kassel, Massachusetts Correctional Legal Services, Boston, MA, John Reinstein, Civil Liberties Union of Massachusetts, Boston, MA, Daniel S. Manning, Greater Boston Legal Services, Boston, MA, Allan G. Rodgers, Mass Law Reform Institute, Boston, MA, J. Paterson Rae, Western Mass. Legal Services, Springfield, MA, James Breslauer, Neighborhood Legal Services, Inc., Lawrence, MA, for Interested parties.

MEMORANDUM AND ORDER WITH REGARD TO PLAINTIFFS' AMENDED MOTION FOR FURTHER RELIEF CONCERNING SPECIALIZED SERVICES (Docket No. 243)

NEIMAN, United States Magistrate Judge.

Presently before the court is Plaintiffs' amended motion for further relief concerning specialized services. Plaintiffs comprise a class of developmentally disabled and mentally retarded individuals in Massachusetts nursing homes. Their motion arises directly from this court's March 27, 2001 finding, that Defendants, various state officials, had failed to substantially comply with that part of the parties' settlement agreement governing the provision of specialized services to members of Plaintiffs' class. As a result of its finding, the court lifted the stay imposed by the settlement agreement and agreed to address the propriety and extent of further relief. As ***27** described below, the court believes that certain relief is necessary to ensure that Plaintiffs are provided services to which they are entitled under the settlement agreement. It will, therefore, allow Plaintiffs' motion.

I. *BACKGROUND*

The court will not describe the factual and procedural background of this matter, it having done so in prior memoranda. *See Rolland v. Cellucci,* 164 F.Supp.2d 182 (D.Mass.2001); *Rolland v. Cellucci,* 191 F.R.D. 3 (D.Mass.2000); *Rolland v. Cellucci,* 52 F.Supp.2d 231 (D.Mass.1999).[1] Suffice it to say for purposes here that on June 4, 1999, the court denied Defendants' motions to

dismiss Plaintiffs' class action, which was brought pursuant to 42 U.S.C. § 1983 ("section 1983") and the Nursing Home Reform Act ("NHRA"), 42 U.S.C. § 1396r. *See Rolland,* 52 F.Supp.2d 231. Then, on January 10, 2000, the court approved the parties' settlement agreement (Docket No. 115), thus making it an order of the court. The implementation of certain aspects of the agreement, over which the court has retained jurisdiction, is currently at issue.

By its own terms, the settlement agreement, although approved by the court, is "not ... enforceable by contempt or by a breach of contract action in state or federal court." (Settlement Agreement ¶ 27.) Rather, the agreement obligates Plaintiffs to attempt mediation and, if unsuccessful, to "file a motion with the Court seeking a judicial determination that Defendants are not substantially complying with the Agreement." (*Id.* ¶ 32.) If the court so finds, "it may lift the stay otherwise imposed under paragraph [twenty-eight] and the Plaintiffs may seek injunctive and other relief based upon the then existing facts and law." (*Id.* ¶ 32.)[2]

The present issue concerns Defendants' compliance with paragraphs fifteen and sixteen of the settlement agreement. Taken together, these two paragraphs obligate Defendants to provide class members specialized services identified through a process known as preadmission screening and annual resident review ("PASARR").[3] The PASARR process prohibits nursing facilities participating in the federal Medicaid program from admitting an individual who is mentally ill or retarded unless the state has first determined, before admission, that the prospective resident requires the level of services provided by the facility and whether the individual requires "specialized services." *See* 42 U.S.C. § 1396r(b)(3)(F). PASARR applies to all potential residents whether or not they are Medicaid-eligible. *See* 57 Fed.Reg. 56450, 56452 (Nov. 30, 1992). The PASARR process ***28** also requires regular reviews of all such residents. *See* 42 U.S.C. § 1396r(b).

On September 26, 2000, after mediation with respect to paragraph fifteen and sixteen of the settlement agreement proved unsuccessful, Plaintiffs filed a Motion for Further Relief Concerning Specialized Services (Docket No. 159) in which they argued that a significant number of class members were not receiving all, and that some class members were not receiving any, of the specialized services they were determined to need. On March 27, 2001, the court allowed the motion to the extent it sought a finding of substantial noncompliance as of June 30, 2000, and lifted the stay with respect to paragraphs fifteen and sixteen of the settlement agreement. *See Rolland,* 138 F.Supp.2d at 120. The court also granted Plaintiffs leave to "seek injunctive and other relief based upon the then existing facts and law." *Id.*

Plaintiffs filed the instant motion for further relief—which technically amends their September 26, 2000 motion—on August 26, 2001. In November of 2001, following an agreed-upon period of discovery, the court held a four day evidentiary hearing. Thereafter, the parties filed proposed findings of fact and additional memoranda of law and the court heard oral argument on January 23, 2002. In some contrast to Plaintiffs' initial motion for further relief, the parties agreed that August 31, 2001, should be the measuring date with respect to the present motion.

II. *DISCUSSION*

As discussed in part B *infra,* the court makes specific findings of fact and conclusions of law with respect to Defendants' compliance with federal law concerning the provision of specialized services. In summary, the court believes that Defendants have not adequately provided specialized services and, therefore, further relief is appropriate. The particulars of that relief are spelled out in part C. Before describing the ordered relief, however, the court will address in part A a number of preliminary matters.

A. *PRELIMINARY ISSUES*

Although Defendants assert in their memorandum that "[t]he sole issue in this case is whether the Commonwealth is in compliance with federal law concerning the provision of specialized services," (Docket No. 316, Defendants' Trial Brief ("Defs.' Brief"), at 1), they have raised five preliminary challenges to Plaintiffs' motion which go well beyond this narrow scope: (1) whether Plaintiffs even have a privately enforceable right to specialized services under the NHRA; (2) whether the NHRA's implementing regulations go too far beyond the statute; (3) whether the NHRA is even subject to judicial enforcement; (4) whether an "active treatment" standard is so ill-defined as to make Defendants' obligations with respect thereto impossible to discern; and (5) whether certain evidentiary "failures" eviscerate Plaintiffs' position. The court will consider these five questions in turn.

1. *Do Plaintiffs have a privately enforceable right to specialized services under the NHRA?*

Defendants first assert that Plaintiffs do not have a privately enforceable right to specialized services under the NHRA. Relatedly, Defendants contend that the term "specialized services" is too vague and amorphous to be enforceable. The court rejected these same arguments in its decision denying Defendants' motions to dismiss. In essence, the court found that section 1983 was an appropriate vehicle for Plaintiffs to vindicate their NHRA-based right to specialized services. *See Rolland,* 52 F.Supp.2d at 234–36. To leave no lingering ***29** doubt, the court revisits these matters, albeit briefly.

There are three factors to consider in determining whether a particular statutory provision gives rise to a federal right: (1) whether Congress intended the provision to benefit the plaintiffs; (2) whether the right "is not so 'vague and amorphous' that its enforcement would strain judicial competence" and (3) whether the provision unambiguously imposes a binding obligation on the states. *Blessing v. Freestone,* 520 U.S. 329, 340–41, 117 S.Ct. 1353, 137 L.Ed.2d 569 (1997). As for the first factor, there is no question but that Congress intended that the NHRA benefit members of Plaintiffs' class. Defendants do not contend otherwise.

With regard to the second factor, the right to specialized services, in the court's view, "is not so 'vague and amorphous' that its enforcement would strain judicial competence." *Id.* at 341, 117 S.Ct. 1353. *See Rolland,* 52 F.Supp.2d at 235–36. As the court previously noted, and as remains true now, Defendants' very assertion that they comply with the "specialized services" standard is proof enough "that the term ... is [not] so nebulous and ill-defined" as to preclude judicial enforcement. *Rolland,* 52 F.Supp.2d at 235.

Finally, as for the third factor, it is clear that the NHRA unambiguously imposes a binding obligation on the states. *See id.* at 234–36. As Plaintiffs point out, the NHRA was informed by a history of states neglecting and warehousing persons with mental disabilities in nursing facilities. *See* H.Rep. 100–391(I) at 459, 100th Cong. 1st Sess. (1987), 1987 U.S.C.C.A.N. 2313–1, 2313–279, 1987 WL 61524 (Leg.Hist.) (documenting that "substantial numbers of mentally retarded and mentally ill residents [in Massachusetts and other states] are inappropriately placed" in nursing facilities and "do not receive the active treatment or services that they need"). To prevent the indiscriminate transfer of individuals with mental retardation to nursing homes, Congress mandated that states provide active treatment to such nursing facility residents deemed in need. *See* 42 U.S.C. §§ 1396r(e)(7)(A), (B)(ii) and (C).

Defendants' present reliance on *Alexander v. Sandoval,* 532 U.S. 275, 121 S.Ct. 1511, 149 L.Ed.2d 517 (2001), decided after Defendants' motions to dismiss were denied, does not convince the court otherwise.[4] *Sandoval* involved the private enforceability ***30** of certain agency regulations promulgated pursuant to the Civil Rights Act of 1964. The Supreme Court found that because the regulations proscribed what the statute permitted, Congress could not have intended to create a private right of action to enforce them. *See id.* at 281–82, 121 S.Ct. 1511. This conclusion was reinforced by the fact that the regulations directly addressed actions by federal agencies, not benefits or entitlements of private individuals. *See id.* at 289–90, 121 S.Ct. 1511. In addition, the Court found that the existence of elaborate restrictions belied any inference that Congress intended to create a private right of action with respect to the promulgated regulations. *See id.* at 289–92, 121 S.Ct. 1511.

These rationales are inapposite here. First, the NHRA, in obligating states to provide specialized services to certain nursing home residents, does not preclude what its regulations permit. *See Rolland,* 52 F.Supp.2d at 235. Rather, the regulations clarify and amplify what Congress imposed, i.e., an obligation on states to provide specialized services to residents of nursing facilities who have been determined to need that level of care by the statutorily mandated assessment procedures. Second, as indicated, there is little question but that the NHRA was intended to protect individuals with disabilities. The NHRA was designed to ensure that persons with mental disabilities were not inappropriately admitted to, or retained in, nursing facilities by the states and, to accomplish that end, afforded individualized protections for those determined to be in need of specialized services. *See* 42 U.S.C. § 1396r(7)(C). Third, the absence of an agency enforcement mechanism with respect to the provision of specialized services supports rather than undermines the inference of a private right of action. *Compare Frazier v. Fairhaven Sch. Comm.,* 276 F.3d 52, 68–69 (1st Cir.2002) (no private right of action under Family Educational Rights and Privacy Act in light of specific remedy accorded Secretary of Education).

Any remaining doubt about *Sandoval's* inapplicability is dispelled by the fact that Plaintiffs' claims were also brought pursuant to section 1983 which, of course, provides an independent avenue for private enforcement of a federal law such as the NHRA. *See Evans v. Avery,*

100 F.3d 1033, 1036 (1st Cir.1996); *Boulet v. Cellucci,* 107 F.Supp.2d 61, 71–73 (D.Mass.2000). The plaintiffs in *Sandoval,* in contrast, did not advance a section 1983 cause of action.[5] In short, for the reasons stated, the court still believes that Plaintiffs have a privately enforceable right to "specialized services."

2. *Do the administrative regulations go beyond the statute?*

The court is equally disinclined to accept Defendants' renewed argument that the implementing regulations go beyond the NHRA and are, therefore, ultra vires. Accordingly, the court's prior conclusion—that Congress did not foreclose, and the Secretary of Health and Human Services ("Secretary") properly construed Congressional intent to impose, a duty to provide specialized services to all nursing facilities ***31** residents found to be in need—will stand. *See Rolland,* 52 F.Supp.2d at 235.

In order to prevent the denial of adequate care, Congress mandated that all persons with mental retardation and related conditions be screened before admission to a nursing facility, *see* 42 U.S.C. § 1396r(e)(7)(A), and that a determination be made whether the individual requires specialized services, *see* 42 U.S.C. § 1396r(e)(7)(B)(ii)(II). Moreover, states were obligated to provide such services to persons who were not in need of nursing facility services only. *See* 42 U.S.C. § 1396r(e)(7)(C). Congress also required that persons who had been in a nursing facility for less than thirty months, and those who had resided there longer and who chose to leave, be provided not only specialized services but a discharge to an appropriate placement. *See id.* In effect, Congress prioritized its goals by obligating states to facilitate an alternative placement of persons who needed specialized services and to provide specialized services in the interim. Finally, Congress specifically entrusted the Secretary to promulgate regulations which gave meaningful and practical application to its intent. *See* 42 U.S.C. § 1396r(f). In the court's opinion, the Secretary's regulations appropriately reflect these statutory mandates, many of which, by the way, are reflected in the parties' settlement agreement.

3. *Is the statute subject to judicial enforcement?*

As a third line of defense, Defendants point to the court's statement in its ruling on their motion to dismiss—that "the question of judicial enforcement of the NHRA is for another day"—as justification for its reconsidering now the enforceability of Plaintiffs' rights. This argument reads too much into the court's remark.

What the court reserved for another day was not whether the NHRA was enforceable by private citizens—the court having concluded that it was—but what remedy might be appropriate were Plaintiffs to prove that Defendants were not in compliance with their statutory and regulatory obligations. However, even that question faded when the parties entered into their settlement agreement which, as indicated, became an order of the court on January 10, 2000.

As far as the court is concerned, Defendants, when executing the settlement agreement, not only recognized their duty to provide class members with specialized services under the NHRA, but Plaintiffs' right to enforce that duty as well. By its very terms, the agreement recognized that the parties entered into their settlement in order "to resolve the issues raised in the Plaintiffs' Amended Complaint and the Defendants' Answer by providing specialized services and residential supports to the plaintiff class members pursuant to the provisions [here]of." (Settlement Agreement ¶ 1.) At the present time, the court "can discern no sound reason that [Defendants] like any other litigant who knowingly and voluntarily stipulates to judgment, should not be bound by the obligations undertaken in the [settlement agreement], which obligations plainly constituted the consideration that prompted [Plaintiffs] to settle their ... action against [Defendants]." *Whitehouse v. LaRoche,* 277 F.3d 568, 578 (1st Cir.2002).

4. *Is an "active treatment" standard so ill-defined as to make Defendants' obligations with respect thereto impossible to discern?*

Yet another roadblock which Defendants attempt to construct to defeat Plaintiffs' motion is their claim that an "active treatment" standard, as distinct ***32** from "specialized services," is so ill-defined as to make their obligations with respect thereto impossible to discern. This argument has several layers, none of which, in the court's view, precludes a finding that Defendants have failed to provide services in the manner contemplated both by the NHRA and the parties' agreement.

As an initial matter, Defendants argue that the use of the active treatment standard by the Massachusetts Department of Mental Retardation ("DMR"), through its

designated agent, MetroWest, ought not be deemed any sort of admission on their part. Indeed, throughout the course of their opposition to Plaintiffs' motion, Defendants have tried their best to distance themselves from MetroWest. In any case, Defendants assert, the interpretation of NHRA requirements is not a factual issue amenable to such an admission, but a legal issue to be determined by the court.

In pursuing this argument, Defendants fail to acknowledge that the court, when issuing its March 27, 2001 ruling, concluded as a matter of law that the "active treatment" standard was required not only by the NHRA but by the terms of the settlement agreement. *See Rolland,* 138 F.Supp.2d at 115–17. To be sure, as Defendants note, the court's finding of noncompliance was based on the narrower definition of "specialized services." That approach, however, was simply a matter of convenience to the court, for Defendants' own data demonstrated that, as of June 30, 2000, they were in substantial noncompliance with their obligations to provide specialized services as they themselves defined it. *See id.* at 121. Thus, little more was needed for the court to find noncompliance with paragraphs fifteen and sixteen of the settlement agreement. Even so, the court opined that, had the active treatment standard been applied, Defendants' noncompliance was likely more serious. *See id.* at 115–17.

In any event, at the time it ruled on Plaintiffs' original motion for further relief, the court thought it appropriate, if not necessary, to provide guidance to the parties as to how future compliance would be measured. The court concluded that Plaintiffs did indeed have the right to "active treatment." *See id.* at 117. In so ruling, the court rejected Defendants' argument, repeated here, that active treatment means something different for persons with mental retardation or developmental disabilities in nursing facilities than it does for such persons in all other settings. *See id.* The court also rejected Defendants' further argument, pursued here again, that specialized services "analogous to active treatment" is the appropriate standard to apply to eligible individuals in nursing facilities. *See id.* at 116–17.[6]

Given this guidance, Defendants' continuing resistance to the "active treatment" standard concerns the court. For one thing, Defendants must concede that DMR's agent, MetroWest, incorporated the active treatment standard into its measuring instrument for over a decade. (See Docket No. 314, Plaintiffs' Proposed Findings of Fact ("Pls.' Facts"), ¶¶ 19 and 20.) MetroWest completed the PASARR forms during the period of time relevant here, i.e., through August 31, 2001, recorded the specialized services deemed needed for each individual and thereafter assessed whether such services were being provided. (See Docket No. 315, Defendants' Proposed Findings of Fact ("Defs.' Facts"), ¶¶ 180, 181.) Whether or not this ***33** amounts to an admission on Defendants' part, it is certainly evidence that "active treatment" can not only be discerned but implemented.

Moreover, the evidence reveals that MetroWest did not employ the active treatment standard in a vacuum. When training its staff, DMR itself used a document which incorporated the federal criteria for active treatment. (See Plaintiffs' Exhibit ("Pls.' Ex.") 40. See also Docket No. 311, November 6, 2001 Transcript ("Tr.Vol.II"), at 121–22.) In addition, DMR, the Department of Medical Assistance ("DMA") and the Department of Public Health ("DPH") created a joint training program which mirrored active treatment criteria. (Pls.' Ex. 44 at 3.) Similarly, DMA's day habilitation regulations mandated that services provided at nursing facilities, as well as other settings, comply with the active treatment standard. (*See id.*) Furthermore, the independent expert chosen by the parties left no doubt that she employed an active treatment standard. (See Tr.Vol. II at 201–02.) She also testified that the active treatment standard is appropriate for, and commonly used at, nursing facilities which have residents with mental retardation or developmental disabilities. (*Id.* at 203.)

Although Defendants disparage the active treatment standard as ambiguous, they themselves claim to meet the requirements of "active treatment" in addition to the requirements of "specialized services," the term their counsel preferred to use. (See Docket No. 310, November 8, 2001 Transcript ("Tr.Vol.IV"), at 129; Docket No. 309, November 5, 2001 Transcript ("Tr.Vol.I"), at 69–70.) Granted, Defendants condition their claim on "any kind of reasonable definition" of the term "active treatment." (Tr.Vol. I at 69–70. See also Tr.Vol. IV at 129.) However, nowhere do Defendants provide a more reasonable definition than that utilized by the court—a "continuous, aggressive program that is designed to enable a client with optimal independence and to guard against the loss of that ability." *Rolland,* 138 F.Supp.2d at 116 (citing 42 C.F.R. § 483.440(a)(1)). At best, Defendants suggest that only qualified professionals can define such terms as "continuous" and "aggressive" and thereby give meaning to "active treatment." (Tr. Vol. IV at 130.) At worst, Defendants fear that the court might adopt "some extreme version of active treatment" without factoring in "accepted professional standards." (*Id.*)

Defendants' assertions to the contrary, the regulatory definition of active treatment, on which the court has

relied, is anything but extreme. Moreover, in measuring Defendants' compliance with that standard, the court has had the opportunity, in accord with Defendants' suggestion, to consider the professional testimony offered by both sides. In particular, the court has considered the testimony of Dr. Theodore Kastner, one of Defendants' experts, who appears to have best articulated their position. Dr. Kastner has worked exclusively in the field of health care with regard to persons with mental retardation and developmental disabilities, has managed related hospital programs, and has served as a consultant to the Department of Justice, the President's Committee on Retardation and the Surgeon General. (See Docket No. 308, November 7, 2001 Transcript ("Tr.Vol.III"), at 107.) Dr. Kastner testified that "[a]ctive treatment is a slippery concept to evaluate in the context of a nursing home community" and suggested that the better standard was services "analogous to active treatment." (*Id.* at 127–28.) "To require active treatment to be provided in the nursing home," Dr. Kastner opined, "means that a nursing home is no longer a nursing home. The nursing home then becomes an [intermediate ***34** care facility ('ICF/MR')]," which, he noted, has to provide active treatment. (*Id.*)

Despite his criticism, Dr. Kastner utilized the active treatment definition identified in PASARR forms in his own written report, never once using the word "analogous." (See *id.* at 150, 153.) This PASARR definition, in the court's estimation, is indistinguishable from the federal regulatory standard. Although the court seriously doubts whether the individual cases analyzed by Dr. Kastner actually reflect the active treatment he found (see *id.* at 155 (noting that "[a]ll of the identified patients are in receipt of *active treatment* to the degree that they consent for [sic] treatment")), the important point for purposes here is his ready use of the standard (see Pls.' Facts ¶ 24).

To be sure, Dr. Kastner attempted to modify that standard during his testimony by using the word "analogous." He acknowledged, however, that he has never seen an instrument which uses such a modified standard, (see Vol. III at 178; Pls.' Facts ¶¶ 30, 73), nor have Defendants offered one. "The only instrument I have seen that is used to assess whether active treatment is present or not," Dr. Kastner conceded, "is defined" in relation to standards employed by "HCFA," the Health Care Financing Administration. (*Id.*) As it turns out, these are the same regulatory standards which the court cited when concluding that "active treatment" was not only applicable, but enforceable as well. *See* 42 C.F.R. § 483.440(a)(1).[7]

In contrast to Dr. Kastner, Lynn Rucker, one of Plaintiffs' experts, explained the relative ease with which active treatment could be measured for nursing home residents. Ms. Rucker directed case management services for a sixteen-county program in Nebraska for fifteen years and thereafter was state director of developmental disabilities services in Arizona. (Tr.Vol. 1 at 166–67.) She is presently a consultant on health care for people with disabilities. (*Id.* at 168.) Citing 42 C.F.R. § 443.440(a)(1), Ms. Rucker described in detail the ways in which active treatment could be appropriately measured. (Tr.Vol. I at 176–182. See also Pls.' Ex. 4 at 6–9.) As Ms. Rucker testified, "active treatment is active treatment": "The issue isn't location. The issue is, is this active treatment? Is the person receiving it." (Tr.Vol. I at 182.)

In sum, the court is not inclined to apply anything other than an active treatment standard to measure Defendants' compliance, as it indicated it would on March 27, 2001. This is not to say that providing active treatment to class members in nursing facilities is simple. For example, as Defendants point out (see Defs.' Facts ¶¶ 111, 121), nursing facilities have an independent obligation to provide medically-related services to their residents. *See* 42 U.S.C. § 1396r; 42 C.F.R. §§ 483.12, 483.15, 483.25, 483.40, 483.45 and 483.70. These medically-related services ought not be confused with the state's obligation to provide "specialized services." (*See* Defs.' Facts § 115.)

For present purposes, however, Plaintiffs make no claim with respect to the quality of medically related nursing services. (See. Tr.Vol. III at 201–07.) Thus, the court has assumed for purposes here that such services as are provided to class ***35** members meet applicable regulatory standards. Accordingly, any alleged failure in that respect has not played a part in assessing Defendants' compliance with the settlement agreement and, to the extent that one or more of Plaintiffs' experts may have addressed the adequacy of medical services, the court has disregarded that testimony.

5. *Are there evidentiary "failures" which eviscerate Plaintiffs' position?*

Finally, Defendants attack the strength of Plaintiffs' evidence in three ways. First, Defendants assert that Plaintiffs failed to qualify several of their experts and, accordingly, cannot meet their burden of proving their case. Second, Defendants challenge the statistical validity of Plaintiffs' sampling method. Third, Defendants question the methodology by which Plaintiffs' experts gathered their underlying data.

Defendants' first assertion can be dealt with in short order. As Defendants know, the court denied both sides' motions in limine with respect to the various experts and indicated that it would thereafter consider arguments only as to the weight to be accorded such testimony. (See Docket Nos. 291, 292 and 293. See also Tr.Vol. IV at 147.) That issue has been adequately addressed in the parties' memoranda of law and proposed factual findings.

Defendants' second contention is unsuccessful as well, but requires some explanation. Noting that one of Plaintiffs' experts, Dr. James Conroy, acknowledged a margin of error of fourteen percent with respect to Plaintiffs' sampling methodology, Defendants claim that the actual margin is at least twice that. (See Defs.' Facts ¶ 155.) Moreover, Defendants assert, Plaintiffs' sample size of thirty-nine was simply too small to permit conclusions to be drawn on class-wide service delivery. (See *id.* ¶ 159.)

It is certainly true that, had Plaintiffs had the resources, Dr. Conroy would have recommended a larger sample. (See Tr.Vol. I at 158–59). That would have been preferable to the court as well. But, as Dr. Conroy testified, a larger sample is most important when one is "looking for the prevalence of something rare." (*Id.* at 150.) Dr. Conroy continued:

> If you're looking for a common event for a dominant or prevalent pattern in something, small samples work very well. If you find a big dominant pattern, then the small sample is going to be fine. If you find something very rare and only a couple instances out of 39, then you might have to find a bigger sample.

(*Id.* at 150–51.) As will be shown, Plaintiffs' experts in the case at bar found dominant patterns. Accordingly, the court is satisfied that the margin of error is acceptable for purposes here.[8]

Third, Defendants assert that Plaintiffs' experts were highly, and therefore improperly, individualistic in performing their reviews. For example, as Dr. Walsh testified, it was not always clear how Plaintiffs' experts translated their observations into subjective judgments about service delivery. (See Tr.Vol. II at 270.) Moreover, ***36** Dr. Walsh suggested, the court should treat with scepticism any conclusion that *no* individuals were receiving specialized services. (See *id.* at 270–72.)

Defendants' third argument has merit. Unfortunately, Defendants' criticism can as easily be directed at the methodology used and subjective conclusions drawn by their own experts. For example, Dr. Walsh opted to rely on inferences drawn from Dr. Conroy's methodologies in 1999 and 2000, not Dr. Conroy's explanation of his 2001 sampling. (See Defs.' Ex. 1–A at 32.) In addition, although Defendants' review was designed to test the methodology used by Plaintiffs' experts, their critique was limited principally to Plaintiffs' year 2000, not 2001 findings. (See Tr.Vol. III at 12–13.)[9] Defendants' experts also intentionally eliminated from their review all class members residing in the western part of Massachusetts, as well as all nursing homes in which there was only one class member. (See Tr.Vol. II at 308, 311–12; Tr.Vol. III at 48, 50.) Finally, and perhaps more problematically, Defendants' experts were willing to opine, in direct contradiction of Plaintiffs' experts, that *all* class members were in receipt of active treatment. The court, therefore, must be as skeptical of Defendants' conclusion as they urge it be of Plaintiffs'.

At bottom, however, Defendants' final attack misses the mark. While inadequacies on both sides have proven problematical, the court believes that enough information was gathered and presented to measure Defendants' ongoing compliance. As Dr. Walsh himself indicated, "the issue of what ... people are getting for services is fairly discernible to professionals," (Tr.Vol. II at 286), and the court has had the benefit of professional testimony adequate to make its findings.

B. *THE MERITS OF PLAINTIFFS' MOTION*

Having addressed Defendants' preliminary challenges, the court turns to the core issue: whether Defendants are in compliance with their obligations to provide specialized services. For the reasons which follow, the court concludes that, as of August 31, 2001, the measuring date chosen by the parties, Defendants remain in substantial noncompliance with the specialized services portion of the settlement agreement and that further relief is necessary. In reaching this conclusion, the court makes the following findings of fact and conclusions of law.

1. *Specific Findings of Fact*[10]

When an individual is recommended for specialized services through the PASARR process, he or she is assessed in relation to identified specialized service need areas, in some cases participating in services on a trial basis. (Defs.' Facts ¶ 1.) The resulting assessment is then used in an individualized planning process. (*Id.* ¶ 2.) Generally, an individual's service plan describes the objectives established to address the assessed need areas. It also describes the activities (including intensity, frequency and duration) to be implemented that will assist the individual in attaining the goals within a particular time line. (*Id.* ¶ 3.) DMR is supposed to assess and monitor progress; rapid progress, or absence ***37** thereof, is to be identified and modifications to the service plan may occur in order to achieve or revise goals. (*Id.* ¶ 4.) An assessment should not only involve the review of available records, but also interviews with the individual's family and nursing facility staff, as well as observation and analysis of the individual's capabilities. (*Id.* ¶ 5.)

The selection of specialized services may be affected by different clinical judgments. (*Id.* ¶ 6.) Moreover, there may be individuals who refuse one or more services. (*Id.* ¶ 7.) In addition some individual class members may have died, moved from the nursing facility, or simply experienced a medical event such that services are no longer appropriate. (*Id.* ¶ 8.)

There are four primary models which are used to deliver specialized services to class members: day habilitation, in-facility day habilitation, individual support and pediatric model services. (*Id.* ¶¶ 9, 12, 14 and 15.) "Day habilitation" offers services in one setting outside the nursing home. (*Id.* ¶ 9.) It is a Medicaid state-plan service that is governed by federal and state regulations and is available to Medicaid eligible individuals who are determined to have a need for this service. (*Id.*) As of 2001, there were day habilitation programs located throughout Massachusetts servicing over four thousand total individuals: ninety-one day habilitation programs have the capacity to serve up to seventy-five individuals each, five serve between seventy-five and one hundred individuals and four serve between one hundred and one hundred and fifty individuals. (*Id.* ¶ 10.)

"In-facility day habilitation" was developed by DMR and DMA to deliver services at nursing facilities to individuals with complex medical presentations, those choosing not to leave their nursing facility to obtain specialized services, or where community day habilitation is not available. (*Id.* ¶ 12.) Of the class members identified to need specialized services, approximately eighty-five percent receive them primarily through the day habilitation models, half of whom receive specialized services primarily through the in-facility model. (*Id.* ¶¶ 12, 13.) A small percentage receive services in both settings either because of personal preference or because they are undergoing a transition from in-facility to community day habilitation. (*Id.* ¶ 13.)

The "individual support" model of service delivery addresses a discreet number of individuals. Thus, an individual may have a need which is not a covered service in a day habilitation program but which can be met through the provision of a staff person at the nursing facility or another location. (*Id.* ¶ 14.) In the case of individuals with developmental disabilities, there may be a particular provider with extensive experience in treating a particular set of physical limitations (such as those associated with traumatic brain injury) that is retained under contract to provide individual treatment. (*Id.*) Of class members identified to receive specialized services, approximately ten percent are receiving services primarily through this model. (*Id.*)

Finally, DMR and DMA created a "pediatric model" for delivering services to meet the specialized service needs of class members residing in Massachusetts' four pediatric nursing facility units. (*Id.* ¶ 15.) These class members, admitted prior to age eighteen, have complex medical needs and were provided special educational services until they lost eligibility upon turning twenty-two years of age, although they remained in the pediatric nursing facility. (*Id.*) Of the one hundred and fifteen residents of pediatric facilities identified to receive specialized services, eighty-eight (or seventy-seven percent of the total) receive ***38** them through the pediatric model. (*Id.* ¶ 16.)[11]

For two hundred and thirty-eight class members who are developmentally disabled but not mentally retarded, their specialized service needs while they reside in nursing facilities are provided through services arranged through a University of Massachusetts project team. (*Id.* ¶ 18.) The needs of this group often can be provided through one of the models described above. (*Id.*) At other times, for example, individuals suffering from brain injury, these models are not appropriate to the needs of the individual and arrangements must be made with providers with appropriate expertise. (*Id.*)

As required by the settlement agreement, DMR must regularly report upon the status of specialized service delivery. (*Id.* ¶ 19.) These reports describe the services to be arranged to meet specialized service needs, as well as various types of situations and circumstances that may affect their delivery. (*Id.*) DMR training materials for the

provision of specialized services incorporate the components of active treatment: development of specific goals by an interdisciplinary team, individualized objectives and strategies, staff training, carry-over and documentation. (Tr.Vol. II at 121–22, 126–28; Pls.' Exs. 40, 44.) These are the same standards used at an ICF/MR facility. (Tr.Vol. II at 122.)

2. *Conclusions of Law*

For convenience sake, the court divides its five legal conclusions as follows: (a) only a few class members are receiving specialized services; (b) specialized services are not being provided in a timely manner; (c) Plaintiffs' experts independently confirm Defendants' noncompliance; (d) over three hundred class members may have been erroneously rejected for specialized services; and (e) there are problems with the dichotomy between nursing homes and day habilitation programs.

a. *Only a few class members are receiving specialized services.*

The evidence is clear that only a few class members are receiving specialized services individually tailored to address their needs. (See Pls.' Exs. 4 at 90–95, 5 at 39–43, 8 at 50–54, and 11 at 38–42.) DMR's own checklists of day habilitation participants reveal that significant numbers of class members do not have habilitation plans that address all identified areas of specialized services. (See Tr.Vol. II at 128–29; Pls.' Ex. 48 at 2.) Among other things, DMR's draft report in July of 2001 indicates that thirteen percent of those receiving on-site or off-site services were not receiving all the services identified as needed. (Tr.Vol. II at 128–30; Pls.' Ex. 48.)

To be sure, Defendants try to explain away this data as neither comprehensive nor individualized. (Defs.' Facts ¶ 96.) Even assuming the draft nature of the report, however, DMR checklists derived from MetroWest data reveal a lack of adequate day habilitation plans and a failure to implement these plans for many class members. (Pls.' Ex. 48 at 1–3; Pls.' Facts ¶ 57.) Moreover, Defendants have never offered a final version of the document.

Similarly, DMR's semi-annual report of August 17, 2001, reveals that nearly six hundred class members—more than seventy-five percent of the class with identified specialized service needs—had at least one finding of a "needed but not provided" service. (Pls.' Facts ¶ 53; Pls.' Ex. 76.) To be sure, as Defendants' experts noted, ***39** MetroWest's review process could result in errors.[12] These inadequacies, however, do not explain the majority of cases found by MetroWest where services were not being provided in accord with stated objectives. Even taking into account those individuals who referred services, the number of individuals not receiving all the services deemed necessary for them was still exceptionally high.

MetroWest's review process—to determine whether specialized services that had been identified as needed were in fact received—was conducted by qualified mental retardation professionals. (Tr.Vol. I at 107–09.) Evaluators would make an appointment with a particular individual, or the nursing home if the individual was not able, and then spend an hour or two reviewing the clinical record, conducting interviews and making their own observations. (*Id.* at 108.) Evaluators were also required to follow specific criteria and to record their views on appropriate PASARR forms. (*Id.* at 110–11.)[13]

Granted, MetroWest evaluators did not visit day habilitation programs, that not being part of their contract and DMR having specifically requested that they not do so. (See *id.* at 112.) However, the evaluators would either review such day habilitation records as were included in nursing facility records or request those records from DMR service coordinators or University of Massachusetts case managers. (*Id.* at 112–13.) "[O]ne way or another," Ellen Zarek testified, "we generally get the opportunity [to review the day habilitation records] before we make a decision." (*Id.* at 113.) In light of this evidence, it is impossible to accept Defendants' contrary claim that "all" class members—excluding those who had died, moved or no longer needed services, or those whose services were in the process of being arranged—"were receiving all the specialized service[s] recommended for them [and to] which they consented." (Defs.' Facts ¶ 20.)

b. *Specialized services are not being timely provided.*

Even if the data provided by MetroWest was inaccurate at times, as claimed by Christine Oliveira, DMR's PASARR Director, (Tr.Vol. II at 150), there was sufficient independent testimony to confirm that specialized services were not being provided in a timely manner. Ms. Oliveira herself acknowledged that an individual identified as "DS," who needed day habilitation, had not received those services in a timely manner. (*Id.* at 112–15.) Similarly, the report for "Ms. M" indicated that

the services she needed as of June 30, 2001, would not be provided until February 15, 2002, over seven months later. (***40** *Id.* at 115.) Likewise, Ms. Oliveira acknowledged that services due by December 21, 2000, to an individual identified as "FB" had not been provided nearly five months later. (*Id.* at 116–17; Pls.' Ex. 42.) Ms. Oliveira also acknowledged that a "JB," for whom services were due in 1995, did not have those services as of May, 2001, over five years later. (*Id.* 117–118. See also Pls.' Ex. 42.) As it turns out, Defendants were not even aware of JB's presence in the nursing home until May of 2001. (*Id.* at 152–53.) This meant, Ms. Oliveira testified, that specialized services, "active treatment" aside, were simply not being provided. (*Id.* at 118.) In short, all too often specialized services were not being provided in a timely manner.

c. *Plaintiffs' experts independently confirm Defendants' noncompliance.*

Even were the court to ignore DMR's own findings, Plaintiffs' expert witnesses provided independent confirmation that, as of August 31, 2001, Defendants were failing to substantially comply with their obligations to provide specialized services to class members. To be sure, Defendants, relying on their own experts' testimony that the PASARR reports were unreliable, (see Defs.' Facts ¶ ¶ 180–99), assert that Plaintiffs' experts relied too much on PASARR findings. This assertion, in the court's opinion, is not accurate. Although Plaintiffs' experts used PASARR findings as a starting point, they each made individual observations, interviewed staff and family members and utilized multiple sources of information, including nursing home notes, patient files and day habilitation progress notes. (See, e.g., Tr.Vol I at 171–73, 183, 211–12, 217 and 223; Pls.' Ex. 4.) They each found that numerous class members simply were not receiving active treatment.

Ms. Rucker, who reviewed twenty-one cases, found no instance in which active treatment was being provided. For example, she described "JM," a thirty-four year old woman, as receiving some services, but not active treatment. The day program was trying to increase JM's awareness of nutritional values, Ms. Rucker testified, but the nursing home provided no carryover services. (Tr.Vol. I at 185–88. See also Pls.' Ex. 4 at 47–52.) The same problem was found with respect to "RM," a forty-four year old man for whom there was no apparent continuity between the day habilitation program and the nursing home. (See Tr.Vol. I at 188–90; Pls.' Ex. 4 at 59–63. Compare Tr.Vol. IV at 30–31 (testimony of Defendants' expert, Karen Williams, that RM is only able to tolerate a few hours of support).)

Barbara Pilarcik, another of Plaintiffs' experts, is a registered nurse who had previously worked for DMR as an appeals mediator and had managed intermediate care facilities for the Association for Community Living ("ACL"). (Tr.Vol. I at 214.) She presently directs ACL's specialized home care program for one hundred and thirty individuals with developmental disabilities and mental retardation. (*Id.* at 215.) In preparation for her testimony, Ms. Pilarcik reviewed thirteen individuals, eleven of whom she had reviewed at an earlier stage of this litigation. (*Id.* at 217.) She too found that active treatment was not being provided.[14] Although there were ***41** exceptions (see Tr.Vol. II at 11–12), Ms. Pilarcik attributed such problems to a consistent lack of trained staff at nursing homes qualified in serving people with mental retardation and developmental disabilities (see Tr.Vol. I at 229–30).

Another of Plaintiffs' experts, Elizabeth Jones, testified similarly. Ms. Jones has twenty-eight years of experience in the field of mental retardation and developmental disabilities. (Tr.Vol. II At 19.) She was the director of staff development at the Belchertown State School from 1977 until 1982, during which time she was responsible for ensuring compliance with court orders. (*Id.* at 19–20.) For one year thereafter she was the acting superintendent responsible for insuring that active treatment was provided to residents. (*Id.* at 20.) Thereafter she was district manager for western Massachusetts.

With respect to the case at bar, Ms. Jones reviewed eleven class members, eight of whom she had visited during an earlier stage of the litigation, often following the particular client to the day habilitation program. (*Id.* at 22–23.) She, too, concluded that clients were not receiving active treatment. (*Id.* at 29.) With the exception of two instances, she found that the frequency and intensity of services were weak. (See *id.* at 30.) "JL," for example, spends all her time stringing plastic beads, while "GM" was engaged in a Sisyphean cycle of filling clay flower pots with soil, only to have them quickly emptied by staff. (*Id.* at 30–31.) Ms. Jones also found a lack of carryover between day habilitation programs and nursing homes, calling it "one of the most serious problems underlying this entire set of circumstances." (*Id.* at 32.) She continued:

> And I saw it in virtually every case, even—even where I thought this might not be a problem. Certainly

> in nursing homes where the day programs are located in the nursing home where I thought for sure staff would be talking to each other, in fact, there was no evidence of carry-over between day program staff and nursing home staff.

(*Id.*)

To be sure, Defendants point to some "success stories." For example, Frederick Huntington, DMR's area director for Berkshire County, testified about "EA," a forty-nine year old woman who has lived in a nursing home for thirty-one years. Mr. Huntington averred that, Plaintiffs' expert's views to the contrary, EA has had work opportunities, e.g., volunteering at Berkshire Community College. (Tr.Vol IV at 13. *See also* Defs.' Facts ¶¶ 78–81.) Nonetheless, Mr. Huntington was unable to counter the crux of Ms. Jones' testimony, namely, that EA was not able to utilize an electric wheelchair at her nursing home, although she thrived with such use at the day habilitation center. (*Id.* at 14.) Mr. Huntington also acknowledged that nursing staff was actively discouraging EA from leaving the nursing facility. (*Id.* at 18.)

It may well be, as Defendants argue, that Plaintiffs' experts have set a high bar for measuring Defendants' compliance. (See Tr.Vol. II at 270–73.) But, in the court's opinion, Defendants' ability to question certain aspects of Plaintiffs' experts' testimony does not undermine their ***42** basic findings, namely, that all too often class members are simply not receiving the active treatment to which they are entitled.

This should come as no surprise to Defendants. As described, they have resisted the very notion that active treatment applies to Plaintiffs' class. Indeed, despite the fact that the active treatment standard had been used historically by Defendants, their experts disregarded that standard when analyzing Plaintiffs' experts' reports. They saw "no worth in evaluating active treatment using HCFA standards," having concluded that such standards "are not applied to nursing homes." (Tr.Vol. III at 97.) Rather, they looked only "at specialized services." (*Id.*)[15]

d. *Over three hundred class members may have been erroneously rejected for services.*

Yet another troubling shortcoming of Defendants' provision of specialized services is the real possibility that, during the time period in question, more than three hundred additional individuals failed to receive treatment because they had been erroneously rejected for *all* specialized services. Evidence of this comes from the independent expert called for in paragraph nine of the settlement agreement, Karen McGowan.

Ms. McGowan was required by the agreement to review the negative determinations of class members' needs for specialized services when the rate of such determinations fell below seventy-five percent of individuals reviewed in a particular quarter. (See Tr.Vol. II at 197; Pls.' Ex. 61 at 2; Pls.' Facts ¶ 109.) She conducted her initial reviews for the first and second quarters of 2000 on October 2 through 10, 2000, and submitted a report on January 27, 2001. (Pls.' Ex. 61 at 1; Pls.' Facts ¶ 110.) She reviewed a fifteen percent sample of the total number of individuals determined not to be appropriate for specialized services by MetroWest. (Tr.Vol. II at 200; Pls.' Ex. 6 at 3; Pls.' Facts ¶ 112.) For the first quarter of 2000, she determined that nine of the nineteen individuals sampled were in need of specialized services, representing more than a forty-seven percent disagreement rate with the PASARR evaluations. (Pls.' Ex. 61 at 11; Pls.' Facts ¶ 113.)

Ms. McGowan also submitted reports for the third and fourth quarters of 2000 and the first and second quarters of 2001. (Pls.' Exs. 62–64; Pls.' Facts ¶ 117.) These subsequent reports used a similar sampling procedure and resulted in disagreement rates with the PASARR evaluations ranging from forty-three to seventy-six percent. (Pls.' Exs. 62–64; Pls.' Facts ¶ 118.)

At bottom, Ms. McGowan's reports indicate a unacceptably high rate of error in the so-called "negative recommendations" for specialized services by MetroWest. She testified that more than three hundred class members had likely been without specialized services to which they were entitled. (See Tr.Vol. II at 206; Pls.' Facts ¶ 122.)

The parties treat Ms. McGowan's findings in significantly different ways. Plaintiffs assert that, prior to August 31, 2001, DMR, at a minimum, had not begun to provide specialized services for any of the forty-four class members determined by Ms. McGowan to have been erroneously ***43** denied services during the first and second quarters of 2000. (Pls.' Facts ¶ 123; Pls.' Ex. 41.) Moreover, Plaintiffs contend, DMR has not established a systematic process to review erroneous determinations concerning the need for specialized services and could not identify one class member as of August 31, 2001, who had been provided specialized services where there had

been an erroneous negative determination of the need for such services. (Pls.' Facts ¶¶ 119, 120.)

Defendants, on the other hand, see Ms. McGowan's reports as confirming DMR's previous decision to assume from MetroWest the responsibility for the PASARR screening process. (Defs.' Facts ¶ 144.) Moreover, they consulted with Ms. McGowan as they undertook the task of redesigning the PASARR screening tool. (*Id.* ¶ 145.) In addition, Defendants decided as of August 31, 2001, to provide services to the particular individuals found by Ms. McGowan to have been erroneously determined not to need such services. (*Id.* ¶ 147.)

There is little doubt that Plaintiffs welcome the effort undertaken by Defendants to provide service to those individuals, belated though that effort may be. Still, for purposes here, the information provided by Ms. McGowan demonstrates that many class members went without specialized services prior to August 31, 2001.

e. *There are problems with the dichotomy between nursing homes and day habilitation centers.*

Another fundamental flaw in Defendants' approach to the delivery of specialized services is their evident willingness to date to permit class members to exist in parallel universes, nursing homes and day habilitation centers, with neither world adequately communicating with the other. Indeed, Defendants' experts' own report concludes by noting the very different missions of nursing homes and day habilitation programs. (See Defs.' Ex. 1–A at 81–82. See also Tr.Vol. II at 59–60.) Unfortunately, as Ms. Jones testified, nursing homes focus on "basic management of health needs, like the taking of temperatures [and the administration of] medications" and do not themselves "have a very strong focus at all on issues like learning or development." (Tr.Vol. II at 59.)

The court believes, at least with respect to provision of specialized services, that the mission of nursing homes and day habilitation centers needs to be the same, i.e., to provide active treatment so that individual class members have the opportunity, as Ms. Jones described, "to grow and develop and learn and enjoy life to the greatest degree possible." (*Id.* at 41.) Without that, opportunities will be missed and resources wasted. This is particularly true since class members in nursing homes often have "more skills and in some ways [are] less disabled than the people [Ms. Jones saw] at Belchertown and who are now in community based programs." (*Id.* at 58.)

Defendants appear to agree that this lack of coordination between service providers can no longer be tolerated. John Riley, DMR's Deputy Assistant of Operations, testified about recent efforts by DMR and DMA to improve such coordination, including communicating the content of day habilitation individual service plans to nursing facility staff and facilitating joint meetings between service providers and nursing facilities. (See Defs.' Facts ¶ 126.) In addition, Defendants point to a letter dated December 20, 2000, to administrators of long term care facilities which indicates that DPH would be "increas[ing] its scrutiny of services provision to residents in nursing facilities who have mental ***44** retardation or developmental disability." (Defs.' Ex. 8; Pls.' Ex. 53.) Defendants also cite a September 21, 2001 letter reminding long term care facilities of their obligation to complement and reinforce specialized services chosen through the PASARR process. (Pls.' Ex. 54.) This letter suggests several "initial steps" that long term care facilities "should take" to meet these requirements, including "inviting the DMR Service Coordinator/[University of Massachusetts] Case Manager to the annual MDS/Care Planning Meeting for each MR/DS resident; ensuring that the Specialized Service Plan is available to LTCF staff for the purpose of ongoing resident care planning; and ensuring that care plan interventions complement, reinforce and are consistent with the Specialized Services Plan." (*Id.* at 2.)

Other than coming too late, Defendants' missives merely suggest, but do not require, the incorporation of specific goals, objectives and strategies into nursing home plans. (See also Tr.Vol. IV at 116.) There is no requirement that day habilitation, whether within or outside the facility, and nursing facilities develop and abide by a single plan. (*Id.* See also Tr.Vol. III at 228 (testimony of Kelly Lawless, DMA's special compliance coordinator).) Indeed, Defendants' draft day habilitation review checklist reveals that, as of August 19, 2001, nearly twenty percent of the 566 day habilitation program participants had no plan at all or an inadequate plan for specialized services. (Pls.' Facts ¶ 180; Pls.' Ex. 48.) More importantly for purposes here, DPH surveys at nursing home facilities found some class members with no individual service plan on file, others whose plans did not incorporate goals and strategies from the day habilitation plan, and yet others whose services were so poorly documented that it is unclear what services were provided and when. (Pls.' Facts ¶ 181.)

At bottom, the evidence confirms the unfortunate parallel tracks which Defendants appear intent on pursuing. While greater coordination in the general sense is no doubt

helpful, a significantly more formal coordination is needed to ensure Defendants' compliance with their obligations to provide specialized services to class members. Nursing homes should not become new backwards in terms of the delivery of such services.

C. RELIEF

Plaintiffs propose a number of steps which they believe will provide a meaningful remedy for Defendants' noncompliance with respect to the provision of specialized services. For their part, Defendants argue that, there being no violation, no remedy is appropriate. Alternatively, Defendants argue that, should the court find a lack of substantial compliance, court-ordered relief should be limited, that is, the court ought not become the "superintendent" of DMR with respect to the delivery of specialized services, as they argue many of Plaintiffs' suggestions would entail. As will be evident, the relief ordered by the court falls somewhere between the parties' positions.

1. *Overview*

On March 27, 2001, the court found Defendants in noncompliance as of June 30, 2000, with their obligations under paragraphs fifteen and sixteen of the settlement agreement. *Rolland,* 138 F.Supp.2d at 121. Despite efforts on Defendants' part, this noncompliance has continued, as described, in large part because they have been willing to have the class members' services governed by a divided administrative regime, enhanced by their resistance to an active treatment standard. Granted, it is DPH, not DMR, which has certain ***45** oversight responsibilities for nursing homes. But the defendant agencies cannot act in isolation, as Defendants themselves would concede. Neither can they simply communicate at times, as if such communication is sufficient to ensure that class members receive their services in a manner required not only by law, but by the settlement agreement itself.

Accordingly, certain relief proposed by Plaintiffs is more than appropriate in accord with the court's power under paragraph thirty-two of the settlement agreement. As District Judge Keeton recently observed: "It is well established by tradition and practice in the American Legal System that a court may make orders in aid of enforcement of its Judgment." *Atlantic Research Marketing Systems, Inc. v. G.G. & G., L.L.C.,* 167 F.Supp.2d 458, 475 (D.Mass.2001). *See Rufo v. Inmates of Suffolk County Jail,* 502 U.S. 367, 380, 112 S.Ct. 748, 116 L.Ed.2d 867 (1992) ("[S]ound judicial discretion may call for the modification of the terms of an injunctive decree if the circumstances, whether of law or fact, obtaining at the time of its issuance have changed, or new ones have since arisen.") (citation omitted).

However, given the particulars of Defendants' noncompliance to date, some of Plaintiffs' suggestions are simply too broad and intrusive. For example, the court finds inappropriate Plaintiffs' suggestion that the court should increase the number of individuals placed yearly in community settings. The parties' settlement agreement, as the court understands it, was carefully negotiated with respect to community placement and, for the moment, the court will not use Defendants' failure to comply with their specialized services obligations to expand their community placement obligations.

Similarly, the court will not order Defendants to pay for an independent expert to review all individuals who had been determined not to require specialized services. The role of Ms. McGowan, the present independent expert, with respect to such determinations is set forth in a part of the settlement agreement not directly in issue (paragraph nine), and, at most, Defendants are required only to consider that expert's recommendations in good faith. (See Settlement Agreement ¶ 10.) To be sure, the court has considered the independent expert's findings pursuant to paragraph nine as further proof that many class members went without specialized services prior to August 31, 2001. But the court does not believe that a remediation is mandated with respect to paragraph nine, particularly in light of Defendants' representations that, without further assessments, services would be provided to those individuals who the independent expert determined to be in need. (See Defs.' Facts ¶¶ 147–48.)

Likewise, the court is not going to appoint a special master to oversee Defendants' implementation of specialized services. The settlement agreement is comprehensive enough at this time to ensure, and Plaintiffs' attorneys skilled enough to monitor, Defendants' ongoing compliance.[16]

2. *Relief Summary*

"[I]njunctive relief should be no more burdensome to the [enjoined party] ***46** than necessary to provide complete relief to the [parties complaining of violation of their right]." *Atlantic Research Marketing,* 167 F.Supp.2d at

475–76 (quoting *Califano v. Yamasaki,* 442 U.S. 682, 702, 99 S.Ct. 2545, 61 L.Ed.2d 176 (1979)). Thus, although the court is obviously reluctant to redesign the entire structure of service delivery, there are five specific changes which must be made in order to remedy Defendants' noncompliance. Defendants shall promptly seek and consider Plaintiffs' views with respect to designing and implementing each of the changes.

First, the fragmented assessment of class members' needs can no longer be tolerated. Each class member must have a coherent, integrated treatment plan which guides his or her services across all settings. Accordingly:

> 1. Within sixty days Defendants shall establish and implement a system for (a) a DMR coordinator and one individual service plan for each class member with mental retardation, and (b) a case manager and an interdisciplinary treatment plan for each class member with other developmental disabilities.

Second, as described, the court has interpreted both federal law and the Settlement Agreement as requiring active treatment. Given Defendants' resistance, it is necessary to spell out their obligations in greater depth and require as follows:

> 2. Within sixty days, Defendants shall establish and implement a clear policy of "active treatment" to be provided to all class members who need specialized services. *See* 42 C.F.R. §§ 483.120(b) and 483.440(a)(1). Active treatment shall be comprised of the provision of services which are: (a) relevant to meet assessed needs; (b) sufficient in intensity and frequency to promote growth or prevent deterioration; (c) individualized and integrated; and (d) continuous and which carry over from community programs and settings to nursing facilities. Specialized services determined to be needed pursuant to this policy shall be provided regardless of whether or not they are covered in Massachusetts' Medicaid plan.

Third and fourth, given Defendants' failure to fully implement the active treatment standard, the court will also require the following:

> 3. Within sixty days, Defendants' reports pursuant to ¶ 24(b) of the settlement agreement shall incorporate measuring devices in compliance with the active treatment standard; and
>
> 4. Within one hundred and twenty days, DMR and nursing facilities staff shall be trained in the requirements of the settlement agreement as well as in the policies and structures implemented as a result of this order.

Fifth, the court orders as follows:

> 5. Defendants shall immediately utilize the services of the independent expert to evaluate the accuracy, validity and reliability of their new PASARR instrument. The evaluation shall be completed no later than sixty days from the date hereof. If the evaluation suggests further changes but such changes are not implemented within forty-five days thereafter, Plaintiff may return to court for further relief.

After all, it was at the recommendation of the independent expert that Defendants decided to amend the instrument so as to address the problems described herein. Finally, the court orders Defendants to certify and file with the court a detailed report regarding compliance with respect to paragraphs one, two, three and five within sixty days and with respect to paragraph four within one hundred and twenty days.

***47** In the court's estimation, the ordered relief falls well within its powers under paragraph thirty-two of the settlement agreement. As importantly, the relief is designed to ensure that Plaintiff class members properly receive specialized services in a manner required by law, while respecting Defendants' responsibilities to design the particular mechanisms by which those ends will be

accomplished.

IT IS SO ORDERED.

III. *CONCLUSION*

For the foregoing reasons, Plaintiffs' Amended Motion for Further Relief Concerning Specialized Services is hereby ALLOWED as described.

All Citations

198 F.Supp.2d 25

Footnotes

[1] *See also Rolland v. Cellucci,* 151 F.Supp.2d 145 (D.Mass.2001); *Rolland v. Cellucci,* 138 F.Supp.2d 110 (D.Mass.2001); *Rolland v. Cellucci,* 106 F.Supp.2d 128 (D.Mass.2000).

[2] The settlement agreement's stay provision, paragraph twenty-eight, simply states that "[f]urther proceedings in [this action] will be stayed, subject to the [agreement's enforcement] provisions." (*Id.* ¶ 28.)

[3] In their entirety, the paragraphs provide as follows:

> 15. Of the 858 nursing facility residents, according to the PASARR evaluators, who were not receiving all specialized services recommended in their PASARR evaluations as of July 1, 1998, the Defendants shall provide or arrange for those specialized services to all such residents by December 31, 1999.
>
> 16. For all other Massachusetts residents who are class members whose PASARRs recommend specialized services, Defendants shall provide or arrange for the provision of those specialized services by April 30, 2000, or within 90 days of the individual's admission to a nursing facility, whichever is later.

(*Id.* ¶¶ 15, 16.)

[4] *Sandoval,* by the way, presents the only grounds upon which Defendants may appropriately argue that a "change" in the law requires the court to take a second look at its previous conclusions. In this regard, the following colloquy between the court and Defendants' attorney is instructive:

> MR. WECHSLER: And there are, of course, various enforcement provisions that the plaintiffs have if they're dissatisfied with the implementation of this agreement. One is to confer. A second is mediation. And then they have the various rights to go back into this court if they're dissatisfied.
>
> THE COURT: Right, and I think that it's within those paragraphs that I saw something that could be interpreted, *then existing facts and law,* something along those lines that take that at least kinds of changes into account.
>
> MR. WECHSLER: Right, so that the agreement is between the parties. But if the plaintiffs were dissatisfied and believed that the defendants are not carrying out their obligations, they have the right to go back into court. And at that point, to argue that there's a violation of then applicable law. So, for example, if the defendants don't meet the schedule for placement within a period, the plaintiffs can go back on that basis and reopen the case

> with the state and argue that the defendant's practices violate the law.
>
> So that it places them in the same position that they would be absent an agreement in terms of enforceability. They could make that claim at that time. And the court would, of course, be considering any changes in facts or law, for example, but facts may well change at that point in terms of who's already been placed and there may be legal developments.

(Docket No. 118, Transcript of October 20, 1999 Conference at 23–24 (emphasis added). See also *id.* at 42–43.)

[5] The *Sandoval* dissent suggested that, on remand, the plaintiffs might be able to invoke section 1983 in order to obtain relief, *see id.,* 532 U.S. at 300–01, 121 S.Ct. 1511 (Stevens, J., dissenting), but the majority did not address that point.

[6] As the court noted, the sole reference to "analogous" services is limited to a data-gathering process, *see* 42 C.F.R. § 483.136(a), which in no way alters the definition of active treatment. *See Rolland,* 138 F.Supp.2d at 116.

[7] Dr. Kastner also noted that it is "extremely important" to observe both the nursing home side and the day habilitation side of the service delivery system "to see what services people are receiving and to be able to conclude whether they have achieved specialized services or active treatment." (Tr.Vol. III at 168.) This very point was made by the court in its memorandum and order of March 27, 2001. *See Rolland,* 138 F.Supp.2d at 116–17.

[8] Interestingly enough, Defendants' experts also claim to have found dominant, albeit contradictory, patterns, even though their sampling technique was admittedly at risk. (See, e.g., Tr.Vol. II at 267.) Defendants restricted their initial sample pool to the thirty individuals reviewed by Plaintiffs' experts in the summer of 2000, ended with only eight members from that pool and handpicked an additional eight classmembers from those same nursing facilities. (See *id.* at 237–38; Docket No. 281, Defendants' Exhibit ("Defs.' Ex.") 1–A at 8; Tr.Vol. III at 43; Tr.Vol. II at 237–38; Defs.' Facts ¶ 26.)

[9] Dr. Walsh's criticism of two of Plaintiffs' experts in particular was based on their outdated September and November affidavits. (See Tr.Vol. II at 269–71. See also Defs.' Ex. 1–A at 39–43.) Dr. Kastner, too, did not review three of Plaintiffs' experts' 2001 reports. (See Tr.Vol. IV at 147–48.)

[10] Additional factual findings are either interspersed in the court's conclusions of law or have been mentioned in the previous discussion of Defendants' preliminary arguments.

[11] Approximately five percent of the total active specialized services population receives specialized services through other service delivery models combined. (*Id.* ¶ 17.)

[12] For example, as conceded by Ellyn Zarek, MetroWest's director of state-wide assessments since July of 1989, the

absence of documentation could often result in a finding that services were needed, but not provided. (See Tr.Vol. I at 119.) Similarly, an individual's need to obtain services sequentially could result in a finding that certain services were not being provided and an individual who refused services would be shown as not receiving them. (See *id.* at 124, 127. See also Tr.Vol. III at 23–24 (testimony regarding individual who was not receiving services because his guardian did not consent) Tr.Vol. IV at 24–25 (similar).)

[13] It is also noted that MetroWest used an active treatment standard which DMR had agreed to in 1993. (Id. at 115–16; Pls.' Ex. 29.) As Ms. Zarek testified, "it seemed the fair thing to do to give [individuals] credit for receiving specialized services when they're going to a full-time program that is supposed to be providing active treatment." (Tr.Vol. I at 116.) Unfortunately, Ms. Zarek concluded in May of 2001 that "few day habilitation programs or nursing facilities seem to understand specialized services or how to write objectives." (*Id.;* Pls.' Ex. 29.)

[14] For example, with respect to "WD," a forty-four year old developmentally disabled woman, the nursing home was not able to follow through on day habilitation activities. (*Id.* at 224–25. Compare Tr.Vol. IV at 27–28.) Similarly, "SB," a sixty-seven year old mentally retarded man who suffered from gastroesophageal reflux disease, failed to have implemented at his nursing home the swallowing and communication programs developed for him at the Stone Educational Collaborative Program (Tr.Vol. I at 225–28); a nursing home aide was simply unaware of the swallowing program (*id.* at 228–29). (Compare Tr.Vol. IV at 32–33 (testimony of Karen Williams that nursing staff had been trained in a feeding protocol).) Ms. Pilarcik also testified with respect to "BG," a seventy year old woman with Down's syndrome (who repeatedly showed up at day habilitation with feces under her fingernails), that staff members at the nursing home were completely unaware of her needs. (See Tr.Vol. I at 230–33.)

[15] The court notes that while Dr. Walsh, one of Defendants' experts, initially designed an instrument to measure Plaintiffs' experts' reports through use of an active treatment standard (see Tr. Vol. II at 250–52, 281–83), the standard was not included in his final guidelines (see *id.;* Pls.' Exs. 71 and 72).

[16] The court is also not yet convinced of the necessity of still other remedies offered by Plaintiffs, e.g., requiring sufficient numbers of trained professionals be placed in nursing facilities, mandating the provision of specialized services in settings other than nursing facilities, barring the admission of class members into nursing facilities in favor of intermediate care facilities, shortening the agreed upon time limit for the provision of specialized services, or barring the admission of class members into nursing facilities deemed unable to provide all recommended services.

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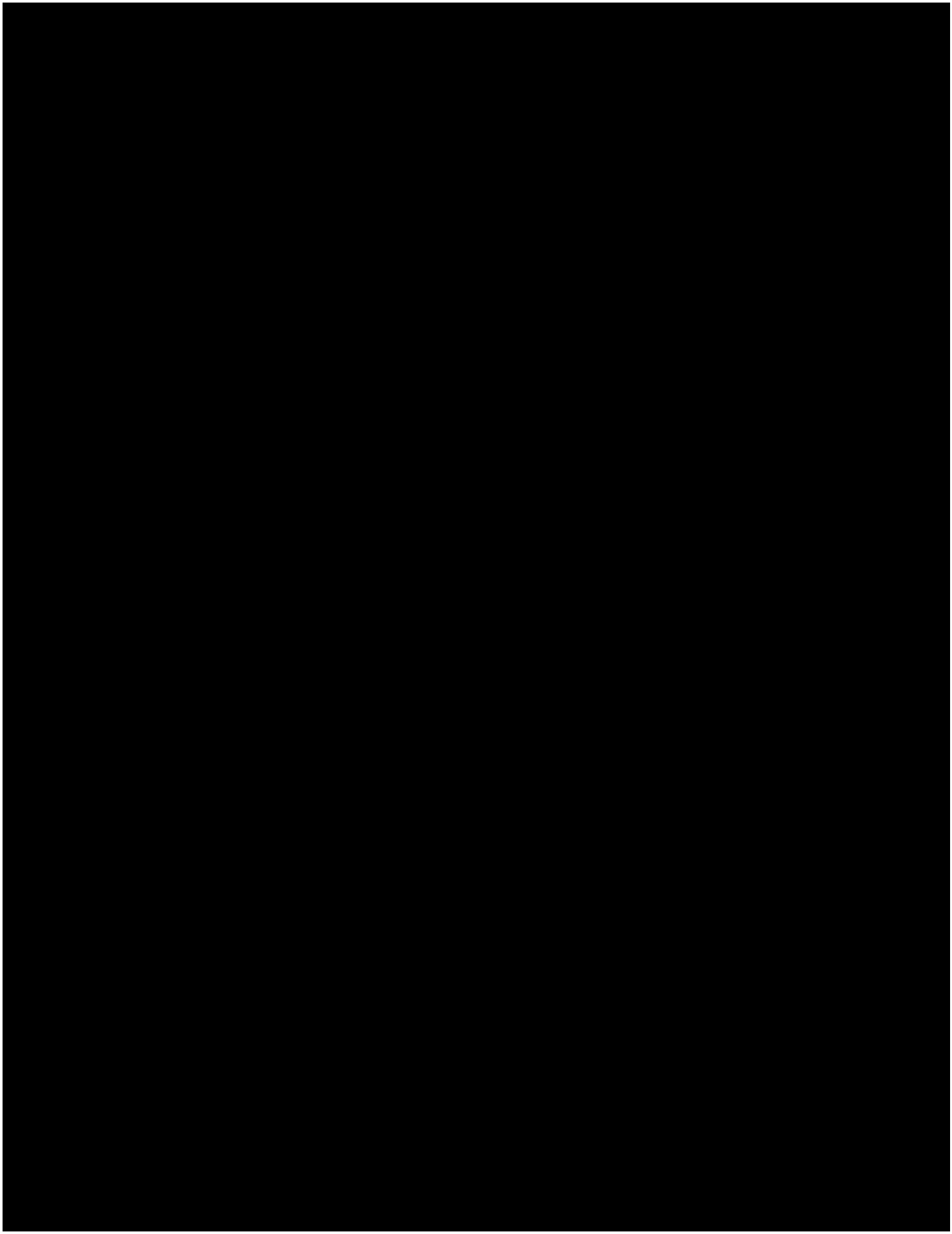

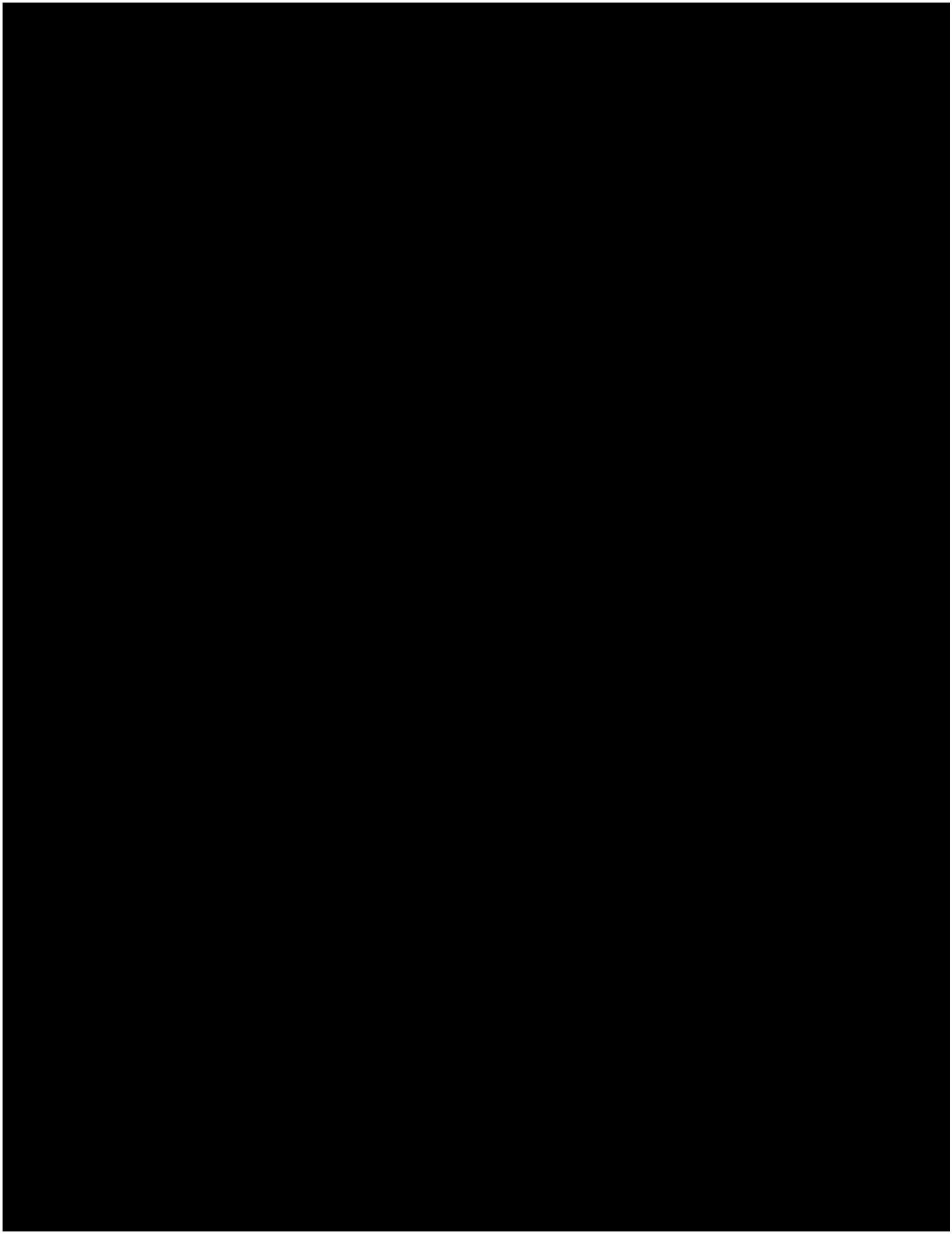

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Developmental Disabilities Services
P.O. Box 1437, Slot N501, Little Rock, AR 72203-1437
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November 13, 2020

Mr. Tom Masseau
Executive Director
Disability Rights Arkansas
400 West Capitol Avenue, #1200
Little Rock, AR 72201

Mr. Masseau,

I'm writing to formally respond to an investigation conducted by Disability Rights Arkansas that you provided me on October 23, 2020. As I stated in my initial email response that day, I do appreciate you sending the report and including additional recommendations that can be applied across all five Human Development Centers. I also appreciate your involvement with the Behavioral Consultation Committee and your attendance at the meeting held on November 5, 2020. I also appreciate the feedback you provided me yesterday ensuring that all recommendations were included in the subcommittee projects.

I reviewed your investigation surrounding the death and then went back and read through the internal reports, witness statements, hospital records, and his social and medical history. When a death occurs, the records not only detail the death but you also get to read about the person. He had lived at Booneville for thirteen years. He liked the Dukes of Hazard. He liked listening to music by the Monkeys. He didn't like to be alone. He had a mother and a sister and I am sorry for their loss.

This response isn't intended to argue with your report or point out discrepancies. I agree with you that people with disabilities, whether they live at a facility or out in the community, deserve the best possible care. I agree that we need to renew our effort to actively reduce restraints. I am committed, with your help and other members of the Behavioral Consultation Committee, to change the culture and significantly reduce restraint usage. Below I have included the four focus areas for the subcommittees that we will tackle over the next several months. I think we can bring about real change.

Behavioral Consultation Committee Subcommittee Project Plans

Data-Informed Practices

Co-Chairs: Dr. Julie Howard and Dr. Jeremy Thompson

Goal: Develop a project plan, timeline and recommendations for the collection and use of data to inform restraint practices, as well as, consistent and effective use of the data to reduce restraint usage

Action #1: Review and update how we report, categorize and define restraints

Action #2: Review current metrics and methods used for tracking personal, mechanical and chemical restraints, as well as entire episodes involving individual clients.

Action #3: Update how incidents involving restraints are tracked on the HDC Statistical Report. Improve the report's restraint tracking methodologies and terminology.

Action #4: Develop a template for collecting, reviewing and utilizing data that will be utilized throughout the strategic process.

DRA Recommendation and Action #5: Ensure that the use of restraint is regularly monitored, including careful evaluation and scrutiny of the reasons staff utilized restraint, alternatives to restraint, and follow-up actions in response to restraint. This includes requiring that clinical and senior administrative staff be more involved in the day-to-day activities of residents to ensure that individualized treatment or behavior plans are effective, and that adequate active treatment is provided. A process for this oversight should be included in the project plan.

Preferred Restraint and Communication Options while working to reduce restraint usage

Chair: Shannon Roberts

Goal: Develop a project plan, timeline and recommendations for implementing the best devices, including communication devices.

Action #1: Review current mechanical restraint devices used at each human development center.

Action #2: Research and recommend improved devices.

Action #3: Develop action plan for phasing out obsolete devices while implementing improved, standardized devices.

DRA Recommendation and Action #4: Ban the use of the papoose board as a form of restraint at the HDCs.

Restraint Reduction Methods

Chair: Dr. Carl Reddig

Goal: Develop a project plan, timeline and recommendations for reducing the use of restraints. *will need incorporate items from Dr. Howard and Dr. Thompson's project plan.

Action #1: Identify and recommend alternative tools and intervention methods for reducing restraint use.

Action #2: Review client behavioral support plans and identify minimal language required to allow restraint usage as a last resort.

Action #3: Develop an action plan for reviewing and modifying all client behavioral support plans. Ensuring specific restraint language is removed, all support plans have all intervention methods, and support plan templates do not revert back to having specific restraint language.

DRA Recommendations and Action #4: evaluate mental health and other treatment service for clients at each HDC and make recommendations on needed services.

External Advocate Recommendations

Chair: Tom Masseau, Disabilities Rights Arkansas

Goal: Develop a project plan and timeline for implementing recommendations made by Disabilities Rights Arkansas not included in the project plans listed above.

Action #1: Research the use of independent experts with expertise in working with facilities to develop and implement current evidence-based best practices to significantly reduce and/or eliminate the use of restraint at the facility. Outline appropriate options that includes how an expert would be utilized.

Action #2: Research the best comprehensive training on person-centered and trauma-informed, recovery-oriented, evidence-based services and supports. Outline recommendations on who should be trained, including frequency.

Action #3: Develop a plan to increase the frequency of NCI/CPI training with all staff, while incorporating, where appropriate, the comprehensive training recommended in Action #2.

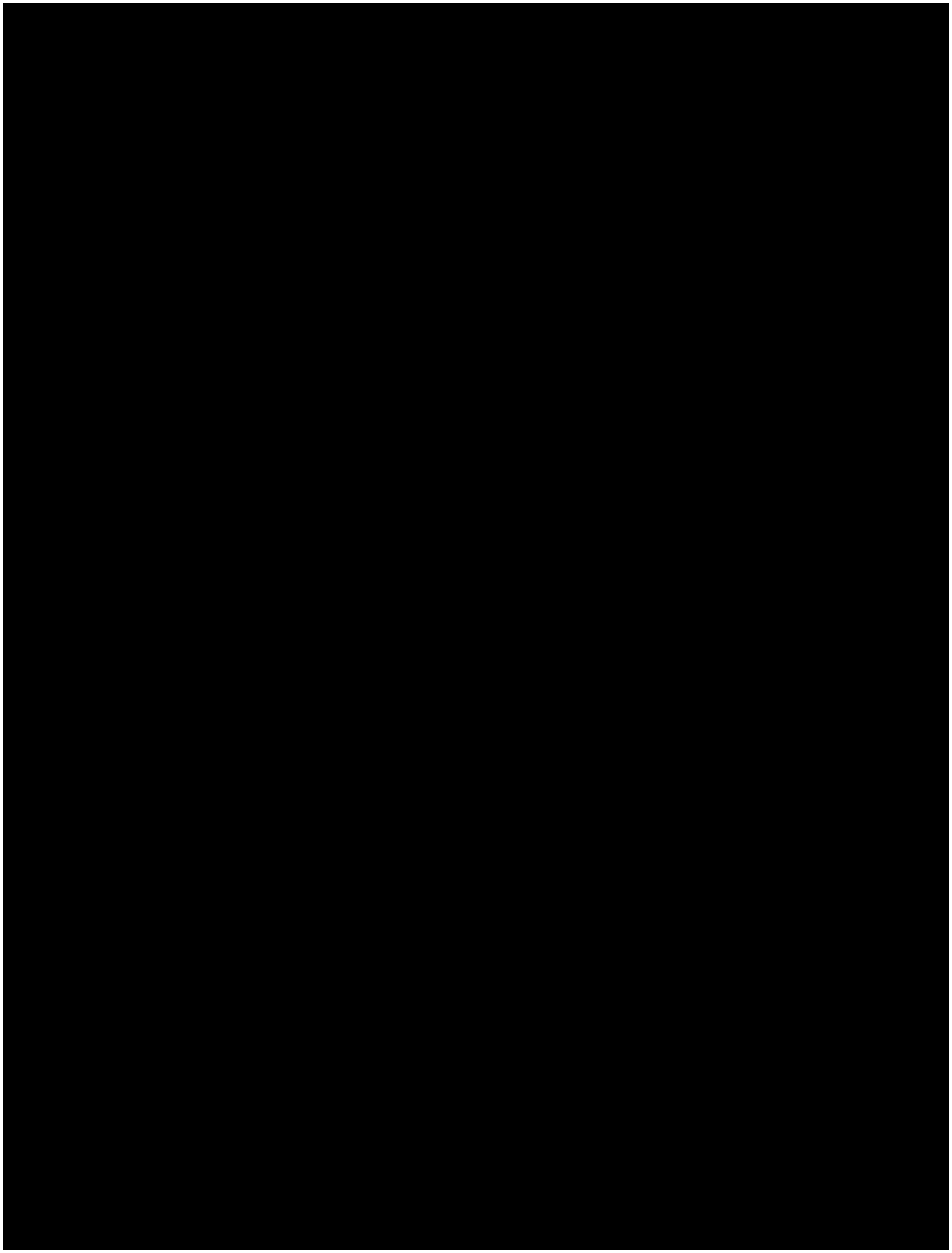
Action #4: Clarify or Modify policy to permit staff to contact 911 in response to emergency medical situations. Staff must have permission to identify and respond in an emergency.

Action #5: Research the use of independent investigators to complete investigations on all deaths.

Thank you for agreeing to lead the External Recommendations Team. You and I may not always agree but I know that we both want people with disabilities to be safe and respected and live their best possible life.

Sincerely,

Melissa Stone, Director
Division of Developmental Disabilities Services
Department of Human Services



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From: Tom M. Masseau <TMasseau@disabilityrightsar.org>
Sent: Friday, October 23, 2020 10:45 AM
To: Melissa Stone <Melissa.Stone@dhs.arkansas.gov>
Subject: Booneville Human Development Center (BHDC) Death Investigation
Importance: High

[EXTERNAL SENDER]
Melissa,

I wanted to send this investigative report to you myself, since we previously communicated about your office's efforts to reexamine the use of restraint at the HDCs. Preventing events like this is a necessary goal and we hope that this galvanizes your effort to do so. The use of restraints on individuals at the Human Development Centers has been an issue we have been asking the state to

address for over eight years with little to no progress.

This death at Booneville Human Development Center (BHDC) was a tragedy that arose from a dangerous and barbaric practice and should have never occurred. Aside from this gentleman's death itself, the way the investigation and this gentleman's family were treated was unacceptable. I am astounded that this death did not result in any findings from any agency tasked with investigation. The conclusion from the administrator that nobody could have done anything differently and that there was no need to reevaluate policies or practices is a short-sighted, if not lazy evaluation of this event. Yet the most important aspect of the death, the use of restraint, was never mentioned to EMS or those who might have investigated this incident outside of DHS. We can only speculate as to the motivation behind such a cursory review of this death, but we do not have to guess whether the BHDC residents and their families deserved better than this. David deserved better than this.

In January 2016, we issued a report on the use of restraint at Booneville Human Development Center and DDS spent more time defending the Center and the state than doing something about the use of restraint. For the sake of David and others within the Human Development Centers, I certainly hope DDS will spend more time implementing new procedures on the use of restraints, conducting more thorough investigations and holding individuals accountable for the lack of reporting.

Once again, I want to state that if this incident happened in the community within the confines of someone's home there would be different outcome in the reporting and accountability. Individuals entrusted in the care of DDS deserve the same amount of dignity and respect as those living in private homes.

I certainly hope that you will give serious consideration to these recommendations. I look forward to hearing from you.

Thank you,

Tom Masseau
Executive Director

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ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

1. **Purpose**. This policy is intended to provide guidelines for managing challenging behaviors of individuals residing in DDS operated programs (Human Development Centers).

2. **Scope**. This policy applies to all DDS operated programs (Human Development Centers) and their employees/volunteers. All such programs will include a review of this policy as part of the employee orientation process.

3. **Definition of Terms**

Behavior management, as covered by this policy, serves as a guide to ensure that an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others are managed with the least restrictive method. Behavior management is not a substitute for other forms of active treatment and is incorporated into program plans, based on individual needs.

Qualified Mental Retardation Professional (QMRP) or QMRP designee is used in this policy as a person designated to monitor, supervise, and make decisions regarding specific behavioral situations. QMRP/designee will be assigned by the administrator of the DDS program in which he/she works. Criteria for selection will involve prior training, experience, and demonstrated ability in the area of behavioral management. The QMRP/designee must be in a position that is on a level involving supervisory or decision-making responsibilities. The QMRP designee is authorized to perform any of the duties of the QMRP as outlined by regulations or policy.

Interdisciplinary Team (IDT) is defined as a group of persons (professionals, paraprofessionals and non-professionals) who develop an individual's program plan and whose participation is required in order to identify the needs of the individual and to devise ways to meet those needs. The IDT includes the individual and may also include those persons who have worked or will work most closely with the individual, those persons who provide needed assessments or services, and the individual's family, guardian, or advocate. In general, the IDT includes persons professionally qualified in such fields as health care, education, psychology, and social work.

Licensed nurse is defined as a registered nurse or licensed practical nurse. The agency may use a physician, in lieu of a licensed nurse, but this is not required.

Replacement: This policy replaces DDS Commissioner's Policy 3011-D, dated January 28, 1981, March 13, 1981, and DDS Director's Policy dated October 1, 1991; December 1, 1993; and January 30, 1998.

Reviewed: Arkansas Legislative Council Rules and Regulations Subcommittee _____, 2003



Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

4. Policy

NOTE: It is the philosophy of the agency to utilize all positive approaches to behavior management prior to and in conjunction with more restrictive programmatic techniques. Positive approaches may include, but are not limited to: positive reinforcement, gentle teaching, redirection, graduated guidance, and modeling of appropriate behaviors. Measures to address positive behavior should be incorporated into formal program efforts to the extent feasible.

Efforts at positive programming prove to be successful with the majority of maladaptive behaviors. All Human Development Centers will maintain policies and procedures for positive programming. The use of behavioral programming other than positive is designed for the individuals who repetitively engage in dangerously aggressive behavior and for whom other interventions have not been effective. All behavior programs developed in accordance with this policy will be designed to reduce or eliminate the target behavior(s) within a specified time frame, will be supported by documentation that positive, less restrictive methods have been systematically attempted and failed, will be monitored regularly by the individual's QMRP and Interdisciplinary Team (IDT), and will be revised if proved to be ineffective. The potential harmful effects of each procedure will be weighed carefully against the harmful effects of the targeted behavior and the IDT will determine if the harmful effects of the behavior outweigh the potentially harmful effects of the procedure.

Category I:

Category I procedures are those which may be used without prior approval of the Human Rights Committee or psychology staff. To ensure consistency, they should be addressed by the IDT. Frequent use (as determined by IDT) of these procedures with an individual indicates the need for consideration of the development of a behavior plan by the individual's IDT.

The individual must be supervised during these procedures. With the exception of verbal intervention, any use of Category I procedures, whether part of a formal behavior program or not, requires documentation on a Behavior Incident Report, Data Sheet, or other locally used behavior documentation system.

A. Verbal Intervention: Verbal intervention is utilized to stop an inappropriate behavior in progress and involves telling the individual "no" or "stop", identifying the behavior, and redirecting to an appropriate activity. The command is given in a firm but normal tone of voice. Threats, screaming, yelling or issuing repetitive or multiple sets of commands are not considered verbal correction and are inappropriate.

B. Separation From Activity Up to 30 Minutes: The individual is prevented from engaging in a reinforcing activity in which he/she has displayed inappropriate behavior. Separation is maintained within the same room or outdoor area where the activity is conducted. This is considered a Category I procedure if compliance by the individual can be

accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

C. Separation From Setting Up to 30 Minutes: The individual is removed from the area where the reinforcing activity is taking place. Separation must occur under observation either outdoors or in a living or training area (bathrooms, storage rooms and closets do not constitute living/training area). This is considered a Category I procedure if compliance by the individual can be accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

Note: Separation to Allow Calming (STAC) – Also available is the positive procedure of STAC whereby the person is encouraged to move to an area away from the person or situation that upset them. At the same time, they are assisted in directing their attention to talking about the problem, listening to music, talking about family, relaxing quietly, going for a walk, etc. The activity should be chosen by the person in need of calming. When sufficiently calm, staff will assist the person in resuming normal activities.

D. Assignment of Additional Chores: The individual is assigned additional chores as a consequence for inappropriate behavior. Additional chores may be assigned only if such chores are already a part of the Individual Program Plan (IPP) and are not designed to replace work assignments of housekeeping personnel.

E. Restitution: The individual is cued to restore any property damaged, stolen or defaced. If appropriate to the individual's level of functioning, he/she may be cued to offer a verbal apology to the offended person. If appropriate to the individual's ability to comprehend, monetary reimbursement for the value of the damaged or stolen property may be required if this is a part of the IPP. In lieu of full value, a symbolic portion of the value may be required. Monetary reimbursement requires Human Rights Committee approval and Guardian consent.

Note: The individual is not degraded nor put on display while restoring damage. The individual is given the same equipment and protection to complete the restitution as would normally be given to a person not responsible for the damage.

F. Withholding Privileges: The individual loses a particular privilege following the occurrence of an inappropriate behavior. Privileges include such things as special planned community activities. However, trips off grounds are special and should only be curtailed if problem behavior is anticipated during that trip. Examples of situations where problem behaviors may be anticipated include a problem behavior having already occurred and the person is not fully calm, or, a problem behavior has not yet occurred, but there are indications that a problem behavior is likely. The curtailing of trips off grounds should be done after consultation with psychology staff, or with supervisory staff if psychology staff is not available. Privileges do not include basic living activities, such as meals, habilitation activities, or basic rights afforded all individuals.

G. Personal Property Removal (less than one hour): Removal of an individual's personal item that is being used in an inappropriate or unsafe manner or location. For example, if an individual disturbs others in a common TV room by playing his radio too loudly and will not reduce the volume when instructed, the radio may be removed from that individual for a time not to exceed one hour. The item will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate (See Section 6, *Page 8 of 9*).

Category II:

Category II procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian.

A. Response Cost: The individual loses reinforcers previously earned in a behavior management system, (i.e., Token Economy Program)

B. Overcorrection - includes the following procedures:
   1) Restitutional Overcorrection: Requires the individual to restore the environment to a state that is better than it was before the occurrence of the inappropriate behavior.

   2) Positive Practice Overcorrection: Requires the individual to engage in an intensive practice period in which the alternative appropriate behavior is practiced.

C. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or individual directly, as appropriate. This procedure is considered Category II if the individual voluntarily (without duress or coercion) surrenders the property upon request.

Category III:

Category III procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, other professionals, as indicated by the nature of the program, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian. The individual's record documents the IDT's conclusion that the potential harmful effects of each restrictive procedure (restraint, etc.) are clearly outweighed by the harmful effects of the targeted behavior.

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A. Separation Time Out (Activity or Setting): Placement of an individual in a quiet area away from reinforcing activities or persons as a result of an inappropriate behavior occurring. The individual will be visually monitored during the time out. Further conditions include ***either:***

1) Separation lasting for over 30 minutes to one (1) hour maximum.

2) Separation (any length of time) requiring physical intervention/personal restraint to ensure compliance.

B. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate. This procedure is considered Category III if the individual does not voluntarily surrender the property upon request, and it must be physically removed.

C. Sensory Deprivation: Involves the temporary impeding of one of the individual's senses for a period of time, contingent upon the occurrence of the target behavior. Most often, this procedure includes only the use of a blindfold or cloth placed over the individual's eyes when it has been shown to facilitate calming. The individual must be visually supervised during the use of this procedure, which may be used in combination with other Category III procedures, as designated in the individual program. It could also include lessening auditory input by covering the individual's ears, or covering a body part (usually the hands) to limit tactile stimulation, hand in mouth, or biting.

D. Restraint: When utilizing restraint as a programmatic option, a hierarchy of lesser restrictive procedures will be attempted prior to restraint, except in limited cases where this is clearly clinically contraindicated. IDT consideration will be given to parent/guardian notification of the use of restraint and address it in the behavior program.

1) Personal Restraint: **In order to prevent personal injury or serious property damage**, the individual or a portion of an individual's body is immobilized by another person or persons in order to prevent personal injury or serious property damage. Approved methods of intervention must be in the individual's behavior program. This is planned personal restraint, contingent upon occurrence of a target behavior. When available, a licensed nurse should monitor the personal restraint and/or check the individual's physical condition as soon as possible following restraint.

Excluded as personal restraint are: physical assistance, prompting of graduated physical guidance to assist individuals during such procedures as toothbrushing and feeding, or to control random head or arm movements during such procedures

as haircutting, or the use of physical assistance in escorting, redirecting, or in manual guidance techniques are not considered personal restraint and do not require documentation as personal restraint. Also excluded as programmed personal restraint is the use of personal restraint in an emergency situation (Section 6, ***Page** 8 of **9***) or during a necessary medical or dental procedure.

In the event of personal restraint, the QMRP/designee of the area must be notified as soon as possible. Programmed personal restraint will occur until the individual is calm and will not exceed fifteen (15) minutes. The IDT will define what constitutes calm behavior for this individual when used in a behavior program.

2) Mechanical Restraint: **In order to prevent personal injury or serious property damage,** the individual or a portion of the individual's body is immobilized until calm by an approved device or devices which may also prevent normal functioning, as described in section C, above. Restraints must be checked for safety and integrity prior to use. The device's use will not exceed 15 minutes without an extension of time approved and documented by the QMRP/designee, preferably, after face-to-face attention. Unless otherwise determined by the IDT, QMRP/designee extensions will be obtained every 15 minutes until the individual is calm. The IDT should define what constitutes calm behavior for this individual when used in a behavior program. Unless determined clinically contraindicated by the QMRP/designee, should the time in restraint reach 55 minutes, the individual must be released for five minutes for motion, liquid intake, or toileting.

Should time in restraint reach 1 hour and 50 minutes, the individual must be released for at least 10 minutes–for motion, liquid intake, or toileting. If this 10-minute release is judged to be a danger to the individual and/others, additional staff should be called to ensure safety for all concerned. In addition, the individual will be checked, face to face, at least every 15 minutes for safety, well being, and integrity of the restraint. Constant observation is required.

Note: On-site monitoring by the QMRP/designee is recommended. When available, a licensed nurse should monitor the mechanical restraint. If unavailable to monitor, a licensed nurse shall check the individual's physical condition as soon as possible following restraint, but in no case later than thirty minutes after the initiation of the restraint.

Excluded as programmed mechanical restraint is the use of restraints in an emergency situation (Section 6, *Page 8 of 9*), during a necessary medical or dental procedure, or to promote healing following a medical procedure or injury. Devices such as a helmet which are not prescribed for the purpose of restricting an individual's movement and/or normal functioning, but rather for their safety and protection are not considered a mechanical restraint.

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

Note: For medical management, please refer to local site Policy on drugs to manage behavior (Behavior Management/Psychiatric Interventions).

5. **Conditions for Use of Behavior Programs.**

A. A formal behavior program will be developed by the IDT, written by a licensed psychological professional, and approved by a psychologist. It will include the following elements:

1) Description of the behavior to be modified;
2) Functional Analysis;
3) Thorough description of each step of the program to include duration and intensity of specific procedures, the methods of monitoring and analyzing the process, and special precautions that will be taken;
4) Description of any alternatives to the specific procedures;

B. The Individual Program Plan or behavior program will include:
1) Description of all procedures already attempted;
2) Side effects and risks, if any, of the intervention, in comparison with those of allowing the maladaptive behavior to continue; and
3) Behavioral objectives.

C. Behavior Management Procedures should be used in order of least restrictive, unless clinically contraindicated. Exceptions to this order must be fully documented and substantiated as to why more restrictive procedures are advisable before less restrictive ones.

D. All persons administering Category II and III procedures must have been trained in the administration of those specific procedures and have personally experienced those particular procedures, unless medically contraindicated for that person.

E. The Human Rights Committee will review all Category II and III programs at least every 6 months.

F. IDT consideration will be given to seeking consultation from outside expertise when IDT staff resources have been exhausted, as evidenced by the use of Category III procedures for over one (1) year without significant progress. If an outside consultant has been used without success, the agency should continue to access this or other outside expertise until an effective strategy is realized.

An outside consultant is defined as a professional of any discipline and who is not a member of the IDT. For instance, the outside consultant may be a member of the HDC

staff not on the identified IDT, the agency staff, or a professional not affiliated with the agency.

6. **Emergency Procedures**. Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. This includes the use of restraint procedures in the course of an established program, when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy. However, it is emphasized that emergency procedures may not be used at frequent intervals, becoming a routine method of intervention. If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. The emergency use of restraint must conform to ICF/MR regulations and must be reported immediately to the facility administrator or designee.

7. **Prohibitions**: These activities are expressly prohibited.

   A. Corporal punishment - refers to the application of painful stimuli to the body as a penalty for certain behavior, and includes, but is not limited to, hitting, pinching, the use of electrical shock or other infliction of pain, whether or not applied as part of a systematic behavior intervention program.

   B. Individuals who receive services from the agency disciplining other individuals unless involved in an organized and approved self-governing program. Individuals will not participate in the actual administration of discipline.

   C. Seclusion of an individual alone in a room or other area from which entry/exit is prevented. This does not include placement in a time-out area for brief, programmed time segments, as part of a behavior program that meets all applicable standards.

   D. ***Unless specifically requested by family/guardian,*** any procedure that denies visitation or communication with family members.

   E. Any procedure that denies sleep, shelter, bedding, food, drink, or use of bathroom facilities.

   F. Inappropriate vocalizations, maltreatment, neglect, or forced exercise.

8. **Informed Consent**. The individual served and/or guardian, as appropriate, will be provided a copy of the behavior program which utilizes Category II and III procedures. Informed consent will be obtained PRIOR to the implementation of the program, with the following procedures:

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A. Persons 18 years of age or older who have no legally appointed guardian may give informed consent for their behavior program. If there is a question about the individual's ability to give informed consent and no guardian can be located, appropriate legal action must be pursued to have someone appointed who can give consent.

B. Consent by the legal guardian(s) is required if guardianship has been established.

C. The legally adequate consent will:
1) Specify, in terms that are easily understood, the restrictive or intrusive procedure(s) involved;
2) Inform the person(s) giving consent of any potentially harmful effects of the procedure(s);
3) Be time-limited, not to exceed one year; and
4) State that consent may be withdrawn at any time.

9. **Uncategorized Procedures**. In the event a proposed procedure does not readily fit in one of the prescribed categories, it may be utilized on an emergency basis, if necessary, at the discretion of the administrator or designee until the appropriate category is determined.

NOTE: Behavior Management Policy 3011-D does not preclude the use of other restrictive/intrusive procedures that would prevent serious bodily harm and/or destruction of property or death. These procedures can only be considered when lesser restrictive procedures have been proven ineffective or their implementation are determined to be clinically contraindicated. Approvals required are the same as those for Category III procedures. Additional approvals may be required as deemed necessary by the facility administrator.

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

DHS PRETRIAL BRIEF

COMES NOW Respondent, Arkansas Department of Human Services, by and through its counsel, Rich Rosen, and submits the following facts, points, and legal authorities which support its denial of liability herein and the denial of the claim submitted by Claimant, Christine McAuliffe, as Special Administrator of the Estate of David Cains:

"These are people that we deeply care about. This is not just a job."

Amanda Schmitt, LPN
Booneville Human Development Center
Deposition transcript p. 58
Deposition Summary, p. 8

Prologue

Although dozens of depositions were taken by Claimant and several by DHS, the factual and legal issues presented are not complicated. As more fully explained below, the threshold issue before the Commission is whether, under Arkansas law, the Booneville Human Development Center (hereinafter "Booneville" or "BHDC") was negligent and, if so, whether that negligence caused the death of Mr. Cains. On this issue, Claimant has the burden of proof. The burden of proof is always on the party asserting negligence, as negligence is never presumed. *Taylor v. Texas Gas Transmission*, 2012 Ark. App. 625, *7 citing *Mangrum v. Pigue*, 359 Ark. 373 (2004).

In Arkansas, the essential elements of a negligence claim are (1) the existence of a duty on the part of the defendant to conform to a specific standard of conduct; (2) breach of that duty by the defendant; (3) injury to the plaintiff actually and proximately caused by the defendant's breach; and (4) resulting damages to the plaintiff. *Peregrine Trading, LLC v. Rowe*, 2018 Ark. App. 176, 17 (emphasis added).

It has long been held that **"[f]oreseeability is an essential ingredient of negligence"** *Dollins v. Hartford Accident & Indemnity Co*., 252 Ark. 13, 18 (1972) (empahasis added). "Conduct becomes negligent only as it gives rise to appreciable risk of injury to others, and there is **no** negligence in not guarding against a danger which there is no reason to anticipate." *Ethyl Corp. v. Johnson,* 345 Ark. 476, 481 (2001). **"In other words, "negligence cannot be predicated on a failure to anticipate the unforeseen."** *Id. citing Keck v. American Employment Agency, Inc.*, 279 Ark. 294, 299 (1983).

Due to the several volumes of relevant facts stated established through deposition, and in order for the Commission for more fully understand DHS's evidence and arguments, it is crucial for the Commission to review the DHS Deposition Summaries of the individuals identified below. These DHS Summaries include many quotes from the witness testimony *in lieu of paraphrasing* key testimony and, where necessary for a clear understanding of both the *substance* and *context* of the witness testimony, the DHS Summaries included the actual dialogue of the testimony and "notes for context" so the Commission can see what was actually said by the witness and, where appropriate, a footnote for context.

- Tyler Mattson
- Amy Jones
- Amanda Schmitt, LPN
- Scott Scow, EMT
- Jennifer Berry, BHDC Assistant Superintendent
- Ted Kastner, M.D.

- Dian Elliott, OLTC Surveyor
- Rickie Brown-Forestiere, M.D.
- Janice LeBel, Ph.D.

Dr. Kastner's opinions, with the detailed medical and factual bases therefore, are contained in Dr. Kastner's Reports of January 5, 2023 and January 6, 2023, introduced in his deposition as Kastner deposition Ex. 2A and 2B. The two Reports are now **DHS Exhibits 2A and 2B** and are quite extensive in nature. Dr. Kastner's extensive Curriculum Vitae is **DHS Exhibit 1**.

Factual Summary

Claimant, Christine McAuliffe, as Special Administrator of the Estate of David Cains, seeks damages against the Arkansas Department of Human Services ("DHS") for the death of David Cains on June 13, 2020. At the time of his death, Mr. Cains had been a resident of the Booneville Human Development Center ("BHDC") for approximately 13 years. Mr. Cains had been [redacted] *See* McAuliffe depo. p. 13, lines 12-19.

Mr. Cains tragically died during an aggressive behavioral episode where, from a seated position in a lobby chair location where he sat in order to calm down, he abruptly jumped up, tore paper off the wall, and charged Mr. Mattson, with such force and impact that, during the ensuing struggle, the two toppled over onto the floor. The behavior episode occurred in the lobby of the Commons Building just outside the doors to the lunchroom at lunchtime. Due to the hour, the building was filled with BHDC residents and staff. [1]

[1] In his written statement made during the BHDC internal investigation, Mr. Mattson described in the initiation of Mr. Cains' behavior towards him as "he then jumped up after me." *See* **Mattson statement - DHS Ex. 13** (emphasis added)**.** At his deposition two years later, Mr. Mattson

Mr. Cains' aggressive behavior continued on the floor, unabated, requiring staff to employ an emergency physical hold for Mr. Cains' safety and the safety of staff. Emergency holds are a form of physical restraint expressly authorized for safety in 42 C.F.R. §483.450, the CMS State Operations Manual (known as Appendix J) [**DHS Ex. 3**], and DDS Policy 3011-D [**DHS Ex. 4**].

Unfortunately, Mr. Cains' behavioral episode continued while on the floor and he did not calm. [redacted]

characterized Mr. Cains' act of jumping after him as "charging" him. *See e.g.* **Mattson depo. pp. 100. 101**. It has also been characterized as "lunging" at him.

This is significant because it is anticipated that Claimant's narrative of the facts will ignore that part of the written statement or even argue that Mr. Mattson's interchangeable descriptions of "jumping up after him," "charging him" or "lunging at him" are somehow inconsistent or changed.

For example, Dr. LeBel, Claimant's restraint prevention expert, ignored Mr. Mattson's written statement in her rendition of the facts as if he didn't mention it all at in his statement. *See* Lebel depo. p. 37; summary, p. 3. Although her opinion relied extensively on Mr. Mattson's written OLTC statement, she overlooked this key point. It is unclear whether this omission was inadvettent or intentional.

Also, Claimant herself claimed in her testimony that Mr. Mattson's story had changed. *See McAuliffe* depo. pp. 85-86. Such was not the case.

[redacted] Dr. Brown-Forestiere, Claimant's *own* medical expert, testified: **"Without any intervention, someone who suffocates will likely die within five minutes." Brown-Foresterie depo, pp. 20-21**. She then acknowledged **"It did take the paramedics 13 minutes to get there."** The BHDC is in rural Logan County. [redacted] **(DHS Ex. 12)**. [redacted]

Dr. Brown-Forestiere agreed that Mr. Cains was restrained while on his left side, and that she would want somebody who is vomiting to be placed on their side, and not on their back. Brown-Forestiere, depo pp. 56-57. Although Dr. Brown-Forestiere *initially* expressed concern that Mr. Cains was placed on his back too quickly thereby causing him to choke, she later resolved her

initial concerns and testified: "**My opinion is that he choked from vomiting when he was on his left side.**" Brown-Forestiere, depo. p. 61.

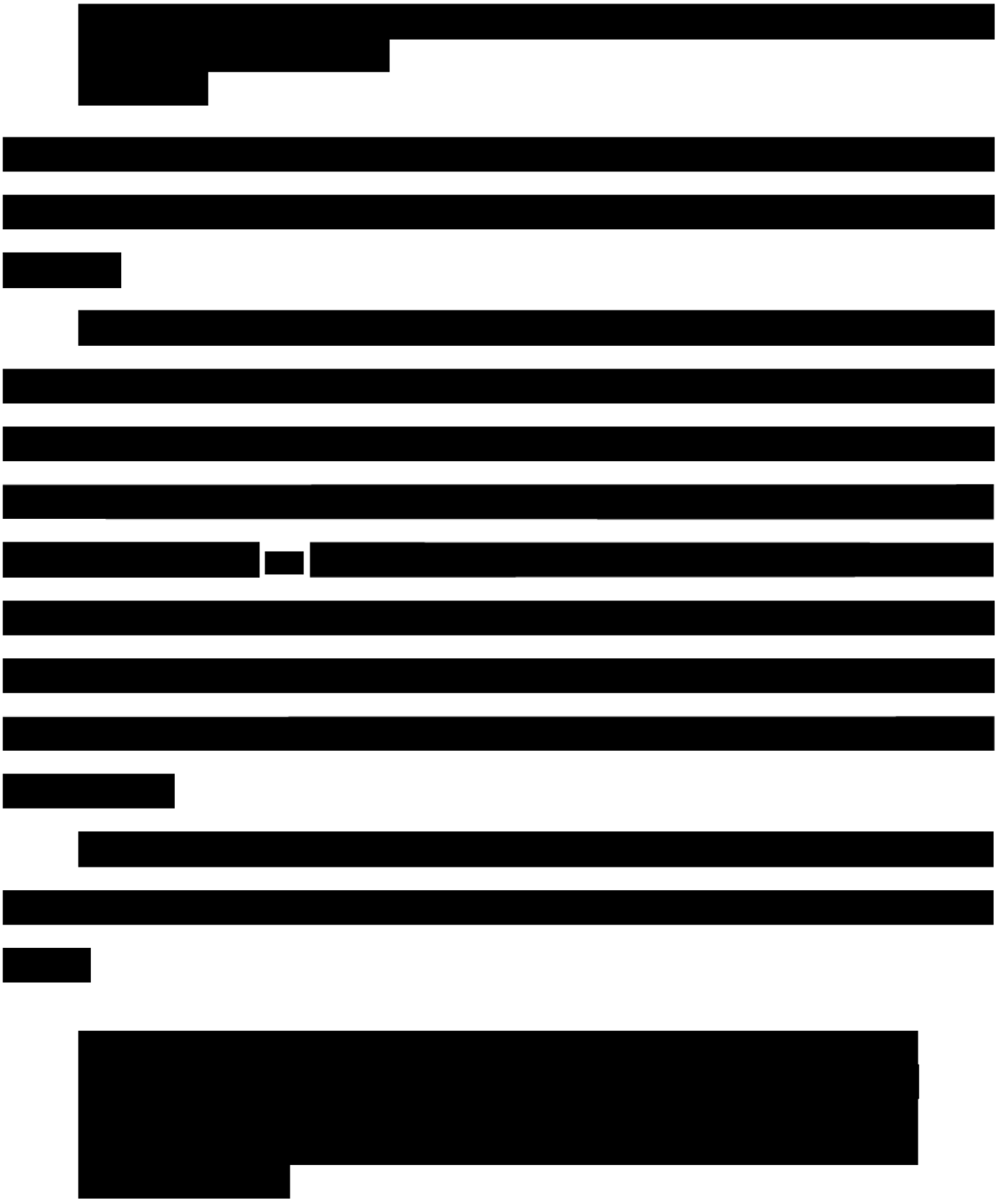
Although Dr. Brown-Forestiere is a relatively new physician, having just completed her residency, according to her C.V., in June, 2021, she opined that that the struggle with Tyler Mattson caused Mr. Cains to vomit, [redacted] Dr. Brown-Forestiere depo. p. 14.

However, when asked about the intensity of the struggle, Dr. Brown-Forestiere admitted:

> I - - I would ***assume*** that it was an intense struggle. **But, no, of course, I have not way of knowing exactly how intense it was."** Brown-Forestiere depo. 69.[2]

[redacted]

[2] Dr. Brown-Forestiere's testimony is purely speculative and does not rise to the standard of a reasonable degree of medical certainty. In Arkansas, the burden of proof is always on the party asserting negligence, as negligence is never presumed. *Taylor v. Texas Gas Transmission*, 2012 Ark. App. 625, *7 citing *Mangrum v. Pigue*, 359 Ark. 373 (2004). Although a party may establish negligence by direct or circumstantial evidence, he ***cannot rely upon inferences based on conjecture or speculation***. *Id*. (emphasis added).



[redacted]

Moreover, Dr. Kastner, a physician board certified in four specialties, including Developmental and Behavioral Pediatrics and Neurodevelopmental Disabilities, with over 40 years experience clinically treating individuals with intellectual disabilities and developmental disabilities, who has been award millions of dollars in research grants, has 70 peered reviewed publications, who was a full professor of medicine at Albert Einstein College of Medicine in New York City, whose public service included appointment as the New York State Commissioner overseeing the New York state department that provided services to 121,000 developmentally disabled and the intellectually disabled individuals (*see* **C.V. – DHS Ex. 1**), opined, among other things:

- To a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting was not [redacted] *See* Dr. Kastner Report dated January 5, 2023 - **DHS Ex. 2A, pp. 9, 14**

[3] The Arkansas Supreme Court has "made it clear in Arkansas that the failure to guard against an occurrence that is not reasonable to anticipate is not negligence**.** *Browning v. Browning,* 319 Ark. 205, 209 (1995) citing *Benson v. Shuler Drilling Co.,* 316 Ark. 101 (1994). (emphasis added). Consequently, applying Arkansas law to Dr. Hamid's testimony, as the treating physician, it is not foreseeable that David Cains would choke to death on vomit [redacted]

- To a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting was not due to the restraint. *See* Dr. Kastner Report dated January 5, 2023 - **DHS Ex. 2A, pp. 9, 15**
- To a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting was [redacted] *See* Dr. Kastner Report dated January 5, 2023 - **DHS Ex. 2A, pp. 9, 20.**

Consistent with both Dr. Hamid's opinion and Dr. Kastner's opinions that the cause of the vomiting was [redacted] (**DHS Exhibits 2A, 2B**), Amanda Schmitt testified that she had previously removed Mr. Cains from his scheduled activities a few times because she felt he was too *overwhelmed* to go to class that day or to his work area or to go to Commons to eat, and placed him back at the dorm. Schmitt depo. p. 8. Mr. Mattson also testified his deposition, that he Mattson noticed Mr. Cains becoming agitated in the lunchroom, removed him, and took him to the bathroom, after which, Mr. Cains asked to sit in a lobby chair to calm himself before the behavioral episode began. *See* Mattson depo. pp. 99, 100. **Dr. Kastner noted in his deposition that Mr. Cains was [redacted] to reduce Mr. Cains's vomiting**:

[redacted]

Kastner depo. p.54.

Even Claimant, Ms. McAuliffe, testified Mr. Cains' stomach would get upset when he got anxious and, at times, vomit, but not often"

Q: Did you ever notice that he would vomit at times?
A: When he was upset, or just in general?
Q; Anytime?

> **A:** Yeah. I mean, his whole life he dealt – you know he had stomach issues. Like if he ate certain things, his stomach would get upset, and *when he got anxious*. His stomach would get upset.
> **Q:** So, he would vomit often"
> **A:** I wouldn't say that he vomited often, no.

McAuliffe depo. pp. 29-30.

Dr. Kastner also opined, to a reasonable degree of medical certainty that Mr. Cains, a 6'2", approximately 250 pound obese man, [redacted], and who resided in a facility based institution, had a life expectancy of six more years. *See* Kastner January 5, 2023 Report, pp. 10, 51. Significantly, Claimant's offered no contrary medical expert testimony or opinion.

What is the Booneville Human Development Center ("BHDC")?

The Booneville Human Development ("BHDC") is an intermediate care facility for adults with intellectual disabilities. Berry depo. p.8. BHDC trains individuals in:

- Independent living skills
- Pre-vocational skills, and
- Behavioral management.

Ms. Berry explained the BHDC was originally the Arkansas Tuberculosis Sanitorium opened in 1909. In 1973, it switched to a Human Development Center, then called The Children's Colony. Berry depo. p. 9. It is facility-based care for adults with developmental disabilities. *Id*. There are five Human Development Centers in Arkansas. *Id.*

BHDC's main campus is 1,000 acres with dormitory-style cottages where the residents live. BHDC has both new and old buildings. BHDC is also in the process of building additional buildings. BHDC also has its own water treatment plant and sewer plant.

The State of Arkansas has invested money into BHDC and is committed to BHDC, as evidenced by the new construction on campus. Berry depo. pp. 16-17. BHDC is located in Logan

County and **employs approximately 250 people.** Berry depo., pp. 16-17. Ms. Berry described the newly constructed buildings and those currently under construction. *See* Berry depo., pp. 18-19; *see* **DHS Ex. 6A-6E** (photos of new buildings – Berry depo. Ex. 2A, 2B).

Aside from HDC facility-based services, the State of Arkansas offers the IID population other service options, as well. In addition to admission to Human Development Centers, Individuals may elect to:

- Reside in their home and receive community-based waiver services;
- Reside in small, privately owned, ICF-IIDs who provided their services;
- Reside in and receive services in group homes; and
- Reside in nursing facilities.

See Berry depo. p. 9. These community-based service options were available in 2020 and in the years before 2020. Ms. Robinson, in her deposition, confirmed that community-based services were available for David Cains and stated "I explored them" but that she choose the BHDC because it was a good placement. *See* Robinson depo. p. 69, lines 16-25.

As Ms. Berry explained, admission to the BHDC is voluntary. A resident's continued stay at the BHDC is also voluntary. There are no involuntary commitments at BHDC. All individuals who reside at BHDC are there because someone – family or legal guardian – wants them to be there. Berry depo. p. 10.

When an individual applies for HDC facility-based services, a DDS review team meets in order to determine if the criteria is met for the individual's placement in an HDC. Berry depo pp. 10-12, If the criteria is met, **each HDC will then look to determine if that particular individual would fit in their center**. *Id.* In other words, the HDCs review the individual's needs and determine *which* HDC the individual is properly suitable for. Ms. Berry explained that different HDCs cater to a different type of developmentally delayed individual. *Id.*

Individuals placed at BHDC must be ambulatory and are, typically, "dually diagnosed" individuals who have both a mental illness and intellectual disability. Berry depo. 12. The BHDC is licensed through State's Office of Long Term Care ("OLTC") and is CARF accredited. Berry depo. pp.12-13. CARF is a national organization that accredits facilities if the facility meets the CARF standards. *Id*. In June 2020, BHDC was a CARF accredited facility. CARF accreditation requires a facility to inspection. *Id.*

Ms. McAuliffe testified that prior to his death, she felt, overall, that Mr, Cains did well at BHDC. *See* McAuliffe depo. p. 125. She confirmed he was friends with lots of BHDC staff and she felt like the staff loved him too. *See* McAuliffe depo. p. 125 *See* McAuliffe depo. p. 125. Describing BHDC, Claimant testified "I was happy that he seemed to excel there." *See* McAuliffe depo. p. 126.

BHDC Population Characteristics – Majority Dually Diagnosed

Unlike the other HDCs, the BHDC "population is majority dually diagnosed" which means they have both an intellectual disability and a mental illness such as schizophrenia, bi-polar, depression, anxiety, ADHD, and behavior problems. Berry depo. pp. 49-50. **The BHDC admits dually diagnosed persons with "the most severe behavior outbursts."** *Id*. BHDC has a higher population of individuals with behavior problems than the other HDCs and many of BHDC clients come from the Arkansas State Hospital (commonly referred to as ASH), jail, and other inpatient facilities. They are funneled to BHDC.[4] *Id.*

[4] As BHDC has a higher population of residents with dual diagnoses of intellectual disability and mental illness, who are ambulatory with behavioral problems, it has higher instances of restraint use than other Arkansas HDCs. Consequently, any comparison of restraint use between BHDC and other HDCs would be like comparing apples to oranges. BHDC simply has a higher percentage of dually diagnosed individuals with behavioral problems than other HDCs.

The BHDC also accepts transfers from *other* Arkansas HDCs when "they can't behaviorally manage them at their particular center." Berry depo. p. 51. The "dually diagnosed" population at BHDC is currently 96 percent. In June, 2020, it was "probably between 90 and 94" percent. That is the way was at BHDC in 2014 through 2020. *Id.* Ms. Berry explained our population is different." As BHDC has a higher population of behavioral residents than other Arkansas HDCs. Berry depo. 52, line 13.

Resident Vocational Programs at BHDC

As stated earlier, the BHDC provides individuals with, among other things, vocational skills. Berry depo., p. 8. In fact, the vocational training was one of the many programs that Mr. Robinson, Mr. Cain's mother, considered when deciding to place Mr. Cains at BHDC. *See* Robinson depo, pp. 45-46.

In 2020, BHDC had two vocational programs for residents – recycling and rugs making. Berry depo., p. 21. David Cains work in recycling program. Berry depo. p. 24-25. Residents working in the recycling program separate recyclable materials, tear books, and use the shredders. BHDC picks up recyclable materials from businesses – paper, boxes, books – brings them to the center for the residents to unload materials, separate, shred, and put into the bailor. Berry depo. p. 22. The program gives residents purpose to their day and a skill set. *Id.* Residents in the rug program make rugs out of sock lops, which they sort, dye, and weave into rugs. Berry depo. p. 23.

`As part of the vocational program at BHDC, residents are taught "This is how much you have worked; this is how much you are going to get paid." Berry depo. p. 24-25. Residents then have a payday and can buy what they want at:

- The BHDC Canteen;
- vending machines; or
- go into town to a local business.

It teaches clients how to us money and clients go into Booneville and Ft. Smith to interact with the community, go to restaurants and movies with their pay. Berry depo. p. 26, 28.

Oddly, the 2015 DRA Report attached to the claim included a photo of a storage area of the Hamp Williams Building which DRA depicted as "trash and debris." The Hamp Williams building is the vocational training building and the bags actually contained the sock loops to make rugs. Berry depo. pp. 28-29.

BHDC is Regulated by the State Office of Long Term Care

The State's Office of Long Term Care is the state regulatory body for facilities licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities. BHDC's OLTC license was last renewed July 1, 2022. It was also licensed by OLTC in June, 2020. **BHDC is required to comply with CMS guidelines which are federal requirements.** CMS is the Centers for Medicare and Medicaid. *See* Berry depo. p. 14.

As part of the federal ICF/IID regulations, OLTC must inspect all Arkansas IFC/IIDs at least once per year and at other times. OLTC inspected BHDC in June 2020 *after* David Cains died and **found no regulatory deficiencies**. *See* Berry depo. p. 15; Elliott depo. pp. 16-17. Ms. Elliott, the federally trained and certified CMS surveyor, testified she surveyed BHDC for two complaints as a result of Mr. Cains' death and found the complaints to be "unsubstantiated."

Q: **And what was the outcome of that determination?**
A: That there were no deficient practices.

Elliott depo. pp. 16-17. *See also* **DHS Exhibits 5A, 5B, 5C** – the CMS Form 2567 survey results issued and the Survey Investigation Reports of OLTC. (**DHS Ex. 3**). A deficiency is where the facility is found to have done something incorrect. **OLTC, applying federal standards, issued**

no deficiencies to the BHDC as a result of Mr. Cains' death and determined the two complaints it received resulting from his death as "unsubstantiated."

Applicable Federal and State Restraint Standards

Because the BHDC is licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities, commonly referred to as an ICF/IID, it is governed by federal regulations and the CMS" State Operations Manual – Appendix J" which is the federally promulgated guidance from the Centers for Medicare and Medicaid Services, a federal regulatory agency governing all Medicare and Medicaid facilities nationwide. **Appendix J specifically applies to Intermediate Care Facilities for Individuals with Intellectual Disabilities.** The applicable provisions of Appendix J pertaining to use of restraints in ICF/IIDs, such as BHDC, are contained in **DHS Exhibit. 3.** The DDS Policy 3011-D governing resident "Behavior Management" **is DHS Ex. 4**.

As more fully explained below, both federal regulations - 42 C.F.R. §483.450 - and CMS Appendix J *expressly* authorize ICF/IIDs, such as BHDC, to employ physical restraints.

The CMS "State Operations Manual, Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities," **DHS Ex.3,** was introduced at several depositions, including at the deposition of Dian Elliott. These are the provisions which the BHDC must follow and upon which OLTC surveyors determine facility compliance. The restraint provisions of Appendix J are under the section titled: **"(d) Standard: Physical Restraints."** Appendix J includes both the applicable federal regulation and the corresponding CMS guidance.

The applicable restraint provisions are in the federal regulations and CMS Appendix J are as follows:

1. **Federal Code of Regulations:**

- 42 U.S.C §483.450(d) ***Physical restraints.***

(1) The facility may employ physical restraint only -

(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;

(ii) As an emergency measure, but only if absolutely necessary to protect the client or others from injury; *or*

(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

* * *

(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints, **released from the restraint as quickly as possible,** and a record of these checks and usage must be kept.

(emphasis added for convenience of identification)

2. **CMS State Operations Manual for Intermediate Care Facilities for Individuals With Intellectual Disabilities**

- The CMS State Operations Manual – Appendix J:
  - **Guidance** §483.450(d)(1)(ii): W296
    - "Physical restraint may be used as an **emergency intervention** only in situations where the client is **exhibiting behaviors** which:
      1) the client has not exhibited before;
      2) were not identified in the functional analysis; ***or***
      3) **are harming other people or themselves."** [5]

[5] The Arkansas Supreme Court has long held that the disjunctive "or" means, is a disjunctive particle which, in its ordinary sense, the word "or" marks an alternative, generally corresponding to "either," as "either this or that". *Bakalekos v. Furlow*, 2011 Ark. 505, *12. It is a connective particle that marks an alternative. *Id.* Thus, the presence of any one of the three behaviors is calls for the employment of emergency restraints

- **Guidance** §483.450(d)(4): W302
  - "As quickly as possible means as soon as the client is no longer a danger to self or others. Documentation should support that the client was released from restraint as soon as they became calm."

- **Guidance** §483.450(d)(1)(iv)(B): W280
  - " 'Physical restraint' is defined as any manual hold or mechanical restraint … which restricts the free movement of, normal functioning of, or normal access to a portion or portions of a client's body."

In addition to the federal provisions governing restraint use in an ICF/IID, such as the BHDC, Arkansas DDS has a behavior management policy, known as Policy 3011-D, which includes the provisions on the use of emergency restraints. Policy 3011-D, which is a DDS behavior management policy, addresses the use of there (3) separate "categories" of restraints in Section 4 of Policy 3011-D. These are "category" restraints and the rules governing "category" restraints depend on which category applies -- Category I, Category II, or Category III. Category restraints use addressed are in Section 4 of Policy 3011-D. DDS Policy 3011-D is **DHS Ex. 4**.

Not to be confused with the "category" restraints in Section 4 of Policy 3011-D are the "Emergency Procedures" in Section 6 of Policy 3011-D (emphasis in original). Section 6 "Emergency" restraints are *different* from Section 4 "Category" restraints. Even Mr. Cains' 2019 IPP, **DHS Ex. 10,** distinguishes between the use of "category" restraints and "emergency restraints."

Per **DHS Ex. 10**, **pp. 9-10 (Bates Stamped p. 1469-1471),** Mr. Cains 2019 IPP, at the bottom of the page in the "**Note**, provides:

> **Note:** The primary treatment for David's psychiatric condition is medication. In the event that symptoms [physical aggression] persist at a rate that interferes with programing, staff may employ *Category I procedures* (DDS 3011-D), TACT,

procedures, **or** *other Center emergency procedures if necessary, to protect from injury to client or others*. [6]

Relationship History with Family

Per the deposition of Claimant, Mr. Cain's sister, Mr. Cains went to live with other families in 1991 when he was 14 years old and, eventually, at the BHDC. *See* McAuliffe depo. p. 18. She testified that neither she nor her mother, Mr. Robinson, actually lived with David Cain after 1991. *See McAuliffe* depo, p. 18, 21. He would only come home for periodic visits after 1991. Claimant confirmed that Mr. Cains was sent away when he was 14 years old. *See* McAuliffe depo.

Ms. McAuliffe later moved to Vermont and visited Mr. Cains when she return to Arkansas which, according to Mrs. Robinson, was only "once or twice a year." Robinson depo. p. 78.

Ms. McAuliffe [redacted]

Ms. McAulliffe testified that David Cains was a tall and big man – 6'2" and weighed 250 pounds. McAuliffe depo. p. 110. She testified "I've been on the receiving end of his punch." *Id.*

Claimant Has the Burden of Proving Negligence – Including Foreseeability and Proximate Cause

The threshold issue before the Commission is whether, under Arkansas law, BHDC was negligent and, if so, whether that negligence caused the death of Mr. Cains. On this issue, Claimant

[6] *See* footnote 5 for Arkansas law on the meaning of the disjunctive "or." Just above the "note" the 2019 IPP identifies David Cains primary symptoms as "Noncompliance" and "Physical Aggression." *See* 2019 IPP, p. 9 (Bates stamp p. 1469).

has the burden of proof. The burden of proof is always on the party asserting negligence, as negligence is never presumed. *Taylor v. Texas Gas Transmission*, 2012 Ark. App. 625, *7 citing *Mangrum v. Pigue*, 359 Ark. 373 (2004).

In order to establish a prima facie case of negligence, a claimant must show that they sustained damages, that the defendant was negligent, and that such negligence was a proximate cause of their damages. *Id*. Although a party may establish negligence by direct or circumstantial evidence, he ***cannot*** rely upon inferences based on conjecture or speculation. *Id*. (emphasis added).

In Arkansas, the essential elements of a negligence claim are (1) the existence of a duty on the part of the defendant to conform to a specific standard of conduct; (2) breach of that duty by the defendant; (3) injury to the plaintiff actually and proximately caused by the defendant's breach; and (4) resulting damages to the plaintiff. *Peregrine Trading, LLC v. Rowe*, 2018 Ark. App. 176, 17 (emphasis added).

It has long been held that **"[f]oreseeability is an essential ingredient of negligence"** *Dollins v. Hartford Accident & Indemnity Co*., 252 Ark. 13, 18 (1972) (empahasis added). "Conduct becomes negligent only as it gives rise to appreciable risk of injury to others, and there is **no** negligence in not guarding against a danger which there is no reason to anticipate." *Ethyl Corp. v. Johnson,* 345 Ark. 476, 481 (2001). **"In other words, "negligence cannot be predicated on a failure to anticipate the unforeseen."** *Id. citing Keck v. American Employment Agency, Inc.*, 279 Ark. 294, 299 (1983). If risks of harm cannot be foreseen by a reasonably prudent and intelligent man, the risk is not unreasonable, hence there is no negligence, consequently, no liability." *North Little Rock Transp. Co. v. Finkbeiner*, 243 Ark. 596, 602 (1967). Moreover **"Arkansas law has long since recognized that there is no duty to guard against merely possible, as opposed to likely or probable harm."** *Ethyl Corp. V. Johnson,* 345 Ark. 476, 482 (2001).

"In short, to demonstrate foreseeability, the harm must be 'within the range of probability as viewed by the *ordinary* man,' and must, therefore, be more than 'merely possible.'" *Ethyl Corp. v. Johnson,* 345 Ark. 476, 482 (2001) citing *Larcson Machine, Inc. v. Wallace*, 268 Ark. 192, 208 (1980). "It is a matter of ordinary observation that frequently there is some danger attendant upon the most common and ordinary transactions, but the care required is only to provide against such dangers as ought to be foreseen in the light of the attendant circumstances, and the ideal "prudent person" will therefore not neglect what he can foresee as probable nor divert his attention to the anticipation of events barely possible, *but will order his conduct by the measure of what appears likely in the ordinary course of events*." *Ethyl Corp. V. Johnson,* 345 Ark. 476, 482 (2001) citing *St. Louis-San Francisco Ry. Co. v. Ward*, 197 Ark. 520 (1939) (italics original)

In Arkansas, "[t]he duty owed is not without bounds; rather, it is limited to the risk of harm that is reasonably foreseeable." *Ethyl Corp. V. Johnson,* 345 Ark. 476, 482 (2001) The concept of risk is thus an aspect of foreseeability. The Court explained:

> Courts are likely to use the term "foreseeable" to mean that harm was not only foreseeable but also too ***likely to occur*** to justify risking it without added precautions…. Along the same lines, when courts say that harm is ***unforeseeable, they may mean that although harm was actually foreseeable on the facts of the case, a reasonable person would not have taken action to prevent it because the risk of harm was low, and harm was so improbable that a reasonable person would not have taken safety precautions***. [Footnote omitted.]

Ethyl Corp. V. Johnson, 345 Ark. 476, 482-483 (2001)

Significantly, the Arkansas Supreme Court has **"made it clear in Arkansas that the failure to guard against an occurrence that is not reasonable to anticipate is not negligence.** *Browning*

v. Browning, 319 Ark. 205, 209 (1995) citing *Benson v. Shuler Drilling Co.,* 316 Ark. 101 (1994). (emphasis added).

Based on the established facts of this case and applying the applicable law stated above, it was not foreseeable that David Cains would vomit, choke and die during his behavioral episode. Moreover, neither the restraint, struggle, [redacted] was the proximate cause of Mr. Cains' death.

Tragically, Mr. Cains became agitated in the lunchroom and was the removed to the bathroom and to the lobby to calm down. Then, from a seated position, Mr. Cains suddenly jumped after and charged Mr. Matteson with sufficient momentum and force as to cause them both to topple to the floor. As Mr. Matteson described it, he was standing about 6-7 feet away **when David Cains charged him, he "was running after me" and grabbed me."** Mattson depo. p. 101. He then testified:

> **Q: And then what – what did you do?**
> **A: I tried to hold him and we kind of just *fell*.**
> **Q: How did you try to hold him? Stand up and show us, please.**
> **Like, I was – like, I just kind of grabbed him by the shoulders the best as I could , you know, with him – *momentum* –**
> **Q: Yeah.**
> **A: -- and we just kind of *stumbled over*, you know.**
> * * *
> **A: Like we tripped. Like – like, we just kind of fumbled around. Because it was, like, all in *one big momentum*, you know**

Mattson depo. 102-103. He further explained **"He [Mr. Cains] fell and I kind of went with him, as far as I can recall."** Mattson depo. 105.

Unfortunately, Mr. Cains behavior continued while on the floor and emergency restraints for safety were employed as Mr. Cains had not yet calmed down. As Dr. Brown-Forestiere

characterized it, there was a struggle. Brown-Forestiere depo. p. 14. Dr. Brown-Forestier testified that Mr. Cains, while restrained on his left side, vomited and choked. Brown-Forestiere depo. p. 56, 61-62. Although she believed that the ensuing struggle with Mr. Mattson caused Mr. Cains to choke (Brown-Forestiere depo. p. 14), when pressed to explain further, she was unable to medically (or factually) support her opinion.. Dr. Brown-Forestiere admitted her opinion that Mr. Cains vomited due to the struggle was only her assumption that the struggle was so intense it made Mr. Cains vomit. Dr. Brown-Forestiere testified**: "I - - I would assume that it was an intense struggle. But, no, of course, I have not way of knowing exactly how intense it was."** She further stated:



Brown-Forestiere depo. p. 72.

Although Dr. LeBel also testified as to her opinion of the cause of the vomiting. Dr. LeBel is has the title of "doctor" only because she has a Ph.D in psychology; not because she is a medical doctor or a physician of any type. She testified she had no medical training to determine the cause of death:

Q: Tell me, do you have any medical training to determine the cause of death?
A: No.
Q: Have you previously been allowed to testify by any court of law to opine on an individual's cause of death?
A: No.
Q: Have you previously been allowed by any court to opine on factors, whether directly or indirectly, contributing to a cause of death?
A: No.

Lebel depo. p. 84. [7] Despite her admission, she claimed:

> **Q:** So, are you saying to a reasonable degree of medical certainty, in your medical opinion, that the restraint caused Mr. Cains to vomit and choke? Is that what you're saying?
> **A:** Yes.

Based on her own testimony noted above, Dr. LeBel concedes she is not medically trained to determine a cause of death and has never been qualified by any court to do so. She is not even a physician. Consequently, her "medical" opinion as to the cause of Mr. Cains' vomiting is mere speculation and conjecture.

Dr. Kastner, who is a board certified physician, stated in his opinion, that Dr. LeBel's achievement of a Ph.D. would not qualify her to offer an opinion about causality, medical care, medical practice, or anything related to the practice of medicine. Kastner depo. p. 48

Clearly established in Mr. Cains' 2019 IPP pp. 9-10 (**DHS Ex. 10**), by the deposition testimony of Jennifer Berry, and reflected in Dr. Kastner's Reports and deposition testimony, Mr. Cains had aggressive behaviors, that periodically required the employment of emergency restraints

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[7] Significantly, Dr. LeBel does not even claim to be an expert in restrain use. Instead, she states her expertise is in restraint prevention.

> **Q:** But the question is do you profess, or do you claim to be an expert in restraint policy?
> **A:** I don't know what the qualifications would be for being an expert in restraint policy. She stated she has expertise in the reduction and prevention of restraints.

Lebel depo. p. 87

for safety by BHDC staff. Dozens of examples of Mr. Cains; aggression and destructive behaviors were introduced in the 2019 and 2020 behavior reports discussed by Jennifer Berry in her deposition testimony. *See* **DHS Exhibits 11A, 11B, 11C**. These reports include, among other behaviors, hitting his mother (Mrs. Robinson) and calling her vulgar names (**DHS Ex. 11A)**, repeatedly throwing fire extinguishers at staff, throwing glass, breaking glass, hitting staff, destroying property, and ripping a thermostat off the wall, to name a few. *See* **DHS Ex. 11B, 11C** for the dozens of incidents in just 2019 and 2020 alone.

Dr. Kastner opined, to a reasonable degree of medical certainty, that the cause of Mr. Cains' vomiting was [redacted]. *See* Dr. Kastner Report dated January 5, 2023 - **DHS Ex. 2A, pp. 9, 20.** Dr. Kastner explained that Mr. Cains had previously been restrained over a hundred times and had not previously choked on his vomit and died. He further noted that Mr. Cains was [redacted] Kastner depo. pp. 54-55. He testified there is no evidence that David Cains ever vomited [redacted]. Kastner depo. p. 50-52. He explained there was no evidence of any complaints from Mr. Cains [redacted]. Kastner depo. p. 52. [redacted]

This is consistent with *both* Claimant's deposition testimony, noted herein, that Mr. Cains, on occasion, would [redacted]

[redacted]

McAuliffe depo. page 29, line 21 to page 30, line 3.

Based on this testimony, it was not foreseeable that Mr. Canis would vomit during an emergency restraint for safety, choke, and die. Moreover, Claimant's evidence on the cause of the vomiting, [redacted] the struggle, or the restraint, is premised on assumption and speculation by Dr. Brown-Forestiere and the unqualified opinion of a clinical psychologist who openly admits she has no medical training to determine the cause of death or any of the factors, directly or indirectly, causing death. Moreover, Dr. Brown-Forestiere testified " I was not able to rule out whether he had an upset stomach or not." Brown-Foresteier depo. p. 74.

> **Q:** In your review of the records, was there any reports of David Cains having a history of vomiting?
>
> **A:** Yes, there were. In particular, [redacted] **Kastner Depo. p 52 lines 17-21**

For these reasons alone, and those articulated by Dr. Kasnter in his deposition testimony and his Reports (**DHS Ex. 2A and 2B**) and Dr. Hamid's testimony, Claimant has failed to prove the elements of negligence by the BHDC. It simply was not foreseeable that Mr. Cains would vomit and choke during an authorized restraint for safety.

BHDC staff conduct restraining Mr. Cains did not give rise to an appreciable risk of choking on vomit as, per the evidence, he has been restained dozens or more times for his aggression without choking or dying. As stated earlier, in Arkansas, "[c]onduct becomes negligent only as it gives rise to appreciable risk of injury to others, and there is no negligence in not guarding against a danger which there is no reason to anticipate." *Ethyl Corp. v. Johnson,* 345 Ark. 476, 481 (2001). **"In other words, "negligence cannot be predicated on a failure to anticipate the unforeseen."** *Id. citing Keck v. American Employment Agency, Inc.*, 279 Ark. 294, 299 (1983). If risks of harm cannot be foreseen by a reasonably prudent and intelligent man, the risk is not unreasonable, hence there is no negligence, consequently, no liability." *North Little Rock Transp. Co. v. Finkbeiner*, 243 Ark. 596, 602 (1967). **"Arkansas law has long since recognized that there is no duty to guard against merely possible, as opposed to likely or probable harm."** *Ethyl Corp. V. Johnson,* 345 Ark. 476, 482 (2001).

"A plaintiff cannot rely on inference based on conjecture to establish a claim of negligence and the mere fact that an accident occurred is not evidence of negligence*." Sammons v. Seeco*, 2012 Ark. App. 650, *5, *citing Nichols v. Int'l Paper Co*., 278 Ark. 226 (1983) (emphasis added). In *Sammons*, the Court articulated further stating "In other words, negligence is not imposed in the absence of proof" and "conjecture and speculation, however plausible, cannot be permitted to supply the place of proof. *Id.* The Court made it clear that, in Arkansas, "the fact that an accident occurred with nothing more is not evidence of negligence. *Id.*

It is certainly unfortunate that Mr. Cains choked on vomit during an emergency restraint where that all attempts to clear his airway were unsuccessful. Mr. Cains choking was not a foreseeable event and, per both Dr. Hamid and Dr. Kastner, was not the [redacted]. As Dr. Kastner opined (**DHS Ex. 2A, 2B**), Mr. Cains vomited due to

[redacted], which is consistent with the testimony of Claimant that Mr. Cains vomited when he became anxious, but not often.

Moreover, the standard of whether to employ emergency restraints is determined not by what Dr. LeBel would do or what Dr. Brown-Forestier would do in her emergency room but, instead, by what an ordinary man would do under the circumstances faced by Tyler Matteson. As cited above, in Arkansas in order "**to demonstrate foreseeability, the harm must be 'within the range of probability as viewed by the *ordinary* man.** *Ethyl Corp. v. Johnson,* 345 Ark. 476, 482 (2001). Mr. Matteson did what he thought needed to be done when faced with an emergency situation and the struggle described by Dr. Brown-Forestiere. Two investigations – the BHDC internal investigation and the OLTC survey – cleared Mr. Mattson (and BHDC) of any deficiencies as a result of the incident. As Mr. Mattson explained "**"[w]e were using what I thought was our best judgment."** Mattson depo. pp. 116-117.

Consequently, under Arkansas, the tragic events on June 13, 2020 were not foreseeable and were not the proximate cause of Mr. Cains' death. As a result, BHDC was not negligent.

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Confidentiality of Pending Maltreatment Investigations

At various times throughout the litigation, Claimant complained that BHDC did not inform the family of any pending maltreatment investigation conducted as a result of Mr. Cains' death for approximately a week or more. Mrs. Robinson testified that she received a letter from BHDC that enclosed a "Final Synopsis" of the incident from which she first "learned that there was a maltreatment [investigation] of some sort." Robinson depo. pp. 82-84. She stated that prior to receiving this letter she had not been informed there was a maltreatment investigation conducted

by the facility. Robinson depo. p. 85. She testified she received this letter on, by mail, on June 22, 2020 or June 23, 2020, a few days after Mr. Cains' funeral. *See* Robinson depo. p. 85.

In Arkansas, *pending* maltreatment investigations are "confidential." Ark. Code Ann. §12-12-1718. Even Mrs. Robinson acknowledged that an investigation is an inquiry which would take time to determine:

> **Q:** So, investigations take a little bit of time, don't they?
> **A:** Normally, yes.
> **Q:** So, it wouldn't be unusual, in your mind, would it, for something, an event to happen, whatever it is, and the investigation to be conducted once it happened would several days, or even sometimes longer?
> **A:** It could take a while, yes.
> Q: Okay. So that wouldn't be unusual?
> **A:** No.
> Robinson depo. 93-94.

Although the family complains that the maltreatment results were received *after* Mr. Cains' funeral and, thus, they were unable to order an autopsy, Arkansas law provides otherwise. In Arkansas, a mother, guardian, or next of kin who assume custody of the body may consent to an autopsy. Ark. Code Ann. §20-17-302. Thus, the family *always* had the authority to consent to an autopsy of Mr. Cains.

Moreover, the lack of an autopsy was <u>not</u> the proximate cause of Mr. Cains' death and has no relevance to this action. Even Dr. Brown-Forestiere, Claimant's own medical expert, testified that Mr. Cains died of [redacted]. *See* Brown-Forestiere depo. p. 12. It is unclear what other information an autopsy would need to provide.

Claimant also complained that the use of the restraint during Mr. Cains' behavioral episode was not communicated to EMT Scow. EMT Scow testified that in his experience, they aren't always given the most accurate information. Scow depo. p. 36. He explained that "[r]adio reports

aren't always reliable whether it's from a skilled professional at a nursing home or this facility or someone's cousin who found grandma." *Id.* Mr. Scow testified if it's a hectic environment, he takes what information he can get and he tries to get the clearest picture. *Id.*

Although EMT Scow was *initially* unsure with who he spoke at the scene, he *later* verified he spoke with the nurses. *See* Scow depo. p. 40. The nurses, however, arrived *after* Mr. Cains choked and stopped breathing. In their BHDC emergency response, the nurses were not aware of the behavior episode or emergency restraint needed. Nurse Deborah Noah testified the call for assistance came in stating a resident was not breathing and did not state what happened. (Noah depo. 15-16). Nurse Amanda Schmitt, who was with Nurse Noah when the call came in, testified she immediately responded when told a resident was choking and not breathing (Schmitt depo. pp. 38, 40). Whichever nurse Mr. Scow spoke with during the emergency could only relate what *she* knew and what *she* observed.

Significantly, EMT Scow testified that whatever happened to Mr. Cains *before* he went into asystole doesn't change the outcome for Mr. Scow. Scow depo. pp. 42-43. Instead, he explained:

> A: And the knowledge just helps me to pass that on or paint a picture when I go to the hospital. And for my narrative.
>
> But, otherwise, like if he was restrained, that all has an issue with what led up to the problem and I'm dealing with what's after the problem. The problem after, so it just paints a picture.

Scow depo. pp. 42-43. As succinctly put by EMT Scow above, that information would not have made a difference to him even if he had spoken to staff with that information instead of the nurses.

Again, the fact that EMT Scow spoke with the nurses who were unaware of the prior restraint and not with the aides involved in the behavioral episode, was not the cause of

Mr.Cains' death and, thus, not a relevant fact. Knowing that information was, per EMT Scow, not something that would have changed what he would have done.

Significantly, even counsel for claimant acknowledged this point is irrelevant to the case, stating, during the deposition of Dr. Hamid:

> **Mr. Gillespie:** I'll represent to you that the paramedic who responded to the scene claims that he was given faulty information, specifically says that I think a female nurse told him that David had choked on his food while eating his food and omitted the part about the ground restraint. **Frankly, I don't really care about that part. It's not important to my case.**

Hamid depo. p. 32.

BHDC Met And Exceeded All Direct Care Staffing Requirements

It is anticipated that Claimant may argue to the Commission that the BHDC was somehow "short staffed" because several aides testified, in response to Counsel's leading questions, that they were "short staffed." Such, however, was not the case. **BHDC met and exceeded all federal staffing level regulations for ICF/IDD in June, 2020.**

As explained by Jennifer Berry, BHDC staffing levels are regulated by the ICF/IID regulations found in the CMS State Operations Manual, Appendix J, in Section W187, which was Exhibit 10 to her deposition. *See* Berry depo. pp. 90-91.

Ms. Berry the identified **DHS Exhibits 9A and 9B** (identified at her deposition as Ex. 11 and 12) which, she explained reflect the *actual staffing levels* both in Davidson House (where Mr. Cains resided) and facility-wide for the period of June 1, 2020 through June 13, 2020. She further testified:

> **Q: And so, at any time in June of 2020 did the Boonville Human Development Center fall below the staffing levels required by the State of Arkansas**

A: We did not.

* * *

Q: And so, at that point in time, in that location did DHS --- or any location, did Booneville Human Development Center fall below the state required minimum staffing levels?

A: We did not.

See Berry depo. p.92-93.

As explained, **DHS Exhibits 9A and 9B** are broken down by shift because the regulations direct different staffing levels for different shifts. On June 13, 2020, the required ratios for the midnight to 8:00 a.m. shift was one staff per 16 residents. **The daily census that day was 123 residents** and BHDC had **25 direct care staff present for the overnight shift**. That ratio exceeded the staffing levels required. Berry depo. p. 94.

Significantly, **during the 8:00 a.m. to 4:00 p.m. on June 13, 2020, BHDC had 29 direct care staff for 123 residents.** The requirement was one staff per eight residents and, for the shift on which Mr. Cains died, BHDC had a staff to client ratio of approximately one direct care staff for every 4.2 residents, which far exceeds the staffing levels required that day.

Q: So, you were over the limit?
A: We were.
Q: So you did not have any --- you did not fall short – you were not short staffed that day?
A: We were not.

Berry depo. p. 95. Ms. Berry further explained that for June 1-13, 2020, facility-wide, BHDC did *not* fall below the minimum staffing levels for *any* shift during that time period. *Id.*

The difference between **DHS Ex 9A and 9B**, is that Exhibit 9B is specific to Davison House whereas Exhibit 9A is facility-wide levels.[8] Berry depo. 97. Davison House is where David Cains lived.

> **Q:** So, what were the staffing levels – what was the census of that house that day on June 13th, 2020?
> **A:** The census was – we only—well, for the 12:00 to 8:00 [a.m.] shift for Davidson House Blue, if we are looking at that specifically, that was the area that David lived in, was we had ten clients in that area, we had two staff, **so we were more than covered under the ratio from one [staff] to 16 [residents].**
> **Q:** So, just so I understand, you say one to 16. **So, that's one staff per 16 individuals?**
> **A; Correct.**
> **Q: And you had ten [residents]"**
> **A: We had ten [residents], and we had two staff per 10.**
> **Q: So, the, you had well more than –**
> **A: Yes. We were one to five actually.**

Berry depo pp. 97-98.

Consequently, any claim or argument that Claimant may be now assert suggesting that short-staffed is factually untrue and is contrary to the evidence.

The Purported Disability Rights Arkansas "Investigation"

Finally, it is anticipated that Claimant may introduce the deposition testimony of Kris Stewart, who is employed by an "advocacy" organization called Disability Rights Arkansas ("DRA"). Ms. Stewart, who testified she holds ***no*** *licenses or certifications* issued by any federal agency or State of Arkansas board, commission, or agency, and who admitted she only reportable to her own employer, testified she "investigated" the BHDC after Mr. Cains' death. Stewart depo.

[8] Ms. Berry identified **DHS Exhibit 12** which are the staffing levels for Davidson House from June 1, 2020 - June 13, 2020. Although the top of the document states 2022, that is a typo. She stated these are the staffing levels for 2020. Ms. Berry prepared this document.

p. 6, 10. However, she admitted she **never even went to BHDC to investigate**. Stewart depo. p. 18. She also admitted she was unsure whether the state ICF/IID regulatory agency [OLTC] even investigated. Stewart depo. p. 18. She was wrong; they did. *See* **DHS Exhibits 5A, 5B, 5C** – The OLTC survey Form 2567 and Survey Investigation Report.[9]

Ms. Stewart admitted she never went to medical school and has *no training* in determining cause of death. Stewart depo. p. 85. Apparently, Ms. Stewart's lack of training did not prevent her from expressing an opinion of cause of death, which she determined, was the "likely" cause of death. Stewart depo. pp. 84-85. She defined likely to mean "probably" but conceded her opinion was not made to a reasonable degree of medical certainty, as she is not a medical doctor. Stewart depo. p. 84-85. She admitted her "report" did not even reference Mr. Cains' IPP and her investigation involved her "hunches." Stewart depo. pp. 94, 98. Significantly, she testified that she previously worked in HDC is other states which also used restraints for safety. Stewart depo. p. 101. Ms. Stewart agreed that sometimes restraints are necessary in ICF/IIDs. Stewart depo p. 103.

Ms. Stewart's lack of qualifications, lack of training, and lack of state or federal certification to conduct an investigation, coupled with her admission that she is only answerable to her employer negates any validity of the report and places it firmly in the category of speculation and conjecture attributed to any other lay person purporting to investigate and opine on a cause of death, particularly when based, in whole or in part, on "hunches."

[9] The OLTC survey investigation was conducted by Dian Elliott who, unlike Ms. Stewart, was ***federally certified*** ICF/IID investigator with years of experience. Ms. Stewart later changed her testimony and conceded there actually was an OLTC report but that she "found it lacking." Stewart depo. p. 21.

CONCLUSION

For the reasons stated above and those summarized in the DHS deposition summaries, neither the Boonville Human Development Center nor its care team staff were negligent in its actions toward Mr. Cains on June 13, 2020. Although the outcome was tragic, it was unavoidable because neither the BHDC care team, the medical team nor the Logan County EMS were able to clear Mr. Cains' airway in time to save his life. It took the Logan County EMS 13 minutes to arrive after placement of the 9-1-1 call, then another 9 minutes to even partially clear Mr. Cains' airway. Although Claimant's initial narrative believed there was an 8 minute delay in calling 9-1-1, the actual facts proved that narrative to be incorrect and, by all accounts, was based on time estimates made during an emergency situation in a lobby with no clocks. The facts established that the BHDC nurse team arrived 2 minutes after it was noticed that Mr. Cains had choked, stopped breathing, and was unresponsive, and the 9-1-l call was made immediately upon the nurses' arrival on the scene.

As EMS recorded the call at 11:37 a.m., two minutes prior to that recorded time would place the actual time that Mr. Cains stopped beathing and the call to the BHDC nurse team at 11:35 a.m. give or take one minute. Emergency efforts - [redacted] – were immediately by the direct care team and continued by the nurse team and then, by the EMT.

As opined by Dr. Brown-Forestiere, Claimant's *own* medical expert "**Without any intervention, someone who suffocates will likely die within five minutes**." Dr. Brown-Forestiere acknowledged that "**It did take the paramedics 13 minutes to get there**."

Although Dr. LeBel, Claimant's "restraint prevention expert," who holds a Ph.D. in psychology and is not a medical doctor, confirmed that it is the Code of Federal Regulations and the CMS State Operations Manual – Appendix J that sets the standard of care for restraint use in

ICF/IIDs, such as the BHDC. Federal regulations expressly authorize emergency restraints as a modality for use in ICF/IIDs in situations where the client is exhibiting behaviors which, among other things, are harming other people or themselves.

Dr. LeBel's references and insinuations about United Nations and World Health Organization standards for restraint use are inapplicable in the United States, a fact which she later admitted in her deposition. Although Dr. Lebel claimed to be the Massachusetts interagency lead on restraint prevention, she admitted that even in Massachusetts, *her home state*, state-run Human Development Centers use restraints in its facilities. Lebel depo. pp. 119-120.

Standing in contrast to the factually speculative opinions of Dr. Brown-Forestiere and the opinions of Janice LeBel, Ph.D. on "restraint prevention," which are not even followed in her home state of Massachusetts, is Dr. Kastner who provided this Commission with extensive medically justified and factually supported opinions on the restraint used, the applicable federal and state standards of care for restraint use, the cause of Mr. Cains' vomiting, and Mr. Cains' life expectancy. See Dr. Kastner opinions, made to a reasonable degree of medical certainty – **DHS Exhibits 2A, 2B**, as well as his extensive C.V. (**DHS Ex. 1**)

Consequently, the Claimant's complaint asserting that that the Arkansas Department of Human Services and the Booneville Human Development Center were negligent, should be denied and dismissed, and the State be discharged from all liability thereon.

Respectfully Submitted,
Arkansas Department of Human Services

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Certificate of Service

On February 16, 2023, a copy of the above Brief was served by hand-delivery to:

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Richard Rosen

CURRICULUM VITAE

DATE OF PREPARATION: February 1, 2022

NAME: Theodore Andrew Kastner, M.D., M.S.

PROFESSIONAL EDUCATION:

Colgate University Hamilton, NY	1973-1977	B.A.
University of Connecticut School of Medicine Farmington, CT	1977-1981	M.D.
University of Wisconsin School of Preventive Health Madison, Wisconsin	1995-1997	M.S.

POST-GRADUATE TRAINING:

Intern	Bronx Municipal Hospital Center	7/1981-6/1982
Resident	Bronx Municipal Hospital Center	7/1982-6/1984
Fellowship	Developmental Medicine	7/1984-6/1986

PROFESSIONAL EMPLOYMENT, HOSPITAL AND ACADEMIC APPOINTMENTS:

Employment:

Morristown Memorial Hospital, Medical Director, Developmental Disabilities Center	7/1986-12/1998
Morristown Memorial Hospital, Medical Director, Center for Human Development and Rehabilitation	7/1986-7/1989
Morristown Memorial Hospital, Director, Center for Human Development	7/1989-1/1998
Developmental Disabilities Health Alliance, Inc., President,	1/1998 to Present
Co-Director Rose F. Kennedy Center (Albert Einstein)	4/2015 to 1/2019
Director Children's Evaluation and Rehabilitation Center (Montefiore)	4/2015 to 1/2019
Commissioner, NYS Office for Persons with Developmental Disabilities (OPWDD)	1/2019 to 10/2021

Hospital Appointments:

2013-2019	Montefiore Medical Center, Attending Physician
2001-2018	Mountainside Hospital, Consultant

EXHIBIT DHS 1

EXHIBIT 1 Kastner

1998-2018	Robert Wood Johnson Hospital at Hamilton, Consultant
1995-1999	Mountainside Hospital, Attending Physician
1995-1999	Morristown Memorial Hospital, Attending Physician
1989-1993	Morristown Memorial Hospital, Associate Attending Physician
1986-1989	Morristown Memorial Hospital, Assistant Attending Physician
1984-1986	Bronx Municipal Hospital Center, Assistant Attending Physician

Academic Appointments:

2015-2019	Albert Einstein College of Medicine, Professor of Pediatrics, Department of Pediatrics Professor of Psychiatry, Department of Psychiatry and Behavioral Sciences
2015-2019	Ruth L. Gottesman Chair in Developmental Pediatrics
2015-2019	Chief, Division of Developmental Medicine, Department of Pediatrics
2004-2016	University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, Clinical Associate Professor of Medicine
1999-2014	University of Medicine and Dentistry of New Jersey, New Jersey Medical School Clinical Associate Professor of Pediatrics
1992-1999	University of Medicine and Dentistry of New Jersey, New Jersey Medical School Associate Professor of Pediatrics
1988-2004	Columbia University College of Physicians and Surgeons Assistant Professor of Clinical Pediatrics
1986-1988	Columbia University College of Physicians and Surgeons Instructor in Clinical Pediatrics

BOARD CERTIFICATION:

Pediatrics, American Board of Pediatrics, 1986
Medical Management, 1998, American Board of Medical Management
Certified Physician Executive, 1998, American College of Physician Executives
Developmental and Behavioral Pediatrics, 2022, American Board of Pediatrics
Neurodevelopmental Disabilities, 2024, American Board of Pediatrics

ADDITIONAL OPTIONAL INFORMATION:

Professional Society Membership:

-American Academy of Pediatrics New Jersey Chapter

Treasurer (2012-2014)
Secretary (2010-2012)

Nominating Committee (2008-2010)
Councilor (At-large) (1999 to 2003)
Councilor (District 3) (1993-1998)

-American Association on Mental Retardation (American Association on Intellectual and Developmental Disabilities) (1986-2016)

President, New Jersey Board of Directors (1996-1998)
Fellow (1996)
National Board of Directors (Term 1994-1996)
National Legislative and Social Issues Committee (1993- 1996)
National President Medicine Division (1992-1994)
New Jersey Board of Directors (Medicine) (1987-1998)
Region IX Board of Directors (Medicine) (1988- 1992)

-American College of Physician Executives (1992- present)

-American Epilepsy Society (1992-1998)

-New Jersey Medical Society (1986-1996, 2000-2006)

-New Jersey Academy of Medicine (1990-2002)

-Northwest New Jersey Pediatric Society (1986-1998)

-Pediatric Council on Research and Education (2002-2006)

Founding Board Member (2000 to 2007)

-Society for Behavioral Pediatrics (1988-2005)

-Society for Developmental Pediatrics (1991-2000)

Other Boards of Directors:

- Developmental Disabilities Health Partners

Founding Board Member (2013-2020)

Northwest New Jersey Early Intervention Collaborative

Founding Board Member (1993-1994)

-Community Health Law Project Board of Directors (1989-1992)

-Academy on Mental Retardation (1986-2005)

-American Academy of Cerebral Palsy and Developmental Medicine (1986-2012)

Committees:

-American Academy of Pediatrics (1986-Present)

-Co-Chair, New Jersey Chapter, Committee on Firearms Prevention (2001-2006)

-New Jersey Chapter Committee on Children With Disabilities (1986-2015)

-National Committee on Children With Disabilities (1997-2003)

-AAP Workgroup on Transition to Adult Health Care (September 2001)

(Member of Invitational Conference Planning Committee) Proceedings published as a supplement Pediatrics December 2002, Volume 110, Number 6 Part 2 of 2.

-AAP Medical Necessity Meeting (February 2002)

-AAP Task Force on Medication Administration (April 2000)

-AAP Representative to Planning Committee for Surgeon General's Conference on Health Disparities and Mental Retardation (December 2001); Proceedings Published as "Closing the Gap: A National Blueprint to Improve the Health of Persons With Mental Retardation." US Department of Health and Human Services. 2002

-American Association on Mental Retardation (American Association on Intellectual and Developmental Disabilities) (1986-2015)

-National Legislative and Social Issues Committee (1993- 1996)

-Association for Retarded Citizens (New Jersey) (1986-2015)

Chairperson, Mainstreaming Medical Care Advisory Committee (1988-1998)

Mainstreaming Medical Care Advisory Committee (1988-2018)

Network on Prevention of Mental Retardation (1986-1998)

Member, New Jersey State Health Care Project Advisory Committee 1987

Professional Advisory Committee (Morris Unit) (1987-1993)

-Epilepsy Foundation of New Jersey (1992-2002)

Professional Advisory Board (1993-1998)

-Other National and Regional Committees

New Jersey Division of Developmental Disabilities Advisory Committee (1998-2003)

New Jersey Department of Human Services Advisory Committee on Developmental Disabilities and Medicaid Managed Care (1995-2004)

NY United Cerebral Palsy Medicaid Managed Care Advisory Committee (1994-2000)

New Jersey Department of Human Services Advisory Committee on Medicaid Managed Care (1994-2003)

State of New Jersey Interagency Coordinating Council (1992-1998)

American Association of University Affiliated Programs Task Force on HIV and Developmental Disabilities (1988- 1998)

New Jersey Department of Health Pediatric AIDS Advisory Group (1988-1998)

Research Committee of the Governor's Council on the Prevention of Mental Retardation & Developmental Disabilities (1989-2000)
State of New Jersey Consortium on Disability (1987-1998)
Matheny School, Member, Medical Committee, Peapack, NJ (1986-1989)
-New York City Mayor's Ad Hoc Committee on Zika Virus (2015-2017)

Awards and Honors:

2008 American Medical Association Leadership Award, American Medical Association
2007 Ann Klein Advocate Award, Community Health Law Project
2007 Health Care Professional of the Year Award (Developmental Disabilities Health Alliance) Bergen Passaic (New Jersey) Arc
2006 Volunteer Excellence Award, Brain Injury Association of New Jersey
2000 Enable Incorporated, Special Recognition Award
1999 St. John's Community Services, Community Service Award
1999 Arc of Bergen and Passaic Counties, Health Care Professional of the Year Award
1998 Epilepsy Foundation of New Jersey, Distinguished Service Award
1993 Morris County Office for the Disabled, Advocate of the Year Award
1993 Union County Arc, Physician of the Year Award
1992 Special Recognition Award, New Jersey Center for Outreach and Services for the Autism Community
1991 United Cerebral Palsy Associations of New Jersey, Elizabeth M. Boggs Citizenship Award
1990 New Jersey Association for Retarded Citizens, Health Care Professional of the Year
1990 Morris County Association for Retarded Citizens, Physician of the Year Award
1984-1986 United Cerebral Palsy Fellowship Award
1980 Joseph Goldberger Scholar in Clinical Nutrition

Other Professional Activities:

Editorial Positions:

2002-2003 Consulting Editor: Archives of Pediatrics and Adolescent Medicine
2001-2002 Consulting Editor: Milbank Quarterly
2000-2003 Consulting Editor: Pediatrics
1999-2009 Associate Editor: Mental Health Aspects of Developmental Disabilities
1993-2012 Associate Editor: Mental Retardation/ Intellectual and Developmental Disabilities
1993-2012 Consulting Editor: American Journal on Mental Retardation/American

Journal on Intellectual and Developmental Disabilities

1993-2012 Consulting Editor: Mental Retardation/ Intellectual and Developmental Disabilities

National Grant Review Panels, Study Sections, Committees

1995 US Department of Health and Human Services, Administration on Developmental Disabilities, Projects of National Significance

2012 US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Chairperson Review Panel

Grant Support:

2019:

Administration on Community Living. "University Center of Excellence on Developmental Disabilities (UCEDD)." 7/1/2017-6/30/2022. $2,700,000.

New York City. "RFK CERC Early Childhood Center." (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. "Developmental Disabilities Clinic Services." 7/1/2016-6/30/2019. $555,678.

New York City. "Socialization and Recreation Services for Children with Autism." 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Developmental Behavioral Pediatric Fellowship Training Program 7/1/2018-6/30/2022. $785,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2016-6/30/2021. $3,527,225.

Heath Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Audiology Supplement." 7/1/2016-6/30/2021. $400,000.

"Statewide Community Integration and Preservation Program (SCIPP)." New Jersey Division of Developmental Disabilities; 1/1/17-12/31/17: $1,200,000

2018:

Administration on Community Living. "University Center of Excellence on Developmental Disabilities (UCEDD)." 7/1/2017-6/30/2022. $2,700,000.

New York City. "RFK CERC Early Childhood Center." (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. "Developmental Disabilities Clinic Services." 7/1/2016-6/30/2019. $555,678.

New York City. "Socialization and Recreation Services for Children with Autism." 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Developmental Behavioral Pediatric Fellowship Training Program 7/1/2018-6/30/2022. $785,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2016-6/30/2021. $3,527,225.

Heath Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Audiology Supplement." 7/1/2016-6/30/2021. $400,000.

"Statewide Community Integration and Preservation Program (SCIPP)." New Jersey Division of Developmental Disabilities; 1/1/18-12/31/18: $1,200,000

2017:

Administration on Community Living. "University Center of Excellence on Developmental Disabilities (UCEDD)." 7/1/2017-6/30/2022. $2,700,000.

New York City Administration on Children's Services. "GABI Replication." (Co-PI) 7/1/2016-6/30/2019. $8,400,000.

Bronxworks. "GABI Replication." (Co-PI) 9/1/2016-8/30/2017. $384,000.

Brooklyn Catholic Charities. "GABI Replication." (Co-PI) 9/1/2016-8/30/2017. $384,000.

New York City. "RFK CERC Early Childhood Center." (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. "Developmental Disabilities Clinic Services." 7/1/2016-6/30/2019. $555,678.

New York City. "Socialization and Recreation Services for Children with Autism." 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2016-6/30/2021. $3,527,225.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Audiology Supplement." 7/1/2016-6/30/2021. $400,000.

"Statewide Community Integration and Preservation Program (SCIPP)." New Jersey Division of Developmental Disabilities; 1/1/17-12/31/17: $1,200,000

2016:

New York City Administration on Children's Services. "GABI Replication." (Co-PI) 7/1/2016-6/30/2019. $8,400,000.

Bronxworks. "GABI Replication." (Co-PI) 9/1/2016-8/30/2017. $384,000.

Brooklyn Catholic Charities. "GABI Replication." (Co-PI) 9/1/2016-8/30/2017. $384,000.

New York City. "RFK CERC Early Childhood Center." (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. "Developmental Disabilities Clinic Services." 7/1/2016-6/30/2019. $555,678.

New York City. "Socialization and Recreation Services for Children with Autism." 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2016-6/30/2021. $3,527,225.

Special Hope Foundation."Evaluation of the Developmental Disabilities Health Home." 1/1/2016-12/31/2016: $50,000.

"Statewide Community Integration and Preservation Program (SCIPP)." New Jersey Division of Developmental Disabilities; 1/1/16-12/31/16: $1,200,000

2015:

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2015-6/30/2016. $669,789

Centers for Disease Control. "A Training Curriculum for Parents of Children with ADHD." 9/1/2015-6/30/2015. $300,000.

Administration on Community Living. "University Center of Excellence on Developmental Disabilities (UCEDD)." 7/1/2015-6/30/2016. $545,000.

Centers for Medicare and Medicaid Services (CMS): "Health Home for Persons with Developmental Disabilities." July 1, 2014 – December 31, 2015. $900,000.

"Integrated Service Delivery Team." New Jersey Division of Developmental Disabilities; 1/1/15-12/31/15: $1,200,000

2014:

New York State Department of Health: "Enhancing the Developmental Disabilities Health Home: DDHA Subcontract." Balancing Incentive Program." 8/1/2014-3/31/2016. $850,000.

Centers for Medicare and Medicaid Services (CMS): "Health Home for Persons with Developmental Disabilities." July 1, 2013 – June 30, 2014. $1,800,000.

"Arkansas Best Practices in Developmental Disabilities." State of Arkansas: July 1, 2013 – June 30, 2014; $450,000

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/14-12/31/14: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14; $190,000

2013:

Centers for Medicare and Medicaid Services (CMS): "Health Home for Persons with Developmental Disabilities." July 1, 2013 – June 30, 2014. $1,000,000.

"Arkansas Best Practices in Developmental Disabilities." State of Arkansas: July 1, 2013 – June 30, 2014; $450,000

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/13-12/31/13: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13; $190,000

2012:

Care Management Demonstration Program. NJ Council on Developmental Disabilities. 10/1/12-9/30/13: $48,000.

Centers for Medicare and Medicaid Services (CMS): "Health Home for Persons with Developmental Disabilities." July 1. 2012 – June 30, 2013. $1,700,000.

"Arkansas Best Practices in Developmental Disabilities." State of Arkansas: 10/1/2011-6/30/2012; $450,000

"Clinical Improvements Arkansas State Hospital II." State of Arkansas: 12/15/2011-3/15/2012; $220,000

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/12-12/31/12: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12; $190,000

2011:

"Clinical Improvements Arkansas State Hospital I." State of Arkansas: 7/1/2011-9/30/2011; $394,668

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/11-12/31/11: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11; $190,000

2010:

"Clinical Improvements Alexander Human Development Center." State of Arkansas: 5/1/2010-6/6/2011; $2,150,000.

Care Management Contracts with Americhoice Inc. 1/1/10-12/31/10: $2,125,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10: $550,000

"Community Program of Support and Training (CPEP)," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10: $165,100

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10; $190,000

2009:

"IPP Development." State of Nebraska: 1/1/2009-8/30/2009; $750.000

Care Management Contracts with Americhoice Inc. 1/1/09-12/312/09: $2,125,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $550,000

"Family Support Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $150,000

"Community Program of Support and Training (CPEP)," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $165,100

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09; $190,000

2008: $3,565,000

Care Management Contracts with University Health Plan and Americhoice Inc. 1/1/08-12/31/08: $2,125,000.

Olmstead Plan Behavioral Services: Statewide, New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $50,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $450,000

"Family Support Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $50,000

"Community Program of Support and Training (CPST)," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $80,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08; $190,000

2007: $4,570,000

"Care Management Subcontracts: University Health Plan and Americhoice Inc." Robert Wood Johnson Health Network. 1/1/07-12/31/07: $1,567,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital: 1/1/07-12/31/07; $20,000

"Community Program of Support and Training (CPST)," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07: $240,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07: $460,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07: $350,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07; $140,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07; $190,000

2006:

"Care Management Subcontracts: University Health Plan and Americhoice Inc." Robert Wood Johnson Health Network. 1/1/06-12/31/06; $1,515,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/06-12/30/06; $255,000

"Community Program of Support and Training (CPST)," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $1,700,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $450,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06 $340,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $130,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $180,000

2005:

"Care Management Subcontracts: University Health Plan and Americhoice Inc." Robert Wood Johnson Health Network. 1/1/05-12/31/05; $1,300,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/05-12/30/05; $240,000

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/05-6/30/05; $420,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/05-12/30/05; $435,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/05-12/31/05; $340,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/05-12/31/05; $125,000

"Developmental Disabilities Center at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/05-12/31/05; $165,000

2004

"Care Management Subcontracts: University Health Plan." Robert Wood Johnson Health Network. 1/1/04-12/312/04; $800,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/04-12/30/04; $233,793

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $700,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $421,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $325,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $118,224

"Developmental Disabilities Center at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $159,335

2003

"Care Management Subcontracts: University Health Plan." Robert Wood Johnson Health Network. 1/1/03-12/31/03; $246,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/03-12/31/03; $241,500

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $700,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/03-12/30/03; $421,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $420,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $118,224

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $159,335

2002

"Care Management Subcontracts: University Health Plan and Horizon/Mercy Health Plan." Robert Wood Johnson Health Network. 1/1/02-12/31/02; $158,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/02-12/31/02; $237,906

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $700,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/02-12/30/02; $413,876

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $300,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $116,568

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $157,879

2001

"Care Management Subcontracts: University Health Plan and Horizon/Mercy Health Plan." Robert Wood Johnson Health Network. 1/1/01-12/31/01; $82,000.

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 7/1/01-6/30/04; $1,500,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $407,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $300,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $114,808

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $155,464

2000

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 7/1/00-12/31/01; $339,000

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 7/1/00-6/30/01; $400,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $400,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $131,500

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $113,000

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $152,600

1999

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 7/1/99-6/30/00; $300,000

"Care Management Demonstration Program," Robert Wood Johnson Health Network; 9/1/99-6/30/2001; $330,000

"Care Management Demonstration Program," New Jersey Division of Medical Assistance and Health Services; 9/1/99-6/30/2001; $648,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 7/1/99-12/31/00; $300,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 4/1/99-12/31/99; $26,500

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 11/1/99-12/31/00; $87,500

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities;1/1/99-12/31/99; $152,600

1998

"Mental Health Consultation Services: Northern Region," New Jersey Division of Developmental Disabilities; 11/1/98-6/30/99; $75,000

"Case Management in Managed Care for People With Developmental Disabilities," Center for Health Care Strategies; 7/1/98-12/31/98; $10,000

"A Retrospective Analysis of the Effects of Risperidone on Tardive Dyskinesia in People With Mental Retardation." Janssen Pharmaceutical Research Foundation; 1/1/98-6/30/98; $55,000

"Quality Measurement in Managed Care for People With Developmental Disabilities," Center for Health Care Strategies; 2/1/98-6/30/98; $10,000

"Technical Assistance to the New Jersey Division of Developmental Disabilities Regarding Managed Care: Case Management and Behavioral Programming," New Jersey Division of Developmental Disabilities; 2/1/98-12/31/98; $27,900

"Developmental Disabilities Center at Robert Wood Johnson University Hospital Hamilton," New Jersey Division of Developmental Disabilities; 2/1/98-12/31/98; $150,000

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities, Contract #06PX6N; 1/1/98-12/31/98; $1,672,064

1997

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities, Contract #06PX6N; 1/1/97-12/31/97; $1,672,064

"Morris County Special Child Health Services Case Management Program," New Jersey Department of Health and Senior Services Special Child Health Services, 7/196-6/30/97; $60,456.

"Service Coordination," New Jersey Department of Health and Senior Services Early Intervention Program, 7/196-6/30/97; $166,700.

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/96-12/31/96. $89,144

"Comprehensive Child Evaluation Center," New Jersey Department of Health and Senior Services Special Child Health Services, 7/1/96 - 6/30/97, $75,000.

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract;1/1/96-12/31/96: $21,219.

"Early Intervention Program", New Jersey Department of Health and Senior Services Early Intervention Program, 7/1/96 - 9/30/97; $167,820

"Parent Infant Specialist in Behavioral Issues", Northwest New Jersey Regional Early Intervention Collaborative, 10/1/96 - 6/30/97; $21,000

"Morris/Dover Expansion of Early Intervention Services", Northwest New Jersey Regional Early Intervention Collaborative, 10/1/96 - 6/30/97; $66,700

"Prevention of Cerebral Palsy With Prenatal Magnesium Sulfate," New Jersey Office of Prevention; 1/1/97-12/31/97: $10,000.

1996

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX5N; 1/1/95-12/31/95. ($1,161,071)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/95 - 6/30/96, ($75,000).

"Early Intervention Program", New Jersey Department of Health 7/1/95 - 9/30/96, Ted Kastner, Principal Investigator.

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract; 1/1/96-12/31/96. ($20,910)

1995

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX5N; 1/1/95-12/31/95. ($1,161,071)

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract; 1/1/95-12/31/95. ($20,910)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/95-12/31/95. ($162,056)

1994

"Morris County Case Management Program," New Jersey Department of Health, 7/1/94-6/31/95. ($162,056)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/94 - 6/30/95. ($75,000)

"Early Intervention Program", New Jersey Department of Health 7/1/94 - 6/30/95, ($160,800)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX4N; 1/1/94-12/31/94, ($1,127,245)

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract;1/1/95-12/31/95. ($19710)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/94-12/31/94. ($89,144)

1993

"Morris County Case Management Program," New Jersey Department of Health, 7/1/93-6/31/94. ($105,862)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/93 - 6/30/94. ($75,000)

"Early Intervention Program", New Jersey Department of Health 10/1/93 - 6/30/94, ($123,135)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX3N; 1/1/93-12/31/93. ($1,054,909)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/93-12/31/93. ($89,144)

1992

"Morris County Case Management Program," New Jersey Department of Health, 1/1/92-6/31/93. ($73,692)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/92 - 6/30/93. ($75,000)

"Early Intervention Program", New Jersey Department of Health 7/1/92 - 9/30/93, ($192,579)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX2N; 1/1/92-12/31/92. ($1,020,374)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/92 - 6/30/93. ($75,000)

1991

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX1N; 1/1/91-12/31/91. ($976,261)

"Morris County Case Management Program," New Jersey Department of Health, 1/1/92-12/31/92. ($29,700)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/93-12/31/93. ($83,610)

"Morris County Case Management Program," New Jersey Department of Health, 1/1/91-12/31/91. ($29,700)

1990

"An Educational Program to Reduce the Incidence of Fragile X Syndrome in New Jersey," New Jersey Office of Prevention, 3/1/90-2/28/91. ($15,000)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX0N; 1/1/90-12/31/90. ($914,003)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/90-12/31/90. ($81,175)

"Morris County Case Management Program," New Jersey Department of Health, 1/1/90-12/31/90. ($47,140)

1989

"An Educational Program to Reduce the Incidence of Fragile X Syndrome in New Jersey," New Jersey Office of Prevention, 3/1/89-2/28/90. ($15,000)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #EP069PC; 1/1/89-12/31/89. ($931,691)

1989

"Develop Curricula and Training Materials for HIV and AIDS," Administration on Developmental Disabilities, Department of Health and Human Services (Office of Human Developmental Services), 12/1/89-11/30/90; Allen Crocker, Principal Investigator; T. Kastner, Project Director, Component on Implementing Service Guidelines in New Jersey. ($20,000)

1988

"Develop Curricula and Training Materials for HIV and AIDS," Administration on Developmental Disabilities, Department of Health and Human Services (Office of Human Developmental Services), 12/1/88-11/30/89; Allen Crocker, Principal Investigator; T. Kastner, Project Director, Component on Implementing Service Guidelines in New Jersey. ($20,000)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #E8P0903; 1/1/88-12/31/88. ($855,593)

PUBLICATIONS

Peer-reviewed original articles in journals:

70. Kastner, TA, Walsh, KK, Shulman L, Alam F, Flood S. "Ketamine and the core symptoms of autism." International Journal on Disability and Human Development. 2015:15(1):121–123.

69. Kastner, T. A., & Walsh, K. K. (2012). Health Care for Individuals with Intellectual and Developmental Disabilities: An Integrated Developmental Disabilities Health Home Model. In: R. M. Hodapp (Ed.), *International Review of Research in Developmental Disabilities* (pp. 1–45). Elsevier Inc.: Academic Press.

68. Kastner T and Walsh K. "Diagnostic Manual – Intellectual Disability." Intellectual and Developmental Disabilities. 2009:47(4): 323-327.

67. Kastner T and Walsh K. "Divided We Stand, United We Fall: Personal Budgets vs. Universal Coverage." Mental Retardation. 2008:46(3): 239-242.

66. Walsh K and Kastner T. "On the need for a procedure for expulsion of manuscripts that do not meet the peer-review standard." Mental Retardation. 2007:45(6): 408-411.

65. Walsh K and Kastner T. "The Hissom Closure in Oklahoma: Errors and Interpretation Problems in Conroy, et al. (2003)." Mental Retardation. 2006:44(5);353-369.

64. Kastner T and Walsh K. "Medicaid Managed Care Model of Primary Care and Health Care Management for Individuals With Developmental Disabilities. Mental Retardation. 2006:44(1);41-55.

63. Kastner T. "Comment on the Use of Risperidone in Developmentally Disabled Children." Pediatrics. 2005:115(4);1447-1448.

62. CP Johnson, TA Kastner and the American Academy of Pediatrics Committee/Section on Children With Disabilities. "Helping Families Raise Children With Special Health Care Needs at Home." Pediatrics. 2005;115(2);507-511.

61. T. A. Kastner and the American Academy of Pediatrics Committee on Children With Disabilities. "Managed Care and Children With Special Health Care Needs." Pediatrics. 2004;114(6);1693-1707.

60. Kastner T, Walsh K. " A Retrospective Analysis of the Efficacy of Risperidone in People With Developmental Disabilities Living in Institutions." Mental Health Aspects of Developmental Disabilities. 2004; 7(1); 10-20.

59. Walsh K, Kastner T, Green R. "Cost Comparisons of Community and Institutional Residential Settings: Historical Review of Selected Research." Mental Retardation. 2003;41(2):103-122.

58. Blum R, Hirsch D, Kastner T, Quint R, Sandler A. "A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs." Pediatrics. 2002;110(6); 1304-1305.

57. Kastner T, Walsh K, Fraser M. "Undiagnosed Medical Conditions and Medication Side Effects Presenting as Behavioral/Psychiatric Problems Among People With Mental Retardation." Mental Health Aspects of Developmental Disabilities. 2001; 4(3); 101-108.

56. Kastner T. "On the Need for Policy Requiring Data Sharing Among Researchers Who Publish in AAMR Journals: A Critique of Conroy and Adler's, 'Mortality Among Pennhurst Class Members, 1979 to 1989." Mental Retardation. 2000;38(6):519-529.

55. American Academy of Pediatrics Committee on Children With Disabilities. "Care Coordination: Integrating Health and Related Systems of Care for Children With Special Health Care Needs," Pediatrics. 1999; 104: 978 - 981. Page 5

54. Kastner T and Walsh K. "Cost of Care Coordination for Children With Special Health Care Needs." Archives of Pediatrics and Adolescent Medicine.1999;153:1003-1004.

53. Ronder R, Kastner T, Parker S, Walsh K. "Serving People With Developmental Disabilities in Medicaid Managed Care." Managed Care Quarterly. 1999;7(2):23-30.

52. Walsh K and Kastner T. "Quality of Health Care for People With Developmental Disabilities: The Challenge of Managed Care." Mental Retardation. 1999;37(1):1-15.

51. American Academy of Pediatrics Committee on Children With Disabilities. "Learning Disabilities, Dyslexia, and Vision: A Subject Review." Pediatrics. 1998;102:1217-1219.

50. Strauss D, Kastner T, Shavelle R. " Mortality of Adults With Developmental Disabilities Living in California Institutions and Community Care, 1985-1994." Mental Retardation. 1998;360-371.

49. American Academy of Pediatrics Committee on Children With Disabilities. "Managed Care and Children With Special Health Care Needs: A Subject Review." Pediatrics. 1998;102:657-660.

48. Strauss D, Kastner T, Chaney R. "Tubefeeding." Pediatrics. 1998;100:160.

47. Kastner T. "Cost-Effectiveness of Evaluating the New Technologies." Mental Retardation. 1997;35(6):475-476

46. Kastner T, Walsh K, Criscione T. "Medicaid Managed Care for People With Developmental Disabilities Part I: Overview and Implications," Mental Retardation. 1997;35:257-269.

45. Kastner T, Walsh K, Criscione T. "Medicaid Managed Care for People With Developmental Disabilities Part II: Models, Demonstration Projects and Technical Elements," Mental Retardation. 1997;35:270-285.

44. Walsh K, Kastner T, Criscione T. "Characteristics of Hospitalizations for People With Developmental Disabilities." American Journal on Mental Retardation. 1997;101:505-520.

43. Strauss D, Kastner T, Chaney R. "Tubefeeding and Mortality in Severely Disabled Children With Mental Retardation." Pediatrics. 1997;99:358-362.

42. Kastner T, Walsh K, Criscione T. "Access to Preventive Clinical Services," in Access to Preventive Clinical Services for People With Disabilities: A Guide to Healthy Persons 2000, Silver Spring MD. American Association of University Affiliated Programs. 1996.

41. Kastner T. "Consumer Behavior in the Health Care Marketplace." Journal of the American Medical Association. 1996;275:1083-1084.

40. Strauss D & Kastner T. "Comparative Mortality in Institutions and the Community of People With Developmental Disabilities." American Journal on Mental Retardation. 1996;101:26-40.

39. Walsh K, Kastner T, Huron R. "Further Comment on Crack Cocaine Study." Developmental And Behavioral Pediatrics. 1996,17:107-109.

38. Kastner T. "The Medical Outcomes Study." Journal of the American Medical Society. 1996:2775;1084.

37. Kastner T, Walsh K. "Are Gastric Emptying Procedures Effective in Treating Gastresophageal Reflux in Children?" Journal of The American College of Surgeons, 1995;181:383-384.

36. Criscione T, Walsh K, Kastner T. "An Evaluation of Care Coordination in Controlling Inpatient Hospital Utilization of People With Developmental Disabilities." Mental Retardation. 1995;33:364-373.

35. Kastner T, Haller K, Shenouda N, Walsh K. "Sleep-Wake Schedule Disorders?" Journal of The American Academy of Child and Adolescent Psychiatry, 1995;34:1557-1558.

34. Selvaggi Fadden K & Kastner T. "Common Behavioral and Emotional Problems in Children With Developmental Disabilities." Pediatric Annals. 1995;24:1-4.

33. Philips M, O'Chesky S, Kastner T. "Defining Nurse Practitioner and Nursing Roles." Nurse Practitioner. 1995;20:10-12.

32. Kastner T, Walsh K. "Interdisciplinary Team Review of Psychotropic Drug Use in Community Settings," Mental Retardation, 1994;32;243-245.

31. Kastner T, Walsh K, Criscione T. "The Role of Tube Feeding in the Mortality of Profoundly Retarded People With Severe Mental Retardation,"Archives of Pediatric and Adolescent Medicine, 1994;148;537-538.

30. Criscione T, Kastner T, O'Brien D, Nathanson. "Replication of a Managed Health Care Initiative for People With Mental Retardation Living in the Community." Mental Retardation, 1994;32:43-52.

29. Kastner T, Walsh K, Criscione T. "Policy Issues in Health Care Reform for People With Mental Retardation," Washington D.C.. President's Committee on Mental Retardation, 1994.

28. Kastner T, Walsh K, Finesmith R. "Long-Term Administration of Valproic Acid in the Treatment of Affective Symptoms in People With Mental Retardation," Journal of Clinical Psychopharmacology, 1993;13:448-451

27. Criscione T, Kastner T, Walsh K, Nathanson R. "Managed Health Care Services for People With Mental Retardation: Impact on Inpatient Parameters." Mental Retardation, 1993:31;297-306.

26. Kastner T, Nathanson R, Friedman D. "Mortality in Persons with Mental Retardation Living in the Community." American Journal on Mental Retardation, 1993;98:285-292.

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24. Kastner T. "Does Gastrostomy and Fundoplication Prevent Aspiration Pneumonia in Mentally Retarded Persons?" American Journal on Mental Retardation, 1992;97:351-353.

23. Kastner T, Selvaggi K. "Pinworm Eradication in Community Residential Settings for People With Developmental Disabilities ." Mental Retardation, 1992; 30:237-240.

22. Kastner T, Berkner P, DeSouza T, Wight D, Waran S. "Rett Syndrome and Elevated Urinary Dolichols." J Am Acad Child Adol Psychiatry, 1992;31:567-568.

21. Friedman D, Kastner T, Plummer A, Ruiz M, Henning D. "Adverse Behavioral Effects in Individuals With Mental Retardation and Mood Disorders Treated With Carbamazepine." American Journal on Mental Retardation, 1992;96:541-546.

20. Kastner T, Friedman D, Pond,W. "Carbamazepine-Induced Hyponatremia in Patients with Mental Retardation." American Journal on Mental Retardation, 1992;96534-540.

19. Kastner T, Friedman D. "Verapamil and Valproic Acid Treatment of Prolonged Mania" J Am Acad Child Adol Psychiatry, 1992; 31:271-275.

18. Kastner T. "Who Cares For The Young Adult With Mental Retardation?" J Developmental Behavioral Pediatrics, 1991;12:196-198.

17. Kastner T, Ruiz P, Nathanson R. "Immunization Patterns of High Risk Infants with Pertussis Vaccine." J Developmental Behavioral Pediatrics, 1991;12:38-41.

16. Kastner T, Luckhardt J. "Medical Services for the Developmentally Disabled." New Jersey Medicine,1990;87:819-822.

15. Kastner T, Friedman D, Burlingham K. "Metoprolol for Control of Aggressive Behavior in Individuals with Mental Retardation." American Family Practice, 1990;42:1585-1588.

14. Kastner T, Friedman D, Plummer A, Ruiz M, Henning D. "Use of Valproic Acid in the Treatment of Children with Mental Retardation and Mood Disorders." Pediatrics,1990;86:467-472.

13. Kastner T, DeLotto P, Scagnelli B. "Proposed Guidelines for Agencies Serving Persons with Developmental Disabilities and Infection with HIV." Mental Retardation, 1990;28:138-145.

12. Marchetti A, Nathanson R, Kastner T, Owen R. "AIDS and State Developmental Disability Agencies: A National Survey." American Journal of Public Health 1990;80:54-56.

11. Friedman D, Kastner T, Pond W, O'Brien D. "Thyroid Dysfunction in Individuals with Down Syndrome." Archives of Internal Medicine 1989;149:1990-1993.

10. Kastner T, Nathanson R, Marchetti A, Pincus S. "HIV and Developmental Services for Adults." Mental Retardation 1989;27:229-232.

9. Kastner T, Hickman M, Bellehumier D. "The Provision of Services to People with Mental Retardation and Subsequent Infection with HIV." American Journal of Public Health 1989;79:491-495.

8. Kastner T, Friedman D, O'Brien D, Albrecht K. "Child Life Services and Persons with Mental Retardation.: Journal of Developmental and Behavioral Pediatrics 1989: 10:198-200.

7. Kastner T, Berkner P, Skolnick L. "Chronic Ipecac Poisoning in Infancy: A Case Report." Pediatrics 1988;82(3):384-385.

6. Kastner T. "Medical Decision Making for the Mentally Impaired." New England Journal of Medicine 1988;318:1400.

5. Ziring P, Kastner T, Friedman D, Pond W, Barnett M, Sonnenberg E. "Provision of Health Care for Persons with Developmental Disabilities Living in the Community: The Morristown Model." Journal of the American Medical Association 1988;260(10):1439-1444.

4. Barnett M, Friedman D, Kastner T. "The Prevalence of Mitral Valve Prolapse in Patients with Down Syndrome: Implications for Dental Management." Oral Surgery, Oral Medicine, Oral-pathology 1988:66:445-447.

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Abstracts:

9. Kastner T. "Developmental Disabilities Health Alliance/Robert Wood Johnson Health Network Care Management Program for People With Developmental Disabilities in New Jersey, USA." Journal of Intellectual Disability Research, 2000;44:342.

8. Burns C, Liptak G, Birenbaum A, Kastner T. "Health Care for Children With Disabilities in the New Millennium." Journal of Intellectual Disability Research, 2000;44:225.

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4. Kastner T. "Juvenile Delinquency and Developmental Disabilities: Failure of the Multisystem Approach. Presented at the Annual Meeting of the American Association on Mental Deficiency, May 1986.

3. Kastner T, Carlson-Perez B, Brier N. "Juvenile Delinquency and Developmental Disabilities." Ambulatory Pediatric Association, May 1986.

2. Kastner T, Carlson-Perez B, Brier N. "Viability of Self-Reporting Measures in Developmentally Disabled Adolescents." American Pediatric Society, May, 1986.

1. Crain E, Gerschel J, Kadar A, Kastner T. "An Evaluation of Dosing Schedules of Metaproterenol in Ambulatory Pediatric Patients with Asthma." American Journal of Disease of Children 1986; 140 (April):320.

Invited Articles:

42. Murphy A, Steele H, Steele M, Allman B, Kastner T, Dube SR. "The Clinical Adverse Childhood Experiences (ACEs) Questionnaire: Implications for Trauma Informed Behavioral Health Care." In Integrated Early Childhood Behavioral Health in Primary Care: A Guide to Implementation and Evaluation. Briggs R. (Ed). Springer. 2016.

41. Kastner T, Walsh K. "Medical Care for Children With Mental Retardation," Marilyn Augustyn, Barry Zuckerman, and Elizabeth Caronna (eds.) Behavioral and Developmental Pediatrics: A Handbook for Primary Care, Third Edition, Boston, MA: Little Brown and Co. , 2010.

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39. Walsh K, Kastner T, Savage, T. "Service, Legal and Ethical Issues Pertaining to the Continuum of Needs of Adolescents With Special Health Care Needs and Disabilities." In Promoting Health Care Transitions for Adolescents With Special Health Care Needs and Developmental Disabilities. Betz, Cecily PhD, RN, FAAN, Nehring WM. RN, PhD, FAAN, FAAMR (Ed). Paul H. Brooks Publishing Co. 2007.

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29. Walsh K and Kastner T. Behavioral Networks for People With Developmental Disabilities. New Jersey Division of Developmental Disabilities. Trenton, New Jersey. 1999.

28. Kalachnick J, Leventhal B, James D, Sovner R, Kastner T, Walsh K, Weisblatt S, Klitze M. "Guidelines for the Use of Psychotropic Medication." in International Consensus Handbook on Psychotropic Medications and Developmental Disabilities. Nisonger Center. Columbus, Ohio. 1998.

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26. Kastner T. "Managed Care: Obstacles to Implementation." Families. 1997.

25. Kastner T. "Medicaid Managed Care for People With Developmental Disabilities in New Jersey." Families. 1996.

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9. Kastner T. "Fragile X Syndrome and Sensory Integration Therapy: A Dissenting Opinion." Fragile X: In Focus 1991;1:3-4.

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PRESENTATIONS:

182: May 2021: "Overview of NYS OPWDD." Albert Einstein College of Medicine, RFK CERC Faculty. Bronx, NY.

181: October 2018: "Introduction to Disability." Albert Einstein College of Medicine, 2nd Year Medical Students. Bronx, NY.

180: October 2018: "Transformation of RFK CERC: October 15, 2018." Bronx, New York.

179: October 2018: "Introduction to RFK CERC." Bronx, New York.

178: June 2018: "The Transition from Medicaid Service Coordination to Care Coordination Organizations." Bronx Developmental Disabilities Planning Council. Bronx, NY.

177: April 2018: "Transformation of RFK CERC: April 9, 2018." Bronx, New York.

176: January 2018: "Proposal to Create a CCO/HH." Bronx, New York.

175: October 2017: "Transformation of RFK CERC: October 16, 2017." Bronx, New York.

174: July 2017: "Health Care Reform." Roundtable at Autism Care Conference. AUCD, Bethesda Md.

173: July 2017: "Integrated Primary Care/Mental Health Services." Department of Family Medicine. Montefiore Medical Center. Bronx, New York.

172: November 2016: "Health Care Reform." Roundtable at AUCD Conference. Washington DC.

171: November 2016: "The Developmental Disabilities Health Home." AUCD, Washington DC.

170: November 2015: "The Developmental Disabilities Health Home." Keynote Presentation. Bronx DD Council. Bronx, New York.

169: November 2015: "Outcomes of the Developmental Disabilities Health Home." Association of University Centers of Excellence in Disability. Washington DC.

168: November 2015: "Integrated Primary Care/Mental Health Services for Children and Adults with Intellectual and Developmental Disabilities." Barnett Lecture Keynote Presentation. Montefiore Medical Center. Bronx, New York.

167. September 2015 "Update on CERC Integration with Montefiore." Rose F, Kennedy Center Children's Evaluation and Rehabilitation Center. Bronx, NY.

166. June 2015 "An Overview of the Children's Health Home." Rose F, Kennedy Center Children's Evaluation and Rehabilitation Center. Bronx, NY.

165. April 2015 "Financing Children's Services in the New York State Developmental Disabilities System." Rose F, Kennedy Center Children's Evaluation and Rehabilitation Center. Bronx, NY.

164. January 2014 "Financing of the New York State Developmental Disabilities System." Bronx DDSO Support Coordination Training. Bronx, NY.

163. January 2014 "An Overview of the Health Home for People with Intellectual and Developmental Disabilities." Bronx DDSO Support Coordination Training. Bronx, NY.

162. November 2013 "An Overview of the Financing of the New York State Developmental Disabilities System." Bronx DD Planning Council 2013 Health Conference. Bronx, NY.

161. May 2013 "An Overview of the Children's System of Care." Mainstreaming Medical Care 2013 Conference. New Brunswick, NJ.

160. May 2013 "Health Home Services for Persons with Developmental Disabilities." HealthFirst 2013 Spring Health Home Symposium. NY, NY.

159. November 2012 "The Developmental Disabilities Health Home." Bronx DD Planning Council 2012 Health Conference. Bronx, NY

158. October 2012 "Integrating Physical and Mental Health Services for Persons with Developmental Disabilities." HealthFirst 2012 Fall Symposium, Managing Long-Term Services and Supports. New Brunswick, NJ.

157. August 2012 "The Developmental Disabilities Health Home." Arkansas State Providers Association, Hot Springs Arkansas.

156. June 2012 "The Developmental Disabilities Health Home." ICNY. New York, New York

155. March 2012 "Mental Health Services for Persons with Developmental Disabilities." Arkansas State Hospital. Little Rock, Arkansas

154. March 2011 "Mental Health Services for Persons with Developmental Disabilities." Open Horizons Conference. Warren, Arkansas

153. March 2010 "Adequate Insurance to Pay for Needed Services." Community Care Consortium for Children and Youth With Special Health Care Needs Summit. Freehold, New Jersey

152. January 2010 "Financing the Medical Home," Pediatric Council on Research and Education, Trenton, New Jersey

151. June 2008 "Medical Home for Persons With Developmental Disabilities," Mainstreaming Medical Care Arc of New Jersey, Princeton, New Jersey

150. April 2007 "Diagnosis and Treatment of Children with Autism," Linden, New Jersey

149. February 2005 "Medicaid Managed Care for Persons With Developmental Disabilities" US Surgeon General's National Conference on Health Disparities. Atlanta, Georgia

148. November 2004 "Diagnosis of Psychiatric Disorders in People With Developmental Disabilities," Trinitas Hospital, SCCAT, West Windsor, New Jersey

147. June 2004 "Diagnosis of Psychiatric Disorders in People With Developmental Disabilities," Mainstreaming Medical Care Arc of New Jersey, Princeton, New Jersey

146. September 2002 "A Comprehensive Model of Care Management and Primary Care for Persons with Developmental Disabilities in Managed Care: Developmental Disabilities Health Alliance, Inc." Healthcare Financial Management Association. Woodbridge, New Jersey.

145. June 2002 "Developmental Disabilities Health Alliance, Inc: A Business Model for Managed Care for Persons with Developmental Disabilities." Center for Health Care Strategies. Denver, Colorado.

144. May 2002 "A Model of Comprehensive Primary Care in Managed Care." Mainstreaming Medical Care, Princeton, New Jersey.

143. May 2002 "Business Opportunities for Mental Health Providers in Medicaid Managed Care." New Jersey Association of Mental Health Agencies. Princeton, New Jersey.

142. April 2002 "National Medical Management Forum." Blue Cross Blue Shield Association. Chicago, Illinois.

141. April 2002 "The Child With Chronic Illness." Childrens Health Initiative. Newark, New Jersey.

140. January 2002 "Behavioral Aspects of Epilepsy in Persons With Developmental Disabilities." Exceptional Parent Conference. Woodcliff Lakes, New Jersey.

139. September 2001"Aging and Developmental Disabilities." Vineland Developmental Center, Vineland, New Jersey.

138. May 2001 "Continuing Medical Education in Developmental Disabilities." Mainstreaming Medical Care, Princeton, New Jersey.

137. December 2000 "Practice Pattern Profiling and Risk Assessment in Developmental Disabilities Community Services." State of Illinois Department of Human Services, Chicago, Illinois.

136. May 2000 "Health Care for People With Developmental Disabilities," American Association on Mental Retardation 2000 National Conference, New Orleans.

135. September 1999 "Integration in Managed Care for People With Developmental Disabilities," American Academy of Cerebral Palsy and Developmental Medicine, 1999 National Conference, Washington DC.

134. May 1999 "Managed Care for People With Developmental Disabilities," American Association on Mental Retardation 1999 National Conference, New Orleans.

133. May 1999 "Community Mental Health Services for People With Developmental Disabilities. Mainstreaming Medical Care, Princeton, New Jersey.

132. October 1998 "Health Care Outcomes for People With Developmental Disabilities," United Cerebral Palsy Associations of New York 1998 National Conference, Albany New York.

131. October 1998 "Managed Care for Persons With Developmental Disabilities," New Jersey Family Support Awareness Day. Lawrenceville, New Jersey.

130. September 1998 "Quality Management for Children With Special Health care Needs in Medicaid Managed Care," Society for Developmental and Behavioral Pediatrics 1998 National Conference, Cleveland, Ohio.

129. June 1998 "Disease Management for People With Developmental Disabilities," American Association on Mental Retardation 1998 National Conference, San Diego.

128. November 1997 "Medicaid Managed Care for Persons With Developmental Disabilities," Pediatric Grand Rounds. New York Medical College, Valhalla, New York.

127. June 1997 "Disease Management and Persons With Developmental Disabilities," Making Managed Care Work for People With Disabilities New Jersey Law Center, New Brunswick, New Jersey

126. May 1997 "Strategic Planning for Managed Care and Persons With Developmental Disabilities," American Association on Mental Retardation 1997 National Conference, New York.

125. April 1997 "Managed Care and Persons With Developmental Disabilities," Laurie Lecture, Robert Wood Johnson School of Medicine, Piscataway, New Jersey

124. April 1997 "Measuring Quality of Care in Developmental Disabilities," Ohio Department of Mental Retardation and Developmental Disabilities, Columbus, Ohio

123. March 1997 "Managed Care and Persons With Developmental Disabilities," Young Adult Institute 1997 National Conference, New York, New York

122. June 1996 "Managed Care and Persons With Developmental Disabilities," American Association on Mental Retardation 1996 National Conference, San Antonio, Texas

121. June 1996 "Effects of the DRG Payment System on Hospitalization Outcomes for People With Developmental Disabilities." American Association on Mental Retardation 1996 Conference, San Antonio, Texas.

120. June 1996 "An Overview of Psychiatric Disorders in People With Developmental Disabilities," Independent Care, Milwaukee, Wisconsin

119. May 1996 "Developing Capitation Rates for People With Developmental Disabilities" Mainstreaming Medical Care, Princeton, New Jersey

118. May 1996 "An Overview of New Jersey's Managed Care Program for People With Developmental Disabilities" Mainstreaming Medical Care, Princeton, New Jersey

117. April 1996 "An Overview of Psychiatric Disorders in People With Developmental Disabilities," New Jersey AAME, Princeton, New Jersey

116. February 1996 "An Overview of Treatments in Autism," Morris/Union Jointure Commission

115. June 1995 "Health Care Reform and Persons With Developmental Disabilities," American Association on Mental Retardation 1995 National Conference, San Francisco, California.

114. June 1995 "Quality of Life Outcomes for People With Mental Retardation and Epilepsy Treated With Felbatol," American Association on Mental Retardation 1995 National Conference, San Francisco, California.

113. June 1995 "An Overview of Managed Care for People With Developmental Disabilities," Association Court Monitors and Special Masters, San Francisco, California.

112. May 1995 "Health Care Reform" Mainstreaming Medical Care, Princeton, New Jersey

111. May 1994 "The President's Committee on Mental Retardation: Health Care Reform Proposals" American Association on Mental Retardation, Boston, MA

110. May 1994 "Health Care Reform Proposals" Mainstreaming Medical Care, New Brunswick, New Jersey

109. April 1994 "Health Care Reform", President's Committee on Mental Retardation, Alexandria Virginia

108. April 1994 "Shared Responsibilities: Mental Illness and Developmental Disabilities", Morristown Memorial Hospital, Morristown, New Jersey

107. March 1994 "Standards of Care in Developmental Disabilities", Children's Evaluation and Rehabilitation Center, Bronx, NY

106. February 1994 "Primary Care for People with Down Syndrome Across the Lifespan", Hunterdon Developmental Center, Clinton, New Jersey

105. December 1993 "Managed Care for People With Developmental Disabilities," New Jersey Division of Developmental Disabilities, Budd Lake, NJ

104. December 1993 "Health Care Reform and Persons With Developmental Disabilities", National Association of Superintendents of Facilities for Persons With Mental Retardation, 1993 National Conference, Washington, D.C.

103. November 1993 "Standards of Care in Developmental Disabilities", National Physician's Conference on Developmental Disabilities Medicine, New Orleans, LA

102. November 1993 "What's New in Developmental Disabilities Medicine: The 10 Best Articles of 1991", National Physician's Conference on Developmental Disabilities Medicine, New Orleans, LA

101. November 1993 "The Relationship Between Epilepsy and Mental Illness", Epilepsy Foundation of New Jersey, Somerset, New Jersey

100. October 1993 "The Impact of Managed Care on Inpatient Utilization by Persons With Developmental Disabilities", American Association of University Affiliated Programs National Conference, Bethesda, Maryland

99. June 1993 "Health Care Reform and Persons With Developmental Disabilities", American Association on Mental Retardation 1993 National Conference, Washington, D.C.

98. June 1993 "Mortality and Advanced Directives for People With Developmental Disabilities", American Association on Mental Retardation 1993 National Conference, Washington, D.C.

97. November 1992 "Medical and Psychiatric Management for People With Developmental Disabilities", New Jersey Chapter of the American Academy of Pediatrics, Jamesburg, New Jersey

96. October 1992 "AIDS and Developmental Disabilities: Where Are We Now? Were Should We Go?" National Physician's Conference on Developmental Disabilities Medicine New Orleans, LA

95. October 1992 "What's New in Developmental Disabilities Medicine: The 10 Best Articles of 1991", National Physician's Conference on Developmental Disabilities Medicine New Orleans, LA

94. July 1992 "HIV and Developmental Disabilities: An Overview", New Jersey Association of Community Residential Providers, Trenton, New Jersey

93. June 1992 " Infectious Disease Concerns", Warren Day Training, Washington Township New Jersey

92. May 1992 "An Introduction to Managed Care for Persons With Developmental Disabilities", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

91. May 1992 "Transdisciplinary Evaluation of Behavioral Symptoms in People With Developmental Disabilities", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

90. May 1992 "Health Care Services for Children and Adults With Developmental Disabilities: The Morristown Model", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

89. May 1992 "AIDS: The Facts", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

88. March 1992 "AIDS: Myths and Reality", Tri-State Camping Conference, E. Brunswick, New Jersey

87. March 1992 "Ethical Concerns in Caring for People With Special Needs", University of Iowa, Iowa Hospital School, Iowa City, Iowa

86. February 1992 "Ethical Concerns in Caring for People With Special Needs", Phoenix Association for Retarded Citizens, Phoenix, AZ.

76-85. "Primary Care for People with Down Syndrome Across the Lifespan", A 12/1991 - 5/1992 series of lectures at 10 New Jersey Family Practice Residency Training Programs. Sponsored by the NJ Association for Retarded Citizens and the New Jersey Academy of Medicine.

75. November 1991 "HIV and Adults With Developmental Disabilities", American Association on Mental Retardation Training Institute on HIV and Developmental Disabilities, Philadelphia, PA

74. November 1991 "Recent Advances in Medication Use", Epilepsy Foundation of New Jersey, Middlesex, New Jersey

73. October 1991 "Transdisciplinary Evaluation of People With Developmental Disabilities and Behavioral Complaints", American Association of University Based Programs, Austin, Texas

72. October 1991 "A Statewide Public and Professional Education Program on Fragile X Syndrome", American Association of University Based Programs, Austin, Texas

71. October 1991 "HIV and Developmental Disabilities", N.J. Association for Retarded Citizens, New Brunswick, N.J.

70. October 1991 "Epilepsy, Mood Disorders and Anticonvulsant Medication", Region IX, American Association on Mental Retardation, Princeton, New Jersey

69. October 1991 "An Overview of Managed Care", Region IX, American Association on Mental Retardation, Princeton, New Jersey

68. August 1991 "HIV and Developmental Disabilities: A National Teleconference", In Collaboration With the ARC of the United States

67. June 1991 "Update on Immunizations" St. Joseph School for the Blind, Jersey City

66. May 1991 "Infectious Disease Concerns for Community Health Care Providers", American Association on Mental Retardation 1991 National Conference, Washington D.C.

65. May 1991 "Valproate Therapy for People With Developmental Disabilities and Mood Symptoms", 1991 American Association on Mental Retardation National Conference, Washington D.C.

64. April 1991 "Epilepsy, Mood Disorders, and Anticonvulsant Medication", Association for Retarded Citizens, New Brunswick, New Jersey

63. April 1991 "People With Developmental Disabilities and Mental Illness", Community Health Law Project Lecture Series, New Brunswick, New Jersey

62. March 1991 "Adults With Developmental Disabilities and HIV Infection", Third National HIV Infection and Developmental Disabilities Conference, Alexandria Virginia

61. March 1991 "Specialized Services", Health Care for Youth and Adults with Developmental Disabilities: Policies and Partnerships, Rockville Maryland

60. January 1991 "Down Syndrome and The Primary Care Physician", Family Practice Grand Rounds,UMDNJ-RWJ, New Brunswick, NJ

50-59. "Health Care Problems of People With Developmental Disabilities - 12/1990 - 5/1991 Epilepsy, Mood Disorders, and Anticonvulsant Medication", A series of lectures at 10 New Jersey Family Practice Residency Training Programs. Sponsored by the NJ Association for Retarded Citizens and the New Jersey Academy of Medicine.

49. November 1990 "An Overview of HIV and Developmental Disabilities", United States Association for Retarded Citizens 40th Annual Conference, Tampa Florida

48. November 1990 "Agency Preparedness in Serving People With HIV and Developmental Disabilities", United States Association for Retarded Citizens 40th Annual Conference, Tampa Florida

47. October 1990 "A Comparison of National Surveys on HIV and Developmental Disabilities 1987 vs. 1990", American Association of University Based Programs, Madison Wisconsin

46. October 1990 "The Morristown Model: A Managed Health Care Inititative For Adults With Developmental Disabilties", American Association of University Based Programs, Madison Wisconsin

45. October 1990 "Epilepsy, Mood Disorders, And Anticonvulsant Medication", N.J. Association for Retarded Citizens, New Brunswick, N.J.

44. October 1990 "HIV and Developmental Disabilities", Region IX, American Association on Mental Retardation, Wilmington, Delaware

43. October 1990 "The Ethical Function Of The Interdisciplinary Team", Region IX, American Association on Mental Retardation, Wilmington, Delaware

42. October 1990 "Obsessive Compulsive Disorder in People With Developmental Disabilities", Region IX, American Association on Mental Retardation, Wilmington, Delaware

41. September 1990 "Principles of Health Care For People With Developmental Disabilities" NJ Chapter, American Association on Mental Retardation, Piscataway, N.J.

40. June 1990 "The Relationship Between Mood Disorders And Epilepsy" Children's Evaluation And Rehabilitation Center, Bronx, N.Y

39. June 1990 "Perinatal Causes of Developmental Disabilities" The New Jersey Coalition for the Prevention Of Developmental Disabilities, Morris, N.J.

38. May 1990 "A National Survey of Developmental Disabilities and HIV: Policy and Epidemiology" American Association on Mental Retardation 1990 National Conference, Atlanta, Georgia

37. May 1990 "Exceptional Health Care: Health Care Abstracts for Physicians Serving People With Developmental Disabilities" American Association on Mental Retardation 1990 National Conference, Atlanta, Georgia

36. May 1990 "Valproate Therapy of People With Mood Symptoms And Developmental Disabilities" American Association on Mental Retardation 1990 National Conference, Atlanta, Georgia

35. May 1990 "Three Models of Health Care Delivery: The Morristown Model" New Jersey A.R.C. Mainstreaming Medical Care Conference, New Brunswick, N.J.

34. May 1990 "The Relationship Between Undiagnosed Medical Disorders and Behavioral Outbursts." New Jersey A.R.C. Mainstreaming Medical Care Conference, New Brunswick, N.J.

33. April 1990 "Psychopharmacologic Treatment of Psychiatric Illness in People With Developmental Disabilities" Hunterdon Developmental Center, Clinton N.J.

32. January 1990 "Recent Advances in Down Syndrome" Grand Rounds, Pediatric Department, Morristown Memorial Hospital, Morristown, N.J.

31. January 1990 "Psychopharmacologic Treatment of Psychiatric Illness in People With Developmental Disabilities" Woodbine Developmental Center, Woodbine N.J

30. November 1989 "HIV and Adults with Developmental Disabilities," A National Conference on Developmental Disabilities and HIV: Accessing the System, Bethesda, MD.

29. October 1989 "Mortality in Community Settings," AAMR Region IX Conference Williamsburg, VA

28. October 1989 "Planning Services for Persons with HIV and Developmental Disabilities," NJ ARC Annual Conference. Princeton, NJ.

27. October 1989 "Mental Health Issues with Developmentally Handicapped Infants and Toddlers: Medical Issues," Thirty-sixth Annual Meeting of the American Academy of Child and Adolescent Psychiatry. New York, NY.

26. September 1989 "Planning Services for Persons with HIV and Developmental Disabilities," Maryland AAMR Annual conference. Timonium, MD.

25. September 1989 "Mental Illness and Mental Retardation," NJ AAMR Annual Conference. Piscataway, NJ.

24. September 1989 "HIV and Developmental Disabilities: A New Jersey Perspective," NJ ARC Annual Leadership Conference. Princeton NJ.

23. June 1989 "Adults with Developmental Disabilities and HIV," at Children, AIDS and Developmental Disabilities: Challenge for the 1990's, sponsored by the Rose F. Kennedy Center of Albert Einstein College of Medicine, New York, NY.

22. June 1989 "AIDS and Institutions for Persons with Developmental Disabilities and Mental Illness," Twelfth Annual Conference of the National Association of Protection and Advocacy Systems, Bethesda, MD.

21. June 1989 "Pediatric AIDS: Legal and Service Issues," Twelfth Annual Conference of the National Association of Protection and Advocacy Systems, Bethesda, MD.

20. May 1989 "HIV and Developmental Services," American Association of Mental Retardation, 1989 National Conference, Chicago IL.

19. May 1989 "Mortality in Persons with Mental Retardation Living in the Community," American Association on Mental Retardation, 1989 National Conference, Chicago, IL.

18. May 1989 "Immunization of High Risk Infants with Pertussis Vaccine," American Association on Mental Retardation, 1989 National Conference, Chicago, IL.

17. May 1989 "Health Care Coordination and Its Effects on Inpatient Parameters for Persons with Mental Retardation," American Association on Mental Retardation, 1989 National Conference, Chicago, IL.

16. November 1988 "HIV and Developmental Services for Adults," First National HIV and Developmental Disabilities Conference, Administration on Developmental Disabilities, Bethesda, MD.

15. September 1988 "AIDS and Developmental Disabilities: Guidelines for Service Agencies," Association for the Advancement of the Mentally Handicapped, 1988 Board Meeting, Elizabeth, NJ.

14. July 1988 "AIDS and Developmental Disabilities: Issues for Service Providers," New Jersey Association of Community Residential Providers. Trenton, NJ.

13. May 1988 "Impact of AIDS on Mental Retardation/Developmental Disabilities Services," American Association on Mental Retardation 1988 National Conference, Washington, DC.

12. May 1988 "Ethical Considerations in Medical Decision Making: AIDS and Persons with Mental Retardation," American Association on Mental Retardation 1988 National Conference, Washington DC.

11. May 1988 "Bioethical Frontiers in Mental Retardation: The Impact of the AIDS Epidemic on Persons with Developmental Disabilities," American Association on Mental Retardation 1988 National Conference, Washington DC.

10. May 1988 "Models for Community Based Services to Persons with Developmental Disabilities and Mental Illness," American Association on Mental Retardation 1988 National Conference, Washington DC.

9. October 1987 "AIDS and Developmental Disabilities," American Association on Mental Deficiency, 1987 Region IX Annual Meeting. Martinsville, WV.

8. September 1987 "Communicable Diseases," United Cerebral Palsy Staff Training Institute. New York, NY

7. June 1987 "A System for the Provision of Comprehensive Health Care for Persons with Developmental Disabilities Living in the Community," Rose F. Kennedy Center Annual Alumni Meeting. Bronx, NY.

6. May 1987 "Managing Clients with Mental Retardation and AIDS: Medical Aspects," American Association on Mental Deficiency 1987 Annual Meeting. Los Angeles, CA.

5. April 1987 "Delivering Coordinated and Comprehensive Health Care Services to Children and Adults with Mental Retardation," Young Adult Institute 8th Annual National Conference. New York, NY.

4. April 1987 "Implications of Public Law 99-457," Keynote Speech, Tri-County Resource Symposium. Morristown, NJ.

3. November 1985 "The Relationship Between Learning Disabilities and Juvenile Delinquency," Straight Talk, WOR-TV.

2. October 1985 "Developmental Disabilities and Juvenile Delinquency," Third Annual Juvenile Health Care Conference, American Correctional Health Services Association. New York, NY.

1. September 1985 "Spina Bifida," Ithaca College School of Physical Therapy.

Expert Report in the Matter of

CHRISTINE MCAULIFFE, as Special
Administrator of the ESTATE OF
DAVID CAINS CLAIMANT
V CLAIM NO. 220374
THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) RESPONDENT

Prepared by

Theodore Kastner MD, MS

January 5, 2023

Professional Background:

I began work in the field of Intellectual and Developmental Disabilities (IDD) in 1976 when I was employed as a direct service professional (DSP) by the Massachusetts Association for the Blind. I graduated from Colgate University in 1977 and from the University of Connecticut School of Medicine in 1981. I completed my residency in Pediatrics in 1984 at the Jacobi Hospital. I completed my training in the care of children and adults with developmental disabilities and handicapping conditions at the Rose F. Kennedy Center of the Albert Einstein College of Medicine in 1986. In addition, in 1997 I received a Master of Science in population health from the University of Wisconsin.

I am triple-boarded in Pediatrics, Developmental Behavioral Pediatrics and Neurodevelopmental Disabilities. I also hold Board Certification from the American Board of Medical Management. Until 2019, I held an appointment at the Albert Einstein College of Medicine where I was Professor of Pediatrics and Professor of Psychiatry. I also held the Ruth L. Gottesman Chair in Developmental Medicine. My primary responsibilities involved my role as Co-Director of the Rose F. Kennedy Center at the Albert Einstein College of Medicine where he was the Principal Investigator on four federally-funded training programs and half a dozen state and local contracts.

In 2019 I left academia to serve as the Commissioner NYS Office for Persons With Developmental Disabilities where I lead an organization with a budget of $10B and 19,000 employees serving 140,000 individuals with intellectual and developmental disabilities (I/DD). I led the NYS response to COVID-19 in support of persons with I/DD.

I am a leading authority on the health care concerns of people with I/DD. For more than 25 years I served as the President of Developmental Disabilities Health Alliance, Inc.



(DDHA), at one time the largest provider of health care services to persons with I/DD in New Jersey. DDHA is nationally recognized for its health care programs for persons with I/DD having received an award a CMS Health Care Innovations Challenge Award. We served approximately 4,000 people with IDD at 9 locations across New Jersey and New York City.

I have been a member of many professional groups in the field of developmental disabilities including the National Board of Directors of the American Association on Mental Retardation (AAMR), the New Jersey State Interagency Coordinating Council (SICC), and the NJ Department of Human Services Medicaid Managed Care Task Force. I have been a recipient of more than a dozen awards and honors including the Health Care Professional of the Year Award by the New Jersey Association for Retarded Citizens (now The Arc) and the Elizabeth M. Boggs Citizenship Award from the United Cerebral Palsy Associations of New Jersey.

I have presented at over 200 conferences and training workshops and authored more than 100 publications in the field, of which approximately 70 were peer-reviewed. I have served as a consultant to the US Department of Justice, The Province of Ontario, and dozens of States in regard to various matters related to IDD including the operation of more than 50 ICF IDDs. I have consulted in general and medical malpractice matters. I have consulted to private corporations and foundations.

I have been admitted as an expert witness in approximately 10 Federal District Courts. I have been qualified as an expert witness in dozens of cases and testified in regard to all matters related to the IDD field including: the clinical management of health, behavioral and psychiatric conditions; organizational management and compliance; cause of death, life expectancy, and economic damages: standards of care including federal, state and professional standards; and other topics.

I have been retained by the State of Arkansas Department of Human Services to serve as an expert witness in the above-referenced matter. I will testify about the applicable standards of care, the medical management of Mr. Cains, the behavioral management of Mr. Cains, the timelines and other facts related to his demise, the cause of death, life expectancy, damages and whatever other topics are relevant to the matter. I will base my opinions upon a reasonable degree of medical certainty.

Document Review:

The following materials were reviewed:

2015 Psychology Report 001
2016 Psychology Report 001
2017 Psychology Report 001
2018 Psychology Report 001
2018_IPP_001
2019_IPP_001
2017 - 2019 Physician's Orders_001
AmyJones_PDFTran (8)
BHDC Maltreatment Report 5-2020 (BHDC IRIS 87707)
BHDC Policy I-D-2_001
Cains David Behavior Reports for PA VA 04062007-05292020
CainsDavid Psychological Evaluation 05282020
CainsDavidIPP 07182019
Claimant's_3rd_Suppl_Responses_to_Discovery_001 (2)
Claim-Ex1-DRA-2015report
Claim-Ex2-DRA-Jan2016report
Claim-Ex3-DRA-Oct2020letter
EMS Report_001
Hamid (2)
I-D-4 2018 Policy
Medical_Clearance_Restraint_Use_001
NCI-training-instructor-guidance-resource
Physician's Orders 6-2020_001
Ryann_Campos_5-12-22 (2)
Samuel_Scow_5-5-22 (2)
Social History
State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities
Tyler_Mattson_Depo_001 (Compressed)

Standard for Opinions:

Throughout this report I will use the standard, "based upon a reasonable degree of medical certainty," to express my opinions. This report does not contain every opinion which I may offer during testimony. I reserve the right to amend this report and my opinions based upon any information that I subsequently acquire or any other issue.

Background and History

[redacted]

According to the Social History:

[redacted]

Further,

[redacted]

[redacted]

Mr. Cains' guardian, his mother Charlene Robinson, had been very pleased with the care provided at BHDC. Ms. Robinson was offered the option of community services and continued to want HDC placement for David. She was opposed to Community Placement.

[redacted]

[redacted]

[redacted]. He was extremely difficult to manage from a behavioral perspective. Between 4/6/2007 and 5/29/2020, Mr. Cains engaged in 187 aggressive incidents, usually in the form of aggressive behavior towards staff. Staff were well aware of this risk and generally took precautions to protect themselves, Mr. Cains and other individuals. Staff responded to these 187 incidents with personal or mechanical restraints in 120 instances. This included Mr. Cains being restrained on a Papoose Board on 77 occasions or being placed in personal holds on 43 occasions. In 67 instances staff were able to use procedures other than restraint including counseling, redirection, graduated guidance or other techniques. There was one episode of vomiting associated with use of personal holds on 5/11/2012. However, medical staff determined that neither this event nor the order to remain upright after meals became a contraindication against the use of restraints, including their use after meals.

[redacted]

On June 13, 2020, Mr. Cains experience some type of [redacted] and was taken to the rest room. Upon exiting the rest room Mr. Cains became agitated and aggressive. After pulling papers off of the wall, he turned his attention to his staff, Tyler Mattson. He charged Mr. Mattson, attacking him with his hands.

Q. And then you said he --- he came after you?
A. Yes. He charged me.
Q. Charged you.
A. Yes
Q. Okay. Does --- describe that for me as best you
A. He just went to grab me. I mean
Q. How far away from him were you?
A. Maybe from here to that pole. Maybe a little bit shorter.
Q. This pole?
A. Yeah, about there. Maybe to the chair.
Q. My chair?
A. Between there.
Q. Okay.
A. Yeah.
Q. So about 6, 7 feet?
A. Maybe.
Q. Okay. And when you say "charge, " was he running at you?
A. Lunging, running. Yeah, just --- he went after me. He didn't really have room to necessarily run.
(Mattson Deposition, Pages 101-103)

Mr. Cains' large mass and speed combined to led both Mr. Cains and Mr. Mattson to fall to the floor.

Q. How did he fall? What caused him --
A. We
Q. to fall?
A. We just kind of tripped up on each other. It was all one big motion, like I had said.
Q. Okay. And why did you not attempt to do the blocking technique where you block and kind of get out of his way?
A. I wouldn't have had room. I was against a ledge.
Q. You were against a ledge?
A. Yes.
Q. Why would a ledge prevent you from being able to do like this?
A. Because I would have fell over be- if he had put

enough momentum into me.
O. Okay. So you guys fall- over.
(Mattson Deposition, Pages 105)

At that time, Mr. Mattson, consistent with BDSC policy, employed personal holds to address "dangerous behavior" in an "emergency situation." A short-time later he was assisted by two staff. Mr. Cains was lying on his side while staff held his wrists and legs to prevent injury to themselves, Mr. Cains or other individuals.

The exact timelines of what occurred are not known since there was no clock in the location where Mr. Cains fell. According to Disability Rights Arkansas, "All times are estimates as there are not any clocks visible in the area..." (DRA October 2020 Page 2)

[redacted]

Findings and Expert Opinions

The following is a list of the opinions offered in this report. As noted, the opinions in this report are not considered exhaustive and I reserve the right to amend this report and my opinions based upon any information that I subsequently acquire.

1. Based upon a reasonable degree of medical certainty, Mr. Cains died [redacted] (Page 11)

2. Based upon a reasonable degree of medical certainty, Mr. Cains is entirely responsible for the fact that [redacted]. (Page 11)

3. [redacted] (Page 14)

4. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was not the use of restraints in [redacted] because there is no reasonable theory to support the claim that the use of restraints could lead to vomiting in general. (Page 15)

5. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was not the use of restraints in [redacted] because there is insufficient empirical evidence to support the claim that the use of restraints, [redacted] led to Mr. Cains vomiting on June 13, 2020. (Page 18)

6. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was [redacted]. (Page 20)

7a. Based upon a reasonable degree of medical certainty, Mr. Mattson and other BHDC staff met and/or exceeded the standard of care for a Residential Care Technician (RCT) staff when they applied personal holds to Mr. Cains. (Page 22)

7b. Based upon a reasonable degree of medical certainty, Mr. Mattson and other BHDC staff complied with all applicable BHDC policies and procedures when engaged in applying personal holds to Mr. Cains. (Page 22)

8. Based upon a reasonable degree of medical certainty, inconsistencies in the recording of the timing of the events was so frequent that all time notations, with the exception of when EMS was notified and the team dispatched, should be considered approximate. (Page 28)

9. Based upon a reasonable degree of medical certainty, BHDC staff met the standard of care for providing emergency medical services to Mr. Cains. Based upon a reasonable degree of medical certainty, there were no unreasonable delays in calling 911. (Page 33)

10. Based upon a reasonable degree of medical certainty, BHDC medical staff could not have effected [redacted]. (Page 35)

11. Based upon a reasonable degree of medical certainty, Mr. Cains would have died even if BHDC contacted EMS at the moment when Mr. Cains was noted to have stopped breathing. Any alleged delay in contacting EMS, even a delay associated with staff performing their assessment, was inconsequential. (Page 36)

12a. Based upon a reasonable degree of medical certainty, at all times, the BHDC operated within the standard of care for a publicly-funded ICF IDD. (Page 39)

12b Further, based upon a reasonable degree of medical certainty, at all times, the staff of BHDC provided care consistent with the standard of care for their training and scope of practice. (Page 39)

13. Based upon a reasonable degree of medical certainty, Mr. Cains was positioned appropriately – [redacted]. (Page 45)

14. Based upon a reasonable degree of medical certainty, Mr. Cains death was not accompanied by severe pain. (Page 50)

15. Based upon a reasonable degree of medical certainty, Mr. Cains had a life expectancy of only 6 more years. (Page 51)

Findings and Expert Opinions

1. Based upon a reasonable degree of medical certainty, Mr. Cains died [redacted].

2. Based upon a reasonable degree of medical certainty, Mr. Cains is entirely responsible for the fact that [redacted].

Mr. Cains was [redacted].

As the events were described by Mr. Mattson, it was Mr. Cain who initiated the process which led to both Mr. Mattson and Mr. Cains to fall onto the floor. Mr. Cains lunged and charged at Mr. Mattson. Given Mr. Cains' size, this assault caused Mr. Mattson to fall backward and Mr. Cains to land on top of or adjacent to him.

Mr. Mattson, the only eyewitness, describes the events as follows:

> O. Okay. What's he doing as he's sitting there?
> A. Just sitting. He was just sitting look- staring out.
> O. All right. And then what happens?
> A. He grabs a paper and goes after me.
> O. Where does he grab paper from?
> A. There was a flyer on the wall.
> O. Does he stand up to grab it?
> A. He grabbed it and then went after me. He was sitting down and then went after me to attack me.
> O. What --- what kind of paper was it? Just---
> A. It was just it was just a printout paper, just a flyer.
> O. What did he do with it after grabs it?
> A. He was throwing it and then went after me. He threw it down and then went after me.
> O. He threw it down and then went after you. Did he say anything?
> A. No. He just screamed "bitch."
> O. He screamed "bitch"?
> A. Yes. That I recall.
> O. Anything else that you recall him saying?
> A. No.
> O. And then you said he --- he came after you?

A. Yes. He charged me.
O. Charged you.
A. Yes
O. Okay. Does --- describe that for me as best you
A. He just went to grab me. I mean
O. How far away from him were you?
A. Maybe from here to that pole. Maybe a little bit shorter.
O. This pole?
A. Yeah, about there. Maybe to the chair.
O. My chair?
A. Between there.
O. Okay.
A. Yeah.
O. So about 6, 7 feet?
A. Maybe.
O. Okay. And when you say "charge, " was he running at you?
A. Lunging, running. Yeah, just --- he went after me. He didn't really have room to necessarily run.
O. Can you --- do you mind standing up and showing me?
A. I -- as best as I can. Like, he just --- it was like just a classic --- like, he went to grab at me.
O. Okay. Went to grab at you?
A. Yes.
O. So not swing at you but grab at you?
A. Grab at me.
But, like he had --- like --- like I said, that distressed face.
O. Okay.
A. Like he was agitated and --- yeah.
O. All right. And --- okay. And then what --- what did you do?
A. I tried to hold him and we kind of just fell.
O. How did you try to hold him? Stand up and show us, please.
A. Like, I was --- like, I just kind of grabbed him by the shoulders the best as I could, you know, with him -- momentum --
O. Yeah.
A. and we just kind of stumbled over, you know.
O. Okay. So he's coming at you arms raised like this?
A. It --- yeah.
O. Like this?

A. Outwards, yeah.
And I just kind of grabbed, like, here and here. I didn't, like, grab by the wrist. You know, but, like we kind of just awkwardly fell.
O. Did he get a --- did he get a grip around you?
A. No, he didn't get a grip around me.
O. Okay. Sorry.
A. No, that's all right.
O. This won't take long.
So he's coming at you. Show me and slowly so --- so I can really see it: What --- what do --- show me what you do as he's coming at he's lunging at you.
What do you do? What do your hands do? Where do they go?
A. I'm just like --- biceps, like, arms.
O. Okay. So you would have your --- your right hand on his left bicep and your left hand on his right bicep?
A. Yeah.
O. Pretty much?
A. Pretty much, yeah.
O. Okay. And --- and do you stay there locked like ---
A. No.
Like we tripped. Like --- like, we lust kind of fumbled around. Because it was, like, all in one biq momentum, you know.
O. Uh-huh. And you fall to the ground, and he hits his face on the ground?
A. No, he didn't hit his face on the ground.
It wasn't a fast f all. It was a controlled fall as much as I could control it. (Mattson Deposition Pages 100-103)

Mr. Mattson's description indicates that he attempted appropriate blocking technique (engaging the inside of the arms at the biceps) but was unable to prevent the fall as he was moving backwards. Mr. Cains landed with his front side towards the ground, indicating that it was Mr. Cains' momentum which carried them to the ground.

In reviewing his Written Statement, Mr. Mattson offered the same description:
O. And it says I -- and it says that you "Applied personals by grabbing his arms. He ended up falling over. I did not land on him. "
So that's a little different than what you're describing now. What you're kind of describing now is that he lunged at you, and you grabbed him by the biceps; and then the force caused you guys to tumble over.

That's what you're describing now, but that's different. than what you wrote here. So how -- I mean, how can you .?
A. He fell and I just kind of went with him, as far as I can recall.
O. How did he fall? What caused him --
A. We
O. to fall?
A. We just kind of tripped up on each other. It was all one big motion, like I had said.
O. Okay. And why did you not attempt to do the blocking technique where you block and kind of get out of his way?
A. I wouldn't have had room. I was against a ledge.
O. You were against a ledge?
A. Yes.
O. Why would a ledge prevent you from being able to do like this?
A. Because I would have fell over be- if he had put enough momentum into me. (Mattson Deposition, Pages 104-105)

Mr. Cains was fully responsible for aggressively moving toward Mr. Mattson and causing them both to land on the ground, an outcome which was [redacted] There is no evidence that Mr. Mattson initiated any action which would have led to a fall to the ground. The responsibility for violating the [redacted].

3. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13 at approximately 11:30AM was [redacted]

According to Dr. Brown-Forestiere, Mr. Cains was only "a little more at risk than normal." Therefore, Dr. Brown-Forestiere's testimony suggests that the primary reason for Mr. Cains vomiting on June 13, 2020 was the use of restraints.

4. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was not the use of restraints in [redacted] because there is no reasonable theory to support the claim that the use of restraints could lead to vomiting in general.

Dr. Brown-Forestiere offered a theory to support her allegation that restraint use caused Mr. Cains to vomit when he was restrained on June 13, 2020. As Dr. Brown-Forestiere explained it, with Mr. Cains in the prone position, pressure on the chest and abdomen would force stomach contents into the esophagus in the form of vomiting. This pressure would occur as a result of muscular contraction associated with a fight or flight reaction and from external pressure applied to the abdomen/chest. As she described it:

> Okay.
> And, Dr. Brown, are you also able to say within a reasonable degree of medical certainty what caused Mr. Cains to vomit?
> A Yeah. I -- I think that I can. So there's a lot of physics to this. I'll try -- I'll do my best to make it in easy to understand terms.
> So, when someone is struggling in this scenario that's been described by all the participants, someone who is struggling has what's called a fight or flight response, meaning they're -- have adrenaline surges and they are fight -- essentially fighting for their life.
> Their muscles constrict to fend off what they feel is an attack. They -- so their muscles constrict, their breathing increases, (interference) set of physiological (interference) leads to increased (interference) pressure which is the pressure in your chest.
> And it also constricts the abdomen which increases the intra-abdominal pressure. Both of these are cavities in the body where the stomach is.
> The inferior or superior aspect on top of the stomach is the diaphragm in the chest above that, and just below it, the abdomen. And increased pressure on both of these does place increased pressure on the stomach and from the sides.
> Obviously, there's a definitive end to the body and how far it can stretch. And also his left side being on the floor is another definitive mechanical block as to where it can expand.
> So, if you think of the stomach as a cube, it's having pressure from all different angles for -- because

of the struggle and the position and the increased pressures. And it caused him to vomit.

[redacted]

So the struggle with being restrained on the floor definitely led to him fighting that. And there's pressure coming from multiple different reasons, regions, and it caused vomiting.

Q Okay. So if I'm hearing you correctly, Dr. Brown, and in my very nonmedical layman's terms, intense struggle that produces a fight or flight reflex and adrenaline can, is itself, increases the likelihood of triggering vomiting; is that correct?

A In this scenario, it would, yes, due to gravity.

Q And being on his left side increased the likelihood that the pressure, intrathoracic pressure and gravity, would --

A Yeah.

Q -- trigger vomiting?

A Yeah. Unfortunately, the stomach -- and the stomach's on the left. So it means everything in the body and all the pressures above him were pressing down onto the stomach; which was butting up against the ground, essentially.

Q Okay.

And the fact that he had -- if I'm hearing you correctly [redacted]

(Brown-Forestiere Deposition Pages 12-15)

Dr. Brown's theory relies upon several claims for which supporting facts do not exist.

First, Dr. Brown-Forestiere claimed that Mr. Cains experienced a "fight or flight reaction" because he believed that he was "essentially fighting for (their) life" when he was placed in restraints.

> Q And so what -- how do you know or do you -- did you form an opinion on the intensity of this, quote/unquote, struggle, unquote?
> A I mean, form an opinion, I don't know if it's a direct opinion or just a typical instinctual reaction. Your body instinctually fights as hard as it possibly can to survive when it feels that it may be dying. Regardless of your mental state, your body fights, so --
> Q Are you --
> A -- I would assume that it would be a very intense struggle, given your death being the alternative.
> (Brown-Forestiere Deposition Page 66)

However, there is no reason to suggest that Mr. Cains would have thought that he would die as a result of being restrained. Mr. Cains had been restrained approximately 120 times during a 13-year period and had learned that if he was able to calm himself, he would be released from restraints. Indeed, in every one of the 120 instances when restraints were previously used, he was removed from restraints without harm. Mr. Cains had no reason to fear that anything different would occur on June 13, 2020.

Second, Dr. Brown-Forestiere later admitted that she did not know when during the course of a restraint, Mr. Cains would have experienced such a fight or flight reaction or whether he would have experienced such a reaction at all:

> Well, I mean, so when the -- when the restraint started, there was a behavioral episode. Was he fighting for his life then?
> A What he thought was a fight for his life and when it came down to that, I can't say.
> (Brown-Forestiere Deposition Page 75-76)

The "fight or flight" reaction, if it occurred at all, could have occurred after the restraint were removed.

Third, Dr. Brown-Forestiere alleged that:

> "pressures above him were pressing down onto the stomach; which was butting up against the ground, essentially."

However, staff statements indicate that they exerted no pressure on the abdomen or chest during the period of restraint prior to the onset of vomiting. They restrained his arms and legs. They did not employ holds that put pressure on the body. Dr. Brown-Forestiere later admitted to this fact during her testimony:

> Q And so they were just -- if they were holding his arms and his feet, what -- is it your opinion that somebody was on top of him?
> A I -- no. I didn't say that either.
> Q So he wasn't pinned to the floor --
> A I believe that --
> Q -- (inaudible)?
> A -- Tyler had his hand on his waist holding him on the ground. He said he was holding him there but did not place his weight on him.
> (Brown-Forestiere Deposition Page 77)

5. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was not the use of restraints in [redacted]

In explaining her theory, Dr. Brown-Forestiere opined that the struggle associated with being placed in restraints "often induces vomiting."

> Q Okay.
> A The only thing I can rule in is that a struggle often induces vomiting.
> Q Okay. You don't know how intense the struggle here was?
> A If you're fighting for your life, I think it's without question that it's going to be --
> Q Well --
> A -- an intense fight.
> (Brown-Forestiere Deposition, Page 75)

Her use of the word "often" implies causality - when one thing occurs, a second "often" follows. However, the evidence does not support her opinion that being placed in restraints "often" induces vomiting.

I reviewed the 515-page document titled, "Cains David Behavior Reports for PA VA 04062007-05292020." The document includes notes describing 193 sperate instances over 13 years, between 4/6/2007 and 5/29/2020, when Mr. Cains presented with challenging behavior. The materials document 187 aggressive incidents, usually in the form of aggressive behavior towards staff.

Clearly, Mr. Cains was extremely difficult to manage from a behavioral perspective. Staff were well aware of this risk and generally took precautions to protect themselves, Mr. Cains and other individuals. Staff responded to these 187 incidents with personal or mechanical restraints in 120 instances. This included Mr. Cains being restrained on a Papoose Board on 77 occasions or being placed in personal holds on 43 occasions. In 67 instances staff were able to use procedures other than restraint including counseling, redirection, graduated guidance or other techniques. There was one episode of vomiting associated with use of personal holds on 5/11/2012.

The occurrence of one instance of vomiting during 120 episodes of mechanical restraint is insufficient to demonstrate causality between restraint use and vomiting. Even if the incident of 6/13/2020 was included, 2 episodes of vomiting occurring in 121 incidents of restraint use is far fewer than the number that would be needed to demonstrate causality. As Dr. Brown-Forestiere implies, proof of causality suggests the expectation of vomiting occurring "often" when restraints are used.

Vomiting did not occur in 119 of the 121 incidents of restraint use. In other words, if restraints caused Mr. Cains to vomit, why is it that 98% of restraint use was not accompanied by vomiting? The answer to that question is that restraints did not cause Mr. Cains to vomit.

Further, if Dr. Brown-Forestiere's theory were correct, forms of restraint associated with high body pressures should be associated with higher rates of vomiting. The pressures applied to the chest and abdomen during the use of a full-body restraint, such as a Papoose Board, are much greater than those that are generated by personal holds. Based upon Dr. Brown-Forestiere's theory, the use of a Papoose Board should be associated with rates of vomiting that are higher than the rates of vomiting observed when using low pressure restraints such as personal holds.

The attached picture is a Papoose Board currently in use by Arkansas DHS. You will see that the individual is placed on the Board and that he/she is then wrapped with three bands of fabric which cover the lower extremities, the torso, and the head. There are 15 separate Velcro straps which are used to attach the bands of fabric together, creating a snug fit and pressure across the entire body.



Dr. Brown-Forestiere's theory predicts that vomiting should be more common when using a Papoose Board in comparison to low-pressure physical holds of the extremities.

However, the evidence does not support her theory. At no time, during 77 instances in which the Papoose Board was used, did Mr. Cains vomit. In spite of the fact that the intraabdominal pressures generated during use of the Papoose Board are much higher than those generated during the use of personal holds on the extremities, there was never an instance of vomiting associated with the use of a Papoose Board. This lack of empirical evidence disproves her theory that possible increases in chest/abdominal pressure associated with physical restraint were associated with Mr. Cains' vomiting.

6. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was [redacted].

[redacted]

Second, just prior to the behavioral outburst on June 13, 2020, Mr. Cains wanted to use the restroom. [redacted]. There is one prior episode when Mr. Cains was noted to have soiled himself just prior to a behavioral outburst. (8/22/2012.) There are no other episodes of restraint associated with the occurrence of a bowel movement during the restraint. It is quite possible that Mr. Cains had a [redacted] during previous episodes of restraint. Indeed, Dr. Brown Forestiere could not rule out the possibility of a gastrointestinal illness.

[redacted]

Finally, Dr. Brown-Forestiere could not rule out an unknown cause of Mr. Cains vomiting.

> If somebody has a higher risk of something, that doesn't mean that -- if I have a higher risk of vomiting, it doesn't mean that I actually vomited [redacted], does it? I can vomit for other --

A I don't --
Q Okay. I can vomit for other reasons; correct?
A Absolutely.
(Brown Forestiere Deposition Page 74)

7a. Based upon a reasonable degree of medical certainty, Mr. Mattson and other BHDC staff met and/or exceeded the standard of care for a Residential Care Technician (RCT) staff when they applied personal holds to Mr. Cains.

7b. Based upon a reasonable degree of medical certainty, Mr. Mattson and other BHDC staff complied with all applicable BHDC policies and procedures when engaged in applying personal holds to Mr. Cains.

Staff exercised reasonable judgment in keeping Mr. Cains on the floor because he exhibited behaviors which, according to definitions contained within BHDC policies, were maladaptive.

BHDC Policy defines Maladaptive Behaviors as follows:

> "Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, of the destruction of property." DDS Policy 3011-D

It is important to note that that the definition contained within DDS Policy 3011 does not distinguish between behaviors that result in injury or behaviors that have the potential for causing injury. Both types of behavior are considered maladaptive behaviors and subject to staff intervention. BHDC policy permits the use of personal holds in either situation.

> Personal Restraint: In order to prevent personal injury or serious property damage, the individual or a portion of an individual's body is immobilized by another person or persons in order to prevent personal injury or serious property damage. (DDS Policy 3011)

Mr. Mattson noted (above) that he was attacked by Mr. Cains and that this led them both to fall to the ground. Ryann Campos wrote in her statement that Mr. Cains spat at Mr. Mattson:

> I, Ryann Campos, arrived at commons for lunch. I noticed David Cains on his left side fighting Tyler in the lobby, Tyler on his left side holding both wrists. I saw David Cains look up at Tyler and spit." Ryann Campos Witness Statement

Mr. Cains harmed staff and attempted to further harm them but was prevented from doing so by staff use of personal holds. DDS policy allows the use of restraints in such emergency situations. According to DDS Policy 3011:

> Emergency Procedures. Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. (DDS Policy 3011-D)

Staff testified repeatedly that they used personal holds only for the purpose of protecting themselves and Mr. Cains and that the holds would have been removed once Mr. Cains calmed down. Again, this is consistent with BHDC policy and their training.

> The goal of restraint use is to keep the client and/or others safe until control of the client's behavior can be returned safely to the client (i.e., when the client has calmed). Clients shall be released from physical restraint immediately upon calming. "Calm" for a client is defined by the Interdisciplinary Team ("IDT"). The typical definition of calm is below, but the IDT may identify client-specific indicators in the client's IPP and/or Safety Plan:
> i. The client's behavior indicates that the dangerous behavior has ceased;
> ii. The client is quiet and responding to staff in their normal tone of voice or other way of communicating; and
> iii. The client demonstrates cooperation by accepting direction from staff (BHDC Policy I-D-4 Documentation and Response to Maladaptive Behaviors.)

It would be absurd to expect an RTC, as has been suggested (Mattson Deposition, Page 117), that Mr. Cains be released from a personal hold, allow staff or Mr. Cains to be injured, and, then reapply a personal hold. Staff need to be able to use professional judgment when providing services which incorporates regard to their own personal safety. Injured staff cannot provide care.

Mr. Mattson. Ms. Jones and Ms. Campos all testified that they felt they were acting within the scope of their training and practice in applying personal holds in order to protect Mr. Cains and themselves.

> Ms. Campos stated:
>
> A All I remember was he was trying to kick. And I was trying to help him from hurting himself or others.
> (Campos Deposition Page 61)
>
> And:
> Q You don't know if, after you got there, there was an attempt made to de-escalate the situation without --
> A I mean, we were --

Q -- without grabbing him?
A All I seen when I got there was him kicking, him on his side and still trying to kick.
I mean -- and I tried to refrain anybody get hurt or him hurting himself. And I know I keep repeating myself and repeating myself. But I don't know -- I -- I can't talk for them. And I don't know how else to word it.
(Campos Deposition, Page 80)

Ms. Jones stated:

Okay. But yet you -- you, for at least a minute, participated in a restraint with him on the ground?
A Yes. If we had been able to get him up off the ground we would've.
Q Well, I haven't heard that you tried.
Nowhere in any of this, nowhere in anything you've said, has it been suggested that any of you attempted just to get him back on his feet at any point before he started choking.
A He hadn't calmed down at any point until he started choking.
Q Okay. And you made the determination then that the threat of him spitting or the threat of him slapping behind himself at Tyler was a greater risk than his doctor's orders to not put him on the ground after meals because he might literally aspirate and die just like he did? That was the decision y'all made?
A We didn't make that decision. It --
Q But you did. You did make that decision. And he's dead.
A We made the decision to try to keep from harming himself or someone else. No one asked for what happened. No one wanted that --
Q He didn't harm himself. He didn't harm himself. You three harmed him.
A Had he gotten up -- we did not harm him. We -- we did not harm him.
Q All right.

(Jones Deposition Page 111-112)

As noted in Mr. Mattson's direct testimony, once on the ground, staff demonstrated appropriate judgment in continuing to try to get Mr. Cains to calm down while providing

"personal holds."

Q. How is that violent?
A. He was trying to resist and fight me.
Q. Why didn't you just get up and give him some space, since he's already on the ground?
A. Because he was still very agitated.
Q. Well, so. Let him calm down. Why didn't you do that ?
A. That's not how it works immediately.
Q. How does it work?
A. He would still be agitated afterwards, very agitated.
Q. So you thought it was best to turn him on his side and pin him on the ground?
A. I was wanting him to calm down. I was trying to get him to calm down.
Q. And in order to get
A. And I was talking f was talking to him.
Q. And, in order to get what you wanted, you turned him over, held him down?
A. I—I guess.
Q. Well, you guess. You were there.
Did you --- is that what happened or isn't it?
A. Yes.
Q. Okay. And is he talking to you at that point?
A. No. He was just still insulting me, calling me names and screaming.
Q. Okay.
A. That was another semblance that I knew he was still agitated.
Q. Yep, still- agitated. Still needed to be controlled. I understand.
About how long --- and where are your hands on him?
A. On, like, his upper body. Not, like, on his head but, like, controlling his arms. Like, not on his wrists but just --- generally his arms, upper area.
Q. Okay. And you didn't have one hand on his --- on his --- kind of his waist, one on his shoulder area?
A. No.
I just had, like, his arms controlled. Because that's --- he was infamous for, like, kind of winging back and swinging at you.
Q. Well, you said he's never hit you before. He's

never made contact with you before.
So how can you tell me he's infamous for that?
A. Because I have seen him do it. I have --- and just from hearsay.

(Mattson Deposition Pages 109-111)

As is evident in the tone of this exchange, Mr. Mattson may have been intimidated by Plaintiff's Counsel. This had an impact on his ability to offer consistent testimony about the facts of the matter. For example, in the testimony above, Mr. Mattson responded to a leading question which could be used to infer that he restrained Mr. Cains for the purpose of holding Mr. Cains to the ground:

O. So you thought it was best to turn him on his side and pin him on the ground?
A. I was wanting him to calm down. I was trying to get him to calm down.
O. And in order to get
A. And I was talking I was talking to him.
O. And, in order to get what you wanted, you turned him over, held him down?
A. I—I guess.
O. Well, you guess. You were there.
Did you --- is that what happened or isn't it?
A. Yes.
B. (Mattson Deposition Pages 109-111)

However, after an objection by Respondent's Counsel, Mr. Mattson was able to collect himself and clarify his earlier testimony. Mr. Mattson did not "pin" Mr. Cains to the ground as was implied during his questioning. Rather Mr. Mattson was restraining one arm from striking staff – consistent with BHDC policy and the training and scope of practice for an RCT.

O. Okay.
A. I wasn't really necessarily restraining. I was more holding. But -- there was --- like, I was actively restraining the right arm because he was like ---
O. Okay.
A. --- that's whenever he was, like, most flailing.
O. Okay. And I know you weren't holding his head. That's not what. I'm -- what I'm suggesting. I just want to make sure I understand where your hands were.
A. Right.
O. How long did this go on before Mandy Jones arrived on the scene?

A. That f can remember a couple of minutes. It wasn't shortly after because her area ---
Q. Okay. (Mattson Deposition Pages 112-113)

In spite of this testimony, leading questions, incorporating the allegation that Mr. Cains was "pinned" to the floor, continued to be used.

Q. Well, I mean, you know [redacted]. They get aggressive sometimes. I tell you what I don't do. I don't pin them to the ground until --
MR. COLLINS: Are you testifying now?
Q. -- until they say what I want to them to say. Okay. So how long are you three pinning him to the ground now that Ryann's arrived before he starts changing colors and defecating on himself and throwing up and dying?
A. As best I remember, maybe a minute or two. But it Wasn't very it wasn't a long time.

(Mattson Deposition Pages 116)

(8) **Based upon a reasonable degree of medical certainty, inconsistencies in the recording of the timing of the events was so frequent that all time notations, with the exception of when EMS was notified and the team dispatched, should be considered approximate.**

The estimated timeframes contained within the EMS Report are internally inconsistent and unreliable. Witnesses appeared to pick and choose whatever "facts" were contained within the EMS Report to support their opinions. However, because of the internal consistencies, the EMS Report cannot reliably be used to create a timeline at all.

[redacted]

[redacted]

Mr. Scow relied upon staff for the information he included in the report. However, he did not obtain a first-person statement about witnessing the "collapse." The only one to have witnessed the "collapse" was Tyler Mattson and, according to Mr. Scow's deposition, he did not speak to Mr. Mattson. Mr. Scow stated in his deposition that he spoke only to female staff in attendance at Mr. Cains resuscitation.

> Do you remember that it -- can you say whether –
> was it men, women? Do you have any memory of that?
> A I remember, besides myself and my partner, there was
> three women. And I remember that there was one man that
> was sent to be kind of the gofer to run and get things
> and do things as we needed them.
> Q But the only people you spoke to were these three
> women?
> A Yep. Or my partner.

In spite of the lack of first-hand evidence, during his testimony, Mr. Scow alleged that there was an 8-minute delay between the occurrence of the respiratory obstruction and calling 911. He reached this conclusion solely based on his understanding that the patient experienced a respiratory arrest at approximately 11:30 and that EMS was called at 11:38.

> Q Your report indicates that eight minutes of time
> lapsed between when the patient stopped breathing and
> when 9-1-1 was called; correct?
> A Correct.
> Q And how -- okay. And that's correct?
> A Correct.
> Q Okay. And could you briefly tell us, you know, how
> you came to that conclusion?
> A So the estimated CPR and time of collapse was a --
> so it was a witness collapse.
> I do remember turning that in here at some point.
> Someone said they witnessed the patient collapse and the

CPR was started immediately after he collapsed and 9-1-1 was called.
Q Okay.
A And -- so we have a -- I think that's on page -- witness time of collapse, I think that's Page Four. It could be.
Q Take your time.
A Yes. So page -- actually, Page Three. The second box, specialty patient, CPR.
Under the time of call, you see the rest witness by layperson.
Q Okay. And you were specifically told that that was 11:30?
A Yes.
Q You wouldn't have just guessed at a time? You would have --
A No, sir. No, sir.

(Scow Deposition Page 10-11)

Dr. Brown-Forestiere also alleged that there was an 8-minute delay between the respiratory obstruction and calling 911. Following a very leading question from Mr. Gillespie, Dr. Brown-Forestiere agrees – 8 minutes.

And you reviewed records and testimony that state that there was a gap of eight minutes between when Mr. Cains began suffocating and when 9-1-1 was called; correct?
A Correct. (Deposition Brown-Forestiere, Page 20)

And again

A So I did take a look. And, based on the facts from all the different documents that there was an eight minute duration before 9-1-1 is called, I can give you the facts on a resuscitation. (Deposition Brown-Forestiere, Page 21)

Later in her testimony, Dr, Brown-Forestiere indicates that she is not sure whether the 8 minute period refers to the time between Mr. Cains falling to the floor and 911 being called or the time between the onset of choking and the call to 911.

Q Is that what you would conclude?
A I conclude the same thing I've concluded 12 times. It's my understanding it was eight minutes from the --
Q But I --
A -- initial onset of the situation to when the phone

call was made.
Q Okay.
A And how they concluded that timeline is not up to me. I just read it.
Q Okay. And, when you say from the beginning of the, of the incident, you talking from the time that he choked or from the time that the incident started?
A You would have to ask the people involved. I was not there.
Q Okay. So fair enough. Fair enough. You don't know?
A I -- I was given the information, same as you, that it took eight minutes.

(Brown-Forestiere Deposition Page 96)

However, the timeframes present in the EMS Report contradict the testimony of both Mr. Scow and Dr. Brown-Forestiere. [redacted] Both Mr. Scow and Dr. Brown-Forestiere are incorrect. From their testimony, I cannot determine why they both make the same error. It is a remarkable coincidence that two witnesses, independent of esach other, make the same obvious mistake.

This may be explained by Dr. Brown-Forestiere when she suggests that she did not reach an independent conclusion that there was an 8-minute delay. She acknowledged that this opinion was provided to her:

Q Okay. So fair enough. Fair enough. You don't know?
A I -- I was given the information, same as you, that it took eight minutes.
(Brown-Forestiere Deposition Page 96)

The source of this "information" is not disclosed.

[redacted]

[redacted]

However, there are additional internal inconsistencies.

[redacted]

[redacted]

The lack of accurate timekeeping in the EMS Report is obvious. Staff acknowledge in their depositions that they are making guesses as to when the event may have begun and how much time was required for each step in the response. DRA noted that there were no clocks in the area and as a result, they recommended that all time notations should be considered estimates. The 2020DRA Report stated that:

> All times are estimates as there are not any clocks visible in the area..." (DRA October 2020 Page 2)

The best explanation for these inconsistencies is that the report is erroneous. Mr. Scow acknowledged that errors can occur when he is taking the history and simultaneously rendering care:

> On scene, when we're doing patient care, if it's a hectic environment, you take what information you can get and you try to get as clear as -- clearest picture of what you can get when you're asking questions and interviewing while you're doing your work at the same time, so -- yeah.
> It's -- it's not always the most accurate but – (Scow Deposition Page 36)

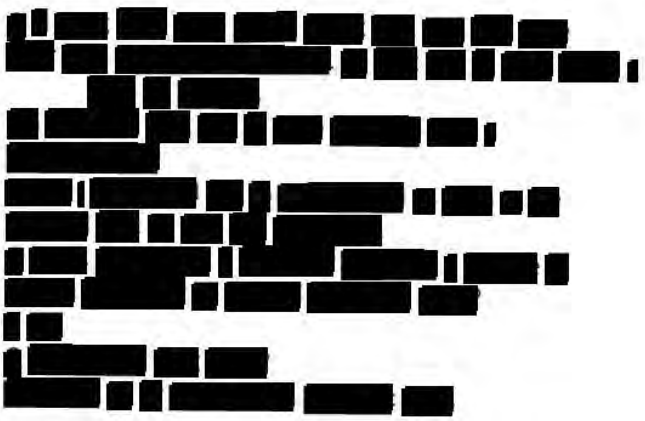
9. Based upon a reasonable degree of medical certainty, BHDC staff met the standard of care for providing emergency medical services to Mr. Cains. Based upon a reasonable degree of medical certainty, there were no unreasonable delays in calling 911

BHDC staff testified that [redacted]



(Jones Deposition, Page 75)

And again:



(Jones Deposition Page 83)

Medical staff were called. Ms. Jones believed that it took one to two minutes for medical staff to arrive and assess Mr. Cains.

> But you told me you don't really know how long it took them to get there because you're not even sure

exactly when you would have told Ryann to call them; right?
A I was guessing about how long it was when I said one to two minutes. (Jones Deposition Page 100)

Ms. Jones agreed that the call to medical for assistance was made at approximately 11:33.

According to the documents I was provided, the nurse -- medical says it received the call at 11:33.
Do you have any reason to think that that's wrong?
A It's probably pretty close.
Q Okay.
A I don't remember the exact time. But I'd – (Jones Deposition, Page 85)

However, there is no assurance that the clock in the nurses office at BHDC was actually correct.

In total, it appears that whatever the clocks said, the BHDC staff worked to support Mr. Cains for only 2 to 4 minutes before calling 911.

Two to four minutes may seem like an inordinately long period of time for the medical team to conduct an assessment. However. Mr. Scow has testified that it took him, a licensed EMT with advanced training and equipment, up to two minutes to conduct his assessment after arriving on the scene and before laying hands on Mr. Cains. Scow did not "put a finger on the patient" for one to two minutes after his arrival.

Q I don't need the exact time. I mean, I trust that it was what you're saying --
A I just want to make sure. Yeah. So I got it written down here. I'm just double checking. Yeah. So it looks like, from my time of call, was roughly 13 minutes to scene. And then looks like a minute or two to at patient. And roughly 20 minutes on scene and eight minutes from destination from leaving the departure to destination. (Scow Deposition Page 47)

And

Q Okay. So the time from the call until the time you put a finger on the patient was 15 minutes?
A Looks like it. Yeah. (Scow Deposition, Page 48)

[redacted]

This timeline created from staff testimony indicates that there was no inordinate delay in BHDC staff providing emergency care to Mr. Cains and in seeking additional assistance. Events which occurred during this time included the RCTs recognizing that [redacted]

10. Based upon a reasonable degree of medical certainty, BHDC medical staff could not [redacted]. This conclusion is supported by three separate pieces of evidence. [redacted]

[redacted]

Use of these devices exceeds the standard of care available at BDHC at the time.

11. Based upon a reasonable degree of medical certainty, Mr. Cains would have died even if BHDC contacted EMS at the moment when Mr. Cains was noted to have stopped breathing. Any alleged delay in contacting EMS, even a delay associated with staff performing their assessment, was inconsequential.

The incident is alleged to have occurred at approximately 11:30. According to the EMS Report, [redacted]

[redacted]

According to Dr. Brown-Forestiere, a delay of this length would certainly have resulted in brain injury or death:

> Without any intervention, someone who suffocates

> will likely die within five minutes. If there is a resuscitation, meaning the CPR that was immediately started for him, that leads into a resuscitation time. Our research, and it's plentiful in emergency medicine, shows that a resuscitation past 20 minutes drastically drops the possibility of a meaningful outcome, meaning not only that we can revive the body but also the brain.
>
> (Brown-Forestiere Deposition Page 21)

Later, Dr. Brown-Forestiere appeared to disagree with her own conclusions. She stated that indeed an 8 minute delay "could" have had an impact because a paramedic "could" have applied advanced techniques.

> So, yes, it is very unfortunate. Those eight minutes, honestly, in my opinion, I think that it could have had a very large impact.
>
> (Brown-Forestiere Deposition Page 21-22)

However, Dr. Brown-Forestiere did not assert that an 8-minute delay did have any impact in this specific case. She also did not comment on the fact that after [redacted] She also did not conduct an analysis of the timelines noted above.

In addition, Mr. Scow stated that he could not be certain that any delay on the part of BHDC staff affected the outcome:

> Q Is it possible that, had 9-1-1 been called immediately, is it possible at least that you could have -- that the outcome here could have been different?
> A I can't give any specific like certainty.
> (Scow Deposition Pages 14- 15)

Mr. Scow's opinion was likely measured against the fact that [redacted]

Brown-Forestiere Deposition Page 22)

It is likely that Mr. Scow recognized the futility of his efforts during his attempt to [redacted]

As a result, there is no evidence that any delay in calling 911 could have had an impact on the outcome. Even if, as is alleged, there were unreasonable delays in calling 911, these delays, plus EMS transit time it required 20 minutes. [redacted]

Given that "someone who suffocates will likely die within five minutes," and that the distance between BHDC and the local EMS unit requires at least 8 minutes of time to transit, the distance and associated delay in accessing emergency medical care likely puts the benefit of EMT services beyond the reach of anyone at BHDC who suffocates.

12a. Based upon a reasonable degree of medical certainty, at all times, the BHDC operated within the standard of care for a publicly-funded ICF IDD.

12b. Further, based upon a reasonable degree of medical certainty, at all times, the staff of BHDC provided care consistent with the standard of care for their training and scope of practice.

An assessment of the care rendered by the BHDC and its staff to Mr. Cains turns on the question of whether each provided care consistent with the "standard of care." The care provided by BHDC overall and its staff in this particular matter does meet the standard of care.

The matter of whether or not BHDC meets the standard of care is easily resolved. Since the facility is regulated by the Centers for Medicare and Medicaid Services (CMS), one need only look at whether or not the facility is certified. Indeed, BHDC is certified by CMS, indicating that the facility meets all applicable Conditions of Participation. This exercise may seem overly simplistic, however, it is generally accepted. LeBel notes that "Regulations are minimum standards." (See LeBel J. Regulatory change: a pathway to eliminating seclusion and restraint or "regulatory scotoma"? Psychiatr Serv. 2008 Feb; 59(2):194-6. PMID: .) While States may do more than meet minimum standards, there is no requirement for them to do so. In regard to this matter, the fact that BHDC meets minimal standards is sufficient to dispel any concern that the care practices embodied in the training, rules, regulations, policies, procedures or other facility-wide instruments is not sufficient.

For example, the State Operations Manual (SOM) Appendix J 42 CFR 483.450 Client and Facility Practices (W266) contains five Key Standards (W268; W278: W285: W295; W310) and 35 additional standards corresponding to the Key Standards, which delineate the expectations for the provision of behavioral services within an ICF IDD. Contrary to what some may claims, these are the only "standards" which are applicable to the BHDC.

In regard to the use of personal holds to address dangerous behavior in an emergency situation, the SOM Appendix J states that restraints may be used:

> As an emergency measure, but only if absolutely necessary to protect client or others from injury (W296 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.450(d)(1)(ii))

Given that BHDC is certified, the certifying body, CMS in this instance, represents that BHDC meets all applicable Conditions of Participation and their Key Standards.

In regard to the care provided by BHDC staff, the standard of care is based upon the question, "What care could the staff be reasonably expected to deliver based upon their training and experience," or "What would a reasonably qualified RCT do when confronted by the same situation?"

As has been previously noted, BHDC staff provided care in a manner that was consistent with all BHDC policies and procedures. In addition, staff provided care that was consistent with their training and scope of practice. Given the tools and resources at their disposal, they did the best they could.

> A. Oh, yeah, absolutely. I would do my best to try to just deescalate as best I can. Like, I did not want to put hands on anyone
> (Mattson Deposition Page 46)

And:

> A. So I didn't want to it to escalate further and other clients get involved, so I would try my best to kind of remove them and maybe then walk away. Like, move take them to their room –
> (Mattson Deposition Page 48)

And:

> We didn't put him on his stomach; we didn't put him face like, we didn't roll him face down or anything. We were using what I thought was our best judgment.
> (Mattson Deposition Page 117)

And:

> That's what we thought would be the best. course of action at the time.
> (Mattson Deposition Page 118)

And:

> At it was my best judgment at the time. It was a traumatic moment that I was --
> (Mattson Deposition Page 118)

And:

> And, like, [redacted]

[redacted]
(Mattson Deposition Page 118)

And:

Q. Okay. So, ds you sit here today, is it is it ·
your testimony that what -- what you and Mandy and Ryann
did complies with this policy?
A. As best as we could in the situation.
(Mattson Deposition Page 122)

And:

A. Like I said, he was flailing; he was whipping
around. I was doing the best I could for my only person.
(Mattson Deposition Page 132)

And

A. [redacted]
(Mattson Deposition Page 136)

Thought is the precursor to action. In order to evaluate what staff did during the medical/behavioral emergency, Plaintiff's would need to have a basic understanding of what staff were thinking at the time. However, Plaintiff's expert dismisses this as irrelevant and does not seem concerned:

Q So if he was on his left side and vomited and then
they turned him on his back and did abdominal thrusts,
would you conclude that they believed or had reason to
believe that he was choking?
A I can't comment on what they thought. I'm sorry.

(Deposition of Brown-Forestiere, Page 61)

If Dr. Brown-Forestiere cannot comment on what staff were thinking – what they had been taught and how they employed their knowledge - she cannot assess whether or not BHDC staff met the standard of care.

Dr. Brown-Foresteire acknowledged that she had no interest in the behavioral management of Mr. Cains:

> So, no, actually, my medical opinion has absolutely nothing to do with his personal -- whether he had personal aggression or not.
> My interest in the forums of his medical records and IPP was much more so to his physical, any physical conditions, in regards to if he had any diet specifics that made -- would have made him more of a choking risk and -- which he didn't, and if he had any special considerations and conditions in regards to eating; [redacted]
> Outside of that, my opinion is purely medical and scientifically driven and does not take into account whether he was a violent person or not. It has no bearing on whether he died from suffocation from choking.
>
> (Deposition of Brown-Forestiere, Page 52)

Dr. Brown-Forestiere also acknowledged that she was not familiar with Mr. Cains' specific plan of care:

> Are you familiar with the training on restraints and what authority there is to restrain David Cains in the Human Development Center?
> A In the Human Development Center, I do not believe I read specifics on --
> Q Okay.
> A -- their particular protocols.
> I recall them talking about it, but I don't see -- I did not see a specific protocol.
>
> (Deposition of Brown-Forestiere, Pages 52-53)

Dr. Brown-Forestiere also acknowledged that she was not familiar with any rules or regulations governing the operation of ICF IDDs or the Plan of Care, called the Individual Program Plan (IPP.)

Q Okay. All right. Well, are you -- so but you're not aware of what -- are you aware of what the laws are or the policies or rules regarding restraints in Human Development Centers in 2020?
A I am not.
Q Okay. Fair enough. So your opinion has nothing to do with whatever was authorized in the IPP or allowed in Arkansas in HDCs at that time?
A Correct. It is not.

(Deposition of Brown-Forestiere, Page 54)

In the matter of Mr. Cains' death and the applicable standard of care, Dr. Brown-Forestiere substituted the standard of care for the physician expert for that of the BHDC staff and suggests that BHDC staff should be able to meet this higher standard. This is an impossible expectation. No one other than an expert in the provision of emergency care in a hospital setting could possibly meet such a standard.

In terms of training and the specifics of this situation, multiple different areas are of importance. Initially, I would say the most important is that we are experts in resuscitation, meaning, people in their most emergent and critical settings, that is where we are experts to take care of these patients. So we see people in all different settings.
But, in this scenario, [redacted] is something that we do on a daily basis. And we're highly trained and we're definitely the experts for that. We're called in all over the hospitals for our expertise on that.
In addition, in regards to restraints, we have extensive training in how to use chemical and physical restraints safely; as we, you know, occasionally need to use those in the emergency department.
And we also have extensive training in how to deal with situations that come from physical restraints not being done properly and when we need to take care of someone for that.

(Brown-Forestiere Deposition Pages 5-6)

And again:

Okay.
A I do know, that in our training, the first thing to do is verbal de-escalation so that you can avoid restraints. And it does not appear that that happened.
Q It didn't appear to you that they tried to de-escalate it?
A I heard that he was given a chance to go to the bathroom and sit down.
Q And was the sit down a calming mechanism?
A I don't know.
Q As a matter of fact, the reason he sat down was to calm down, was it not?
A That might have been what it was directly --
Q So, in other words, there was a de-escalation or a calming before this outburst?
A Not what I would call the traditional, but potentially the way they thought of it, maybe.
Q Okay.
A It's not my training in de-escalation for -- to use those particular methods.

(Brown-Forestiere Deposition Pages 78-79)

It is readily transparent, Dr. Brown-Forestiere substituted her standard of care (people in emergency room and critical care settings) for that of the direct support professionals working at BHDC.

This problem with is approach, applying the physician standard of care to a professional who has received lesser or different training for application in a different setting, is illustrated by the following anecdote in which Dr. Brown-Forestiere describes her decision to become a physician:

I was a PA. I had just completed my training had just completed my training, which at a very high level surgical field, was four weeks of training on the job. I had just completed that and was on my own as first call at a Level 1 Trauma Center caring for adult and pediatric patients and I had my very first patient was a two year old who sustained extensive injuries and was left by myself, walking into a room. I looked at this child and the tubes going in and out of her I couldn't even name. I was presented with a scan I could not interpret. I was terrified and time mattered. This child's life was in my hands and I needed to make a quick

decision I didn't know how to make. It was late at night. I had to call my physician. I remember him just being angry that I didn't know the answer and that I couldn't handle it myself. And I just remember in that moment thinking, 'I'm never doing this again. I don't have the information of the training to do the job I'm being asked to do. This is dangerous. And it matters. And this child's life is in my hands and I'm not walking into another situation without a chance to know what I need to know to make these decisions.' So that was the, actually that night. Only four weeks out of school that I decided that I was going back to be a physician."

Accessed at

It is clear that Dr. Brown-Forestiere, working as a newly graduated Physician's Assistant at the time, was presented with a case that exceeded her level of training and experience. She acknowledged that she did not have the tools to do what was asked of her and that only a physician had the level of training needed to do what was necessary. She even described the situation as "dangerous." However, did she violate the standard of care for a PA? Based upon the evidence present in the anecdote, I don't believe so. A PA cannot meet the standard of care for a physician. In regard to the management of Mr. Cains challenging behavior, an RCT cannot meet the standard of care for a physician.

Based upon her acknowledged lack of understanding about ICF IDD rules and regulations, her lack of familiarity with basic treatment planning and IPP processes, her indifference to the behavioral training received by staff at BHDC, her inability to appreciate what BHDC staff were thinking at the time they were engaged to provide care to Mr. Cains, and her substitution of the medical standard of care for the direct support professional standard of care, Dr. Brown-Forestiere is completely unqualified to offer an opinion about the quality of care provided at BHDC or by BHDC staff.

13. Based upon a reasonable degree of medical certainty, Mr. Cains was positioned appropriately – on his side when he was vomiting and, later, on his back when he needed [redacted].

Dr. Brown-Forestiere testified that Mr. Cains was on his left side while being restrained. She also testified that this was the proper position for someone who was vomiting.

Q You had said earlier on, as I recall, that it was --
that you would want somebody to be -- who is vomiting to
be placed on their side and not on their back --
A Correct.
Q -- is that correct? Okay.

> And we all agree that David Cains, on that day, was placed, was on his side when he started vomiting.
> A Correct.

Dr. Brown-Forestiere also testified that Mr. Cains [redacted]

(Brown-Forestiere Deposition Page 30)

And:

> Q Okay. And what accounts -- so based upon your understanding of the facts, [redacted]

(Brown-Forestiere Deposition Page 58)

And:

> My opinion is that he choked from vomiting when he was on his left side.
>
> (Brown-Forestiere Deposition Page 61)

Dr. Brown-Forestiere admitted that the choking occurred when Mr. Cains was in the proper position, on his left side, and that once he had stopped breathing, he was rolled onto his back. The behavior of staff was completely consistent with basic CPR training.

Dr. Brown-Forestiere contradicts herself and is factually mistaken when she suggested that Mr. Cains was rolled on his back before he began choking.

> Having them on their right or left side, mostly right side, is the chosen, but a side so that the -- anything that could possibly vomit, like I said, it's more likely to vomit in a restraint situation, that gravity could help you by pouring it out of the mouth instead of settling to the back.
> So unfortunate but, yes, laying on his back was -- definitely contributed quite a bit.

Is it fair to say, that once he started vomiting while on his left side in the restraint, that placing him, quickly placing him onto his back, was essentially the worst thing that they could have done?
A Yes, unfortunately.

(Brown-Forestiere Deposition Page 16)

And:

There's actually -- when I referred to the restraint and special training, we are trained very much so to not have someone on their back when restrained. Having them on their right or left side, mostly right side, is the chosen, but a side so that the -- anything that could possibly vomit, like I said, it's more likely to vomit in a restraint situation, that gravity could help you by pouring it out of the mouth instead of settling to the back.
So unfortunate but, yes, laying on his back was -- definitely contributed quite a bit.
Q Is it fair to say, that once he started vomiting while on his left side in the restraint, that placing him, quickly placing him onto his back, was essentially the worst thing that they could have done?
A Yes, unfortunately.
The very first thing that is taught is to turn them onto their side if there's any sign of vomiting.
Q Okay.
A That is absolutely the just very unfortunate wrong thing.

(Brown-Forestiere Deposition Page 16)

Later in her testimony, Dr. Brown-Forestiere contradicts herself claiming that individuals in respiratory distress should never be laid on their backs.

Q But that -- so you're saying -- it's your testimony here today, as a medical expert in the emergency room resuscitation, that abdominal thrusts in the stomach to pop out an obstruction in the esophagus, in the airways, is not an appropriate procedure?
A It is not the appropriate procedure.
It is the idea that they had to try it, from what I can see. But, unfortunately, that is not the teaching.
The teaching is quite clear that laying someone on

their back occludes their airway and it is never the teaching to lay them on their back –

(Brown-Forestiere Deposition Pages 62-63)

Dr. Brown-Forestiere is in error when she stated that Mr. Cains should not have been placed on his back after his breathing had stopped. Mr. Cains had to be laid on his back [redacted]. Dr. Brown-Forestiere later agrees noting that it is always appropriate to lay someone who is not breathing on their back [redacted].

[redacted]

Q Okay. And you don't -- and that was appropriate, in your opinion; right?
A Yes.
Q And that was an attempt to save David Cains' life, was it not?
A Yes, it was. As far as I can tell.

Brown-Forestiere Deposition Pages 82-83)

Mr. Scow concurred, [redacted].

[redacted]

(Scow Deposition Pages 46-47)

And again:

[redacted]

(Scow Deposition Page 28)

The evidence indicates that BHDC staff complied with the standard of care in providing emergency behavioral services to address dangerous behavior and provide appropriate emergency medical care, consistent with their level of training and scope of practice, to Mr. Cains during the event.

14. Based upon a reasonable degree of medical certainty, Mr. Cains death was not accompanied by severe pain.

The definition of pain has long challenged clinicians. In 2020, the International Association for the Study of Pain (IASP) approved a definition of pain that not only

coupled the sensory and emotional dimensions of the experience, but also recognized the association between tissue injury and pain:

> "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage."
>
> Raja SN, Carr DB, Cohen m, et. al "The revised International Association for the Study of Pain definition of pain: concepts, challenges, and compromises. Pain DOI:

In order to feel pain, this definition requires that there be actual or potential tissue damage.

There is no professional agreement in regard to the amount or degree of pain associated with specific causes of death. Pain associated with a cause of death is proportionate to the degree of tissue damage, not the mechanism of death. However, Dr. Brown-Forestiere opined that:

> ...when someone chokes and their airway is
> closed off, obviously, they can no longer receive oxygen
> or expel CO2.
> This quickly induces kind of what we would call a
> terror fight or flight response, similar to a drowning
> victim. They start fighting with everything they can.
> Unfortunately, as the airway is blocked, CO2 which
> is -- turns into a toxic substance, which is an acid,
> builds up in their body, their muscles fighting against
> and are unable to expel the lactic acid they build up.
> So, essentially, you're not only suffocating, but
> it's a feeling of burning. Your lungs begin burning,
> your whole body, because of the acid build up.
> And the struggle -- and eventually you become
> unconscious and -- and your body continues to struggle
> until it no longer can.
> Q Is it a painful death?
> A It's probably the -- one of the most painful deaths
> there could be. That and I assume burning to death.
> But strangulation or suffocation and burning are the

-- are known as the two most awful ways to die.
(Brown-Forestiere Deposition Pages 18-19)

The basis for her opinion, that "strangulation or suffocation and burning are known as the two most awful ways to die" is pure speculation.

Dr. Brown-Forestiere is also incorrect in her description of the impact of anoxia on lactic acidosis and anaerobic metabolism. Mr. Cains lost consciousness after a brief period – a matter of seconds. This occurs well before the onset of anaerobic metabolism leading to the build-up of lactic acid in the muscles. Further, people who are resuscitated do not recall a feeling of being burned or burning prior to losing consciousness.

The consensus statement states that the experience of pain requires actual or potential tissue damage. Traumatic injuries cause severe tissue damage and include falls, motor vehicle accidents, gunshot wounds, stabbings, burns, and other mechanisms associated with severe tissue injury. These could all be associated with severe pain under specific circumstances. Diseases such as cancer or sickle cell crisis can cause severe tissue injury. Illnesses of this type could also be associated with severe pain. However, suffocation and drowning are associated with much lower amounts of tissue injury and, therefore, would be associated with lower levels of pain. Of course, each event is unique and the circumstances would vary from individual to individual death.

In the matter of Mr. Cains, it was reported by staff that [redacted]. There was very little tissue damage. The entire episode – from the onset of choking to the loss of consciousness – was over in a matter of seconds. It most certainly was not a pleasant way to die - what manner of death could be described as pleasant. However, based upon my reasonable medical judgment, and predicated upon my understanding of the definition of death and the pathophysiology of this choking episode, I do not believe that Mr. Cains suffered a painful death.

15. Based upon a reasonable degree of medical certainty, Mr. Cains had a life expectancy of only 6 more years.

[redacted]

[redacted]

McCallion, P. 'Mortality of People with Intellectual and Developmental Disabilities from [redacted] and [redacted]'

[redacted]

Expert Report: Findings and Expert Opinions

in regard to the Report of Janice LeBel

in the Matter of

CHRISTINE MCAULIFFE, as Special
Administrator of the ESTATE OF
DAVID CAINS CLAIMANT
V CLAIM NO. 220374
THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) RESPONDENT

Prepared by

Theodore Kastner MD, MS

January 6, 2023

Purpose: Dr. LeBel was engaged by Plaintiffs to offer expert opinions on (1) behavioral services offered at BHC in general and to Mr. Cains specifically and (2) the system of health care services at the BHDC. Based upon her review of materials, Dr. LeBel offered two opinions in a letter to Joshua D. Gillispie dated December 28, 2022 (hereafter called the Report.) A review was undertaken to understand the specific opinions which were offered and the basis for these opinions. My opinions are summarized at the beginning of this report and justified through the discussion which subsequently occurs.

Document Review:

The following materials were reviewed:

2015 Psychology Report 001
2016 Psychology Report 001
2017 Psychology Report 001
2018 Psychology Report 001
2018_IPP_001
2019_IPP_001
2017 - 2019 Physician's Orders_001
AmyJones_PDFTran (8)
BHDC Maltreatment Report 5-2020 (BHDC IRIS 87707)
BHDC Policy I-D-2_001
Cains David Behavior Reports for PA VA 04062007-05292020



CainsDavid Psychological Evaluation 05282020
CainsDavidIPP 07182019
Claimant's_3rd_Suppl_Responses_to_Discovery_001 (2)
Claim-Ex1-DRA-2015report
Claim-Ex2-DRA-Jan2016report
Claim-Ex3-DRA-Oct2020letter
EMS Report_001
Hamid (2)
I-D-4 2018 Policy
Medical_Clearance_Restraint_Use_001
NCI-training-instructor-guidance-resource
Physician's Orders 6-2020_001
Ryann_Campos_5-12-22 (2)
Samuel_Scow_5-5-22 (2)
Social History
State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities
Tyler_Mattson_Depo_001 (Compressed)

In addition, the following materials cited by Dr. LeBel in her Report, were also reviewed.

Centers for Medicare and Medicaid Services (CMS) (2018). Psychiatric Hospitals. Retrieved on June 2, 2018, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/PsychHospitals.html

Clarke RW, Harris J. The organization of motor responses to noxious stimuli. Brain Res Brain Res Rev. 2004 Oct;46(2):163-72. doi: 10.1016/j.brainresrev.2004.07.005. PMID: 15464205.

Evans, S. (2022, May 5). Zoom deposition transcript of Sandy Evans.

Hise, M. (2022, May 12). Zoom deposition transcript of Mark Hise.

UN Convention on the Rights of Persons with Disabilities (2006). Department of Economic and Social Affairs Disability. Available at: Convention on the Rights of Persons with Disabilities (CRPD) | United Nations Enable (accessed 22 November 2022).

World Health Organization (2019). Strategies to end seclusion and restraint. WHO Quality Rights Specialized training. Course guide. Geneva: World Health Organization; 2019. License: CC BY-NC-SA 3.0 IGO. Retrieved on November 12, 2022, from https://www.who.int/publications/i/item/9789241516754

In order to understand the foundational assumptions of Dr. LeBel in regard to her understanding of the standard of care and the appropriateness of restraint use, the following document was also reviewed.

LeBel J. Regulatory change: a pathway to eliminating seclusion and restraint or "regulatory scotoma"? Psychiatr Serv. 2008 Feb; 59(2):194-6. PMID: 18245163.

Standard for Opinions:

Throughout this report I will use the standard, "based upon a reasonable degree of medical certainty," to express my opinions. This report does not contain every opinion which I may offer during testimony. I reserve the right to amend this report and my opinions based upon any information that I subsequently acquire or any other issue.

Opinions:

The following is a list of the opinions offered in this report. As noted, the opinions in this report are not considered exhaustive and I reserve the right to amend this report and my opinions based upon any information that I subsequently acquire.

1. **Based upon a reasonable degree of medical certainty, CMS rules and regulations, ARDDS policies and procedures, and BHDC policies and procedures represent the standard of care for the delivery of behavioral services at BHDC.**

2. **Based upon a reasonable degree of medical certainty, other documents cited by LeBel, including materials generated by the United Nations, the World Health Organization, SAMSHA and other sources, do not represent the standard of care for the delivery of behavioral services at BHDC.**

3. **Based upon a reasonable degree of medical certainty, the suggestions, recommendations or opinions contained within cited references and other materials, to the degree that they diverge from CMS rules and regulations, AR DDS policies and procedures, and BHDC policies and procedures, do not represent the standard of care for the delivery of behavioral services at BHDC at BHDC**

4. **Based upon a reasonable degree of medical certainty, I agree with Dr. LeBel that the CMS regulations are "centrist."**

5. **Based upon a reasonable degree of medical certainty, Dr. LeBel does not recognize the authority of CMS, AR DDS and BHDC documents as representing the standard of care. Dr. LeBel has characterized the current CMS regulations as a "retreat from**

the standard-setting high ground." Dr. LeBel suggests that BHDC be required to deliver "low/no restraint services for people with developmental disabilities."

6. **Based upon a reasonable degree of medical certainty, Dr. LeBel regularly attributed statements to CMS which are not contained within CMS regulations in an effort to misrepresent the standard of care.**

   For example, Dr. LeBel claimed that:

   > "the Centers for Medicare and Medicaid Services (CMS 483.12; CMS 483.420) mandate that **patients/residents of facilities have the right to be free** from abuse and neglect..." (Report, Page 4, Bold in original)

   However, there is no such right articulated by CMS in the citation.

   In addition, Dr. LeBel also claimed that:

   > "Physical restraint is a potentially lethal procedure of last resort which is used in an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or ruled out (42 C.F.R. § 483.450)." (Report, Page 4)

   However, there is no such right articulated by CMS in the citation.

7. **Based upon a reasonable degree of medical certainty, Dr. LeBel considers herself a "legal advocate" and stated that "states and facilities must not rely on national standard-setting entities to lead change toward preventing and even eliminating seclusion and restraint." This opinion led Dr. LeBel to state that BHDC should be "compelled" "to action to change their use of restraint with persons-served creating a safer environment of care for staff and patients alike."**

8. **Based upon a reasonable degree of medical certainty, Mr. Cains, who weighed approximately 244 pounds at the time of the event, "charged at" or "lunged" at his staff, Mr. Mattson, and thereby initiated the process which led to physical contact between the two.**

9. **Based upon a reasonable degree of medical certainty, Mr. Mattson employed appropriate blocking techniques in an effort to protect himself, Mr. Cains and avoid escalation.**

10. **Based upon a reasonable degree of medical certainty, Mr. Cains's assault upon Mr. Mattson led Mr. Mattson and Mr. Cains to fall to the floor.**

11. Based upon a reasonable degree of medical certainty, while on the floor, Mr. Cains continued to demonstrate aggressive behavior towards Mr. Mattson and, subsequently, to other staff.

12. Based upon a reasonable degree of medical certainty, while on the floor, Mr. Mattson and other staff applied personal holds for the purpose of protecting Mr. Cains, staff and other individuals.

13. Based upon a reasonable degree of medical certainty, while on the floor, staff made no effort to hold or "pin" Mr. Cains to the floor. The application of personal holds was solely for the purpose of protecting Mr. Cains, staff and other individuals from Mr. Cains's aggressive behavior.

14. Based upon a reasonable degree of medical certainty, at all times, staff exercised their professional judgment in order to meet the standard of care including the use of less restrictive procedures, "time and space," and other appropriate means.

15. Based upon a reasonable degree of medical certainty, BHDC personnel are not required to demonstrate "imminent danger" before the use of restraint.

16. Based upon a reasonable degree of medical certainty, BHDC staff did not apply "lethal restraints."

17. Based upon a reasonable degree of medical certainty, Mr. Cains did not demonstrate a "withdrawal reflex."

18. Based upon a reasonable degree of medical certainty, [redacted] did not contribute to Mr. Cains vomiting.

19. Based upon a reasonable degree of medical certainty, Mr. Cains being restrained while on the ground did not contribute to Mr. Cains vomiting.

20. Based upon a reasonable degree of medical certainty, [redacted] did not complicate or represent a contraindication to the use of restraints with Mr. Cains.

21. Based upon a reasonable degree of medical certainty, there were no medical contraindications to the use of restrictive behavioral procedures. Dr. Hamid provided medical clearance to BHDC staff to employ restrictive procedures, when indicated, without condition or limitation.

22. Based upon a reasonable degree of medical certainty, [redacted]

23. Based upon a reasonable degree of medical certainty, there is no need to place Mr. Cains on a "Do Not Restrain List."

24. Based upon a reasonable degree of medical certainty, the emergency response system at BHDC is effective and appropriate to meet the needs of residents who require emergency treatment.

25. Based upon a reasonable degree of medical certainty, the emergency response system at BHDC does not represent an obstacle to emergency response and life-saving intervention.

26. Based upon a reasonable degree of medical certainty, activation of the county-level emergency response system by staff at BHDC and by passing the current requirement to first contact BHDC medical staff, would have had no impact on the quality of care provided to Mr. Cains or the outcome resulting from the care he received.

Expert Report: Findings and Expert Opinions

in regard to the Report of Janice LeBel

Opinions Offered by Dr. LeBel:
Dr. LeBel offers the following opinions at the beginning of her Report (Page 2):

> 1) The physical restraint used on DC proximal to his death fell below the standard of care established by recognized standard setting entities. In addition, the physical restraint used on DC fell below the standard of care established by BHDC.
>
> 2) The BHDC emergency response policy, whereby direct care staff were prohibited from calling 911, fell below the standard of care and created a dangerous situation for DC and other clients and resulted in a delay in emergency service response and intervention.

In the body of the Report, the two Opinions are highlighted in bold. I have copied out each Opinion and note that the Opinions within the body of the Report are subtly but substantively different that the Opinions listed at the top of the report.

> Opinion One: The physical restraint used on DC proximal to his death fell below the standard of care, including BHDC's standard of care. (Page 2)

and

> Opinion Two: The respondent facility's emergency response policy fell below the standard of care. (Page 11)

The difference in the Opinions, appearing literally on the same page of the Report (Opinion One Page 2), complicates the review of the Opinions.

In my analysis of the Report, I have copied each of the Opinions contained within the body of the Report and followed them with a Response. In addition, there are six arguments made by Dr. LeBel in support of Opinion 1. The arguments are highlighted in bold/italic and followed by a Response.

Opinion One: The physical restraint used on DC proximal to his death fell below the standard of care, including BHDC's standard of care (Page 2-3).
Dr. LeBel stated that:

The standard of care required the Respondent to comply with federal CMS/ICF Regulations found at 42 C.F.R. § 483.00 et seq.; Arkansas DDS policies and procedures; and BHDC's own policies and procedures. These policies establish that: a) only the least restrictive approved form of physical restraint can be used, b) for only the least amount of time necessary, c) only to prevent imminent and serious harm in emergency situations, d) only as a last resort after nonviolent techniques have been exhausted, e) the form of physical restraint used must be an authorized method clearly stated in the client's IPP, f) the form of physical restraint must be clearly identified in the facility's policies, and g) the authorized form of physical restraint must be taught to staff. The Respondent failed to meet the standard of care in this case.

Specifically, the Respondent failed in the following ways:

- The physical restraint was not necessary or justified and violated DC's right to be free from abuse and restraint;
- The physical restraint was not implemented in response to a life-threatening emergency or behavior that presented a risk of serious injury/harm;
- The physical restraint was not the least restrictive option;
- The physical restraint did not follow a reasonable effort at nonviolent de-escalation;
- The physical restraint was in violation of the [redacted];
- The physical restraint method used by staff was not an approved, authorized or instructed technique recognized by BHDC or documented in DC's IPP.

Response

(1) On page 2 of her Report, Dr. Lebel states that the "standard of care" requires that BHDC comply with the following documents:

Federal CMS/ICF Regulations found at 42 C.F.R. § 483.00 et seq.;
Arkansas DDS policies and procedures; and
BHDC policies and procedures

While she implied in the first iteration of Opinion One (Page 2), that BHDC should comply with "recognized standard-setting entities," that requirement was no longer applied to the second iteration of Opinion One (Page 2). The reason for her excluding these references in her discussion is unclear and should be explored. Are the

"standards" established by the UN and WHO applicable to the US? Do they supersede the "standards" published by CMS? Do CMS "standards" meet the standards set by WHO and UN? If not, are the CMS standards valid?

(2) The reference to 42 C.F.R. § 483.00 as a standard of care for ICF IDDs is overly broad. Federal CMS ICF IDD regulations are found within 42 C.F.R. § 483.00 but limited to Part I. Other portions of CMS 42 C.F.R. § 483.00 reference other facility types including Psychiatric Residential Treatment Facilities and other skilled nursing facilities which have no bearing in this discussion. The regulatory citations should generally be limited to those contained in Part I. The fact that Dr. LeBel chose to do otherwise created confusion when attempting to identify the source documents which she alleged represented the "standard of care."

(3) Dr. LeBel also states that compliance with "standards" must be reflected in the following manner:

> These policies establish that: a) only the least restrictive approved form of physical restraint can be used, b) for only the least amount of time necessary, c) only to prevent imminent and serious harm in emergency situations, d) only as a last resort after nonviolent techniques have been exhausted, e) the form of physical restraint used must be an authorized method clearly stated in the client's IPP, f) the form of physical restraint must be clearly identified in the facility's policies, and g) the authorized form of physical restraint must be taught to staff.

I have reviewed the CMS documents cited by Dr. LeBel and cannot identify all of these specific requirements. Specifically, I conducted a cross-reference of the 7 components (a through g) which she states must be met in order for BHDC to meet federal and State standards. However, I could not find evidence to support her claim that all 7 conditions must be met in order to determine that a facility such as BHDC meets CMS "standards." Indeed, State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities makes no such reference to these 7 specific requirements. As a result, they appear to derive from Dr. LeBel's ideological bias against the use of restraints and her interest in applying her ideological beliefs to BHDC rather than to actual Federal standards.

In order to verify that Dr. Lebel's opinion has a sufficient legal and regulatory basis, Dr. Lebel should be asked to walk through each item (a through g) and reference the

specific Federal. AR DHS or BHDC standard which makes the component a requirement for meeting the "standard of care."

Dr. LeBel made allegations that the BHDC did not meet the standard of care in 6 specific respects. Dr, LeBel alleged that:

> Specifically, the Respondent failed in the following ways:
>
> • The physical restraint was not necessary or justified and violated DC's right to be free from abuse and restraint;
>
> • The physical restraint was not implemented in response to a life-threatening emergency or behavior that presented a risk of serious injury/harm;
>
> • The physical restraint was not the least restrictive option;
>
> • The physical restraint did not follow a reasonable effort at nonviolent de-escalation;
>
> • The physical restraint was in violation of the [redacted];
>
> • The physical restraint method used by staff was not an approved, authorized or instructed technique recognized by BHDC or documented in DC's IPP.
> (LeBel Report, Page 2)

In the early portions of her Report (Pages 1 and 2) Dr. LeBel offered little specific evidence to support these 6 claims. To the extent that these general concerns are offered with specific supporting evidence, they are addressed in the subsequent narrative. However, for the sake of completeness, a general rebuttal is provided here.

• The physical restraint was not necessary or justified and violated DC's right to be free from abuse and restraint;

> **Response:** The use of personal holds was justified as staff sought to prevent Mr. Cains from harming himself, staff or others. As noted below, Mr. Cains had no unqualified "right to be free from abuse and restraint." Standards of care allow for restraint use so long as it meets the conditions set forth within CMS regulations. As is evident in the following discussion, BHDC complied with all applicable Federal regulations governing the use of restraints in this specific instance.

• The physical restraint was not implemented in response to a life-threatening emergency or behavior that presented a risk of serious injury/harm;

Response: In making this claim, Dr. LeBel does not appear to be referencing a specific Federal regulation. CMS regulations permit the use of restraint in response to behaviors which have the potential to cause harm to an individual, to staff or to others.

> As an emergency measure, but only if absolutely necessary to protect the client or others from injury. 42 C.F.R. § 483.450(d)(1)(i)

Mr. Cains's behavior (spitting) was harmful to the staff. In addition, his aggressive behavior towards Mr. Mattson certainly had the potential to cause additional harm. Mr. Cains weighed approximately 244 pounds at the time of his death and attacked Mr. Mattson, "charging" at him. Allowing Mr. Cains to charge unimpeded to Mr. Mattson or any other individual would have been reckless and inconsistent with both the standard of care and staff training.

CMS does not require that the potential harm rise to the level of "life threatening." In addition, CMS does not require that the level of harm be deemed "serious."

- The physical restraint was not the least restrictive option;

Response: The personal holds used in this instance were part of a hierarchy of responses which included less restrictive measures. Prior to the use of personal holds, Mr. Cains was offered the less restrictive opportunity to relocate to a different area and to take his time to gain control over his feeling. However, less restrictive procedures were ineffective, After Mr. Cains attacked Mr. Mattson, physical restraint was necessary to protect Mr. Cains, his staff and others from harm.

- The physical restraint did not follow a reasonable effort at nonviolent de-escalation;

Response: BHDC staff attempted to implement least restrictive behavioral interventions along a hierarchy consistent with their training and experience. This included the non-violent "time and space" to allow Mr. Cains to gain control over his behavior. Unfortunately, despite the use of less restrictive alternatives, Mr. Cains's behavior escalated and staff were compelled to use personal holds in order to protect themselves, Mr. Cains and others.

- The physical restraint was in violation of the [redacted]

Response: Dr. LeBel lacks any qualifications which would allow her to testify in this regard. That being said, as a matter of general health, [redacted]

• The physical restraint method used by staff was not an approved, authorized or instructed technique recognized by BHDC or documented in DC's IPP.

Response: Staff employed "personal restraint," an emergency procedure limiting movement by the holding of a hand or limb," which is identified in "Boonville HDC Policy I-D-4 Documentation and Response to Maladaptive Behaviors" as an Approved Restraint Procedure, Technique or Device. Staff also receive instruction in the use of "personal holds."

The content of the behavioral services curriculum (NCI) does not represent BHDC policy. In addition, the content of the curriculum is not exhaustive of every application of the Approved Restraint Procedure, Technique or Device. Staff are trained in the application of personal holds in the standing and seated positions. They are not trained in the application of personal holds while an individual is on the ground. However, that fact does not represent a prohibition against the use of restraints when an individual is on the ground. In addition, staff are instructed in the principles of behavior management including the need to provide restraint in the least restrictive manner. Based upon their training and experience, staff may use their professional judgment to determine that the application of personal holds while an individual is on the ground is less restrictive than transitioning an individual to a more restrictive mechanical restraint such as a papoose board.

The use of restraints is reviewed and approved for each individual through an interdisciplinary process and reflected in the IPP. Consent to the use of restraints is always obtained. In regard to Mr. Cains, a member of his family was aware of the clinical need for restraints, participated in the interdisciplinary process, and gave consent for restraint use.

Right to be Abuse and From Restraint (Pages 3-4)

On Page 4, Dr. LeBel articulates her interpretation of the "standard of care." To that end, she states:

> "The Respondent's use of restraint in this case was a violation of patient/resident rights and a violation of the facility's obligation to uphold the patient's right to be free from abuse and restraint use. Physical restraint is defined by the federal government (Centers for Medicare & Medicaid Services [CMS]) as: *Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely* 42 C.F.R. § 482.13 and C.F.R. § 483.420. Physical restraint is a potentially lethal procedure of last resort which is used in an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or ruled out (42 C.F.R. § 483.450)." (Page 4)
>
> Patients/residents in health care settings have a right to be free from restraint. To affirm this position and prevent the risk of serious harm associated with restraint use, standard setting organizations such as the United Nations(UN) (2006), World Health Organization (WHO) (2019), and the Centers for Medicare and Medicaid Services (CMS 483.12; CMS 483.420) mandate that **patients/residents of facilities have the right to be free** from abuse and neglect including but not limited to ...**any physical** or chemical **restraint** ... (emphasis added) imposed for purposes of discipline or convenience. When physical restraints are used, the facility is obligated to use the least restrictive alternative for the least amount of time and ensure that staff have and demonstrate needed competencies to effectively and appropriately interact with clients; monitor and take immediate action to address circumstances where possible abuse, neglect or mistreatment has occurred and prevent reoccurrence of abuse (CMS 483.12; Halverson et al., 2023; Huckshorn et al., 2021; AR DDS 3011-D; UN, 2006; & WHO, 2019)."

Response:

There are several errors in Dr. LeBel's interpretation of CMS regulations and the standard of care:

(1) The only standard which applies to BHDC are those standards established by CMS for the operation of ICF IDDs, in addition to AR DDS and BHDC policies and procedures which derive from these requirements. Dr, LeBel has previously acknowledged that CMS regulations represent the standard of care. As Dr. Lebel has noted, "Regulations are minimum standards." (See LeBel J. Regulatory change: a pathway to eliminating seclusion and restraint or "regulatory scotoma"? Psychiatr Serv. 2008 Feb; 59(2):194-6. PMID: 18245163.)

(2) Although Dr. Lebel suggests that Halverson et al., 2023 and Huckshorn et al., 2021 are standards of care, they are not. Even if they were, their publication date, after the death of Mr. Cains, disqualifies them from being relevant to the events under discussion.

(3) Although Dr. LeBel states that the WHO is a "standard-setting organization," in regard to the standard of care for the implementation of behavioral services at BHDC, it is not.

(4) Although Dr. Lebel implies that WHO, 2019 is a standard, it is not. WHO, 2019 is a "course guide" to a curriculum developed by a third-party for general use. The WHO makes no warranty as to its specific applicability in any setting. Un the section, General disclaimers, WHO notes:

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(5) Although Dr. LeBel states that the UN is a "standard-setting organization," in regard to the standard of care for the implementation of behavioral services at BHDC, it is not.

(6) Although Dr. Lebel implies that UN, 2006 is a standard, it is not. UN, 2006 is a document intended to drive social change recognizing that people with disabilities have the same rights as others, including the right to provide consent to treatment either themselves, or appropriately designated proxies – rights which are already reflected in the CMS ICF IDD regulations. As UN, 2006 notes:

> The Convention follows decades of work by the United Nations to change attitudes and approaches to persons with disabilities. It takes to a new height the movement from viewing persons with disabilities as "objects" of charity, medical treatment and social protection towards viewing persons with disabilities as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.
>
> The Convention is intended as a human rights instrument with an explicit, social development dimension. It adopts a broad categorization of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms. It clarifies and qualifies how all

categories of rights apply to persons with disabilities and identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights and areas where their rights have been violated, and where protection of rights must be reinforced.

(7) Dr. LeBel states that:

> Physical restraint is a potentially lethal procedure of last resort which is used in an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or ruled out (42 C.F.R. § 483.450).

I reviewed 42 C.F.R. § 483.450 and cannot find this language. The full text of the standard, as it relates to physical restraint use is as follows:

> **(d)** ***Standard: Physical restraints.***
>
> **(1)** The facility may employ physical restraint only -
>
> **(i)** As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;
>
> **(ii)** As an emergency measure, but only if absolutely necessary to protect the client or others from injury; or
>
> **(iii)** As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.
>
> **(2)** Authorizations to use or extend restraints as an emergency must be:
>
> **(i)** In effect no longer than 12 consecutive hours; and
>
> **(ii)** Obtained as soon as the client is restrained or stable.
>
> **(3)** The facility must not issue orders for restraint on a standing or as needed basis.
>
> **(4)** A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints, released from the restraint as quickly as possible, and a record of these checks and usage must be kept.

> **(5)** Restraints must be designed and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.
>
> **(6)** Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed, and a record of such activity must be kept.
>
> **(7)** Barred enclosures must not be more than three feet in height and must not have tops.

Specifically, CMS does not characterize restraint as a "potentially lethal procedure of last resort." In addition, CMS does not limit restraint use to "in the event of imminent danger." Restraint use is permitted "to protect the client or others from injury." Such a determination can only be made by staff at the time the restraint is needed and based upon the specific circumstances present.

Dr. LeBel's opinion about the conditions under which restraint use may occur align with her personal beliefs. However, there is no evidence that CMS is in agreement with Dr. LeBel's personal opinions about restraint use. As a result, Dr. LeBel's interpretation of the standard of care and CMS regulations should not be relied upon when contemplating the standard of care for behavioral restraints at settings like BHDC.

(8) Dr. LeBel states "Patients/residents in health care settings have a right to be free from restraint." This is not true. There is no instance do CMS regulations offer an unqualified right to be free from restraint. Restraint is an approved medical/behavioral procedure which is designed to protect staff, the individual, and others from harm. To suggest that such a right exists would be to imply that facilities, such as BHDC, be prohibited from taking action to prevent harm to staff, individuals and others, especially in emergency situations. This would be contrary to CMS regulations as it could create an unsafe environment. CMS determined that there is a role for restraint use in settings such as BHDC and this opinion is reflected in CMS regulations.

(9) That being said, residents of facilities such as BHDC must be protected from unwarranted and inappropriate use of restraint. For example, as noted in §483.12(a)(2)

> The facility must:
> Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility

must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

Contrary to Dr. LeBel's opinion, CMS, through the use of surveyors and its survey instrument (State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities Rev. 178, 04-13-18), has determined that Arkansas DDS and BHDC comply with all aspects of §483.12 and §483.420.

Threshold for Restraint use was not Met (Page 4)

Dr. LeBel argues that the standard of care includes an "imminent danger" threshold which must be met before the application of restraints:

"In health care settings, physical restraint is an emergency procedure of last resort and should only be used in the event of imminent danger to the patient/resident or others."

As noted earlier, no such "imminent danger" standard exists in CMS regulations.
In addition, Dr. LeBel generated a list of the behaviors demonstrated by Mr. Cains while in the dining area and the lobby near the restrooms. Her Report states the following:

BHDC staff documented and described DC's behavior as:

1. "yelling" (Jones, deposition testimony, p. 67); "screaming" (Jones OLTC Witness statement, labeled exhibit 4, p. 1)
2. "slightly agitated ...became aggressive in common area" (IRIS report)
3. "irritated...screaming and cussing...ripped paper off the wall... jumped up ... spitting and attempting to hit..." (Mattson, OLTC Witness statement, labeled exhibit 9, p. 1-2)

She goes on to state that this behavior was "not lethal or life threatening, nor does it pose a risk of serious injury." (Report, Page 5) LeBel concluded that since these behaviors were not lethal

or life threating nor posed a risk of serious injury, they did "not require the use of force or a hands-on containment procedure." (Report, Page 5).

Dr. LeBel reiterates her "imminent danger" standard, which has already been demonstrated to fall outside the CMS standard of care. She states that:

> "The antecedent actions described in the various documents do not meet the BHDC threshold of imminent danger requiring the implementation of physical restraint."

Knowing that the "Imminent danger" standard falls outside of the CMS standard of care, Dr. LeBel cites Halverson et al., 2023; Huckshorn et al., 2021; Huckshorn & LeBel, 2015; Ridley & Leitch, 2019) as "restraint standards of practice."

Response:

(1) The publications cited by LeBel are not "restraint standards of practice." LeBel has noted that federal regulations are standards. (See LeBel J. Regulatory change: a pathway to eliminating seclusion and restraint or "regulatory scotoma"? Psychiatr Serv. 2008 Feb; 59(2):194-6. PMID: 18245163.) The federal regulations supersede any proposed standard of care which LeBel attempts to install in this instance.

(2) LeBel created an ad hoc standard, the "imminent danger standard," as a condition for the use of restraint:

> "The antecedent actions described in the various documents do not meet the BHDC threshold of imminent danger requiring the implementation of physical restraint." (Report, Page 5)

This substitution of her desired "standard" for the generally accepted "standard" is inappropriate and inconsistent with CMS regulations §483.12 and reflects her continued desire to use the consultation to eliminate restraint use at BHDC.

(3) The standards which LeBel identified for the use of restraint are at odds with BHDC Policy. "BHDC Policy 1-D-4 Documentation and Response to Maladaptive Behaviors" allows for the use of restraints when maladaptive behaviors occur. The document defines maladaptive behavior, noting:

> "Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, or the destruction of property."

In no instance does CMS or BHDC policy limit the application of restraints to only situations where there is imminent danger. CMS allows that restraint be utilized when behaviors arise which could "potentially" result in injury or harm.

(4) The Policy also requires that a hierarchy of behavioral interventions be used, with least restrictive procedures preceding more restrictive restraints:

> Personal restraint of a client is used when the behavior is such that verbal control has been lost and other less restrictive measures have failed to control the behavior.

(5) Dr. LeBel provided an incomplete listing of the behavioral strategies used by Mr. Matson to address Mr. Cains's maladaptive behavior. Specifically, Mr. Matson spoke softly to Mr. Cains, then took Mr. Cains to the bathroom, then, at Mr. Cains's request, relocated Mr. Cain to a quiet location. Finally, Mr. Mattson used defensive blocking techniques to address Mr. Cains' aggressive behavior – all prior to the use of restraints. Mr. Matson clearly employed the hierarchy of behavioral interventions, beginning with less restrictive procedures, consistent with his training and CMS regulations. As noted by Mr. Mattson in his witness statement:

> I was at lunch with David. He had finished eating his sandwich and cucumber and put his tray up. He sat down and seemed fine. Shortly after he asked if he could go to the restroom. I followed him inside the bathroom because he seemed irritated beforehand. While in there I heard no abnormal sounds such as vomiting due to his history of intentional vomiting when he is upset. We went out and he asked if he could sit in the lobby to calm down. I said that's fine. Shortly after, he began screaming and cussing and ripped paper off of the wall to throw. He then jumped up after me and attempting to hit me. I applied personals by grabbing his arms and he ended up falling over. I did not land on him. He continued fighting and I rolled him on his left side as to not put any pressure on his stomach because he had just ate. At that time he was still fighting and Mandy joined to assist me, grabbing his hands, all while I was squatted over him, not putting any weight on him during any of this, holding his shoulder and sides. He was still continuously fighting and Ryann Campos showed

up and held his legs down. Still fighting, We had him in personals for approx. 1 min and [redacted]

(6) Further, Dr. LeBel provided an incomplete listing of maladaptive behaviors which Mr. Cains demonstrated prior to the use of restraints. Most noteworthy, she failed to accurately report that Mr. Cains "charged" at Mr. Mattson. The event is described more fully in the Deposition of Mr. Matson. In his deposition, he noted

O. And then you said he --- he came after you?
A. Yes. He charged me.
O. Charged you.
A. Yes
(Mattson Deposition, Pages 101-103)..

Consistent with his training, Mr. Matson employed blocking techniques, including placing his hands on the inside of Mr. Cains' extended arms in an effort to prevent himself from being harmed by Mr. Cains. Unfortunately, Mr. Cains, a very large man with a weight of 244 pounds, caused both himself and Mr. Matson to fall to the ground. Having employed less restrictive behavioral strategies and subsequently being the subject of Mr. Cains's physical assault, Mr. Matson appropriately used personal holds – the least restrictive intervention that would protect himself, Mr. Cains and others from Mr. Cains's escalating behaviors.

Finally, Dr. LeBel implies that Mr. Mattson inappropriately took Mr. Cains to the ground. Mr. Mattson contradicts this opinion in his deposition. Mr. Cains' large mass and speed combined to lead both Mr. Cains and Mr. Mattson to fall to the floor.

O. How did he fall? What caused him --
A. We
O. to fall?
A. We just kind of tripped up on each other. It was
all one big motion, like I had said.
O. Okay. And why did you not attempt to do the
blocking technique where you block and kind of get out of

his way?
A. I wouldn't have had room. I was against a ledge.
O. You were against a ledge?
A. Yes.
O. Why would a ledge prevent you from being able to do like this?
A. Because I would have fell over be- if he had put enough momentum into me.
O. Okay. So you guys fall- over.
(Mattson Deposition, Pages 1)

(7) Dr. LeBel turns the events completely on their head when she alleges that it was Mr. Matson who initiated contact with Mr. Cains:

> "In addition, **it does not appear that DC initiated physical contact with staff or physically harmed anyone** (emphasis added). Per Mattson's OLTC Witness Statement (labeled exhibit 9, p. 2), he (Mattson) initiated physical contact with DC (*"I applied personal by grabbing his arms"*). Mattson grabbed DC's arms. Mattson activated an autonomic, defensive physical response from DC referred to as the "Withdrawal Reflex" (Clarke & Harris, 2004). Mattson initiated the physical interaction with DC; he did so without first utilizing required supported stance and blocking techniques or any other form of nonviolent de-escalation required to be exhausted prior to physical restraint. (Pages 5-6)

Dr. LeBel did not consider the evidence in Mr. Mattson's deposition which more fully describes the event. According to the description of events offered by Mr. Mattson during his deposition, it was Mr. Cain who charged Mr. Mattson, initiating the process which led to both Mr. Mattson and Mr. Cains to fall onto the floor. Mr. Cains lunged and charged at Mr. Mattson. Given Mr. Cains' weight of 244 pounds, this assault caused Mr. Mattson to fall backward or on his side and Mr. Cains to land on top of or adjacent to him.

Mr. Mattson, the only eyewitness, describes the events as follows:

O. Okay. What's he doing as he's sitting there?
A. Just sitting. He was just sitting look- staring out.
O. All right. And then what happens?
A. He grabs a paper and goes after me.

O. Where does he grab paper from?
A. There was a flyer on the wall.
O. Does he stand up to grab it?
A. He grabbed it and then went after me. He was sitting down and then went after me to attack me.
O. What --- what kind of paper was it? Just---
A. It was just it was just a printout paper, just a flyer.
O. What did he do with it after grabs it?
A. He was throwing it and then went after me. He threw it down and then went after me.
O. He threw it down and then went after you. Did he say anything?
A. No. He just screamed "bitch."
O. He screamed "bitch"?
A. Yes. That I recall.
O. Anything else that you recall him saying?
A. No.
O. And then you said he --- he came after you?
A. Yes. He charged me.
O. Charged you.
A. Yes
O. Okay. Does --- describe that for me as best you
A. He just went to qrab me. I mean
O. How far away from him were you?
A. Maybe from here to that pole. Maybe a little bit shorter.
O. This pole?
A. Yeah, about there. Maybe to the chair.
O. My chair?
A. Between there.
O. Okay.
A. Yeah.
O. So about 6, 7 feet?
A. Maybe.
O. Okay. And when you say "charge, " was he running at you?
A. Lunging, running. Yeah, just --- he went after me.

He didn't really have room to necessarily run.
O. Can you --- do you mind standing up and showing me?
A. I -- as best as I can. Like, he just --- it was like just a classic --- like, he went to grab at me.
O. Okay. Went to grab at you?
A. Yes.
O. So not swing at you but grab at you?
A. Grab at me.
But, like he had --- like --- like I said, that distressed face.
O. Okay.
A. Like he was agitated and --- yeah.
O. All right. And --- okay. And then what --- what did you do?
A. I tried to hold him and we kind of just fell.
O. How did you try to hold him? Stand up and show us, please.
A. Like, I was --- like, I just kind of grabbed him by the shoulders the best as I could, you know, with him -- momentum --
O. Yeah.
A. and we just kind of stumbled over, you know.
O. Okay. So he's coming at you arms raised like this?
A. It --- yeah.
O. Like this?
A. Outwards, yeah.
And I just kind of grabbed, like, here and here. I didn't, like, grab by the wrist. You know, but, like we kind of just awkwardly fell.
O. Did he get a --- did he get a grip around you?
A. No, he didn't get a grip around me.
O. Okay. Sorry.
A. No, that's all right.
O. This won't take long.
So he's coming at you. Show me and slowly so --- so I can really see it: What --- what do --- show me what you do as he's coming at he's lunging at you.
What do you do? What do your hands do? Where do

they go?
A. I'm just like --- biceps, like, arms.
O. Okay. So you would have your --- your right hand on his left bicep and your left hand on his right bicep?
A. Yeah.
O. Pretty much?
A. Pretty much, yeah.
O. Okay. And --- and do you stay there locked like ---
A. No.
Like we tripped. Like --- like, we lust kind of fumbled around. Because it was, like, all in one big momentum, you know.
O. Uh-huh. And you fall to the ground, and he hits his face on the ground?
A. No, he didn't hit his face on the ground.
It wasn't a fast f all. It was a controlled fall as much as I could control it. (Mattson Deposition Pages 100-103)

It is inconceivable that Dr. Lebel would allege that Mr. Mattson initiated the physical interaction when it was Mr. Cains who attacked him. Mr. Mattson's description indicates that he attempted appropriate blocking technique (engaging the inside of the arms at the biceps) but was unable to stop the attack. It was Mr. Cains' momentum which carried them to the ground.

Having employed defensive blocking techniques which included grabbing the inside of Mr. Cains's arms in an effort to avoid being attacked, Mr. Mattson and Mr. Cains fell to the floor. They "awkwardly fell" or "tripped." There was no effort on Mr. Mattson's part to place Mr. Cains on the ground. The fall to the ground occurred as a result of Mr. Cains' unprovoked attack.

(8) Finally, Dr. LeBel offers the highly unlikely theory that Mattson "grabbed DC's arms," and that:

> "Mattson activated an autonomic, defensive physical response from DC referred to as the 'Withdrawal Reflex' (Clarke & Harris, 2004)."

Dr. LeBel's theory that Mr. Cains demonstrated a "withdrawal reflex" as a result of Mr. Mattson's use of blocking techniques is inconsistent with our knowledge of neurology, neuroanatomy, and neurophysiology.

Clarke & Harris is a review of the spinal cord responses to noxious stimuli, with a particular focus on the response to painful stimuli following spinal cord injury. The intent of the authors was to assist researchers in improving the quality of studies aiming to understand the body's response to painful stimuli. The authors state:

> The article was published as a guide to researchers designing studies to investigate the body's response to noctious stimuli.

Dr. LeBel is incorrect when she describes the "withdrawal reflex" as "an autonomic, defensive physical response." The "withdrawal reflex" is neither an autonomic response nor defensive in nature.

The autonomic nervous system is a component of the peripheral nervous system that regulates involuntary physiologic processes including heart rate, blood pressure, respiration, digestion, and sexual arousal. It contains three anatomically distinct divisions: sympathetic, parasympathetic, and enteric. The autonomic nervous system is not involved in withdrawal reflexes. Withdrawal reflexes are generated through afferent and efferent fibers in the spinal cord.

In addition, the reflex is not defensive. Defense suggests a determination by the cortex to discriminate between those stimuli which are aggressive vs those which are not. In regard to spinal reflexes, the cortex is not involved.

The authors note that the utility of "withdrawal reflexes" is most often observed in the clinical assessment of individuals with brain or spinal cord injury:

> ...although these data indicate that differentiation of withdrawal reflexes is most readily seen from stimuli applied to the plantar surface of the foot.

Dr. LeBel's opinion appears to be purely speculative. Dr. LeBel does not offer any opinion as to how such an "autonomic, defensive response" would have been manifest in Mr. Cains's behavior. What would a "withdrawal reflex" have looked like? Would any observed "withdrawal reflex" have been sudden or slow? Would he have withdrawn his arms from his attempt to grab Mr. Matson? Would such a reflex have stopped Mr. Cains's forward motion? Would he have fallen backwards?

Further, the issue of the role of "higher centres" is important in understanding human motor behavior. In Dr. Lebel's view, simply blocking the biceps would be sufficient to cause Mr. Cains

to stop his "charge" and retreat. To a degree of medical certainty, it is not likely that a "withdrawal reflex" occurred as a result of Mr. Mattson grabbing an arm or employing a blocking technique. The reasons that Mr. Cains charged at Mr. Mattson, although unknown, more than likely involved cognitive centers located above the spinal cord and would have been overcome by simply pressing on his biceps.

No Reasonable Effort at Least Restrictive Intervention and Non-violent De-escalation Intervention (Page 6)

Dr. LeBel stated that:

> "The documentation provided does not identify any reasonable effort to de-escalate DC's distress. The most basic de-escalation strategies (time and physical space) were not apparent in the direct care staff OLTC witness statements (Campos & Jones). Mattson appears to be the only staff member with DC at the time the problem started. Mattson's written OLTC witness statement (p. 1-2) regarding the sequence of actions is disjointed. Mattson describes DC as: 'sitting, then screaming and cussing, then ripping paper off the wall to throw'. It is unclear how ripping paper off a wall occurs in a seated position. Mattson says DC then "jumped up ... spitting and attempting to hit me." If DC was holding paper and attempting to throw it, one of DC's arms was likely elevated and rotated. It is not clear how quickly DC could rise to a standing position and attempt to hit Mattson. DC's physical actions were likely to have been slow, given his physical limitations. Mattson offers no detail about any verbal attempts he made to aid in calming DC, redirecting him, asking him to stop, offering DC any form of support, or utilizing the "supported stance" training.

Response:

(1) Mr. Mattson's written Witness Statement may appear somewhat disjointed. It was taken within a short time of the incident and, no doubt, Mr. Mattson was upset by Mr. Cains's death.

(2) In spite of this shortcoming, the Witness Statement indicates that Mr. Mattson did make reasonable efforts to employ the least restrictive intervention and non-violent de-escalation Intervention. Mr. Mattson wrote:

> We went out and he asked if he could sit in the lobby to calm down. I said that's fine.

(3) Dr. LeBel relies exclusively on the Witness Statement of Campos & Jones to conclude that "the most basic de-escalation strategies (time and physical space) were not apparent in the direct care staff OLTC witness statements." However, neither of these

witnesses were present at any time before Mr. Cains charged Mr. Mattson resulting in the two men falling to the floor. Neither witness was in a position to comment on this issue at all.

However, if Dr. LeBel had relied upon Mr. Mattson's Witness Statement, she would have been compelled to reach the opposite conclusion: Mr. Mattson did make reasonable efforts to employ the least restrictive intervention and non-violent de-escalation Intervention.

(4) Dr. LeBel materially misrepresents the actual conduct of BHDC staff. As noted previously, a more detailed description of the staff response to the event is contained within Mr. Mattson's deposition, a document which Dr. LeBel has cited at various points in her Report but ignores in this discussion. Mr. Mattson's deposition indicates that the incident began in the dining area and was addressed with both "time and physical space" – Mr. Cains was permitted to use the bathroom, relocate to the lobby and given as much time as he needed to compose himself. However, the use of "time and physical space" was unsuccessful in helping Mr. Cains to control himself.

Use of Restraint Violated BHDC Attending Physician's Order

Dr. LeBel stated that:

> Staff could have and should have taken DC's medical risks into consideration (Evans, 58) and used another approach to help DC manage his distress. Moreover, Dr. Hamid did not approve of the use of floor/ground restraint for DC (77) nor was any restraint method identified in the IPP (483.450(d)(1)(i); Evans, 29, 35). Given the medical risk of restraint use with DC, BHDC could have put DC on their *Do Not Restrain List* but did not.

Response:

(1) Direct care staff, including Mr. Mattson, neither could have nor should have taken DC's medical risks into consideration and used another approach to help Mr. Cains manage his distress. A determination as to "another approach" would have required direct care personnel to make a medical determination – something which exceeded their training, experience or scope of practice. Only a health care provider could reasonably be excepted "to take DC's medical risks into consideration" and "devise another approach."

(2) Dr. LeBel does not appear to understand the role played by health care professionals in the delivery of behavioral services. As a matter of general practice, Dr. Hamid does not "approve" the use of any specific restraint. In executing the document, his review is performed solely for the purpose of proving medical clearance indicating that restraints can or cannot be safely used. In completing the Form "Medical Clearance for Restraint Use" he makes a determination that specific types of restraints can be safely used with or without conditions. Dr. LeBel has no qualifications which would support her ability to offer an opinion in this area.

(3) In regard to the care provided to Mr. Cains, Dr. Hamid did review the relevant documents and identified which restraint techniques could be safely used. His report states:

> "I have reviewed the medical history, the physical health issues and the social history for trauma caused by physical or sexual abuse, neglect, or exposure to violence for Mr. Cains and have determined that the following restraint techniques or devices can be used safely:
>
> Personal restraint, an emergency procedure limiting movement by the holding of a hand or limb;
> Chemical intervention ordered by the Physician;
> Protective Helmet;
> Papoose Board, a Mechanical Device limiting movement and range of motion;
> Wrist Restraint, a Mechanical Restraint device limiting movement and range of motion."

(4) Dr. Hamid did not identify any medical basis to restrict the use of restraints. In particular, he did not identify any medical contraindications to restraint use or any modification of restraint procedures which might be necessary to address any medical condition including the presence or GERD. Dr. Hamid identified no restrictions on restraint use related to mealtime or a requirement that the head remain elevated for any period of time. Staff were compliant with Dr. Hamid's assessment and treatment recommendations as he articulated them in the Form "Medical Clearance for Restraint Use."

(5) Further, there was no limitation as to whether or not restraints should or should not be applied in sitting or prone positions. Given his knowledge that, for example, use of a Papoose Board, can only be performed in a prone position, his report

incorporates his opinion that these restraints can be used safely when either standing, sitting or lying in the ground.

(6) Dr, Hamid confirms this opinion in his deposition when he noted no evidence to support an association between restraint use and vomiting/aspiration:

> Q But to be clear, you do not think that a physical restraint of this sort -- are you saying you don't think the physical restraint had any causal effect on him vomiting and going into cardiac arrest?
> A I was not there, so I don't know how much strength Was used, but in real world, again, physical, if somebody is restrained and he chokes to death, you know, does not happen. So I don't think so physical restraint -- there's no way for me to tell because I'm not there at that particular point in time and how much strength was used. No.
> Q I don't think I quite understand something you just said.
> MR. GILLISPIE: Hey, Kristi, could you read back his passage just there for me?
> (WHEREUPON, the court reporter read back the previous answer.)
> BY MR. GILLISPIE:
> Q If you could, finish your thought for me about in the real world. In the real world, what? I don't quite understand what you meant there.
> A I mean, I have not come across any case studies that the patient who was physically restrained ended up choking to death because of that physical restraint. I have not seen any case reports. It has not come in my practice, you know, even working at BHDC here and other facilities.
>
> (Hamid Deposition, Pages 37-38)

(7) Dr. Lebel claims that "Given the medical risk of restraint use with DC, BHDC could have put DC on their *Do Not Restrain List* but did not." However, as noted above, Dr. Hamid is a medical practitioner and did not believe that such a risk existed. Dr. LeBel, lacking any medical training, experience or licensure, has no standing upon which to contradict Dr. Hamid's opinion.

Use of Restraint Violated Policy Standards

Dr. LeBel alleged that:

> The use of restraint was not consistent with BHDC policies (BATES: 4342). According to the deposition testimony of S. Evans, Residential Services Director, restraint is to be used, *"Only as an emergency measure but only if absolutely necessary* ***to protect client or others from injury****" (p.30*); per ICF/CMS regulation 483.450(d)(5) and Evans (2022, p.32), *"restraints must be designed and used* ***so as not to cause physical injury to the client"*** *(emphasis added) and implementation of behavior management policy and practices is done when an individual's actions are aggressive, disruptive, and/or present a danger to the individual or others, are* ***managed with the least restrictive method*** *(emphasis added)."* In this case, less restrictive interventions were not documented and the client (DC) was not protected. The client (DC) was fatally injured as a result of unwarranted restraint. No injury to staff was documented and no threat of serious injury was documented. Furthermore, the unwarranted restraint used was not described, addressed or documented in the facility's policies or in DC's IPP, as required by federal regulation (483.450(b)(1)(IV)); it was, in fact, unauthorized. This use of restraint was not justified per BHDC policy.

Response: Dr. LeBel is incorrect on several points.
First, Dr. LeBel notes that "restraint is to be used, 'Only as an emergency measure but only if absolutely necessary to protect client or others from injury.'" Staff did not violate this directive. Based upon their training and experience, staff made a clinical judgment based upon the existing conditions. The need to protect themselves, Mr. Cains and others was met at the time that restraint was utilized.

Second, as noted above, Dr. LeBel has made a medical determination that the use of restraints caused harm. She is not qualified to offer such an opinion.
Third, a causal relationship between the use of restraint and vomiting, in this specific instance, has not been proven. The evidence indicates only that Mr. Cains vomited while restraints were applied. This association does not mean that a causal relationship exists. Dr. LeBel is not qualified to reach a conclusion about medical causality.

Third, Mr. Cains indicated that it was his intent to harm Mr. Mattson when Mr. Cains spat at Mr. Mattson and attempted to strike Mr. Mattson. These behaviors represented a potential for harm and were justifiably addressed by physical restraint. Mr. Mattson and other staff were fully compliant with BHDC policies when they used physical restraints in this emergency situation and attempted to prevent Mr. Cains from engaging in these behaviors.

Fourth, the deposition of Mr. Mattson indicates that he took specific steps to de-escalate the behavior and employ less restrictive procedures including blocking Mr. Cains attempt to physically harm.

Fifth, as noted above, Mr. Cains was not "fatally injured as a result of unwarranted restraint." Dr. LeBel failed to establish any causality in regard to the relationship between restraint use and vomiting.

Sixth. Dr. LeBel does not recognize that CMS allows the use of restraints for two general purposes. CMS states:

> The facility may employ physical restraint only -
>
> (i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;
>
> (ii) As an emergency measure, but only if absolutely necessary to protect the client or others from injury; ((483.450(d)(1)(i-ii))

The conduct of staff in regard to this specific incident was in response to an emergency, In such an emergency, staff are not required to meet the conditions of (483.450(d)(1)(i). Emergency use of restraints is addressed in (483.450(d)(2)(i)

> Authorizations to use or extend restraints as an emergency must be:
>
> (i) In effect no longer than 12 consecutive hours; and
>
> (ii) Obtained as soon as the client is restrained or stable

In such emergency situations, the documentation occurs after the restraint procedure, rather than preceding it.

It is important to note that CMS has determined, through its survey procedure, that BHDC is compliant with all required aspects of behavioral service. Dr. LeBel's unilateral determination that BHDC is in violation of CMS standards is contradicted by CMS itself.

Use of Restraint Violated BHDC Staff Training and Practice Standards

Dr. LeBel alleged that:

> DC died as a result of being physically restrained by staff on the floor/ground. According to the deposition of BHDC Staff Development Coordinator and Non-Violent Crisis

Intervention Restraint Trainer (Hise, 2022):• (p. 21, 18-20): *"The only reason that they would use the transition to the ground is putting a resident in mechanical restraint."* • (p. 22, 8-9): *"I do not teach staff to hold a resident on the ground."* • (p. 22,19-21): *"The training that we teach in NCI is a standing personal hold and a seated personal hold. There is no on-the-ground personal hold."* • (p. 24, 20+): *"... use verbal strategies to de-escalate and redirection also teach blocking, stepping back..."• (p. 25): "In the supported stance, if a resident was coming at you, you would put your hands up and deflect and step away."* • (p. 28, 6) *"No, sir; do not restrain by yourself, use a supported stance to prevent falling over, if restraint on the ground, then prepare for mechanical restraint."•* (p. 34*) So Booneville Human Development Center does not authorize the use or train staff in the use of restraining clients on the ground except when doing so for the specific purpose of transitioning to a mechanical restraint; correct? Hise's Answer: "Correct."*
BHDC Staff Development Coordinator and Restraint Trainer Mark Hise affirms that the fatal restraint used on DC was not authorized, that the facility did not adhere to relevant restraint-related policies, and BHDC direct care staff did not follow the training they were provided.

There are several steps the Respondent should have taken to prevent this situation including but not limited to:

1) Adhering to international, federal, state, and facility standards identified above,
2) Adhering to AR DDS policy 311-D,
3) Adhering to BDHC relevant policies,
4) Using only BHDC approved and taught restraint methods,
5) Adhering to DC's Attending Physician's Orders and ensuring DC remained upright for one hour after meals,
6) Not laying hands on and grabbing DC's arms,
7) Attempting non-violent de-escalation techniques, both before initiating the restraint and after DC was taken to the ground, when staff could have simply given DC space as opposed to forcefully holding him on the ground,
8) Per Hise (2022), following BHDC restraint training and NCI protocol and using supportive stance blocking and/or a pivoting technique, particularly if there was a location/position concern,
9) Adopting an organized approach to preventing the use of restraint such as the Six Core Strategies© or Ukeru which was developed with a DD population,
10) Allocating resources to train, retrain, and support/maintain staff competence in restraint prevention and establishing a culture of non-violence,
11) Teaching staff to not restrain any patient with a comorbidity that compromises digestion, respiration, cardiac functioning, etc.,

12) Obtaining external consultation to more effectively respond to DC's distress without hands-on procedures, e.g., considered safety circles, Ukeru approach (blocking pads and ensuring soft items in the environment), etc.,
13) Ensuring patients with [redacted] including DC, are put on the *Do Not Restrain List,*
14) Ensuring physician's orders are known and followed by staff,
15) [redacted]
16) Emphasizing restraint prevention and implementing effective alternatives to restraint use such as sensory-based approaches and other methods for staff to support clients in distress without hands-on procedures,
17) Ensuring greater medical oversight of the use of restraint including nursing presence for initiating, monitoring, and determination of earliest possible release,
18) Explicitly prohibiting ground restraint unless medically contraindicated,
19) Developing an organizational action plan of restraint prevention/reduction with a committee representing leadership, staff and families/persons-served.

In short, the Respondent should know the standard of care is rising. In an era of evidenced-based practice, accountability to the persons-served and others is owed. Exemplar programs and organizations serving a similar population have done significant work in creating low/no restraint services for people with developmental disabilities. This information should have compelled the organization to action to change their use of restraint with persons-served creating a safer environment of care for staff and patients alike.

Response:

This section of Dr. LeBel's report, perhaps the most important in the entire document, must be placed in the context of Dr. LeBel's ideological beliefs in order to be fully understood.

In January 2007, CMS's Final Rule governing patients' rights went into effect. The revisions to CMS standards were viewed as a setback in the opinion of some professionals, including Dr. LeBel, who have advocated for the elimination of seclusion and restraint in federally-funded facilities. In 2008, Dr. LeBel published a manuscript denouncing the regulatory change abd calling for an alternative approach to standard setting – one which would rely upon local quality improvement practices (LeBel. 2008):

> However, a new challenge to the national effort has emerged. In January 2007 CMS's Final Rule governing patients' rights went into effect (7). The Final Rule appears to move to a centrist position, dilute previous protections, focus on "safe" seclusion and restraint practices despite identifying their risks, and ultimately retreat from the standard-setting high ground claimed during the seven years the Interim Final Rule was in place. (LeBel 2008, Page 195)

In spite of her acknowledgement that the new regulations were more "centrist," Dr. LeBel called out mainstream advocacy and professional groups for their support of the revisions:

> It appears that CMS ultimately yielded to some of the most influential stakeholders who were among the 4,200 Interim Final Rule commenters, including the American Medical Association, the American Psychiatric Association, the American Hospital Association, and the National Association of Psychiatric Health Systems. These provider groups ... lobbied against the Interim Final Rule. (LeBel 2008, Page 195)

Dr. LeBel and her colleagues, most notably Kevin Ann Huckshorn who was cited as a contributor to the 2008 critique, were undaunted. Dr. LeBel proposed that advocates for the elimination of seclusion and restraint focus their efforts on States and specific facilities. She noted that these jurisdictions could implement policies and procedures which exceeded the "minimal standards" contained in the new CMS regulations:

> Ultimately, advancing seclusion and restraint standards is in the hands of facility and agency administrators. (LeBel 2008, Page 195)

However, Dr. LeBel went further, calling for a more activist role on the part of professionals seeking to in achieve the changes to clinical practice which she advocates. She stated that standard-setting entities, most likely including States, facilities, legislators and the Courts, should challenge this regulatory retreat:

> The failure to recognize these advances and incorporate this knowledge into the new standards not only threatens practice gains but also has spurred legal advocates to analyze the impact of this change, examine federal statutory language, and consider challenging this regulatory retreat (Huckshorn K, personal communication, March 19, 2007). In a quality improvement model, states and facilities must not rely on national standard-setting entities to lead change toward preventing and even eliminating seclusion and restraint. (Page 196)

It is worth noting that while Dr. LeBel incorporates 13 references in support of her opinions, her beliefs are not widely supported and the references provide only the thinnest of justifications for her opinions. In many respects, she is merely referencing her own thinking. For example, Kevin Ann Huckshorn, noted as a contributor to LeBel (2008), is the lead author of 3 of the references in the Cains Report. (Dr. LeBel's CV indicates that she served as a member of Dr.

Huckshorn's Doctoral Dissertation Committee or Doctoral Dissertation Discussant. In addition, Dr. LeBel is a co-author of all three of the citations.) Four references are to depositions collected in this matter. Documents prepared by the United Nations (UN) and World Health organization (WHO) and a British charity are also included. The list of references also includes one basic science article (Clark and Harris, 2004). Finally, there is one reference to CMS and that applies only to psychiatric hospitals.

It is self-evident that Dr, LeBel's opinions fall outside of the mainstream of thinking on the current standard of care for facilities such as BHDC. Dr. LeBel's dissatisfaction with the "centrist" opinion of CMS indicates that her opinions cannot be considered to be representative of the majority opinion of her peers regarding the standard of care for the use of seclusion and restraint. Further, given her non-centrist position on these issues, it is reasonable to question whether she can describe the standard of care for the use of seclusion or restraint at all. Having broadly rejected the appropriateness of seclusion and restraint in general, how could she define their appropriate use in the specific instance of Mr. Cains? Therefore, she does not appear to be qualified to offer an opinion that would reasonably reflect the current standard of care in the field.

In addition, Dr. LeBel likely sees her consultation as an opportunity to practice the same "legal advocacy" that she called for in 2008. As she noted,

> In a quality improvement model, states and facilities must not rely on national standard-setting entities to lead change toward preventing and even eliminating seclusion and restraint. (LeBel 2008, Page 196)

This language ties closely to the specific critique offered of care at BHDC:

> In an era of evidenced-based practice, accountability to the persons-served and others is owed. (LeBel Report, Page 10.)

Quality improvement is an approach to practice which involves constant revisions to practice parameters. As noted by CMS:

> Quality is defined by the National Academy of Medicine as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
>
> Quality improvement is the framework used to systematically improve care. Quality improvement seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations. (accessed on 1/5/2023 at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-Improvement-

#:~:text=Quality%20improvement%20is%20the%20framework,%2C%20healthcare%20systems%2C%20and%20organizations.)

Quality improvement is a dynamic process which can result in changes to care practices, However, quality improvement outcomes do not represent the standard of care. The results of quality improvement are highly variable depending upon the area of study, the target population, local resources and other factors and conditions, proposed interventions, and the types of data collected and their analysis. To suggest, as does Dr. LeBel, that quality improvement approaches supersede the existing standard of care is inappropriate.

However, this philosophy explains Dr. LeBel's opinions in the Cains matter. Having implied that quality improvement represents the standard of care, Dr. LeBel gives herself the latitude to specify what "improvements" "should" be made at BHDC in order to meet this new standard. This approach results in her making recommendations for 19 specific changes to practice at BHDC. In Dr. LeBel's thinking, BHDC cannot meet the "standard of care": without implementation of these requirements. She sees herself, and her role in the Cains matter, in heroic terms:

> Without forthright, consistent leadership to elevate practice standards, the possibility of seclusion and restraint "regulatory scotoma" looms large— (Lebel 2008, Page 196)

Dr. LeBel's use of this consultation as an opportunity to "elevate practice standards" rather than function in a more "centrist" role as an arbiter of the current standard of care is readily transparent. She states:

> Exemplar programs and organizations serving a similar population have done significant work in creating low/no restraint services for people with developmental disabilities. This information should have compelled the organization to action to change their use of restraint with persons-served creating a safer environment of care for staff and patients alike. (LeBel Report, Pages 10-11)

At this point, Dr. LeBel is no longer discussing the standard of care. She is advocating for the elimination of restraints at BHDC – a position which is inconsistent with the standard of care. In regard to specific claims made by Dr. LeBel in this section, Dr. LeBel claims that:

> "DC died as a result of being physically restrained by staff on the floor/ground."

However, reaching such a conclusion would require Dr. LeBel to make a medical judgment, something which she is not qualified to do. Dr. LeBel assumes that since Mr. Cains vomited while he was being restraint, the restraints caused him to vomit. The simultaneous occurrence

of two events does not determine causality. No evidence has been presented to establish causality. Indeed, BHDC staff dny any knowledge that such an association may exist. As noted by Mr. Hise:

> Q Uh-huh. Okay.
> A I personally never heard of a death due to a restraint incident and choking together.
> Q I'm sorry. Say that again.
> A In my career, I haven't experienced a choking death with a resident during a restraint procedure. (Hise Deposition, Page 41)

This perspective was shared by Dr. Hamid:

> Q If you could, finish your thought for me about in the real world. In the real world, what? I don't quite understand what you meant there.
> A I mean, I have not come across any case studies that the patient who was physically restrained ended up choking to death because of that physical restraint. I have not seen any case reports. It has not come in my practice, you know, even working at BHDC here and other facilities.
> (Hamid Deposition, Page 38)

In addition, Dr, LeBel stated that:

> BHDC Staff Development Coordinator and Restraint Trainer Mark Hise affirms that the fatal restraint used on DC was not authorized, that the facility did not adhere to relevant restraint-related policies, and BHDC direct care staff did not follow the training they were provided.

This was not the case. Mr. Hise repeatedly stated that he was unaware of the specific circumstances around the restraint and death of Mr. Cains and could not render an opinion about the quality of care that was rendered.

> So if a staff member, if a direct care staff member, were to hold a client on the ground because that client is having a behavior episode and that staff member were to hold that client on the ground, restrain that client while they're on the ground for several minutes, hoping the client will calm down, would that be an improper restraint?
> A I really don't have enough information to speculate on that. That's -- you know, I don't know the details of the situation. (Hise Deposition, Page 21)

And:

> But, assuming he's telling the truth about being close to that ledge, couldn't he still have sidestepped away? Couldn't he have sidestepped away to avoid the client and the ledge?
> A It's kind of hard to say, I mean, unless you're in that situation yourself. I mean, I can't -- I don't want to say that he did the wrong thing or did the right thing. I can't really say. (Hise Deposition, Page 54)

Dr. Lebel mistakenly implies that the NCI curriculum used to train staff on behavioral management techniques represents actual BHDC policy. It does not. The curriculum cited by Dr. LeBel is used for educational not regulatory purposes. Although they were not specifically asked, staff could have reasonably believed that the application of personal holds on the ground was less restrictive than the application of personal holds followed by the use of a mechanical restraint (Papoose Board).

As is evident from the results of regular CMS surveys, BHDC demonstrates a high level of compliance with CMS policy. In contrast, there is no expectation that staff will master and consistently apply every element of the NCI curriculum. After all, staff are deemed to be proficient in behavioral techniques if they achieve a test score of 70%.

> Q And my understanding is, in order to pass, each person has to get 70 percent or better, at least 70 percent of the answers correct; is that right?
> A Correct.
> Q And that's both for the restraint portion of the test but then also just the overall score of their test as well?
> A Correct. (Hise Deposition, Page 15)

Effectively, the NCI curriculum represents a practice parameter in which substantial deviation from the curriculum is anticipated. (See Eddy D. A Manual for Assessing Health Practices and Designing Practice Policies: The Explicit Approach. American College of Physicians. 1992)
As a result, Mr. Hise would expect a high degree of variation in the application of skills acquired as a result of the training he provides.

In regard to certification, the Crisis Prevention Institute (CPI) only certifies Trainers. CPI does not certify users or others who receive training in NCI. As noted by CPI:

> Nonviolent Crisis Intervention® Trainings previously concluded with a post-test and evaluation which measured that growth and learning goals were met.
> Now CPI Nonviolent Crisis Intervention® 2nd Edition Training concludes

> with a classroom test to measure staff growth and determine if learning goals are met. The culmination of the program is also an opportunity for staff to take steps towards developing an action plan to implement the strategies learned in the program into everyday practice. (CPI Nonviolent Crisis Intervention® 2nd Edition Training Instructor Guidance Resource.)

Finally, Dr. LeBel includes a list of 19 specific actions which she states that BHDC "should have taken to prevent this situation." However, most of these recommendations are not contained within the standard of care embodied in CMS, AR DDS and BHDC regulations. Dr. LeBel justifies her recommendation that these 19 additional requirements are incorporated within the standard of care by stating:

> In short, the Respondent should know the standard of care is rising. In an era of evidenced-based practice, accountability to the persons-served and others is owed. Exemplar programs and organizations serving a similar population have done significant work in creating low/no restraint services for people with developmental disabilities. This information should have compelled the organization to action to change their use of restraint with persons-served creating a safer environment of care for staff and patients alike. (LeBel Report, Pages 10-11)

As noted previously, this paragraph represents Dr. LeBel's philosophy about restraint use. Her statement does not reflect the standard of care. However, Dr. LeBel's statement clearly demonstrates the underlying bias she holds against the role of CMS in setting the standard of care. In recommending that 19 additional requirements be met in order for BHDC to meet the standard of care, Dr. LeBel denies the validity of the role of CMS in setting standards of care. She suggests that the standard of care is "rising" but offers no definition of what she means or why this should.d be the case. To suggest that BHDC is required by the standard of care to be "an exemplar program or organization" and deliver "low/no restraint services for people with developmental disabilities" is simply an exercise in advocacy, mirroring what she has articulated in her publications – that having moved to a "centrist" position, CMS should not be relied upon to define the standard of care. She has called for "legal advocates" should focus their efforts on effecting change at the State and facility level. In regard to the matter of evaluating whether or not BJHDC met the standard of care in rendering care to Mr. Cains, these opinions, and the burden of additional requirements needed to meet the standard of care, are simply not relevant.

Opinion Two: The respondent facility's emergency response policy fell below the standard of care.

Dr. LeBel stated that:

The Respondent facility's policy, which prevented non-medical staff from calling 911, created an unnecessary obstacle to emergency response and life-saving intervention. The artificial layer of on-site communication created a dangerous circumstance for DC and all residents and likely contributed to DC's death. This approach to emergency intervention no longer occurs in other DDS state systems, such as Massachusetts, New Jersey, and Washington. Massachusetts DDS policies have required staff working in DDS settings to report events that they have reason to believe are harmful, including calling 911, since 1999 (#1999-4). New Jersey DDS enacted *Danielle's Law* in 2003 requiring staff working in services for people with intellectual/developmental or traumatic brain injury to call 911 when there is a life-threatening emergency to prevent delayed medical response Division of Developmental Disabilities | Danielle's Law (nj.gov). Washington state encourages staff and caretakers serving people with developmental disabilities to dial 911 and reach out online in the event of emergency circumstances (Report Concerns Involving Vulnerable Adults | DSHS (wa.gov)).

Recognizing the importance of unimpeded 911 access, broad federal legislation (Kari's Law) enacted in 2020 establishes that employers have a duty of care and a legal responsibility to help protect anyone using their phone system. When an emergency call takes place from within an organizations' network and the caller cannot connect to 9-1-1, or if dispatchers cannot pinpoint the caller's location, the employer can be liable in the event of an unfavorable outcome due to a delayed response. New legislation has also introduced penalties for any business or organization that does not comply.

Response:

(1) As previously noted, Dr. LeBel has no standing as a medical expert and has no basis for offering an opinion as to the standard of care for the delivery of medical services, including emergency medical services, at a facility such as BHDC.

(2) As previously noted, Dr. LeBel has stated that CMS regulations are the standard of care for the delivery of health care services at ICF IDDs including BHDC. CMS conducts surveys of BHDC and has determined that the system of emergency response services at BHDC is reasonable and consistent with the standard of care for settings like BHDC which exist in rural, medically-understaffed areas. Dr. LeBel's opinion is inconsistent with that of CMS.

(3) As previously noted, Dr. LeBel has stated that CMS regulations are the standard of care for the delivery of health care services at ICF IDDs including BHDC. She has also noted that jurisdictions are permitted to provide additional services which may exceed the standard of care but that there is no Federal requirement for them to do so. Dr. LeBel has publicly expressed her frustration that CMS does not do more to restrict the use of

restraints at publicly funded facilities. These opinions have no merit. The State of Arkansas is not obligated to implement the service system modifications described as currently in place in Massachusetts, New Jersey, or Washington nor is the State of Arkansas compelled to respond to Kari's Law or some other, irrelevant corporate mandate.

(4) Finally, Dr. LeBel claims that "the artificial layer of on-site communication created a dangerous circumstance for DC and all residents and likely contributed to DC's death." Based upon the available evidence (summarized in my general report), I most strongly disagree. In using its own staff, BHDC was able to provide emergency care to Mr. Cains within one to two minutes of the call for assistance. In contrast, it took 13 minutes after the 911 call for emergency medical services to arrive on campus and begin to provide care to Mr. Cains. Further, it took an additional 9 minutes for emergency medical personnel to achieve a partial reopening of the airway. There is no reason to believe that the outcome would have been any different if the partial opening of the airway occurred at 22 minutes rather than 24 minutes after the onset of the event.

State Operations Manual

Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities

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(Rev. 178, 04-13-18)

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E. Interviews to Clarify Observations



CONDITION OF PARTICIPATION	Key Standard(s) Regulatory Reference within the CoP	W-tag associated with the key standard regulation	Corresponding standard(s) and/or the key standard W-tag reference(s)
	employ physical restraint only (i) As integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. 42 CFR 483.450(e)(1) The facility must not use drugs in doses that interfere with the individual client's daily living activities	W310	W302, W303, W304, W305, W306, W307, W308, W309 W311, W312, W313, W314, W315, W316, W317
42 CFR 483.460 Health Care Services (W318)	42 CFR 483.460(a)(3) The facility must provide or obtain preventive and general care 42 CFR 483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including, licensed dentists and dental hygienists either through organized dental services in-house or	W322 W348	W319, W320, W321, W323, W324, W325, W326, 327, W328, W329, W330, W331, W332, W333, W334, W335, W336, W337, W338, W339, W340, W341, W342, W343, W344, W345, W346, W347, W393, W394 W349, W350, W351, W352, W353, W354, W355, W356, W357, W358, W359, W360

2. The ability to make choices;
3. The ability to identify preferences; and
4. Cognitive abilities including tracking, attention span, communication, and the client's ability to understand the cause and effect. (The client understands of cause and effect is significant in the determination.)

Money management includes a broad spectrum of programs with varying levels of participation by the client ranging from the use of choice in money expenditures, to an understanding of the concept of money, and ultimately to actual money handling and budgeting. The IDT must not conclude that a money management program is inappropriate based solely upon the level of intellectual or physical disability of the client.

The CFA must be reviewed at least annually per 42 C.F.R.483.440(f)(2). As a part of this annual review, a client's ability to participate in money management will also be reviewed. The annual review should always include an update to the CFA and take into consideration any changes in the client's circumstances since the last IPP. The need for a formal money management program must be addressed in every client's IPP by the IDT on an annual basis.

The determination of the appropriateness of a formal money management program is made by the IDT and must be based upon a CFA. The IDT discussions resulting in that determination must be established through documentation in the client's IPP.

W127

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(5) Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment;

Guidance §483.420(a)(5)

Identification of patterns or isolated instances of physical, verbal, sexual or psychological abuse or punishment without prompt identification and corrective action by the facility would result in a non-compliance determination for this Standard and Condition level non-compliance.

The facility must develop and implement systems that protect clients from all forms of abuse, neglect, or mistreatment, including client to client abuse, neglect, or mistreatment.

a. The facility is expected to ensure that staff possess and demonstrate needed competencies to effectively and appropriately interact with clients.

b. The facility must monitor to assure that systems are effectively implemented and the facility takes immediate actions to address circumstances where abuse, neglect, or mistreatment have occurred and prevent reoccurrence.

c. The facility must be organized in such a manner as to proactively assure clients are free from any threat to their physical and psychological health and safety.

d. The facility must act to prevent physical, verbal, sexual or psychological abuse.

If the facility fails to implement appropriate corrective action, the potential of additional threats to the clients remain at the facility.

"Threat", for the purposes of this guideline, is considered any condition/situation which could cause or result in severe, temporary or permanent injury or harm to the mental or physical condition of clients, or in their death.

"Abuse", for the purposes of this guideline, is the willful infliction of injury, unreasonable confinement, intimidation or punishment with the resulting physical harm, pain or personal anguish.

Physical abuse refers to any action intended to cause physical harm or pain, trauma or bodily harm (e.g., hitting, slapping, punching, kicking, pinching, etc.). It includes the use of corporal punishment as well as the use of any restrictive, intrusive procedure to control inappropriate behavior for purposes of punishment.

Verbal abuse refers to any use of insulting, demeaning, disrespectful, oral, written or gestured language directed towards and in the presence of the client. Psychological abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation, sexual

coercion and intimidation (e.g. living in fear in one's own home). Since many clients residing in ICF/IIDs are unable to communicate feelings of fear, humiliation, etc. associated with abusive episodes, the assumption is made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, would also be viewed as abusive by the client residing in the ICF/IID, regardless of that client's perceived ability to comprehend the nature of the incident.

Sexual abuse includes any incident where a client is coerced or manipulated to participate in any form of sexual activity for which the client did not give affirmative permission (or gave affirmative permission without the attendant understanding required to give permission) or sexual assault against a client who is unable to defend him/herself.

The facility must implement, through policies, oversight and training, safeguards to ensure that clients are not subjected to abuse by anyone including, but not limited to, facility staff, consultants or volunteers, staff of other agencies serving the client, family members or legal guardians, friends, other clients, or the general public.

The facility must take whatever action is necessary to protect the clients residing there. For example, if a facility is forced by court order or arbitration rulings to retain or reinstate an employee found to be abusive, the facility must take measures to protect the clients of the facility (such as assigning the employee to an area where there is no contact with clients).

W128

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.420(a)(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;

Guidance §483.420(a)(6)

The facility must implement an aggressive active treatment program, which includes appropriate replacement behaviors, to address the reduction/elimination of physical restraints and drugs to manage behaviors.

For purposes of this Guideline drugs to manage behavior are "unnecessary" if there is evidence the drugs are being used:

- In excessive dose (duplicate therapy);
- For excessive duration;
- Not monitored adequately;
- Without adequate indications for its use;
- With adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combination of the reasons listed above.

The long term use of a drug/physical restraint to manage behavior combined with one or more of the following may indicate unnecessary use:

- The client's developmental and/or behavioral needs are not being met and the appropriateness of less restrictive approaches to manage inappropriate behaviors should be questioned;
- Staff behavior may be prompting behaviors in clients which result in the chronic use of physical restraints and drugs to control behavior;
- Staff may have inadequate training and/or experience to provide active treatment and employ preventive measures;

Restraints applied for behaviors when less restrictive measures have not been tried or have been tried and found to be just as effective.

W129

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.420(a)(7) Provide each client with the opportunity for personal privacy and

Guidance §483.420(a)(7)

(Rev. 144, Issued: 08-14-15, Effective: 08-14-15, Implementation: 08-14-15)

§483.430(e)(2) developmental,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- developmental programming principles and techniques (e.g. techniques to involve clients in their programs to their highest capability, use of positive reinforcement, use of assistive technology, use of appropriate materials and providing informal opportunities to practice skills);
- use of adaptive equipment and augmentative communication devices and systems; and
- effective recordkeeping procedures.

W191

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) behavioral,

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- use of behavioral principles during interactions between staff and clients;
- use of accurate procedures regarding abuse detection and prevention, restraints, drugs to manage behaviors, client safety, emergencies, etc.;
- use of least restrictive interventions;

- use of positive behavior intervention programming; and
- training clients in appropriate replacement behaviors.

W192

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(2) and health needs

Guidance §483.430(e)(2)

Staff receive training in the following areas:

- signs and symptoms of the client's changing health (e.g. constipation, urinary tract infections, adverse drug reactions, as indicated);
- exercise and diet;
- first aid;
- infection control;
- reporting to appropriate healthcare professionals; and
- for those staff who can administer medications, how to include clients in their medication administration by recognizing and encouraging the use of applicable skills.

W193

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.430(e)(3) Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

Guidance §483.430(e)(3)

Staff correctly and consistently implement the interventions specified in the behavior plans of clients with whom they are working.

§483.440(f)(3)(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

Guidance §483.440(f)(3)(i)

Any program that utilizes restrictive or intrusive techniques must be reviewed and approved by the specially constituted committee prior to implementation. This includes, but is not limited to:

- restraints;
- drugs to manage behavior;
- restrictions on community access;
- contingent denial of any right; or
- restrictions of materials or locations in the home.

The committee should ensure that consequences within a written behavior management program do not violate the client's rights.

There is no requirement for the committee to evaluate whether the proposed program is consistent with current practices in the field. Documentation should verify that the specially constituted committee considered factors, such as whether less intrusive methods have been attempted, whether the severity of behavior outweighs the risks of the proposed program and whether replacement behaviors are included within the plan.

Any revision to a behavior plan that increases the level of intrusiveness must be re-reviewed by the specially constituted committee. The committee need not reapprove a program when revisions are made in accordance with the approved plan. For example, if the physician changes the dosage of a medication in accordance with the drug treatment component of the active treatment plan to which the legally authorized person has given consent and which has already been approved by the committee, then there is no need for the committee or the legally authorized person to reapprove the plan. Generally, this would also apply if the medication was changed to another within the same therapeutic class or family.

W276

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(i) Specify all facility approved interventions to manage inappropriate client behavior;

Guidance §483.450(b)(1)(i)

All interventions for the management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy. Examples of positive interventions include, but are not limited to, verbal praise reward systems, and prompting. Examples of negative interventions include, but are not limited to, removal of a privilege, implementation of restraint, and/or the use of exclusionary time out.

W277

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(ii) Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive;

Guidance §483.450(b)(1)(ii)

Policies and procedures must include a clear progression as to how staff implement interventions to manage inappropriate client behavior.

Facility policy and procedures must define the entire hierarchy of possible interventions from the most positive, functionally appropriate approaches to most intrusive approaches authorized. The facility determines at what level in the hierarchy the IPP will begin for each client based on their individual assessment. The plan must still begin at the least intrusive technique shown effective for that client. Individual plans should specify the specific techniques that have been determined through assessment to be least restrictive for each client.

The facility policy for unexpected behavioral incidents must provide direction for the staff in the

utilization of the hierarchy. For clients not on a behavior plan, staff must apply the appropriate level of intervention per the established hierarchy, including emergency measures to prevent harm to self or others.

W278

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iii) Insure prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective; and

Guidance §483.450(b)(1)(iii)

Policies must be implemented to ensure that all restrictive procedures begin at the lowest level of the hierarchy unless there is documented evidence that less intrusive interventions have been tried and have been found to be ineffective.

The facility is not required to justify discontinuing the use of a more restrictive technique before initiating a less restrictive technique, since the intent of the regulation is to use the most positive, least intrusive technique possible.

In emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.

§483.450(b)(1)(iv) Address the following:

W279

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(A) The use of time-out rooms;

Guidance §483.450(b)(1)(iv)(A)

"Time-out room" is defined as a separate room that is used to remove a client from stimulation that may be triggering and reinforcing maladaptive behavior. The facility must have written

policies and procedures for the use of time out rooms which address all the requirements of 483.450 (c) (1-4) standard: time out room.

W280

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(B) The use of physical restraints;

Guidance §483.450(b)(1)(iv)(B)

"Physical restraint" is defined as any manual hold or mechanical device that the client cannot remove easily, and which restricts the free movement of, normal functioning of, or normal access to a portion or portions of a client's body. Examples of mechanical devices may include arm splints and mittens.

Policies and Procedures must address:

- the types of physical restraint that are allowed in the facility;
- the persons who apply such restraints;
- the parameters for duration of application;
- the methods that assure the health and safety of clients while in restraints; and
- the specific training required for staff allowed to apply such restraints.

W281

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(b)(1)(iv)(C) The use of drugs to manage inappropriate behavior;

Guidance §483.450(b)(1)(iv)(C)

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(3) Clients placed in time-out rooms must be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.

Guidance §483.450(c)(3)

Because placement in the time out room is typically secondary to extreme behaviors, it is acceptable that there be no furniture in this room.

A door that opens inward can potentially be held closed, either intentionally or inadvertently, by the client in the room, thereby denying staff immediate access to the room.

W294

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(c)(4) A record of time-out activities must be kept.

Guidance §483.450(c)(4)

The documentation in the client's record accurately reflects planned (e.g. part of the IPP) usage and presents a picture of events prior to, during, and following the use of time-out. The IPP should include direction as to how often data must be collected during each use of time out for each individual client.

(d) Standard: Physical restraints

§483.450(d)(1) The facility may employ physical restraint only- -

W295

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;

Guidance §483.450(d)(1)(i)

The use of physical restraint is specified within the IPP. The plan must address:

1) The specific type of client behavior to be managed by this plan;
2) The less restrictive behavioral approaches which were previously used, but were unsuccessful;
3) The hierarchy of measures that must be utilized prior to the application of physical restraint;
4) The type of physical restraint;
5) The type of client behavior that would indicate that the patient is calm and can be released from the restraint; and
6) The replacement behavior being taught to the client to reduce the need for future restraints.

W296

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(ii) As an emergency measure, but only if absolutely necessary to protect client or others from injury; or

Guidance §483.450(d)(1)(ii)

Physical restraint may be used as an emergency intervention only in situations where the client is exhibiting behaviors which:

1) the client has not exhibited before;

2) were not identified in the functional analysis of behavior; or

3) are harming other people or themselves.

When there are repeated episodes of the use of physical restraint as an emergency safety measure, these episodes should be assessed for their predictability by the IDT, and revisions to the IPP considered addressing the behaviors through a formal behavior plan in order to reduce/eliminate the use of physical restraint.

W297

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(1)(iii) As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.

Guidance §483.450(d)(1)(iii)

Physical restraint during medical procedures must be utilized only when absolutely necessary and be used as a last resort in order for the facility or practitioners to deliver needed medical care to the client. The restraint must be released as soon as the medical procedure is completed unless it is necessary to continue restraint for a longer period of time to continue to deliver care or to prevent the client from displacing tubes or dressings. These restraints may only be used as long as the physician indicates them to be necessary.

For instances where physical restraint are used by the facility or a practitioner during a medical procedure, the client record and interviews should verify that less restrictive measures were attempted before using physical restraint and verify whether any injuries occurred during the use of the physical restraint. Written orders by medical personnel for the application of a physical restraint should include the reason that the restraint is necessary, the type of restraint to be used and the length of time the restraint will be applied.

A restraint device used to prevent a client engaging in self-injurious behavior is not considered a restraint for medical condition.

§483.450(d)(2) Authorizations to use or extend restraints as an emergency measure must be:

Guidance §483.450(d)(2)

Facility policies should list who in the facility is allowed to authorize the emergency use of restraints or to extend the use of an emergency restraint, and the training that is required for those persons who may authorize. Documentation in the client record in those instances should confirm that the facility follows that policy.

W298

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(2)(i) In effect no longer than 12 consecutive hours; and

Guidance §483.450(d)(2)(i)

This regulation does not mean that restraints may be authorized to be applied for up to a 12 hour period. The client must be released from the physical restraint as soon as the client is no longer a risk to self or others. Once the behavior has ceased, the emergency has ended, and the client has been released, another authorization would be required for any new emergency situation.

The 12 consecutive hour period is the absolute maximum period of time that emergency physical restraint may be utilized for a client during an individual behavioral incident. It is reasonable to expect that the facility will reassess the emergency situation for any client who remains in physical restraint for longer than one hour and reassess the situation at least every 30 minutes thereafter up to 12 hours when the physical restraint must be removed.

W299

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(2)(ii) Obtained as soon as the client is restrained or stable.

Guidance §483.450(d)(2)(ii)

There may be instances where the maladaptive behaviors of a client or clients escalate into a serious and immediate event that must be de-escalated quickly in order to prevent harm to clients, staff, other clients, or by standers when incidents occur in the community. In these instances, the staff should contact the appropriate person to obtain authorization for the use of physical restraint as soon as the situation is stable. Retrospective documentation of the incident should confirm the need for authorization after application.

W300

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(3) The facility must not issue orders for restraint on a standing or as needed basis.

Guidance §483.450(d)(3)

All instances of physical restraint must be ordered on a case by case basis with individual assessment of the situation and authorization based upon the individual client. Authorizations should include the rationale for the use of the physical restraint versus other less restrictive measures.

W301

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints,

Guidance §483.450(d)(4)

The frequency of monitoring will vary according to the type and design of the device and the

psychological and physical well-being of the client. The facility should be checking the client often enough to adequately assess the physical status of the client (e.g., circulation, respiration and vital signs) of the client and the need to continued restraint. The more restrictive the intervention, the greater the risk to the client and the more often the client must be assessed. Frequent assessment will assure that the client will be released as soon as possible, however, in no instance may the staff go longer than 30 minutes without checking the client.

W302

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) released from the restraint as quickly as possible, and

Guidance §483.450(d)(4)

"As quickly as possible" means as soon as the client is no longer a danger to self or others. Documentation should support that the client was released from restraint as soon as they became calm.

W303

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(4) a record of these checks and usage must be kept.

§483.450(d)(5) Restraints must be designed and used

W304

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(5) so as not to cause physical injury to the client

Guidance §483.450(d)(5)

Physical restraints to include mechanical devices must be the correct size for the client and be applied with the correct amount of pressure according to manufacturer's directions. In addition to observation of any physical mechanical restraint in use at the time of the survey, review incident reports for any injuries as a result of restraint use.

W305

§483.450(d)(5) and so as to cause the least possible discomfort.

§483.450(d)(6) Opportunity for motion and exercise must be provided

W306

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(6) for a period of not less than 10 minutes during each two hour period in which restraint is employed,

Guidance §483.450(d)(6)

This requirement does not apply to cases of medical restraints that are specifically ordered for the immobilization of bones and joints during the physical healing process involved with fractures, sprains, etc. (e.g. a broken bone immobilized by a cast or splint). See 331 483.460(c) regarding surveillance of skin integrity during the use of medical restraints.

However, if a mechanical physical restraint is applied to an extremity to prevent a client from removing post-operative sutures, the restraint must be released every two (2) hours for a period of not less than ten (10) minutes in order to maintain adequate circulation.

Mechanical restraints placed on the client during sleeping hours must be medically based and specifically ordered by a physician. There should be evidence in the client's record why the mechanical physical restraint is necessary during sleeping hours. While it is not necessary to wake the client every two (2) hours to release the restraint and provide opportunity for exercise, the staff must check the restraint frequently during the night to ensure that the

restraint is still properly applied and the client appears comfortable.

W307

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(6) and a record of such activity must be kept.

§483.450(d)(7) Barred enclosures

Guidance §483.450(d)(7)

A bed or play equipment with bars that prevent the client from leaving the bed or voluntarily climbing out of the bed are barred enclosures. The use of such enclosures must be a part of the written IPP and behavioral assessments must clearly state why such an enclosure is necessary, the risks of using the enclosure versus not using it and what less restrictive measures have been tried prior to the implementation of the barred enclosures.

Such devices may not be used in lieu of adequate staffing.

W308

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(7) must not be more than three feet in height and

W309

(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15)

§483.450(d)(7) must not have tops.

(e) Standard: Drug usage

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
DDS DIRECTOR'S OFFICE POLICY MANUAL

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

1. **Purpose**. This policy is intended to provide guidelines for managing challenging behaviors of individuals residing in DDS operated programs (Human Development Centers).

2. **Scope**. This policy applies to all DDS operated programs (Human Development Centers) and their employees/volunteers. All such programs will include a review of this policy as part of the employee orientation process.

3. **Definition of Terms**

Behavior management, as covered by this policy, serves as a guide to ensure that an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others are managed with the least restrictive method. Behavior management is not a substitute for other forms of active treatment and is incorporated into program plans, based on individual needs.

Qualified Mental Retardation Professional (QMRP) or QMRP designee is used in this policy as a person designated to monitor, supervise, and make decisions regarding specific behavioral situations. QMRP/designee will be assigned by the administrator of the DDS program in which he/she works. Criteria for selection will involve prior training, experience, and demonstrated ability in the area of behavioral management. The QMRP/designee must be in a position that is on a level involving supervisory or decision-making responsibilities. The QMRP designee is authorized to perform any of the duties of the QMRP as outlined by regulations or policy.

Interdisciplinary Team (IDT) is defined as a group of persons (professionals, paraprofessionals and non-professionals) who develop an individual's program plan and whose participation is required in order to identify the needs of the individual and to devise ways to meet those needs. The IDT includes the individual and may also include those persons who have worked or will work most closely with the individual, those persons who provide needed assessments or services, and the individual's family, guardian, or advocate. In general, the IDT includes persons professionally qualified in such fields as health care, education, psychology, and social work.

Licensed nurse is defined as a registered nurse or licensed practical nurse. The agency may use a physician, in lieu of a licensed nurse, but this is not required.

Replacement: This policy replaces DDS Commissioner's Policy 3011-D, dated January 28, 1981, March 13, 1981, and DDS Director's Policy dated October 1, 1991; December 1, 1993; and January 30, 1998.

Reviewed: Arkansas Legislative Council Rules and Regulations Subcommittee _____, 2003



Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

4. **Policy**

NOTE: It is the philosophy of the agency to utilize all positive approaches to behavior management prior to and in conjunction with more restrictive programmatic techniques. Positive approaches may include, but are not limited to: positive reinforcement, gentle teaching, redirection, graduated guidance, and modeling of appropriate behaviors. Measures to address positive behavior should be incorporated into formal program efforts to the extent feasible.

Efforts at positive programming prove to be successful with the majority of maladaptive behaviors. All Human Development Centers will maintain policies and procedures for positive programming. The use of behavioral programming other than positive is designed for the individuals who repetitively engage in dangerously aggressive behavior and for whom other interventions have not been effective. All behavior programs developed in accordance with this policy will be designed to reduce or eliminate the target behavior(s) within a specified time frame, will be supported by documentation that positive, less restrictive methods have been systematically attempted and failed, will be monitored regularly by the individual's QMRP and Interdisciplinary Team (IDT), and will be revised if proved to be ineffective. The potential harmful effects of each procedure will be weighed carefully against the harmful effects of the targeted behavior and the IDT will determine if the harmful effects of the behavior outweigh the potentially harmful effects of the procedure.

Category I:

Category I procedures are those which may be used without prior approval of the Human Rights Committee or psychology staff. To ensure consistency, they should be addressed by the IDT. Frequent use (as determined by IDT) of these procedures with an individual indicates the need for consideration of the development of a behavior plan by the individual's IDT.

The individual must be supervised during these procedures. With the exception of verbal intervention, any use of Category I procedures, whether part of a formal behavior program or not, requires documentation on a Behavior Incident Report, Data Sheet, or other locally used behavior documentation system.

A. Verbal Intervention: Verbal intervention is utilized to stop an inappropriate behavior in progress and involves telling the individual "no" or "stop", identifying the behavior, and redirecting to an appropriate activity. The command is given in a firm but normal tone of voice. Threats, screaming, yelling or issuing repetitive or multiple sets of commands are not considered verbal correction and are inappropriate.

B. Separation From Activity Up to 30 Minutes: The individual is prevented from engaging in a reinforcing activity in which he/she has displayed inappropriate behavior. Separation is maintained within the same room or outdoor area where the activity is conducted. This is considered a Category I procedure if compliance by the individual can be

accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

C. Separation From Setting Up to 30 Minutes: The individual is removed from the area where the reinforcing activity is taking place. Separation must occur under observation either outdoors or in a living or training area (bathrooms, storage rooms and closets do not constitute living/training area). This is considered a Category I procedure if compliance by the individual can be accomplished through verbal prompting/physical prompting without requiring personal restraint (holding).

Note: Separation to Allow Calming (STAC) – Also available is the positive procedure of STAC whereby the person is encouraged to move to an area away from the person or situation that upset them. At the same time, they are assisted in directing their attention to talking about the problem, listening to music, talking about family, relaxing quietly, going for a walk, etc. The activity should be chosen by the person in need of calming. When sufficiently calm, staff will assist the person in resuming normal activities.

D. Assignment of Additional Chores: The individual is assigned additional chores as a consequence for inappropriate behavior. Additional chores may be assigned only if such chores are already a part of the Individual Program Plan (IPP) and are not designed to replace work assignments of housekeeping personnel.

E. Restitution: The individual is cued to restore any property damaged, stolen or defaced. If appropriate to the individual's level of functioning, he/she may be cued to offer a verbal apology to the offended person. If appropriate to the individual's ability to comprehend, monetary reimbursement for the value of the damaged or stolen property may be required if this is a part of the IPP. In lieu of full value, a symbolic portion of the value may be required. Monetary reimbursement requires Human Rights Committee approval and Guardian consent.

Note: The individual is not degraded nor put on display while restoring damage. The individual is given the same equipment and protection to complete the restitution as would normally be given to a person not responsible for the damage.

F. Withholding Privileges: The individual loses a particular privilege following the occurrence of an inappropriate behavior. Privileges include such things as special planned community activities. However, trips off grounds are special and should only be curtailed if problem behavior is anticipated during that trip. Examples of situations where problem behaviors may be anticipated include a problem behavior having already occurred and the person is not fully calm, or, a problem behavior has not yet occurred, but there are indications that a problem behavior is likely. The curtailing of trips off grounds should be done after consultation with psychology staff, or with supervisory staff if psychology staff is not available. Privileges do not include basic living activities, such as meals, habilitation activities, or basic rights afforded all individuals.

G. Personal Property Removal (less than one hour): Removal of an individual's personal item that is being used in an inappropriate or unsafe manner or location. For example, if an individual disturbs others in a common TV room by playing his radio too loudly and will not reduce the volume when instructed, the radio may be removed from that individual for a time not to exceed one hour. The item will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate (See Section 6, *Page 8 of 9*).

Category II:

Category II procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian.

A. Response Cost: The individual loses reinforcers previously earned in a behavior management system, (i.e., Token Economy Program)

B. Overcorrection - includes the following procedures:
   1) Restitutional Overcorrection: Requires the individual to restore the environment to a state that is better than it was before the occurrence of the inappropriate behavior.

   2) Positive Practice Overcorrection: Requires the individual to engage in an intensive practice period in which the alternative appropriate behavior is practiced.

C. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or individual directly, as appropriate. This procedure is considered Category II if the individual voluntarily (without duress or coercion) surrenders the property upon request.

Category III:

Category III procedures may only be used as part of a formal behavior program designed by the individual's IDT, written by a licensed psychological professional, and approved by a licensed psychologist, physician, other professionals, as indicated by the nature of the program, Human Rights Committee, and the facility administrator. Behavior program approval will include receipt of a signed consent from the individual and/or guardian. The individual's record documents the IDT's conclusion that the potential harmful effects of each restrictive procedure (restraint, etc.) are clearly outweighed by the harmful effects of the targeted behavior.

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

A. Separation Time Out (Activity or Setting): Placement of an individual in a quiet area away from reinforcing activities or persons as a result of an inappropriate behavior occurring. The individual will be visually monitored during the time out. Further conditions include ***either:***

1) Separation lasting for over 30 minutes to one (1) hour maximum.

2) Separation (any length of time) requiring physical intervention/personal restraint to ensure compliance.

B. Contingent Personal Property Removal (up to 24 hours maximum): Immediate removal of an individual's personal belongings contingent on the occurrence of a targeted behavior. Confiscated property will be held in a secure area and will be returned to the individual's room or to the individual directly, as appropriate. This procedure is considered Category III if the individual does not voluntarily surrender the property upon request, and it must be physically removed.

C. Sensory Deprivation: Involves the temporary impeding of one of the individual's senses for a period of time, contingent upon the occurrence of the target behavior. Most often, this procedure includes only the use of a blindfold or cloth placed over the individual's eyes when it has been shown to facilitate calming. The individual must be visually supervised during the use of this procedure, which may be used in combination with other Category III procedures, as designated in the individual program. It could also include lessening auditory input by covering the individual's ears, or covering a body part (usually the hands) to limit tactile stimulation, hand in mouth, or biting.

D. Restraint: When utilizing restraint as a programmatic option, a hierarchy of lesser restrictive procedures will be attempted prior to restraint, except in limited cases where this is clearly clinically contraindicated. IDT consideration will be given to parent/guardian notification of the use of restraint and address it in the behavior program.

1) Personal Restraint: **In order to prevent personal injury or serious property damage**, the individual or a portion of an individual's body is immobilized by another person or persons in order to prevent personal injury or serious property damage. Approved methods of intervention must be in the individual's behavior program. This is planned personal restraint, contingent upon occurrence of a target behavior. When available, a licensed nurse should monitor the personal restraint and/or check the individual's physical condition as soon as possible following restraint.

Excluded as <u>personal restraint</u> are: physical assistance, prompting of graduated physical guidance to assist individuals during such procedures as toothbrushing and feeding, or to control random head or arm movements during such procedures

as haircutting, or the use of physical assistance in escorting, redirecting, or in manual guidance techniques are not considered personal restraint and do not require documentation as personal restraint. Also excluded as programmed personal restraint is the use of personal restraint in an emergency situation (Section 6, ***Page** 8 of 9*) or during a necessary medical or dental procedure.

In the event of personal restraint, the QMRP/designee of the area must be notified as soon as possible. Programmed personal restraint will occur until the individual is calm and will not exceed fifteen (15) minutes. The IDT will define what constitutes calm behavior for this individual when used in a behavior program.

2) Mechanical Restraint: **In order to prevent personal injury or serious property damage,** the individual or a portion of the individual's body is immobilized until calm by an approved device or devices which may also prevent normal functioning, as described in section C, above. Restraints must be checked for safety and integrity prior to use. The device's use will not exceed 15 minutes without an extension of time approved and documented by the QMRP/designee, preferably, after face-to-face attention. Unless otherwise determined by the IDT, QMRP/designee extensions will be obtained every 15 minutes until the individual is calm. The IDT should define what constitutes calm behavior for this individual when used in a behavior program. Unless determined clinically contraindicated by the QMRP/designee, should the time in restraint reach 55 minutes, the individual must be released for five minutes for motion, liquid intake, or toileting.

Should time in restraint reach 1 hour and 50 minutes, the individual must be released for at least 10 minutes–for motion, liquid intake, or toileting. If this 10-minute release is judged to be a danger to the individual and/others, additional staff should be called to ensure safety for all concerned. In addition, the individual will be checked, face to face, at least every 15 minutes for safety, well being, and integrity of the restraint. Constant observation is required.

Note: On-site monitoring by the QMRP/designee is recommended. When available, a licensed nurse should monitor the mechanical restraint. If unavailable to monitor, a licensed nurse shall check the individual's physical condition as soon as possible following restraint, but in no case later than thirty minutes after the initiation of the restraint.

Excluded as programmed mechanical restraint is the use of restraints in an emergency situation (Section 6, *Page 8 of 9*), during a necessary medical or dental procedure, or to promote healing following a medical procedure or injury. Devices such as a helmet which are not prescribed for the purpose of restricting an individual's movement and/or normal functioning, but rather for their safety and protection are not considered a mechanical restraint.

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

Note: For medical management, please refer to local site Policy on drugs to manage behavior (Behavior Management/Psychiatric Interventions).

5. **Conditions for Use of Behavior Programs.**

A. A formal behavior program will be developed by the IDT, written by a licensed psychological professional, and approved by a psychologist. It will include the following elements:

1) Description of the behavior to be modified;
2) Functional Analysis;
3) Thorough description of each step of the program to include duration and intensity of specific procedures, the methods of monitoring and analyzing the process, and special precautions that will be taken;
4) Description of any alternatives to the specific procedures;

B. The Individual Program Plan or behavior program will include:
1) Description of all procedures already attempted;
2) Side effects and risks, if any, of the intervention, in comparison with those of allowing the maladaptive behavior to continue; and
3) Behavioral objectives.

C. Behavior Management Procedures should be used in order of least restrictive, unless clinically contraindicated. Exceptions to this order must be fully documented and substantiated as to why more restrictive procedures are advisable before less restrictive ones.

D. All persons administering Category II and III procedures must have been trained in the administration of those specific procedures and have personally experienced those particular procedures, unless medically contraindicated for that person.

E. The Human Rights Committee will review all Category II and III programs at least every 6 months.

F. IDT consideration will be given to seeking consultation from outside expertise when IDT staff resources have been exhausted, as evidenced by the use of Category III procedures for over one (1) year without significant progress. If an outside consultant has been used without success, the agency should continue to access this or other outside expertise until an effective strategy is realized.

An outside consultant is defined as a professional of any discipline and who is not a member of the IDT. For instance, the outside consultant may be a member of the HDC

staff not on the identified IDT, the agency staff, or a professional not affiliated with the agency.

6. **Emergency Procedures**. Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. This includes the use of restraint procedures in the course of an established program, when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy. However, it is emphasized that emergency procedures may not be used at frequent intervals, becoming a routine method of intervention. If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. The emergency use of restraint must conform to ICF/MR regulations and must be reported immediately to the facility administrator or designee.

7. **Prohibitions**: These activities are expressly prohibited.

   A. Corporal punishment - refers to the application of painful stimuli to the body as a penalty for certain behavior, and includes, but is not limited to, hitting, pinching, the use of electrical shock or other infliction of pain, whether or not applied as part of a systematic behavior intervention program.

   B. Individuals who receive services from the agency disciplining other individuals unless involved in an organized and approved self-governing program. Individuals will not participate in the actual administration of discipline.

   C. Seclusion of an individual alone in a room or other area from which entry/exit is prevented. This does not include placement in a time-out area for brief, programmed time segments, as part of a behavior program that meets all applicable standards.

   D. ***Unless specifically requested by family/guardian,*** any procedure that denies visitation or communication with family members.

   E. Any procedure that denies sleep, shelter, bedding, food, drink, or use of bathroom facilities.

   F. Inappropriate vocalizations, maltreatment, neglect, or forced exercise.

8. **Informed Consent**. The individual served and/or guardian, as appropriate, will be provided a copy of the behavior program which utilizes Category II and III procedures. Informed consent will be obtained PRIOR to the implementation of the program, with the following procedures:

Policy Type	Subject of Policy	Policy No.
Service	Behavior Management	3011-D

A. Persons 18 years of age or older who have no legally appointed guardian may give informed consent for their behavior program. If there is a question about the individual's ability to give informed consent and no guardian can be located, appropriate legal action must be pursued to have someone appointed who can give consent.

B. Consent by the legal guardian(s) is required if guardianship has been established.

C. The legally adequate consent will:
1) Specify, in terms that are easily understood, the restrictive or intrusive procedure(s) involved;
2) Inform the person(s) giving consent of any potentially harmful effects of the procedure(s);
3) Be time-limited, not to exceed one year; and
4) State that consent may be withdrawn at any time.

9. **Uncategorized Procedures**. In the event a proposed procedure does not readily fit in one of the prescribed categories, it may be utilized on an emergency basis, if necessary, at the discretion of the administrator or designee until the appropriate category is determined.

NOTE: Behavior Management Policy 3011-D does not preclude the use of other restrictive/intrusive procedures that would prevent serious bodily harm and/or destruction of property or death. These procedures can only be considered when lesser restrictive procedures have been proven ineffective or their implementation are determined to be clinically contraindicated. Approvals required are the same as those for Category III procedures. Additional approvals may be required as deemed necessary by the facility administrator.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G003	A. BUILDING _____ B. WING _____	C 06/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONEVILLE HUMAN DEVELOPMENT CENTER	87 REED ROAD, HWY 116 SOUTH BOONEVILLE, AR 72927

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A COVID-19 Focused Emergency Preparedness Survey was conducted by the Centers for Medicare and Medicaid Services (CMS) on June 30, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6). Client Census: 117	E 000		
W 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on June 30, 2020. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Preventions (CDC) recommended practices to prepare for COVID-19. Client Census: 117	W 000		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

7/14/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

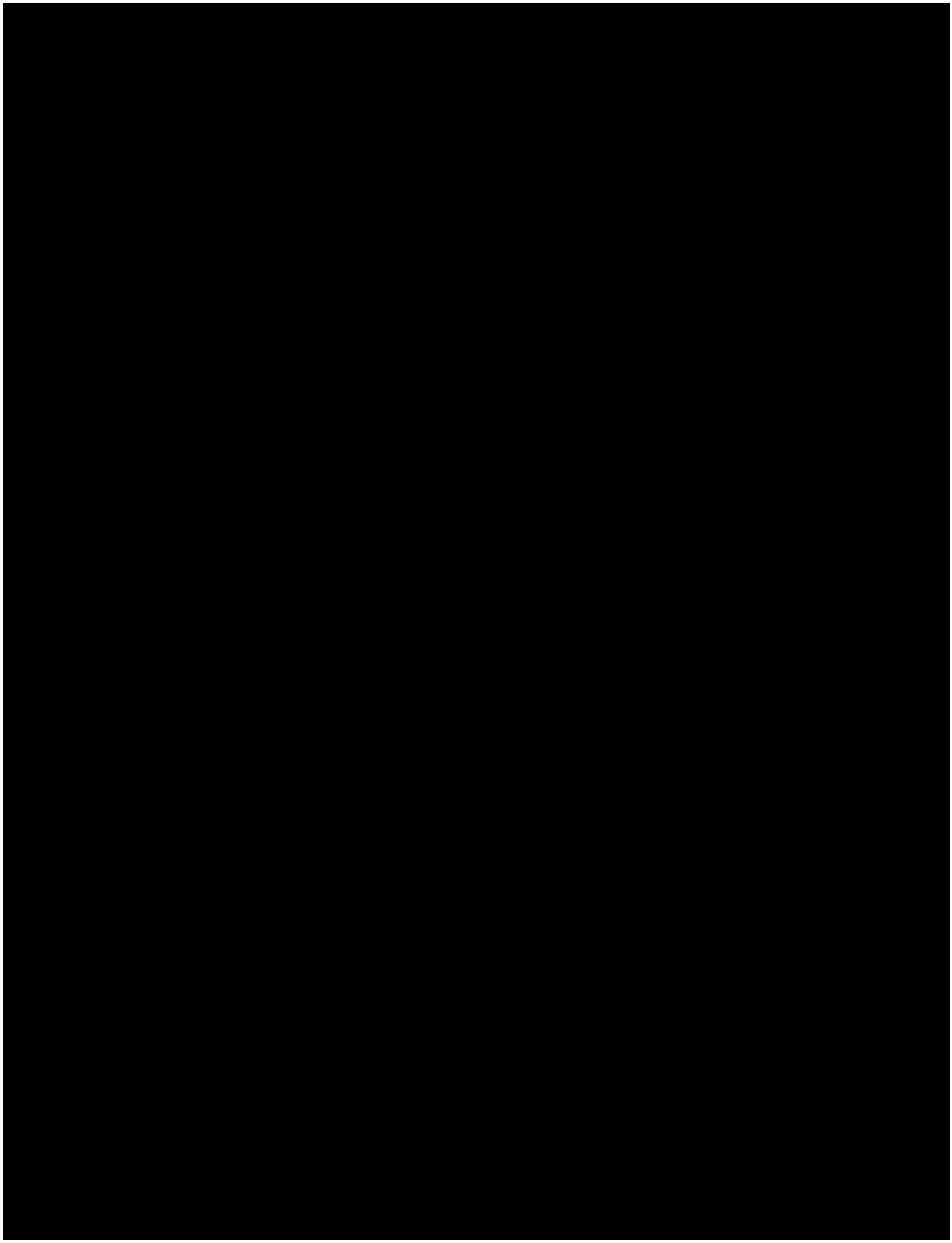
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

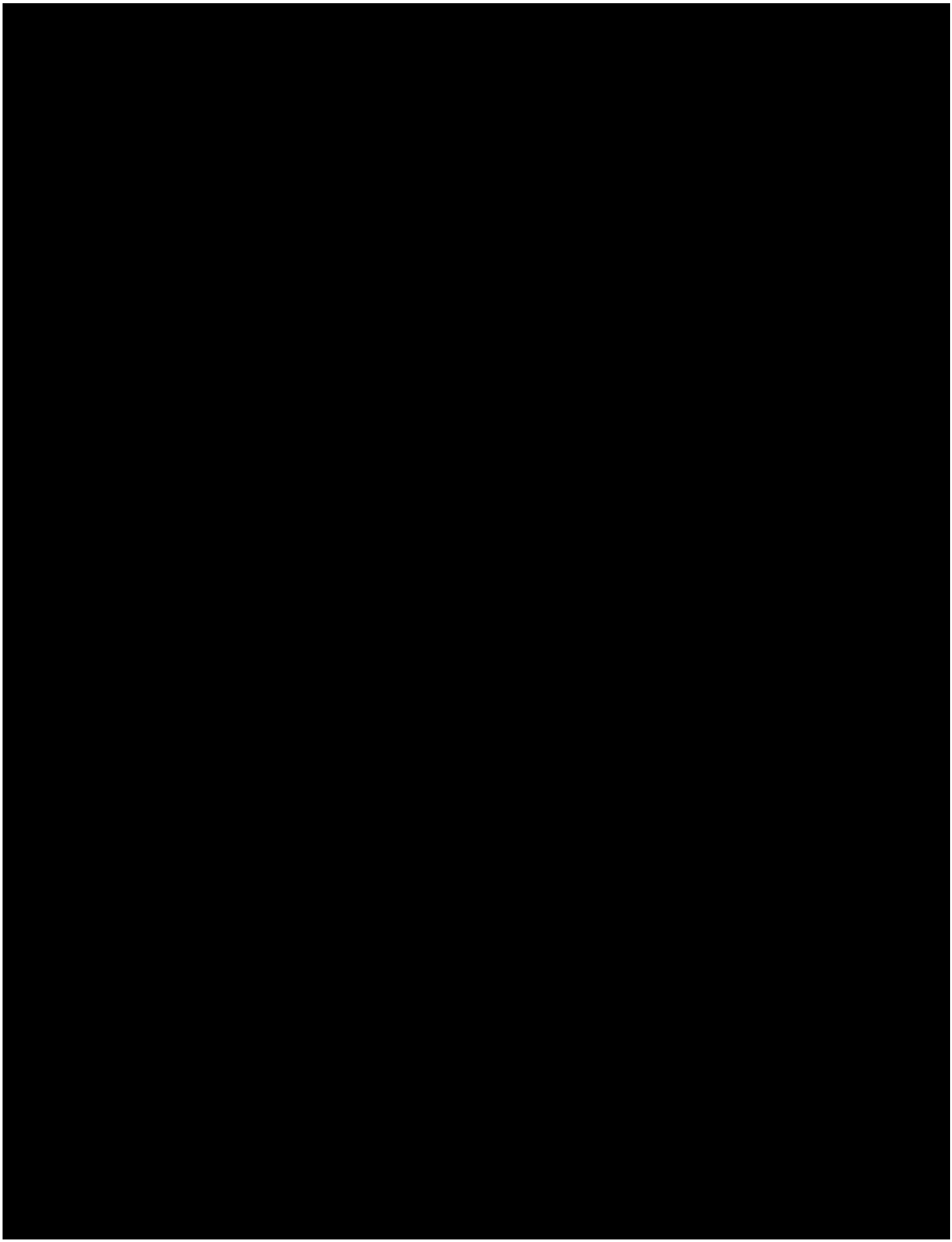
PRINTED: 07/14/2020
FORM APPROVED
OMB NO. 0938-0391

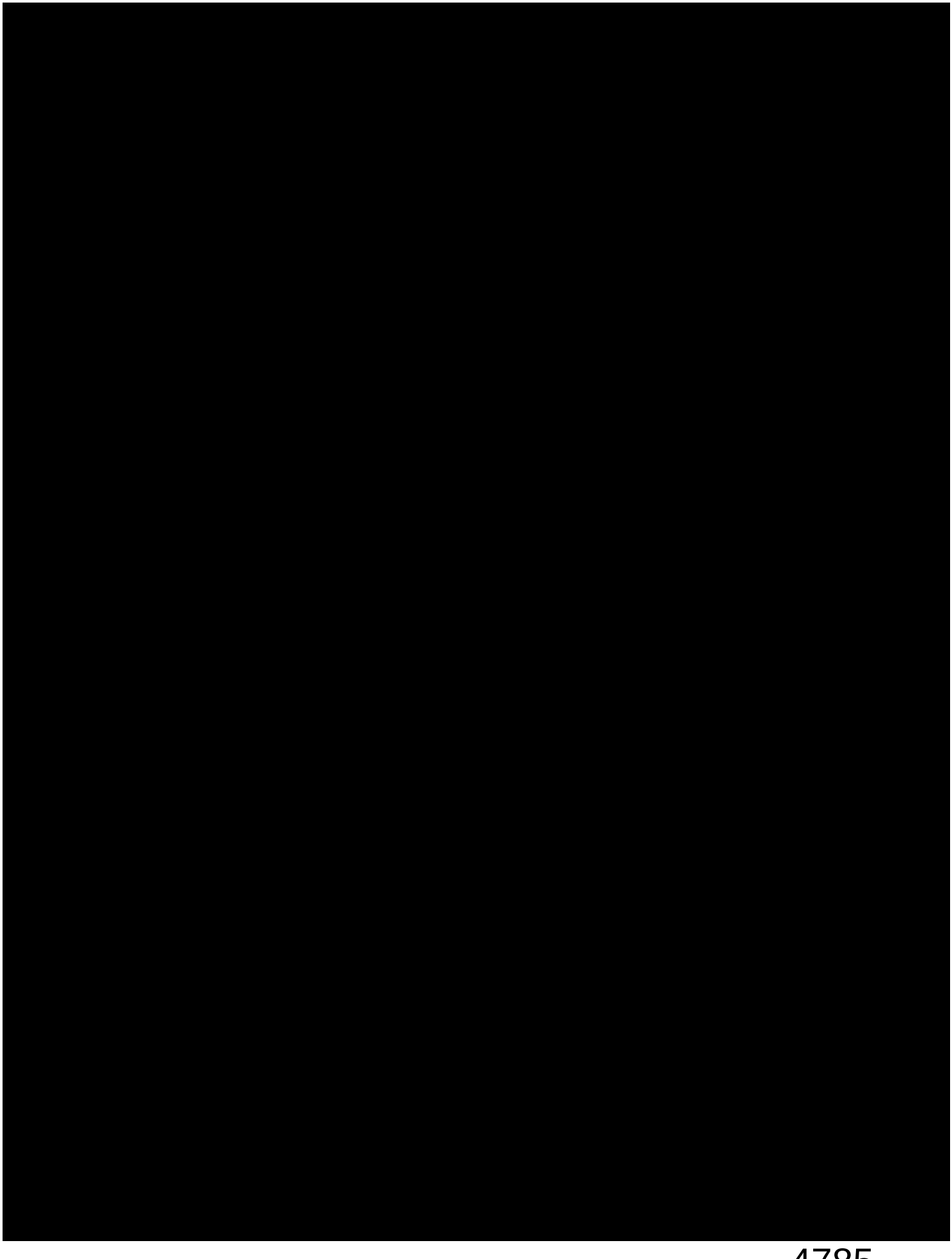
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G003	A. BUILDING _____ B. WING _____	C 06/30/2020

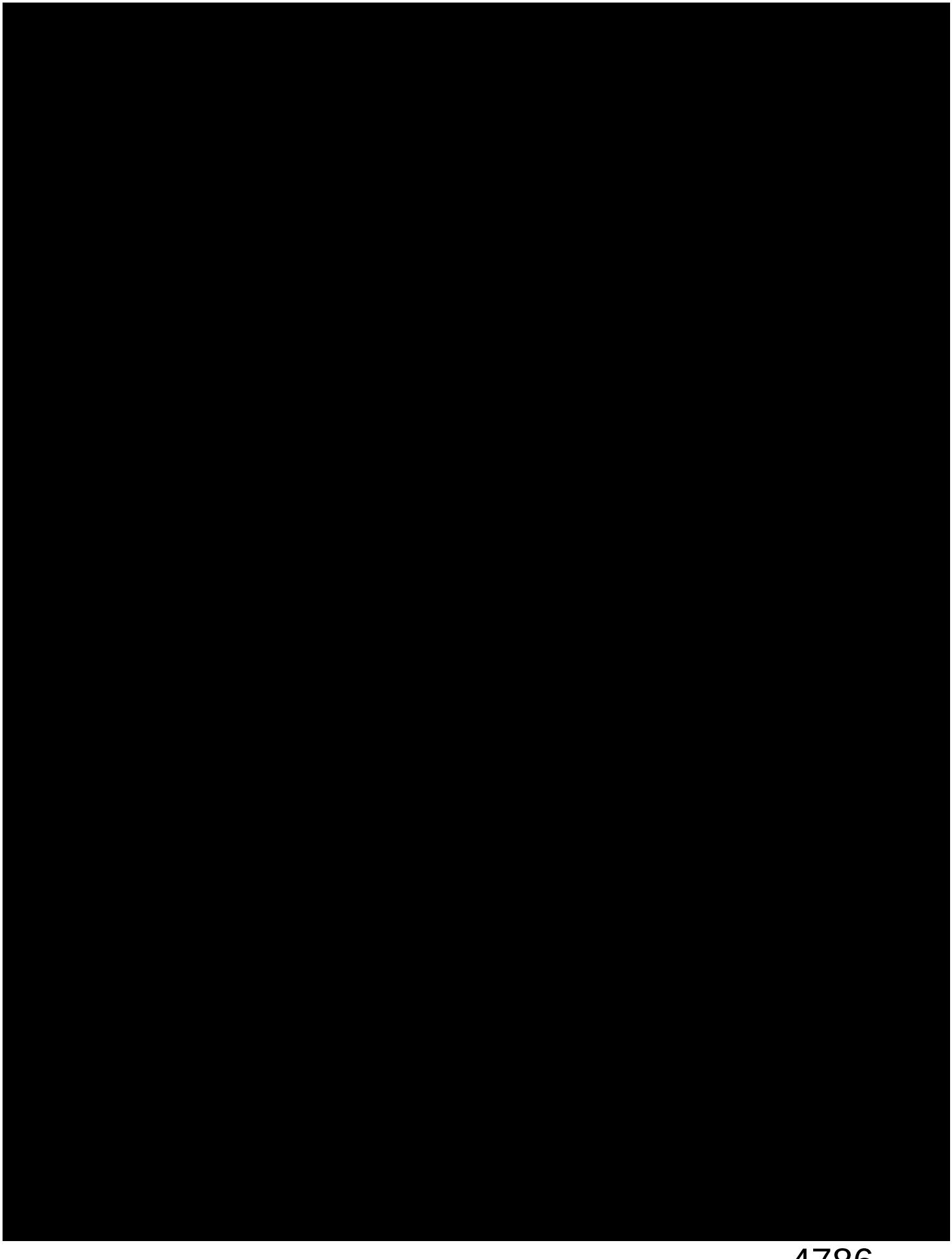
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONEVILLE HUMAN DEVELOPMENT CENTER	87 REED ROAD, HWY 116 SOUTH BOONEVILLE, AR 72927

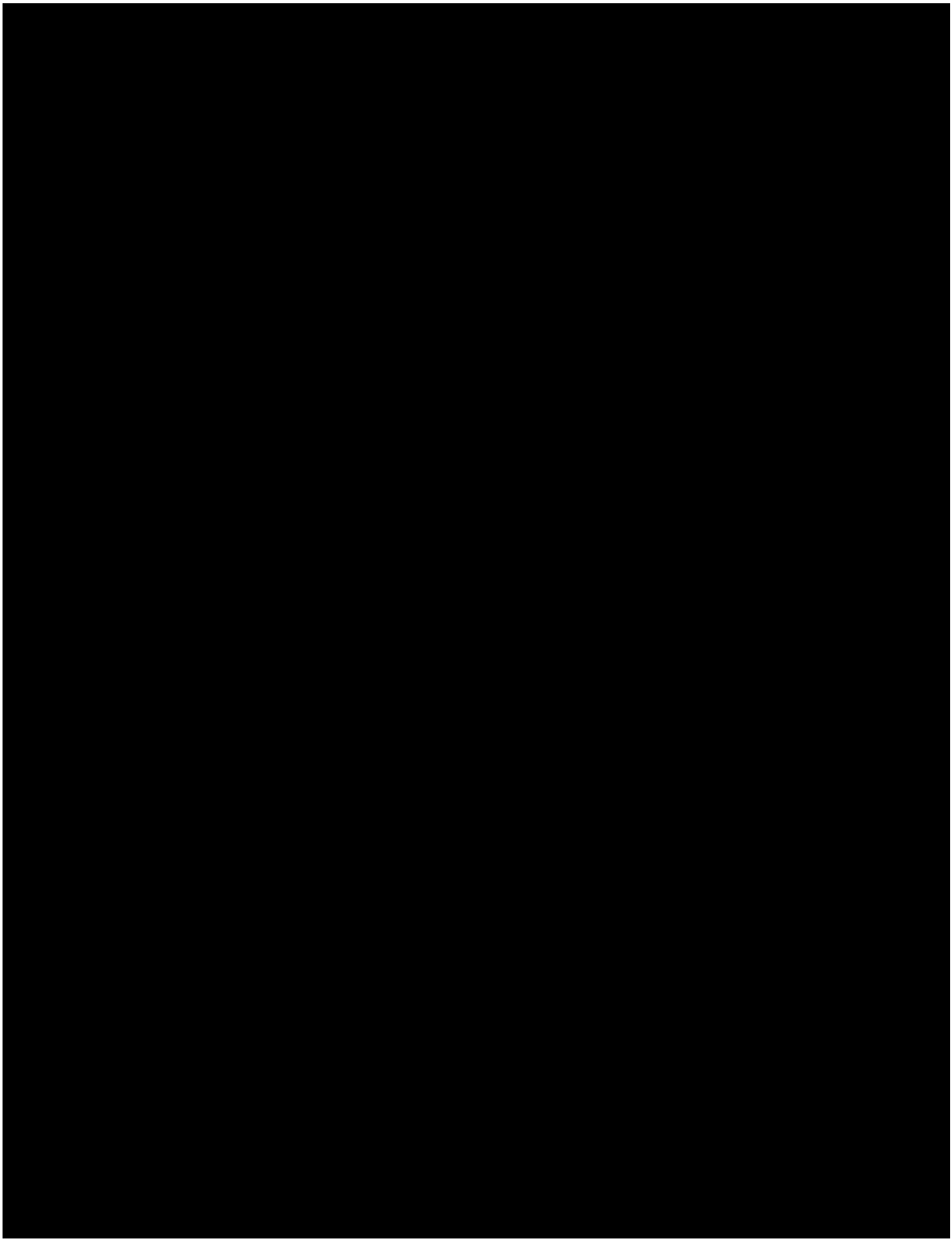
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	Continued From page 1 The facility was in compliance with the requirements of the 42 CFR, Part 483, subpart I for the Intermediate Care Facilities for Individuals with Intellectual Disabilities. Complaint #25772 (AR00024518) was unsubstantiated. Complaint #25996 (AR00024946) was unsubstantiated. Complaint #26043 (AR00024997) was unsubstantiated.	W 000		

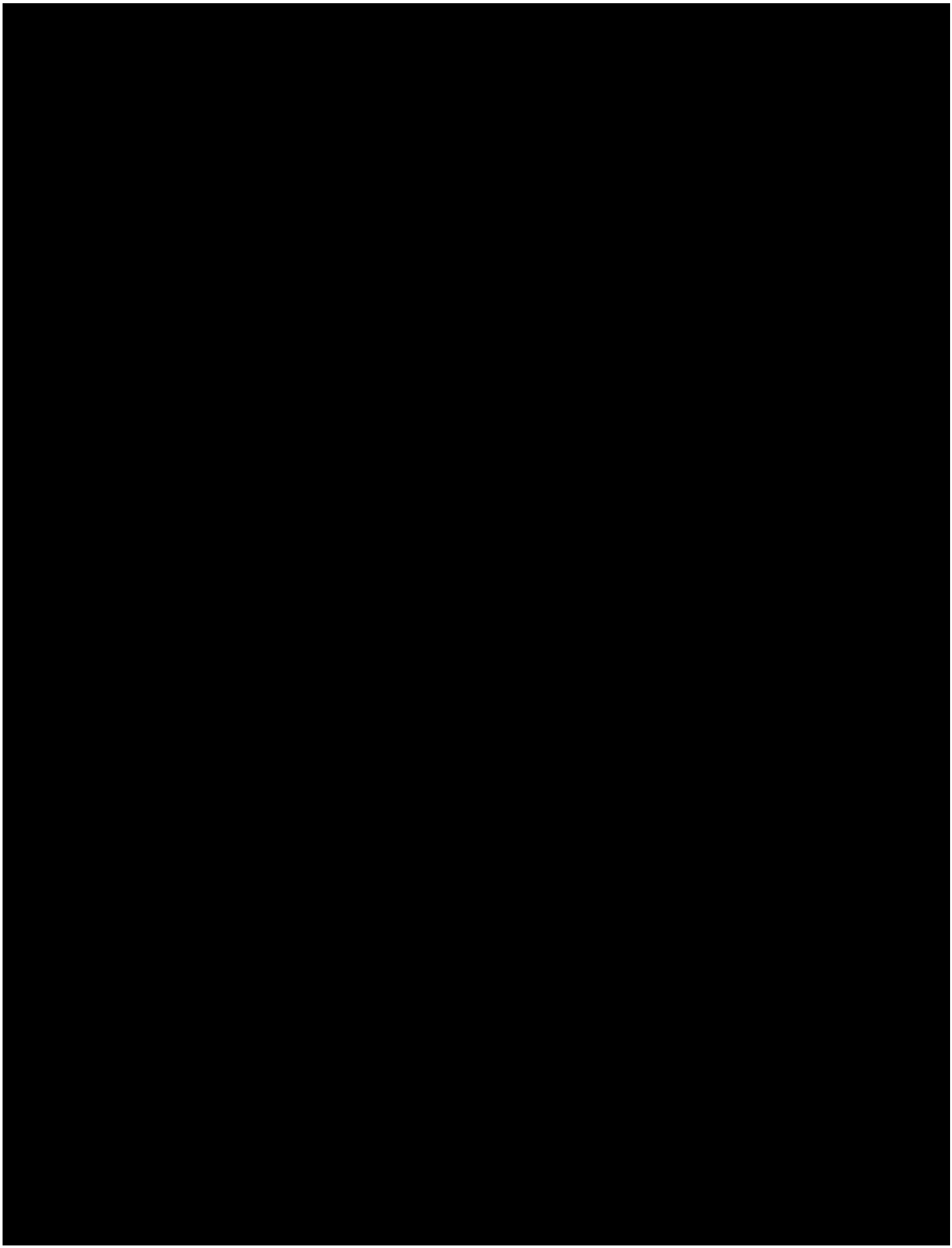


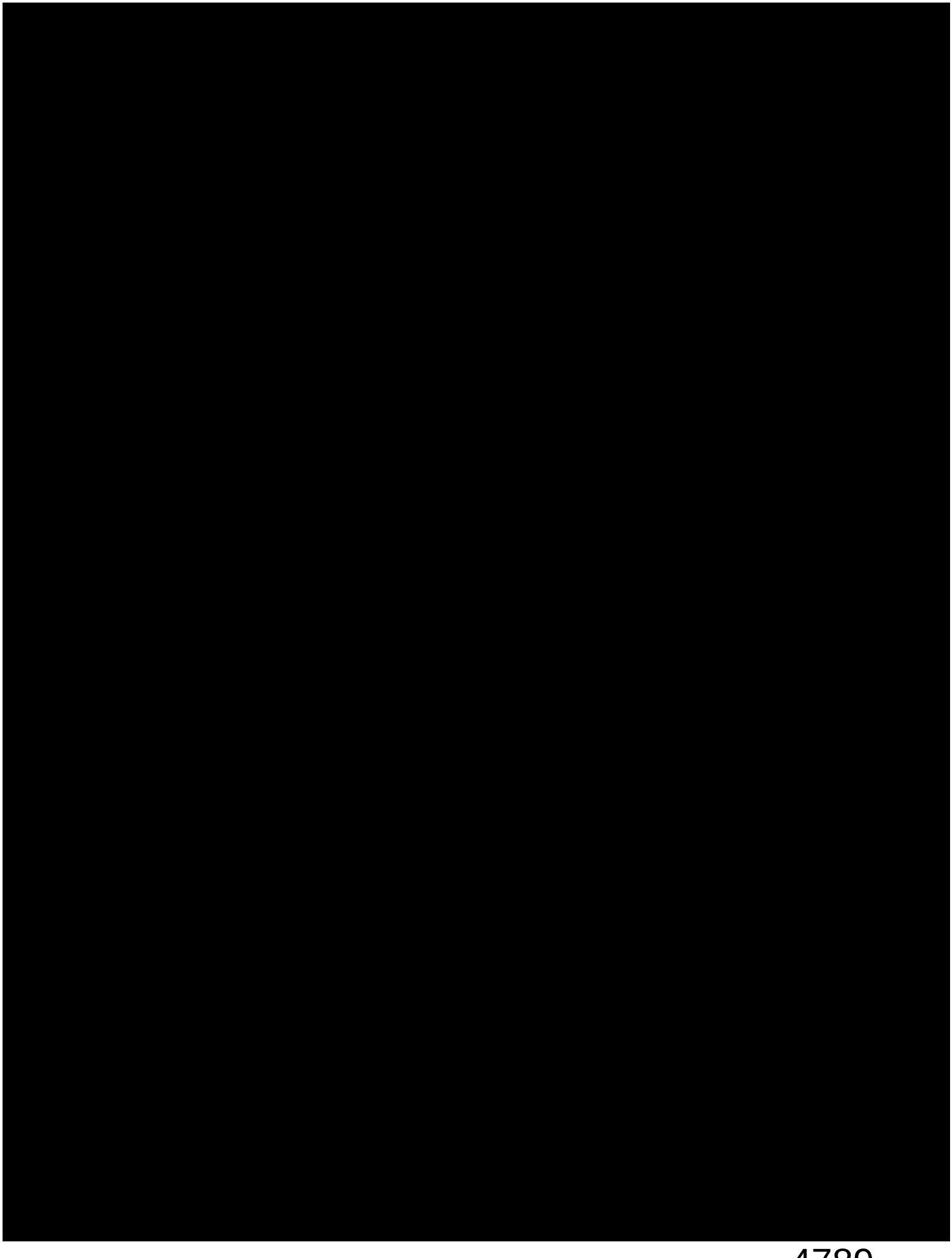


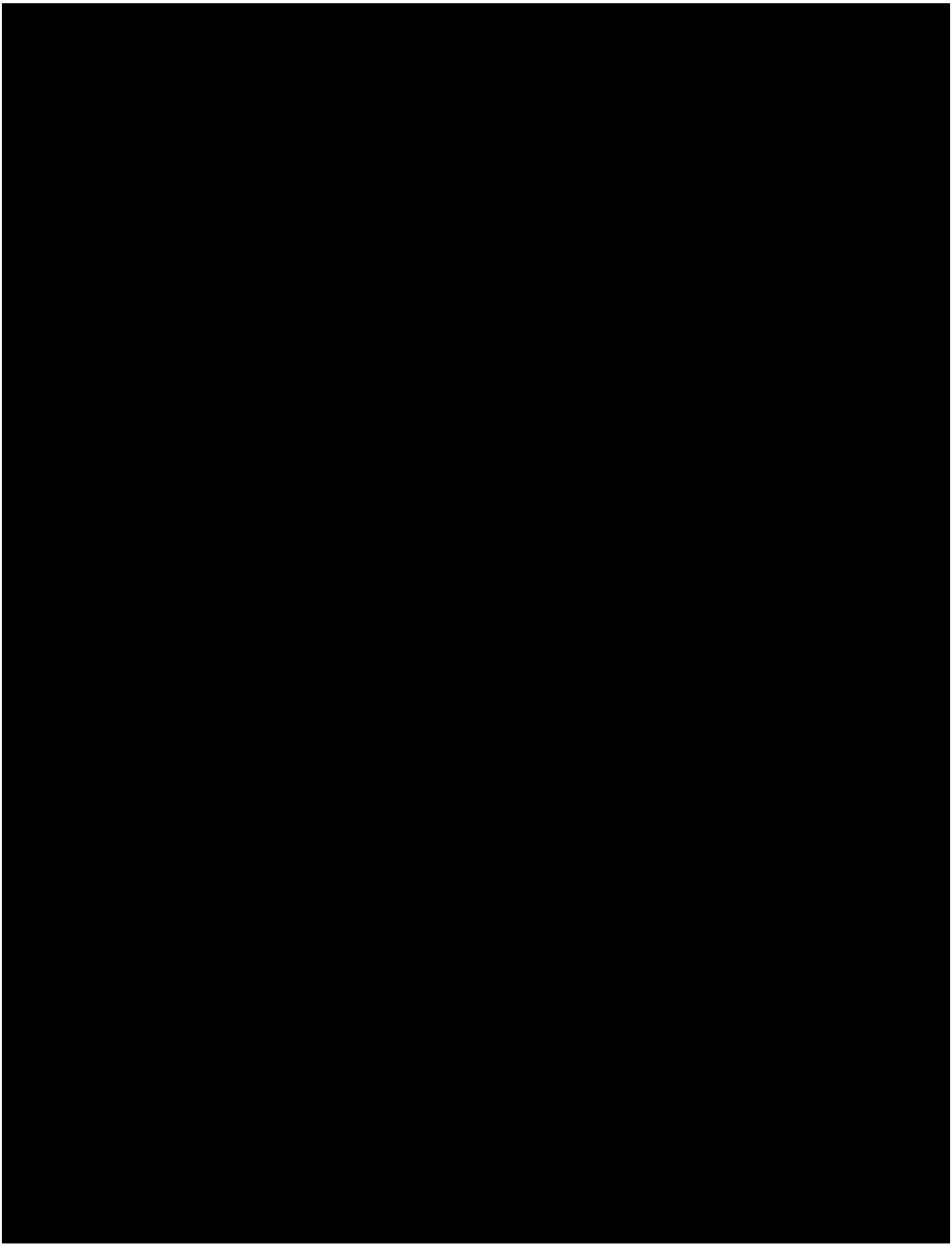












PENGAD 800-631-6989
EXHIBIT
2A
DHS Berry
PENGAD 800-631-6989
EXHIBIT
6A
DHS

PENGAD 800-631-6989 EXHIBIT 28

PENGAD 800-631-6989 EXHIBIT 6B DHS

PENGAD 800-631-6989
EXHIBIT
2a
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DTB

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EXHIBIT
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PENGAD 800-631-6989
EXHIBIT
69
DHS


PENGAD 800-631-6989
EXHIBIT
22
PENGAD 800-631-6989
EXHIBIT
69
DHS

EVACUATION
COMMONS BUILDING - MAIN FLOOR

301 CARRY ROAD

REVISED 03/01/07
PAGE 65

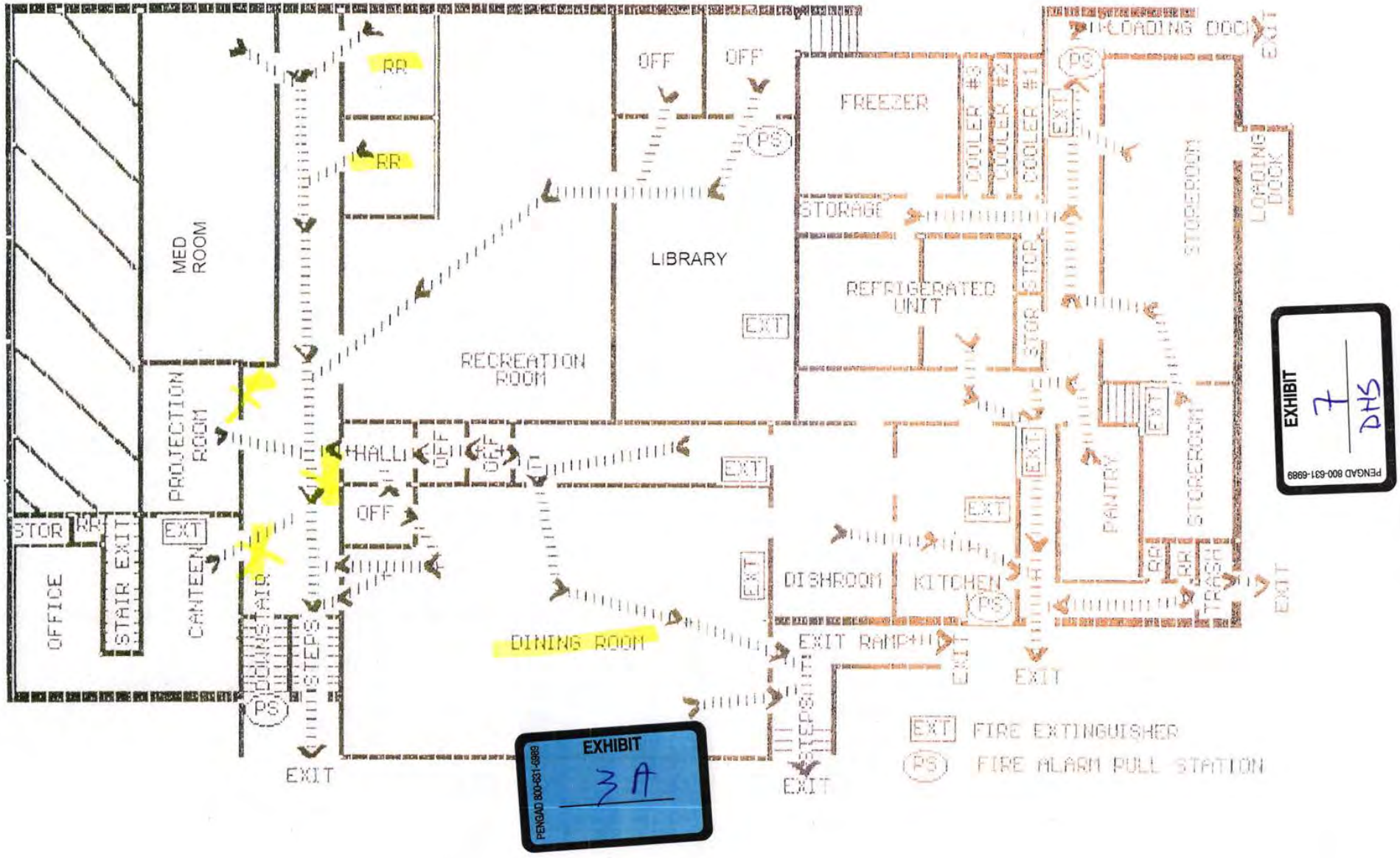

EXHIBIT 7 DHS
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EXHIBIT 3A
PENGAD 800-631-6989

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EVACUATION

COMMONS BUILDING - BASEMENT

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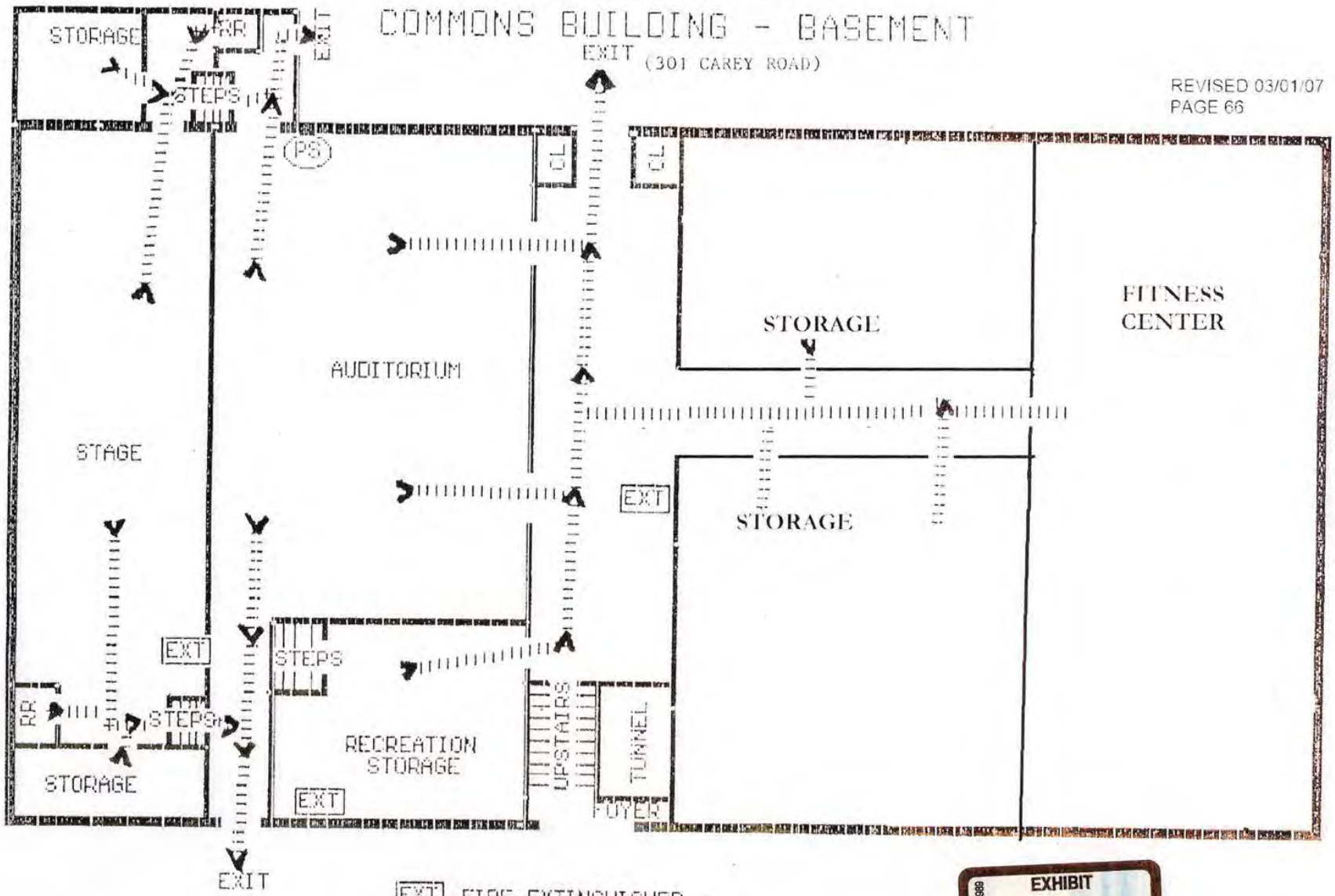
PAGE 66



EXT FIRE EXTINGUISHER

PS FIRE ALARM PULL STATION

EXHIBIT

3B

PENGAD 800-631-6989

PENGAD 800-631-6989
EXHIBIT
8A
DHS


PENGAD 800-631-6989
EXHIBIT
8B
DTS

EXIT
PENGAD 800-631-6989
EXHIBIT
8C
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8D
DHS

PENGAD 800-631-6989
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BE
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CANTEEN
PENGAD 800-631-6989
EXHIBIT
8F
DHS



PENGAD 800-631-6989

EXHIBIT

89

DHS


EXIT
Leave your thoughts here
PENGAD 800-631-6989
EXHIBIT
BH
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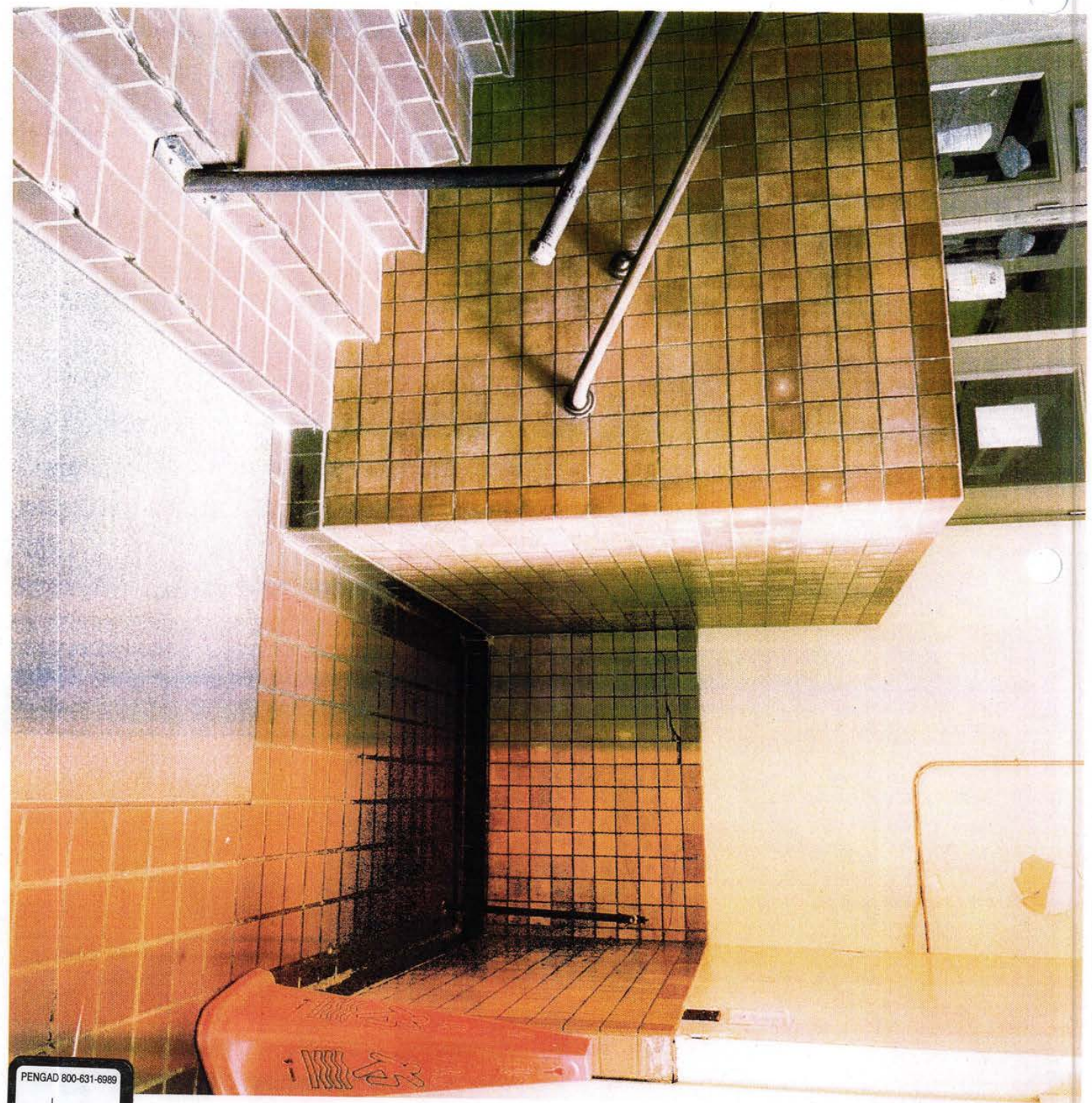

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EXHIBIT
8T
DHS

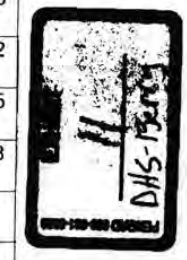
Booneville Human Development Center – All Residential Living Areas

June 1-13, 2022

JUNE 1, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	29

JUNE 2, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	30

JUNE 3, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	25
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	32





JUNE 4, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	25
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	123
Staffing – 1600 to 2400	30

JUNE 5, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	25
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	123
Staffing – 1600 to 2400	30

JUNE 6, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	123
Staffing – 0800 to 1600	29
Required Ratio – 1600 to 2400	1 to 8
Daily Census	123
Staffing – 1600 to 2400	29

Booneville Human Development Center – All Residential Living Areas

June 1-13, 2022

JUNE 7, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	123
Staffing – 0800 to 1600	29
Required Ratio – 1600 to 2400	1 to 8
Daily Census	123
Staffing – 1600 to 2400	29

JUNE 8, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	30

JUNE 9, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	30

JUNE 10, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	32

JUNE 11, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	122
Staffing – 0000 to 0800	24
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	31

JUNE 12, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	25
Required Ratio – 0800 to 1600	1 to 8
Daily Census	
Staffing – 0800 to 1600	
Required Ratio – 1600 to 2400	1 to 8
Daily Census	123
Staffing – 1600 to 2400	31

- Booneville Human Development Center – All Residential Living Areas

June 1-13, 2022

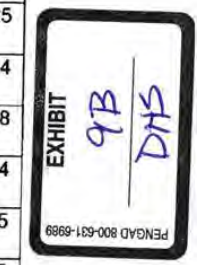
JUNE 13, 2020	BHDC
Required Ratio – 0000 to 0800	1 to 16
Daily Census	123
Staffing – 0000 to 0800	25
Required Ratio – 0800 to 1600	1 to 8
Daily Census	123
Staffing – 0800 to 1600	30
Required Ratio – 1600 to 2400	1 to 8
Daily Census	122
Staffing – 1600 to 2400	29

Booneville Human Development Center –Davison House

June 1-13, 2022

JUNE 1, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	25
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 1600 to 2400	2	2	5

JUNE 2, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	25
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 1600 to 2400	3	2	4





JUNE 3, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	24
Staffing – 0000 to 0800	2	1	3
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 0800 to 1600	3	3	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 1600 to 2400	3	2	4

JUNE 4, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	24
Staffing – 0000 to 0800	2	1	3
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 0800 to 1600	3	2	4
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 1600 to 2400	3	2	4

Booneville Human Development Center –Davison House

June 1-13, 2022

JUNE 5, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	24
Staffing – 0000 to 0800	2	1	3
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 1600 to 2400	3	2	5

JUNE 6, 2020	Davison2 House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	25
Staffing – 0000 to 0800	1	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 0800 to 1600	2	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 1600 to 2400	2	2	5

JUNE 7, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	25
Staffing – 0000 to 0800	1	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 0800 to 1600	2	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 1600 to 2400	2	2	5

JUNE 8, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	25
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	25
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 1600 to 2400	3	2	5

Booneville Human Development Center –Davison House

June 1-13, 2022

JUNE 9, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	24
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 1600 to 2400	3	2	5

JUNE 10, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	11	24
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	11	24
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 1600 to 2400	3	2	5

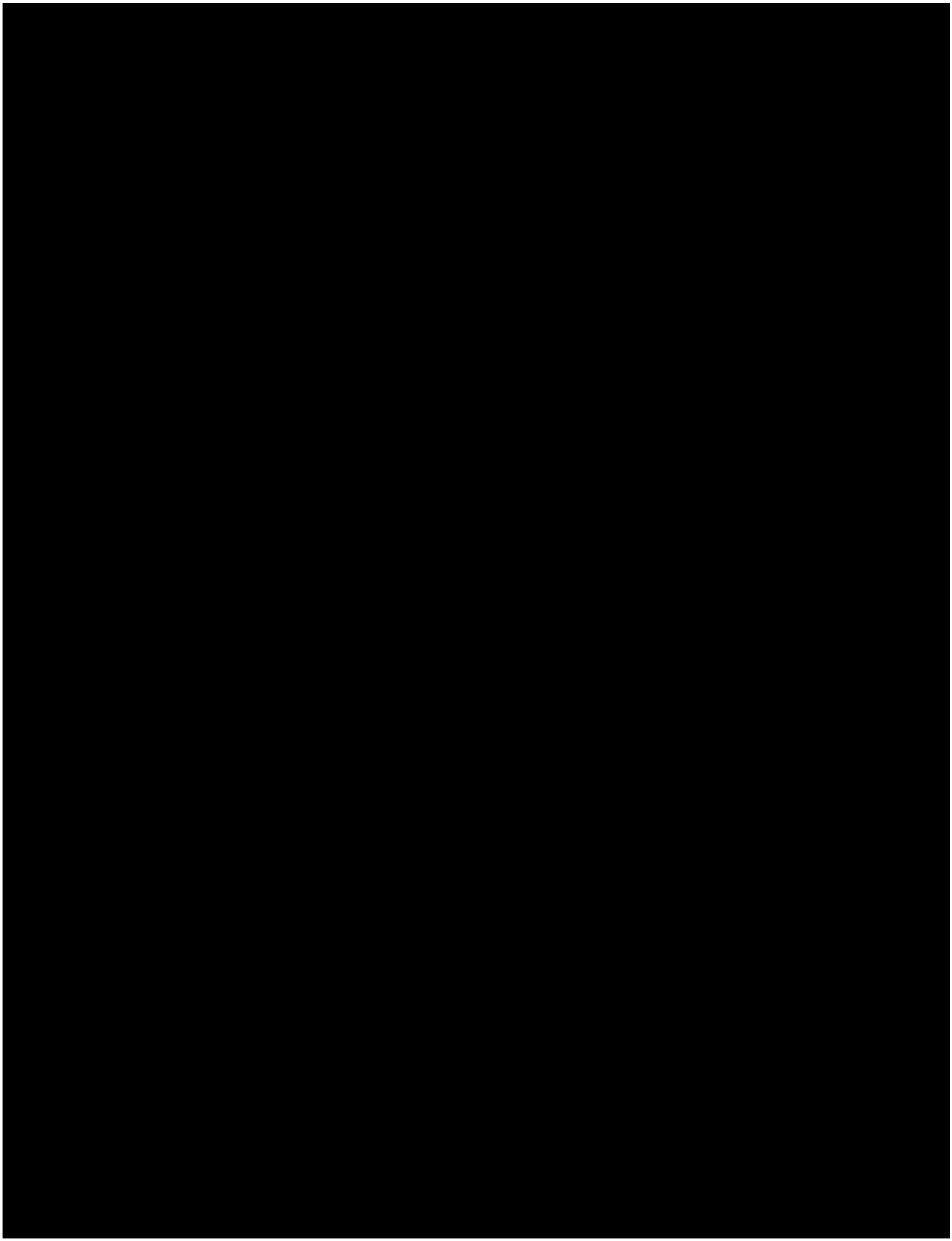
JUNE 11, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	10	24
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 1600 to 2400	3	2	5

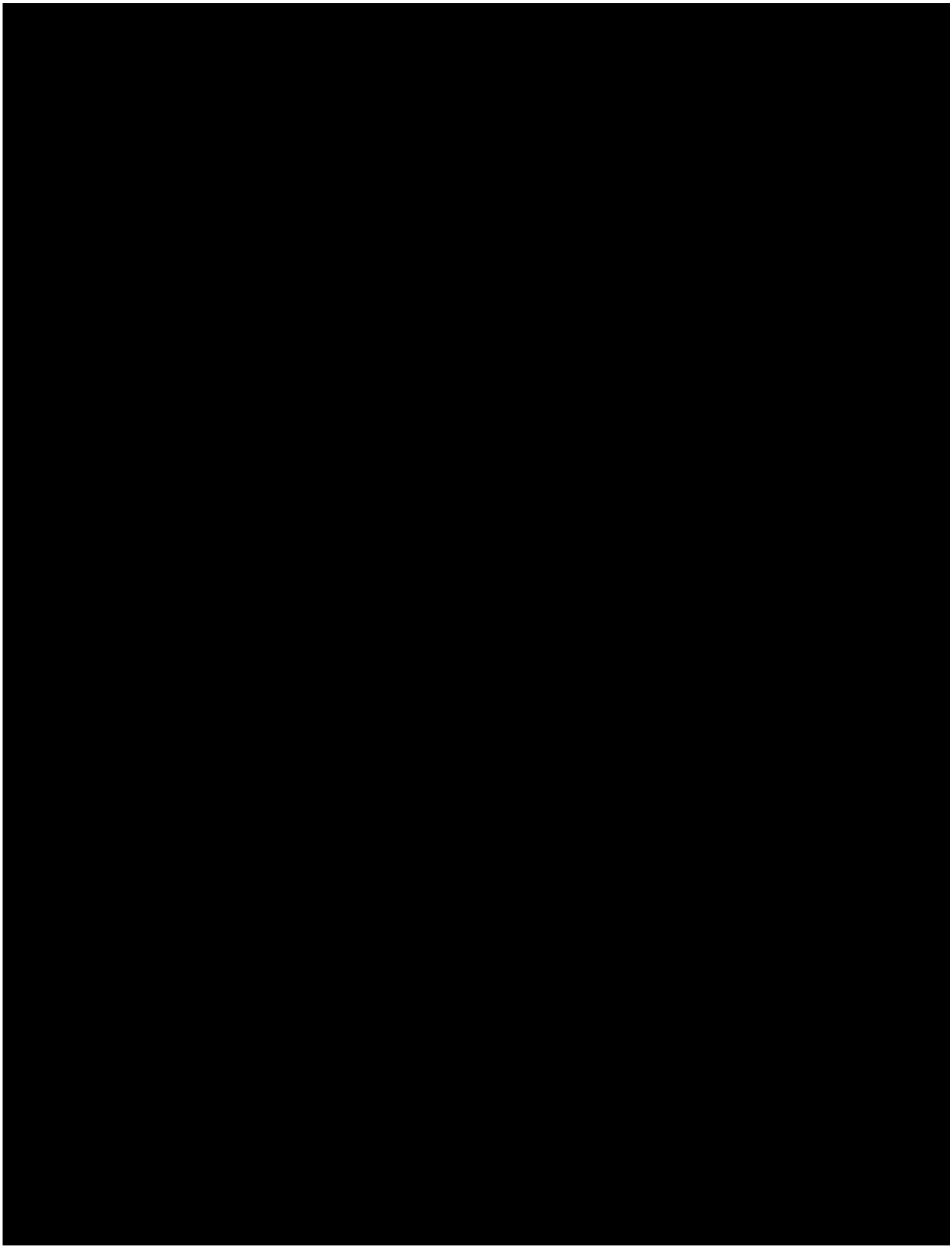
JUNE 12, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	10	24
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 0800 to 1600	3	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 1600 to 2400	3	2	5

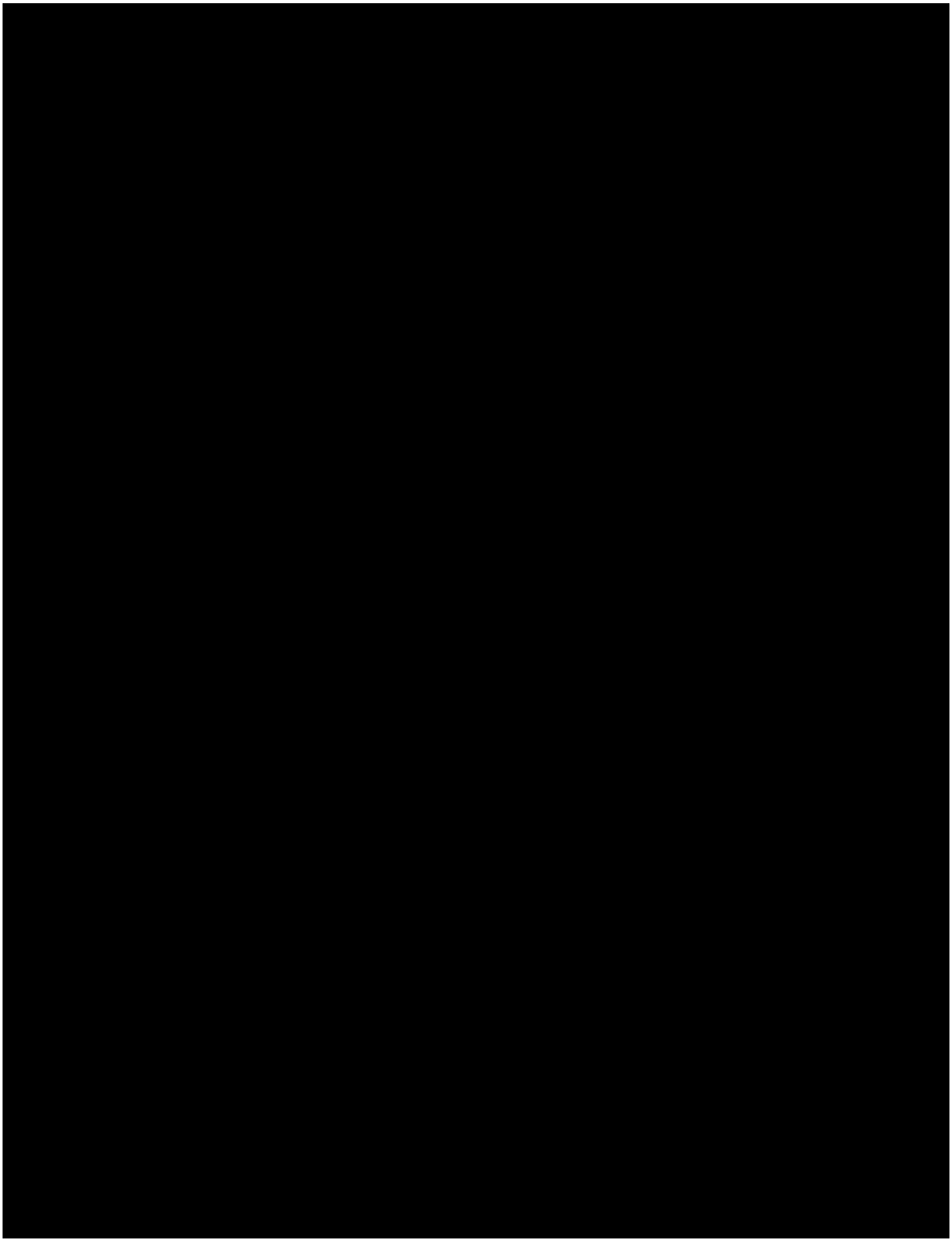
Booneville Human Development Center –Davison House

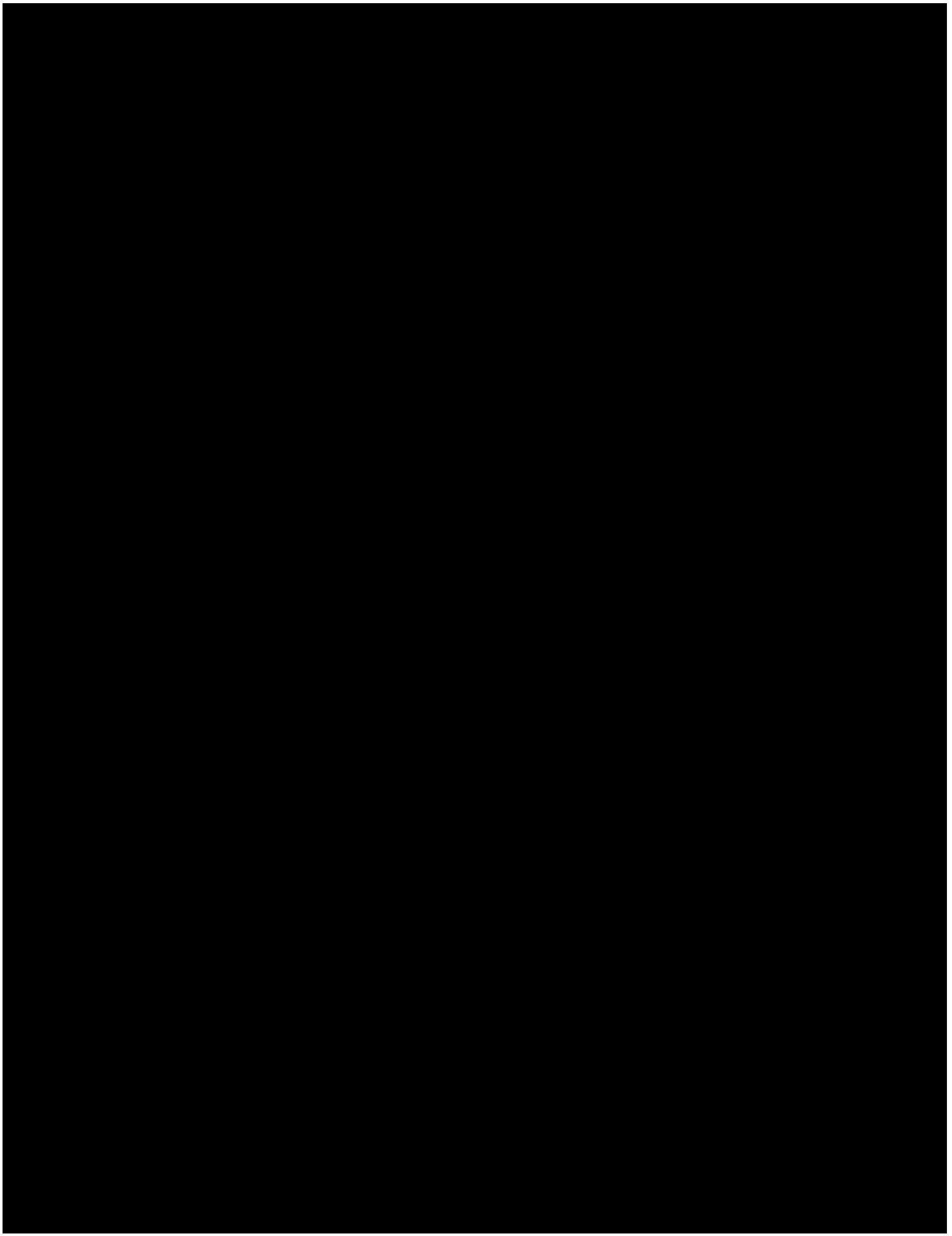
June 1-13, 2022

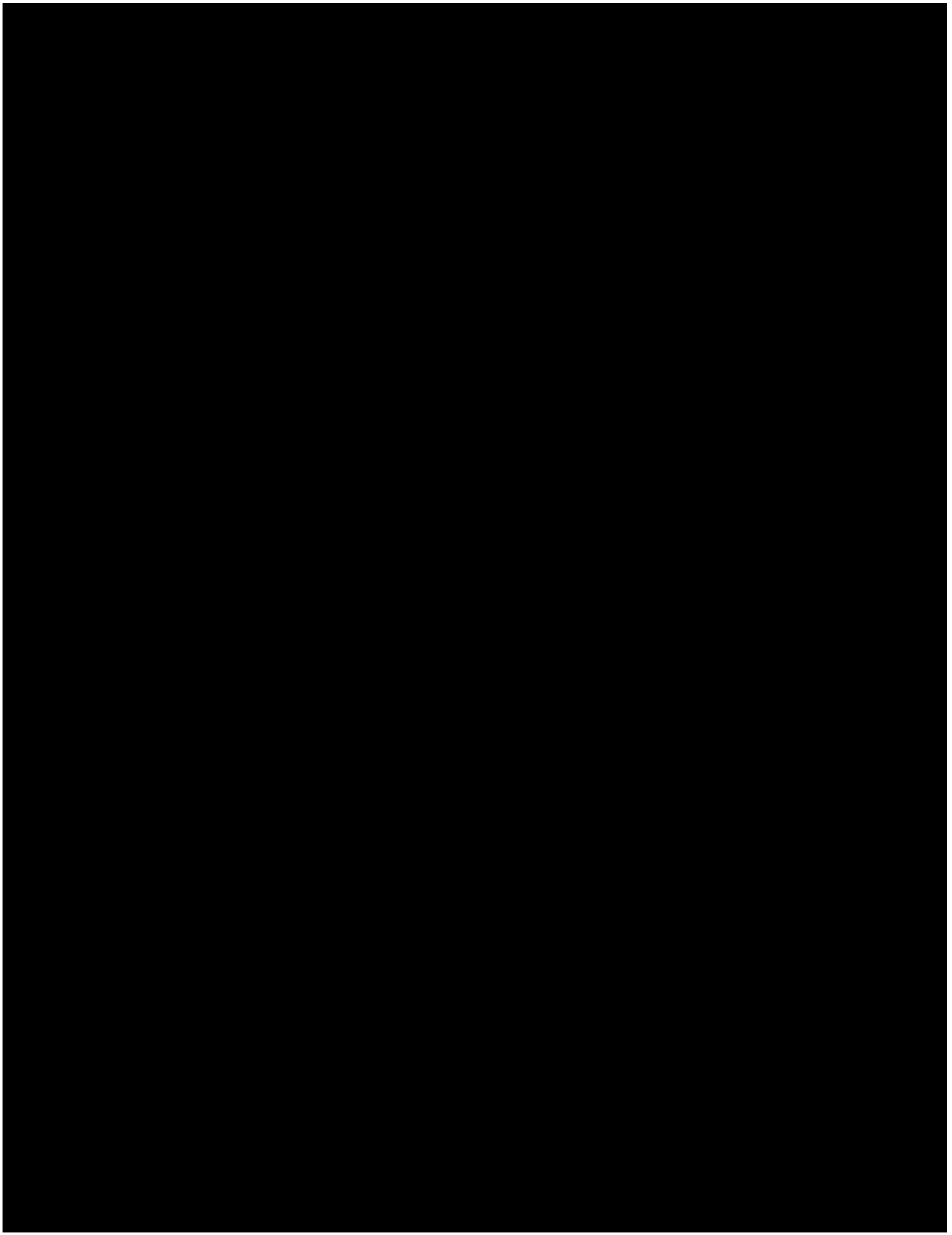
JUNE 13, 2020	Davison House Blue	Davison House Green	Davison House Orange/Yellow
Required Ratio – 0000 to 0800	1 to 16	1 to 16	1 to 16
Daily Census	10	10	24
Staffing – 0000 to 0800	2	1	4
Required Ratio – 0800 to 1600	1 to 8	1 to 8	1 to 8
Daily Census	10	10	24
Staffing – 0800 to 1600	2	2	5
Required Ratio – 1600 to 2400	1 to 8	1 to 8	1 to 8
Daily Census	9	11	24
Staffing – 1600 to 2400	2	2	5

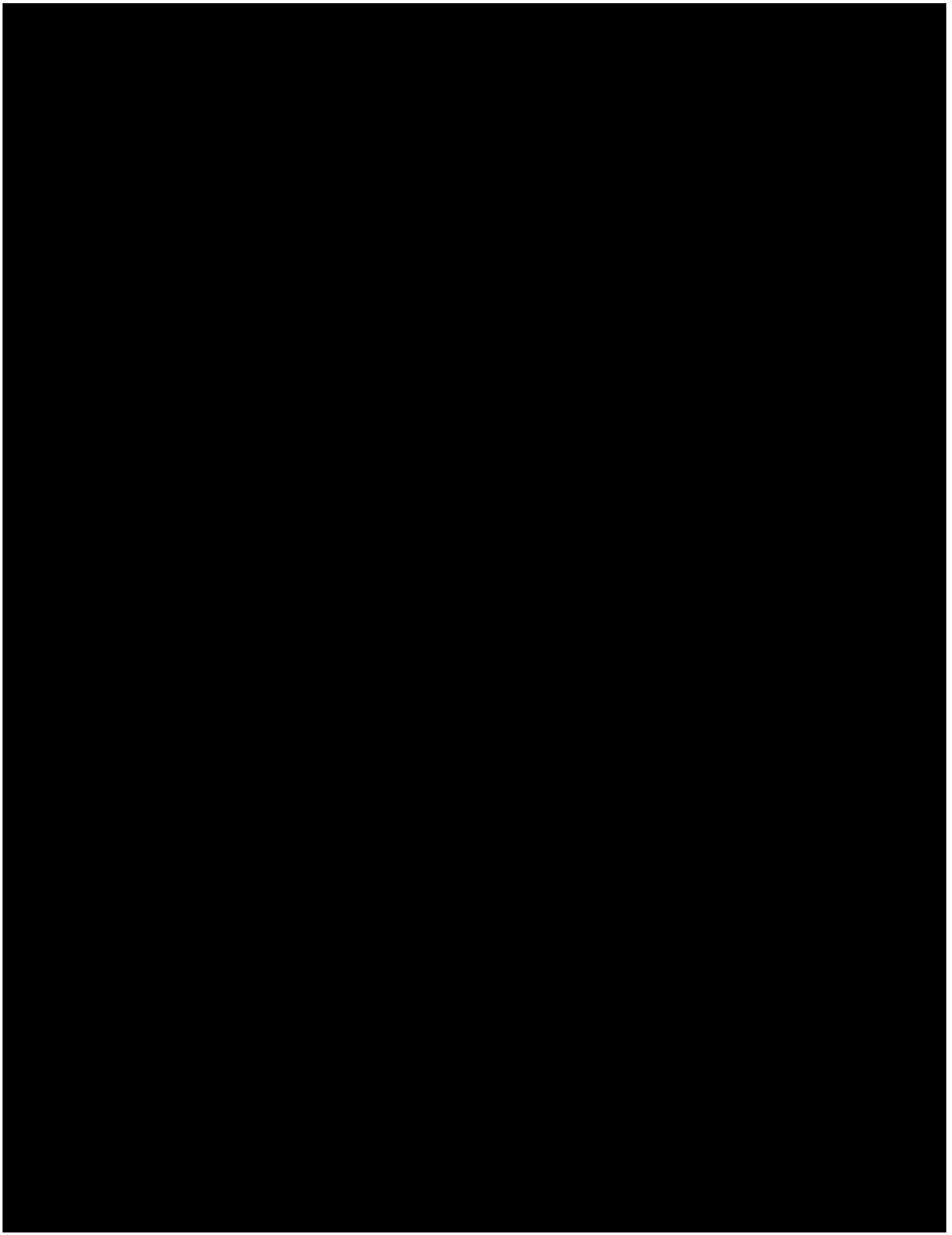


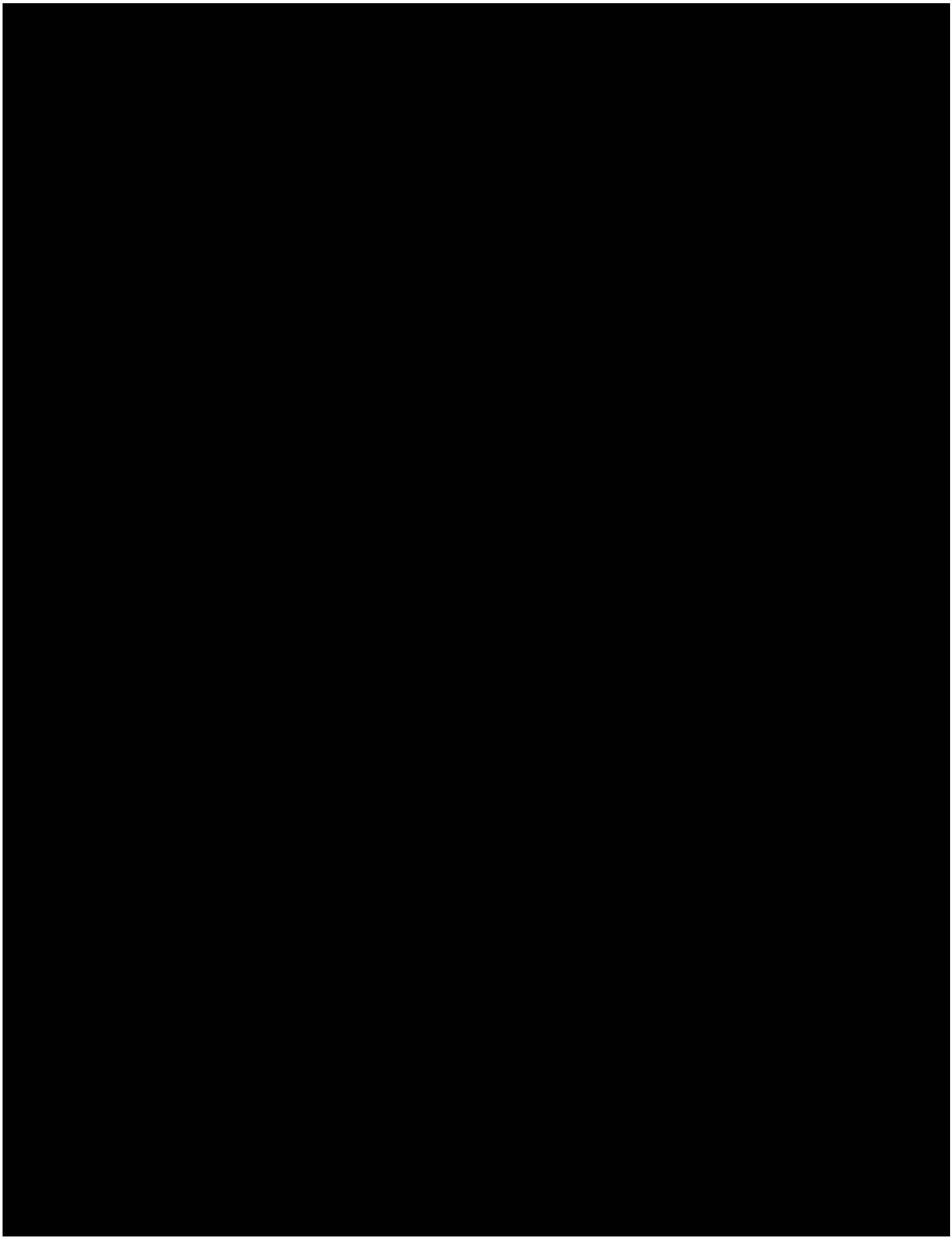


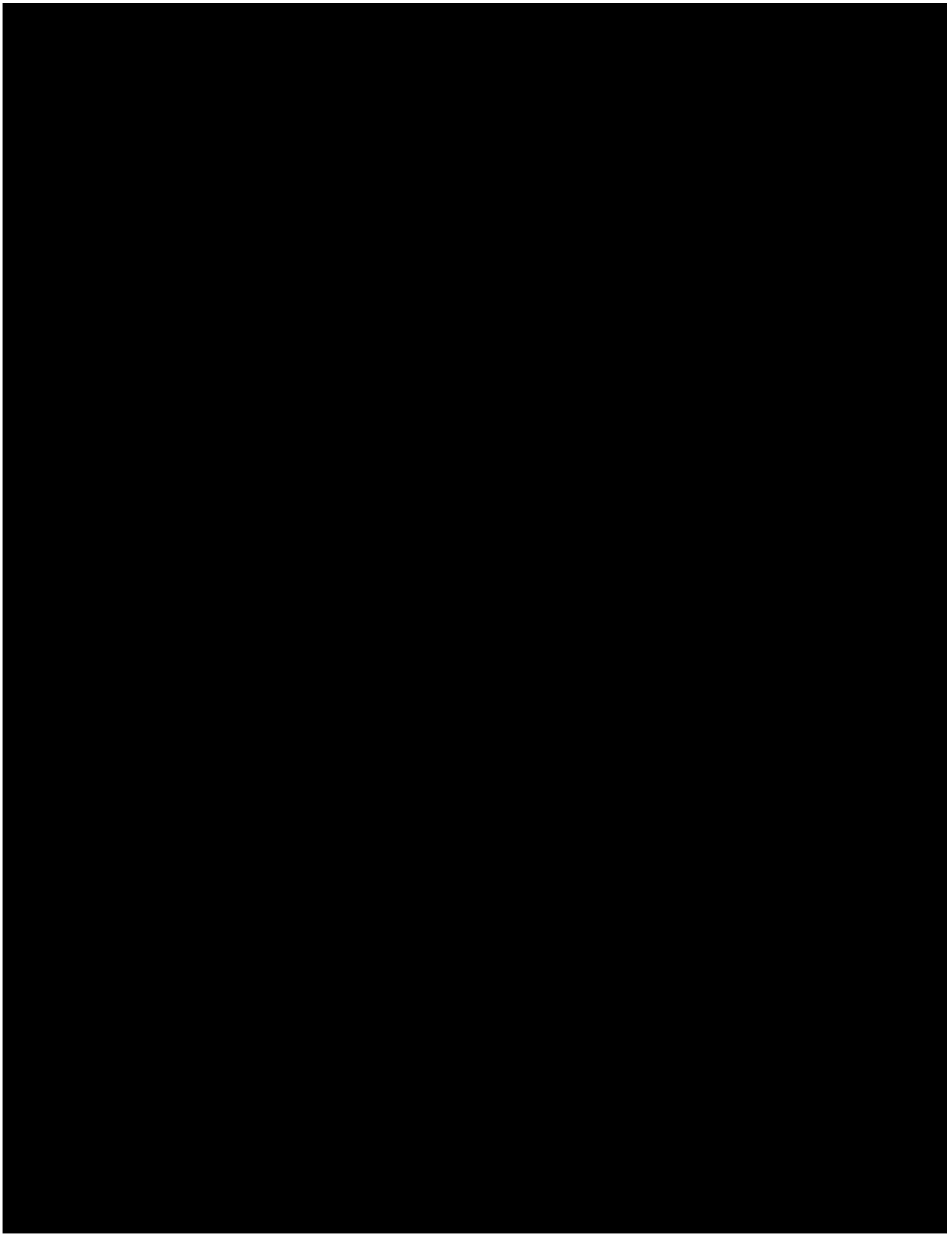


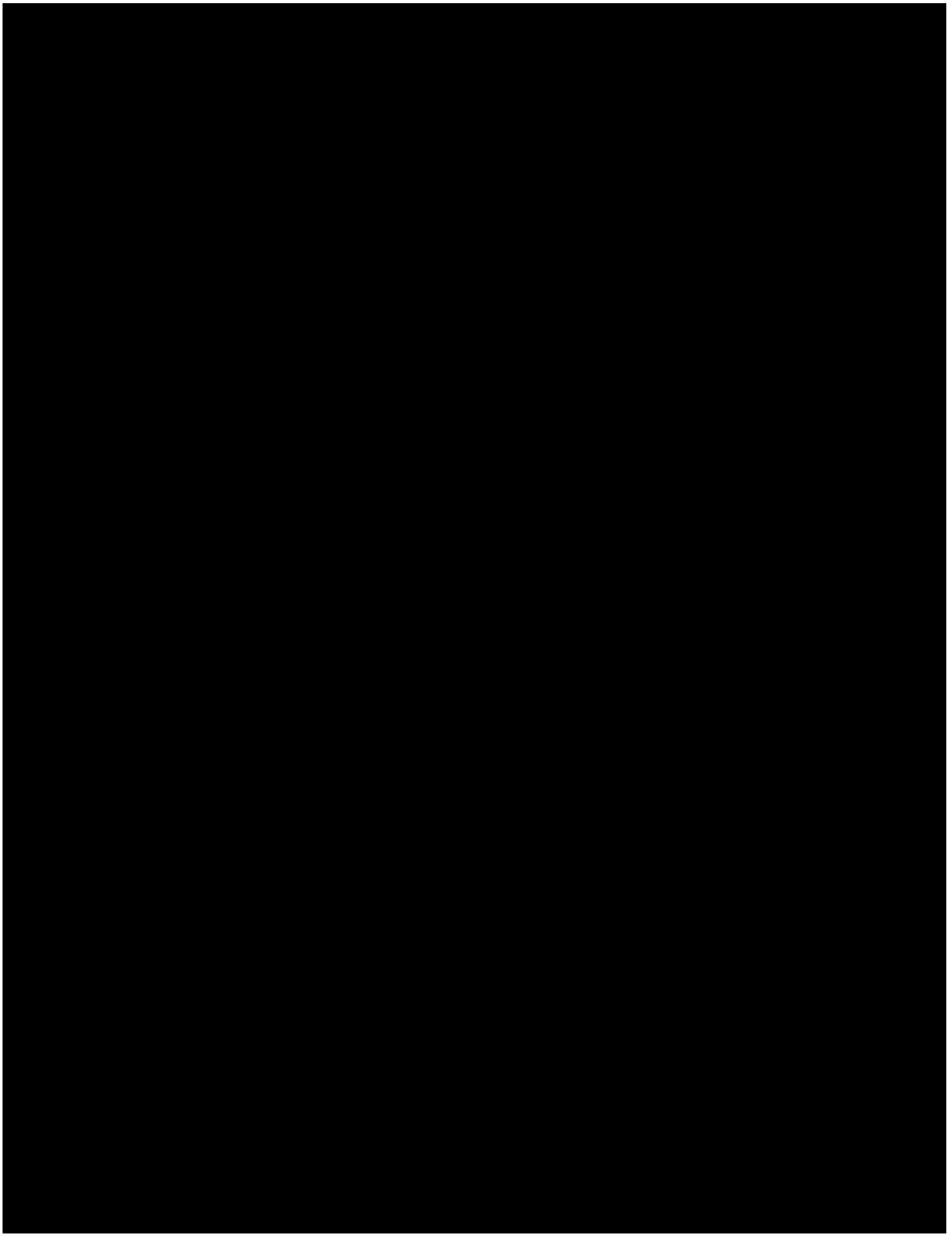


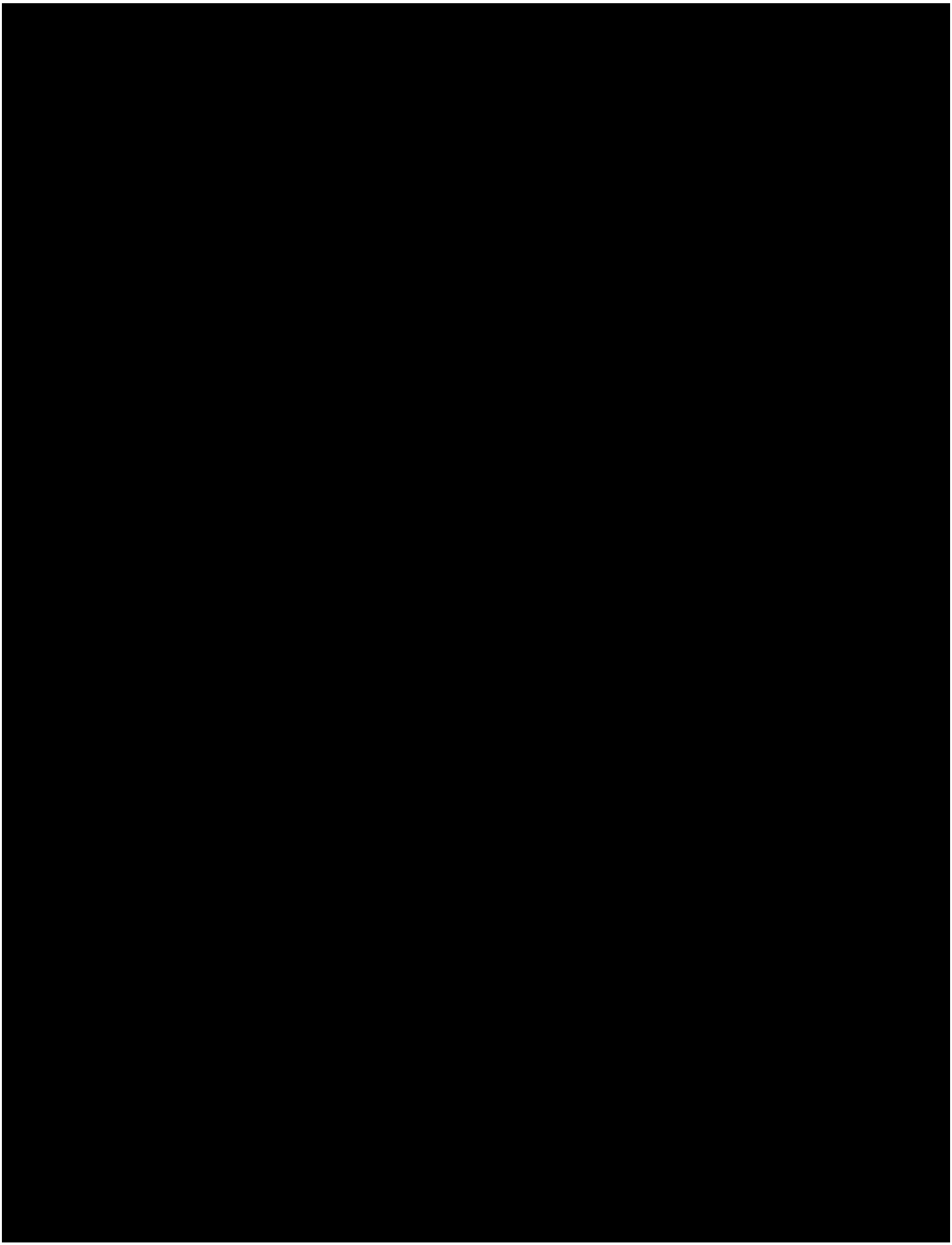


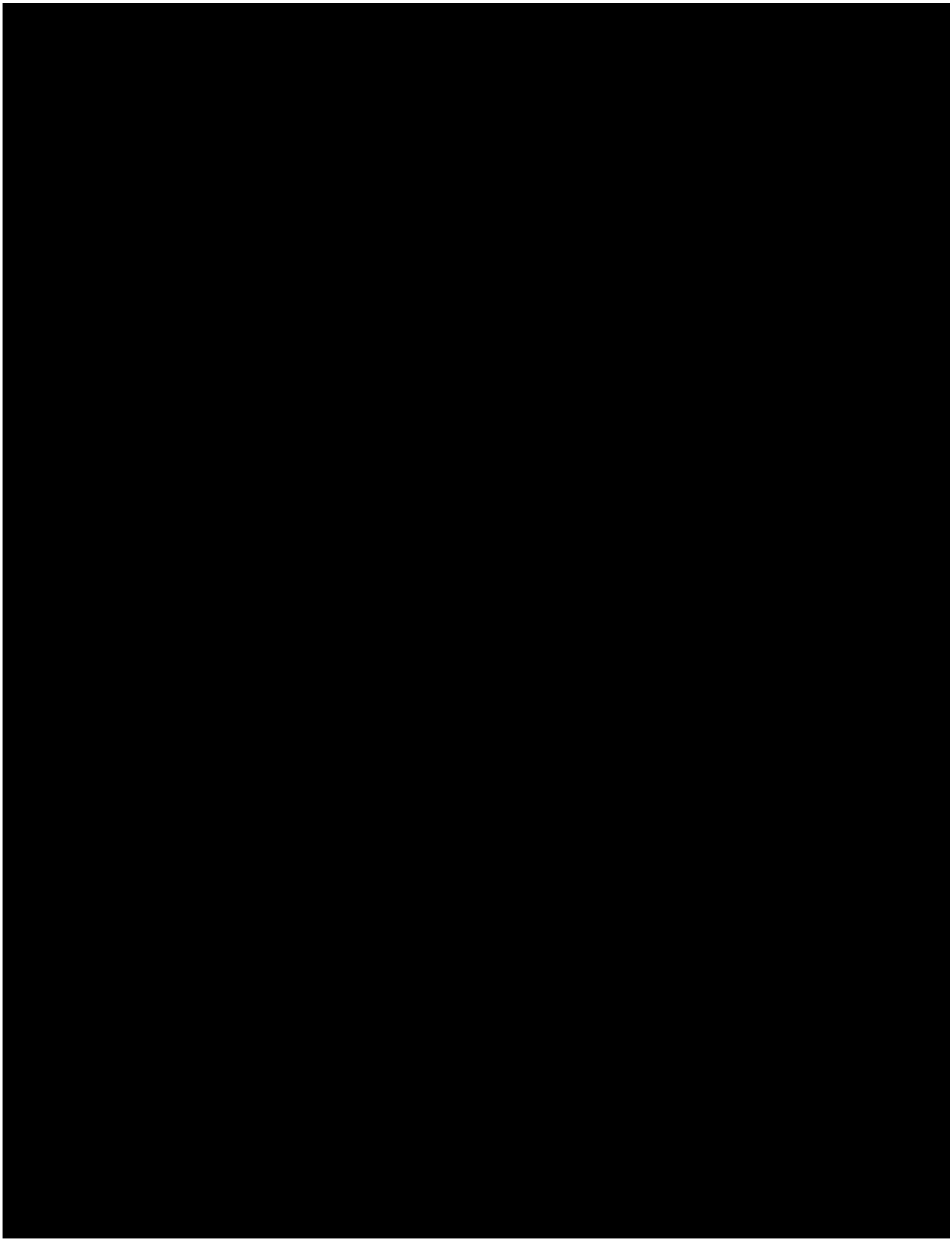


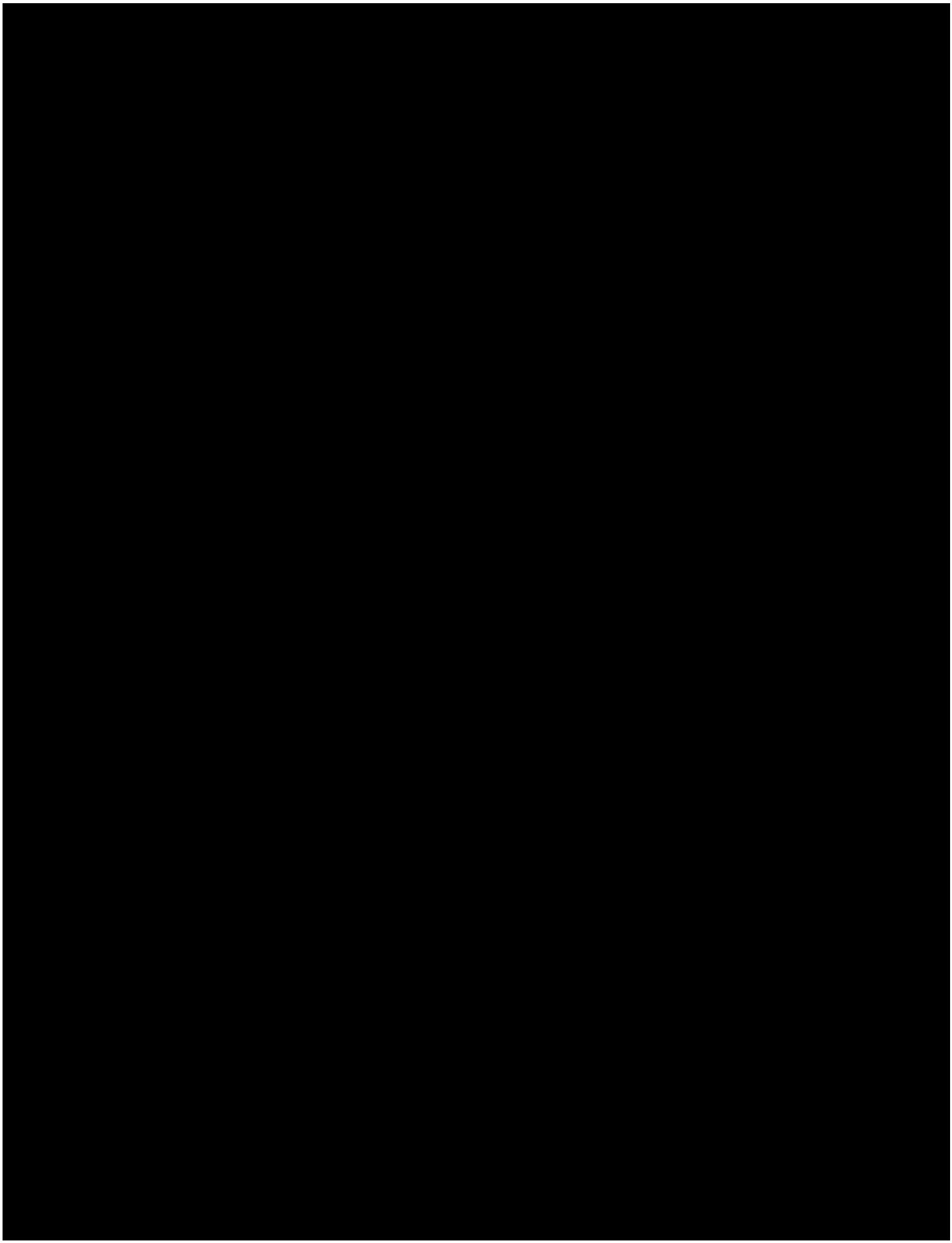


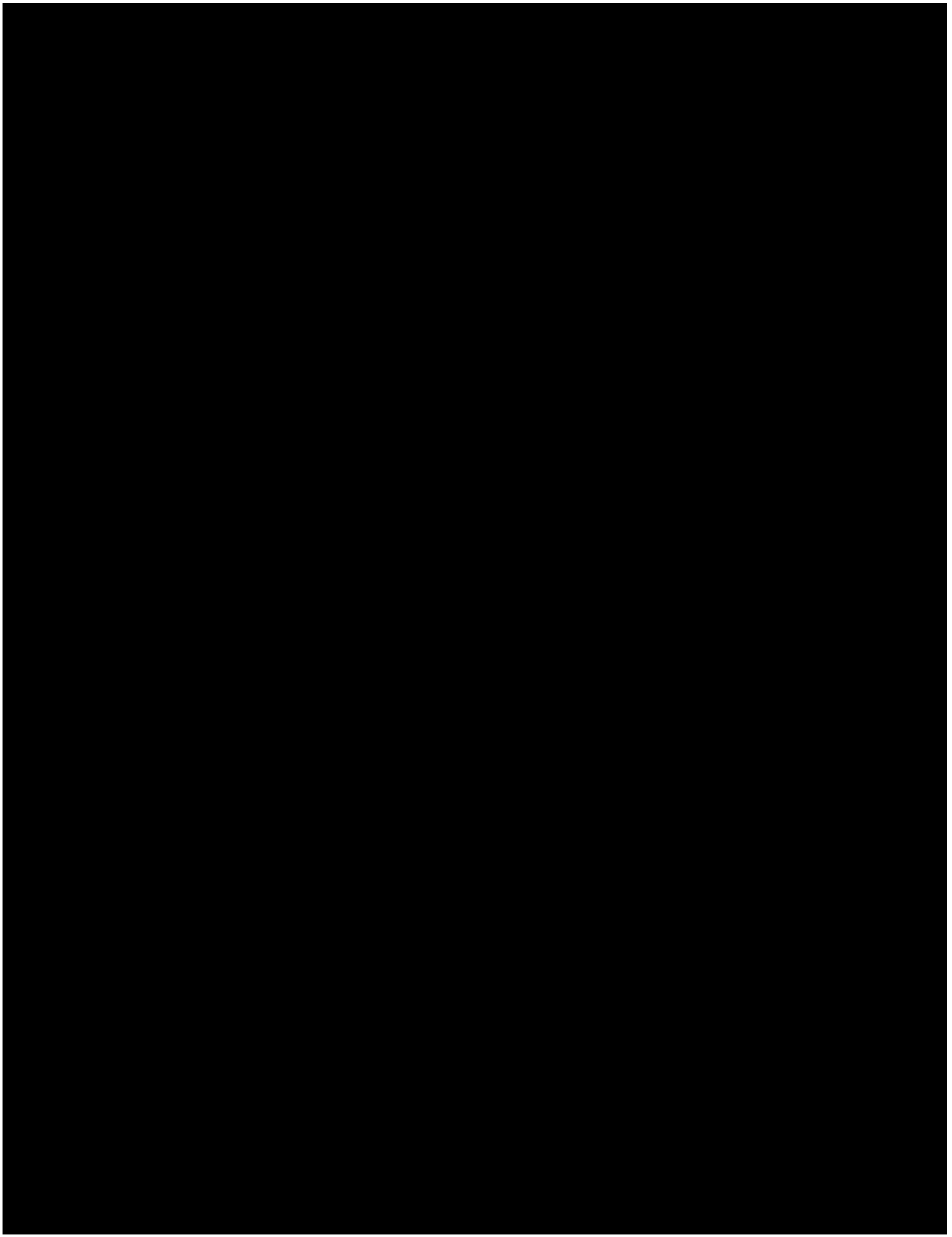


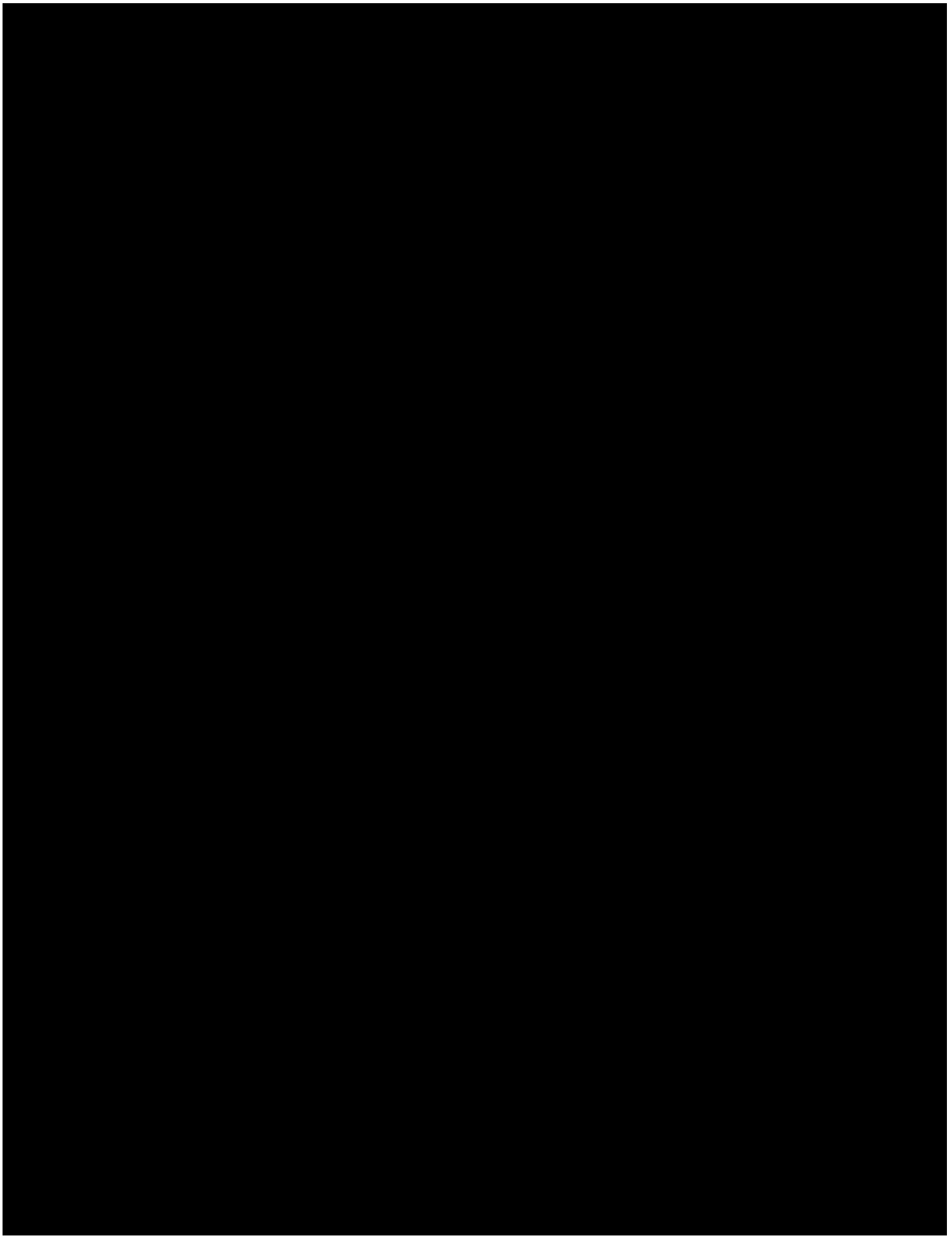


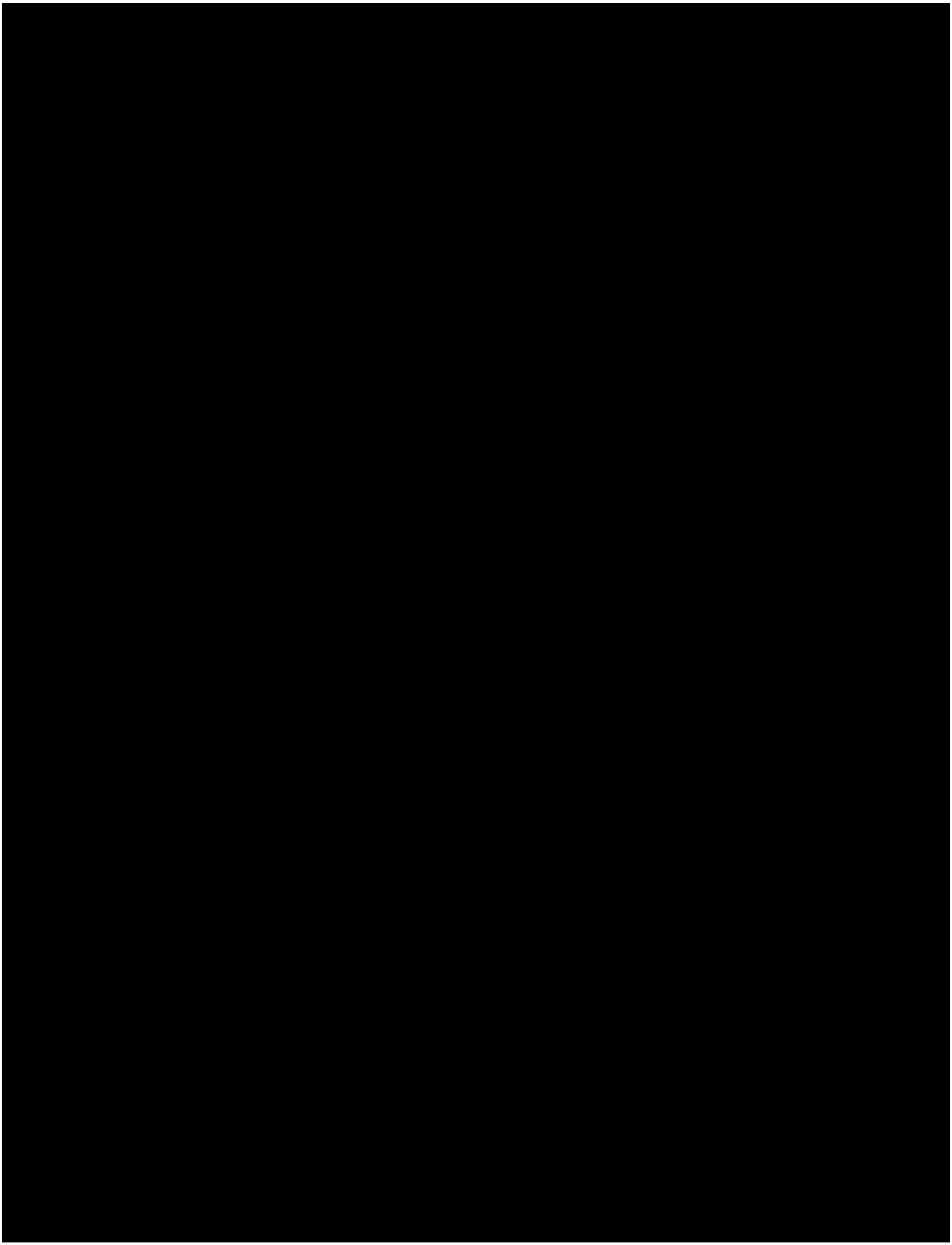


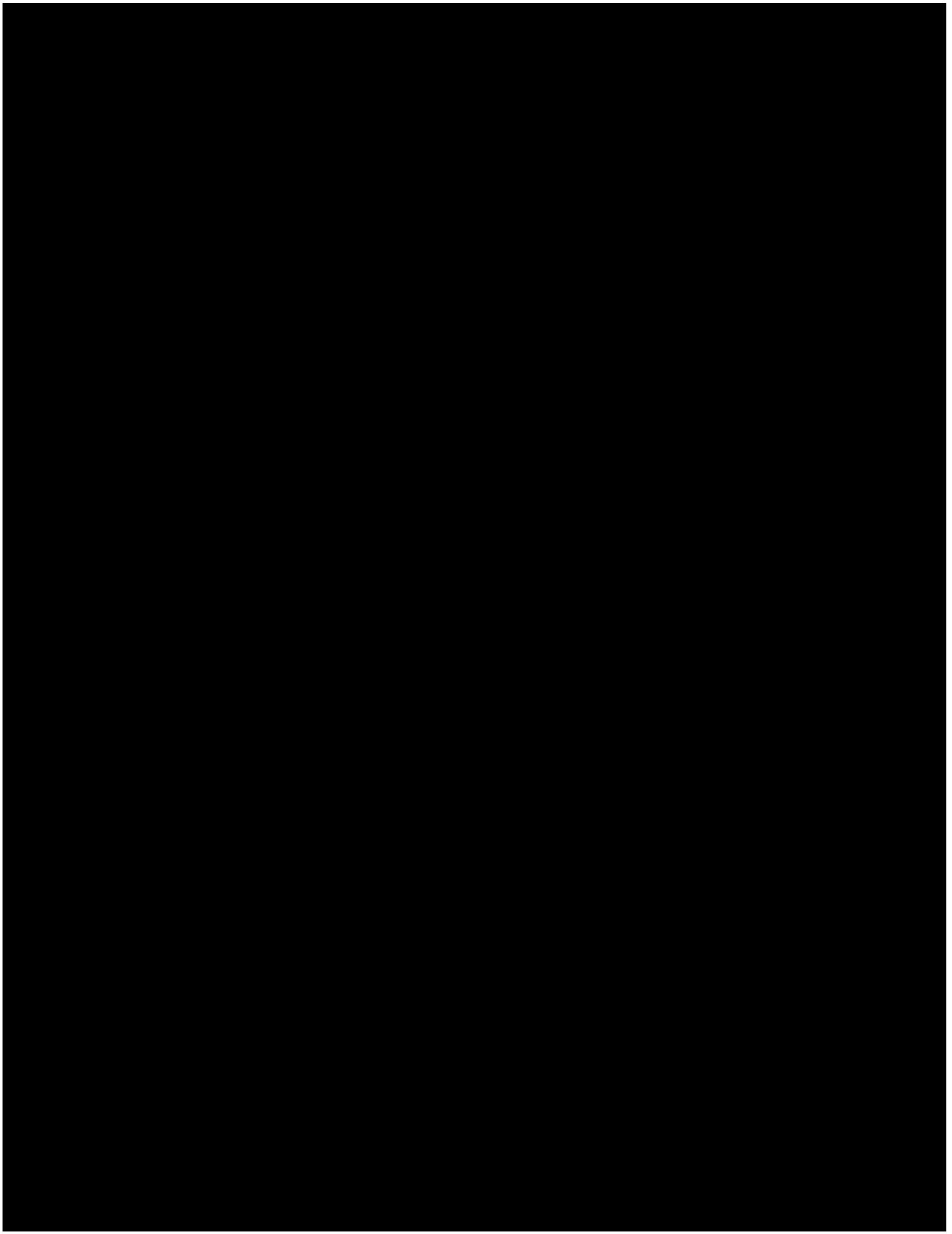


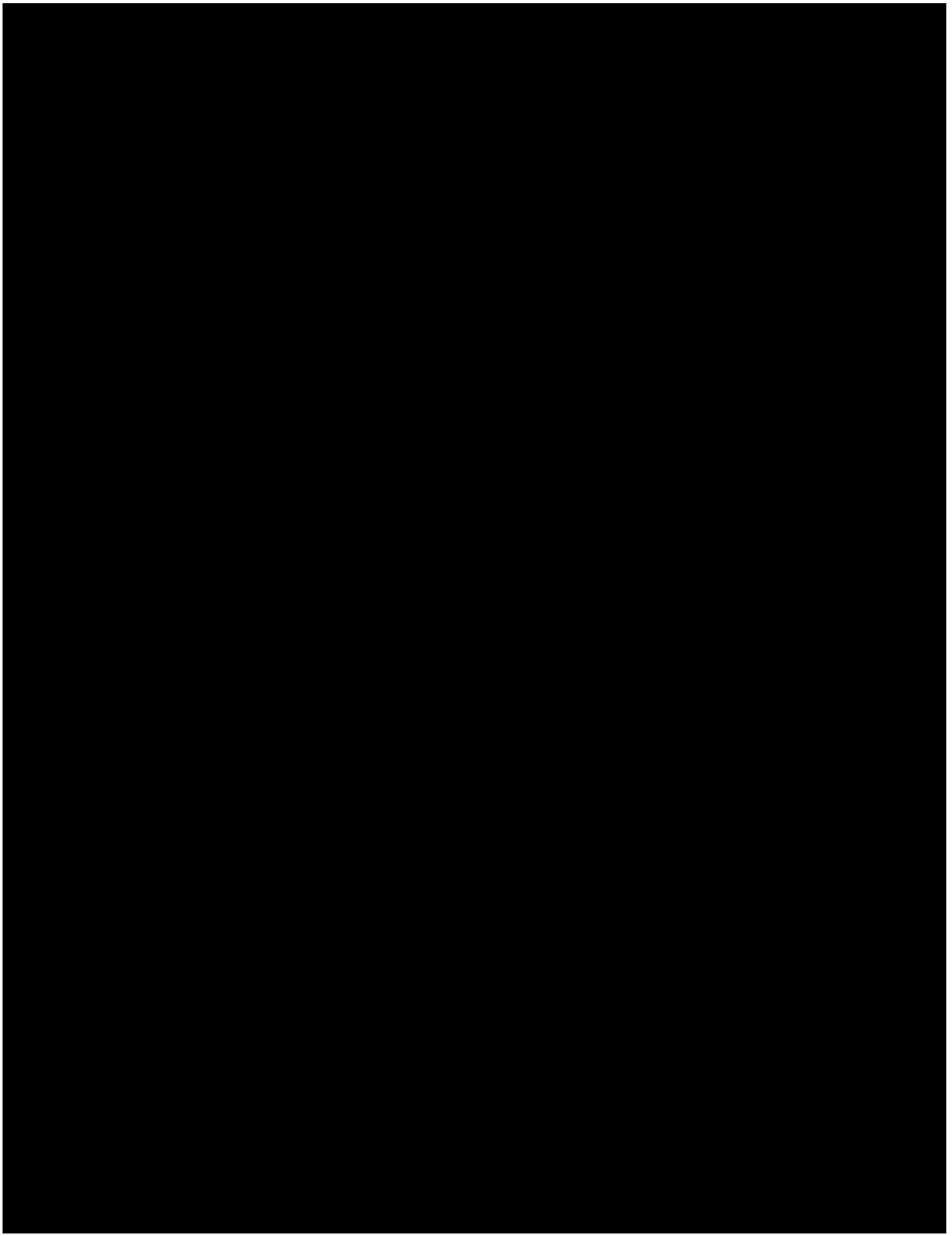


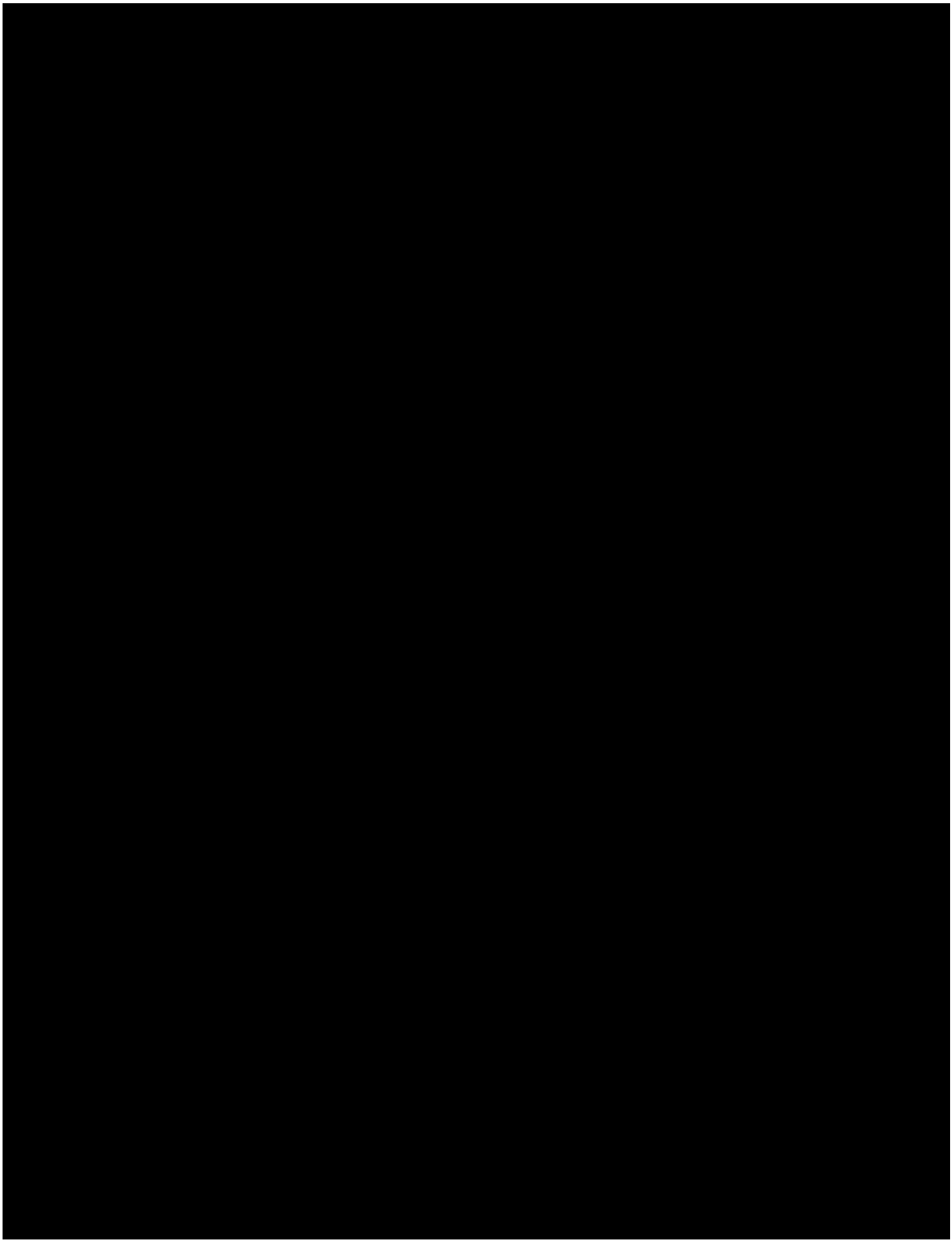


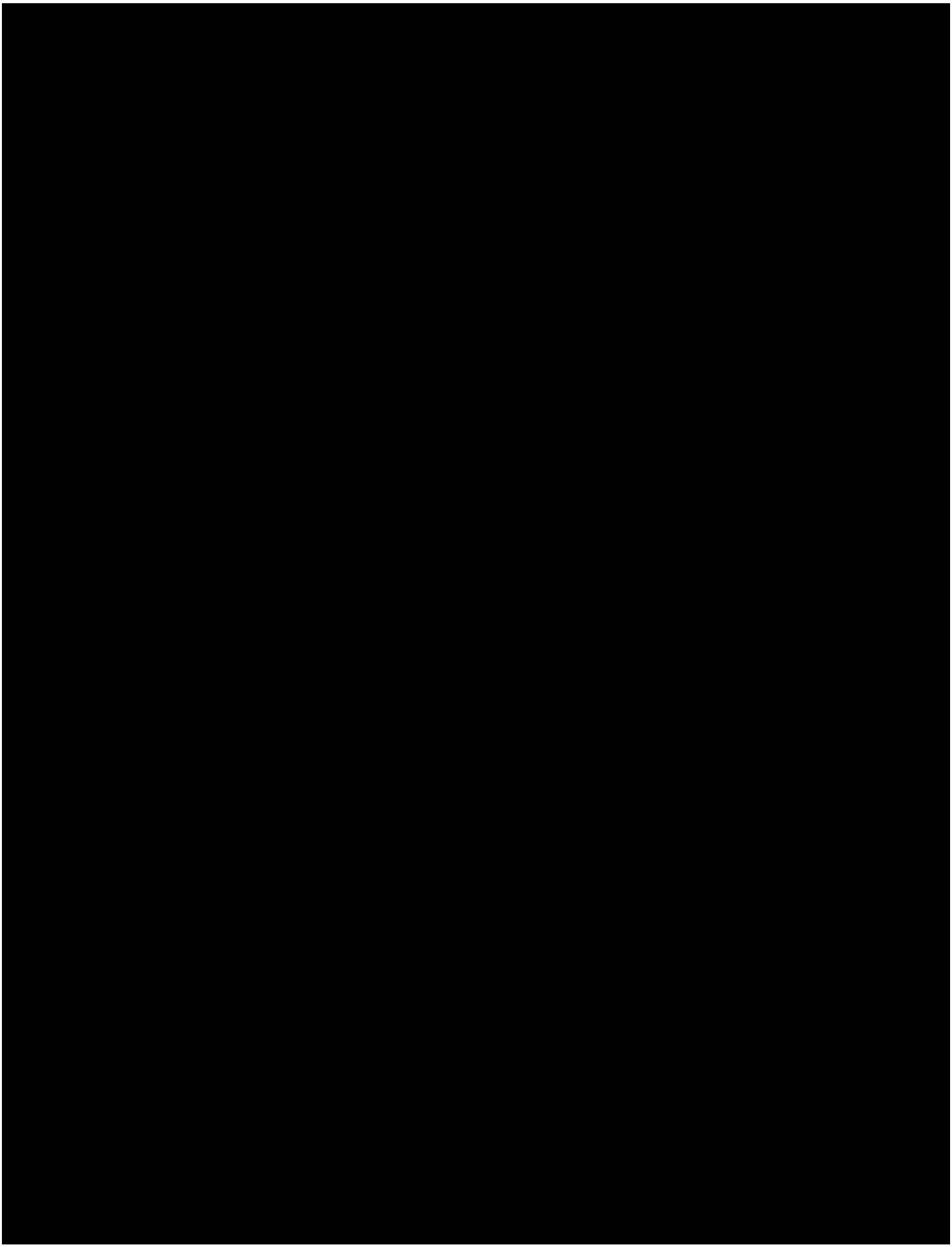


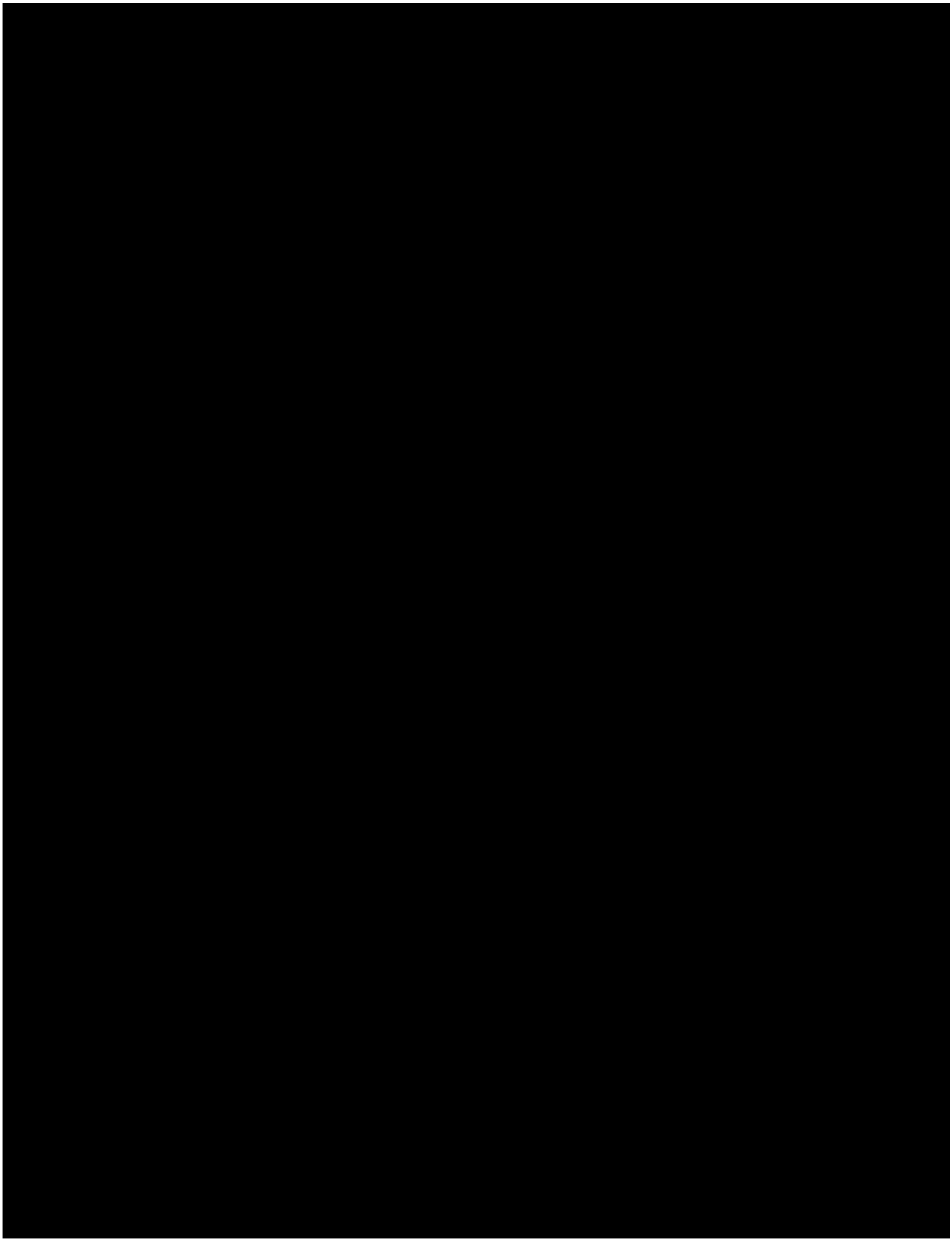


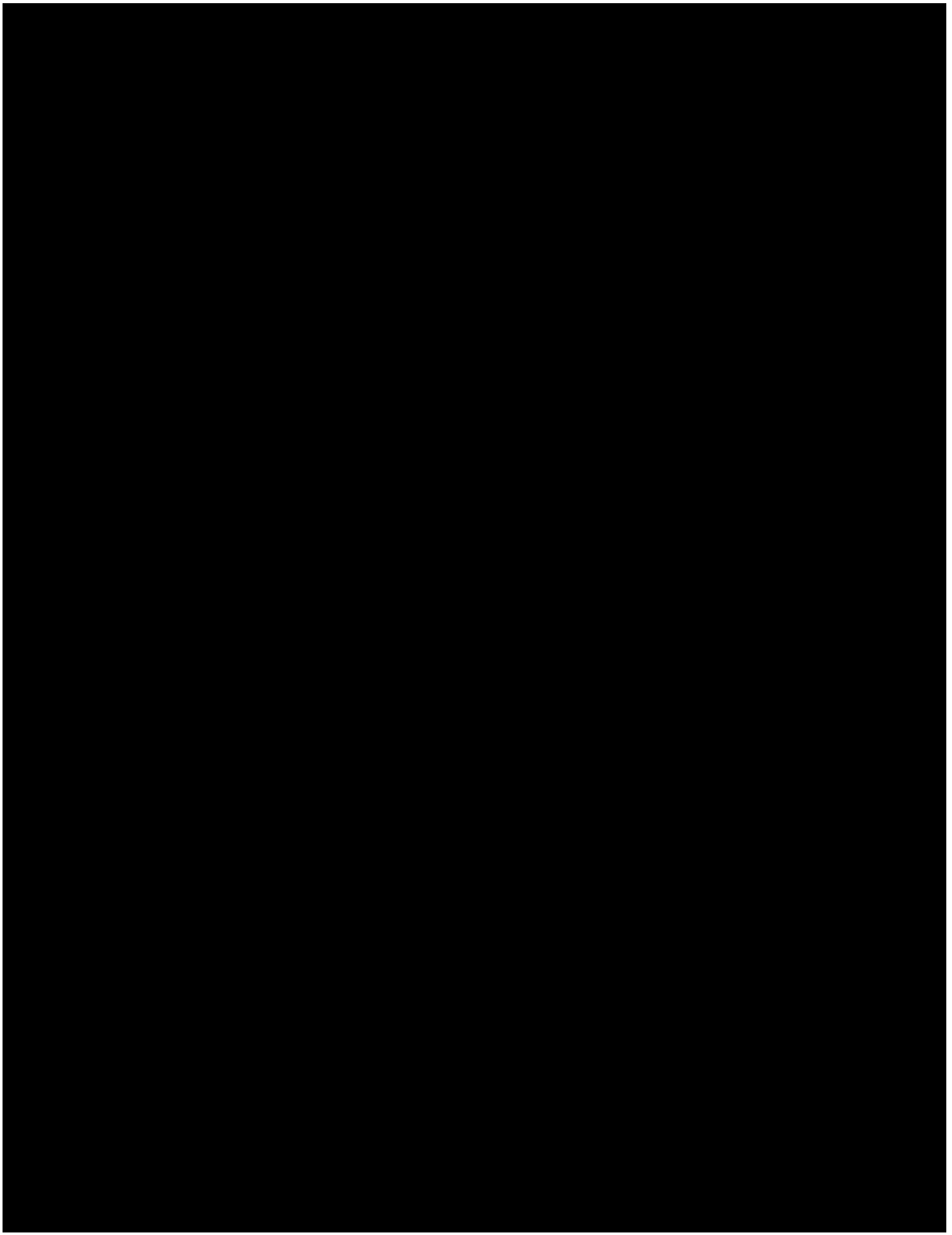


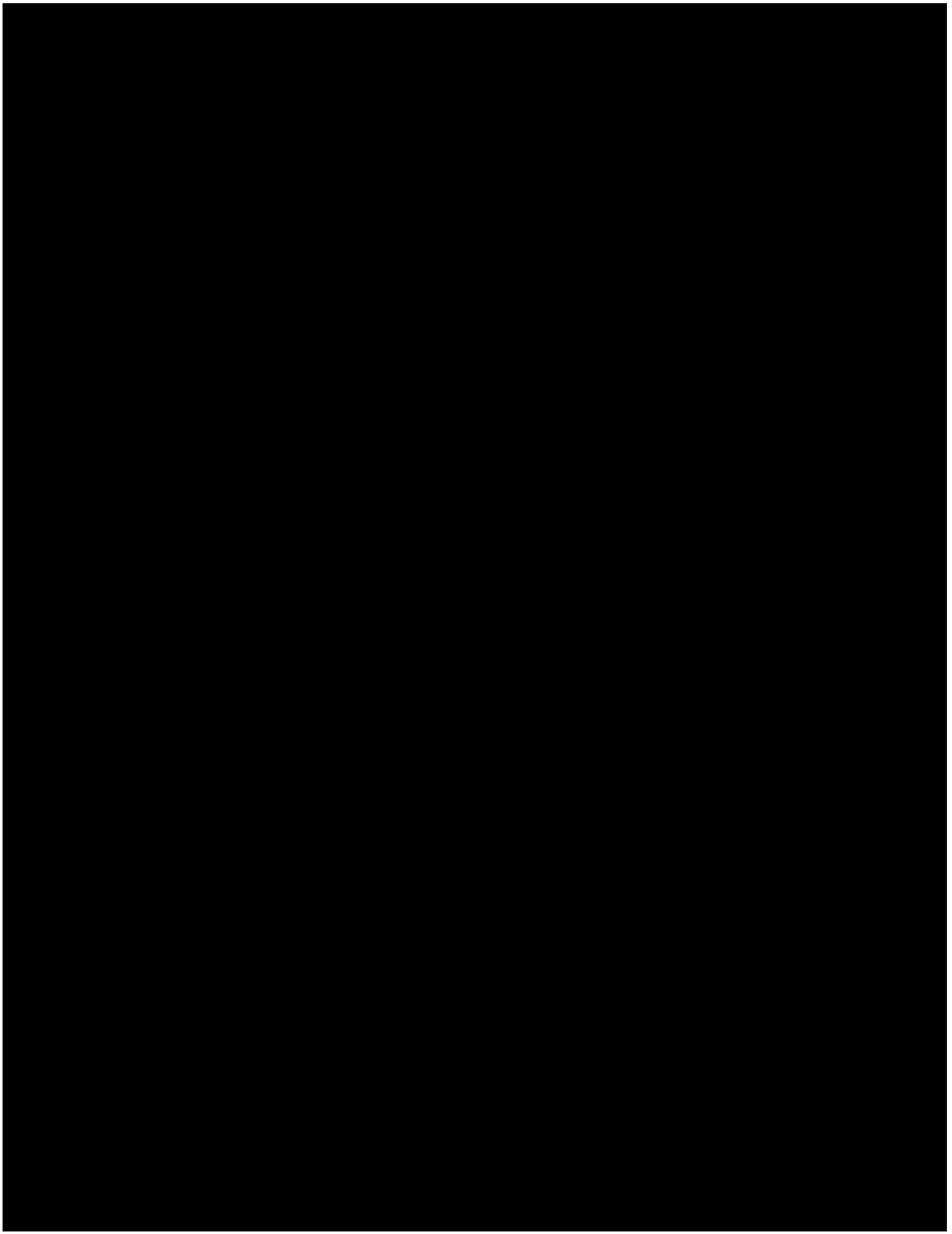


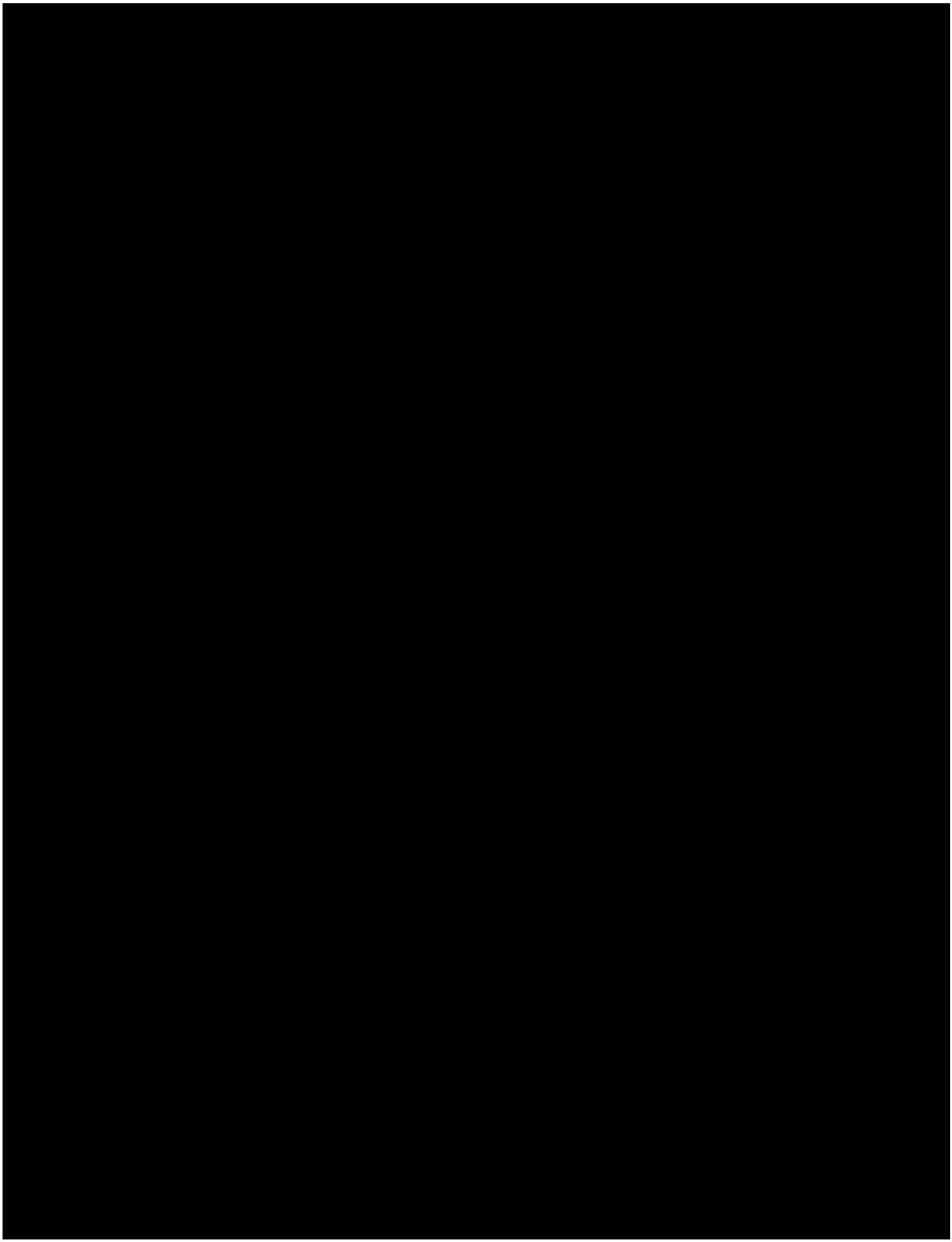


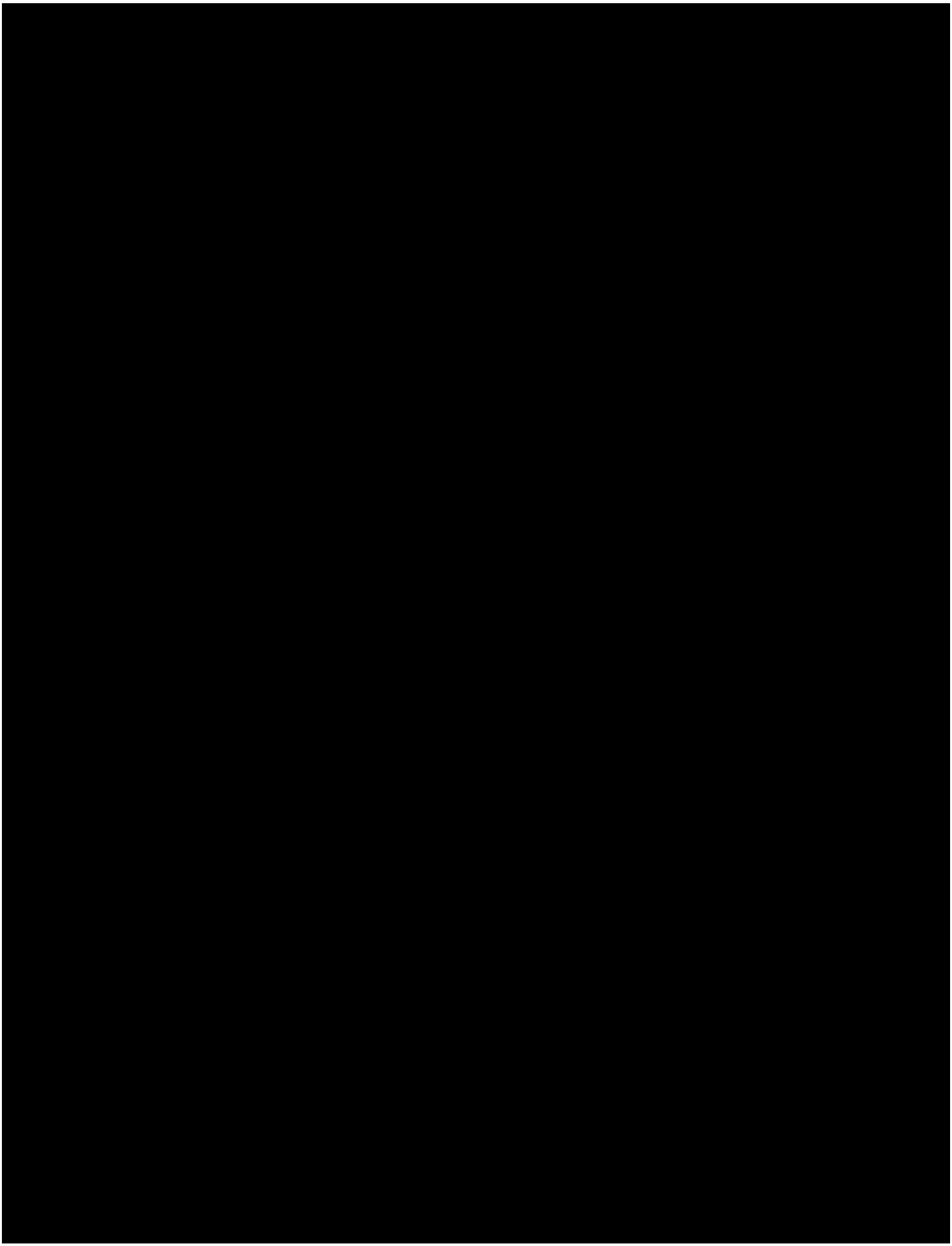


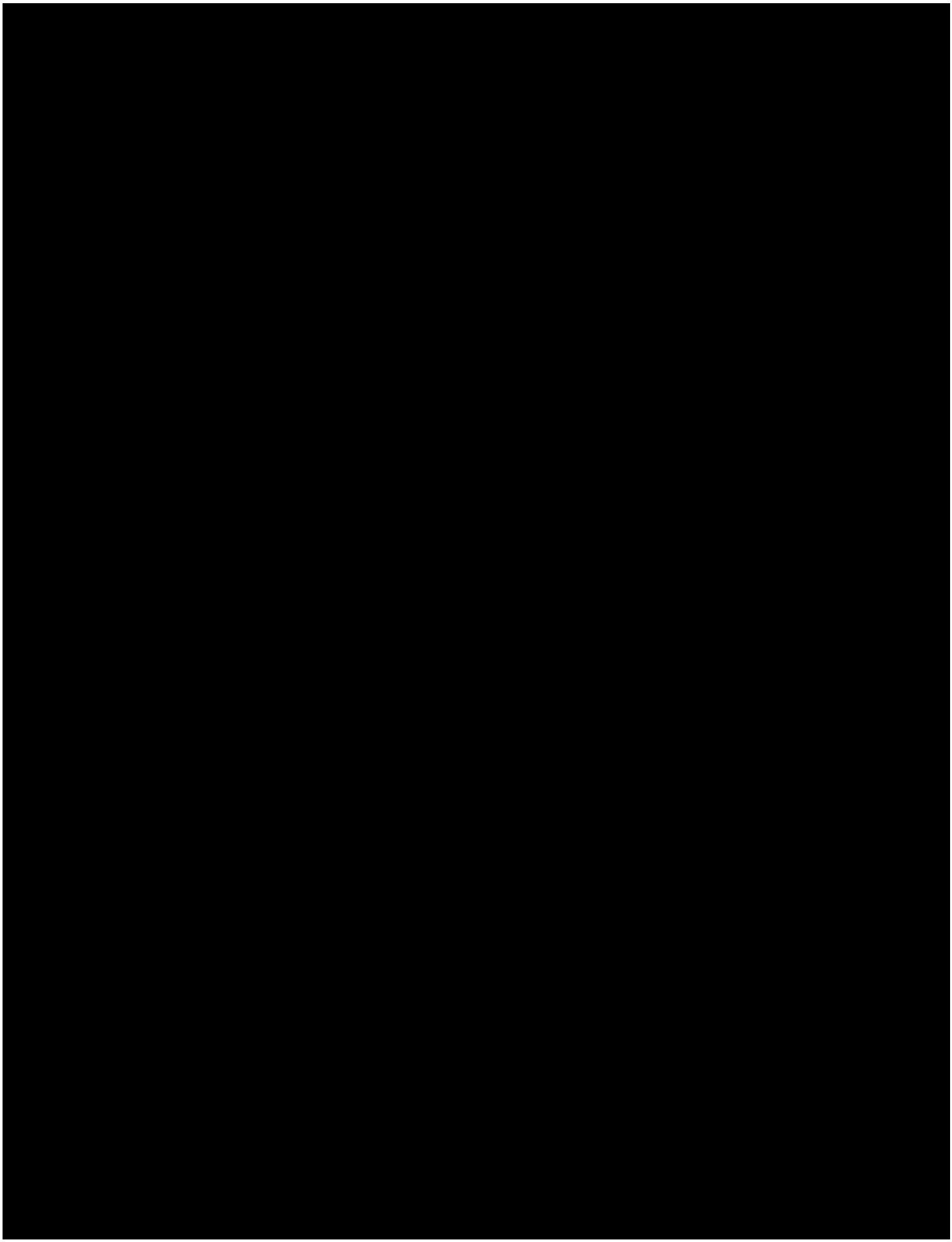


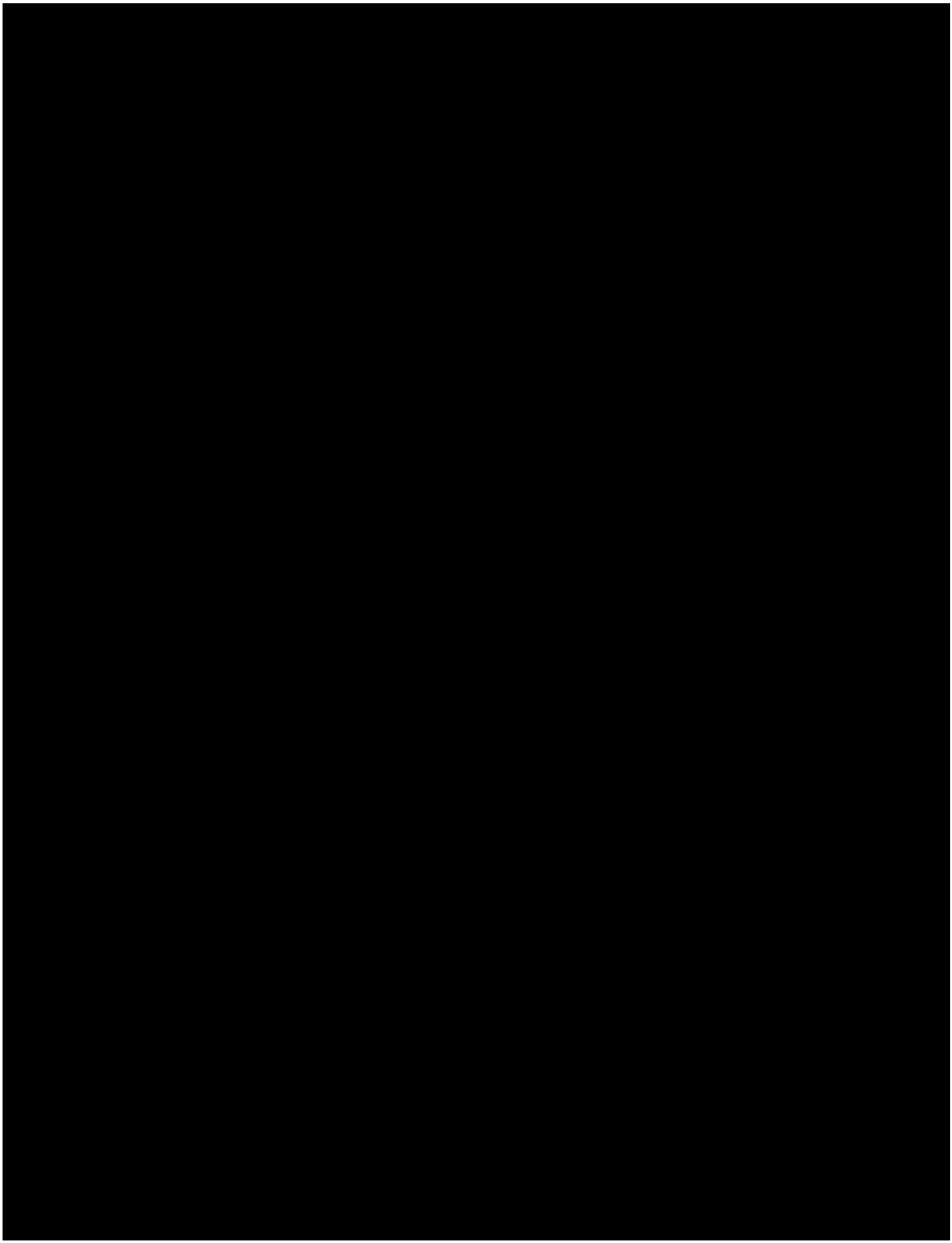


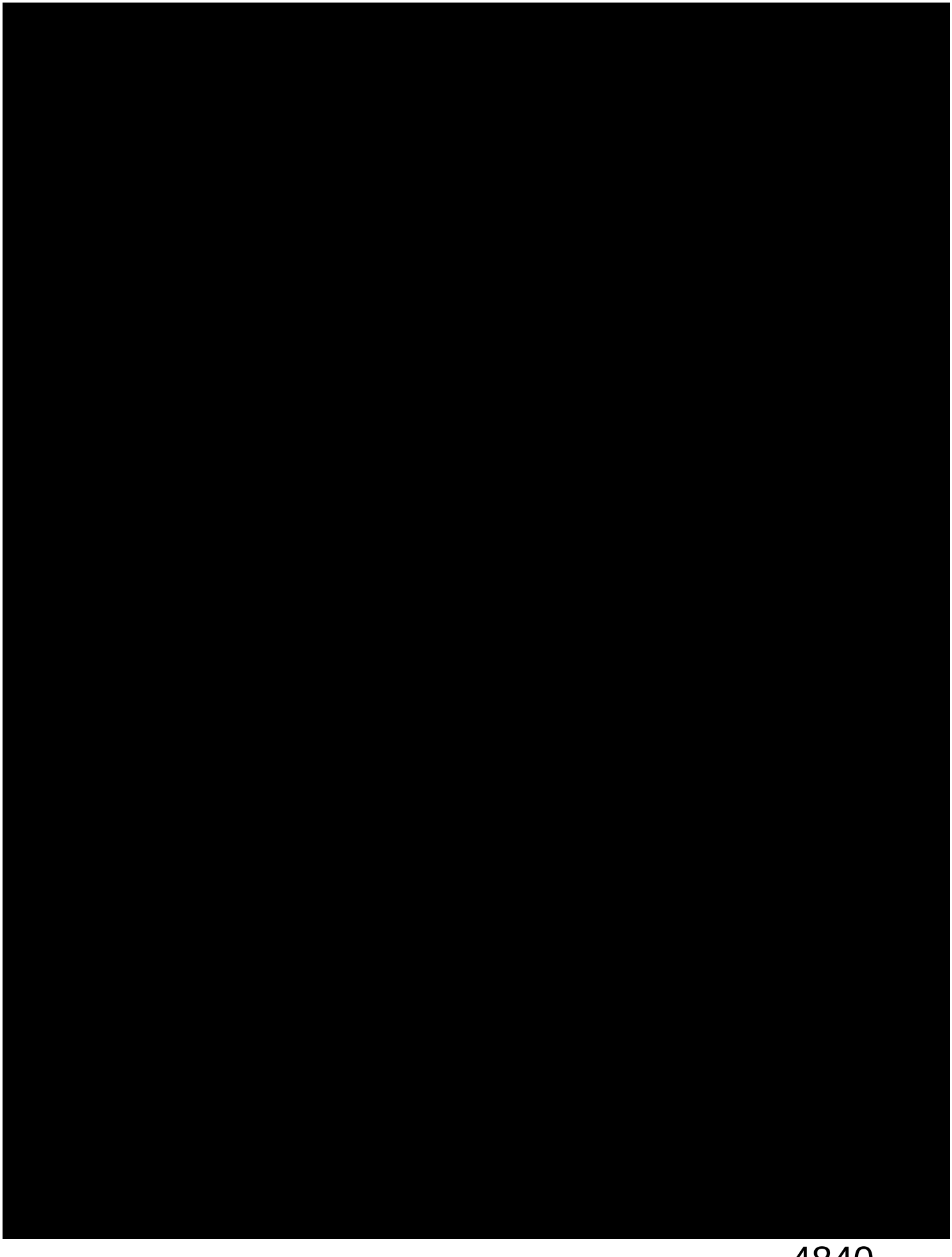


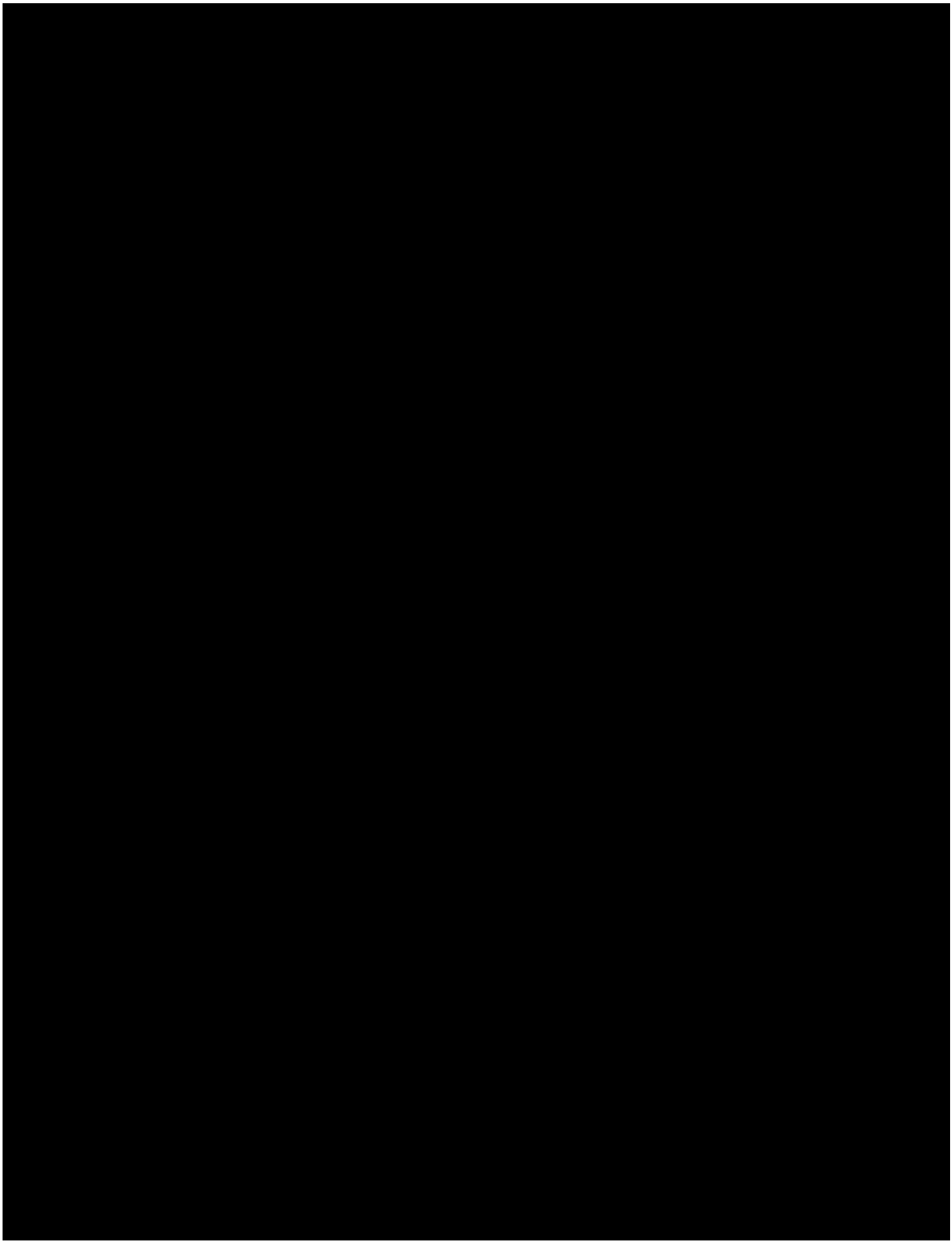


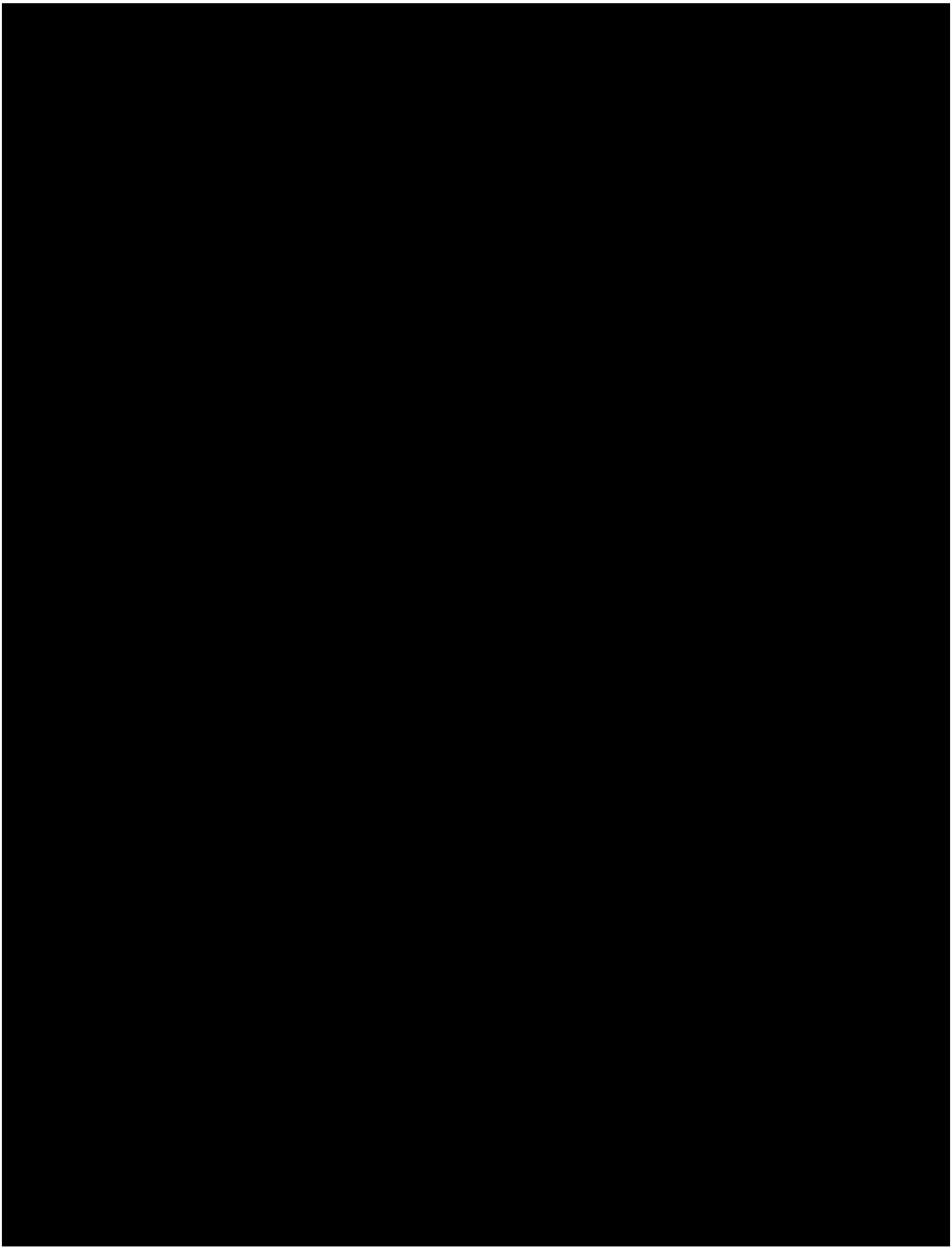


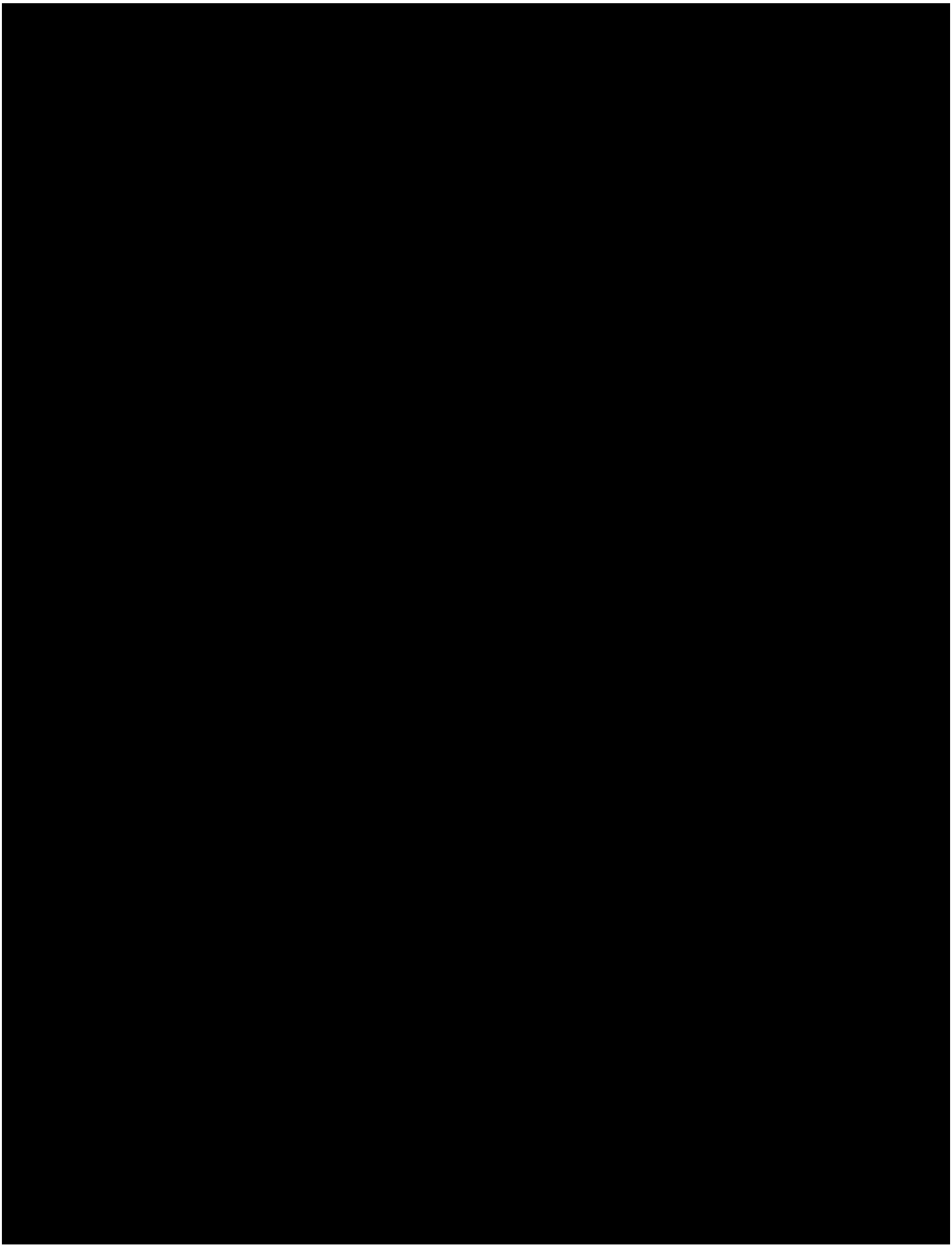


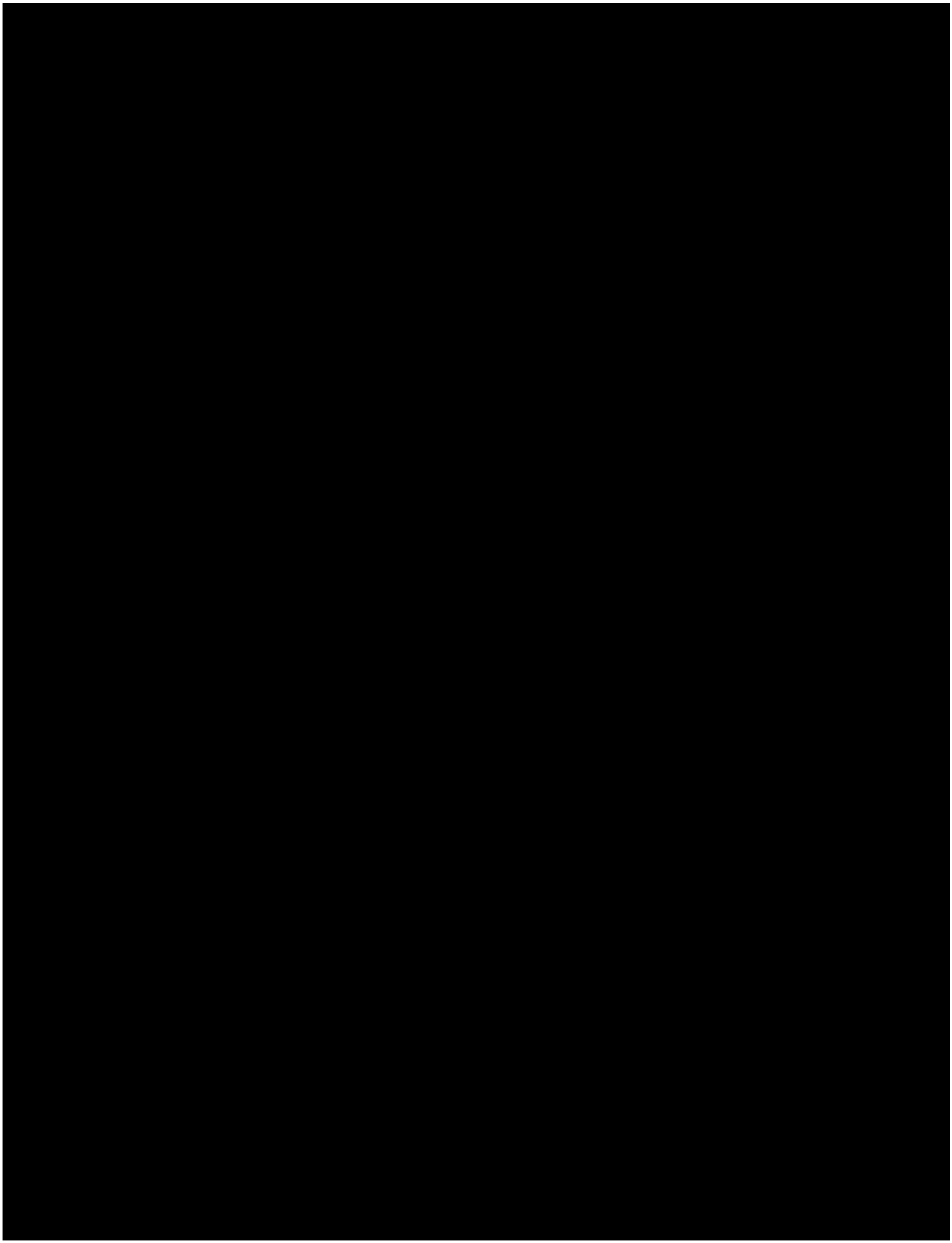


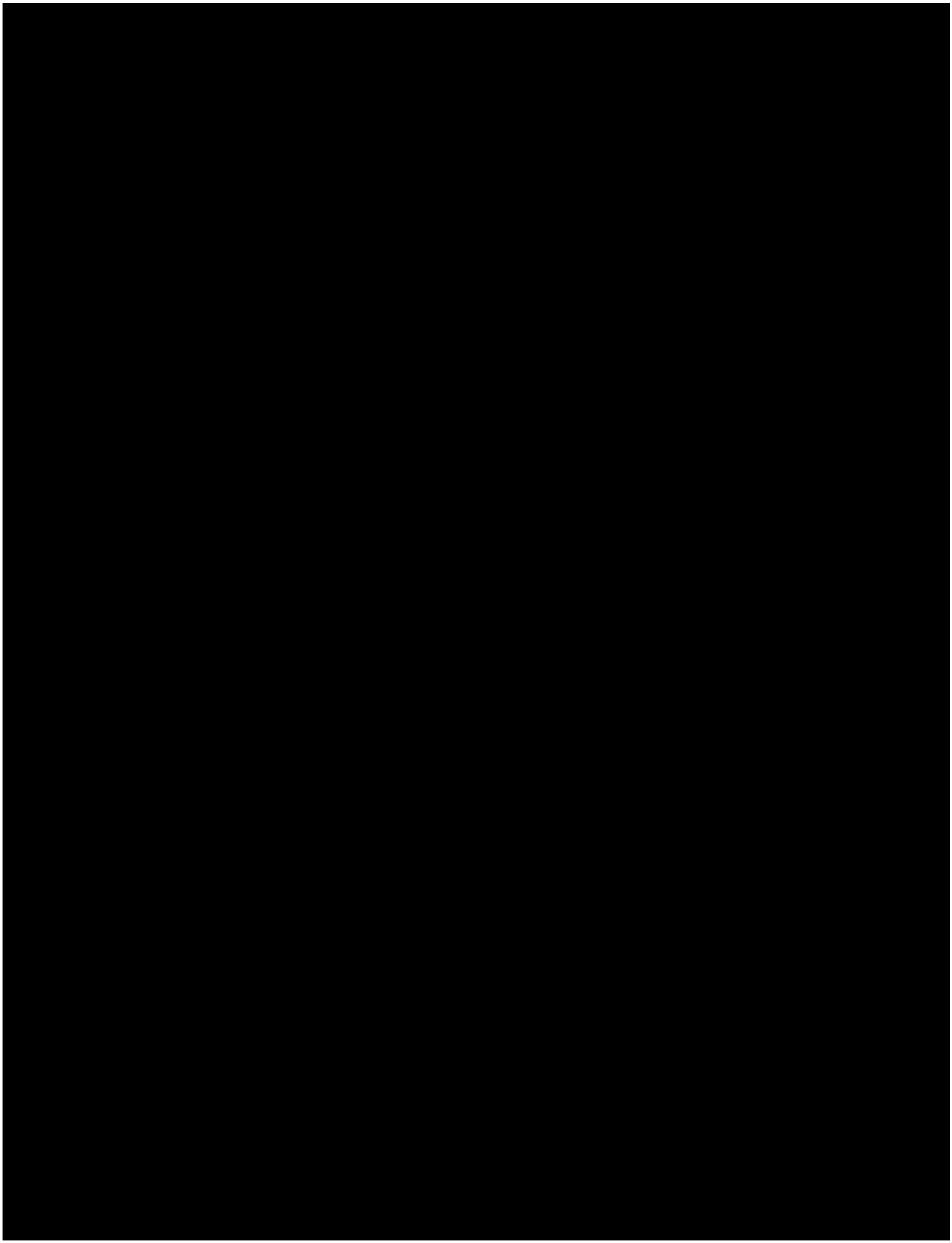


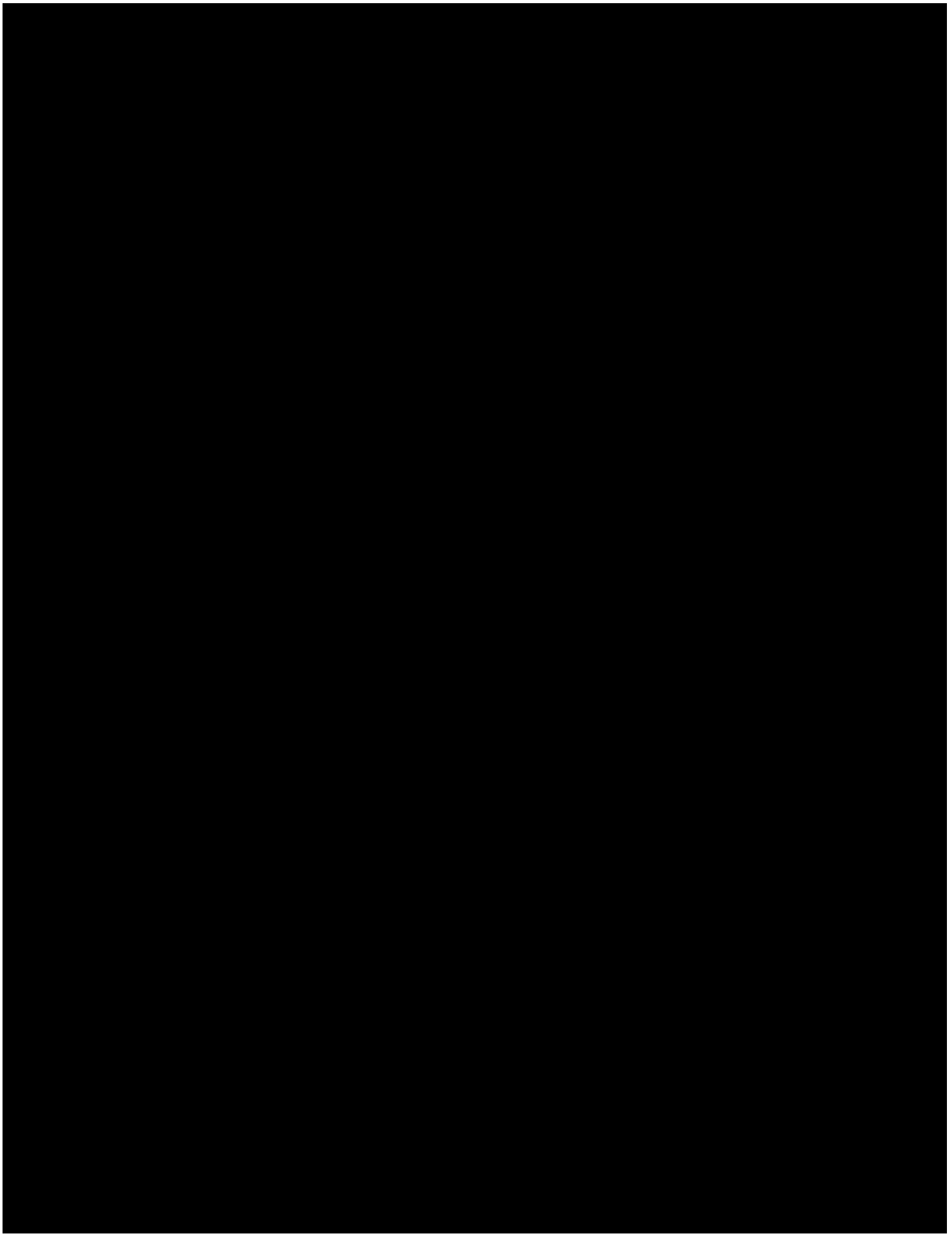


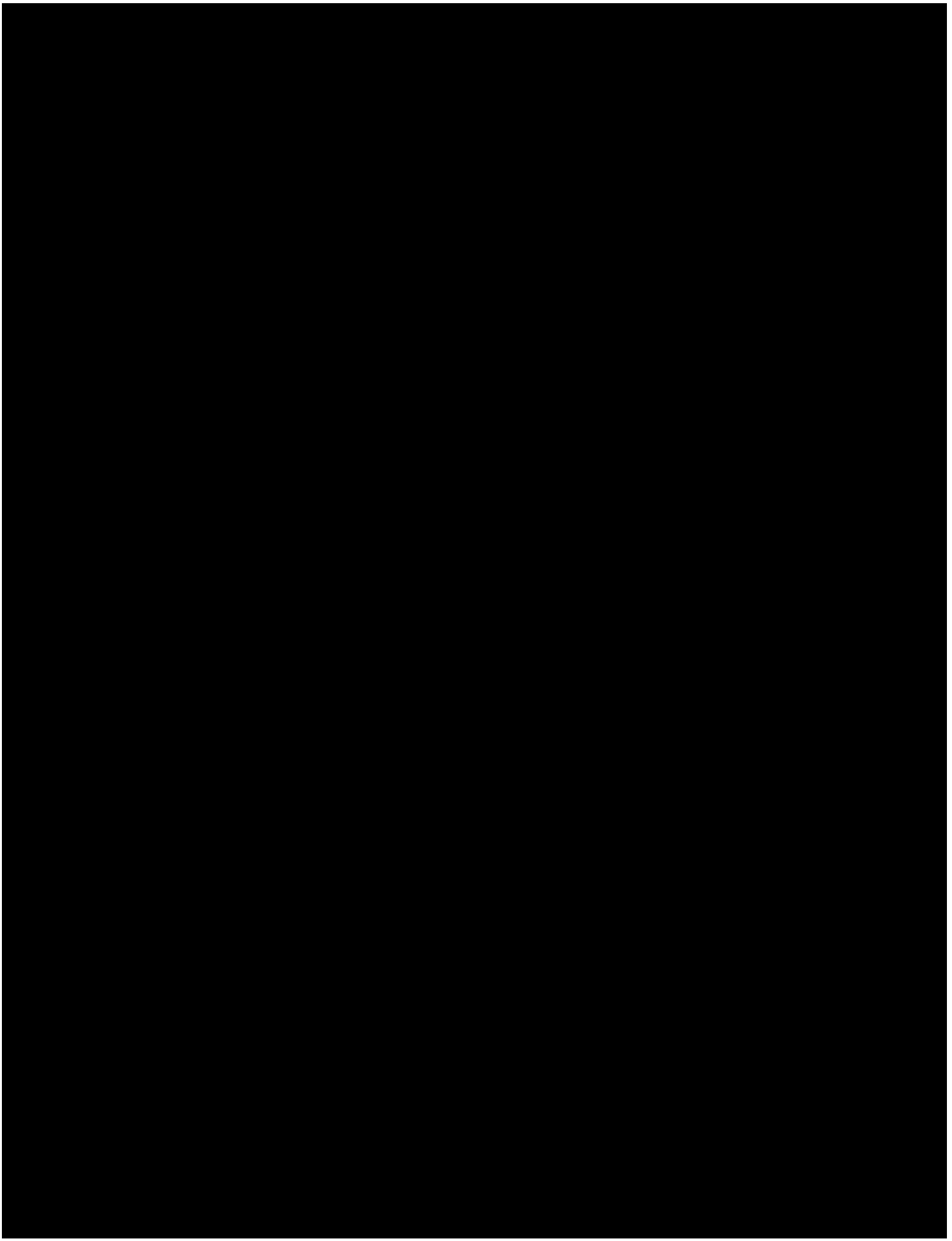


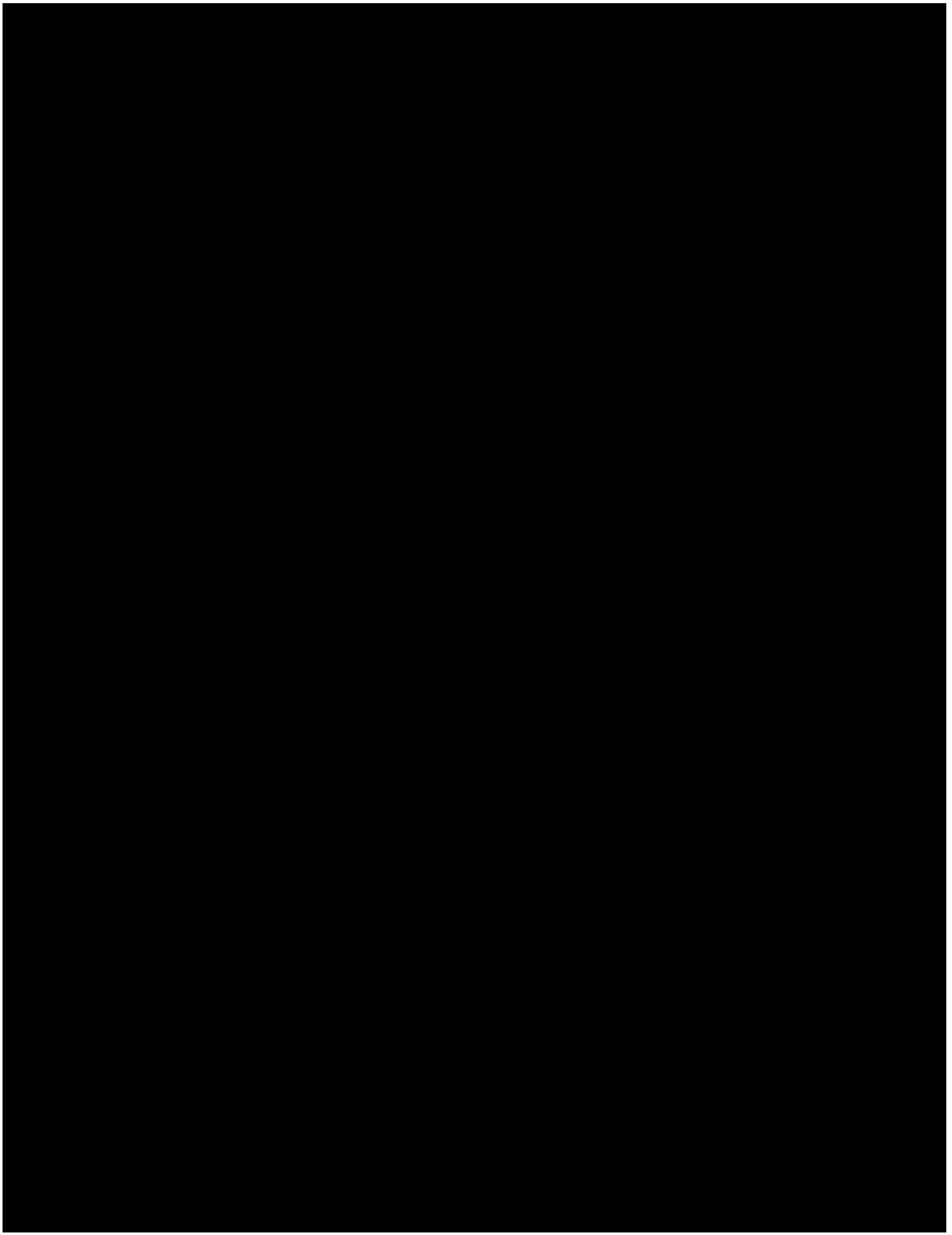


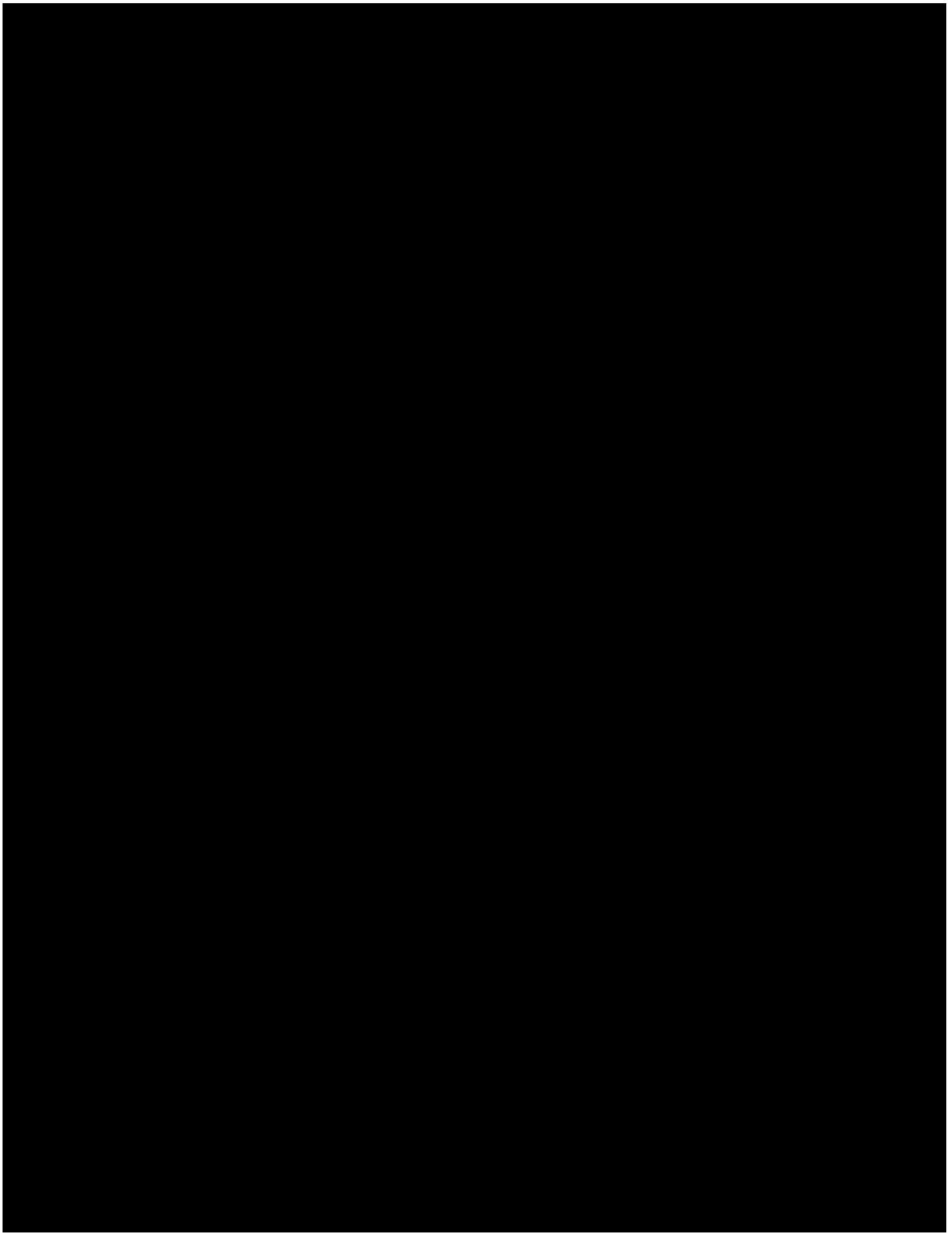


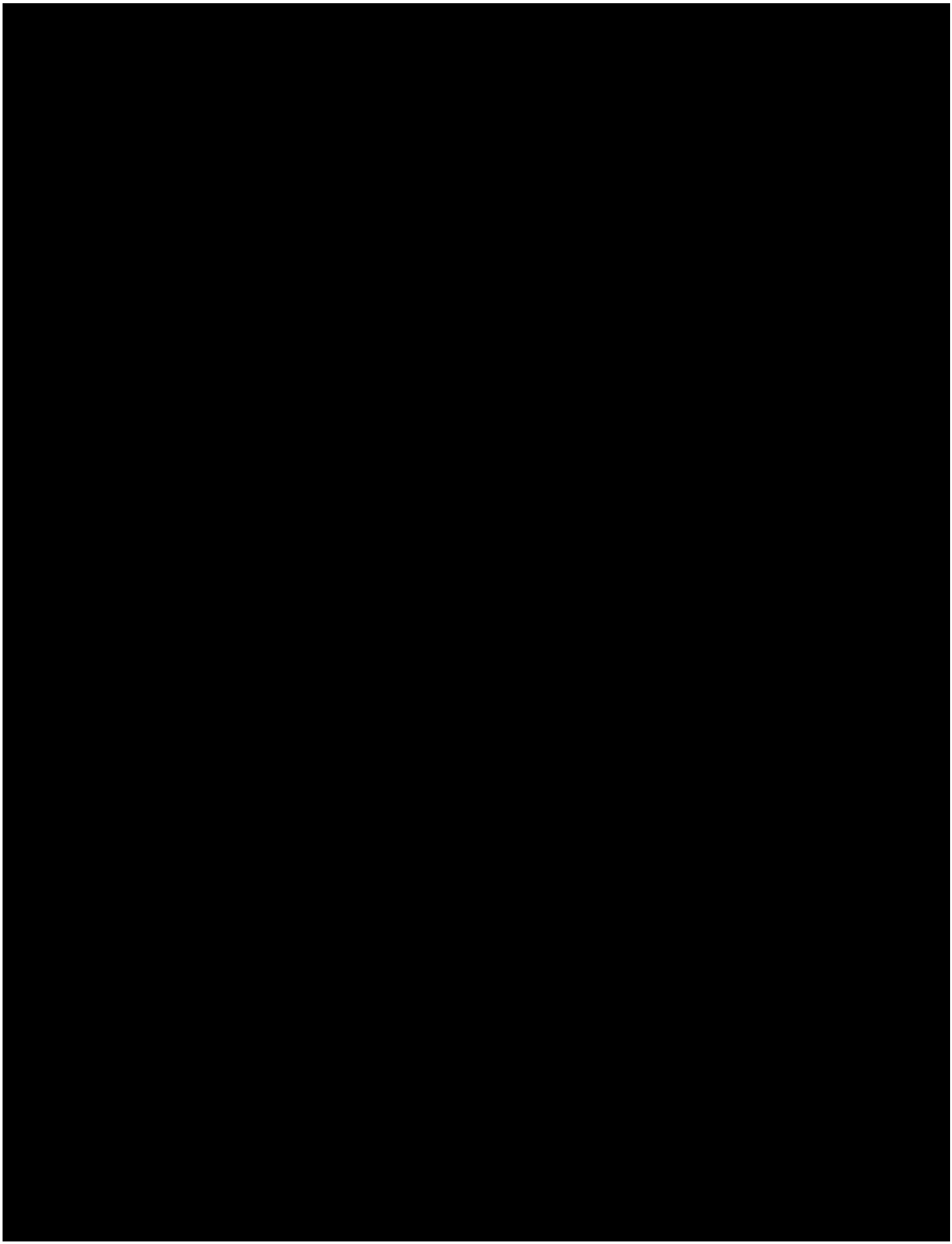


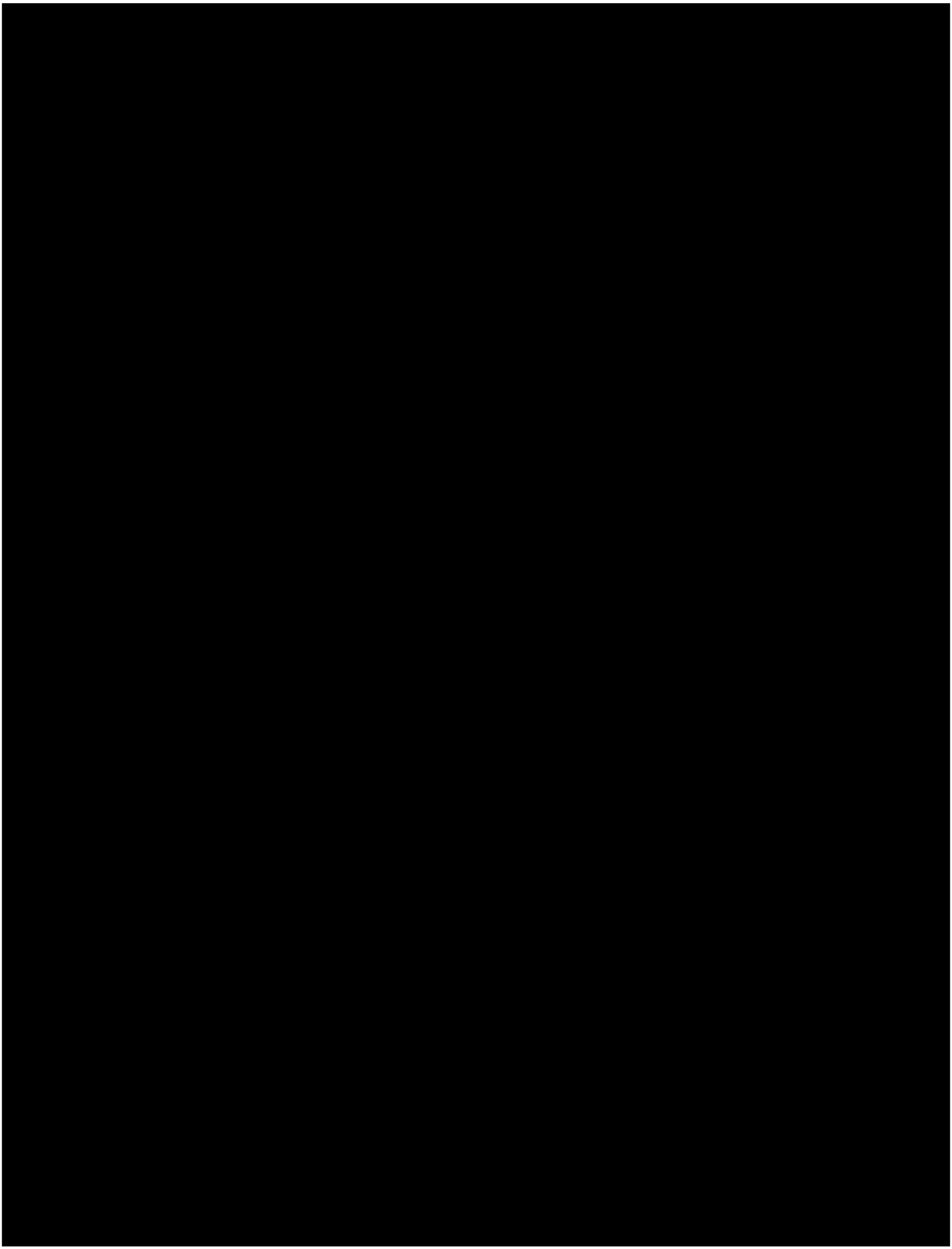


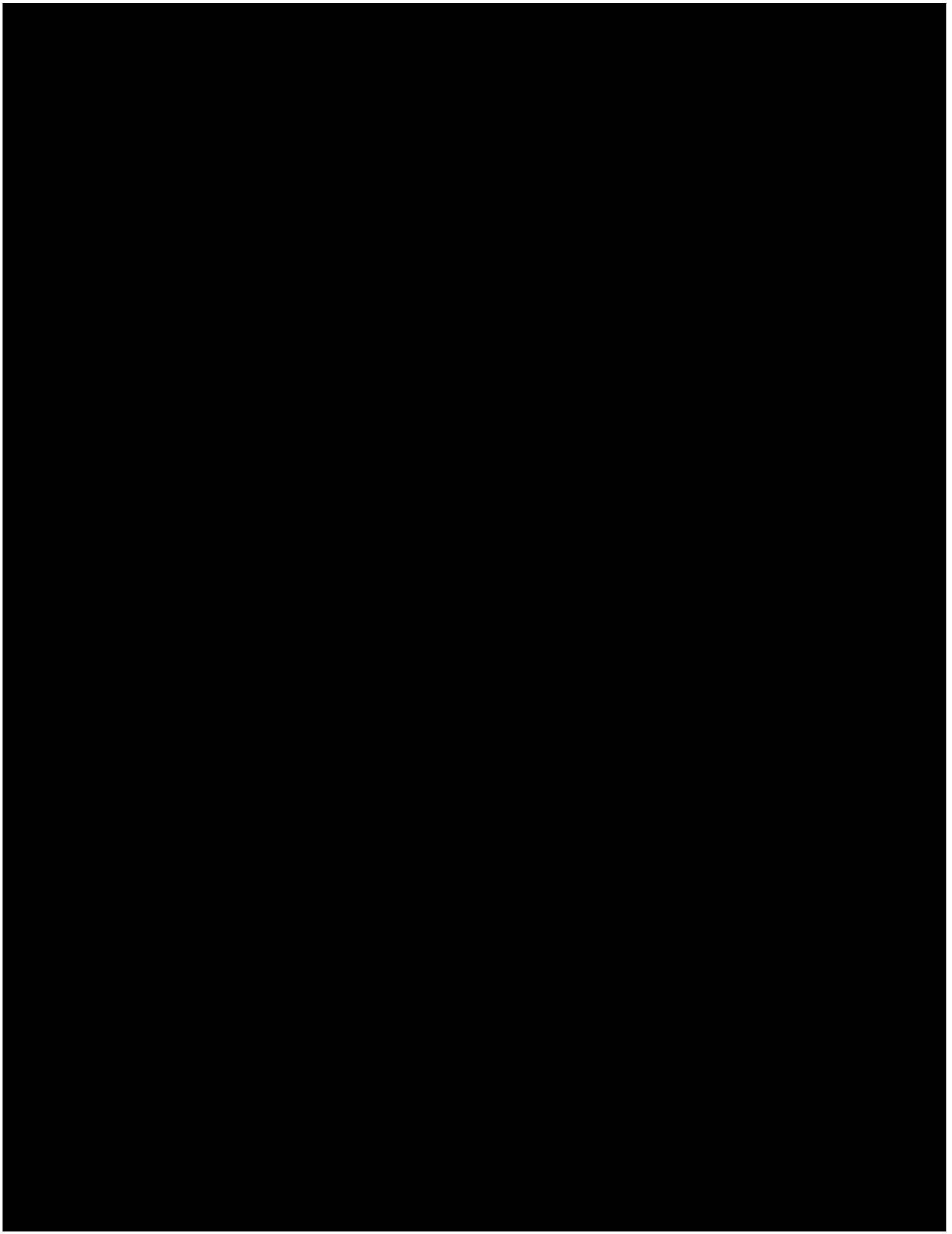


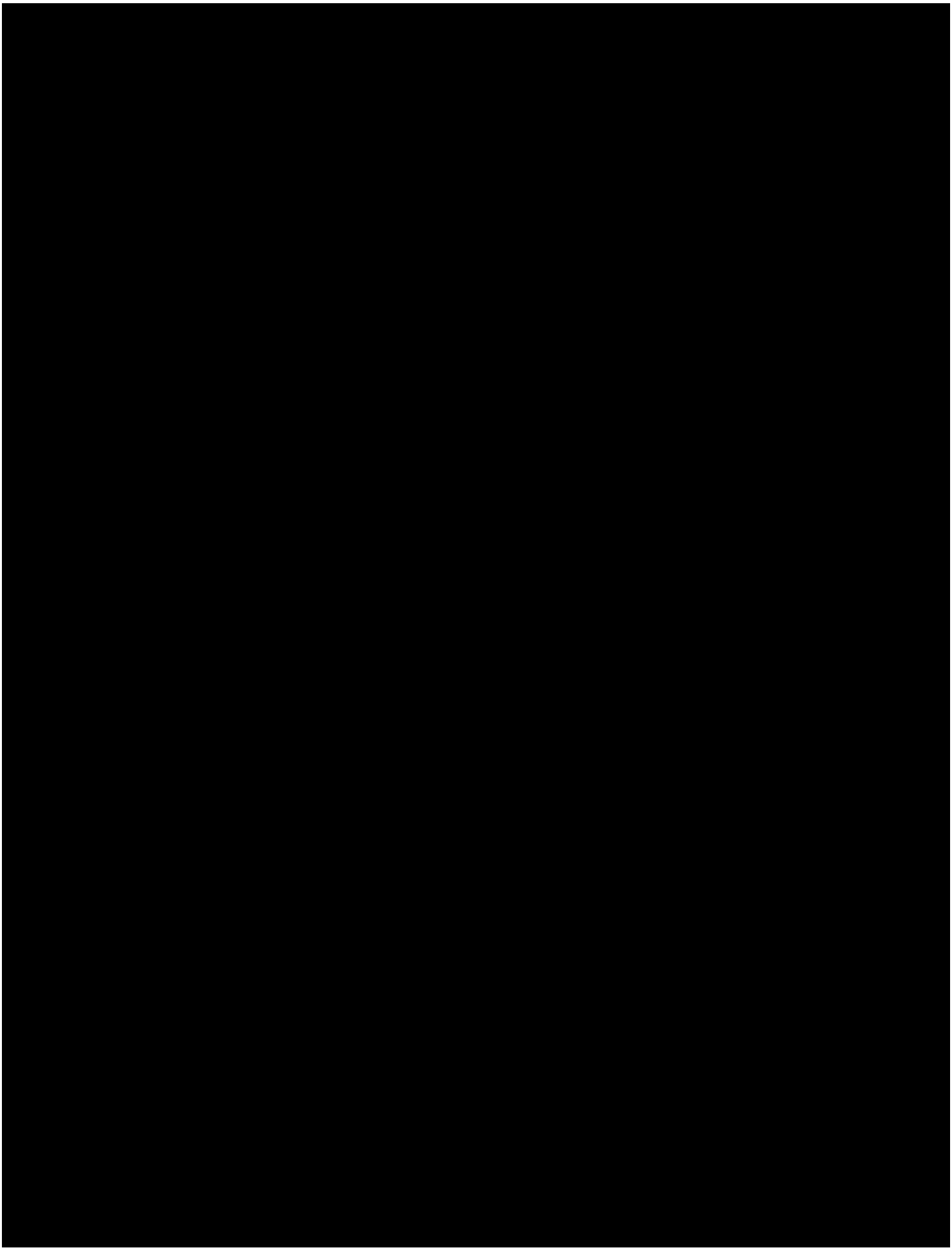


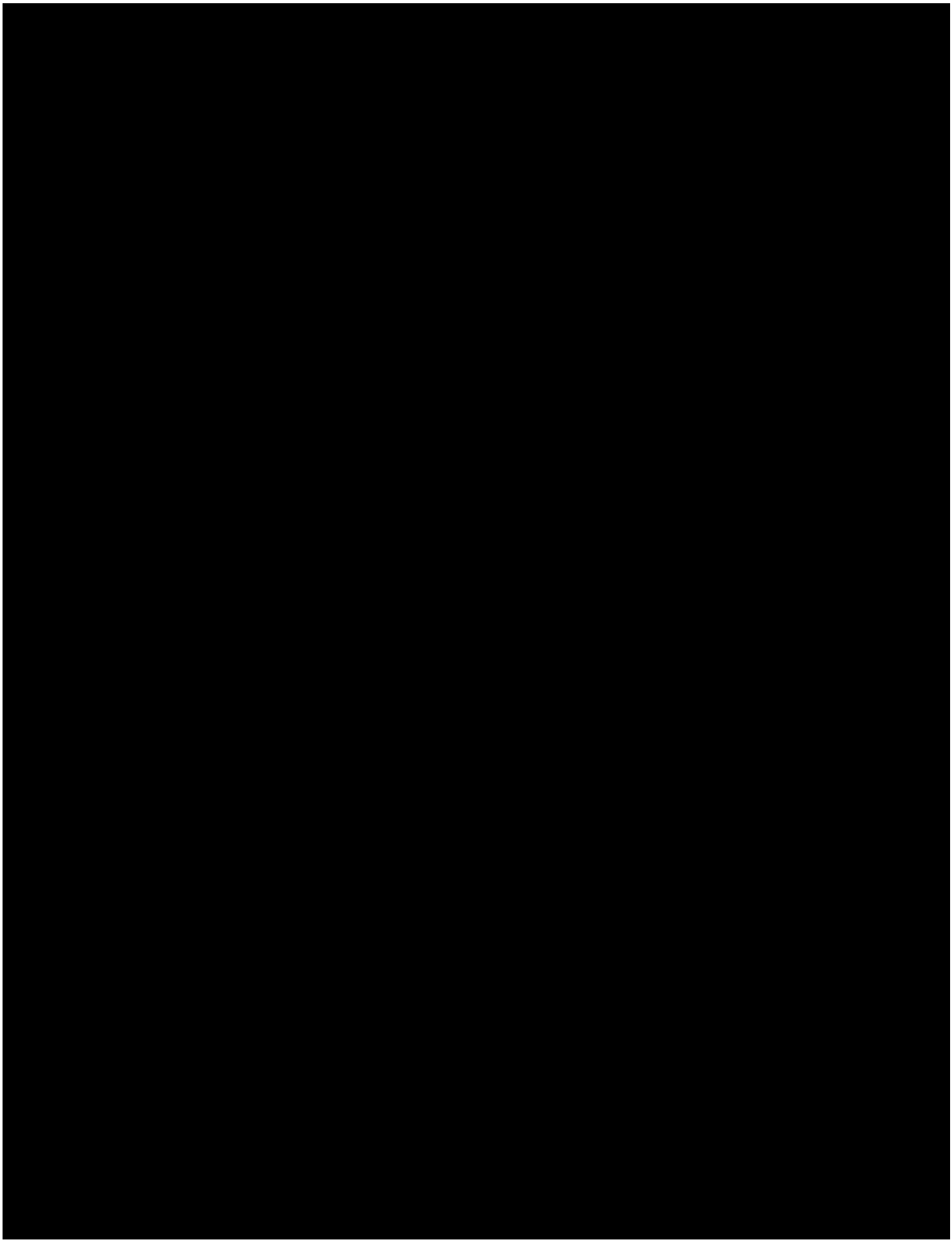


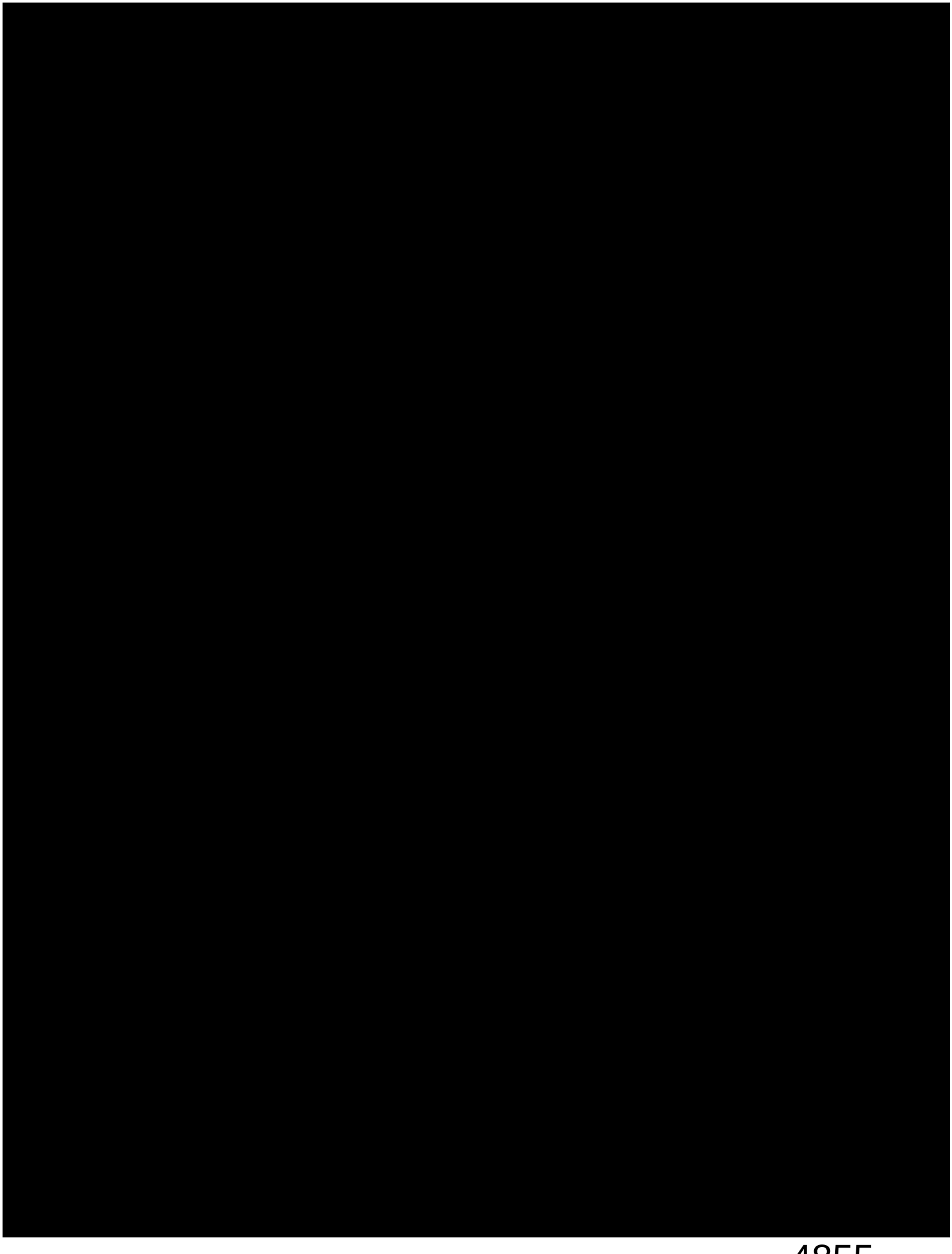


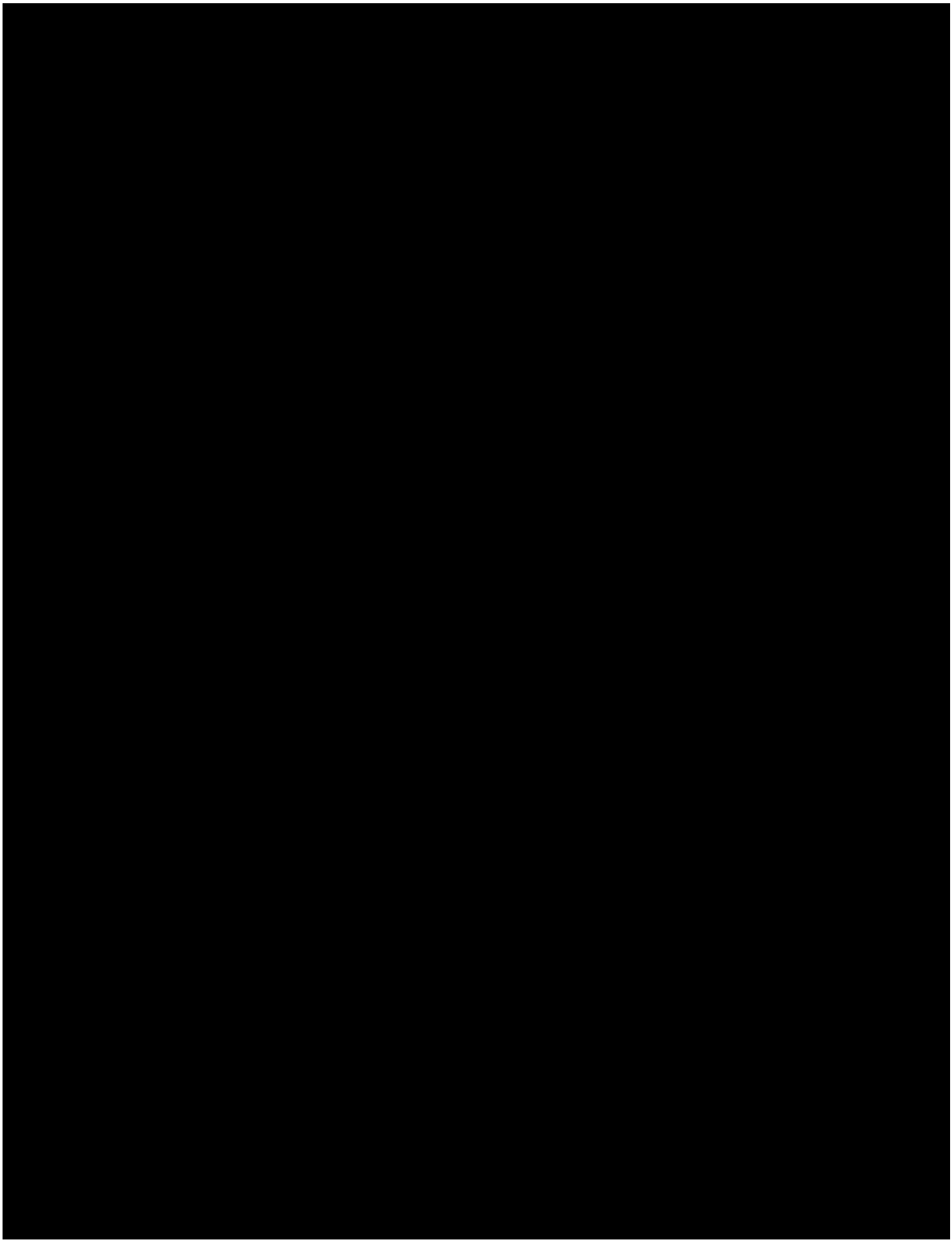


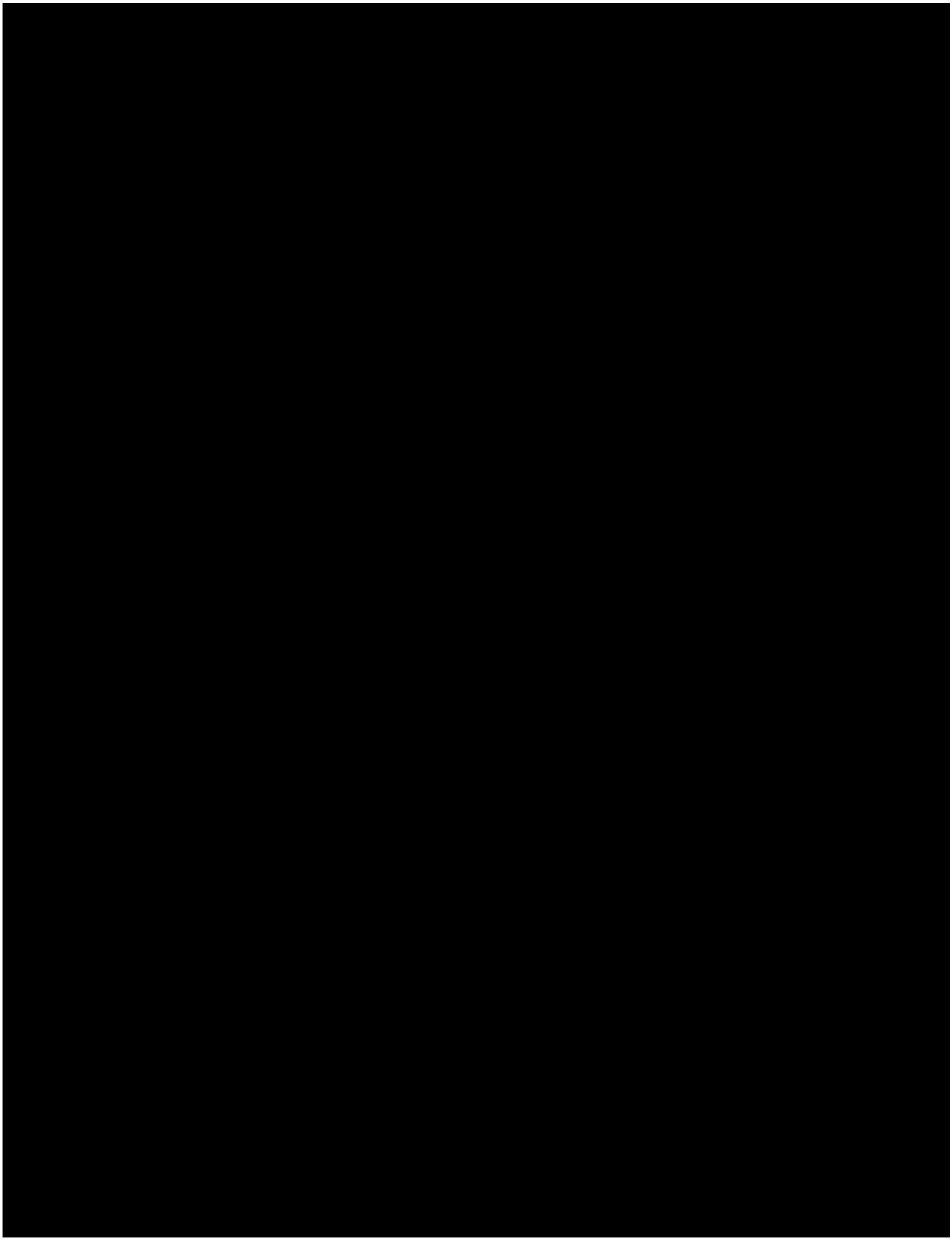


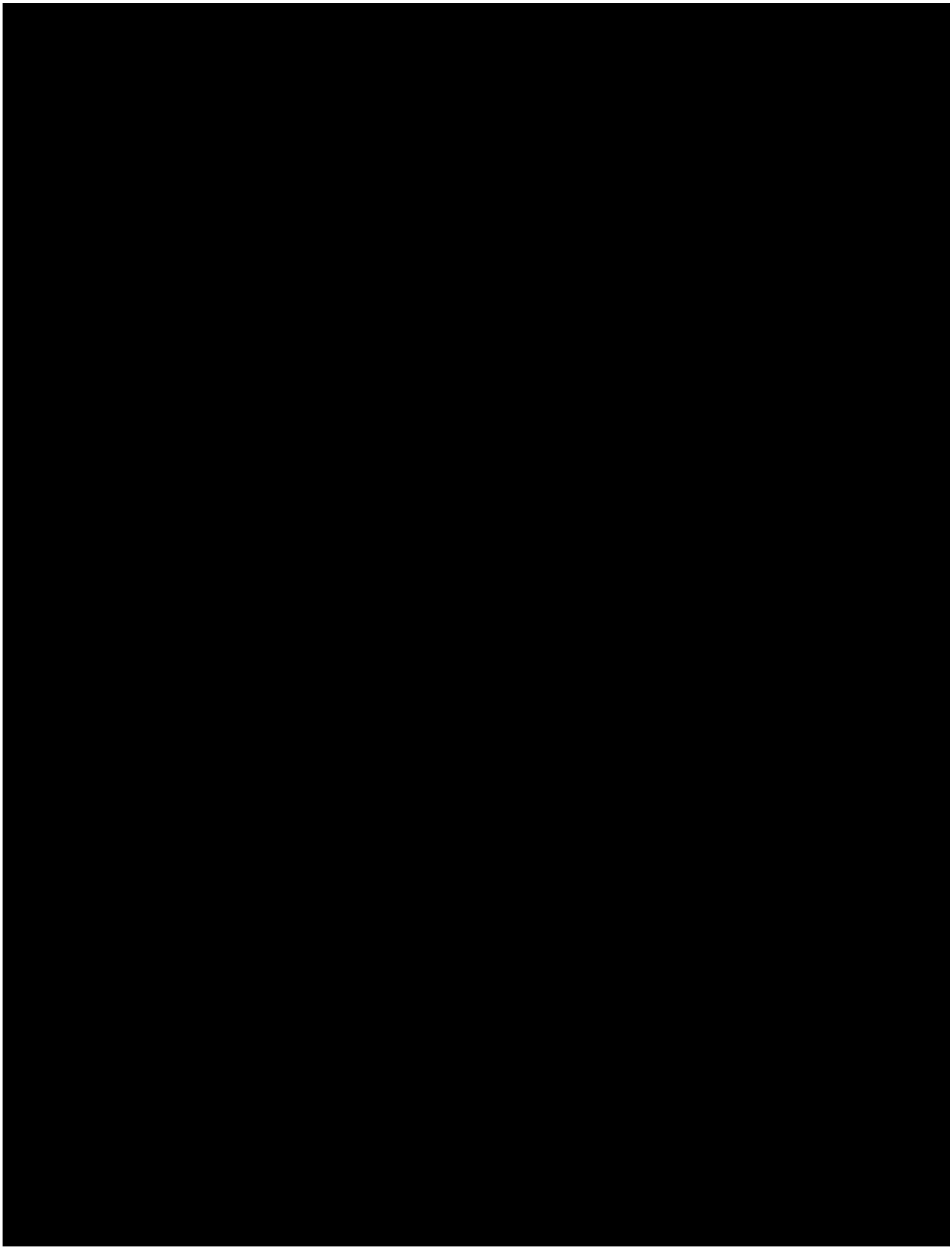












BOO[redacted]VILLE HUMAN DEVELOPMENT [redacted]ENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 12/[redacted]6/19 Living Area DH Blue

Location of Event Kitchen Time Started 1215 Time Ended 1245

Print Name/Title of person writing BR Elizabeth Skye Ross

What happened immediately *before* the problem behavior occurred? (check all that apply)

___Arrived at area
X Change in client's routine
X Contact with family (phone call, visit)
___Desired object present but out of reach
___Difficult / Non-preferred task presented
___Environment loud or hectic
___Involved in grooming/hygiene activities
___Involved in leisure activities
___Involved in off-campus activity
___Other
___Involved in work/Training activities
___Transitioning different setting
___Meal time
___Medication administration time
___Moving from one activity to another
___Other clients receiving attention
___Had seizure
___Toileting accident
In bed
___Physical aggression by another
___Verbal aggression by another
___Personal space invaded
___Preferred activity interrupted
___Request refused
Snack time
___Request made of client
___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials_____ Objects, Own_____

Hit Mom ___Apparent Injury/Marks Card Completed Objects, Others ✓ table (Initials)

Self_____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials_____

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

___Pacing
___Confused/disoriented
___Had another's property
___Noncompliance
___Throwing self in floor
___Day sleep
___Medication refusal
___Stomping
___Repeating self
___Left functional control From (area):
___Fidgety
___Not responding to cues
___Personal space violation (non-sexual)
___Putting inedible items in mouth
___Wet or soiled (unintentional)
___Disrupting programming/environment
___In another's bedroom
___Lying
___Other
___Demand attention
___Inappropriate toileting
X Screaming/shouting
X Meal refusal
___Inappropriate sexual behavior
___Awake during sleep time
___Instigating conflict
___Snack refusal
___Other
To (area):

INTERVENTIONS (check all that apply; write details on back)

X Allowed processing time
___Graduated guidance
___Time out to calm
___Separate from setting up to 30 minutes
___Separate from activity up to 30 minutes
___Medical contacted
X Supervisory staff contacted
Name/Title Amanda Thompson
X Counseling/instruction
___Ignoring
X Labeling
X Redirection
___Verbal intervention
___Mechanical restraint (form completed)
___Other
___Distraction
___Implemented BTP
___Restitution
___Reinforcer withheld
___Personal restraint _____ (time)
___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___Client complied with request
___Excess behavior stopped; client calmed
___Other
___Client was successfully redirected
X Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** SE

Behavior Report Revised 2019.9.26

CM 000541

EXHIBIT 11A DHS PENGAD 800-631-6989

EXHIBIT 84 DHS-BERRS PENGAD 800-631-6989

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: Describe what happened. ***DO NOT INCLUDE*** personal opinions or comments. ***Legible Signature, Title, Date.***

(DC) was in the kitchen eating lunch w/ his mom. He had just came back from (LOA). Staff heard a loud Commotion. Staff ran into the kitchen and (dc) had hit his mom and flipped the kitchen table. He shouted at his Calling her a "fuckin bitch." Staff intervined and (dc) went to his room. Staff notified the (PS) at the time. (DC) mom left and did not return. Had (DC) checked out by medical no marks. Elizabeth Zykowski
12/26/19

RECEIVED
DEC 30 2019
RECORDS ROOM
BHDC AR 72927

2 pages

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name DAVID CAINS Date 12/18/19 Living Area DAVIDSON BLUE

Location of Event HAMP - DINING ROOM Time Started 1050 Time Ended 1120

Print Name/Title of person writing BR BRENDA RICHARDSON, TA (CDT)

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ✓ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ___ Involved in work/Training activities
- ___ Transitioning different setting
- ✓ Meal time
- ✓ Medication administration time
- ✓ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials DC Staff, Initials_____ Objects, Own_____

___ Apparent Injury/Marks Card Completed Objects, Others DINING ROOM (Initials)

Self BITING SELF CHRISTMAS DECO. outside labels
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials_____

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ___ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ✓ Repeating self
- ___ Left functional control From (area):
- ___ Fidgety
- ✓ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ✓ Other CRYING
- To (area):
- ___ Demand attention
- ___ Inappropriate toileting
- ___ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other

EXHIBIT SD Mis-Barry PENGAD 800-631-6989

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ✓ Graduated guidance
- ✓ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ✓ Medical contacted
- ___ Supervisory staff contacted
- Name/Title Seen by nurse - low blood sugar (CDT)
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Labeling
- ✓ Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ✓ Personal restraint 1055, 1105 (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ✓ Other client was sent back to living area Vo Rhonda Vickers
- ___ Client was successfully redirected
- ___ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Tim Alderidge **Revie**

EXHIBIT 11B DHS PENGAD 800-631-6989

CM 000550

DEC 19 2019

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

David was sitting on the bench outside of the classroom and was crying. When asked what was wrong he kept repeating "I'm in trouble, I'm in trouble". His teacher Paula Angel informed me that David had behaviors with throwing objects etc. ~~I took~~ It was almost time for Lunch, so I asked David if he was ready to get something to eat, he nodded yes. Once we got outside the Hamp W building, David pushed over the outside table. (Crying the whole time). I counseled with David and David said he had a headache. I encouraged him to come with me to see the Nurse and she may be able to get him something for his headache, David (still crying) complyed. He asked me if there's work tomorrow and I said "Yes", but its almost the weekend". When we were halfway accross the dining room, David picked up a Christmas ornament and threw it accross the room, almost hitting a nother client, I held David in personnel restraints ~~and~~ 2 minutes until he calmed. Again I encouraged him to come see the Nurse

page 1 of 2

Behavior Report Revised 2019.9.26

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000551

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name DAVID CAINS Date 12/18/19 Living Area Davidson House Blue

Location of Event Hamp + Dining Room Time Started 1050 Time Ended 1120

Print Name/Title of person writing BR Brenda Richardson TA

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ✓Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ✓Meal time
- ✓Medication administration time
- ✓Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials DC Staff, Initials_____ Objects, Own_____

___Apparent Injury/Marks Card Completed Objects, Others outside table (Initials)

Self Biting self Christmas decor in Dining room
Method, Body Part or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ___Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ✓Repeating self
- ___Left functional control From (area): To (area):
- ___Fidgety
- ✓Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ✓Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ✓Other crying
- ___Demand attention
- ___Inappropriate toileting
- ___Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ✓Graduated guidance
- ✓Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ✓Medical contacted
- ___Supervisory staff contacted Name/Title
- ✓Counseling/instruction
- ___Ignoring
- ___Labeling
- ✓Redirection
- ✓Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ✓Personal restraint 1055 - 2 min 1105 - 5 min (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ___Excess behavior stopped; client calmed
- ✓Other Client was sent back to living area Yo Rhonda Walkers
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Tim Alderidge Reviewed by CTM/RSR

Behavior Report Revised 2019.9.26

CM 000552

BEHAVIOR REPORT NARRATIVE SUMMARY

DEC 19 2019

INSTRUCTIONS: Describe what happened. ***DO NOT INCLUDE*** personal opinions or comments. ***Legible Signature, Title, Date.***

David came with me. While waiting in line he asked me "Work tomorrow?" and I answered "yes, but it's close to the weekend. David then took off into the Rec. Room and staff followed. After calming him he seen the Nurse and we went to eat Lunch. David's blood-sugar was low and he needed to eat as soon as possible. Once we got to the food line, David picked up the Christmas decorations and tried to throw them, I intervened and David tried to bite himself. At this point I held David in personal's (about 5 min) to keep him from self injury and harming others. LaRonda Vickers came in and after David calmed, we escorted him to Mobile to return to his living area to eat and calm down before returning to schedule. All personal restraints were appeared by Tim Aldridge

page 2 of 2

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name DAVID CAINS Date 12/18/19 Living Area Davidson House Blue

Location of Event Hamp + Dining Room Time Started 1050 Time Ended 1120

Print Name/Title of person writing BR Brenda Richardson TA (BSP)

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ✓Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ✓Meal time
- ✓Medication administration time
- ✓Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials DC Staff, Initials_____ Objects, Own_____

___Apparent Injury/Marks Card Completed Objects, Others cubicle table (Initials) Chairman desk in Dining room

Self Biting self
Method, Body Part or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials_____

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ___Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ✓Repeating self
- ___Left functional control From (area):
- ___Fidgety
- ✓Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ✓Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ✓Other crying To (area):
- ___Demand attention
- ___Inappropriate toileting
- ___Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ✓Graduated guidance
- ✓Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ✓Medical contacted
- ___Supervisory staff contacted Name/Title
- ✓Counseling/instruction
- ___Ignoring
- ___Labeling
- ✓Redirection
- ✓Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other_____
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ✓Personal restraint 1055 - 2 min 1105 - 5 min (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ___Excess behavior stopped; client calmed
- ✓Other Client was sent back to living area Yo Rhonda Walkers
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Tim Alderidge **Reviewed by** CSTM/RSS

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date.***

David came with me, While waiting in line he asked me "Work tomorrow?" and I answered "yes, but it's close to the weekend. David then took of into the Rec. Room and staff followed. After calming him he seen the Nurse and we went to eat Lunch. David's blood-sugar was low and he needed to eat as soon as possible. Once we got to the food line, David picked up the Christmas decorations and tried to throw them, I intervened and David tried to bite himself. At this point I had David in personal's (about 5 min) to keep him from self injury and harming others. Rhonda Vickers came in and after David calmed, we escorted him to Mobile to return to his living area to eat and calm down before returning to schedule. All personal restraints were approved by Tim Aldridge

__QIDP __Medical __Psychology __Social Services __Living Area

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 12/18/19 Living Area Davison House

Location of Event Hamp Williams Time Started 0930 Time Ended 1050

Print Name/Title of person writing BR Paula Angel, R.T

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ✓Involved in work/Training activities
- ___Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials Y.A. Objects, Own _____

___Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials _____ Staff, Initials P.A.

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ___Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area): To (area):
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ✓Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other
- ✓Demand attention
- ___Inappropriate toileting
- ✓Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ___Graduated guidance
- ___Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted
  Name/Title
- ✓Counseling/instruction
- ✓Ignoring
- ___Labeling
- ✓Redirection
- ✓Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ___Personal restraint_____ (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ___Excess behavior stopped; client calmed
- ___Other
- ___Client was successfully redirected
- ✓Excess behavior stopped, client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** CM/RS

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date*.**

D.C cried for around fifteen minutes. He got up from his workstation and walked up to me and began spitting on me several times. He took off his hat and hit me several times with it. I tried to restrain him and he began slapping me. A nurse was called and she checked his blood sugar. It was normal. He then sat alone (supervised) in hallway crying off and on until lunch time. At that time I handed him over to the staff he eats lunch with.

Behavior Report Revised 2019.9.26

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000555

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 12/2/19 Living Area Davison House

Location of Event Hamp Williams Time Started 0930 Time Ended 1040

Print Name/Title of person writing BR Paula Angel, RT

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ✓ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ✓ Involved in work/Training activities
- ___ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials J.A. Objects, Own_____

___ Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self_____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials_____

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ___ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area):
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other_____
- ✓ Demand attention
- ___ Inappropriate toileting
- ___ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other_____
- To (area):

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ___ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ✓ Medical contacted
- ✓ Supervisory staff contacted
- Name/Title Amanda Thompson
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Labeling
- ✓ Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other_____
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ___ Personal restraint_____ (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by**_____

BEHAVIOR REPORT NARRATIVE SUMMARY

RECEIVED
DEC 06 2019
[illegible] ROOM
[illegible] 78927

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

Within five minutes of training David picked up an object to throw at me I asked him to stop and he did but began crying uncontrollably for about 30 minutes. He kept repeating that he wants to move upstairs at Davison House and that he misses his mom. Medical came and assessed his behavior ~~and he got a couple of shots to calm~~ physical ECT was administered him down. About twenty five minutes later he picked up another object to throw at me I asked him to stop. He was sent back to his living area.

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only ____

Name David Cains Date 11-21-19 Living Area DH ↓

Location of Event Stone Building Time Started 1150 Time Ended 1151

Print Name/Title of person writing BR Randy McLemore, RIS COM

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ✓ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ___ Involved in work/Training activities
- ___ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials ____ Staff, Initials ____ Objects, Own ✓ table

___ Apparent Injury/Marks Card Completed Objects, Others ____ (Initials)

Self ____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials ____ Staff, Initials BM

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ___ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area): ____ To (area): ____
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ___ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other ____
- ✓ Demand attention
- ___ Inappropriate toileting
- ✓ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other ____

INTERVENTIONS (check all that apply; write details on back)

- ___ Allowed processing time
- ___ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ___ Medical contacted
- ___ Supervisory staff contacted
- Name/Title
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Labeling
- ___ Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other ____
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ___ Personal restraint ____ (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified ____ **Reviewed by** COM/RS

Behavior Report Revised 2019.9.26

CM 000566

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.** ***Legible Signature, Title, Date.***

D.C. had just came into the Stone Building after he had finished his lunch around 1145 A.m. and was sitting down in a ~~chair~~ chair behind a table and after about five minutes he jumped up and flipped the table and screamed i hate you son of a bitch for no reason that i know of. I told D.C. he needed to calm down and that everything would be alright and that he didn't even have to work today if he didn't feel like it. D.C. started crying and said am i in trouble and i said no your not in trouble i just want you to calm down. D.C. went to work at 1230 on his own without being told. He still seemed to be a little agitated.

RECEIVED
NOV 22 2019
RECORDS ROOM
BHDC AR 72927

Randy McLemore RB
11-22-19

Behavior Report Revised 2019.9.26

__QIDP __Medical __Psychology __Social Services __Living Area

M 000567

BOON[redacted]ILLE HUMAN DEVELOPMENT [redacted]NTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cainas Date 11-16-2019 Living Area DH Blue

Location of Event Commons - Lunch line Time Started 11:14 Time Ended 11:15

Print Name/Title of person writing BR Eileen Helm RCP

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ✓Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ✓Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ✓Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials_____ Objects, Own_____

___Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self Bit Scar on Hand - No marks at this time.
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ___Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area):
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other
- ___Demand attention
- ___Inappropriate toileting
- ___Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other
- To (area):

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ___Graduated guidance
- ___Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted
- Name/Title
- ✓Counseling/instruction
- ___Ignoring
- ___Labeling
- ✓Redirection
- ✓Verbal intervention
- ___Mechanical restraint (form completed).
- ___Other
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ___Personal restraint_____ (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ✓Client complied with request
- ___Excess behavior stopped; client calmed
- ___Other
- ✓Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** CM/KS

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: Describe what happened. ***DO NOT INCLUDE*** personal opinions or comments. ***Legible Signature, Title, Date.***

DC was waiting in line for lunch when he became agitated and bit himself on his hand. Staff (EH) was in line with DC and talking with DC and another client (RJ) before DC bit himself. Staff asked ~~DC~~ Self DC if he would rather eat back at the dorm where it was Quieter. DC said "NO I want to stay here." Staff said "ok but let's not bite ourselves. If it's to loud it's OK to go back. I'm ok with that. DC said No I want to stay. DC calmed down and continued to get his lunch. Staff didn't see any marks at that time but will check again later when returning to living area.

Eileen Helm
BCT

No marks found.

11-16-19.

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NOV 18 2019
SHOSHONE ROOM
IHDC AK 72927

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 11/2/19 Living Area DHB

Location of Event Kitchen/Outside Time Started 1045 Time Ended 1100

Print Name/Title of person writing BR Elizabeth Slye, RCSS

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- X Transitioning different setting
- X Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- X Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials CM Objects, Own_____

__Apparent Injury/Marks Card Completed Objects, Others table (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials ES

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- X Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- X Stomping
- ___Repeating self
- ___Left functional control From (area):
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other_____
- X Demand attention
- ___Inappropriate toileting
- X Screaming/shouting
- X Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____
- To (area):

INTERVENTIONS (check all that apply; write details on back)

- X Allowed processing time
- ___Graduated guidance
- ___Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted
  Name/Title
- X Counseling/instruction
- ___Ignoring
- X Labeling
- X Redirection
- ___Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other_____
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ___Personal restraint_____ (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- X Client complied with request
- ___Excess behavior stopped; client calmed
- X Other Still refused lunch time.
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** CM/ES

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date.***

It was time for lunch and (DC) was asked to get on mobile. We were walking towards the door when (DC) picked up a table and threw it at staff. Staff tabled and Counciled w/(DC) He told me that he hated me and was not going to lunch. Staff tried to Council w/(DC) He began to cry and told staff he just didn't want to go. He went back inside and to his room. Staff let medical know so that his blood sugar could be taken. The nurse delivered his meds to the dorm.

Elizabeth Ross
11/2/19

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NOV 04 2019
RECORDS ROOM
TDCJ-AR 72927

Behavior Report Revised 2019.9.26

M 000579

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Calma Date 10-31-2019 Living Area Davison House

Location of Event mobile van Time Started 1455 Time Ended 1457

Print Name/Title of person writing BR Delaine DeWitt R.I.

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ✓ Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ✓ Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ✓ Physical aggression by another
- ✓ Verbal aggression by another
- ✓ Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials RJ (no contact) Staff, Initials DD, Objects, Own

___Apparent Injury/Marks Card Completed Objects, Others (Initials)

Self
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ✓ Noncompliance (Com)
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area):
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other
- To (area):
- ✓ Demand attention
- ___Inappropriate toileting
- ✓ Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other

INTERVENTIONS (check all that apply; write details on back)

- ___Allowed processing time
- ___Graduated guidance
- ___Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted
  Name/Title
- ✓ Counseling/instruction
- ___Ignoring
- ___Labeling
- ___Redirection
- ✓ Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ✓ Personal restraint 30 seconds (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ___Excess behavior stopped, client calmed
- ✓ Other CRying ons he got off mobile
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Miller **Reviewed by** CJM/R.S

Behavior Report Revised 2019.9.26

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date.***

D.C. was on mobile and it was loud and he tried to hit R.J. Staff intervened and D.C. slapped Staff then Staff grabbed him and put him in personal restraints for approx. 30 seconds, then D.C. started crying, then he refused to get off mobile, other staff got on mobile and he got off with them

Delaine DeWitt RT

10-31-2019

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RECORDS ROOM
NHDC AR 72927

Behavior Report Revised 2019.9.26

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only ____

Name David Cains Date 10-31-19 Living Area Down H Blue

Location of Event Stone Building Time Started 1440 Time Ended 1440

Print Name/Title of person writing BR Bandy McLemore RFS

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ✓ Involved in work/Training activities
- ___ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials ____ Staff, Initials ____ Objects, Own ____

✓ Apparent Injury Marks Card Completed Objects, Others ____ (Initials)

Self He bit his own arm
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials ____ Staff, Initials ____

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ___ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area): To (area):
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ✓ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other ____
- ✓ Demand attention
- ___ Inappropriate toileting
- ✓ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other ____

INTERVENTIONS (check all that apply; write details on back)

- ___ Allowed processing time
- ___ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ___ Medical contacted
- ___ Supervisory staff contacted Name/Title
- ✓ Counseling/instruction
- ✓ Ignoring
- ___ Labeling
- ___ Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other ____
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ___ Personal restraint ____ (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified ____ **Reviewed by** ____

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date.***

At 1440 D.C. started screaming for no reason and started biting his right arm. Staff conversed with D.C. and I got him to quit biting his arm. D.C. seemed to still be ~~agitate~~ agitated. Marks Card was filled out and D.C. talking to medical and his living area and the P.S. was notified.

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NOV 05 2019
RECORDS ROOM
BHDC AR 72927

10:31 - 14

BEHAVIOR REPORT DOCUMEN G EMERGENCY RESTRAINT

NAME David Cains LOCATION Hamp Williams DATE 10/23/19 TIME 0945

Client has a BTP? Yes ✓ No ___ *(Information only)* Device inspected before use? ☑ Initials of inspector PA Device used papoose board

Describe the event; the staff response; and efforts made by staff to avoid the use of restraint. Mechanical Restraint must be authorized/reauthorized every 15 minutes.

Initial Behavior Leading to Restraint: David became upset and began spitting and picking up items to throw at staff. Staff tried stopping him and he began hitting and kicking us

Verbal Intervention/Redirection Attempts (be specific):

Asked him to stop.

Choices offered: Told him that he could put his head down and relax.

Graduated Guidance used? Yes ✓ **No** ___

Behavior threatening injury to people or damage to property (be specific): About 15 minutes after eating his snack David began puking. He then started spitting at staff. He then items to throw at staff. When staff tried to stop him he began hitting and kicking us.

Staff Signature and Title: Laura Angel, R.T. **Date** 10/23/19 **Time** 0945

Authorization for Restraint Signature and Title T. Aldridge P/QDM **Date** 10/23/19 **Time** 09:45

NURSE NOTIFIED: Kelley King *(Nurses Name (PRINT):)* ***at*** 9:10 AM *Time*

Revised: February 15, 2018

BEHAVIOR REPORT DOCUMEN G EMERGENCY RESTRAINT

Time started	15 minute checks	Staff Name, Title	Indicate behavior requiring restraint; whether the dangerous behavior is continuing; and what resulted in release.	Authorization every 15 minutes
0945	1000	Paula Angel, RT	hitting, kicking	Tim Aldridge
1000	1015	Paula Angel, RT	crying, calling me names, pulling from restraints	Tim Aldridge
1015	1025	Paula Angel, RT	appears calm - released	
	55 minutes Release		Was released for fluids, meals, toileting _____ Initial Ongoing Behavior:	Reauthorized every 15 minutes
	55 minutes Release		Released for fluids, meals, toileting: _____ Initial Ongoing Behavior:	Reauthorized every 15 minutes
	55 minutes Release		Released for fluids, meals, toileting: _____ Initial Ongoing Behavior:	Reauthorized every 15 minutes

JUSTIFICATION AND AUTHORIZATION FOR MECHANICAL RESTRAINTS

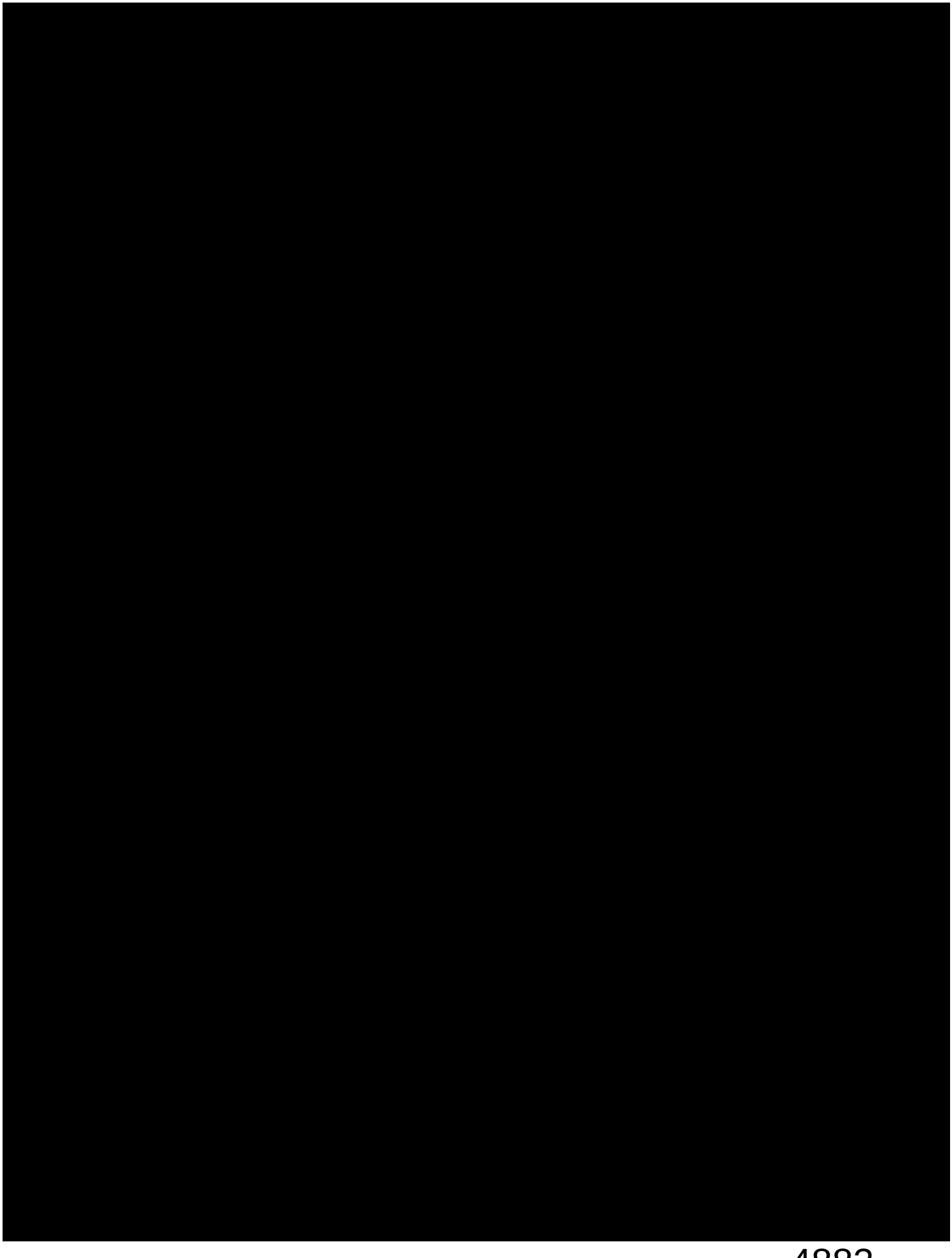
Client response to intervention and alternate behavioral choices: He was upset at first but calmed down.

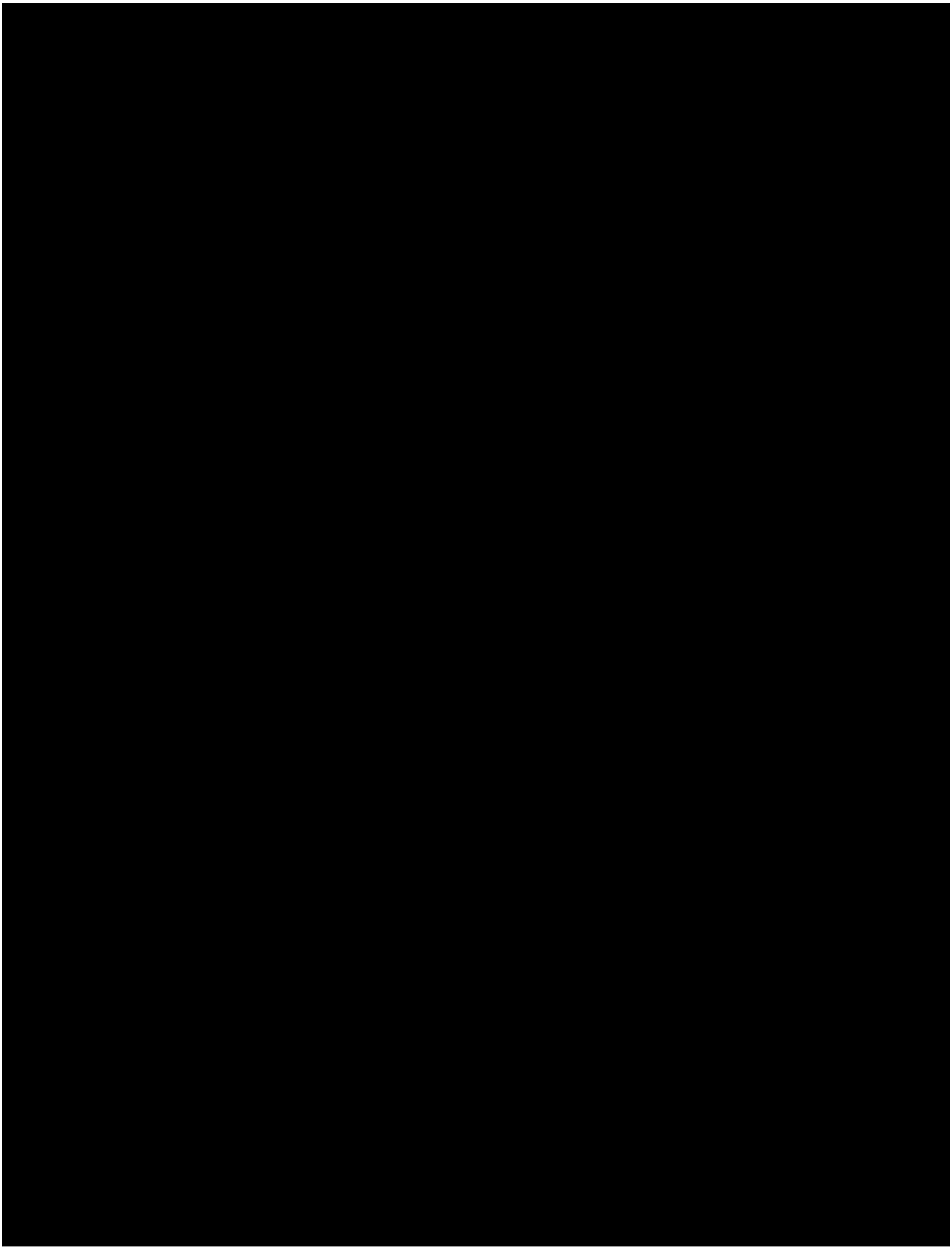
Staff debriefing form completed by Restraint Incident Leader? ✓ *Restraint Incident Leader Signature, Title, and Date:* Paula Angel, RT · 10/23/19

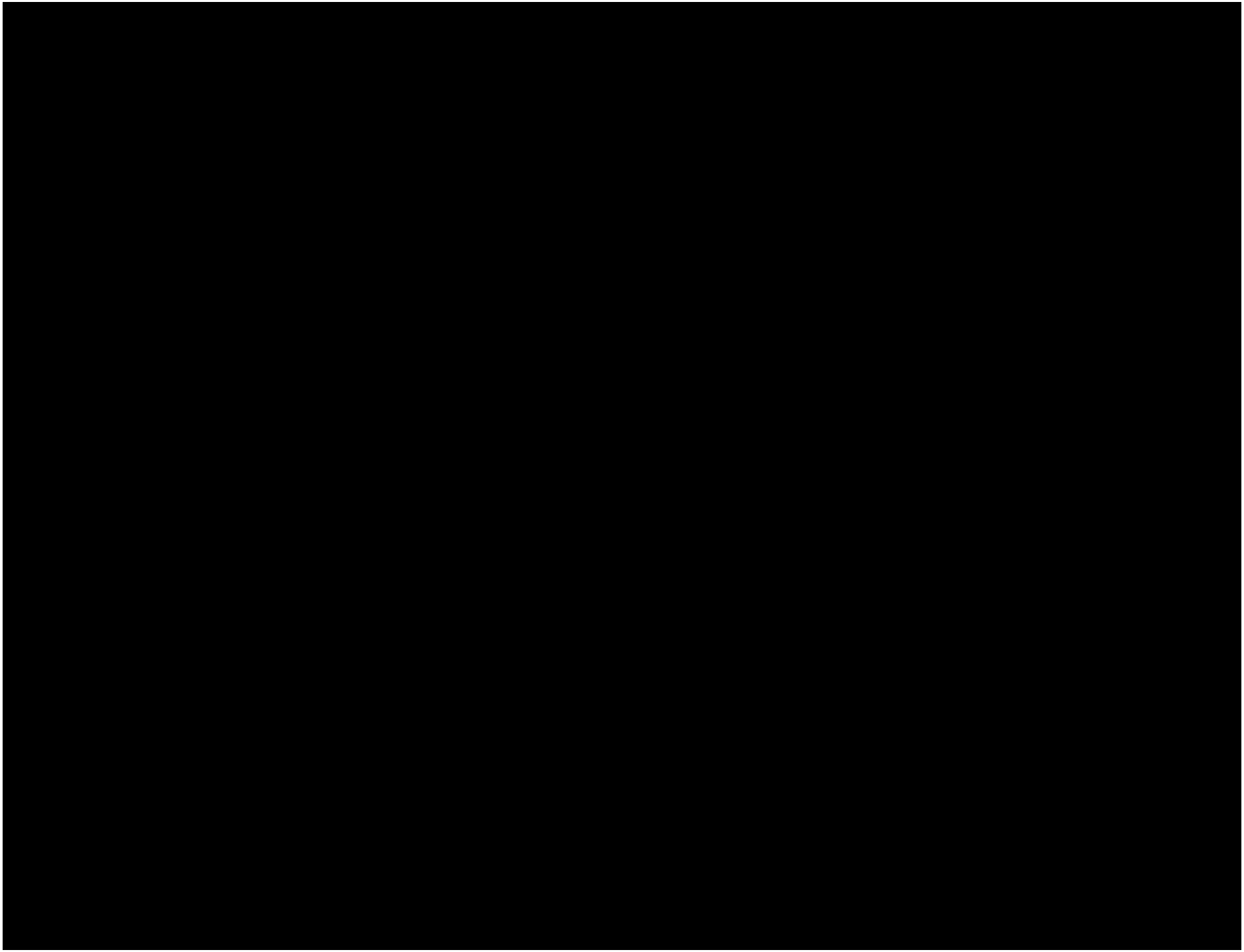
Suggested measures to avoid restraint use: none

Injury noted upon release ☑NO ☐YES **Suggested** *measures to insure safety:* None

Regulations: Restraint is only used as an emergency procedure to prevent or minimize imminent danger of injury to people or serious damage to property. All efforts must be made to deescalate the incident prior to the use of restraint. The person in restraint must be under constant staff observation, documented every 15 minutes. The person must be released when calm. The person must be released from restraint every 55 minutes for fluids, toileting, meals, or exercise. Restraint use must be authorized: continued use must be reauthorized after 15 minutes.







CM 000589

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 10/15/19 Living Area Blue (OH)

Location of Event Blue Time Started 1405 Time Ended 1407

Name/Title of person writing BR Chasity Pennebaker RCT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___Alone	___In a group 5 or less	___In a group more than 5	___Off campus
___Waiting in line	___Structured activity	___Unstructured activity	___Medication pass
___Area quiet	___Area noisy	___Outside	✓Inside
___Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	___Clients, Initials_____	✓Staff, Initials CP	
___Self	___Objects	___Apparent injury	___Marks Card completed
Verbal Aggression towards	___Clients, Initials	✓Staff, Initials CP	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

✓Agitated/angry language	___Anxious/nervous	___Caught stealing
✓Confused/disoriented	___Delusional or paranoid talk/behavior	✓Demand attention/disrupt others
___Had another's property	___Hyperactive or impulsive behavior	___Inappropriate toileting
___Inappropriately touching others	___Inattention	___Incoherent speech
___Noncompliance	___Personal space violation	___Pretended to be ill
___Public exposure/masturbation	___Putting inedible items in mouth	___Ran away (actual)
___Ran away (threatened)	___Repetitive/compulsive speech/behavior	✓Screaming/shouting
✓Temper tantrum	___Wet or soiled	
___Other_____		
___Other_____		

INTERVENTIONS (check all that apply; write details on back)

✓Allowed processing time	✓Counseling/instruction	___Distraction
___Graduated guidance	___Ignoring	___Implemented BTP
✓Labeling	___Mechanical restraint	✓Personal restraint 1 min
___Prevention	___Redirection	___Reinforce other behavior
___Restitution	___Separate from activity up to 30 m.	___Separate from setting up to 30 m.
___Verbal intervention	___Verbal prompting	___Withholding reinforcer
___Other_____		
___Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___Client complied with request	___Client was successfully redirected
✓Excess behavior stopped; client calmed	___Excess behavior stopped; client still agitated/angry
___Other	

If Personal Restraint was used: QIDP notified J. Bancroft Reviewed by CSM/RSA

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000592

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.***

@1405 DC returned from schedule agitated. He proceeded to walk in to the hallway and yell "Bitch" multiple times. Staff tried to counsel with client D.C. when client attempted to hit staff up. Staff up then placed D.C. in personals for 1 minute. Staff counseled with client and allowed processing time, client complied with request. No further behaviors.

Charity Rudyk RCA

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OCT 16 2019
RECORDS ROOM
BHDC AR 72927

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 8/8/19 Living Area DH Blue

Location of Event Mobile Time Started 1230 Time Ended 1245

Name/Title of person writing BR Laura Fiddelke RCT

___ Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___ Alone	___ In a group 5 or less	___ In a group more than 5	___ Off campus
___ Waiting in line	___ Structured activity	___ Unstructured activity	___ Medication pass
___ Area quiet	___ Area noisy	___ Outside	___ Inside
___ Other Mobile			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards

✓ Self	___ Clients, Initials ___	✓ Staff, Initials UM.F, VS, SR	✓ Marks Card completed
	✓ Objects	___ Apparent injury	

Verbal Aggression towards Clients, Initials ___ Staff, Initials ___

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

✓ Agitated/angry language	___ Anxious/nervous	___ Caught stealing
___ Confused/disoriented	___ Delusional or paranoid talk/behavior	✓ Demand attention/disrupt others
___ Had another's property	___ Hyperactive or impulsive behavior	___ Inappropriate toileting
___ Inappropriately touching others	___ Inattention	___ Incoherent speech
___ Noncompliance	___ Personal space violation	___ Pretended to be ill
___ Public exposure/masturbation	___ Putting inedible items in mouth	___ Ran away (actual)
___ Ran away (threatened)	___ Repetitive/compulsive speech/behavior	✓ Screaming/shouting
✓ Temper tantrum	___ Wet or soiled	
___ Other		
___ Other		

INTERVENTIONS (check all that apply; write details on back)

___ Allowed processing time	✓ Counseling/instruction	___ Distraction
___ Graduated guidance	___ Ignoring	___ Implemented BTP 2.5 min x 2 @
___ Labeling	___ Mechanical restraint	✓ Personal restraint 5min J. Bancroft
___ Prevention	✓ Redirection	___ Reinforce other behavior
___ Restitution	___ Separate from activity up to 30 m.	___ Separate from setting up to 30 m.
✓ Verbal intervention	✓ Verbal prompting	___ Withholding reinforcer
___ Other		
___ Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___ Client complied with request	___ Client was successfully redirected
___ Excess behavior stopped; client calmed	___ Excess behavior stopped; client still agitated/angry
___ Other	

If Personal Restraint was used: QIDP notified J. Bancroft **Reviewed by** COM/RS

Behavior Report Revised 2015-4-8

___ QIDP ___ Medical ___ Psychology ___ Social Services ___ Living Area

CM 000604

BEHAVIOR REPORT NARRATIVE SUMMARY

RECEIVED AUG 23 201

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.***

DC
DS came on to Mobile Calm and Sat down. Mobile started to take off and DS (DC) stood up and hit Staff (MF that was sitting in the seat across from him. I asked him to stop and sit down he hit me again and Sat down and started to bite himself on the outter wrist. I had to use personal restraits on him till mobile stopped and then I escorted him to the back seat (MF) due to him acting out the Client Sitting next him was ready to go off himself. DS then proceeded to bang on the window and started to bite himself again. I then asked him to stop but he cont. with the behavior. I then had to hold him in personals again and he then bit me on the finger. Then we got to his living area to drop him off and the Blue staff said he needed to go to his work area. Mobile took us to the stone and DS cont. with his behavior hitting the windows and attacking staff. Staff from stone came out and assisted to get him off mobile. When DC had calmed down Staff took him to Medical and they took care of his bite mark and Kelly Herra Nurse made out a marks card.

Behavior Report Revised 2015-4-8

__QIDP __Medical __Psychology __Social Services __Living Area

Jennifer Bancroft was MW#00605.

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cairns Date 6-25-19 Living Area DHUB

Location of Event End of Commons Time Started 0930 Time Ended 0935

Name/Title of person writing BR Chuck Hay RCT.

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

✓ Alone	___In a group 5 or less	___In a group more than 5	___Off campus
___Waiting in line	___Structured activity	✓ Unstructured activity	___Medication pass
✓ Area quiet	___Area noisy	✓ Outside	___Inside
___Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	___Clients, Initials_____	___Staff, Initials_____	
___Self	✓ Objects	___Apparent injury	___Marks Card completed
Verbal Aggression towards	___Clients, Initials	Staff, Initials	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

___Agitated/angry language	___Anxious/nervous	___Caught stealing
___Confused/disoriented	___Delusional or paranoid talk/behavior	___Demand attention/disrupt others
___Had another's property	___Hyperactive or impulsive behavior	___Inappropriate toileting
___Inappropriately touching others	___Inattention	___Incoherent speech
___Noncompliance	___Personal space violation	___Pretended to be ill
___Public exposure/masturbation	___Putting inedible items in mouth	___Ran away (actual)
___Ran away (threatened)	___Repetitive/compulsive speech/behavior	___Screaming/shouting
___Temper tantrum	___Wet or soiled	
✓ Other Hit window. Did not break.		
___Other		

INTERVENTIONS (check all that apply; write details on back)

___Allowed processing time	___Counseling/instruction	___Distraction
___Graduated guidance	___Ignoring	___Implemented BTP
___Labeling	___Mechanical restraint	___Personal restraint
✓ Prevention	✓ Redirection	___Reinforce other behavior
___Restitution	___Separate from activity up to 30 m.	___Separate from setting up to 30 m.
___Verbal intervention	___Verbal prompting	___Withholding reinforcer
___Other		
___Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___Client complied with request	___Client was successfully redirected
___Excess behavior stopped; client calmed	✓ Excess behavior stopped; client still agitated/angry
___Other	

If Personal Restraint was used: QIDP notified_____ **Reviewed by** [signature]

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000608

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title*.**

David was at the end of Commons when he ran to the window at the end of the building and started hitting it. It did not break.

Staff were able to prevent any further aggression and Namp staff came out and escorted him in. HS

No injury noted.

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RECORDS ROOM
3HDC AR 22927

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Caini Date 5/20/19 Living Area DH Blue

Location of Event Laundry Room Time Started 1607 Time Ended 1610

Name/Title of person writing BR Christa Gollet KG

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

- ✓ Alone
- ___ Waiting in line
- ✓ Area quiet
- ___ Other
- ___ In a group 5 or less
- ✓ Structured activity
- ___ Area noisy
- ___ In a group more than 5
- ___ Unstructured activity
- ___ Outside
- ___ Off campus
- ___ Medication pass
- ✓ Inside

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards
- ___ Self
- ___ Clients, Initials ___
- ✓ Objects Fire extinguisher
- ___ Staff, Initials ___
- ___ Apparent injury
- ___ Marks Card completed

Verbal Aggression towards ___ Clients, Initials ___ Staff, Initials ___

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ✓ Agitated/angry language
- ___ Confused/disoriented
- ___ Had another's property
- ___ Inappropriately touching others
- ___ Noncompliance
- ___ Public exposure/masturbation
- ___ Ran away (threatened)
- ✓ Temper tantrum
- ___ Other ___
- ___ Other ___
- ___ Anxious/nervous
- ___ Delusional or paranoid talk/behavior
- ___ Hyperactive or impulsive behavior
- ___ Inattention
- ___ Personal space violation
- ___ Putting inedible items in mouth
- ___ Repetitive/compulsive speech/behavior
- ___ Wet or soiled
- ___ Caught stealing
- ✓ Demand attention/disrupt others
- ___ Inappropriate toileting
- ___ Incoherent speech
- ___ Pretended to be ill
- ___ Ran away (actual)
- ___ Screaming/shouting

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ___ Graduated guidance
- ___ Labeling
- ___ Prevention
- ___ Restitution
- ___ Verbal intervention
- ___ Other ___
- ___ Other ___
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Mechanical restraint
- ✓ Redirection
- ✓ Separate from activity up to 30 m.
- ___ Verbal prompting
- ___ Distraction
- ___ Implemented BTP
- ___ Personal restraint
- ___ Reinforce other behavior
- ___ Separate from setting up to 30 m.
- ___ Withholding reinforcer

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ✓ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ✓ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified ___ **Reviewed by** COM/RS

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000612

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title*.**

While client DC was doing his laundry-(loading washing machine in Laundry room), client DC grabbed the Fire extinguisher and threw it out the laundry room door hitting the wall in kitchen with Fire extinguisher. Staff asked client DC to go relax in his room. Client DC complied with request was successfully redirected but still agitated.

Christopher

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BHDC AR 72927

Behavior Report Revised 2015-4-8

M 000613

__QIDP __Medical __Psychology __Social Services __Living Area

4894

BOOKSVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 4-29-19 Living Area DHBlue

Location of Event Stone Bldg Time Started 1405 Time Ended 1410

Name/Title of person writing BR Audra DeLay RI

___ Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___ Alone	___ In a group 5 or less	✓ In a group more than 5	___ Off campus
___ Waiting in line	✓ Structured activity	___ Unstructured activity	___ Medication pass
✓ Area quiet	___ Area noisy	___ Outside	✓ Inside
___ Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards

___ Self	___ Clients, Initials ___	✓ Staff, Initials AD	
	✓ Objects	___ Apparent injury	___ Marks Card completed

Verbal Aggression towards ___ Clients, Initials ___ ✓ Staff, Initials AD

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

___ Agitated/angry language	___ Anxious/nervous	___ Caught stealing
___ Confused/disoriented	___ Delusional or paranoid talk/behavior	✓ Demand attention/disrupt others
___ Had another's property	___ Hyperactive or impulsive behavior	___ Inappropriate toileting
___ Inappropriately touching others	___ Inattention	___ Incoherent speech
✓ Noncompliance	___ Personal space violation	___ Pretended to be ill
___ Public exposure/masturbation	___ Putting inedible items in mouth	___ Ran away (actual)
___ Ran away (threatened)	___ Repetitive/compulsive speech/behavior	✓ Screaming/shouting
___ Temper tantrum	___ Wet or soiled	
___ Other		
___ Other		

INTERVENTIONS (check all that apply; write details on back)

___ Allowed processing time	✓ Counseling instruction	___ Distraction
___ Graduated guidance	___ Ignoring	___ Implemented BTP
✓ Labeling	___ Mechanical restraint	✓ Personal restraint 1 min
___ Prevention	___ Redirection	___ Reinforce other behavior
___ Restitution	___ Separate from activity up to 30 m.	___ Separate from setting up to 30 m.
✓ Verbal intervention	___ Verbal prompting	___ Withholding reinforcer
___ Other		
___ Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___ Client complied with request	___ Client was successfully redirected
___ Excess behavior stopped; client calmed	✓ Excess behavior stopped; client still agitated angry
___ Other	

If Personal Restraint was used: QIDP notified Jennifer Bandcroft Reviewed by [signature] COM/RSM

Behavior Report Revised 2015 1 8

CM 000616

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.*

Time to go back to work from break. David started working with no problems. A few moments later he hit staff with his hat. Asked David to stop. He started crying and asking if he was in trouble. I explained to him that he was not in trouble. He then went over and started hitting the window. Asked him to stop without success. Held him in personals for approx 1 minute. He sat down & cont. to cry but had no more physical or verbal aggression.

Andra DeLay RT
4-29-19

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BHDC AR 72927

Behavior Report Revised 2015-4-8

M 000617

__QIDP __Medical __Psychology __Social Services __Living Area

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 4-18-19 Living Area DH Blue

Location of Event Hallway @ DH Blue Time Started 16:40 Time Ended 16:50

Name/Title of person writing BR Charles O Davis RCT

___ Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

- X Alone
- ___ Waiting in line
- X Area quiet
- ___ Other
- ___ In a group 5 or less
- ___ Structured activity
- ___ Area noisy
- ___ In a group more than 5
- ___ Unstructured activity
- ___ Outside
- ___ Off campus
- X Medication pass
- X Inside

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards
- ___ Self
- X Clients, Initials CF (Attempted)
- X Staff, Initials CD
- X Objects
- ___ Apparent injury
- ___ Marks Card completed

Verbal Aggression towards ___ Clients, Initials X Staff, Initials CD

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- X Agitated/angry language
- ___ Confused/disoriented
- ___ Had another's property
- ___ Inappropriately touching others
- X Noncompliance
- ___ Public exposure/masturbation
- ___ Ran away (threatened)
- X Temper tantrum
- ___ Other
- ___ Other
- ___ Anxious/nervous
- ___ Delusional or paranoid talk/behavior
- X Hyperactive or impulsive behavior
- ___ Inattention
- ___ Personal space violation
- ___ Putting inedible items in mouth
- ___ Repetitive/compulsive speech/behavior
- ___ Wet or soiled
- ___ Caught stealing
- X Demand attention/disrupt others
- ___ Inappropriate toileting
- ___ Incoherent speech
- ___ Pretended to be ill
- ___ Ran away (actual)
- X Screaming/shouting

INTERVENTIONS (check all that apply; write details on back)

- X Allowed processing time
- ___ Graduated guidance
- X Labeling
- X Prevention
- ___ Restitution
- X Verbal intervention
- ___ Other
- ___ Other
- X Counseling/instruction
- ___ Ignoring
- ___ Mechanical restraint
- X Redirection
- ___ Separate from activity up to 30 m.
- X Verbal prompting
- ___ Distraction
- ___ Implemented BTP
- X Personal restraint (3 min)
- ___ Reinforce other behavior
- ___ Separate from setting up to 30 m.
- ___ Withholding reinforcer

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- X Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ___ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Johnson Reviewed by CJM/RS

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000618

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.***

Staff prompted DC to come get his meds and then went to get another client. When staff started back down the hallway DC was walking towards another client (CC) with the fire extinguisher Raised above his head. Staff intervened and DC turned and threw the fire extinguisher at staff. At this time DC was placed in Personal Restraint to ensure the safety of everyone in the area. While in restraint DC continued to scream and spit at staff. After approx. 3 minutes (1642-1645) DC calmed and complied with all requests. He took his medicine, but was still upset. Staff counseled and was able to calm DC. Staff checked DC for marks and none were noted at the time. No further incidents occurred.

[redacted]

4/18/19

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ADOC AR 72927

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 4-18-19 Living Area DH Blue

Location of Event Client Room/living area Time Started 1450 Time Ended 1520

Name/Title of person writing BR Jessica Reeves RCT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

- ✓ Alone
- ___ Waiting in line
- ✓ Area quiet
- ___ Other
- ___ In a group 5 or less
- ___ Structured activity
- ___ Area noisy
- ___ In a group more than 5
- ___ Unstructured activity
- ___ Outside
- ___ Off campus
- ___ Medication pass
- ✓ Inside

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards
- ✓ Self
- ___ Clients, Initials ___
- ✓ Objects
- ✓ Staff, Initials JR
- ___ Apparent injury
- ___ Marks Card completed

Verbal Aggression towards
- ___ Clients, Initials ___
- ✓ Staff, Initials

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ✓ Agitated/angry language
- ___ Confused/disoriented
- ___ Had another's property
- ___ Inappropriately touching others
- ✓ Noncompliance
- ___ Public exposure/masturbation
- ___ Ran away (threatened)
- ✓ Temper tantrum
- ___ Other
- ___ Other
- ✓ Anxious/nervous
- ___ Delusional or paranoid talk/behavior
- ___ Hyperactive or impulsive behavior
- ___ Inattention
- ✓ Personal space violation
- ___ Putting inedible items in mouth
- ___ Repetitive/compulsive speech/behavior
- ___ Wet or soiled
- ___ Caught stealing
- ✓ Demand attention/disrupt others
- ___ Inappropriate toileting
- ___ Incoherent speech
- ___ Pretended to be ill
- ___ Ran away (actual)
- ✓ Screaming/shouting

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ✓ Graduated guidance
- ✓ Labeling
- ___ Prevention
- ___ Restitution
- ___ Verbal intervention
- ___ Other
- ___ Other
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Mechanical restraint
- ✓ Redirection
- ___ Separate from activity up to 30 m.
- ✓ Verbal prompting
- ___ Distraction
- ___ Implemented BTP
- ✓ Personal restraint 45 seconds & 2 min
- ___ Reinforce other behavior
- ___ Separate from setting up to 30 m.
- ___ Withholding reinforcer

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Justin Tobb **Reviewed by** CTM/RS

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention?** ***DO NOT INCLUDE*** **personal opinions or comments.** ***Legible Signature, Date, Title.***

DC came back from schedule anxious. Went to his room and refused to get out of bed to take his afternoon medications. Staff allowed process & cool down time, and tried again. DC became more agitated yelling, spitting, throwing objects, cussing, attempting to hit staff. DC was placed in personal restraints for 45 seconds until calm and compliant to take his meds. After DC got his med he went into his room, got ready for a bath and then began slamming the tub room door, biting self and attempting to hit staff. Staff placed DC in personal restraints again for about 2 minutes. Once DC was calm enough to be released, he was released. DC got into the tub, crying and still upset. QIDP Justin Tobb authorized personals. Medical checked blood sugar it was 94. No marks found at this time.

Jessica Reyes RC
4-18-19

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RECORDS ROOM
BHDC AR 72927

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 4-12-19 Living Area DH Blue

Location of Event Dining Area & Bathroom Time Started 1725 Time Ended 1733

Name/Title of person writing BR Richard Smith RCA

___ Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___ Alone	___ In a group 5 or less	X In a group more than 5	___ Off campus
___ Waiting in line	___ Structured activity	___ Unstructured activity	___ Medication pass
___ Area quiet	X Area noisy	___ Outside	X Inside
___ Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	___ Clients, Initials ___	X Staff, Initials R.S	
X Self	X Objects	___ Apparent injury	___ Marks Card completed
Verbal Aggression towards	Clients, Initials	X Staff, Initials R.S	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

X Agitated/angry language	___ Anxious/nervous	___ Caught stealing
___ Confused/disoriented	___ Delusional or paranoid talk/behavior	___ Demand attention/disrupt others
___ Had another's property	___ Hyperactive or impulsive behavior	___ Inappropriate toileting
___ Inappropriately touching others	___ Inattention	___ Incoherent speech
___ Noncompliance	___ Personal space violation	___ Pretended to be ill
___ Public exposure/masturbation	___ Putting inedible items in mouth	___ Ran away (actual)
___ Ran away (threatened)	X Repetitive/compulsive speech/behavior	X Screaming/shouting
X Temper tantrum	___ Wet or soiled	
___ Other		
___ Other		

INTERVENTIONS (check all that apply; write details on back)

X Allowed processing time	X Counseling/instruction	___ Distraction
X Graduated guidance	___ Ignoring	___ Implemented BTP
X Labeling	___ Mechanical restraint	X Personal restraint 30 secs 1730-1731
___ Prevention	X Redirection	___ Reinforce other behavior
___ Restitution	X Separate from activity up to 30 m.	___ Separate from setting up to 30 m.
X Verbal intervention	___ Verbal prompting	___ Withholding reinforcer
___ Other		
___ Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___ Client complied with request	X Client was successfully redirected
X Excess behavior stopped; client calmed	X Excess behavior stopped; client still agitated/angry
___ Other	

If Personal Restraint was used: QIDP notified Carrie Johnson Reviewed by com/RS

Behavior Report Revised 2015-4-8

___ QIDP ___ Medical ___ Psychology ___ Social Services ___ Living Area

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.***

Prior to being seated for supper, client DC became agitated and tried biting himself. Staff intervened and used graduated guidance to redirect D.C to his room. Staff counciled with DC about his behavior and he appologized, but was still agitated. After a few minutes, client DC came out of his room to the dining area and had sat at his seat when he picked up his glass of tea and threw it at staff and began to scream and shout. Staff intervened and used graduated guidance to redirect D.C from the dining area to his room. D.C was still shouting and screaming and went to bite himself. Staff than held D.C in P.R for 30 seconds. DC was still attempting to bite himself and scratch staff. D.C eventually calmed down and was released from P.R @ 1731. Staff counciled with D.C and allowed processing time. DC appologized to staff. He opted to stay in his room till everyone else was finished eating. DC eventually come out of his room and ate his supper and was calm. No physical marks where found on D.C

Richard Smith RCA

4-12-19

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BHDC AR 72927

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name Dwil Cains Date 4-8-19 Living Area DH Blue

Location of Event State Bldg Time Started 1148 Time Ended 1217

Name/Title of person writing BR Kenneth Matthews RT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___Alone	___In a group 5 or less	✓In a group more than 5	___Off campus
___Waiting in line	___Structured activity	✓Unstructured activity	___Medication pass
___Area quiet	✓Area noisy	___Outside	✓Inside
___Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	✓Clients, Initials PB	___Staff, Initials	
___Self	___Objects	___Apparent injury	___Marks Card completed
Verbal Aggression towards	___Clients, Initials	___Staff, Initials	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

✓Agitated/angry language	___Anxious/nervous	___Caught stealing
___Confused/disoriented	___Delusional or paranoid talk/behavior	___Demand attention/disrupt others
___Had another's property	___Hyperactive or impulsive behavior	___Inappropriate toileting
___Inappropriately touching others	___Inattention	___Incoherent speech
✓Noncompliance	___Personal space violation	✓Pretended to be ill
___Public exposure/masturbation	___Putting inedible items in mouth	___Ran away (actual)
___Ran away (threatened)	___Repetitive/compulsive speech/behavior	___Screaming/shouting
✓Temper tantrum	___Wet or soiled	
___Other		
___Other		

INTERVENTIONS (check all that apply; write details on back)

✓Allowed processing time	✓Counseling/instruction	___Distraction
___Graduated guidance	___Ignoring	___Implemented BTP
___Labeling	___Mechanical restraint	✓Personal restraint 4 min
___Prevention	✓Redirection	___Reinforce other behavior
___Restitution	___Separate from activity up to 30 m.	___Separate from setting up to 30 m.
___Verbal intervention	___Verbal prompting	___Withholding reinforcer
___Other		
___Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___Client complied with request	___Client was successfully redirected
✓Excess behavior stopped; client calmed	___Excess behavior stopped; client still agitated/angry
___Other	

If Personal Restraint was used: QIDP notified Carrie Miller **Reviewed by** CM/RS

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000636

BEHAVIOR REPORT NARRATIVE SUMMARY

RECEIVED
APR 10 2019
RECORDS ROOM
BHDC AR 72927

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.***

When David C. came to the Store Building he was crying and telling he wanted to go back to his living area so we had him sit in a chair and put his head on the table and rest. Some more clients came in to break room and he got up and said he wasn't going to work and then tried to hit another client. I had to grab him to keep him for hitting anyone and held him in personal restraint for about ~~3 or~~ 4 minutes. I asked him if he was calm and he said he wanted to go back to his living area but he remained sitting and I let him calm for awhile and he calmed and was good when it was time to go to work we asked him to get up and started tearing books which he did and worked good till quitting time.

4-8-19 Kenneth Mathews RE

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APR 10 2019
RECORDS ROOM
BHDC AR 72927

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 4-6-19 Living Area DH Blue

Location of Event living area Time Started 0825 Time Ended 0845

Name/Title of person writing BR Jessica Reeves RCT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___Alone	___In a group 5 or less	✓In a group more than 5	___Off campus
___Waiting in line	___Structured activity	___Unstructured activity	___Medication pass
___Area quiet	___Area noisy	___Outside	✓Inside
___Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards			
✓Self	✓Objects	✓Staff, Initials JR attempted	___Marks Card completed
		___Apparent injury	
Verbal Aggression towards	___Clients, Initials	Staff, Initials	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

___Agitated/angry language	___Anxious/nervous	___Caught stealing
___Confused/disoriented	___Delusional or paranoid talk/behavior	✓Demand attention/disrupt others
___Had another's property	___Hyperactive or impulsive behavior	___Inappropriate toileting
___Inappropriately touching others	___Inattention	___Incoherent speech
✓Noncompliance	✓Personal space violation	___Pretended to be ill
___Public exposure/masturbation	___Putting inedible items in mouth	___Ran away (actual)
___Ran away (threatened)	✓Repetitive/compulsive speech/behavior	✓Screaming/shouting
✓Temper tantrum	___Wet or soiled	
✓Other Spitting		
___Other		

INTERVENTIONS (check all that apply; write details on back)

✓Allowed processing time	✓Counseling/instruction	___Distraction
✓Graduated guidance	✓Ignoring	___Implemented BTP
✓Labeling	___Mechanical restraint	✓Personal restraint 3min
___Prevention	✓Redirection	___Reinforce other behavior
___Restitution	___Separate from activity up to 30 m.	✓Separate from setting up to 30 m.
___Verbal intervention	✓Verbal prompting	___Withholding reinforcer
___Other		
___Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___Client complied with request	✓Client was successfully redirected
___Excess behavior stopped; client calmed	✓Excess behavior stopped; client still agitated/angry
___Other	

If Personal Restraint was used: QIDP notified Michelle Welch Reviewed by COTM/RCT

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000638

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title*.**

DC came into the kitchen to eat breakfast. He sat down at the table looked at staff, threw his juice at staff, threw his plate, and began spitting & cussing and screaming at staff. DC attempted to hit staff. Staff prompted DC to stop, staff redirected and labeled. DC continued to try to hit and spit at staff and bite himself. Staff placed DC in personal restraints for 3 minutes until calmed. Staff allowed DC to go to his room for cool down time. Medical notified, PS notified. Nurse checked DC's blood sugar @ 0843 it was 90. No marks found at time. QIDP Michelle Welch authorized personal restraint.

Jessica Reeves RBT
4-6-19

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APR 08 2019
RECORDS ROOM
BHDC AR 72927

BEHAVIOR REPORT DOCUME[N]T G EMERGENCY RESTRAINT

NAME DAVID CAYNS LOCATION Hamp W. Hallways DATE 4/2/19 TIME 1010 AM

Client has a BTP? Yes ✓ No ___ *(Information only)* Device inspected before use? ☒ Initials of inspector BR Device used YES Papoose board.

Describe the event; the staff response; and efforts made by staff to avoid the use of restraint. Mechanical Restraint must be authorized/reauthorized every 15 minutes.

Initial Behavior Leading to Restraint:

David came to class throwing personal belongings, started spitting and hitting himself, cursing staff

Verbal Intervention/Redirection Attempts (be specific):

David sat w. staff in the Hallway and staff was trying to calm David, behavior increased

Choices offered: David was allowed to lay his head down, to calm down, offered a snack, tried to communicate to find out why he was so upset.

Graduated Guidance used? Yes ✓ No ___

Behavior threatening injury to people or damage to property (be specific):

throw hat, hitting self, threatened to bite staff, but staff, tried to hit, bite, scratch, kick staff, placed in personal restrains for 5 min, He refused to calm down, then went in Emergency Restraint. Michele Welch authorized restraints

Staff Signature and Title: Brenda Richardson TA **Date** 4/2/19 **Time** 1010

Authorization for Restraint Signature and Title Michele Welch, RSM **Date** 4/2/19 **Time** 1010

NURSE NOTIFIED: PATRICIA KICK *Nurses Name (PRINT):* ***at*** 1005 *Time*

BEHAVIOR REPORT DOCUMEN[illegible]G EMERGENCY RESTRAINT

Time started	*15 minute checks*	*Staff Name, Title*	*Indicate behavior requiring restraint; whether the dangerous behavior is continuing; and what resulted in release.*	*Authorization every 15 minutes*
1010	1025	Brenda Richards	David still aggitated	Michele Welch
1025	1040	Brenda Richardson	David was calmed and was released	Michele Welch
	55 minutes Release		*Was released for fluids, meals, toileting _____Initial Ongoing Behavior:*	*Reauthorized every 15 minutes*
	55 minutes Release		*Released for fluids, meals, toileting: _____Initial Ongoing Behavior:*	*Reauthorized every 15 minutes*
	55 minutes Release		*Released for fluids, meals, toileting: _____Initial Ongoing Behavior:*	*Reauthorized every 15 minutes*

JUSTIFICATION AND AUTHORIZATION FOR MECHANICAL RESTRAINTS

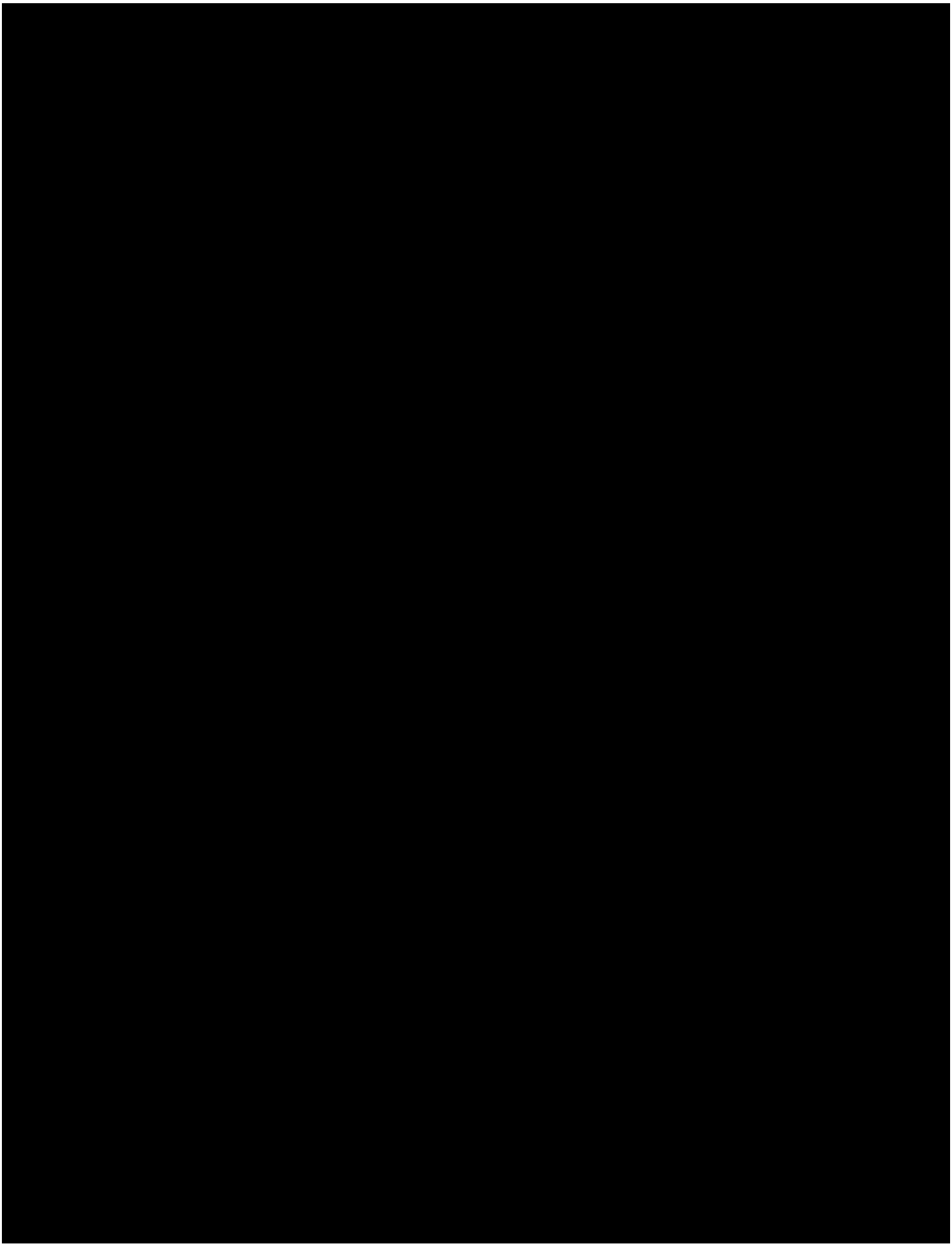
Client response to intervention and alternate behavioral choices: no positive response, continued aggitated state

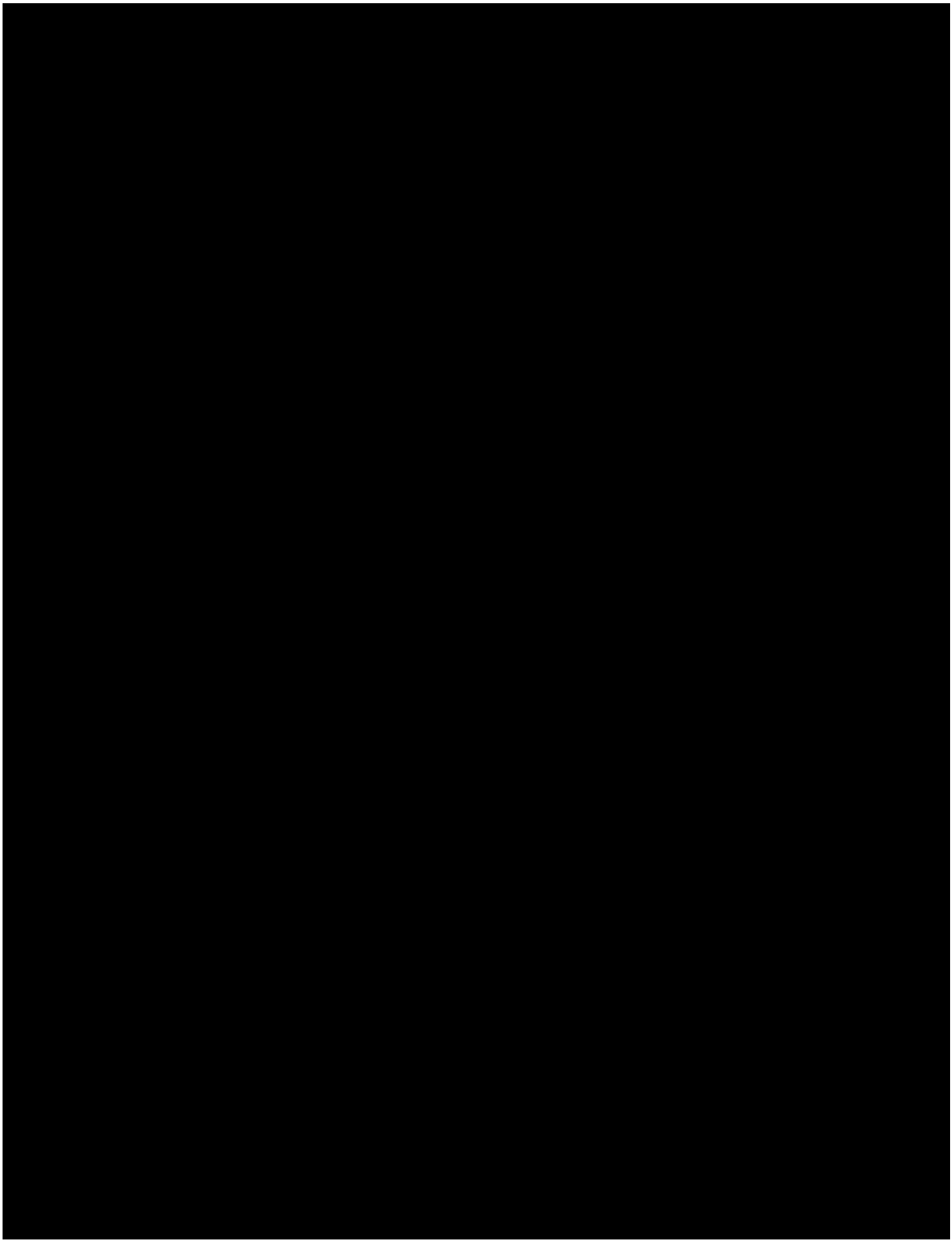
Staff debriefing form completed by Restraint Incident Leader? ✓ *Restraint Incident Leader Signature, Title, and Date:* Brenda Richardson TA 4/2/19

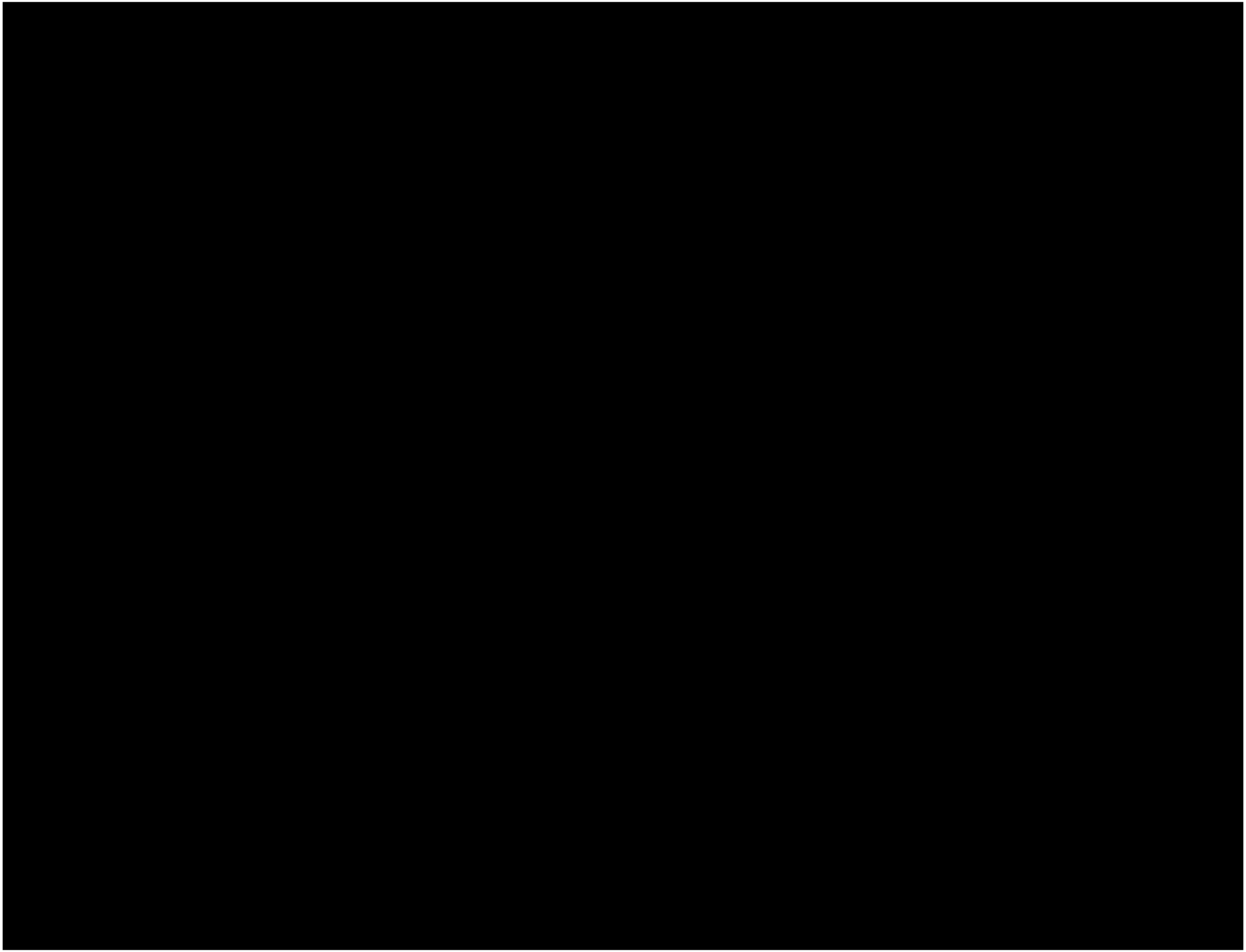
Suggested measures to avoid restraint use: counseling,

Injury noted upon release ☐NO ☒YES **Suggested** *measures to insure safety:* for client not to wear backpack also suggest medical review

Regulations: Restraint is only used as an emergency procedure to prevent or minimize imminent danger of injury to people or serious damage to property. All efforts must be made to deescalate the incident prior to the use of restraint. The person in restraint must be under constant staff observation, documented every 15 minutes. The person must be released when calm. The person must be released from restraint every 55 minutes for fluids, toileting, meals, or exercise. Restraint use must be authorized: continued use must be reauthorized after 15 minutes.







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BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 3-31-19 Living Area DH Blue

Location of Event Medpass Time Started 1535 Time Ended 1542

Name/Title of person writing BR Jessica Reeves RCT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

- ✓ Alone
- ___ Waiting in line
- ✓ Area quiet
- ___ Other
- ___ In a group 5 or less
- ___ Structured activity
- ___ Area noisy
- ___ In a group more than 5
- ___ Unstructured activity
- ___ Outside
- ___ Off campus
- ___ Medication pass
- ✓ Inside

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards
- ✓ Self
- ___ Clients, Initials ____
- ___ Objects
- ✓ Staff, Initials JL
- ___ Apparent injury
- ___ Marks Card completed

Verbal Aggression towards
- ___ Clients, Initials ____
- ✓ Staff, Initials JL

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ✓ Agitated/angry language
- ___ Confused/disoriented
- ___ Had another's property
- ___ Inappropriately touching others
- ✓ Noncompliance
- ___ Public exposure/masturbation
- ___ Ran away (threatened)
- ✓ Temper tantrum
- ___ Other ____
- ___ Other ____
- ___ Anxious/nervous
- ___ Delusional or paranoid talk/behavior
- ___ Hyperactive or impulsive behavior
- ___ Inattention
- ___ Personal space violation
- ___ Putting inedible items in mouth
- ___ Repetitive/compulsive speech/behavior
- ___ Wet or soiled
- ___ Caught stealing
- ___ Demand attention/disrupt others
- ___ Inappropriate toileting
- ___ Incoherent speech
- ___ Pretended to be ill
- ___ Ran away (actual)
- ✓ Screaming/shouting

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ✓ Graduated guidance
- ✓ Labeling
- ___ Prevention
- ___ Restitution
- ___ Verbal intervention
- ___ Other ____
- ___ Other ____
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Mechanical restraint
- ✓ Redirection
- ___ Separate from activity up to 30 m.
- ✓ Verbal prompting
- ___ Distraction
- ___ Implemented BTP
- ✓ Personal restraint 4min
- ___ Reinforce other behavior
- ___ Separate from setting up to 30 m.
- ___ Withholding reinforcer

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Sandy Evans **Reviewed by** COM/RSS

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000651

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title*.**

DC. came back to campus he was agitated. Staff called medical & notified them. @ 1535 nurse came to give DC medicine. DC threw water at staff, began biting himself and trying to attack staff. DC was placed in personal restraints. DC's blood sugar was checked and was 137 @ 1538. DC calmed enough to be released, take meds and go to his room. DC remains upset & crying. Staff and nurse looked for marks. None Found at this time. QIDP Sandy Evans authorized Personal restraints.

Jessica Reeves RCT
3-31-19

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APR 01 2019
[illegible] DIVISION
[illegible] 72927

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 3/15/19 Living Area DH-Blue

Location of Event Hallway DH-Blue Time Started 1645 Time Ended 1713

Name/Title of person writing BR Rachel Sunstrum RBT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

- ✓ Alone
- ___ Waiting in line
- ___ Area quiet
- ___ Other
- ✓ In a group 5 or less
- ✓ Structured activity
- ___ Area noisy
- ✓ In a group more than 5
- ___ Unstructured activity
- ___ Outside
- ___ Off campus
- ✓ Medication pass
- ✓ Inside

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards
- ✓ Self COR
- ✓ Objects COR
- Clients, Initials ___
- ✓ Staff, Initials COR
- ___ Apparent injury
- ___ Marks Card completed

Verbal Aggression towards
- Clients, Initials ___
- ✓ Staff, Initials COR

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ✓ Agitated/angry language
- ___ Confused/disoriented
- ___ Had another's property
- ___ Inappropriately touching others
- ✓ Noncompliance
- ___ Public exposure/masturbation
- ___ Ran away (threatened)
- ✓ Temper tantrum
- ✓ Other distruction of property
- ___ Other
- ✓ Anxious/nervous
- ___ Delusional or paranoid talk/behavior
- ✓ Hyperactive or impulsive behavior
- ___ Inattention
- ___ Personal space violation
- ___ Putting inedible items in mouth
- ✓ Repetitive/compulsive speech/behavior
- ___ Wet or soiled
- ___ Caught stealing
- ✓ Demand attention/disrupt others
- ___ Inappropriate toileting
- ___ Incoherent speech
- ✓ Pretended to be ill
- ___ Ran away (actual)
- ✓ Screaming/shouting

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ✓ Graduated guidance
- ✓ Labeling
- ___ Prevention
- ___ Restitution
- ✓ Verbal intervention
- ___ Other
- ___ Other
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Mechanical restraint
- ✓ Redirection
- ___ Separate from activity up to 30 m.
- ✓ Verbal prompting
- ___ Distraction
- ___ Implemented BTP
- ✓ Personal restraint 5 min x2
- ___ Reinforce other behavior 3 min
- ___ Separate from setting up to 30 m.
- ___ Withholding reinforcer

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ✓ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Johnson Reviewed by COM/RES

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000665

BEHAVIOR REPORT NARRATIVE SUMMARY

RECEIVED MAR 18 2019

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.***

@1645 while waiting to be seated for supper D.C. became agitated & grabbed the fire extinguisher and threw it down on the ground & started to bite himself, spit & curse at staff. Immediately staff intervened & used graduated guidance to remove D.C. from the enviroment into his bedroom so he could calm down. D.C. continued to bite & try to hit staff. Staff then put D.C. in personal restraints for approximently 5 minutes @ 1650 to prevent further injury to himself & others. No marks were found on DC. After allowing time to calm client D.C. began to apologize to staff. D.C. was succesfully redirected back to his seat for supper. D.C. than became agitated again & tried to hit staff & spit at staff. Staff had to put D.C. in PR @1700 for approximately 5 minutes to prevent further injury to himself & staff. Staff then prompted D.C. to take deep breathes & to think about his actions. After allowing processing time D.C. had apologized to staff but still appeared to be agitated. D.C. was successfully redirected back to his chair. A few moments later D.C picked up his cup & attempted to ~~throw~~ throw it at staff. D.C. started to bite & spit staff again put D.C. in PR @ 1708 for approx. 3 minutes. Staff ~~prop~~ Prompted D.C. to take deep breaths to calm & think about his actions, after allowing processing time D.C. complied & began apologizing to staff. D.C. was successfully redirected back to his seat for supper. P.S. notified. No marks cord needed. Rachel Dunsford RCT 3-15-19

Behavior Report Revised 2015-4-8

__QIDP __Medical __Psychology __Social Services __Living Area

M 000666

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 3/11/19 Living Area D1-1 Blue

Location of Event Med pass Time Started 1640 Time Ended 1645

Name/Title of person writing BR Chanti Gullet RCT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___Alone	✓In a group 5 or less	___In a group more than 5	___Off campus
___Waiting in line	✓Structured activity	___Unstructured activity	___Medication pass
✓Area quiet	___Area noisy	___Outside	✓Inside
___Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	___Clients, Initials	___Staff, Initials	
___Self	✓Objects Fire extinguisher	___Apparent injury	___Marks Card completed
Verbal Aggression towards	Clients, Initials	Staff, Initials	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

___Agitated/angry language	___Anxious/nervous	___Caught stealing
___Confused/disoriented	___Delusional or paranoid talk/behavior	✓Demand attention/disrupt others
___Had another's property	___Hyperactive or impulsive behavior	___Inappropriate toileting
___Inappropriately touching others	___Inattention	___Incoherent speech
___Noncompliance	___Personal space violation	___Pretended to be ill
___Public exposure/masturbation	___Putting inedible items in mouth	___Ran away (actual)
___Ran away (threatened)	___Repetitive/compulsive speech/behavior	___Screaming/shouting
✓Temper tantrum	___Wet or soiled	
___Other		
___Other		

INTERVENTIONS (check all that apply; write details on back)

✓Allowed processing time	✓Counseling/instruction	✓Distraction
___Graduated guidance	___Ignoring	___Implemented BTP
✓Labeling	___Mechanical restraint	___Personal restraint
✓Prevention	✓Redirection	___Reinforce other behavior
___Restitution	___Separate from activity up to 30 m.	___Separate from setting up to 30 m.
___Verbal intervention	✓Verbal prompting	___Withholding reinforcer
___Other		
___Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

✓Client complied with request	✓Client was successfully redirected
✓Excess behavior stopped; client calmed	___Excess behavior stopped; client still agitated/angry
___Other	

If Personal Restraint was used: QIDP notified ___ **Reviewed by** MW

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000667

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title*.**

Client DC was going to get his evening meds from the nurse, he attempted to hit the fire extinguisher while looking around to see if anyone was watching. Staff labeled behavior and redirected asked DC to "go to room to calm then go back to get meds- try again" Client DC complied with request and was successfully redirected - distracted. Client was calm.

[signature]

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BHDC AR 72927

Behavior Report Revised 2015-4-8

__QIDP __Medical __Psychology __Social Services __Living Area

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 3-9-19 Living Area DH Blue

Location of Event Commons Time Started 1110 Time Ended 1115

Name/Title of person writing BR Jessica Reeves RCT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___Alone	___In a group 5 or less	___In a group more than 5	___Off campus
✓Waiting in line	___Structured activity	___Unstructured activity	___Medication pass
___Area quiet	✓Area noisy	___Outside	✓Inside
___Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	✓Clients, Initials SW attempted	___Staff, Initials	
Self	✓Objects attempted	___Apparent injury	___Marks Card completed
Verbal Aggression towards	Clients, Initials	Staff, Initials	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

✓Agitated/angry language	___Anxious/nervous	___Caught stealing
___Confused/disoriented	___Delusional or paranoid talk/behavior	✓Demand attention/disrupt others
___Had another's property	___Hyperactive or impulsive behavior	___Inappropriate toileting
___Inappropriately touching others	___Inattention	___Incoherent speech
___Noncompliance	✓Personal space violation	✓Pretended to be ill
___Public exposure/masturbation	___Putting inedible items in mouth	___Ran away (actual)
___Ran away (threatened)	___Repetitive/compulsive speech/behavior	___Screaming/shouting
___Temper tantrum	___Wet or soiled	
___Other		
___Other		

INTERVENTIONS (check all that apply; write details on back)

✓Allowed processing time	✓Counseling/instruction	___Distraction
___Graduated guidance	___Ignoring	___Implemented BTP
✓Labeling	___Mechanical restraint	___Personal restraint
___Prevention	✓Redirection	___Reinforce other behavior
___Restitution	___Separate from activity up to 30 m.	✓Separate from setting up to 30 m.
✓Verbal intervention	✓Verbal prompting	___Withholding reinforcer
___Other		
___Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___Client complied with request	___Client was successfully redirected
___Excess behavior stopped; client calmed	✓Excess behavior stopped; client still agitated/angry
___Other	

If Personal Restraint was used: QIDP notified _____ **Reviewed by** CM/RSS

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000669

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.***

DC's blood sugar was checked by nurse. It was 95. Shortly after having blood suger checked and getting noon meds, DC got in line for lunch and attempted to rip off the papers on the door to commons. He could not, because they were taped to the inside of the door. He then turned to another individual who was standing behind him and then attempted to hit the individual (SW). Staff intervened. Labeled, redirected and seperated DC from the setting. Staff then notified PS and medical staff of attempted PA and DC repeatedly saying "I don't feel good" while crying. No marks on DC as he did not ever make any contact. DC remains agitated.

Jessica Reeves RCT
3-9-19

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MAR 11 2019
RECORDS ROOM
BHDC AR 72927

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Caines Date 3-8-19 Living Area DH Blue

Location of Event mobile Time Started 8:19 Time Ended 8:24

Name/Title of person writing BR Eileen Helm RCT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___Alone	___In a group 5 or less	✓ In a group more than 5	___Off campus
___Waiting in line	___Structured activity	___Unstructured activity	___Medication pass
___Area quiet	___Area noisy	___Outside	___Inside
✓ Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	___Clients, Initials	✓ Staff, Initials EH	
✓ Self	___Objects	✓ Apparent injury	✓ Marks Card completed
Verbal Aggression towards	___Clients, Initials	✓ Staff, Initials EH	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

✓ Agitated/angry language	___Anxious/nervous	___Caught stealing
___Confused/disoriented	___Delusional or paranoid talk/behavior	✓ Demand attention/disrupt others
___Had another's property	___Hyperactive or impulsive behavior	___Inappropriate toileting
___Inappropriately touching others	___Inattention	___Incoherent speech
___Noncompliance	___Personal space violation	___Pretended to be ill
___Public exposure/masturbation	___Putting inedible items in mouth	___Ran away (actual)
___Ran away (threatened)	___Repetitive/compulsive speech/behavior	✓ Screaming/shouting
✓ Temper tantrum	___Wet or soiled	
✓ Other Spitting		
___Other		

INTERVENTIONS (check all that apply; write details on back)

✓ Allowed processing time	✓ Counseling/instruction	___Distraction
___Graduated guidance	___Ignoring	___Implemented BTP
✓ Labeling	___Mechanical restraint	✓ Personal restraint 2 min
✓ Prevention	___Redirection	___Reinforce other behavior
___Restitution	___Separate from activity up to 30 m.	___Separate from setting up to 30 m.
✓ Verbal intervention	___Verbal prompting	___Withholding reinforcer
___Other		
___Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___Client complied with request	___Client was successfully redirected
✓ Excess behavior stopped; client calmed	___Excess behavior stopped; client still agitated/angry
___Other	

If Personal Restraint was used: QIDP notified Jennifer Bancroft **Reviewed by** CDM/RSM

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000673

BEHAVIOR REPORT NARRATIVE SUMMARY

RECEIVED
MAR 11 2019
RECORDS ROOM

INSTRUCTIONS: Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? ***DO NOT INCLUDE*** personal opinions or comments. ***Legible Signature, Date, Title.***

DC was riding mobile to dental clinic when he started to grab for staff, and attempted to hit staff (EH). DC also begin to spit and cuss at staff. DC then tried to bite himself. STaff grabbed for DC to prevent him from harming himself. DC again begin to spit and hit staff. STaff (EH) held DC in personals for Two minutes. Staff explained to DC that if something was bothering him to just let us know. It was better to talk then to hit or spit at people. Staff asked DC if he was ready to talk. DC said yes and he was Sorry. DC Calmed at that point. when Staff and DC got to dental Clinic staff checked DC for Marks. DC had a Small mark on his hand where he had bitten himself. Marks Cand was filled out. DC was Calm. PS notified for Personal retraints.

Eileen Helm RCS
3-8-19

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cremes Date 3-4-19 Living Area DH Blue

Location of Event DH Blue Hallway by Nurse Station Time Started 15:52 Time Ended 15:53

Name/Title of person writing BR Eileen Helm RCT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

✓ Alone	___In a group 5 or less	___In a group more than 5	___Off campus
___Waiting in line	___Structured activity	___Unstructured activity	___Medication pass
✓ Area quiet	___Area noisy	___Outside	✓ Inside
___Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	___Clients, Initials_____	___Staff, Initials_____	
___Self	✓ Objects	___Apparent injury	___Marks Card completed
Verbal Aggression towards	___Clients, Initials	___Staff, Initials	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

___Agitated/angry language	___Anxious/nervous	___Caught stealing
___Confused/disoriented	___Delusional or paranoid talk/behavior	___Demand attention/disrupt others
___Had another's property	___Hyperactive or impulsive behavior	___Inappropriate toileting
___Inappropriately touching others	___Inattention	___Incoherent speech
___Noncompliance	___Personal space violation	___Pretended to be ill
___Public exposure/masturbation	___Putting inedible items in mouth	___Ran away (actual)
___Ran away (threatened)	___Repetitive/compulsive speech/behavior	___Screaming/shouting
✓ Temper tantrum	___Wet or soiled	
___Other_____		
___Other_____		

INTERVENTIONS (check all that apply; write details on back)

✓ Allowed processing time	✓ Counseling/instruction	___Distraction
___Graduated guidance	___Ignoring	___Implemented BTP
___Labeling	___Mechanical restraint	___Personal restraint
___Prevention	___Redirection	___Reinforce other behavior
___Restitution	___Separate from activity up to 30 m.	___Separate from setting up to 30 m.
___Verbal intervention	___Verbal prompting	___Withholding reinforcer
___Other_____		
___Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

✓ Client complied with request	___Client was successfully redirected
___Excess behavior stopped; client calmed	___Excess behavior stopped; client still agitated/angry
___Other	

If Personal Restraint was used: QIDP notified_____ **Reviewed by** SC

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000679

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.***

RECEIVED
MAR 05 2019
RECORDS ROOM

DC was going to the Nurse at the blue for his afternoon meds when he opened the Fire Extingusher clear and took it out. DC then tossed it towards staff. Staff told DC to not throw it. Staff then Asked DC why he threw it. DC Started to Cry and Said Sorry. Staff was able to get DC to the nurse for his meds. DC was calm and took his medicine. DC then went to his room.

Eileen Helm RCT

Behavior Report Revised 2015-4-8

CM 000680

__QIDP __Medical __Psychology __Social Services __Living Area

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 2-28-19 Living Area DH Blue

Location of Event Client Room Time Started 1350 Time Ended 1354

Name/Title of person writing BR Jessica Reeves RCT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

- ✓ Alone
- ___ Waiting in line
- ✓ Area quiet
- ___ Other
- ___ In a group 5 or less
- ___ Structured activity
- ___ Area noisy
- ___ In a group more than 5
- ___ Unstructured activity
- ___ Outside
- ___ Off campus
- ___ Medication pass
- ✓ Inside

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards
- ✓ Self
- ___ Clients, Initials
- ___ Objects
- ✓ Staff, Initials JR
- ___ Apparent injury
- ___ Marks Card completed

Verbal Aggression towards
- Clients, Initials
- ✓ Staff, Initials JR

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ✓ Agitated/angry language
- ___ Confused/disoriented
- ___ Had another's property
- ___ Inappropriately touching others
- ✓ Noncompliance
- ___ Public exposure/masturbation
- ___ Ran away (threatened)
- ✓ Temper tantrum
- ✓ Other spitting
- ___ Other
- ___ Anxious/nervous
- ___ Delusional or paranoid talk/behavior
- ___ Hyperactive or impulsive behavior
- ___ Inattention
- ___ Personal space violation
- ___ Putting inedible items in mouth
- ___ Repetitive/compulsive speech/behavior
- ___ Wet or soiled
- ___ Caught stealing
- ___ Demand attention/disrupt others
- ___ Inappropriate toileting
- ___ Incoherent speech
- ___ Pretended to be ill
- ___ Ran away (actual)
- ✓ Screaming/shouting

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ___ Graduated guidance
- ✓ Labeling
- ___ Prevention
- ___ Restitution
- ___ Verbal intervention
- ___ Other
- ___ Other
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Mechanical restraint
- ✓ Redirection
- ___ Separate from activity up to 30 m.
- ✓ Verbal prompting
- ___ Distraction
- ___ Implemented BTP
- ✓ Personal restraint 3min
- ___ Reinforce other behavior
- ___ Separate from setting up to 30 m.
- ___ Withholding reinforcer

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ✓ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ___ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Tim Aldridge **Reviewed by** CTM/RS

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000693

BEHAVIOR REPORT NARRATIVE SUMMARY

RECEIVED
MAR 01 2019
RECORDS ROOM

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.***

After allowing DC time to dress himself after shaver. Staff went to client room and had prompted DC to put the cushion on and to start laundry. DC started Spitting. Screaming "Fuck You" "Bitch" and yelling other things staff could not understand. Staff allowed DC process time. Staff then asked DC to stop and DC began Spitting, biting self, and got up to attack staff. DC was then held in personal restraints until he calmed. (3 min) PS notified, medical notified. QIDP Tim Aldridge authorized personal restraints. When DC calmed he was released. DC then got his laundry and took it to the laundry room. No marks found @ this time.

Jessica Reeves RT

BOC[redacted]EVILLE HUMAN DEVELOPMENT [redacted]ENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 2/27/19 Living Area Blue Davison House
Location of Event Hemp Williams Hallway Time Started 0848 Time Ended 0916
Name/Title of person writing BR Angela Yancy RT

✓ Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___ Alone	___ In a group 5 or less	✓ In a group more than 5	___ Off campus
___ Waiting in line	___ Structured activity	___ Unstructured activity	___ Medication pass
✓ Area quiet	___ Area noisy	___ Outside	✓ Inside
___ Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	___ Clients, Initials ____	✓ Staff, Initials AY, YS	
___ Self	✓ Objects	___ Apparent injury	___ Marks Card completed
Verbal Aggression towards	Clients, Initials	✓ Staff, Initials AyVSBZPATM	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

✓ Agitated/angry language	___ Anxious/nervous	___ Caught stealing
___ Confused/disoriented	___ Delusional or paranoid talk/behavior	___ Demand attention/disrupt others
___ Had another's property	___ Hyperactive or impulsive behavior	___ Inappropriate toileting
___ Inappropriately touching others	___ Inattention	___ Incoherent speech
___ Noncompliance	✓ Personal space violation (cor)	___ Pretended to be ill
___ Public exposure/masturbation	___ Putting inedible items in mouth	___ Ran away (actual)
___ Ran away (threatened)	✓ Repetitive/compulsive speech/behavior	✓ Screaming/shouting
✓ Temper tantrum	___ Wet or soiled	
___ Other		
___ Other		

INTERVENTIONS (check all that apply; write details on back)

✓ Allowed processing time	✓ Counseling/instruction	___ Distraction
✓ Graduated guidance	___ Ignoring	___ Implemented BTP
___ Labeling	✓ Mechanical restraint	✓ Personal restraint 3 m
___ Prevention	___ Redirection	___ Reinforce other behavior
___ Restitution	___ Separate from activity up to 30 m.	___ Separate from setting up to 30 m.
✓ Verbal intervention	✓ Verbal prompting	___ Withholding reinforcer
___ Other		
___ Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___ Client complied with request	___ Client was successfully redirected
___ Excess behavior stopped; client calmed	___ Excess behavior stopped; client still agitated/angry
✓ Other At 0916 D.C. was released from mechanical restraint, crying but calmer.	

If Personal Restraint was used: QIDP notified Gus Calvo Reviewed by COM/RES

Behavior Report Revised 2015-4-8

QIDP ___ Medical ___ Psychology ___ Social Services ___ Living Area

CM 000705

BEHAVIOR REPORT NARRATIVE SUMMARY

RECEIVED FEB 28 2019 RECORDS ROOM ADHDC AR 72927

INSTRUCTIONS: Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.*

The teacher assistant assigneed to my room stated that D.C. was leaving the room upset, so I went to see what was going on and met him in the hall upset and crying. I tried to talk to him but he was crying hard and I Couldnt understand him. He then tried to hug me and I stepped away and said how about a fist bump. He got even more upset and took off down to the stairwell and ripped the thermostat off of the wall. D.C. was held in personal restraints for around three minutes. We talked to D.C. trying to calm him and tried to release him but he then started hitting staff and spitting at staff. D.C. was placed in emergency mechanical restraint. Medical & P.S. notified

Gus Calvo authorized the personal & mechanical restraint

DH

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Cains Date 2/21/19 Living Area Blue

Location of Event exercise Time Started 0850 Time Ended 0910

Name/Title of person writing BR Crystal Nash RCA

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

___Alone	___In a group 5 or less	X In a group more than 5	___Off campus
___Waiting in line	X Structured activity	___Unstructured activity	___Medication pass
___Area quiet	X Area noisy	___Outside	X Inside
___Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	X Clients, Initials SV	X Staff, Initials ___	
___Self	X Objects	___Apparent injury	___Marks Card completed
Verbal Aggression towards	___Clients, Initials	X Staff, Initials DJ CK	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

X Agitated/angry language	___Anxious/nervous	___Caught stealing
___Confused/disoriented	___Delusional or paranoid talk/behavior	X Demand attention/disrupt others
___Had another's property	___Hyperactive or impulsive behavior	___Inappropriate toileting
___Inappropriately touching others	___Inattention	___Incoherent speech
X Noncompliance	X Personal space violation	___Pretended to be ill
___Public exposure/masturbation	___Putting inedible items in mouth	___Ran away (actual)
___Ran away (threatened)	X Repetitive/compulsive speech/behavior	X Screaming/shouting
X Temper tantrum	___Wet or soiled	
___Other		
___Other		

INTERVENTIONS (check all that apply; write details on back)

X Allowed processing time	X Counseling/instruction	___Distraction
X Graduated guidance	___Ignoring	___Implemented BTP
X Labeling	___Mechanical restraint	X Personal restraint 1 min
___Prevention	X Redirection	___Reinforce other behavior
___Restitution	___Separate from activity up to 30 m.	___Separate from setting up to 30 m.
X Verbal intervention	___Verbal prompting	___Withholding reinforcer
___Other		
___Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___Client complied with request	___Client was successfully redirected
___Excess behavior stopped; client calmed	X Excess behavior stopped; client still agitated/angry
___Other	

If Personal Restraint was used: QIDP notified V/O Jennifer Bancroft Reviewed by COM/ES

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

CM 000709

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? ***DO NOT INCLUDE*** personal opinions or comments. ***Legible Signature, Date, Title.***

DC was riding his bike, he started yelling & spitting. Staff Counsled and DC attempted to hit another client (SV) staff interviened and DC was redirected to another work area. DC continued to scream and cuss. A min. later he jumped up and flipped his bike he was riding. Staff interviened again he hit & spit on staff DC was held in personals for apx 1 min. Client then rode his bike but still agitated.

C Nash RCA

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED April 8, 2015

Client's Name David Caines Date 1-14-19 Living Area DH Blue

Location of Event DH Blue Room 108 Time Started 15:15 Time Ended 15:25

Name/Title of person writing BR Eileen Helm, RCT

___Emergency Mechanical Restraint required and Behavior Report Documenting Emergency Restraint completed

ENVIRONMENT (check all that apply; write details on back)

✓ Alone	___In a group 5 or less	___In a group more than 5	___Off campus
___Waiting in line	___Structured activity	___Unstructured activity	___Medication pass
✓ Area quiet	___Area noisy	___Outside	✓ Inside
___Other			

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards	___Clients, Initials	✓ Staff, Initials	
___Self	✓ Objects	___Apparent injury	___Marks Card completed
Verbal Aggression towards	___Clients, Initials	✓ Staff, Initials	

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

✓ Agitated/angry language	___Anxious/nervous	___Caught stealing
___Confused/disoriented	___Delusional or paranoid talk/behavior	✓ Demand attention/disrupt others
___Had another's property	___Hyperactive or impulsive behavior	___Inappropriate toileting
___Inappropriately touching others	___Inattention	___Incoherent speech
___Noncompliance	___Personal space violation	___Pretended to be ill
___Public exposure/masturbation	___Putting inedible items in mouth	___Ran away (actual)
___Ran away (threatened)	___Repetitive/compulsive speech/behavior	✓ Screaming/shouting
✓ Temper tantrum	___Wet or soiled	
___Other		
___Other		

INTERVENTIONS (check all that apply; write details on back)

✓ Allowed processing time	✓ Counseling/instruction	___Distraction
✓ Graduated guidance	___Ignoring	___Implemented BTP
___Labeling	___Mechanical restraint	___Personal restraint
___Prevention	___Redirection	___Reinforce other behavior
___Restitution	___Separate from activity up to 30 m.	___Separate from setting up to 30 m.
✓ Verbal intervention	___Verbal prompting	___Withholding reinforcer
___Other		
___Other		

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

___Client complied with request	___Client was successfully redirected
✓ Excess behavior stopped; client calmed	___Excess behavior stopped; client still agitated/angry
___Other	

If Personal Restraint was used: QIDP notified _____ **Reviewed by** COM/RS

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

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JAN 15 2019
RECORDS ROOM

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Narrative to include the following: (1) Where did it occur, how many people were in the area? (2) Were any other clients involved? (3) What did the client do? (4) What was the immediate result of the client's behavior? (5) What intervention did the staff use? (6) How did the client react to the intervention? *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Date, Title.***

DC was in his room getting ready for his shower when he became agitated and slammed his door. Staff went to check on DC and ask what was wrong. DC started to cuss and took a picture off his wall ~~and~~ threw it towards staff. The picture shattered. Staff got DC to calm down and step away from the broken glass. Staff (EH) cleaned it up. DC was still calm at this point. Staff left DC in his room to calm down a little more. Staff went to check on DC and he was crying. Staff again asked DC what was wrong. DC said he wasn't feeling good. Staff talked with DC a little more and was able to calm him. DC was calm. Medical was notified, Blood Sugar was checked, 101, and the Nurse gave him his medicine.

Eileen Helm RCT
1-14-19

Behavior Report Revised 2015-4-8

___QIDP ___Medical ___Psychology ___Social Services ___Living Area

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 5-29-20 Living Area Blue-DH

Location of Event Blue Time Started 1405 Time Ended 1410

Print Name/Title of person writing BR Tyler Mattson, RCT (COM)

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ✓ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ___ Involved in work/Training activities
- ___ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials ___ Staff, Initials RL TM (COM) Objects, Own ___

___ Apparent Injury/Marks Card Completed Objects, Others ___ (Initials)

Self ___

Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials ___ Staff, Initials ___

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ✓ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area): ___ To (area): ___
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ✓ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other ___
- ✓ Demand attention
- ___ Inappropriate toileting
- ✓ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other ___

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ✓ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ___ Medical contacted
- ✓ Supervisory staff contacted Name/Title
- ✓ Counseling/instruction
- ___ Ignoring
- ✓ Labeling
- ___ Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other ___
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ✓ Personal restraint 1 min (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Johnson-Miller **Reviewed by** COM/RS

Behavior Report Revised 2019.9.26

EXHIBIT 11C DHS (PENGAD 800-631-6989)

EXHIBIT 9 DHS-Beaty (PENGAD 800-631-6989)

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.** ***Legible Signature, Title, Date.***

DC arrived from Schedule on mobile crying and screaming, TA Rick Libby told me he for no reason slapped him, I went outside to get him after mobile called saying they needed help, I went outside and asked him to come in to take a shower relax, DC complied, but when we got inside he began screaming and tried to pull the fire alarm, I removed him from that area, when he got into the blue he began screaming more and attempted to smack me. I put him in personals for 1 minute, he seemed, to calm down and went to his room. [signature] RCY TM 5-29-20

JUN 01 2020

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 4-28-20 Living Area DHB

Location of Event Stone Bldg Time Started 12:40 Time Ended 12:45

Print Name/Title of person writing BR Rhonda Harris TA

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ✓Involved in work/Training activities
- ___Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials RH Objects, Own_____

___Apparent Injury/Marks Card Completed Objects, Others BHDC (Initials)

Self_____

Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ ✓Staff, Initials RH

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ___Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ✓Repeating self
- ___Left functional control From (area):_____ To (area):
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other_____
- ✓Demand attention
- ___Inappropriate toileting
- ✓Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ✓Graduated guidance
- ✓Time out to calm
- ___Separate from setting up to 30 minutes
- ✓Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted Name/Title
- ✓Counseling/instruction
- ___Ignoring
- ___Labeling
- ___Redirection
- ___Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other_____
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ✓Personal restraint 3 min (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ✓Client complied with request
- ___Excess behavior stopped; client calmed
- ___Other
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Johnson **Reviewed by** [signature] COM/RS

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date.***

DC arrived at work set down finished drinking his soda, got up to throw it away walked back to chair picked it up and threw it at staff. Tried going to window with his fist up, but staff prevented him from getting to window. Staff held him in personals for approx 3min. Staff counseled, used graduated guidance to another room. Allowed processing time, time out to calm, and seperated him from activity for 30 min. After this he complied with staffs request to come set back down at work area until mobile came to pick him up. Checked for marks before leaving none found at this time.

Rhonda Harris TA
4-28-2020

RECEIVED
7 4 2020
RECORDS ROOM
BHDC AR 72827

BOONE[redacted]LLE HUMAN DEVELOPMENT C[redacted]TER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name Daniel Cains Date 4-27-20 Living Area DH Blue

Location of Event HAMP Time Started 9:25 A.M. Time Ended 10:35 A.M.

Print Name/Title of person writing BR Rena H. CSRI

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ✓ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ✓ Involved in work/Training activities
- ___ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials BP Objects, Own_____

___ Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self_____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials ✓

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ✓ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area):
- ___ Fidgety
- ✓ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other_____
- ___ Demand attention
- ___ Inappropriate toileting
- ✓ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other_____

To (area):

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ___ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ✓ Medical contacted
- ___ Supervisory staff contacted Name/Title
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Labeling
- ___ Redirection
- ✓ Verbal intervention
- ___ Mechanical restraint (form completed)
- ✓ Other Chemical intervention
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ___ Personal restraint_____ (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** CSM/RSS

Behavior Report Revised 2019.9.26

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date*.**

David came to Hemp showing physical aggression, verbal aggression and non compliance. Staff counseled with David but he refused to calm down. Staff called the nurse and David received 10 mgs of Haldol and 1 mg. of Ativan, David did calm down some, but he was still showing bad behaviors. Staff sent David back to his living area.

David was throwing rocks at mobile. David was taking his hat off and hitting staff with his hat. David picked up the broom as to hit staff with broom.

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cain 5 Date 4.20-20 Living Area Dawson House

Location of Event Mobile Van Time Started 1425 Time Ended 1427

Print Name/Title of person writing BR Richard Libby, TA

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ✓ Other- Mobile Van
- ___Involved in work/Training activities
- ✓ Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ✓ Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials SW Staff, Initials RL Objects, Own ~~RL~~

___Apparent Injury/Marks Card Completed SW's glasses Objects, Others_____ (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ✓ Confused/disoriented
- ___Had another's property
- ✓ Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area): To (area):
- ✓ Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other_____
- ✓ Demand attention
- ___Inappropriate toileting
- ___Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ___Graduated guidance
- ___Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted Name/Title
- ✓ Counseling/instruction
- ___Ignoring
- ___Labeling
- ✓ Redirection
- ___Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other_____
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ___Personal restraint_____ (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ___Excess behavior stopped; client calmed
- ___Other
- ___Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** COM/RSS

Behavior Report Revised 2019.9.26

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date*.**

David was crying and upset on the mobile van. He grabbed SW's glasses and threw them. David was counseled with over this behavior. He did stop but was still angry.

4-20-20
Richard Tolley IV

BOONVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 4-20-20 Living Area Blue

Location of Event Outside/Mobile Time Started 1425 Time Ended 1430

Print Name/Title of person writing BR [redacted]

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ✓ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ___ Involved in work/Training activities
- ✓ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials_____ Objects, Own_____

___ Apparent Injury/Marks Card Completed Objects, Others Mobile (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials_____

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ___ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Left functional control From (area):
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ___ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other_____
- ___ Demand attention
- ___ Inappropriate toileting
- ✓ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other_____
- To (area):

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ___ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ___ Medical contacted
- ___ Supervisory staff contacted
- Name/Title
- ___ Counseling/instruction
- ___ Ignoring
- ___ Labeling
- ✓ Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other_____
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ___ Personal restraint_____ (time)
- ___ Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Excess behavior stopped; client calmed
- ___ Other
- ___ Client was successfully redirected
- ✓ Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** CM/RS

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date*.**

D.C was getting off the mobile van ~~to~~ after class he got to the door turned around started screaming ran in the parking lot grabbed a rock + threw it at the windshield steps asked D.C to calm down he began crying but refused steps had to lay down on his head still crying.

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only____

Name David Cairns Date 3-6-19 Living Area Blue (DH)

Location of Event Blue Time Started 1525 Time Ended 1535

Print Name/Title of person writing BR Tyler Mattson RCT

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- X Difficult / Non-preferred task presented
- X Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials TM, CS Objects, Own X

___Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials TM, CS

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- X Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area) To (area):
- X Fidgety
- X Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other
- X Demand attention
- ___Inappropriate toileting
- X Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other

INTERVENTIONS (check all that apply; write details on back)

- ___Allowed processing time
- X Graduated guidance
- X Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- X Medical contacted
- X Supervisory staff contacted
- Name/Title Elizabeth Skye
- X Counseling/instruction
- ___Ignoring
- X Labeling
- X Redirection
- X Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- X Personal restraint 5 min (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- X Excess behavior stopped; client calmed
- ___Other
- ___Client was successfully redirected
- ___Excess behavior stopped, client still agitated/angry

If Personal Restraint was used: QIDP notified Carrie Johnson **Reviewed by** com/RSr

Behavior Report Revised 2019.9.26

CM 000759

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

DC was in his room, he had his trash can and threw it down the hall way, Staff intervened and ask what was wrong, DC did not say and began screaming at staff. Staff asked if he wanted to take a nap, he refused and continual screaming, staff continued to counsel asking if he wanted to sit in his chair and relax, he did and staff went on down the hall, shortly after DC began screaming again, Staff went back down to his room where he was standing and had a shampoo bottle, he then threw it at staff, and reached for a deodorant stick, which he threw in his bathroom he then lunged at staff, Staff placed DC in personals for approx. 5 minutes, he continual to fight. After a few minutes he calmed down and apologized, Staff then contacted medical to check his blood sugar levels, his levels were 81. There were no more issues, DC apologized and behavior ended. 2m

[signature] 3-5-20

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Behavior Report Revised 2019.9.26

__QIDP __Medical __Psychology __Social Services __Living Area

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 2-25-2020 Living Area Davison House

Location of Event mobile van Time Started 1455 Time Ended 1459

Print Name/Title of person writing BR Delaine DeWitt RI

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ✓ Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials_____ Objects, Own_____

___Apparent Injury/Marks Card Completed Objects, Others ✓ (Initials)

Self _____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials ✓ D.D E H

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ✓ Had another's property
- ✓ Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area):_____ To (area):_____
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other_____
- ✓ Demand attention
- ___Inappropriate toileting
- ✓ Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other_____

INTERVENTIONS (check all that apply; write details on back)

- ___Allowed processing time
- ✓ Graduated guidance
- ✓ Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted
- Name/Title
- ✓ Counseling/instruction
- ___Ignoring
- ___Labeling
- ✓ Redirection
- ✓ Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other_____
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ✓ Personal restraint one minute (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ✓ Client complied with request
- ___Excess behavior stopped; client calmed
- ✓ Other Crying
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified N.M Nakita Martin **Reviewed by** [signature] COM/RSM

New Behavior Report Revised 2019.9.26

CM 000769

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.**
Legible Signature, Title, Date.

We had a party at Stone Bldg. and when D.C. got on mobile he was yelling and screaming he grabbed the broom on mobile Staff took it from him, Then he strated hitting the window with both hands no visual marks at this time. Staff held him in personal restraints for one minute, then he refused to get off mobile, Staff gave him cool down time, Then Staff took graduated guidance to get him off mobile once off mobile He was crying refusing to go in with his staff after cool down time he went in crying, layed on his bed.

2-25-2020

Delaine DeWitt

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New Behavior Report Revised 2019.9.26

__QIDP __Medical __Psychology __Social Services __Living Area

CM 00077

BEHAVIOR REPORT
REVISED 9/26/19

Information Only

Name David Cairns Date 2/18/2020 Living Area DH Blue

Location of Event Mobile Time Started 8:25 Time Ended 8:47

Print Name/Title of person writing BR Eileen Helm RCT

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- ___ Other
- ___ Involved in work/Training activities
- ✓ Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ✓ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- ___ Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials ___ Staff, Initials EH, DA Objects, Own ___

___ Apparent Injury/Marks Card Completed

Objects, Others ___ (Initials) Mobile Window

Self ___

Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials ___ Staff, Initials EH

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- ✓ Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ✓ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- ___ Other ___
- ✓ Demand attention
- ___ Inappropriate toileting
- ✓ Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other ___

Verbal functional control From (area): ___ To (area): ___

INTERVENTIONS (check all that apply; write details on back)

- ✓ Allowed processing time
- ✓ Graduated guidance
- ___ Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- ___ Medical contacted
- ✓ Supervisory staff contacted
- ✓ Counseling/instruction
- ___ Ignoring
- ___ Labeling
- ___ Redirection
- ✓ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other ___
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld
- ✓ Personal restraint 3 mins (time)
- ___ Suicide precautions started

Name/Title

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ✓ [illegible]
- ___ [illegible] calmed
- ___ Client was successfully redirected
- ___ Excess behavior stopped; client still agitated/angry

[illegible] Justin [illegible] CO [illegible]

CM 000775

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: Describe what happened. ***DO NOT INCLUDE*** personal opinions or comments.
Legible Signature, Title, Date.

DC was getting on mobile to go to schedule when he started to spit and shout at the mobile Driver. He then attempted to hit the driver with his hat. Staff (EH) grabbed DC's Hat to prevent him from doing so and DC then began to spit and cus at staff and begin to hit the window and then take a swing at staff. Staff Guided DC to sit down and put DC in P.R. for three mins to calm down. DC was still cussing at staff and attempting to swing at staff for a minute before calming down. Staff asked DC if he was calm and ready to talk about it. DC said he was. Once mobile got to exercise to drop DC off he became upset again. Exercise staff got DC to calm enough to head into class. DC was calm at that time. No marks where found at this time. PS notified for Restraint.

Eileen Helm
RCT

2-18/2020

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BOONE[redacted]LE HUMAN DEVELOPMENT CE[redacted]TER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cains Date 2/18/20 Living Area DHBlue

Location of Event Hosp Hallway Time Started 0905 Time Ended 0910

Print Name/Title of person writing BR Amanda Thompson RTS

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ✓Involved in work/Training activities
- ___Transitioning different setting
- ___Meal time
- ___Medication administration time
- ___Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials AT Objects, Own_____

___Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self Hands- bruise.
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials Staff, Initials

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ✓Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area)
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ✓Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other
- To (area)
- ___Demand attention
- ___Inappropriate toileting
- ___Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ___Graduated guidance
- ___Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted
  Name/Title
- ✓Counseling/instruction
- ___Ignoring
- ✓Labeling
- ✓Redirection
- ___Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ✓Personal restraint 3min (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ✓Excess behavior stopped, client calmed
- ___Other
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified Nakita Martin **Reviewed by** COM/RS

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date*.**

David was standing @ the end of the hall - refusing to go to class - I asked David to come with me & go to class - He walked down with me - then sat on a Bench - He began crying - I counseled with him - David sat there for a min - then attempted to bite me & tuying to bite his hands. I held in personals about 3 min. Counseled & allowed processing time. David then asked if he was in trouble - I redirected him to class. He complied.
Nakita Mastin QIDP
Checked for marks - none found

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REVISED 9/26/19 Information Only

Name David Cains Date 2-8-2020 Living Area DH Blue

Location of Event Nurse Station Room Time Started 1530 Time Ended 1545

Print Name/Title of person writing BR Elizabeth Skye RCSS Page 1 of 2

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___ Arrived at area
- ___ Change in client's routine
- ___ Contact with family (phone call, visit)
- ___ Desired object present but out of reach
- ___ Difficult / Non-preferred task presented
- ___ Environment loud or hectic
- ___ Involved in grooming/hygiene activities
- ___ Involved in leisure activities
- ___ Involved in off-campus activity
- X Other Shift Change's
- ___ Involved in work/Training activities
- X Transitioning different setting
- ___ Meal time
- ___ Medication administration time
- ___ Moving from one activity to another
- ___ Other clients receiving attention
- ___ Had seizure
- ___ Toileting accident
- ___ In bed
- ___ Physical aggression by another
- ___ Verbal aggression by another
- ___ Personal space invaded
- ___ Preferred activity interrupted
- X Request refused
- ___ Snack time
- ___ Request made of client
- ___ Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials ___ Staff, Initials LF, LS EH Objects, Own Fan, DVD's

___ Apparent Injury/Marks Card Completed Objects, Others ___ (Initials)

Self biting hand
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials ___ Staff, Initials EH, LF, LS

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___ Pacing
- ___ Confused/disoriented
- ___ Had another's property
- X Noncompliance
- ___ Throwing self in floor
- ___ Day sleep
- ___ Medication refusal
- ___ Stomping
- ___ Repeating self
- ___ Lack functional control From (area):
- ___ Fidgety
- ___ Not responding to cues
- ___ Personal space violation (non-sexual)
- ___ Putting inedible items in mouth
- ___ Wet or soiled (unintentional)
- ___ Disrupting programming/environment
- ___ In another's bedroom
- ___ Lying
- X Other Spitting
- X Demand attention
- ___ Inappropriate toileting
- X Screaming/shouting
- ___ Meal refusal
- ___ Inappropriate sexual behavior
- ___ Awake during sleep time
- ___ Instigating conflict
- ___ Snack refusal
- ___ Other ___ To (area):

INTERVENTIONS (check all that apply; write details on back)

- X Allowed processing time
- X Graduated guidance
- X Time out to calm
- ___ Separate from setting up to 30 minutes
- ___ Separate from activity up to 30 minutes
- X Medical contacted
- X Supervisory staff contacted
- X Counseling/instruction
- ___ Ignoring
- X Labeling
- X Redirection
- ___ Verbal intervention
- ___ Mechanical restraint (form completed)
- ___ Other ___
- ___ Distraction
- ___ Implemented BTP
- ___ Restitution
- ___ Reinforcer withheld 1.5X2
- X Personal restraint 8min (time)
- ___ Suicide precautions started

Name/Title Rinda Porter, Thomas Black

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___ Client complied with request
- ___ Client was successfully redirected
- ___ Client calmed
- X Excess behavior stopped; client still agitated/angry

[illegible] Carl Johnson [illegible] CTM/RS

CM 000789

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RECORDS ROOM
BHDC R 72927

BEHAVIOR REPORT NARRATIVE SUMMARY

[redacted]: Describe what happened. ***DO NOT INCLUDE*** personal opinions or comments.
[redacted]

David went down to the nurses station and started to take the Sign off the wall and yell at Eileen. I went down to the nurses station and david was over by the Coke machine. I tried talking with david and he began to cry. I asked David if he would go and see the nurse to have his blood Sugar checked. He let Lacy check his Sugars. After She checked them he began to yell and Spit at Lacy. I tried to talk w/ David and he grabbed my hand and Pinned them between the ~~he~~ door and began to Scratch them. He continued to Spit at Eileen and Lacy. He then Went to attack Lacy while Still Scratching my hand David was held in personals for about a 1½. He then began to Cry, Said Sorry. Lacy gave him Some Orange Juice. He went down to his room. He was in his room and Started to yell and Scream. Staff went to check on him and he threw his fan and DVD's at me. Staff tried to councile but David came at staff and grabbed them. David Started to Scratch and hit at Staff. Staff had to hold

page 1 of 2

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Cairns Date 2-5-20 Living Area Dawson House Blue

Location of Event Dining Room Time Started 11:00 A.M. Time Ended 11:10 A.M.

Print Name/Title of person writing BR Dena Hicks, RT

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ___Arrived at area
- ___Change in client's routine
- ___Contact with family (phone call, visit)
- ___Desired object present but out of reach
- ___Difficult / Non-preferred task presented
- ___Environment loud or hectic
- ___Involved in grooming/hygiene activities
- ___Involved in leisure activities
- ___Involved in off-campus activity
- ___Other
- ___Involved in work/Training activities
- ___Transitioning different setting
- ✓Meal time
- ___Medication administration time
- ✓Moving from one activity to another
- ___Other clients receiving attention
- ___Had seizure
- ___Toileting accident
- ___In bed
- ___Physical aggression by another
- ___Verbal aggression by another
- ___Personal space invaded
- ___Preferred activity interrupted
- ___Request refused
- ___Snack time
- ___Request made of client
- ___Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials___ Staff, Initials ___ Objects, Own ___

Apparent Injury/Marks Card Completed Objects, Others ✓ Kitchen Staff (Initials)

Self ___
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials ___ Staff, Initials ___

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ___Pacing
- ___Confused/disoriented
- ___Had another's property
- ✓Noncompliance
- ___Throwing self in floor
- ___Day sleep
- ___Medication refusal
- ___Stomping
- ___Repeating self
- ___Left functional control From (area): To (area):
- ___Fidgety
- ___Not responding to cues
- ___Personal space violation (non-sexual)
- ___Putting inedible items in mouth
- ___Wet or soiled (unintentional)
- ___Disrupting programming/environment
- ___In another's bedroom
- ___Lying
- ___Other___
- ✓Demand attention
- ___Inappropriate toileting
- ✓Screaming/shouting
- ___Meal refusal
- ___Inappropriate sexual behavior
- ___Awake during sleep time
- ___Instigating conflict
- ___Snack refusal
- ___Other___

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ___Graduated guidance
- ___Time out to calm
- ___Separate from setting up to 30 minutes
- ___Separate from activity up to 30 minutes
- ___Medical contacted
- ___Supervisory staff contacted
- Name/Title
- ✓Counseling/instruction
- ___Ignoring
- ___Labeling
- ___Redirection
- ✓Verbal intervention
- ___Mechanical restraint (form completed)
- ___Other___
- ___Distraction
- ___Implemented BTP
- ___Restitution
- ___Reinforcer withheld
- ___Personal restraint___ (time)
- ___Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ___Client complied with request
- ___Excess behavior stopped; client calmed
- Other see back
- ___Client was successfully redirected
- ___Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** CTM/RS

Behavior Report Revised 2019.9.26

CM 000797

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened.** ***DO NOT INCLUDE*** **personal opinions or comments.** ***Legible Signature, Title, Date.***

David walked into dining room, walked over to table, picked up bottle of soap and hurled the soap across the room. He stood there for awhile, then he picked up bottle and threw the bottle at Kitchen stoff. He did calm down some to take his medication Stoff Counseled with David. David returned to his living area.

Dena H. B
25-20

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BHDC AR 72927

Behavior Report Revised 2019.9.26

__QIDP __Medical __Psychology __Social Services __Living Area

CM 00079

BOONEVILLE HUMAN DEVELOPMENT CENTER
BEHAVIOR REPORT
REVISED 9/26/19

Information Only_____

Name David Caimi Date 1-29-20 Living Area DH

Location of Event Hamp classroom Time Started 9:55 Time Ended 10:15

Print Name/Title of person writing BR Jack Featherston TA

What happened immediately *before* the problem behavior occurred? (check all that apply)

- ____Arrived at area
- ____Change in client's routine
- ____Contact with family (phone call, visit)
- ____Desired object present but out of reach
- ____Difficult / Non-preferred task presented
- ____Environment loud or hectic
- ____Involved in grooming/hygiene activities
- ____Involved in leisure activities
- ____Involved in off-campus activity
- ____Other
- ✓Involved in work/Training activities
- ____Transitioning different setting
- ____Meal time
- ____Medication administration time
- ____Moving from one activity to another
- ____Other clients receiving attention
- ____Had seizure
- ____Toileting accident
- ____In bed
- ____Physical aggression by another
- ____Verbal aggression by another
- ____Personal space invaded
- ____Preferred activity interrupted
- ____Request refused
- ____Snack time
- ____Request made of client
- ____Other client displaying problem behavior

AGGRESSION (check all that apply; write details on back; write client(s) and/or staff initials targeted by the aggression)

Physical Aggression towards Clients, Initials_____ Staff, Initials JJ ✓Objects, Own_____

____Apparent Injury/Marks Card Completed Objects, Others_____ (Initials)

Self_____
Method, Body Part, or Threats of Self-harm

Verbal Aggression towards Clients, Initials_____ Staff, Initials DH, [redacted]

OTHER BEHAVIORS that interfere with programming (check all that apply; write details on back)

- ____Pacing
- ____Confused/disoriented
- ____Had another's property
- ✓Noncompliance
- ____Throwing self in floor
- ____Day sleep
- ____Medication refusal
- ____Stomping
- ____Repeating self
- ____Left functional control From (area):
- ____Fidgety
- ____Not responding to cues
- ____Personal space violation (non-sexual)
- ____Putting inedible items in mouth
- ____Wet or soiled (unintentional)
- ____Disrupting programming/environment
- ____In another's bedroom
- ____Lying
- ____Other_____ To (area):
- ✓Demand attention
- ____Inappropriate toileting
- ✓Screaming/shouting
- ____Meal refusal
- ____Inappropriate sexual behavior
- ____Awake during sleep time
- ____Instigating conflict
- ____Snack refusal
- ____Other_____

INTERVENTIONS (check all that apply; write details on back)

- ✓Allowed processing time
- ✓Graduated guidance
- ✓Time out to calm
- ____Separate from setting up to 30 minutes
- ✓Separate from activity up to 30 minutes
- ✓Medical contacted
- ____Supervisory staff contacted Name/Title
- ✓Counseling/instruction
- ____Ignoring
- ____Labeling
- ✓Redirection
- ✓Verbal intervention
- ____Mechanical restraint (form completed)
- ✓Other Chemical intervention (COM)
- ✓Distraction
- ____Implemented BTP
- ____Restitution
- ____Reinforcer withheld
- ____Personal restraint_____ (time)
- ____Suicide precautions started

CLIENT RESPONSE TO INTERVENTIONS (check all that apply; write details on back)

- ____Client complied with request
- ____Excess behavior stopped; client calmed
- ____Other
- ✓Client was successfully redirected
- ____Excess behavior stopped; client still agitated/angry

If Personal Restraint was used: QIDP notified_____ **Reviewed by** COM/RS

BEHAVIOR REPORT NARRATIVE SUMMARY

INSTRUCTIONS: **Describe what happened. *DO NOT INCLUDE* personal opinions or comments. *Legible Signature, Title, Date.***

David came to class. He appeared fine. He then jumped up and went in the hallway. Sat on the bench for a while then got up and turned over the trash can full of pop cans. Client calmed down enough to re-enter the class. He was given his ordered snack and juice. he then threw the juice at staff. Medical was notified and evaluated for intervention. 1mg Ativan administered @ 10:12. After the medical intervention he went back out in the hall slamming the door and cursing at staff. After ample time for the conditions to improve he was taken back to living area.

Jack Featherston TA
1/29-20

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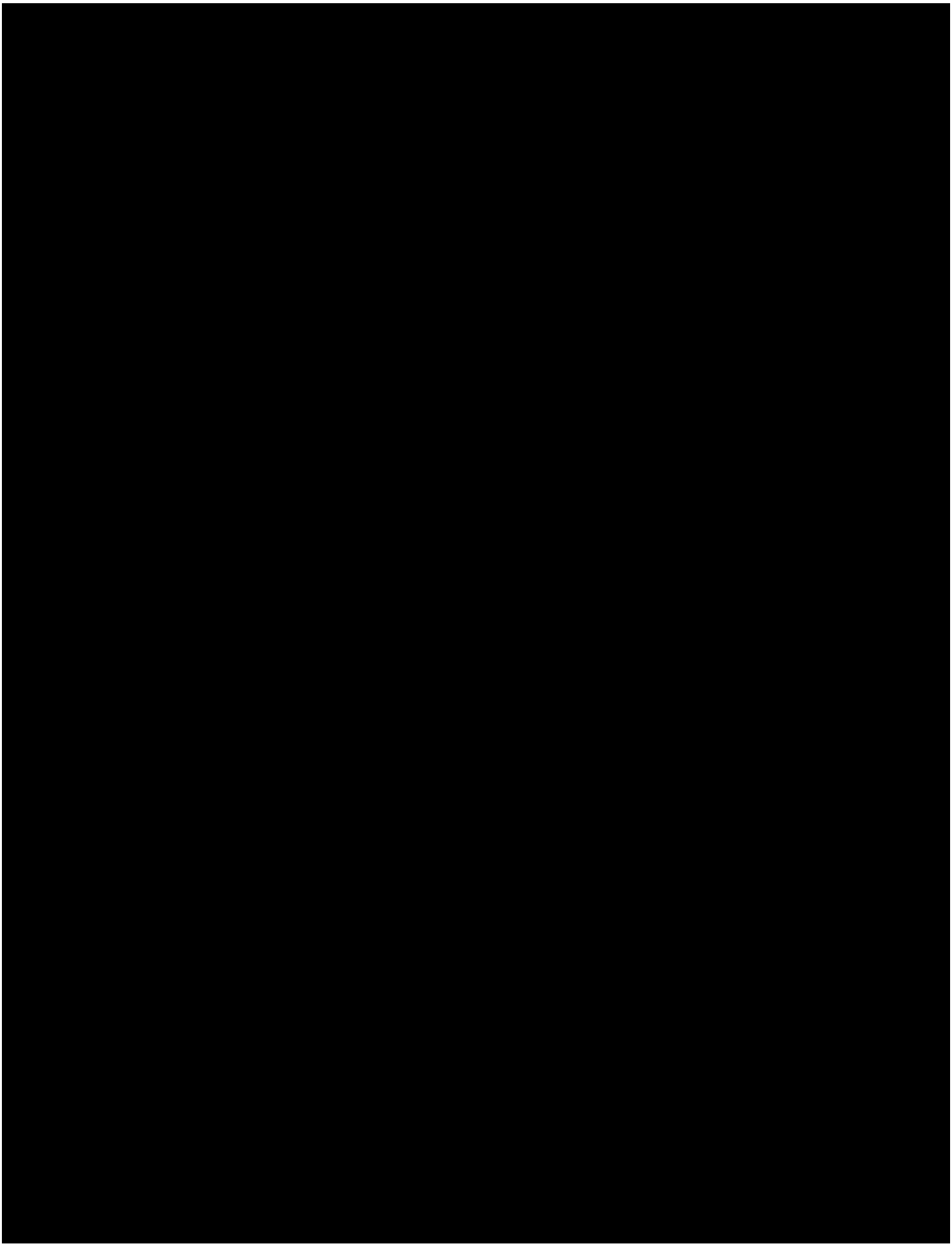
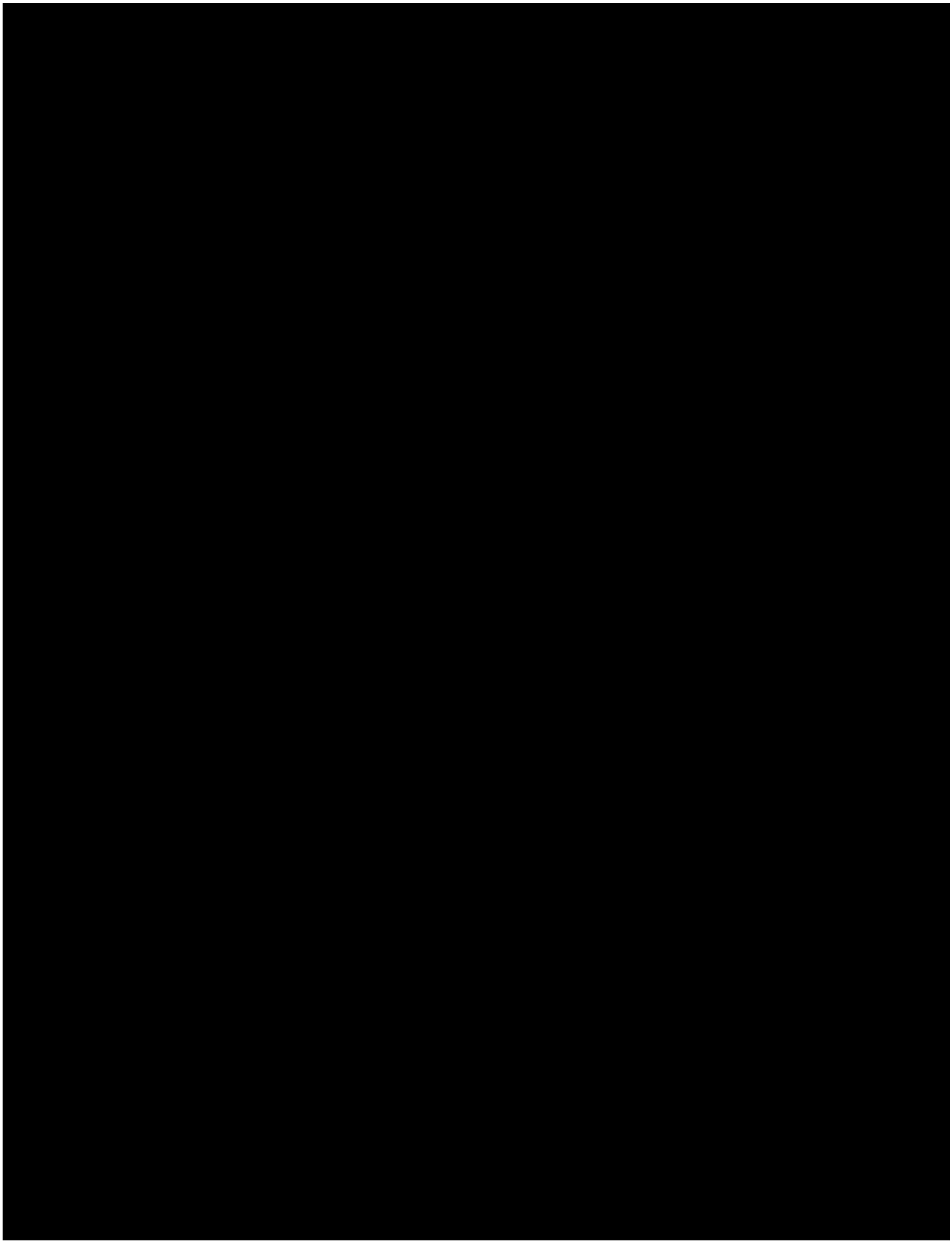
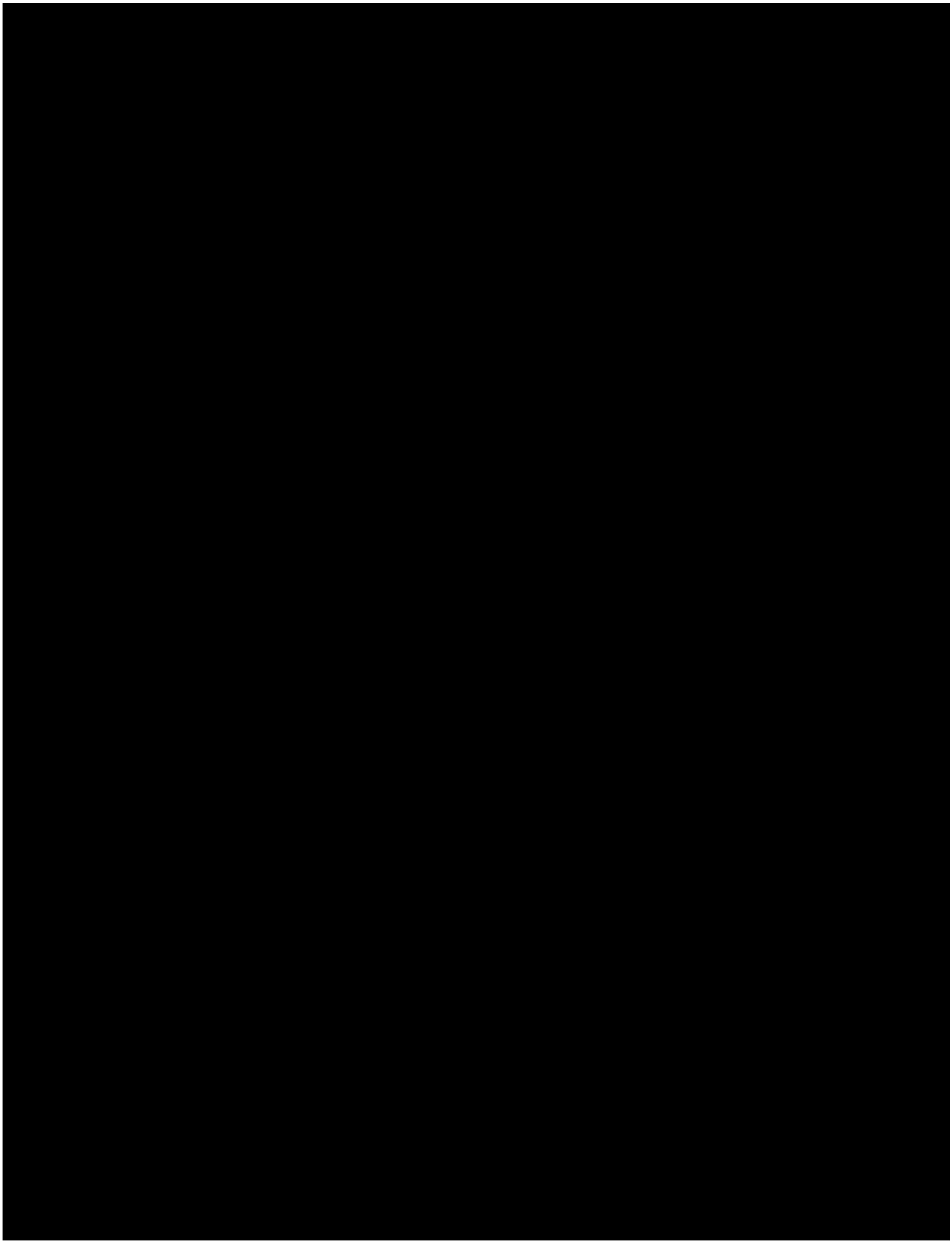
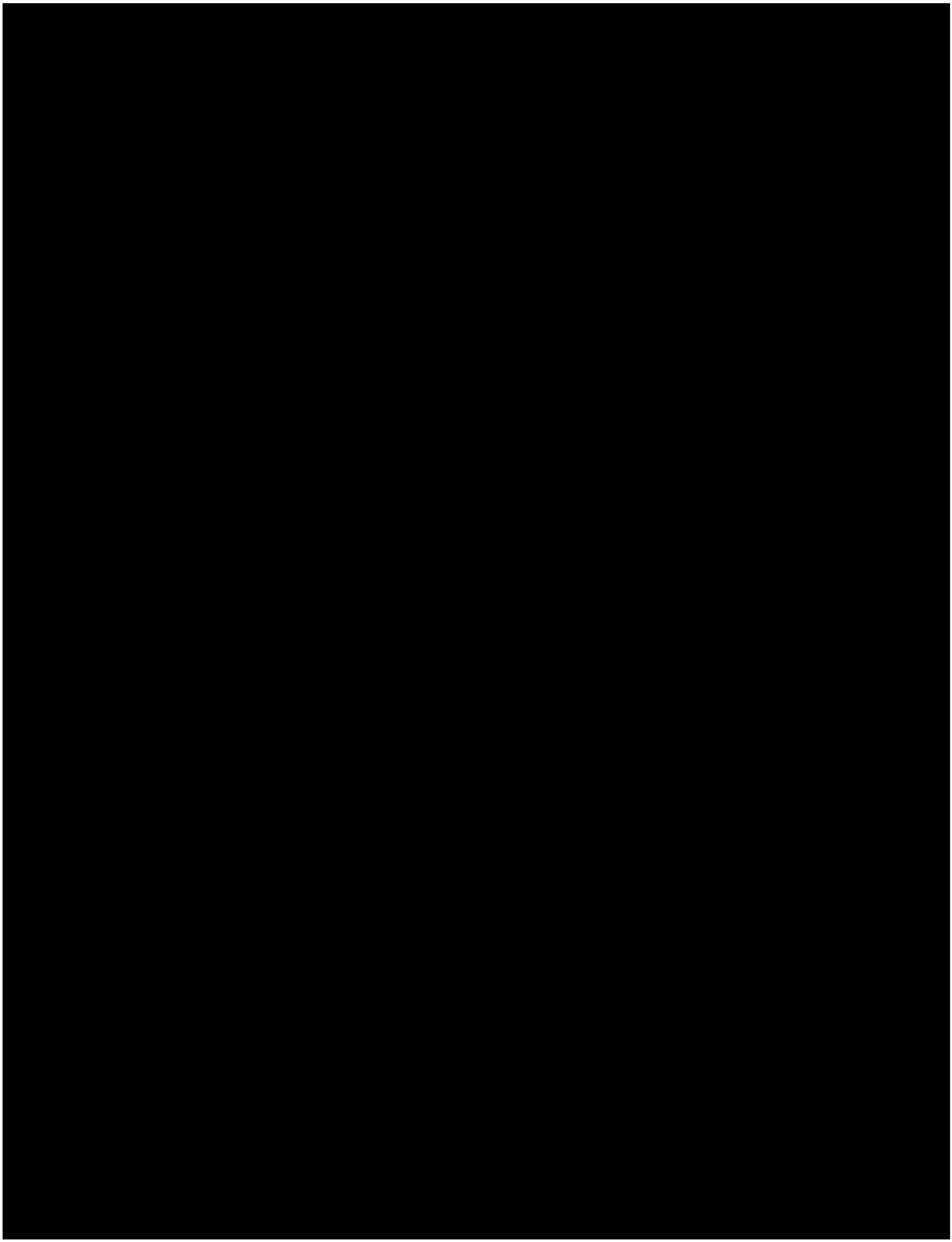
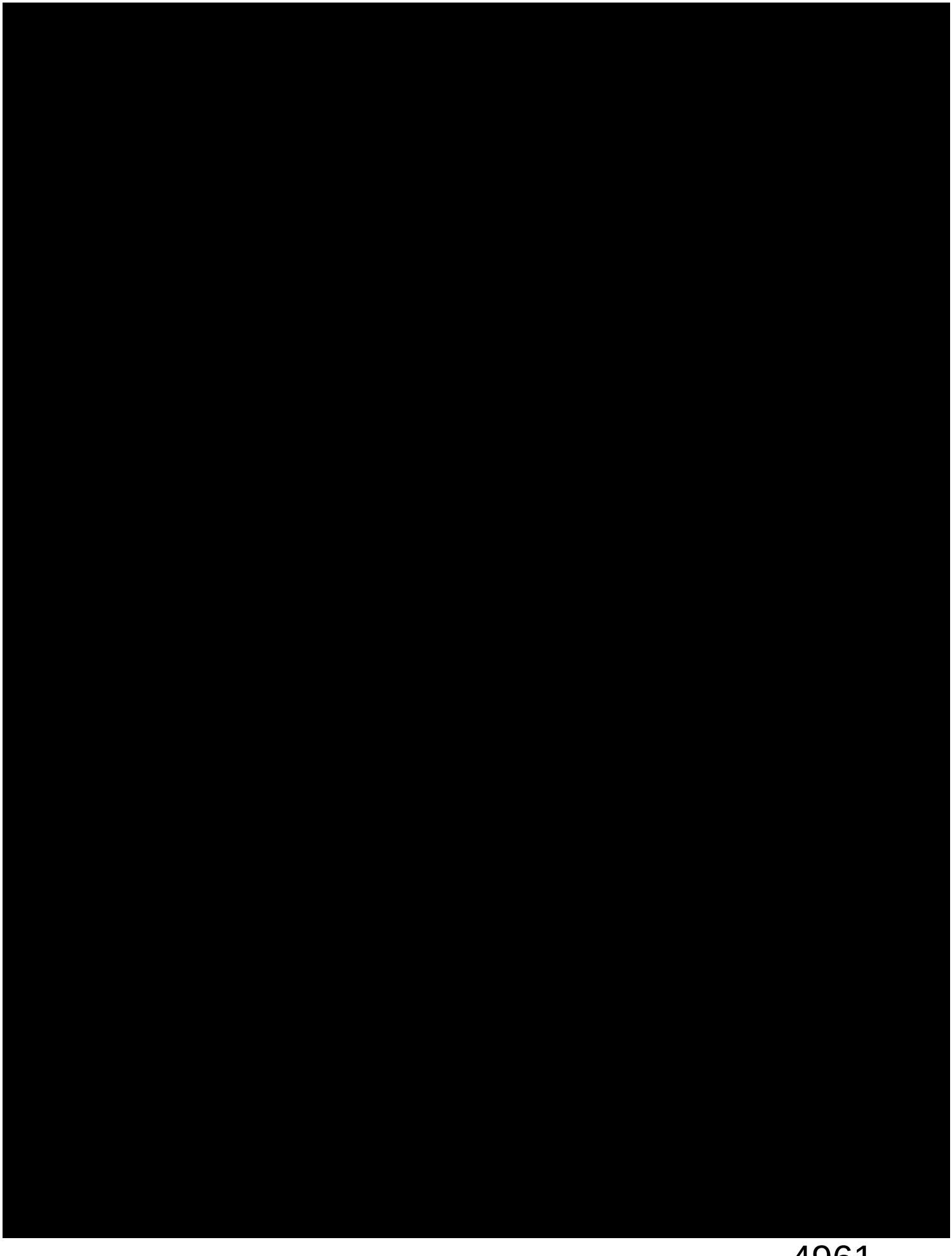
JAN 31 2020
BHDC AR 72227

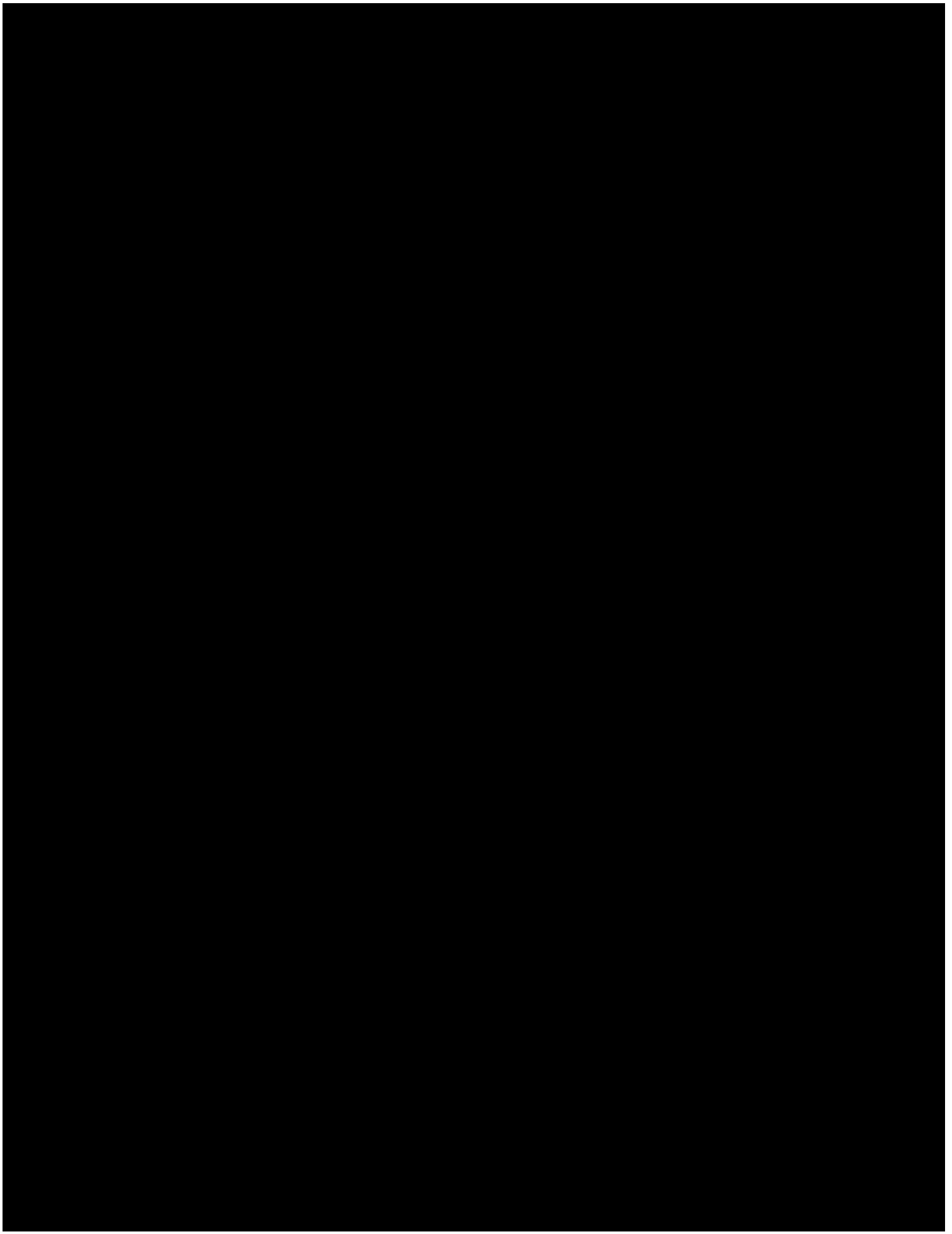


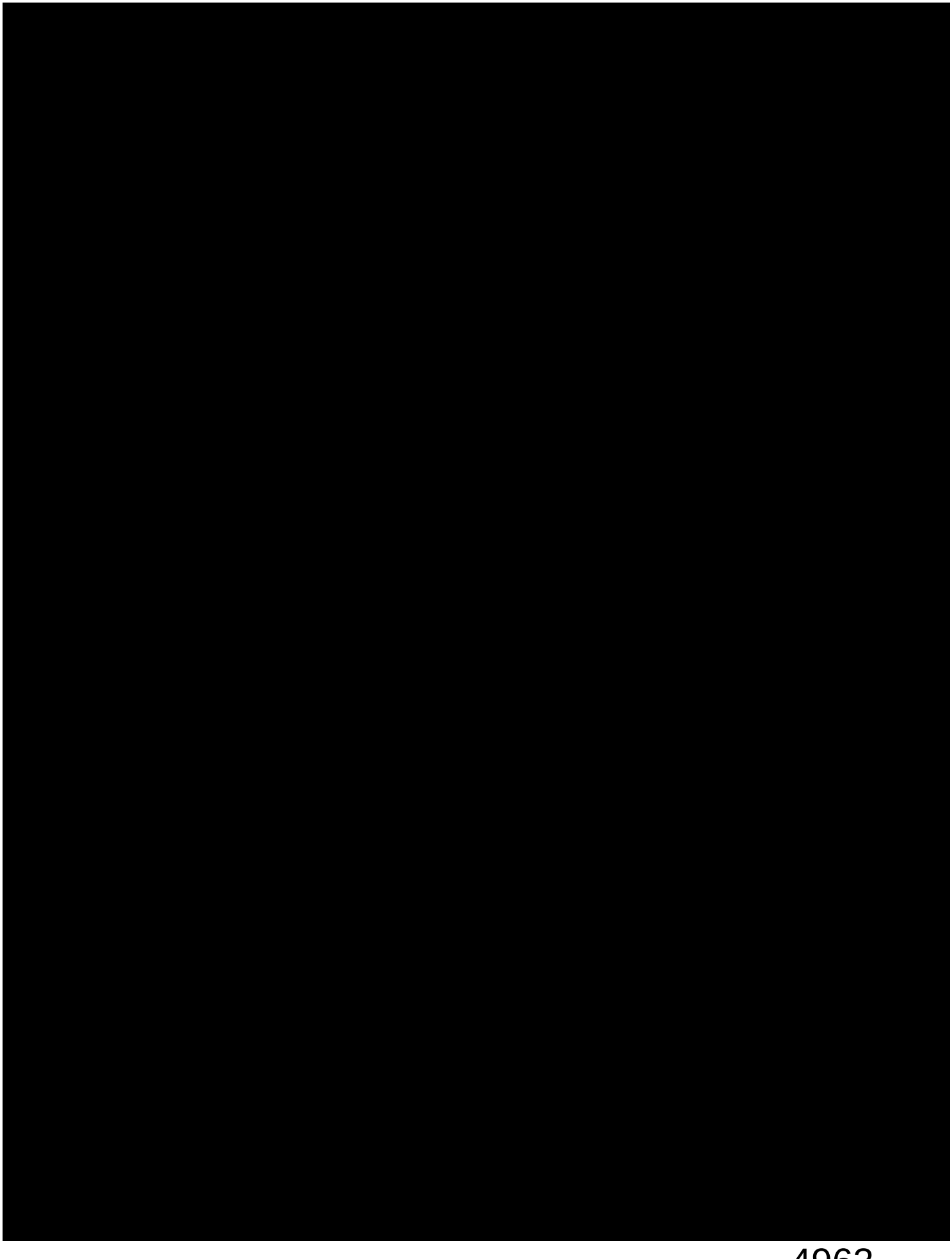


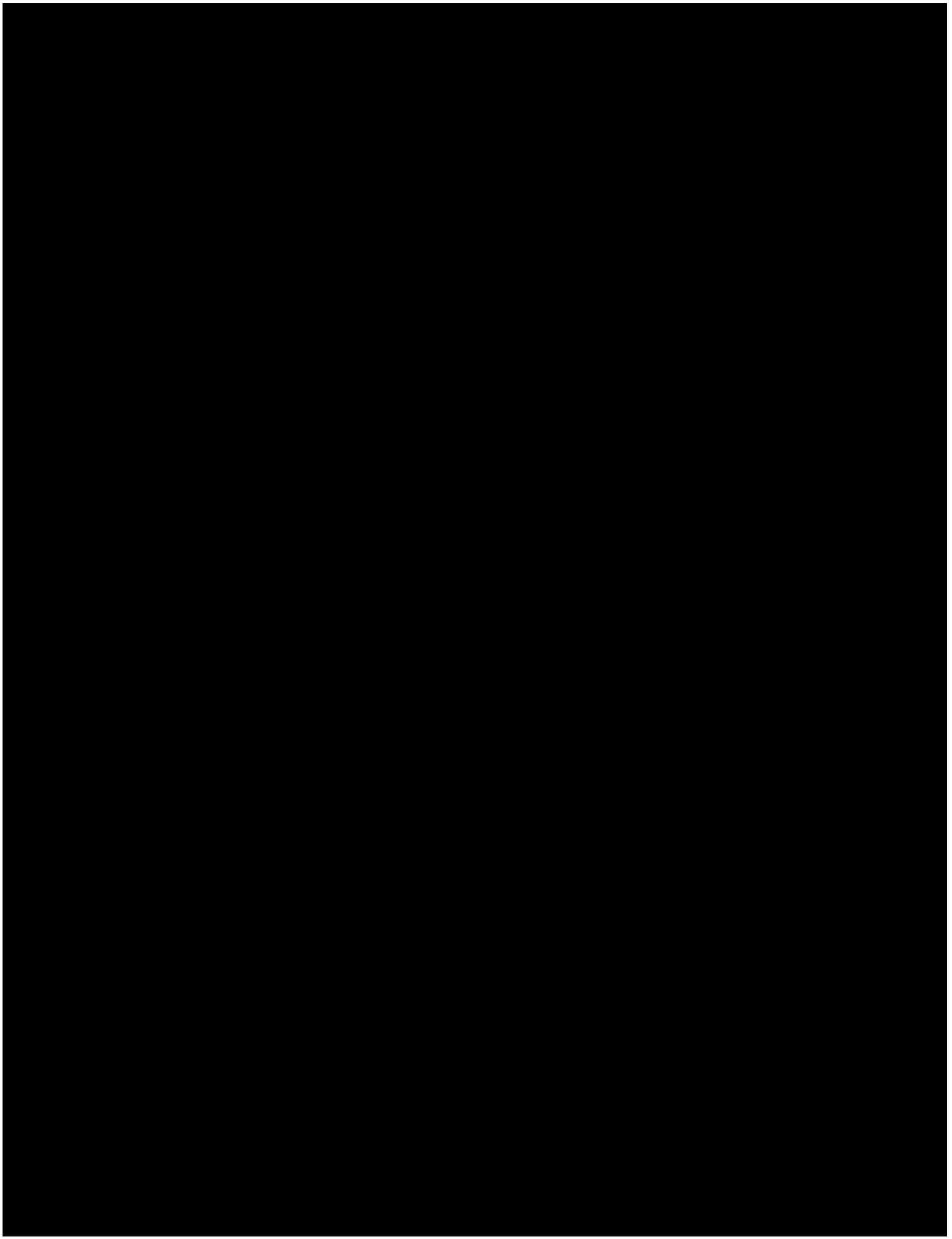


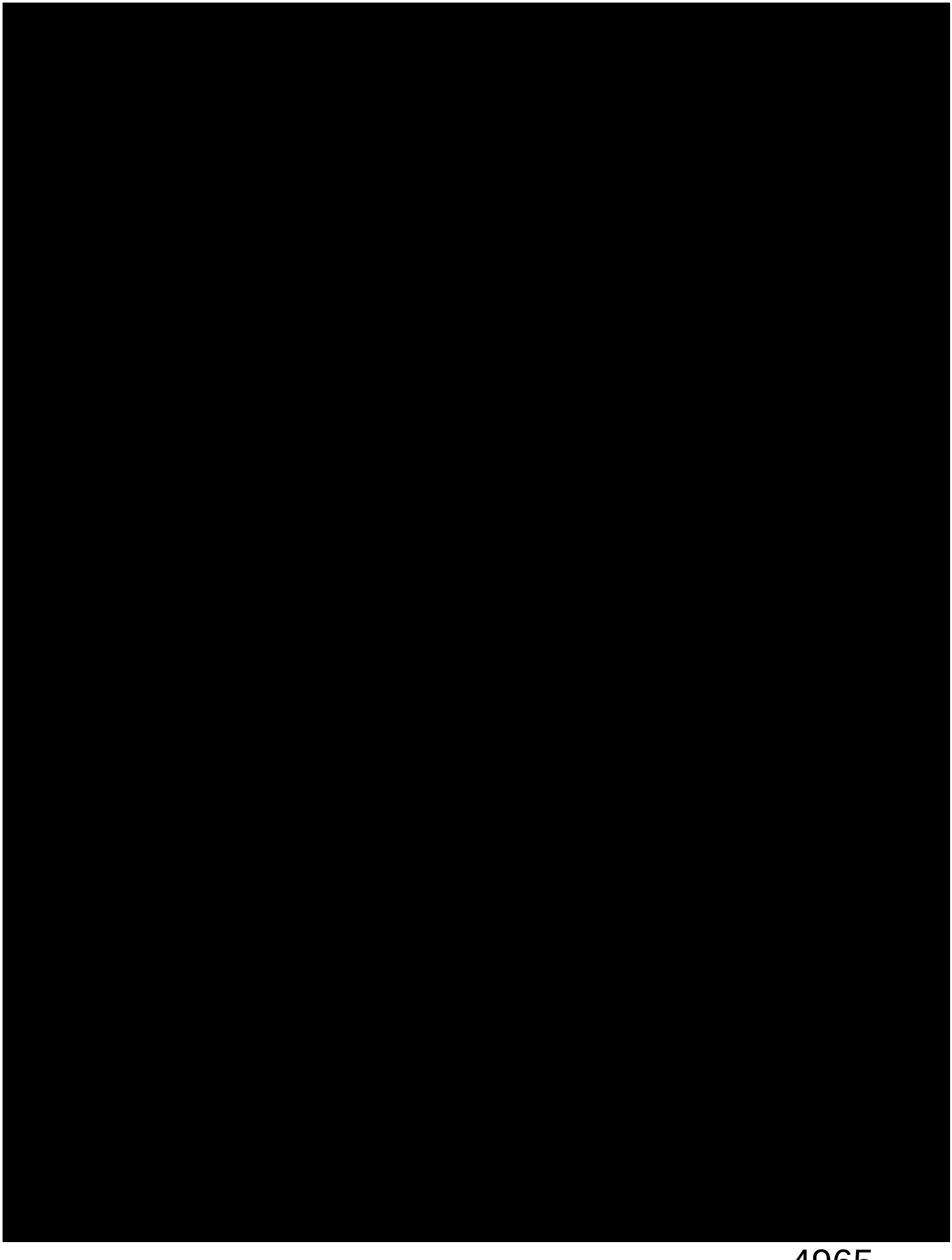


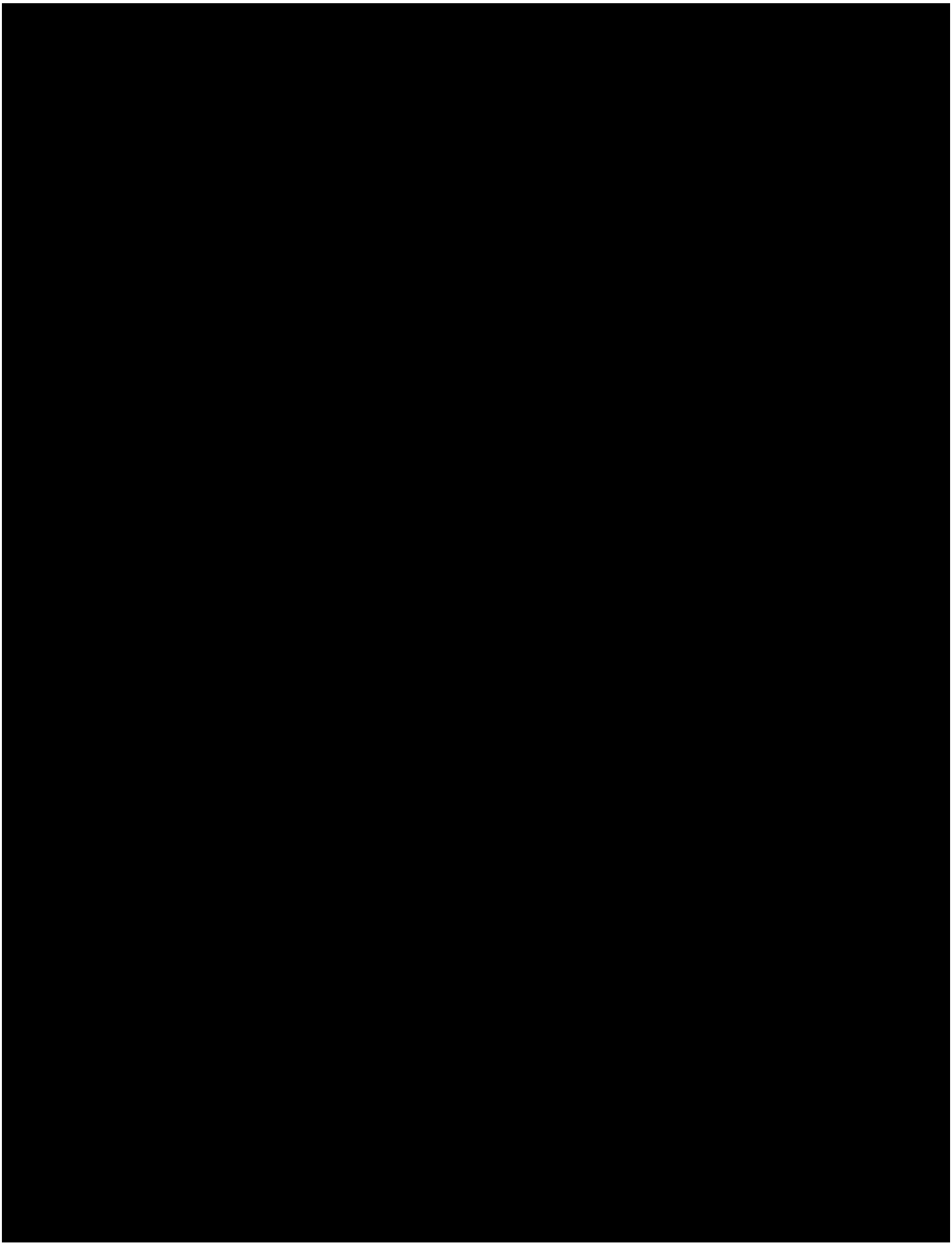












BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, as Special Administrator
of the ESTATE OF DAVID CAINS — CLAIMANT

V. — CLAIM NO. 220374

DEPARTMENT OF HUMAN SERVICES
(BOONEVILLE HUMAN DEVELOPMENT
CENTER) — RESPONDENT

DHS SUMMARY OF JENNIFER BERRY DEPOSITION
(Taken December 6, 2022)

Direct Examination by DHS

Page 6:

Ms. Berry is the Assistant Superintendent at Booneville Human Development Center. Ms. Berry has been the Co-Administrator of the facility since March, 2020. Ms. Berry has been a licensed as a nursing home administrator in Arkansas since February, 2020. There is a state test and national test for licensure, which Ms. Berry passed.

Page 8:

Ms. Berry started working for DHS in January, 1999 and started at Booneville Human Development Center in January of 2008. Booneville Human Development Center is an intermediate care facility for adults with intellectual disabilities. BHDC trains individuals in

- Independent living skills
- Pre-vocational skills, and
- Behavioral management.
- Individuals reside at Booneville Human Development Center.

Page 9:

There are five Human Development Centers in Arkansas, all under DHS, Division of Disabilities Services. BHDC was originally the Arkansas Tuberculosis Sanitorium opened in 1909. In 1973, it switched to a Human Development Center, then called The Children's Colony. It is facility-based care for adults with developmental disabilities.

Page 9:

In Arkansas, there are also other options besides Human Development Centers. Individuals may:

- Reside in their home;
- Receive community waiver services;
- Reside in small ICF-IIDs that are privately owned;
- Live in group homes; and
- Live in nursing facilities.

Page 10:

HDC's are just one option available. Community-based service options were available in 2020 and in the years before 2020. **Admission to BHDC is voluntary. Continued staying at BHDC is voluntary. There are no involuntary commitments at BHDC. Individuals reside at BHDC because someone – family or guardian – wants them to be there.**

Page 11-12:

When an individual applies for HDC services a review team meets to determine if criteria is met for HDC placement. If criteria is met, **each HDC will look to determine if that particular individual would fit in their center**. BHDC requires individuals be ambulatory and services individuals who have a mental illness and intellectual disability. She explained different HDCs cater to a different type of developmentally delayed individual. [1]

Page 12:

BHDC is licensed through the Office of Long Term Care ("OLTC") and is CARF accredited. CARF is a national organization that accredits facilities if the facility meets the CARF standards. In June 2020, BHDC was accredited by CARF.

Page 13:

BHDC has been continuously accredited by CARF since 2014. CARF comes to the facility to inspect.

Page 14

BHDC is regulated by OLTC, the state regulatory body, as an Intermediate Care Facility for Individuals with Intellectual Disabilities. BHDC's OLTC license was last renewed July 1, 2022. It was licensed by OLTC in June of 2020. **BHDC is required to follow CMS guidelines which are federal requirements.** CMS is the Centers for Medicare and Medicaid Services.

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[1] Note for context: As Ms. Berry will explain later, BHDC has a large population of ambulatory dually diagnosed individuals who have both mental illness and intellectual disabilities (IID) with behavioral problems.

Page 15:

As part of the regulations, OLTC must inspect the facility at least once per year. OLTC inspected BHDC in June 2020 *after* David Cains died and **found no regulatory deficiencies. A deficiency is where the facility is found to have done something incorrect.** ***OLTC did not find BHDC did anything incorrect when they came out as a result of David Cains' death.***

Page 16-17:

BHDC's main campus is 1,000 acres. Residents live in dormitory style residences. BHDC has both new and old buildings. BHDC is also in the process of building additional buildings. BHDC also has its own water treatment plant and sewer plant. It is located in Logan County **and employs approximately 250 people.**

Page 17:

State of Arkansas has invested money into BHDC and is committed to BHDC. There is new construction.[2]

Page 18-19:

Ms. Berry identified and described Exhibit 2A as a photo of one of the new living residences and Exhibit 2B as a photo of another new building.

Page 20-21:

Ms. Berry identified and described Exhibit 2C as a photo of the inside of one of training areas in the Stone Building. It is a work area for residents involved in the recycling program. Residents separate recyclable materials, tear books, and use the shredders. It is part of their vocational program. Ms. Berry stated she took the photograph (Ex. 2C) recently but explained the building was "essentially the same" in June of 2020. She testified BHDC also has a "rug program" where the residents make rugs.

Page 22:

BHDC picks up recyclable materials from businesses – paper, boxes, books – brings them to the center. The residents unload materials and separate them. The materials are then shredded and

[2] Note for context: The DRA "reports" referenced in the compliant dwell on the old buildings and suggested BHDC be closed and the funds spent on community services only. The State of Arkansas, however, invested funds into new buildings in order to provide both facility-based options and community-based options to the IID population.

BHDC has a bailer. This is part of the resident's vocational program. The program gives residents purpose to their day and a skill set.

Page 23:

Clients also make rugs out of sock loops. They sort the loops, clean them, dye them, and weave them into rugs. **Clients get paid for their work**.

Page 24-25:

In 2020, David Cains was in the recycling program and was paid for his work. Ms. Berry explained that some clients have a basic understanding of money, and they are taught.

"This is how much you have worked; this is how much you are going to get paid." They have a payday and clients can buy what they want at:

- The BHDC canteen;
- vending machines; or
- go into town to a local business.

It teaches clients how to us money. Clients go into Booneville and Ft. Smith and interact with the community. BHDC took clients to restaurants, pre-covid, and to movies that the residents paid for.

Page 27:

Ms. Berry identified and described Ex. 2D as a photo as a resident work area which, although recently taken, looked substantially the same in June, 2020. She also identified and described Ex. 2E as another photo of a vocational training area building - Hamp Williams Building.

Page 28:

Ms. Berry stated the building is still used but only on the first floor. She explained the Disability Rights Arkansas (DRA) Report of 2015 discussed the Hamp Williams building.

Page 29:

In the 2015 DRA report, DRA depicted a photograph of "trash and debris" in this building. Ms. Berry explained what was classified as "trash and debris" by DRA was "actual rug material to make rugs, the sock loops." She explained that while DRA stated the photo depicted "trash and debris" it really was work material for the vocation. It was on the third floor of the building which was not occupied and was used for storage.

Page 30-31:

The building was used in 2014 and 2015 [the DRA report was in 2015] for vocational training and storage. She did not know why DRA would label resident work materials as "trash and debris."

Page 32:

An RCT is a residential care technician, which is an aide. RCT perform the direct care of clients.

Page 33:

They go thru a three-week phase training – two weeks in classroom, one week on the job training. She explained that RCTs go through a three week training – two weeks in classroom and one week on-the-job training and have sporadic training throughout the year. **All certified in CPR**. There is a medical team on campus. BHDC has medical director, nurse manager, assistant nurse manager RNs and LPNs. It has 15 nurses on campus during 8:00 – 4:00 business hours.

Page 34:

The Medical Center building is The Judge Hill building. The dining hall is in the Commons Building, which has two levels.

Commons Building Photographs

Page 35:

Ms. Berry identified two documents marked as Exhibits 3A and 3B. Exhibit 3A is a layout of the top floor of Commons Building where clients eat lunch. Exhibit B is a layout on the bottom floor.

Page 37:

Ms. Berry described the entry to the building is via a foyer; to the right are stairs to the dining room; to the left are the stairs to the first floor. There is a bathroom at the end of the hallway [upstairs]. The [lobby] bathroom is marked in yellow on Exhibit 3A.

Page 38-39:

In June 2020, there were chairs in lobby area. She marked an "X" on Exhibit 3A where chairs were. She identified and escribed Exhibit 4A as a photograph she took photo several months ago With exception of yellow sign in the photograph, she stated it looks essentially the same as in June 2020. The "half wall" is on the left coming up the stairs; the dining room is on the right. She explained the bathroom is straight down hallway – the two doors on the right past water fountain.

Page 40:

Ms. Berry described Ex. 4B as a photo of the area that goes into the dining room. On the other side of the half wall [looking down] is the foyer when you enter through the main doors. It's a half wall. You can stand [on the second floor] and look down into the foyer.

Exhibit 4B is a photo of the other side of steps.

Page 41-43:

Ms. Berry identified and described Ex. 4C as a photo of the top of the stairs when you come to the front [of the lobby]. She stated you can see the half wall. Ms. Berri identified Ex. 4D as a photo of the main level of the Commons Building. It was recently taken but is basically the same as it was in June, 2020 except for the layout of the chairs. And the TV monitor was not there then. The Canteen store is where residents can buy snacks with the money earned. In June, 2020, there were similar chairs in the lobby.[3]

Page 44:

Ms. Berry identified and described Exhibit 4E as a photo of the stairs going up to the main floor of the Commons. The bathrooms are on the right-hand side. The men's room is the 1st door.[4]

Page 44:

Ms. Berry identified and described Ex. 4F as the common area [lobby] of the main floor.

Page 46-47:

Ms. Berry identified and described Ex. 4G as a photo of bathrooms at end of hallway on main floor. The open door in the photo is the men's room.

Page 47-48:

Ms. Berry identified and described Exhibit 4H which shows the half wall in the lobby of the top floor of the Commons Building. The layout has not been changed since June, 2020.[5]

Page 48-49:

Ms. Berry identified and described Exhibit 4I as a photo of the Commons Building foyer looking up the stairs and the half wall by the dining room. Aside from cone, the area is the same in photo as in June 2020. The doors at top go into dining room.

Distance from Nurses Station to Commons Building

Page 49:

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[3] Note for context: This is the area where Mr. Cains was seated just before his behavioral episode.

[4] Note for context: This is the bathroom used by Mr. Cains just prior to the behavioral episode.

[5] Note for context: This half wall is the "ledge" which Mr. Mattson identified in his deposition where he stated he could not just use a blocking technique because "**I wouldn't have had room. I was against a ledge**. *See* Mattson depo. p. 105; Mattson summary, p. 14.

Ms. Berry testified that **the distance from the Judge Hill Building nurses' station to Commons Building is 932 feet**. She had the maintenance department measure the distance.

BHDC Population – Majority Dually Diagnosed

Page 49-50:

Ms. Berry testified that the BHDC "population is majority dually diagnosed" which means they have both an intellectual disability and a mental illness such as schizophrenia, bi-polar, depression, anxiety, ADHD, and behavior problems. **The BHDC admits dually diagnosed persons with "the most severe behavior outbursts."** BHDC has a higher population of individuals with behavior problems [than the other HDCs]. **A lot of BHDC clients came from ASH [Arkansas State Hospital], jail, and other inpatient facilities.** They are funneled to BHDC.[6]

Page 51:

She testified BHDC also accepts transfers from other Arkansas HDCs because "they can't behaviorally manage them at their particular center." The dually diagnosed population at BHDC is currently 96 percent. In June, 2020, it was "probably between 90 and 94" percent. That is the way was at BHDC in 2014 through 2020.

Page 52, Line 13:

Ms. Berry testified "our population is different." As BHDC has a higher population of behavioral residents than other Arkansas HDCs.

Individual Program Plan (IPP)

Page 53:

Ms. Berry stated she is familiar with Individual Program Plans also called "IPPs." An IPP is the program for the year which addresses every need a client has in that year from medical to psychological, pre-vocational, independent living and lists social history. It is developed by the program coordinator.

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[6] Note for context: As BHDC has a higher population of residents with dual diagnoses of intellectual disability and mental illness, who are ambulatory with behavioral problems, it has higher instances of restraint use than other Arkansas HDCs who do not have as many dually diagnosed ambulatory residents with behavior problems.

Page 55:

Ms. Berry identified Mr. Cains IPP, dated July 18, 2019, as DHS Exhibit 5. This was Mr. Cains last IPP and was the one in effect when he died. She stated the next IPP would have been reviewed on July 17, 2020. They are completed every 365 days.

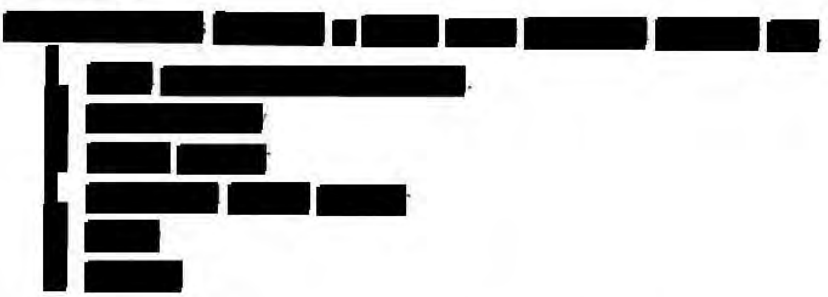
Page 56:

It is created by an "interdisciplinary team" whose core members included, among others, the Mr. Cains' guardian, Charlene Robinson., who signed the IPP.

Page 57:

Ms. Berry testified that the IPP was also signed by "Chrissie Cains." [7] They directly participated in the development of the IPP. On page 3 of the IPP [Ex. 5, Bates # 1457] it identifies all those who participated in the review.

Page 58-59:



She explained the IPP also identified that David Cains has history of behavior of physical aggression, noncompliance, destroying of personal belongings, which included TVs, radios, DVD player, and, among other things, breaking windows. She explained that the IPP, Bates p. 1465, implemented "planned restrictions" for health and safety which included having his TV secured in a plexiglass box mounted to wall and a shatter proof mirror in his bedroom.

Page 60-61:

Ms. Berry testified when the term "physical aggression" is used in Mr. Cains' IPP, which it defines to mean "striking, hitting, kicking other people or objects with the intent to cause injury or

[7] Note for context: Chrissie Cains is the Claimant, Christine Cains McAuliffe.

damage." It is under the heading, on Bates p. 1469, of "Primary symptoms to be monitored." **The IPP states that Mr. Cains has a "demonstrated history of physical aggression."** [8]

She explained that on Bates page 1469 of the IPP, Mr. Cains' [redacted] and directs that in the event of his aggression or symptoms which interfere with anything, staff can "employ the category one procedures, which is part of DDS' 3011-D policy" "[a]nd other center emergency procedures if necessary to protect client or others."

Page 62-63:

Ms. Berry identified **DHS Exhibit 6** which is the **DDS Policy 3011-D** which was in effect in June, 2020. Policy 3011-D states "This policy is intended to provide guidelines managing challenging behaviors of individuals residing in DDS operated programs."

Page 63, Lines 15-24:

In response to a question, Ms. Berry read a portion of **Policy 3011-D** which states:

- "Nothing in this policy prohibits the use of emergency restraint (mechanical or personal) ... for the purpose of protecting the individual and others around him/her."
- 'This includes the use of restraint procedures in the course of an established program when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy."
- The emergency use of restraint must conform to ICF/MR [now IID] regulations."

Page 64:

Ms. Berry testified that "personal" in 3011-D means an emergency personal hold.

Page 67:

The IPP identified Mr. Cains' symptoms as noncompliance and physical aggression.

Page 68:

The treatment team on page 10 of the IPP, Bates p. 1471, stated "**The team agreed that David's Behavior Treatment Program is appropriate and recommended no revisions." Mrs.**

[8] Note for context. Mr. Cains 2019 IPP defines "physical aggression" as "the attempted or actual striking, hitting, or kicking other people or objects with the intent to cause injury or damage." *See* IPP, p. 9.

Robinson, David Cains' legal guardian and mother, was on the treatment team and agreed to the treatment terms.

David Cains' Behavior Reports:

Page 69-71:

Ms. Berry identified **Exhibit 8A** as a 12/26/19 behavior report, Bates pp. 541-542, documenting Mr. Cains' maladaptive behaviors. The report states that Mrs. Robinson was visiting with Mr. Cains at BHDC when staff heard a loud commotion in the kitchen and Mr. Cains had "**hit his mom and flipped the kitchen table."** David Cains shouted and called her a "F" ing bitch. Mrs. Robinson then left the facility. .

Page 72:

Ms. Berry identified **Exhibit 8B,** p. 551, as a 12/18/19 behavior report where Mr. Cains pushed over an outside table, picked up a Christmas ornament, threw across the room almost hitting another resident. He was put into a personal hold for two minutes.

Ms. Berry described the following behavior incidents/ reports:

Page 74:

- 12/18/19 Mr. Cains spit and hit staff - Bates p. 554;
- 12/02/19 Mr. Cains threw an object at staff – Bates p. 564-565;
- 11/21/19 Mr. Cains jumped up and flipped over a table - Bates 566-567

Page 75:

- 11/16/29 Mr. Cains attempted to bite himself - Bates 570-571
- 11/02/19 Mr. Cains picked up a table and threw it at staff – Bates 578-579
- 10/31/19 Mr. Cains was on the BHDC bus and tried to hit another resident and then slapped staff – Bates 580-581

Page 76:

- 10/31/19 Mr. Cains screamed and bite his arm, - Bates 582-583
- 10/15/19 Mr. Cains spit and threw items at staff, hit and kicked staff – Bates 584-591

Page 77:

- 10/15/19 Mr. Cains tried to hit staff -Bates 592
- 08/08/19 Mr. Cains stood up on the BHDC van, hit staff, banged on van window, bit staff - Bates 604-605

Page 78:

- 05/20/19 Mr. Cains grabbed a fire extinguisher and threw it at the wall in the kitchen - Bates 2613

Page 79:

- 04/18/19 Mr. Cains threw fire extinguisher at a resident and then threw it at staff – Bates 618-619

Page 80:

- 04/12/19 Mr. Cains picked up a glass and threw it at staff. – Bates 628

Page 81:

- 04/06/19 Mr. Cains threw his juice at staff and threw a plate – Bates 636-637
- 04/08/19 Mr. Cains tried to hit another resident – Bates 636-637

Page 82:

- 03/15/19 Mr. Cains grabbed a fire extinguisher and threw it – Bates 665-666

Page 83:

- Bates 669-670 Mr. Cains attempted to hit another resident.
- 03/4/19 Mr. Cains threw a fire extinguisher at staff – Bates 679-680.
- 02/27/19 Mr. Cains *ripped thermostat off wall and hit staff* - Bates 705-706

Page 84:

- 01/14/19 Mr. Cains took a picture off wall and threw it at staff, *shattering the glass* – Bates 730-731.

**** All these 2019 reports were collectively marked as Exhibit 8B. (Page 84)**

***** Page 85: Counsel stipulated to the 2020 behavior reports as DHS Exhibit 9.**

Additional Testimony on IPP

Page 85-86:

Ms. Berry testified [redacted]

Page 86-87:

She explained on Bates page 1483, the IPP identified [redacted]

Page 88:

P. 1497 says "Living Area Service objectives" [redacted]

Page 89:

She stated that, on Bates p. 1501, the IPP identified that Mr. Cains was on [redacted]

Staffing Levels at BHDC in June 2020

Page 90-91:

Ms. Berry explained that BHDC is regulated by state and has certain staffing requirements. She identified Exhibit 10 as the ICF regulations. These ICF regulations mandate the minimum staffing levels for direct care staff at the facility. Section W187 of Exhibit 10, is where the regulations are for direct care staff. ICF means Intermediate Care Facility.[10]

Page 92:

> **Q: And so, at any time in June of 2020 did the Boonville Human Development Center fall below the staffing levels required by the State of Arkansas**
> **A: We did not.**

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[9] Note for context: Dr. Hamid, Mr. Cains physician, testified that Mr. Cains had such precautions *only* because he had a [redacted] *See* Hamid depo. p. pp. 15-17; Hamid depo. summary, pp. 2-3.

[10] Note for context: BHDC is an intermediate care facility for individuals with intellectual disabilities.

Ms. Berry stated that the incident involving David Cains happened in the Commons Building not in the dorm. And there were at least 3 direct care aides nearby, with others in the dining room.

Page 93:

There was plenty of direct care staff nearby.

> **Q: And so, at that point in time, in that location did DHS --- or any location, did Booneville Human Development Center fall below the state required minimum staffing levels?**
> **A: We did not.**

Ms. Berry the identified **DHS Exhibit 11** and stated the document shows the staffing ratios for residential areas for the period of June 1, 2020 through June 13, 2020.

Page 94:

Ms. Berry explained there are different requirements for different shifts. On June 13, 2020, the required ratios for the midnight to 8:00 a.m. shift was one staff per 16 residents. The daily census that day was 123 residents and BHDC had 25 direct care staff present.

Page 95:

Ms. Berry said the 8:00 to 4:00 shift and the 4:00 to 12:00 shift require the most staff. **On June 13, 2020, on the 8:00 a.m. to 4:00 p.m., BHDC had 29 direct care staff. The requirement is one staff for eight residents.**

> **Q**: So, you were over the limit?
> **A:** We were.
> Q: So you did not have any --- you did not fall short – you were not short staffed that day?
> **A**: We were not. [11]

We did this for the whole 13 days of June of 2020. Facility-wide, BHDC did not fall below the minimum staffing levels for any shift during that time period.

Page 96:

[11] Note for context: Mr. Cains' behavior episode and the emergency response in the lobby occurred during this shift.

Ms. Berry identified **DHS Exhibit 12** which are the staffing levels for Davidson House from June 1, 2020 - June 13, 2020. The top says 2022 but that is a typo. These are the staffing levels for 2020. Ms. Berry prepared this document.

Page 97:

Ms. Berry said the difference between Exhibit Number 12 and Exhibit 11 is that Exhibit 12 is specific to Davison House whereas Exhibit 11 is facility-wide levels. Davison House is where David Cains lived. The different categories are the different living areas within the Davidson House building.

Page 97-98:

> **Q:** So, what were the staffing levels – what was the census of that house that day on June 13th, 2020?
> **A:** The census was – we only—well, for the 12:00 to 8:00 shift for Davidson House Blue, if we are looking at that specifically, that was the area that David lived in, was we had ten clients in that area, we had two staff, **so we were more than covered under the ratio from one [staff] to 16 [residents].**
> **Q:** So, just so I understand, you say one to 16. **So, that's one staff per 16 individuals?**
> **A; Correct.**
> **Q: And you had ten [residents]"**
> **A: We had ten [residents], and we had two staff per 10.**
> **Q: So, the, you had well more than –**
> **A: Yes. We were one to five actually.**

She explained that it also breaks it down for the other shifts. Blue is on - - blue and green are on the first floor, and then orange and yellow are on the second floor. BHDC met the minimum staffing levels even for the other areas.

Page 98-99

She stated from June 1, 2020 through June 13, 2020, in Davidson House, BHDC met or exceeded all minimum staffing levels.

State Office of Long Term Care Survey Inspection of BHDC – June 2020

Page 99:

Ms. Berry identified DHS Exhibit 13 as the CMS 2567 form from the State Office of Long Term Care for the survey [inspection] of BHDC, dated 06/30/2020. She recognized the 2567 form.

Page 100-102

Ms. Berry explained that it has various complaints. One of them was about David Cains. When the surveyors came to visit the facility on June 30, 2020, as part of their investigation. She stated she recognized this 2567 from being from that investigation. The complaints investigated were found to be "unsubstantiated" by state regulators. **Unsubstantiated means the regulators found no fault at the facility. Booneville was found *not* to be deficient.** [12] *She confirmed that OLTC actually came out to the facility to investigate the complaints.*

Ms. Berry stated she is familiar with the Disability Rights Arkansas report on Mr. Cains conducted by Kris Stewart. **Ms. Stewart did not come to the facility to inspect it.** [13]

BHDC Experience with Logan County EMS Response Times

Page 103:

Ms. Berry has been at the Booneville Human Development Center for 15 years. She is familiar with the response times of the Logan County EMS system. She testified there have been incidents where a call to 9-1-1 had to be implemented.

Page 104:

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[12] Note for context: The OLTC surveyor who conducted the investigation was Dian Elliott. Ms. Elliott explained the survey was conducted on behalf of the Centers for Medicare and Medicaid Services applying applicable federal ICF/IID regulations and the CMS State Operations Manual – Appendix J. *See* Elliott depo., p.7-8. Ms. Elliot testified two of the three complaints identified on the Form 2567 involved David Cains death. She testified the complaints of failed facility practices were "unsubstantiated" which means there were deficiencies found and the facility was in compliance with the federal regulations investigated. *See* Elliott depo. p. 12.

[13] Note for context: Kris Stewart of Disability Rights Arkansas issued a "report" which reflects the opinions of her employer about facility-based services. **DRA is an non-profit advocacy group. It is neither a state nor federal regulator of ICF/IIDs. The report, selective in its facts, is NOT based on any violation of ICF/IID regulation or any CMS guidance.** Interestingly, though the report opines on a possible direct or indirect cause of death, Ms. Stewart testified she is not physician and does not have medical training to determine cause of death.

Ms. Berry stated the few ambulances in the county cover the entire county of Logan County. If it's on the other side of the county, it may take a while for them to get to us. BHDC had an incident where it took 45 minutes for the ambulance to arrive after being called and a second emergency where it took an hour for EMS to arrive. She explained that we have been told when we called the 9-1-1 that they had to get an ambulance from another county because the Logan County units were out.

Q: But you have a medical team of nurses; correct?
A; We do.
Q: And so, are they able to respond to many of these [emergency] instances?
A: They are.
Q: And about how long does it take to for them to respond?
A: A couple of minutes. BHDC has a medical team of nurses. It takes the BHDC medical team just a couple of minutes to arrive.

Nonviolent Crisis Intervention Course – "NCI" "CPI"

Page 105:

Ms. Berry stated NCI stands for Nonviolent Crisis Intervention. It's a **de-escalation program** where our staff are **taught how to de-escalate behaviors**. And then, it **also entails doing certain personal holds to kind of de-escalate a situation**.

Q: And so, is that [NCI] the only protocols or policy that Booneville Human Development Center implemented for behavior modification or management for residents in June of 2020?
A: No.

Page 106-107:

Ms. Berry stated BHDC uses mechanical restraint; a papoose board. It's a board that lays on the ground that is cushioned, and there are straps that go around their legs. It's to ensure the health and safety of individuals.

Q: So, are restraints used for therapeutic purposes?
A: No.
Q: Are they used for disciplinary purposes?
A: No.

CPI is Crisis Prevention Institute. That's the organization that developed NCI. NCI is a program. CPI has other programs that teach more, they have an advanced NCI. In 2020, Booneville Human Development Center didn't buy those protocols. **A personal hold is where an employee has their hands on the individual to calm them.**

Page 108:

Ms. Berry testified **personal holds are to prevent residents from harming themselves and others**. It is also referred to as an alternate hold or a restraint. **The purpose is the health and safety of the individual and the individuals around them.** [14]

Early chemical intervention is where it is identified by the medical staff that this person would benefit from having [redacted] as their behaviors start to increase. It is administered only before the behavior gets violent. If we get them an early chemical intervention, then that client's behaviors will not escalate.

Page 109:

Ms. Berry said there is the maltreatment investigation and sometimes they have admin reviews. An admin review is where there is a situation that is presented to us, and we look further into it to determine if we need to expand upon it and make it a full-fledged investigation. Ms. Berry said [redacted]

Page 110:

Ms. Berry said the difference between a review and an investigation is if it is reportable or not. Only certain things are reportable.

Page 110-111:

Ms. Berry stated the behavior incidents that were from 2019 and 2020 were just certain ones.

Page 111:

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[14] Note for context: Although Claimant's restraint prevention expert, Dr. LeBel, testified that she is the interagency lead on restraint prevention for the state of Massachusetts Department of Health (Lebel depo. pp. 5-6), and widely lectures on the "six core strategies" curriculum which she developed addressing restraint prevention (and from which she receives compensation for her lectures), ***Dr. Lebel conceded, on cross-examination, that the state-run HDCs in her home state of Massachusetts utilize restraints on IID residents***. *See* LeBel depo. p. 119-120.

Ms. Berry stated there are a lot more behavior incidents.

Cross Examination by Claimant

Page 115:

She agreed that Mr. Cains and the other residents of the BHDC are there voluntarily. They or their loved ones choose for them to be there. They can removed them at any time.

Page 116:

Ms. Berry stated the facility has to comply with federal ICF regulations. She agreed the facility has to follow the DDS policies.

Page 117:

Exhibit 13 is the OLTC report that was generated as a result of Mr. Cains' death. Ms. Berry stated those were the findings.

Page 118:

Ms. Berry said Ms. Evans did the maltreatment investigation and then she generated what is called a maltreatment Investigative Report. They are sent to OLTC. OLTC is not a part of DDS. OLTC reviews the investigation and then conduct *their own investigation*. This is when they came on campus.[15]

Page 119:

Ms. Berry stated OLTC conducted this investigation just within weeks of the death.

Page 121-122:

Ms. Berry stated an OLTC came out to the campus and did the groundwork at the facility. Diane was her name. The surveyor was at BHDC on June 30, 2020.

Page 123:

Ms. Berry stated the surveyor did not complete her investigation on the same day.

Page 129:

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[15] Note for context: The OLTC survey is a type of OLTC investigation and is *independent* from the BHDC internal maltreatment investigation submitted to OLTC. As stated, OLTC performs its own investigation in order to determine if the facility was in compliance with applicable federal ICF/IID regulations and the CMS State Operations Manual – Appendix J. As reflected on the Form 2567, the complaint investigations were determined to be "unsubstantiated" and BHDC was found to be in compliance with the applicable federal regulations investigated.

Ms. Berry stated she has personal knowledge of Mr. Cains' behavioral incidents. She said they had daily meetings at BHDC and reviewed all the Behavior Reports and incidents that took place at the BHDC. They were done daily.

Page 130:

Ms. Berry stated she was present for the meetings, or the Superintendent was present.

Page 131:

Ms. Berry agreed that personal restraints or personal holds can only be used at Booneville in emergency situations. Emergency use of restraints must also conform to ICF and Policy 3011-D regulation and be for health and safety.

Page 132:

Ms. Berry explained anyone can call 9-1-1. There is a policy that said that they needed to call 1422 first, but that they can call 911.[16]

Page 133-134:

Ms. Berry was asked by Counsel for Claimant to read portions of Policy IV-B-1. She read: "A call to the Medical Department should be made. This should be the first call so that Medical staff can respond immediately to the situation. A call to Medical at 1422 should be made and the following information should be given… Number three, Medical will assess the situation and call an ambulance if appropriate. The document was introduced as Claimant's Ex. 1.

Page 134:

Ms. Berry stated they don't prohibit people from calling 9-1-1. We preferred that they call 1422 so our medical staff would assess the situation because EMS takes a while to get to our facility.[17]

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[16] Note for context: A call to 1422 is a call to the nurses' station for assistance.

[17] Note for context: Although the direct care team called the nurses first, the BHDC nurses arrived and rendered emergency assistance *within two minutes* and the call to 9-1-1 was made *upon their arrival in the lobby*. Unfortunately, it took **EMS** 13 minutes ***after*** the 9-1-1 call to arrive and then another nine (9) minutes to partially clear Mr. Cains' airway = 22 minutes.

Dr. Brown-Forestiere, Claimant's medical expert, testified death ensues within about 5 minutes. Even if 9-1-1 was called first (two minutes earlier), the outcome would have been the same as [redacted]

Page 136:

Ms. Berry stated they had a policy in place for them to call 1422. But nothing that says - - that forbid them from calling 911. Ms. Berry guessed they were following what they believed the policy said.

Page 140:

Ms. Berry stated Mark Hise does the CPR certification for Booneville. It is through the American Heart Association. Ms. Berry stated she did not mark out page 2 on page 1525 of Exhibit Five, which is the 2019 IPP. She does not know who did.

Page 140-141:

**** At this point there is an objection and an lengthy discussion which is in the transcript but not included in this summary.**

Mr. Rosen: I'm going to let her answer the question, but I'm going to make the objection that that's your view of something.

Page 144:

Ms. Berry stated "[t]his is part of the Annual Pharmacy Report. So, that's why there is only one page, because this first page shows all the medications." She testified "the Annual Pharmacy Report only reviews the medications."[18]

Page 145:

> **Ms. Berry**: It is just for the medication (indicating).
> **Mr. Gillispie**: I see that.

Ms. Berry stated [redacted]

Page 146-147 :

[18] Note for context: Whatever page of a document to which counsel for the claimant was referring, as explained, was as not part of the medication record and, per Ms. Berry, was therefore not included in the 2019 IPP Pharmacy Report Section.

Ms. Berry stated go to [Bates p.] 1497 and it says [redacted]

Ms. Berry was then shown a document by Counsel for Claimant – Claimant's Exhibit Two, Bates marked 1327. Counsel asked:

[redacted]

Page 150:

Ms. Berry then stated, in response to a question as to why the second page of the Physician's Order is not in the IPP we have been talking about?" sated because the order is in the IPP. It is under the Annual Medical Review, Staffing Reports," starting on p. 1501.[20]

Page 151:

Ms. Berry said it is page 1501. She agreed it was under number six, [redacted]

[19] Note for context: As explained in the transcript, the document, Claimant's Exhibit 2, was NOT part of the 2019 IPP as counsel insinuated. It was not even printed until June 15, 2020, two days after Mr. Cains died. Of note, it is unsigned by the doctor.

[20] Note for context: For clarification, Counsel for Claimant is now referring to a different document than the one printed June 15, 2020.

Redirect Examination by DHS

Page 152:

Ms. Berry said on 1497 is says, [redacted]

Page 153:

The behavior reports are in David Cains' master file maintained at BHDC. Those reports were pulled from the file maintained.

Page 155:

Ms. Berry stated the reports on in the master file records. They are kept in the regular course of providing services for Mr. Cains in the business of the HDC. They were recorded at or near the time of the incidents indicated. Those are the records she pulled out of the file. Those are his records.

OLTC Investigations

Page 156:

Referring to the Form 2567 [DHS Ex. 13] Ms. Berry stated that is the Office of Long Term Care survey. At the top of the form, it is called "Department of Health and Human Services, Centers for Medicaid and Medicare Services." That is the federal government. This is a federal government form - Form CMS 2567. This is filled out by the surveyors who are checking to see that we are following all the rules and regulations set forth. The survey is to look at the facility practices.

Page 156-157:

It is to see whether the facility practices conform with the CMS standards.

Page 157-158:

Ms. Berry stated **the survey is different from a the OLTC maltreatment investigation**. She explained that the HDC submits its maltreatment investigation report to OLTC and OLTC has their own investigators. That investigation is different for the survey investigation.

Q: So, one is a maltreatment investigation, one is a deficiency or standards investigation.
A: Correct.
Q: What is this Exhibit 13.
A: Deficiencies.

Ms. Berry explained the OLTC maltreatment investigation is when the HDC submits the report to the Office of Long Term Care, and they have their own investigators that reach out to obtain different information. It is different from the surveyors. **There are two different investigations by Long Term Care.** One determines if the person actually needs to be put on the Maltreatment Registry or not; the other is whether the facility was deficient. The maltreatment investigation. is about the individuals involved. [21]

Respectfully Submitted,

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[21] Note for context: These two OLTC investigations are in addition to the internal investigation conducted by Sandy Evans at the BHDC.

BEFORE THE ARKANSAS STATE CLAIMS COMMISION

CHRISTINE MCAULIFFE, as Special Administrator of the Estate of DAVID CAINS — CLAIMANT

VS. CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

DHS' Summary of the Direct Examination Deposition Testimony of
Theodore Kastner, M.D., M.S.
(Taken on January 19, 2023)

Direct Examination by DHS

Medical Credentials

Page 7:

Dr. Kastner has a Bachelor of Arts from Colgate University, a Doctor of Medicine from the University of Connecticut and a master's degree from the University of Wisconsin. He received his Doctor of Medicine in 1981. His master's degree is in population health in general. It was content from both the medical school and the business school, so the MPH side would be population health, the MDA side would be management.

Page 8:

The degree was awarded by the school of medicine at the University of Wisconsin. Dr. Kastner completed an internship and residency in pediatrics at the Bronx Municipal Hospital Center, between 1981 and 1984. He completed a fellowship in the care of children and adults with developmental disabilities and related conditions at the Rose F. Kennedy Center of the Albert Einstein College of Medicine, between 1984 and 1986. The last two years are additional years of specialty training in developmental medicine. He has been licensed in New Jersey, Arkansas and New York; currently licensed in New York only.

Page 9:

Dr. Kastner has been licensed as a physician continuously since the initial date of his licensure. He is board certified in four areas of specialty:

- Pediatrics
- Developmental and Behavioral Pediatrics
- Neurodevelopmental Disabilities
- Medical Management.

The board certification signifies that an individual has completed a course of work and subsequently passed an examination thereby certifying that they have met a certain standard in terms of their ability to practice as a specialist in that field.

Page 10- 11:

Dr. Kastner said the examination is a national board examination. Board certification is done by national boards in that subject area. Dr. Kastner is a **board-certified pediatrician**. He is also **board certified in developmental behavior pediatrics,** which is a field of study related to the general development of children and the general management of behavioral disorders.

Page 11:

Dr. Kastner also has a board certification from a national board in **neurodevelopmental disabilities. That is a board that is related primarily to the evaluation and diagnosis and treatment of conditions that arise from the development and functioning of the brain and spinal cord, includes genetic, a variety of other topics. It is more neurology psychiatry based. It relates to disabilities more broadly rather than simply cognitive. It includes individuals with intellectual disabilities**.

Page 12:

Dr. Kastner's fourth area is **medical management. The general administrative and management activities related to the practice of medicine.** The curriculum has aspects of public health, epidemiology, statistics, finance and budgeting, marketing, strategic planning, data analytics and semantics.

Page 13:

Dr. Kastner initially began working in the field with people with intellectual and developmental disabilities in 1976. It was his summer job between his junior and senior year in college. He has been on the faculty of at least three (3) medical schools. Columbia University, the University of Medicine and Dentistry of New Jersey, and the Alert Einstein College of Medicine. Recently, he was **a full professor in both the departments of pediatrics and psychiatry at the Albert Einstein College of Medicine.**

Page 14:

Dr. Kastner explained there is an academic ladder which begins with an appointment as an instructor. He said Dr. LeBel, for example, is an instructor in a medical school, and that would be the *very entry level*. There is the assistant level, then there is the associate level, and then there is the unqualified professor level.

Page 15-16:

Generally, a medical school wants to see accomplishments in three broad areas that would include service, teaching and research to be appointed at a professor level.

Dr. Kastner has **published more than 100 manuscripts**, of which 70 were peer reviewed. Peer review is really the critical element in looking at an individual's qualifications for academic appointment. In a peer review, the reviewers don't simply offer an opinion; they make a determination as to whether or not the journal should accept and publish a manuscript.

Page 17:

The Ruth L. Gottesman chair in developmental medicine is a medical school endowed chair created by funding from benefactors. Those chairs are highly prestigious and coveted. While at Albert Einstein School of Medicine. Dr. Kastner held an endowed chair, meaning that the benefactor in this case, Ruth Gottesman, had donated funding specifically to support the individual that held the chair. It is quite an honor.

Commissioner of New York State Office For People With Developmental Disabilities

Page 18:

In 2019, Dr. Kastner became the Commissioner of the New York State Office for people with developmental disabilities. The office is a part of State government. It is effectively an independent department within the State of New York and operates at the cabinet level. The scope of his work in that area was to operate a $10 billion system that supported 121,000 people with intellectual and developmental disabilities with a staff of 19,000. The office he headed delivered services, operated about a thousand group homes, several hundred-day programs, and 40 or 50 clinics, in addition to funding 400 or 500 service providers that delivered services across the State of New York.

Page 19:

Dr. Kastner's job was to oversee the operation of that department. He stated "effectively I was the CEO." It would be equivalent to a Secretary [level appointment in Arkansas]. Dr. Kastner was the **head of a $10 billion state agency that provided services to the developmentally disabled and the intellectually disabled.**

Additional Credentials

Page 20-21:

Dr. Kastner testified his publications, his peer reviewed publications. and his other publications included areas of research and medicine that addressed or opined on the care and treatment of individuals with intellectual disabilities and persons with developmental disabilities. Almost his entire publication record is focused on people with developmental disabilities.

Dr. Kastner explained he also wrote abstracts which are usually presented at a scientific meeting. It like an introduction or an overview of a project.

Page 22-23:

Dr. Kastner has also been a guest speaker or lecturer and has presented at many conferences which are listed on his C.V. He stated his list of grants received for his work are on his C.V. Dr. Kastner's C.V. was introduced as **DHS Exhibit 1.** Counsel for Claimant stated he had "[n]o objection."

Primary Care Provider for People with Intellectual & Developmental Disabilities

Page 24:

Dr. Kastner explained that the Developmental Disabilities Help Alliance, Inc., was effectively Dr. Kastner's medical practice. It was an organization he created in 1996, which eventually operated nine primary care locations across New Jersey and New York state. It had a staff of approximately 70 and provided healthcare, mental health and neurology services to about 4,000 people with intellectual and developmental disabilities.

Page 25-26:

In 2019, he was a primary care provider for people with developmental disabilities and a specialty care provider that provided both mental health and neurological services to people with developmental disabilities.

Based upon his medical training, degrees and certifications, his running the State office, being a direct care provider during college, and as a clinician, he is quite familiar with the intellectual disability and developmental disability population

Dr. Kastner has ***qualified as an expert in the field of developmental disabilities and intellectual disabilities*** in federal courts***. He was recognized as an expert in an Arkansas federal court.***

Page 27:

Dr. Kastner explained that the ICF/IDD is a unique care setting in which individuals receive a range of habilitative services, which is different from rehabilitative services.[1]

Page 28:

Habilitation is to be contrasted with rehabilitation. Habitation is the practice of helping individuals gain and acquire new skills versus rehabilitation, which is to help individuals relearn previously gained skills.

Page 29:

Dr. Kastner is familiar with the Booneville Human Development Center. It is an ICF/IID. He has been to the Booneville Human Development Center.

Page 30:

In the DD field, "dual diagnosis" refers to people who have a developmental or intellectual disability, and a co-occurring mental illness. He is generally familiar with the restraint used at Booneville Human Development Center in 2020. He is quite familiar with the facility in terms of

[1] Note for context: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) are also referred to ICF/IDDs. They are one and the same.

having reviewed the policies and procedures and practices. He is familiar with the [CMS] State Operations Manual with regard to ICF/IID.

Page 30-31:

Dr. Kastner explained that the Centers for Medicare and Medicaid Services [CMS] is the primary regulator for the Medicaid and Medicare programs, especially for the ICF/IDD program. They promulgate rules and regulations for the operation of an ICF/IDD, and they also created a manual to assist surveyors in assessing whether or not the state complies with those rules and regulations. The CMS manual is referred to as Appendix "J" of the [CMS] State Operations Manual. Appendix "J" focuses solely on the ICF/IDD program.

Page 32:

Appendix "J" covers, among other things, the CMS guidelines and regulations on restraint use in ICF/IIDs.

Page 33:

Appendix "J" is the test that you have to pass in order for a facility to retain its certification to operate as an ICF/IDD. Specific questions are asked by the surveyor when onsite in order to determine whether or not the facility is in compliance with the rules and regulations. **A survey is an inspection for compliance with the rules and regulations promulgated by CMS for the operation of an ICF/IDD found within the CFR [Code of Federal Regulations] – it is called Appendix "J". When a surveyor comes to the facility to inspect or regulate an ICF/IID, such as a human development center, they are going to look to see if the facility complied with the regulations in the State Operations Manual, specifically Section "J".**

Page 34:

- Appendix "J" is the interpretive guidelines used by surveyors to ascertain whether or not a facility complies with relevant rules and regulations promulgated by CMS.
- If no deficiencies were found, that signifies that overall, the facility is in compliance with relevant rules and regulations promulgated by CMS and can maintain its certification and funding by the federal government.

Page 34-35:

Dr. Kastner considers himself a expert due to his clinical care for persons with intellectual disabilities and developmental disabilities, teaching medicine [full professor], four board certifications including specialty board certification in developmental behavioral pediatrics and neurodevelopmental disabilities. Courts have treated him as an expert in those fields.

Dr. Kastner reviewed documents and records including various reports pertaining to David Cains, his individual program plans, which are called IPPs.

Page 36:

Dr. Kastner has done two reports on this case. The reports were bifurcated because he received the material regarding Dr. LeBel *after* completing his initial review. The initial report was dated January 5, 2023, and is marked as DHS Exhibit 2A. The January 6, 2023, report is marked DHS as Exhibit 2B. [2]

Page 37:

> **Mr. Rosen**: Okay. We are going to introduce those reports as DHS Exhibit 2A and 2B. Is there any objection?

[2] Note for context: As noted in the transcripts on page 30, the reason Dr. Kastner's reports were bifurcated is that Claimant did not provide DHS with Dr. LeBel's report until late December. Dr. Lebel's report, itself, is dated December 28, 2022. Although Counsel for Claimant was unwilling to stipulate to the approximate date Dr. Lebel's report was provided to DHS without reviewing the email, he did state: "But I don't disagree that that's generally accurate."

Mr. Green: No Objection.

Page 38-41:

Dr. Kastner stated there is a specific *typographical* error which appeared on *page five* of his January 6, 2023 report, which is the second (of the two reports). It is *opinion 20 on page five* of Exhibit 2B which is the January 6th, 2023 report:

[redacted]

Page 42-44:

DHS Exhibits 2A, 2B, were prepared by Dr. Kastner. He prepared them based upon his knowledge, experience that he has described earlier, and reviewing the documents that are identified in each report. **The exhibits contain his expert medical opinions to a reasonable degree of medical certainty.** They opine on (1) David Cains' cause of death; (2) [redacted]; and (3) the role, if any, that the restraint used, the personal hold, led to David Cains' vomiting; (4) David Cains' life expectancy in the facility; and (5) whether the standard of care for restraint use in ICF/IID, such as Booneville Human

[3] Note for context: The typographical error was that the "not" in the January 6, 2023 report, page 5, opinion #20, was inadvertently dropped in the report attached to the deposition as DHS Exhibit 2B. Dr. Kastner's testimony corrected the error on the record. DHS Trial Ex. 2B is the corrected report.

Development Center, is determined by CMS rules and regulations [Appendix J] and Booneville policies and not as Dr. LeBel has articulated, the United Nations and World Health Organization.

Page 45:

> **Q:** Well, let me ask you this, Doctor. What is the standard of care for restraint use in human development centers in the State of Arkansas, who determines that standard of care?
>
> **A:** The standard of care is determined by the Centers for Medicaid and Medicare – Medicare and Medicaid Services and subsequent state and facility based documents**.**
>
> **Q:** Okay. And so when we talk about the Centers for – CMS documents, we are talking about the State Operations Manual, Appendix J, right?
>
> **A:** We are talking about the CFR and Appendix J being used as an interpretive guide for surveyors to measure compliance with the CFR, the federal regulations**.**

Page 46:

In preparation for his deposition, Dr. Kastner read the deposition of Doctor LeBel. He is aware that Doctor LeBel is not a medical doctor.[4]

[4] Note for context: Dr. LeBel states she has a Ph.D. in psychology and is not a medical doctor. *See* LeBel depo. pp 75-76. Dr. LeBel states she is a "restraint reduction expert," not a restraint expert. LeBel depo. p. 77, 118. Although a licensed psychologist, Dr. LeBel last practiced clinical psychology in about 1990. LeBel depo. p. 79-80.

Page 47:

> **A:** [Dr. LeBel] is in the broad sense of the term, a doctor given that she has a Doctorate degree. But she is not a medical doctor, nor a physician. And therefore, would not be qualified to offer an opinion that fell under the scope of medical practice.
> **Q:** And that would include cause of death, would it not?
> **A:** Yes. It would.[5]

Page 48:

Dr. Kastner said in his opinion, Dr. LeBel's achievement of a Ph.D. would not qualify her to offer an opinion about causality, medical care, medical practice, or anything related to the practice of medicine.

Page 49:

Dr. Kastner explained that [redacted].[6]

[5] Note for context: Consistent with Dr. Kastner's opinion, Dr Lebel, in her deposition, p. 84, testified, as follows:

> **Q: Tell me, do you have any medical training to determine the cause of death?**
> **A: No.**
> **Q:** Have you previously been allowed to testify by any court of law to opine on an individual's cause of death?
> **A:** No.

[6] Note for context: [redacted].

Page 50:

[redacted]

Page 51-52:

[redacted]

Page 52:

[redacted]

Page 53:

[redacted]

[7] Note for context: This is consistent with the testimony of LPN Amanda Schmitt and Tyler Mattson. LPN Schmitt testified she previously had to remove Mr. Cains from his scheduled activities because she felt he was too overwhelmed to go to class, to his work area, or to go to Commons to eat. *See* Schmitt depo. pp. 7-8. Recall also that Mr. Cains behavioral episode began when, as described by Mr. Mattson, he appeared agitated in the lunchroom and was removed by taking him the bathroom and then having him sit in the lobby to calm down. *See* Mattson depo. pp. 92-93.

[redacted]

Page 54-55:

[redacted]

Page 56:

[redacted]

Page 57-58:

In the 2019 IPP, Mr. Cains was identified as an individual who had a long history of maladaptive behavior. A behavior and treatment plan was developed which focused on noncompliance and physical aggression. The medical clearance form reviewed which determined whether or not an individual can safely receive the behavioral services that are recommended for the individual in

the IPP. It's simply an attestation by the physician that there is no health concern that contraindicates the use of any of the approved behavioral treatment that might be offered.

Page 58-60:

Dr. Kastner said Dr Hamid performed an evaluation specifically looking at whether there were any contraindications to the use of behavioral treatments or modalities that might be employed on behalf of Mr. Cains. Dr. Hamid found no contraindication to any of the five different behavioral techniques [restraints] that might be employed, including personal restraint. Dr. Kastner said **Doctor Hamid determined that those five restraint techniques or devices could be safely used without qualification.**

Page 60:

Dr. Kastner said Dr. Hamid, did not find that any conditions such as avoiding the use of a papoose board, for example, one hour after meals should be required. The papoose board would require a lying and prone position to be administered.

Page 61:

[redacted]

Page 62:

Dr. Kastner reviewed the deposition testimony of several people that have been deposed in this case, including Tyler Mattson and Mr. Scow, who was the EMS EMT.

Page 64-65:

Dr. Kastner stated there were two documents which provided the primary evidence for the events that occurred while only Mr. Mattson was present. Those two documents were his written witness

statement and his deposition. He relied upon **both** in painting a picture, if you will, of what transpired while Mr. Mattson was with Mr. Cains during that event.[8]

Page 65:

Mr. Mattson described Mr. Cains as being agitated and aggressive while being seated in a chair, he proceeded to pull papers off of a wall, and then stood up and charged or lunged at Mr. Mattson.

Page 66:

Dr. Kastner stated Mr. Cains asked if he could sit and rest. Mr. Cains was then offered a chair and sat for some time before becoming additionally agitated. He began pulling papers off of a wall. And at some point, he stood up and became aggressive, he either lunged or charged at Mr. Mattson, and made an attempt to grab Mr. Mattson.

Dr. Kastner agreed that the actual dialogue from Mr. Mattson's transcript is reflected in his report. He stated he believed that was important to do because Doctor LeBel did not include any of the testimony offered by Mr. Mattson in describing Mr. Cains' behavior. She limited her description of Mr. Cains' antecedent behavior to only what was in the written witness statement and excluded the evidence in the deposition.[9]

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[8] Note for context: Although Dr. Kastner's relied on both Mr. Mattson's written statement and deposition testimony, Dr. LeBel relied solely on Mr. Mattson's written statement but *ignored* the portion of the written statement where Mr. Mattson described that Mr. Cains, after sitting down to calm, "jumped up after [him]."

[9] Note for context: As noted earlier, Dr. LeBel's testimony and opinions also *ignored* Mr. Mattson's written OLTC Statement where, when describing what happened while Mr. Cains was seated, Mr. Mattson wrote "he [Mr. Cains] then jumped up after me" spitting and attempting to hit me." *See* Mattson depo. Ex. 9 [DHS Trial Ex. 13]. This is the written statement taken on June 13, 2020. **Dr. LeBel never explained why she failed to include this relevant fact in her testimony or opinions.**

Page 67-68:

Mr. Kastner stated Dr. LeBel did not mention Mr. Cains as being aggressive. He stated this was an important oversight on her part. Dr. Kastner stated that Mr. Mattson's deposition was very helpful and Mr. Gillispie did an excellent job in helping him see exactly what was happened, in particular when Mr. Gillispie asks Mr. Mattson, "Where were your hands?" Mr. Mattson indicates that he puts his left hand on Mr. Cains' right bicep, and his right hand on Mr. Cains' left bicep. **Dr. Kastner explained that indicated to him that Mr. Mattson is attempting to block Mr. Cains from grabbing him, and to deflect the lunge or charge.**

Page 68:

Dr. Kastner stated there was no aggressiveness on Mr. Mattson's part. Mr. Mattson' behavior is consistent with his training and understanding of how to manage an aggressive individual.

Page 70:

Dr. Kastner opined on the standard of care stating:

> "We go to the standard of care. The **standard of care** is going to rely on what a reasonably qualified direct support professional, or RCT in this instance, would have done under the circumstances in which Mr. Mattson found himself." [10]

Dr. Kastner testified he was able to reach an opinion to a reasonable degree of medical certainty as to whether the event described by Mr. Mattson would constitute an emergency situation to

[10] Note for context: This point is the epitome of the "foreseeability" requirement for negligence in Arkansas. The Arkansas Supreme Court has stated that "to demonstrate foreseeability, the harm must be 'within the range of probability as viewed by the ***ordinary*** man,' and must, therefore, be more than 'merely possible.'" *Ethyl Corp. v. Johnson,* 345 Ark. 476, 482 (2001) (emphasis added).

.

employ a personal hold and that the circumstances described qualified themselves as an emergency, consistent with both the federal and state guidance in those areas.[11]

Page 71-72:

Dr. Kastner stated he believed that Mr. Mattson's conduct in employing personal restraints in response to Mr. Cains' aggressive behavior was consistent with the standard of care and consistent with CMS guidance, the Appendix "J" interpretive guideline, Arkansas DHS policies and procedures, and **with the standard being that of an RCT, who in a similar situation with similar training and experience would employ the same approach**.

Page 73:

[redacted]

Page 74:

[redacted]

[11] Note for context: *See* 42 C.F.R. §483.450(d)(1)(ii), which states restraints may be used as "an emergency measure but only if absolutely necessary to protect the client or others from injury." *See also* Appendix J – Section W296 which provides that "[p]hysical restraints may be used as an emergency intervention only in situations where the client is exhibiting behaviors which … 3) are harming other people or themselves.

[redacted].[12]

Page 75:

[redacted]

Page 76:

[redacted]

Page 77:

[redacted]

Page 79:

[redacted]

Page 80:

[12] Note for context: [redacted]

[redacted]

Page 81:

[redacted]

Page 82-83:

Dr. Kastner is familiar with Doctor Forestiere's opinions expressed in her deposition regarding a "fight or flight" response. He found her explanation to be confusing because she did not explain whether the she believed the reaction was the result of being placed in restraints, when he vomited, or when he stopped breathing. Dr. Kastner does not believe Mr. Cains was fighting for his life when he was placed in physical holds. He stated even Dr. Forestiere "was unable to describe when that flight or flight reaction did occur."

Page 84:

Dr. Kastner stated Doctor Hamid ascertained that personal restraint, among other treatments, could be safely used with Mr. Cains without any restriction or condition.

Page 85:

Dr. Kastner stated he read Doctor Brown-Forestiere's deposition testimony.

Page 86:

As noted in his report, Dr. Brown-Forestiere could not say with any confidence that Mr. Cains was fighting for his life when he attacked Mr. Mattson, when he was restrained by staff, or after he

vomited. Dr. Kastner also noted in his report that Dr. Forestiere acknowledged that "What he thought was a fight for his life, and when it came down to that, **I can't say**."

Page 87:

Dr. Kastner stated he does not understand what relevance a fight or flight reaction has to the delivery of behavioral services and whether or not they met a standard of care. Mr. Cains had been restrained on at least 120 occasions in the past, and in none of those occasions had he died. His expectation would have been, based on prior experience, that he would survive being restrained, and once calmed down, restraints would have been removed.

Page 89-90:

Dr. Kastner stated **he has determined cause of death in hundreds of instances and has** testified in court on many occasions on cause of death.

Page 91:

Dr. Kastner stated there is no evidence that any *alleged* delay in contacting the Booneville Emergency Response System resulted in any harm to Mr. Cains or contributed to his death.

Page 91-92:

[redacted]

Page 93-94:

Dr. Kastner believes that **Doctor Brown-Forestiere substituted the standard of care for a physician working in an emergency room or critical care setting for the standard of care for a direct support professional or RCT working at a human developmental center.** [13]

Page 94:

The direct care staff at the Booneville Human Development Center, are not physicians. The only standard of care that is applicable to the conduct of an RCT in performing their duties is the standard for what an RCT is expected to know and to do.

Dr. Kastner stated:

> "substituting a physician's judgment for what would be appropriate in a specific setting would be inappropriate, because the training for a physician is so much different than that received by an RCT."

Page 95:

[redacted] [14]

[13] Note for context: This is not a medical malpractice lawsuit. Dr. Brown-Forestiere testified (1) that she received training in medical school or residency related to choking and suffocation (Brown depo. p. 7); (2) [redacted]. She is a medical doctor; Tyler Mattson , Amy Jones, and Ryann Campos are not.

[14] Note for context: Even Dr. Brown-Forestiere admitted, on cross-examination, that it was her opinion that [redacted]

Page 96:

Dr. Kastner opined that Mr. Cains' positioning was appropriate and met the standard of care for what an RCT would have been expected to do and, for that matter, for what anyone would be expected to do. He noted that even Doctor Forestiere agreed that [redacted]

It is his opinion, to a reasonable degree of medical certainty, that Mr. Cains' death was not accompanied by severe pain.

Page 97:

Dr. Kastner stated it is his opinion that Mr. Cains' death was not accompanied by severe pain. He explained that a generally accepted definition of what pain actually is has two components, based on a 2020 study by the International Association for the Study of Pain. One component being a sensory or emotional experience, and the second being actual tissue damage. And in order for an individual to experience pain, both conditions need to be met.

Page 98:

Dr. Kastner said Doctor Brown-Forestiere claimed that the two most painful causes of death would be strangulation or suffocation and burning. He testified "he has no idea where that came from." It makes no sense to him in terms of how physicians conceptualize pain because obviously in burning instances there is an extraordinary amount of tissue damage. In suffocation, there is generally much less damage. Going specifically to Mr. Cains, Dr. Kastner opined he does not believe that Mr. Cains experienced any moderate or severe degree of tissue damage prior to his

.

becoming unconscious. He does not believe Mr. Cains met the criteria that were set forth by the International Association for the Study of Pain.

Page 99-100:

Dr. Kastner stated in his report, item number 15, that "Based upon a reasonable degree of medical certainty, Mr. Cains had a life expectancy of only six more years." That is his opinion. Dr. Kastner explained:

> In general, the mortality rate for the general population is about eight per thousand per year. For people with intellectual and developmental disabilities, depending upon where they live and their age and their related medical conditions, the range in mortality rates is anywhere from 16 to 60 deaths per thousand. We all recognize that the life expectancy of people with intellectual and developmental disabilities is shortened simply because of the presence of the intellectual and developmental disability.

[redacted].[15]

In his experience as a researcher, having published in the area of life expectancy, **his opinion is that Mr. Cains' life expectancy was only six years more.** [redacted][16]

Page 101:

[redacted]

Page 102:

[15] Note for context: [redacted]

[16] Note for context: Dr. Brown-Forestiere did not opine on Mr. Cains' life expectancy.

Dr. Kastner stated it is his opinion that "CMS rules and regulations, ARDDS policies and procedures and BHDC policies and procedures represent the standard of care for delivery of behavioral services at Booneville HDC."

Page 103:

Dr. Kastner agreed he stated "the United Nations, the World Health Organization, SMSSHA and other sources, do not represent the standard of care for delivery of behavioral services at Booneville Human Development Center.[17]

Page 105-106:

Dr. Kastner stated based upon his knowledge of the rules and regulations pertaining to ICF/IID, of those like Booneville Human Development Center, it is CMS regulations, which interpret the federal rules, in addition to the Arkansas and facility specific regulations.

Page 106:

Dr. Kastner stated the United Nations, the World Health Organization, SAMSHA, and other non-CMS or Booneville or Arkansas sources is **not** the standard to be applied.

Page 107:

Dr. Kastner said Appendix "J" is the interpretive guideline used by CMS to make a determination as to whether a facility complies with rules and regulations that CMS has established.

Page 108:

[17] Note for context: Although Dr. LeBel confirmed, on cross-examination, that the federal regulations and the CMS State Operations Manual are the standards governing restraint use in ICF/IIDs, including BHDC, in her direct questioning by Counsel for Claimant, she suggested and insinuated that it was the United Nations and the World Health Organization that set the standards for restraint use in the United States.

Dr. Kastner stated there is *no unqualified right* not to be restrained contained within the CFR or CMS rules and regulations or Appendix "J". BHDC is licensed and approved by CMS to operate a clinical treatment model, which incorporates restraint as one of the potential treatment modalities.

Page 109:

Dr. Kastner stated CMS recognizes the use of restraint as an approved treatment modality under certain conditions

> "When Dr. LeBel states that individuals have a right to be free of restraint, she is mistaken, period. There is no right for individuals in an ICFMR to be free of restraints. Restraints may be used subject to certain conditions".

Page 110:

Dr. Kastner found the statement by Dr. LeBel, in that her requirement of imminent danger in the CFR confusing and misleading. He reviewed the CFR [federal regulations] 483.45 and could find no language that specifically identified a condition for the use of restraint related to imminent danger. The language "Imminent danger' did not appear in CFR 483.450.

Page 111:

Dr. Kastner agreed that imminent danger might be some type of reference or standard for some other type of situation, but not for the use in administration of restraints in an ICF/IID. To the extent that she imposed that additional requirement, she would be wrong.

Page 112:

Dr. Kastner stated the testimony of the witnesses indicated that Mr. Cains had not calmed down or achieved control over himself, which would have then allowed the staff to remove the restraints.

Page 115:

Dr. Kastner stated CMS allows restraints to be used in two broad categories of application. The first being what are called ***program restraints***, which would be very much described in the individual's behavior treatment plan. And the second would be ***emergency restraints***.[18]

Page 116:

Dr. Kastner stated we are referring here in this section to the application of restraints in emergency situations, not program restraints, which would be characterized in a very different way. These are restraints which are being used specifically to address more of an emergency situation. Some people would say, "This is a program restraint," but it's not.

Page 117:

Dr. Kastner testified if individuals are engaging in behaviors which can harm other people or can harm themselves, then staff meet the standard of care when they apply emergency safety measures, including the application of restraints.

Page 119:

Dr. Kastner stated [Appendix J], which is applying 42 CFR 483.450 (d)(4), states: "The client, released from the restraint as quickly as possible." The guidance from CMS defines what "quickly

[18] Note for context: *See* DDS Policy 3011-D which distinguishes between program Category restraints (Category I, Category II, and Category III) in Section 4 and Emergency Procedure restraints in Section 6. *See also* Mr. Cains 2019 IPP, pp. 9-10, which also distinguishes between the program Category restraints and an Emergency restraints. The 2019 IPP states: "In the event that symptoms persist at a rate that interferes with programming, staff may employ Category I procedure (DDS 3011-D), TACT procedures, ***or*** other Center emergency procedures if necessary, to protect from injury to client or others." Mr. Mattson employed emergency retains for safety.

as possible" means. The CMS Manual (Appendix J) states "as quickly as possible" means when the individual is no longer a danger to their self or others as manifested by their becoming calm.[19]

Page 121:

Dr. Kastner stated: referring back to Exhibit 2B, his January 6, 2023, report, on number 17 he states: Based upon a reasonable degree of medical certainty, Mr. Cains did not demonstrate a "withdrawal reflex." Dr. LeBel made those references about a withdrawal reflex.

Page 122:

Dr. Kastner said Dr. LeBel characterized "withdrawal reflex" as an autonomic nervous system response, which was primarily defensive. She referred specifically to the reflex as having its origins in the autonomic nervous system, which is completely *inconsistent with even the most basic understanding of neuroanatomy and neurophysiology*. The autonomic nervous system controls heart rate, blood pressure, breathing rate and sexual arousal. *It's inappropriate to characterize a reflex as either defensive or offensive, they are neither.* They are simply a reflection of the way the nervous system is wired.

Page 124:

In response to a question that pointed out that *Dr. LeBel, says Mr. Cains had a withdrawal reflex*, and she is not a physician, but *Dr. Brown-Forestiere, who is a physician, says it's a fight or flight* response, Dr. Kastner testified they "completely different." He explained that one is related to the anatomy of the spinal cord and the peripheral nervous system and the other is related to the functioning of the adrenal glands sitting on top of the kidney. **They are completely different.**

[19] Note for context: the CMS State Operations Manual, Section W302 , defines "As quickly as possible" to mean "as soon as the client is no longer a danger to self or others. Documentation should support that the client was released from restraint as soon as they become calm."

Page 127:

In Exhibit 2B, Dr. Kastner states "Based upon a reasonable degree of medical certainty, the emergency response system at BHDC, does not represent an obstacle for emergency response and life saving intervention." There is a policy that staff needs to call the nursing personnel and allow the nursing personnel to perform an assessment and make a determination as to whether additional treatment is required or not.

Page 127-128:

He does not believe that that policy is an impediment to people receiving appropriate emergency services and life saving intervention. His opinions incorporate his belief that the nursing staff are perfectly qualified to provide lifesaving interventions.

Page 128:

[redacted]

Page 129:

[redacted]

[20] Note for context: [redacted]

Page 130:

[redacted]

Respectfully Submitted,

Arkansas Department of Human Services

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BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE McAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS, CLAIMANT, VS. THE ARKANSAS DEPARTMENT OF HUMAN SERVICES, RESPONDENT.	CLAIM NO. 220374

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DEPOSITION

OF

THEODORE KASTNER, M.D., M.S.

---o---

THURSDAY, JANUARY 19, 2023

---o---

VOLUME I

---o---

COURT REPORTER:

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The deposition of Theodore Kastner, M.D., M.S., was taken before me, Donna K. Petre, Certified Court Reporter within and for the County of Pulaski, State of Arkansas, duly commissioned and acting, on Thursday, January 19, 2023, beginning at the hour of 9:00 a.m., all parties present via Zoom.

---o---

THEREUPON, the following proceedings were had, to-wit:

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* * * * * *

P R O C E E D I N G S

* * * * * *

WHEREUPON,

MR. ROSEN: If we are all ready to begin, then let's go ahead and swear in the witness.

(WHEREUPON, the witness was sworn.)

MR. ROSEN: Okay. Good morning everybody. My name is Rich Rosen, and I'm the attorney for the Department of Human Services, as you know. And this is a deposition of Doctor Ted Kastner in the case of Christine McAuliffe, as Special Administrator for the Estate David Cains. It's in the Arkansas Claims Commission, State Claims Commission as claim number 220374. The claim is against the Arkansas Department of Human Services.

We are here today to take the deposition of the Doctor. And several of the exhibits, Exhibit's One, 2-A and 2-B have been provided to counsel, Mr. Gillispie and Mr. Green, those were sent to you about a week or two ago, did you receive -- or a

couple of days ago. Did you receive that?

MR. GREEN: We did.

MR. ROSEN: I'm hearing an echo, Mr. Green.

MR. GREEN: Okay. I will try to get that corrected. Let's see, is the echo gone?

MR. ROSEN: Mostly. It's still a little there. We can give a few minutes to fix that.

MR. GREEN: All right. I think it should be good. I'm going to mute unless someone objects.

MR. ROSEN: Yes, I think you are a little better right now. Okay. Great. If everybody is ready to begin, then we will.

WHEREUPON,

THEODORE KASTNER, M.D., M.S., (Via Zoom) having been called for examination, and having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. ROSEN:

Q Doctor Kastner, please state your full name.

A My name is Theodore Andrew Kastner.

Q Okay. And spell your last name if you would.
A It's K-A-S-T-N-E-R.
Q Okay. And Doctor Kastner, what is your educational history and background?
A I have a Bachelors of Arts from Colgate University. I have a Doctor of Medicine from the University of Connecticut. And I have a Masters degree from the University of Wisconsin.
Q Okay. So your medical degree, you went to the University of Connecticut School of Medicine?
A Correct.
Q When did you graduate that and get awarded your Doctor of Medicine?
A 1981.
Q And then after that, you also received a Masters of Science, did you say?
A Correct, from the University of Wisconsin.
Q Okay. In what field?
A In population health in general. It was a hybrid MDA/MPH. It was content from both the medical school and the business school, so the MPH side would be population health, the MDA side would be management.
Q All right. So, and that was in a -- the Masters of Science was in a health related field, at least

partially?
A Yes. The degree is awarded by the school of medicine at the University of Wisconsin.
Q Okay. Thank you. And after you finished medical school and before you went and got your Masters, did you do any postgraduate training in medicine?
A Yes. I completed an internship and residency in pediatrics at the Bronx Municipal Hospital Center, primarily at Jacobi Hospital, between 1981 and 1984. And then I completed a fellowship in the care of children and adults with developmental disabilities and related conditions at the Rose F. Kennedy Center of the Albert Einstein College of Medicine. And the fellowship was between 1984 and 1986.
Q So these are additional years of specialty training in developmental medicine?
A Correct. The last two years, it's true.
Q And when did you complete that fellowship?
A 1986.
Q Okay. And are you a licensed physician?
A Yes.
Q Okay. Where?
A I have been licensed in New Jersey, Arkansas and New York. I'm currently licensed in New York only.

Q Okay. And is that where you principally reside or practice?
A Yes.
Q Okay. And have you been licensed as a physician continuously since the initial date of your licensure?
A Yes. 1981.
Q Okay. And are you board certified in any medical fields?
A I'm board certified in four areas of specialty, pediatrics, developmental and behavioral pediatrics, neurodevelopmental disabilities and medical management.
Q Okay. Let's go through those a little bit in more detail. Tell me what board certification signifies.
A The board certification signifies that an individual has completed a course of work, preparing themselves for an attempt at certification, and subsequently has passed an examination that could be verbal or written, thereby certifying that they have met a certain standard in terms of their ability to practice as a specialist in that field.
Q So it's a certification recognizing a specialty in that field?

A Correct.
Q Okay. And when you mentioned an examination, is that a national board examination?
A Correct.
Q And board certification is done by national boards in that subject area?
A Correct.
Q And as a result of that, you become a specialist in that area or you can call yourself a specialist in that area?
A I believe that that's a fair statement, yes.
Q And so let's go back. You mentioned that you had four board certifications. The first one you had mentioned was pediatrics and something else, I think you said?
A Pediatrics, that was the first I mentioned.
Q Okay. So you are a pediatrician, you are a board certified pediatrician?
A Correct.
Q Okay. And you are also board certified in developmental behavior of pediatrics, is that correct?
A Correct.
Q Okay. And what is that exactly?
A That's a field of study related to the general

development of children and the general management of behavioral disorders.

Q Would that -- okay. And then you also have a board certification from a national board in neurodevelopmental disabilities, you stated?

A Yes.

Q Okay. Tell me what that is, because that I don't know.

A That is a board that is related primarily to the evaluation and diagnosis and treatment of conditions that arise from the development and functioning of the brain and spinal cord, includes genetics, a variety of other topics. It's more --

Q So it's --

A It's more neurology psychiatry based.

Q Okay. And it deals with -- it's a specialty in the area of cognitive disabilities, would that be fair to say?

A It relates to disabilities more broadly rather than simply cognitives.

Q Okay. And would that include individuals with intellectual disabilities?

A Yes.

Q And would it include a study and training, additional training and certification on individuals

with developmental disabilities?
A Yes.
Q Okay. And these board specialties that you are certified in, they are over and above your medical training, internship and residency, correct?
A Correct.
Q Not every doctor could be board certified in these areas, can they?
A No, no, not at all. They would have to complete additional training and study.
Q And then they can sit for the board, and if they pass they are board certified?
A Correct.
Q Okay. And that's what you did?
A Yes.
Q Okay. And did you say a fourth area as well?
A Correct. Medical management.
Q Okay. What does that mean?
A The general administrative and management activities related to the practice of medicine. So the curriculum incorporated, as I mentioned earlier, aspects of public health, epidemiology, statistics, things of that type. But also content related to what might typically be considered an MBA, so things like capital finance and budgeting, marketing, strategic

planning, data analytics and semantics, things of that type. So it's a very interesting hybrid degree. But that did qualify me for the boards in medical management.

Q Okay. And so when did you initially begin working in the field with people with intellectual and developmental disabilities?

A That would be 1976 when I was employed by the Massachusetts Mission on the Blind to provide services at a summer program that was operated in Scituate, Massachusetts.

Q And what year was this, 1976, did you say?

A Yes, it was.

Q So you were working while you were in college then?

A Well, it was my summer job between my junior and senior in college, yes.

Q And so do you have any -- going back to -- do you have any academic or prior academic appointment to medical colleges?

A Yes. I have been on the faculty of at least three medical schools. Columbia University, the University of Medicine and Dentistry of New Jersey, and the Albert Einstein College of Medicine. But most recently I was a full professor in both the

departments of pediatrics and psychiatry at the Albert Einstein College of Medicine.

Q And is Albert Einstein College of Medicine, that's in New York City?

A Correct. That's in the Bronx.

Q Okay. And so tell me, is there a hierarchy for appointment to be a full professor and what level of achievement that signifies?

A Yes, there is. The academic ladder, if you will, begins with an appointment as an instructor. Generally an instructor can be appointed to the faculty of the medical school upon completion of their postgraduate training. So immediately upon completing my fellowship in developmental disabilities at the Kennedy Center, I was appointed as an instructor. You don't have to publish, you don't have to do a lot of teaching. It's simply a recognition of the fact that you are now a subspecialist in the particular field that you have chosen to study.

So Doctor LeBel, for example, is an instructor in a medical school, and that would be the very entry level. Subsequent to that, there is the assistant level, then there is the associate level, and then there is the unqualified professor level.

Q And so to become a full professor of medicine, what types of achievements do you have to have made over the course of your career to be able to reach that level?

A Generally a medical school wants to see accomplishments in three broad areas that would include service, teaching and research to be appointed at a professor level. But I will have to say that criterias do vary from school to school, but generally they will want to see a national level of recognition in those three areas, an extensive publication record, a lot of experience in teaching. So really the youngest I have ever heard of someone becoming a full professor, you know, would be around the age of 40. But generally it's something that people don't accomplish until their 50s, and often into their 60s.

Q Okay. And I noticed in your resume, which I have provided to counsel and is marked as the Exhibit One to this deposition has been provided, and I know that you have it in front of you. There is an extensive list in there of your various peer reviewed publications, is there not?

A Yes, there is. I have published more than 100 manuscripts, of which 70 would be considered peer

reviewed, and the peer review is really the critical element in looking at an individual's qualifications for academic appointment. The committee that recommends appointments generally doesn't put much value on nonpeer reviewed materials, which are included in chapters, editorials, opinion pieces in nonpeer reviewed journals, things of that type. So we separate the articles into both peer reviewed and nonpeer reviewed categories in order to help the committee understand the value of the scholastic record.

Q Okay. And a peer review is what I assume is exactly that, it's reviewed by peers in the field?

A Correct. And usually that's a blind review.

Q So it's anonymous?

A Correct.

Q Okay. And so they are commenting on the quality of the research or the opinions reached before it's published -- before it's published?

A Well, they make a determination as to whether or not it's published or not.

Q Okay.

A So they don't simply offer an opinion. They make a determination as to whether or not the journal should accept and publish a manuscript.

Q Okay. So the peer review process is -- determines whether the work, the article, the publication that a physician has done meets the high qualities of your peers in order to be published in a medical or scientific journal?

A Correct.

Q Okay. Now, did you ultimately -- oh, excuse me. What is the Ruth L. Gottesman Chair in developmental medicine?

A So many medical schools and universities receive funding from benefactors to create endowed chairs. And those chairs are highly prestigious and coveted. While I was at Einstein I had held an endowed chair, meaning that the benefactor in this case, Ruth Gottesman, had donated funding specifically to support the individual that held the chair. So I received a portion of my salary support from that endowment, which gives me latitude to engage in activities that other faculty might not necessarily be able to.

You know, my -- the expectations for my clinical productivity would have been reduced and offset by the fact that I had external funding support from the endowed chair. So it was quite an honor. Ruth Gottesman is the present of the board of the Albert

Einstein College of Medicine. To hold a chair endowed in her name is quite an honor.

Q Okay. And did you ultimately leave academic medicine recently?

A In 2019 I was invited to become the Commissioner of the New York State Office for people with developmental disabilities.

Q Okay. Let --

A That was a kind of -- excuse me?

Q Let me ask you about that. So what is that office?

A The office is a part of State Government. It is effectively an independent department within the State of New York, and operates at the cabinet level, meaning that commissioners like myself running those levels of departments would report in to the executive chamber, which then reported directly to the governor. So the scope of my work in that area was to operate a $10 billion system that supported 121,000 people with intellectual and developmental disabilities. And we had a staff of 19,000.

We delivered services, we operated about a thousand group homes, several hundred day programs, you know, 40 or 50 clinics, in addition to funding 400 or 500 agencies that delivered services across

the State of New York.
Q Okay. And as commissioner, what was your role in that?
A My job was to oversee the operation of that department. So effectively I was the CEO.
Q Okay. So in this state, we could call it the secretary, I would assume, or --
A It's interesting the language changes, it would be equivalent to a secretary.
Q You were the head of this $10 billion agency that provided services to the developmentally disabled and the intellectually disabled, is that correct?
A Right.
Q So you are broad -- you have a broad array of experience from the medical side, the specialty side and from administering and programs providing services to intellectually disabled and physically and mentally disabled individuals, is that correct?
A I wouldn't discount my experience as a direct support professional, which I think in 1976 created a foundation for me in helping to understand the important role of DSPs in service delivery. So that's an experience that has stayed with me throughout my career.

Q So with that, you have a -- you even have a broader array of experience than I anticipated, so -- and I asked you about, including your direct care experience?

A I feel that in the course of my career I have done almost everything that you could do with the training and credentials that I have.

Q Okay. And let me go back to your peer reviewed publications. And I saw some other things I'm going to ask you about in your CV. Did these publications, the peer reviewed publications and other publications include areas of research and medicine that addressed or opined on the care and treatment of individuals with intellectual disabilities and persons with developmental disabilities?

A Yes. Almost my entire, you know, publication record is focused on people with developmental disabilities, and that would be consistent with my practice as a subspecialist in those fields.

Q Okay. And that's listed in your -- those articles are listed and identified in your CV?

A Yes.

Q Okay. You also in your CV identified what you called abstracts which you published. What is an abstract?

A An abstract is usually something that is presented at a scientific meeting, it's more like an introduction or an overview of a project. Generally abstracts reflect work that is in an earlier preliminary type of form which would go on to be explored in more detail and potentially published as a research report in a publication.

Q Now, when you identify abstracts, are these abstracts in which you are one of -- either working on, or one of the people working on, or are they -- are you abstracting what other people have done?

A It's a -- I see where you are coming from. It's not akin to the legal use of the term "abstract". It's an overview of a project that is usually in process. So it might be a preliminary finding or a report about some study that's underway. But usually it's not sufficient to stand on it's own as a peer reviewed or other form of publication.

Q Okay.

A Preliminary.

Q All right. So it's the initial phase perhaps?

A It's usually to -- you know, it's presented at a conference, often as a poster. So it's an opportunity for a researcher to share with colleagues a preliminary finding and invite their input and

eventually collaboration. It may lead to other types of projects, grant funding, other kinds of activities. So it's kind of a dance that happens in academia where people network around certain topics.

Q Okay. Now, I also saw in your CV that you are a -- you appear also a guest speaker or lecturer at many -- and have presented at many conferences, is that the case?

A Yes.

Q And those are identified on the CV, are they not?

A That was a requirement of, again, the committee on promotions at the Albert Einstein College of Medicine, so my CV is in the required format. It identifies all of the contents areas that the committee on promotions requires candidates to present.

Q Okay. So it's part of the qualifications for a professor and perhaps even maybe an assistant professor, there is a certain level of national recognition that includes not only research and publications in peer reviewed journals, but also presentations at appropriate lectures to other physicians and research, is that correct?

A Yes. But the major criteria would be the peer

reviewed contributions, and I think, you know, there is also an interest in ensuring that full professors can generate revenues that support the university, so they do require that contracts, grants and other kinds of funds, generating activities, also be referenced in there.

Q Okay. And I'm going to -- and you list your grants in your CV as well, and I'm going to ask you about that in a second.

A Yes.

Q But these presentations, are these presentations -- are you invited to present?

A Yes, generally. And there are opportunities where I would have volunteered to present, there would be conferences where I might have submitted a potential panel or presentation as part of the, you know, invitation to participate in conference. There are a variety of different ways that you can become -- make a presentation, if you will.

MR. ROSEN: And so at this point in time, I'm going to introduce as DHS Exhibit One, Doctor Kastner's CV, and I'm going to ask counsel if there's any objections to it at this point in time?

MR. GREEN: No objection.

MR. ROSEN: Thank you. So we will move, Ms. Court Reporter, Ms. Petre, we are moving that into evidence and you should have a record, and I send -- I think that the original has already been sent to you to be attached to the original transcript.

COURT REPORTER: Yes, sir. Thank you.

MR. ROSEN: Okay.

(WHEREUPON, DHS Exhibit Number One was marked for identification and received into evidence.)

BY MR. ROSEN:

Q Doctor Kastner, what is the Developmental Disabilities Health Alliance, Inc.?

A The Developmental Disabilities Health Alliance, Inc. was effectively my practice, it was an organization I created in 1996, which eventually operated nine primary care locations across New Jersey and New York State. We had a staff of approximately 70. We provided healthcare, mental health and neurology services to about 4,000 people with intellectual and developmental disabilities across those nine sites. And I believe that is the simplest way to look at that organization.

Q So in addition to what we have already discussed

from your academic positions, from your running the New York State office for disabilities, you also at certain points in time were a provider, you were a physician and provided clinical services to the developmentally delayed and intellectually delayed?

A Between 1981 and 2019 I provided healthcare services to people with developmental disabilities. Between 1996 -- I'm sorry, 1986 and 19 -- I'm sorry, 2019, I identified myself as a primary care provider for people with developmental disabilities, and also as a specialty provider in that I provided both mental health and neurological services to people with developmental disabilities. So I have a somewhat unorthodox background for someone who has achieved the level of a full professor, in particular that I was not a full-time academic prior to 2015.

Q So you are quite familiar based upon your medical training, degrees and certifications, your running the office and you are -- and being a direct care provider during college and now as a clinician to the intellectual disability and developmental disability population, is that correct?

A Yes, very much so.

Q Okay. Now, have you ever qualified as an expert

in the field of developmental disabilities and intellectual disabilities in any federal courts?
A Yes. I would say somewhere around the order of ten different occasions in Massachusetts, Connecticut, I think Pennsylvania, Texas, Arkansas, Florida, but I can't remember them all.
Q Okay.
A But yes, the answer is yes.
Q So at least let's talk -- so in Arkansas you were recognized as an expert in an Arkansas Federal Court?
A Yes, I was.
Q Okay. And you qualified as the expert by the -- and the Court recognized you as such?
A Yes.
Q In what fields was that, do you remember?
A The qualification was very broad, it related to the general practice of delivery of services, healthcare services, mental health services, behavioral services, rehabilitation and habilitation services, behavioral services. In addition it related to the management and operation of the facilities' systems, the use of data. It was a fairly wide and broad qualification, which allowed me to opine on a wide range of, you know, content areas.

Q Okay. Did that include any -- strike that question. Do you know what an intermediate care facility for the intellectually -- for individuals with intellectual disabilities is?
A Yes.
Q Okay. And we often call it an ICF/IID, do we not?
A Yes.
Q And what are those generally, what are those facilities?
A So when the Medicaid program was established there was one type of long-term care facility that was created, and that was called an ICF. And over time it became clear that the needs of people with developmental disabilities supported through the Medicaid program were not just met in a general ICF or nursing home setting. And as a result a separate unique setting for people with intellectual development disabilities was created, and that became the ICF/IDD. And the ICF/IDD is a unique care setting in which individuals receive a range of habilitative services, which is different from rehabilitative services typically provided in a more traditional ICF.
Q Okay. And what is habilitative services just

briefly?
A The habilitation, to be contrasted with rehabilitation. Habitation is the practice of helping individuals gain and acquire new skills versus rehabilitation, which is to help individuals relearn previously gained skills that may have been lost as a result of some trauma or injury by stroke or for things of that type. So bottom line is the educational process continues for people with intellectual and developmental disabilities throughout their lifetime. And the ICF/IDD is seen as the means of implementing that goal.
Q Okay. And that's a facility based program, correct?
A It generally -- I understand in Arkansas that would be the perception. There are what are called community ICFs, which are, you know smaller in size that operates the thin neighborhoods, if you will. Now, in New York they can be up to 30, 40 beds. But generally they all have to comply with the standards that have been set by the federal government for the operation of an ICF/IDD.
Q Okay. Well, let me get a little more specific. And so are you familiar with what we call here in Arkansas human development centers?

A Yes, I am.
Q And are you familiar with specifically the Booneville Human Development Center?
A Yes, I am.
Q Okay. Are they ICF/IIDs?
A Yes, they are.
Q Okay. Have you ever --
A And so it doesn't rate community ICF/IDDs, so it's a mute point outside of Arkansas.
Q And so have you ever been to the Booneville Human Development Center?
A Yes, I have.
Q Okay. So you have been to Arkansas, and obviously you were licensed to practice medicine in Arkansas and testified as an expert in Arkansas. But you -- is that correct?
A Yes that's true.
Q And so approximately how many times do you think you have been to the Booneville Human Development Center over the course of your career?
A Oh, I don't know. Maybe in the order of ten. It's within single digits. I would say ten is a reasonable estimate.
Q And are you -- do you know what we call here, dually diagnosed individuals, what we are referring

to?
A Yes. In the DD field, dual diagnosis generally refers to people who have a developmental or intellectual disability, and a co-occurring mental illness.
Q And are you familiar with the restraint use at the Booneville Human Development Center now and as it was in 2020?
A Generally yes. My personal experience at the facility probably the last time I was there was 2010, 2011, maybe 2012. But I am quite familiar with the facility in terms of having reviewed the policies and procedures and practices. They are not particularly -- or substantially different than they were, you know, ten years ago, for example.
Q Okay. And do you know what CMS is or the Centers for Medicare and Medicaid Services?
A Yes.
Q Okay. And are you familiar with their State Operations Manual with regard to ICF/IID?
A Yes.
Q Okay. And generally what is that, can you describe it?
A So the Centers for Medicare and Medicaid Services are the primary regulator for the Medicaid

and Medicare programs, and specially for the ICF/IDD program. They promulgate rules and regulations for the operation of an ICF/IDD, and they also created a manual to assist surveyors in assessing whether or not the state complies with those rules and regulations, and that's the document you are referring to the Appendix "J" of the State Operations Manual.

Q Okay. And Appendix "J", that's what people commonly in the industry also call the State Operations Manual?

A The State Operations Manual is the Big Book, if you will of the state's Medicaid program. It describes everything that a state does as part of it's Medicaid program. The Appendix "J" focuses solely on the ICF/IDD program.

Q So it --

A Multiple appendices relate to different operations within the state plan.

Q So would you expect somebody who was well-versed and experienced in the ICF/IID industry and programs to recognize what a reference to Appendix "J" would mean?

A If the CMS regs are the content of the course, then the Appendix "J" is really the test that one

would need to complete in order to pass the course. The Appendix "J", because it is the instructions to the reviewers or the cite visitors really tells you what you have to do to comply with the federal rules and regulations. And I couldn't imagine going into a test without preparing for a test. The best way to prepare for the test is to use the same questions that will be on the test. So Appendix "J" is something everyone would be familiar with if they had the least amount of experience and familiarity with an ICF/IDD.

Q Okay. And so does Appendix "J", which is the State Operations Manual, cover among other things the CMS guidelines and regulations on restraint use in ICF/IID?

A Yes. The Appendix "J" provides specific guidance to the site visitors to assist them in measuring whether or not the state complies with federal regulations, including those related to behavior services.

Q Does the state -- just jumping ahead a little bit and we will get into this in a little more detail. But if the state complies the federal regulations in Appendix "J" with regard to restraint use, no deficiency in -- strike that question,

please. You had mentioned a survey -- or a surveyor uses Appendix "J". And what do they do it for?
A If they -- as I said before, I described it earlier, it's the test that you have to pass in order to become -- and retain your certification to operate an ICF/IDD.
Q Okay.
A Specific questions that the surveyor will ask when onsite in order to determine whether or not you comply with those rules and regs.
Q So if you comply with -- so when a surveyor is out inspecting -- and a survey is an inspection, is it not?
A Correct.
Q Okay. And it's an inspection for compliance with what?
A With the rules and regulations promulgated by CMS for the operation of an ICF/IDD within the CFR.
Q Okay. And that would be what we call Appendix "J", correct?
A Correct.
Q Okay. So when a surveyor comes out to inspect or regulate an ICF/IID such as a human development center, they are going to look to see if the facility complied with the regulations in the State Operations

Manual, specifically Section "J"?
A Correct.
Q Is that your understanding?
A Correct. Appendix "J" are the interpretive guidelines used by surveyors to ascertain whether or not a facility complies with relevant rules and regulations promulgated by CMS.
Q And so in your experience, have you -- in your experience, if a -- I'm going to strike that question. Do you have any experience with surveys, compliance surveys?
A Yes.
Q Okay. And so if a facility such as the Booneville Human Development Center is surveyed, at that -- for certain aspects, including, say, restraint use, would that mean that -- and no deficiencies were found, what does that signify?
A That signifies that overall the facility is in compliance with relevant rules and regulations promulgated by CMS and can maintain its certification and funding by the federal government.
Q Okay. Now, based upon your education, medical training, medical degree, Masters of Science, your decades of medical experience, including clinical care for persons with intellectual disabilities and

developmental disabilities, running the New York State office, providing services to these people, teaching medicine, doing your lectures, being a full professor and a three or four -- I'm sorry, four board certifications including a specialist in developmental behavioral pediatrics and neurodevelopmental disabilities, do you consider yourself an expert in healthcare and treatment of people with intellectual and developmental disabilities?

A Yes.

Q And as a matter of fact, Courts have treated you as an expert in those fields as well?

A Correct.

Q Okay. At my request, did you review documents and records including various reports pertaining to David Cains, his individual program plans, which we call IPPs?

A Yes.

Q And did you also review -- and for 2018 and 2019?

A Yes, though some documents are older than that, but yes.

Q And maybe even more, but at least those, is that correct?

A Correct.
Q Okay. And did you also review the 2015 and 2016 and 2020 Disability Rights Arkansas, and I will put these in quotes, "reports," unquote, and David Cains' physician's medical clearance for restraint use, the physician orders, the EMS report and several depositions including the depositions of Booneville Human Development Center employees, Tyler Mattson and several others, and Mr. Scow, the EMT who responded?
A I think, yes, that would be the response. If you want to be more specific, you can look at page three of my report and see a list of approximately 20 documents which I specifically made note of having reviewed.
Q Yes. And so they are on -- and you have done two reports on this in this case, have you not?
A Correct. I received the materials related to the consultation provided by Doctor LeBel, after I completed my initial review, and I just felt it was easier to, you know, bifurcate and create a separate report related to her findings.
Q Okay. And so your initial report was dated January 5th, 2023, correct?
A Correct.
Q Okay. And that we have marked as DHS Exhibit

2-A for the court reporter and for counsel, and they have been provided that. And then, I think you just said that because we had just then received Doctor LeBel's opinions and report, you provided a part two, so to speak, with regard to restraint use in a report dated January 6, 2023?

A Correct.

Q Okay.

MR. ROSEN: And we have marked that and provided it to the counsel and the court reporter as Exhibit 2-B. I just want to make sure. Counsel, have you received that?

MR. GREEN: I have.

MR. ROSEN: Okay. We are going to introduce those reports as DHS Exhibit 2-A and 2-B. Is there any objection?

MR. GREEN: No objection.

MR. ROSEN: Thank you.

(WHEREUPON, DHS Exhibit Numbers 2-A and 2-B were marked for identification and received into evidence.)

THE WITNESS: Can I make a comment on that? I want to apologize from the outset about the second report in particular. As

you can imagine, there was a very rapid turnaround, and I think I worked until 4:00 in the morning one night, 1:00 in the morning and 1:00 in the morning the next nights. And there are typographical errors.

In particular there is a specific typographical error related to opinion 21, which appeared on page five. I noted that and pointed that out to Mr. Rosen, but I want everyone to understand, I made a typographical error incorporating that recommendation email.

BY MR. ROSEN:

Q Okay. I'm going to ask you about that in a second.

A Okay.

Q I just want to -- I had asked you to submit a written report in response to Doctor LeBel, and that -- do you know the reason why it was expedited?

A No. I mean, you have timelines, and my understanding was that I had to complete the review of that document -- I can't remember the date, it was the Friday of that week. It would have been January 6th.

Q Okay. Well, we had just -- would you, in

looking at your documents, and I don't think this is disputed, we had just received Doctor LeBel's opinion just a week or two earlier, is that correct?

MR. GREEN: Object to form.

MR. ROSEN: Well, let me ask you this. Counsel, do you stipulate that we received the report in late December, and that's why we needed it quickly in January?

MR. GREEN: Without having the email in front of me, I'm not going to stipulate. But I don't disagree that that's generally accurate.

MR. ROSEN: Okay. I think it was right around, right before the Christmas break that we received it, but somewhere in the late December.

MR. GREEN: Okay.

MR. ROSEN: And we will just move on. Thank you.

MR. GREEN: Thank you.

THE WITNESS: But before you asked, I just -- I wanted to make note of that and apologize for the typographical errors, and particularly that one specific error on page five.

BY MR. ROSEN:
Q Okay. I'm going to ask you, because I wasn't intending here, Doctor, and of course the exhibits are in evidence and they are self-explanatory, and I know you have an executive summary of all your opinions at the beginning of each report and then with the details of the fact and the rationale in support of that, and the rest of the reports are lengthy, totalling approximately 90 pages in total. But if you would just -- you identified it was opinion 21 to which report?
A The LeBel report on page --
Q Okay. That would be page five of the LeBel report, so that's the second report, the January 6th, 2023, which is identified as Exhibit 2-B?
A Correct.
Q Okay. Can you just, since -- since I wasn't going to go through every one of your opinions per se, can you just read what the opinion actually is without the typo?
A If you would just give a moment, because I just want to pull this up.
Q How many --
MR. GREEN: And can you, Rich, again, identify which page and paragraph of that

report?

MR. ROSEN: Yes. It's paragraph -- it's opinion 21 on page five of Exhibit 2-A, which is the January 6th, 2023 report.

MR. GREEN: Got it. Thank you.

THE WITNESS: I'm sorry, it's opinion 20.

BY MR. ROSEN:

Q I'm sorry, 20, okay. If you would read it as it should read without the typographical error?

A Yes, I will read. "Based upon a reasonable degree of medical certainty, [redacted]

Q Okay. That's the way it should read?

A Correct.

Q Okay. Now, and just for the record, just so that everybody knows what documents and how many pages there were, the January 5th, 2023 report, which is Exhibit 2-A is how many pages?

A You are asking me?

Q Well, would you agree that it's 52 pages long?

A Okay. From memory, I would say that that's probably accurate.

Q And the Exhibit 2-B, which is the January 6th

report is 41 pages long. I just want to make sure counsel has all those documents.

A It's probably a reasonable number, yes.

MR. GREEN: We have the complete documents.

MR. ROSEN: Thank you.

BY MR. ROSEN:

Q Doctor Kastner, do these reports that have been identified as Exhibit 2-A, 2-B, first of all, you prepared those reports, correct?

A Correct.

Q Okay. And you prepared them based upon your knowledge, experience that you have described here today, and reviewing the documents that are identified in each report, correct?

A Correct.

Q Okay. And these exhibits contain your expert medical opinions to a reasonable degree of medical certainty, is that correct?

a Correct.

Q And they also opine on the -- do they opine on David Cains' cause of death?

A They do.

[redacted]

A Yes.
Q Okay. And among other things that you have opined on. And the role, if any, that the restraint used, the personal hold, led to David Cains' vomiting?
A Yes.
Q Okay. And does it also include the standard of care for restraint used by the Booneville Human Development Center's direct care team and other staff under the circumstances presented by David Cains on June 13th, 2020?

MR. GREEN: Richard, can you just make sure that you identify which report? Part one can be January 5th, part two can be the January 6th? That way I know which particular report he is testifying about.

THE WITNESS: I will --

MR. ROSEN: Okay. Well, we are going to get in to --

MR. GREEN: I appreciate it.

MR. ROSEN: Like I say, we are going to get into it some more in specific detail. The reports do speak for themselves.

MR. GREEN: Thanks.

BY MR. ROSEN:

Q But Doctor, you specifically mention in Exhibit 2-A, which is the January 6th, 2023 report, about the standard of care for restraint use by the facility staff, is that correct?
A Yes.
Q And I believe that there were some references to that in the 2-A report as well?
A I'm confused. I think I made reference to the standard of care for behavioral services in both 2-A and 2-B.
Q Yes, okay. All right. And do these reports also express your opinion to a reasonable degree of medical certainty as to David Cains' life expectancy in the facility?
A Yes.
Q Okay. And do they also express your expert opinion to a reasonable degree of medical certainty of whether the standard of care for restraint use in ICF/IID, such as Booneville Human Development Center is determined by CMS rules and regulations and Booneville policies and not the United Nation's and World Health Organizations as Doctor LeBel articulated?
A Yes.
MR. GREEN: Object to form.

BY MR. ROSEN:
Q Well, let me ask you this, Doctor. What is the standard of care for restraint use in human development centers in the State of Arkansas, who determines that, standard of care?
A The standard of care is determined by the Centers for Medicaid and Medicare -- Medicare and Medicaid Services, and subsequent state and facility based documents.
Q Okay. And so when we talk about the Centers for -- the CMS documents, we are talking about the State Operations Manual, Appendix "J", right?
A We are we talking about CFR and Appendix "J" being used as an interpretive guideline for surveyors to measure compliance with the CFR, the federal regulations.
Q And so those interpretive guidelines of the Code of Federal Regulations, particularly -- well, strike that. Those interpretive guidelines in Appendix "J" of the Code of Federal Regulations is what CMS -- first of all, it was a promulgated document, right?
A Correct.
Q And that's what CMS uses to enforce the regulations, correct?
A That CMS uses to measure compliance with

regulations.
Q And so that is -- strike that question. Now, did you also read in preparation for your deposition today the report and deposition of Doctor LeBel?
A Yes.
Q Okay. Are you aware that Doctor LeBel is not a medical doctor?
A Yes.
Q I mean, that was brought out in the deposition, right?
A It was discussed at length. I believe she said she had a medical education, but I found no evidence to support that claim.
Q She, I think, identified herself as Doctorate level, she has a Ph.D. in psychology and a Ph.D. in education, is that at least on her resume?
A To be honest, I'm actually confused about her Doctorate degree or degrees and the source of those degrees. But she does claim to have at a Doctorate level education.
Q Okay. So, but actually the gist of my question is that her not being a doctor, she cannot opine to a reasonable degree of medical certainty on anything, can she?
MR. GREEN: Object to form.

BY MR. ROSEN:
Q Go ahead, Doctor.
A She is, in the broad sense of the term, a doctor given that she has a Doctorate degree. But she is not a medical doctor, nor a physician. And therefore would not be qualified to offer an opinion that fell under the scope of medical practice.
Q And that would include cause of death, would it not?
A Yes, it would.
MR. GREEN: Object to form and the response.
BY MR. ROSEN:
Q Okay. Well, Doctor, what -- as not being a medical doctor, and I think she said she's not a pathologist or a neurologist, would a Ph.D. in psychology and education, in your opinion, give her the credentials and qualifications to opine on a cause of death?
MR. GREEN: Object to form, it exceeds his qualifications as an expert.
THE WITNESS: In my opinion --
BY MR. ROSEN:
Q Go ahead.
A In my opinion, her achievement of a Ph.D. would

not qualify her to offer an opinion about causality, medical care, medical practice, or anything related to the practice of medicine. And I think it would be clear in looking at the Arkansas Board of Medicine that she would not be qualified to opine in any of those content areas.

Q Okay. Now, I'm going to -- and you have the Exhibits 2-A and 2-B in front of you, correct?

A Yes, I do.

Q Now, because they are self-explanatory, I'm not going to ask you every word to be repeated here, every opinion. But let's discuss all of those opinions -- some of the things in there, okay? So let's turn to page -- Exhibit 2-A, which is the January 5th, 2023 report of yours, and page four.

A Yes.

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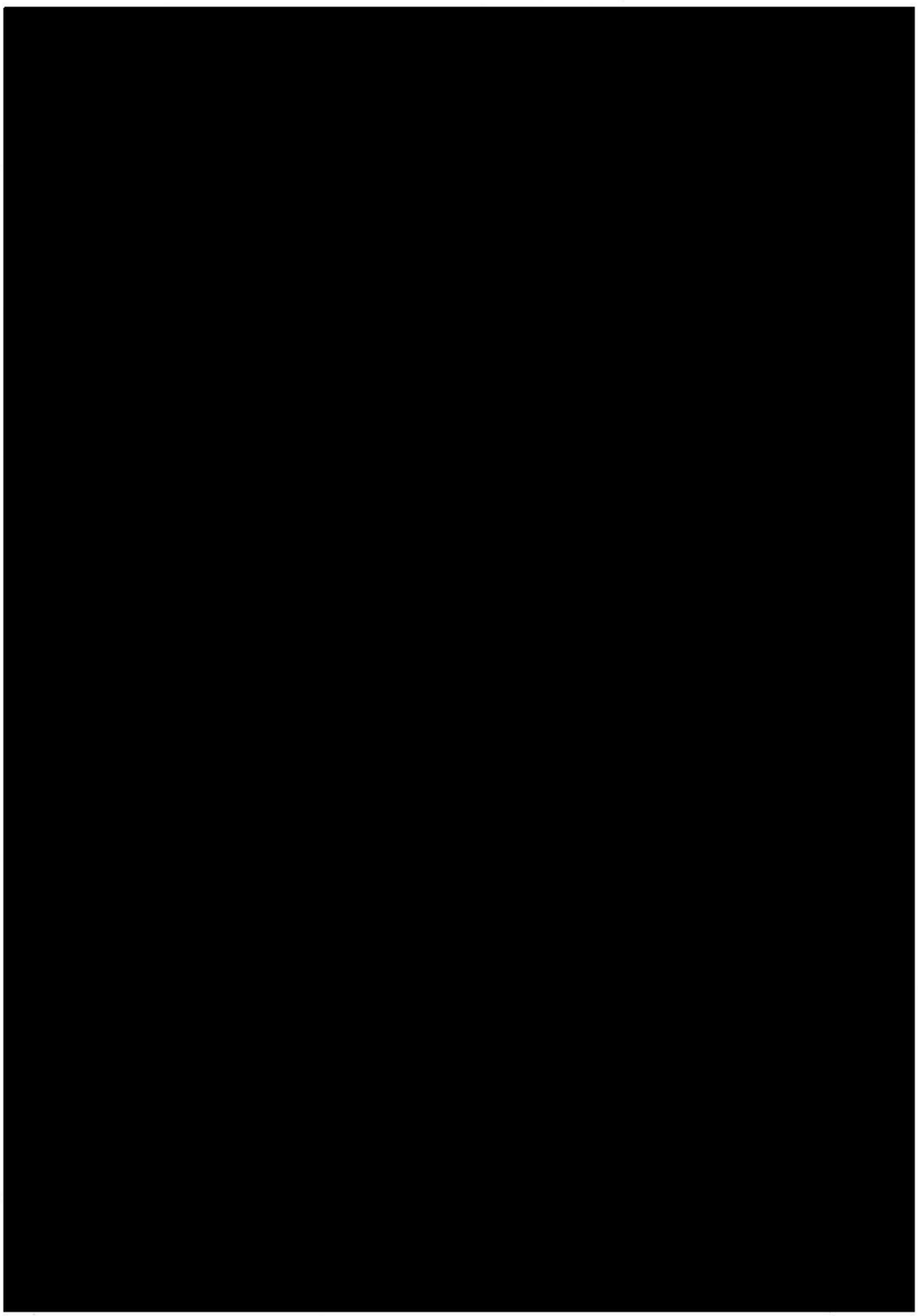

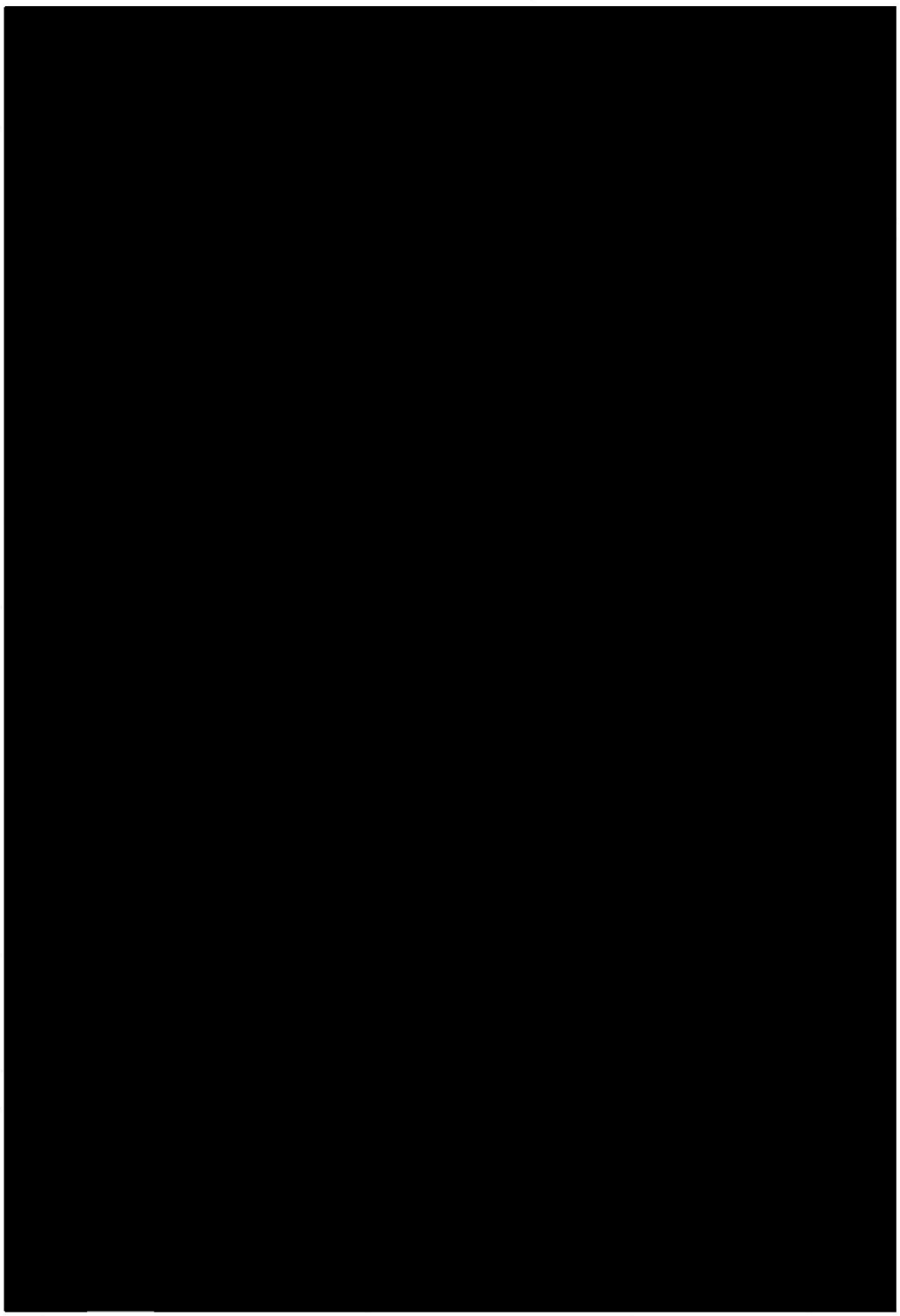

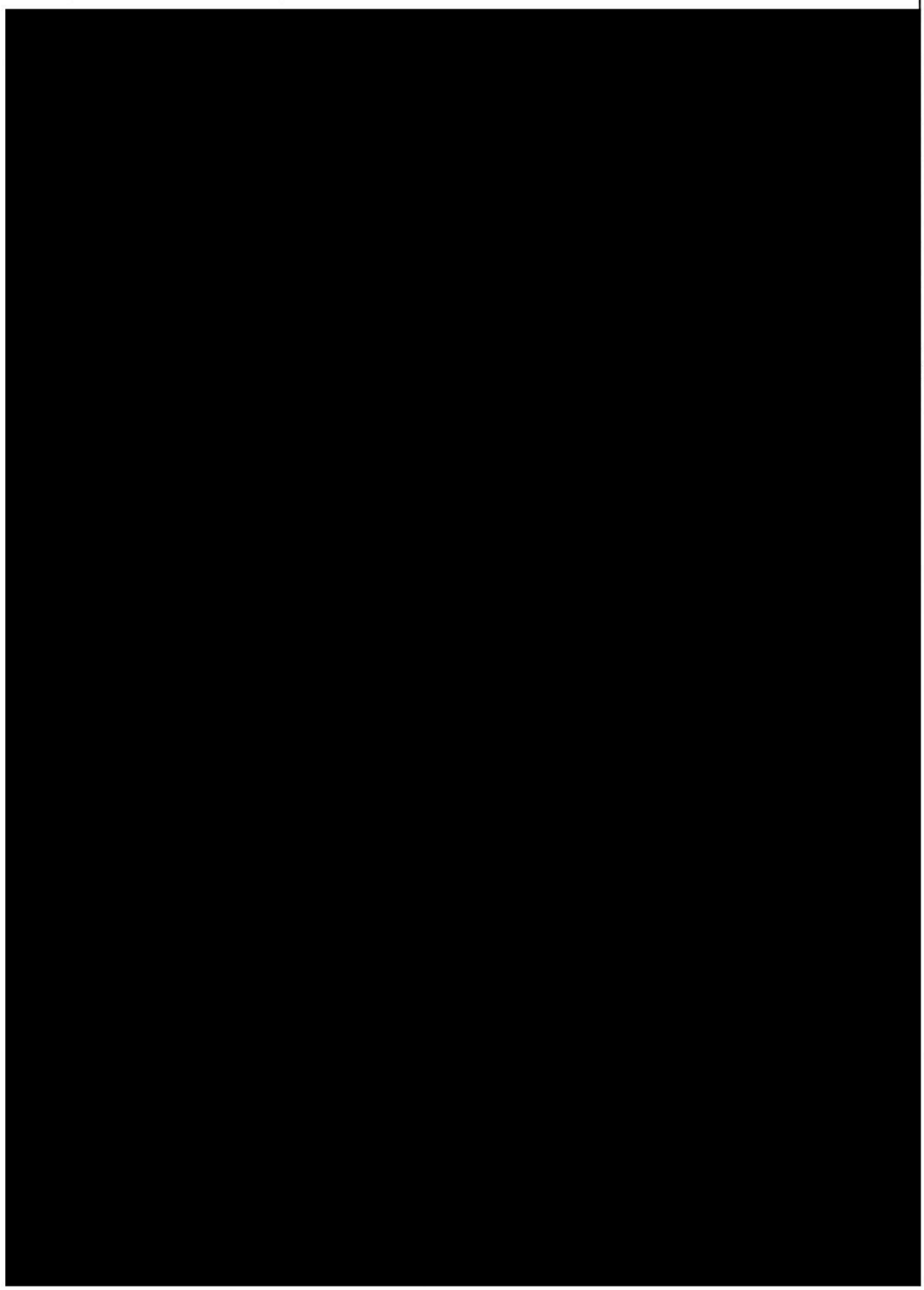

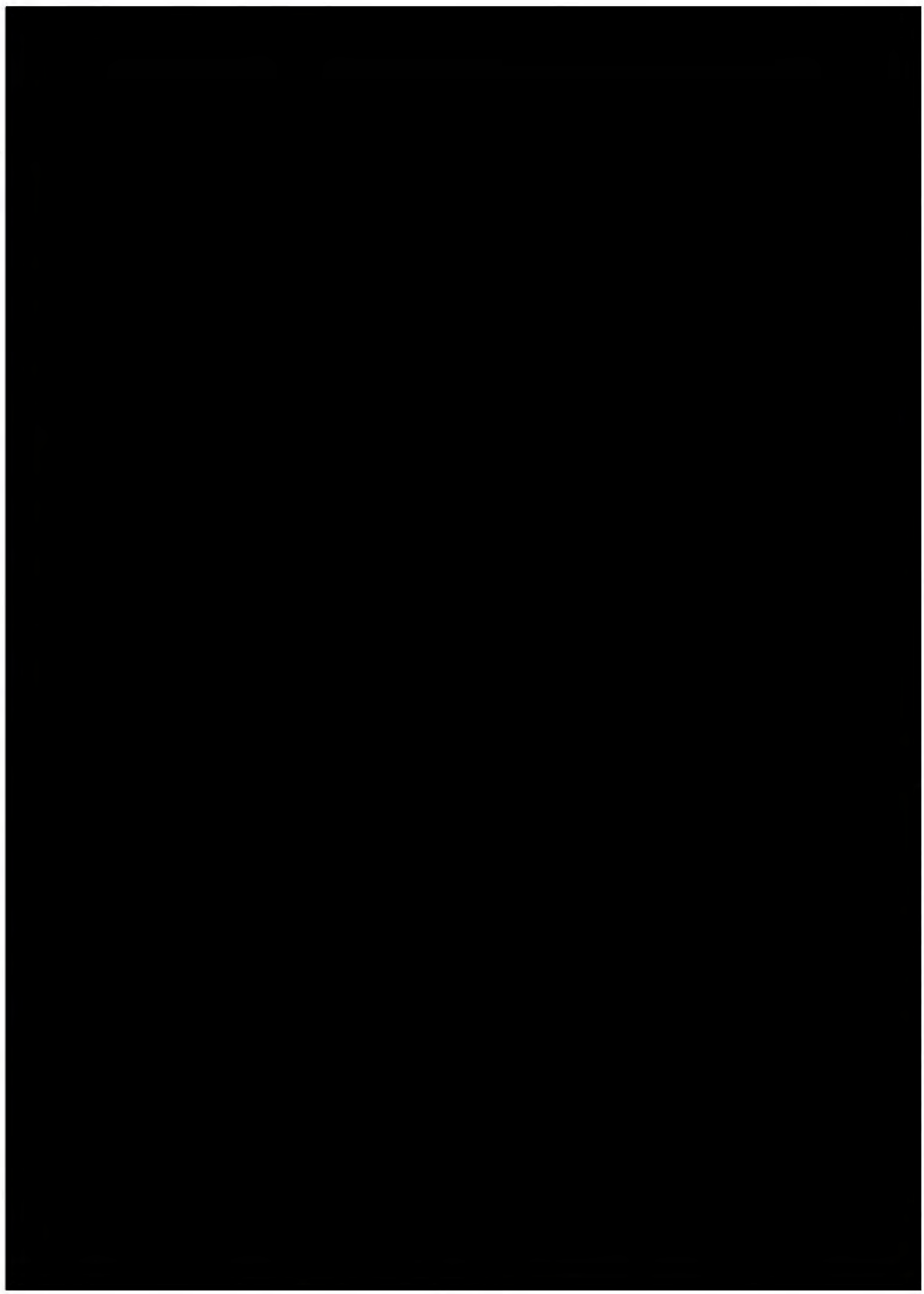

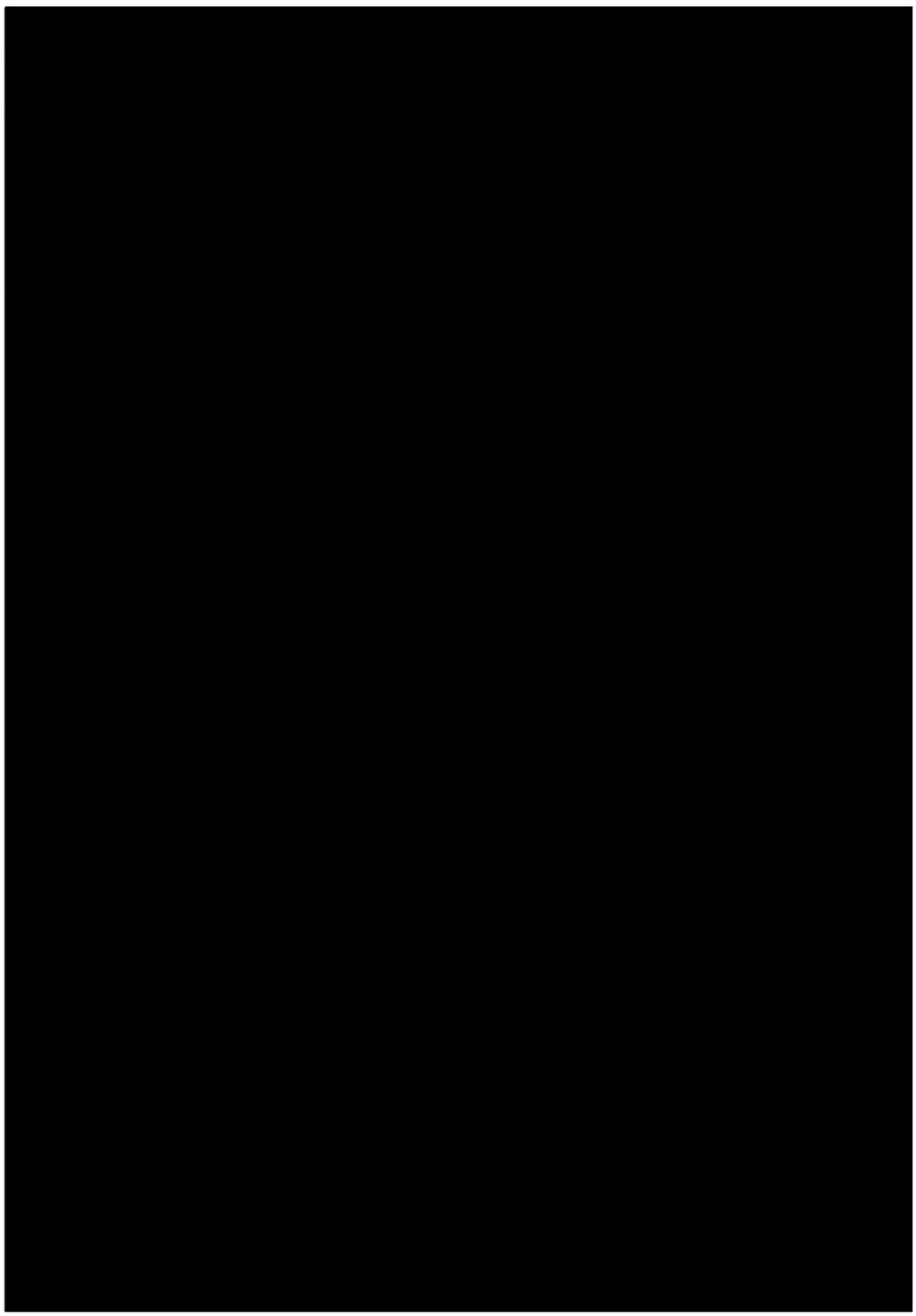

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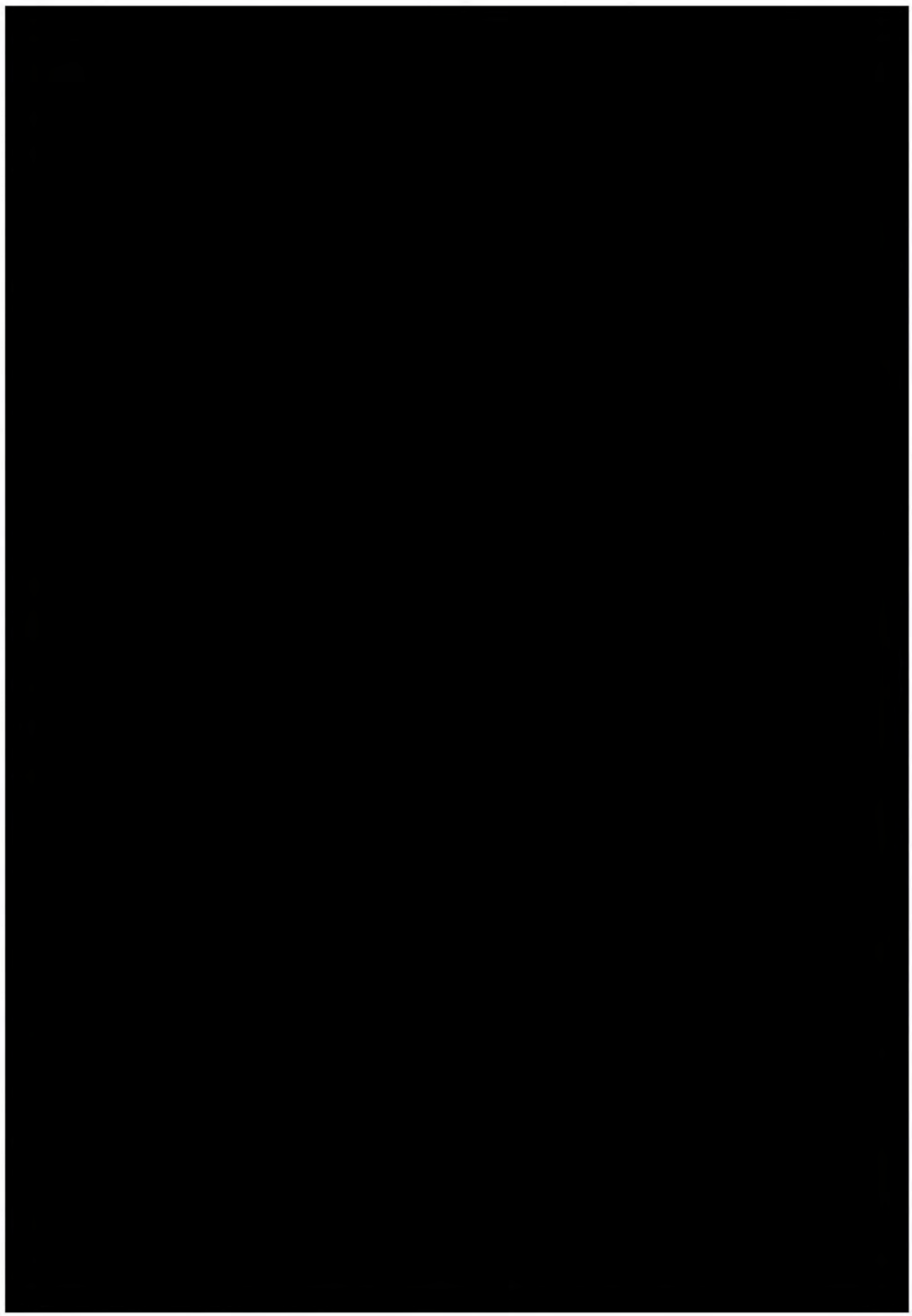
Q Now, you reviewed in the course of your -- the documents, you reviewed the David Cains' 2019 IPP, did you not?

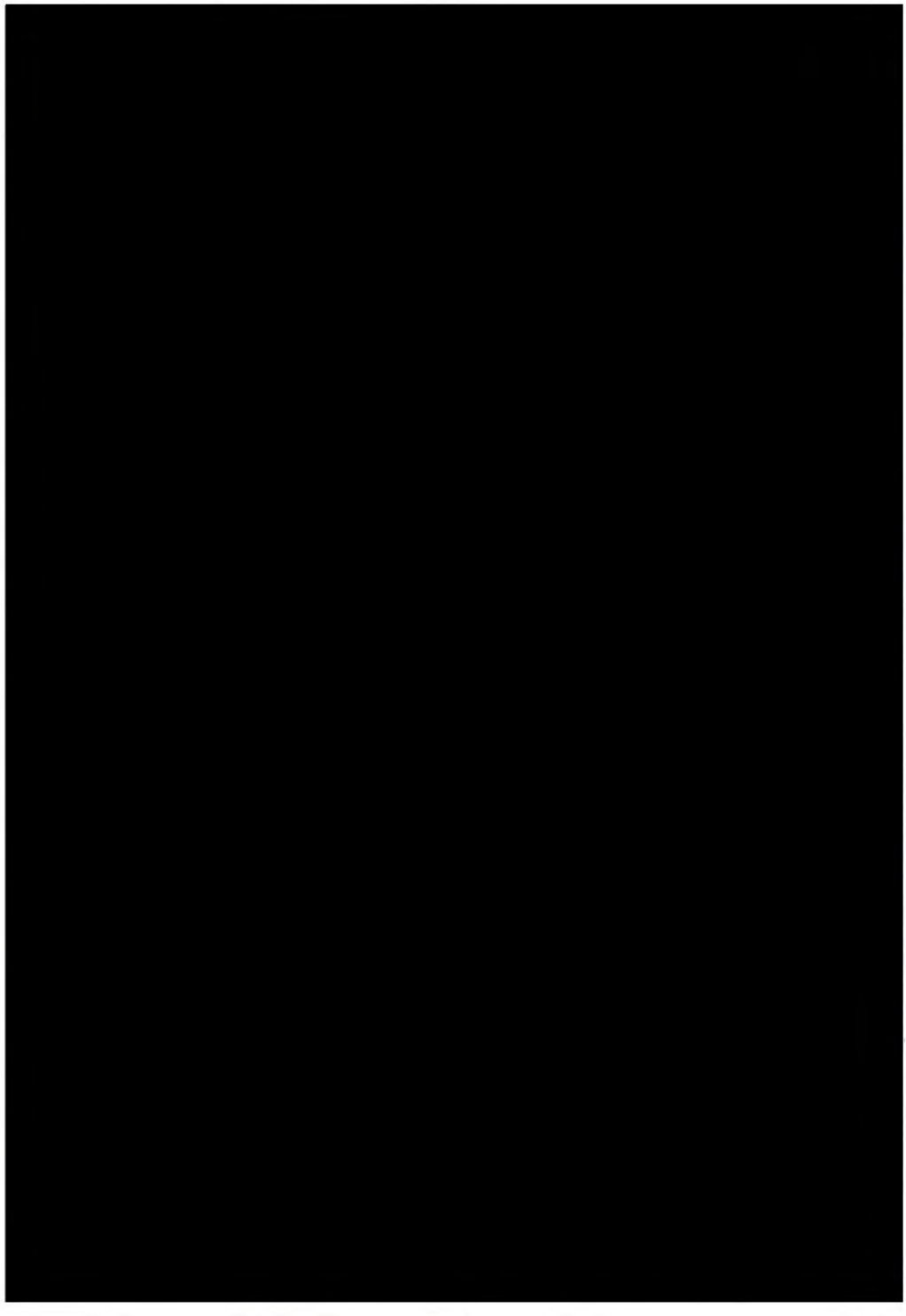
A Yes.

Q And that's noted on your report that you reviewed it, correct?

A Yes.

[redacted]





Q Okay. Did they -- did David Cains -- what, if anything, did David Cains' 2019 IPP address with regard to his behavioral treatment program?
A Mr. Cains was identified as an individual who had a long history of maladaptive behavior, and in particular, a behavior and treatment plan was developed which focused on noncompliance and physical aggression.
Q Okay. And so to what extent, if at all, did David Cain's 2019 IPP define, quote, "physical aggression", unquote?
A I would have to back and look specifically at the document. But it was defined and described, if you will, based on the history of the last ten or 15 years of his having lived at the facility.
Q Okay. And we had talked about it a few minutes earlier, about a medical clearance form. Are you familiar -- did you review that document?
A Yes, I did.
Q And tell me what that was and what that did.
A The medical clearance is a process used by the facility to determine whether or not an individual can safely receive the behavioral services that are recommended for the individual in the IPP. It's simply an attestation by the physician that there is

no health concern that contraindicates the use of any of the approved behavioral treatment that might be offered to the individual at the facility.

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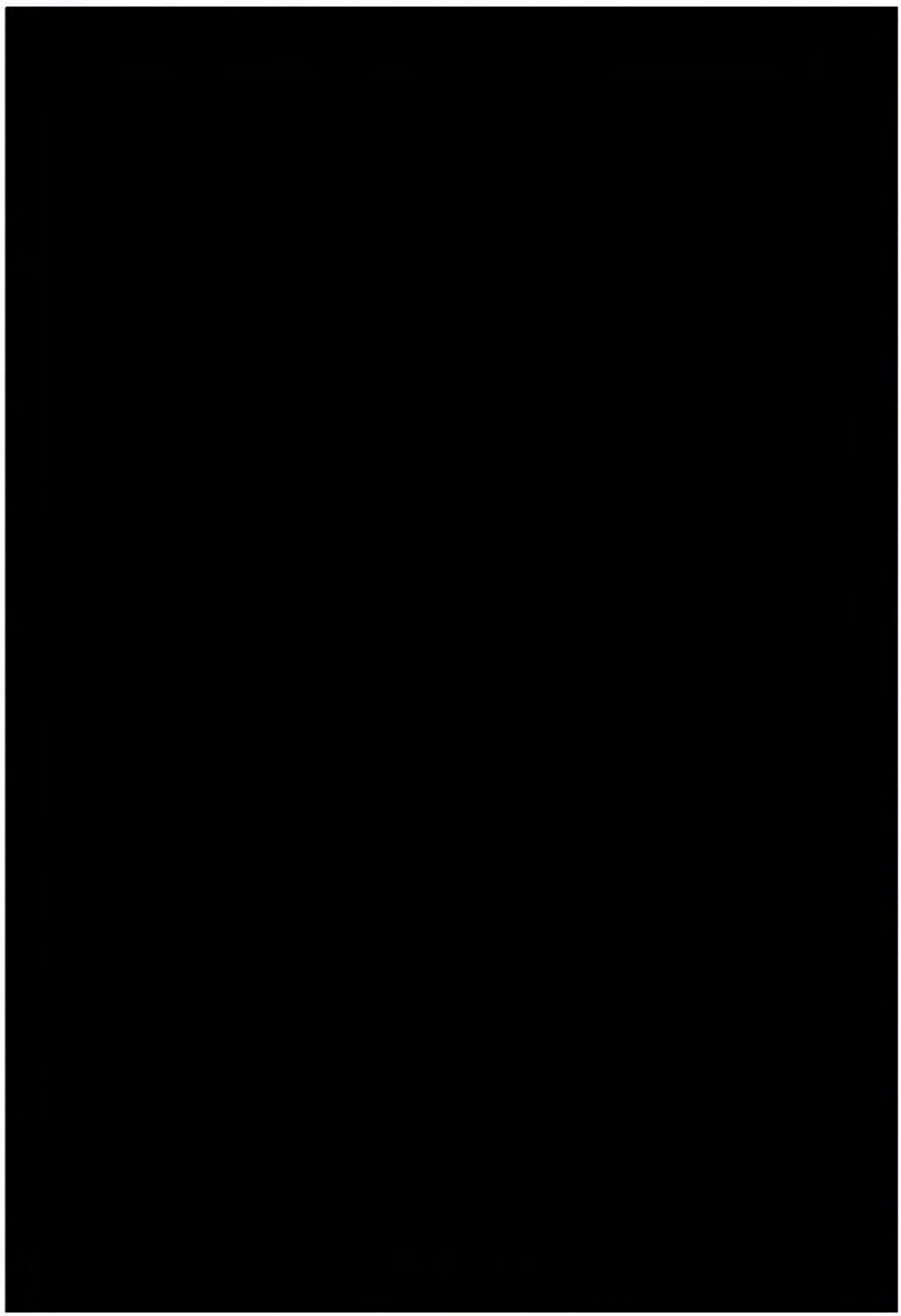

[redacted]

Q And would a -- and so when you say without qualifications, can you --

A Oh, for an example and, you know, getting to the heart of what we are discussing here, Doctor Hamid made no recommendation that the use of personal restraints or the papoose board should be limited or prohibited after meals, for example.

Q Okay.

A He has an opportunity in the course of defining what modalities can be used safely, to place qualifications on the use of any of these modalities. In his medical opinion, he did not find that any conditions such as avoiding the use of a papoose board, for example, one hour after meals should be required.

Q Okay. And a papoose board, would that be require a lying and prone position to be administered?

A Yes, it would.

Q So the individual, if they were going to -- if a papoose board was used, and it wasn't used here, but if it was going to be used, the person would have to be laying down on the ground?

A Correct. And Doctor Hamid could have placed a qualification on the use of the papoose board, and said that the papoose board could not be used for an hour after meals, if there were a concern for the individual's health or safety related to any underlying issues [redacted]

Q Okay. Now, I think in your report you noted certain physical characteristics of David Cains such as his height, weight and obesity level. What were your determinations there based upon the record, any at all?

A Yes. The social history from 2020 identified [redacted]

Q And so he was a big man, correct?

A He was a big guy, yeah.

Q All right.

MR. ROSEN: I'm going to -- we have been going for about an hour and 20 minutes. I think it might be prudent to take a five minute break. Counsel, do you have any objection to a five or six minute break?

MR. GREEN: Not at all, let's make it

ten.

MR. ROSEN: Okay. Ten it is.

MR. GREEN: Thanks.

MR. ROSEN: But be back around, Central Time about 10:31 or so. And I'm going to turn off my camera right now and mute. Doctor Kastner, you can get up and stretch and turn off your camera and put yourself on mute as well.

THE WITNESS: You want to reconvene at 10:30, is that correct?

MR. ROSEN: 10:31. Your time would be 11:31.

THE WITNESS: Okay.

MR. ROSEN: All right. Thank you.

THE WITNESS: Thank you.

(WHEREUPON, there was a short break.)

MR. ROSEN: Okay. Let's go back on the record. We are back on the record.

BY MR. ROSEN:

Q Doctor Kastner, I see in your reports that you considered or you reviewed the deposition testimony of several people that have been deposed in this case, including Tyler Mattson and Mr. Scow, who was the EMS EMT. Do you recall that?

A Yes.
Q Okay. And you did review their testimony under oath?
A Correct.
Q Okay. And do you consider in -- strike that question. I see in your report, particularly the January 5th report, Exhibit 2-A, extensive reference to testimony of Tyler Mattson and Mr. Scow, the EMT, as well as other testimony too?
A Correct.
Q And so you didn't pick and chose, when you were writing the report and making your medical decisions -- or, excuse me, opinions in this case, you reviewed the evidence that was presented in the deposition, correct?
A I reviewed all of the evidence that I was provided, correct.
Q And you were provided the deposition of Tyler Mattson and Mr. Scow, the EMT provider, correct?
A Correct.
Q Okay. And you cite in your factual narrative of kind of the factual basis, what the records indicate. You cite a lot of the dialogue between counsel for the claimant and Mr. Scow and Mr. Mattson, correct?
A Yes.

Q Now, and what, if any, significance -- let me ask it this way. You found certain aspects significant enough to put it in your report, correct?
A Correct.
Q And I'm referring, specifically for counsel, to pages seven and eight of the January 5, 2023 report, admitted as Exhibit 2-A. Now, as you note in the report and cite in there, you referenced the deposition of Tyler Mattson with regard to the events that happened immediately preceding the restraint, did you not?
A Correct.
Q Okay. And I think you cited the pages 101 to 103 of Tyler Mattson's deposition testimony?
A Yes, among other --
Q Well, what --
A Among other cites, yes.
Q Okay. What was -- and what was -- strike that question. And in the parts that you describe, Tyler Mattson testified as to kind of the events that immediately happened, and really what happened in the incident, correct?
A There were two documents which provided the primary evidence for the events that occurred while only Mr. Mattson was present. Those two documents

were his written witness statement and his deposition. And I relied upon both in painting a picture, if you will, of what transpired while Mr. Mattson was with Mr. Cains during that event.

Q Okay. And as reflected on pages 11 and 12 of your January 5, 2023 report, which is Exhibit 2-A, what did -- how did -- what did you note that how Tyler Mattson described David Cains' activities from the time that he was sitting in a chair and why he was sitting on the chair?

A Mr. Mattson described Mr. Cains as being agitated and aggressive while being seated in a chair, he proceeded to pull papers off of a wall, and then stood up and charged or lunged at Mr. Mattson.

Q And was there any reflection in the testimony or in the witness statements as to why Mr. Cains, David Cains was sitting in that chair?

Q Well, Mr. Mattson and Mr. Cains had been discussing how Mr. Cains felt while he was in the dining area. He had experienced and communicated some nonspecific gastrointestinal distress. Mr. Mattson brought Mr. Cains to the restroom, which from what I can gather is outside of the larger cafeteria area. Upon exiting the restroom, Mr. Mattson was -- I'm sorry, Mr. Cains was still in

some state of distress. He asked if he could sit and rest, and Mr. Mattson agreed, yes, that would be fine. And Mr. Cains was offered a chair and sat for some time before becoming additionally agitated.

Q Okay. And then according to the deposition testimony and the statements that were reviewed, what did Mr. Cains do while he was -- from the time that he was sitting in the chair?

A Again, as I just mentioned, he continued to be agitated and began pulling papers off of a wall. And at some point he stood up and became aggressive, he either lunged or charged at Mr. Mattson, and made an attempt to grab Mr. Mattson.

Q And this is all reflected on our report, in fact, the actual dialogue from the transcripts is included on page 11 and 12 describing the incident, did it not?

A Yes, it is. And I believed that was important to do. And as it turned out, it's quite important because Doctor LeBel did not include any of the testimony offered by Mr. Mattson in describing Mr. Cains' behavior. She limited her description of Mr. Cains' antecedent behavior to only what was in the written witness statement, and excluded the evidence in the deposition that described Mr. Cains

as being aggressive. And I think that was a very important oversight on her part in helping readers understand exactly what transpired between Mr. Cains and Mr. Mattson.

Q Okay. And so in your report, I see that in there on page 12, is it correct that Tyler Mattson, in response to counsel for claimant's questions of him under oath, that he uses the terms "heaving, David Cains charged me and grabbed at me and lunged at me," are those the terminology that you recall from the deposition testimony that you put in the report?

A Yes.

Q Okay. And so then, there's a note here, and particularly in Doctor -- one of the physicians for the claimants mention, about how they ended up on the ground. Were you able to -- does your report address that issue?

A Yes, it does.

Q Okay.

A And I think the deposition was really helpful and Mr. Gillispie did an excellent job in helping me to see exactly what was happening, in particular when Mr. Gillispie asks Mr. Mattson, you know, "Where were your hands?" And Mr. Mattson indicates that he puts

his left hand on Mr. Cains' right bicep, and his, Mr. Mattson's right hand, on Mr. Cains' left bicep. That indicates to me that Mr. Mattson is attempting to block Mr. Cains from grabbing him, and to deflect the lunge or charge, which Mr. Cains has engaged in, that Mr. Mattson's placement of his hands, it's purely for blocking and defensive purposes.

There is no aggressiveness on Mr. Mattson's part, and his -- Mr. Mattson's behavior is consistent with his training and understanding of how to manage an aggressive individual.

Q I saw that you noted somewhere in your report about -- in response to counsel's questioning of Mr. Mattson on this issue, counsel being counsel for the claimant, that Mr. Cains landed facing his -- the front part of his body on the floor. What would that tell you about momentum and what happened there?

MR. ROSEN: Object to form, exceeds the scope of his expertise.

THE WITNESS: Mr. Mattson testified that there was some barrier or obstacle behind him that led to him falling, and falling backwards as a result of Mr. Cains' forward momentum. And as he describes it, you know, "our feet got tangled up, we

fumbled around, we tripped, it was one big momentum."

And Mr. Mattson was not pushing back, he was not forcing Mr. Cains backwards. They did not fall with Mr. Cains' on his back and Mr. Mattson on top of him. Again, because Mr. Mattson was deploying a blocking technique, he fell backwards. He was not moving forward, he was blocking, and as a result of tripping over this impediment or obstacle, they all fell backwards in as much of a controlled fashion as Mr. Mattson could accomplish at that time.

BY MR. ROSEN:

Q And these are all facts that you derived from the records that you were provided, including the depositions, correct?

A As I said earlier, I think the two primary sources of information about what happened while Mr. Mattson was with Mr. Cains alone, prior to the fall, and prior to the use of restraints is particular important in helping us understand what happened, and what Mr. Mattson was thinking at the time that he was with Mr. Cains.

Q Okay.

A There is a --
Q Well, based on --
A We go to the standard of care. The standard of care is going to rely on what a reasonably qualified direct support professional, or RCT in this instance, would have done under the circumstances in which Mr. Mattson found himself. The only reason we can -- the only way that we can understand the situation and the thinking that Mr. Mattson brought to that situation is to have a full understanding of what exactly happened.
Q Okay. And so based upon those facts, as described by Mr. Mattson in both his deposition testimony under oath and his witness statement would -- are you able to reach an opinion to a reasonable degree of medical certainty as to whether this would constitute an emergency situation to employ a personal hold?

MR. GREEN: Object to form.

THE WITNESS: Yes, I believe that the circumstances described by Mr. Mattson qualified themselves as an emergency, you know, consistent with both the federal and state guidance in those areas.

BY MR. ROSEN:

Q Was Tyler Mattson, and perhaps Mr. Cains' safety at risk, based upon Mr. Cains' conduct as described under oath by Mr. Mattson?
A Yes. Mr. Cains certainly had the potential for harming Mr. Mattson when he engaged in lunging towards him.
Q And based upon the description of Mr. Mattson, as related in your report, the details, the dialogue, and the other documents that you read, was this emergency hold, to a reasonable degree of medical certainty, in your opinion --
MR. GREEN: Object to the form.
BY MR. ROSEN:
Q Were you able to form an opinion as to whether this emergency hold was applied by Tyler Mattson under these circumstances as described consistent with the CMS
State Operations Manual, Appendix "J" and DHS policy governing the use of restraints?
A Yes, I was. I --
Q Okay. What was that opinion, what is that opinion?
A I believe that Mr. Mattson's conduct in employing personal restraints in response to Mr. Cains' aggressive behavior was consistent with

the standard of care and consistent with CMS guidance, the Appendix "J" interpretive guidelines, Arkansas DHS policies and procedures, and with the standard of care for an RCT, who in a similar situation with similar training and experience would employ the same approach.

Q Okay. Now, let's jump ahead a little bit, because based upon review of the documents, the narratives and the witness statements, there came a point in time where Mr. Cains vomited, is that correct?

A Yes.

Q Okay. And based upon -- and you read more than just Mr. Mattson's deposition, did you not?

A I read every document that's on my -- in my report.

Q Okay.

A In addition to other materials.

Q Okay. And so we know based upon what you have just described what happened. Now they are on the ground. Mr. Cains has vomited and there came a point in time at that time when the staff realized there was a situation here that needed intervention. And were you able to determine what, if anything, the Booneville Human Development staff did after they

noticed that Mr. Cains had vomited and stopped breathing?

MR. GREEN: Object to the form of the question. I mean, he stated, and he can continue to state what Mr. Mattson testified to, but to characterize it as "we know what happened", I think is improper form.

BY MR. ROSEN:

Q Doctor Kastner, let me reword the question a little bit. Based -- Doctor Kastner, based upon your review of the records including the deposition testimony taken under oath, including the questioning by claimant's counsel of the direct care staff, what, if any, action was taken by Booneville Human Development staff once they were able to ascertain Mr. Cains had vomited and stopped breathing?

A Based upon the documents that I reviewed, the

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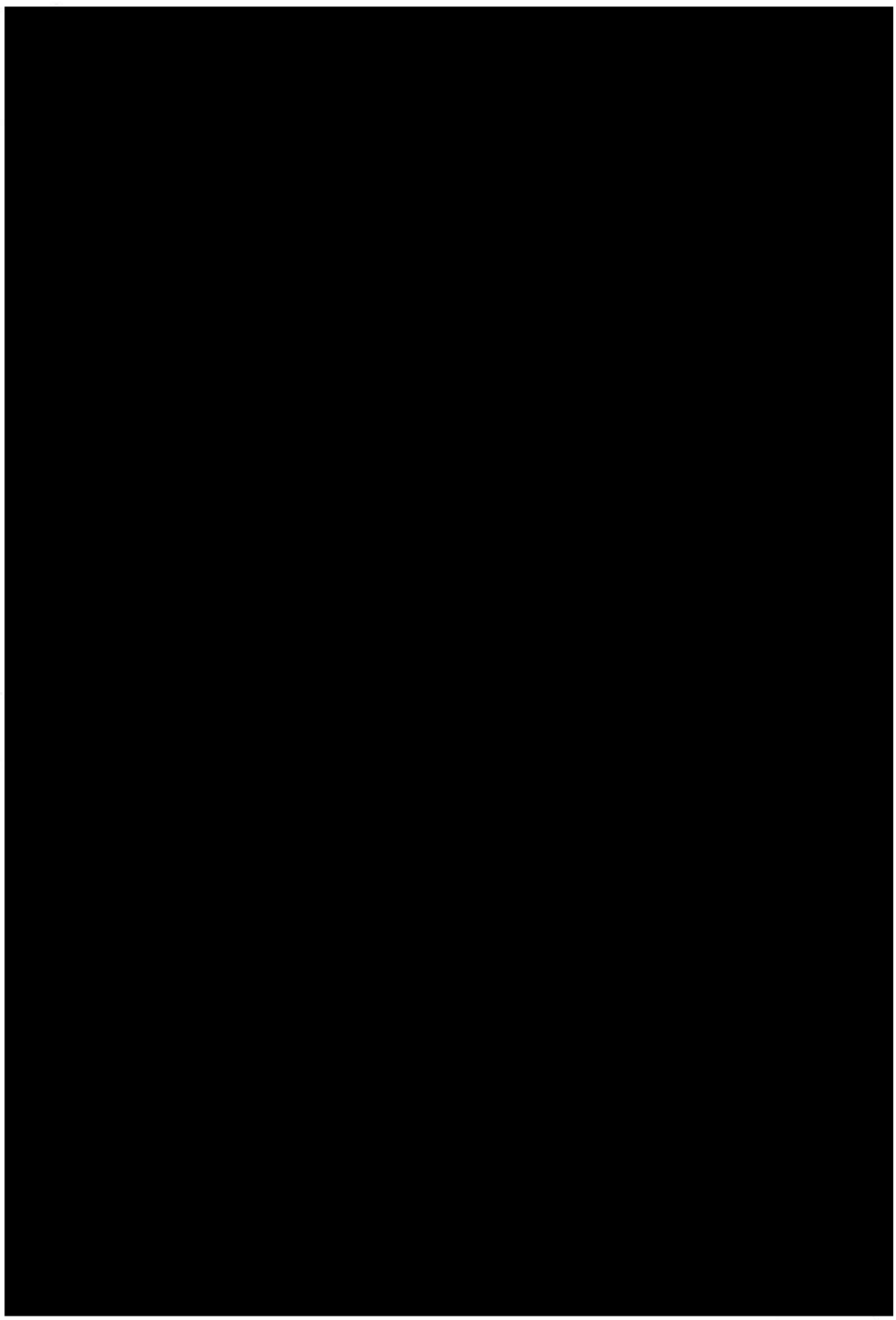

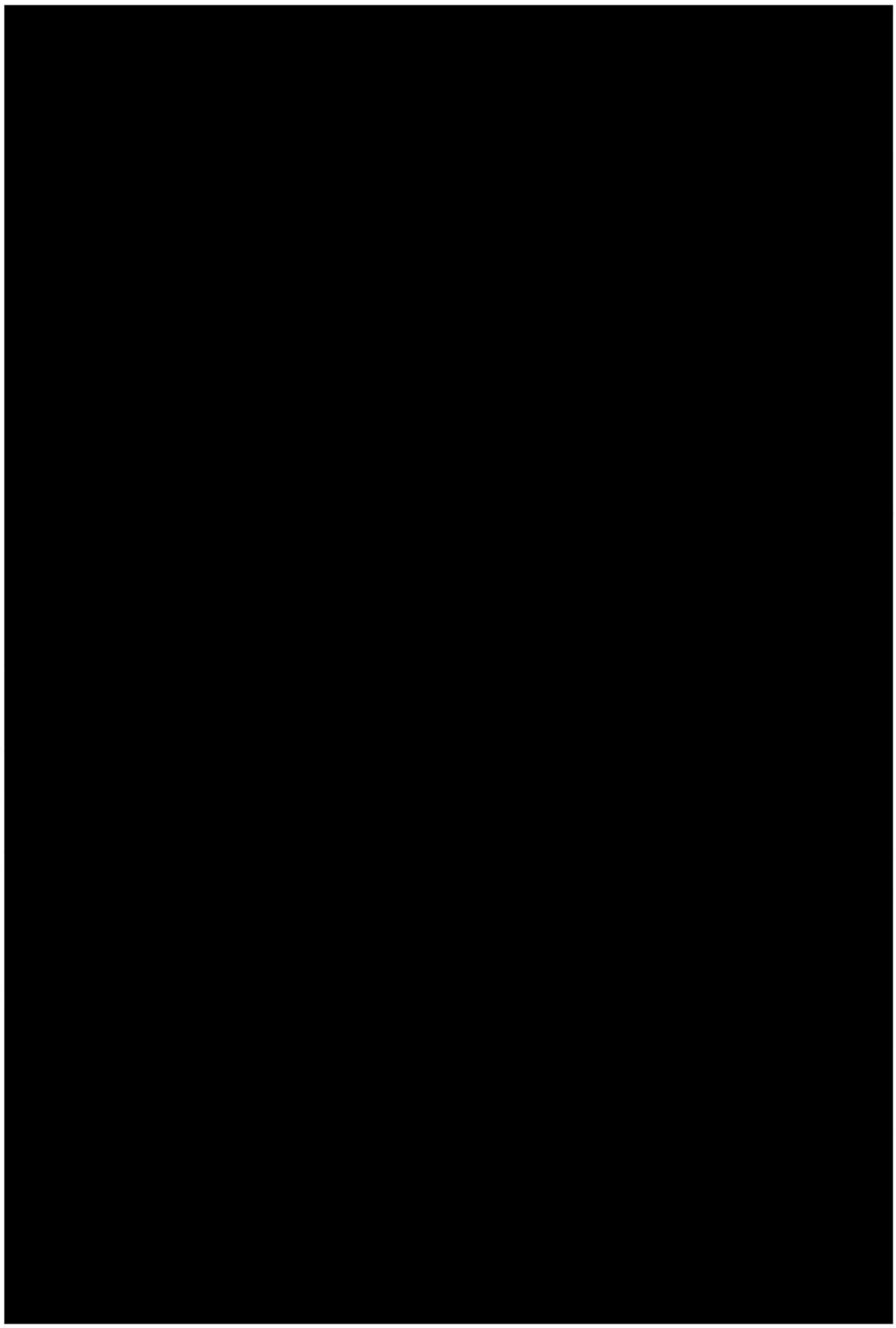

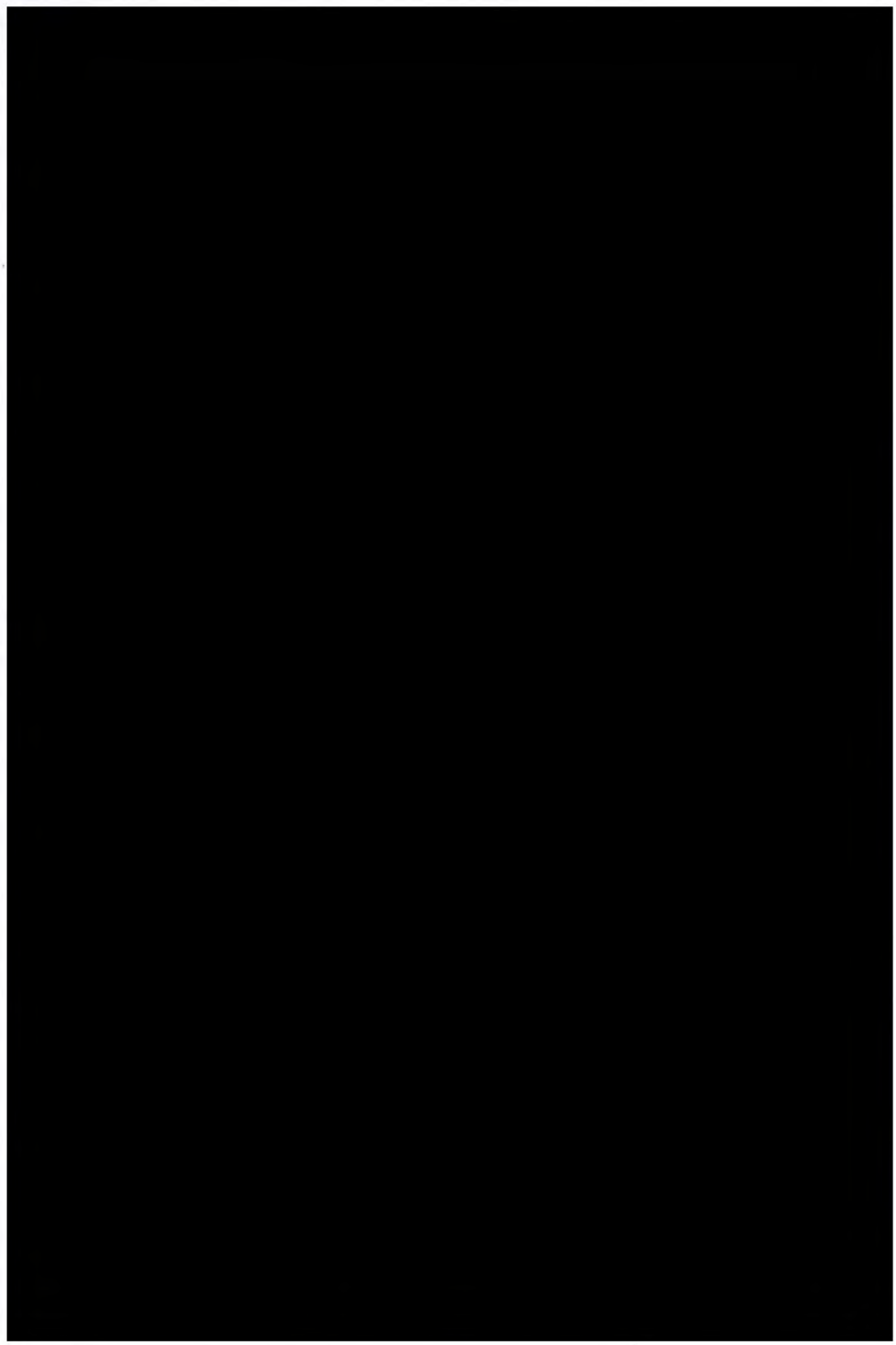

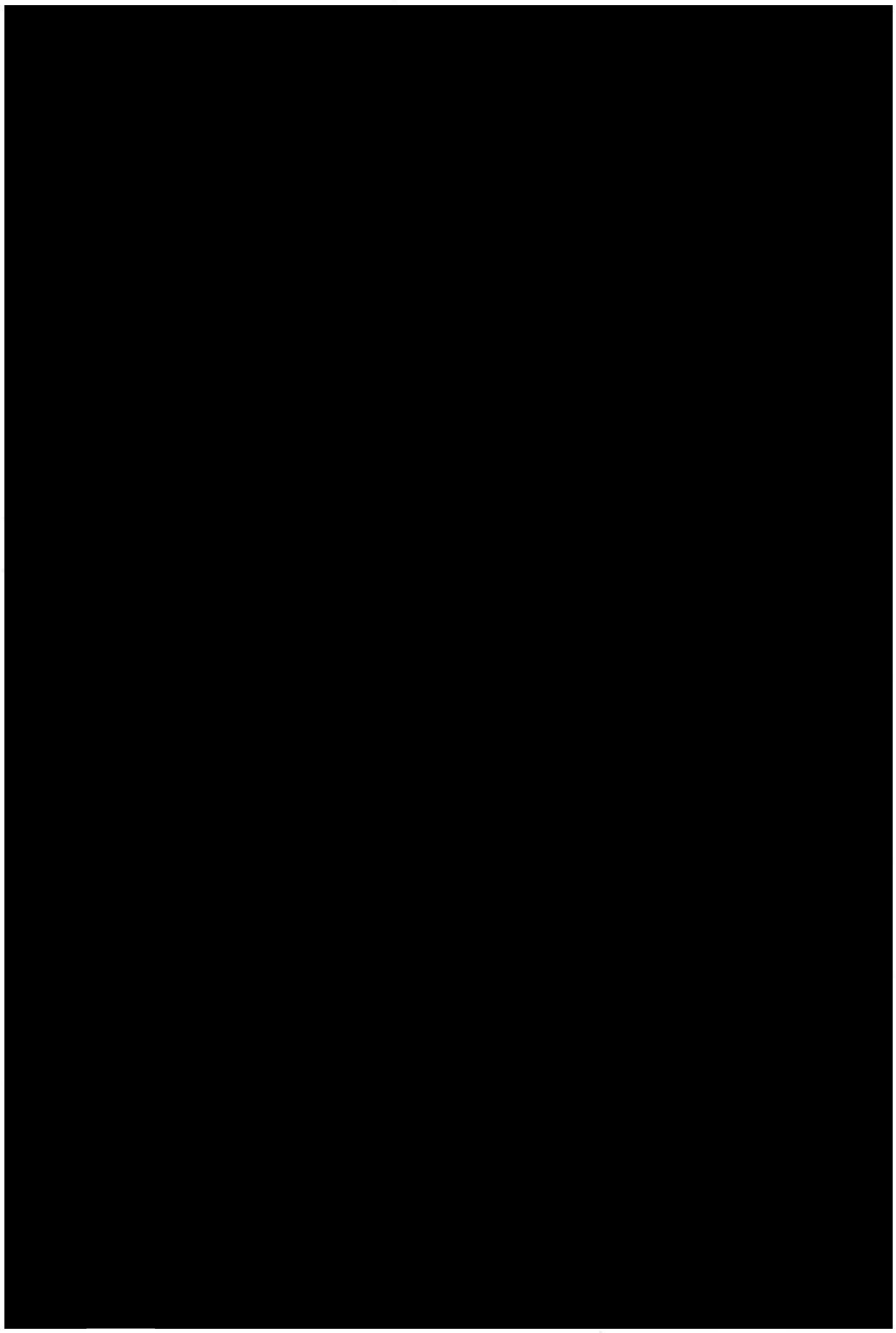

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Q Okay. And so EMT arrived, it took them 13 minutes -- no, strike that question. This is rural Arkansas, correct?

A Yes.

Q I mean, you are familiar with Booneville and where it is, correct?

A Yes, I am.

Q And so the response times are not a quick as perhaps they would be in New York City or in Little Rock, are they?

A I think response times are what they are, it took 13 minutes after the call was placed before Mr. Scow arrived at the scene and saw Mr. Cains.

Q And then, he waited approximately two minutes before he intervened?

A According to his testimony, yes.

Q Okay. That's about 15 minutes now, correct?

A Correct.

Q Okay. Now, the EMT, the ambulance people,

Mr. Scow, the ambulance were at the scene for how long?

A Oh, I believe they were there until at least 12:11, 11 minutes after 12:00 --

Q In the --

A I'm sorry, 12:18.

Q Well, 12:18, let me get to the reference about it.

A I'm sorry. 12:10, I'm sorry.

Q Okay. 12:10.

A Yes.

Q So they were there 20 minutes according to their time frame, correct?

A Yes, exactly 20 minutes.

Q And I think you were referencing, as you put in your report, that then, once they Booneville, it took eight minutes to get to the hospital, which would have been 12:18?

A Yes. According to the Logan County EMS record, yes.

Q Now, during the 20 minutes that the EMT was at the Booneville facility on that day, with regard to David Cains, based upon the records that you reviewed

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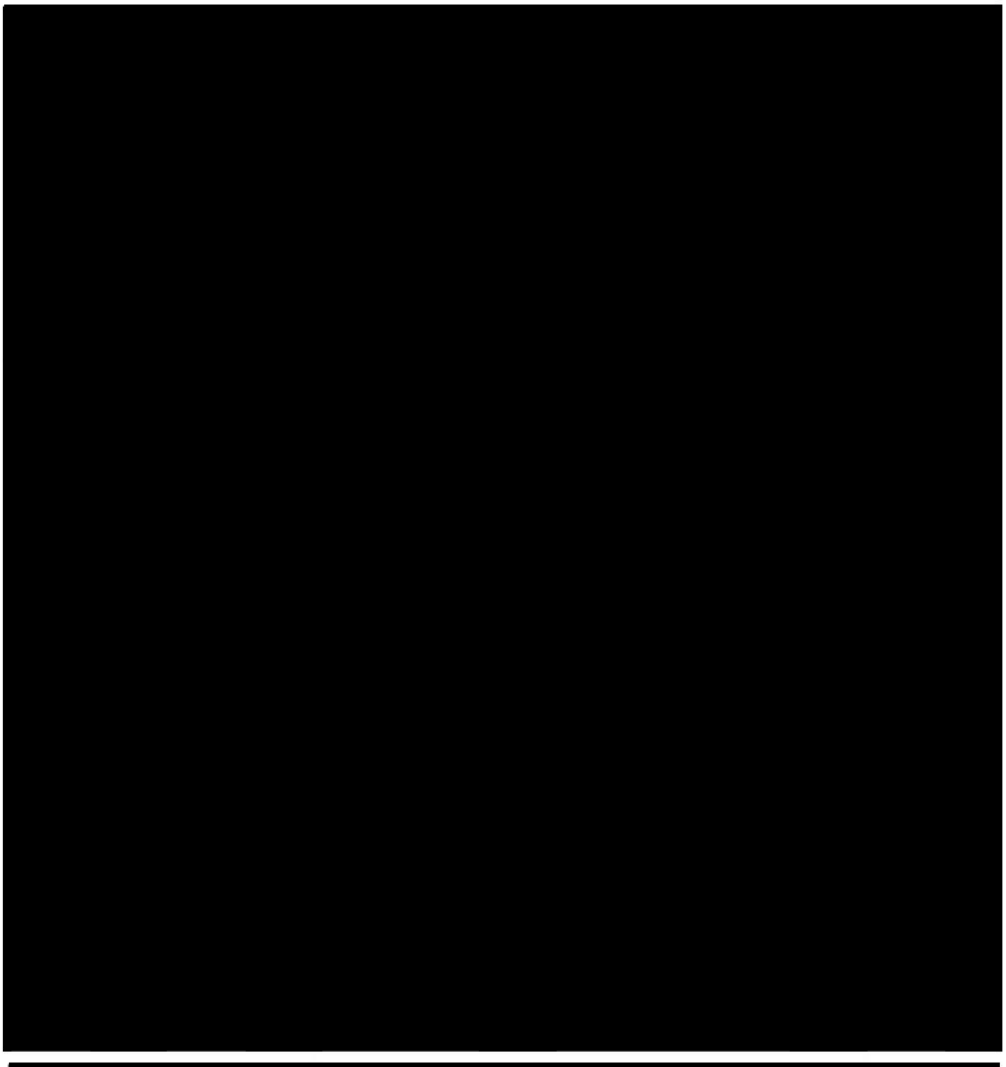
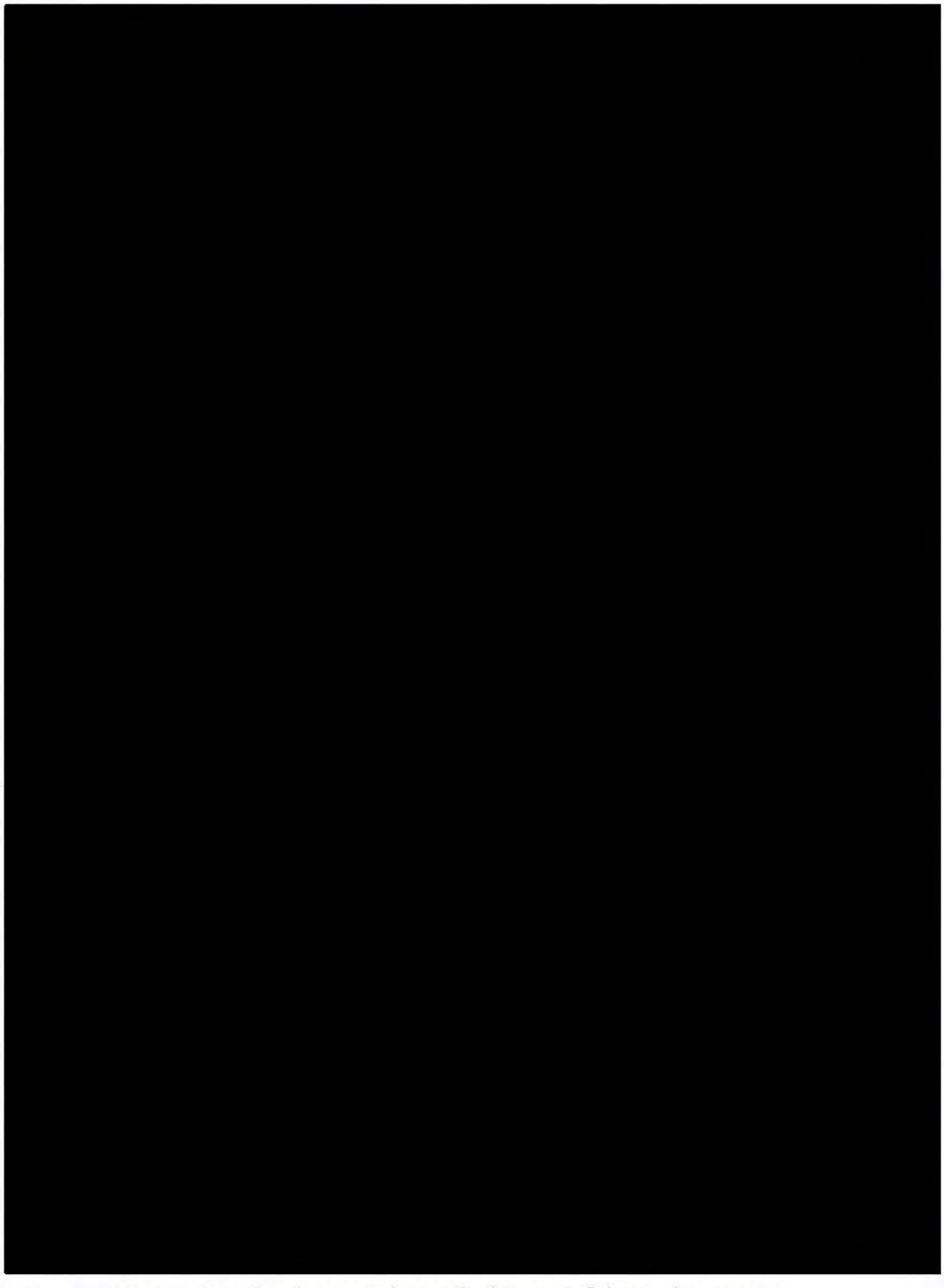




Q Now, you had mentioned it earlier in your

testimony, and it's referenced in your report, which is Exhibit 2-A, the January 5, 2023 report. You are familiar with Doctor Brown-Forestiere's opinions as expressed in her deposition, and in her responses to discovery that counsel provided DHS as to what her opinions are. Did you review those documents from the doctor that were provided?

A Yes, I did.

Q Did you review her -- also her deposition testimony?

A Yes, I did.

Q Okay. Now, in there, she spent a portion of her time talking about what she used the word, quote "fight or flight", unquote. Did you see that?

A Yes, I did.

Q As a medical doctor with three or four board certifications in specialty areas, and including a review of the deposition testimony of Tyler Mattson, which she did not rely upon at all in her opinions, were you able to form an opinion, based upon a reasonable degree of medical certainty, whether David Cains had a fight or flight instinct reaction when he was in a personal hold by Tyler Mattson?

A I found Doctor Forestiere's description of the fight or flight reaction, and it's applicability to

this specific set of events to be very confusing. I could not ascertain from her statement whether she was -- whether she believed that a flight or fight reaction occurred when Mr. Cains was placed in restraints, or when Mr. Cains vomited or when Mr. Cains was found to be not breathing.

I also found it odd for her to characterize Mr. Cains' behavior as a quote, unquote, "fight for his life", because I didn't understand where she applied that. I do not believe Mr. Cains was fighting for his life when he was placed in physical holds. I just don't know when that could have been relevant.

Q And I think, as you noted in your reports, and based upon questioning in deposition, even Doctor Brown-Forestiere admitted that she was unable to determine exactly at what point he would have been in a fight or flight situation and what David Cains was thinking, is that not correct?

A That is true. She was unable to describe when that fight or flight reaction did occur.

Q Okay. Now, I think, as you noted in your report, which is 2-A in regard to this, that David Cains had been -- well, let's just say David Cains had, based upon his IPP, he had a behavioral history

of physical aggression, correct?
A Correct.
Q And they define physical aggression in that IPP, and we don't have to go to that definition, but it's in there, correct?
A Correct.



Q So, and you reviewed -- did you review any behavioral reports or anything with regard to David Cains?
A Yes.
Q Okay. And so, and I think in your report you actually talk about, do you not, that -- about some numbers that he had been, due to his physical aggression, restrained at various points throughout his recent stay before he passed away, correct?
A Yes.
Q Now, did he ever -- so were you able to

ascertain or determine from Doctor Brown's opinions and her rationale for those opinions as to why in this particular event, under these particular circumstances, David Cains would have a quote, "fight or flight", unquote, reaction as opposed to all the other ones that he -- restraints that were employed against him?

A As I said, I found --

MR. GREEN: Object to form, mischaracterizes the doctor's deposition testimony.

BY MR. ROSEN:

Q Well, let me reword it just to clarify. Doctor Kastner, you read Doctor Brown-Forestiere's deposition testimony, correct?

A Correct.

Q Were you able to form -- or do you have any questions as to the medical basis for Doctor Brown's conclusions of fight or flight in this instance as opposed to all the other times he was restrained for his behavioral outbursts?

A Doctor Brown-Forestiere stated that, quote, "Your body instinctively fights as hard as possible to survive when it feels that it may be dying," end of quote. She goes on to say this is a very intense

struggle given your death being the alternative. I don't know how or where that applies in this specific instance.

Q As a matter of fact, I think she admitted it. Did you not see in her deposition that she admitted she didn't know how intense the struggle was?

A Well, she said that "What he thought was a fight for his life, and when it came down to that," comma, "I can't say," end of quotes. I don't think she could say with any confidence that he was fighting for his life when he attacked Mr. Mattson, when he was being restrained by staff, or after he vomited. And I just don't understand it's applicability at all to the scenario that was present.

Q Okay. Hold on. Give me a second right here. So based upon your review of the depositions and the statements of the various people that you were provided, and you have discussed, and the facts that they related, were you able to determine -- do you have an opinion to a reasonable degree of medical certainty whether David Cains would have thought that he was going to die as result of a particular hold, so as to trigger the fight or flight reaction?

MR. GREEN: I object to form, I don't believe that this witness is qualified as an

expert in being able to testify as to the internal thoughts of Mr. Cains.

MR. ROSEN: Well --

MR. GREEN: I don't know what scientific basis, also lack of foundation.

MR. ROSEN: Okay. Well, those would be the same objections that would be applied to Doctor Brown-Forestiere's testimony on that.

BY MR. ROSEN:

Q But I'm going to ask, Doctor Kastner, based upon the facts that you have seen, was -- and as described in the various deposition testimony, was there a fight or flight reaction?

A First of all, I don't understand what relevance a fight or flight reaction has to the delivery of behavioral services and whether or not they met a standard of care.

Q Okay. What's --

A But specifically to respond to your question, Mr. Cains had been restrained on at least 120 occasions in the past, and in none of those occasions had he died. His expectation would have been, based on prior experience, that he would survive being restrained, and once calmed down, restraints would have been removed. I don't understand what evidence

he would have relied upon to believe that the simple application of restraints would have represented a life threatening treatment.

Q Okay. Hold on one second. Give me a minute, please. Doctor Kastner, based upon your review of the deposition testimony, the direct care workers and nurses, Mr. Scow, the EMT, based upon the records that you reviewed, and your medical training and expertise and experience, to a reasonable -- do you have an opinion to a reasonable degree of medical certainty as to whether the outcome would have been different if 911 had been called approximately two minutes, anywhere from one to three minutes earlier than it was, knowing that the ambulance took 13 minutes to arrive and another nine minutes to [redacted] after that? Do you have an opinion on that?

A My --

MR. GREEN: I object to form, it exceeds the scope of this witness' expertise, he is not board certified in emergency medicine. So I'm going to object to form.

MR. ROSEN: Okay.

BY MR. ROSEN:

Q Doctor, first of all, I want you to remember that question, but you are a medical physician that has testified and are able to testify on cause of death, is that correct?
A It's sad, but I have testified --
MR. GREEN: Object to form.
THE WITNESS: -- on cause of death on many, many occasions. And I have completed hundreds of death certificates.
BY MR. ROSEN:
Q Okay. So you are legally and medically qualified to -- and have experience in determining the cause of death, and have determined the cause of death for individuals, is that correct?
MR. GREEN: Object to form. Whether he is medically or legally qualified is not a medical opinion that he can give. It's a legal opinion. The question calls for a legal opinion.
MR. ROSEN: No, it doesn't.
BY MR. ROSEN:
Q Go ahead, Doctor.
A Yes. I have performed that function in hundreds of instances.
Q Okay. And have you ever testified in a court of

law as to a cause of death?
A Yes, on many occasions.
Q And you were qualified as an expert physician with the qualifications of the National Foundation to do so?
A Yes, in particular in the State of Arkansas.
Q Okay. Now, so going back to the question, were you able to, based upon your documentation, your experience, your board certification, your medical degrees, your clinical experience and your working with the IDD and DD population, were you able to form a reasonable -- an opinion as to whether the outcome for Mr. Cains would have been different had 911 been called anywhere from one to three minutes before it was, knowing that the EMT arrived 13 minutes after the call and took another nine minutes to partially clear the airway?

MR. GREEN: Object to the form, again, exceeds the scope of this witness's area of expertise.

MR. ROSEN: Okay. Well, I think we have already established that it doesn't.

BY MR. ROSEN:
Q But go ahead, Doctor.
A Any alleged --

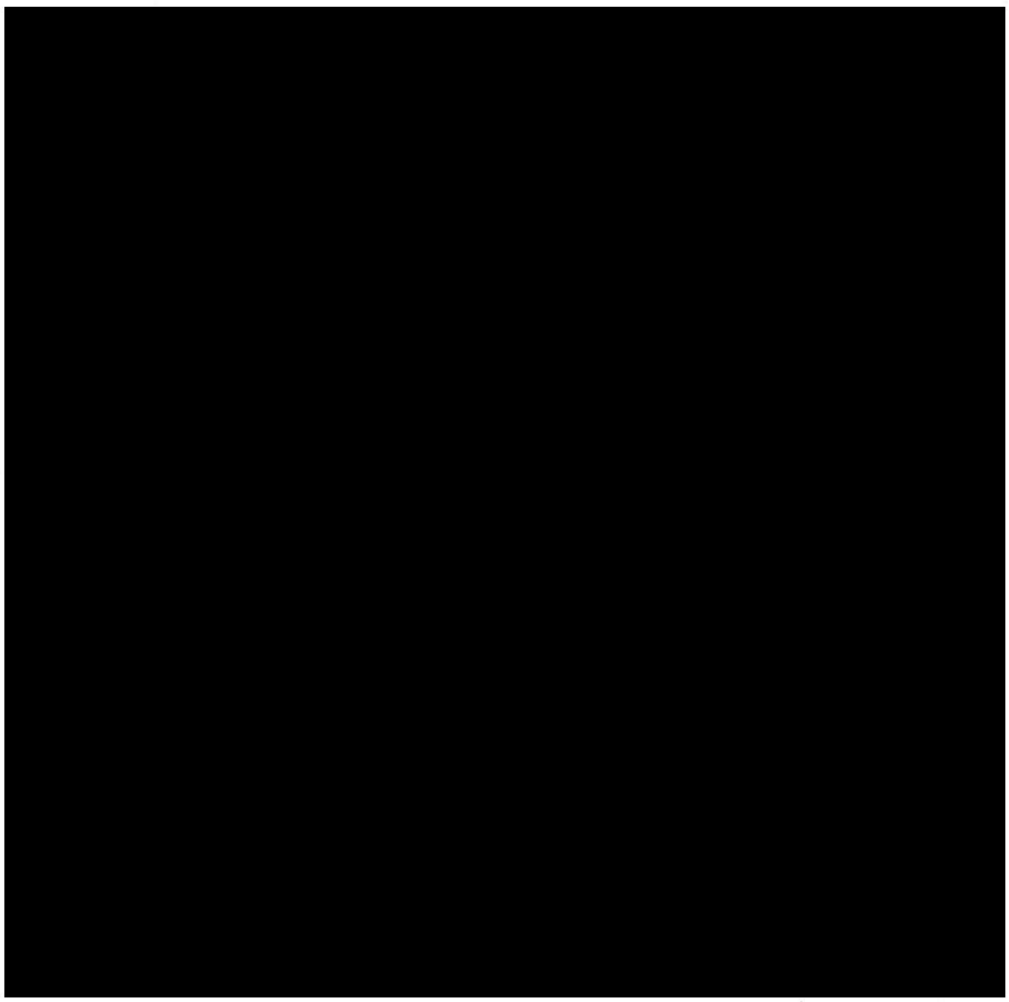
MR. GREEN: Well, let me -- it's fine for you to go ahead and move forward with the questioning. But nobody has established anything. There is no judge here, so I would just ask not to declare what had been determined. There is no determining body here. But Doctor, sorry, go ahead and answer.

THE WITNESS: Now I feel free to testify. Thank you for allowing me to continue.

BY MR. ROSEN:

Q Go ahead.

A There is no evidence that any alleged delay in contacting the Booneville Emergency Response System resulted in any harm to Mr. Cains or contributed to his death. As I noted earlier, at the time Mr. Scow arrived, [redacted]



Q Hold on one moment, Doctor. Now, on page 44 of your January 5, 2023 report, which is Exhibit 2-A, let me get to it, you make a reference to Doctor Brown-Forestiere's opinions on the standard of care, and applying that standard of care for a hospital emergency room to direct care aides in the Booneville Human Development Center in Logan County, Arkansas? Did you see that?

A I'm sorry. Can you just refer me to the page number?
Q Yes, page 44 of Exhibit 2-A.
A I am scrolling down now. Okay, I'm there.
Q And before -- and I guess beginning on page 43, you are referencing and quoting Doctor Brown-Forestiere's deposition testimony with regard to her training as a physician, correct?
A Correct.
Q Okay. And then, you express an opinion about -- well, strike that question. In her testimony, Doctor Brown-Forestiere seemed to indicate to me as a layperson, and I will ask you about it, that she was applying a hospital emergency room standard of care to the Booneville Human Development Center and direct care aides administering lifesaving procedures. Did she --

MR. GREEN: Object to form, leading.

BY MR. ROSEN:
Q Well, I'm only asking, did you note that in your -- right now, did you note that in your -- on page 43 and 44 of your report, which is Exhibit 2-A?
A Yes, that is true. I believe that Doctor Brown-Forestiere substituted the standard of care for a physician working in an emergency room or critical

care setting for the standard of care for a direct support professional or RCT working at a human developmental center. And --

Q Okay. Now, we know that Tyler -- these RCTs, these aides, this direct care staff at the Booneville Human Development Center, they are not physicians, are they?

A Correct, they are not.

Q And they are not in a hospital emergency room, are they?

A Correct.

Q And as a physician, a clinician, an expert in working with -- as an expert in being a medical doctor and working with IID and DD individuals, would that be an appropriate analogy to apply a physician, an emergency room physician standard to aides in a rural county in Arkansas?

A The only standard of care that is applicable to the conduct of an RCT in performing their duties is the standard for what an RCT is expected to know and to do. And that would be based upon their training, their experience and their judgment as to what was the most appropriate course of treatment.

Substituting a physician's judgment for what would be appropriate in a specific setting would be

inappropriate, because the training for a physician is so much different than that received by an RCT.

Q Thank you. Hold on one second, Doctor. Let me just review my notes. Now, I'm directing your attention to page 45 of your January 5, 2023 report, which is Exhibit 2-A, you express an opinion there, which is item number 13, and while this is in the record, and we not going to go through every one of your opinions, I do want to ask you about this one in particular. Do you have your report in front of you?

A Yes, I do.

Q And item 13, what was your opinion that you expressed in there?

[redacted]

Q Okay. Now, and then you cite extensively from Doctor Brown-Forestiere's testimony, do you not?

[redacted]



Q Okay.

A I don't think there was any disagreement about that.

Q Okay. And on page 49 of your January 5, 2023 report, Exhibit 2-A, you express an opinion based upon a reasonable degree of medical certainty that Mr. Cains' death was not accompanied by severe pain, and you go through and explain that. Can you -- is that your opinion?

A Yes, that is my opinion.

Q Okay. And tell us, based upon your experience and knowledge, how you know this, how you reach that opinion?

MR. GREEN: Sorry, I couldn't get unmuted. I just object to the form, it exceeds the scope of this witness's expertise. I don't believe he is an expert in the mechanisms of pain and pain management.

MR. ROSEN: Well, I don't know that Doctor Brown-Forestiere was, based upon her credentials.

BY MR. ROSEN:

Q But Doctor, go ahead and testify. That is your opinion, it has been admitted here. Can you tell us the basis for your opinion?

A My opinion was that Mr. Cains' death was not accompanied by severe pain. And I think the point -- the place to start in that discussion is to begin with a generally accepted definition of what pain actually is. And fortunately there are people who studied this, and in 2020 the International Association for the Study of Pain agreed upon a definition, which included two components. One being a sensory or emotional experience, and the second being actual tissue damage.

And in order for an individual to experience pain, both conditions need to be met. And in

particular, actual or potential tissue damage needs to be present. Doctor Brown-Forestiere claimed that the two most painful causes of death would be strangulation or suffocation and burning. I have no idea where that came from. It makes no sense to me in terms of how we, as physicians, conceptualize pain, because obviously in burning there is an extraordinary amount of tissue damage. But in strangulation or suffocation there is generally much less.

And there are other causes of death which have the potential for much greater degrees of tissue damage. Going specifically to Mr. Cains, I don't believe that he experienced any moderate or severe degree of tissue damage prior to his becoming unconscious. And as a result, I don't believe he meets the criteria that were set forth by the International Association for the Study of Pain, or having experienced pain subsequent to his -- or prior to his death.

Q Okay. And in addition to that, Doctor, you have also -- strike that question. I think earlier in your testimony you had testified as to that you have been qualified to talk about in Courts to about life expectancy of individuals in facilities?

A Yes.
Q Okay.
A In or -- within or without facilities, yes.
Q Okay. So life expectancy in general?
A Correct.
Q And on page 51 of your report, you state in item number 15 that, "Based upon a reasonable degree of medical certainty, Mr. Cains had a life expectancy of only six more years." Is that your opinion?
A Yes, that is my opinion.
Q Okay. And tell me how you reached that opinion.
A In general the mortality rate for the general population is about eight per thousand per year. For people with intellectual and developmental disabilities, depending upon where they live and their age and their related medical conditions, the range in mortality rates is anywhere from 16 to 60 deaths per thousand. I have actually been involved with the CareOne facility where the mortality rate was 200 per thousand in a single year.

So in general we all recognize that the life expectancy of people with intellectual and developmental disabilities is shortened simply because of the presence of the intellectual and developmental disability. There are other factors

which contribute to a shorter life expectancy, and I referenced a few of them, obesity, epilepsy, serious mental illness.

All of those factors have a secondary impact on shortening the life expectancy. So I simply provided a couple of references, not meant to be exhaustive, but to demonstrate that there is a basis for my opinion in why the life expectancy would be shorter. And in my experience working with people, and in my experience as a researcher, having published in the area of life expectancy, my opinion is that the life expectancy was only six years more.

[redacted]



Q Okay. Thank you, Doctor.

MR. ROSEN: I'm going to move to another subject, but before we do, this is directed towards counsel, Mr. Green, Mr. Gillispie. It is now 11:40 Central Time and 12:40 Eastern Time where Doctor Kastner is, I'm suggesting we take about a 45 minute break. I probably have about another 45 minutes after that, and then we can commence with the cross-examination. I'm asking what your thoughts on that are.

MR. GREEN: I think it's good to go ahead and break. I have got like 11:38.

Why don't we come back at 12:30 Central Time, that's like 50 minutes.

MR. ROSEN: Okay. Doctor, I didn't ask you, I should have asked you. Are you okay with that as well?

THE WITNESS: As I said, I am perfectly comfortable working around whatever time frames you both agree on.

MR. ROSEN: Okay. Well then, why don't we do this and, Ms. Petre, we will pause the deposition here. I'm going to leave my screen on so I don't have to do the Zoom back in. I will just turn off my -- I will mute it and turn off the video. And we will all meet back here at 12:30 Central, 1:30 Eastern. Okay?

MR. GREEN: See you at 12:30.

MR. ROSEN: Thank you, everybody.

(WHEREUPON, a lunch break was taken.)

MR. ROSEN: We're back to the deposition after a lunch break.

BY MR. ROSEN:

Q Doctor Kastner, we have already introduced your report, which is Exhibit 2-B, which is the January 6, 2023 report, mostly dealing with Doctor LeBel and the

issue of restraints. We are going to switch gears and start talking about that report, and it has already been introduced into this deposition. So I do want to start, and again like the other report. Your report has like a -- like an executive summary of all of the opinions at the beginning and then goes through and explains the rationale and the medical basis, and the basis for your opinion.

But I want to start out on this subject area, asking you to turn to page three of the January 6, 2023 report, which is Exhibit 2-B.

A Yes.

Q Okay. And so in there, your first opinion, based upon a reasonable degree of medical certainty, you state that, "CMS rules and regulations, ARDDS policies and procedures and BHDC policies and procedures represent the standard of care for delivery of behavioral services at Booneville HDC."

A Yes.

Q Do you see that?

A Yes.

Q Is that your opinion?

A Yes, it is.

Q And when you are talking about CMS rules and regulations, you are talking about the CFRs, the Code

of Federal Regulations, and as applied to Booneville Human Development Center, the CMS State Operations Manual, Appendix "J", is that correct?

A For the purposes of interpreting CMS rules and regs, yes.

Q Yes. And including the Booneville policies as well?

A Correct.

Q And so your next opinion, and that's why I ask you this, is that -- number two on page three of Exhibit 2-B, your January 6, 2023 report. You state, "Based upon a reasonable of medical certainty, other documents cited by LeBel," and you are referring to Doctor LeBel, the psychologist, with a Ph.D. in education as well, right?

A Yes, I am referring to Doctor LeBel.

Q That's what you --

A Yes.

Q Yes, to Doctor LeBel. You state that "other documents cited by LeBel, including materials generated by United Nations, the World Health Organization, SAMSHA," which is S-A-M-S-H-A, "and other sources, do not represent the standard of care for delivery of behavioral services at Booneville Human Development Center, Is that your statement?

A Yes.
Q Okay. And is that -- and I think we have established you reviewed Doctor LeBel's deposition and her report, did you not?
A Yes.
Q Okay. And in her report, did she not, at least, argue that the standard -- and her deposition that -- or at least insinuates that the standard of care per the Booneville Human Development Center was determined by the United Nations and the World Health Organization and SAMSHA, and a few other organizations?
A I think her report is difficult to interpret, because she offers her opinions in two different places in the report, and the opinions are not the same. On page one, or the first time she iterates her two opinions is materially different than the second place where she offers her opinion. So it makes it difficult to know exactly what her opinion is.
Q And I think -- so that's why I just want the record to be clear. Based upon your knowledge of the rules and regulations pertaining to ICF/IID, of those like Booneville Human Development Center, is it World Health Organization and United Nations guidelines

that apply that determine the standard of care to be applied or is it CMS regulations interpreting the federal rules that apply?

A It is CMS regulations, which interpret the federal rules, in addition to the Arkansas and facility specific regulations, which can exceed the standard -- I will call it the minimal standards set by CMS. So Arkansas and BHDC are not constrained by a CMS if they wish to enact rules and regulations that might exceed in some way this CMS standard. But they at least, from a minimal perspective, need to be in compliance.

Q And that's -- but just to make it clear, my point being, is because of her testimony and reference to the United Nations, the World Health Organization, SAMSHA, and other nonCMS or Booneville or Arkansas sources is not the standard to be applied, correct?

A Correct.

Q Okay. But I think it -- have you read -- did you read -- strike that question. Now, we know that, from what you -- well, you have stated and other witnesses stated, that the Appendix "J", the State Operations Manual's standard of care, and that also addresses how and when to perform restraints of

residents, does it not?
A Appendix "J" is the interpretive guideline used by CMS to make a determination as to whether a facility complies with rules and regulations that CMS has established.
Q Okay. In Doctor LeBel's report, which you examined, correct, you reviewed?
A Yes.
Q She states that a -- in some places that a resident has the right to be free from abuse and restraint, does she not?
A She specifically states that residents have, quote, "a right to be free from abuse and restraint," end of quote.
Q Okay. And so would you agree with -- I mean, obviously with regard to abuse, I think, would you agree with the abuse, that they have a right to be free of abuse?
A Yes, I would.
Q Okay. And we are not talking about abuse in this case, are we?
A No, we are not.
Q Okay. We are talking about restraints here. Does other CMS regulation, does -- or even the CFR is just why you have a right to be free, a client of an

HDC have a right to be free from restraint?
A There is no such unqualified right contained within the CFR or CMS rules and regulations or Appendix "J".
Q So to the extent Doctor LeBel holds an opinion that a resident of an ICF/IID, such as the Booneville Human Development Center, has a right to be free from restraint, would she be incorrect in that opinion?
A It's not simply a matter of her being incorrect in that opinion, it would have bearing upon her continuing to them use that as a standard of care with expectations that it could be met by BHDC. And it's an unrealistic expectation, because BHDC could never be expected to comply with, you know, that requirement that there be an unconditional right to be free from restraint.

BHDC is licensed and approved by CMS to operate a clinical treatment model, which incorporates restraint as one of the potential treatment modalities. It's contradictory to say that they would be approved to use those modalities, and at the same time residents had an unqualified right to be -- to not be subject to restraint.
Q Okay. And so just following up on that to be clear, CMS and the CFRs do authorize, when in

compliance with their rules and regulations as interpreted by CMS, restraint of resident under those conditions?

A CMS recognizes the use of restraint as an approved treatment modality under certain conditions.

Q Okay. So in the United States of America and particularly in Arkansas and in Logan County, restraints in an ICF/IID, such as the Booneville Human Development Centers, when performed in compliance with CMS regulations as interpreted and Booneville Human Development Center policy, would be okay?

A It would be consistent with the standard of care.

Q Okay. So anybody, including Doctor LeBel, who said otherwise would be -- what would they be?

A They would be mistaken when Doctor LeBel states that individuals have a right to be free of restraint, she is mistaken, period, you know, there is no right for individuals in an ICFMR to be free of restraints. Restraints may be used subject to certain conditions.

Q Okay. Hold on one second. Now, in your report, which is Exhibit 2-B, your January 6, 2023, on page four you state that, quoting Doctor LeBel's report,

quote, "Physical restraint is a potentially lethal procedure of last resort which is used as an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or ruled out," and she was citing 42 CFR Section 483.450. And that's on her report on page four as well. Are you familiar with that?

A Yes, I am.

Q Is she accurate in that her requirement of imminent danger in the CFR, and then -- that's cited?

A No. I found this statement to be extremely confusing and misleading. I went to review CFR 483.45, I could find no language that specifically identified a condition for the use of restraint related to imminent danger.

Q Okay. That's --

A That language, "Imminent danger" did not appear in CFR 483.450.

Q Okay. And have you checked to see whether it appears in the restraint requirements under the Appendix "J" from CMS?

A Imminent danger does not appear anywhere in CFR, Appendix "J" or state or facility specific, you know, following these procedures. I don't know how anyone could have come to believe that language is

reflective of the standard of care.
Q And we are talking about the standard of care for restraints if used, correct?
A Correct.
Q So imminent might be different standard, but that's not the one that is applied -- imminent danger might be some type of reference or standard for some other type of situation, but not for the use in administration of restraints in an ICF/IID, is that correct?
A Correct. An assessment of the risk of danger in leading to the use of restraints does not require that assessment of the risk of danger be imminent.
Q And so to the extent that she imposed that additional requirement, would she be wrong?
A She would be wrong, correct.
Q Now, I also want to point out in your report, Exhibit 2-B, which is the January 6, 2023 report on page five of your report, number, your opinion number 11, you state, "Based upon a reasonable degree of medical certainty, while on the floor, Mr. Cains continued to demonstrate aggressive behavior towards Mr. Mattson and, subsequently, to other staff." Are you familiar with that opinion?
A Yes, yes, I am.

Q And is that based upon your review of the deposition testimony of Mr. Mattson and the other direct care staff who were present?

MR. GREEN: Objection form, exceeds the scope of this witness's areas of expertise.

MR. ROSEN: Well, I would disagree in that I'm asking him whether he reviewed the transcript testimony of those witnesses.

THE WITNESS: Yes.

BY MR. ROSEN:

Q Doctor --

A Yes. I reviewed the transcript testimony of the witnesses, and witnesses indicated that Mr. Cains spat at Mr. Mattson and attempted to hit or strike Mr. Mattson and/or other direct care personnel.

Q And so based upon your review of Mr. Mattson's testimony and statements and the other witnesses who responded, direct care staff who responded, and their statements and testimony that you reviewed, based upon that testimony were you able to ascertain whether Mr. Cains had calmed down during the restraint while on the floor or not?

A The testimony of the witnesses indicated that Mr. Cains had not calmed down or achieved control over himself, which would have then allowed the staff

to remove the restraints.
Q Okay. And so by any chance -- so you are familiar with the references in Appendix "J", right?
A Yes.
Q And so Appendix "J" has been provided to counsel in both discovery and it has been admitted to other depositions several times. I'm going to ask you, so in Appendix "J", I'm going to ask you to look at W296, it's a section reference.

MR. GREEN: Rich, I'm sorry. Did you say you were admitting this as an exhibit, Appendix "J"?

MR. ROSEN: I haven't yet. But what I was saying is that that has been provided to you many times.

MR. GREEN: It has. I just wanted to make sure I didn't -- I mean, I don't object to it being admitted, I just wanted to make sure I didn't miss it.

MR. ROSEN: Okay.

BY MR. ROSEN:
Q Doctor Kastner, are you there yet?
A Yes, yes, I'm -- I'm here.
Q And so W296 is interpreting the CFR 483.450(d)(1), and for the lack of better terms, two

little (ii)s, correct? That's what it says, does it not?
A Can you give me a page number, would that be possible?
Q Yes, it would be. Hold on.
A I can do a quick search.
Q I don't know that it has page numbers on it.
A The pdf does.
Q It's under the restraint policy.
A Right, I see it, it's page 158. Okay.
Q Okay.
A Yes.
Q And so one -- I'm referring to Appendix "J", section W296, do you see that?
A Yes, I do.
Q Okay. And so this is, as we have -- as you have stated before, this is the Federal Government CMS's interpretation of how to apply the federal rules in facilities, correct?
A Correct.
Q Okay. Now, and this is interpreting 42 CFR 483.450(d)(1)(ii)?
A Correct.
Q Okay. And that is -- this is the restraint policy for the use at the Booneville Human

Development Center, at least the federal requirement, correct?

A Correct.

Q And so even guidance from CMS as to how it needs to be applied, the standard to be applied, it says, "Physical restraint may be used as emergency intervention only in situations where the client is exhibiting behaviors which:", and it has three, one being "the client has not exhibited before"; two, "were not identified in the functional analysis of behavior; or three, "are harming other people or themselves".

Now, you are familiar with this document and that section, are you not?

A Yes, I am.

Q Okay. And so would people who were familiar with the operation and administration of ICF/IIDs and the administration of restraint use in there be expected to understand these as well?

A Let me provide you with a little bit of context. CMS allows restraints to be used in two broad categories of application. The first being what are called program restraints, which would be very much described in the individual's behavior treatment plan. And the second would be emergency restraints.

And so we are referring here in this section to the application of restraints in emergency situations, not program restraints, which would be characterized in a very different way. These are restraints which are being used specifically to address more of an emergency situation.

Q Okay. And so -- okay.

A That's important, because some people would say, "This is a program restraint," and it's not. And therefore, it won't meet the same standards for documentation as a program restraint.

Q Okay. And so for those people that -- and as a matter of fact, both in the CFR and in the guidance of the CFR, the interpretation of the CFR has to be applied, says, talks about an emergency interventions, is that correct?

A It's an emergency safety measure as is noted here.

Q Okay. And so you are explaining that there is also, I guess, program intended restraint use, but that's not what we are talking about here?

A Correct. And it's important not to confuse the two, because program restraints are more fully described in the behavior support plan. Whereas emergency restraints are employed to address, as it

notes here, emergency safety measures to support the health and safety of individuals and the staff at the facility. So these are different, and the criteria for their use and the manner in which they are used is very much different.

Q Okay. And so what I'm asking is, is that, so there is -- for emergency restraint use, it identifies three circumstances, with semicolons, using an "or". Do you see that?

A Yes.

Q Okay. How would you -- how is that applied and interpreted by CMS, how is the "or", what is the -- strike that question. Let me ask you. What is the impact of the disjunctive "or" in interpretation or application of this policy?

MR. GREEN: Object to form, calls for a legal conclusion.

BY MR. ROSEN:

Q Go ahead.

A The functional level. If individuals are engaging in behaviors which can harm other people or can harm themselves. Staff meets the standard of care when they apply emergency safety measures, including the application of restraints.

Q Okay. So when you are -- would it be people who

are familiar in this industry, would they -- would all three have to be existing at the same time or is it any or all of them, or any of them rather?

A In this instance, if staff are -- I'm sorry. If the individuals being supported at the facility engage in behaviors which are harmful to people or themselves, staff are permitted to use emergency safety measures, including restraint, to address those behaviors.

Q So you don't need one, two and three, because it says "or", you would need one, two or three that are listed, is that correct?

A I think that's a reasonable interpretation. There are some behaviors which may be addressed through, as we described it, the planned behavioral programming. But in this instance, for the purposes of emergency intervention, it is appropriate to use those emergency safety measures when individuals are harming other people or themselves.

Q Okay. So, and you would expect that some, would you -- let me ask it this way. Would you expect somebody familiar with these regulations and interpretations of CMS, as applies to ICF/IIDs to know that not all three of them are required at the same time under emergency intervention?

A Yes.
Q Okay. Now, also, since you have your -- the manual out, the -- excuse me, Appendix "J" out, I'm going to ask you to look at W302, okay? And W302, which is a few pages later states, you know, it's applying 42 CFR 483.450(d)(4), which says, "The client," just says, "released from the restraint as quickly as possible." Okay. Do you see that?
A Yes.
Q Okay. And the guidance from CMS is defining here what "quickly as possible" means?
A Yes, I see this.
Q Okay. And so how does the state -- CMS in their State Operations Manual, Appendix "J" define "release as quickly as possible"?
A CMS and the surveyors want individuals to be able to control themselves, and specifically in regard to how long restraints should be used, "As quickly as possible" means the time at which a determination is made that the individual is no longer a danger to theirself or others as manifested by their becoming calm.
Q In fact, becoming calm is exactly what the interpretation says, correct?
A Correct, yes. That's the observable measure,

the behavior that staff would need to observe in order to ascertain that the individual was no longer a danger to themselves or others.

Q Okay. Now, just working our way through these opinions, and again, your opinions. I'm not going to go through every one, because they are in the record. But on number 15 on page five of Exhibit 2-B, you state, "Based upon a reasonable degree of medical certainty, Booneville Human Development Center personnel are not required to demonstrate," quote, "imminent danger," unquote, "before the use of restraint." Is that your opinion?

A Yes, it is.

Q Okay. And that -- and you have explained this a few minutes ago when we were talking about the requirements, or lack of requirements, for imminent danger and the use of restraints, right?

A Correct. The staff need to use the correct language in order to reach a determination as to whether or not restraints should be used, or not, and imminent is not a criteria or a categorization of the risk that occurs within any of relevant guidance.

Q Are you familiar with -- let me ask you this. Do you know what the Booneville Human Development Center maltreatment reporting requirements are?

A I'm familiar with them, yes.
Q Okay. And so there is a -- so is there a difference between employment of restraints and the requirement to report abuse, are they two different things?
A They are very different things,
Q Okay. Now, again referring back to Exhibit 2-B, your January 6, 2023 report, on number 17 you state, "Based upon a reasonable degree of medical certainty, Mr. Cains did not demonstrate a, quote, "withdrawal reflex", period, unquote.
A Correct.
Q And you reviewed, as you said, Doctor LaBel's report and testimony, and she made those references about a withdrawal reflex. Do you recall that?
A Yes, yes, I do, very much so.
Q And that's why you put that in there, to discuss that, correct?
A Yes. I read Doctor LeBel's opinion and her description about what a withdrawal reflex was, and I actually reviewed the citation that was included in her report. Doctor LeBel characterized "withdrawal reflex" as an autonomic nervous system response, which was primarily defensive. She referred specifically to the reflex as having its origins in

the autonomic nervous system, which is completely inconsistent with even the most basic understanding of neuroanatomy and neurophysiology.

The autonomic nervous system controls hear rate, blood pressure, breathing rate and sexual arousal. And I don't understand the relevance of any of those systems to a withdrawal reflex. And reflexes, by their nature, are involuntary. It's inappropriate to characterize a reflex as either defensive or offensive, they are neither. They are simply a reflection of the way the nervous system is wired.

Reflexes are observed, not withdrawal reflexes, in particular, observe primarily an individual to have severe brain injury. The article makes it clear that they are talking about things like the withdrawal of the large toe to stimulation on the bottom of the sole of the foot. I have no idea what she is talking about. It's inconsistent with neuroanatomy and physiology.

There is nothing behavioral that she can describe in terms of what a withdrawal reflex would look like. It's just -- it's gratuitous, that's all I can say.

Q Okay. And so you know, as a layperson, she -- and I understand you disagree with her, and you are a

physician and she is not, right?
A I am a physician and she is not. That is correct.
Q And so I see here she is talking about a withdrawal reflex, which you have just described what it really -- what that means. Another witness, Doctor Brown-Forestiere said, "fight or flight" reaction. Is that something different than a withdrawal reflex?
A Withdrawal reflex reflects the anatomy of the nervous system. There is a sensory nerve -- let's say we are talking about the bottom of the foot, there is a sensory nerve in the bottom of your foot, it runs all the way from the bottom of the foot to the spinal cord. That is one nerve cell, reaches all the way to three feet in length, connects to a motor neuron in the spinal cord, which goes back down to the muscles of the foot, and activates a withdrawal of the foot when you stimulate the sole of the foot.

That's really -- spinal cord anatomy, the fight or flight reaction is related to a discharge of norepinephrine from the adrenal glands, which sits on top of the kidney. It's -- it involves the nervous system to the degree that, again this is an involuntary function, and they have some -- the

nervous system has an impact on the discharge of catecholamine, but they are completely different and unrelated. Again, I don't understand how the fight or flight reaction applied to this specific instance.

Q So each -- in the opinion of each of these doctors, Doctor LeBel, who thinks it's a withdrawal reflex, and she is not a physician, and Doctor Brown-Forestiere, who is a physician says it's a fight or flight. They are talking about two different things, are they not?

A Well, those are completely different.

Q Even if it was --

A One is related to the anatomy of the spinal cord and the peripheral nervous system. And the other is related to the functioning of the adrenal glands sitting on top of the kidney. They are completely different. I have no idea how anyone could possibly connect the two.

Q Now, on page six of your report, which is Exhibit 2-B, the January 6, 2023 report, you state, number 23, "Based upon a reasonable degree of medical certainty, there is no need to place Mr. Cains on a," quote, "Do Not Restrain List," period, unquote.

A Correct.

Q There was testimony by -- or an opinion

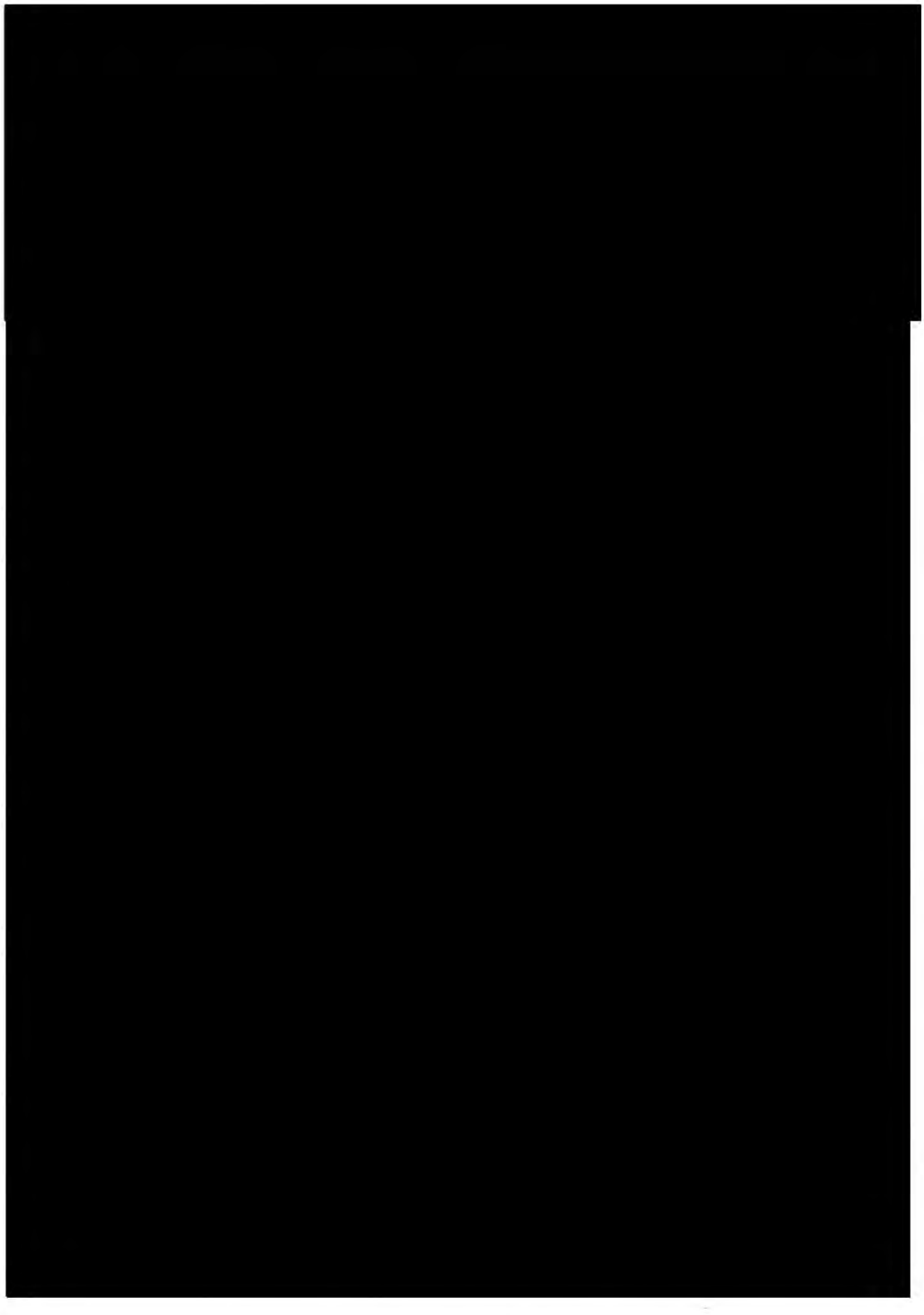
expressed by Doctor LeBel that David Cains could have been put on a "Do Not Restrain List", is that correct?

A She did testify to that. And if he had been put on a "Do Not Restrain List", it would have deprived him of treatment, which the staff at BHDC and the guardian both agreed were important to his health and safety. There is an interdisciplinary process that's in place to look at the behavioral programming that he received, that behavioral programming was explained to the guardian, who consented to it. To place Mr. Cains on a Do Not Restrain List would have deprived him of the treatments that the team and the guardian felt were appropriate to meet his needs.

Q Okay. And it's -- because I understand -- are you aware whether there are people at the Booneville Human Development Center who are on the Do Not Restrain List?

A I didn't review any material that would allow me to reach a conclusion in that regard.

[redacted]



[redacted]

So he doesn't maintain a list. It's really information that he provides to the interdisciplinary process that makes a final determination about which treatments are appropriate.

Q Now, on page six again, your opinion number 25 of Exhibit 2-B states, "Based upon a reasonable degree of medical certainty, the emergency response system at BHDC," which is the Booneville Human Development Center, "does not represent an obstacle for emergency response and life saving intervention", period. And we discussed this a little bit earlier, did we not, about the timing and so on. Can you explain that in a little more detail?

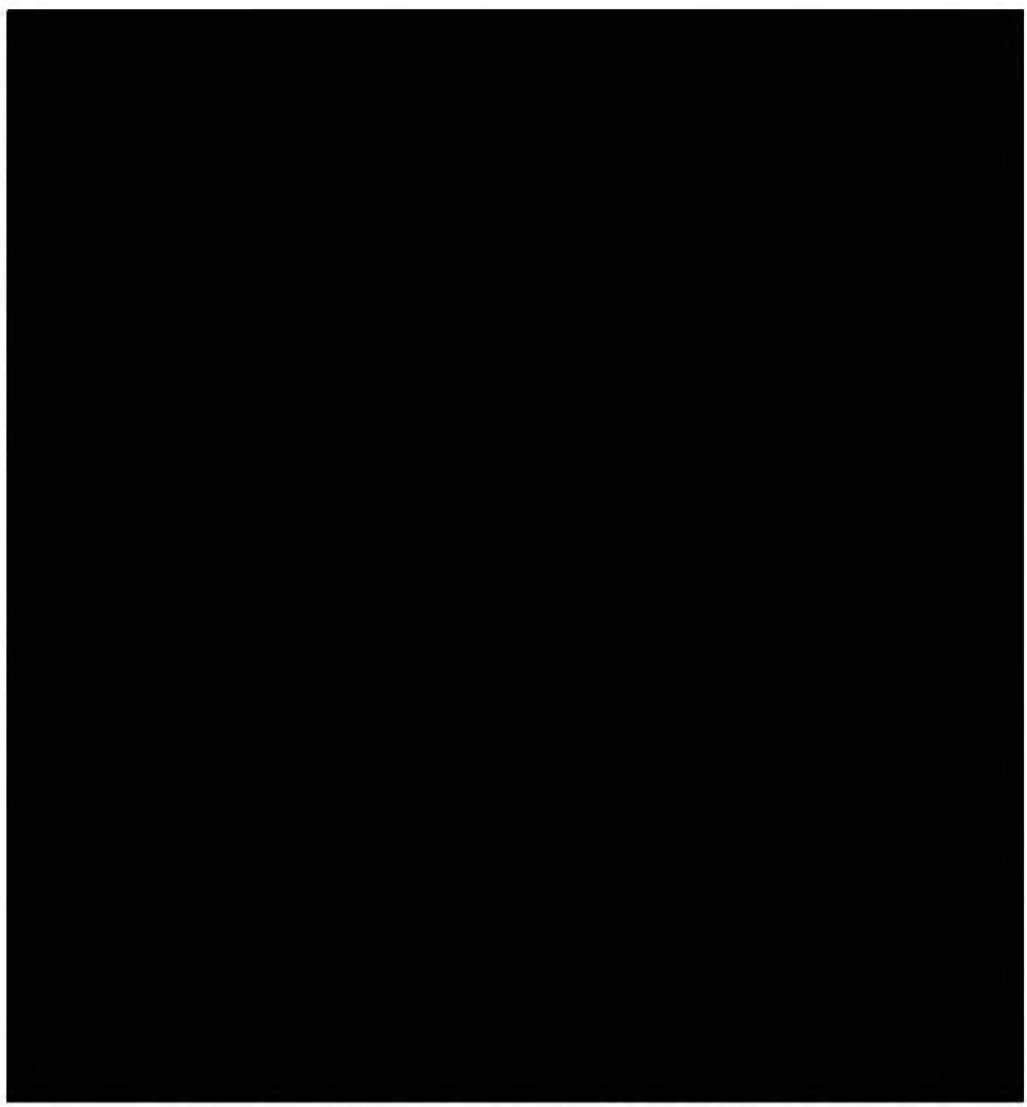
A My opinion in 25 is a general opinion about the emergency response system and how emergency care is rendered to people at the facility in general. There is a policy that staff needs to call the nursing personnel, and allow the nursing personnel to perform an assessment and make a determination as to whether additional treatment is required or not.

I do not believe that that policy is an impediment to people receiving appropriate emergency

services and life saving intervention. My opinions incorporate my belief that the nursing staff are perfectly qualified to provide life saving support. And this is a matter of general operation of the facility.

Q Well --

[redacted]



Q And so the fact that they called for the nurse team to respond and provide emergency services, and they responded within, some say one to two minutes, I think somewhere else in the record it said two to three minutes. So around two minutes, in your -- to a reasonable degree of medical certainty based upon

what you just testified to and your opinion in your report, would have made a different outcome in this case?

A Absolutely not. If Mr. Scow had been sitting next to Mr. Cains in that hallway at the time Mr. Cains stopped breathing, it would have taken Mr. Scow nine minutes to clear the airway, well beyond the four or five minutes that Doctor Forestiere has testified result in brain injury. The --

Q And the --

A It was not able -- it was not something that could be overcome by appropriate emergency care.

Q Just a few more questions, Doctor. In your report on page seven of Exhibit 2-B, you are restating what Doctor LeBel testified to. And there is a term in there that I don't what it's meaning is, at least I don't remember it, and it's "proximal". She says "The physical restraint used on DC proximal to his death." What does "proximal" mean?

A I can't offer my personal opinion on proximal, because I didn't use the term. But I believe in her deposition there was a discussion about the term, and she used "proximal" to mean occurring at around the same time. So I think she agreed that the physical restraints and vomiting and subsequently death

occurring around the same time. But she also clarified that "proximal" did not mean it was a causative, that one did not lead to the other. The restraint in this instance did not lead to vomiting.

Q Okay.

MR. ROSEN: Counsel, it is 1:20. If we could take about a five minute break, I just want to wrap up and make sure I have asked all the questions that I intend to ask, and review my notes.

MR. GREEN: Let's -- can we make it ten since I'm going to be starting after that?

MR. ROSEN: Yes.

MR. GREEN: All right. Thanks.

MR. ROSEN: So for everybody, it's about 1:20 or so. Why don't we come back at 1:30?

MR. GREEN: Sounds good.

(WHEREUPON, there was a brief break.)

MR. ROSEN: We are back on the record after a break. I have completed my questions. Thank you, Doctor Kastner. Counsel?

MR. GREEN: Thank you.

CROSS EXAMINATION

BY MR. GREEN:

Q Good afternoon, Doctor Kastner. How are you?

A Good. How are you, Mr. Green?

Q I'm all right. I'm going to be asking you some questions today. If you can't hear me at any time, will you please let me know right away?

A Yes.

Q And if you don't understand my question, will you let me know right away so that I can rephrase it or clarify it?

A Yes.

Q And if you need to take a break, you know, for any reason, just let me know. This isn't an endurance contest, it's not torture. So any time you need a break, just ask for a break. I just ask that if I have asked a question, you answer before we take a break. Is that okay?

A Yes. Thank you.

Q Doctor, you testified earlier about serving as a commissioner in the State of New York and described that. When did you leave that position?

A I have got my dates straight, just a moment, October 2021.

Q And what was the reason that you left the

position?
A Change in leadership in state government.
Q Okay. So was there --
A A new governor came in and wanted to appoint her own cabinet.
Q Got you. All right. And since October 2021, I know you have obviously done consulting on this, but have you been employed by any other agency or institution?
A No.
Q Has, since October 2021, have you been solely self-employed?
A Yes.
Q And I know obviously you have this work you are doing for the State of Arkansas, do you do consulting with other agencies and governmental organizations?
A Yes.
Q Since October 2021, approximately how many other organizations or agencies have you provided consulting services to?
A I don't know offhand. At least one, and possibly a couple of others, but one for certain.
Q Okay. So it is under half a dozen?
A Oh, yes, yes, under half a dozen.

Q I'm going to use the word "client", not in the sense of the people at the human development center, but as the State of Arkansas is your client that you are providing services for. Do you currently have any other client that you are providing consulting services for as of today?
A No.
Q All right. When is the first time that you did work for the State of Arkansas?
A I don't recall exactly. It would have been in the mid-2000s, and I'm thinking is 2005 or '06 --
Q I'm sorry. I did not mean to interrupt you.
A In 2005 or '06, somewhere around there.
Q Okay. And do you remember what you did for the state back then?
A It was in regard to potential litigation at the Conway Human Developmental Center.
Q And did you end up having to testify in any depositions or court proceedings?
A Yes.
Q And do you know for approximately how many years you provided those services for that project?
A I believe the trial occurred in 2010, although again, I could be mistaken. And that would then mean, you know, four or five years of engagement in

that activity.
Q And that case was tried in federal court, correct?
A Correct.
Q In providing those services that you just described for that particular case, do you remember approximately how much in total you billed the State of Arkansas and received as payment for your services?
A No.
Q Would approximately $900,000.00 over that period sound accurate to you?
A No, it would not.
Q Do you believe it would be higher or lower?
A Lower.
Q In the mid-2000s, 2005 or '06, I think you said, until around 2010, the date of when you thought the trial was, was the only case that you were working for the State of Arkansas that particular one that you have mentioned involving the Conway Human Development Center?
A To the best of my recollection.
Q And I know your name is Theodore, but I think it was stated early you do go by "Ted", is that correct?

A Correct.
Q I will call you Doctor Kastner, but I just want to make sure, because I think on some documents you are referred as Theodore, some as Ted. After the Conway Human Development Center case, when was the next time that you performed services for the State of Arkansas?
A After that case, I was engaged as a neurology consultant at the Southeast Arkansas Human Developmental Center.
Q And where was it located?
A That's in Warren, Arkansas.
Q And what type of work did you -- or services did you provide in relation to that Center?
A Clinical work.
Q And do you know approximately how long or from what date to what date you did work at that Center in Warren?
A I don't remember the specific dates, it was about three or four years.
Q And was that after the Conway Human Development Center case had resolved?
A To my memory, the best of my memory, yes.
Q After your three to four year time at Warren, what was the next time that you performed services or

otherwise did work for the State of Arkansas?
A I don't believe there have been any since then.
Q Until this case?
A I believe that that's correct -- oh, I'm sorry. There was an engagement earlier this year -- last year, I'm sorry, around the development of -- some recommendations for behavioral services. I --
Q Okay. Tell me -- I'm sorry, I didn't mean to interrupt you.
A No, I'm done.
Q And that was the beginning of, I think you said "this year", do you mean 2023, or last year, 2022?
A Last year, 2022.
Q I have still been making the mistake. It usually is mid-February before I get it right.
A Right.
Q So approximately when in 2022 did you start work on these recommendations?
A Oh, February and March 2022. And I think we concluded the work in September of 2022.
Q Okay. Can you just briefly describe for me what type of services you provided during that time period with respect to the recommendations?
A We were asked to partner with an individual who had been referred by Disability Rights Arkansas to

provide some recommendations to the state regarding the delivery of behavioral services.
Q All right. When you say "we", did you do this work in conjunction with other people?
A There were three, all together, myself, someone named Kevin Walsh, and Robert Bowen.
Q Can you tell me who those gentlemen are?
A Kevin Walsh is a Ph.D. level psychologist. Robert Bowen is -- I will try to describe him. He is not -- he doesn't have any advance training, but he is utilized in some instances as a behavioral consultant.
Q And you say it concluded in September of last year?
A I believe it concluded in September 2022 with the submission of a final report.
Q That was my next question. So was there a final report that you submitted?
A Yes, on behalf of the three of us.
Q Of the three of you that worked on that, were you the lead essentially on the project? Would that be fair to say?
A No, it wouldn't. I think we approached it as partners, all sharing in the work.
Q Okay. All right. So the report would reflect

all, the consensus among all three of you as to the recommendations?

A I believe that's fair to say, yes.

Q Okay. All right. So you did a final report in September. Did you submit any interim reports, monthly reports, email, check-ins with any particular people with the state?

A There was a process of -- that was agreed upon and put into place for disseminating information and collecting information, so there are multiple emails exchanged between the three of us and the state.

Q Did you have a primary contact person at the state?

A Yes. There were multiple contacts, because we were collecting data at each of the HDCs. There was an HDC contact and there were also contacts within the central office. So there are multiple contacts.

Q Who were your main contacts at the central office?

A Tammy Bimbrook.

Q Okay.

A I think there were some contacts with the Director Stone -- I'm sorry, I know that she's married, I don't know her married name. And then contacts with the superintendents at the facilities

and also staff who worked at those facilities, in particular, the behavioral specialist.

Q All right. Do you remember who you had contact or communication with at the Booneville center? And when I say "center", you know I "mean human development center", correct?

A Sure, yes. Well, we had multiple contacts, because we were engaged in collecting information from multiple sources within each center. So we would have been in contact with the superintendent, with the head of the psychology department, and others. I don't remember the specific protocol, but there individuals who were responsible for providing us with surveys that were to be completed, who were made available for interviews. So there would be probably five or six people at each facility.

Q You said "surveys to be completed". Did you have the individuals at Booneville center fill out these surveys themselves or did you conduct these surveys or one of the members of your team? And by "team" I mean the three of you that wrote the report. Did y'all conduct the surveys or did the people at the center -- the Booneville center fill them out themselves?

A Both. So there were requests for information

around behavioral restraint use data that -- resources from the centers in order to look at their use of restraints. And then there was also a more qualitative survey, which was comprised of interviewing individuals using a structured interview.

Q And did you -- well, let me ask first just about you personally. Did you travel to Arkansas to personally or in person meet with the individuals at the Booneville center, or was it conducted at a distance?

A The entire consultation was conducted remotely.

Q Okay. When you say "entire", do you mean the other two people that worked on the project with you, you all did it remotely?

A Yes.

Q Do you know approximately how much you were compensated for the work on the recommendations?

A I have to -- I know that you are characterizing these as recommendations. I have to back and be sure that that's exactly what the purpose of the consultation was, but to respond to your question, I'm not sure exactly what the compensation was.

Q Okay. And yes, I thought you had said that it involved evaluating and dealing with some, I think

you used the word "recommendations", I could be wrong. And certainly, if I use a word while we are in this deposition that's not correct, will you let me know?

A Yes, I will.

Q Do you think that you yourself may have received approximately $12,800.00 for those services? Does that sound about right?

A Sure, it is the right ballpark.

Q And I know you said that you worked at the Warren facility, and then I think you said, between that and work on this particular case involving Mr. Cains, you did the consulting services we just discussed with the other two gentlemen. When were you hired to work specifically on Mr. Cains' case, or related to Mr. Cains' case?

A You broke up a little bit and there was a connection that you were trying to make between work at Warren and this consultation, and I didn't hear that.

Q I wasn't making a connection, I was just trying to get a timeline. My question is, when were you hired to specifically provide services on this case, the case related to Mr. Cains?

A I was engaged, I wouldn't say hired. I don't

see myself as their agent. But I was engaged as an expert in probably November of 2022.

Q So November 2022. And I wasn't trying to infer that you are the agent, I just meant that you were retained, hired, agreed to provide services. So, I'm not trying to infer any kind of agency relationship. Do you know how much you have billed for since November 2022 to this particular case?

A No, I haven't billed -- I haven't billed for anything.

Q Do you have a written contract regarding the services that you are providing for this case involving Mr. Cains'?

A No.

Q Is your billing on an hourly basis for this particular case, or is there some other type of structure as far as compensation?

A It's hourly billing.

Q How much are you billing per hour?

A $300.00 per hour for reviewing materials and preparation of reports, and $400.00 per hour for attendance at depositions and testimony.

Q Do you have an idea of approximately how many hours in review and preparation you spent on this particular case?

A Not right now, no.
Q All right. I'm assuming you keep records of those hours, correct?
A Yes.
Q And I'm going to ask questions occasionally that you know I know the answer, that you keep those records, and you know that I know it, and I know you would tell it, and I have to ask it just to get it on the record. So if I ask a question that seems obvious, I'm just trying to make sure we have a clean record, all right?
A Yes.
Q All right. Now, did you perform any work related to the former human development center that was located at Alexander?
A Yes.
Q Do you --
A Excuse me?
Q Do you remember when that was approximately?
A 2008, 2009, 2010, somewhere in there.
Q So I'm trying to -- I have to put my readers back on here. So that would have been during the same time frame that you were providing the services related to the Conway Human Development Center case that was involved in litigation in federal court?

A Yes, they would have overlapped.
Q Okay. So earlier when you said that while you were doing that work on the Conway Human Development Center case, you didn't believe you were doing any other work for the State of Arkansas, you were mistaken, you actually were doing some work related to the Alexander Human Development Center, correct?
A It was to the best of my recollection. And I appreciate the reminder.
Q Yes. And I'm not implying you were intentionally lying, you just forgot about that particular engagement or work, correct.
A It has been 15 years ago, it's not something at the front of mind.
Q I understand. Are there any other times that you have provided work for services for the State of Arkansas, other than those that we have discussed, that you can recall at this time?
A Well, as I recall, the work at the Alexander Human Developmental Center involved depopulating the center and closing it. Some of the individuals who left the center were hospitalized at the Arkansas State Hospital. And we did provide consultation at the State Hospital to a unit that was specifically built for the purposes of supporting people with

intellectual and developmental disabilities.

But I don't know if I would consider that a separate engagement or a continuation of the work at Alexander. But we were certainly involved with care at the State Psychiatric Hospital.

Q Would the care that you provided at the State Hospital, did that involve children or adults?

A Children.

Q All right. And when you were -- I'm going to use the word "hired", again, I don't mean to imply anything by it. But when you were engaged, hired to do the work with respect to the Alexander facility or human development center, were you told right from the moment that you were informed about the work they needed, that their goal was to go ahead and shut down that facility, and as you say, depopulate it?

A I don't believe that that was a plan that was in place at the time we were engaged. But it was clear that that became the goal of the consultation while we were engaged. And ultimately we were responsible for the closure of the facility.

Q All right. Can you just give me a little more detail on the Alexander facility, what type of services you provided?

A Well, you --

Q Were they consultant type services -- I'm sorry, or were they administrative type services providing medical care services?

A It was inclusive of both. We had a staffing relationship in that we provided the key clinical staff to oversee the process of simultaneously improving the quality of care at the facility and closing the facility. So we hired and retained the services of an individual to serve as the superintendent.

We provided infrastructure for managing the facility, the morning rounds, the on-calls, you know, the things that are necessary to successfully operate a facility and to try to improve the quality of care while at the same time looking at how we could downsize and ultimately close the facility.

Q Earlier you told me about the consulting work you did last year, and mentioned that there were two gentlemen that you did that work with as a group. The work that you did Alexander, was there a similar group of other people that you worked with, or were you hired or engaged independently?

A There had been an organization that had a staffing relationship with Arkansas to operate the facility, I believe that was Liberty Healthcare. At

some point Arkansas made a determination that they no longer wished to continue with Liberty. And our initial engagement, I believe, was to assume the responsibility for providing that staffing resource.

So we worked with multiple individuals who we engaged as contractors to provide services. And I believe there were other agencies involved, though, but -- other organizations involved, though, but I can't recall specifically. One of them may have been a behavioral health provider in New Jersey. But I don't recall the specific details around the contract and --

Q I understand. I guess my question is, as you were just answering, you several times said "We did this, we did that." I guess I'm wondering who the "we" is.

A Well, I don't believe that the contract was between the State of Arkansas and Ted Kastner or T. Kastner, and I don't remember or recall specifically the agent -- agencies that contracted, you know, if it was DDHA or some other. So I'm using the term, because there is some ambiguity which reflects my uncertainty as to who or what, specifically, entered into a contract with Arkansas.

Q Understood. So you said that you -- or "we" did

the -- hired a superintendent. So do you recall, did you advertise that position? Do you recall how you recruited the person?

A I'm -- you're probably aware, I know a lot of people, I have been doing this a long time, and I have a network of relationships that I could rely upon to identity an individual to serve as an interim superintendent. So I utilized my personal network to identify someone.

Q And you had hiring authority over that person, is that right?

A It was a staffing relationship, so the -- we provided the staff to the State of Arkansas for the purposes of delivering the services needed to support Alexander in very much the same way that had existed prior, I believe with Liberty Healthcare. There are a --

Q Did you --

A -- number of agencies that do that, so it's a fairly commonly accepted practice within the field.

Q Have you ever been either the sole owner or a partial owner of a business that was incorporated or chartered here in the State of Arkansas?

A Yes.

Q Can you tell me the names of those organizations

or entities?
A I believe it was called Arkansas Psychiatric Management Services.
Q Do you recall, were you the sole owner or did you have co-owners?
A I had a co-owner. There were two owners of that corporation.
Q Do you recall when it came into existence and if it's still in existence, or if not, when it ended?
A It came into existence in 2012 or '13. And it was for the purposes of contracting with the State of Arkansas to provide services at the Warren Human Developmental Center. And as I mentioned, I discontinued my provision of services in Warren sometime in the middle of the prior decade, and it was at that point that I ended my relationship with Arkansas Psychiatric Management Services.

I don't know if it continues to exist, what contracts it had or currently has. It has been a number of years since I have had any affiliation with that organization.
Q All right. Are there any other organizations that fit the description that I described earlier when you said that you had been an owner or a partial owner?

A Not that I am aware of, no.
Q Okay.
A Now, you are specifically referring to organizations in Arkansas?
Q Yes. Those corporations or other -- yes, corporations or businesses, licensed, chartered in the State of Arkansas.
A I believe that's the only one.
Q You told me -- not me, told us all that earlier your residency was in pediatrics, is that correct?
A Correct.
Q All right. And I know that you did work with children at the Arkansas State Hospital, as you have testified to. Are you -- before you went to work for the State of New York, were you working more predominantly with children or adults, or was that an equal mix? Can you give me an approximation?
A I think I mentioned earlier that my practice had a total caseload of about 4,000 individuals, and I would say that two/thirds to 75 percent, three/quarters were adults, with the remainder being children.
Q Okay. And I know we testified about a lot of standards, and I will ask you about some specifics later. But in general are there policies and

standards regarding the use of restraints as used involving children that are different than those involving adults?

A The answer would depend upon what jurisdiction you would be discussing.

Q Well, let me first ask about federal standards, so federal rules, regulations, statutes. Did those differentiate between -- the use of restraints between children and adults?

A I think the standards are more site specific than age specific. So for example, a facility licensed as an ICFMR or ICF/IDD, which could serve children and adults, would have one set of standards, whereas a facility that was licensed under some different authority would have different standards. So I don't think it's necessarily children versus adults from the federal perspective as much as it is setting to setting.

Q Did the State of New York have different rules and procedures and policies, regulations, with respect to the differentiation between children and adults as regarding restraint use?

A Within the state agency that I had oversight, we served children and adults. Our policies and procedures related to restraint use at the two public

ICF/IDDs that we operated were the same. There are other state agencies that provided oversight of services to children and others that provided oversight to children and adults. I can't speak to what they do, because that was not under the scope of my authority.

So for example, the mental health service system provides services to children and adults. If you have had any residential and nonresidential settings, I can't speak to how the system of care is organized for children and adults with mental health services, and nor could I comment on how the state approached restraint in its foster care system.

But I would say in the IDD system, the approach to restraint was more specific to the licensing requirements for the settings in which individuals resided, not so much their age.

Q Understood. And this is going to be my last question about children and adults. Do you know if the State of Arkansas has any different standards, regulations or rules regarding the use of restraints as to differentiate between children and adults?

A Just as in the State of New York, I believe that the human service system in Arkansas is divided into different entities in which the scope varies. So in

the DDS system, relative to the operation of human developmental centers, the ICF/IDDs, I do not believe that there are different standards for the care provided to children versus adults.

I believe that the only standards which apply are the CMS standards and Arkansas policy and local facility policy. That doesn't mean that there aren't rules and regs that were applied to children in other types of settings, even perhaps within the DD system. But I don't believe within the ICF/IDD that there is a division, a set of standards that apply to adults versus a set of standards that apply to children.

Q Okay. With respect to the human development centers, I'm going to focus on those for a moment. I know that you have discussed the standard of care that applies and where it comes from. And I think you said it comes from a few different places. One is the federal government, right?

A Correct.

Q And those are what have been referred to as the CMS regulations, correct?

A Yes.

Q And you testified those are a minimum level of standards that must be complied with, correct?

A I chose that word "minimal" because it's a word

that Doctor LeBel uses in her publications and in her report. She characterizes the CMS standards as minimal. I characterize them as the standard that needs to be met.

Q As it applies -- the standard that needs to be met with respect to standards established by the federal government, correct?

A No. I'm saying the standard of care.

Q Okay. Well, doesn't the State of Arkansas also set it's own rules and regulations that must be complied with by the human development centers?

A The state -- there must be some consistency between the state and the federal government in terms of state and facility policies. So they should incorporate the federal standards and not create a disagreement. As, I think Doctor LeBel has noted, states can exceed the federal requirement in certain respects, if they so choose to do so. But they can't diminish or, you know, under-perform relative to the federal standards.

Q Good. And that is exactly what I thought you had testified to earlier. And in addition to the state rules and regulations, the individual facility, the Booneville Human Development Center, in this case, sets it's own set of rules and policies and

procedures, correct?
A There are policies and procedures that have been promulgated by Booneville Human Development Center, yes.
Q And am I correct in saying that the procedures and policies that are set by the Booneville center cannot go below what CMS dictates as the standards, but they can go above, just like the state can, is that correct?
A Yes, they could.
Q And so am I correct in believing that the overall standard of care is a combination of the CMS rules, the state rules, and the rules of the facility combined? And then, I understand they may all be the same, the state and the facility made, to the exact same as CMS. But if they do more, the standard of care would incorporate the more that they do, correct?
A That could be the case.
Q Well, is there an instance where that would not be the case with --
A I'm not aware --
Q -- respect to the Booneville Human --
A I'm not aware -- I'm sorry. I didn't hear you.
Q That's okay. Could that be the case with

respect to the Booneville Human Development Center?
A I can't speculate about what could or could not be the case. I can say I am unaware of any Booneville specific policy that is inconsistent with both the state and federal standards of care.
Q Right. And I'm -- my question wasn't exactly about inconsistencies. My question is this, and I will be very specific with respect to the Booneville Human Development Center, would you agree with me that in June of 2020, the appropriate standard of care would have been the rules and regulations promulgated by CMS, plus anything extra required by the state's rules and regulations, plus anything extra, if at all, that are put in place by the facility?
A I can't comment because of the speculative nature of the question.
Q Well --
A I wasn't asked to opine about speculative, you know, events. My opinions are related to the practices that I observed and the policies and procedures that I reviewed, and I did not find, in my review, an instance that would be described in the manner in which you have just presented your speculative scenario.

Q So you're not aware of any situation where, as of June 2020, the State of Arkansas or the Booneville Human Development Center, provided additional extra rules and regulations above what CMS required?
A In specific to the care provided to Mr. Cains, I would say, yes, I am unaware. But that is not exhaustive of every instance in which BHDC or Arkansas may have policies and procedures in place that have a relationship to the federal regulations.
Q Okay. So part of your work on this case was to give an opinion as to the standard of care that applied to Mr. Cains, correct?
A In part, correct.
Q And is what you are saying, that your testimony is that the standards established by the State of Arkansas and Booneville center are the same as what was established by CMS at the time of this incident?
A I believe that they are consistent.
Q My questions isn't "are they consistent", it's "are they the same"?
A They are not exactly the same, because there are different words that are used. For example, in Booneville policy, the staff are instructed that they can use restraint when there is a potential for harm and a risk to safety. And I believe that word

"potential" is used, but I'm not sure that that word appears in the relevant CMS guidance.

CMS clearly indicates that restraint can be used when there is a risk, but doesn't use that word "potential". So there are differences, but I don't believe there are inconsistencies.

Q All right. And I just want to make sure I'm clear. Are you also saying you don't believe there are extra protections or extra regulations that go above and beyond the CMS? And if you don't know what I mean by "extra", let me know.

A I would like you to help me understand what you mean by "extra", if you can give me a --

Q Do you remember --

A -- give me an example -- excuse me. Let me finish, please.

Q I will.

A If you would give me an example, I would appreciate that, because in the materials which I did review, I didn't see anything, quote, unquote, "extra".

Q Okay. Well, I will go through some specific rules and regulations a little bit later, and then I may come back around to this point at that time. All right. But you don't disagree with me that the

standard of care that applied to my client at the time of this incident would have been to make sure that there was compliance with the rules and regulations from CMS, the state, and the facility, correct?

A Again, let me just say a couple of things. The first -- the standard of care doesn't apply to Mr. Cains. Mr. Cains was an individual receiving treatment and care from the facility, the standard of care applies to the facility itself, and the professionals rendering care at the facility.

Second, I anticipated that we were going to have a discussion at some point about what exactly a standard means, and that we may have a difference of opinion as to how a standard is defined and implemented. So if regulation, which I agree would represent a standard says that professional staff need to consider something, then my estimation of compliance with that standard would mean that they did consider what would be subsequent in that policy.

Or if a "standard", quote, unquote, represented a policy that was intended to provide a guideline, my assessment would be that a facility and staff would be compliant with that policy, if they accepted the guideline. And in accepting the guideline, you

recognize there is just a lot of variation in practice.

So I just want to make it clear, we are talking -- we are potentially talking about different things when you talk about compliance with a standard and I talk about clinical practice.

Q Okay. What do you mean, when you earlier testified about standard of care, what did you mean by "standard"?

A Well, again, I was responding to Doctor LeBel's report, in particular, when she uses that term "standard". I found it really difficult to read her report and see her say that the standard of care was defined by the United Nations or the World Health Organization, or publications that she has written, when I know that they have absolutely no bearing on what is required to happen at a facility.

I realize in providing a consultation to Arkansas I need to be able to discuss a standard of care. And my appraisal of what a standard is, is the expectation of what a reasonably qualified person or facility in this instance, would be expected to do, based upon their education, training and experience. That would be my definition of a standard or the standard of care. You know, what would a comparably

qualified reasonable person be expected to do when confronted with these specific circumstances that they are presented with.

Q And I think you said based on their training, experience, and I think there was a third item that you said that I didn't catch. But I may be wrong.

A Their judgment, based upon the particular circumstances in which they find themselves.

Q So that is how -- that is what you mean when you say "standard", correct, in the context of this case?

A Yes, I think for the most part. I view the standard of care as related to a practice in which the anticipated consequences are known or understood, such that they permit a practitioner to act with some idea that's -- of what will be the outcome.

Q Okay. This definition, I'm going to use the word "definition" or "meaning", whatever way you want to characterize it, that you have for a standard as it applies in this case, did you get that from any rule or regulation or any other source?

A The standard of care for a facility, and it is generally agreed upon, to derive from CMS. Both Doctor LeBel and I have agreed on that point.

Q Okay.

A The standard of care in the delivery of individual services is really a clinical practice parameter. And the American College of Physicians defines a standard as a practice policy where the health and economic consequences of an intervention are sufficiently well known to permit decisions.

And if there is virtual unanimity among patients about the desirability of the intervention. Deviations from standards are expected to be rare, other terms for standard include requirements, rules, strict indication or strict contraindications. And that's the definition that I use in my practice. Again, it's the same from the American College of Physicians -- American College of Physicians.

Q American College of Physicians?

A Correct.

Q Okay. But that definition for standard -- let me back up and ask a different question. Your definition of standard, not standard of care, but standard that you articulated a moment ago, that doesn't come from any CMS or federal regulation or rule, correct?

MR. ROSEN: I'm going to object. I don't -- I think you are mischaracterizing what he is says. Doctor Kastner, you can go

ahead and answer. But I think you already explained that.

THE WITNESS: The standard of care for an ICF/IDD is reflected in the federal, state, and facility specific policies and procedures that would apply. So in regard to BHDC, it would be the ICF/IDD standards, which again, Doctor LeBel has cited, which are incorporated into Appendix "J", plus whatever state and local documents are generated, you know, in addition. That would reflect a standard of care for the facility.

BY MR. GREEN:

Q And I'm not asking --

A The standard --

Q Go ahead.

A The standard of care for the individual practitioner really relates to practice, and specifically to the degree to which the consequences of treatment are fully understood. And they reflect the individual's training, experience and judgment, based upon what is presented to them in that specific instance.

So again, just to be kind of specific and help

you with this, when we talk about the standard of care and whether Mr. Mattson met the standard of care, we need to take into account, what would someone with a high school level education, a two week orientation, a brief training in behavioral services, be expected to do when confronted by a 248 pound individual who was lunging at him, and when that staff finds himself in the position of being unable to back away, and topples to the ground as a result of the individual lunging at them.

We need to be able to ask, what would a reasonably qualified DSP do in that setting? You have to be able to think as the DSP in that instance.

Q All right. I want to ask you something else about standard in a moment. But you mentioned something that I want to ask about since you brought up Mr. Mattson. You said "brief training". So is it your opinion that the training that Mr. Mattson and the others that were involved in this incident in June of 2020 was not sufficient?

A I'm trained -- I went through medical school, I did a three year -- that's four years. I did a three year residency. I did a senior fellowship and I did another two years in graduate school. What is that, 11 years. I'm -- my basis of comparison in calling

something brief, is something less than 11 years. So with all DSPs, in all settings regulated by CMS, the training is brief compared to the level of training that me or Doctor LeBel or Doctor Forestiere had.

It's in a matter of weeks or a month. They are not expected to be able to meet the standard of care that the three docs should be able to meet in the provision of services. So when I say "brief", I'm measuring that against the training that people with doctorates receive, which is much, much longer. I certainly am not implying that it was inadequate and did not meet the federal standards for a training requirement.

Q Okay. So I think you answered there at the end, it was not inadequate, that's your testimony, correct?

A For the purposes of qualifying staff to work at an ICF/IDD, the federal government sets the standard and Arkansas met that standard at Booneville in providing the training that was afforded the staff prior to their working with individuals.

Q Okay. I want to go back a minute because I appreciate you explaining some of those things, but I am not asking about standard of care. You mentioned earlier that the word "standard" may be a problem,

that we may have different conceptions of that, and I asked you what you meant when you used the word "standard". You gave a very specific definition, and then you cited the American College of Physicians.

So I'm only asking you about the word "standard", not standard of care. And my question is, the meaning that you testified that you ascribe to standard, you did not get that definition or meaning from a federal statute or regulation or rule, correct?

A I have used the word "standard" in two different ways. One is to talk about the federal rules and regulations that govern the operation of an ICF/IDD. The federal government calls those standards. Appendix "J" lists those requirements and calls them standards in Appendix "J".

In addition, there are professional practices that occur within an HDC where the practice is defined by professional organizations or not, but they incorporate the idea that the care provided by a professional at a certain level, is only going to reflect their education, training and judgment based upon what they see at that time.

So the federal government uses the word

"standards" when they apply -- when it's discussing the implementation of CFR. Professionals use the word "standard" when we are talking about what we do with our patients, the individuals that we work with. They are used in both senses. And I'm trying to help you understand, there are differences, and they each derive from a different authority.

Q I understand. And my question is, you are testifying in this case about a standard of care. I'm not asking right now about the entire standard of care, but specifically the word "standard" in that phrase. And you have defined it a very specific way. I'm going to be paraphrasing, because I don't have a transcript, but you mentioned the expected practice of what a reasonably qualified person would do, based on their training, experience and judgment when presented with that situation.

I know I'm paraphrasing. That meaning, would you agree with me, that definition or meaning does not appear in any of the CMS Federal Rules and Regulations that apply to the human development centers in Arkansans?

A Definition of standard used by the federal government is contained in Appendix "J", with the interpretive guidelines. The document lists

standards that ICF/IDDs have to meet, and that is the second meaning of my term "standard" in this discussion.

So there are standards that relate to compliance, to federal rules and regulations, and there are standards that relate to the practice by individuals in their specific profession, including the profession of being an RCT or direct support professional. They are both applicable at the same time. We are talking -- we are using that word "standards" for two different things.

But the word "standard" is used by the federal government to describe it's rules and regulations throughout Appendix "J".

Q Yes. I understand the use of the word "standard", and it sounds like you are saying you have got at least two different meanings that you could use from two different sources, is that right?

A No. I think there are two different uses, not necessarily meanings. But if we were looking at Webster's Dictionary, Webster's might say, in terms of standards, "One, referring to the State Operations Manual, the criteria for demonstrating compliance with federal rules and regulations; two, the demonstrated competencies that professionals need to

evidence in meeting the level of care that should be rendered to patients."

I mean, there's different uses of that word, "standard". So I'm saying this could be confusing. Let's not have any confusion, let's be sure that we are having a discussion and using the right word in the right way when we are talking about standards. And so to a degree that this is helpful to you, you know, I hope it's useful.

But the feds require -- the feds define their expectations as of standards, it's throughout Appendix "J". And professionals define standards as they relate to the specific care that we provide to individuals in the course of their work.

Q I meant to ask you this earlier. What materials did you review before today to prepare for this deposition?

A I have listed the documents that I reviewed at the front of my reports. There was some addition -- and I think it's the same in both, you know, "A" and "B". There were some additional materials that I referenced in terms of Doctor LeBel's report, things that she cited as references in her work. And inside my report there are a couple of other occasional references, for example, a monograph published by

someone named Eddie. It was published by the American College of Physicians that relates to, you know, clinical practice parameters, of which standards are considered one form.

In addition, I have to say I'm pretty familiar with the literature, so there are other things that I have looked at and can recall as I formed my opinions and I wouldn't necessarily have a list of those.

Q And I noticed earlier it appeared that you were looking off to read, when you were talking about the meaning of the word "standard" from the American College of Physicians. Do you have other materials available to you, either paper or digital forms that you can look at throughout this deposition?

A So Mr. Rosen asked me to just make sure I had access to at least four things. I see the Appendix "J", some Arkansas policies, and my two reports. And so I borrowed my wife's computer, and I sent -- emailed Appendix "J" and my CV to her so that I could pull those up, simultaneously look at them, and my reports, and be able to be responsive to Mr. Rosen's questions and I hope to yours. So I do have two computer screens open at the same time, that allows me to move back and forth, depending on need.

Q Are you able to access the other materials you

listed that you reviewed at the beginning of each of your reports?

A Yes, I can. They are in a file on my computer.

Q Okay. And you testified earlier that the documents that you reviewed for each report are contained in that list, correct?

A It's a partial listing, it's not complete. But I can guarantee that at a minimum I read every one of them in their entirety.

Q Okay. All right. And if something isn't on the list, and you reviewed it, would it be fair to characterize it as not a major basis of your opinion?

A Oh, no, I wouldn't say that at all. I think -- you know, we are having a discussion about standards of care, this is a topic that is dear to me and very, very important, because we as professionals need to be responsible for defining what we believe to be reasonable practice in our field. That's deeply important, and it's philosophical and it kind of undercuts all of, you know, who I -- my professional identity as a physician.

So, you know, I routinely think about the monograph by Eddie. I routinely look at websites to get an idea of what clinical practice parameters are published and recommended in our field. So I don't

necessarily cite all that stuff. But I can tell you it's really dear to me.

Q Let me ask you this question. In the two reports that you drafted that we have been talking about today, you list depositions of different people that you may have reviewed. Are there any persons' depositions that you reviewed that didn't make it onto those lists that you know of?

A Not that I can think of offhand, although I wouldn't -- I wouldn't want to testify that it were, you know, I think there is always the possibility they looked at something else and they didn't put it on that list. As I said in particular, in preparing the report for Doctor LeBel, I was constrained by time, and it's reflected in the number of typographical errors I made. I wouldn't be surprised if there were some oversights in particular related to that.

Q Okay. And with respect to your testimony earlier about Doctor LeBel and her mentioning of the UN and World Health Organization, those other agencies or organizations, and I think you essentially testified that the standard of care does not come from that, is that essentially your testimony, that applies to Booneville in this case?

A I don't --
Q Do you want me to repeat the question?
MR. ROSEN: I didn't -- I'm not sure I understood the question. Can you just repeat it, please?
MR. GREEN: Sure.
BY MR. GREEN:
Q You testified earlier that Doctor LeBel was not correct in citing to the UN standards from the United Nations, or World Health Organization, and you said they don't provide standard of care for the human development centers in Arkansas, is that correct?
A Well, I began the discussion by saying I found Doctor LeBel's opinions to be difficult to interpret, because she listed her opinions twice in her report, and they are different in each appearance. So specifically in regard to physical restraint, she said that the physical restraints used fell below the standard of care established by recognized standard setting entities, which I took to mean the World Health Organization, the UN, and later, as she cites, I think four articles that she and her colleagues have written.
In the second iteration of that same opinion, it simply says, "Fell below the standard of care". So,

I don't know whether she truly believes that recognized standard setting entities, including the WHO or UN. And she goes to argue that they have some relevance. But I read the document and I don't understand how they are relevant at all. The federal government maintains the authority to set the standard in regard to how ICFs are written. And when you go back and you read Doctor LeBel's work from 2007, she acknowledges that CMS sets the standards for how these facilities should operate.

She also says that she is deeply dissatisfied with what CMS has done, and that advocates for the elimination and reduction of restraint use should find other ways around the fact that CMS seems to have abandoned -- I think she called it the "high ground", and find other strategies to create facilities when they are either very limited or restricted to the use of restraints all together.

So this is a very troubling issue in regard to her opinions, but what the --

Q I understand --

A -- the standard of care is, and who has the authority to represent that they are setting the standard of care?

Q I understand that it's upsetting to you. My

question is, are you not testifying that the UN and World Health Organization, and similar organizations that are not CMS, do not have the authority to state what the standard of care is? Isn't that your testimony?

A They can set whatever standard they want. But those standards do not have any bearing on whether or not an ICF/IDD meets the standards for its operation. The standard for operating an ICF/IDD, Doctor LeBel and I have both agreed, is set by CMS. Doctor LeBel characterized those as minimal standards in both her 2007 article and her 2022 report. She agreed they were minimal standards.

Q Yes. And I'm not -- I'm really not trying to trip you up. I agree with you that CMS sets them. I'm just trying to -- I thought you testified earlier that other outside agencies of CMS, such as the World Health Organization and United Nations do not set the standard of care for the human development centers in Arkansas, that they are required to follow. I thought that was your testimony. I'm just trying to get a yes or a no.

A Well, I'm going to go look for my opinions to be sure that I'm saying exactly what -- responding exactly to what you are saying. In my opinion number

two -- number one of the CMS rules, regulations, along with state and BHDC policies represent the standard of care for delivering behavioral services of the HDCs, and two, that the other documents cited by Doctor LeBel, including those materials generated by the UN, World Health Organization, SAMSHA and other sources, do not represent the standard of care for the delivery of behavioral services at BHDC. Those are my opinions.

Q Okay. So, and your reading the record that's the January 6th report, page three, correct?

A Correct, numbers one and two.

Q Okay. And so -- all right. All right. I think you have stated pretty clearly there where they come from and where they don't come from. Would you also agree with me that they do not come the American College of Physicians?

A No. As I described it, the American College of Physicians is talking about the practice of professionals, what we as professionals are expected to do in rendering care to our individuals. So there have been lots of allegations, not simply that the facility didn't meet the standards, but that Mr. Mattson, the nurses, doctors, and whatever, individual practitioners to meet the standard of care

in their field in the care that was rendered to Mr. Cains.

And in regard to the specific practice employed by those professionals, my definition of a standard really reflects what we expect to happen at the level of the practitioner. It's different --

Q Let me ask you --

A It's not CMS anymore. That definition applies to what specific professionals are doing with specific patients or individuals.

Q And earlier -- so your answer to my question, would you agree with me, that the American College of Physicians does not set the standards, I think you started out with no, you don't agree with me, correct?

MR. ROSEN: I let -- I think we have been through this at least five or six times. He is talking about two things --

MR. GREEN: No.

MR. ROSEN: We are talking about the standard, one was the -- and the objection is that Doctor Kastner has made it quite clear, by reading his report and by testifying as to what the standard of care -- who sets the standard of care for

restraint use in the facility. It's clear.

MR. GREEN: Well, I --

MR. ROSEN: Now, five or six, I don't know how many times we need to go over this --

MR. GREEN: Well, I --

MR. ROSEN: -- for you to understand it.

MR. GREEN: I thought it was clear too. And that's why I thought he would easily agree with me that it's not set by the American College of Physicians, but he did not agree with me.

MR. ROSEN: What standard of care are you talking about? Because that's the question. There's two -- as Doctor Kastner has explained it in three or four times, he uses the terms in two different contexts, the way that it was done in his report is talking about the standard of care for setting the regulations for the facility, including the restraint use. Now, are you talking about that, or are you talking about something else? That's what needs clarification. And Doctor Kastner has said

it numerous times.

MR. GREEN: Yes.

BY MR. GREEN:

Q So Doctor Kastner, I will ask it this way. In your reports that you wrote, when you talk about standard of care, are you, in fact, only referring to what you stated on page three of that second report dated January 6th, that -- actually, do you have that in front of you where you can see it? Your January 6th report?

A Yes.

Q It's Exhibit 2-B?

A Yes.

Q And page three up in front of you?

A Yes.

Q Okay. On your opinion number three, I'm going to read what mine says, because I think this may be a typo, but I want to clarify it with you. Paragraph three says, "Based upon a reasonable degree of medical certainty, suggestions, recommendations or opinions within cited references and other materials, to the degree that they diverge from CMS rules and regulations, Arkansas DDS policies and procedures, and BHDC policies and procedures do not represent the standard of care for the delivery of behavioral

services."

Let me make sure I understand. Are you saying that Doctor LeBel's other citations do not represent the standard of care for delivery of behavioral services at BHDC?

A I'm saying that the materials generated by the UN, World Health Organization, SAMSHA, and the other sources that she cited, do not represent the standard of care for the delivery of behavioral services at BHDC.

Q Very good. And your opinion one, which you read earlier, states again, "Based upon a reasonable degree of medical certainty, CMS rules and regulations, Arkansas DDS policies and procedures and BHDC policies and procedures represent the standard of care for the delivery of behavioral services at BHDC." Did I read that correct?

A Yes. And that represents a partial articulation of my opinions about the standard of care.

Q Okay. And --

A So you need to go to page five, item 14, to see where I have stated that the standard of care also needs to be examined at the level of staff. And staff and the implementation of their professional judgment, the services that they deliver, need to

meet the standard of care for, you know, their field. Right? So we have to make a judgment --

Q No. I understand the document.

A -- to understand the standard of care for the entire facility. But in this specific instance, did the staff comport themselves with the standard of care for their relevant field?

Q So when you say that you believe the staff and the facility at Booneville -- at the Booneville center, complied with the applicable standard of care, are you incorporating both those things that are promulgated by CMS, the state and the facility, and the standards imposed by their particular field or profession? Are you combing those when you say "standard of care"?

A No. I'm using them in different ways. So standard of care for the facility, in general, is defined by CMS and the state and BHDC rules and regs. And my opinion is that the facility, as a whole, meets those standards of care. You know, for example, the policy around the use of activating the 911 system, I believe that that policy is appropriate, effective, provides adequate care, and complies with CMS rules and regulations about heath and safety.

And I believe CMS is in agreement, because they find no fault with that policy, or with how BHDC as a facility, chooses to address the activation of the community 911 system. And the second --

Q Can you --

A -- issue around this individual, Mr. Cains, and what staff did to support him, there is a lot of [redacted] Based upon the level of experience, training and skill, and the situation in which they were confronted, I believe that those RCTs behaved admirably. They did everything that they were trained to do, everything that would be reasonably expected of them as RCTs.

They are not M.D.s, they are not Ph.D.s, they are not practicing in an emergency room with access to high technology. These are folks with generally high school educations who generally had weeks or months of training, who are trying to address, as really complex people with emergent needs, and they did a very good job, based upon their training, experience and the judgments that they made. So that use of standards is incorporated in both ways in my recommendations throughout both reports.

Q Okay. So the use of standard, as it applies to their field, is incorporated, is that correct?
A Yes. I think, you know, item 14 page five is an example of how I have applied that word to the professional judgment exercised by staff.
Q Right, right.
A That's completely different than federal rules and regulations.
Q I understand. I understand what you are saying. Let me ask you this. Can you tell me where in any of the CMS rules or regulations, or in Appendix "J", where it states that the standard for standard of care in any way incorporates language similar to the expected practice of what a reasonably qualified person would do, based on their training, experience and judgment in that situation? Is there any language similar to that that you can point me to in Appendix "J" or any of the federal regulations or state regulations?
A Sure. And if you go to the federal regulations, practitioners need to be licensed in order to practice out at the BHDC. Right? I mean, the physicians, you can't just walk on to the facility grounds and say, you know, "I want to be the facility's physician," you have got to be licensed to

be a physician.

In order to be licensed, you have to complete a course of training. And that course of training defines what services you will provide within the scope of practice of being a physician. It applies to every discipline for services that are rendered at the facility. It --

Q Where in --

A Where is a requirement for a license within the federal regs?

Q No. I know there is, I believe you. But that is -- that, again, wasn't my question. My question was not, is there a requirement for a license. My question was, does that language itself, that I just recited, about the reasonable or the expectations in practice of what a reasonably qualified person, with two, based on their training, experience and judgment, do those words themselves, can you point me to where in the federal rules and regulations or Appendix "J" where those words or the general gist of those words are used to define what a standard or standard of care is? Can you point me to those words?

A When the federal government delegates the responsibility, making that determination to a state

licensing board, they are now subject to the interpretation by that board of what constitutes practice in that discipline. So if the feds say a physician needs to have a license, well, then you have got to go to the state licensing board and determine what it means to be a physician in that state and what it means to practice medicine in that state.

And professional boards incorporate the idea that professionals can only be expected to practice within, you know, what they have been trained to do and what they encounter in their practice. It is contingent upon what state licensing boards have to say about those practitioners.

Q All right. So you can't point me to that specific language, you are telling me you have to refer to what the state boards do, I get it. With respect to the individuals such as Mr. Mattson, what state agency or licensing agency provided a standard for him, acting as a reasonable person?

A The Appendix "J" has numerous requirements for what facilities are supposed to be able to offer individuals, and within those requirements, broadly, there are specific statements about what they call direct support professionals, or QMRPs, qualified

mental retardation professionals, or QIDDs, qualified intellectual and developmental disabilities professionals, are supposed to be able to do in the course of their work.

And I am not going to go through Appendix "J" and tease out every one, but there are expectations set within that document for what, broadly are called direct support professionals, are supposed to be able to do. Now, specifically in regard to -- let's talk about behavioral services, because that is what is being discussed here. The feds require that staff be trained in the use of behavioral procedures.

Arkansas provides training to staff regarding behavioral procedures. Now, the feds don't require that a certain level of competency be met. They don't require that staff needs to be able to demonstrate that they can competently provide behavioral services consistent with their training one hundred percent of the time. The feds don't say that. The feds don't say anything about the level of competency.

Now, the state engages a private contractor, CPI, Crisis Prevention Institute, to provide behavioral training or certify their trainers to deliver crisis intervention services, the NCI model.

Now, NCI only requires that staff demonstrate competency 70 percent of the time, which means that you can complete the training and be able to practice with the expectation that you may only deliver the services consistent with your training 70 percent of the time.

The other 30 percent may not be consistent with their training. That is sufficient to meet the standard set by CMS for the training of DSPs. That's a lot of variation. And some might say it's unacceptable, but it is consistent with what the feds require. So there is a -- when you look at what happens at the individual client level, the individual staff level, there is abundant information in the state and federal rules and regs that will describe the fact that there will be variations in outcome and variations in practice amount the direct support professionals employed at a facility. And that's acceptable.

Q All right. Let me ask you about the NCI/CPI training. You would agree with me that that is the training for the State of Arkansas, specifically the Booneville center, that they have implemented, correct?

A Yes.

Q And that was the only authorized training in existence at the time of this incident involving Mr. Cains, for that center, correct?
A Well, that's the only curriculum that's used. I wouldn't say training authorized, because much of the training that this provided to direct support professionals is not curriculum based, it's practical, it occurs in the field with staff working --
Q Yes. I was going to go --
A -- under the supervision of other trained and qualified staff. So the training is much broader than the NCI curriculum.
Q Let me be a little more specific in my question.
A Okay.
Q Would you agree with me that the only authorized training with respect to the use of restraint or the restraints at the Booneville center in June of 2020 was that that is in accordance with the NCI/CPI standards?
A Could you just repeat that question?
Q Sure.
A Because I want to make sure heard exactly what you asked.
Q Would you agree with me that the only training

with respect to the use of restraints that was authorized to be used and implemented at the Booneville center in June of 2020, is that that is the NCI/CPI training?

A I would disagree with you, because of your use of one word, and that is "training". As I just discussed, training incorporates not only the curriculum published by PHI -- or CPI, but also the -- that the hands-on supervision and work that is accomplished in the field when trainees are supervised and mentored by other staff. That is a very large part of the training. It's not part of the curriculum, but it is of the training.

Q Sure. I understand that. But on the job training type of experienced, is that kind of what you are talking about a little bit.

A Absolutely.

Q Okay.

A It's an important component of the process for ensuring that the staff are qualified to meet the standard of care for their role, whether it's as an RCT or a QIDD.

Q So you would agree with me, then, I guess, the only approved curriculum to be taught or trained regarding restraint at Booneville center with respect

to restraints in June of 2020, the staff that is NCI/CPI?

A I wouldn't necessarily go that far. I would say that the CPI/NCI curriculum is currently used, but it may not be the only one that is approved for you.

Q Are you aware of any other curriculum that was approved for use at the Booneville Human Development Center --

A I can say that --

Q Hold on. I have to finish my question, I'm sorry. As it relates to restraint use at that center as it existed in June of 2020?

A I'm aware that there have been other trainings, I am not aware that there are other curricula.

Q I'm asking about approved curriculum that can be taught and used for training with respect to the use of restraint in June of 2020. Are you aware of any other that was authorized to be used, curriculum that is, at the Booneville center in June of 2020?

A As I said, I'm aware of other training, but not of other curricula.

Q My question wasn't training, it was curriculum. Are you aware of any other curriculum as it applies to restraints in June of 2020 that was approved for use at the Booneville center?

A As I said, I am aware of other training, but not of other curriculum.
Q All right. Yes. Not of other, okay, finally the answer. All right. So is your testimony that the staff at the Booneville Human Development Center in June of 2020, would not be expected to use restraint in accordance with their training? Specifically their training they received based off the NCI/CPI curriculum 30 percent of the time? That it would be okay for them to not follow that up to 30 percent of the time?
A Can you repeat your question, so I can try to --
Q I will try to be more succinct. Earlier you said that the feds don't mandate any competency, generally, I think that's what you said. I'm not trying to lock you in on it, trick there. But basically my question is, are you saying that in June of 2020, the staff at the Booneville center, with respect to the use of restraints, that it was acceptable for them to use methods of restraint, techniques of restraint that were not in accordance with the NCI/CPI curriculum up to 30 percent of the time?
A There are a couple of issues with that question.
Q Okay.

A The first is that NCI is not exhaustive of every restraint procedure that might be employed by staff at the facility? There are eight or six approved behavioral approaches. And NCI does not address all of those approved procedures. So NCI is incomplete as far as a curriculum that would support the implementation of all of the approved procedures at the facility.

For example, the staff are trained to provide restraint to individuals on the ground. But that training does not occur as part of NCI. Mr. Hise testified that he only trains staff to provide restraints in individuals who are seated or upright. But we know that because we are restraints are provided to individuals in the prone position, you know, in particular with the papoose board, and training does occur for those staff when they work with other staff and learn those techniques.

So NCI is not the universe of training or of approved practice at the facility. That's the first point. The second point is that, CPI recognizes that staff will not be able to employ all of its training upon the completion of its training upon the completion of its training program. They set an expectation of 70 percent in terms of completing a

test.

Now, if you only expect staff to be able to employ 70 percent of their training, the moment they walk out the door, you can't expect that they are going to be able to provide 80, 90 or 100 percent of that training when they are in the field. It's simply unrealistic. So embedded in the way that CPI has developed the curriculum, and makes whatever representation as to the value of completing that course, embedded in that is the assumption that there will be a significant variation or deviation from those trained practices once individual practitioners are in the field.

Q I like the word you just used there, which was "assumption". That's what you are doing, correct, because the percentage required to pass the NCI training is 70 percent, you are assuming that it's acceptable once in the field, to perform at only a 70 percent proficiency level, correct?

A No, that's not what I'm saying.

Q Okay.

A I'm saying that as a matter of a group of people who are being trained, if the expectation was that there is that group, and those individuals that comprise the group, could pass a test with a 70

percent proficiency level, that as a group, they are not going to be proficient at 100 percent, at 100 percent of the time. It's unrealistic to expect that as a group, if they have only had to demonstrate a 70 percent proficiency, that they are going to implement at 100 percent in the field.

And the further they get away from their training, and the more they encounter content or experiences that fall outside of the NCI curriculum. There will be variations in practice. And I think, you know, Mr. Mattson was confronted by such a situation. He employed a blocking procedure consistent with his NCI training, but because he was charged at by a 248 pound man, he found himself on the ground as a result of that individual.

And at that point he had to rely upon his judgment as to what was the best manner in which to proceed. In particular, what was the least restrictive procedure that he could employ, and weighing the risk of Mr. Cains harming staff or himself against a more restrictive procedure such as a papoose board.

Mr. Mattson made a decision to employ personal holds, which in -- and along the continuum are not as restrictive as a papoose board, but are maybe more

restrictive than simply letting the individual up. The question is, did Mr. Mattson employ reasonable judgment in doing that. And he and the staff all testified they did what they thought was best. They tried to protect the individual and the staff, which were consistent with the core recommendations of NCI, to so the least restrictive procedure and protect the health and safety of everyone.

They made a judgment based on their skill and experience, the training and the specific circumstances where Mr. Mattson found himself on the ground with a 248 pound individual. That's not covered by NCI. So there's going to be some variation in practice as it relates to what happens in the real world, and CPI acknowledges that.

Q Do they acknowledge it in their literature?

A No.

Q Is it --

A But in the fact that they accept someone can leave the training room and score 70 percent on the exam, which means that they don't -- they don't have 100 percent -- a grasp of 100 percent of the material.

Q Okay. So you infer they accept it based on their grading percentage, not by any express

statement in their policy, correct?
A It's one thing to say something, it's another to do something, to allow people to say they completed their training when they can only answer 70 percent of the questions correctly.
Q Do you recall Mr. Hise's testimony that the only training that is given to the staff at Booneville at the time of this incident with respect to restraining someone on the ground, was restraining them on the ground for the purpose of transitioning to mechanical restraint. Do you recall testimony along those lines?
A Yes, I do.
Q Okay. Great. And you testified earlier that you are board certified in several different specialties, I think four, correct?
A Correct.
Q Do you recall, for instance, the board certification and -- or can you just tell me them again, and I will let you know which one I want to ask you about?
A Pediatrics,
Q Pediatrics.
A Developmental behavioral pediatrics, neurodevelopmental disabilities.

Q The neuro -- the neuromatic physiological disabilities, that one that you just described.
A Neurodevelopmental disabilities.
Q Neurodevelopmental disabilities. Do you recall what the -- did you have to take an actual exam or a series of exams to get that certification?
A Yes, I took an exam in all four of my boards.
Q And they are referred to as boards by people in the industry, correct?
Q And is it one exam for each specialty? And did you --
A Pediatrics had both a written and verbal examination. The other three were written.
Q Okay. Do you recall what the required percentage was that you were required to get correct in order to pass your boards for each of those specialties?
A No. But I can -- I'm certain it's less than 100 percent.
Q Okay. All right. And so if, for instance, the percentage required to pass your boards for pediatrics was 85 percent, would that mean that the agency or the organization that grants you that specialty once you pass your boards has accepted that 15 percent of the time you will be wrong in the real

world, like when you come out from passing your boards?

A This is a great question. You are beginning to appreciate what I'm saying. What it says about the field is that the certifying bodies, the organizations that determine the standard of care recognized that there would be variation in practice. And it goes to the fact that we often don't know what is the best or most appropriate practice to offer at a specific time.

That there may be a lack of evidence that, even when there is good evidence, it may not speak to a specific situation or specific resources. And it's directly applicable to the position that Mr. Mattson finds himself in on the -- when he is dealing with Mr. Cains on the ground. As you mentioned, Mr. Hise said the only time we train to put people on the ground is to put them into a physical restraint.

On the other hand, Mr. Hise tells his trainees, "We always employ the least restrictive measure." And here you have Mr. Mattson, a person with a high school education who has had several weeks of training in the implementation of behavioral services. And he finds himself on the ground with a 248 pound individual, and conflicting

recommendations.

On the ground, he can go to physical restraints, he could tell the staff, "Let's go to a papoose board, that's the right thing to do." On the other, he could say, "I don't want to restrain this guy unnecessarily, why don't we just use these personal holds and continue in that regard."

And he is conflicted. He could do either one. He makes a professional judgment that they should continue the personal holds and give him a chance to calm down, rather than escalating the restraint and using a more restrictive procedure, like a papoose board. So training doesn't necessarily -- it's not a cookbook, it doesn't tell you what to do in every instance.

And in every profession, whether it's being a DSP or being a physician, or a Ph.D., or an educator. Variation in practice is anticipated, because situations are different, resources are different. And I think Mr. Mattson's judgment that the safest and least restrictive procedure was to continue with personal holds, was a reasonable one. It may not be what I, as a physician, or Doctor Forestiere, as an emergency room physician, or Doctor LeBel, as an expert in restraint reduction, would

have recommended.

But it was reasonable for somebody who had several weeks of training and a high school education. That's the point, that's why we tolerate flexibility and variation in practice. It's reflected in the exam that they are not cookbooks, we are not robots.

Q All right. When you were reviewing materials to write your opinions and to testify, do you recall reading any depositions of staff at the Booneville center wherein they testified that their opinion is that the least restrictive practice was not, in fact, used against Mr. Cains?

A No, I don't recall that.

Q Okay. Very good. So you didn't read a deposition where anyone testified to that?

A No, I have read all of the materials that are listed. I don't recall staff, and if you are talking about the three RCT level staff, saying that they did not believe what they did was the reasonable course. I mean, obviously, they were restraining the individual --

Q Well, what -- I think you have changed my question a little bit, because you limited it to the three staff that were involved. And I'll limit it

to them for now. But my question is, do you recall reading any of their depositions where any of them stated that they believe that the least restrictive means of restraint was not used on Mr. Cains? I think you said you don't recall that? I'm just trying to clarify that you don't recall seeing that in any of their depositions?

A I recall all three staff saying that they were trying to protect Mr. Cains and other staff from harm. And they believed that the form of restraint that they employed was the most appropriate, based upon their training and experience. And I can't recall specific language as to least restrictive, but their judgments were that it was the most appropriate and consistent with what they had been trained to do.

Q And that's how you recall their testimony, correct?

A No. I believe I quoted them in my first report, and I would welcome an opportunity to go back and look at that, because they were adamant about trying to do the right thing and realizing that this was a really complicated issue.

Q All right. And other than those three, do you recall reading any other depositions from anyone employed by the State of Arkansas that their opinion

was the least restrictive means of restraint was not used on Mr. Cains?
A Mr. Hise may have said something to that effect, but I would not have focused on that, because I am not certain that he was referring to the standard of care for the RCTs. I think he might have been referring to, you know, what he trains staff to do. So I can't recall specifically, although there may have been some discussion about that.
Q With respect to Mr. Hise?
A I can't remember -- I can't remember exactly, so I don't --
Q All right. Let's go turn to the State Operations Manual. I do want to ask you some questions about it.
A Okay.
MR. ROSEN: Counsel, if --
MR. GREEN: Do y'all need a break?
MR. ROSEN: Yes. I was going to say, before we switch subjects, why don't we take a few minutes?
MR. GREEN: That's good.
MR. ROSEN: We have been going for quite awhile.
MR. GREEN: Do y'all want to do -- it's

3:20. Do you want to come back at 3:30?

MR. ROSEN: Yes.

MR. GREEN: Okay.

MR. ROSEN: Okay. Thanks.

(WHEREUPON, a short break was taken.)

BY MR. GREEN:

Q Doctor Kastner, you understand you are still under oath, correct?

A Correct.

Q All right. I'm going to ask you some questions from Appendix "J". I'm not going to have you look at every page, I'm just going to ask you some questions as it relates to it. You are free, of course, to look at it, if you want. Would you agree with me that -- and I'm going to be asking about human development centers, and how Appendix "J" applies to Booneville Human Development Center, specifically back in June of 2020, and these series of questions as they relate to Appendix "J". Do you understand what I'm saying?

A I believe so.

Q Okay. And if you don't, you will let me know, correct?

A Yes.

Q All right. Would you agree with me that the

Booneville center was required to ensure that clients are not subjected to physical, verbal, sexual or psychological abuse for punishment?
A Are you referring to a specific standard or guidance or tag in --
Q Sure. I don't -- I can refer either by the "W" numbers or the 483. What do you prefer?
A Like the "W", that will be easier.
Q Okay.
A If we are going to look at Appendix "J", yes, that will be easy.
Q All right. I'm going to make it easy. Let's go to W127. I think it's the third page in. They are not numbered on my copy.
A Okay. 127, I've been there. It's --
Q And I understand that -- well, let me first ask you, you are looking at that page, correct?
A Not quite yet, but I'm going to be there in a second.
Q Let me know when you get there.
A I'm there, okay.
Q Okay. Do you see where it says "W127"?
A Correct, yes.
Q That underneath it, it says, "Rev. 135", and there's some additional language past that?

A Yes.
Q And then, underneath that it says, "483" -- well, it doesn't say it. If I use the word "say", I don't mean "speak". Do you understand, I'm just saying what the document contains, all right?
A If I were to read it, I would understand, yes.
Q Okay. So does this document state that 483.420, subsection "a", subsection "5", "Ensure the clients are not subjected to physical, verbal, sexual or psychological abuse or punishment."
A So we are in the abuse and neglect section of Appendix "J", is that correct? Because it comes in different sections. There is healthcare services, behavioral services. There is other kinds of things. But I don't think we are in the behavioral services section of Appendix "J" anymore, are we? These -- like, again, my point is that these are in the context of a broader category of thinking.

So I want to make sure that we set -- so "Condition of Participation". Let's go up to 483.420,
"Condition of Participation. Client protections." And the standard is, "Protection of client rights." This is what we are looking at, correct?
Q Well, I'm not trying to be rude, but I don't --

I'm not here to answer questions. But we are looking at the same thing, I believe, based on how you have represented it.

A Okay. So I just wanted to make sure that we had the proper context. We are not talking about behavioral services any longer. Now we are talking about the general standard for protection of client rights.

Q Okay. My question is, did I read -- I haven't even gotten to does it apply or anything yet. Just simply, did I read it correctly, the 483.420(a)(5), "Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment"?

A I've got to go back to where we were. It was W127?

Q Right.

A So do you want me to engage with you in an exercise in verifying the accuracy of your ability to read, or to interpret something, because --

Q You can --

A And you can read as well as I can and probably read legalese even better. I don't understand the point in walking me through a tag related to client protection of rights when my consultation and the scope of what I was asked to do was to look at

behavioral services and clinical services, not the overall operation of the facility, state regulations and rules regarding client protections and rights, or even the CMS regs about protection rights.

So is -- you want to go through this exercise of you reading and me confirming that you read accurately?

Q Well, I don't really care how you characterize my questioning. I just simply want to ask questions that I believe are relevant, or could lead to relevant information and just have you simply answer the question. That's all I'm asking. That's all I'm asking.

And I think I do need to ask some of these, because I think you just said that you were not engaged to give your opinion on the facility, did I hear it, what did you mean by that?

A No. On the scope of -- the entire scope of Appendix "J" with my engagement, I don't believe, was to review every tag or standard or a condition of participation for the facility, relative to its certification by CMS.

I believe we could agree that the facility has been surveyed by the federal government, and meets the standards that the federal government has

established for continued participation in the ICF/IDD program. So knowing that, I wonder now why we are confirming your ability --

Q Can I --

A -- to read.

Q Can I -- I appreciate your curiosity, but frankly I just need you to answer the question, it's not really ultimately important whether you understand why I'm asking it or not.

A No. And I completely --

Q And I don't mean it rudely, it's just one of my --

A I'm not -- let me -- if I could please finish my response?

Q Okay.

A I'm not -- I was not engaged to confirm your ability to read. My opinions have nothing to do with your ability to read. My engagement was not for the purposes of reviewing tags related to client protections or other sections of the ICFMR standards. So I have no opinion as to whether or not you can adequately read or whether or not these have any bearing.

Q Okay.

A So I'm going to respond that I offered no

opinion on any of these. And this may turn out to be a waste of your time, but --

Q It may be. But I am --

A That's your -- that's your choice.

Q You know, I think it's important I understand what you were engaged to do. So I guess I will just ask you that. What is your understanding of what you were engaged to do, specifically with respect to Mr. Cains' case?

A I think my engagement is characterized fully in the opinions I have to offer. So as you read through the opinions, you will see that I was engaged to provide opinions about whether BHDC meets federal standards of care. I was engaged to provide an opinion as to whether or not staff at BHDC met their respective standards of care. I was engaged to offer an estimate of life expectancy for Mr. Cains, to opine as to whether or not his death was painful.

My opinions are reflective of the engagement that was made. So I think if I could read my opinions into the record, and we can go at it that way, and I can tell you how it reflects my understanding of the engagement. But I think we decided at the beginning not to do that.

Q I don't need you to read your full opinion. And

I'm not asking you to confirm my reading ability cued for some other purpose. Opposing counsel asked you to read specific things from your report. Sometimes I need to get you to confirm with me that I'm not misrepresenting what a particular item says.

I just want it to be clear on the record that I'm not misrepresenting what something says. So it's not about whether I can read it, it's about am I accurately stating what it says?

A Well, I'm telling you right now, I have no opinion on what you are reading.

Q Okay.

A That it was not within the scope of the engagement. I was not asked to comment on all of these standards within Appendix "J" to comment on tags which don't have any relationship to the specific incidents that we are here to discuss.

MR. ROSEN: And counsel, I want to raise an objection to the relevancy of, you know, of the initial question that you were -- that started this conversation. I mean, how is that relevant to this --

MR. GREEN: Did I read this correctly?

MR. ROSEN: Well, I don't know whether --

MR. GREEN: But that's the question.

MR. ROSEN: Well, I mean the question is -- I mean, as I agree with Doctor Kastner, is like why are we sitting here -- ask the question, not whether you read it correctly, but ask the question, and if it's within his scope then he can answer it or I will object to the relevance. But right now, the question that you asked is not relevant, whether you read it correctly. And second is, this has nothing to do with -- as Doctor Kastner testified to the behavioral health or restraint services requirements. But go ahead. Ask the question and then I will object or Doctor Kastner will answer the question if he can.

BY MR. GREEN:

Q All right. So Doctor Kastner, am I understanding you that your testimony is, you are not going to offer an opinion as to whether I read, while that purported to be the language of Section 483.240(a)(5) as it appears in Appendix "J"? You have no -- you're not offering --

A As to whether or not you are reading accurately?

Q Correct.

A And I said to you, that exceeds the scope of my engagement with the State of Arkansas.
Q Okay. All right. Whether I read it exceeds the scope. That's good. Does that regulation that I just cited 483.420(a)(5) apply -- did it apply to the Booneville center in June of 2020?
A As I have stated, the CMS rules and regulations, and in particular as they are interpreted by Appendix "J", were applicable to BHDC.
Q Okay. I will take that as a yes. But you were not engaged to give an opinion on the application of 483.420(a)(5) at this --
A CMS -- CMS has already offered an opinion, which is that BHDC satisfies the requirements contained in Appendix "J", including W127, and thereby can continue to participate in the program as an ICF/IDD. And CMS has the authority to do that, and has done so. There is no point in me going back and investigating whether or not BHDC met that standard when CMS has provided an authoritative opinion in that regard.
Q Okay. My question just simply was, are you saying that it was not part of your engagement to assess that particular regulation that I have cited, as it applies to Booneville in June of 2020, in this

incident?
A As I said, the scope of my engagement is embodied in my opinions. And I'll be happy to walk you through the opinions and help you understand the breadth of the scope. But I have no opinions as to whether or not the HDC complied with W127, because CMS has already offered an authoritative opinion that the facility is in compliance with that standard.

There is no point to me reviewing that if we agree that the feds have that -- you know, defined the standard and the means of measuring compliance with that standard.

MR. GREEN: Well, I was going to make it very clear for the record. I'm not agreeing to any proposition that you are stating if you say "We can agree."

BY MR. GREEN:
Q All right. So in not --
A I think that we agreed that the feds set the standard, we agree that the feds use Appendix "J" for the purposes of measuring compliance with the standards. And I think we can agree that the feds determined that BHDC meets the standards that they define, using the instrument that they produce as a result of the survey. So there is no point in my

going back and looking at tags in Appendix "J" and trying to reference it back into the CMS standards when it's a moot issue.

The facility is compliant with W127, and the standards around client protections.

Q All right. I'm simply just trying to ask you questions. I am not tasking you to give an opinion as to the mootness or relevance of my question. A very simple, "I'm not offering an opinion on it, because CMS has made a determination and I accept that," would have been fine. We don't have to have the round and round. We can, though, as long as you want. But it would be a little quicker if you would just answer my question.

MR. ROSEN: I think he did.

MR. GREEN: He did there at the end, yes.

BY MR. GREEN:

Q Okay. Let me ask you about W128. If you will let me know when you get to that page, I would appreciate it, or if you want me to ask you about it beforehand, I will.

A (Witness reviews documents.) I'm there now.

Q Okay. Section 483.420(a)(6), are you going to be giving an opinion as whether or not that applied

to Booneville in June of 2020?
A Yes.
Q Did it apply to them in June of 2020?
A Yes. And the facility met that standard according to CMS.
Q I understand that --
A The reason I looked at this specifically in regard to Mr. Cains, I will also confirm, and I think my opinions do confirm that they have appropriate behavioral treatments for individuals that address the elimination of restraints and the management of drugs to the extent possible. The interdisciplinary process addresses this concern.
Q That wasn't my question. But I'm going to ask you a different question. You said earlier that you reviewed Appendix "J" before this deposition, correct?
A Correct.
Q And so are you familiar with it?
A Yes, I am.
Q Are there any of the federal regulations listed in Appendix "J" that began with 483 that did not apply to Booneville Human Development Center in June 2020?
MR. ROSEN: I'm going to object. In

what respects, in what aspect of application? Are you saying -- are you alleging that they violated that, or are you just asking does 483 or Appendix "J" in general apply, whether it applies specifically or was relevant specifically on a different date or not.

MR. GREEN: If I want your -- the doctor's opinion on whether they violated it, I will ask that. I'm just simply trying to get his testimony as to whether they applied in the first instance.

MR. ROSEN: Well, be a little more specific.

MR. GREEN: I just --

MR. ROSEN: Applied to what, in general are you talking about or --

MR. GREEN: Okay. We'll go one by one, that's fine.

MR. ROSEN: Okay.

BY MR. GREEN:

Q So 128 applies. W129, let me know when you get there. It's 483 --

MR. ROSEN: Counsel, let me just be clear. What I'm saying is, you are saying,

does it apply, you know. And I think the Doctor has testified as to what Appendix "J" applies to. The questions I think that you're asking is whether -- what you are really asking, without saying, is whether it applies in a specific date at a specific time to the factual circumstances. And that -- you know, you need to be specific if you are going to ask the question, as opposed to a general just vague question. That's my objection.

BY MR GREEN:

Q Doctor, I'm going to ask you a question. The federal regulations contained in Appendix "J", they begin with 483. Do you know what I'm talking about when I state those regulations, do you know which collection of regulations I am referring to?

A I am familiar with Appendix "J".

Q Did those sections of the federal regulations apply to the Booneville Human Development Center on June 13th of 2020?

A As I said, the Appendix "J" is used to evaluate the compliance of the facility at the time of the survey. And Appendix "J" applies in its entirety, just to -- we can abbreviate this process, I am --

Q Okay. It's --
A I would say these regulations apply.
Q Very good. Thank you.
A But they are beyond the scope of my work relative to the instance of Mr. Cains. And they are not intended to be applied to specific instances of care. These are facility-wide standards that are looked at and examined. They are not defining the standard of care for an individual practitioner in an individual circumstance with a specific person.
Q Okay.
A In those instances it falls to the standard of care for the practitioner within the scope of their practice.
Q Okay. Can you point me to the federal statute or regulation that says exactly what you just said, that these do not apply to a specific individual in a specific instance, and instead it falls to the standards for the professional's practice? Can you cite me the federal law that states that, not an inference, but just states what you just said?
A That's a question that I was not -- that I don't have an opinion on. I have discussed this earlier about the professionals requiring a license in order to practice within the scope of their discipline.

And I believe that in doing so, the federal government requires that state defer to those licensing standards.

There are multiple citations within Appendix "J". I think there are 42 when you type in a search for the word "license". I would have to look at each one of those to try to be responsive. But I think in general my comments are accurate and reflect the intent of the CMS survey process.

So for example, professional program staff under W170 must be licensed, certified or registered as applicable to provide services in which the state -- in the state in which they practice. And then there are other qualifications, W171 that are in addition to licensure requirements for OTs in particular, OT assistants. My guess is the section of 170s are going to be around licensure.

We can walk through them if you would like, you know, 173 is PT, 174 PT aides, and 175 is a psychologist. The standards for training and licensure are embedded in Appendix "J". I think -- you know, it could take some time to go through them, but I think that that's responsive to your question.

Q Okay. All right. So that's your response. Let

me ask you to jump off of "J" for just a moment. Did Tyler Mattson possess -- was he required to possess any license issued by the state on June 13, 2020 to hold the position that he held with the Booneville center?

A No. I don't believe he was required to have a license.

Q Okay.

A I believe his education was at the level of a high school graduate. I don't remember if he graduated or completed a GED, or some college work. But generally he was about the level of a high school graduate.

Q Would our answer be the same with respect to Amy Jones and Ryann Campos? I may be pronouncing her first name wrong. But Ms. Campos and Ms. Amy Jones, that neither of them was required to have a license on June 13 of 2020?

A I can't recall. I don't believe that any of the three were required to have a license. I recall Ms. Jones had a higher level of training, and had some supervisory responsibility, but I don't remember any specific detail.

Q Okay. Thank you. All right. Give me just a minute to flip through this document. We are

probably going to move on to something else here in a moment. Let me ask you about W278. If you will let me know when you are on the page that contains W278, I will ask my question.

A (Witness reviews documents.) Okay. It's going to take me a while just to scroll down.

Q Sure.

A Okay.

Q All right.

A I'm on 278.

Q Okay. Section 483.450(b)(1)(iii). Do you see that section?

A Yes.

Q And by the way, the formatting of this document, when it cites to the 483, that language that follows it is in bold type. Is that right?

A Correct.

Q And does the bold type that follows 483 represent the actual wording of the regulation or do you know?

A I don't know offhand. I would check before offering an opinion.

Q Okay. All right. Very good. 483 point -- I'm just going to refer to it as W278, but I'm referring to 483.450(b)(1)(iii). Do you understand if I say

W278 I'm using it interchangeably?
A Yes.
Q Okay. Were you engaged to give an opinion with respect to W278, and it's application to Mr. Cains in June 13, 2020?
A Well, as I discussed with you previously, there are, in broad terms, two type of restraint procedures that are used at a facility. One, are programmed restraints, and the other are emergency restraints. W278 applies to program restraints. The restraints that were employed with Mr. Cains in this specific instance were not program restraints, they were emergency restraints.

278, I don't believe would apply to the conditions under which restraint was utilized, and therefore, I would not offer an opinion about the programmed restraints in Mr. Cains' IPPs.
Q Okay. Do know whether he had any program restraints in his IPP?
A He had a behavior support plan to address -- I know I said this at the beginning of my testimony, aggressive behavior and some other maladaptive behavior. But again, the specific instance that I was asked to look at didn't fall within the program restraints, it fell within the emergency restraints.

Q Okay. Let me ask you, though, W278, I just want to make sure I understood something you said earlier. I think what you said, and I may have misunderstood, is that the regulations contained in Appendix "J" apply to the facility, but not to a specific individual's treatment in a particular situation, is that correct?

A In broad terms. But that's not -- it's not absolutely true. There are many of the tags which surveyors can go in and look at the specific individuals and reach a conclusion based on what they see for a specific individual. So as a broad rule, the tags are meant for the facility. But surveyors certainly do and can look at individuals in reaching a conclusion about facility-wide practices. And that's clear in the guidance to surveyors.

Q Okey-doke. With respect to 278, and then I'm going to move on.

A So 278 is, I think, a good example of where Mr. Mattson finds himself conflicted between the use of a restraint, which is more restrictive -- you know, a mechanical restraint, which is more restrictive than a physical hold versus letting Mr. Cains up, which poses a danger to Mr. Cains and

others.

And Mr. Mattson, based upon his training and professional judgment determined that the balance between more restrictive procedure papoose board versus the risk of harm to individuals in letting Mr. Cains up. His death balanced with the use of ongoing physical holds. And that's just the way things are in real life practice settings.

Q All right. I thought just a moment ago, you said W278 did not apply to the situation involving Mr. Cains because it was not a program restraint. But it seemed like you were just then giving -- or at least somehow giving an opinion or testifying in some way that it did connect with the incident of Mr. Cains?

A Well, as you can see, the 278 are at the bottom, the last sentence is that in emergency situations where an unanticipated behavior requires immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible. And that sentence, I think is really important, because it implies that a judgment needs to be made by a professional as to what is the least restrictive appropriate technique possible.

And Mr. Mattson made such a determination in

the context of an emergency situation where he deemed it not necessary, not the least restrictive to employ in mechanical restraint, but that ongoing restraint was appropriate, given the risk of harm to individuals. So it's this kind of language which isn't prescriptive, it allows professionals to make judgments about what is the appropriate technique.

But for the most part, the bold and the tag from CFR relates to programs which are the approved behavior support plans, and not to emergency restraints.

Q So the actual text of 483.450(B)(1)(iii) does not fly in Mr. Cains' specific incident, but the guidance of it does, is that right, am I hearing correct?

A This issue of emergency situations is addressed in both, 278 in one sentence, but also in other portions of the guidance. And I think it's consistent throughout, it's used in terms of the guidance. But generally this tag 278, I believe, is around programmed restraints, not emergency restraints.

Q Okay. All right. So let me ask you this question, based on the answers you have given, if an emergency situation where there is an unanticipated

behavior requires immediate protection to client and others, technique chosen is the least restrictive appropriate technique. That is this -- that is guidance given from CMS, is that right?

A I'm sorry. Can you just repeat that question?

Q Is that guidance given by CMS?

MR. ROSEN: You faded out for a second in your original question.

MR. GREEN: All right.

BY MR. GREEN:

Q Okay. The language that you read earlier that says "in emergency situations where an unanticipated behavior", do you see that language?

A Yes, the last sentence under 278.

Q Yes. Is that the guidance from CMS?

A Appendix "J" are the interpretive guidelines used by surveyors to determine compliance with federal regulations. So this is a document prepared by CMS for use in the field as a measurement tool to determine compliance.

Q And right above that last paragraph I'm asking you about, there's two paragraphs above it, correct?

A What's the first word in the paragraph just so I know what you are talking about?

Q "Policies must be implemented".

A Correct.
Q And right above that it says "Guidance", correct?
A Correct.
Q Okay. So those three paragraphs that follow are the guidance given by CMS, is that right?
A Those are a guidance, they are not regulations.
Q Okay.
A They are an interpretive guidance that's used by a surveyor to determine whether or not a facility is in compliance with those federal standards.
Q So they are the guidance, they are not the actual regulation, I understand. My question is, that third paragraph that you read, if there were an emergency situation and they were -- it involved unanticipated behavior that required immediate protection of the client or others, the technique chosen is the least restrictive appropriate technique possible.

If a person within a human development center in a state where the human development center had a -- the state or the center had a written policy that no papoose boards shall be used, but the person with the unanticipated behavior that required the immediate protection chose to use that technique, would the

person be in violation of their state regulations and facility ones, but not this one, is that -- am I reading that right?

MR. ROSEN: First of all, before Doctor Kastner answers, I'm going to object. That's not relevant here in this situation.

BY MR. GREEN:

Q Well, it's a hypothetical that, Doctor, if you have an answer you can give it.

A I can't respond. It's outside of the scope of my engagement.

Q Very good.

A BHDC does permit the use of papoose boards.

Q And do you have an opinion as to whether the Booneville Human Development Center should continue or discontinue the use of papoose boards?

A I am not --

MR. ROSEN: I'm going to object on that on the grounds of relevancy here, that we are talking about a time period two years ago, in June of 2020. And a papoose board wasn't even used. So it wouldn't be relevant to any aspect that the Claims Commission is going to decide or not. So I object.

MR. GREEN: Okay.

MR. ROSEN: Irrelevant.

BY MR. GREEN:

Q All right. But Doctor, you still can answer. So do you have an opinion as to whether or not a papoose board should be used or not used at the Booneville Human Development Center?

A That opinion would fall outside the scope of this consultation.

Q So you won't tell me whether you have an opinion because you believe it falls outside of the scope of your engagement?

A In this specific engagement, absolutely. I was not asked to opine, and I offer no opinion as to the merits of any specific behavioral approach.

Q You offer no opinion today under oath in this testimony or at all about the use, continued use of papoose boards?

MR. ROSEN: Okay. I mean, counsel, a papoose board was not used here. So what's the relevance of any testimony as to, particularly now, two years later? Are you asking back then or are you asking about right now? Actually I need that clarification, for my objection.

MR. GREEN: You know, it's --

MR. ROSEN: Because if you are asking about back then, perhaps, you know, the doctor could, if he knows the answer. But if you are asking about now, in January of 2023, how is that relevant? Please tell me how that's relevant to anything related to this case that happened in June of 2020.

MR. GREEN: Well, I believe the doctor testified that the testimony of Mr. Hise was that the only curriculum based training that was given at the facility at the time with respect to restraints while a person is on the ground is for the purpose to transfer into a mechanical restraint, which would include a papoose board.

MR. ROSEN: Agreed.

MR. GREEN: And so it's relevant in that manner. In --

MR. ROSEN: In 2020? So if your time frame is June of 2020, I would withdraw my objection. But if your time frame is 2023, two and a half years later, what is the relevance of that with regard to any issue the Claims Commission is going to have

to decide in this case?

MR. GREEN: Well, I will ask for --

MR. ROSEN: If we limit it to that, then it's fine.

MR. GREEN: Well, I'm going to ask about now, too, but I'm going -- because the doctor stated something that I want ask him about to see with respect to potential impeachment material, and credibility is always relevant.

BY MR. GREEN:

Q But I'm going to go back to 2020, Doctor. So in June of 2020, did you have an opinion as to whether or not a papoose board was an appropriate method for a restraint that should be used at Booneville center?

A I offered no opinion about papoose boards.

Q Okay. So your answer is, "I offer no opinion as to papoose boards"?

A No, no. My answer is that in my report, I offered no opinion about papoose boards.

Q But I'm asking, did you have one, that's a different question.

A Did I ever have an opinion, or do I have an opinion or --

Q I will ask --

A I would respond by saying that my personal opinions or other opinions about papoose boards are outside of the scope of this consultation. And I have no opinion to offer about papoose boards regarding the care provided to Mr. Cains.

Q Okay. Well, you know, respectfully, I'm not constrained in the scope of my questions by the scope of your engagement with the state. And my question is, as an expert, with your qualifications that you testified to earlier, in June, specifically June of 2020, did you have an opinion as to whether or not papoose boards should be used at the Booneville center? That's my first question.

MR. ROSEN: Objection, relevancy.

MR. GREEN: That's not the point.

MR. ROSEN: A papoose board wasn't used.

MR. GREEN: Well --

MR. ROSEN: Are you talking about a specific date in June of 2020 when they were used on Mr. Cains and that something was a result?

MR. GREEN: I think my question was clear, and you have objected to relevance, and we have talked about it. The doctor

needs to answer my question.

THE WITNESS: I have answered your question. And I will answer it in the same manner, which is that I did not offer an opinion about papoose boards in my consultation regarding the care provided to Mr. Cains.

BY MR. GREEN:

Q Okay. I understand that you did not offer an opinion. But I'm asking if you had one? Do you understand my question?

A I understand your question quite well. I hope you understand my answer, which is that I did not offer an opinion about papoose boards in regard to the consultation in this specific matter.

Q Okay. So you will not answer, did you have one, because you didn't give one in your report? Is that --

A My opinions are contained within my report. We can read them if you would like, if that would help to clarify this issue. But I offer no opinions about the use of papoose boards in regard to the care provided to Mr. Cains.

Q And your reports, somewhere early in each report states something -- well, let's not say what it --

let me look at the exact language that you put in your report. And by the way, these two reports, you drafted each of these reports yourself, correct?
A Yes. Unfortunately I have to admit to that given all the typographical errors. I have no one to blame but myself.
Q All right. So I just wanted to make sure we were on the same page there. All right. Let's just look at your first report from January 5th of this year, page three. You can flip to it, but at the bottom it says, "I reserve the right to amend this report and my opinions based upon any information I subsequently acquire, or any other issue," and it also says "This report does not contain every opinion which I may offer during testimony." So the report doesn't necessarily contain all of your opinions with respect this matter, correct?
A It does not contain every opinion which I may offer during testimony.
Q Okay. And -- all right. Well, I think the record is clear that you are going to be nonresponsive to my question whether you had an opinion, so we will move on. Let me ask you about restraints in general. Because I do believe that you have given opinions in this case about

restraints. Would you agree with me that a goal of the human development center should be to reduce the number of restraints that are used?

A What do you mean by "number of restraints"?

Q Okay. What, in the phrase "number of restraints", do you not understand?

A Well, like are you talking about the number of forms of restraint, you know, the five or six restraint procedures that are incorporated in policy that were subject to the medical review, are you talking about --

Q Okay. I understand, I understand. I will clarify it.

A -- the number of minutes of restraint, the number of episodes of restraint? What is it that you are trying to get at?

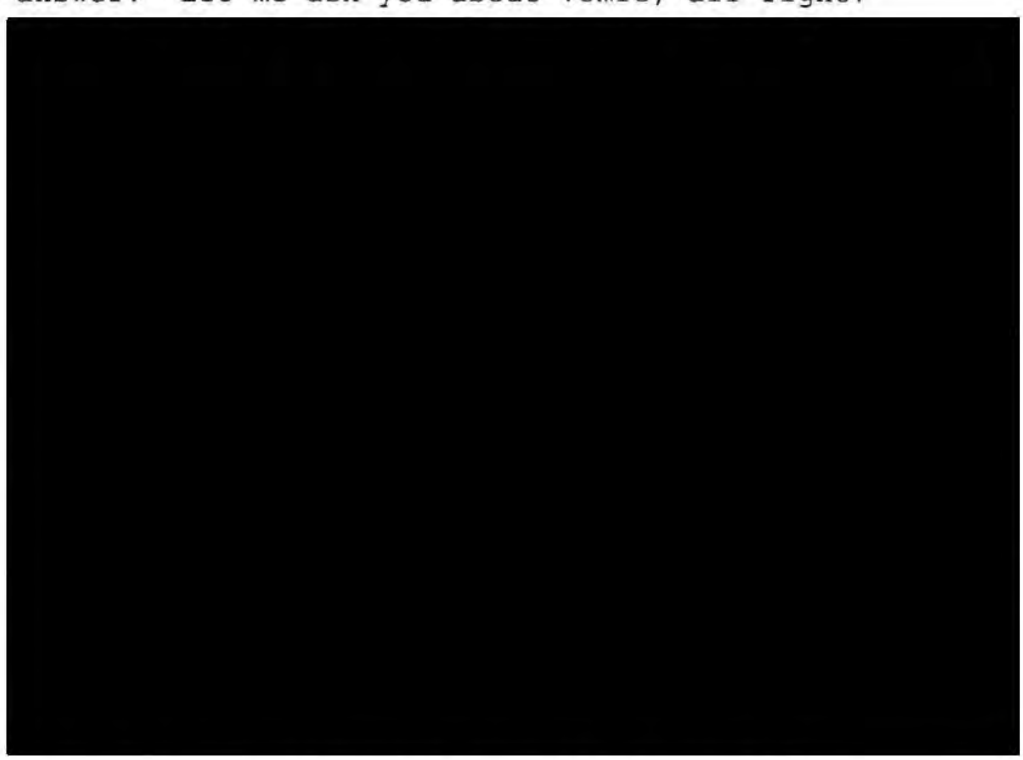
Q Here, let me clear it up. Do you agree with me that it should -- that the Booneville center, and all of the human development centers in the State of Arkansas, should have as a goal to reduce the number of restraints used in a given time period, say per year, that that should be a goal, to reduce the number of restraints used? And by that, I mean, incidents that it's used, not the types, but the incidents. Do you understand that question?

A The numbers of times that --
Q The numbers of times of the incidents, yes. Do you agree with me that reducing that is a goal that human development centers should strive for?
A I think that that's a kind of simplistic way of looking at restraint. It's helpful to look at that as an objective. But I think, you know, in broader terms, a goal would be to create a safe and healthy environment in which people can learn and develop as humans. So reducing restraints in and of itself, may or may not necessarily to be conducive to meeting those broader goals.
Q So you didn't like my use of the word "goals". Should it be an objective of the centers to reduce the number of times restraints are used?
A I think everyone would agree that restraints should be used, and reserved for those episodes in which it is clinically appropriate, and that the goal of minimizing restraint is a desirable goal, but it should not necessarily be at the expense of other outcomes.

So for example, again, and going to Mr. Mattson, there is a balance that needs to be struck in that specific incident of care about the use of a restraint and creating a more restrictive environment

versus the health and safety goals of the facility. I mean, if you said to Booneville today that they could not implement restraint, one of the potential outcomes would be that it would become a less safe environment, because staff would not be able to employ something which does protect individuals from harm. So it's something that needs to be looked at in a broader context, not simply as a stand alone goal, if you will.

Q Okay. All right. I think I understand your answer. Let me ask you about vomit, all right?



A That's really outside of the scope of the

complication I was asked to provide. I would --

Q Is that the --

[redacted]

Q All right. Doctor, I understand your answer. Again, respectfully, the scope of your engagement with the state does not limit the scope of my questions.

A Well, then, I can't answer your question if I'm not prepared. And I'm telling you I'm not prepared, because I didn't do the literature search that I would typically do to answer your specific question.

[redacted]

[redacted]

Q Okay.

A Contained -- those findings are contained in my opinion.

[redacted]

[redacted]

A Well, as I have demonstrated in my report, I like to cite evidence. So when I talked about the life expectancy, I incorporated four references that would help someone understand that my opinion was founded and based in the evidence and data. I'm not prepared to discuss any alleged associations between one thing or another or causality without the benefit of being able to cite literature.

Q Okay. Now, I understand your answer. You are not prepared and able to answer it. That's fine. My next question is, you said that Mr. Cains had [redacted] is that correct?

[redacted]

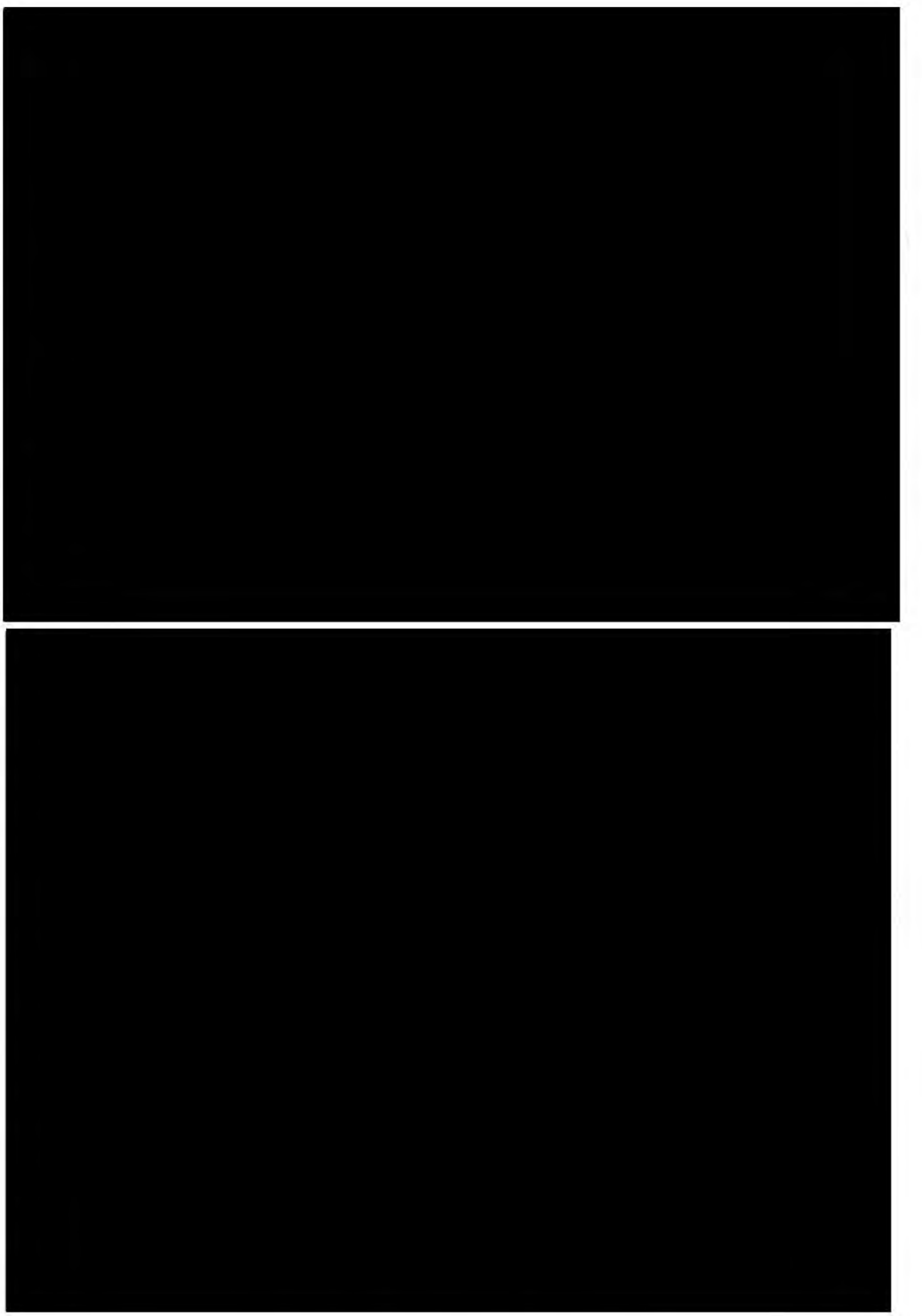
Q Okay.

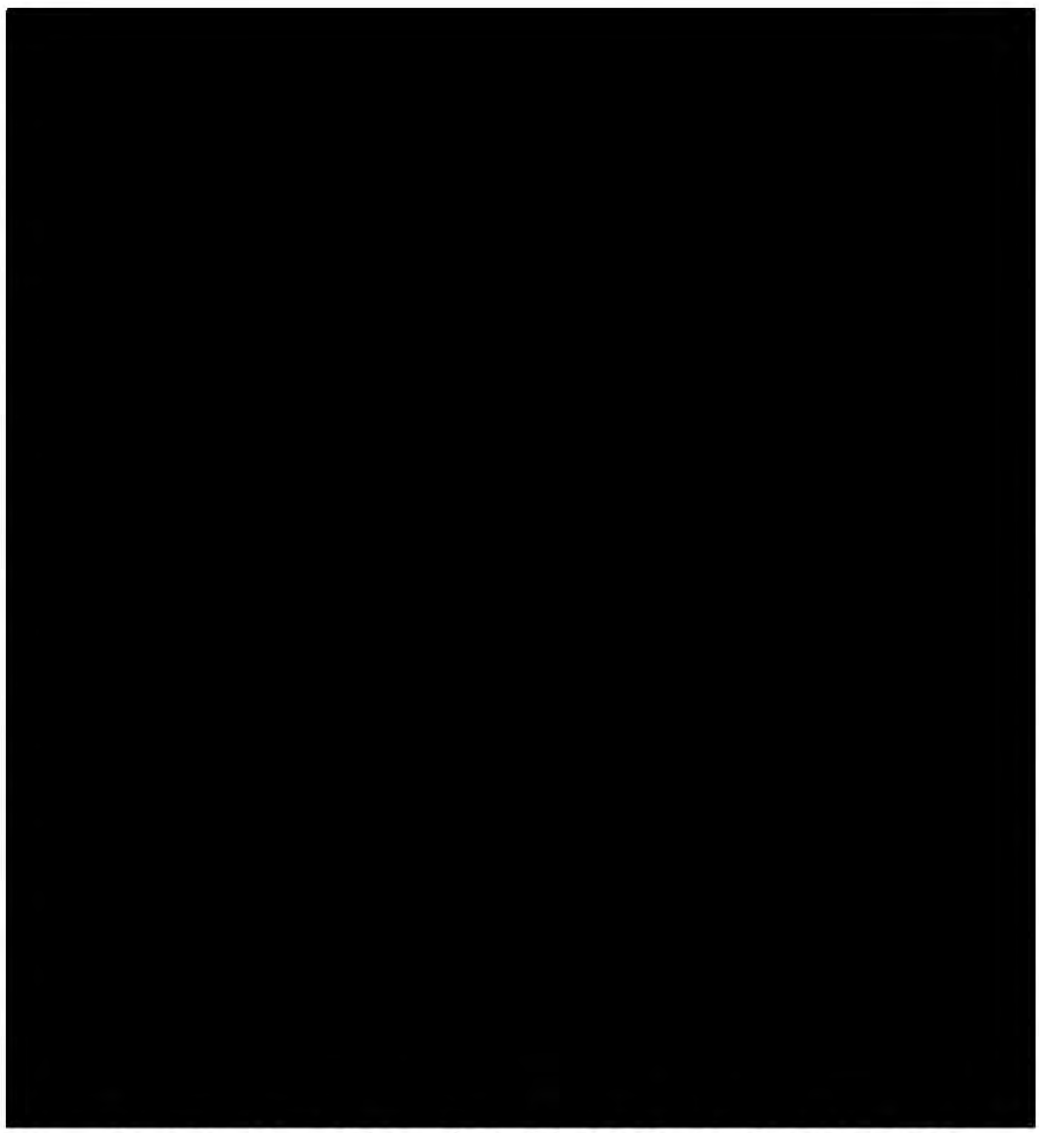
[redacted]

[redacted]

Q Okay.

[redacted]





Q So you are saying that if there is an emergency, the staff are authorized to operate outside of the behavior treatment program?

A CMS allows for two separate approaches to the management of individual's behavior. We have discussed this and reviewed actually the applicable

rules and regs. Programmed restraints are described in a behavior support plan and reviewed by the IDT with consent given by the guardian. Emergency restraints are different. They fall outside of the behavior support plan. There are different regulations that apply to them. And again, we have looked at those.

[redacted]

Q Okay. My question is, are you testifying under oath that if there was an emergency situation involving Mr. Cains, that the staff was authorized to operate outside of the written behavior treatment program for Mr. Cains?

A What I have said, and I think I'm saying the same thing I have said before, which is that there are two separate approaches to the management of maladaptive behavior at any ICF/IDD. The first are programmed restraints that are implemented as part of the comprehensive behavior support plan reviewed by an IDT and consented to by a guardian. There are -- the second set of behavioral strategies are employed

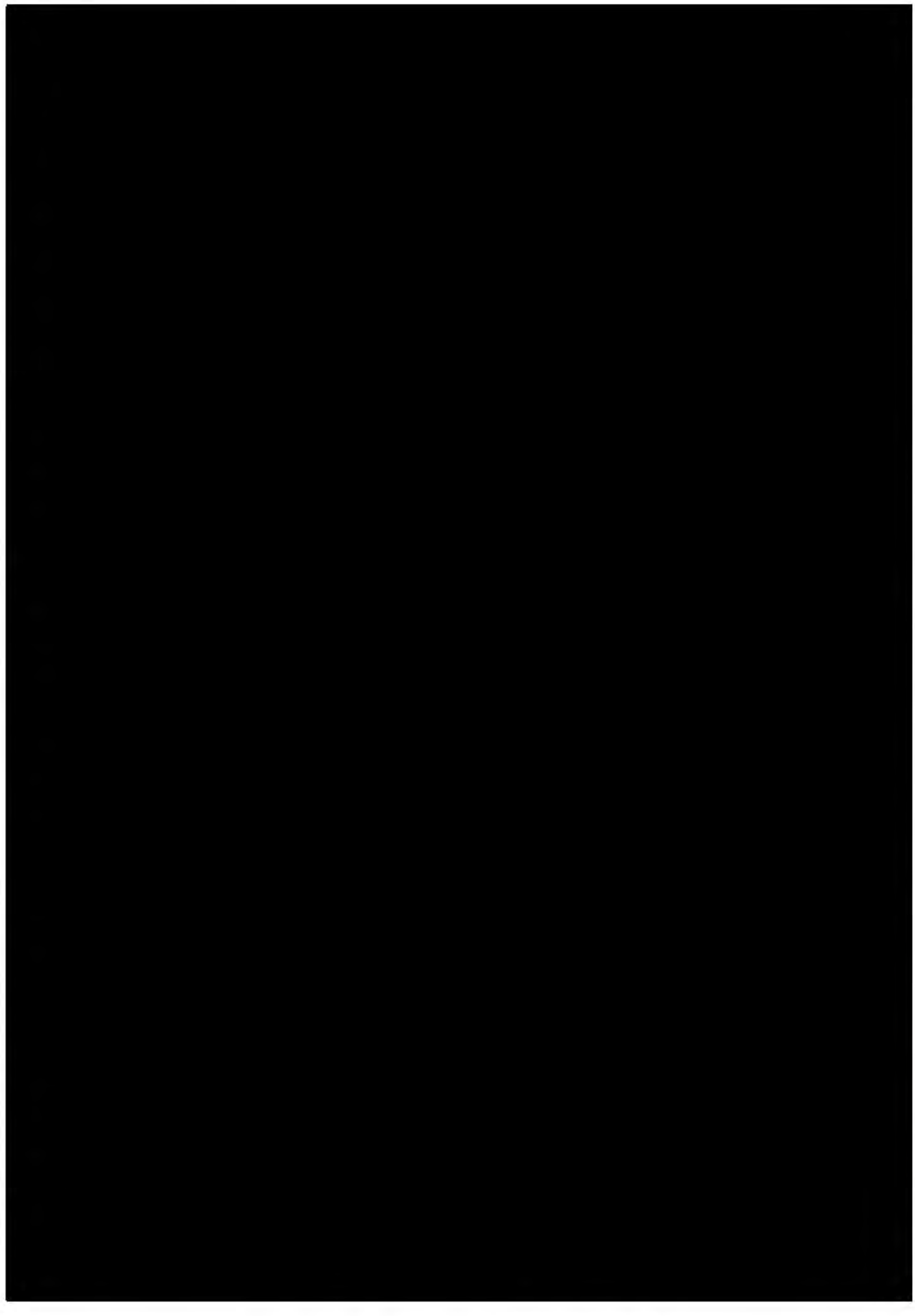
in emergency situations.

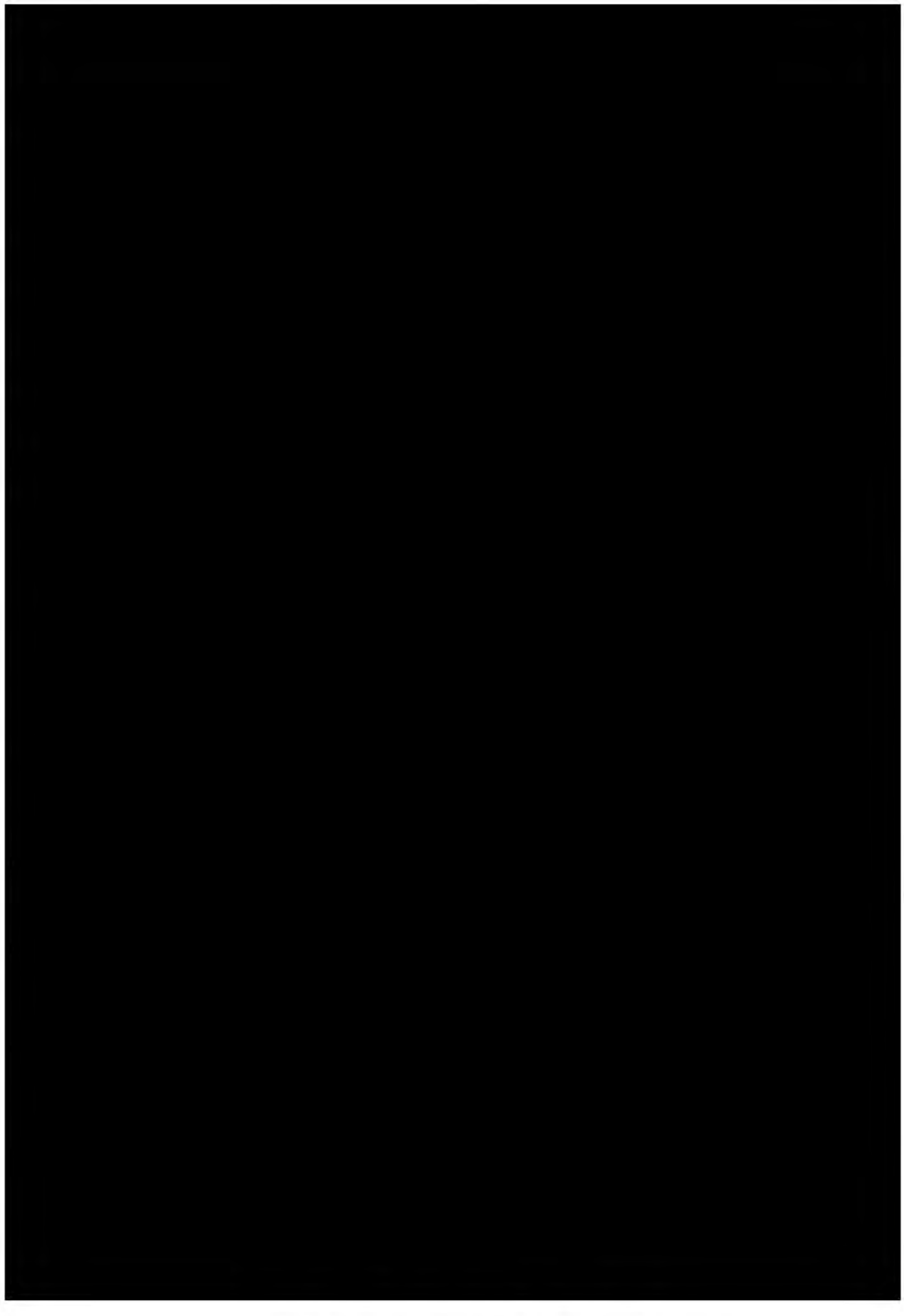
[redacted]

But that is separate than emergency restraints. The emergency restraints fall outside of the scope of the behavior support plan. And there were no limitations or restraints placed -- or conditions placed on staff's ability to use any one of these five treatments or techniques.

Q All right. So I have asked you a couple of times if your testimony is they can operate outside of his behavior treatment program in an emergency. I haven't heard a yes or a no, given a couple of explanations. We will just have to leave it at that, I suppose.

[redacted]







MR. ROSEN: I'm going to object. Whatever -- and the testimony will speak for itself. I don't that's appropriate to paraphrase and characterize testimony. If you have a transcript of the record, let's take a look at it. But it's clear what Doctor Kastner is saying now. I don't think it's appropriate to -- unless you have a transcript, to tell him what he said. And he is testifying now, he is telling you three times already.

MR. GREEN: Well, I can certainly ask him if he recalls his prior testimony. But I think that he has already answered my question sufficiently, frankly.

THE WITNESS: I will just -- I will tell you, I -- in absolutely no way do I

believe that [redacted]

If you go to, you know, page five of my LeBel report, item number 20, I disclosed this at the very beginning. My opinion is that, based upon a reasonable degree of medical certainty, [redacted]

I mean, I said that before we even got started, because I wanted to correct the error in my report. [redacted]

BY MR. GREEN:

Q Now, I understand that's your opinion. And I think you have answered --

A Okay. So there is no confusion, what I said at the very beginning, what I said in the middle, and what I'm saying now has been consistent. [redacted]

Q Okay. Were you aware that Doctor Hamid has testified that the use of ground restraints were not

approved for Mr. Cains on June 13th of 2020?
A I don't recall that. Again, that would be outside of the scope of Mister -- or Doctor Hamid, the approval of restraints, as I said earlier, rests with the interdisciplinary team, not with the physician. The physician's role is to offer an opinion about whether restraint techniques could be used safely. His role is not to approve or disapprove of the use of specific restraints other than chemical interventions which, of course, require a license by a prescriber. But --
Q I may have --
A But it makes no sense that that would be the case. It's inconsistent with the way they run the teams.
Q Well, I may have misspoke. But I thought I stated that his testimony was that the use of ground restraints for David on June 13th, 2020 was not approved, not necessarily that he was the one who had not approved it, but that they simply were not approved, that that was a fact he had testified to. Were you aware of that?
MR. ROSEN: I'm going to object. I'm not aware that -- unless you can give me a quote. I mean, you have asked him to

comment on whether he thinks it should have been approved or what. But I mean, you know, if Doctor Hamid said what he said, that's what he said. But I don't know that that can be a fact or a paraphrase or a misquote.

MR. GREEN: I understand.

MR. ROSEN: So whether this doctor is aware of that, unless that would change his testimony, it would be irrelevant. And Doctor --

MR. GREEN: All right.

MR. ROSEN: You have Doctor Hamid's testimony, so it is what it is.

MR. GREEN: It is. You are absolutely right.

BY MR. GREEN:

Q Do you recall reviewing Doctor Hamid's deposition in your engagement in this case?

A Yes.

Q Do you recall him testifying that ground restraints for any purpose other than transitioning to mechanicals is not allowed -- was not allowed at Booneville center on June 13th, 2020?

A Could you refer me to a specific statement that

he made so that I can understand exactly what you are referring to?

Q So without a referral to a specific cite, you don't recall at this point?

A No, I --

MR. ROSEN: Well, I'm going to object to this context. I mean, you can pull a statement out, I don't know. Let's look at the transcript. But I don't even know why you are asking this witness to comment on what Doctor Hamid has -- what you are saying he has determined. You can ask Doctor Kastner what he thinks and what his opinion is, but --

THE WITNESS: I think it was unclear.

MR. GREEN: I can explore --

THE WITNESS: -- Doctor Hamid was --

MR. GREEN: -- facts that formed the basis of his opinion some -- whether he was aware of other things that have been testified to as facts by other people involved with this matter. Certainly I can probe the factual basis of his opinions.

MR. ROSEN: The point --

THE WITNESS: I think --

BY MR. GREEN:

Q Just a minute, Doctor, I know you were wanting to offer something up. But I'm going to -- I didn't mean to interrupt you.

A If Doctor Hamid, like many of the witnesses in this matter, was subjected to a variety of very leading questions in which a portion of the question may have been accurate, but another portion of the question may not. I think there was a discussion about whether or not he agreed that that training was put into place around the use of restraints on the ground, and asked to comment on whether that was approved or not.

If it -- I think that there is some confusion in the record as to exactly what he was speaking to. But again, Doctor Hamid wouldn't have a role in approving or disapproving the use of a behavioral technique. It's outside of the scope of his independent practice --

Q Wait a minute.

A To talk to a group --

Q Let me ask you a question. He wouldn't have a role, but you're relying -- your opinion is based on his role in determining that these could be safely used. Is that not a role, in the determination of

whether they can be used? Do you really want to stand by the statement under oath that he had no role?

A If you would allow me to finish --

Q Please.

A -- my answer, then I can respond to this new question. But as I was in the midst of saying, the process for determining the appropriateness of behavioral treatment falls to an interdisciplinary process in which Doctor Hamid participates. But he doesn't have the unilateral ability to approve or disapprove of specific behavioral techniques. That is part of a bigger process that involves all of the members of the team, particularly in developing a behavior support plan.

He has a very specific role in defining whether or not specific behavioral techniques can be implemented safely. But he doesn't have a unilateral role in determining or deciding which behavioral strategy should be employed. So I hope that answers the question clearly so you understand my understanding of what Doctor Hamid's role is.

But going back to your point, I don't believe he would have said that physical restraints or ground restraints, as you are describing them, were

prohibited.
Q For Mr. Cains? Is that the rest of your answer, or do you want to leave it as just "prohibited", and that's the end of your answer?
A Oh, no, in terms of Mr. Cains, in particular.
Q Okay.
A But I just don't know where that would come from, it's -- it would be an odd position for him to take. It would really fall within the scope of the broader interdisciplinary process. And then I can also say there was some confusion in many of the depositions around how deponents responded to ambiguous questions.
Q All right. So let me move on to the issue --

MR. GREEN: Do y'all want to take a quick ten minute break?

MR. ROSEN: Well, it's five of 5:00 here. It's five to 6:00 in New York.

MR. GREEN: Oh, yes, it's 6:00.

MR. ROSEN: About how long do you anticipate to continue?

MR. GREEN: I don't think, Rich, there is realistically any way we are going to finish today, unfortunately. So my suggestion would be, you know, we can

adjourn this to be completed on another day.

MR. ROSEN: Well, I mean, if you think you are going to go for several more hours, then I would -- depending on Doctor Kastner, and I guess the Court Reporter has a say in this too. I'm sure she's tired. I don't know when we would do this. Why don't we take a five minute break and -- well, what are you proposing? What are you saying?

COURT REPORTER: Me?

MR. GREEN: Oh, me?

MR. ROSEN: What are you proposing, I don't know about tomorrow morning, but --

MR. GREEN: Yes, I can't be here to do this tomorrow morning. But yes, I mean, I think we can adjourn it to be completed on another day.

MR. ROSEN: Doctor Kastner, what is your schedule like, and what is your position on this?

THE WITNESS: I'm going to make myself available to you to continue and complete this. I can't tell you what my schedule or my availability would be right now.

MR. ROSEN: Well --

THE WITNESS: I won't be available until next week, at the earliest.

MR. ROSEN: Counsel, if you are saying that you anticipate it will take more than an hour or so --

MR. GREEN: Yes, that's right.

MR. ROSEN: Okay.

MR. GREEN: And if people don't have schedules, you know, we don't have to pick the exact date as of this moment. But we can get in touch with everyone tomorrow to arrange schedules to get it completed as soon as possible.

COURT REPORTER: Do y'all want this part on the record?

MR. ROSEN: And Donna, you are -- and I know that, you know, we could have a different Court Reporter. But I assume that you are pretty exhausted, are you not?

COURT REPORTER: Yes. But I will do whatever.

MR. ROSEN: Doctor Kastner, if it's going to take several more hours, I'm going to -- why don't we take a five minute

break.

MR. GREEN: Okay.

MR. ROSEN: And what time is it? Five of 5:00, so we will come back around 5:01 and make a decision.

MR. GREEN: Sounds good.

MR. ROSEN: Okay. Off the record.

(WHEREUPON, there was a brief break.)

MR. ROSEN: All right. So we are adjourned then, Donna. And I will contact your office and let you know what date and all that stuff.

COURT REPORTER: Just let me know when, and I will be ready.

MR. ROSEN: All right. Mark that we are off the record.

(WHEREUPON, at 5:05 p.m., the taking of the above-entitled deposition was adjourned.)

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DHS EXHIBIT ONE:

DHS EXHIBIT 2-A:

DHS EXHIBIT 2-B:

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, DONNA K. PETRE, Certified Court Reporter in and for the County of Pulaski, State of Arkansas, duly commissioned and acting, do hereby certify that the above-entitled proceedings were taken by me in Stenotype, and were thereafter reduced to print by means of computer-assisted transcription, and the same fully, truly, and correctly reflects the proceedings had, with portions dependent on the quality of the Zoom audio or video taken.

I FURTHER CERTIFY that I am not attorney or counsel of any of the parties, nor am I relative or employee of any attorney or counsel or party connected with the action, and have no interest in the outcome or results of this proceeding.

WHEREFORE, I have subscribed my signature and seal as such Court Reporter in the City of Little Rock, County of Pulaski, State of Arkansas, this the 9th day of February, 2023.

Donna K. Petre

DONNA K. PETRE, CCR #125
COURT REPORTER IN AND FOR
PULASKI COUNTY, ARKANSAS

---o---

BEFORE THE STATE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE McAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS, CLAIMANT,	
VS.	CLAIM NO. 220374
THE ARKANSAS DEPARTMENT OF HUMAN SERVICES, RESPONDENT.	

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CONTINUED DEPOSITION

OF

THEODORE KASTNER, M.D., M.S.

---o---

THURSDAY, FEBRUARY 2, 2023

---o---

VOLUME II

---o---

COURT REPORTER:

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(None marked.)

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The Continuation of the Deposition of Theodore Kastner, M.D., M.S., was taken before me, Debbye L. Petre, Certified Court Reporter within and for the County of Pulaski, State of Arkansas, duly commissioned and acting, on Thursday, February 2, 2023, beginning at the hour of 9:00 a.m., all parties present via Zoom.

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THEREUPON, the following proceedings were had, to-wit:

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P R O C E E D I N G S

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THURSDAY, FEBRUARY 2, 2023

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MR. ROSEN: We are back on the record. It is Thursday, February 2nd, about 9:10 or so. And this is the continuation of Doctor Kastner's cross examination. Everybody is ready. Counsel?

MR. GREEN: We are ready.

MR. ROSEN: Okay.

WHEREUPON,

THEODORE KASTNER, M.D., M.S., (Via Zoom) having been called for examination, and having been previously duly sworn, was examined and testified as follows:

CROSS EXAMINATION (Continued)

BY MR. GREEN:

Q Good morning, Doctor Kastner. Can you hear me all right?

A Yes. Good morning.

Q If you can't hear me at any time, will you let me know?

A I will.

Q And if you don't understand one of my questions, will you let me know?
A Yes.
Q And I know it was said earlier, but you are under oath. You understand that?
A Yes.
Q Okay. When we spoke a couple of weeks ago, I had asked you about what agencies or governments you were providing professional services or consultation to, and I think you said, as of right now the State of Arkansas was the only one that you had such a contract with for services. Is that right?
A You are referring to currently?
Q Currently.
A Yes.
Q Okay. Since we talked last a couple of weeks ago, have you obtained any new clients or anyone else who you are providing professional services consultation to?
A I mentioned there are other activities, but none related to litigation, depositions, expert reports, things of that type.
Q Okay. All right. Have you obtained new employment?
A No, no.

Q Okay. All right. Very well. Doctor, I wanted to go through some of your reports. You generated two reports, as you recall, in this case, at least two I have been provided. Do you remember us discussing those?

A Yes.

Q And one is dated January 5th of this year, and the other one is dated January 6th of this year.

A Yes.

Q For ease of reference, I'm going to refer to the January 5th report as your first report and the January 6th report as your second report. Is that okay with you?

A Yes.

Q Okay. In your January 5th report, you have lots of opinions. And one of the -- at the beginning of your report, you have listed on page three of that report your standard for opinion. And you say, throughout this report, you will use the standard, quote, "Based upon a reasonable degree of medical certainty," end quote, to express your opinions. What do you mean when you say, "Based upon a reasonable degree of medical certainty"?

A That based upon my training and experience, I make these judgments.

Q Okay. So, is it safe to assume that when you say "Based upon a reasonable degree of medical certainty" that it relates to you giving an opinion as it relates to the medical field?

A No. I'm sure, as a lawyer, you are familiar with the fact that this idea of the "reasonable degree of medical certainty" is somewhat ambiguous. I'm not absolutely certain that courts, lawyers have applied it in the same fashion in every instance. But in my reading of, you know, health law and issues around professional practice, the "degree of medical certainty" term is meant to describe the opinions based upon my training and experience. But they are not limited to those of the practice of medicine, for example. They are related to other issues, for example, life expectancy, cause of death, things of that nature.

Q Okay. Well, life expectancy and cause of death is medical in nature, to some degree. You would agree?

A It has relevance to medicine, yes.

Q Right. In other words, my question is, when you say "Based upon a degree of reasonable medical certainty", your opinion you are giving in using that standard is going to be related to the field of

medicine in some way; correct?
A No, not necessarily.
Q Okay. Well, give me an example of something that would not be in the field of medicine that you are giving that opinion based on that standard for.
A Well, I will give you an example and you make a judgment as to whether or not you feel it relates to medicine. For example, I opined that, I believe, the RCTs met the standard of care in the services they provided to Mr. Cains. I believe I'm qualified to make that determination and offer that opinion. But you would have to tell me whether you think that's consistent with the language that you are citing, "reasonable degree of medical certainty".
Q Okay.
A My understanding about the language is it's fairly vague and ambiguous, but I certainly feel comfortable opining about whether or not the RCTs met the standard of care in this regard.
Q And the RCTs aren't providing medical care; correct?
A It's a matter of how you define "medical care". They certainly provided CPR. They are implementing a Treatment Plan that was developed by an interdisciplinary team, which included the input of

health care providers. They are billing Medicaid for their services. It is easy to make the case that RCTs are providing medical care in the course of their duties at the HDC.

Q And if they were, they would have to be providing it in accordance with a Physician's Orders; correct?

A No, not necessarily.

Q Okay.

A The process of providing care and authorizing care at an HDC is driven through an interdisciplinary process, and is reflected in the individual's Program Plan, or IHP or IPP, whatever the term of art is.

Q Are you saying that an RCT is authorized to provide medical care that is something not in accordance with a medical doctor's directives and orders?

A Not at all.

Q No?

A I'm not saying that medical orders are inconsistent with IPPs. But you asked me if -- and my understanding of your question was, that RCTs were limited in what they could do to what appeared on a Physician's Orders, for example. But my understanding of an RCT's scope is much broader than

that.
Q And I'm not asking about their entire scope. I'm asking very specifically, because I asked you if they provide medical care. So, my question is very specific. Are you saying that an RCT is authorized to provide medical care that is not in accordance with a Physician's Orders?
A The RCTs are responsible for implementing a program plan, which is developed by the interdisciplinary team and identifies a wide range of activities, which I'm going to argue for the purpose of this discussion are medical in nature. They bill Medicaid, they are under the supervision of licensed professionals, et cetera.
Q Okay. Again, my question is, are the RCTs free to take the actions they deem necessary with respect to medical care for someone at a facility like Booneville, or are they required to follow the Physician's Orders?
A RCTs are professionals, and as a result, they are responsible for implementing the Treatment Plan at the facility. They, as trained professionals, have the ability to exercise judgment in terms of how they deploy their skills and implement that Treatment Plan.

Q All right. So, my question, I will ask it for the last time. Are they free to not follow a Physician's Orders?

A No, they are not free to not follow a Physician's Orders.

Q Okay. Thank you. Thank you. All right. On your first report, the one that we discussed that you wrote, on page nine you have a list of findings and expert opinions. Now, your opinion number two says, "Based upon a reasonable degree of medical certainty,

[redacted]

Q And what do you base that opinion on?

A Mr. Cains initiated an interaction with Mr. Mattson which resulted in the two of them landing on the floor and Mr. Cains being in a horizontal position as opposed to a vertical position. Because of Mr. Cains' activity directed toward Mr. Mattson,

[redacted]

Q One question I have -- well, first of all, that opinion and most of your opinions you base on statements made by Tyler; correct?

A Mr. Mattson, I think you are referring to, is the only person, other than Mr. Cains, who was present in the room at the time that Mr. Mattson states he was attacked by Mr. Cains. So, those are the only two primary sources that can be used.
Q Right. And, of course, our client is dead, so he can't talk. But in making your opinions, you assume that Mr. Mattson is telling the truth when he describes what happened in his different accounts; correct?
A There were two accounts offered by Mr. Mattson. One was his witness statement and the second was his testimony at deposition. I have no reason to believe that Mr. Mattson made false statements in either of those instances.
Q I'm not asking you to give an opinion as to his truthfulness or veracity. My question is, you assume he is telling the truth when you are forming these opinions; correct?
A As I said, I have no reason to believe that Mr. Mattson offered any false statement in either one of those regards.
Q Okay. So, I'm going to ask it for a third time, and if you don't want to answer, fine. You assume he is telling --

MR. ROSEN: Objection. I'm just going to object to the characterization, because, counsel, as you just heard, Doctor Kastner did answer it.

MR. GREEN: Respectfully disagree.

BY MR. GREEN:

Q My question is very simple, Doctor Kastner. In forming your opinions, you assume, or take the statements made by Mr. Mattson as truthful; correct?

A I have no evidence upon which to have an opinion that Mr. Mattson was not fully truthful in both his written witness statement and his deposition.

Q So, if you have no reason, you take them as truthful; correct?

MR. ROSEN: I'm going to object. That's argumentative. You are arguing with the witness. He just said it for the third time.

MR. GREEN: Okay.

MR. ROSEN: And I think you can reach your own conclusions and argue what you want on that. But Doctor Kastner has now said it three times.

MR. GREEN: No, he will not answer my question. He gives a statement.

MR. ROSEN: He just answered it.

MR. GREEN: Doctor Kastner --

MR. ROSEN: You just don't like the answer, the way he answered it. But Doctor Kastner has answered the question three times. I have heard it, same thing three times.

MR. GREEN: I have heard that he has explained why he thinks there may or may not be honesty, but he will not just simply answer the question of he takes his statements as truthful.

BY MR. GREEN:

Q Doctor Kastner, is that what I'm hearing you say, that you have no reason to think he is not, so therefore, you take them as truthful?

A I have no reason to believe that Mr. Mattson offered any statements that were not truthful.

Q Okay. So, I'm going to take that as you are basing all of your opinions on Mr. Mattson being truthful. That's how I'm going to take your answer and proceed forward.

MR. ROSEN: Objection, because he didn't say all of his opinions. But --

MR. GREEN: Well, did he answer my

question or did he not answer my question --

MR. ROSEN: He answered your question about --

MR. GREEN: -- because you objected that he answered it, but he is not answering my question.

MR. ROSEN: Okay.

MR. GREEN: He is giving speeches. And we can come back for a round three. Because this can take all day if we have to do this. It is a very simple, "Yes, I take it as truthful."

MR. ROSEN: Counsel, you can reach your own conclusions and you can argue what you wish. The fact is he has said it now four times. And you can put your characterization on it all you want. What I was objecting to is you said "all opinions". There are 20-something opinions on this, and not all of them are probably based upon Tyler Mattson's statements in his deposition or written statements. That was what my objection went to, the characterization.

MR. GREEN: All right.

BY MR. GREEN:

Q Mr. Kastner, let's go back to, again --

MR. ROSEN: And that would be Doctor Kastner.

BY MR. GREEN:

Q Okay. Well, Doctor Kastner, number two, "Based upon a reasonable degree of medical certainty, [redacted] When you say, "Based upon a reasonable degree of medical certainty", what medical standards are you applying to come up with that opinion?

A I'm using my training and experience to reach a conclusion that that outcome occurred as a result of -- the outcome being that Mr. Cains was placed in a horizontal position resulted from Mr. Cains attacking Mr. Mattson.

Q Right. So, if Mr. Cains attacks Mr. Mattson and then was held horizontally, I guess my question is, how is that a medical opinion that you are giving? Isn't that just an opinion as to what occurred as opposed to a medical opinion?

A Well, medical certainty isn't necessarily limited to medical opinions. It can apply to activities which, when viewed from the perspective of a physician, reflect an agreement among physicians

that it would be reasonable to reach a specific conclusion. So, in this instance, if a group of physicians were asked to look at the events that transpired, I believe there would be agreement among those physicians that it was Mr. Cains who initiated the contact that led to both Mr. Cains and Mr. Mattson falling to the ground, and as a result, Mr. Cains resting in a horizontal position.

Q So, when you say, "In your opinion, based upon a reasonable degree of medical certainty," you may not be using that in a context of a medical opinion or an opinion related to something medical; correct?

A I believe it's much broader than something, quote, "medical", end of quote.

Q Okay. So, you use that standard for things other than medical opinions?

A No, no, I'm not saying that at all. That physicians, in looking at specific events, will reach conclusions. And that if my thinking is consistent with the thinking of the larger group, I feel I am appropriate in using the term, you know, "reasonable degree of medical certainty", because that reflects what my peers would also believe to be true. I think if you ask 50 doctors to look -- physicians to look at the events that are described in both Mr.

Mattson's witness statement and in his testimony, they would all agree that -- well, the majority would agree, or the consensus would be that Mr. Mattson initiated contact -- I'm sorry, Mr. Cains initiated contact with Mr. Mattson that resulted in Mr. Mattson and Mr. Cains falling to the ground and Mr. Cains resting in a horizontal position.

Q And early in your report, you say that "Based upon a reasonable degree of medical certainty" is a standard. And then, I think you later said it's kind of vague. Is did you -- there any particular source on which you derive that standard?

A I think you could probably go to something like Black's Law Dictionary or -- I looked at other documents in my profession related to malpractice and testimony at trials. There is some ambiguity in terms of how the legal profession views that term. I think it has to do with prior case law and assumptions in terms of how it has been used subsequently. But you are asking me for a legal opinion that's not necessarily my strength.

Q No, I'm not asking for a legal opinion. You, yourself, said it was a standard, and you put it in quotes. So, I'm just asking the source of the standard.

A Can you refer me back to my report, just so that --
Q Sure.
A -- I'm aware of it?
Q Sure. It's on page -- the first report, page three at the bottom, it says," quote, "Throughout this report, I will use the standard," quote,"'based upon a reasonable degree of medical certainty'," end quote, "to express my medical opinions."
A Okay. Got it. Thank you.
Q So, based on that, using the standard "Based upon a reasonable degree of medical certainty", in your report you say you are using that to express your opinions; correct?
A Yes.
Q Okay. But you can't tell me specifically where you derived that standard from?

MR. ROSEN: Counsel, I'm going to object, because I agree with Doctor Kastner that you are asking him a legal issue. He has said that he -- the "reasonable degree of medical certainty" is based upon his training and experience and education, so on, as counsel well knows. So, to the extent that you are asking for a legal

opinion, we certainly object. Ask a lawyer. You are a lawyer. But Doctor Kastner has explained what it was based upon and what information he utilized. It's in his report and he just testified to it.

BY MR. GREEN:

Q Okay. So, Doctor Kastner, when you say you used the standard, you are not aware of any particular standard, it's just based on what you have testified to earlier as far as experience and training?

A No, it's not necessarily what I'm saying. I'm saying that as I reviewed the literature to try to understand exactly what that term meant, I found it to be ambiguous. It's defined differently in, for example, like Black's Law Dictionary versus some of the case law that I looked at around the origin of that term and its application in various, you know, courtroom settings or depositions. It's not clear to me, as a nonlawyer without expertise in the law, that there is a consistent and agreed-upon definition. So, I use a definition which I think is widely used, which is that my opinions reflect my belief as to what other physicians would say when they look at these same materials. I believe that there is a consensus that would be reached by a group of

physicians around each of the opinions and would be consistent with my opinions. So, my opinions are intended to reflect the broader thinking of physicians as they look at the questions which I examined in this consultation.

Q Doctor, I want to ask you, on page nine of your first opinion, one of the opinions that you gave is number six, where you state, "Based upon a reasonable degree of medical certainty, [redacted]

Q Okay. So, he asked to go to the restroom. Were you aware that he, in that trip to the restroom, just urinated, that he didn't defecate while he was in the bathroom?

A I believe that that was a statement that Mr. Mattson made during his deposition.
Q And are you also aware that Mr. Cains didn't complain of any stomach pain or stomach upset prior to this episode?
A Yes.
Q Okay.
A But, on the other hand, I would also note that many of my patients who have the same communication skills as Mr. Cains fail to report symptoms of illness because it's just not something that they are -- they unfortunately have the skills to do. So I discount the fact that Mr. Cains didn't offer a specific history prior to asking to use the bathroom. It doesn't rule out the presence of a gastrointestinal virus or gastrointestinal symptoms.
Q Okay. But you say you discount. Do you think he didn't have the ability to say if his stomach hurt or if he needed to go use the bathroom?
A Well, he did indicate that he wanted to use the bathroom. But the fact that he did not indicate any stomach pain does not necessarily mean that he did not have stomach pain.
Q Okay. And a gastrointestinal virus, a virus is something that can be detected through a test or

other examination; correct?
A Not necessarily.
Q Okay. So, if a person had a gastrointestinal virus, you are saying that you don't believe that that could be detected through examination or testing of any kind?
A There are very few gastrointestinal viruses which are the subject of a test. Rotavirus, for example, cannot be identified through a test. Most viruses that cause gastrointestinal symptoms are not identified through a test. Most gastrointestinal symptoms are -- which are attributed to a virus are based upon the presumption that a virus is present but there is not a confirmatory test to indicate in most instances that a virus is actually present.
Q When you say "there is not a confirmatory test", do you mean a test on a patient that you are treating?
A Well, you used that term "test", and I take that to mean some form of diagnostic evaluation, generally involving a laboratory, which would be used to confirm the presence of a virus. So, unless you had some other meaning, that's how I took your question.
Q Okay. Well, for instance, if there had been an autopsy performed -- and you are not certified as a

forensic pathologist; correct?
A Correct.
Q Okay. Are you aware that during an autopsy that, by its nature, because the body is cut open, that there are tests that can be performed of stool, stomach contents, stomach linings, intestinal linings, to determine what types of bacteria or viruses may be present?
MR. ROSEN: Objection, irrelevant.
MR. GREEN: Okay.
BY MR. GREEN:
Q You can answer, Doctor.
A There are a number of tests that can be employed post-mortem depending upon the discretion of the pathologist or other physician performing the autopsy.
Q Okay. Thank you.
COURT REPORTER: Could I stop for a second? Doctor, what did you say was the virus you couldn't test for? I didn't understand what you said.
THE WITNESS: Rotavirus.
COURT REPORTER: Rotavirus. Thank you. I apologize.
THE WITNESS: Sure. No problem.

BY MR. GREEN:

Q Doctor, one of the questions I have for you is on page ten of your first report, opinion 13, you state, "Based upon a reasonable degree of medical certainty, Mr. Cains was positioned appropriately on his side when he was vomiting, and later on his back [redacted]" Do you recall that opinion?

A Yes, I do.

Q You would agree with me that if a person is lying down and begins to vomit, that the appropriate response and care is to position the person on their side; correct?

A Correct.

Q And why is that?

A Well, because the first thing to ensuring that the airway stays open is to allow gravity to remove fluid from the mouth and oral pharynx, out of the mouth and to maintain an open airway.

Q Okay. And so, a person positioned on their side vomiting, it should be able to maintain an open airway, and that's the position they should be kept in to maximize the safety of the person vomiting; correct?

A Not necessarily. I heard your sentence as including a statement of fact which I would disagree

with. You stated that, "By lying on one's side, they should be able to keep their airway open." And I don't accept that premise. It's not necessarily true.

Q Okay. Well, I'm sure there are some exceptions to everything that you do in medicine. But most of the time a person on their side who is vomiting is -- you have them on their side to maintain an open airway; correct?

A Lying on one's side is recommended in order to try to maintain an open airway.

Q Correct. All right. And would you agree with me if someone were lying down and began vomiting, you would not want to immediately roll them onto their back while they still had vomitus coming out of their mouth?

A You can't -- I think that's too general. There are considerations that need to be examined in each instance.

Q Okay. So, there might be a situation where someone lying down begins to vomit that you would want to immediately roll them onto their back?

A As you said earlier, there are many instances in which things occur which may not necessarily be consistent with other instances. I forget how you

phrased it.
Q If a person were lying down, say, in a bed and began vomiting and you instantly rolled them onto their back, you mentioned something about gravity, wouldn't the vomitus most likely go down the -- I'm going to use a nonmedical word -- down the throat, down the windpipe, not out of the mouth most of the time?
A In the management of young infants, the recommendation is for those infants to sleep on their back, because infants do regurgitate or ruminate stomach contents. When they lie on their back, the contents are in the back of the pharynx, which is proximate to the esophagus and allows the infant to swallow that material and return it back to the stomach. Placing an infant on their stomach, when they were to vomit, would then allow, because of gravity, that material to be proximate to the larynx and potentially be aspirated during breathing. So, you know, with infants, we recommend that they sleep on their back so that they minimize the risk of choking due to any vomitus or aspiration.
Q That's right. You are a pediatrician; correct?
A Yes, among other things.
Q All right. But in my questions, understanding

there might be a difference with respect to an infant or a child, if I don't ask specifically about that, would you assume that I'm -- I will be asking about adults. All right?

A (Indicated yes.)

Q So, my question is -- I want to talk a little bit about your testimony you gave before about pain and the pain that would not have been experienced by Mr. Cains. Can you just tell me a little bit more about how you came to that conclusion?

A If you give me a moment, I would like to refer to my report.

Q Okay. If you will let me know which report and which page so I can take a look, as well.

A So, it's my first report, and I think it's page 50 -- it's page 50. Sorry. Are you with me?

Q Sure.

A Okay. So, I think when discussing pain, it's important to have a definition which is agreed upon. And Doctor Forestiere did not offer a definition of pain. And as a result, again, I found her testimony somewhat confusing and difficult to interpret.

The International Association for the Study of Pain has an approved definition that incorporates two separate components. One is the emotional or sensory

experience associated with an event, and the other is actual or potential tissue damage. In order for an individual to experience pain, both conditions need to be met, according to this national -- or international group. So --

Q And let me ask you -- you just said there is -- one component is emotional? And what else, emotional and what kind of pain?

A So, page 50 at the top --

Q Sensory?

A -- I quoted the definition used by the International Association for the Study of Pain. And their definition is, quote, "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage," end of quote.

Q Okay. And --

A And so, I believe that's a really important foundation in having a discussion about pain, to be sure that we all agree on the definition of what pain actually is.

Q Okay. And you would agree with me that contents, in general, of a person's stomach are acidic?

A Yes, they generally are acidic.

Q Quite acidic; correct?
A I would not say "quite acidic". I kind of know what you mean by that.
Q All right.
A But I wouldn't consider overly acidic. They are simply acidic.
Q Okay. And would you agree with me that stomach contents, if vomited, the acidity of that will cause some tissue damage, even if just at the cellular level, to other tissues it comes into contact with that are not the stomach?
A No, I would not necessarily agree with that.
Q Okay.

[redacted]

Q Okay. [redacted] Let me ask you this. If a person vomits up acidic stomach contents, are you saying that the acidity of those stomach contents will not cause some level of tissue or cellular damage in the mouth or tongue of that person?
A The surfaces of the gastrointestinal tract, which include the mouth, esophagus, have a protective

layer of mucus and other body fluids, and those offer protection to the body in the instance in which gastrointestinal contents may be refluxed, whether [redacted] I have seen thousands of patients with vomiting. And individuals who have intermittent or episodic vomiting, I have never seen or documented in my records that they were injured by the vomit, itself. Now, the caveat is, I have seen folks with vomiting, you know, a hundred, 200 times a day, and in those instances, yes, they can experience tissue injury. [redacted]

I have never, ever encountered a patient who had tissue injury following a single episode of vomiting as a result of acidic contents of the stomach. I think that's just an implausible hypothesis.

Q Well, with respect to those patients that you are discussing, I'm assuming you did not take any cultures or samples to have the tissues examined under a microscope after those vomiting incidents, because that normally wouldn't be done; is that right?

A Well, first of all, cultures are not -- they don't correlate with tissue injury, they are completely different. Cultures are for the purposes of identifying a pathogen, whether it's a virus or bacteria. So, no one would ever do cultures in order to ascertain any degree of tissue injury. Second, after a single episode of vomiting, I'm not aware of any practitioner who would recommend a biopsy or assessment of tissue integrity, as most physicians would probably agree that a biopsy was more invasive than whatever amount of tissue injury could possibly have occurred as a result of a single episode of vomiting.

Q Correct.

A That it's not good standard of care to ascertain the amount of tissue injury, because it's believed to be negligible after a single episode of vomiting.

Q Correct. Understood. And you would agree with me, though, that during an autopsy, the pathologist

would be able to perform additional tests such as -- I won't use the word biopsy, but taking tissue samples, evaluating those, looking at those microscopically, that you would never do on a live patient after an incident of vomiting? In other words, during an autopsy there would be the opportunity for a more in-depth examination of a person; correct?

A I have looked at hundreds of autopsy studies and I have never seen a pathologist conduct an assessment for the potential of tissue injury associated with a single episode of vomiting.

Q Okay. But they would have the ability to do so; correct?

A There are -- pathologists have the ability to do many things. But most of what they do is based upon a reasonable suspicion or concern for a specific pathophysiology or etiology. The pathologists generally would not pursue a biopsy of tissue if they had no reason to believe that there was any tissue injury present. As I'm saying, as a physician, a single episode of vomiting is -- there is no evidence anywhere, in any literature that there is any tissue injury associated with a single episode of vomiting. As a result, I don't believe a reasonably qualified

pathologist or physician would recommend any other testing, whether it be a biopsy or microscopic examination or anything to evaluate the potential for tissue injury following a single episode of vomiting. The pathologists in an autopsy are trying to determine the cause of death.

Q Well --

A And whether or not the mucosa are intact on some organ would have little bearing on that.

Q Well, it would have bearing on pain experience, according to your testimony; correct?

A Absolutely. But not cause of death.

Q Right. I understand.

A The pathologists are not --

Q Are you aware --

A -- pursuing their examinations for the purposes of opining or reaching a conclusion about the amount of pain.

Q Right.

A That's not what pathologists do. I have never seen an autopsy result -- and again, I have seen hundreds -- where a pathologist said, "This occurred and it was painful." They don't offer opinions about pain.

Q But they --

A It's not within the scope of what they do.
Q But you would agree with me that they document, to the extent they can, any noted injury or damage to a body, internal and external, in general?
A To the extent that it is used to.
Q Exactly.
A And a lot of them --
Q And are you aware that there was no autopsy conducted in this situation with Mr. Cains?
A Yes, I am aware.
Q And are you aware that the coroner stated that if he had known restraints or a restraint hold had been used prior to the vomiting episode that he would have most likely wanted to have an autopsy conducted?

MR. ROSEN: I'm going to object. One is, that's hearsay and it's not a quote, and "most likely" is not a determination. He could have had an autopsy conducted at any time, as the family saw it. I object to that. But go ahead.

THE WITNESS: I'm not aware of that, no.

BY MR. GREEN:
Q Okay. Would you agree with me that if a person aspirated acidic stomach contents into their airway,

into their lungs, that that acidic stomach content would cause some level of damage to the tissue in the lungs and airway?

A Can you define what you mean by "aspiration"?

Q Yes. I will say it in just laymen's terms. Would you agree --

A I think it's very important that it be in precise terms. So, can you define what you mean by "aspiration"?

Q If a person vomited acidic stomach contents and those contents went into the airway, including bronchi and/or lungs, that that stomach contents would cause some level of tissue or cellular damage?

A So, you are asking me a hypothetical, you are not asking me what occurred in this instance?

Q Exactly.

A Because there is no evidence that Mr. Cains aspirated.

Q Well, we don't have an autopsy, you are right. But my question is what I just posed to you. So, could you please answer?

A Well, it may or may not. Stomach contents, when they are in the stomach, are generally -- when it's just the stomach secretions are generally acidic. Depending upon what a person eats and the amount in

which they have eaten, they neutralize those stomach secretions and reduce the level of acidity. So, when stomach contents are regurgitated they may or may not be acidic.

Q Okay. So, are you testifying that stomach contents that make their way into the lungs of a person or the airway of a person sometimes will not cause any tissue or cellular damage?

A No. You asked me about whether the acidity of stomach contents --

Q Right. And you gave an answer. And now I'm asking a different question, which is --

A And my answer -- just to clarify and be certain I understand your question. The first question had to do with whether stomach contents, which were assumed to be acidic, would cause an injury. And I'm saying there is no evidence to support whether or not the vomitus in Mr. Cains' instance was acidic or not. Having eaten, the food could very well have neutralized that acid.

Q Right. So, again, my question was, acidic contents. And instead of answering that, you have said, "Mr. Cains may not have been acidic." So I'm just trying to clarify. Are you saying that a person whose stomach contents make their way into their

airway -- do you know what I mean when I say "airway"?

A I'm assuming that you are saying that the contents reached below the vocal cords.

Q Correct. Are you saying that there are instances where stomach contents can enter the airway and not cause any cellular or tissue damage?

A Yes.

Q Okay. And what kinds of circumstances would that occur where there is no damage?

A Well, that happens all the time when we eat and we cough. The reason we cough is because material has presented itself at the level of the vocal cords or below. We cough in order to expel that foreign material. And generally there is, I think, a consensus among medical professionals that there is no tissue injury or permanent injury as a result of that event.

Q And I'm not asking about permanent injury. But you are saying there is no cellular injury or damage?

A As I said, there are certainly conditions when there will be no cellular or tissue injury, tissue damage.

Q Okay.

A And I spoke to the instance of people coughing

as a result of material passing into their airway. And again, there is no evidence that there is a permanent or even temporary injury --

COURT REPORTER: Wait, wait. Coughing as a result of what, Doctor?

THE WITNESS: I'm sorry, I can't remember. Coughing as a result of material passing through the larynx into the airway.

COURT REPORTER: Okay. The screen just froze up. Thank you.

THE WITNESS: There is no evidence of any permanent or even temporary injury in those instances, tissue injury.

BY MR. GREEN:

Q And is that based on your experience or do you have a particular study that you can cite to?

A I think it's a trivial issue. I can't imagine that physicians would invest the time and resources to conduct a study of individuals who have coughed as a result of material moving into their airway, and to determine whether or not there was a permanent or even temporary injury as a result of that incident.

Q Well, you can have pain without a permanent injury; correct?

A I will be happy to switch to a discussion about

pain, if you would like. We can go back.
Q No, just a general question. You testified earlier about pain and that there is tissue damage. I'm just asking, you can have pain without it being permanent tissue damage; correct?
A Oh, yes, absolutely.
Q Okay. That's all. I want to go to your opinion that Mr. Cains had a life expectancy of only six more years. How did you come up with six more years? Walk me through that process. And did you use any equations, calculations? How did you come up with that number?
A So, my opinion is found on page 51 of my report. It says that the current life expectancy in the United States is about 77 years. It's well known that people with intellectual/developmental disabilities have a shortened life expectancy. And I cited Lauer and McCallion and their study, which indicated that the average age of death for people with intellectual and developmental disabilities that are participating in state systems was in their 50s, 58, 59 years. So, it's clear. And again, this wasn't intended to be an exhaustive literature search, but simply to just support my opinion in general. But it is clear that the age at which

people with intellectual and developmental disabilities die is much lower than that of the general population.

In addition, it's well known that people with certain health risks have a shortened life expectancy. And in this regard, in terms of Mr. Cains in particular, [redacted] So, I just cited some references to, again, be supportive of my opinion.

[redacted]

Q And I would imagine that that is hard to -- in

the example you are using with Ms. Kersee, that that is hard to quantify because it is such a sudden, unexpected episode; correct?

A I'm not sure what you mean by "quantify".

Q Well, I think in your report you say that the presence of epilepsy alone reduces life expectancy by about 12 years in a male. So, if a person had one episode of epilepsy when they were 20 and they are 45, they still have that 12 years less of a life expectancy as opposed to if they had had an epileptic episode every single year for ten years leading up to that; is that what you are saying?

A No. I'm not in a position to opine about the subdividing or parsing the risks of a shortened life expectancy based upon clinical characteristics. I didn't conduct that type of analysis for this purpose.

Q Okay. And I'm looking at page 51. You start out saying that estimate of life expectancy in the U.S. is 77.2 years. You used the World Bank as a source for that. And then, you mentioned that the average age at death for people in state intellectual and developmental disabilities systems was 50.4 to 58.7 years. And then, you state for obese and severely obese, the loss in life expectancy

was 5.6 to 7.6 and then 8.1 to 10.3 for men and women aged 20 to 29 years. And by the way, how old was Mr. Cains?

A [redacted]

Q Okay. So, this statistic of 8.1 to 10.3 for men and women aged 20 to 29 years wouldn't be relevant to him; correct?

A My point in citing these articles was not to conduct an exhaustive analysis of the relative risk of each of these conditions, but simply to indicate that my thinking was consistent with the broader consensus among physicians that illnesses or conditions, [redacted]

Q Sure. And I don't disagree with you.

A Not trying to be exhaustive or to be specific or to go in and criticize specific articles, that's not my intent, certainly.

Q Okay. But my question just is simply, when you cite to this 8.1 to 10.3 years for men and women aged 20 to 29, that wouldn't apply to Mr. Cains, that portion that you cited; correct?

A I would have to go back and look at the study. Again, I don't recall all of the details.

Q All right.

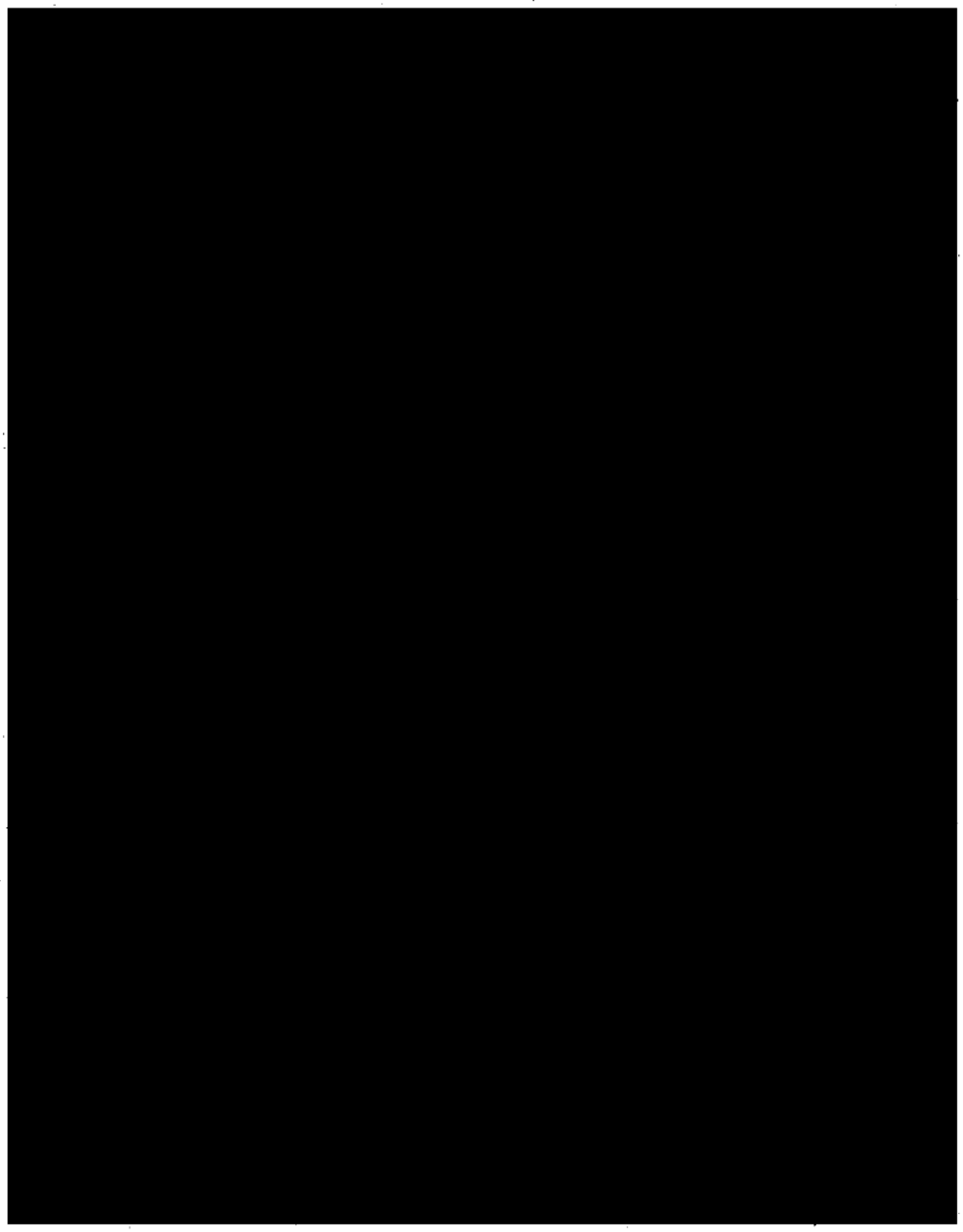
A I believe it was a bigger study, and you are simply taking my quote, which I took to be illustrative and not specific. And my point was to say, [redacted]

Q Totally understand. But I'm only asking because you did cite specific figures. So, I'm trying to understand those figures. And I understand some of those figures, but then where it says it applies to age 20 to 29, you have already testified Mr. Cains was outside of -- he was older than 29; correct?

A Sure.

Q Okay.

[redacted]



Q Did you start out with the average of 77.2 and then subtract amounts off for these different characteristics?

A No.
Q Okay. So, it's just your opinion based on what you have just testified to?
A If I were to start with a base, I would have started with a number more consistent with the McCallion article rather than the WHO estimate for the general population.
Q All right. But just so I'm clear, this will be the last question on this, you don't have any sort of equation or mathematical calculations you performed to calculate six more years; correct?
A No.
Q Okay. All right. And same with last time, any time you need a break, let me know. I'm bad sometimes to not pay attention to the clock and take breaks. I will probably take one here in a moment. But just feel free to ask for one if you need one.
A Thank you.
Q Doctor, I asked you last time about some of your compensation from the State of Arkansas in the past. Let me back up, let me ask you a different question.
Since our last part of this deposition a week or two, or however long it was, until today, have you reviewed any additional materials to prepare for today?

A No.
Q And I think you told me that you at one point were hired, retained, whatever word you want to use, to have involvement with the human development facility that was in Alexander, Arkansas in the past; correct?
A So, I need to get some clarification. So, I have performed services on behalf of Arkansas specifically, for example, at the Alexander Human Developmental Center. But I was not retained by the State of Arkansas to do so. I was retained by a company called Developmental Disabilities Health Management to provide services through their contract with the State of Arkansas. So, in much of my work around the country over the last 35 to 40 years, I have worked for many similar intermediary organizations or companies, and in very few instances have I been retained personally. And I wouldn't characterize payments to those companies as my compensation, as you kind of suggested.
Q Okay. Who owns or owned Developmental Disabilities Health Management, Incorporated?
A I was the sole proprietor.
Q So, solely owned by you; correct?
A Correct.

Q And that was -- did that have an address based out of New Jersey?
A Yes.
Q Okay. And was the total compensation paid to Developmental Disabilities Health Management, Incorporated in connection with the services provided for the Alexander Center approximately $900,000.00?
MR. ROSEN: Objection, irrelevant to this case.
BY MR. GREEN:
Q You may answer, Doctor.
A I have no idea.
Q Okay. Do you recall -- so, by you saying you have no idea, I take it you mean you have no idea whether it was $900,000.00 or $10.00 or anything in between; correct?
A As I said to you at the last deposition, you quoted a figure of $900,000.00, and you were, I think, quoting that in regard to my compensation, and it was a number that exceeded my best guess as to what my compensation would have been in relationship to any work performed at the Alexander Human Developmental Center.
Q Sure. Yes. I do remember asking you about that in the past. And I think I actually was asking about

it in terms of your previous work to the Conway Human Development Center, which I think was mistaken in my part. So, that's why I'm asking today to be clear. Isn't it true that Developmental Disabilities Health Management, Inc., which you were the sole proprietor of, entered into a contract with the State of Arkansas and was compensated somewhere in the neighborhood of approximately $900,000.00 for those services in 2010, approximately?

A As I said, I have no idea. That was 13 years ago.

Q Okay.

A The company was dissolved ten years ago -- roughly ten years ago. I have no recollection at all.

Q Okay. And last year, how much were you paid by the State of Arkansas for services rendered last year, whether it's related to this case or your other consulting, any services rendered to the State of Arkansas for 2022?

A I do not have a specific recollection of a specific amount. I think you asked me if my compensation was $12,600.00, and I thought that was closer than the $900,000.00 that had been previously suggested. I mean, $12,600.00 seemed to be in the

ballpark of what my compensation would have been, but I can't testify with certainty.

Q Got you. And to be clear, the $900,000.00 I'm asking about would have been during the time period of the work at Alexander, which was approximately 2010; correct?

A 2009, 2010, I believe, could have been 2008. I'm not sure.

Q So, with respect to last year, 2022, do you believe that you -- is it true that you may have been paid, or that you were paid approximately $11,500.00 for work you performed January 1 through June 30th of last year, and then an additional $12,875.00 for work performed July 1st through October of last year by the State of Arkansas? So, that would be two amounts, one for approximately $11,500.00, and one for approximately $12,800.00? Does that sound right?

A It could be. I would have to look at specific invoices to be able to confirm the accuracy of those numbers. But I do recall the consultation extended over two different state fiscal years, and as a result, my invoices were split with a portion reflecting time and effort in the prior state fiscal year and a portion reflecting time and effort in this state fiscal year. So, you know, that could very

well be true. I mean, I think the ballpark is fine. I don't have any concern about the general amount.

Q And you still have to be compensated for the services you have performed since October, at least with respect to this case; correct?

A Correct. I have received no compensation for this case.

Q Okay. All right. We have been kind of going almost an hour and a half. Are y'all okay with maybe a ten-minute break?

MR. ROSEN: Sure.

MR. GREEN: Okay. All right. 10:30, is that all right?

MR. ROSEN: Yes.

MR. GREEN: All right. Thanks.

MR. ROSEN: Thank you.

(WHEREUPON, a break was taken.)

MR. ROSEN: Go back on the record.

MR. GREEN: All right. Are y'all ready?

COURT REPORTER: Yes.

MR. GREEN: All right.

BY MR. GREEN:

Q Doctor, can you hear me?

A Yes.

Q The last time we talked in our previous deposition, you had talked a little bit about your familiarity with the human development centers in the State of Arkansas; correct?

A Yes.

Q Okay. And part of that familiarity is knowing the ways that the different centers operate, and especially with respect to restraints and their restraint usage or policies; correct?

A Correct.

Q Okay. And isn't it true that in 2018 through 2020 the Booneville Center had a much higher rate of usage of personal restraints than any of the other facilities?

A Can you refer me to a source for that?

COURT REPORTER: Wait. You said in 2018 the Booneville Center had what?

BY MR. GREEN:

Q From 2018 to 2020 the Booneville Center employed personal restraints on their clients at a much higher rate than the other facilities?

A And I was going to say, can you refer me to a source for that? I think you are describing some of the findings in the consultation that I participated in during the previous year. It would be helpful for

me to look at exactly what it is you are describing.
Q Well, I guess I'm wondering, was that part of your consultation last year?
A We did look at restraint use at the five HDCs. I believe there were some tables that were created in our report.
Q And you can't recall whether or not during the time period of 2018 to 2020 the Booneville Center employed personal restraints at a much higher rate than the others?
A So, define for me what you mean by "rate".
Q The amount of restraints used per person per year.
A I think we had this discussion last time. Are you referring to incidents of use or types of restraints used or --
Q Incidents of use.
A -- other restraints?
Q Incidents of use.
A So, the total number of incidents in which restraints are used at the HDC was higher than the rate at other HDCs; that's what you are asking me? You asked me a question, and I'm trying to understand exactly what the question was. So your question was, am I aware that at the HDC the number of restraints

per person per year was higher than at other HDCs?
Q Correct.
A And I said, I know that we looked at that data last year as part of the consultation, but I don't recall the specific findings.
Q Okay.
COURT REPORTER: I'm sorry. I have missed some of that. My Zoom went down.
(WHEREUPON, a discussion was held off the record to provide the Zoom recording to the Court Reporter to capture any lost audio.)
(WHEREUPON, a break was taken.)
BY MR. GREEN:
Q All right, Doctor. So, you know, my question is about the number of incidents that we discussed. Isn't it true that the rate of those incidents from 2018 to 2020 were significantly higher at the Booneville facility as compared to the other human development centers in Arkansas?
A Okay. So, just to kind of be transparent, I pulled up a copy of the final report that we submitted on that consultation just so I can use it as a reference for this discussion, my assumption being that that is the source of whatever data you

are relying upon to form that opinion. And I can't confirm or deny it. I haven't had a chance to look at that report.

Q Okay.

A So, I have no opinion currently.

Q Okay.

A I haven't had a chance to read the report.

Q Okay. So, no opinion on whether or not it was a higher rate. That's good enough.

A I was going to tell you, if you are relying on our report for the purposes of making comparisons between HDCs, we specifically did not do that, because there is no evidence that the populations at each HDC are comparable. They are comprised of different ages, sexes, different forms of disabilities, different co-occurring illnesses, including mental illness. We did not encourage or perform any comparison between facilities or make any recommendations of one facility versus the other, because there is no comparability between the populations.

Q Well --

A And we also noted in the report that the large -- the biggest contributors to the frequency of restraint use at all the HDCs were very small numbers

of people. So, you know, five, ten people who were restrained at a very high level or very high frequency rate accounted for most of the restraint use at HDCs. And if those individuals were to move from one HDC to another would significantly affect rates. So, again, we didn't perform a comparison because the populations weren't comparable, and we didn't derive into the contribution made by a small number of people to these overall rates.

Q Well, and certainly there are some variances in the population. But you are not saying that -- well, I will back off of that. Let me ask you this. When you did this report, you did not have data available to you with respect to Booneville as to the number of restraints per individual; isn't that correct?

A Can you refer me to the specific page in the report, and I would be happy to talk about it? Because, as I said, I just pulled it up in the last two or three minutes, haven't had a chance to read it. If you are citing the report and something specifically in it, I would prefer the opportunity to review that.

Q Okay. My question is -- look at page 28 of your report. And we were not provided this in discovery, but we have obtained it. So, go ahead and look at

page 28.

MR. ROSEN: And, counsel, do you have a -- I do not have a copy of the report. I don't know what you are referring to.

MR. GREEN: I don't have one to share. I mean, I don't have to refer to the page number. If not, it's a report that was provided to Arkansas DDS by Doctor Kastner. He apparently has it. We were able to get it, although it wasn't provided in discovery.

THE WITNESS: It was not provided by me to Arkansas --

MR. ROSEN: I didn't have it. I'm simply saying, I don't have it. But go ahead and ask your questions. But, you know, I will just get a copy.

MR. GREEN: Right.

BY MR. GREEN:

Q Doctor, my question is very simply, on page 28, right above -- do you see where it says, "See Conway Restraint Data"?

A Yes.

Q And in the paragraph above that, it is discussing the data at Booneville; correct?

A Correct.
Q And the last sentence there, it says, "In the future, it would be a useful statistic to report the number of restraints per individual. This is the practice at the other HDCs"; correct?
A Correct.
Q Okay. So, all the other human development centers kept data as to the amount -- the number of restraints per individual, but Booneville did not keep that data; correct?
A So what? I mean, we have all the restraint data that we need for Mr. Cains.
Q Sir, I'm not asking -- sir, some of my questions will be specific to Mr. Cains and some will not. My question is not this time about Mr. Cains, specifically. It is very simply, in the 2018 to 2020 time period, Booneville did not keep data as to the number of restraints used per individual. You already said that was correct; right?
A No, no, I didn't say that. Booneville has data. They collect reams of data.
Q Let's go back to page 28.
A They collect the --
MR. ROSEN: Counsel, let him answer the question.

MR. GREEN: Well, he is not answering the question. He's trying to --

MR. ROSEN: Well, he is.

THE WITNESS: What you just stated was not true.

MR. GREEN: It's unresponsive.

BY MR. GREEN:

Q Let's look back at 28. "In the future, it would be a useful statistic to report the number of restraints per individual. This is the practice at the other HDCs." That's what is written in your report; correct?

A Correct.

Q And that means that the Booneville facility at the time of this report was not keeping the statistic that indicated the number of restraints per individual; correct?

MR. ROSEN: Objection, irrelevant. This whole line is irrelevant. But he can answer, if he knows.

THE WITNESS: Booneville collects the data that can be used to calculate that statistic, but it does not calculate that statistic.

BY MR. GREEN:

Q Okay. I will just let your report stand for itself. And with respect to the different populations at the different human development centers, you would agree with me that there is a variety of types of clients at each center; correct?

A Correct.

Q And some of the centers have -- well, let me back up to a different topic, because I don't want us to have to go into a day three, that's for sure. So, let me go through some of my notes from when we last visited.

Would you agree that a person who begins to vomit while lying horizontally is more at risk of aspirating and dying from that vomit than a person that is vertical, such as standing or sitting up?

A Hypothetically, yes.

Q Okay. And would you agree with me that for a

[redacted]

[redacted]

MR. ROSEN: Objection, speculation.

[redacted]

BY MR. GREEN:

[redacted]

[redacted]

[redacted]

MR. ROSEN: Objection.

THE WITNESS: Can you --

(Zoom interruption. Unintelligible.)

COURT REPORTER: Everyone, remember where you were on that question for when we come back.

(WHEREUPON, a break was taken.)

MR. ROSEN: We are back on the record.

BY MR. GREEN:

[redacted]

[redacted]

Q Well, if you don't know them offhand, that's fine, I will just move on to something else.

[redacted]

Q Okay. Doctor, what is your understanding of emergency restraint policy at the Booneville Center?

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Do you have an understanding of their emergency restraint policies?
A Yes, I do have an understanding of the emergency restraint policies.
Q And those emergency restraints are not designed to be used on a regular basis; correct?
A They are designed to be used in emergency circumstances.
Q Correct. Isn't there a policy that if there are three or more of the usage of those restraints in a certain time period, there is supposed to be a re-evaluation of the client's plan to see how their Behavioral Plan might need to be altered or changed?
A I believe there is something along those lines, although I can't recall specifically.
Q Okay. And when you did an evaluation of Mr. Cains' case, I think last time when we talked you said that you did not review, or you did not recall reviewing the prior incidents where Mr. Mattson had restrained Mr. Cains; is that correct?
A No. I reviewed every behavioral report for something like a 13, 14-year period, 12 or 13 years.
Q Okay. And that would have been in the list of materials that you reviewed in your reports?
A Correct.

Q Okay. And just so I'm clear, I'm assuming you have not revised or updated or changed your reports as they have previously been provided to us, you haven't updated them or added an addendum?

MR. ROSEN: Counsel, there was one change, if you remember, at the beginning of Doctor Kastner's report where there was a typo that left off a "not" in a particular opinion that was corrected. And I don't have it directly in front of me. But I think it was on the January 5th report. It was one of those.

BY MR. GREEN:

Q I do recall the testimony to that effect. Has it actually been corrected and a new one generated, Doctor?

A Yes, I provided Mr. Rosen with a new page with that reflected.

MR. ROSEN: It's sitting here on my desk and I will send it -- e-mail it to you today.

MR. GREEN: No problem. I just wanted to make sure there wasn't any other changes or additions before I moved on.

MR. ROSEN: Is that a question or was

that a comment?

MR. GREEN: No, I'm -- no, that wasn't a question. I was just saying, I wanted to make sure before I moved on. I think he said there wasn't. So, I'm going back through my 20 some-odd pages of notes from our prior time to make sure I'm covering all of the things that I want to make sure I cover. So, there may be a few moments of silence.

MR. ROSEN: I fully understand, counsel. I didn't know if you were expecting a question or not. So, that's just fine.

MR. GREEN: No, I understand.

BY MR. GREEN:

Q Doctor, I did want to ask you, because I know that in this particular case, there is the NCI CPI training that has been discussed. Do you recall that?

A Yes.

Q And you are not a certified instructor in those methods; is that right?

A Correct.

MR. ROSEN: Actually, just for the

record, Mr. Green, and correct me if I'm wrong, Doctor, the one change was to the January 6th report, not the January 5th report. And it was to number 20, about GERD. So, I just wanted to make that correction, because I don't know, counsel, if you were asking about -- which report you were talking about, but just in case, I just wanted to make it clear.

MR. GREEN: Yes, I was asking about either one. But I think you have clarified it.

BY MR. GREEN:

Q Doctor, I believe at the last time that we spoke, there was a little bit of discussion on the policy at the time at Booneville that required staff to, in the event of an emergency, call the nursing staff. Do you recall that conversation?

A Yes.

Q Okay. And then, the nursing staff would make an evaluation as to whether or not to call an ambulance. Do you remember that policy?

A Yes.

Q Okay. And I believe you testified that you thought that was a completely appropriate policy. Is

that still your testimony?
A In regard to the care provided to Mr. Cains, yes.
Q Okay. Do you believe -- has your opinion as to whether or not staff should be allowed to directly call for an ambulance changed since Mr. Cains?
A I don't believe I opined as to whether or not they should be allowed to, as a general rule or not.
Q So, you don't think -- I'm sorry. Go ahead.
A There may be other considerations which I am not aware of which have some bearing on the matter of policy for the facility in its entirety. So, I really can't opine as to whether or not that policy is appropriate or not. I did not conduct any assessment of issues that would be relevant to that specific policy.
Q You have never conducted an evaluation as to that policy?
A No, no, no. For the purposes of developing that policy, information would need to be considered. In particular, the capacity of the local emergency management system to provide response, and at what cost that would be to not just the county, but the people who live in the county. If, for example, the county did not have adequate staffing and did not

feel that they could support both the HDC and the general population of the county, that would be relevant to a decision about whether or not the BHDC policy should be different than what it currently is. And I have no information upon which to provide additional information that would be relevant to that broader policy discussion. So, I can't evaluate whether in this specific instance at BHDC, given the needs of the local community and the resources of the local community and the needs and resources of the BHDC, whether or not that is the appropriate policy or not.

Q The Booneville Human Development Center is an intermediate care facility; correct?

A Correct.

Q Would you agree with me that a policy -- let me rephrase it. Would you agree with me that staff at an intermediate care facility should be empowered to directly call for an ambulance themselves if they come upon a client without a pulse and who is not breathing?

A We are specifically talking about ICF/IDDs, not ICFs in general?

A If your opinion is different for each, then please give me your opinion as to each.

A I have no opinion about ICFs. I think that is well beyond what I was retained to look at. I make no claim about my expertise in looking at general nursing homes, for example. So, I really can't comment on --

Q Well, then, let's go with ICF/IDDs.

A Can you rephrase your question, or repeat your question?

Q Sure. Would you agree with me that staff at the -- let me just say, staff at the ICF/IDDs should be empowered to directly call 911 or similar service for an ambulance themselves directly if they come upon a client without a pulse and who is not breathing?

MR. ROSEN: Objection, irrelevant.

BY MR. GREEN:

Q You can answer.

A I said there are -- you are talking about policy. And there are considerations around the development of policy at specific ICF/IDDs that I lack information on. And, therefore, I can't opine broadly about your question as a matter of policy.

Q So, you can envision an instance where a person who is a staff member at an ICF/IDD might not -- should not be empowered to directly call 911 if they come upon a person without a pulse and is not

breathing?
A Well, I believe that is currently the case at the HDC where staff are instructed to contact the nursing staff for the purposes of obtaining emergency medical care and are advised not to contact the local emergency management system for that support.
Q And you think that's an appropriate procedure for someone who is not -- for someone who does not have a pulse and is not breathing?
A As I said, as a matter of policy, I'm not in a position to evaluate whether that is appropriate or not. I am not privy to the data and information that would be necessary to render such an opinion. What I can say is, the HDC does have an appropriate system of responding to medical emergencies which relies upon qualified medical personnel being called at the moment such a medical emergency may exist and rendering care and making a determination as to whether additional support is required. I believe that the practices are consistent with CMS regulations, and that the CMS surveyors agree because they have never identified this as a concern.
Q Okay. All right. So, you can't categorically say that all staff should be empowered to call 911 if someone is not breathing and doesn't have a pulse? I

think that's what I hear you saying, I just want to make sure I understand.

A No. I'm saying I don't have sufficient information upon which to offer an opinion about a policy --

Q That's good enough. You don't have an opinion. Got it. One of the questions I had about previous opinions -- well, let me move on to something else, because I don't want to take the rest of the day, and I also don't want us to have any more technical issues. So, I want to make sure I cover the most important things that I want to discuss.

There was some testimony about fight or flight. And I don't want to go into that too horribly much. You testified about it before, and something about having to have a fear of death. But you would agree with me that the body going into a, quote, "fight or flight" response doesn't require a conscious fear of death; correct?

A I believe it was Doctor Forestiere, that's the name of the doctor, who opined that, in one instance, the occurrence of a fight or flight reaction would be based upon the individual's perception of their impending death. So, it was not my opinion, that was hers.

Q I understand that. And my question to you is, you would agree with me that it does not require an impending conscious fear of death for the body to have the, quote, "fight or flight" response?
A Again, I found her testimony and the whole narrative around a fight or flight reaction to be very confusing. So I don't want to offer an opinion about her opinion --
Q I'm not asking about her opinion, I'm asking about your opinion. Are you aware of what we refer to as the fight or flight response?
A Yes.
Q You have knowledge about it, I presume?
A Yes.
Q And you would agree with me that it does not require a person to have a conscious belief that they are about to die in order for that fight or flight reaction to occur; correct?
A That is possible.
Q Okay. And would you agree with me that when a person experiences the fight or flight response, it generally is going to increase anxiety in that person?
A No, not necessarily.
Q Okay. All right. Does it generally increase

their heart rate?
A My understanding of the fight or flight response is that there is a discharge of catecholamines, and catecholamines cause an increase in the heart rate.
Q And you also understand that it is, by its nature, a stress response that the body has to some stimuli; correct?
A Generally, yes.
Q Okay.
A Although there is no evidence that Mr. Cains suffered a fight or flight --
Q And Doctor, I understand --
A -- response in this specific --
Q I understand that -- your position on Mr. Cains. But if I don't ask specifically about Mr. Cains, I would ask you to just please answer my question. Opposing counsel is competent, will do a good job on redirect of asking you that if he needs to. It just prolongs the questioning, because then I have to follow up with more specific questions to Mr. Cains. But I'm not going to with this particular question.
MR. ROSEN: And just for the record, Doctor Kastner can answer the question as he deems fit as a physician.
MR. GREEN: And the record will show

whether he is being responsive or not.
BY MR. GREEN:
Q One quick question, Doctor. Back to the life expectancy. And I know that you cited in your report what you referred to. I take it, by seeing what you referred to, you didn't refer to any specific mortality tables that are specific to the State of Arkansas, did you?
A I don't believe that mortality tables for people with intellectual and developmental disabilities for the State of Arkansas exist.
Q Okay. So, that would be a "no"?
A I don't believe that relevant life tables exist for the population under consideration, so I could not have referred to them.
Q Okay. So, you are saying "no" because you don't believe they exist; correct?
A General tables for the general population do exist, but they would not be applicable to this specific population.
Q Okay. All right. One of the things, Doctor, I know you had testified before about, and these are my words, I'm paraphrasing, but essentially that Mr. Cains couldn't have been saved given the circumstances, due to travel time for the ambulance

to get there and then travel time to get back and the time they were on the scene. And again, those are my words. I'm not holding you to that exact phrasing. But do you recall us talking about that a little bit before?

A I can recall being fairly specific in saying that Doctor Forestiere opined that the brain begins to die and suffer irreparable damage after four or five minutes of lacking oxygen. And I agree with her opinion in that regard. And that also [redacted]

[redacted]

Q You had never heard that in medical training or amongst doctors that you have worked with that --

A Yes.

[redacted]

Q Okay. Okay. Very good. And you would agree with me that emergency situations where a person has stopped breathing, they have died, they are dynamic; correct?

A Yes. I'm not sure what you mean by "dynamic", but --

Q Changing, they change from moment to moment?

A They can.

[redacted]

[redacted]

Q Okay.

A So, there is no evidence of that being a, quote, unquote, "dynamic process". He was stable, his care was consistent, it did not appear that there was anything that changed during that interval.

Q What do you mean by "stable"? How was he stable?

[redacted]

MR. ROSEN: Objection. That's not an accurate characterization of other people's

testimony. But go ahead.

THE WITNESS: I do recall that [redacted]

BY MR. GREEN:

[redacted]

Q Okay. But you would agree with me that the circumstances could have been different had Mr. Scow arrived earlier, either way? I'm not saying they could have been different to have made it easy, for sure, [redacted] but that certainly the circumstances would have been different on some level?

MR. ROSEN: Objection, that's speculation. And we know the time that it took for the EMS to respond was 13 minutes, as the doctor has said. So, the question is -- I don't know how it could be answered.

BY MR. GREEN:

Q Okay. You can answer, Doctor, if you can.

A I'm not going to offer a guess.

Q Okay. You won't offer a guess on that.
A I'm not going to offer a guess.
Q All right. Very good. And part of your opinion as to whether or not it would have been effective to have summoned an ambulance sooner you have based on the time it took for the ambulance to get there, among other things; correct?
A We are specifically talking about Mr. Cains?
Q Yes.
A Yes, that's true.
Q Okay.
A It took 13 minutes for the ambulance to arrive after they were called.
Q After they were called. And, of course, we have no idea if they had been called five minutes earlier whether they would have been closer to the facility or further away from the facility; correct?

MR. ROSEN: Objection. Because based upon what has been established through other testimony outside this witness, but I'm sure he reviewed, five minutes earlier he was -- it appears that Mr. Cains was breathing. So I don't know how you can answer that speculative hypothetical question. And perhaps we need to -- well, I object to it

because it's argumentative and assumes facts that are not only not in evidence, but don't exist.

BY MR. GREEN:

Q Doctor, you can answer my question. If I need to rephrase it, I will.

A If you could, I would appreciate it.

Q Okay. It's very simple. If an ambulance was called for Mr. Cains, would you agree with me that if an ambulance had been called sometime earlier, one minute, two minutes, three minutes, four minutes earlier, that it is possible that the ambulance might have been closer to the facility and able to have arrived earlier, or there could have been less traffic, any number of things could have affected the speed at which the ambulance arrived?

MR. ROSEN: Objection. EMT Scow testified where the ambulance was and that -- what the response time was. The rest of it is just mere speculation and guess as to the traffic in rural Booneville. But Mr. Scow responded to that. He answered all those questions. So, it's inappropriate to ask this witness on something so speculative and hypothetical.

MR. GREEN: It's a perfectly fine question to ask. He doesn't have to answer it.

BY MR. GREEN:

Q My question is simply this: If you call for an ambulance at one point in time, if you had called a few minutes earlier, the ambulance may have been at a different location and the response time may have been different, "yes" or "no"?

MR. ROSEN: Objection, because that's not what EMT Scow testified.

MR. GREEN: Are you instructing him to not answer it or not?

MR. ROSEN: No, he's not my -- I don't represent him.

MR. GREEN: Okay.

MR. ROSEN: But you are asking a question that is absurd because -- and you already know the answer to it, because we know -- we know where the ambulance was through Mr. Scow and how they responded and how long it took. And it's not appropriate to ask such a speculative question to another witness when you know the answer.

MR. GREEN: Let me ask an absurd

question and you can point out to the Commission how absurd and ridiculous my question is. That is perfectly fine, if you believe it's an absurd question.

MR. ROSEN: Yes.

BY MR. GREEN:

Q My question is simply -- we do know where the ambulance was at the time of the call. My question is, isn't it possible, Doctor, the ambulance would have been at a different location at a time of a prior call, "yes" or "no"? It's not a complicated question. It's not a trick question.

MR. ROSEN: I'm going to object. How long beforehand are you speculating?

MR. GREEN: At any time prior, one minute to three minutes.

THE WITNESS: I'm not in a position to offer a guess.

MR. GREEN: Okay. All right. So, I will leave that alone. We will save that for argument to the Commission. But it's not appropriate to not answer a question because you think it's ridiculous. I'm sure I will ask a ridiculous question or something you think is absurd, but the

witness is still obligated to answer the question unless there's some kind of a privilege.

THE WITNESS: Are you speaking to me?

MR. GREEN: I'm not speaking to you, Doctor, I'm speaking to opposing counsel.

MR. ROSEN: Well, I'm not --

THE WITNESS: Well, I have offered an opinion answer, so I think we can probably just move on.

MR. GREEN: Yes, I'm moving on to something else here.

BY MR. GREEN:

Q And just so I'm clear, again, Doctor, you were the -- the Commissioner, I think is what you called it, not Director, of the Office of People with Developmental Disabilities for the State of New York until fairly recently; correct?

A Correct.

Q And would you agree with me that for persons who have developmental disabilities -- and I'm not asking about Mr. Cains specifically here. But in general, okay, would you agree with me that persons who have

[redacted]



A So, rephrase your question.

Q Sure. I'm going to ask you a question, and what I'm going to do is, I'm going to read you a portion of something I found from the Office of People With Developmental Disabilities New York training materials, because that may help you to better conceptualize the meaning of what I'm asking, and I don't want to mess up a definition. But there is a discussion about prevention of choking and aspiration in these materials.

MR. ROSEN: Can you identify the materials?

MR. GREEN: I can tell you what they are.

MR. ROSEN: What is the title of it?

MR. GREEN: Sure. It's available on the "Office of People With Developmental Disabilities New York State of Opportunity", is what it says, "Prevention of Choking and

Aspiration, Stop Choking Hazards".

MR. ROSEN: And who is it produced by?

MR. GREEN: The Office for People With Dis -- the Office for People With Developmental Disabilities, the OPWDD for the State of Arkansas (sic). That is the Department -- I'm going to call it a Department --

BY MR. GREEN:

Q What did you call it, the Office -- Division? How did you refer to it when you ran it?

A It's an office.

Q The office. So I'm going to refer to it as the office. It is a publication -- training publication available on their website as of today, and prior, according to the way-back machine, and it says, "Common issues: For people with developmental disabilities, common issues exist that place a person at risk for choking and aspiration." There are lots of things that don't really apply to our case that I'm not going to discuss, such as decreased muscle tone, I don't think that's a factor here. One of the common issues it says is, quote, "A person has been diagnosed with [redacted]

So, do you agree with that statement that people with developmental disabilities have a greater risk for choking and aspiration if they have been [redacted] "yes" or "no"?

A I'm still -- can you point me to look at that document? Because I'm confused in how it's being represented?

Q I'm not --

A I didn't hear in your representation that a comparison was made between the general population and people with developmental disabilities. I would like to be able to see that that's exactly what was the case in that document. I mean, I can do the search as easily as you, or I could wait for you to send it to me. But I don't want to comment on a document based solely on your representation of it.

Q Okay. That's fine. All right. So, let me ask you, then, the way it is phrased in this training document is that people with developmental disabilities, there are common issues that exist that place a person at risk for choking and aspiration, [redacted] Do you disagree with that?

MR. ROSEN: Objection. This is

irrelevant as to general populations, because David Cains, we know what his risks were. It's in the IPP, it's in the evidence. So, asking about people in New York State and a generalized risk, when we know what the risk is for David Cains, would be a little misleading and certainly not relevant.

MR. GREEN: Well, I object as to what we know. The Commission will determine the facts.

BY MR. GREEN:

Q But do you want to answer my question or not, Doctor?

A I can't comment on it --

Q Okay.

A -- a document without looking at it.

Q All right. We will just let the document speak for itself.

MR. ROSEN: Well, if you would provide it to him, he might be able to look at it and compare it in context. But until then, it's out of context.

BY MR. GREEN:

Q Well, I think -- Doctor, you have testified that

you are an expert in dealing with people with developmental disabilities; correct?

A Correct.

Q And so, you have a wide range of knowledge of risk factors that they may have as it pertains to choking or aspiration; correct?

A Correct.

Q And isn't it true that -- and I'm not talking about Mr. Cains. But isn't it true that, in general, [redacted] "yes" or "no"?

MR. ROSEN: I'm going to object, because just a general diagnosis -- are you [redacted] are you talking with active symptoms? What are you talking about? These generalized statements, you know, when we --

MR. GREEN: My question was clear --

MR. ROSEN: Hold on, I'm making an objection, counsel. Because somebody with [redacted]who does not -- the question is, are [redacted]

[redacted] which? Which are you talking about, so that we can put that in the hypothetical to ask the physician?

MR. GREEN: I have asked my question.

BY MR. GREEN:

Q Doctor, if you don't remember it, we can have the court reporter read it back.

MR. ROSEN: I object to the question simply because it's nonsensical.

MR. GREEN: Okay. Well, that's fine, it can be nonsensical. But that's not a valid reason for the witness not to answer it.

BY MR. GREEN:

Q Doctor, do you have an opinion on that or not?

[redacted]

Q Okay.

A And that's a well established fact.

Q And I understand you have testified before that you didn't believe Mr. Cains was having [redacted] I get all that. I'm not trying to rehash that.

A Okay.

Q I appreciate your direct answer just then.

Thank you. Doctor, in preparing your reports, did you review the report written by Sandy Evans where she found there was no maltreatment? Do you recall reviewing that report?

A I don't necessarily recall that.

Q Okay. I'm almost done. Just let me check a couple of notes here. Would you agree with me, Doctor, that in giving your opinions, that if any of the factual assumptions that you have used to form those opinions turned out not to be correct, that might change your overall opinion?

A I'm not sure what you mean by "factual assumptions". There are facts and there are assumptions.

Q Okay.

A I have tried not to assume facts when they were not present.

Q Well, for instance, if Tyler said something happened, I wasn't there, you weren't there, really no one else knows whether it is true or not, I would say my wording would be that you assume that to be a fact because you assume him to tell the truth, and he may be telling the truth, but it's not a fact that you observed. So, my question is, if things that you have read in reports that you don't have personal

knowledge of that you have assumed to be true, if it turns out some of those things are not true, those could potentially change your opinions; correct?

A I make no representations about any first person facts that I was party to. Everything that I looked at relies upon the testimony of people or their reporting or other, you know, documents. I have no firsthand information.

Q Perfect. Perfect. And if any of their testimony or statements turned out not to be accurate as it was reported to you, that could potentially have changed your opinion; correct?

A It would depend upon what that specific concern were.

Q Sure. Understood.

A But this is the position that all of the experts find themselves in. None of the experts have any firsthand information because none of us were there at the time. We rely upon the materials that we receive to form our opinions.

Q Understood. Understood. And that's why we have fact-finders. Usually it's a court or a jury. Here it's going to be the Claims Commission, they will ultimately determine what did or did not happen based on all of these statements. And I wasn't accusing

you of doing anything inappropriate, just establishing that you have to rely on what is reported to you to form your opinions.

A Just as all the experts do in this regard.

Q I don't disagree. I understand that's the case.

MR. GREEN: Can we take five minutes? I may be completely done. Give me just a moment.

MR. ROSEN: Make it about seven minutes, seven or eight.

MR. GREEN: Seven. Okay. Thanks.

(WHEREUPON, a break was taken.)

BY MR. GREEN:

Q All right. Doctor, just a couple more questions. You had testified before that you have given testimony in many other legal proceedings. Specifically, I think you testified that you had testified as to the cause of death in some legal proceedings. Is that right?

A Yes.

Q Okay. Can you tell me in what proceedings you testified as to the cause of death for any person?

A I apologize. I can't cite any specific case. I have worked on probably 30 medical malpractice cases in which that's a component. The last one would be

ten or 15 years ago, and honestly, I can't remember.
Q So, just so I'm clear, your testimony related to cause of death would have been primarily in the context of medical malpractice cases?
A No, no. It was also in the context of the larger consultations that I have done at facilities, federal litigation. I just don't remember specific instances. But I know that it's common, and I have published a fair amount in the area. So, it's an area of expertise that I have.
Q So, you have published articles in journals about cause of death?
A Yes. And actuarial studies and all types of things related to cause of death, life expectancy, the content which we have been discussing today.
Q And those are all listed in your CV; correct?
A Yes.
Q Let me ask you, though -- and when I say "testimony in a legal proceeding", I mean either testimony during a deposition, or testimony during a court hearing, or other trial court proceeding, not like you writing a report for someone that wasn't used in a deposition or at a hearing. Does that make sense?
A Yes.

Q Okay. So, can you remember, is the last time you gave oral testimony, whether in a hearing or deposition related to cause of death, ten to 15 years ago?
A I don't recall offering any oral or written testimony in the last ten years. I mean, I could be wrong, but I just don't remember anything.
Q Okay. Do you recall if these were all federal cases or was it a mixture of federal and state cases?
A I would assume a mixture of federal and state.
Q Okay.
A And obviously the medical malpractice cases are different than I think what you are describing.
Q Sure. Do you recall what states you would have provided testimony in? And when I say "in", obviously right now we are doing this via Zoom, so I presume you are in New York right now. I'm in Arkansas. But I would say that this case is an Arkansas case. So, my question is, can you recall what states the cases originated in where you provided testimony related to cause of death? And I'm not expecting you to have an exhaustive, complete, perfect list. But can you tell me states that you do recall that having occurred in?
A I think, in our last session, I identified

states where I had provided testimony. Off the top of my head, Pennsylvania, New Jersey, Connecticut, Massachusetts, Florida, Texas. I'm sure there are others. Nebraska. But I can't recall specifically in what state I would have opined about a cause of death.

Q Okay. So, in all those states you mentioned, that would have been testimony, but you can't remember which ones were cause of death, which ones were not; correct?

A Correct. They are generally large, complicated projects that require looking at many, many components of the system of care. And so, I can't be specific.

Q Okay.

A I do remember in Nebraska an individual who passed away and there were questions about that individual's specific care and whether it met the standard of care. And, yeah, I can recall those details. I don't know how that helps you. But I do recall those details in that one instance.

Q Okay. All right, Doctor. Did you understand my questions today?

A I believe so.

Q Were you able to hear me?

A Yes, I could hear you.
Q Do you want to change any of your answers to any of the questions I asked today or that I asked in our previous session?
A Not without the benefit of having the opportunity to look at the transcript.
Q Right. And I will ask you to take a look at that, and then if you need to correct something, you will be able to do that. And the other attorney will explain that to you.

MR. GREEN: All right. I will pass the witness.

MR. ROSEN: All right. Very brief.

REDIRECT EXAMINATION

BY MR. ROSEN:
Q Doctor Kastner, just a few minutes ago, a little bit ago, counsel was asking you about a document that counsel says is from New York State. Do you remember that conversation?
A Yes.
Q And counsel asked you -- he asked you about people with developmental disabilities and GERD in general. Do you remember that conversation?
A Yes.
Q About a general population, nobody in specific;

right?

A Correct.

Q Okay. But he didn't ask you specifically about David Cains, or if he did, I don't recall. But I'm going to ask you about David Cains. Okay? And did



MR. GREEN: Objection, asked and answered. He went over that last time. But feel free to go over it again.

MR. ROSEN: Well, you raised that in your -- and I just want to make the record clear. Because you were talking about people in general, and I want to be more specific, because we have the information with David Cains.

BY MR. ROSEN:

Q So, I'm going to ask you, Doctor --

MR. GREEN: And that's fine. That's why I said, "Go ahead." I'm not throwing a fit over it.

MR. ROSEN: All right.

BY MR. ROSEN:

Q So, Doctor, what was -- first of all, there was -- in 2019, which is the year -- or for the 2019 IPP, which was the year of the IPP in effect at the time

[redacted]

[redacted]

MR. ROSEN: I have no other questions. Thank you.

MR. GREEN: Just real quick.

RECROSS EXAMINATION

BY MR. GREEN:

[redacted] with respect to whether a person is being held and pinned down against the ground; correct?

A I don't believe that you are characterizing the circumstances in which Mr. Cains --

Q I'm not asking about whether that -- I'm just asking about, they do not test to see whether or not a person in a certain position held on the ground would have a greater risk; correct?

A Risks are based upon evidence and data. For example, there is a small risk of a person living in the United States being attacked by a shark. But for those people who don't swim in the ocean, we know the risk is zero because we are not going to encounter sharks unless we swim in the ocean. In the case of Mr. Cains, [redacted]

[redacted]

Q Okay. I understand what you feel about Mr. Cains. I think it is very clear. My simple question is this: When they perform an assessment for a person's risk of choking or aspiration, they do not test to see whether or not the person is at an increased risk of choking or aspiration if they are being held on the floor and cannot get up; correct?

A You would have to go and speak to them about how they performed that assessment.

Q Okay. So, you are not familiar with how they performed the assessment?

A I'm quite familiar with the tool, and I would believe they rely upon the evidence in the collective medical record. But I don't want to opine about their specific practice. I think they are in a better position to do that than I am.

Q And this will be one last thing, and I don't mean to be silly by it. Your analogy was about being

attacked by sharks and that you wouldn't be attacked by a shark if you swam in the ocean; right?

A Excuse me. I think I said you would only be attacked by a shark if you swam in the ocean.

Q In the ocean. Okay.

A And so your risk of being attacked by the shark would be zero if you never swam in the ocean, unless you believe in the Sharknado nonsense.

Q My only point in asking that is, you presume that sharks only exist in the ocean. Were you aware that sharks have been found in the Mississippi River as far north as above St. Louis?

A Sure. They are called bull sharks. I'm familiar with it. And you could also be attacked in an aquarium.

Q Right.

A So, but the bigger point is, if you have never vomited [redacted] based upon your specific health and the evidence that is available to make decisions. So, a clinician has to rely on data, they rely on that data which says, [redacted] and they act upon it. That was my point. So, the risk is zero.

Q Right. According to your opinion.

MR. GREEN: All right. Well, thank you. I don't think I have any further questions.

MR. ROSEN: And I have no questions. Thank you, Doctor. Well, I guess as counsel raised it, under our rules you have a right to review your deposition. I'm not your attorney, so I can't advise you. You have a right to review it and make any changes on an errata sheet or you can waive that. That's up to you, since counsel raised that. I can't advise you on that, I'm not your attorney.

MR. GREEN: I would request that he review it and make any corrections, or just simply note that he has no corrections.

MR. ROSEN: Well, that's up to the doctor to decide whether you want to read it completely first. And then, that would take up to -- either of the Ms. Petres, how long does the deponent have to review a deposition? And I assume that you have to type it up first.

COURT REPORTER: Thirty days after he

gets it, normally, unless you ask him to do it sooner.

MR. ROSEN: Well, since counsel wants that, it's 30 days from the time that you type it up. So, that would put us past the deadline for the briefing. But if that's what counsel is requesting, then that's what counsel is requesting.

MR. GREEN: Well, unless he does not -- if he wants to waive it, I'm okay with him waiving it. I just want to make sure it's clear one way or the other that he either takes the opportunity to correct it or waives it.

MR. ROSEN: Okay. So, I thought you -- well, anyway. So, Doctor Kastner, that would be your call since counsel raised it and has given you the opportunity. If you want to read it or you can waive it under the anticipation that the Petres, both Donna and Debbye, accurately got your testimony correct, and with the proviso that there was a gap for a minute or two that caused us to change the process of court reporter.

THE WITNESS: I don't feel like I need

to respond right now. So, unless you are asking me or requiring me.

MR. ROSEN: The only reason I'm asking you is because counsel raised it. I wouldn't have raised it. So, would you prefer to read it or would you prefer to waive?

THE WITNESS: I would prefer to read.

MR. ROSEN: Okay. All right. Since counsel raised it, we're going to have to do that, and I will have to address the briefing issue, then. Okay. Thank you, everybody.

(WHEREUPON, at 12:30 p.m., the taking of the above-entitled deposition was concluded.)

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CURRICULUM VITAE

DATE OF PREPARATION: February 1, 2022

NAME: Theodore Andrew Kastner, M.D., M.S.

PROFESSIONAL EDUCATION:

Colgate University Hamilton, NY	1973-1977	B.A.
University of Connecticut School of Medicine Farmington, CT	1977-1981	M.D.
University of Wisconsin School of Preventive Health Madison, Wisconsin	1995-1997	M.S.

POST-GRADUATE TRAINING:

Intern	Bronx Municipal Hospital Center	7/1981-6/1982
Resident	Bronx Municipal Hospital Center	7/1982-6/1984
Fellowship	Developmental Medicine	7/1984-6/1986

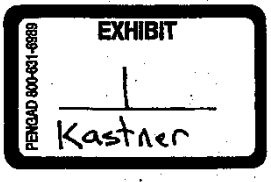
PROFESSIONAL EMPLOYMENT, HOSPITAL AND ACADEMIC APPOINTMENTS:

Employment:

Morristown Memorial Hospital, Medical Director, Developmental Disabilities Center	7/1986-12/1998
Morristown Memorial Hospital, Medical Director, Center for Human Development and Rehabilitation	7/1986-7/1989
Morristown Memorial Hospital, Director, Center for Human Development	7/1989-1/1998
Developmental Disabilities Health Alliance, Inc., President,	1/1998 to Present
Co-Director Rose F. Kennedy Center (Albert Einstein)	4/2015 to 1/2019
Director Children's Evaluation and Rehabilitation Center (Montefiore)	4/2015 to 1/2019
Commissioner, NYS Office for Persons with Developmental Disabilities (OPWDD)	1/2019 to 10/2021

Hospital Appointments:

2013-2019	Montefiore Medical Center, Attending Physician
2001-2018	Mountainside Hospital, Consultant



1998-2018	Robert Wood Johnson Hospital at Hamilton, Consultant
1995-1999	Mountainside Hospital, Attending Physician
1995-1999	Morristown Memorial Hospital, Attending Physician
1989-1993	Morristown Memorial Hospital, Associate Attending Physician
1986-1989	Morristown Memorial Hospital, Assistant Attending Physician
1984-1986	Bronx Municipal Hospital Center, Assistant Attending Physician

Academic Appointments:

2015-2019	Albert Einstein College of Medicine, Professor of Pediatrics, Department of Pediatrics Professor of Psychiatry, Department of Psychiatry and Behavioral Sciences
2015-2019	Ruth L. Gottesman Chair in Developmental Pediatrics
2015-2019	Chief, Division of Developmental Medicine, Department of Pediatrics
2004-2016	University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, Clinical Associate Professor of Medicine
1999-2014	University of Medicine and Dentistry of New Jersey, New Jersey Medical School Clinical Associate Professor of Pediatrics
1992-1999	University of Medicine and Dentistry of New Jersey, New Jersey Medical School Associate Professor of Pediatrics
1988-2004	Columbia University College of Physicians and Surgeons Assistant Professor of Clinical Pediatrics
1986-1988	Columbia University College of Physicians and Surgeons Instructor in Clinical Pediatrics

BOARD CERTIFICATION:

Pediatrics, American Board of Pediatrics, 1986
Medical Management, 1998, American Board of Medical Management
Certified Physician Executive, 1998, American College of Physician Executives
Developmental and Behavioral Pediatrics, 2022, American Board of Pediatrics
Neurodevelopmental Disabilities, 2024, American Board of Pediatrics

ADDITIONAL OPTIONAL INFORMATION:

Professional Society Membership:

-American Academy of Pediatrics New Jersey Chapter

Treasurer (2012-2014)
Secretary (2010-2012)

Nominating Committee (2008-2010)
Councilor (At-large) (1999 to 2003)
Councilor (District 3) (1993-1998)

-American Association on Mental Retardation (American Association on Intellectual and Developmental Disabilities) (1986-2016)

President, New Jersey Board of Directors (1996-1998)
Fellow (1996)
National Board of Directors (Term 1994-1996)
National Legislative and Social Issues Committee (1993- 1996)
National President Medicine Division (1992-1994)
New Jersey Board of Directors (Medicine) (1987-1998)
Region IX Board of Directors (Medicine) (1988- 1992)

-American College of Physician Executives (1992- present)

-American Epilepsy Society (1992-1998)

-New Jersey Medical Society (1986-1996, 2000-2006)

-New Jersey Academy of Medicine (1990-2002)

-Northwest New Jersey Pediatric Society (1986-1998)

-Pediatric Council on Research and Education (2002-2006)

Founding Board Member (2000 to 2007)

-Society for Behavioral Pediatrics (1988-2005)

-Society for Developmental Pediatrics (1991-2000)

Other Boards of Directors:

- Developmental Disabilities Health Partners

Founding Board Member (2013-2020)

Northwest New Jersey Early Intervention Collaborative

Founding Board Member (1993-1994)

-Community Health Law Project Board of Directors (1989-1992)

-Academy on Mental Retardation (1986-2005)

-American Academy of Cerebral Palsy and Developmental Medicine (1986-2012)

Committees:

-American Academy of Pediatrics (1986-Present)

-Co-Chair, New Jersey Chapter, Committee on Firearms Prevention (2001-2006)

-New Jersey Chapter Committee on Children With Disabilities (1986-2015)

-National Committee on Children With Disabilities (1997-2003)

-AAP Workgroup on Transition to Adult Health Care (September 2001)

(Member of Invitational Conference Planning Committee) Proceedings published as a supplement Pediatrics December 2002, Volume 110, Number 6 Part 2 of 2.

-AAP Medical Necessity Meeting (February 2002)

-AAP Task Force on Medication Administration (April 2000)

-AAP Representative to Planning Committee for Surgeon General's Conference on Health Disparities and Mental Retardation (December 2001); Proceedings Published as "Closing the Gap: A National Blueprint to Improve the Health of Persons With Mental Retardation." US Department of Health and Human Services. 2002

-American Association on Mental Retardation (American Association on Intellectual and Developmental Disabilities) (1986-2015)

-National Legislative and Social Issues Committee (1993- 1996)

-Association for Retarded Citizens (New Jersey) (1986-2015)

Chairperson, Mainstreaming Medical Care Advisory Committee (1988-1998)

Mainstreaming Medical Care Advisory Committee (1988-2018)

Network on Prevention of Mental Retardation (1986-1998)

Member, New Jersey State Health Care Project Advisory Committee 1987

Professional Advisory Committee (Morris Unit) (1987-1993)

-Epilepsy Foundation of New Jersey (1992-2002)

Professional Advisory Board (1993-1998)

-Other National and Regional Committees

New Jersey Division of Developmental Disabilities Advisory Committee (1998-2003)

New Jersey Department of Human Services Advisory Committee on Developmental Disabilities and Medicaid Managed Care (1995-2004)

NY United Cerebral Palsy Medicaid Managed Care Advisory Committee (1994-2000)

New Jersey Department of Human Services Advisory Committee on Medicaid Managed Care (1994-2003)

State of New Jersey Interagency Coordinating Council (1992-1998)

American Association of University Affiliated Programs Task Force on HIV and Developmental Disabilities (1988- 1998)

New Jersey Department of Health Pediatric AIDS Advisory Group (1988-1998)

Research Committee of the Governor's Council on the Prevention of Mental Retardation & Developmental Disabilities (1989-2000)
State of New Jersey Consortium on Disability (1987-1998)
Matheny School, Member, Medical Committee, Peapack, NJ (1986-1989)
-New York City Mayor's Ad Hoc Committee on Zika Virus (2015-2017)

Awards and Honors:

2008 American Medical Association Leadership Award, American Medical Association
2007 Ann Klein Advocate Award, Community Health Law Project
2007 Health Care Professional of the Year Award (Developmental Disabilities Health Alliance) Bergen Passaic (New Jersey) Arc
2006 Volunteer Excellence Award, Brain Injury Association of New Jersey
2000 Enable Incorporated, Special Recognition Award
1999 St. John's Community Services, Community Service Award
1999 Arc of Bergen and Passaic Counties, Health Care Professional of the Year Award
1998 Epilepsy Foundation of New Jersey, Distinguished Service Award
1993 Morris County Office for the Disabled, Advocate of the Year Award
1993 Union County Arc, Physician of the Year Award
1992 Special Recognition Award, New Jersey Center for Outreach and Services for the Autism Community
1991 United Cerebral Palsy Associations of New Jersey, Elizabeth M. Boggs Citizenship Award
1990 New Jersey Association for Retarded Citizens, Health Care Professional of the Year
1990 Morris County Association for Retarded Citizens, Physician of the Year Award
1984-1986 United Cerebral Palsy Fellowship Award
1980 Joseph Goldberger Scholar in Clinical Nutrition

Other Professional Activities:

Editorial Positions:

2002-2003 Consulting Editor: Archives of Pediatrics and Adolescent Medicine
2001-2002 Consulting Editor: Milbank Quarterly
2000-2003 Consulting Editor: Pediatrics
1999-2009 Associate Editor: Mental Health Aspects of Developmental Disabilities
1993-2012 Associate Editor: Mental Retardation/ Intellectual and Developmental Disabilities
1993-2012 Consulting Editor: American Journal on Mental Retardation/American

	Journal on Intellectual and Developmental Disabilities
1993-2012	Consulting Editor: Mental Retardation/ Intellectual and Developmental Disabilities

National Grant Review Panels, Study Sections, Committees

1995 US Department of Health and Human Services, Administration on Developmental Disabilities, Projects of National Significance

2012 US Department of Health and Human Services, Centers for Medicare and Medicaid Services, Chairperson Review Panel

Grant Support:

2019:

Administration on Community Living. "University Center of Excellence on Developmental Disabilities (UCEDD)." 7/1/2017-6/30/2022. $2,700,000.

New York City. "RFK CERC Early Childhood Center." (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. "Developmental Disabilities Clinic Services." 7/1/2016-6/30/2019. $555,678.

New York City. "Socialization and Recreation Services for Children with Autism." 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Developmental Behavioral Pediatric Fellowship Training Program 7/1/2018-6/30/2022. $785,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2016-6/30/2021. $3,527,225.

Heath Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Audiology Supplement." 7/1/2016-6/30/2021. $400,000.

"Statewide Community Integration and Preservation Program (SCIPP)." New Jersey Division of Developmental Disabilities; 1/1/17-12/31/17: $1,200,000

2018:

Administration on Community Living. "University Center of Excellence on Developmental Disabilities (UCEDD)." 7/1/2017-6/30/2022. $2,700,000.

New York City. "RFK CERC Early Childhood Center." (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. "Developmental Disabilities Clinic Services." 7/1/2016-6/30/2019. $555,678.

New York City. "Socialization and Recreation Services for Children with Autism." 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Developmental Behavioral Pediatric Fellowship Training Program 7/1/2018-6/30/2022. $785,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2016-6/30/2021. $3,527,225.

Heath Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Audiology Supplement." 7/1/2016-6/30/2021. $400,000.

"Statewide Community Integration and Preservation Program (SCIPP)." New Jersey Division of Developmental Disabilities; 1/1/18-12/31/18: $1,200,000

2017:

Administration on Community Living. "University Center of Excellence on Developmental Disabilities (UCEDD)." 7/1/2017-6/30/2022. $2,700,000.

New York City Administration on Children's Services. "GABI Replication." (Co-PI) 7/1/2016-6/30/2019. $8,400,000.

Bronxworks. "GABI Replication." (Co-PI) 9/1/2016-8/30/2017. $384,000.

Brooklyn Catholic Charities. "GABI Replication." (Co-PI) 9/1/2016-8/30/2017. $384,000.

New York City. "RFK CERC Early Childhood Center." (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. "Developmental Disabilities Clinic Services." 7/1/2016-6/30/2019. $555,678.

New York City. "Socialization and Recreation Services for Children with Autism." 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2016-6/30/2021. $3,527,225.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND) Audiology Supplement." 7/1/2016-6/30/2021. $400,000.

"Statewide Community Integration and Preservation Program (SCIPP)." New Jersey Division of Developmental Disabilities; 1/1/17-12/31/17: $1,200,000

2016:

New York City Administration on Children's Services. "GABI Replication." (Co-PI) 7/1/2016-6/30/2019. $8,400,000.

Bronxworks. "GABI Replication." (Co-PI) 9/1/2016-8/30/2017. $384,000.

Brooklyn Catholic Charities. "GABI Replication." (Co-PI) 9/1/2016-8/30/2017. $384,000.

New York City. "RFK CERC Early Childhood Center." (Co-PI) 7/1/2016-6/30/2019. $1,275,000.

New York City. "Developmental Disabilities Clinic Services." 7/1/2016-6/30/2019. $555,678.

New York City. "Socialization and Recreation Services for Children with Autism." 7/1/2016-6/30/2019. $360,000.

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2016-6/30/2021. $3,527,225.

Special Hope Foundation."Evaluation of the Developmental Disabilities Health Home." 1/1/2016-12/31/2016: $50,000.

"Statewide Community Integration and Preservation Program (SCIPP)." New Jersey Division of Developmental Disabilities; 1/1/16-12/31/16: $1,200,000

2015:

Health Resources Services Administration, Maternal and Child Health Bureau. "Leadership Education in Neurodevelopmental and Related Disabilities (LEND)." 7/1/2015-6/30/2016. $669,789

Centers for Disease Control. "A Training Curriculum for Parents of Children with ADHD." 9/1/2015-6/30/2015. $300,000.

Administration on Community Living. "University Center of Excellence on Developmental Disabilities (UCEDD)." 7/1/2015-6/30/2016. $545,000.

Centers for Medicare and Medicaid Services (CMS): "Health Home for Persons with Developmental Disabilities." July 1, 2014 – December 31, 2015. $900,000.

"Integrated Service Delivery Team." New Jersey Division of Developmental Disabilities; 1/1/15-12/31/15: $1,200,000

2014:

New York State Department of Health: "Enhancing the Developmental Disabilities Health Home: DDHA Subcontract." Balancing Incentive Program." 8/1/2014-3/31/2016. $850,000.

Centers for Medicare and Medicaid Services (CMS): "Health Home for Persons with Developmental Disabilities." July 1, 2013 – June 30, 2014. $1,800,000.

"Arkansas Best Practices in Developmental Disabilities." State of Arkansas: July 1, 2013 – June 30, 2014; $450,000

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/14-12/31/14: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/14-12/31/14; $190,000

2013:

Centers for Medicare and Medicaid Services (CMS): "Health Home for Persons with Developmental Disabilities." July 1, 2013 – June 30, 2014. $1,000,000.

"Arkansas Best Practices in Developmental Disabilities." State of Arkansas: July 1, 2013 – June 30, 2014; $450,000

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/13-12/31/13: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/13-12/31/13; $190,000

2012:

Care Management Demonstration Program. NJ Council on Developmental Disabilities. 10/1/12-9/30/13: $48,000.

Centers for Medicare and Medicaid Services (CMS): "Health Home for Persons with Developmental Disabilities." July 1, 2012 – June 30, 2013. $1,700,000.

"Arkansas Best Practices in Developmental Disabilities." State of Arkansas: 10/1/2011-6/30/2012; $450,000

"Clinical Improvements Arkansas State Hospital II." State of Arkansas: 12/15/2011-3/15/2012; $220,000

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/12-12/31/12: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/12-12/31/12; $190,000

2011:

"Clinical Improvements Arkansas State Hospital I." State of Arkansas: 7/1/2011-9/30/2011; $394,668

Care Management Contracts with HealthFirst of New Jersey Inc. 1/1/11-12/31/11: $720,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11: $550,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/11-12/31/11; $190,000

2010:

"Clinical Improvements Alexander Human Development Center." State of Arkansas: 5/1/2010-6/6/2011; $2,150,000.

Care Management Contracts with Americhoice Inc. 1/1/10-12/31/10: $2,125,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10: $550,000

"Community Program of Support and Training (CPEP)," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10: $165,100

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/10-12/31/10; $190,000

2009:

"IPP Development." State of Nebraska: 1/1/2009-8/30/2009; $750.000

Care Management Contracts with Americhoice Inc. 1/1/09-12/312/09: $2,125,000.

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $550,000

"Family Support Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $150,000

"Community Program of Support and Training (CPEP)," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $165,100

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/09-12/31/09; $190,000

2008: $3,565,000

Care Management Contracts with University Health Plan and Americhoice Inc. 1/1/08-12/31/08: $2,125,000.

Olmstead Plan Behavioral Services: Statewide, New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $50,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $450,000

"Family Support Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $50,000

"Community Program of Support and Training (CPST)," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $80,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08: $470,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08; $150,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/08-12/31/08; $190,000

2007: $4,570,000

"Care Management Subcontracts: University Health Plan and Americhoice Inc." Robert Wood Johnson Health Network. 1/1/07-12/31/07: $1,567,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital: 1/1/07-12/31/07; $20,000

"Community Program of Support and Training (CPST)," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07: $240,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07: $460,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07: $350,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07; $140,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/07-12/31/07; $190,000

2006:

"Care Management Subcontracts: University Health Plan and Americhoice Inc." Robert Wood Johnson Health Network. 1/1/06-12/31/06; $1,515,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/06-12/30/06; $255,000

"Community Program of Support and Training (CPST)," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $1,700,000

"Integrated Service Delivery Team: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $450,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06 $340,000

"Integrated Service Delivery Team: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $130,000

"Integrated Service Delivery Team: Lower Central Region," New Jersey Division of Developmental Disabilities; 1/1/06-12/31/06; $180,000

2005:

"Care Management Subcontracts: University Health Plan and Americhoice Inc." Robert Wood Johnson Health Network. 1/1/05-12/31/05; $1,300,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/05-12/30/05; $240,000

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/05-6/30/05; $420,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/05-12/30/05; $435,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/05-12/31/05; $340,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/05-12/31/05; $125,000

"Developmental Disabilities Center at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/05-12/31/05; $165,000

2004

"Care Management Subcontracts: University Health Plan." Robert Wood Johnson Health Network. 1/1/04-12/312/04; $800,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/04-12/30/04; $233,793

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $700,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $421,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $325,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $118,224

"Developmental Disabilities Center at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/04-12/31/04; $159,335

2003

"Care Management Subcontracts: University Health Plan." Robert Wood Johnson Health Network. 1/1/03-12/31/03; $246,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/03-12/31/03; $241,500

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $700,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/03-12/30/03; $421,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $420,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $118,224

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/03-12/31/03; $159,335

2002

"Care Management Subcontracts: University Health Plan and Horizon/Mercy Health Plan." Robert Wood Johnson Health Network. 1/1/02-12/31/02; $158,000.

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 1/1/02-12/31/02; $237,906

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $700,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/02-12/30/02; $413,876

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $300,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $116,568

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/02-12/31/02; $157,879

2001

"Care Management Subcontracts: University Health Plan and Horizon/Mercy Health Plan." Robert Wood Johnson Health Network. 1/1/01-12/31/01; $82,000.

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 7/1/01-6/30/04; $1,500,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $407,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $300,000

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $114,808

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/01-12/31/01; $155,464

2000

"Statewide Clinical Consultation and Training Program," New Jersey Division of Mental Health Services/Trinitas Hospital, 7/1/00-12/31/01; $339,000

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 7/1/00-6/30/01; $400,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $400,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $131,500

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $113,000

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities; 1/1/00-12/31/00; $152,600

1999

"Integrated Therapeutic Network," New Jersey Division of Developmental Disabilities; 7/1/99-6/30/00; $300,000

"Care Management Demonstration Program," Robert Wood Johnson Health Network; 9/1/99-6/30/2001; $330,000

"Care Management Demonstration Program," New Jersey Division of Medical Assistance and Health Services; 9/1/99-6/30/2001; $648,000

"Mental Health Consultation Team Services: Northern Region," New Jersey Division of Developmental Disabilities; 7/1/99-12/31/00; $300,000

"Family Support Services: Northern Region," New Jersey Division of Developmental Disabilities; 4/1/99-12/31/99; $26,500

"Mental Health Consultation Services: Upper Central Region," New Jersey Division of Developmental Disabilities; 11/1/99-12/31/00; $87,500

"Developmental Disabilities Center at Robert Wood Johnson University Hospital at Hamilton," New Jersey Division of Developmental Disabilities;1/1/99-12/31/99; $152,600

1998

"Mental Health Consultation Services: Northern Region," New Jersey Division of Developmental Disabilities; 11/1/98-6/30/99; $75,000

"Case Management in Managed Care for People With Developmental Disabilities," Center for Health Care Strategies; 7/1/98-12/31/98; $10,000

"A Retrospective Analysis of the Effects of Risperidone on Tardive Dyskinesia in People With Mental Retardation." Janssen Pharmaceutical Research Foundation; 1/1/98-6/30/98; $55,000

"Quality Measurement in Managed Care for People With Developmental Disabilities," Center for Health Care Strategies; 2/1/98-6/30/98; $10,000

"Technical Assistance to the New Jersey Division of Developmental Disabilities Regarding Managed Care: Case Management and Behavioral Programming," New Jersey Division of Developmental Disabilities; 2/1/98-12/31/98; $27,900

"Developmental Disabilities Center at Robert Wood Johnson University Hospital Hamilton," New Jersey Division of Developmental Disabilities; 2/1/98-12/31/98; $150,000

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities, Contract #06PX6N; 1/1/98-12/31/98; $1,672,064

1997

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities, Contract #06PX6N; 1/1/97-12/31/97; $1,672,064

"Morris County Special Child Health Services Case Management Program," New Jersey Department of Health and Senior Services Special Child Health Services, 7/196-6/30/97; $60,456.

"Service Coordination," New Jersey Department of Health and Senior Services Early Intervention Program, 7/196-6/30/97; $166,700.

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/96-12/31/96. $89,144

"Comprehensive Child Evaluation Center," New Jersey Department of Health and Senior Services Special Child Health Services, 7/1/96 - 6/30/97, $75,000.

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract;1/1/96-12/31/96: $21,219.

"Early Intervention Program", New Jersey Department of Health and Senior Services Early Intervention Program, 7/1/96 - 9/30/97; $167,820

"Parent Infant Specialist in Behavioral Issues", Northwest New Jersey Regional Early Intervention Collaborative, 10/1/96 - 6/30/97; $21,000

"Morris/Dover Expansion of Early Intervention Services", Northwest New Jersey Regional Early Intervention Collaborative, 10/1/96 - 6/30/97; $66,700

"Prevention of Cerebral Palsy With Prenatal Magnesium Sulfate," New Jersey Office of Prevention; 1/1/97-12/31/97: $10,000.

1996

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX5N; 1/1/95-12/31/95. ($1,161,071)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/95 - 6/30/96, ($75,000).

"Early Intervention Program", New Jersey Department of Health 7/1/95 - 9/30/96, Ted Kastner, Principal Investigator.

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract; 1/1/96-12/31/96. ($20,910)

1995

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX5N; 1/1/95-12/31/95. ($1,161,071)

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract; 1/1/95-12/31/95. ($20,910)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/95-12/31/95. ($162,056)

1994

"Morris County Case Management Program," New Jersey Department of Health, 7/1/94-6/31/95. ($162,056)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/94 - 6/30/95. ($75,000)

"Early Intervention Program", New Jersey Department of Health 7/1/94 - 6/30/95, ($160,800)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX4N; 1/1/94-12/31/94, ($1,127,245)

"Child Sex Abuse," New Jersey Division of Youth and Family Services Contract;1/1/95-12/31/95. ($19710)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/94-12/31/94. ($89,144)

1993

"Morris County Case Management Program," New Jersey Department of Health, 7/1/93-6/31/94. ($105,862)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/93 - 6/30/94. ($75,000)

"Early Intervention Program", New Jersey Department of Health 10/1/93 - 6/30/94, ($123,135)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX3N; 1/1/93-12/31/93. ($1,054,909)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/93-12/31/93. ($89,144)

1992

"Morris County Case Management Program," New Jersey Department of Health, 1/1/92-6/31/93. ($73,692)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/92 - 6/30/93. ($75,000)

"Early Intervention Program", New Jersey Department of Health 7/1/92 - 9/30/93, ($192,579)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX2N; 1/1/92-12/31/92. ($1,020,374)

"Comprehensive Child Evaluation Center", New Jersey Department of Health 7/1/92 - 6/30/93. ($75,000)

1991

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX1N; 1/1/91-12/31/91. ($976,261)

"Morris County Case Management Program," New Jersey Department of Health, 1/1/92-12/31/92. ($29,700)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/93-12/31/93. ($83,610)

"Morris County Case Management Program," New Jersey Department of Health, 1/1/91-12/31/91. ($29,700)

1990

"An Educational Program to Reduce the Incidence of Fragile X Syndrome in New Jersey," New Jersey Office of Prevention, 3/1/90-2/28/91. ($15,000)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #06PX0N; 1/1/90-12/31/90. ($914,003)

"Morris County Case Management Program," Morris County Board of Chosen Freeholders, 1/1/90-12/31/90. ($81,175)

"Morris County Case Management Program," New Jersey Department of Health, 1/1/90-12/31/90. ($47,140)

1989

"An Educational Program to Reduce the Incidence of Fragile X Syndrome in New Jersey," New Jersey Office of Prevention, 3/1/89-2/28/90. ($15,000)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #EP069PC; 1/1/89-12/31/89. ($931,691)

1989

"Develop Curricula and Training Materials for HIV and AIDS," Administration on Developmental Disabilities, Department of Health and Human Services (Office of Human Developmental Services), 12/1/89-11/30/90; Allen Crocker, Principal Investigator; T. Kastner, Project Director, Component on Implementing Service Guidelines in New Jersey. ($20,000)

1988

"Develop Curricula and Training Materials for HIV and AIDS," Administration on Developmental Disabilities, Department of Health and Human Services (Office of Human Developmental Services), 12/1/88-11/30/89; Allen Crocker, Principal Investigator; T. Kastner, Project Director, Component on Implementing Service Guidelines in New Jersey. ($20,000)

"Developmental Disabilities Center Program and Components," New Jersey Division of Developmental Disabilities Contract #E8P0903; 1/1/88-12/31/88. ($855,593)

PUBLICATIONS

Peer-reviewed original articles in journals:

70. Kastner, TA, Walsh, KK, Shulman L, Alam F, Flood S. "Ketamine and the core symptoms of autism." International Journal on Disability and Human Development. 2015:15(1):121–123.

69. Kastner, T. A., & Walsh, K. K. (2012). Health Care for Individuals with Intellectual and Developmental Disabilities: An Integrated Developmental Disabilities Health Home Model. In: R. M. Hodapp (Ed.), *International Review of Research in Developmental Disabilities* (pp. 1–45). Elsevier Inc.: Academic Press.

68. Kastner T and Walsh K. "Diagnostic Manual – Intellectual Disability." Intellectual and Developmental Disabilities. 2009:47(4): 323-327.

67. Kastner T and Walsh K. "Divided We Stand, United We Fall: Personal Budgets vs. Universal Coverage." Mental Retardation. 2008:46(3): 239-242.

66. Walsh K and Kastner T. "On the need for a procedure for expulsion of manuscripts that do not meet the peer-review standard." Mental Retardation. 2007:45(6): 408-411.

65. Walsh K and Kastner T. "The Hissom Closure in Oklahoma: Errors and Interpretation Problems in Conroy, et al. (2003)." Mental Retardation. 2006:44(5);353-369.

64. Kastner T and Walsh K. "Medicaid Managed Care Model of Primary Care and Health Care Management for Individuals With Developmental Disabilities. Mental Retardation. 2006:44(1);41-55.

63. Kastner T. "Comment on the Use of Risperidone in Developmentally Disabled Children." Pediatrics. 2005:115(4);1447-1448.

62. CP Johnson, TA Kastner and the American Academy of Pediatrics Committee/Section on Children With Disabilities. "Helping Families Raise Children With Special Health Care Needs at Home." Pediatrics. 2005;115(2);507-511.

61. T. A. Kastner and the American Academy of Pediatrics Committee on Children With Disabilities. "Managed Care and Children With Special Health Care Needs." Pediatrics. 2004;114(6);1693-1707.

60. Kastner T, Walsh K. " A Retrospective Analysis of the Efficacy of Risperidone in People With Developmental Disabilities Living in Institutions." Mental Health Aspects of Developmental Disabilities. 2004; 7(1); 10-20.

59. Walsh K, Kastner T, Green R. "Cost Comparisons of Community and Institutional Residential Settings: Historical Review of Selected Research." Mental Retardation. 2003;41(2):103-122.

58. Blum R, Hirsch D, Kastner T, Quint R, Sandler A. "A Consensus Statement on Health Care Transitions for Young Adults With Special Health Care Needs." Pediatrics. 2002;110(6); 1304-1305.

57. Kastner T, Walsh K, Fraser M. "Undiagnosed Medical Conditions and Medication Side Effects Presenting as Behavioral/Psychiatric Problems Among People With Mental Retardation." Mental Health Aspects of Developmental Disabilities. 2001; 4(3); 101-108.

56. Kastner T. "On the Need for Policy Requiring Data Sharing Among Researchers Who Publish in AAMR Journals: A Critique of Conroy and Adler's, 'Mortality Among Pennhurst Class Members, 1979 to 1989." Mental Retardation. 2000;38(6):519-529.

55. American Academy of Pediatrics Committee on Children With Disabilities. "Care Coordination: Integrating Health and Related Systems of Care for Children With Special Health Care Needs," Pediatrics. 1999; 104: 978 - 981. Page 5

54. Kastner T and Walsh K. "Cost of Care Coordination for Children With Special Health Care Needs." Archives of Pediatrics and Adolescent Medicine.1999;153:1003-1004.

53. Ronder R, Kastner T, Parker S, Walsh K. "Serving People With Developmental Disabilities in Medicaid Managed Care." Managed Care Quarterly. 1999;7(2):23-30.

52. Walsh K and Kastner T. "Quality of Health Care for People With Developmental Disabilities: The Challenge of Managed Care." Mental Retardation. 1999;37(1):1-15.

51. American Academy of Pediatrics Committee on Children With Disabilities. "Learning Disabilities, Dyslexia, and Vision: A Subject Review." Pediatrics. 1998;102:1217-1219.

50. Strauss D, Kastner T, Shavelle R. " Mortality of Adults With Developmental Disabilities Living in California Institutions and Community Care, 1985-1994." Mental Retardation. 1998;360-371.

49. American Academy of Pediatrics Committee on Children With Disabilities. "Managed Care and Children With Special Health Care Needs: A Subject Review." Pediatrics. 1998;102:657-660.

48. Strauss D, Kastner T, Chaney R. "Tubefeeding." Pediatrics. 1998;100:160.

47. Kastner T. "Cost-Effectiveness of Evaluating the New Technologies." Mental Retardation. 1997;35(6):475-476

46. Kastner T, Walsh K, Criscione T. "Medicaid Managed Care for People With Developmental Disabilities Part I: Overview and Implications," Mental Retardation. 1997;35:257-269.

45. Kastner T, Walsh K, Criscione T. "Medicaid Managed Care for People With Developmental Disabilities Part II: Models, Demonstration Projects and Technical Elements," Mental Retardation. 1997;35:270-285.

44. Walsh K, Kastner T, Criscione T. "Characteristics of Hospitalizations for People With Developmental Disabilities." American Journal on Mental Retardation. 1997;101:505-520.

43. Strauss D, Kastner T, Chaney R. "Tubefeeding and Mortality in Severely Disabled Children With Mental Retardation." Pediatrics. 1997;99:358-362.

42. Kastner T, Walsh K, Criscione T. "Access to Preventive Clinical Services," in Access to Preventive Clinical Services for People With Disabilities: A Guide to Healthy Persons 2000, Silver Spring MD. American Association of University Affiliated Programs. 1996.

41. Kastner T. "Consumer Behavior in the Health Care Marketplace." Journal of the American Medical Association. 1996;275:1083-1084.

40. Strauss D & Kastner T. "Comparative Mortality in Institutions and the Community of People With Developmental Disabilities." American Journal on Mental Retardation. 1996;101:26-40.

39. Walsh K, Kastner T, Huron R. "Further Comment on Crack Cocaine Study." Developmental And Behavioral Pediatrics. 1996,17:107-109.

38. Kastner T. "The Medical Outcomes Study." Journal of the American Medical Society. 1996:2775;1084.

37. Kastner T, Walsh K. "Are Gastric Emptying Procedures Effective in Treating Gastresophageal Reflux in Children?" Journal of The American College of Surgeons, 1995;181:383-384.

36. Criscione T, Walsh K, Kastner T. "An Evaluation of Care Coordination in Controlling Inpatient Hospital Utilization of People With Developmental Disabilities." Mental Retardation. 1995;33:364-373.

35. Kastner T, Haller K, Shenouda N, Walsh K. "Sleep-Wake Schedule Disorders?" Journal of The American Academy of Child and Adolescent Psychiatry, 1995;34:1557-1558.

34. Selvaggi Fadden K & Kastner T. "Common Behavioral and Emotional Problems in Children With Developmental Disabilities." Pediatric Annals. 1995;24:1-4.

33. Philips M, O'Chesky S, Kastner T. "Defining Nurse Practitioner and Nursing Roles." Nurse Practitioner. 1995;20:10-12.

32. Kastner T, Walsh K. "Interdisciplinary Team Review of Psychotropic Drug Use in Community Settings," Mental Retardation, 1994;32;243-245.

31. Kastner T, Walsh K, Criscione T. "The Role of Tube Feeding in the Mortality of Profoundly Retarded People With Severe Mental Retardation,"Archives of Pediatric and Adolescent Medicine, 1994;148;537-538.

30. Criscione T, Kastner T, O'Brien D, Nathanson. "Replication of a Managed Health Care Initiative for People With Mental Retardation Living in the Community." Mental Retardation, 1994;32:43-52.

29. Kastner T, Walsh K, Criscione T. "Policy Issues in Health Care Reform for People With Mental Retardation," Washington D.C.. President's Committee on Mental Retardation, 1994.

28. Kastner T, Walsh K, Finesmith R. "Long-Term Administration of Valproic Acid in the Treatment of Affective Symptoms in People With Mental Retardation," Journal of Clinical Psychopharmacology, 1993;13:448-451

27. Criscione T, Kastner T, Walsh K, Nathanson R. "Managed Health Care Services for People With Mental Retardation: Impact on Inpatient Parameters." Mental Retardation, 1993:31;297-306.

26. Kastner T, Nathanson R, Friedman D. "Mortality in Persons with Mental Retardation Living in the Community." American Journal on Mental Retardation, 1993;98:285-292.

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24. Kastner T. "Does Gastrostomy and Fundoplication Prevent Aspiration Pneumonia in Mentally Retarded Persons?" American Journal on Mental Retardation, 1992;97:351-353.

23. Kastner T, Selvaggi K. "Pinworm Eradication in Community Residential Settings for People With Developmental Disabilities ." Mental Retardation, 1992; 30:237-240.

22. Kastner T, Berkner P, DeSouza T, Wight D, Waran S. "Rett Syndrome and Elevated Urinary Dolichols." J Am Acad Child Adol Psychiatry, 1992;31:567-568.

21. Friedman D, Kastner T, Plummer A, Ruiz M, Henning D. "Adverse Behavioral Effects in Individuals With Mental Retardation and Mood Disorders Treated With Carbamazepine." American Journal on Mental Retardation, 1992;96:541-546.

20. Kastner T, Friedman D, Pond,W. "Carbamazepine-Induced Hyponatremia in Patients with Mental Retardation." American Journal on Mental Retardation, 1992;96534-540.

19. Kastner T, Friedman D. "Verapamil and Valproic Acid Treatment of Prolonged Mania" J Am Acad Child Adol Psychiatry, 1992; 31:271-275.

18. Kastner T. "Who Cares For The Young Adult With Mental Retardation?" J Developmental Behavioral Pediatrics, 1991;12:196-198.

17. Kastner T, Ruiz P, Nathanson R. "Immunization Patterns of High Risk Infants with Pertussis Vaccine." J Developmental Behavioral Pediatrics, 1991;12:38-41.

16. Kastner T, Luckhardt J. "Medical Services for the Developmentally Disabled." New Jersey Medicine,1990;87:819-822.

15. Kastner T, Friedman D, Burlingham K. "Metoprolol for Control of Aggressive Behavior in Individuals with Mental Retardation." American Family Practice, 1990;42:1585-1588.

14. Kastner T, Friedman D, Plummer A, Ruiz M, Henning D. "Use of Valproic Acid in the Treatment of Children with Mental Retardation and Mood Disorders." Pediatrics,1990;86:467-472.

13. Kastner T, DeLotto P, Scagnelli B. "Proposed Guidelines for Agencies Serving Persons with Developmental Disabilities and Infection with HIV." Mental Retardation, 1990;28:138-145.

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11. Friedman D, Kastner T, Pond W, O'Brien D. "Thyroid Dysfunction in Individuals with Down Syndrome." Archives of Internal Medicine 1989;149:1990-1993.

10. Kastner T, Nathanson R, Marchetti A, Pincus S. "HIV and Developmental Services for Adults." Mental Retardation 1989;27:229-232.

9. Kastner T, Hickman M, Bellehumier D. "The Provision of Services to People with Mental Retardation and Subsequent Infection with HIV." American Journal of Public Health 1989;79:491-495.

8. Kastner T, Friedman D, O'Brien D, Albrecht K. "Child Life Services and Persons with Mental Retardation.: Journal of Developmental and Behavioral Pediatrics 1989: 10:198-200.

7. Kastner T, Berkner P, Skolnick L. "Chronic Ipecac Poisoning in Infancy: A Case Report." Pediatrics 1988;82(3):384-385.

6. Kastner T. "Medical Decision Making for the Mentally Impaired." New England Journal of Medicine 1988;318:1400.

5. Ziring P, Kastner T, Friedman D, Pond W, Barnett M, Sonnenberg E. "Provision of Health Care for Persons with Developmental Disabilities Living in the Community: The Morristown Model." Journal of the American Medical Association 1988;260(10):1439-1444.

4. Barnett M, Friedman D, Kastner T. "The Prevalence of Mitral Valve Prolapse in Patients with Down Syndrome: Implications for Dental Management." Oral Surgery, Oral Medicine, Oral-pathology 1988:66:445-447.

3. Kastner T, Friedman D. "Pediatric Acquired Immune Deficiency Syndrome and the Prevention of Mental Retardation." Developmental and Behavioral Pediatrics 1988;9(1):47-48.

2. Crain E, Gerschel J, Kadar A, Kastner T. "Dose Related Effects of Nebulized Metaproterenol in Asthmatic Children." Pediatric Emergency Care 1987;3(3):143-146.

1. Kastner T. "The Twin Paradox." Colgate Journal of the Sciences, Hamilton, New York, 1975.

Abstracts:

9. Kastner T. "Developmental Disabilities Health Alliance/Robert Wood Johnson Health Network Care Management Program for People With Developmental Disabilities in New Jersey, USA." Journal of Intellectual Disability Research, 2000;44:342.

8. Burns C, Liptak G, Birenbaum A, Kastner T. "Health Care for Children With Disabilities in the New Millennium." Journal of Intellectual Disability Research, 2000;44:225.

7. Kastner T, Friedman D, Plummer A, Ruiz M, Henning D. "Valproic Acid in the Treatment of Children with Mental Retardation and Mood Symptomatology." Pediatric Digest, 1991;2:8-9

6. Szymanski L, Zeanak C, Lourie I, Kastner T, Prizant B, Feinstein O. "Mental Health Issues with Developmentally Handicapped Infants and Toddlers." Scientific Proceedings of the Annual Meeting of the American Academy of Child and Adolescent Psychiatry. 1989 Vol. V, S14-A, P. 41.

5. Kastner T, Ruiz M, Hill P, Harris N, Hurd K, Blanton C, Vayianos M. "Medical and Developmental Aspects of High Risk Follow-up." Scientific Proceedings of the Annual Meeting of the Academy of Child and Adolescent Psychiatry 1989 Vol. V, S-14E, P. 42.

4. Kastner T. "Juvenile Delinquency and Developmental Disabilities: Failure of the Multisystem Approach. Presented at the Annual Meeting of the American Association on Mental Deficiency, May 1986.

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Invited Articles:

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40. Walsh K, Kastner T. "The Medical Home for Persons With Developmental Disabilities." Healthy Times. The Arc of New Jersey. Winter, 2009.

39. Walsh K, Kastner T, Savage, T. "Service, Legal and Ethical Issues Pertaining to the Continuum of Needs of Adolescents With Special Health Care Needs and Disabilities." In Promoting Health Care Transitions for Adolescents With Special Health Care Needs and Developmental Disabilities. Betz, Cecily PhD, RN, FAAN, Nehring WM. RN, PhD, FAAN, FAAMR (Ed). Paul H. Brooks Publishing Co. 2007.

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19. Selvaggi Fadden K & Kastner T. "Common Behavioral and Emotional Problems in Children With Developmental Disabilities." Pediatric Annals. 1995;24:1-4.

18. Kastner T. "Down Syndrome." in Barkley (ed.):Caring for Individuals With Down Syndrome and Their Families. Report of the Third Ross Roundtable on Critical Issues in Family Medicine. Columbus Ohio, Ross Products Division, Abbott Laboratories. (1995)

17. Selvaggi-Fadden K, Kastner T. "Nutritional Aspects of Developmental Disabilities" in Rickert (ed) Adolescent Nutrition: Assessment and Management., Boston MA, Little Brown and Co.,1995

16. Kastner T, Walsh K. "Medical Care for Children With Mental Retardation, " in Parker S, Zuckerman B. (ed.) Behavioral and Developmental Pediatrics: A Handbook for Primary Care, Boston, MA: Little Brown and Co. ,1995

15. Kastner T. "Prospects for Health Care Reform." Mental Retardation, 1992;30: v-viii.

14. Crocker A, Cohen H, Kastner T, eds. HIV and Developmental Disabilities: A Resource for Service Providers Baltimore, Md: Brooks Publishing Co., 1992

13. Kastner T, Nathanson R, Marchetti A. "The Epidemiology of HIV Infection in Adults With Developmental Disabilities" In: Crocker A, Cohen H, Kastner T, eds. HIV and Developmental Disabilities Baltimore, Md: Brooks Publishing Co., 1992

12. Nathanson R, Kastner T,Marchetti A. "A Review of State HIV Guidelines and Policies" In: Crocker A, Cohen H, Kastner T, eds. HIV and Developmental Disabilities Baltimore, Md: Brooks Publishing Co., 1992

11. Kastner T. "Developmental Disabilities in Adolescence." In: Friedman S,Fischer M, Schonberg K, eds. Comprehensive Adolescent Health Care St. Louis, Mo: Quality Medical Publishing Inc., 1992

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10. Kastner T. "Specialized Services. "In: Health Care for Youth and Adults with Developmental Disabilities: Policies and Partnerships" American Association of University Affiliated Programs for Persons with Developmental Disabilities. Silver Spring Md 1992.

9. Kastner T. "Fragile X Syndrome and Sensory Integration Therapy: A Dissenting Opinion." Fragile X: In Focus 1991;1:3-4.

8. Kastner T, Nathanson R, Rudigier A, Harvey D, Grosz J, Hopkins K, Murphy A. "Human Immunodeficiency Virus and Developmental Disabilities: A Leader's Guide for a Workshop." American Association of University Affiliated Programs for Persons with Developmental Disabilities. Silver Spring, Md 1991.

7. Kastner T, Nathanson R. "Technical Report on Developmental Disabilities and HIV Infection: HIV Infection in Adults with Developmental Disabilities." American Association of University Affiliated Programs for Persons with Developmental Disabilities. Silver Spring Md. January 1990

6. Kastner T, Friedman D, O'Brien D, Pond W. "Health Care and Mental Illness in Persons with Mental Retardation." The Habilitative Mental Healthcare Newsletter. March 1990

5. Crocker A, Cohen H, Diamond G, Seibert J, Sulkes S, Levinson W, Kastner T, Rudigier A. "Guide-lines on Developmental Services for Children and Adults with HIV Infection." American Association of University Affiliated Programs for Person with Developmental Disabilities, Silver Spring MD, August 1988.

4. Kastner, T. "AIDS and Mental Retardation." News and Notes, The National Newsletter of the American Association on Mental Retardation, June 1988.

3. Kastner T. "Emergency Management of Parasitic Infections." In: Crain E, Gerschel J, eds. A Clinical Manual of Emergency Pediatrics. Norwalk , CT: Appleton-Century Crofts, 1986.

2. Kastner T. "Hand Injuries." In:Crain E, Gerschel J, eds. A Clinical Manual of Emergency Pediatrics. Norwalk, CT: Appleton-Century Crofts, 1986.

1. Kastner T. "HIV and Developmental Disabilities." AAMR New Jersey Chapter Newsletter, May 1988.

PRESENTATIONS:

182: May 2021: "Overview of NYS OPWDD." Albert Einstein College of Medicine, RFK CERC Faculty. Bronx, NY.

181: October 2018: "Introduction to Disability." Albert Einstein College of Medicine, 2nd Year Medical Students. Bronx, NY.

180: October 2018: "Transformation of RFK CERC: October 15, 2018." Bronx, New York.

179: October 2018: "Introduction to RFK CERC." Bronx, New York.

178: June 2018: "The Transition from Medicaid Service Coordination to Care Coordination Organizations." Bronx Developmental Disabilities Planning Council. Bronx, NY.

177: April 2018: "Transformation of RFK CERC: April 9, 2018." Bronx, New York.

176: January 2018: "Proposal to Create a CCO/HH." Bronx, New York.

175: October 2017: "Transformation of RFK CERC: October 16, 2017." Bronx, New York.

174: July 2017: "Health Care Reform." Roundtable at Autism Care Conference. AUCD, Bethesda Md.

173: July 2017: "Integrated Primary Care/Mental Health Services." Department of Family Medicine. Montefiore Medical Center. Bronx, New York.

172: November 2016: "Health Care Reform." Roundtable at AUCD Conference. Washington DC.

171: November 2016: "The Developmental Disabilities Health Home." AUCD, Washington DC.

170: November 2015: "The Developmental Disabilities Health Home." Keynote Presentation. Bronx DD Council. Bronx, New York.

169: November 2015: "Outcomes of the Developmental Disabilities Health Home." Association of University Centers of Excellence in Disability. Washington DC.

168: November 2015: "Integrated Primary Care/Mental Health Services for Children and Adults with Intellectual and Developmental Disabilities." Barnett Lecture Keynote Presentation. Montefiore Medical Center. Bronx, New York.

167. September 2015 "Update on CERC Integration with Montefiore." Rose F, Kennedy Center Children's Evaluation and Rehabilitation Center. Bronx, NY.

166. June 2015 "An Overview of the Children's Health Home." Rose F, Kennedy Center Children's Evaluation and Rehabilitation Center. Bronx, NY.

165. April 2015 "Financing Children's Services in the New York State Developmental Disabilities System." Rose F, Kennedy Center Children's Evaluation and Rehabilitation Center. Bronx, NY.

164. January 2014 "Financing of the New York State Developmental Disabilities System." Bronx DDSO Support Coordination Training. Bronx, NY.

163. January 2014 "An Overview of the Health Home for People with Intellectual and Developmental Disabilities." Bronx DDSO Support Coordination Training. Bronx, NY.

162. November 2013 "An Overview of the Financing of the New York State Developmental Disabilities System." Bronx DD Planning Council 2013 Health Conference. Bronx, NY.

161. May 2013 "An Overview of the Children's System of Care." Mainstreaming Medical Care 2013 Conference. New Brunswick, NJ.

160. May 2013 "Health Home Services for Persons with Developmental Disabilities." HealthFirst 2013 Spring Health Home Symposium. NY, NY.

159. November 2012 "The Developmental Disabilities Health Home." Bronx DD Planning Council 2012 Health Conference. Bronx, NY

158. October 2012 "Integrating Physical and Mental Health Services for Persons with Developmental Disabilities." HealthFirst 2012 Fall Symposium, Managing Long-Term Services and Supports. New Brunswick, NJ.

157. August 2012 "The Developmental Disabilities Health Home." Arkansas State Providers Association, Hot Springs Arkansas.

156. June 2012 "The Developmental Disabilities Health Home." ICNY. New York, New York

155. March 2012 "Mental Health Services for Persons with Developmental Disabilities." Arkansas State Hospital. Little Rock, Arkansas

154. March 2011 "Mental Health Services for Persons with Developmental Disabilities." Open Horizons Conference. Warren, Arkansas

153. March 2010 "Adequate Insurance to Pay for Needed Services." Community Care Consortium for Children and Youth With Special Health Care Needs Summit. Freehold, New Jersey

152. January 2010 "Financing the Medical Home," Pediatric Council on Research and Education, Trenton, New Jersey

151. June 2008 "Medical Home for Persons With Developmental Disabilities," Mainstreaming Medical Care Arc of New Jersey, Princeton, New Jersey

150. April 2007 "Diagnosis and Treatment of Children with Autism," Linden, New Jersey

149. February 2005 "Medicaid Managed Care for Persons With Developmental Disabilities" US Surgeon General's National Conference on Health Disparities, Atlanta, Georgia

148. November 2004 "Diagnosis of Psychiatric Disorders in People With Developmental Disabilities," Trinitas Hospital, SCCAT, West Windsor, New Jersey

147. June 2004 "Diagnosis of Psychiatric Disorders in People With Developmental Disabilities," Mainstreaming Medical Care Arc of New Jersey, Princeton, New Jersey

146. September 2002 "A Comprehensive Model of Care Management and Primary Care for Persons with Developmental Disabilities in Managed Care: Developmental Disabilities Health Alliance, Inc." Healthcare Financial Management Association. Woodbridge, New Jersey.

145. June 2002 "Developmental Disabilities Health Alliance, Inc: A Business Model for Managed Care for Persons with Developmental Disabilities." Center for Health Care Strategies. Denver, Colorado.

144. May 2002 "A Model of Comprehensive Primary Care in Managed Care." Mainstreaming Medical Care, Princeton, New Jersey.

143. May 2002 "Business Opportunities for Mental Health Providers in Medicaid Managed Care." New Jersey Association of Mental Health Agencies. Princeton, New Jersey.

142. April 2002 "National Medical Management Forum." Blue Cross Blue Shield Association. Chicago, Illinois.

141. April 2002 "The Child With Chronic Illness." Childrens Health Initiative. Newark, New Jersey.

140. January 2002 "Behavioral Aspects of Epilepsy in Persons With Developmental Disabilities." Exceptional Parent Conference. Woodcliff Lakes, New Jersey.

139. September 2001"Aging and Developmental Disabilities." Vineland Developmental Center, Vineland, New Jersey.

138. May 2001 "Continuing Medical Education in Developmental Disabilities." Mainstreaming Medical Care, Princeton, New Jersey.

137. December 2000 "Practice Pattern Profiling and Risk Assessment in Developmental Disabilities Community Services." State of Illinois Department of Human Services, Chicago, Illinois.

136. May 2000 "Health Care for People With Developmental Disabilities," American Association on Mental Retardation 2000 National Conference, New Orleans.

135. September 1999 "Integration in Managed Care for People With Developmental Disabilities," American Academy of Cerebral Palsy and Developmental Medicine, 1999 National Conference, Washington DC.

134. May 1999 "Managed Care for People With Developmental Disabilities," American Association on Mental Retardation 1999 National Conference, New Orleans.

133. May 1999 "Community Mental Health Services for People With Developmental Disabilities. Mainstreaming Medical Care, Princeton, New Jersey.

132. October 1998 "Health Care Outcomes for People With Developmental Disabilities," United Cerebral Palsy Associations of New York 1998 National Conference, Albany New York.

131. October 1998 "Managed Care for Persons With Developmental Disabilities," New Jersey Family Support Awareness Day. Lawrenceville, New Jersey.

130. September 1998 "Quality Management for Children With Special Health care Needs in Medicaid Managed Care," Society for Developmental and Behavioral Pediatrics 1998 National Conference, Cleveland, Ohio.

129. June 1998 "Disease Management for People With Developmental Disabilities," American Association on Mental Retardation 1998 National Conference, San Diego.

128. November 1997 "Medicaid Managed Care for Persons With Developmental Disabilities," Pediatric Grand Rounds. New York Medical College, Valhalla, New York.

127. June 1997 "Disease Management and Persons With Developmental Disabilities," Making Managed Care Work for People With Disabilities New Jersey Law Center, New Brunswick, New Jersey

126. May 1997 "Strategic Planning for Managed Care and Persons With Developmental Disabilities," American Association on Mental Retardation 1997 National Conference, New York.

125. April 1997 "Managed Care and Persons With Developmental Disabilities," Laurie Lecture, Robert Wood Johnson School of Medicine, Piscataway, New Jersey

124. April 1997 "Measuring Quality of Care in Developmental Disabilities," Ohio Department of Mental Retardation and Developmental Disabilities, Columbus, Ohio

123. March 1997 "Managed Care and Persons With Developmental Disabilities," Young Adult Institute 1997 National Conference, New York, New York

122. June 1996 "Managed Care and Persons With Developmental Disabilities," American Association on Mental Retardation 1996 National Conference, San Antonio, Texas

121. June 1996 "Effects of the DRG Payment System on Hospitalization Outcomes for People With Developmental Disabilities." American Association on Mental Retardation 1996 Conference, San Antonio, Texas.

120. June 1996 "An Overview of Psychiatric Disorders in People With Developmental Disabilities," Independent Care, Milwaukee, Wisconsin

119. May 1996 "Developing Capitation Rates for People With Developmental Disabilities" Mainstreaming Medical Care, Princeton, New Jersey

118. May 1996 "An Overview of New Jersey's Managed Care Program for People With Developmental Disabilities" Mainstreaming Medical Care, Princeton, New Jersey

117. April 1996 "An Overview of Psychiatric Disorders in People With Developmental Disabilities," New Jersey AAME, Princeton, New Jersey

116. February 1996 "An Overview of Treatments in Autism," Morris/Union Jointure Commission

115. June 1995 "Health Care Reform and Persons With Developmental Disabilities," American Association on Mental Retardation 1995 National Conference, San Francisco, California.

114. June 1995 "Quality of Life Outcomes for People With Mental Retardation and Epilepsy Treated With Felbatol," American Association on Mental Retardation 1995 National Conference, San Francisco, California.

113. June 1995 "An Overview of Managed Care for People With Developmental Disabilities," Association Court Monitors and Special Masters, San Francisco, California.

112. May 1995 "Health Care Reform" Mainstreaming Medical Care, Princeton, New Jersey

111. May 1994 "The President's Committee on Mental Retardation: Health Care Reform Proposals" American Association on Mental Retardation, Boston, MA

110. May 1994 "Health Care Reform Proposals" Mainstreaming Medical Care, New Brunswick, New Jersey

109. April 1994 "Health Care Reform", President's Committee on Mental Retardation, Alexandria Virginia

108. April 1994 "Shared Responsibilities: Mental Illness and Developmental Disabilities", Morristown Memorial Hospital, Morristown, New Jersey

107. March 1994 "Standards of Care in Developmental Disabilities", Children's Evaluation and Rehabilitation Center, Bronx, NY

106. February 1994 "Primary Care for People with Down Syndrome Across the Lifespan", Hunterdon Developmental Center, Clinton, New Jersey

105. December 1993 "Managed Care for People With Developmental Disabilities," New Jersey Division of Developmental Disabilities, Budd Lake, NJ

104. December 1993 "Health Care Reform and Persons With Developmental Disabilities", National Association of Superintendents of Facilities for Persons With Mental Retardation, 1993 National Conference, Washington, D.C.

103. November 1993 "Standards of Care in Developmental Disabilities", National Physician's Conference on Developmental Disabilities Medicine, New Orleans, LA

102. November 1993 "What's New in Developmental Disabilities Medicine: The 10 Best Articles of 1991", National Physician's Conference on Developmental Disabilities Medicine, New Orleans, LA

101. November 1993 "The Relationship Between Epilepsy and Mental Illness", Epilepsy Foundation of New Jersey, Somerset, New Jersey

100. October 1993 "The Impact of Managed Care on Inpatient Utilization by Persons With Developmental Disabilities", American Association of University Affiliated Programs National Conference, Bethesda, Maryland

99. June 1993 "Health Care Reform and Persons With Developmental Disabilities", American Association on Mental Retardation 1993 National Conference, Washington, D.C.

98. June 1993 "Mortality and Advanced Directives for People With Developmental Disabilities", American Association on Mental Retardation 1993 National Conference, Washington, D.C.

97. November 1992 "Medical and Psychiatric Management for People With Developmental Disabilities", New Jersey Chapter of the American Academy of Pediatrics, Jamesburg, New Jersey

96. October 1992 "AIDS and Developmental Disabilities: Where Are We Now? Were Should We Go?" National Physician's Conference on Developmental Disabilities Medicine New Orleans, LA

95. October 1992 "What's New in Developmental Disabilities Medicine: The 10 Best Articles of 1991", National Physician's Conference on Developmental Disabilities Medicine New Orleans, LA

94. July 1992 "HIV and Developmental Disabilities: An Overview", New Jersey Association of Community Residential Providers, Trenton, New Jersey

93. June 1992 " Infectious Disease Concerns", Warren Day Training, Washington Township New Jersey

92. May 1992 "An Introduction to Managed Care for Persons With Developmental Disabilities", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

91. May 1992 "Transdisciplinary Evaluation of Behavioral Symptoms in People With Developmental Disabilities", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

90. May 1992 "Health Care Services for Children and Adults With Developmental Disabilities: The Morristown Model", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

89. May 1992 "AIDS: The Facts", American Association on Mental Retardation 1992 National Conference, New Orleans, LA.

88. March 1992 "AIDS: Myths and Reality", Tri-State Camping Conference, E. Brunswick, New Jersey

87. March 1992 "Ethical Concerns in Caring for People With Special Needs", University of Iowa, Iowa Hospital School, Iowa City, Iowa

86. February 1992 "Ethical Concerns in Caring for People With Special Needs", Phoenix Association for Retarded Citizens, Phoenix, AZ.

76-85. "Primary Care for People with Down Syndrome Across the Lifespan", A 12/1991 - 5/1992 series of lectures at 10 New Jersey Family Practice Residency Training Programs. Sponsored by the NJ Association for Retarded Citizens and the New Jersey Academy of Medicine.

75. November 1991 "HIV and Adults With Developmental Disabilities", American Association on Mental Retardation Training Institute on HIV and Developmental Disabilities, Philadelphia, PA

74. November 1991 "Recent Advances in Medication Use", Epilepsy Foundation of New Jersey, Middlesex, New Jersey

73. October 1991 "Transdisciplinary Evaluation of People With Developmental Disabilities and Behavioral Complaints", American Association of University Based Programs, Austin, Texas

72. October 1991 "A Statewide Public and Professional Education Program on Fragile X Syndrome", American Association of University Based Programs, Austin, Texas

71. October 1991 "HIV and Developmental Disabilities", N.J. Association for Retarded Citizens, New Brunswick, N.J.

70. October 1991 "Epilepsy, Mood Disorders and Anticonvulsant Medication", Region IX, American Association on Mental Retardation, Princeton, New Jersey

69. October 1991 "An Overview of Managed Care", Region IX, American Association on Mental Retardation, Princeton, New Jersey

68. August 1991 "HIV and Developmental Disabilities: A National Teleconference", In Collaboration With the ARC of the United States

67. June 1991 "Update on Immunizations" St. Joseph School for the Blind, Jersey City

66. May 1991 "Infectious Disease Concems for Community Health Care Providers", American Association on Mental Retardation 1991 National Conference, Washington D.C.

65. May 1991 "Valproate Therapy for People With Developmental Disabilities and Mood Symptoms", 1991 American Association on Mental Retardation National Conference, Washington D.C.

64. April 1991 "Epilepsy, Mood Disorders, and Anticonvulsant Medication", Association for Retarded Citizens, New Brunswick, New Jersey

63. April 1991 "People With Developmental Disabilities and Mental Illness", Community Health Law Project Lecture Series, New Brunswick, New Jersey

62. March 1991 "Adults With Developmental Disabilities and HIV Infection", Third National HIV Infection and Developmental Disabilities Conference, Alexandria Virginia

61. March 1991 "Specialized Services", Health Care for Youth and Adults with Developmental Disabilities: Policies and Partnerships, Rockville Maryland

60. January 1991 "Down Syndrome and The Primary Care Physician", Family Practice Grand Rounds,UMDNJ-RWJ, New Brunswick, NJ

50-59. "Health Care Problems of People With Developmental Disabilities - 12/1990 - 5/1991 Epilepsy, Mood Disorders, and Anticonvulsant Medication", A series of lectures at 10 New Jersey Family Practice Residency Training Programs. Sponsored by the NJ Association for Retarded Citizens and the New Jersey Academy of Medicine.

49. November 1990 "An Overview of HIV and Developmental Disabilities", United States Association for Retarded Citizens 40th Annual Conference, Tampa Florida

48. November 1990 "Agency Preparedness in Serving People With HIV and Developmental Disabilities", United States Association for Retarded Citizens 40th Annual Conference, Tampa Florida

47. October 1990 "A Comparison of National Surveys on HIV and Developmental Disabilities 1987 vs. 1990", American Association of University Based Programs, Madison Wisconsin

46. October 1990 "The Morristown Model: A Managed Health Care Inititative For Adults With Developmental Disabilties", American Association of University Based Programs, Madison Wisconsin

45. October 1990 "Epilepsy, Mood Disorders, And Anticonvulsant Medication", N.J. Association for Retarded Citizens, New Brunswick, N.J.

44. October 1990 "HIV and Developmental Disabilities", Region IX, American Association on Mental Retardation, Wilmington, Delaware

43. October 1990 "The Ethical Function Of The Interdisciplinary Team", Region IX, American Association on Mental Retardation, Wilmington, Delaware

42. October 1990 "Obsessive Compulsive Disorder in People With Developmental Disabilities", Region IX, American Association on Mental Retardation, Wilmington, Delaware

41. September 1990 "Principles of Health Care For People With Developmental Disabilities" NJ Chapter, American Association on Mental Retardation, Piscataway, N.J.

40. June 1990 "The Relationship Between Mood Disorders And Epilepsy" Children's Evaluation And Rehabilitation Center, Bronx, N.Y

39. June 1990 "Perinatal Causes of Developmental Disabilities" The New Jersey Coalition for the Prevention Of Developmental Disabilities, Morris, N.J.

38. May 1990 "A National Survey of Developmental Disabilities and HIV: Policy and Epidemiology" American Association on Mental Retardation 1990 National Conference, Atlanta, Georgia

37. May 1990 "Exceptional Health Care: Health Care Abstracts for Physicians Serving People With Developmental Disabilities" American Association on Mental Retardation 1990 National Conference, Atlanta, Georgia

36. May 1990 "Valproate Therapy of People With Mood Symptoms And Developmental Disabilities" American Association on Mental Retardation 1990 National Conference, Atlanta, Georgia

35. May 1990 "Three Models of Health Care Delivery: The Morristown Model" New Jersey A.R.C. Mainstreaming Medical Care Conference, New Brunswick, N.J.

34. May 1990 "The Relationship Between Undiagnosed Medical Disorders and Behavioral Outbursts." New Jersey A.R.C. Mainstreaming Medical Care Conference, New Brunswick, N.J.

33. April 1990 "Psychopharmacologic Treatment of Psychiatric Illness in People With Developmental Disabilities" Hunterdon Developmental Center, Clinton N.J.

32. January 1990 "Recent Advances in Down Syndrome" Grand Rounds, Pediatric Department, Morristown Memorial Hospital, Morristown, N.J.

31. January 1990 "Psychopharmacologic Treatment of Psychiatric Illness in People With Developmental Disabilities" Woodbine Developmental Center, Woodbine N.J

30. November 1989 "HIV and Adults with Developmental Disabilities," A National Conference on Developmental Disabilities and HIV: Accessing the System, Bethesda, MD.

29. October 1989 "Mortality in Community Settings," AAMR Region IX Conference Williamsburg, VA

28. October 1989 "Planning Services for Persons with HIV and Developmental Disabilities," NJ ARC Annual Conference. Princeton, NJ.

27. October 1989 "Mental Health Issues with Developmentally Handicapped Infants and Toddlers: Medical Issues," Thirty-sixth Annual Meeting of the American Academy of Child and Adolescent Psychiatry. New York, NY.

26. September 1989 "Planning Services for Persons with HIV and Developmental Disabilities," Maryland AAMR Annual conference. Timonium, MD.

25. September 1989 "Mental Illness and Mental Retardation," NJ AAMR Annual Conference. Piscataway, NJ.

24. September 1989 "HIV and Developmental Disabilities: A New Jersey Perspective," NJ ARC Annual Leadership Conference. Princeton NJ.

23. June 1989 "Adults with Developmental Disabilities and HIV," at Children, AIDS and Developmental Disabilities: Challenge for the 1990's, sponsored by the Rose F. Kennedy Center of Albert Einstein College of Medicine, New York, NY.

22. June 1989 "AIDS and Institutions for Persons with Developmental Disabilities and Mental Illness," Twelfth Annual Conference of the National Association of Protection and Advocacy Systems, Bethesda, MD.

21. June 1989 "Pediatric AIDS: Legal and Service Issues," Twelfth Annual Conference of the National Association of Protection and Advocacy Systems, Bethesda, MD.

20. May 1989 "HIV and Developmental Services," American Association of Mental Retardation, 1989 National Conference, Chicago IL.

19. May 1989 "Mortality in Persons with Mental Retardation Living in the Community," American Association on Mental Retardation, 1989 National Conference, Chicago, IL.

18. May 1989 "Immunization of High Risk Infants with Pertussis Vaccine," American Association on Mental Retardation, 1989 National Conference, Chicago, IL.

17. May 1989 "Health Care Coordination and Its Effects on Inpatient Parameters for Persons with Mental Retardation," American Association on Mental Retardation, 1989 National Conference, Chicago, IL.

16. November 1988 "HIV and Developmental Services for Adults," First National HIV and Developmental Disabilities Conference, Administration on Developmental Disabilities, Bethesda, MD.

15. September 1988 "AIDS and Developmental Disabilities: Guidelines for Service Agencies," Association for the Advancement of the Mentally Handicapped, 1988 Board Meeting, Elizabeth, NJ.

14. July 1988 "AIDS and Developmental Disabilities: Issues for Service Providers," New Jersey Association of Community Residential Providers. Trenton, NJ.

13. May 1988 "Impact of AIDS on Mental Retardation/Developmental Disabilities Services," American Association on Mental Retardation 1988 National Conference, Washington, DC.

12. May 1988 "Ethical Considerations in Medical Decision Making: AIDS and Persons with Mental Retardation," American Association on Mental Retardation 1988 National Conference, Washington DC.

11. May 1988 "Bioethical Frontiers in Mental Retardation: The Impact of the AIDS Epidemic on Persons with Developmental Disabilities," American Association on Mental Retardation 1988 National Conference, Washington DC.

10. May 1988 "Models for Community Based Services to Persons with Developmental Disabilities and Mental Illness," American Association on Mental Retardation 1988 National Conference, Washington DC.

9. October 1987 "AIDS and Developmental Disabilities," American Association on Mental Deficiency, 1987 Region IX Annual Meeting. Martinsville, WV.

8. September 1987 "Communicable Diseases," United Cerebral Palsy Staff Training Institute. New York, NY

7. June 1987 "A System for the Provision of Comprehensive Health Care for Persons with Developmental Disabilities Living in the Community," Rose F. Kennedy Center Annual Alumni Meeting. Bronx, NY.

6. May 1987 "Managing Clients with Mental Retardation and AIDS: Medical Aspects," American Association on Mental Deficiency 1987 Annual Meeting. Los Angeles, CA.

5. April 1987 "Delivering Coordinated and Comprehensive Health Care Services to Children and Adults with Mental Retardation," Young Adult Institute 8th Annual National Conference. New York, NY.

4. April 1987 "Implications of Public Law 99-457," Keynote Speech, Tri-County Resource Symposium. Morristown, NJ.

3. November 1985 "The Relationship Between Learning Disabilities and Juvenile Delinquency," Straight Talk, WOR-TV.

2. October 1985 "Developmental Disabilities and Juvenile Delinquency," Third Annual Juvenile Health Care Conference, American Correctional Health Services Association. New York, NY.

1. September 1985 "Spina Bifida," Ithaca College School of Physical Therapy.

DHS EXHIBIT 2-A:

Expert Report in the Matter of

CHRISTINE MCAULIFFE, as Special
Administrator of the ESTATE OF
DAVID CAINS CLAIMANT
V CLAIM NO. 220374
THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) RESPONDENT

Prepared by

Theodore Kastner MD, MS

January 5, 2023

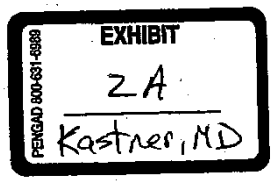
Professional Background:

I began work in the field of Intellectual and Developmental Disabilities (IDD) in 1976 when I was employed as a direct service professional (DSP) by the Massachusetts Association for the Blind. I graduated from Colgate University in 1977 and from the University of Connecticut School of Medicine in 1981. I completed my residency in Pediatrics in 1984 at the Jacobi Hospital. I completed my training in the care of children and adults with developmental disabilities and handicapping conditions at the Rose F. Kennedy Center of the Albert Einstein College of Medicine in 1986. In addition, in 1997 I received a Master of Science in population health from the University of Wisconsin.

I am triple-boarded in Pediatrics, Developmental Behavioral Pediatrics and Neurodevelopmental Disabilities. I also hold Board Certification from the American Board of Medical Management. Until 2019, I held an appointment at the Albert Einstein College of Medicine where I was Professor of Pediatrics and Professor of Psychiatry. I also held the Ruth L. Gottesman Chair in Developmental Medicine. My primary responsibilities involved my role as Co-Director of the Rose F. Kennedy Center at the Albert Einstein College of Medicine where he was the Principal Investigator on four federally-funded training programs and half a dozen state and local contracts.

In 2019 I left academia to serve as the Commissioner NYS Office for Persons With Developmental Disabilities where I lead an organization with a budget of $10B and 19,000 employees serving 140,000 individuals with intellectual and developmental disabilities (I/DD). I led the NYS response to COVID-19 in support of persons with I/DD.

I am a leading authority on the health care concerns of people with I/DD. For more than 25 years I served as the President of Developmental Disabilities Health Alliance, Inc.



(DDHA), at one time the largest provider of health care services to persons with I/DD in New Jersey. DDHA is nationally recognized for its health care programs for persons with I/DD having received an award a CMS Health Care Innovations Challenge Award. We served approximately 4,000 people with IDD at 9 locations across New Jersey and New York City.

I have been a member of many professional groups in the field of developmental disabilities including the National Board of Directors of the American Association on Mental Retardation (AAMR), the New Jersey State Interagency Coordinating Council (SICC), and the NJ Department of Human Services Medicaid Managed Care Task Force. I have been a recipient of more than a dozen awards and honors including the Health Care Professional of the Year Award by the New Jersey Association for Retarded Citizens (now The Arc) and the Elizabeth M. Boggs Citizenship Award from the United Cerebral Palsy Associations of New Jersey.

I have presented at over 200 conferences and training workshops and authored more than 100 publications in the field, of which approximately 70 were peer-reviewed. I have served as a consultant to the US Department of Justice, The Province of Ontario, and dozens of States in regard to various matters related to IDD including the operation of more than 50 ICF IDDs. I have consulted in general and medical malpractice matters. I have consulted to private corporations and foundations.

I have been admitted as an expert witness in approximately 10 Federal District Courts. I have been qualified as an expert witness in dozens of cases and testified in regard to all matters related to the IDD field including: the clinical management of health, behavioral and psychiatric conditions; organizational management and compliance; cause of death, life expectancy, and economic damages: standards of care including federal, state and professional standards; and other topics.

I have been retained by the State of Arkansas Department of Human Services to serve as an expert witness in the above-referenced matter. I will testify about the applicable standards of care, the medical management of Mr. Cains, the behavioral management of Mr. Cains, the timelines and other facts related to his demise, the cause of death, life expectancy, damages and whatever other topics are relevant to the matter. I will base my opinions upon a reasonable degree of medical certainty.

Document Review:

The following materials were reviewed:

2015 Psychology Report 001
2016 Psychology Report 001
2017 Psychology Report 001
2018 Psychology Report 001
2018_IPP_001
2019_IPP_001
2017 - 2019 Physician's Orders_001
AmyJones_PDFTran (8)
BHDC Maltreatment Report 5-2020 (BHDC IRIS 87707)
BHDC Policy I-D-2_001
Cains David Behavior Reports for PA VA 04062007-05292020
CainsDavid Psychological Evaluation 05282020
CainsDavidIPP 07182019
Claimant's_3rd_Suppl_Responses_to_Discovery_001 (2)
Claim-Ex1-DRA-2015report
Claim-Ex2-DRA-Jan2016report
Claim-Ex3-DRA-Oct2020letter
EMS Report_001
Hamid (2)
I-D-4 2018 Policy
Medical_Clearance_Restraint_Use_001
NCI-training-instructor-guidance-resource
Physician's Orders 6-2020_001
Ryann_Campos_5-12-22 (2)
Samuel_Scow_5-5-22 (2)
Social History
State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities
Tyler_Mattson_Depo_001 (Compressed)

Standard for Opinions:

Throughout this report I will use the standard, "based upon a reasonable degree of medical certainty," to express my opinions. This report does not contain every opinion which I may offer during testimony. I reserve the right to amend this report and my opinions based upon any information that I subsequently acquire or any other issue.

Background and History

[redacted]

According to the Social History:

> In 1991 at the age of fourteen, David was standing and looking out the door and witnessed someone come out of the bushes and shoot and kill his father. Understandably, David began to have problems after this and subsequently his mother sought assistance through Friendship Services, Inc. in Russellville as she was unable to handle him alone.

Further,

[redacted]

[redacted]

Mr. Cains' guardian, his mother Charlene Robinson, had been very pleased with the care provided at BHDC. Ms. Robinson was offered the option of community services and continued to want HDC placement for David. She was opposed to Community Placement.

[redacted]

[redacted]

Mr. Cains had a Behavior Treatment Program which targeted Noncompliance and Physical Aggression. He was extremely difficult to manage from a behavioral perspective. Between 4/6/2007 and 5/29/2020, Mr. Cains engaged in 187 aggressive incidents, usually in the form of aggressive behavior towards staff. Staff were well aware of this risk and generally took precautions to protect themselves, Mr. Cains and other individuals. Staff responded to these 187 incidents with personal or mechanical restraints in 120 instances. This included Mr. Cains being restrained on a Papoose Board on 77 occasions or being placed in personal holds on 43 occasions. In 67 instances staff were able to use procedures other than restraint including counseling, redirection, graduated guidance or other techniques. There was one episode of vomiting associated with use of personal holds on 5/11/2012.

[redacted]

On June 13, 2020, Mr. Cains experience some type of GI distress and was taken to the rest room. Upon exiting the rest room Mr. Cains became agitated and aggressive. After pulling papers off of the wall, he turned his attention to his staff, Tyler Mattson. He charged Mr. Mattson, attacking him with his hands.

O. And then you said he --- he came after you?
A. Yes. He charged me.
O. Charged you.
A. Yes
O. Okay. Does --- describe that for me as best you
A. He just went to grab me. I mean
O. How far away from him were you?
A. Maybe from here to that pole. Maybe a little bit shorter.
O. This pole?
A. Yeah, about there. Maybe to the chair.
O. My chair?
A. Between there.
O. Okay.
A. Yeah.
O. So about 6, 7 feet?
A. Maybe.
O. Okay. And when you say "charge, " was he running at you?
A. Lunging, running. Yeah, just --- he went after me. He didn't really have room to necessarily run.
(Mattson Deposition, Pages 101-103)

Mr. Cains' large mass and speed combined to led both Mr. Cains and Mr. Mattson to fall to the floor.

O. How did he fall? What caused him --
A. We
O. to fall?
A. We just kind of tripped up on each other. It was all one big motion, like I had said.
O. Okay. And why did you not attempt to do the blocking technique where you block and kind of get out of his way?
A. I wouldn't have had room. I was against a ledge.
O. You were against a ledge?
A. Yes.
O. Why would a ledge prevent you from being able to do like this?
A. Because I would have fell over be- if he had put

enough momentum into me.
O. Okay. So you guys fall- over.
(Mattson Deposition, Pages 105)

At that time, Mr. Mattson, consistent with BDSC policy, employed personal holds to address "dangerous behavior" in an "emergency situation." A short-time later he was assisted by two staff. Mr. Cains was lying on his side while staff held his wrists and legs to prevent injury to themselves, Mr. Cains or other individuals.

The exact timelines of what occurred are not known since there was no clock in the location where Mr. Cains fell. According to Disability Rights Arkansas, "All times are estimates as there are not any clocks visible in the area..." (DRA October 2020 Page 2)



Findings and Expert Opinions

The following is a list of the opinions offered in this report. As noted, the opinions in this report are not considered exhaustive and I reserve the right to amend this report and my opinions based upon any information that I subsequently acquire.

1. Based upon a reasonable degree of medical certainty, Mr. Cains [redacted] 11)

2. Based upon a reasonable degree of medical certainty, Mr. Cains is entirely responsible for th[redacted] Page 11)

3. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13 at approximately 11:30AM was [redacted] (Page 14)

4. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was not the use of restraints in [redacted] because there is no reasonable theory to support the claim that the use of restraints could lead to vomiting in general. (Page 15)

5. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was not the use of restraints in [redacted] ecause there is insufficient empirical evidence to support the claim that the use of restraints, [redacted] led to Mr. Cains vomiting on June 13, 2020. (Page 18)

6. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was [redacted]

7a. Based upon a reasonable degree of medical certainty, Mr. Mattson and other BHDC staff met and/or exceeded the standard of care for a Residential Care Technician (RCT) staff when they applied personal holds to Mr. Cains. (Page 22)

7b. Based upon a reasonable degree of medical certainty, Mr. Mattson and other BHDC staff complied with all applicable BHDC policies and procedures when engaged in applying personal holds to Mr. Cains. (Page 22)

8. Based upon a reasonable degree of medical certainty, inconsistencies in the recording of the timing of the events was so frequent that all time notations, with the exception of when EMS was notified and the team dispatched, should be considered approximate. (Page 28)

9. Based upon a reasonable degree of medical certainty, BHDC staff met the standard of care for providing emergency medical services to Mr. Cains. Based upon a reasonable degree of medical certainty, there were no unreasonable delays in calling 911. (Page 33)

10. Based upon a reasonable degree of medical certainty, BHDC medical staff could [redacted] (Page 35)

11. Based upon a reasonable degree of medical certainty, Mr. Cains would have died even if BHDC contacted EMS at the moment when Mr. Cains was noted to have stopped breathing. Any alleged delay in contacting EMS, even a delay associated with staff performing their assessment, was inconsequential. (Page 36)

12a. Based upon a reasonable degree of medical certainty, at all times, the BHDC operated within the standard of care for a publicly-funded ICF IDD. (Page 39)

12b Further, based upon a reasonable degree of medical certainty, at all times, the staff of BHDC provided care consistent with the standard of care for their training and scope of practice. (Page 39)

13. Based upon a reasonable degree of medical certainty, Mr. Cains was positioned appropriately – on his side when he was vomiting and, later, on his back when he needed CPR. (Page 45)

14. Based upon a reasonable degree of medical certainty, Mr. Cains death was not accompanied by severe pain. (Page 50)

15. Based upon a reasonable degree of medical certainty, Mr. Cains had a life expectancy of only 6 more years. (Page 51)

Findings and Expert Opinions

1. Based upon a reasonable degree of medical certainty, Mr. Cain [redacted]

2. Based upon a reasonable degree of medical certainty, Mr. Cains is entirely responsible for the fact that [redacted]

As the events were described by Mr. Mattson, it was Mr. Cain who initiated the process which led to both Mr. Mattson and Mr. Cains to fall onto the floor. Mr. Cains lunged and charged at Mr. Mattson. Given Mr. Cains' size, this assault caused Mr. Mattson to fall backward and Mr. Cains to land on top of or adjacent to him.

Mr. Mattson, the only eyewitness, describes the events as follows:

> O. Okay. What's he doing as he's sitting there?
> A. Just sitting. He was just sitting look- staring out.
> O. All right. And then what happens?
> A. He grabs a paper and goes after me.
> O. Where does he grab paper from?
> A. There was a flyer on the wall.
> O. Does he stand up to grab it?
> A. He grabbed it and then went after me. He was sitting down and then went after me to attack me.
> O. What --- what kind of paper was it? Just---
> A. It was just it was just a printout paper, just a flyer.
> O. What did he do with it after grabs it?
> A. He was throwing it and then went after me. He threw it down and then went after me.
> O. He threw it down and then went after you. Did he say anything?
> A. No. He just screamed "bitch."
> O. He screamed "bitch"?
> A. Yes. That I recall.
> O. Anything else that you recall him saying?
> A. No.
> O. And then you said he --- he came after you?

A. Yes. He charged me.
O. Charged you.
A. Yes
O. Okay. Does --- describe that for me as best you
A. He just went to grab me. I mean
O. How far away from him were you?
A. Maybe from here to that pole. Maybe a little bit shorter.
O. This pole?
A. Yeah, about there. Maybe to the chair.
O. My chair?
A. Between there.
O. Okay.
A. Yeah.
O. So about 6, 7 feet?
A. Maybe.
O. Okay. And when you say "charge, " was he running at you?
A. Lunging, running. Yeah, just --- he went after me. He didn't really have room to necessarily run.
O. Can you --- do you mind standing up and showing me?
A. I -- as best as I can. Like, he just --- it was like just a classic --- like, he went to grab at me.
O. Okay. Went to grab at you?
A. Yes.
O. So not swing at you but grab at you?
A. Grab at me.
But, like he had --- like --- like I said, that distressed face.
O. Okay.
A. Like he was agitated and --- yeah.
O. All right. And --- okay. And then what --- what did you do?
A. I tried to hold him and we kind of just fell.
O. How did you try to hold him? Stand up and show us, please.
A. Like, I was --- like, I just kind of grabbed him by the shoulders the best as I could, you know, with him -- momentum --
O. Yeah.
A. and we just kind of stumbled over, you know.
O. Okay. So he's coming at you arms raised like this?
A. It --- yeah.
O. Like this?

A. Outwards, yeah.
And I just kind of grabbed, like, here and here. I didn't, like, grab by the wrist. You know, but, like we kind of just awkwardly fell.
O. Did he get a --- did he get a grip around you?
A No, he didn't get a grip around me.
O. Okay. Sorry.
A. No, that's all right.
O. This won't take long.
So he's coming at you. Show me and slowly so --- so I can really see it: What --- what do --- show me what you do as he's coming at he's lunging at you.
What do you do? What do your hands do? Where do they go?
A. I'm just like --- biceps, like, arms.
O. Okay. So you would have your --- your right hand on his left bicep and your left hand on his right bicep?
A. Yeah.
O. Pretty much?
A. Pretty much, yeah.
O. Okay. And --- and do you stay there locked like ---
A. No.
Like we tripped. Like --- like, we lust kind of fumbled around. Because it was, like, all in one biq momentum, you know.
O. Uh-huh. And you fall to the ground, and he hits his face on the ground?
A. No, he didn't hit his face on the ground.
It wasn't a fast f all. It was a controlled fall as much as I could control it. (Mattson Deposition Pages 100-103)

Mr. Mattson's description indicates that he attempted appropriate blocking technique (engaging the inside of the arms at the biceps) but was unable to prevent the fall as he was moving backwards. Mr. Cains landed with his front side towards the ground, indicating that it was Mr. Cains' momentum which carried them to the ground.

In reviewing his Written Statement, Mr. Mattson offered the same description:
O. And it says I -- and it says that you "Applied personals by grabbing his arms. He ended up falling over. I did not land on him. "
So that's a little different than what you're describing now. What you're kind of describing now is that he lunged at you, and you grabbed him by the biceps; and then the force caused you guys to tumble over.

That's what you're describing now, but that's different. than what you wrote here. So how -- I mean, how can you .?
A. He fell and I just kind of went with him, as far as I can recall.
O. How did he fall? What caused him --
A. We
O. to fall?
A. We just kind of tripped up on each other. It was all one big motion, like I had said.
O. Okay. And why did you not attempt to do the blocking technique where you block and kind of get out of his way?
A. I wouldn't have had room. I was against a ledge.
O. You were against a ledge?
A. Yes.
O. Why would a ledge prevent you from being able to do like this?
A. Because I would have fell over be- if he had put enough momentum into me. (Mattson Deposition, Pages 104-105)

Mr. Cains was fully responsible for aggressively moving toward Mr. Mattson and causing them both to land on the ground, an outcome which was contraindicated by the [redacted] here is no evidence that Mr. Mattson initiated any action which would have led to a fall to the ground. The responsibility for violating the medical order to remain upright after his meal rests entirely on Mr. Cains.

3. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13 at approximately 11:30AM was [redacted]
Nowhere in the medical record, including the IPP and Nutritional Evaluation, is there any evidence that Mr. Cains was reported to have vomiting [redacted]
Therefore, it seems unlikely that the only time that vomiting, [redacted] would occur would be during the use of restraints on June 13, 2020.
Dr. Brown-Forestiere agreed with this opinion when she opined that the additional risk of [redacted]

According to Dr. Brown-Forestiere, Mr. Cains was only [redacted] Therefore, Dr. Brown-Forestiere's testimony suggests that the primary reason for Mr. Cains vomiting on June 13, 2020 was the use of restraints.

4. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was not the use of restraints in [redacted] because there is no reasonable theory to support the claim that the use of restraints could lead to vomiting in general.

Dr. Brown-Forestiere offered a theory to support her allegation that restraint use caused Mr. Cains to vomit when he was restrained on June 13, 2020. As Dr. Brown-Forestiere explained it, with Mr. Cains in the prone position, pressure on the chest and abdomen would force stomach contents into the esophagus in the form of vomiting. This pressure would occur as a result of muscular contraction associated with a fight or flight reaction and from external pressure applied to the abdomen/chest. As she described it:

> Okay.
> And, Dr. Brown, are you also able to say within a reasonable degree of medical certainty what caused Mr. Cains to vomit?
> A Yeah. I -- I think that I can. So there's a lot of physics to this. I'll try -- I'll do my best to make it in easy to understand terms.
> So, when someone is struggling in this scenario that's been described by all the participants, someone who is struggling has what's called a fight or flight response, meaning they're -- have adrenaline surges and they are fight -- essentially fighting for their life.
> Their muscles constrict to fend off what they feel is an attack. They -- so their muscles constrict, their breathing increases, (interference) set of physiological (interference) leads to increased (interference) pressure which is the pressure in your chest.
> And it also constricts the abdomen which increases the intra-abdominal pressure. Both of these are cavities in the body where the stomach is.
> The inferior or superior aspect on top of the stomach is the diaphragm in the chest above that, and just below it, the abdomen. And increased pressure on both of these does place increased pressure on the stomach and from the sides.
> Obviously, there's a definitive end to the body and how far it can stretch. And also his left side being on the floor is another definitive mechanical block as to where it can expand.
> So, if you think of the stomach as a cube, it's having pressure from all different angles for -- because

of the struggle and the position and the increased pressures. And it caused him to vomit.
Additionally, [redacted] made him a little more at risk than normal for being under pressure for causing vomiting.
[redacted]
So the struggle with being restrained on the floor definitely led to him fighting that. And there's pressure coming from multiple different reasons, regions, and it caused vomiting.
Q Okay. So if I'm hearing you correctly, Dr. Brown, and in my very nonmedical layman's terms, intense struggle that produces a fight or flight reflex and adrenaline can, is itself, increases the likelihood of triggering vomiting; is that correct?
A In this scenario, it would, yes, due to gravity.
Q And being on his left side increased the likelihood that the pressure, intrathoracic pressure and gravity, would --
A Yeah.
Q -- trigger vomiting?
A Yeah. Unfortunately, the stomach -- and the stomach's on the left. So it means everything in the body and all the pressures above him were pressing down onto the stomach; which was butting up against the ground, essentially.
Q Okay.
And the fact that he had -- if I'm hearing you correctly, [redacted] that also increased the likelihood that he would vomit?
A Correct.

(Brown-Forestiere Deposition Pages 12-15)

Dr. Brown's theory relies upon several claims for which supporting facts do not exist.

First, Dr. Brown-Forestiere claimed that Mr. Cains experienced a "fight or flight reaction" because he believed that he was "essentially fighting for (their) life" when he was placed in restraints.

> Q And so what -- how do you know or do you -- did you form an opinion on the intensity of this, quote/unquote, struggle, unquote?
> A I mean, form an opinion, I don't know if it's a direct opinion or just a typical instinctual reaction. Your body instinctually fights as hard as it possibly can to survive when it feels that it may be dying. Regardless of your mental state, your body fights, so --
> Q Are you --
> A -- I would assume that it would be a very intense struggle, given your death being the alternative.
> (Brown-Forestiere Deposition Page 66)

However, there is no reason to suggest that Mr. Cains would have thought that he would die as a result of being restrained. Mr. Cains had been restrained approximately 120 times during a 13-year period and had learned that if he was able to calm himself, he would be released from restraints. Indeed, in every one of the 120 instances when restraints were previously used, he was removed from restraints without harm. Mr. Cains had no reason to fear that anything different would occur on June 13, 2020.

Second, Dr. Brown-Forestiere later admitted that she did not know when during the course of a restraint, Mr. Cains would have experienced such a fight or flight reaction or whether he would have experienced such a reaction at all:

> Well, I mean, so when the -- when the restraint started, there was a behavioral episode. Was he fighting for his life then?
> A What he thought was a fight for his life and when it came down to that, I can't say.
> (Brown-Forestiere Deposition Page 75-76)

The "fight or flight" reaction, if it occurred at all, could have occurred after the restraint were removed.

Third, Dr. Brown-Forestiere alleged that:

> "pressures above him were pressing down onto the stomach; which was butting up against the ground, essentially."

However, staff statements indicate that they exerted no pressure on the abdomen or chest during the period of restraint prior to the onset of vomiting. They restrained his arms and legs. They did not employ holds that put pressure on the body. Dr. Brown-Forestiere later admitted to this fact during her testimony:

> Q And so they were just -- if they were holding his arms and his feet, what -- is it your opinion that somebody was on top of him?
> A I -- no. I didn't say that either.
> Q So he wasn't pinned to the floor --
> A I believe that --
> Q -- (inaudible)?
> A -- Tyler had his hand on his waist holding him on the ground. He said he was holding him there but did not place his weight on him.
> (Brown-Forestiere Deposition Page 77)

5. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was not the use of restraints in [redacted] because there is <u>insufficient empirical evidence</u> to support the claim that the use of restraints, in the presence of a diagnosis of GERD, led to Mr. Cains vomiting on June 13, 2020.

In explaining her theory, Dr. Brown-Forestiere opined that the struggle associated with being placed in restraints "often induces vomiting."

> Q Okay.
> A The only thing I can rule in is that a struggle often induces vomiting.
> Q Okay. You don't know how intense the struggle here was?
> A If you're fighting for your life, I think it's without question that it's going to be --
> Q Well --
> A -- an intense fight.
> (Brown-Forestiere Deposition, Page 75)

Her use of the word "often" implies causality - when one thing occurs, a second "often" follows. However, the evidence does not support her opinion that being placed in restraints "often" induces vomiting.

I reviewed the 515-page document titled, "Cains David Behavior Reports for PA VA 04062007-05292020." The document includes notes describing 193 sperate instances over 13 years, between 4/6/2007 and 5/29/2020, when Mr. Cains presented with challenging behavior. The materials document 187 aggressive incidents, usually in the form of aggressive behavior towards staff.

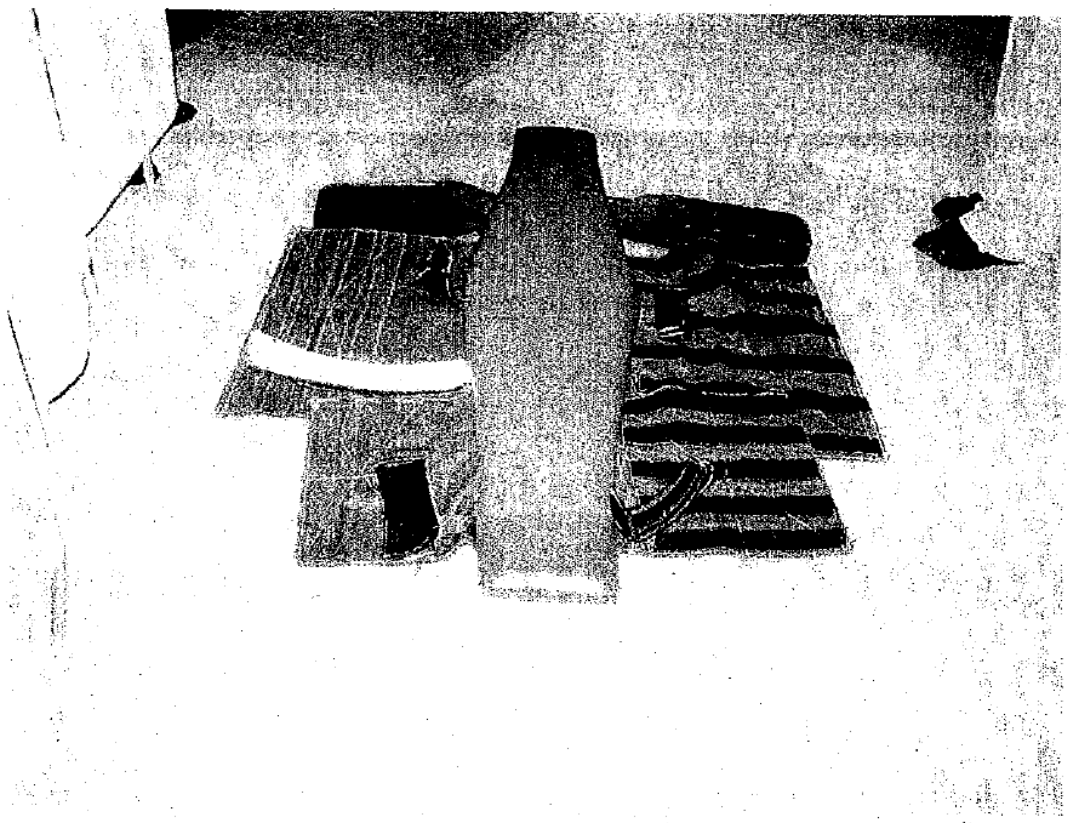
Clearly, Mr. Cains was extremely difficult to manage from a behavioral perspective. Staff were well aware of this risk and generally took precautions to protect themselves, Mr. Cains and other individuals. Staff responded to these 187 incidents with personal or mechanical restraints in 120 instances. This included Mr. Cains being restrained on a Papoose Board on 77 occasions or being placed in personal holds on 43 occasions. In 67 instances staff were able to use procedures other than restraint including counseling, redirection, graduated guidance or other techniques. There was one episode of vomiting associated with use of personal holds on 5/11/2012.

The occurrence of one instance of vomiting during 120 episodes of mechanical restraint is insufficient to demonstrate causality between restraint use and vomiting. Even if the incident of 6/13/2020 was included, 2 episodes of vomiting occurring in 121 incidents of restraint use is far fewer than the number that would be needed to demonstrate causality. As Dr. Brown-Forestiere implies, proof of causality suggests the expectation of vomiting occurring "often" when restraints are used.

Vomiting did not occur in 119 of the 121 incidents of restraint use. In other words, if restraints caused Mr. Cains to vomit, why is it that 98% of restraint use was not accompanied by vomiting? The answer to that question is that restraints did not cause Mr. Cains to vomit.

Further, if Dr. Brown-Forestiere's theory were correct, forms of restraint associated with high body pressures should be associated with higher rates of vomiting. The pressures applied to the chest and abdomen during the use of a full-body restraint, such as a Papoose Board, are much greater than those that are generated by personal holds. Based upon Dr. Brown-Forestiere's theory, the use of a Papoose Board should be associated with rates of vomiting that are higher than the rates of vomiting observed when using low pressure restraints such as personal holds.

The attached picture is a Papoose Board currently in use by Arkansas DHS. You will see that the individual is placed on the Board and that he/she is then wrapped with three bands of fabric which cover the lower extremities, the torso, and the head. There are 15 separate Velcro straps which are used to attach the bands of fabric together, creating a snug fit and pressure across the entire body.



Dr. Brown-Forestiere's theory predicts that vomiting should be more common when using a Papoose Board in comparison to low-pressure physical holds of the extremities.

However, the evidence does not support her theory. At no time, during 77 instances in which the Papoose Board was used, did Mr. Cains vomit. In spite of the fact that the intraabdominal pressures generated during use of the Papoose Board are much higher than those generated during the use of personal holds on the extremities, there was never an instance of vomiting associated with the use of a Papoose Board. This lack of empirical evidence disproves her theory that possible increases in chest/abdominal pressure associated with physical restraint were associated with Mr. Cains' vomiting.

6. Based upon a reasonable degree of medical certainty, the cause of Mr. Cains' vomiting on June 13, 2020 at approximately 11:30AM was [redacted]

[redacted]

Second, just prior to the behavioral outburst on June 13, 2020, Mr. Cains wanted to use the restroom. Further, Mr. Cains was noted to have had a bowel movement at approximately the same time that he began vomiting. There is one prior episode when Mr. Cains was noted to have soiled himself just prior to a behavioral outburst. (8/22/2012.) There are no other episodes of restraint associated with the occurrence of a bowel movement during the restraint. It is quite possible that Mr. Cains had [redacted] This type of explanation is consistent with the lack of a pattern of vomiting or diarrhea during previous episodes of restraint. Indeed, Dr. Brown Forestiere could not rule out the possibility of a gastrointestinal illness.

[redacted]

(Brown Forestiere Deposition Page 74)

[redacted]

[redacted]

(Brown Forestiere Deposition Page 74)

7a. Based upon a reasonable degree of medical certainty, Mr. Mattson and other BHDC staff met and/or exceeded the standard of care for a Residential Care Technician (RCT) staff when they applied personal holds to Mr. Cains.

7b. Based upon a reasonable degree of medical certainty, Mr. Mattson and other BHDC staff complied with all applicable BHDC policies and procedures when engaged in applying personal holds to Mr. Cains.

Staff exercised reasonable judgment in keeping Mr. Cains on the floor because he exhibited behaviors which, according to definitions contained within BHDC policies, were maladaptive.

BHDC Policy defines Maladaptive Behaviors as follows:

> "Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, of the destruction of property." DDS Policy 3011-D

It is important to note that that the definition contained within DDS Policy 3011 does not distinguish between behaviors that result in injury or behaviors that have the potential for causing injury. Both types of behavior are considered maladaptive behaviors and subject to staff intervention. BHDC policy permits the use of personal holds in either situation.

> Personal Restraint: In order to prevent personal injury or serious property damage, the individual or a portion of an individual's body is immobilized by another person or persons in order to prevent personal injury or serious property damage. (DDS Policy 3011)

Mr. Mattson noted (above) that he was attacked by Mr. Cains and that this led them both to fall to the ground. Ryann Campos wrote in her statement that Mr. Cains spat at Mr. Mattson:

> I, Ryann Campos, arrived at commons for lunch. I noticed David Cains on his left side fighting Tyler in the lobby, Tyler on his left side holding both wrists. I saw David Cains look up at Tyler and spit." Ryann Campos Witness Statement

Mr. Cains harmed staff and attempted to further harm them but was prevented from doing so by staff use of personal holds. DDS policy allows the use of restraints in such emergency situations. According to DDS Policy 3011:

> Emergency Procedures. Nothing in this policy prohibits the use of emergency restraint (mechanical or personal), confiscation of any item used in a threatening manner, or removal from the environment for the purpose of protecting the individual and others around him/her. (DDS Policy 3011-D)

Staff testified repeatedly that they used personal holds only for the purpose of protecting themselves and Mr. Cains and that the holds would have been removed once Mr. Cains calmed down. Again, this is consistent with BHDC policy and their training.

> The goal of restraint use is to keep the client and/or others safe until control of the client's behavior can be returned safely to the client (i.e., when the client has calmed). Clients shall be released from physical restraint immediately upon calming. "Calm" for a client is defined by the Interdisciplinary Team ("IDT"). The typical definition of calm is below, but the IDT may identify client-specific indicators in the client's IPP and/or Safety Plan:
> i. The client's behavior indicates that the dangerous behavior has ceased;
> ii. The client is quiet and responding to staff in their normal tone of voice or other way of communicating; and
> iii. The client demonstrates cooperation by accepting direction from staff (BHDC Policy I-D-4 Documentation and Response to Maladaptive Behaviors.)

It would be absurd to expect an RTC, as has been suggested (Mattson Deposition, Page 117), that Mr. Cains be released from a personal hold, allow staff or Mr. Cains to be injured, and, then reapply a personal hold. Staff need to be able to use professional judgment when providing services which incorporates regard to their own personal safety. Injured staff cannot provide care.

Mr. Mattson. Ms. Jones and Ms. Campos all testified that they felt they were acting within the scope of their training and practice in applying personal holds in order to protect Mr. Cains and themselves.

Ms. Campos stated:

> A. All I remember was he was trying to kick. And I was trying to help him from hurting himself or others.
> (Campos Deposition Page 61)

And:

> Q You don't know if, after you got there, there was an attempt made to de-escalate the situation without --
> A I mean, we were --

Q -- without grabbing him?
A All I seen when I got there was him kicking, him on his side and still trying to kick.
I mean -- and I tried to refrain anybody get hurt or him hurting himself. And I know I keep repeating myself and repeating myself. But I don't know -- I -- I can't talk for them. And I don't know how else to word it.
(Campos Deposition, Page 80)

Ms. Jones stated:

Okay. But yet you -- you, for at least a minute, participated in a restraint with him on the ground?
A Yes. If we had been able to get him up off the ground we would've.
Q Well, I haven't heard that you tried.
Nowhere in any of this, nowhere in anything you've said, has it been suggested that any of you attempted just to get him back on his feet at any point before he started choking.
A He hadn't calmed down at any point until he started choking.
Q Okay. And you made the determination then that the threat of him spitting or the threat of him slapping behind himself at Tyler was a greater risk than his doctor's orders to not put him on the ground after meals because he might literally aspirate and die just like he did? That was the decision y'all made?
A We didn't make that decision. It --
Q But you did. You did make that decision. And he's dead.
A We made the decision to try to keep from harming himself or someone else. No one asked for what happened. No one wanted that --
Q He didn't harm himself. He didn't harm himself. You three harmed him.
A Had he gotten up -- we did not harm him. We -- we did not harm him.
Q All right.

(Jones Deposition Page 111-112)

As noted in Mr. Mattson's direct testimony, once on the ground, staff demonstrated appropriate judgment in continuing to try to get Mr. Cains to calm down while providing

"personal holds."

Q. How is that violent?
A. He was trying to resist and fight me.
Q. Why didn't you just get up and give him some space, since he's already on the ground?
A. Because he was still very agitated.
Q. Well, so. Let him calm down. Why didn't you do that ?
A. That's not how it works immediately.
Q. How does it work?
A. He would still be agitated afterwards, very agitated.
Q. So you thought it was best to turn him on his side and pin him on the ground?
A. I was wanting him to calm down. I was trying to get him to calm down.
Q. And in order to get
A. And I was talking f was talking to him.
Q. And, in order to get what you wanted, you turned him over, held him down?
A. I—I guess.
Q. Well, you guess. You were there.
Did you --- is that what happened or isn't it?
A. Yes.
Q. Okay. And is he talking to you at that point?
A. No. He was just still insulting me, calling me names and screaming.
Q. Okay.
A. That was another semblance that I knew he was still agitated.
Q. Yep, still- agitated. Still needed to be controlled. I understand.
About how long --- and where are your hands on him?
A. On, like, his upper body. Not, like, on his head but, like, controlling his arms. Like, not on his wrists but just --- generally his arms, upper area.
Q. Okay. And you didn't have one hand on his --- on his --- kind of his waist, one on his shoulder area?
A. No.
I just had, like, his arms controlled. Because that's --- he was infamous for, like, kind of winging back and swinging at you.
Q. Well, you said he's never hit you before. He's

never made contact with you before.
So how can you tell me he's infamous for that?
A. Because I have seen him do it. I have --- and just from hearsay.

(Mattson Deposition Pages 109-111)

As is evident in the tone of this exchange, Mr. Mattson may have been intimidated by Plaintiff's Counsel. This had an impact on his ability to offer consistent testimony about the facts of the matter. For example, in the testimony above, Mr. Mattson responded to a leading question which could be used to infer that he restrained Mr. Cains for the purpose of holding Mr. Cains to the ground:

Q. So you thought it was best to turn him on his side and pin him on the ground?
A. I was wanting him to calm down. I was trying to get him to calm down.
Q. And in order to get
A. And I was talking I was talking to him.
Q. And, in order to get what you wanted, you turned him over, held him down?
A. I—I guess.
Q. Well, you guess. You were there.
Did you --- is that what happened or isn't it?
A. Yes.
B. (Mattson Deposition Pages 109-111)

However, after an objection by Respondent's Counsel, Mr. Mattson was able to collect himself and clarify his earlier testimony. Mr. Mattson did not "pin" Mr. Cains to the ground as was implied during his questioning. Rather Mr. Mattson was restraining one arm from striking staff – consistent with BHDC policy and the training and scope of practice for an RCT.

Q. Okay.
A. I wasn't really necessarily restraining. I was more holding. But -- there was --- like, I was actively restraining the right arm because he was like ---
Q. Okay.
A. --- that's whenever he was, like, most flailing.
Q. Okay. And I know you weren't holding his head. That's not what. I'm -- what I'm suggesting. I just want to make sure I understand where your hands were.
A. Right.
Q. How long did this go on before Mandy Jones arrived on the scene?

A. That f can remember a couple of minutes. It wasn't shortly after because her area ---
Q. Okay. (Mattson Deposition Pages 112-113)

In spite of this testimony, leading questions, incorporating the allegation that Mr. Cains was "pinned" to the floor, continued to be used.

Q. Well, I mean, you know, I have two-year-old twin toddlers. They get aggressive sometimes. I tell you what I don't do. I don't pin them to the ground until --
MR. COLLINS: Are you testifying now?
Q. -- until they say what I want to them to say. Okay. So how long are you three pinning him to the ground now that Ryann's arrived before he starts changing colors and defecating on himself and throwing up and dying?
A. As best I remember, maybe a minute or two. But it Wasn't very it wasn't a long time.

(Mattson Deposition Pages 116)

(8) Based upon a reasonable degree of medical certainty, inconsistencies in the recording of the timing of the events was so frequent that all time notations, with the exception of when EMS was notified and the team dispatched, should be considered approximate.

The estimated timeframes contained within the EMS Report are internally inconsistent and unreliable. Witnesses appeared to pick and choose whatever "facts" were contained within the EMS Report to support their opinions. However, because of the internal consistencies, the EMS Report cannot reliably be used to create a timeline at all.

The EMS Report (Page 3) identifies the alleged timing of events which transpired. The following timelines are asserted in the document:



[redacted]

Depending on how they are interpreted, the relative timing of these separate events can be used to create timelines which suggest that the "collapse" or the "arrest" and the initiation of CPR and call to 911 occurred at 11:22, 11:29, 11:30. 11:35, 11:37 or 11:38. Several examples are described below.

[redacted]



(Scow Deposition Page 10-11)

Dr. Brown-Forestiere also alleged that there was an 8-minute delay between the respiratory obstruction and calling 911. Following a very leading question from Mr. Gillespie, Dr. Brown-Forestiere agrees – 8 minutes.



And again



Later in her testimony, Dr, Brown-Forestiere indicates that she is not sure whether the 8 minute period refers to the time between Mr. Cains falling to the floor and 911 being called or the time between the onset of choking and the call to 911.

Q Is that what you would conclude?
A I conclude the same thing I've concluded 12 times.
It's my understanding it was eight minutes from the --
Q But I --
A -- initial onset of the situation to when the phone

call was made.
Q Okay.
A And how they concluded that timeline is not up to me. I just read it.
Q Okay. And, when you say from the beginning of the, of the incident, you talking from the time that he choked or from the time that the incident started?
A You would have to ask the people involved. I was not there.
Q Okay. So fair enough. Fair enough. You don't know?
A I -- I was given the information, same as you, that it took eight minutes.

(Brown-Forestiere Deposition Page 96)

However, the timeframes present in the EMS Report contradict the testimony of both Mr. Scow and Dr. Brown-Forestiere. [redacted] Both Mr. Scow and Dr. Brown-Forestiere are incorrect. From their testimony, I cannot determine why they both make the same error. It is a remarkable coincidence that two witnesses, independent of esach other, make the same obvious mistake.

This may be explained by Dr. Brown-Forestiere when she suggests that she did not reach an independent conclusion that there was an 8-minute delay. She acknowledged that this opinion was provided to her:

> Q Okay. So fair enough. Fair enough. You don't know?
> A I -- I was given the information, same as you, that it took eight minutes.
> (Brown-Forestiere Deposition Page 96)

The source of this "information" is not disclosed.

[redacted]



However, there are additional internal inconsistencies.



[redacted]

The lack of accurate timekeeping in the EMS Report is obvious. Staff acknowledge in their depositions that they are making guesses as to when the event may have begun and how much time was required for each step in the response. DRA noted that there were no clocks in the area and as a result, they recommended that all time notations should be considered estimates. The 2020DRA Report stated that:

> All times are estimates as there are not any clocks visible in the area..." (DRA October 2020 Page 2)

The best explanation for these inconsistencies is that the report is erroneous. Mr. Scow acknowledged that errors can occur when he is taking the history and simultaneously rendering care:

> On scene, when we're doing patient care, if it's a hectic environment, you take what information you can get and you try to get as clear as -- clearest picture of what you can get when you're asking questions and interviewing while you're doing your work at the same time, so -- yeah.
> It's -- it's not always the most accurate but – (Scow Deposition Page 36)

9. Based upon a reasonable degree of medical certainty, BHDC staff met the standard of care for providing emergency medical services to Mr. Cains. Based upon a reasonable degree of medical certainty, there were no unreasonable delays in calling 911

BHDC staff testified that Mr. Cains was [redacted]



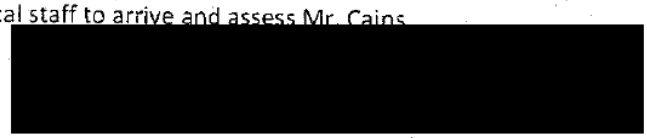
(Jones Deposition, Page 75)

And again:



(Jones Deposition Page 83)

Medical staff were called. Ms. Jones believed that it took one to two minutes for medical staff to arrive and assess Mr. Cains.



[redacted]

Ms. Jones agreed that the call to medical for assistance was made at approximately 11:33.

> According to the documents I was provided, the nurse
> -- medical says it received the call at 11:33.
> Do you have any reason to think that that's wrong?
> A It's probably pretty close.
> Q Okay.
> A I don't remember the exact time. But I'd – (Jones Deposition, Page 85)

However, there is no assurance that the clock in the nurses office at BHDC was actually correct.

In total, it appears that whatever the clocks said, the BHDC staff worked to support Mr. Cains for only 2 to 4 minutes before calling 911.

[redacted]

This timeline created from staff testimony indicates that there was no inordinate delay in BHDC staff providing emergency care to Mr. Cains and in seeking additional assistance. [redacted]

10. Based upon a reasonable degree of medical certainty, BHDC medical staff could not have effected a partial clearing of the airway as they lacked access to the training, skill and equipment needed by Mr. Scow to achieve a partial clearing of the airway. [redacted]

[redacted]

Use of these devices exceeds the standard of care available at BDHC at the time.

11. Based upon a reasonable degree of medical certainty, Mr. Cains would have died even if BHDC contacted EMS at the moment when Mr. Cains was noted to have stopped breathing. Any alleged delay in contacting EMS, even a delay associated with staff performing their assessment, was inconsequential.

[redacted]

[redacted]

(Brown-Forestiere Deposition Page 21)

Later, Dr. Brown-Forestiere appeared to disagree with her own conclusions. She stated that indeed an 8 minute delay "could" have had an impact because a paramedic "could" have applied advanced techniques.

> So, yes, it is very unfortunate. Those eight minutes, honestly, in my opinion, I think that it could have had a very large impact.
>
> (Brown-Forestiere Deposition Page 21-22)

However, Dr. Brown-Forestiere did not assert that an 8-minute delay did have any impact in this specific case. She also did not comment on the fact that after Mr. Scow arrived it took him 9 minutes to partially clear the airway. She also did not conduct an analysis of the timelines noted above.

In addition, Mr. Scow stated that he could not be certain that any delay on the part of BHDC staff affected the outcome:

> Q Is it possible that, had 9-1-1 been called immediately, is it possible at least that you could have -- that the outcome here could have been different?
> A I can't give any specific like certainty.
> (Scow Deposition Pages 14- 15)

[redacted]

Brown-Forestiere Deposition Page 22)



12a. Based upon a reasonable degree of medical certainty, at all times, the BHDC operated within the standard of care for a publicly-funded ICF IDD.

12b. Further, based upon a reasonable degree of medical certainty, at all times, the staff of BHDC provided care consistent with the standard of care for their training and scope of practice.

An assessment of the care rendered by the BHDC and its staff to Mr. Cains turns on the question of whether each provided care consistent with the "standard of care." The care provided by BHDC overall and its staff in this particular matter does meet the standard of care.

The matter of whether or not BHDC meets the standard of care is easily resolved. Since the facility is regulated by the Centers for Medicare and Medicaid Services (CMS), one need only look at whether or not the facility is certified. Indeed, BHDC is certified by CMS, indicating that the facility meets all applicable Conditions of Participation. This exercise may seem overly simplistic, however, it is generally accepted. LeBel notes that "Regulations are minimum standards." (See LeBel J. Regulatory change: a pathway to eliminating seclusion and restraint or "regulatory scotoma"? Psychiatr Serv. 2008 Feb; 59(2):194-6. PMID: .) While States may do more than meet minimum standards, there is no requirement for them to do so. In regard to this matter, the fact that BHDC meets minimal standards is sufficient to dispel any concern that the care practices embodied in the training, rules, regulations, policies, procedures or other facility-wide instruments is not sufficient.

For example, the State Operations Manual (SOM) Appendix J 42 CFR 483.450 Client and Facility Practices (W266) contains five Key Standards (W268; W278: W285: W295; W310) and 35 additional standards corresponding to the Key Standards, which delineate the expectations for the provision of behavioral services within an ICF IDD. Contrary to what some may claims, these are the only "standards" which are applicable to the BHDC.

In regard to the use of personal holds to address dangerous behavior in an emergency situation, the SOM Appendix J states that restraints may be used:

> As an emergency measure, but only if absolutely necessary to protect client or others from injury (W296 (Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.450(d)(1)(ii))

Given that BHDC is certified, the certifying body, CMS in this instance, represents that BHDC meets all applicable Conditions of Participation and their Key Standards.

In regard to the care provided by BHDC staff, the standard of care is based upon the question, "What care could the staff be reasonably expected to deliver based upon their training and experience," or "What would a reasonably qualified RCT do when confronted by the same situation?"

As has been previously noted, BHDC staff provided care in a manner that was consistent with all BHDC policies and procedures. In addition, staff provided care that was consistent with their training and scope of practice. Given the tools and resources at their disposal, they did the best they could.

> A. Oh, yeah, absolutely. I would do my best to try to just deescalate as best I can. Like, I did not want to put hands on anyone
> (Mattson Deposition Page 46)

And:

> A. So I didn't want to it to escalate further and other clients get involved, so I would try my best to kind of remove them and maybe then walk away. Like, move take them to their room –
> (Mattson Deposition Page 48)

And:

> We didn't put him on his stomach; we didn't put him face like, we didn't roll him face down or anything. We were using what I thought was our best judgment.
> (Mattson Deposition Page 117)

And:

> That's what we thought would be the best course of action at the time.
> (Mattson Deposition Page 118)

And:

> At it was my best judgment at the time. It was a traumatic moment that I was --
> (Mattson Deposition Page 118)

And:

[redacted]

[redacted]

(Mattson Deposition Page 118)

And:

Q. Okay. So, ds you sit here today, is it is it your testimony that what -- what you and Mandy and Ryann did complies with this policy?
A. As best as we could in the situation.
(Mattson Deposition Page 122)

And:

A. Like I said, he was flailing; he was whipping around. I was doing the best I could for my only person.
(Mattson Deposition Page 132)

And

A. That's why we attempted to just at least put him at some sort of an angle. We didn't just lay him completely flat. Maybe the angle was wrong, but we were just -- we were using our best judgment in the moment.
(Mattson Deposition Page 136)

Thought is the precursor to action. In order to evaluate what staff did during the medical/behavioral emergency, Plaintiff's would need to have a basic understanding of what staff were thinking at the time. However, Plaintiff's expert dismisses this as irrelevant and does not seem concerned:

[redacted]

(Deposition of Brown-Forestiere, Page 61)

If Dr. Brown-Forestiere cannot comment on what staff were thinking – what they had been taught and how they employed their knowledge - she cannot assess whether or not BHDC staff met the standard of care.

Dr. Brown-Foresteire acknowledged that she had no interest in the behavioral management of Mr. Cains:

> So, no, actually, my medical opinion has absolutely nothing to do with his personal -- whether he had personal aggression or not.
> My interest in the forums of his medical records and IPP was much more so to his physical, any physical conditions, in regards to if he had any diet specifics that made -- would have made him more of a choking risk and -- which he didn't, and if he had any special considerations and conditions in regards to eating; which was GERD and needing to be upright.
> Outside of that, my opinion is purely medical and scientifically driven and does not take into account whether he was a violent person or not. It has no bearing on whether he died from suffocation from choking.
>
> (Deposition of Brown-Forestiere, Page 52)

Dr. Brown-Forestiere also acknowledged that she was not familiar with Mr. Cains' specific plan of care:

> Are you familiar with the training on restraints and what authority there is to restrain David Cains in the Human Development Center?
> A In the Human Development Center, I do not believe I read specifics on --
> Q Okay.
> A -- their particular protocols.
> I recall them talking about it, but I don't see -- I did not see a specific protocol.
>
> (Deposition of Brown-Forestiere, Pages 52-53)

Dr. Brown-Forestiere also acknowledged that she was not familiar with any rules or regulations governing the operation of ICF IDDs or the Plan of Care, called the Individual Program Plan (IPP.)

Q Okay. All right. Well, are you -- so but you're not aware of what -- are you aware of what the laws are or the policies or rules regarding restraints in Human Development Centers in 2020?
A I am not.
Q Okay. Fair enough. So your opinion has nothing to do with whatever was authorized in the IPP or allowed in Arkansas in HDCs at that time?
A Correct. It is not.

(Deposition of Brown-Forestiere, Page 54)

In the matter of Mr. Cains' death and the applicable standard of care, Dr. Brown-Forestiere substituted the standard of care for the physician expert for that of the BHDC staff and suggests that BHDC staff should be able to meet this higher standard. This is an impossible expectation. No one other than an expert in the provision of emergency care in a hospital setting could possibly meet such a standard.

In terms of training and the specifics of this situation, multiple different areas are of importance. Initially, I would say the most important is that we are experts in resuscitation; meaning, people in their most emergent and critical settings, that is where we are experts to take care of these patients. So we see people in all different settings.
But, in this scenario, [redacted] something that we do on a daily basis. And we're highly trained and we're definitely the experts for that. We're called in all over the hospitals for our expertise on that.
In addition, in regards to restraints, we have extensive training in how to use chemical and physical restraints safely; as we, you know, occasionally need to use those in the emergency department.
And we also have extensive training in how to deal with situations that come from physical restraints not being done properly and when we need to take care of someone for that.

(Brown-Forestiere Deposition Pages 5-6)

And again:

Okay.
A I do know, that in our training, the first thing to do is verbal de-escalation so that you can avoid restraints. And it does not appear that that happened.
Q It didn't appear to you that they tried to de-escalate it?
A I heard that he was given a chance to go to the bathroom and sit down.
Q And was the sit down a calming mechanism?
A I don't know.
Q As a matter of fact, the reason he sat down was to calm down, was it not?
A That might have been what it was directly --
Q So, in other words, there was a de-escalation or a calming before this outburst?
A Not what I would call the traditional, but potentially the way they thought of it, maybe.
Q Okay.
A It's not my training in de-escalation for -- to use those particular methods.

(Brown-Forestiere Deposition Pages 78-79)

It is readily transparent, Dr. Brown-Forestiere substituted her standard of care (people in emergency room and critical care settings) for that of the direct support professionals working at BHDC.

This problem with is approach, applying the physician standard of care to a professional who has received lesser or different training for application in a different setting, is illustrated by the following anecdote in which Dr. Brown-Forestiere describes her decision to become a physician:

I was a PA. I had just completed my training had just completed my training, which at a very high level surgical field, was four weeks of training on the job. I had just completed that and was on my own as first call at a Level 1 Trauma Center caring for adult and pediatric patients and I had my very first patient was a two year old who sustained extensive injuries and was left by myself, walking into a room. I looked at this child and the tubes going in and out of her I couldn't even name. I was presented with a scan I could not interpret. I was terrified and time mattered. This child's life was in my hands and I needed to make a quick

decision I didn't know how to make. It was late at night. I had to call my physician. I remember him just being angry that I didn't know the answer and that I couldn't handle it myself. And I just remember in that moment thinking, 'I'm never doing this again. I don't have the information of the training to do the job I'm being asked to do. This is dangerous. And it matters. And this child's life is in my hands and I'm not walking into another situation without a chance to know what I need to know to make these decisions.' So that was the, actually that night. Only four weeks out of school that I decided that I was going back to be a physician."

Accessed at

It is clear that Dr. Brown-Forestiere, working as a newly graduated Physician's Assistant at the time, was presented with a case that exceeded her level of training and experience. She acknowledged that she did not have the tools to do what was asked of her and that only a physician had the level of training needed to do what was necessary. She even described the situation as "dangerous." However, did she violate the standard of care for a PA? Based upon the evidence present in the anecdote, I don't believe so. A PA cannot meet the standard of care for a physician. In regard to the management of Mr. Cains challenging behavior, an RCT cannot meet the standard of care for a physician.

Based upon her acknowledged lack of understanding about ICF IDD rules and regulations, her lack of familiarity with basic treatment planning and IPP processes, her indifference to the behavioral training received by staff at BHDC, her inability to appreciate what BHDC staff were thinking at the time they were engaged to provide care to Mr. Cains, and her substitution of the medical standard of care for the direct support professional standard of care, Dr. Brown-Forestiere is completely unqualified to offer an opinion about the quality of care provided at BHDC or by BHDC staff.

13. Based upon a reasonable degree of medical certainty, Mr. Cains was positioned appropriately – on his side when he was vomiting and, later, on his back when he [redacted]

Dr. Brown-Forestiere testified that Mr. Cains was on his left side while being restrained. She also testified that this was the proper position for someone who was vomiting.'

[redacted]

[redacted]

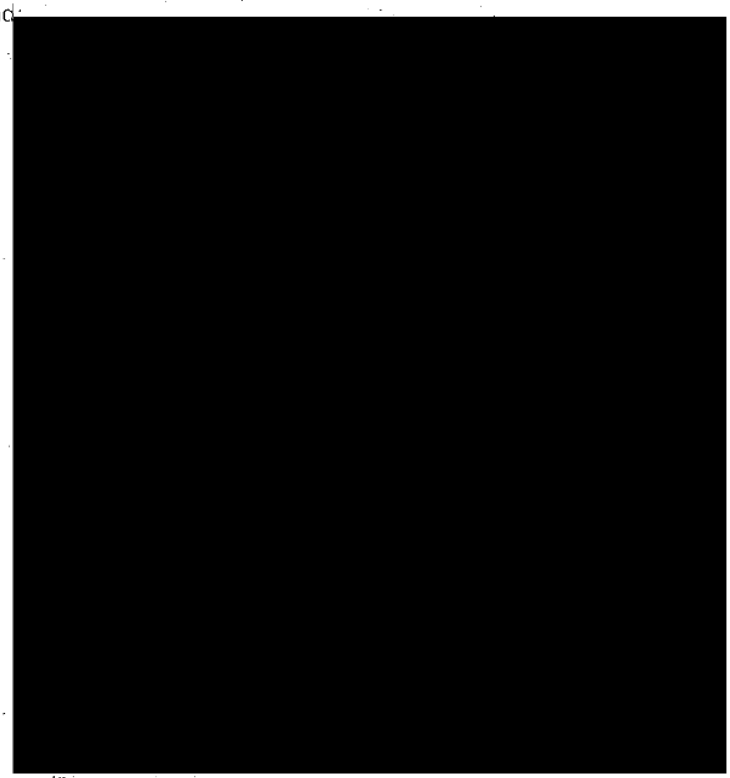
(Brown-Forestiere Deposition Page 61)

[redacted]



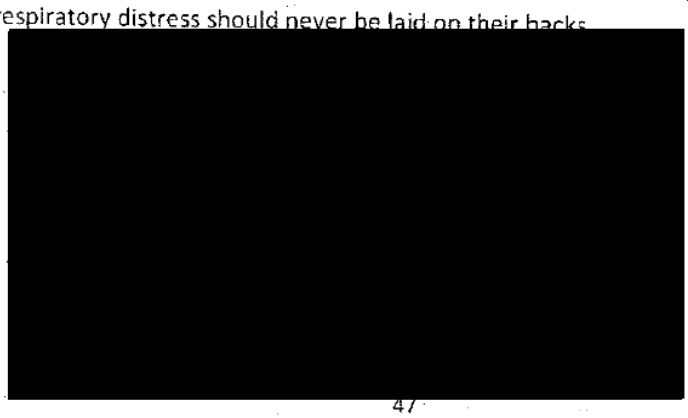
(Brown-Forestiere Deposition Page 16)

And:



(Brown-Forestiere Deposition Page 16)

Later in her testimony, Dr. Brown-Forestiere contradicts herself claiming that individuals in respiratory distress should never be laid on their backs.



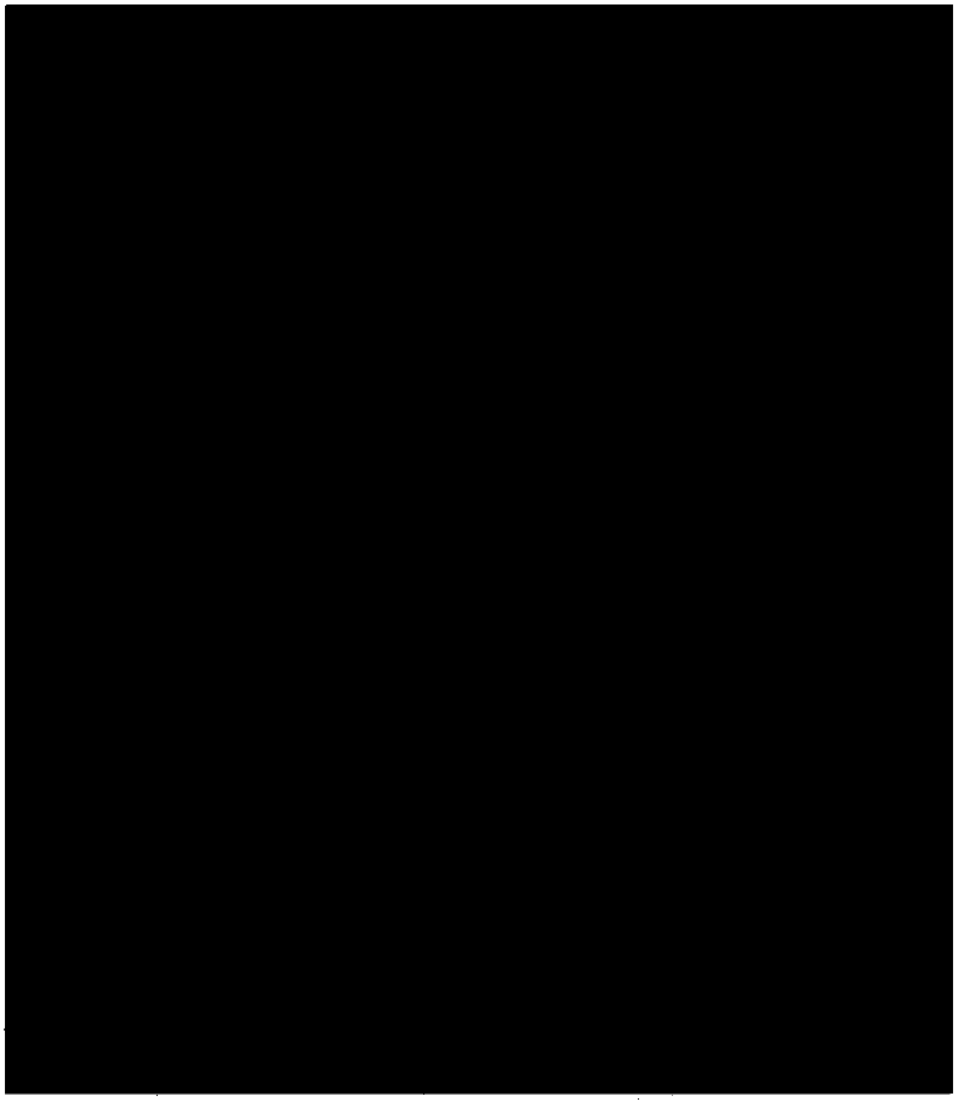
47

[redacted]

(Brown-Forestiere Deposition Pages 62-63)

[redacted]

Brown-Forestiere Deposition Pages 82-83)



(Scow Deposition Page 28)

The evidence indicates that BHDC staff complied with the standard of care in providing emergency behavioral services to address dangerous behavior and provide appropriate emergency medical care, consistent with their level of training and scope of practice, to Mr. Cains during the event.

14. Based upon a reasonable degree of medical certainty, Mr. Cains death was not accompanied by severe pain.

The definition of pain has long challenged clinicians. In 2020, the International Association for the Study of Pain (IASP) approved a definition of pain that not only

coupled the sensory and emotional dimensions of the experience, but also recognized the association between tissue injury and pain:

> "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage".
>
> Raja SN, Carr DB, Cohen M, et al. "The revised International Association for the Study of Pain definition of pain: concepts, challenges, and compromises. Pain 000;

In order to feel pain, this definition requires that there be actual or potential tissue damage.

There is no professional agreement in regard to the amount or degree of pain associated with specific causes of death. Pain associated with a cause of death is proportionate to the degree of tissue damage, not the mechanism of death. However, Dr. Brown-Forestiere opined that:

> ...when someone chokes and their airway is closed off, obviously, they can no longer receive oxygen or expel CO2.
> This quickly induces kind of what we would call a terror fight or flight response, similar to a drowning victim. They start fighting with everything they can. Unfortunately, as the airway is blocked, CO2 which is -- turns into a toxic substance, which is an acid, builds up in their body, their muscles fighting against and are unable to expel the lactic acid they build up. So, essentially, you're not only suffocating, but it's a feeling of burning. Your lungs begin burning, your whole body, because of the acid build up. And the struggle -- and eventually you become unconscious and -- and your body continues to struggle until it no longer can.
> Q Is it a painful death?
> A It's probably the -- one of the most painful deaths there could be. That and I assume burning to death. But strangulation or suffocation and burning are the

-- are known as the two most awful ways to die.
(Brown-Forestiere Deposition Pages 18-19)

The basis for her opinion, that "strangulation or suffocation and burning are known as the two most awful ways to die" is pure speculation.

Dr. Brown-Forestiere is also incorrect in her description of the impact of anoxia on lactic acidosis and anaerobic metabolism. Mr. Cains lost consciousness after a brief period – a matter of seconds. This occurs well before the onset of anaerobic metabolism leading to the build-up of lactic acid in the muscles. Further, people who are resuscitated do not recall a feeling of being burned or burning prior to losing consciousness.

The consensus statement states that the experience of pain requires actual or potential tissue damage. Traumatic injuries cause severe tissue damage and include falls, motor vehicle accidents, gunshot wounds, stabbings, burns, and other mechanisms associated with severe tissue injury. These could all be associated with severe pain under specific circumstances. Diseases such as cancer or sickle cell crisis can cause severe tissue injury. Illnesses of this type could also be associated with severe pain. However, suffocation and drowning are associated with much lower amounts of tissue injury and, therefore, would be associated with lower levels of pain. Of course, each event is unique and the circumstances would vary from individual to individual death.

[redacted]However, based upon my reasonable medical judgment, and predicated upon my understanding of the definition of death and the pathophysiology of this choking episode, I do not believe that Mr. Cains suffered a painful death.

15. Based upon a reasonable degree of medical certainty, Mr. Cains had a life expectancy of only 6 more years.

The current estimate of life expectancy in the United Sates is about 77.2 years. (Source: World Bank.) However, chronic illness, mental illness, obesity, and severe intellectual/developmental disabilities each have a specific and independent impact on the individual which reduces life expectancy. Mr. Cains had several risk factors which are

well known to reduce life expectancy including [redacted]

[redacted]

Given that the average age of death for a person served in a State system is 50.4-58.7 years and combined with the separate risks [redacted] estimate the life expectancy for Mr. Cains to have been significantly reduced at the time of his death. Based upon a reasonable degree of medical certainty, Mr. Cains had a life expectancy of only 6 more years.

DHS EXHIBIT 2-B:

Expert Report: Findings and Expert Opinions

in regard to the Report of Janice LeBel

in the Matter of

CHRISTINE MCAULIFFE, as Special
Administrator of the ESTATE OF
DAVID CAINS CLAIMANT
V CLAIM NO. 220374
THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) RESPONDENT

Prepared by

Theodore Kastner MD, MS

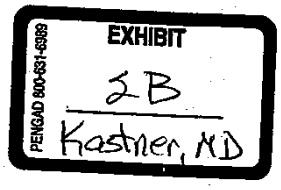
January 6, 2023

Purpose: Dr. LeBel was engaged by Plaintiffs to offer expert opinions on (1) behavioral services offered at BHC in general and to Mr. Cains specifically and (2) the system of health care services at the BHDC. Based upon her review of materials, Dr. LeBel offered two opinions in a letter to Joshua D. Gillispie dated December 28, 2022 (hereafter called the Report.) A review was undertaken to understand the specific opinions which were offered and the basis for these opinions. My opinions are summarized at the beginning of this report and justified through the discussion which subsequently occurs.

Document Review:

The following materials were reviewed:

2015 Psychology Report 001
2016 Psychology Report 001
2017 Psychology Report 001
2018 Psychology Report 001
2018_IPP_001
2019_IPP_001
2017 - 2019 Physician's Orders_001
AmyJones_PDFTran (8)
BHDC Maltreatment Report 5-2020 (BHDC IRIS 87707)
BHDC Policy I-D-2_001
Cains David Behavior Reports for PA VA 04062007-05292020



CainsDavid Psychological Evaluation 05282020
CainsDavidIPP 07182019
Claimant's_3rd_Suppl_Responses_to_Discovery_001 (2)
Claim-Ex1-DRA-2015report
Claim-Ex2-DRA-Jan2016report
Claim-Ex3-DRA-Oct2020letter
EMS Report_001
Hamid (2)
I-D-4 2018 Policy
Medical_Clearance_Restraint_Use_001
NCI-training-instructor-guidance-resource
Physician's Orders 6-2020_001
Ryann_Campos_5-12-22 (2)
Samuel_Scow_5-5-22 (2)
Social History
State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities
Tyler_Mattson_Depo_001 (Compressed)

In addition, the following materials cited by Dr. LeBel in her Report, were also reviewed.

Centers for Medicare and Medicaid Services (CMS) (2018). Psychiatric Hospitals. Retrieved on June 2, 2018, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/PsychHospitals.html

Clarke RW, Harris J. The organization of motor responses to noxious stimuli. Brain Res Brain Res Rev. 2004 Oct;46(2):163-72. doi: 10.1016/j.brainresrev.2004.07.005. PMID: 15464205.

Evans, S. (2022, May 5). Zoom deposition transcript of Sandy Evans.

Hise, M. (2022, May 12). Zoom deposition transcript of Mark Hise.

UN Convention on the Rights of Persons with Disabilities (2006). Department of Economic and Social Affairs Disability. Available at: Convention on the Rights of Persons with Disabilities (CRPD) | United Nations Enable (accessed 22 November 2022).

World Health Organization (2019). Strategies to end seclusion and restraint. WHO Quality Rights Specialized training. Course guide. Geneva: World Health Organization; 2019. License: CC BY-NC-SA 3.0 IGO. Retrieved on November 12, 2022, from https://www.who.int/publications/i/item/9789241516754

In order to understand the foundational assumptions of Dr. LeBel in regard to her understanding of the standard of care and the appropriateness of restraint use, the following document was also reviewed.

LeBel J. Regulatory change: a pathway to eliminating seclusion and restraint or "regulatory scotoma"? Psychiatr Serv. 2008 Feb; 59(2):194-6. PMID: 18245163.

Standard for Opinions:

Throughout this report I will use the standard, "based upon a reasonable degree of medical certainty," to express my opinions. This report does not contain every opinion which I may offer during testimony. I reserve the right to amend this report and my opinions based upon any information that I subsequently acquire or any other issue.

Opinions:

The following is a list of the opinions offered in this report. As noted, the opinions in this report are not considered exhaustive and I reserve the right to amend this report and my opinions based upon any information that I subsequently acquire.

1. **Based upon a reasonable degree of medical certainty, CMS rules and regulations, ARDDS policies and procedures, and BHDC policies and procedures represent the standard of care for the delivery of behavioral services at BHDC.**

2. **Based upon a reasonable degree of medical certainty, other documents cited by LeBel, including materials generated by the United Nations, the World Health Organization, SAMSHA and other sources, do not represent the standard of care for the delivery of behavioral services at BHDC.**

3. **Based upon a reasonable degree of medical certainty, the suggestions, recommendations or opinions contained within cited references and other materials, to the degree that they diverge from CMS rules and regulations, AR DDS policies and procedures, and BHDC policies and procedures, do not represent the standard of care for the delivery of behavioral services at BHDC at BHDC**

4. **Based upon a reasonable degree of medical certainty, I agree with Dr. LeBel that the CMS regulations are "centrist."**

5. **Based upon a reasonable degree of medical certainty, Dr. LeBel does not recognize the authority of CMS, AR DDS and BHDC documents as representing the standard of care. Dr. LeBel has characterized the current CMS regulations as a "retreat from**

the standard-setting high ground." Dr. LeBel suggests that BHDC be required to deliver "low/no restraint services for people with developmental disabilities."

6. **Based upon a reasonable degree of medical certainty, Dr. LeBel regularly attributed statements to CMS which are not contained within CMS regulations in an effort to misrepresent the standard of care.**

   For example, Dr. LeBel claimed that:

   > "the Centers for Medicare and Medicaid Services (CMS 483.12; CMS 483.420) mandate that **patients/residents of facilities have the right to be free** from abuse and neglect..." (Report, Page 4, Bold in original)

   However, there is no such right articulated by CMS in the citation.

   In addition, Dr. LeBel also claimed that:

   > "Physical restraint is a potentially lethal procedure of last resort which is used in an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or ruled out (42 C.F.R. § 483.450)." (Report, Page 4)

   However, there is no such right articulated by CMS in the citation.

7. **Based upon a reasonable degree of medical certainty, Dr. LeBel considers herself a "legal advocate" and stated that "states and facilities must not rely on national standard-setting entities to lead change toward preventing and even eliminating seclusion and restraint." This opinion led Dr. LeBel to state that BHDC should be "compelled" "to action to change their use of restraint with persons-served creating a safer environment of care for staff and patients alike."**

8. **Based upon a reasonable degree of medical certainty, Mr. Cains, who weighed approximately 244 pounds at the time of the event, "charged at" or "lunged" at his staff, Mr. Mattson, and thereby initiated the process which led to physical contact between the two.**

9. **Based upon a reasonable degree of medical certainty, Mr. Mattson employed appropriate blocking techniques in an effort to protect himself, Mr. Cains and avoid escalation.**

10. **Based upon a reasonable degree of medical certainty, Mr. Cains's assault upon Mr. Mattson led Mr. Mattson and Mr. Cains to fall to the floor.**

11. Based upon a reasonable degree of medical certainty, while on the floor, Mr. Cains continued to demonstrate aggressive behavior towards Mr. Mattson and, subsequently, to other staff.

12. Based upon a reasonable degree of medical certainty, while on the floor, Mr. Mattson and other staff applied personal holds for the purpose of protecting Mr. Cains, staff and other individuals.

13. Based upon a reasonable degree of medical certainty, while on the floor, staff made no effort to hold or "pin" Mr. Cains to the floor. The application of personal holds was solely for the purpose of protecting Mr. Cains, staff and other individuals from Mr. Cains's aggressive behavior.

14. Based upon a reasonable degree of medical certainty, at all times, staff exercised their professional judgment in order to meet the standard of care including the use of less restrictive procedures, "time and space," and other appropriate means.

15. Based upon a reasonable degree of medical certainty, BHDC personnel are not required to demonstrate "imminent danger" before the use of restraint.

16. Based upon a reasonable degree of medical certainty, BHDC staff did not apply "lethal restraints."

17. Based upon a reasonable degree of medical certainty, Mr. Cains did not demonstrate a "withdrawal reflex."

18. Based upon a reasonable degree of medical certainty, [redacted] did not contribute to Mr. Cains vomiting.

19. Based upon a reasonable degree of medical certainty, Mr. Cains being restrained while on the ground did not contribute to Mr. Cains vomiting.

20. Based upon a reasonable degree of medical certainty, [redacted] id complicate or represent a contraindication to the use of restraints with Mr. Cains.

21. Based upon a reasonable degree of medical certainty, there were no medical contraindications to the use of restrictive behavioral procedures. Dr. Hamid provided medical clearance to BHDC staff to employ restrictive procedures, when indicated, without condition or limitation.

22. Based upon a reasonable degree of medical certainty, there was no history of swallowing disorder or risk of choking or aspiration which might have increased the risk of a poor outcome as a result of the use of restrictive procedures.

23. Based upon a reasonable degree of medical certainty, there is no need to place Mr. Cains on a "Do Not Restrain List."

24. Based upon a reasonable degree of medical certainty, the emergency response system at BHDC is effective and appropriate to meet the needs of residents who require emergency treatment.

25. Based upon a reasonable degree of medical certainty, the emergency response system at BHDC does not represent an obstacle to emergency response and life-saving intervention.

26. Based upon a reasonable degree of medical certainty, activation of the county-level emergency response system by staff at BHDC and by passing the current requirement to first contact BHDC medical staff, would have had no impact on the quality of care provided to Mr. Cains or the outcome resulting from the care he received.

Expert Report: Findings and Expert Opinions

in regard to the Report of Janice LeBel

Opinions Offered by Dr. LeBel:
Dr. LeBel offers the following opinions at the beginning of her Report (Page 2):

> 1) The physical restraint used on DC proximal to his death fell below the standard of care established by recognized standard setting entities. In addition, the physical restraint used on DC fell below the standard of care established by BHDC.
>
> 2) The BHDC emergency response policy, whereby direct care staff were prohibited from calling 911, fell below the standard of care and created a dangerous situation for DC and other clients and resulted in a delay in emergency service response and intervention.

In the body of the Report, the two Opinions are highlighted in bold. I have copied out each Opinion and note that the Opinions within the body of the Report are subtly but substantively different that the Opinions listed at the top of the report.

> Opinion One: The physical restraint used on DC proximal to his death fell below the standard of care, including BHDC's standard of care. (Page 2)

and

> Opinion Two: The respondent facility's emergency response policy fell below the standard of care. (Page 11)

The difference in the Opinions, appearing literally on the same page of the Report (Opinion One Page 2), complicates the review of the Opinions.

In my analysis of the Report, I have copied each of the Opinions contained within the body of the Report and followed them with a Response. In addition, there are six arguments made by Dr. LeBel in support of Opinion 1. The arguments are highlighted in bold/italic and followed by a Response.

Opinion One: The physical restraint used on DC proximal to his death fell below the standard of care, including BHDC's standard of care (Page 2-3).
Dr. LeBel stated that:

The standard of care required the Respondent to comply with federal CMS/ICF Regulations found at 42 C.F.R. § 483.00 et seq.; Arkansas DDS policies and procedures; and BHDC's own policies and procedures. These policies establish that: a) only the least restrictive approved form of physical restraint can be used, b) for only the least amount of time necessary, c) only to prevent imminent and serious harm in emergency situations, d) only as a last resort after nonviolent techniques have been exhausted, e) the form of physical restraint used must be an authorized method clearly stated in the client's IPP, f) the form of physical restraint must be clearly identified in the facility's policies, and g) the authorized form of physical restraint must be taught to staff. The Respondent failed to meet the standard of care in this case.

Specifically, the Respondent failed in the following ways:

- The physical restraint was not necessary or justified and violated DC's right to be free from abuse and restraint;
- The physical restraint was not implemented in response to a life-threatening emergency or behavior that presented a risk of serious injury/harm;
- The physical restraint was not the least restrictive option;
- The physical restraint did not follow a reasonable effort at nonviolent de-escalation;
- The physical restraint was in violation of the attending physician's standing order for GERD precautions;
- The physical restraint method used by staff was not an approved, authorized or instructed technique recognized by BHDC or documented in DC's IPP.

Response

(1) On page 2 of her Report, Dr. Lebel states that the "standard of care" requires that BHDC comply with the following documents:

Federal CMS/ICF Regulations found at 42 C.F.R. § 483.00 et seq.;
Arkansas DDS policies and procedures; and
BHDC policies and procedures

While she implied in the first iteration of Opinion One (Page 2), that BHDC should comply with "recognized standard-setting entities," that requirement was no longer applied to the second iteration of Opinion One (Page 2). The reason for her excluding these references in her discussion is unclear and should be explored. Are the

"standards" established by the UN and WHO applicable to the US? Do they supersede the "standards" published by CMS? Do CMS "standards" meet the standards set by WHO and UN? If not, are the CMS standards valid?

(2) The reference to 42 C.F.R. § 483.00 as a standard of care for ICF IDDs is overly broad. Federal CMS ICF IDD regulations are found within 42 C.F.R. § 483.00 but limited to Part I. Other portions of CMS 42 C.F.R. § 483.00 reference other facility types including Psychiatric Residential Treatment Facilities and other skilled nursing facilities which have no bearing in this discussion. The regulatory citations should generally be limited to those contained in Part I. The fact that Dr. LeBel chose to do otherwise created confusion when attempting to identify the source documents which she alleged represented the "standard of care."

(3) Dr. LeBel also states that compliance with "standards" must be reflected in the following manner:

> These policies establish that: a) only the least restrictive approved form of physical restraint can be used, b) for only the least amount of time necessary, c) only to prevent imminent and serious harm in emergency situations, d) only as a last resort after nonviolent techniques have been exhausted, e) the form of physical restraint used must be an authorized method clearly stated in the client's IPP, f) the form of physical restraint must be clearly identified in the facility's policies, and g) the authorized form of physical restraint must be taught to staff.

I have reviewed the CMS documents cited by Dr. LeBel and cannot identify all of these specific requirements. Specifically, I conducted a cross-reference of the 7 components (a through g) which she states must be met in order for BHDC to meet federal and State standards. However, I could not find evidence to support her claim that all 7 conditions must be met in order to determine that a facility such as BHDC meets CMS "standards." Indeed, State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities makes no such reference to these 7 specific requirements. As a result, they appear to derive from Dr. LeBel's ideological bias against the use of restraints and her interest in applying her ideological beliefs to BHDC rather than to actual Federal standards.

In order to verify that Dr. Lebel's opinion has a sufficient legal and regulatory basis, Dr. Lebel should be asked to walk through each item (a through g) and reference the

specific Federal. AR DHS or BHDC standard which makes the component a requirement for meeting the "standard of care."

Dr. LeBel made allegations that the BHDC did not meet the standard of care in 6 specific respects. Dr, LeBel alleged that:

> Specifically, the Respondent failed in the following ways:
>
> • The physical restraint was not necessary or justified and violated DC's right to be free from abuse and restraint;
>
> • The physical restraint was not implemented in response to a life-threatening emergency or behavior that presented a risk of serious injury/harm;
>
> • The physical restraint was not the least restrictive option;
>
> • The physical restraint did not follow a reasonable effort at nonviolent de-escalation;
>
> • The physical restraint was in violation of the attending physician's standing order for GERD precautions;
>
> • The physical restraint method used by staff was not an approved, authorized or instructed technique recognized by BHDC or documented in DC's IPP.
> (LeBel Report, Page 2)

In the early portions of her Report (Pages 1 and 2) Dr. LeBel offered little specific evidence to support these 6 claims. To the extent that these general concerns are offered with specific supporting evidence, they are addressed in the subsequent narrative. However, for the sake of completeness, a general rebuttal is provided here.

• The physical restraint was not necessary or justified and violated DC's right to be free from abuse and restraint;

> **Response:** The use of personal holds was justified as staff sought to prevent Mr. Cains from harming himself, staff or others. As noted below, Mr. Cains had no unqualified "right to be free from abuse and restraint." Standards of care allow for restraint use so long as it meets the conditions set forth within CMS regulations. As is evident in the following discussion, BHDC complied with all applicable Federal regulations governing the use of restraints in this specific instance.

• The physical restraint was not implemented in response to a life-threatening emergency or behavior that presented a risk of serious injury/harm;

Response: In making this claim, Dr. LeBel does not appear to be referencing a specific Federal regulation. CMS regulations permit the use of restraint in response to behaviors which have the potential to cause harm to an individual, to staff or to others.

> As an emergency measure, but only if absolutely necessary to protect the client or others from injury. 42 C.F.R. § 483.450(d)(1)(i)

Mr. Cains's behavior (spitting) was harmful to the staff. In addition, his aggressive behavior towards Mr. Mattson certainly had the potential to cause additional harm. Mr. Cains weighed approximately 244 pounds at the time of his death and attacked Mr. Mattson, "charging" at him. Allowing Mr. Cains to charge unimpeded to Mr. Mattson or any other individual would have been reckless and inconsistent with both the standard of care and staff training.

CMS does not require that the potential harm rise to the level of "life threatening." In addition, CMS does not require that the level of harm be deemed "serious."

- The physical restraint was not the least restrictive option;

  Response: The personal holds used in this instance were part of a hierarchy of responses which included less restrictive measures. Prior to the use of personal holds, Mr. Cains was offered the less restrictive opportunity to relocate to a different area and to take his time to gain control over his feeling. However, less restrictive procedures were ineffective, After Mr. Cains attacked Mr. Mattson, physical restraint was necessary to protect Mr. Cains, his staff and others from harm.

- The physical restraint did not follow a reasonable effort at nonviolent de-escalation;

  Response: BHDC staff attempted to implement least restrictive behavioral interventions along a hierarchy consistent with their training and experience. This included the non-violent "time and space" to allow Mr. Cains to gain control over his behavior. Unfortunately, despite the use of less restrictive alternatives, Mr. Cains's behavior escalated and staff were compelled to use personal holds in order to protect themselves, Mr. Cains and others.

- The physical restraint was in violation of the attending physician's standing order for [redacted]

Response: Dr. LeBel lacks any qualifications which would allow her to testify in this regard. That being said, as a matter of general health, the physician made recommendations concerning [redacted] which could be perceived as being in conflict with the need to provide appropriate behavioral services. However, the attending physician testified that he does not believe that there exists any association between restraint use and vomiting. Therefore, he did not place any limitation on restraint use, in particular, in response to Mr. Cains's [redacted]

• The physical restraint method used by staff was not an approved, authorized or instructed technique recognized by BHDC or documented in DC's IPP.

Response: Staff employed "personal restraint," an emergency procedure limiting movement by the holding of a hand or limb," which is identified in "Boonville HDC Policy I-D-4 Documentation and Response to Maladaptive Behaviors" as an Approved Restraint Procedure, Technique or Device. Staff also receive instruction in the use of "personal holds."

The content of the behavioral services curriculum (NCI) does not represent BHDC policy. In addition, the content of the curriculum is not exhaustive of every application of the Approved Restraint Procedure, Technique or Device. Staff are trained in the application of personal holds in the standing and seated positions. They are not trained in the application of personal holds while an individual is on the ground. However, that fact does not represent a prohibition against the use of restraints when an individual is on the ground. In addition, staff are instructed in the principles of behavior management including the need to provide restraint in the least restrictive manner. Based upon their training and experience, staff may use their professional judgment to determine that the application of personal holds while an individual is on the ground is less restrictive than transitioning an individual to a more restrictive mechanical restraint such as a papoose board.

The use of restraints is reviewed and approved for each individual through an interdisciplinary process and reflected in the IPP. Consent to the use of restraints is always obtained. In regard to Mr. Cains, a member of his family was aware of the clinical need for restraints, participated in the interdisciplinary process, and gave consent for restraint use.

Right to be Abuse and From Restraint (Pages 3-4)

On Page 4, Dr. LeBel articulates her interpretation of the "standard of care." To that end, she states:

> "The Respondent's use of restraint in this case was a violation of patient/resident rights and a violation of the facility's obligation to uphold the patient's right to be free from abuse and restraint use. Physical restraint is defined by the federal government (Centers for Medicare & Medicaid Services [CMS]) as: *Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely* 42 C.F.R. § 482.13 and C.F.R. § 483.420. Physical restraint is a potentially lethal procedure of last resort which is used in an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or ruled out (42 C.F.R. § 483.450)." (Page 4)
>
> Patients/residents in health care settings have a right to be free from restraint. To affirm this position and prevent the risk of serious harm associated with restraint use, standard setting organizations such as the United Nations(UN) (2006), World Health Organization (WHO) (2019), and the Centers for Medicare and Medicaid Services (CMS 483.12; CMS 483.420) mandate that **patients/residents of facilities have the right to be free** from abuse and neglect including but not limited to ...**any physical** or chemical **restraint** ... (emphasis added) imposed for purposes of discipline or convenience. When physical restraints are used, the facility is obligated to use the least restrictive alternative for the least amount of time and ensure that staff have and demonstrate needed competencies to effectively and appropriately interact with clients; monitor and take immediate action to address circumstances where possible abuse, neglect or mistreatment has occurred and prevent reoccurrence of abuse (CMS 483.12; Halverson et al., 2023; Huckshorn et al., 2021; AR DDS 3011-D; UN, 2006; & WHO, 2019)."

Response:

There are several errors in Dr. LeBel's interpretation of CMS regulations and the standard of care:

(1) The only standard which applies to BHDC are those standards established by CMS for the operation of ICF IDDs, in addition to AR DDS and BHDC policies and procedures which derive from these requirements. Dr, LeBel has previously acknowledged that CMS regulations represent the standard of care. As Dr. Lebel has noted, "Regulations are minimum standards." (See LeBel J. Regulatory change: a pathway to eliminating seclusion and restraint or "regulatory scotoma"? Psychiatr Serv. 2008 Feb; 59(2):194-6. PMID: 18245163.)

(2) Although Dr. Lebel suggests that Halverson et al., 2023 and Huckshorn et al., 2021 are standards of care, they are not. Even if they were, their publication date, after the death of Mr. Cains, disqualifies them from being relevant to the events under discussion.

(3) Although Dr. LeBel states that the WHO is a "standard-setting organization," in regard to the standard of care for the implementation of behavioral services at BHDC, it is not.

(4) Although Dr. Lebel implies that WHO, 2019 is a standard, it is not. WHO, 2019 is a "course guide" to a curriculum developed by a third-party for general use. The WHO makes no warranty as to its specific applicability in any setting. Un the section, General disclaimers, WHO notes:

> All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use. WHO, 2019)

(5) Although Dr. LeBel states that the UN is a "standard-setting organization," in regard to the standard of care for the implementation of behavioral services at BHDC, it is not.

(6) Although Dr. Lebel implies that UN, 2006 is a standard, it is not. UN, 2006 is a document intended to drive social change recognizing that people with disabilities have the same rights as others, including the right to provide consent to treatment either themselves, or appropriately designated proxies – rights which are already reflected in the CMS ICF IDD regulations. As UN, 2006 notes:

> The Convention follows decades of work by the United Nations to change attitudes and approaches to persons with disabilities. It takes to a new height the movement from viewing persons with disabilities as "objects" of charity, medical treatment and social protection towards viewing persons with disabilities as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.
>
> The Convention is intended as a human rights instrument with an explicit, social development dimension. It adopts a broad categorization of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms. It clarifies and qualifies how all

categories of rights apply to persons with disabilities and identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights and areas where their rights have been violated, and where protection of rights must be reinforced.

(7) Dr. LeBel states that:

> Physical restraint is a potentially lethal procedure of last resort which is used in an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or ruled out (42 C.F.R. § 483.450).

I reviewed 42 C.F.R. § 483.450 and cannot find this language. The full text of the standard, as it relates to physical restraint use is as follows:

> **(d)** ***Standard: Physical restraints.***
>
> **(1)** The facility may employ physical restraint only -
>
> **(i)** As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;
>
> **(ii)** As an emergency measure, but only if absolutely necessary to protect the client or others from injury; or
>
> **(iii)** As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.
>
> **(2)** Authorizations to use or extend restraints as an emergency must be:
>
> **(i)** In effect no longer than 12 consecutive hours; and
>
> **(ii)** Obtained as soon as the client is restrained or stable.
>
> **(3)** The facility must not issue orders for restraint on a standing or as needed basis.
>
> **(4)** A client placed in restraint must be checked at least every 30 minutes by staff trained in the use of restraints, released from the restraint as quickly as possible, and a record of these checks and usage must be kept.

(5) Restraints must be designed and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

(6) Opportunity for motion and exercise must be provided for a period of not less than 10 minutes during each two hour period in which restraint is employed, and a record of such activity must be kept.

(7) Barred enclosures must not be more than three feet in height and must not have tops.

Specifically, CMS does not characterize restraint as a "potentially lethal procedure of last resort." In addition, CMS does not limit restraint use to "in the event of imminent danger." Restraint use is permitted "to protect the client or others from injury." Such a determination can only be made by staff at the time the restraint is needed and based upon the specific circumstances present.

Dr. LeBel's opinion about the conditions under which restraint use may occur align with her personal beliefs. However, there is no evidence that CMS is in agreement with Dr. LeBel's personal opinions about restraint use. As a result, Dr. LeBel's interpretation of the standard of care and CMS regulations should not be relied upon when contemplating the standard of care for behavioral restraints at settings like BHDC.

(8) Dr. LeBel states "Patients/residents in health care settings have a right to be free from restraint." This is not true. There is no instance do CMS regulations offer an unqualified right to be free from restraint. Restraint is an approved medical/behavioral procedure which is designed to protect staff, the individual, and others from harm. To suggest that such a right exists would be to imply that facilities, such as BHDC, be prohibited from taking action to prevent harm to staff, individuals and others, especially in emergency situations. This would be contrary to CMS regulations as it could create an unsafe environment. CMS determined that there is a role for restraint use in settings such as BHDC and this opinion is reflected in CMS regulations.

(9) That being said, residents of facilities such as BHDC must be protected from unwarranted and inappropriate use of restraint. For example, as noted in §483.12(a)(2)

The facility must:
Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility

must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

Contrary to Dr. LeBel's opinion, CMS, through the use of surveyors and its survey instrument (State Operations Manual Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities Rev. 178, 04-13-18), has determined that Arkansas DDS and BHDC comply with all aspects of §483.12 and §483.420.

Threshold for Restraint use was not Met (Page 4)

Dr. LeBel argues that the standard of care includes an "imminent danger" threshold which must be met before the application of restraints:

"In health care settings, physical restraint is an emergency procedure of last resort and should only be used in the event of imminent danger to the patient/resident or others."

As noted earlier, no such "imminent danger" standard exists in CMS regulations.
In addition, Dr. LeBel generated a list of the behaviors demonstrated by Mr. Cains while in the dining area and the lobby near the restrooms. Her Report states the following:

BHDC staff documented and described DC's behavior as:

1. "yelling" (Jones, deposition testimony, p. 67); "screaming" (Jones OLTC Witness statement, labeled exhibit 4, p. 1)
2. "slightly agitated ...became aggressive in common area" (IRIS report)
3. "irritated...screaming and cussing...ripped paper off the wall... jumped up ... spitting and attempting to hit..." (Mattson, OLTC Witness statement, labeled exhibit 9, p. 1-2)

She goes on to state that this behavior was "not lethal or life threatening, nor does it pose a risk of serious injury." (Report, Page 5) LeBel concluded that since these behaviors were not lethal

or life threating nor posed a risk of serious injury, they did "not require the use of force or a hands-on containment procedure." (Report, Page 5).

Dr. LeBel reiterates her "imminent danger" standard, which has already been demonstrated to fall outside the CMS standard of care. She states that:

> "The antecedent actions described in the various documents do not meet the BHDC threshold of imminent danger requiring the implementation of physical restraint."

Knowing that the "Imminent danger" standard falls outside of the CMS standard of care, Dr. LeBel cites Halverson et al., 2023; Huckshorn et al., 2021; Huckshorn & LeBel, 2015; Ridley & Leitch, 2019) as "restraint standards of practice."

Response:

(1) The publications cited by LeBel are not "restraint standards of practice." LeBel has noted that federal regulations are standards. (See LeBel J. Regulatory change: a pathway to eliminating seclusion and restraint or "regulatory scotoma"? Psychiatr Serv. 2008 Feb; 59(2):194-6. PMID: 18245163.) The federal regulations supersede any proposed standard of care which LeBel attempts to install in this instance.

(2) LeBel created an ad hoc standard, the "imminent danger standard," as a condition for the use of restraint:

> "The antecedent actions described in the various documents do not meet the BHDC threshold of imminent danger requiring the implementation of physical restraint." (Report, Page 5)

This substitution of her desired "standard" for the generally accepted "standard" is inappropriate and inconsistent with CMS regulations §483.12 and reflects her continued desire to use the consultation to eliminate restraint use at BHDC.

(3) The standards which LeBel identified for the use of restraint are at odds with BHDC Policy. "BHDC Policy 1-D-4 Documentation and Response to Maladaptive Behaviors" allows for the use of restraints when maladaptive behaviors occur. The document defines maladaptive behavior, noting:

> "Maladaptive behaviors include, but are not limited to, behaviors that result in, or have the potential to result in, injury to self or others, or the destruction of property."

In no instance does CMS or BHDC policy limit the application of restraints to only situations where there is imminent danger. CMS allows that restraint be utilized when behaviors arise which could "potentially" result in injury or harm.

(4) The Policy also requires that a hierarchy of behavioral interventions be used, with least restrictive procedures preceding more restrictive restraints:

> Personal restraint of a client is used when the behavior is such that verbal control has been lost and other less restrictive measures have failed to control the behavior.

(5) Dr. LeBel provided an incomplete listing of the behavioral strategies used by Mr. Matson to address Mr. Cains's maladaptive behavior. Specifically, Mr. Matson spoke softly to Mr. Cains, then took Mr. Cains to the bathroom, then, at Mr. Cains's request, relocated Mr. Cain to a quiet location. Finally, Mr. Mattson used defensive blocking techniques to address Mr. Cains' aggressive behavior – all prior to the use of restraints. Mr. Matson clearly employed the hierarchy of behavioral interventions, beginning with less restrictive procedures, consistent with his training and CMS regulations. As noted by Mr. Mattson in his witness statement:

> I was at lunch with David. He had finished eating his sandwich and cucumber and put his tray up. He sat down and seemed fine. Shortly after he asked if he could go to the restroom. I followed him inside the bathroom because he seemed irritated beforehand. While in there I heard no abnormal sounds such as vomiting due to his history of intentional vomiting when he is upset. We went out and he asked if he could sit in the lobby to calm down. I said that's fine. Shortly after, he began screaming and cussing and ripped paper off of the wall to throw. He then jumped up after me and attempting to hit me. I applied personals by grabbing his arms and he ended up falling over. I did not land on him. He continued fighting and I rolled him on his left side as to not put any pressure on his stomach because he had just ate. At that time he was still fighting and Mandy joined to assist me, grabbing his hands, all while I was squatted over him, not putting any weight on him during any of this, holding his shoulder and sides. He was still continuously fighting and Ryann Campos showed

up and held his legs down. Still fighting, We had him in personals for approx. 1

[redacted]

(6) Further, Dr. LeBel provided an incomplete listing of maladaptive behaviors which Mr. Cains demonstrated prior to the use of restraints. Most noteworthy, she failed to accurately report that Mr. Cains "charged" at Mr. Mattson. The event is described more fully in the Deposition of Mr. Matson. In his deposition, he noted

> O. And then you said he --- he came after you?
> A. Yes. He charged me.
> O. Charged you.
> A. Yes
> (Mattson Deposition, Pages 101-103)..

Consistent with his training, Mr. Matson employed blocking techniques, including placing his hands on the inside of Mr. Cains' extended arms in an effort to prevent himself from being harmed by Mr. Cains. Unfortunately, Mr. Cains, a very large man with a weight of 244 pounds, caused both himself and Mr. Matson to fall to the ground. Having employed less restrictive behavioral strategies and subsequently being the subject of Mr. Cains's physical assault, Mr. Matson appropriately used personal holds – the least restrictive intervention that would protect himself, Mr. Cains and others from Mr. Cains's escalating behaviors.

Finally, Dr. LeBel implies that Mr. Mattson inappropriately took Mr. Cains to the ground. Mr. Mattson contradicts this opinion in his deposition. Mr. Cains' large mass and speed combined to lead both Mr. Cains and Mr. Mattson to fall to the floor.

> O. How did he fall? What caused him --
> A. We
> O. to fall?
> A. We just kind of tripped up on each other. It was
> all one big motion, like I had said.
> O. Okay. And why did you not attempt to do the
> blocking technique where you block and kind of get out of

his way?
A. I wouldn't have had room. I was against a ledge.
O. You were against a ledge?
A. Yes.
O. Why would a ledge prevent you from being able to do like this?
A. Because I would have fell over be- if he had put enough momentum into me.
O. Okay. So you guys fall- over.
(Mattson Deposition, Pages 1)

(7) Dr. LeBel turns the events completely on their head when she alleges that it was Mr. Matson who initiated contact with Mr. Cains:

> "In addition, **it does not appear that DC initiated physical contact with staff or physically harmed anyone** (emphasis added). Per Mattson's OLTC Witness Statement (labeled exhibit 9, p. 2), he (Mattson) initiated physical contact with DC (*"I applied personal by grabbing his arms"*). Mattson grabbed DC's arms. Mattson activated an autonomic, defensive physical response from DC referred to as the "Withdrawal Reflex" (Clarke & Harris, 2004). Mattson initiated the physical interaction with DC; he did so without first utilizing required supported stance and blocking techniques or any other form of nonviolent de-escalation required to be exhausted prior to physical restraint. (Pages 5-6)

Dr. LeBel did not consider the evidence in Mr. Mattson's deposition which more fully describes the event. According to the description of events offered by Mr. Mattson during his deposition, it was Mr. Cain who charged Mr. Mattson, initiating the process which led to both Mr. Mattson and Mr. Cains to fall onto the floor. Mr. Cains lunged and charged at Mr. Mattson. Given Mr. Cains' weight of 244 pounds, this assault caused Mr. Mattson to fall backward or on his side and Mr. Cains to land on top of or adjacent to him.

Mr. Mattson, the only eyewitness, describes the events as follows:

O. Okay. What's he doing as he's sitting there?
A. Just sitting. He was just sitting look- staring out.
O. All right. And then what happens?
A. He grabs a paper and goes after me.

Q. Where does he grab paper from?
A. There was a flyer on the wall.
Q. Does he stand up to grab it?
A. He grabbed it and then went after me. He was sitting down and then went after me to attack me.
Q. What --- what kind of paper was it? Just---
A. It was just it was just a printout paper, just a flyer.
Q. What did he do with it after grabs it?
A. He was throwing it and then went after me. He threw it down and then went after me.
Q. He threw it down and then went after you. Did he say anything?
A. No. He just screamed "bitch."
Q. He screamed "bitch"?
A. Yes. That I recall.
Q. Anything else that you recall him saying?
A. No.
Q. And then you said he --- he came after you?
A. Yes. He charged me.
Q. Charged you.
A. Yes
Q. Okay. Does --- describe that for me as best you
A. He just went to grab me. I mean
Q. How far away from him were you?
A. Maybe from here to that pole. Maybe a little bit shorter.
Q. This pole?
A. Yeah, about there. Maybe to the chair.
Q. My chair?
A. Between there.
Q. Okay.
A. Yeah.
Q. So about 6, 7 feet?
A. Maybe.
Q. Okay. And when you say "charge, " was he running at you?
A. Lunging, running. Yeah, just --- he went after me.

He didn't really have room to necessarily run.
O. Can you --- do you mind standing up and showing me?
A. I -- as best as I can. Like, he just --- it was like just a classic --- like, he went to grab at me.
O. Okay. Went to grab at you?
A. Yes.
O. So not swing at you but grab at you?
A. Grab at me.
But, like he had --- like --- like I said, that distressed face.
O. Okay.
A. Like he was agitated and --- yeah.
O. All right. And --- okay. And then what --- what did you do?
A. I tried to hold him and we kind of just fell.
O. How did you try to hold him? Stand up and show us, please.
A. Like, I was --- like, I just kind of grabbed him by the shoulders the best as I could, you know, with him -- momentum --
O. Yeah.
A. and we just kind of stumbled over, you know.
O. Okay. So he's coming at you arms raised like this?
A. It --- yeah.
O. Like this?
A. Outwards, yeah.
And I just kind of grabbed, like, here and here. I didn't, like, grab by the wrist. You know, but, like we kind of just awkwardly fell.
O. Did he get a --- did he get a grip around you?
A. No, he didn't get a grip around me.
O. Okay. Sorry.
A. No, that's all right.
O. This won't take long.
So he's coming at you. Show me and slowly so --- so I can really see it: What --- what do --- show me what you do as he's coming at he's lunging at you.
What do you do? What do your hands do? Where do

they go?
A. I'm just like --- biceps, like, arms.
O. Okay. So you would have your --- your right hand on his left bicep and your left hand on his right bicep?
A. Yeah.
O. Pretty much?
A. Pretty much, yeah.
O. Okay. And --- and do you stay there locked like ---
A. No.
Like we tripped. Like --- like, we lust kind of fumbled around. Because it was, like, all in one big momentum, you know.
O. Uh-huh. And you fall to the ground, and he hits his face on the ground?
A. No, he didn't hit his face on the ground.
It wasn't a fast f all. It was a controlled fall as much as I could control it. (Mattson Deposition Pages 100-103)

It is inconceivable that Dr. Lebel would allege that Mr. Mattson initiated the physical interaction when it was Mr. Cains who attacked him. Mr. Mattson's description indicates that he attempted appropriate blocking technique (engaging the inside of the arms at the biceps) but was unable to stop the attack. It was Mr. Cains' momentum which carried them to the ground.

Having employed defensive blocking techniques which included grabbing the inside of Mr. Cains's arms in an effort to avoid being attacked, Mr. Mattson and Mr. Cains fell to the floor. They "awkwardly fell" or "tripped." There was no effort on Mr. Mattson's part to place Mr. Cains on the ground. The fall to the ground occurred as a result of Mr. Cains' unprovoked attack.

(8) Finally, Dr. LeBel offers the highly unlikely theory that Mattson "grabbed DC's arms," and that:

> "Mattson activated an autonomic, defensive physical response from DC referred to as the 'Withdrawal Reflex' (Clarke & Harris, 2004)."

Dr. LeBel's theory that Mr. Cains demonstrated a "withdrawal reflex" as a result of Mr. Mattson's use of blocking techniques is inconsistent with our knowledge of neurology, neuroanatomy, and neurophysiology.

Clarke & Harris is a review of the spinal cord responses to noxious stimuli, with a particular focus on the response to painful stimuli following spinal cord injury. The intent of the authors was to assist researchers in improving the quality of studies aiming to understand the body's response to painful stimuli. The authors state:

> The article was published as a guide to researchers designing studies to investigate the body's response to noctious stimuli.

Dr. LeBel is incorrect when she describes the "withdrawal reflex" as "an autonomic, defensive physical response." The "withdrawal reflex" is neither an autonomic response nor defensive in nature.

The autonomic nervous system is a component of the peripheral nervous system that regulates involuntary physiologic processes including heart rate, blood pressure, respiration, digestion, and sexual arousal. It contains three anatomically distinct divisions: sympathetic, parasympathetic, and enteric. The autonomic nervous system is not involved in withdrawal reflexes. Withdrawal reflexes are generated through afferent and efferent fibers in the spinal cord.

In addition, the reflex is not defensive. Defense suggests a determination by the cortex to discriminate between those stimuli which are aggressive vs those which are not. In regard to spinal reflexes, the cortex is not involved.

The authors note that the utility of "withdrawal reflexes" is most often observed in the clinical assessment of individuals with brain or spinal cord injury:

> ...although these data indicate that differentiation of withdrawal reflexes is most readily seen from stimuli applied to the plantar surface of the foot.

Dr. LeBel's opinion appears to be purely speculative. Dr. LeBel does not offer any opinion as to how such an "autonomic, defensive response" would have been manifest in Mr. Cains's behavior. What would a "withdrawal reflex" have looked like? Would any observed "withdrawal reflex" have been sudden or slow? Would he have withdrawn his arms from his attempt to grab Mr. Matson? Would such a reflex have stopped Mr. Cains's forward motion? Would he have fallen backwards?

Further, the issue of the role of "higher centres" is important in understanding human motor behavior. In Dr. Lebel's view, simply blocking the biceps would be sufficient to cause Mr. Cains

to stop his "charge" and retreat. To a degree of medical certainty, it is not likely that a "withdrawal reflex" occurred as a result of Mr. Mattson grabbing an arm or employing a blocking technique. The reasons that Mr. Cains charged at Mr. Mattson, although unknown, more than likely involved cognitive centers located above the spinal cord and would have been overcome by simply pressing on his biceps.

No Reasonable Effort at Least Restrictive Intervention and Non-violent De-escalation Intervention (Page 6)

Dr. LeBel stated that:

> "The documentation provided does not identify any reasonable effort to de-escalate DC's distress. The most basic de-escalation strategies (time and physical space) were not apparent in the direct care staff OLTC witness statements (Campos & Jones). Mattson appears to be the only staff member with DC at the time the problem started. Mattson's written OLTC witness statement (p. 1-2) regarding the sequence of actions is disjointed. Mattson describes DC as: 'sitting, then screaming and cussing, then ripping paper off the wall to throw'. It is unclear how ripping paper off a wall occurs in a seated position. Mattson says DC then "jumped up ... spitting and attempting to hit me." If DC was holding paper and attempting to throw it, one of DC's arms was likely elevated and rotated. It is not clear how quickly DC could rise to a standing position and attempt to hit Mattson. DC's physical actions were likely to have been slow, given his physical limitations. Mattson offers no detail about any verbal attempts he made to aid in calming DC, redirecting him, asking him to stop, offering DC any form of support, or utilizing the "supported stance" training.

Response:

(1) Mr. Mattson's written Witness Statement may appear somewhat disjointed. It was taken within a short time of the incident and, no doubt, Mr. Mattson was upset by Mr. Cains's death.

(2) In spite of this shortcoming, the Witness Statement indicates that Mr. Mattson did make reasonable efforts to employ the least restrictive intervention and non-violent de-escalation intervention. Mr. Mattson wrote:

> We went out and he asked if he could sit in the lobby to calm down. I said that's fine.

(3) Dr. LeBel relies exclusively on the Witness Statement of Campos & Jones to conclude that "the most basic de-escalation strategies (time and physical space) were not apparent in the direct care staff OLTC witness statements." However, neither of these

witnesses were present at any time before Mr. Cains charged Mr. Mattson resulting in the two men falling to the floor. Neither witness was in a position to comment on this issue at all.

However, if Dr. LeBel had relied upon Mr. Mattson's Witness Statement, she would have been compelled to reach the opposite conclusion: Mr. Mattson did make reasonable efforts to employ the least restrictive intervention and non-violent de-escalation intervention..

(4) Dr. LeBel materially misrepresents the actual conduct of BHDC staff. As noted previously, a more detailed description of the staff response to the event is contained within Mr. Mattson's deposition, a document which Dr. LeBel has cited at various points in her Report but ignores in this discussion. Mr. Mattson's deposition indicates that the incident began in the dining area and was addressed with both "time and physical space" – Mr. Cains was permitted to use the bathroom, relocate to the lobby and given as much time as he needed to compose himself. However, the use of "time and physical space" was unsuccessful in helping Mr. Cains to control himself.

Use of Restraint Violated BHDC Attending Physician's Order

Dr. LeBel stated that:

> Staff could have and should have taken DC's medical risks into consideration (Evans, 58) and used another approach to help DC manage his distress. Moreover, Dr. Hamid did not approve of the use of floor/ground restraint for DC (77) nor was any restraint method identified in the IPP (483.450(d)(1)(i); Evans, 29, 35). Given the medical risk of restraint use with DC, BHDC could have put DC on their *Do Not Restrain List* but did not.

Response:

(1) Direct care staff, including Mr. Mattson, neither could have nor should have taken DC's medical risks into consideration and used another approach to help Mr. Cains manage his distress. A determination as to "another approach" would have required direct care personnel to make a medical determination – something which exceeded their training, experience or scope of practice. Only a health care provider could reasonably be excepted "to take DC's medical risks into consideration" and "devise another approach."

(2) Dr. LeBel does not appear to understand the role played by health care professionals in the delivery of behavioral services. As a matter of general practice, Dr. Hamid does not "approve" the use of any specific restraint. In executing the document, his review is performed solely for the purpose of proving medical clearance indicating that restraints can or cannot be safely used. In completing the Form "Medical Clearance for Restraint Use" he makes a determination that specific types of restraints can be safely used with or without conditions. Dr. LeBel has no qualifications which would support her ability to offer an opinion in this area.

(3) In regard to the care provided to Mr. Cains, Dr. Hamid did review the relevant documents and identified which restraint techniques could be safely used. His report states:

[redacted]

(4) Dr. Hamid did not identify any medical basis to restrict the use of restraints. In particular, he did not identify any medical contraindications to restraint use or any modification of restraint procedures which might be necessary to address any medical condition [redacted]

(5) [redacted]

[redacted]

(6) Dr, Hamid confirms this opinion in his deposition when he noted no evidence to support an association between restraint use and vomiting/aspiration:

> Q But to be clear, you do not think that a physical restraint of this sort -- are you saying you don't think the physical restraint had any causal effect on him vomiting and going into cardiac arrest?
> A I was not there, so I don't know how much strength Was used, but in real world, again, physical, if somebody is restrained and he chokes to death, you know, does not happen. So I don't think so physical restraint -- there's no way for me to tell because I'm not there at that particular point in time and how much strength was used. No.
> Q I don't think I quite understand something you just said.
> MR. GILLISPIE: Hey, Kristi, could you read back his passage just there for me?
> (WHEREUPON, the court reporter read back the previous answer.)
> BY MR. GILLISPIE:
> Q If you could, finish your thought for me about in the real world. In the real world, what? I don't quite understand what you meant there.
> A I mean, I have not come across any case studies that the patient who was physically restrained ended up choking to death because of that physical restraint. I have not seen any case reports. It has not come in my practice, you know, even working at BHDC here and other facilities.
> (Hamid Deposition, Pages 37-38)

(7) Dr. Lebel claims that "Given the medical risk of restraint use with DC, BHDC could have put DC on their *Do Not Restrain List* but did not." However, as noted above, Dr. Hamid is a medical practitioner and did not believe that such a risk existed. Dr. LeBel, lacking any medical training, experience or licensure, has no standing upon which to contradict Dr. Hamid's opinion.

Use of Restraint Violated Policy Standards

Dr. LeBel alleged that:

> The use of restraint was not consistent with BHDC policies (BATES: 4342). According to the deposition testimony of S. Evans, Residential Services Director, restraint is to be used, *"Only as an emergency measure but only if absolutely necessary* ***to protect client or others from injury"*** *(p.30)*; per ICF/CMS regulation 483.450(d)(5) and Evans (2022, p.32), *"restraints must be designed and used* ***so as not to cause physical injury to the client"*** *(emphasis added) and implementation of behavior management policy and practices is done when an individual's actions are aggressive, disruptive, and/or present a danger to the individual or others, are* ***managed with the least restrictive method*** *(emphasis added)."* In this case, less restrictive interventions were not documented and the client (DC) was not protected. The client (DC) was fatally injured as a result of unwarranted restraint. No injury to staff was documented and no threat of serious injury was documented. Furthermore, the unwarranted restraint used was not described, addressed or documented in the facility's policies or in DC's IPP, as required by federal regulation (483.450(b)(1)(IV)); it was, in fact, unauthorized. This use of restraint was not justified per BHDC policy.

Response: Dr. LeBel is incorrect on several points.
First, Dr. LeBel notes that "restraint is to be used, 'Only as an emergency measure but only if absolutely necessary to protect client or others from injury.'" Staff did not violate this directive. Based upon their training and experience, staff made a clinical judgment based upon the existing conditions. The need to protect themselves, Mr. Cains and others was met at the time that restraint was utilized.

Second, as noted above, Dr. LeBel has made a medical determination that the use of restraints caused harm. She is not qualified to offer such an opinion.
Third, a causal relationship between the use of restraint and vomiting, in this specific instance, has not been proven. The evidence indicates only that Mr. Cains vomited while restraints were applied. This association does not mean that a causal relationship exists. Dr. LeBel is not qualified to reach a conclusion about medical causality.

Third, Mr. Cains indicated that it was his intent to harm Mr. Mattson when Mr. Cains spat at Mr. Mattson and attempted to strike Mr. Mattson. These behaviors represented a potential for harm and were justifiably addressed by physical restraint. Mr. Mattson and other staff were fully compliant with BHDC policies when they used physical restraints in this emergency situation and attempted to prevent Mr. Cains from engaging in these behaviors.

Fourth, the deposition of Mr. Mattson indicates that he took specific steps to de-escalate the behavior and employ less restrictive procedures including blocking Mr. Cains attempt to physically harm.

Fifth, as noted above, Mr. Cains was not "fatally injured as a result of unwarranted restraint." Dr. LeBel failed to establish any causality in regard to the relationship between restraint use and vomiting.

Sixth. Dr. LeBel does not recognize that CMS allows the use of restraints for two general purposes. CMS states:

> The facility may employ physical restraint only -
>
> (i) As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied;
>
> (ii) As an emergency measure, but only if absolutely necessary to protect the client or others from injury; ((483.450(d)(1)(i-ii))

The conduct of staff in regard to this specific incident was in response to an emergency, In such an emergency, staff are not required to meet the conditions of (483.450(d)(1)(i). Emergency use of restraints is addressed in (483.450(d)(2)(i)

> Authorizations to use or extend restraints as an emergency must be:
>
> (i) In effect no longer than 12 consecutive hours; and
>
> (ii) Obtained as soon as the client is restrained or stable

In such emergency situations, the documentation occurs after the restraint procedure, rather than preceding it.

It is important to note that CMS has determined, through its survey procedure, that BHDC is compliant with all required aspects of behavioral service. Dr. LeBel's unilateral determination that BHDC is in violation of CMS standards is contradicted by CMS itself.

Use of Restraint Violated BHDC Staff Training and Practice Standards

Dr. LeBel alleged that:

> DC died as a result of being physically restrained by staff on the floor/ground. According to the deposition of BHDC Staff Development Coordinator and Non-Violent Crisis

Intervention Restraint Trainer (Hise, 2022):• (p. 21, 18-20): *"The only reason that they would use the transition to the ground is putting a resident in mechanical restraint."* • (p. 22, 8-9): *"I do not teach staff to hold a resident on the ground."* • (p. 22,19-21): *"The training that we teach in NCI is a standing personal hold and a seated personal hold. There is no on-the-ground personal hold."* • (p. 24, 20+): *"... use verbal strategies to de-escalate and redirection also teach blocking, stepping back..."• (p. 25): "In the supported stance, if a resident was coming at you, you would put your hands up and deflect and step away."* • (p. 28, 6) *"No, sir; do not restrain by yourself, use a supported stance to prevent falling over, if restraint on the ground, then prepare for mechanical restraint."•* (p. 34*) So Booneville Human Development Center does not authorize the use or train staff in the use of restraining clients on the ground except when doing so for the specific purpose of transitioning to a mechanical restraint; correct? Hise's Answer: "Correct."* BHDC Staff Development Coordinator and Restraint Trainer Mark Hise affirms that the fatal restraint used on DC was not authorized, that the facility did not adhere to relevant restraint-related policies, and BHDC direct care staff did not follow the training they were provided.

There are several steps the Respondent should have taken to prevent this situation including but not limited to:

1) Adhering to international, federal, state, and facility standards identified above,
2) Adhering to AR DDS policy 311-D,
3) Adhering to BDHC relevant policies,
4) Using only BHDC approved and taught restraint methods,
[redacted]
6) Not laying hands on and grabbing DC's arms,
7) Attempting non-violent de-escalation techniques, both before initiating the restraint and after DC was taken to the ground, when staff could have simply given DC space as opposed to forcefully holding him on the ground,
8) Per Hise (2022), following BHDC restraint training and NCI protocol and using supportive stance blocking and/or a pivoting technique, particularly if there was a location/position concern,
9) Adopting an organized approach to preventing the use of restraint such as the Six Core Strategies© or Ukeru which was developed with a DD population,
10) Allocating resources to train, retrain, and support/maintain staff competence in restraint prevention and establishing a culture of non-violence,
11) Teaching staff to not restrain any patient with a comorbidity that compromises digestion, respiration, cardiac functioning, etc.,

12) Obtaining external consultation to more effectively respond to DC's distress without hands-on procedures, e.g., considered safety circles, Ukeru approach (blocking pads and ensuring soft

[redacted]

16) Emphasizing restraint prevention and implementing effective alternatives to restraint use such as sensory-based approaches and other methods for staff to support clients in distress without hands-on procedures,
17) Ensuring greater medical oversight of the use of restraint including nursing presence for initiating, monitoring, and determination of earliest possible release,
18) Explicitly prohibiting ground restraint unless medically contraindicated,
19) Developing an organizational action plan of restraint prevention/reduction with a committee representing leadership, staff and families/persons-served.

In short, the Respondent should know the standard of care is rising. In an era of evidenced-based practice, accountability to the persons-served and others is owed. Exemplar programs and organizations serving a similar population have done significant work in creating low/no restraint services for people with developmental disabilities. This information should have compelled the organization to action to change their use of restraint with persons-served creating a safer environment of care for staff and patients alike.

Response:

This section of Dr. LeBel's report, perhaps the most important in the entire document, must be placed in the context of Dr. LeBel's ideological beliefs in order to be fully understood.

In January 2007, CMS's Final Rule governing patients' rights went into effect. The revisions to CMS standards were viewed as a setback in the opinion of some professionals, including Dr. LeBel, who have advocated for the elimination of seclusion and restraint in federally-funded facilities. In 2008, Dr. LeBel published a manuscript denouncing the regulatory change abd calling for an alternative approach to standard setting – one which would rely upon local quality improvement practices (LeBel. 2008):

> However, a new challenge to the national effort has emerged. In January 2007 CMS's Final Rule governing patients' rights went into effect (7). The Final Rule appears to move to a centrist position, dilute previous protections, focus on "safe" seclusion and restraint practices despite identifying their risks, and ultimately retreat from the standard-setting high ground claimed during the seven years the Interim Final Rule was in place. (LeBel 2008, Page 195)

In spite of her acknowledgement that the new regulations were more "centrist," Dr. LeBel called out mainstream advocacy and professional groups for their support of the revisions:

> It appears that CMS ultimately yielded to some of the most influential stakeholders who were among the 4,200 Interim Final Rule commenters, including the American Medical Association, the American Psychiatric Association, the American Hospital Association, and the National Association of Psychiatric Health Systems. These provider groups ... lobbied against the Interim Final Rule. (LeBel 2008, Page 195)

Dr. LeBel and her colleagues, most notably Kevin Ann Huckshorn who was cited as a contributor to the 2008 critique, were undaunted. Dr. LeBel proposed that advocates for the elimination of seclusion and restraint focus their efforts on States and specific facilities. She noted that these jurisdictions could implement policies and procedures which exceeded the "minimal standards" contained in the new CMS regulations:

> Ultimately, advancing seclusion and restraint standards is in the hands of facility and agency administrators. (LeBel 2008, Page 195)

However, Dr. LeBel went further, calling for a more activist role on the part of professionals seeking to in achieve the changes to clinical practice which she advocates. She stated that standard-setting entities, most likely including States, facilities, legislators and the Courts, should challenge this regulatory retreat:

> The failure to recognize these advances and incorporate this knowledge into the new standards not only threatens practice gains but also has spurred legal advocates to analyze the impact of this change, examine federal statutory language, and consider challenging this regulatory retreat (Huckshorn K, personal communication, March 19, 2007). In a quality improvement model, states and facilities must not rely on national standard-setting entities to lead change toward preventing and even eliminating seclusion and restraint. (Page 196)

It is worth noting that while Dr. LeBel incorporates 13 references in support of her opinions, her beliefs are not widely supported and the references provide only the thinnest of justifications for her opinions. In many respects, she is merely referencing her own thinking. For example, Kevin Ann Huckshorn, noted as a contributor to LeBel (2008), is the lead author of 3 of the references in the Cains Report. (Dr. LeBel's CV indicates that she served as a member of Dr.

Huckshorn's Doctoral Dissertation Committee or Doctoral Dissertation Discussant. In addition, Dr. LeBel is a co-author of all three of the citations.) Four references are to depositions collected in this matter. Documents prepared by the United Nations (UN) and World Health organization (WHO) and a British charity are also included. The list of references also includes one basic science article (Clark and Harris, 2004). Finally, there is one reference to CMS and that applies only to psychiatric hospitals.

It is self-evident that Dr, LeBel's opinions fall outside of the mainstream of thinking on the current standard of care for facilities such as BHDC. Dr. LeBel's dissatisfaction with the "centrist" opinion of CMS indicates that her opinions cannot be considered to be representative of the majority opinion of her peers regarding the standard of care for the use of seclusion and restraint. Further, given her non-centrist position on these issues, it is reasonable to question whether she can describe the standard of care for the use of seclusion or restraint at all. Having broadly rejected the appropriateness of seclusion and restraint in general, how could she define their appropriate use in the specific instance of Mr. Cains? Therefore, she does not appear to be qualified to offer an opinion that would reasonably reflect the current standard of care in the field.

In addition, Dr. LeBel likely sees her consultation as an opportunity to practice the same "legal advocacy" that she called for in 2008. As she noted,

> In a quality improvement model, states and facilities must not rely on national standard-setting entities to lead change toward preventing and even eliminating seclusion and restraint. (LeBel 2008, Page 196)

This language ties closely to the specific critique offered of care at BHDC:

> In an era of evidenced-based practice, accountability to the persons-served and others is owed. (LeBel Report, Page 10.)

Quality improvement is an approach to practice which involves constant revisions to practice parameters. As noted by CMS:

> Quality is defined by the National Academy of Medicine as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
>
> Quality improvement is the framework used to systematically improve care. Quality improvement seeks to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations. (accessed on 1/5/2023 at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Quality-Measure-and-Quality-Improvement-

#:~:text-Quality%20improvement%20is%20the%20framework,%2C%20healthcare%20systems%2C%20and%20organizations.)

Quality improvement is a dynamic process which can result in changes to care practices, However, quality improvement outcomes do not represent the standard of care. The results of quality improvement are highly variable depending upon the area of study, the target population, local resources and other factors and conditions, proposed interventions, and the types of data collected and their analysis. To suggest, as does Dr. LeBel, that quality improvement approaches supersede the existing standard of care is inappropriate.

However, this philosophy explains Dr. LeBel's opinions in the Cains matter. Having implied that quality improvement represents the standard of care, Dr. LeBel gives herself the latitude to specify what "improvements" "should" be made at BHDC in order to meet this new standard. This approach results in her making recommendations for 19 specific changes to practice at BHDC. In Dr. LeBel's thinking, BHDC cannot meet the "standard of care": without implementation of these requirements. She sees herself, and her role in the Cains matter, in heroic terms:

> Without forthright, consistent leadership to elevate practice standards, the possibility of seclusion and restraint "regulatory scotoma" looms large— (Lebel 2008, Page 196)

Dr. LeBel's use of this consultation as an opportunity to "elevate practice standards" rather than function in a more "centrist" role as an arbiter of the current standard of care is readily transparent. She states:

> Exemplar programs and organizations serving a similar population have done significant work in creating low/no restraint services for people with developmental disabilities. This information should have compelled the organization to action to change their use of restraint with persons-served creating a safer environment of care for staff and patients alike. (LeBel Report, Pages 10-11)

At this point, Dr. LeBel is no longer discussing the standard of care. She is advocating for the elimination of restraints at BHDC – a position which is inconsistent with the standard of care. In regard to specific claims made by Dr. LeBel in this section, Dr. LeBel claims that:

> "DC died as a result of being physically restrained by staff on the floor/ground."

However, reaching such a conclusion would require Dr. LeBel to make a medical judgment, something which she is not qualified to do. Dr. LeBel assumes that since Mr. Cains vomited while he was being restraint, the restraints caused him to vomit. The simultaneous occurrence

of two events does not determine causality. No evidence has been presented to establish causality. Indeed, BHDC staff dny any knowledge that such an association may exist. As noted by Mr. Hise:

> Q Uh-huh. Okay.
> A I personally never heard of a death due to a restraint incident and choking together.
> Q I'm sorry. Say that again.
> A In my career, I haven't experienced a choking death with a resident during a restraint procedure. (Hise Deposition, Page 41)

This perspective was shared by Dr. Hamid:

> Q If you could, finish your thought for me about in the real world. In the real world, what? I don't quite understand what you meant there.
> A I mean, I have not come across any case studies that the patient who was physically restrained ended up choking to death because of that physical restraint. I have not seen any case reports. It has not come in my practice, you know, even working at BHDC here and other facilities.
> (Hamid Deposition, Page 38)

In addition, Dr, LeBel stated that:

> BHDC Staff Development Coordinator and Restraint Trainer Mark Hise affirms that the fatal restraint used on DC was not authorized, that the facility did not adhere to relevant restraint-related policies, and BHDC direct care staff did not follow the training they were provided.

This was not the case. Mr. Hise repeatedly stated that he was unaware of the specific circumstances around the restraint and death of Mr. Cains and could not render an opinion about the quality of care that was rendered.

> So if a staff member, if a direct care staff member, were to hold a client on the ground because that client is having a behavior episode and that staff member were to hold that client on the ground, restrain that client while they're on the ground for several minutes, hoping the client will calm down, would that be an improper restraint?
> A I really don't have enough information to speculate on that. That's -- you know, I don't know the details of the situation. (Hise Deposition, Page 21)

And:

> But, assuming he's telling the truth about being close to that ledge, couldn't he still have sidestepped away? Couldn't he have sidestepped away to avoid the client and the ledge?
> A It's kind of hard to say, I mean, unless you're in that situation yourself. I mean, I can't -- I don't want to say that he did the wrong thing or did the right thing. I can't really say. (Hise Deposition, Page 54)

Dr. Lebel mistakenly implies that the NCI curriculum used to train staff on behavioral management techniques represents actual BHDC policy. It does not. The curriculum cited by Dr. LeBel is used for educational not regulatory purposes. Although they were not specifically asked, staff could have reasonably believed that the application of personal holds on the ground was less restrictive than the application of personal holds followed by the use of a mechanical restraint (Papoose Board).

As is evident from the results of regular CMS surveys, BHDC demonstrates a high level of compliance with CMS policy. In contrast, there is no expectation that staff will master and consistently apply every element of the NCI curriculum. After all, staff are deemed to be proficient in behavioral techniques if they achieve a test score of 70%.

> Q And my understanding is, in order to pass, each person has to get 70 percent or better, at least 70 percent of the answers correct; is that right?
> A Correct.
> Q And that's both for the restraint portion of the test but then also just the overall score of their test as well?
> A Correct. (Hise Deposition, Page 15)

Effectively, the NCI curriculum represents a practice parameter in which substantial deviation from the curriculum is anticipated. (See Eddy D. A Manual for Assessing Health Practices and Designing Practice Policies: The Explicit Approach. American College of Physicians. 1992) As a result, Mr. Hise would expect a high degree of variation in the application of skills acquired as a result of the training he provides.

In regard to certification, the Crisis Prevention Institute (CPI) only certifies Trainers. CPI does not certify users or others who receive training in NCI. As noted by CPI:

> Nonviolent Crisis Intervention® Trainings previously concluded with a post-test and evaluation which measured that growth and learning goals were met.
> Now CPI Nonviolent Crisis Intervention® 2nd Edition Training concludes

> with a classroom test to measure staff growth and determine if learning goals are met. The culmination of the program is also an opportunity for staff to take steps towards developing an action plan to implement the strategies learned in the program into everyday practice. (CPI Nonviolent Crisis Intervention® 2nd Edition Training Instructor Guidance Resource.)

Finally, Dr. LeBel includes a list of 19 specific actions which she states that BHDC "should have taken to prevent this situation." However, most of these recommendations are not contained within the standard of care embodied in CMS, AR DDS and BHDC regulations. Dr. LeBel justifies her recommendation that these 19 additional requirements are incorporated within the standard of care by stating:

> In short, the Respondent should know the standard of care is rising. In an era of evidenced-based practice, accountability to the persons-served and others is owed. Exemplar programs and organizations serving a similar population have done significant work in creating low/no restraint services for people with developmental disabilities. This information should have compelled the organization to action to change their use of restraint with persons-served creating a safer environment of care for staff and patients alike. (LeBel Report, Pages 10-11)

As noted previously, this paragraph represents Dr. LeBel's philosophy about restraint use. Her statement does not reflect the standard of care. However, Dr. LeBel's statement clearly demonstrates the underlying bias she holds against the role of CMS in setting the standard of care. In recommending that 19 additional requirements be met in order for BHDC to meet the standard of care, Dr. LeBel denies the validity of the role of CMS in setting standards of care. She suggests that the standard of care is "rising" but offers no definition of what she means or why this should.d be the case. To suggest that BHDC is required by the standard of care to be "an exemplar program or organization" and deliver "low/no restraint services for people with developmental disabilities" is simply an exercise in advocacy, mirroring what she has articulated in her publications – that having moved to a "centrist" position, CMS should not be relied upon to define the standard of care. She has called for "legal advocates" should focus their efforts on effecting change at the State and facility level. In regard to the matter of evaluating whether or not BJHDC met the standard of care in rendering care to Mr. Cains, these opinions, and the burden of additional requirements needed to meet the standard of care, are simply not relevant.

Opinion Two: The respondent facility's emergency response policy fell below the standard of care.

Dr. LeBel stated that:

The Respondent facility's policy, which prevented non-medical staff from calling 911, created an unnecessary obstacle to emergency response and life-saving intervention. The artificial layer of on-site communication created a dangerous circumstance for DC and all residents and likely contributed to DC's death. This approach to emergency intervention no longer occurs in other DDS state systems, such as Massachusetts, New Jersey, and Washington. Massachusetts DDS policies have required staff working in DDS settings to report events that they have reason to believe are harmful, including calling 911, since 1999 (#1999-4). New Jersey DDS enacted *Danielle's Law* in 2003 requiring staff working in services for people with intellectual/developmental or traumatic brain injury to call 911 when there is a life-threatening emergency to prevent delayed medical response Division of Developmental Disabilities | Danielle's Law (nj.gov). Washington state encourages staff and caretakers serving people with developmental disabilities to dial 911 and reach out online in the event of emergency circumstances (Report Concerns Involving Vulnerable Adults | DSHS (wa.gov)).

Recognizing the importance of unimpeded 911 access, broad federal legislation (Kari's Law) enacted in 2020 establishes that employers have a duty of care and a legal responsibility to help protect anyone using their phone system. When an emergency call takes place from within an organizations' network and the caller cannot connect to 9-1-1, or if dispatchers cannot pinpoint the caller's location, the employer can be liable in the event of an unfavorable outcome due to a delayed response. New legislation has also introduced penalties for any business or organization that does not comply.

Response:

(1) As previously noted, Dr. LeBel has no standing as a medical expert and has no basis for offering an opinion as to the standard of care for the delivery of medical services, including emergency medical services, at a facility such as BHDC.

(2) As previously noted, Dr. LeBel has stated that CMS regulations are the standard of care for the delivery of health care services at ICF IDDs including BHDC. CMS conducts surveys of BHDC and has determined that the system of emergency response services at BHDC is reasonable and consistent with the standard of care for settings like BHDC which exist in rural, medically-understaffed areas. Dr. LeBel's opinion is inconsistent with that of CMS.

(3) As previously noted, Dr. LeBel has stated that CMS regulations are the standard of care for the delivery of health care services at ICF IDDs including BHDC. She has also noted that jurisdictions are permitted to provide additional services which may exceed the standard of care but that there is no Federal requirement for them to do so. Dr. LeBel has publicly expressed her frustration that CMS does not do more to restrict the use of

restraints at publicly funded facilities. These opinions have no merit. The State of Arkansas is not obligated to implement the service system modifications described as currently in place in Massachusetts, New Jersey, or Washington nor is the State of Arkansas compelled to respond to Kari's Law or some other, irrelevant corporate mandate.

(4) Finally, Dr. LeBel claims that "the artificial layer of on-site communication created a dangerous circumstance for DC and all residents and likely contributed to DC's death." Based upon the available evidence (summarized in my general report), I most strongly disagree. In using its own staff, BHDC was able to provide emergency care to Mr. Cains within one to two minutes of the call for assistance. In contrast, it took 13 minutes after the 911 call for emergency medical services to arrive on campus and begin to provide care to Mr. Cains. Further, it took an additional 9 minutes for emergency medical personnel to achieve a partial reopening of the airway. There is no reason to believe that the outcome would have been any different if the partial opening of the airway occurred at 22 minutes rather than 24 minutes after the onset of the event.

C E R T I F I C A T E

STATE OF ARKANSAS)
)
COUNTY OF PULASKI)

I, DEBBYE L. PETRE, Certified Court Reporter in and for the County of Pulaski, State of Arkansas, duly commissioned and acting, do hereby certify that the above-entitled proceedings were taken by me in Stenotype, and were thereafter reduced to print by means of computer-assisted transcription, and the same fully, truly, and correctly reflects the proceedings had, with portions dependent on the quality of the Zoom audio.

I FURTHER CERTIFY that I am not attorney or counsel of any of the parties, nor am I relative or employee of any attorney or counsel or party connected with the action, and have no interest in the outcome or results of this proceeding.

WHEREFORE, I have subscribed my signature and seal as such court reporter in the City of Little Rock, County of Pulaski, State of Arkansas, this the 9th day of February, 2023.

DEBBYE L. PETRE, CCR #118
COURT REPORTER IN AND FOR
PULASKI COUNTY, ARKANSAS

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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFEE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS — CLAIMANT

VS. CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

DHS Summary of Deposition of Dian Elliott
(Taken January 23, 2023)

Direct Examination by DHS

Page 6:

Ms. Elliott works for the Department of Human Services, Office of Long Term Care. The Office of Long Term Care regulates nursing homes, ICFs, PRTFs. She has been with DHS for twelve years. She has an Associate degree in Medical Assisting, an Associate degree, RN, and a certificate for Legal Nurse Consulting. She has served as a certified nurse assistant and as a DON in a nursing home.

Page 7:

Ms. Elliott stated a DON is the Director of Nursing Services. She is familiar with Intermediate Care Facilities for individuals with Intellectual Disabilities. **She said OLTC regulates ICF/IIDs, but it's really for CMS as they go in and survey to make sure the facility is following CMS regulations**. She stated she did that at Booneville Human Development Center in June of 2020. She has performed close to 700 surveys in total.

Page 8:

Ms. Elliott stated she is a state employee but contracted through the CMS. CMS is the Centers for Medicare and Medicaid Services. **CMS is the federal government**.

Surveyors must be certified by passing the CMS "State Minimum Qualification Testing." It is a national test. Ms. Elliott was first certified as nursing home surveyor and then she was certified to survey ICF/IIDs.

Page 8-9:

Ms. Elliott stated a survey is where you go in and you do regular reviews, observations and interviews, for compliance with the regulations. A survey is an inspection.
Ms. Elliott has been certified by CMS since 2001. She is trained by CMS for ICF/IIDs.

Page 10:

For ICF/IIDs there are annual surveys, which are the recertification surveys, and then there are complaint surveys**. In each survey you make sure that the facility is following the regulations. The [ICF/IID] regulations are called Appendix J. That's the State Operations Manual. This is for the ICF facilities.** [Appendix J is DHS Ex. 3].

Page 11:

Ms. Elliott stated she does surveys for ICF/IIDs. She estimated that she has done probably 400 or 500 surveys since she was certified in ICF/IIDs. A complaint survey is where either the facility, family, or anonymous caller complains about something regarding the facility. They then go out and investigate it.

Page 12:

> **Q:** When you go out to the facility, I think you has said earlier, you are looking for compliance?
> **A:** Yes.
> **Q:** Compliance with what?
> **A:** The CMS regulations.
> **Q:** And that would be Appendix J?
> **A;** Yes.

Page 13:

Ms. Elliott stated, during the survey, they do record reviews and interviews. They look at medical records and anything else that would have to do with the complaint including the master records and care plan. **The purpose of the investigation is to determine compliance.**

Page 14:

Ms. Elliott stated once they are done with the investigation, then they write up report and the [form] 2567, which is a Statement of Deficiencies, *if there are any*. The possible outcomes from a survey are :

- "Unsubstantiated" means that the event could have happened but at the time of the event and how the facility responded there was not any deficient practices that were identified.

- "Substantiated" means that the way the facility responded or what happened, that the event happened and that they were not in compliance with the federal regulations.

The federal regulations are Appendix J.

Page 15:

Q: All right. And so, the form that you use, that is called a 2567?

A: Yes.

Looking at the 2567 sent to the BHDC, Ms. Elliott testified the survey was completed 6-30-20. Per the back page, they conducted an infection control survey for COVID and a complaint survey.

Page 16:

Ms. Elliott stated the complaints are identified on the back page. She conducted this survey. All three complaints investigated were "unsubstantiated." Complaint number 26043 is related to David Cains. The others were unrelated to David Cains.[1]

Page 17:

Ms. Elliott identified DHS Exhibit 1 as the Form 2567. Form 2567 never has resident names on it. Her office determines whether there were any deficiencies found based upon her investigation.

[1] Note for context: It was later clarified that there were two complaints which Ms. Elliott surveyed and reported on the Form 2567 which were related to David Cains: **Complaint number 26043 and Complaint number 25996.** Elliott depo pp. 39-40. Elliott depo Exhibits 2 and 3 [**DHS Trial Ex. 5B, 5C**]. **They both were unsubstantiated**. *See* Elliott depo. Ex. 1 -Form 2567 [**DHS Trial Ex. 5A**].

Q: **And what was the outcome of that determination?**
A: That there were no deficient practices.

Page 18:

Ms. Elliott identified deposition Exhibit 2 as the "Complaint Investigation Report" which was completed on July 1, 2020 for the BHDC [DHS Trial Ex. 5B]. Its reflects that she exited BHDC on 6-30-20 at 3:07 p.m.

Page 19-20:

Ms. Elliott stated she reviewed all the documents listed under Section 4 and conducted staff interviews of an LPN and three RCTs. She testified as to which the regulations looked at for the investigation, including W127.

Page 21-22:

Ms. Elliott stated **W127** references federal regulations in Appendix J. Ms. Elliott stated 127 **is "To ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment."** That is what she was determining in her investigation as to whether the facility, Booneville Human Development Center complied with. **She found BHDC was compliance with this regulation.**

Page 23-24:

The next regulation Ms. Elliott look at was **W128** which provides **"**Ensure that clients are free from ***unnecessary*** drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints."

Q: Okay. And so, you know that during the course of this incident with regard to David Cains that you were investigating there was a restraint utilized; correct?
A: Yes.
Q: Now, under this [W128] and from the Office of Long Term Care policy, are restraints allowed?
A: Yes.
* * *
Q: What were you looking for in 128?

A: To make sure there was adequate reason to apply physical restraint.

Q: Okay. With regard to this particular regulation, W128, what was your determination as to whether the facility complied?
A: They were in compliance with this regulation.

In relation to David Cains, **W153** would be to make sure that the required notifications were made.

Page 25:

Ms. Elliott stated **W154** requires "The facility must have evidence that all alleged violations are thoroughly investigated." **She testified she determined the facility investigated the incident and reviewed the facility's investigative report**, which included the incident, who was involved, when it happened., what the facility did to protect any other clients and that staff responded correctly. **She found that the facility was in compliance with the regulations**.

Page 26:

Ms. Elliott stated **W285** is to "make sure that everything was done correctly to try to ensure that there was no harm to the client." She stated that **W285 allows interventions to manage inappropriate client activity and behaviors.**

Page 26-28:

She stated W285 says: "Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected."

Q: And so, were you able to – based upon your investigation, observations, and interviews, were you able to determine whether there was compliance with that section [W285]?
A: I was.
Q: Okay. Was there?
A: Yes.

Ms. Elliott testified that **W286** provides "No intervention was – physical restraint cannot be applied for disciplinary actions." With regard to the complaint of the death of David Cains, she testified the physical restraint was not applied for disciplinary purposes.

> **Q:** -- were you able to determine whether the physical restraint applied prior to the incident was for disciplinary purposes?
> **A:** It was not.
> **Q:** What was it for?
> **A**: **It was a safety for the client and for the staff.**
> * * *
> **Q: Okay. They were compliant?**
> **A: Yes.**

Page 28:

Ms. Elliott stated **W331** says: "The facility must provide clients with nursing services in accordance with their needs." She determined "[**t]he facility was in compliance** based upon her investigation.

Cross-examination by Claimant

Page 30:

Ms. Elliott stated she reviewed notes, the 2567, the complaint report, and Mr. Cains IPP in preparation for the deposition.

Page 31:

The investigation at the facility took one day. It was from 8:40 a.m. until 3:07 p.m.

Page 33:

The reason there can be more than one complaint is if more than one person calls in a complaint. It could be the facility, family or staff.

Page 39-40

*** At this point, a clarification was made that DHS deposition Exhibit 2 pertains to Complaint No. 26043 and deposition Exhibit 3 was introduced by DHS with regard Complaint No. 25996. [2]

[2] Note for context: These are DHS Trial Exhibits 5B and 5C.

Pages 40-42

Ms. Elliott was questioned by counsel for claimant about the various categories labelled and boxes checked on the Complaint Investigation Form by Ms. Elliott during the survey.

Page 43-44:

Ms. Elliott testified that although there is a separate category for noncompliance for abuse and neglect, she testified:

- "And I don't make the categories that they are listed under."
- "Whatever the complaint is, I will investigate what it is.
- "I do not just stick with these categories. This is just something that the office lists them under." [3]

Ms. Elliott states they [the office] chooses the category. She testified she does not choose the category listed.

> **Q**: **Would that suggest that there was no complaint related to restraint usage?**
> **A: No, that's not what that suggests. What it is, is that they put it underneath that category. When I investigate it, I look at the *whole* complaint. And *because it had to do with a restraint, I also looked at that*, also.** [4]

Page 46:

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[3] Note for context: Counsel is questioning Ms. Elliott *only* on how the complaint allegations were characterized by the office as reflected deposition Exhibits 2 and 3, which identifies the category of the complaint allegations. **It is questioning on how the office identified the what the category the category allegations fell under. Counsel is not questioning Ms. Elliott on the actual regulations investigated or the facility's compliance with those regulations.** While both complaints pertained to David Cains, despoition Ex. 2 listed "Quality of Care/Treatment" as the category based on Complaint 26043 and "Accidents/Supervision" as the category based on Complaint 24996.

[4] Note for context: Ms. Elliott already testified she (1) was aware a restraint was utilized during the behavior, and (2) and investigated the complaint under, among other regulations, W128 which pertains to whether the restraint was unnecessary.

Ms. Elliott testified that Mr. Cains had been restrained on either his left or right side and then vomited. The nurses responded but were not able to clear the airway. EMS responded, transported him to the hospital where Mr. Cains died. She stated "I know that it was just a hold to keep him from hurting himself."

Page 55:

> **Q:** In reviewing your notes, does anything stick out to you as particularly relevant to this case that you wanted to tell one of us?
> **A:** Just that as far as the staff was concerned, they responded the way they needed to.

Page 58:

> **Q**: Okay. And for purposes of this investigation, which client care areas were part of your survey?
> **A:** The abuse, neglect, and restraints.

Page 59:

> **A**: But, no, I mean, it – you know but I looked at the – **I looked at the circumstances around his death."**

Page 63-65

Ms. Berry stated she investigates facility compliance with the regulations. If a staff member violated the regulations' it would be on the facility, yes." For a facility to be in compliance o noncompliance it would be based on what the people working there do or not do. If a staff member did something in violation of the regulations, she would cite the facility.

Page 68-69:

If staff were to commit physical or verbal abuse, sexual, psychological abuse, the facility must take steps to ensure that it does not happen again and clients are protected. "I look at the staff's actions, and then I look at the response the facility took related to the staff's actions."

Page 71:

Appendix J is the only set of policies she uses as a surveyor to determine facility compliance.

Page 72:

Appendix J covers restraint use.

Page 73:
She is aware the facility also has it own policies.

Page 75-77:
She reviewed Exhibit #3. [5]

Page 77-80:
There were two complaints because the facility could have reported the incident to OLTC and somebody else may have reported it such as family. It is for the same client. Exhibit 3 states it was reported by the facility because it says "IRIS Generated Complaint."

Page 82:
She interviewed the same LPN and the three RCTs for this complaint as she did for Exhibit 2.[6]

Page 85:
In response to a question for Counsel for Complaint, again, about the ***category of the allegation*** noted on the narrative form, Ms. Elliott testified:

> **A:** That's correct because that is not the category the office listed. Though restraints were --- the restraint categories was looked at on both of them [complaints]. But when we write our – under Decision-Making and Closing Remarks, we use the category that the office decided to put on the intake form.

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[5] Note for context: Counsel is again questioning Ms. Elliott *only* on how the complaint allegations were characterized by the office as reflected deposition Exhibit 3, which identifies the category of the complaint allegations. **It is questioning on how the office identified what the category the category allegations fell under. Counsel is not questioning Ms. Elliott on the actual regulations investigated or the facility's compliance with those regulations.** While both complaints pertained to David Cains, despoition Ex. 2 listed "Quality of Care/Treatment" as the category based on Complaint 26043 and "Accidents/Supervision" as the category based on Complaint 24996.

[6] Note for context: Although there were two complaints regarding David Cains, Ms. Elliott had already testified that survey on these was conducted on June 30, 2020. *See* Elliott depo. p. 31.

Page 88-89:

A: I determined that the facility did not violate [W]127.
Q: Okay. Do you think perhaps the individual staff members abused Mr. Cains?
A: Not according to the investigation that I did.
Q: Okay. And specifically, what is the basis for your opinion that staff members did not physically abuse Mr. Cains?
A: Because during my investigation I could not – I did not determine that there was any abuse or neglect by the staff."
Q: Would you agree with me that *unnecessary – unnecessary* physical restraint is a form of abuse?
A: *Unnecessary?*
Q: *Unnecessary.*
A: Yes.
Q: Look at 128, tag 128.
Q: What does this regulation require?
A: That there is a reason to place a client in a physical restraint or give them drugs that would alter their mental state.
Q: This is a prohibition on unnecessary physical restraint; correct?
A: It's a regulation on *unnecessary* physical restraint. [7]

Page 90-93:

Ms. Elliott testified the incident was "thoroughly" investigated by the facility in their internal maltreatment investigation, which was reported to OLTC within the five days as required, because the facility conducted their interviews. She makes sure the interviews were conducted. She further testified **she does her own investigation and does not reply on what the facility had done.** She stated:

> "I determine myself whether they are in compliance with it [federal regulations] So I do not rely on their investigation, I completely do my own from step one."

Part of the compliance with the regulation is that the facility conducted an investigation.

Page 96:

[7] Note for context: The restraint on David Cains during his behavioral episode was *necessary* and, as a result, she found no abuse or neglect.

Counsel then asked about Appendix J 276 which she stated required the facility to develop and implement written policies governing inappropriate client behavior.[8]

Page 100:

> Q: All interventions – I'm going to read this. "All interventions for management of inappropriate client behaviors which are approved for use in the facility are clearly stated and described in its policy." Did I read that correctly?
> A: Yes.

Page 104:

Counsel the Claimant then asked the witness about the regulations on the least restrictive technique used. Ms. Elliott testified that "The specific techniques that have been determined through assessment have been to be least restrictive for each client." [9]

[8] Note for context: This line of questioning is misleading for two reasons. First, this is not one of the regulations listed by Ms. Elliott. Second it is *undisputed* that the **facility had written policies governing inappropriate client behavior.** *See* DHS Trial Ex. 4 - DDS Policy 3011-D "Behavior Management." Moreover, Mr. Cains 2019 IPP addressed his "physical aggression" behaviors on pp. 9-10. *See* 2019 IPP – DHS Trial Ex. 10. The IPP authorized both Category I procedures (3011-D) and emergency procedures.

[9] Note for context: The CMS State Operations Manual, W278 – **DHS Ex. 3** – states: "In emergency situations where unanticipated behavior requires immediate protection of the client or others, the technique chosen ***is*** the least restrictive appropriate technique possible." (emphasis added). It is unclear why counsel is inquiring about this regulation as the restraint employed was (1) authorized in the 2019 IPP (**DHS Ex. 10, pp. 9-10**), (2) authorized in DDS Policy 3011-D (**DHS Ex. 4**), and (3) is deemed the least restrictive pursuant to CMS State Operations Manual W278 (**DHS Ex. 3, Section W278**).

Page 108-109:

Ms. Elliott explained that under the federal regulations, the IPP says the IPP should state the *type* of restraint but the IPP does not have to describe them. [10]

Page 115:

> Q: For example, if a facility allowed clients to be physically restrained in a seated position, you would agree that would need to addressed in the facility's policies and procedures.
> A: No. [11]

Page 118:

She testified she looked at tag 280.

Page 121:

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[10] Note for context*: See* Note 7 above. The 2019 IPP (**DHS Ex. 10**) states: In the event that symptoms persist at a rate that interferes with programming, staff may employ **Category I procedures** (DDS 3011-D) , TACT**, or other Center emergency procedures if necessary, to protect from injury to client or others.**" DDS 3011-D is the "Behavioral Management" policy which identifies the types of physical restraints authorized including, for Mr. Cains, the Category I restraints and emergency restraints identified in the 2019 IPP on pp. 9-10. The type of restraints authorized *are* identified. David Cains was on the floor because he and Mr. Mattson toppled over when Mr. Cains "charged" or "went after" Mr. Mattson and made physical contact with him. *See* Counsel for Claimant's factually representation, on the record, that Mr. Mattson and Mr. Cains toppled over. Hamid depo. pp. 26-27; *see also* Mattson OLTC statement, DHS Trial Ex. 13.

[11] Note for context: David Cains' IPP authorized emergency restraints for safety of the client and others without qualification or restriction. Neither the IPP nor federal regulation distinguish, as counsel is attempting to do, whether the restraint for safety may be employed on the floor, seated, or standing. Emergency mechanical restraints take place while the client is on the floor being physically restrained.

> **Q:** *Hypothetically*, if you learned in your investigation that this was an unauthorized restraint that was used on David on the ground, could that have changed the outcome of your survey?
> **A:** It's possible that it could have as far as the use of an unauthorized restraint, yes. *As far as the facility being responsible for his death, probably* ***not****.*

Pages 126-134:

Counsel asked a series of questions regarding the least restrictive technique to be used to restrain, when necessary, for safety. Ms. Elliott replied "yes." [12]

Page 139:

Ms. Elliott, again, testified "I do my own investigation" and "I do not go by what their facility has investigated."

Page 141:

> **Q:** Ms. Elliott, what if [hypothetically] one of the three staff members involved in the restraint on David Cains on this day also told you that the restraint used was not the least restrictive option available, would that have been important information to your survey?
> **Mr. Rosen**: **Objection. W278 Guidance tells us what the least restrictive is in an emergency situation**.
> **A:** I would have had to decide myself whether the least restrictive was used, because staff will say whatever about other staff if they don't like them. So, I use my evidence. [13]

---

[12] Note for context: Counsel for Claimant never actually asked the witness whether the physical restraint used was, in fact, the least restrictive. **Factually, Ms. Elliott never stated that the physical restraint for safety was not the least restrictive**. More restrictive restraints would have included mechanical restraints and chemical restraints; neither of which were utilized that day. Per CMS Appendix J, W278 (**DHS Ex. 3**), "In emergency situations where unanticipated behavior requires immediate protection of the client or others, the technique chosen ***is*** the least restrictive appropriate technique possible." (emphasis added).

[13] Note for context. *See* Notes 5 and 11 above regarding what Appendix J, W278, states about what is deemed the least restrictive" technique in an emergency situation.

Redirect Examination by DHS

Q: But under W296, which counsel, I believe asked you about earlier, are restraints allowed as an emergency measure to protect the client from harm or others from injury?

A: Yes.

Respectfully Submitted,

Arkansas Department of Human Services

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BEFORE THE ARKANSAS CLAIMS COMMISSION

CHRISTINE MCAULIFFE, as Special Administrator
of the ESTATE OF DAVID CAINS CLAIMANT

V. CLAIM NO. 220374

DEPARTMENT OF HUMAN SERVICES
(BOONEVILLE HUMAN DEVELOPMENT
CENTER) RESPONDENT

DHS Summary of Deposition of SYED HAMID, M.D.
(Taken May 26, 2022)

Page 5:

Dr. Hamid was David Cains' doctor.

Page 6:

Dr. Hamid is the medical physician in the BHDC. He an internist and hospitalist. Dr. Hamid started working at Booneville in 2007. He was there at least three days a week, including clinics. Dr. Hamid is hospitalist at Mercy Hospital.

Page 7:

Dr. Hamid stated he would see David Cains in the clinic for medical evaluations and yearly physicals but that is all the recollection that he has of him. He stated there are other physicians that come there including a psychiatrist and neurologist.

Page 8:

Dr. Hamid said whatever is discussed in IPP meeting is brought to his attention

Page 9:

Dr. Hamid testified that BHDC clients sometimes need early chemical intervention. Dr. Hamid said he does not recall ever being approached or ever being asked to approve a physical restraint on David Cains he would be restrained on the ground.[1]

[1] Note for context: [redacted] **Later in Dr. Hamid's deposition, on page 28, lines 1-4, Counsel for Claimant represented to Dr. Hamid that that "there was a struggle of some sort and the sort of topple over onto the ground. And I'll represent to you that that's how he got to the ground."**

Page 10:

[redacted]

Page 11:

Dr. Hamid said he does not recall it ever coming across his radar that a particular client was being restrained in an improper way physically, specifically on the ground. [redacted][2]

Page 13:

[redacted]

Page 14:

[redacted]

Page 15-16:

[redacted]

[2] Note for context: As noted by counsel, the order was unsigned and bears a print date on June 15, 2020; two days after Mr. Cains died. As Dr. Hamid testified, it appears this document was prepared to be an update for Mr. Cains but he had already passed away by the date it was printed for review and signature.

[redacted]

Page 17:

[redacted]

Page 18:

[redacted]

Page 20:

Dr. Hamid gave an example [when asked] of the type of resident who would be placed on the do not restrain list stating when you have a client with bad back problems, he would not put that client on a restraint.

Page 24:

Dr. Hamid stated he had not spoken with any other staff members about what happened on that day. [redacted] He said this is what he read and that's all he knows about it.

Page 25:

His understanding of what happened from the records he reviewed is that after lunch David Cains started kicking, yelling, biting and the staff attempted to settle him. He then vomited [redacted]

Page 27-28:

> **Mr. Gillispie**: I'll also represent to you that a behavior occurred. David and a staff member named Tyler Matson end up on the ground. How exactly David landed on the ground, whether he landed on his face, on his back, it's not crystal clear at this point, but he -- according to Mr. Matson, there was a struggle of some sort and **they sort of topple over onto the ground. And I'll represent to you that that's how he got to the ground.** Are you with me so far?
>
> **Dr. Hamid:** Yes, I am.

Page 31:

> **Q:** My question to you is, given your knowledge of David's history and your years of treating David, given the medical conditions that he suffered from, are you able to – do you have any opinion as to what might have triggered that vomiting that led to his choking and his death from a medical standpoint?
>
> **A:** It is impossible to be definite about what happened.

Page 32:

> **Mr. Gillespie:** I'll represent to you that the paramedic who responded to the scene claims that he was given faulty information, specifically says that I think a female nurse told him that David had choked on his food while eating his food and omitted the part about the ground restraint. **Frankly, I don't really care about that part. It's not important to my case.**

[redacted]

Page 34:

[redacted]

Page 35-36:

[redacted]

Page 37:

Dr. Hamid testified:

> I have not come across any case studies that the patient who was physically restrained ended up choking to death because of that physical restraint. I have not seen any case reports. It has not come in my practice, you know, even working at BHDC and other facilities.

Page 39:

Dr. Hamid said he doesn't disagree about the danger of physical restraints but explained, if there is no time for a chemical intervention, you have to hold this client because he is [behaving in a manner] which is a danger to himself or others. Dr. Hamid said a risk with restraining a client on

the ground is the physical assault of putting him on the ground, breaking a bone, or asphyxiation depending on how much physical strength is being used.[3]

Page 40:

[redacted]

Page 41:

> **Q:** Is it your opinion that the physical restraint likely had nothing to do with his death"
> **A:** I have no way to confirm on that, but I don't think so.

Page 42:

Dr. Hamid said extreme agitation can trigger a heart attack and can trigger a stroke but testified "I don't know if it can" trigger vomiting. It's a possibility..

Page 43:

[redacted]

[3] Note for context: Per Tyler Matteson and as represented by Counsel on pp. 27-28 above, David Cains was not taken to the ground but, instead, "toppled over" after making physical contact with Tyler Mattson during a struggle.

[4] Note for context: [redacted]

Page 44:

> **Q:** Is vomiting more likely to lead to choking if a person is on the ground as opposed to if they're standing upright?
> **A:** It can, you know, but, again, if you are in a left lateral position, then less chance, you know.[5]

Page 47:

Dr. Hamid explained it is a standard precaution if somebody is aspirating to put them in left lateral position so that the secretions are not going to the throat. Instead, he explained, they will just drool out through the angle of the mouth.

> **Q:** …but it's your opinion or your belief that most likely this physical restraint whereby David was taken to the ground and held on the ground did not have anything to do with his death.
> **A:** I don't think so.[6]

Page 48-49:

> **Q:** … is it your position that most likely that restraint event did not in any way lead to David's death? Did I state your position correctly? Is that you position, yes, no, or ---
> **A:** Its unlikely, but I cannot promise.

Dr. Hamid explained that he was not present and does not know how much force was used but reiterated that it was "unlikely."

Page 50:

Dr. Hamid further explained that, looking of the medical records, it does not look likely that that amount of force was used that led to his choking episode or event.

---

[5] Note for context: David Cains was in a left lateral position.

[6] Note for context: Although counsel repeatedly uses the term "taken to the ground" in his questioning, such characterization is inaccurate and even counsel has acknowledged and represented earlier that they simply "toppled over" during the struggle. *See* above - Hamid depo pp. 27-28.

Page 61:

Dr. Hamid said this patient had an episode of vomiting on which he aspirated. He testified in looking at the records, what he sees does not seem to him that excessive force was applied. Then [redacted]

Page 63-64:

[redacted] If one were *overly* sedated then anybody can aspirate if loaded up with medications that interfere with swallowing and too drowsy to swallow.

Page 67:

Dr. Hamid said aspiration is more of a risk in patients who are sedated and drowsy.

[redacted]

Dr. Hamid said David was in the left lateral position as required from what he sees in the documents.

Page 68:

[redacted]

Page 69:

[redacted]

[7] Note for context: [redacted]

[redacted]

Page 73:

[redacted]

Page 74:

Q: Again, he died because – he died after aspirating and choking. And your [redacted]

Page 76:

When (again) asked about aspiration, Dr. Hamid testified that, based on the documentation, it does not seem like there was any excessive force used. He testified Mr. Cains was in the left lateral position and that [redacted] So, *again,* that's my observation and that's – I cannot say it with certainty so that's why I said unlikely.

Page 78:

Dr. Hamid said he was aware that restraining clients on the ground for purposes other than transitioning to the mechanical restraints is disallowed.[9]

Page 79:

Dr. Hamid testified that, at that point in time, the restraint "was the only option." There was not time for chemical intervention. Dr. Hamid said they had to control him, and he never got that far

---

[8] Note for Context: Throughout the deposition Dr. Hamid often prefaces his testimony with "Again." Counsel for Claimant also periodically states "again" in his question to Dr. Hamid. The reason is because counsel repeatedly asks Dr. Hamid the same questions which elicits the same response from Dr. Hamid.

[9] Note for context: Mr. Cains was not transitioned to the ground. Both he and Mr. Mattson "toppled over" during the struggle when Mr. Cains made physical contact with Mr. Mattson. *See* above, pp. 27-28

for the chemical intervention because things happened so quickly. The documentation says he was kicking and hitting other people.

Page 80:

A: *Again*, I'm not there at this point in time.

Q: Well, why give me the opinion if you don't want to – you know, if you can't tell me –

A: Well, you kept asking me for my opinion.

BEFORE THE ARKANSAS CLAIMS COMMISSION

CHRISTINE MCAULIFFE,
as Special Administrator
of the ESTATE OF DAVID CAINS — CLAIMANT

V. CLAIM NO. 220374

DEPARTMENT OF HUMAN SERVICES
(BOONEVILLE HUMAN DEVELOPMENT
CENTER) — RESPONDENT

DHS Summary of Deposition of Samuel Scow
(Taken May 5, 2022)

Direct Examination by Josh Gillispie

Page 5:

Samuel Scow is a paramedic for Logan County EMS. The difference between an EMT and a paramedic is the standard of care, level of care.

Page 6:

A paramedic is a higher level of care. Mr. Scow stated he responded to an emergency call at the Booneville Human Development Center on June 13, 2020.

Page 7:

On page three of exhibit 1, it shows the 9-1-1 call came in at 11:37 a.m. and the dispatch received the call at 11:37 a.m. The responders got in route at 11:38.

(Exhibit 1 is introduced - Logan County EMS patient care record)

Page 8:

[redacted]

Page 9:

[1] Note for context: Although Mr. Scow initially testified did not know with whom he spoke, he later confirmed he spoke with [redacted] Mr. Scow may have been told it happened at 11:30,but verified that there were no clocks in the lobby of the Commons building for any accurate time reference.

David Cains was in the hallway which was in the lobby. No one told him David had been restrained by staff members. Mr. Scow said he was never told about any sort of behavior incident or emergency incident that required David to be restrained.[2]

Mr. Scow stated he was told that the patient was found on the floor in hallway and he had choked on his lunch. Mr. Scow [initially] testified **he did not know who he specifically talked to because "it was a pretty hectic scene and I just kind of interviewed as I am trying to do my interventions**. He stated, "**I do not always get to look at who's speaking in the eye or get their name**."

Page 10:

Mr. Scow recalled there were three women there and one man who was "kind of a gofer to get things they needed.[3] **He spoke with the women. He did not speak to the man.** Mr. Scow stated he completed the report. [redacted]

Page 11-12:

[redacted] Mr. Scow stated *he* relayed to the hospital the same things he was told by ones he spoke with at the scene. the folks he spoke to at the scene. Mr. Scow also stated said he was told that Mr. Cains collapsed in the hallway choking on his lunch.

---

[2] Note for context: Mr. Scow spoke to the nurses who were not present during the behavior episode. The BHDC nurses arrived *after* being called to the scene when David Cains became unresponsive.

[3] Note for context: Mr. Scow later confirmed he spoke with the nurse. The man acting as gofer was likely Tyler Mattson, with whom he did not speak.

[4] Note for context: On page 3 of Ex. 1, [redacted]

Page 13:

Mr. Scow state he was not told about a physical restraint and didn't see any restraints on the patient.

Mr. Scow said he was told David appeared to have choked on his lunch.

Page 14:

[redacted]

Page 15:

Mr. Scow stated he can't give any certainty as to whether the outcome would have been different.

He stated he was not able to achieve ROSC which is the return of spontaneous circulation.

Page 16-17:

[redacted]

Page 19:

[redacted]

Page 20:

[redacted]

Page 22:

[redacted]

[5] Note for context: [redacted]

Page 26:

Due to the Mr. Cains weight and the steps from the second floor lobby, Mr. Scow said they went through the cafeteria and used a ramp in order to leave, which required moving the ambulance. They determined there was no physical way to move that patient safely down those steps. Mr. Scow said getting in there took more time because of the steps.

Page 27-28:

[redacted]

Page 29:

[redacted]

Page 30-31:

Mr. Scow said when **arrived at the scene there were three women working the patient**. [redacted]

Page 32:

> **Q:** And this facility waited eight minutes from the time they knew he wasn't breathing to 9-1-1 was called, according to what you were told?
> **A**: Yes. [6]

[6] Note for context: This question and response is misleading and incorrect. Mr. Scow testified he was told it happened at 11:30 which, per his report and this testimony, was an estimated time. Per Mr. Scow, the call to 911 was recorded as 11:37 but did not start his response until 11:38. Nurse Amanda Schmidt testified she and the BHDC medical team arrived 1-2 minutes after the call for assistance (Schmidt depo. pp. 57-58). Nurse Deborah Noah testified it took 2-3 minutes after the call to respond (Noah depo. pp. 27-28). One to three minutes before the 11:37 call to 911 puts the actual time at 11:34 or 11:35.

Cross Examination by DHS

Page 33:

Mr. Scow said they have three stations in the county, two in Paris, one in Booneville. They had to be in Booneville with a 13-minute scene time.

Page 34:

Mr. Scow said his partner handles finding the buildings, because he's driving.

Page 36:

When asked, Mr. Scow stated no, they aren't always given the most accurate information. He stated **"[r]adio reports aren't always reliable whether it's from a skilled professional at a nursing home or this facility or someone's cousin who found grandma."** "Nothing's ever set in stone or specific and he takes it all with a grain of skepticism." Mr. Scow said if it's a hectic environment, he takes what information he can get and he tries to get the clearest picture. It's not always the most accurate. Mr. Scow said he can't identify who was present at the scene but she spoke to the women because, as he recalls, the man was sent off to do something."

Page 38:

Mr. Scow stated that the exhibit [introduced by Claimant's counsel] had a different narrative than the one Mr. Scow got from work. [redacted]

Page 40:

[redacted] **Although he later changed the narrative from *nurse to staff*, he confirmed that the staff he spoke with were the nurses**.[7]

Page 41:

[redacted] He speculated that he asked his usual questions such as how did he [patient] get here,

[7] Note for context: Mr. Scow spoke with the *nurses* who arrived ***after*** Mr. Cains choked and stopped breathing. In their BHDC emergency response, the nurses were not aware of the behavior episode or emergency restraint needed. Nurse Deborah Noah testified the call for assistance came in stating a resident was not breathing and did not state what happened. (Noah depo. 15-16). Nurse Amanda Schmitt, who was with Nurse Noah when the call came in, testified she immediately responded when told a resident was choking and not breathing (Schmitt depo. pp. 38, 40). Whichever nurse Mr. Scow spoke with during the emergency could only relate what *she* knew and what *she* observed.

how long has he been down or in this condition, what have you done, any patient history? **Mr. Scow stated he didn't notice any clocks in the room.**

Page 42-43:

Mr. Scow testified the only clock available was his watch. He did not see any [mechanical] restraints on this person. [redacted] If he had seen a restraint on David, he would have asked clarification. [redacted] Instead, he testified:

> **A: And the knowledge just helps me to pass that on or paint a picture when I go to the hospital. And for my narrative.**
>
> **But, otherwise, like if he was restrained, that all has an issue with what led up to the problem and I'm dealing with what's after the problem. The problem after, so it just paints a picture**

Page 44:

[redacted] He said he has gotten ROSC [on other patients after 30 minutes] but he can't say that patient had a positive outcome and walked out of the hospital.

Page 45:

[redacted]

Page 46:

[redacted]

Page 47:

[redacted]

[redacted]

Page 48:

[redacted]

Redirect Examination by Josh Gillispie

Page 49-50:

Mr. Scow [reviewing page 4 of the report] testified he was on the scene at 11:49 a.m. which means he was right in front of the building at 11:49. He was at patient at 11:50 which means to visualize and start the assessment.

Page 51-52:

[redacted]

Page 53:

[redacted]

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V. CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

DHS Deposition Summary of Tyler Mattson
(Taken March 31, 2022)

Page 8-9

Mr. Mattson graduated from the Booneville High School in 2013. He started college byt dropped out. Before working at Booneville, he worked at Rockline, which made baby wipes, and Walmart.

Page 11

Mr. Mattson started working at BHDC in February 2017. His title is RCA. It stands for residential care assistant.

Page 12

At the time of David Cain's death, Mr. Mattson's title was RCT, which is a residential care technician. After six months, he went from a RCA to a RCT, which is a six-month probation period. He left Booneville about six and a half months ago [early fall of 2021], he does not know specific dates. He left by his own choice. He stated that trauma was an issue for why he left BHDC. He stated "The David situation."

Page 13

Mr. Mattson stated the David situation ate at him. After four and a half years working there he needed a break. Mr. Mattson agreed it can be a difficult job. He then went to work at BOST, which is similar [to an HDC], but on a smaller scale. He stated BOST has facilities where individuals live such as group homes but he went to a person's apartment and watched them on the weekends.

Page 14

Mr. Mattson stated he left BOST and went to Walmart for a short time; and it was not for him. He missed the clients, is what it really boiled down to. He enjoys the work.

Page 15

Mr. Mattson said residential care techs are now required to have CNA training. Mr. Mattson stated that requirement came up about a year and a half ago. He stated he did CPR in his Phase class whenever he first came there, four and a half years ago.

Page 16

Ms. Mattson he has never been terminated from a job. [redacted]
He stated he has not had any other job that would have involved having to intervene in behavioral incidents with a client other than at Booneville.

Page 17

Mr. Mattson stated the BOST clients were not behavioral risks, they were living in an apartment for a reason, because they could be trusted to live in the community. [redacted]

Page 18-21

[redacted]

Page 22-23

Mr. Mattson testified as a residential care technician, he would get the clients ready for their work, clean their rooms and bathrooms. He would do their showers or prompt them to do their showers. He stated at the time of David Cain's death he worked from 8 a.m. to 4 p.m. He stated he worked five days a week.

Page 24

Mr. Mattson testified it was a one RCT for every eight residents. Mr. Mattson testified his job was to supervise the clients.

Page 25

Mr. Mattson stated to him it was kind of a glorified babysitter at times with extra steps such as showering, cleaning residents after accidents happen.

Page 26

Mr. Mattson said if there were eight individuals on the floor, he could be there alone. Otherwise, there would be two staff. He stated on June 13, 2020, he and one other person were responsible for the regular 10.[1]

Page 27

Mr. Mattson said there were two RCT's. He stated the other RCT was Eileen Helms. He stated she was in the lunchroom; she was not with him during the episode as she was with other clients.

Page 30

[1] Note for context: Mr. Cains' behavioral episode occurred in the lobby of the Commons Building, directly outside the cafeteria at lunchtime. It did not happen in the dorm. There were many other direct staff in close proximity, some of whom responded to Mr. Cains' behavior. **BHDC met and exceeded all legal staffing levels on June 13, 2020 which are mandated by state and federal regulations.** *See* Jennifer Berry depo, pp. 91-99, where she explains the staffing level requirements mandated in the CMS State Operations Manual- ICF/IID regulations -- and identified the actual staffing levels at BHDC for the period of June 1, 2020 – June 13, 2020. *See also* Berry Ex. 10 (ICF Regulations) and Ex. 11. (*actual* BHDC staffing ratios). Ms. Berry is the Assistant Superintendent of the BHDC.

Mr. Mattson testified what he remembers about training in 2017 was there were different levels of training. He stated it depended on the severity of the case. He stated it would just be basically walking hip to hip and walking them to sit down per se. Mr. Mattson stated it was called the "basket technique." He stated it is basically holding the elbow and holding the arm and then walking. He said typically you would want another person with that if they were being more aggressive. Mr. Mattson stated Phase 1 is the title of the initial training.

Page 31

He stated in Phase 1 they teach basic psychology and understanding of the different disabilities and how they could possibly respond to them and the techniques they could use to deescalate the situation. Included in the technique is removing them from what could be agitating them.[2]

Page 32

Mr. Mattson said positive reinforcements, removing them from what could be agitating them if there is a physical thing agitating them. He stated it was also in Phase 1 where they learned personal restraint maneuvers.

Page 35

Mr. Mattson stated to him middle-level type aggression is more verbal threats, you could see just them getting more clearly aggravated. He stated there is a little aggression. He said there is a little physical aggression, but there is not enough to apply anything else necessarily.

Page 37

Mr. Mattson testified he would use the "hip to hip" as a removal technique, to get them away from whatever the issue is and separation. He agreed that is for the lowest form of aggression. Mr. Mattson stated the basket is whenever they are kind of resisting, it is a step process. He stated the basket needs two people, it makes it easier.

[2] Note for context: As he explains later in his deposition, Mr. Mattson noticed Mr. Cains becoming agitated in the lunchroom, removed him, and took him to the bathroom, after which, Mr. Cains asked to sit in a lobby chair to calm himself before the behavioral episode began. *See* Mattson depo. pp. 99, 100.

Page 38

Mr. Mattson stated if there is a higher level of aggression, then one person would be behind who you are transitioning so you can lower them to the ground safely. He stated you would put them on the ground if they were in a full blown out of control, basically. Mr. Mattson stated taking them to the ground is more of a control mechanism.[3]

Page 39

Mr. Mattson stated putting the resident on the ground is the easiest way to proceed to mechanical if you need to. He stated there are lots of times where it is necessary to get them on the ground.

Page 40

Mr. Mattson stated the first two maneuvers they just talked about were taught in Phase 1. He does not know about the third one.

Page 42

Mr. Mattson stated the second week of Phase 1 was on-the-job training, and that is when they would give you an assignment of a particular client. Phase 1 lasted three weeks total.

---

[3] Note for context: As explained later in this deposition and acknowledged by Counsel for Claimant in his representations made during Dr. Hamid's deposition, Mr. Cains was **not** put on the ground intentionally but, instead, both Mr. Cains and Mr. Mattson toppled over after Mr. Cains charged at and made physical contact with Mr. Mattson. *See* Mattson depo. pp. 77, 102. *See also* Hamid depo. pp. 27-28:

> **Mr. Gillispie**: I'll also represent to you that a behavior occurred. David and a staff member named Tyler Matson end up on the ground. How exactly David landed on the ground, whether he landed on his face, on his back, it's not crystal clear at this point, but he -- according to Mr. Matson, there was a struggle of some sort and **they sort of topple over onto the ground. And I'll represent to you that that's how he got to the ground.** Are you with me so far?
>
> **Dr. Hamid:** Yes, I am.

Page 43

Mr. Mattson stated Phase 2 is six months after your Phase 1 training. He completed Phase 2 and that is how became a RCT. He stated he does not remember much about Phase 2.

Page 44

He stated after completion of the phase training, BHDC held CPR refreshers which, he believes, were held once a year.

Page 45

Mr. Mattson stated training was given by Mark Hise and Sandra Shipley. Mr. Mattson testified the basket, and the hip-to-hip training is called Noncrisis nonviolent crisis intervention. He stated the NCI was incorporated into the Phase 1.

Page 46

Mr. Mattson stated they were taught to use physical restraint when the resident is "being a threat to objects, to themselves, or to other clients or staff." He testified staff step in whenever the resident starts "getting real physical and actually trying to harm themselves or other people." Mr. Mattson would do his best to deescalate the situation as best as he could. Mr. Mattson stated he did not want to put hands on anyone.

Page 47

Mr. Mattson stated what he would first try to just talk to them. He said because most of the people he worked with were higher functioning, so they understood what they were doing wrong. He stated he could remove them by saying, "hey, let's go over here" and "let's you know, do this." [4]

[4] Note for context: [redacted]

Page 48

Mr. Mattson stated getting up, walking away, and giving the resident some space would be good for some of them, but generally when they were aggravated, they were in a crowded area.[5]

Page 49

Mr. Mattson stated if there was physical aggression to another person, he would lay a hand on the client. He said whether the physical aggression was to him or to another client or to another staff.

Page 53

Mr. Mattson testified he was taught to physically restrain clients on the floor if need be. He stated if he remembered correctly, you could hold a person on the floor for 15-minute check in period. He stated you would have to call back and get reauthorization by a Q [supervisor], that is what they were called.[6]

Page 54-55

He agreed if a client is just really out of control and he had to, he could restrain them on the ground for up to 15 minutes. He stated in his experience it is not going to last 15 minutes because, if they are still fighting, they will be placed into a mechanical intervention.

Page 56

[5] Note for context: Just before the behavioral episode, Mr. Cains had been in the cafeteria with the other BHDC residents and staff eating lunch. Amanda Schmitt, a BHDC nurse, testified that David Cains sometimes would get "overwhelmed" in the Commons Building while eating, and she would remove him and place him back in his dorm. *See* Schmitt depo. pp 7-8. Mr. Mattson testified he removed Mr. Cains from the lunchroom when he noticed Mr. Cains appeared to be getting agitated and took him to the bathroom and then allowed him to sit in the lobby outside the cafeteria to calm himself. *See* Mattson depo. pp. 95, 96, 99,100.

[6] Note for context: Recall that Mr. Cains and Mr. Mattson fell to the floor after Mr. Cains charged or lunged on Mr. Mattson.

Mr. Mattson testified they were taught about behavior patterns, but it was just a time learned. He stated it was a situational thing, you would learn your clients and learn what would trigger them and learn what they would do whenever they were about to have a behavior.

Page 57

Mr. Mattson testified he recognized Exhibit 1 from his annual training, which he said was taught for diffusing or avoiding a violent behavior. He stated that was a form of de-escalation.

Page 58

Mr. Mattson stated he was taught to pay attention to the distance between himself and the client. He agreed if the client is upset you are taught to stand if they stand, sit if they sit. He stated they were taught not to argue, threaten, or raise their voice or become judgmental. He said to keep your face passive and neutral as opposed to frowning and scowling or laughing. Mr. Mattson stated you are to stay relaxed and reassure the individual that you were there to help, and basically just be calm and nonthreatening as possible.

Page 60

Mr. Mattson stated the job is to not overreact to things. He stated "planned ignoring" is the term.

Page 61

When asked, Mr. Mattson testified that David Cains had "the wherewithal" "most of the time." **Mr. Cains would tell him, "I love you," "but that David Cains had his demons and sometimes, "would just explode."** He stated David would get upset and become physically aggressive.

Page 62

He stated he did not notice David having a problem with any staff members. David Cains was one of Mr. Mattson's assigned clients and was around him a lot. He was familiar with him.

Page 64

Mr. Mattson stated at 9:00 a.m. David Cains would be waiting for mobile [the van] to take him to work where he did recycling. He stated David was social with staff.

Page 65 Mr. Mattson stated he cared deeply about David Cains.

Page 66

Mr. Mattson testified he is not aware of David having caused injury to staff members or other clients. He stated he did not consider David a dangerous or violent client.

Page 71

Mr. Mattson stated the most common personal hold he would use for one minute would be hip to hip. He stated because of his knowledge of David Cains, that would be when there not a full-blown situation that would need more. He stated the next usual personal restraint would be "basket". [7]

Page 72-73

Mr. Mattson the described a different behavioral episode of Mr. Cains when asked by Counsel for Claimant. David Cains started screaming at nurse Kelly King and threatening to throw a thermometer at her. Mr. Cains was placed in personal hold for about three minutes and he calmed down.

Page 74

When asked by Counsel for Claimant, Mr. Mattson testified David Cains also had a behavioral episode on March 20, 2020 where he was threatening some of his own personal property.

Page 75

Mr. Mattson David had a tendency to go after smaller people and he did not want the nurse to possibly get hurt whenever he was going to be already agitated. Mr. Mattson stated he made the

[7] Note for context: Recall that the behavioral episode on June 13, 2020 began with a de-escalation by removal of Mr. Cains from the cafeteria, taking he to the bathroom, and then allowing he to sit in the lobby to calm. Mr. Cains then stood-up and charged at and made physical contact with Mr. Mattson. *See* Mattson depo pp. 99, 100. As a result, Mr. Mattson could not employ the "hip-to-hip" and other procedures described in response to counsel's questions about the common restraints used in other more graduated circumstances.

decision to intervene and lay hands on him physically and hold him for three minutes before he attempted to physically strike the nurse [on March 20, 2020].

Page 76

Mr. Mattson described another behavior where he heard a banging noise and saw Mr. Cains kicking his laundry basket. When he inquired what was wrong and that he need to calm, Mr. Cains replied "no, bitch" and tried to spit on Mr. Mattson.. Mr. Cains continued to fight him but then calm down and apologized.

Page 78

Mr. Mattson testified that at the time of David's death, Booneville policy was only medical staff could call for an ambulance.[8]

Page 79

He stated the facility was short-staffed right ***before*** COVID, but not too terribly short staffed. He stated it does not stick out in his memory that short staffing being a factor in his David Cains' death. [9]

Page 80

Mr. Mattson testified that if David's IPP specifically only allows for Category I procedures he would not know what was being talked about. Mr. Mattson was handed Exhibit 4 referred to as

[8] Note for context: BHDC's first aid policy actually informed staff that the first call should be to the medical team- BHDC nurses. It did not state that only medical staff may call for an ambulance.

[9] Note for context: BHDC was not legally or factually short staffed on any day in June, 2020. Staffing levels are determined by federal regulations and BHDC met and exceed the legally required staffing levels every day in June, 2020. *See* Berry Deposition, pp. 91-99.

Policy 3011-D. He stated he does not remember this policy but maybe he saw it in his early Phase 1. [10]

Page 83

Mr. Mattson stated he does not recall it being conveyed to him by a supervisor or anyone else that David's IPP provided for *only* Category I.

Page 84

Mr. Mattson testified he was questioned by Sandy Evans [the BHBC investigator] concerning David Cains' death.

Page 85

Mr. Mattson stated the incident was explained in the witness report and she questioned him immediately after the death. He stated the meeting lasted 15 to 20 minutes.

Page 86 Mr. Mattson stated she asked him what happened, but she did not interrogate him.

Page 87 Mr. Mattson testified Exhibit 5 is Client Rights and it is from the training materials.

Page 88 Mr. Mattson stated his role is to care for the residents.

Page 89

Mr. Mattson said he agreed the clients have a right to be free from physical restraint, except when specifically provided for a specific behavior or *to protect them from injury or causing injury*.

[10] Note for context: The question by Counsel for Claimant is misleading as Category 1 restraints are *different* from the emergency restraint procedures authorized in the IPP. *See* 2019 IPP pp. 9-10 which state "…staff may employ Category I procedures … ***or other Center emergency procedures if necessary , to protect from injury to client or others***." BHDC Policy 3011-D, likewise**, distinguishes between Category one restraints and emergency restraint**s addressing each in different sections of the policy. It is unclear why Counsel for Claimant is asking Mr. Mattson about Category 1. *See* Policy 3011-D.

Page 92-93

Mr. Mattson stated nothing happened on the way to lunch or during lunch that upset Mr. Cains but, from Mr. Cains' facial expression, he could tell, Mr. Cains was getting agitated. That is why Mr. Mattson said "Hey, let's go to the bathroom and get away."

Page 95

The bathroom is just off the lobby. Mr. Mattson testified David Cains was not happy, but he did not argue about being escorted from the cafeteria to the restroom. He stated he went into the bathroom with Mr. Cains.

Page 96

When specifically asked by Counsel for Claimant Mr. Mattson stated David Cains used the bathroom and urinated.

Page 98-99

Mr. Mattson stated David Cains asked "[c]an we stay out here in the lobby" and sat down in a chair.. Mr. Mattson said he "I have no idea" when asked what might have upset Mr. Cains. Mr. Mattson stated **David was sitting in a chair** and he [Mattson] was standing nearby but not towering over him.

Page 100

Mr. Mattson testified that Mr. Cains was sitting there and then grabbed a paper and went after him. "He grabbed it and then went after me. He was sitting down and then went after me to attack me." He stated "[h]e threw it down and then went after me" screaming "bitch." "He charged me ."

Page 101

Mr. Mattson testified he was about 6-7 feet away. **Mr. Mattson explained that when David Cains charged him, he "was running after me" and grabbed me."**

Page 102-103

Q: And then what – what did you do?

A: I tried to hold him and we kind of just *fell*.

Q: How did you try to hold him? Stand up and show us, please.

Like, I was – like, I just kind of grabbed him by the shoulders the best as I could , you know, with him – *momentum* –

Q: Yeah.

A: -- and we just kind of *stumbled over*, you know.

* * *

A: Like we tripped. Like – like, we just kind of fumbled around. Because it was, like, all in *one big momentum*, you know.

Page 104

When Counsel for Claimant asked about Mr. Mattson's written statement about Mr. Cains trying to hit him, he stated he does not remember what was in his statement as that was two years ago. "That is just what I remember." [11]

Page 105

Mr. Mattson testified **"He [Mr. Cains] fell and I kind of went with him, as far as I can recall."**

[11] **Note for context**: Counsel for Claimant **misstated** to Mr. Mattson what Mr. Mattson wrote in his written statement. Counsel for Claimant **incorrectly** represented to Mr. Mattson that in his written statement he only said that Mr. Cains "attempted to hit [him]" and made no mention that Mr. Cains lunged at him, as he had just testified. Mr. Mattson's written statement, which was attached to his deposition as "Mattson Ex. 9," actually included a statement that said "… shortly after he began screaming and cussing and ripped paper off the wall to throw ***he then jumped up after me* , spitting and attempted to hit me**." It is unclear why Counsel for Claimant's representation to Mr. Mattson failed to include this key statement which is consistent with his description at deposition (two years later) that Mr. Cains charged or lunged at him during the behavior. Even Dr. Lebel, who stated she only relied on Mr. Mattson's written statement, omitted that point when testifying and opining that it was Mr. Mattson who was the aggressor.

Mr. Cains testified he could not just use a blocking technique because "**I wouldn't have had room. I was against a ledge**."[12]

Page 106-107

Mr. Mattson testified he vaguely remembers giving a statement to Disability Rights Arkansas on July 29, 2020. He stated he has never seen the report. He stated the report says David landed on his face, but he did not hit his face. Mr. Cains landed face down. He stated they possibly misquoted him. Mr. Mattson stated the report made it sound like he smacked his face, he didn't. He landed towards his face but he did not hit his face.[13]

Page 108 Mr. Mattson stated he immediately turned David Cains on his left and Mr. Cains was resisting him.

Page 109

Mr. Mattson stated Mr. Cains was still resisting and fighting. He was still agitated. Mr. Mattson was wanting him to calm down. And was talking to him.

Page 112

David Cains was on his left side and Mr. Mattson was hold the left side and actively restraining the right arm because he was flailing.

Page 113

[12] Note for context: As described by Jennifer Berry, the lunchroom is on the second floor of the Commons Building and the behavioral episode transpired in the second floor lobby which is open to the first floor. *See* Berry depo. pp. 39-40. *See also* Berry Ex. 4B, 4C, 4H, 4I – photos of the second floor Commons Building lobby outside the cafeteria showing the half wall (which is similar to a balcony wall).

[13] Note for context: This forward facing direction of Mr. Cains face towards the floor is consistent with Mr. Mattson's testimony that Mr. Cains charged him and the "momentum" from Mr. Cains caused them to topple over. Mattson depo. pp. 102-103.

Mr. Mattson testified he believes this went on for a couple of minutes. He said When Mandy Jones arrived she was holding one side because Mr. Mattson was getting worn out. She was coming up to the lunchroom to monitor lunch. He stated he did not recall Ms. Jones holding Mr. Cains' head.

Page 114

Mr. Mattson stated Mr. Cains was still flailing and he is on his knees. Mr. Cains was still resisting, and screaming.

Page 115

Mr. Mattson stated David was screaming "Bitch, I hate you." He testified was going to let him up whenever he was calm.[14]

Page 116-117

[redacted]

Page 118

[redacted]

[14] Note for context: This is consistent with 42 U.S.C 483.450(d)(4) which directs that the client should be "released from restraint as quickly as possible." The CMS State Operations defines "as quickly as possible" to mean "as soon as the client is no longer a danger to self or others" and that "[d]ocumentation should support that the client was released from restraint as soon as they became calm." *See* 42 U.S.C. §483.450(d)(4); CMS State Operations Manual §W302. (emphasis added)

[redacted]

Mr. Mattson stated it was his best judgment at the time and "[i]t was a traumatic moment."

Page 119

[redacted]

Page 120

[redacted]

Page 121

[redacted]

Page 122 [redacted]

Page 123

[redacted]

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[15] Note for context: Although Claimant's narrative attempts to misstate the sequence of events about when Mr. Cains was rolled from his side to his back, Mr. Mattson clears up any question; [redacted]. See Mattson depo. 118, lines 7-11.

[16] Note for context: [redacted].

[17] Note for context: Dr. Brown-Forestiere, *Claimant's* expert witness, testified "[m]ost likely, it would be *futile* to try [redacted] *See* Brown-Forestiere depo. p. 83.

Page 124

Mr. Mattson did not speak to paramedics or the police. He stated he did not know what the paramedics were told.

Page 125

[redacted].

Page 128-129

Exhibit 8 is Booneville HDC Policy, Policy I-D-4. He stated he has been instructed on the policy in his Phase I class. It states that "Emergency restraint is defined as the least restrictive procedure and for the least amount of time to control severely aggressive or destructive behaviors." He described Mr. Cains behavior as severely aggressive stating "he went straight for me" and "had intent of attacking me."

Page 130

Mr. Mattson stated he was the only one there at the time [in the lobby] and there was not "a whole lot of build-up time." Mr. Cains not a little boy. **Physically, he was a big guy and "he was very explosive."**

Page 131

Mr. Mattson, in his direct work with David Cain, it was his experience Mr. Cains was very explosive and unpredictable.

Page 132

Mr. Mattson stated he did not let David up because David was still flailing and being aggressive, he was being violent.

Page 133

Counsel for claimant then asked if you could go back in a time machine, is there anything you would do differently? Mr. Mattson responds he didn't want to put hands on Mr. Mattson but he

was being violent at the time; still agitated, still screaming, still squirming. Mr. Mattson asked him to calm down.

Page 135

[redacted]

Page 136 [redacted]

[redacted].[19]

Respectfully Submitted,

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[18] Note for context: The question is misleading and it appears that counsel for claimant does *not* understand the difference between therapeutic services and an emergency restraint for safety authorized by federal regulation, CMS guidance, and BHDC policy. Emergency restraints for safety are **not** therapeutic treatments.

[19] Note for context: That is incorrect. [redacted] *See* Hamid depo. p. 15-16.

BEFORE THE CLAIMS COMMISION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFEE, As Special Administrator of the Estate Of David Cains — CLAIMANT

VS. CLAIM NO. 220374

The Arkansas Department of Human Services (Booneville Human Development Center) — RESPONDENT

DHS Summary of Deposition of Mark Hise
(Taken May 12, 2002)

Direct Examination by Josh Gillispie

Page 6:

Mark Hise is the staff development coordinator for the Booneville Human Development Center (BHDC).

Page 7:

Mr. Hise has worked at the BHDC for almost 27 years. He has been in staff development since 2016. He started out as a life skills trainer working directly with the residents.

Page 8:

As coordinator, Mr. Hise trains new employees on policies and procedures, including CPR certification and nonviolent crisis intervention training.

Page 9:

Mr. Hise is responsible for teaching the residential service staff and nursing staff CPR, first aid, and AED operations. AED stands for Automated external defibrillator. He also teaches nursing staff BLS, which is basic life support. He also teaches all new-hire staff the nonviolent crisis intervention techniques and emergency procedures. New staff go through a two-week classroom training which is referred to as Phase One.

Page 11:

Phase One includes training on personal restraints which are called personal holds. Personal holds are only used in emergency situations. Mr. Hise is not a supervisor. He just coordinates training.

Page 12:

Mr. Hise is a certified nonviolent crisis intervention instructor. The personal holds taught are all based on nonviolent crisis intervention techniques. The training techniques changed over the years.

Page 13:

BHDC used aggression management training (AMT) when he first started. Later, BHDC switched to another aggression type training called TACT. BHDC later changed to NCI training.

Page 14 -15

Training is for three weeks, including the on-the-job. Personal holds are taught in Phase One, then a refresher on it before new staff are sent on the floor. There are written tests that new hires have to pass by achieving a score of 70 percent or higher.

Page 16:

Staff are recertified every two years.

Page 20:

There is no other form of training provided to staff on personal holds.

Page 21:

There is a video demonstrating how to transition a client to the ground for purpose of putting them in a mechanical restraint. The only reason that staff would transition to the ground is to put a resident in mechanical restraint. No other purpose is taught for transiting a client to the ground.[1]

Page 21-22:

Mr. Hise testified he did not have enough information to speculate whether it would be improper for staff to hold a client on the ground during a behavior episode for several minutes hoping the client would calm down. He stated that he does not teach staff to hold a resident on the ground [as

[1] Note for context: Mr. Cains was *not* transitioned to the ground but, instead, he and Tyler Matson toppled or fell to the ground during the behavior incident. *See* 05/26/22 deposition of Syed Hamid, M.D., p. 27, lines 17 - p. 28, line 5:

> **Mr. Gillispie**: I'll also represent to you that a behavior occurred. David and a staff member named Tyler Matson end up on the ground. How exactly David landed on the ground, whether he landed on his face, on his back, it's not crystal clear at this point, but he -- according to Mr. Matson, there was a struggle of some sort and **they sort of topple over onto the ground. And I'll represent to you that that's how he got to the ground.** Are you with me so far?

See also Tyler Mattson deposition.

part of NCI]. He stated it is correct that clients are only to be taken to the ground [under NCI] in emergency situations where they're needing to be transitioned to a papoose board or a mechanical restraint.[2] The NCI training is for a standing or seated personal hold. There is no training for on-the-ground personal holds. If a staff member were to be using an on-the-ground personal hold, that would be outside of NCI.

Page 23:

Mr. Hise teaches staff to use de-escalation techniques in response to a client who is slapping at them or acting like they're going to hit them or even swinging at them. He teaches verbal control and redirection.[3]

Page 24-25:

We teach our staff to only put hands on when all other measures have been exhausted. Counsel then asks:

> **Q:** And, in the situation where a client swings at a staff member, does that allow the staff to deem that an emergency situation and immediately use physical force:
>
> **A:** [Yes] If they can't gain verbal control of the situation or redirect the resident.
>
> **Q:** Okay. But, if they're being swung on, how do they try to use verbal control or other de-escalations without using force when a client, you know, slaps at them? [4]

Mr. Hise responded by identifying several de-escalation techniques - supported stance, redirection, and blocking.

Page 26-29:

Mr. Hise did not look at any documents to prepare for this deposition and stated he does not have any knowledge about the incident of David Cains' death. Counsel then stated to the witness:

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[2] *See* footnote 1 for context.

[3] Note for context: Factually, Tyler Mattson testified that David Cains, who was first seated in a lobby chair in order to calm down, then stood up and lunged at Mr. Matson after which the two fell to the floor. Counsel's question to Mr. Hise, who was not present during the behavioral episode, did not include this de-escalation technique in his question to Mr. Hise.

[4] Note for context: The question by counsel is premised on a hypothetical situation where a resident merely swings *at* or slaps *at* a staff member which is not what happened here as David Cains made actual physical contact with Tyler Mattson during his behavioral episode.

Q: So what I am going to do is, as best I can, I'm going to tell you what they said happened. When I deposed Mr. Mattson, Mr. Mattson says Mr. Cains became upset and charged him. And originally, he said he swung at him, And then, when I deposed him, Mr. Mattson said that he thought that maybe David was trying to wrap his arms around him. But what was consistent in his story was that he and Mr. Cains both ended up falling over onto the ground in the lobby of the Commons building outside of the cafeteria….

But for purposes of my question, just know that David ended up on his left side and Tyler then knelt behind him and placed his arms on various parts of his body to kind of hold him there….

A couple of minutes later, Ms. Jones hears the commotion, she comes in and kneels down and either holds David by the hands or by the head, depending on who you are asking. If you ask her she says by the hands; if you ask Ms. Campos, she'll say by the head.

A few minutes later, Ms. Campos … holds David by the legs because he's – they're saying he's kicking and flailing and spitting….

So my question would be, in that situation where Tyler or other staff member and David Cains or any other client were to fall over together, would NCI say that the staff members should immediately get up and give the client some space?

A: No. But that's the main reason why we use a supported stance.[5]

Page 30-31:

An emergency situation is "[o]ne you would have to put hands on them [residents]" We like to use the terminology crisis situation. Trying to hit a staff member is not necessarily an emergency situation but it could be an escalation.[6]

Q: I know you weren't there. But assuming that my description of that is accurate, would you agree with me that that was an unnecessary physical contact they were making with him?

[5] Note for context: The facts represented by counsel to Mr. Hise failed to inform him that Mr. Cains was actually seated in a lobby chair to in order to calm down but then stood up and lunged at and made physical contact with Mr. Mattson which caused them both to fall to the ground. He responded without being apprised of all the actual facts.

[6] Note for context: David Cains did more than just *try* to hit staff.

A: You know, I can't really speculate. I don't know the – it's hard to say without being in that situation.

Page 34:

Although testifying about transitioning [on the floor] to mechanical restraints, Mr. Hise testified "[a]nd, if they're calm and not fighting no more, we don't carry on with the restraint procedure.[7] He stated "I just wanted to make that clear."

Page 35-36:

Mr. Hise stated in response to the question from counsel whether there are many de-escalation options that not only could but have to be tried first [before restraint], right.

It would be fair to say it would be unnecessary for a staff member to make that physical contact with the client on the ground in the way that was described.[8]

In response to a question from counsel whether Mr. Hise is familiar with whether ground restraints are dangerous because they can lead to things like asphyxiation, Mr. Hise replied: "Sure. I have a definition… restraint related position asphyxia." [9]

Page 37-38:

Mr. Hise testified he had never seen the restraint related positional asphyxia page in my instructor manual. The definition from his workbook for restraints says: a fatal condition that occurs when the position of a person's body interferes with respiration and results in asphyxia or suffocation. He testified that the manual does not address how ground scenarios will lead to positional asphyxia.

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[7] Note for context: Per 42 CFR §483.450(d)(4), the resident should be "released from restraint as quickly as possible" which, per the federal CMS State Operations Manual, Appendix J, § W302 guidance on §483.450(d)(4), means "as soon as they become calm." David Cains did not become calm until it was noticed that he choked.

[8] Note for context: Recall that the way counsel described it to Mr. Hise did not include any factual representation that Mr. Cains was seated in a lobby chair to in order to calm down but lunged at and made physical contact with Mr. Mattson which caused them to fall to the ground.

[9] Note for context: This line of questioning is misleading because there was no "restraint related positional asphyxia" here nor is any alleged. [redacted]; not because of any *positional* asphyxia.

Page 40:

Q: Would you say that choking is the most likely bad outcome from a personal hold?

A: No, I couldn't say that. That is not what I am saying.

Page 41:

Mr. Hise testified he never heard of a death due to a restraint incident and choking together. In my career, I haven't experienced a choking death with a resident during a restraint procedure. I have heard of bumps and bruises, cuts and scrapes to clients during restraints.

Cross Examination by DHS:

Page 43-44:

Q: Okay. I believe Tyler testified to a ledge that was behind him that, had he backed away or moved behind, he would have fell over anyways; so that why he chose not to back away. So, in that instance, what would he have done if he assessed the situation and decided not to back away?
A: It would be hard for me to speculate on that.
Q: They don't teach them what to do in that situation?
A: Like when you're backed against a ledge?
Q: uh-huh.
A: I personally have never, you know, been put in that type of situation.

When informed that David Cains was around 6'2" and weighed 250 pounds, Mr. Hise replied "Wow, okay."

Page 45:

Q: And, if you had a ledge behind you and were contemplating the fact that you were going to get knocked over, would that possibly change how you would react to the situation?
A: Possibly.

Page 46-47:

Mr. Hise testified that "**It sounds like a heightened stage of a crisis situation**" when you state the additional facts that (1) David Cains stood up and charged Tyler Mattson, (2) swinging at him

or attempting to wrap up Mr. Mattson while simultaneously attempting to kick and punch, and (3) spitting while yelling at them. "**That would be at the high end of a crisis situation**"[10]

Page 49:

Staff is allowed to physically intervene even if they've not been literally hit.

Redirect Examination by Josh Gillispie

Page 50:

Mr. Hise never really knew David to be physically aggressive. He recalled one time, whenever he was a program supervisor, that he got a call from the sheriff's department and had to send staff to go get David from his hometown because he had become aggressive toward his mother.

Page 51:

Mr. Hise did not remember the details. That's been a long time ago but he knew that the incident was serious enough to where he got a call from the sheriff's department to send staff to go get him.

Page 52-53:

Mr. Hise testified that for 27 years he has had "black eyes and bloody noses" from certain clients and was even "stabbed with a piece of glass one time." He states "it's the nature of the profession." Mr. Hise never directly worked with David Cains but previously supervised the unit where David Cains lived for a while. He stated David Cains would "have his, you know, typical bad days to where … he'd throw and break things." He added "[t]hat's just typical."

Page 53-54:

Mr. Hise testified he knows the lobby in the Commons building as it is right outside his office door. He stated there is a ledge in the lobby and a retaining wall to keep somebody from walking off the ledge.[11]

[10] Note for context: This is the first time that Mr. Hise was informed that David Cains stood up and charged Mr. Mattson, and continued kicking, punching, yelling and spitting.

[11] Note for context: The building lobby on the second floor overlooks the floor below. The reference to the retaining wall is to a short (half) wall similar to a railing on a balcony.

BEFORE THE ARKANSAS STATE CLAIMS COMMISION

CHRISTINE MCAULIFFEEAAs Special
Administrator of the Estate Of DAVID CAINS CLAIMANT

VS. CLAIM NO. 220374

THE ARKANSAS DEPT. OF HUMAN
SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) RESPONDENT

DHS Summary of Amy Jones Deposition
(Taken March 3, 2022)

Direct Examination by Josh Gillispie

Page 6-7:

Ms. Jones stated she dropped out of high school in 9th grade and got married.

Page 9:

Ms. Jones started working at Booneville when she was 21. She worked as an LST at the tim; life skills trainer. She helped the individuals learn everyday life skills, so that they may be able to live in the community.

Page 10:

Ms. Jones kept that job around three months and then left BHDC. .

Page 14-16:

Ms. Jones returned to BHDC as a residential care technician in 2017 and has worked there ever since. She goes by the name Mandy.

Page 18:

Ms. Jones' current title at Booneville is Residential Operations Manager.

Page 19:

Ms. Jones' title in June of 2020 was Care Shift Supervisor. Her title prior to that was Residential Care Supervisor. She was promoted from Residential Care Supervisor to Residential Care Shift Supervisor.

Page 21:

Sandy Evans was Ms. Jones' direct supervisor in June of 2020.

Ms. Evans was the Director of Residential Services. Sandy Evans was her direct supervisor in June of 2020. They didn't have a program supervisor assigned at that time. If there'd been a program supervisor, the program supervisor would be above Ms. Jones.

Page 22:

Ms. Jones stated they were short staffed in June of 2020, at the time of David's death.[1]

Page 23:

Ms. Jones clarified we she meant stating "It was bare minimum. I mean, we had enough, but we didn't have any extra at all at that point." [2]

Page 24-25:

Ms. Jones stated they were not allowed to run without adequate staff coverage some, sometimes, staff would work another shift or the they would call others to come in to work that shift.

> **Q:** Had there ever been a time where you had to run a little while with less than whatever that minimum number of people is?
> **A: Not while I've been up there, no**.[3]

Page 26:

Ms. Jones stated she is not an LPN.

Page 28:

She stated she enjoyed her job most of the time.

Page 29:

The two-week course is part of the training, it's not the whole class. NCI course takes a day. Ms. Jones said she went through phase two. Phase two is about six months after phase one. Ms. Jones

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[1] Note for context: Ms. Jones is incorrect. **BHDC met and exceeded all legal staffing levels on June 13, 2020, which are mandated by state and federal regulations.** *See* Jennifer Berry depo, pp. 91-99, where she explains the staffing level requirements mandated in the CMS State Operations Manual (Appendix J) - ICF/IID regulations -- and identified the actual staffing levels at BHDC for the period of June 1, 2020 – June 13, 2020. *See also* Berry Ex. 10 (ICF Regulations) and Ex. 11. (*actual* BHDC staffing ratios). Ms. Berry is the Assistant Superintendent of the BHDC.

[2] Note for context: Although Ms. Jones may perceive she BHDC may be short staffed, **BHDC met and *exceeded* all legal staffing levels on June 13, 2020, which are mandated by state and federal regulations.**

[3] Note for context: Ms. Jones has been at the BHDC since 2017.

thinks phase two is a week. She learned how to properly help people with developmental disabilities and their training and everyday life skills. Nonviolent crisis intervention is just for that particular part of the class.

Page 30:

She testified that nonviolent crisis intervention teaches "[h]ow to intervene when a client is having a behavior that could possibly hurt themselves or someone else." "They teach you techniques to put them in personal restraints without causing harm." For example, is if someone is about to hit you, they teach people how to grab that person's hand or arm and maneuver it to where they're not able to hit someone or hurt themselves. Ms. Jones said you grab their arm and push it back away from their body.

Page 31:

Ms. Jones stated they usually grab their wrist. They also teach people how to interlock their legs in front of the individuals so that they can't kick. It depends on the situation.

Page 34:

If someone is by themself, they are taught techniques to maneuver away from that client so the client can't hit them.

Page 35:

Ms. Jones stated NCI does not teach anything about restraining clients while they're on the ground. Ms. Jones said NCI does not teach to put a client on the ground. [4]

Ms. Jones stated they are expressly prohibited from putting a client on the ground[5]

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[4] Note for context: Recall that Mr. Cains was not put on the floor but, instead, the momentum from his charge at and physical contact with Tyler Mattson caused them both to topple onto the floor. *See* Mattson depo. p. 103; *see also* Hamid depo. pp. 27-28 where ***Counsel for Claimant represented*** to Dr. Hamid that "… there was a struggle of some sort and **they sort of topple over onto the ground. And I'll represent to you that that's how he got to the ground.** " Hamid depo. pp. 27-28. .

[5] Note for Context: This is misleading. Although NCI, per se, does not teach to intentionally restrain a client on the grounds, NCI is a **de-escalation protocol.** However, as Ms. Jone states on p. 36, some clients (including Mr. Cains) were medically cleared for mechanical restraints which require the client to on the ground to employ. A papoose board is one form of mechanical restraint. As noted above, Mr. Cains was not "put" on the ground but, instead, fell or toppled to the ground.

Page 36-37:

Ms. Jones testified they are allowed to do standing to ground technique if they are having to use a papoose board. If we have to use one, yes, they do teach that. Counsel for Claimant then acknowledged "I know that you have other training other than the NCI. It's just that my understanding of NCI was that they're firmly against anything like that." Ms. Jones replied "It's the last measure we use."

Page 42:

When asked about other training related to physical restraints, Ms. Jones stated "[w]e're taught that transitioning to the ground.

Page 43:

The purpose of transitioning to the ground is if they are going to have to put them in mechanical restraints.

Page 44:

> **Q:** And, if fact, you're not authorized --- as far as you know, you're authorized to do that [restraining on the ground other than for mechanical restraints] , are you?
> **A:** Not unless it can't be helped. In a lot of cases, our clients… they become violent, and a lot of times they go to the ground. Like they put themselves in – onto the floor.

Page 45:

When asked by counsel, about authorization to keep them "pinned" to the ground, Ms. Jones replied you keep them on the ground long enough to get them to he papoose board. If a client is hurting or causing harm to themselves or anyone else, they can restrain them on the ground.

Page 46-47:

The longest she has restrained them on the ground is maybe one minute. You should first try to de-escalate the situation before using a restraint, by offering choices and talking clamly to client.

Page 49:

Ms. Jones testified that Mr. Cains would become violent in his work area. She testified she personally witnessed **Mr. Cains becoming violent** prior to the date of his death. She testified she remembered Mr. Cains "**breaking a window at his training area"** and "**throwing books and trying to hit his staff.**"

Page 50:

Ms. Jones testified she saw Mr. Cains vomit:

> **Q:** Anything else you saw?
> **A:** I have seen him on a couple of different occasions throw up and …
> **Q: Vomit**
> **A: Yes.**

Page 51:

> **Q:** Have you ever heard of him [David Cains] causing injury to someone that required medical attention?
> **A:** I believe she – there was girl that had worked with him that was pregnant that he pushed down and hit:
> * * *
> **Q:** She told you?
> **A**: Yes.

Page 52-53:

Ms. Jones remembers there were times when David Cains **threw his tray in the lunchroom**. She saw him throw it.

Page 55-56:

Ms. Jones testified "it has happened a lot" when counsel for Claimant asked her if she knows if any client has actually caused an injury to staff. She testified "I've had to go to the doctor twice because of injuries" and stated "I got my fingers bit." She also testified she had to get x-rays when a client tried to hit her and ended up falling on her.

Page 57:

The policy at the time of David's death was the medical staff could call 9-1-1. Everyone else was supposed to call medical staff. "It makes sense that our medical staff could get there before EMS could."

Page 60:

Ms. Jones stated they were all given some form of CPR training and training in Heimlich maneuver.

Page 61:

Ms. Jones said she was given the same training again as a refresher which she believes is once a year.

Page 64:

Ms. Jones stated her normal shift is 8 a.m. to 4 p.m. She first saw David Cains on June 13, 2020 when she went into the lobby. Mr. Cains was on his left side and Mr. Mattson was behind him trying to gain control. Ms. Jones stated she did not see how David Cains got to the ground. She walked into the lobby because she heard a commotion. She heard yelling coming from the lobby.

Page 65-66:

Ms. Jones stated Mr. Mattson was trying to gain control of Mr. Cains' arms because Mr. Cains was to hit him. Tyler was on his knees. He was holding Mr. Cains' shoulder and wrist. Mr. Cains was yelling that he wanted to kill Mr. Mattson.

Page 67:

Ms. Jones held David Cains' arms, held his arms in front of him with his elbows slightly bent. She had him right above his wrists. Mr. Cains' arms were in front of him**. Ms. Jones asked David Cains to calm down but he didn't react to her**. He kept telling Mr. Mattson he was going to kill Mr. Mattson.

Page 68:

Ms. Jones testified **"I asked David to calm down."**

Page 70:

Ms. Jones held Mr. Cains' wrists from above his head.

Page 71:

Ms. Jones stated that about 20 seconds, maybe, had passed from the time she first heard screaming in the cafeteria before Ryann Capos came through the door.

Page 72-73:

She stated Ms. Campos held Mr. Cains' legs because he was kicking. She was kneeling.

Page 74:

Ms. Jones said she thinks Mr. Cains vomited about 20 seconds after Ms. Campos started holding his legs.

Page 75:

[redacted]

Page 76-77:

[redacted]

Page 78:

[redacted]

Page 79:

[redacted]

Page 80:

[redacted]

Page 83-84:

Ms. Jones stated it didn't take a minute to realize that he wasn't breathing after he started vomiting.

"**Maybe 20 or 30 seconds. It wasn't long**."

Page 85:

[redacted]

[6] Note for context: [redacted]

[7] Note for context: **Dr. Brown-Forestiere, *Claimant's* expert witness, testified "[m]ost likely, it would be *futile* to try** [redacted] *See* Brown-Forestiere depo. p. 83.

"At that point, all I was thinking about was trying to help him."

Page 86:

[redacted]

Page 87:

The next people to arrive were the medical, meaning nurses.

Page 88:

She stated that, once the nurses arrived, they backed off and let the nurses take over.

> **Q: I'm sure you're pretty upset at this point; right?**
> **A: Yes.**

Page 89-92:

[redacted] Ms. Jones then returned to the dining room as she was responsible for monitoring clients and staff inside. She was trying to get the residents through lunch and get them out so that they wouldn't see the paramedics. **She was not questioned by the paramedics,** law enforcement, the coroner, or the hospital staff. **She was upset and it made her feel sad.**

Page 93-94:

She testified she did not hold Mr. Cains but, instead, was leaning over his head. The only time she touched his head was [redacted]

Page 97

Ms. Campos was mistaken in her statement about what she saw.[9]

Page 100:

[8] Note for context: The times stated are not synchronized times between EMS and the BHDC medical team.

[9] Note for context: Ms. Campos timing may be off as to when she saw Ms. Jones holding Mr. Cains' head due to the emergent situation. [redacted].

[redacted] **I was guessing about how long it took medical to get there when I said one to two minutes. It wasn't a minute after he started vomiting. It was a lot quicker than that.**

Page 101:

Ms. Jones asked Mr. Cains to calm down.

> A: I did ask him to calm down when I knelt down and I had his arms, his writs.
> Q: You did? Do you did speak to him then?
> A: I –
> Q: [Counsel for Claimant interrupts] Because I asked you that specifically earlier and you said no, you --- you didn't say anything.
> A: I told you that I asked him to calm down.[10]

Page 102:

I did not try anything before touching Mr. Cains as it had already escalated before I even arrived in. He was trying to hit Mr. Mattson

Page 105-106:

Sandy Evans took my statement after it had happened. It was shortly after the incident. **I did not witness anyone speaking to the paramedics.** I was not aware of David Cains's [redacted] as we have 120 clients. I didn't work with David often at all. I arrived at the job that day approximately five minutes before the behavioral incident happened.[11]

Page 111:

Ms. Jones testified "Yes. If we had been able to get him up off the ground we would have" "He hadn't calmed down at any point until he started choking."

Page 113-114:

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[10] Note for context: **Counsel for Claimant is simply wrong** as Ms. Jones earlier testified earlier "I asked David to calm down." Jones depo p. 68, lines 19-20. *See* p. 6 above.

[11] Note for context: Recall that Ms. Jones happened to be in the lunchroom and came to into the lobby because she heard a commotion and yelling. *See* Jones depo. p. 64; summary p. 6 above. It would not be expected that she would know [redacted] *See* Hamid depo. p. pp. 15-17; Hamid depo. summary, pp. 2-3.

Counsel had Ms. Jones read, aloud, certain parts of Booneville Policy Roman Numeral I-D-4 and she did. She read: "Emergency restraint is defined as the use of the least restrictive procedure and for the least time necessary to control a severely aggressive or disruptive behavior."

Respectfully Submitted,

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BEFORE THE ARKANSAS STATE
CLAIMS COMMISSION

CHRISTINE MCAULIFFE, as Special Administrator
of the ESTATE OF DAVID CAINS CLAIMANT

v. Claim No. 220374

THE ARKANSAS DEPARTMENT OF HUMAN
SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) RESPONDENT

DHS Summary of Deposition LPN Amanda Schmitt
(Taken March 17, 2022)

Page 5-8:

Ms. Schmitt is now employed at Legacy Health and Rehab. She stopped working at BHDC about a month ago [February 2022]. She did not agree with many of the viewpoints of the Director of Nursing and the Assistant Director of Nursing and the [organizational] separation of the medical department and living area department. She also had some personal issues with the Assistant Director of Nursing. When asked whether any of that had to do with David Cains, she stated she did not believe it played a role.[1]

Ms. Schmitt said, from a medical perspective, she had [on other days] removed Mr. Cains from his schedule a few times because she felt he was too overwhelmed to go to class that day or to his work area or to go to Commons to eat, and placed him back at the dorm. She said she was not allowed to make that decision because it has to be made by his team.

Ms. Schmitt said she did not see Mr. Cains the day he died and does not know what type of mood he was in. She was not his nurse that morning.

Page 9:

Ms. Schmitt worked at Booneville for five years. She was an LPN.

[1] Note for context: LPN Schmitt stopped working at the BHDC approximately 17 months after Mr. Cains' died.

Page 12:

Ms. Schmitt stated she worked four or five years in a nursing home in Booneville and then at Mercy Fort Smith in the ER Department, then in-patient hospice, and then she came to work at BHDC.

Page 13:

Ms. Schmitt did not provide direct care to residents.

Page 15:

Ms. Schmitt said she would get to work at the Judge Hill building and then they would go to the dorms to give medications and then go back to the Judge Hill building when the clients would go on for their various schedules. She usually would not see the residents until lunchtime unless called to an area for a problem.

Page 16-17:

Ms. Schmitt had an office in the Judge Hill building and was in that building most of the time. The Davidson House was her normal dorm.

Page 18-20:

Ms. Schmitt said her role was different than that of the direct care providers. She was there for medical purposes and for emergencies, when needed. She did not have the NCI non-violent crisis intervention training but received training on how to get loose when resident got ahold of them or if a resident came up and grabbed them around the chest, from behind, how to wiggle, to scoot down to get loose. Or, how to get your arm loose when a resident grabs you by the wrist. She said she does not have any knowledge of what kind of training the residential staff would have had in restraints.

Page 21:

Ms. Schmitt testified she doesn't know what they're taught in those classes and doesn't know what those techniques are.

Page 22:

Ms. Schmitt testified that although Mr. Cains was a really fun guy, he did have behaviors, would get overwhelmed, and "lash out" and "lose control sometimes." Ms. Schmitt said she didn't consider Mr. Cains to be particularly violent or aggressive but stated "he lashed out a lot when he got overwhelmed: and usually would "throw a fire extinguisher or a stack or cups."

Page 23:

Ms. Schmitt testified sometimes Mr. Cains grab a stack of cups off her med cart and throw them across the room. She testified "[h]e threw a fire extinguisher at my head one time.

Page 24:

Ms. Schmitt testified David could have hurt somebody very easily.

Page 26:

Ms. Schmitt stated she witnessed David throw a fire extinguisher and throw things at people. Ms. Schmitt said David pulls his hand back [as if he is about to hit]. She stated she has seen him pull his hand back several times but not actually saw him hit somebody.

Page 27:

> **Q:** To your knowledge, has any staff member ever had to go to the hospital or get any kind of medical treatment because of something a client has done to them?
> **A:** Yes.

Ms. Schmitt testified several staff members have needed the nurse for "deep scratches, for bite marks."

Page 28:

Ms. Schmitt testified they have had some sexual assaults on campus from residents. There are clients there that are capable of serious things like that. She said there are some residents they really wouldn't want to be left alone with in a room but Mr. Cains was not one of them.

Page 29-30:

> **Q**: --he's [David Cains] nothing to be afraid of?
> **A:** They're all – you should be afraid of all of them. You should really be concerned that any of them, at any point, could hurt you.

Ms. Schmitt has had to administer chemical restraints at times.

When asked approximately how often she administered a chemical intervention to Mr. Cains, Ms. Schmitt could not recall as it had been quite a while. Ms. Schmitt stated "It seems like it was getting more frequently" and was [by her] needed "[a]tleast once every couple of months."

Page 31:

Ms. Schmitt testified nurses don't normally put somebody in mechanical restraints. She said they do check them after they've been in the mechanical restraints. She said she doesn't recall David Cains in mechanical restraints.

Page 32:

Ms. Schmitt stated when she has been called for a *chemical* restraint on David Cains, he is crying when she gets there and not in any type of restraint. She said she would ask him, "David, do you need something to help you calm down" and he would very happily, say yes, and he'd take his coat off, he'd pull his sleeve up.[2]

Page 33:

Ms. Schmitt testified she does not recall ever seeing David restrained on the ground. She knows Tyler Mattson. She said he wasn't always one of the staff at her dorm. He also worked at other dorms. She stated she does not recall Tyler Mattson having any personal issues with David Cains and does not recall any reactions that David Cains had with staff.

Page 34:

Ms. Schmitt said if David was somewhere where things were very loud, if there was a lot going on, or somebody was having an outburst around him, that would really affect him. She said he did not like to go to class. She said she has had to go to Mr. Cains' training area several times because he was upset and either needed to return to the dorm or needed a chemical intervention.

Page 35:

Ms. Schmitt testified she does not recall when Booneville wasn't short staffed but explained that, *in such instance*, staff from a prior shift would stay over to work another shift. She stated that there were times when they had less staff than *she **felt*** was necessary.[3]

Page 36:

Ms. Schmitt *felt* staff was exhausted and "I assume" that made their days more difficult and stressful.

---

[2] Note for context: A chemical restraint for David Cains was for early chemical intervention before his behaviors escalated further.

[3] Note for context: Factually and legally, **Ms. Schmitt is incorrect on this point.** These are her personal opinions. Factually and legally, BHDC meet and exceeded ***all*** direct care staffing requirements **for each and every shift on each any every day in June, 2020, including June 13, 2020**. *See* deposition transcripts Jennifer Berry, pp. 96-99 and DHS Exhibit 12 to the deposition in which Ms. Berry explained the actual staffing levels for each shift in June through June 13, 2020, and the state and federal regulatory staffing level requirements which are based on the number of residents present each day. **BHDC exceeded those staffing levels every day in June**. In addition, this line of questioning is misleading because there were numerous direct care staff present in and around the cafeteria and lobby areas at the time of David Cains' behavior episode.

Page 37:

Ms. Schmitt stated the direct care staff called the emergency number that day. She said Debbie [Noah] took the call and said they had a patient choking. She grabbed the emergency bag, the AED, and ran to her car.

Page 38:

Ms. Schmitt said Debbie Noah received the emergency call. She said she was with Debbie Noah in the Judge Hill building when she got that call. Ms. Schmitt said then Ryann Campos made a call directly to her stating I need you to get here and bring an AED. Ms. Schmitt stated she was pulling up to the building right then.

Page 39:

Ms. Schmitt said the AED will deliver a shock, if necessary. It is an Automated defibrillator. She did not know what time Debbie Noah got the [first] call.

Page 40:

Ms. Schmitt testified Debbie got the call; she hung up and said that a client was not breathing in the Commons building. Ms. Schmitt said she was getting the emergency bag.

Page 41:

Ms. Schmitt grabbed the AED and they jumped into the car which was parked directly in front of the Judge Hill building. They stated they ran in the building and David Cains was laying on his right side. [redacted]

Page 42:

[redacted]

Page 43:

[redacted]

[redacted]

Page 44:

[redacted]

Page 45:

Ms. Schmitt stated when they got on scene, [redacted]

Page 46:

[redacted]

Page 47:

[redacted]

Page 48:

Ms. Schmitt testified as soon as they got on scene, 9-1-1 was notified. She stated she does not believe that there's a policy that said you cannot call 9-1-1. She said they are supposed to call medical. She said you call medical and you can call 9-1-1 for staff or clients who need it.

Page 49:

Exhibit 2 , BHDC Policy 4-B-10, was introduced.

Page 50:

Ms. Schmitt stated it was her understanding that, as a nurse she can make a determination to call 9-1-1.

Page 51:

Ms. Schmitt stated she cannot speak as to what somebody else would read into that situation. She said she does know that, regardless of what the policy is, if somebody is obviously fixing to die in front of her, she is going to call 9-1-1. She said she doesn't think aides knew that he did not have

a pulse and were dealing with somebody who was choking. She said she believes, per policy, they have to call medical first.[4]

Page 52:

Ms. Schmitt said it was her understanding this went from having a behavior to him being on the floor very quickly.

Page 53:

Ms. Schmitt's understanding was that David got upset inside of the dining room, started having a behavior, that they were taking him into the hallway, and he vomited and choked.

> **Q:** What about how he got to the ground? Do you know anything about that?
> **A:** I don't.

Ms. Schmitt was not there for the restraint and was not told of the details.[5]

Page 55:

Ms. Schmitt said in a hospital setting is where they can do advance life support. She said inside of a long-term care facility, they are not able to do advanced lifesaving. She said they have what is called basic life support.

Page 56-57:

> **Q:** And about how long do you think it took you to get to the scene after the call was made to Debbie Noah?
> **A:** It didn't take long at all. I was parked directly in front of the building… [The] Commons [building] is just up the road from where we were.
>
> * * *
>
> **Q:** Approximately how long do you think it took from the time Debbie Noah got this call to the time you got to your car?
> **A**: Until the time I got to my car?

---

[4] Note for context: BHDC is in rural Logan County. The BHDC nurses can (and did) respond in just minutes whereas it took EMS 13 minutes to arrive at the scene per EMT Scow's testimony and the EMS Report. Jennifer Berry, the Assistant Superintendent, explained that in her experience, it has taken up to 45 to 60 minutes for the ambulance to arrive after calling 9-1-1. *See* Berry deposition transcript at pp 103-104.

[5] Note for context: Per EMT Scow, he spoke *only* with the nurses who arrived just after the behavior episode ended in order to provide emergency assistance.

Q: Yeah. Thirty seconds?
A: Thirty second. Forty-Five seconds.

Page 58:

Q: --- about how many seconds or minutes did it take to drive from Judge Hill to the Commons building?
A: Its going to be less than a minute or maybe right at a minute.

She explained "I'm overshooting the amount of time it would take…" They were running as "[t]hese are people that we deeply care about. This is not just a job."

Page 60:

Q: I understand you did absolutely everything you could do. But do you know – do you feel like staff, direct care staff, messed up in an way here?
A: I feel like they responded to a behavior the same way that they would respond to any behavior.

* * *

A: **-- if they are in a situation where they feel that somebody is going to harm themselves or harm other people, they are going to restrain them**. **That is what they are taught to do**; **and that is what they do every day, is to try to stop somebody from harming themselves or harming somebody else.**

Page 61:

Ms. Schmitt testified: "[a]nd when David would have a behavior, he would often vomit."

Page 62:

[redacted]

Page 63:

[redacted]

Page 64:

[redacted]

Page 65:

[redacted]

Page 66:

[redacted]

Page 67:

Ms. Schmitt testified: **"I would trust the staff that was with him [Mr. Cains] with *my* special-needs child.**

Page 69:

[redacted]

Page 71:

Ms. Schmitt testified she thought everybody spoke to the paramedics.[7]

Page 72:

Ms. Schmitt said she does not know who said what to them. She said there was a lot of emotion in the room at the time.

Page 75:

She testified that she does recall David vomiting when he was upset but not having any issues from that.

Page 76

[redacted]

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[6] Note for context: As explained by Dr. Hamid, Mr. Cains physician, although Mr. Cains had a [redacted]

[7] Note for context: EMT Scow testified that he only spoke with the women nurses about what happened. *See* Scow deposition p. 40-41.

Respectfully Submitted,
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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V. CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

DHS Summary of Janice LeBel's Deposition

Direct Examination by Claimant

Page 5-6

Dr. LeBel is employed by the Massachusetts Department of Mental Health. She is the Director of Systems Transformation and has been employed by the state for 38 years. She is also "a consultant on the use of a curriculum called the six core strategies, on which she is the "co-principal investigator" and does "significant teaching and training."[1]

She states she is the agency lead for restraint and seclusion prevention and lead interagency effort that endorsed by seven Massachusetts State agencies.[2]

Page 9

Dr. LeBel developed a training curriculum based on these six core strategies.

[1] Note for context: Dr. LeBel holds a Ph.D. in psychology. She is not a medical doctor. Although the "Six Core Strategies" is not *per se*, a business for her, Dr. LeBel testified she receives compensation for lecturing on her curriculum. *See* LeBel depo. pp.163, line 25- page 164, line 12 ("I'm given compensation to speak about the six core strategies.")

[2] Note for context: Apparently the Massachusetts Department of Developmental Disabilities is not one of them as Dr. LeBel conceded, on cross-examination, that the Department of Developmental Disabilities in her ***own*** state stills allows restraints to be used in its Human Development Centers. *See* LeBel depo. pp. 119-120. She did not offer that significant fact in her direct examination.

Page 12

Restraint reduction has been her key focus for 38 years at the Massachusetts Department of Mental Health.

Pages 15-25

Dr. Lebel generally explains her six core strategies curriculum as an organizational framework, her work and the work of her colleagues, how to generally organize leadership committees in order to adopt basic core strategies, teaching staff, training, and her work with other states, including instances where certain hospital have eliminated restraints.[3]

Pages 26 –28

Dr. Lebel reviews the benefits of adopting her curriculum in Massachusetts where, beginning in 1999, she studied the use of restraints in her home state of Massachusetts. She reviewed the cost benefits resulting in shorter length of facility stays, greater staff retention.[4]

Pages 29-32

Dr. Lebel opined that the standard of care at the BHDC was breached "when you look at international standards from the United Nations and the Convention on Rights of Persons with Disabilities, [and] the World Health Organization."

[3] Note for context: Dr. Lebel's testimony about her six core strategies curriculum and her work preventing restraint in other types of facilities aspirational and contrary to the provisions of 42 U.S.C. 483.450 which expressly allows restraint use for the safety of the individual and others until the individual is calm in ICF/IIDs such as BHDC. Oddly, this testimony is contrary to the testimony of Dr. Brown-Forstiere, Claimant's *other expert witness*, who testified that her facility regularly employs restraints for safety. *See* Dr. Brown-Forestirere's depo. p. 6.

[4] Note for context: Despite Dr. Lebel's claims and insinuations otherwise about her level of success teaching her curriculum, Dr. Lebel concedes that that state-run ICF/IID in Massachusetts still use restraints for safety, just like the BHDC, as authorized by federal regulation and CMS guidance.

Page 33:

Dr. Lebel states "We've got an international standard. We've got a federal standard. We've got a state standard" and opines that BHDC did not follow the CMS standard because "There was no emergency" because there "was no imminent danger." [5]

Page 37:

She stated that she was confused by statements she read and, as she reads it, David Cains did not hit Mr. Mattson. She stated Mr. Cains was spitting and attempted to hit Mr. Mattson. She stated that spitting, screaming cussing, does not "require" a hands-on procedure to touch David Caisn against his will.[6]

She stated that David Cains had a "withdrawal reflex" to "noxious stimuli," such as a hand being placed on you.

Page 43

Dr. Lebel states that the "standard of the emergency, you know, would have to be something in which there was sever aggression, with a "level of lethality attached to it." [7]

---

[5] Note for context: There is no international standard applied in the United States and Dr. Lebel is simply wrong. She later conceded on cross-examination that the standard for restraint use in an HDC is the Code of Federal Regulations and the CMS State Operations Manual – Appendix J. Lebel depo p. 91-92.

[6] Note for context: Dr. LeBel ***selects*** certain facts to support Claimant's narrative but ***ignores*** the rest. Mr. Mattson testified, under questioning *from Claimant's counsel*, that Mr, Cains went after him from the seated position, charged him, and grabbed him. *See* Mattson depo. pp. 100-102. She also fails to consider Mr. Mattson's written statement that Mr. Cains "jumped up after him." *See* Mattson depo. Ex. 9 – written OLTC Statement. Dr. Lebel later asserts insinuates that Mr. Mattson was the aggressor.

It is also apparent that, despite her claims otherwise, Dr. Lebel is unfamiliar with David Cains' 2019 IPP which stated that he has a history of "physical aggression" (IPP p.6) which the IPP defines as the *attempted or actual striking, hitting*, of kicking other people or objects with the intent to cause injury or damage (IPP. 9).

[7] Note for context: Dr. Lebel is wrong about the "standard of emergency" and conceded, when questioned on cross-examination, that lethality is **not** a precondition of to the use of restraints

Cross-Examination by DHS

Page 73-74

Dr. LeBel is a psychologist. She is not a neurologist, a pathologist, or a medical doctor. She is not a medical examiner.

Page 75

Dr. LeBel stated her "opinions are based on a reasonable degree of expertise in the area of restraint reduction and prevention." She is a board-certified psychologist.

Page 76

She stated "I consider myself an expert" She is not a physician. She is not a medical expert.

Page 77

She stated "I would say I am a restraint reduction prevention expert." She has a doctorate in psychology.[8]

Page 79-80

Dr. LeBel has been an adjunct instructor at the University of Massachusetts Medical School for 14 years. She is not on a tenure path at the university. The instructor level is the lowest level of teaching in a university system. Although she is a psychologist, she last practiced clinical psychology in about 1990.

Page 81-82

Dr. LeBel has never been to the Booneville Human Development Center, to Logan County, or to Arkansas. She knows it's a rural environment but does not know how many ambulances Logan County had in 2020. She performed no research on and does not know the typical response time for Logan County EMS to respond to BHDC calls. She stated she was not aware it can sometimes

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under 42 U.S.C. 483.450 or the CMS State Operations Manual – Appendix J, which she begrudgingly admitted set the standards applied to the BHDC.

[8] Note for context: Dr. LeBel acknowledges she was retained to be "a restraint prevention expert. **Not a restraint expert**." *See* LeBel deposition page 118.

take 45-60 minutes after a 911 call for EMS to respond. [9] She stated there are nurses on-site at BHDC and read that it took EMS 13 minutes to arrive after the 9-1-1 call was made for David Cains.

Page 82-83

When asked if she knew how long it took BHDC nurses to arrive at the Commons Building where the incident happened, Dr. LeBel stated: "More than a minute, less than two minutes."

Page 84

Q: Tell me, do you have any medical training to determine the cause of death?

A: No.

Q: Have you previously been allowed to testify by any court of law to opine on an individual's cause of death?

A: No.

Q: Have you previously been allowed by any court to opine on factors, whether directly or indirectly, contributing to a cause of death?

A: No.

Page 87

Q: But the question is do you profess, or do you claim to be an expert in restraint policy?

A: I don't know what the qualifications would be for being an expert in restraint policy. She stated she has expertise in the reduction and prevention of restraints.

Page 90-91

A: I consider myself to be an expert in restraint reduction and prevention. I teach people not to use restraints.

[9] Note for context: *See* deposition of Jennifer Berry, pp. 103-104, who testified it has taken up to 45-60 minutes for ambulances to arrive at BHDC. Jennifer Berry is the Assistant Superintendent of the BHDC.

A: I'm against restraint use when there is no imminent harm or imminent danger. Restraint has its place as a life-saving method of last resort.[10]

Page 90-91

Dr. LeBel knows the Centers for Medicare and Medicaid Services. It is referred to a CMS. She also knows what is the Code of Federal Regulation, often referred to as CFRs. CMS also promulgates a state operations manual which includes restraint use.

Q: And so that CMS manual those code of regulations promulgated, those are the standards that facilities such as Booneville Human Development Center comply with, right?

A: Conceptually, they should be applied.

Q: Okay. Well, I don't know conceptually. **Are they the standard or are they not the standard?**

A: They're the standard.

Page 92

A: My view on standards of care is that they're minimal standards. They're not aspirational.

Q: Okay. But I'm just saying this is what the standard of care for restraint is in the United States in what we call an intermediate care facility for individuals with intellectual disabilities, which is what Booneville Human Development Center is licensed as; correct?

A: Correct.

Q: And those are the standards that they had to follow, at least the minimal standards?

A: Correct.

[10] Note for context: Neither Federal regulation nor BHDC policy requires imminent harm, imminent danger, or lifesaving as a condition for use of restraints in an ICF/IID, such as BHDC.

Page 93

Q: Because if CMS state operations manual and the promulgated Code of Federal Regulations is the standard, then that's all that needs to be met legally; correct?

A: All that needs to be met legally. But, in Booneville's case, they failed to meet that standard.[11]

Page 94

She stated the UN convention, and The World Health Organizations are an international perspective.

Q: But, just to make it clear, because I don't want the Claims Commission to be confused, the standard of care for restraint use is the Code of Federal Regulations governing restraint use for intermediate care facilities for individuals with intellectual disabilities and the CMS State Operations Manual that enforces that against such licensed facilities; correct?

A: Correct.

Page 96-98

She agreed that page six of Mr. Cains' IPP, under background information, stated David had a history of physical aggression including destroying personal property, TV, radios, DVD player, and breaking windows.

Q: Now, as a psychologist, people who are aggressive aren't necessarily physically aggressive 100 percent of the time, are they…

A: Presumable not.

She stated "I have seen people from - - go from calm to disruptive or destructive. I've seen that, yes."

[11] Note for context: Recall, Dr. LeBel stated she is not an expert in use of restraints. Instead, she states she is an expert in restraint prevention. She testified "I was contacted about being a restraint prevention expert. **Not a restraint expert**." LeBel deposition page 118. Yet, she now opines on restraint use.

Page 104

She agreed her report [which was not introduced] made no mention of Tyler Mattson's testimony, under oath to questioning from Mr. Gillispie that describes David Cains' lunging or making contact with Tyler Mattson from a seated position.[12]

Page 106

She stated she saw the description of Mr. Cains being seated and starting to tear paper off the wall and that Mr. Mattson made a statement that Mr. Cains lunged at him.

Page 112-113

She stated Mr. Cains was alive and functional until the restraint but agreed there were other factors that happened; he vomited.

Q: Okay. But there were other factors that happened. He vomited correct?

A: Correct.

Page 117

She was aware Mr. Cains overturned a table at BHDC the day after Christmas but does not recall reading he hit his mother.[13] Dr. LeBel saw in IPP that Mr. Cains destroyed his television set in his room, several radios, and a DVD player, and had broken glass.

Page 118 **A**: I was contacted about being a restraint prevention expert. Not a restraint expert.

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[12] Note for context: Dr. LeBel also ***ignores*** the portion of Mr. Mattson OLTC *written statement* where, describing what happened, he wrote on June 13, 2020, "… shortly after he began screaming and cussing and ripped paper off the wall to throw ***he then jumped up after me*****,** spitting and attempting to hit me…" *See* Mattson 06/13/2020 OLTC written statement, attached to Mattson's deposition as Mattson Ex. 9. Dr. LeBel never explained why she omitted reliance on that portion of Mr. Mattson's written statement when formulating her opinion or when testifying.

[13] Note for context*: See* Jennifer Berry's deposition deposition p. 71, lines 3-11 describing that, during a visit to the BHDC by Mrs. Robinson, David Cains mother, "[s]taff haerd a lound commotion, went into the kitchen, and David had hit his mom and flipped over the kitchen table." Mr. Cains was also heard calling his mother a "F****** Bitch." Mrs. Robinson then mother then left and did not return. *See* Ex. 8A to Berry deposition – Behavioral Report.

Page 119 She stated she read that the 2019 IPP, on page 10, allowed "center emergency procedures when necessary."

Page 120

Dr. LeBel did not read that Mr. Cains bit a staff member twice. She read Mr. Cains threw a fire extinguisher and punched his sister.

Page 119-120

Dr. Lebel explained that, in Massachusetts, the Developmental Disability Services Department has been its own state agency since the early 1990s; about 30 years.

Page 119-120

Dr. Lebel works for the Massachusetts Department of Mental Health [not the Developmental Disability Services department].

Q: So, does Massachusetts have ICF/IIDs, which are intermediate care facilities for individuals with intellectual disabilities, which is what an HDC is, do they run those?

A: They run those.

Q: Okay. So, they – you have them in Massachusetts?

A: Yes.

Q: Okay. State run?

A: State run or contracted.

Q: Okay, and so they don't use restraints at all?

A: They use some restraint.

Q: Oh, okay. So, even in your own state, restraints are used in the equivalent of human development centers, ICF/IIDS; correct?

A: I believe so.

Page 122 She stated Mr. Cains vomited because he was being restrained.

"I make that *observation* on reading the CPI/NCI training, that they describe the sequela of restraint, they describe the *possibility* of positional asphyxia, they describe the *possibility* of choking aspiration, they describe the *possibility* of cardiac arrest.[14]

Page 123

Dr. LeBel conceded "during the course of restraint, a series of medical events happened, and he died."

Page 124

> **Q:** So, are you saying to a reasonable degree of medical certainty, in your medical opinion, that the restraint caused, Mr. Cains to vomit and choke? Is that what you're saying?
>
> **A:** Yes.[15]

Page 125-127

> **Q:** So, if there is a connection between the restraint and vomiting, that means that every time a restraint is used, there would be vomiting, is that your opinion?
>
> **A:** No, that's not my opinion.
>
> **Q:** Okay. Okay. So, how often, when a restraint is used, would there be vomiting?
>
> **A:** I have no capacity to respond to your question.

Page 125-127

> **Q: Dr. LeBel, are you aware that Mr. Cains frequently vomited?**

---

[14] Note for context: Dr. LeBel is a psychologist not a medical doctor. As she noted, these are her mere observations. Dr. LeBel merely states what is ***possible.*** Her reference to positional asphyxia is misleading, at best, as even she admits that Mr. Cains choked on vomit which, by definition, ***rules out*** positional asphyxia.

[15] Note for context: Dr. LeBel has a Ph.D. in psychology and is not a medical doctor. She considers herself a "restraint prevention expert." She previously conceded her opinions are to a reasonable degree of expertise in the area of restraint reduction and prevention. *See* LeBel's deposition pages 75, 77. Yet, she now opines to a reasonable degree of medical certainty.

A: I'm aware Mr. Mattson made reference to that.

Q: Okay. Are you aware that his sister made reference to that?

A: No.

Q: Okay. Would that change your opinion, if sister, if Mr. Cains' sister mentioned that he frequently vomited?

A: Possibly.

Q: Okay. But you weren't provided that information, were you?

A: No.[16]

Page 128

Q: As so, just to be clear, would you agree that physical restraints may be employed in an ICF/IID like Booneville Human Development Center as an emergency measure but only if absolutely necessary to protect others from injury? The client and others from injury, would you agree with that?

A: I would agree with that.

Page 129

Q: So, you're not - - are you familiar with Appendix J from CMS? The State Operations Manual?

A: I don't know. I don't believe that I've reviewed Appendix J.

---

[16] Note for context: Christine McAuliffe testified:

Q: Did you ever notice that he would vomit at times?
A: when he was upset, or just in general?
Q: Anytime?
A: Yeah. I mean his whole life he dealt - - you know he had stomach issues. Like if he ate certain things his stomach would get upset and when he got anxious, his stomach would get upset.
Q: So, he would vomit often?
A: I wouldn't say he vomited often, no.

McAuliffe deposition page 29, line 21 to page 30, line 3.

Page 132

It is her opinion that the emergency situation that would allow restraints must have a potential consequence of lethality without the restraint intervention.[17]

Page 136 It is her testimony that DDS 3004 requires imminent danger or harm.[18]

Page 141 She states that imminent danger "*implies* something of significant risk posing a potential loss of life."

Page 142-143 Dr. LeBel relied on 42 CFR 483.450 and DDS Policy 3011-D as part of her opinion on imminent or serious bodily harm before using a restraint.

Page 144 In Dr. LeBel's written report, she stated "physical restraint is a potentially lethal procedure of last resort which is used in an emergency circumstance in the event of imminent danger when alternatives have been attempted and/or rule out." She agreed she cited 42CFR 483.

Q: Tell me where in 42 CFR 483.450 does it say, use the word imminent?

A: I don't see the word imminent.

Page 146-147

Q: And so, the guidance, the CMS guidance to state regulators and Federal regulators is that physical restraints may be used as an emergency intervention only in situations where the client is exhibiting behaviors which - - and it lists three things; correct?

A: Correct.

Q: And so, any one of those things would be reason for emergency, employment of emergency conditions for restraints; right?

---

[17] Note for context: Neither the CFR nor the CMS State Operations manual imposes such requirement.

[18] Note for context: DDS 3004 is not the restraint policy. DDS 3004 is the maltreatment prohibition prevention and reporting policy.

A: Presumably so.

Page 150

A: To me, when I read the word in this list of three conditions (of when emergency restraints are allowed), I read that number one and number two are rolled up as requirements *or* number three.

Q: So, does that mean - - in your interpretation would - - physical restraint may be used as an emergency intervention when the client exhibits behaviors which are harming other people or themselves? Would that be sufficient?

A: It could be.

Q: Okay. So, you don't need one and two, you just need [number] three, if that's the facts.

A: Possibly.[19]

Page 151

Dr. LeBel testified: "*I'm* opposed to the use of restraints in the human development center when it is used for nonlethal non dangerous circumstance." She further stated restraints are intended "as a lifesaving measure of last resort."[20]

Page 156

Dr. LeBel didn't know whether [redacted].

Page 157

[redacted]

[19] Note for comment: The referenced condition #3 identified in the CMS State Operations Manual, § W296, allows for the use of restraints when then client's behaviors "3) are harming other people or themselves."

[20] Note for context: CMS, CFR, and Arkansas DDS rules provide otherwise.

[redacted]

Page 158 Dr. LeBel said "I do not know" when asked if Dr. Hamid, Mr. Cains doctor, "prohibited ground restraints.

Page 159-160 She agreed that if a papoose board is to be used, you have to be on the ground.

She stated that "withdrawal reflex" is a fight or flight response.

Q: But at what point did David Cains, in your opinion, withdrawal?

A: I have no way of knowing when David Cains withdrew.

Page 161-162

Dr. LeBel states it is "my assumption" that Tyler Mattson was the aggressor.

Q: So, at what point in time did David Cains calm while on the ground?

A: I have no way of knowing.

Q: Okay. So, would you agree or disagree with the statement, that in the State Operations manual, under W-302 that says documentation should support that the that the client was release from the restraint as soon as they become calm.

Q: So, I'm asking you, at what point in time did David Cains become calm?

A: I don't know.

Page 163-164

She stated she "traveled extensively" teaching and training on the use of the (six) core strategies. There is no business associated with that, but she stated, **"I'm given compensation to speak about the six core strategies."**

Page 165 She stated she would define herself as someone who works tirelessly to try to prevent, avoid, the use of restraints.

Redirect by Claimant

Page 167-168

Dr. LeBel stated she relied on 483.450 (d)(i) which provides "The facility may employ physical restraint only - - and then we move down to Roman Numeral Two, as an emergency measure only if absolutely necessary to protect the client or others from injury."[21]

Page 170: Claimant's Exhibit 1 is the CMS State Operations Manual – Appendix J.

Page 172-173 Claimant's Exhibit 2 is two pages from LPN Schmitt's deposition that it took her 45 seconds, after being called when David Cains choked, to get to her car and another 45-60 seconds to arrive at the scene.

Respectfully Submitted,

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[21] Note for context: Recall Dr. LeBel *agreed* the federal regulation allows restraints to protect the client or others.

BEFORE THE ARKANSAS STATE
CLAIMS COMMISSION

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — CLAIMANT

V. — CLAIM NO. 220374

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — RESPONDENT

DHS Summary of the Deposition of Rickie Brown-Forestiere, M.D.
(Taken October 21, 2022)

Direct Examination by Josh Gillispie

Page 5

Dr. Brown-Forestiere ("Dr. Brown") is a board-certified emergency physician. She went to medical school and had a three-year emergency medicine residency, passed the qualifying boards and became a board-certified physician. She stated that she was trained in different areas of importance but that they are experts in resuscitation.

Page 6

Dr. Brown stated, in this scenario, cardiac arrest, which is what the patient suffered, is something that we do on a daily basis and we're highly trained and we're the experts for that. "People have natural choking where they choke on their food."

Page 7

These are all different forms of suffocation leading to cardiac arrest. Dr. Brown stated she received training in medical school or residency related to choking and suffocation.[1]

Page 8

Dr. Brown explained that choking is pretty common describing it as "one of most common" traumas.

[1] **Note for context:** Neither Tyler Mattson, Ryann Campos, nor Amanda Jones went to medical school or received the level of medical training of Dr. Brown.

Page 9

Dr. Brown reviewed [redacted]. These are all part of his IPP. She also reviewed his physician orders and his diet orders. She then reviewed the depositions of Tyler Mattson, Ryann Campos, Amy Jones, and the LPNs, Kelly, Amanda, and Debbie. She also looked through the OLTC statements "from Jones, Mattson, and Campos." She reviewed the paramedic's deposition and looked at his paramedic reports, the coroner's report, ER records, and the deposition of Dr. Hamid. She also reviewed a DRA report.

Page 10

Mr. Gillispie: Are you able to say within a reasonable degree of medical certainty what caused his death on this day?

Mr. Rosen: Objection. In the information provided to us in the first, second, or third supplemental responses to DHS, there was no opinion stated as to a reasonable degree of medical certainty. That opinion has not been submitted to us in the reports. I'm specifically looking at the report of what Dr. Brown would be testifying to, which was provided to DHS in Claimant's third supplemental responses to discovery. So, we're going to make an objection to that, because that is not an opinion that was provided to us, despite numerous requests for updates.

Page 11

> **Mr. Gillispie:** I may have neglected to include that actual language in the response. By the very fact that she's, you know, my expert tells you that she's going to be testifying within a reasonable degree of medical certainty.
>
> **Mr. Rosen:** I would disagree with that. It was not provided to us. And that's an essential part of the opinion.
>
> **Mr. Gillispie:** Well, that's noted.

Page 12

[redacted]

Page 13: Dr. Brown stated that when someone is struggling in the scenario that's been described, someone who is struggling has what's called a fight or flight response, meaning they have

adrenaline surges, and they are fighting for their life. Their muscles constrict to fend off what they feel is an attack. Their breathing increases, set of physiological leads to increased pressure which is the pressure which in your chest. It also constricts the abdomen which increases the intra-abdominal pressure. And increased pressure on both of these does place increased pressure on the stomach and from the sides.

Page 14

She stated being on his **left side**, the floor is another definitive mechanical block as to where it can expand. She stated that the struggle caused Mr. Cains to vomit. She stated he had [redacted]

She stated the struggle with being restrained on the floor definitely led to Mr. Cains to fight and caused pressure from multiple different regions which, she stated caused vomiting.[3]

Page 15-16:

[redacted]

[2] **Note for context:** Dr. Hamid, David Cains' physician, testified that although Mr. Cains had a [redacted] Hamid depo. p. 18.

[3] **Note for context: Dr. Brown later admitted that she did not actually know the intensity of the struggle stating when asked about the intensity of the struggle,** "But, no, of course, I have no way of knowing exactly how intense it was. Brown depo. p. 69.

[4] **Note for context:** Dr. Brown is confused about the sequence here and is testifying inconsistently. [redacted]

Page 17:

Dr. Brown testified that the first thing that is taught is to turn them onto their side if there's any sign of vomiting.[5]

Page 19:

Dr. Brown opined because Mr. Cains was choking, his lungs began burning and he became unconscious. She opined "[i]t's probably the - - one of the most painful deaths there could be. That and I assume burning to death.[6]

Page 20-21:

When asked if she had an opinion with regards to whether the outcome for Mr. Cains could have been different had paramedics arrived eight minutes sooner than they did, Dr. Brown stated **"Without any intervention, someone who suffocates will likely die within five minutes."** She then acknowledged that **"It did take the paramedics 13 minutes to get there."**[7]

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[5] **Note for context:** Dr. Brown is further confused as, just minutes earlier, [redacted].

[6] **Note for context:** Factually, [redacted] Dr. Brown did not explain how, if what she is saying is medically correct, it would be painful to an unconscious, unresponsive individual. Significantly, her comment was not to a reasonable degree of medical certainty and insinuates it may only be an assumption of her part as she compared the pain level to that of a person burning to death which, she also "assume[s]" is painful.

[7] **Note for context:** While Dr. Brown assumed there was an eight-minute delay in calling 9-1-1 because question posed to her (by counsel for the claimant) assumed the EMT could've arrived eight minutes earlier. The question is factually misleading as 9-1-1 was called immediately upon the arrival of the BHDC nurses to the location in the lobby of the Commons Building which, by all accounts, was approximately 1-2 minutes after Mr. Cains stopped breathing. The call to 9-1-1 was made immediately when the BHDC nurses arrived. As the call to 9-1-1 was documented by EMS at 11:37, this places the call to the BHDC nurses at 11:35 a.m., plus or minus one minute. CPR was administered while waiting the 13 minutes for EMS to arrive.

Page 22:

[redacted]

Page 23:

Dr. Brown stated, "I *can't say for sure* if it would have changed whether he died or not, but I can definitely tell you that there would have been a much better chance had it been done earlier."

Page 24:

Dr. Brown stated she cannot imagine a scenario where someone who's fighting for their life would have the wherewithal to intentionally vomit.

Page 25:

She stated I cannot give you a 100 percent certainty, and no one can, but I think that it is probably one of the least possible things that I could imagine.

Page 27:

She stated, Mr. Cains was on the floor being restrained by three people in three different locations of his body. There was a struggle, fight or flight, patient just struggling, adrenaline pumping, causing a lot of constriction of muscles and things of that nature.

---

[8] **Note for context:** Dr. Brown's use of the word "may" indicates only mere possibility but not a likelihood or probability and certainly does not rise to medical standard used by physicians "to a reasonable degree of medical certainty. Per the Logan County EMS Report, EMT Scow was only able to obtain a partial clearing of the airway at 11:59 a.m., which is 9 minutes *after* EMS arrival, and 22 minutes after the call to Ems at 11:37 a.m. Thus, even after calling 9-1-1 it took EMS 22 minutes before even partially clearing the blocked airway. Based on Dr. Brown's medical opinion that death ensues after approximately five (5) minutes then, if Dr. Brown is correct, then there *could be no medical impact on the outcome* even if 9-1-1 was called a few minutes sooner.

[9] **Note for context:** [redacted] It is unclear whether or not EMTs in Arkansas even have such legal authority. Recall Dr. Brown is not licensed in Arkansas.

Cross Examination by DHS

Page 30-31:

Dr. Brown read that David Cains was on his side when he started vomiting stating "[s]ounds like what I read. Dr. Brown agreed that David Cains was then turned over after they noticed he had vomited and **stopped breathing**.

Dr. Brown stated she went to medical school in the West Indies. The name of the school is University of Science, Arts, and Technology, USAT. It is an accredited medical school.

Page 33:

She started the school in 2014.

Page 35:

Dr. Brown stated "I have no idea" when asked if the school is currently accredited. She stated she was not aware that the school's website at USAT.edu/aboutus/under "listing and accreditations," states "we are currently in the process of applying for accreditation."

Page 40-41:

Dr. Brown testified she has never been to Booneville, Arkansas or to Logan County, Arkansas. She stated she did not know the population mix at the Booneville Human Development Center and did not review the differences in the population mixes from the other Human Development Centers in Arkansas.

Page 43:

She is employed at two hospitals in Florida. They are Brandon and Lakeland which are located between Tampa and Orlando.

Page 46:

She did not recall how much money she had been paid in this case and stated she would have to review her records. This was her first deposition.

Page 48:

Dr. Brown testified that she reviewed David Cains' IPP and did not see anything about his violence.

Page 49:

She testified "I heard (he had) irritable behaviors that were to be handled with care, but not aggressive behaviors and his care plan for how to handle aggressive behavior. Mr. Gillispie then objected and notified *his own expert witness* that "The word aggressive is used in his care plan."

Page 50:

She stated she read "things about him ripping a paper off a wall which are not violent. And that was about it." I heard things "that he did have *word outbursts* which are not violent. And that was about it." She did not recall anything about a fire extinguisher being thrown by Mr. Cains or him attacking people or trying to hit people. She stated "he was not known to have ever attacked anyone."[10]

Page 52:

Dr. Brown stated her "medical opinion has absolutely nothing to do with his personal - - whether he had personal aggression or not." She stated "my opinion is purely medical and scientifically driven and does not take into account whether he was a violent person or not. It has no bearing on whether he dies from suffocation from choking."

Page 53:

Dr. Brown stated she has extensive training in chemical and physical restraint.

Page 54:

> Q: So, your opinion [on restraints] has nothing to do with whatever was authorized in the IPP or allowed in Arkansas in HDCs at that time?
>
> A: Correct. It is not.

Page 56:

She agreed when Mr. Cains was restrained, he was on his **left side**.

Page 57:

---

[10] **Note for context:** It is apparent that **Dr. Brown was unfamiliar with David Cains' 2019 IPP** which expressly addressed Mr. Cains history of "physical aggression," defined the term, and identified several instances of violence when Mr. Cains destroyed his television, radio, DVD player, and broke glass. Dr. Brown is also **unfamiliar with the dozens of behavioral incident reports identified by Jennifer Berry, the BHDC Assistant Superintendent, which were introduced at her deposition** which included instances of where, for example, Mr. Cains hit is mother while she was visiting, repeatedly threw fire extinguishers at staff, bit staff, hit and attempted to hit other residents.

Dr. Brown testified that she would want somebody who is vomiting to be placed on their side and not on their back. She agreed that when David Cains started vomiting, he was placed on his side.

Page 58:

Dr. Brown had concerns [redacted]

Page 59:

[redacted]

Page 60:

[redacted]

Page 61-62:

My **opinion is that he choked from vomiting when he was on his left side.**

She stated her typical training [physician training] would be not to turn him over on his back and do abdominal thrusts, but, instead, to perform back thrusts. She stated the proper way at that point is to lean him over a chair.[11]

Page 65-66:

When asked about the intensity of the struggle [between Mr. Cains and Mr. Mattson] Dr. Brown testified "I would ***assume*** that it would be a very intense struggle, given your death being the alternative."

[11] **Note for context:** Recall Mr. Cains was 6'2", weighed approximately 250 pounds, and was unresponsive. Dr. Brown's opinion that he could have been lifted up and leaned over a chair is unrealistic. [redacted]

Page 69:

Dr. Brown testified "I - - I would ***assume*** that it was an intense struggle. **But, no, of course, I have not way of knowing exactly how intense it was."**[12]

Page 72:

[redacted]

Page 74:

[redacted]

Page 75:

She stated that no one can rule out any of this. The only thing she can rule in is that a struggle *often* induces vomiting.

Page 76:

Dr. Brown stated she could not say what David Cains thought was a fight for life or when it came down to that.[13]

Page 77:

When asked, she testified it was "[h]ard to say" if Mr. Cains was pinned to the floor. It was her understanding that Tyler Mattson was holding Mr. Cains there but did not place his weight on him.

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[12] **Note for context**: Because Dr. Brown assumes struggle was "intense" but admits that she does not know how intense it was, her testimony on this is purely speculative and does not raises to the standard of a reasonable degree of medical certainty.

[13] **Note for context:** Dr. Brown's testimony confirms the theoretical and speculative nature of her opinion. If she cannot say what Mr. Cains thought and when he thought it, then her testimony is simply conjecture and speculation because, she admits she does not know.

Page 77-79

Dr. Brown uses restraints in her emergency room to protect the individual from hurting him/her self and to protect staff. They restrain for the individual's own protection. When asked if it appeared that BHDC staff tried to de-escalate Mr. Cains behavior, she testified "I heard he was given a chance to go to the bathroom and sit down." She was then asked:

Q: And was the sit down a calming mechanism?

A: I don't know.

Q: As a matter of fact, the reason he sat down was to calm down, was it not?

A: That might have been what it was directly.

Q: So, in other words, there was a de-escalation or a calming before the outburst?

A: Not what I would call the traditional, but potentially the way they thought of it, maybe.

Page 81:

[redacted]

Page 83:

[redacted]

Page 85-86:

Dr. Brown agreed that the BHDC nurses arrival at the scene within 1-2 minutes was faster than any ambulance would be there even in a city.

Page 88:

Dr. Brown recalled that when the BHDC nurses arrived, someone directed one of the aides to call 9-1-1.

Page 92:

She confirmed that there is a clock on the wall in the emergency room. She stated she would have no idea when somebody has a car accident and they're injured and somebody says it happened at 12:30, whether that is an accurate time or if that is an estimated time.

Page 93:

Dr. Brown testified she did not know one way or another, whether the lobby of the Commons Building where this choking incident happened on June 13, 2020 had a clock.

Page 94:

She testified: If they don't have an exact time that they did it, then we would have to assume it's an approximation. She recalled that the times [in the lobby] were an approximation because there was no clock and nobody looked at a watch.

Page 96:

Although Dr. Brown stated that it was her understanding it was eight minutes from the initial onset of the "situation" to when the phone call was made to 9-1-1, she did not know whether that was from the time of the onset of the behavior ***or*** from when Mr. Cains choked testifying "you would have to ask the people involved. I was not there."[14]

Page 97:

[redacted]

Page 97-98:

[redacted]. Although that is her understanding of the timeline, it does not change her opinion as far as the timeline of events.

Page 99:

[redacted]

[14] **Note for context:** [redacted]

Page 100:

She read the Logan EMS records and they departed the scene at 12:10 and arrived at their destination at 12:18.

Page 105:

Dr. Brown testified that, "however minimal his physical pressure was, if he was restraining him, there was at least some pressure from his arm. She stated, though, she does not know what level of pressure there was. There was pressure on Mr. Cains stomach from the restraint.

Page 106-107:

Dr. Brown stated she did not examine David Cains' body, see any photographs, or see any report addressing any damage to the internal organs. She did not view any x-rays, MRI, or blood samples. She is not a forensic pathologist. She did not treat David Cains.

Respectfully Submitted,

Arkansas Department of Human Services

By: Richard Rosen
Richard Rosen, BAR No. 97164
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Arkansas
State Claims Commission

FEB 16 2023

RECEIVED

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, as Special Administrator of the ESTATE OF DAVID CAINS — **CLAIMANT**

V. — **CLAIM NO: 220374**

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — **RESONDENT**

DHS WITNESS AND EXHIBIT LIST

Comes now, the Respondent, The State of Arkansas, Department of Human Services ("DHS"), by its Attorney, Richard N. Rosen, and for its Witness and Exhibit List states:

A. Witness List

DHS may call the following witnesses at the hearing as indicated below:

1.	Jennifer Berry	in person and by deposition
2.	Dian Elliott	by deposition
3.	Dr. Ted Kastner	in person and by deposition
4.	LPN Schmitt	by deposition
5.	Tyler Mattson	by deposition
6.	Amy Jones	by deposition
7.	EMT Scow	by deposition
8.	Dr. Syed Hamid	in person and by deposition

B. Exhibit List

DHS will present the following exhibits:

DHS Trial Exhibit No:		Admitted as:
1	Dr. Kastner's Curriculum Vitae	Dr. Kastner's depo exhibit **1**
2A	Dr. Kastner's Report dated 1/5/23	Dr. Kastner's depo exhibit **2A**
2B	Dr. Kastner's Report dated 1/6/23	Dr. Kastner's depo exhibit **2B**
3	CMS State Operations Manual Appendix J	Jennifer Berry's depo exhibit **10**
4	DDS Policy 3011-D	
5A	CMS Form 2567 Survey	Dian Elliot's depo exhibit **1**
5B	Survey Investigation Report	Dian Elliot's depo exhibit **2**
5C	Survey Investigation Report	Dian Elliot's depo exhibit **3**

6A-6E	Photos of new construction	Jennifer Berry's depo exhibit **2A-2E**
7	Commons Building Floor Plan	Jennifer Berry's depo exhibit **3A-3B**
8A-8I	Photos Lobby Area	Jennifer Berry's depo exhibit **4A-4I**
9A	BHDC Staffing Levels 6/2020 Facility wide	Jennifer Berry's depo exhibit **11**
9B	BHDC Staffing Levels 6/2020 Davidson House	Jennifer Berry's depo exhibit **12**
10	2019 IPP	Jennifer Berry's depo exhibit **13**
11A	12/29/19 Behavior Report	Jennifer Berry's depo exhibit **8A**
11B	2019 Behavior Reports	Jennifer Berry's depo exhibit **8B**
11C	2020 Behavior Reports	Jennifer Berry's depo exhibit **9**
12	EMS Report	Scott Scow's depo exhibit **1**
13	Mattson OLTC Statement	Tyler Mattson's depo exhibit **9**
14A	Jennifer Berry Deposition Summary	
14B	Jennifer Berry Deposition and Exhibits	
15A	Ted Kastner, M.D. M.S. Deposition Summary	
15B	Ted Kastner, M.D. M.S. Deposition and Exhibits	
16A	Dian Elliott Deposition Summary	
16B	Dian Elliott Deposition with Exhibits	
17A	Syed Hamid, M.D. Deposition Summary	
17B	Syed Hamid, M.D. Deposition	
18	Scott Scow Deposition Summary	
19	Tyler Mattson Deposition Summary	
20	Mark Hise Deposition Summary	
21	Amy Jones Deposition Summary	
22	Amanda Schmitt Deposition Summary	
23	Janice LeBel, Ph.D. Deposition Summary	
24	Rickie Brown-Forestiere, M.D. Deposition Summary	

RESPECTFULLY SUBMITTED:

/s/ Richard Rosen

Richard N. Rosen (AR Bar No 97-164)
Arkansas Department of Human Services
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203
(501) 320-6334 telephone
(501) 682-6720 facsimile
rich.rosen@dhs.arkansas.gov

CERTIFICATE OF SERVICE

I, Richard Rosen, do hereby certify that on February 16, 2023, a true and correct copy of the foregoing document was served on the named individual by way of:

Via Email
Joshua Gillispie
Attorney for Claimant
josh@greenandgillispie.com

/s/Richard Rosen
Attorney for DHS

From: Dana Henderson
To: ASCC Pleadings
Cc: Joshua Gillispie
Subject: Claim No. 22037
Date: Friday, February 17, 2023 10:36:13 AM
Attachments: Kris Stewart Subpoena.pdf

Claims Commission:

Please issue the attached *Subpoena* regarding the above-referenced claim.

Thank you for your time and assistance with this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501.244.0700 (p); 501.244.2020 (f)
www.greenandgillispie.com

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This message does not create an attorney-client relationship.

Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

CLAIM NO. 220374

ARKANSAS DEPARTMENT OF HUMAN SERVICES, Respondent

TO: **Kris Stewart**
c/o Thomas Nichols
400 W Capitol Ave., #1200
Little Rock, AR 72201

_____ YOU ARE COMMANDED to appear at the Arkansas State Claims Commission at the place, date, and time specified below to testify in the above case.

March 9, 2023 at 9:00 a.m.; 101 E Capitol Ave., # 410, Little Rock, AR 72201

____ YOU ARE COMMANDED to appear at the place, date, and time specified below to testify in the taking of a deposition in the above case.

_____ YOU ARE COMMANDED, at the time of trial, hearing, or deposition described above, to produce and permit inspection and copying of the following documents or objects (list documents or objects):

_____ YOU ARE COMMANDED, no more than 3 business days after receiving this subpoena, to produce and permit inspection and copying of the following documents or objects (list documents of objects):

_____
Kathryn Irby, Director
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

_____
Date

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

NOTICE TO PERSONS SUBJECT TO SUBPOENAS

Regardless of his or her county of residence, a witness subpoenaed for examination at a trial or hearing must be properly served with a subpoena at least two days prior to the hearing, or within a shorter time if the court so orders. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the trial or hearing. Ark. R. Civ. Proc. 45(d), Claims Commission Rule 3.2(d).

A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Ark. R. Civ. Proc. 45(e), Claims Commission Rule 3.3.

A subpoena may command the person to whom it is directed to produce for inspection any books, papers, documents, or tangible things designated in the subpoena. The person subpoenaed may ask the court to quash or modify the subpoena if it is unreasonable or oppressive or to require that the person on whose behalf the subpoena is issued pay the reasonable cost of such production. Ark. R. Civ. Proc. 45(b). The person subpoenaed may also object in writing to inspection or copying of any or all of the designated materials or seek a protective order from the Claims Commission. If a written objection is made within ten days of service of the subpoena or on or before the time specified for compliance if such time is less than ten days, the party causing the subpoena to be issued is not entitled to inspect the materials unless the court so orders. Ark. R. Civ. Proc. 45(e). When a witness fails to attend in obedience to a subpoena or intentionally evades the service of a subpoena by concealment or otherwise, the Claims Commission may enforce the subpoena pursuant to Ark. Code Ann. § 19-10-207(d).

From: Kathryn Irby
To: dana@greenandgillispie.com; Joshua Gillispie
Subject: SUBPOENA: Claim No. 220374
Date: Friday, February 17, 2023 4:22:00 PM
Attachments: Kris Stewart Subpoena.pdf

Please see attached subpoena.

Thanks,
Kathryn

From: Misty Scott <Misty.Scott@arkansas.gov> **On Behalf Of** ASCC Pleadings
Sent: Friday, February 17, 2023 3:05 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Subject: FW: Claim No. 220374

From: Dana Henderson <dana@greenandgillispie.com>
Sent: Friday, February 17, 2023 10:36 AM
To: ASCC Pleadings <asccpleadings@arkansas.gov>
Cc: Joshua Gillispie <josh@greenandgillispie.com>
Subject: Claim No. 22037

Claims Commission:

Please issue the attached *Subpoena* regarding the above-referenced claim.

Thank you for your time and assistance with this matter.

Sincerely,

Dana Henderson
Senior Paralegal/Office Manager

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501.244.0700 (p); 501.244.2020 (f)

www.greenandgillispie.com

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Issued by the
ARKANSAS STATE CLAIMS COMMISSION

CHRISTINA MCAULIFFE, as Special Administrator of the Estate of David Cains, Claimant

SUBPOENA

V.

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Kathryn Irby, Director
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201

February 17, 2023
Date

PROOF OF SERVICE

_____
SERVED ON (Print Name)

_____ _____
DATE PLACE

_____
MANNER OF SERVICE

_____ _____
SERVED BY (Print Name) TITLE

DECLARATION OF SERVER

I declare, under penalty of perjury under the laws of the State of Arkansas, that the foregoing information contained in the Proof of Service is true and correct.

Executed on _____ _____
DATE SIGNATURE OF SERVER

_____
ADDRESS OF SERVER

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A witness subpoenaed in connection with a deposition must be properly served with a subpoena at least five business days prior to a deposition, or within a shorter time if the court so orders. The witness is required to attend a deposition at any place within 100 miles of where he or she resides, is employed, or transacts business in person, or at such other convenient place set by court order. The subpoena must be accompanied by a witness fee calculated at the rate of $30.00 per day for attendance and $0.25 per mile for travel from the witness' residence to the place of the deposition. Ark. R. Civ. Proc. 45(e), Claims Commission Rule 3.3.

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Arkansas
State Claims Commission

FEB 21 2023

RECEIVED

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains — **CLAIMANT**

V. — **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER) — **RESPONDENT**

PRE-HEARING BRIEF

COMES NOW Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Pre-hearing Brief submits the following.

FACTS

The evidence in this case tells the following story:

David "Davie" Cains, a severely developmentally disabled resident of the Booneville Human Development Center (BHDC), died on June 13, 2020, while being physically restrained on the ground by three BHDC staff members – Tyler Mattson, Amy Jones, and Ryann Campos. "This entire event took place on the floor while three people were holding David by his legs, torso, and head. A fact that was omitted in reports to EMS, the hospital, the coroner, and the family." **Exhibit 1**, "DRA - Final Report on Cains Death." **Disability Rights Arkansas (DRA), the federally mandated and funded nonprofit organization designated by the state of Arkansas to protect the rights of Arkansans with disabilities, investigated Davie's death and concluded that "this restraint likely, either directly or indirectly, led to David's death."** **Exhibit 1**, "DRA - Final Report on Cains Death."

Davie had finished lunch shortly before being restrained and pinned down to the floor by staff using a method not authorized by the facility. Staff ignored Davie's physician orders to

remain upright for one hour after eating due to [redacted] While he was being held down on his side by three BHDC staff members trained in first aid and CPR, he began to choke and vomit. **Exhibit 18,** BHDC Shift Supervisor Amy Jones p. 74. Davie appeared to be in respiratory distress and the staff turned him over onto his back within "a couple seconds" and attempted "upward thrusts." **Exhibit 18,** BHDC Shift Supervisor Amy Jones p. 7: 13-16. [redacted]

Davie, as he was known to his loved ones, was 42 years old. A longtime resident of the facility, he was well-liked by staff. Davie was close with his family, particularly his sister and mother, who were very involved in his life. Davie loved his family, he loved his friends at BHDC, and he hated being alone. Davie loved to socialize, to talk, laugh, and tease, to sing and dance. Davie loved music; more specifically, Davie loved *The Monkees* – their music was a big part of Davie's life. He did not like silence. Davie did not like it when his friends were sad; he cried when they cried. **Exhibit 45**, Photos of Davie.

Davie died needlessly. The restraint staff used was unnecessary. **Exhibit 2**, BHDC Staff Development Coordinator Mark Hise, p. 35: 14-17. Staff are only allowed to physically restrain residents in emergency situations; restraint is to be used only as an emergency measure at BHDC. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 27, p. 42, p. 44, p. 48; **Exhibit 4,** BHDC Policy I-D-4 (1); **Exhibit 2**, BHDC Staff Development Coordinator Mark Hise, p. 11. The facility may employ physical restraint "as an emergency measure, but only if *absolutely necessary* to protect client or others from injury." **Exhibit 5,** ICF-IID Reg. § 483.450(d)(1)(ii), [W296], Bates 1764; **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 32; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 30.

An emergency situation is one in which there is "imminent danger to the health or safety" of staff or clients. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 48: 12-15. Respondent defines "Imminent danger to health or safety" as a situation in which "**death or severe bodily injury could reasonably be expected to occur without intervention**." **Exhibit 7,** DDS 3004-I-Appendix A (6A), Bates 2052. This was the definition of "imminent danger" in use at BHDC at the time of Davie's death. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 62: 23-25, p. 63: 1-9. **There was no emergency, nothing that could ever have remotely posed a risk of severe bodily injury or death.** "[Davie] began screaming and cussing and ripped paper off of the wall to throw [sic] he then jumped up after me, spitting and attempting to hit me." **Exhibit 8,** Tyler Mattson OLTC Witness Statement. The evidence shows there was not even a risk of minor injury to staff.

Mattson testified at deposition to a different version of events than he gave in his OLTC Witness Statement and in his statement to DRA investigators, which were substantially the same. Almost two years after the event, he provided a very different version of the events leading up to the deadly ground restraint: in this version, Davie did ***not try to hit him***, but rather "grabbed" at him, or perhaps charged at him, but not a running charge because there wasn't enough space between them for momentum, and he added, for the very first time ever in any of his official statements, that he thought he was near a ledge, which he said made it an emergency situation for him. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 100: 24-25, p. 101: 1-25, 102: 1-25, p. 105, 14-23, p. 107: 5-17.

Again, in his written OLTC Witness Statement, completed near the time of Davie's death, Mattson said that Davie tried to hit him, omitting all mention of grabbing, charging, lunging, and omitting all mention of a ledge. **Exhibit 8,** Tyler Mattson OLTC Witness

Statement. Mattson also omitted all mention of the ledge in his statement to DRA investigators, which was conducted within a few months of the event; he never mentioned a ledge, mentioned Davie charging at him, and never mentioned Davie trying to grab him or wrap him up. **Exhibit 30**, DRA Advocate Kris Stewart, p. 63; **Exhibit 1**, "DRA - Final Report on Cains Death." Dian Elliot, the Office of Long-Term Care (OLTC) Surveyor who also interviewed Mattson, approximately two weeks after the event, also reported zero mention whatsoever of a ledge during her deposition, and also zero mention of lunging or charging. See **Exhibit 21,** OLTC Surveyor Dian Elliot.

Mattson's OLTC Witness Statement says he grabbed Davie by both of his arms, causing Davie to fall to the ground. **Exhibit 8,** Tyler Mattson OLTC Witness Statement. At deposition Mattson first testified he grabbed Davie by his shoulders, then moments later said it was actually both of Davie's arms that he grabbed, and that this somehow caused them to lose their balance and fall over together. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 102, p. 103. Either way, one significant constant is that Davie never laid a finger on Mattson; Mattson *grabbed Davie* by either his shoulders or by both of his arms, a restraint violation in itself[1], and *caused* Davie to go to the ground.

Respondent will make much of Davie's size in the hopes of showing he was a threat, because he was over six-feet-tall and supposedly 250 pounds at the time of his death. However, Tyler Mattson was a very large man himself, at least average height if not tall and probably around 250 pounds or more, based on photos and based on his appearance at deposition. **Exhibit 31, Photos of Tyler Mattson. See also the Videographer Footage of Mattson at his Deposition**, which shows Mattson standing with Claimant's counsel during a demonstration.

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[1] Staff are not supposed to grab both arms or both wrists of a resident simultaneously. BHDC Shift Supervisor Amy Jones, p. 54; **Exhibit 9**, BHDC Staff Tyler Mattson, p. 52.

This provides a good comparison, as Claimant's counsel is 6'3 and weighs approximately 220 pounds; Mattson is clearly significantly heavier.

Davie was not dangerous. Davie never caused injury to anyone at BHDC. Exhibit 2, BHDC Staff Development Coordinator Mark Hise, p. 50, p. 52; **Exhibit 9**, BHDC Staff Tyler Mattson, p. 66; **Exhibit 10**, BHDC Staff Ryann Campos, p. 49; **Exhibit 11**, BHDC LPN Kelly King, p. 7, p. 10; **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 22, p. 24, p. 28; **Exhibit 13**, Former BHDC Staff Don Carter, p. 8; **Exhibit 14**, BHDC Psychological Examiner Mike Alvis, p. 59; **Exhibit 15**, BHDC Social Services Worker Caleb Murry, p. 28; **Exhibit 16**, Claimant Christine McAuliffe, p. 21, 22.

At times Davie didn't know what to do with his emotions. His IQ was 36 and his intellectual functioning was believed to be similar to that of a four-year-old. **Exhibit 14**, BHDC Psychological Examiner Mike Alvis, p. 24, p. 29: 20-25, p. 30: 1-10. He was capable of temper tantrums, like any four-year-old: throwing objects that happened to be nearby, spitting, yelling, and even swinging his arms or faux-swatting with his hands. Davie never actually hit anyone, though, at least not anyone that the approximately twenty BHDC staff members deposed could identify. This is because Davie lacked the physical capabilities, like coordination, strength, and dexterity, to do so, even if he had desired to, which he did not. **Exhibit 13**, Former BHDC Staff Don Carter, p. 15, 16 (*not physically capable of intentionally causing harm to a grown man*); **Exhibit 16**, Claimant Christine McAuliffe, p. 98: 9-16, p. 110: 7-25, p. 115: 6-25, p. 116: 1-6.

Even if this had been an emergency situation, staff were required to use only the *"least restrictive"* approved method possible. **Exhibit 17**, DDS 3011-D (3); **Exhibit 5**, Federal ICF-IID Reg. § 483.450(b)(1)(iii), [W278], Bates 1754 (*the least restrictive appropriate technique possible*); **Exhibit 5,** ICF-IID Reg. § 483.450(b)(4), [W289], Bates 1760; **Exhibit 5,**

ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753; **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 30, p. 37: 5-9; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 26: 24-25, p. 27: 1-3, p. 34; **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 113: 3-17; **Exhibit 19**, BHDC Residential Services Manager Carrie Johnson-Miller, p. 43: 17-25, p. 44: 1-4; **Exhibit 20,** BHDC QIDP/Program Manager Justin Jobb Part II, p. 49, p. 50; **Exhibit 21,** OLTC Surveyor Dian Elliot, p. 123: 5-12, p. 133: 23-25, p. 134: 1-4; **Exhibit 22**, Dr. Janice LeBel – Summary of Expert Opinions; **Exhibit 37**, Dr. Janice LeBel – CV; **Exhibit 23**, Dr. Janice LeBel Deposition Transcript. BHDC's written policy states: "*Emergency Restraint is defined as the use of* ***the least restrictive procedure*** *and for the* ***least time necessary*** *to control* ***severely aggressive or destructive behaviors***" [emphasis added]. **Exhibit 4,** BHDC Policy I-D-4 (2)(a).

The evidence revealed a certain amount of disregard within Respondent's ranks for this most primary of Respondent's written policies on restraint usage. **For example, Melissa Weatherton, Director of the Division of Developmental Services since 2016, actually testified she was *not* aware of a requirement that staff at BHDC use only the least restrictive method available when applying restraint**. **Exhibit 32**, DDS Director Melissa Weatherton, p. 14: 24-24, p. 15: 1-8. This is concerning, given this is surely the most oft repeated and foundational safety rule for restraint use within the very division she heads. **Exhibit 17**, DDS 3011-D (3); **Exhibit 5**, Federal ICF-IID Reg. § 483.450(b)(1)(iii), [W278], Bates 1754 (*the least restrictive appropriate technique possible*); **Exhibit 5,** ICF-IID Reg. § 483.450(b)(4), [W289], Bates 1760; **Exhibit 5,** ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753; **Exhibit 4**, BHDC Policy I-D-4 (2)(a).

Sandy Evans was the Residential Services Director at the time of Davie's death, in charge of all direct care staff; she was also who Superintendent Gonyea appointed to conduct the

facility's maltreatment investigation of Tyler Mattson, Amy Jones, and Ryann Campos, all three Evans' subordinates and coworkers. **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 19, p. 59, p. 60; **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 56. Gonyea, in determining the three staff members did nothing wrong, claims he relied almost entirely on Evans' investigation. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 76: 23-25, p. 77: 1-2. Gonyea confirmed that, aside from the three staff members actually involved in the restraint, Sandy Evans possesses the most direct knowledge of anyone concerning the restraint incident on the day of Davie's death. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 77: 3-8.

Sandy Evans admitted at deposition that the restraint used on Davie at the time of his death was *not* the least restrictive option available. **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 50: 1-7, p. 47: 5-25 (*they never gave Davie a chance to calm down and collect himself on the ground unrestrained*), p. 48: 1-13, p. 49: 11-25 (it was an inappropriate use in violation of policy, requiring retraining, but in her opinion did not rise to the level of maltreatment). Amy Jones and Ryann Campos, the two staff members who helped Tyler Mattson perform the restraint, made similar admissions at deposition. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 115: 5-17 (*acknowledging she probably should have made Tyler let Davie up right away*); **Exhibit 10**, BHDC Staff Ryann Campos, p. 80: 17-21, 81: 2-6 ("*there were less restrictive ways that the situation could have been handled*").

DRA's investigation also specifically concluded it was a violation of DDS 3011-D (the "least restrictive" mandate) for staff to continue to restrain Davie after he was on the ground, as opposed to giving him space and time to calm himself, which would have been a less restrictive option readily available to staff. **Exhibit 30**, DRA Advocate Kris Stewart, p. 79: 6-16; **Exhibit 1**, "DRA - Final Report on Cains Death."

Davie certainly posed no danger once Tyler got him on the ground. Amy Jones testified Davie posed no significant danger to Tyler Mattson when she arrived at the scene and joined in the restraint. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 102: 4-13. When asked why Tyler did not simply back off to give Davie some space since he was neutralized on the ground, Jones said, "I don't know." **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 66: 12-15. Tyler had Davie on his left side while he knelt behind him holding him down with his left hand on Davie's shoulder and right hand on Davie's waist; only Davie's right arm was free, but he never once hit Tyler with it. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 66: 1-15. Tyler never asked her for help, but instead of ordering Tyler to release Davie, Jones testified she knelt down, grabbed both of Davie's arms to hold them in front of him near his face[2]. Later, Ryann Campos joined the ground restraint by kneeling down and grabbing both of Davie's legs by the ankles. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 67, p. 68, p. 72.

At no point throughout the ordeal did Davie strike any of them; he never hit one of them, kicked one of them, or spit at one of them. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 77: 1-7; **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 56: 9-11, p. 98: 15-17; **Exhibit 10**, BHDC Staff Ryann Campos, p. 56: 1-3, p. 59: 14-16, p. 63: 7-18, p. 64: 14-25. DRA Advocate Kris Stewart, one of the investigators in Davie's case, illustrated well the needlessness of the ground restraint in her deposition:

> *A He said that they -- let's go back and see exactly what Tyler told me. He applied personals by grabbing his arms. So, Tyler grabs him, okay, and he says they end up falling over.* ***David lands on his face but, then, Tyler is still able to roll him onto his side. So, my point is, if you're able to get up and gain physical whatever***

[2] Ryann Campos stated in her OLTC Witness Statement that Amy Jones was holding Davie by the head, not the arms. **Exhibit 36,** Ryann Campos OLTC Witness Statement. She then repeated this to the DRA investigators. **Exhibit 30,** DRA Advocate Kris Stewart, p. 67, 10-23.

over this guy and roll him on his side, you're probably just as able to be able to walk away and give him some space to see if he calms down [emphasis added].
Q What if he didn't calm down?
A Well, he didn't get a chance to.

Exhibit 30, DRA Advocate Kris Stewart, p. 99: 2-12.

Even there been a real emergency, the ground restraint used on Davie was not even an approved method of restraint at BHDC, much less the least restrictive option. Obviously, an unauthorized restraint technique could never be the least restrictive option. Only "authorized" forms of restraint can be used BHDC. **Exhibit 33,** BHDC Client Rights (17).

It was done in direct violation of training and facility policy. It was disallowed. Mark Hise is the Staff Development Coordinator at BHDC. Staff development is responsible for training staff in emergency procedures, which includes personal (physical) restraints[3]; staff development does "all the training" on the use of personal restraints. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 70, p. 71; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 20. Hise, who has worked at BHDC for 27 years, is NCI certified. He is responsible for showing the staff how to use personal holds or personal restraints in cases of emergencies. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 71, p. 72; **Exhibit 24**, BHDC Assistant Superintendent Jennifer Berry, p. 124. As a Staff Development Coordinator, Hise would have the most knowledge or expertise concerning the use of personal restraints and personal holds in emergency situations at the facility. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 73: 12-17. Hise is BHDC's expert in the use of personal restraints. He is the CPI/NCI expert for the BHDC

[3] BHDC employs the use of chemical restraints, mechanical restraint using a papoose board, and simple physical restraints - which they call "personal restraints" or "personal holds." **Exhibit 24**, BHDC Assistant Superintendent Jennifer Berry, p. 107. The mechanical restraint was the only approved method at BHDC that was not from the CPI/NCI curriculum. **Exhibit 2**, BHDC Staff Development Coordinator Mark Hise, p. 12: 1-22.

facility, the only training curriculum used for personal restraints at the facility. **Exhibit 24**, BHDC Assistant Superintendent Jennifer Berry, p. 127: 9-11, p. 128: 5-19.

According to Mark Hise, the ground restraint used on Davie was not allowed.

Exhibit 2, BHDC Staff Development Coordinator Mark Hise, p. 12: 1-22, p. 21: 8-25, p. 22: 1-25 ("*The training that we teach in NCI is a standing personal hold and a seated personal hold. There is no on-the-ground personal hold.*"), p. 23: 1-8, p. 27: 16-25, p. 28: 1-6, p. 32: 9-22, p. 35: 5-17, p. 42: 5-10. Other staff members, including even restraint participant Amy Jones, agreed the ground restraint used on Davie was not allowed. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 35: 14-23 (expressly prohibited from putting a client on the ground for personal restraint); p. 43: 8-18, p. 44: 9-17; **Exhibit 25**, Dr. Syed Hamid, p. 78: 12-24; **Exhibit 20,** BHDC QIDP/Program Manager Justin Jobb Part II, p. 8. Staff are not authorized to hold a client on the ground even where a client puts himself on the ground during an aggressive episode. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 45: 1-9. Tyler Mattson testified he does not remember what personal restraint techniques he was taught to use in response to severe aggression prior to Davie's death. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 37: 25, p. 38: 1-3. There are good reasons ground restraints are not supposed to be used at BHDC. Ground restraints, particularly side restraints on the ground, are extremely dangerous. **Exhibit 35**, "An Investigation into the Physiological and Psychological Impact of Supine and Side Lying Physical Restraint Techniques."[4] See also **Exhibit 39**, CPI Risks of Physical Restraint - Part of BHDC Annual Training.

[4] "The SLR [side laying restraint] position was found to impose the greatest pressure to the thorax, the greatest ventilatory restriction, and was perceived to be the most anxiety inducing, the least comfortable and the most limiting to breathing when compared to the two supine positions.... In this current study SLR exerted greater pressure on the thorax (116.1 ±17.5) than did unsupported or supported prone restraint, and reduced FVC by 14.6% compared to 16% for unsupported prone, and 11% for supported prone, therefore the recommendation for

The fact that ground restraint was not described anywhere in BHDC's policies and procedures and not identified or even mentioned as an approved restraint in Davie's Individual Placement Plan (IPP) also made its use a violation of federal regulations.

Exhibit 5, ICF-IID Reg. § 483.450(b)(1)(i), [W276], Bates 1753 (*all specific interventions for the management of inappropriate client behaviors which are approved for use in the facility are to be* ***clearly stated and described in its policy***). BHDC had a duty to comply with this policy. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 21; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 24. See also **Exhibit 5,** ICF-IID Reg. § 483.450(b)(1)(iv)(B), [W280], Bates 1755 (*policies and procedures of a facility* ***must address the types of physical restraint allowed at the facility****, the persons who can use the restraints,* ***and*** **the specific training required** for staff allowed to use them), with which BHDC had a duty to comply. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 23, p. 24. See also **Exhibit 5**, ICF-IID Reg. § 483.450(d)(1)(i), [W295], Bates 1764 (facility required to specify, within a client's IPP, the physical restraints that can be used, addressing "the type of physical restraint" and the "specific type of client behavior" for which the physical restraints described in the IPP can be used), with which BHDC had a duty to comply. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 25; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 29, p. 35.

There was only one definition for personal (physical) restraint at BHDC: "an emergency procedure **limiting movement by the holding of a hand or limb**." **Exhibit 4,** BHDC Policy I-D-4 (6)(a); **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 40: 1-25; **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 45, p. 46; **Exhibit 19**, BHDC Residential Services Manager Carrie Johnson-Miller, p. 66. It in no way encompassed ground restraints. **Exhibit 2**,

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the use of SLR as a safer alternative to both prone and supine restraint to minimize the risk of adverse restraint-related outcomes [14] should be challenged."

BHDC Staff Development Coordinator Mark Hise, p. 12: 1-22, p. 21: 8-25, p. 22: 1-25 ("*The training that we teach in NCI is a standing personal hold and a seated personal hold. There is no on-the-ground personal hold.*"), p. 23: 1-8, p. 27: 16-25, p. 28: 1-6, p. 32: 9-22, p. 35: 5-17, p. 42: 5-10.

The OLTC Survery's testimony is further confirmation that what staff did was a violation of federal regulations:

> *Q Staff can't use methods that aren't approved by the facility, can they?*
> *A No.*
> *Q They can't use methods that aren't taught to them by the facility, can they?*
> *A No.*
> *Q* ***Those would be violations of Appendix J, wouldn't they?***
> *A* ***Yes. Dian Elliot,.***

Exhibit 21, OLTC Surveyor Dian Elliot p. 110: 18-25, p. 111: 1. Mark Hise's testimony proves that staff violated Appendix J. Had Elliot interviewed Hise she would have known this:

> *Q Okay.*
> *A So, if he told me -- then at that point, if he looked at me and I would have said, "Was that theleast restrictive that they could have used," and he looked at me and said, "No," that would have been in my investigation, that's part of my evidence. So, it would have been after I did my investigation if I would have asked her that. But she is just the investigator. I would go to the CPI person.*
> *Q* ***And if the CPI person told you that the restraint used was something he did not teach, something that was not part of CPI, and not the least restrictive option, that would have been a big deal to you?***
> *A That would --*
> *Q That would have been a big deal to you?*
> *A* ***I would have considered that strongly in my investigation, yes.***

Exhibit 21, OLTC Surveyor Dian Elliot p. 140.

Tyler Mattson, who described his job caring for Davie and other developmentally disabled residents as "glorified babysitter," is the direct care staff member who initiated the restraint. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 25. **Prior to Davie's death another staff member named Jonathan McCutcheon witnessed Mattson physically abusing another resident; he reported it to administration.** **Exhibit 26**, Former Staff Jonathan McCutcheon, p. 6: 7-23, p. 7: 1-21, p. 8: 4-25, p. 9: 1-25. McCutcheon believes he reported it directly to BHDC Superintendent Jeff Gonyea. **Exhibit 26**, Former Staff Jonathan McCutcheon, p. 10: 1-25. Nothing was done. **Exhibit 26**, Former Staff Jonathan McCutcheon, p. 11: 1-11.

Just two weeks prior to Davie's death, Mattson employed unnecessary and unauthorized physical restraints on Davie twice in the same day. Had BHDC disciplined him, or even provided him additional training, Davie would very likely still be alive. The first one was in violation of policy because there was clearly no emergency to justify physical restraint, as Mattson himself acknowledged. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 71: 4-15 (*"wasn't, like, a full-blown situation"*); **Exhibit 27**, 5/29/20 Behavior Incident Report No. 1. At BHDC, staff can lay hands on residents only in full-blown situations – emergency situations likely to result in serious physical harm or death. **Exhibit 5,** ICF-IID Reg. § 483.450(d)(1)(ii), [W296], Bates 1764; **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 32; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 30. Later this same day Mattson applied physical restraints to Davie again, this time for three minutes, because Davie threatened to throw a thermometer. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 73: 4-20; **Exhibit 28**, 5/29/20 Behavior Incident Report No. 2. Mattson incurred no consequences for either violation. The administrator who reviewed and signed her approval of Mattson's use of physical restraint for this second 5/29/20 incident admitted at her deposition that the situation did not in fact meet the definition of

emergency that would justify physical force, and further, based on what is contained in the report, Mattson was not justified in his use of physical restraint and she should have flagged Tyler for this rather than approving it and moving on. **Exhibit 19**, BHDC Residential Services Manager Carrie Johnson-Miller, p. 53: 1-17, p. 54: 3-16. Davie would likely be alive if she had. This was only two weeks before he died.

Mattson also did this to Davie in March of 2020, less than three months before his death. On 3/20/20, Mattson restrained him on the ground for four minutes; he said Davie "tried to spit and swing on me," but acknowledged Davie never laid a finger on him; he only let him up once Davie apologized. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 77: 1-14; **Exhibit 29,** 3/20/20 Behavior Incident Report. This clear violation of restraint policy, notably the obvious use of an unauthorized ground restraint, was also approved by Carrie Johnson-Miller, whose testimony revealed she also required retraining on the fact that take-downs of clients to the ground for personal restraint on the ground were not allowed. **Exhibit 19**, BHDC Residential Services Manager Carrie Johnson-Miller, p. 13, p. 14, p. 22: 11-20, p. 62: 9-13. BHDC squandered this opportunity to retrain Mattson on ground restraints, which could have saved Davie's life.

By holding Davie down on the ground just after his lunch, **BHDC staff ignored Davie's known [redacted]risk and the physician orders that [redacted]** **Exhibit 46**, Physician Orders at Discharge 6.19.20; **Exhibit 47**, Physician Orders 6.1.20; **Exhibit 48** Physician Orders 3.1.19. [redacted]. Tyler Mattson, who testified he was aware of Davie's [redacted], initiated the ground restraint right after Davie finished lunch. [redacted] See **Exhibit 43**,

"Prevention of Choking and Aspiration" – New York Office of People with Developmental Disabilities, pgs. 3-4. This is noteworthy because Respondent's expert witness, Dr. Kastner, was recently the head of this office in New York, under former Governor Andrew Cuomo; some of Dr. Kastner's expert opinions in this case are in direct conflict with the contents of this document as it relates to [redacted]

Davie was a known [redacted] BHDC staff knew Davie was [redacted] See **Exhibit 49**, BHDC Prevocational Trainer Rhonda Harris, p. 10, p. 11, p. 13, p. 14. He should have never been taken to the ground under any circumstances, particularly after lunch.

The ground restraint caused Davie to vomit, as explained by Claimant's expert witness, Emergency Room physician Dr. Ricki Brown-Forestiere:

> *So, when someone is struggling in this scenario that's been described by all the participants, someone who is struggling has what's called a fight or flight response, meaning they're -- have adrenaline surges and they are fight -- essentially fighting for their life. Their muscles constrict to fend off what they feel is an attack. They -- so their muscles constrict, their breathing increases, (interference) set of physiological (interference) leads to increased [intrathoracic](interference) pressure which is the pressure in your chest. And it also constricts the abdomen which increases the intra-abdominal pressure. Both of these are cavities in the body where the stomach is. The inferior or superior aspect on top of the stomach is the diaphragm in the chest above that, and just below it, the abdomen. And increased pressure on both of these does place increased pressure on the stomach and from the sides. Obviously, there's a definitive end to the body and how far it can stretch. And also his left side being on the floor is another definitive mechanical block as to where it can expand. So, if you think of the stomach as a cube, it's having pressure from all different angles for – because of the struggle and the position and the increased pressures. And it*

caused him to [redacted]

Exhibit 42, Dr. Ricki Brown-Forestiere, p. 13, p. 14; **Exhibit 44**, Dr. Ricki Brown-Forestiere CV. Dr. Brown-Forestiere further testified:

> *Q Okay. So if I'm hearing you correctly, Dr. Brown, and in my very nonmedical layman's terms, intense struggle that produces a fight or flight reflex and adrenaline can, in itself, increases the likelihood of triggering vomiting; is that correct?*
>
> *A In this scenario, it would, yes, due to gravity.*
>
> *Q And being on his left side increased the likelihood that the pressure, intrathoracic pressure and gravity, would --*
>
> *A Yeah.*
>
> *Q -- trigger vomiting?*
>
> *A Yeah. Unfortunately, the stomach -- and the stomach's on the left. So it means everything in the body and all the pressures above him were pressing down onto the stomach; which was butting up against the ground, essentially.*
>
> *Q Okay. And the fact that he had -- if I'm hearing you correctly, the fact that he* [redacted]
>
> *A Correct.*

Exhibit 42, Dr. Ricki Brown-Forestiere, p. 14, p. 15. Respondent's expert witness, Dr. Ted Kastner, similarly opines that anxiety played a role in Davie vomiting during the restraint. **Respondent's Exhibit**, Dr. Kastner Report, Pt.. 1, p. 21. Intense anxiety

would certainly be an element to the "fight or flight" response described by Dr. Brown-Forestiere.

Because Davie was horizontal on the ground, gravity caused him to [redacted]

Q And do you have any opinion as to after he began vomiting while he was on his left side, do you have any opinion or does what happened next, what staff did next, play into your opinion at all?

A Yes. So, unfortunately, [redacted]

Exhibit 42, Dr. Ricki Brown-Forestiere, p. 15, p. 16. Dr. Brown-Forestiere opined further on the role [redacted] might have played:

A So Mr. Cains was on the floor being restrained by three people in three different locations of his body. There was a struggle, fight or flight, patient just struggling, adrenaline pumping, causing a lot of constriction of muscles and things of that nature. If you think -- in simpler terms, if you think of the stomach as a water balloon, essentially, it had pressure coming from every single direction; and the water balloon, eventually the tie at the top, broke. That would be the lower esophageal I was talking about. The tie at the top broke and all the water was released and, unfortunately, the water was a solid substance and it then --

Q And his balloon tie is weaker than most because of his [redacted] *correct?*

A Correct. Yeah, so balloon, weaker tie, breaking, everything coming up. Those are solid substances. He was on his left. They then turn them [him] on his back, allowing the vomit to rest in his throat closing off his air pipe and closing off gas exchange [redacted]

[redacted]

Exhibit 42, Dr. Ricki Brown-Forestiere, p. 27, p. 28, p. 29.

Neither Mattson nor the other two called 911, not after Davie began vomiting, not after he [redacted] **BHDC policy forbade them from doing so; at BHDC, only medical staff are authorized to call for emergency medical help, while all other staff are only allowed to alert the facility's medical department. Exhibit 34**, BHDC First Aid Guidelines – Policy IV-B-10; **Exhibit 6,** BHDC Residential Services Director Sandy Evans, p. 51: 7-25, p. 52: 1-25; **Exhibit 9**, BHDC Staff Tyler Mattson, p. 78: 22-25, p. 79: 1-11 *("I would have like to" been able to call 911 for David)*; p. 123: 8-17 *("We're not allowed to" call 911)*; **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 57: 9-25 (*...it don't really make sense that we couldn't call them [medical department] and then call 9-1-1 as well.*"), p. 115: 5-17 (*wishes she had violated the policy and called 911 right away for Davie*); **Exhibit 11**, BHDC LPN Kelly King, p.20: 16-19; **Exhibit 15**, BHDC Social Services Worker Caleb Murry, p. 56; **Exhibit 30**, DRA Advocate Kris Stewart, p. 54: 14-18, p. 65: 22-25, p. 66: 1-22 *(everyone she interviewed at BHDC confirmed there was a policy forbidding nonmedical staff from calling 911 in the event a resident has a medical emergency)* (*Gonyea told her they did not trust staff to recognize a medical emergency, feared 911 might be called unnecessarily*), p. 67: 1-10 ; **Exhibit 13**, Former BHDC Staff Don Carter, p. 22: 16-23, p. 23: 9-22 (*There were "no exceptions" to the rule)*, p. 26: 11-25.

> *Q Do you have any idea why that was the rule?*
> *A Yes. It was to control a situation. To be blunt with you, BHDC administration wanted to present their narrative in the documentation in an event like an emergency.*
> *Q What do you mean?*

A They wanted total control of what was – would appear in the documentation. Any emergency event would have been documented. And they just presented an attitude where they wanted complete control.
Q Do you know why that was so important to them?
A It was just – they had had problems in the past where things leaked out that was not in their interest.

Exhibit 13, Former BHDC Staff Don Carter, p. 24: 18-25, p. 25: 1-6.

Among many other violations, including basic common sense, BHDC's 911 policy violated its own stated Client Rights policy, which provides residents the "right to receive medical care." **Exhibit 33,** BHDC Client Rights (8).[5] DRA Advocate Kris Stewart testified that in her 27 years of working with and on behalf of developmental disability populations, she has never seen a similar 911policy. **Exhibit 30**, DRA Advocate Kris Stewart, p. 66: 19-22. DRA also documented this glaring deficiency in its report. **Exhibit 1**, "DRA - Final Report on Cains Death." **The facility didn't believe direct care staff possessed the ability to recognize a medical emergency, yet it was these same staff in whom they entrusted the daily care of Davie and other residents, in whom they entrusted the task of performing dangerous restraints on Davie and other residents. If these staff truly were not equipped to know when to call 911, they could not possibly have been equipped to react to an emergency situation with appropriate care.**

So, they called the nursing station instead, located in another building on the BHDC campus; **they informed the three LPNs on duty Davie was not breathing**. **Exhibit 11**, BHDC

[5] This is not the first time a reckless policy instituted by BHDC deprived a resident of their right to medical care and contributed directly to that resident's death; this resident also choked to death on her own vomit. Specifically, BHDC implemented a Behavior Treatment Program for a female client that "emphasized ignoring any behavior that resembled a seizure because it was believed that Jane was deliberately engaging in the seizure-like episodes to garner attention," which is exactly what staff did – ignored her as she suffocated to death on her own vomit on the ground right in front of them. **Exhibit 38**, DRA Investigation Report - BHDC Death - 2016.

LPN Kelly King, p.16: 10-15; **Exhibit 39**, Nurses Notes – Amanda Schmitt; **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 40: 17-19. Despite being told this in no uncertain terms, these three LPNs did *not* call 911 for an ambulance; rather, two of them, Kelly King and Amanda Schmitt, got in a car and drove across campus to the Commons building where Davie wasn't breathing, because they felt they needed to see if for themselves.

> *Q Right. Because 9-1-1 -- everybody that I've talked to tells me that 9-1-1 has equipment and capabilities superior, life-saving equipment and capabilities. You know, they have EpiPens, they can do intubation, they can do deep suctioning, they can, you know, communicate. You know, they have superior life-saving skills. So I'm just asking, you know, why didn't you or Ms. Noah or Ms. Schmitt or somebody else, anybody else, call 9-1-1 the second you heard that a patient --*
> *A I don't --*
> *Q -- was literally not breathing?*
> *A Well, because, I mean, I didn't really know what was going on and a lot of --*
> *Q But you were told he wasn't breathing. Did you not believe the person?*
> *A Well --*
> ***Q Did you need to see it for yourself?***
> ***A Yes. Actually, I did.***

Exhibit 11, BHDC LPN Kelly King, p.22: 7-25 (emphasis added). King testified further that they cannot rely on direct care staff's word, that they sometimes experience false alarms:

> *A Actually, I have had a couple of phone calls where a client is not breathing within the last year; and, when we got there, they were, in fact, breathing.*
> *Q Okay. And, because of that, you guys just don't take staff's word for it? You have to see – medical needs to see for themselves that somebody's dead or not breathing before you call 9-1-1? And that seems like a safe policy to you?*
> *A I -- you know, I don't even know how to answer that, to be honest with you.*

Exhibit 11, BHDC LPN Kelly King, p. 23: 25, p. 24: 1-11.

Q So that's two questions, actually. The first question, Nurse King, is do you have to see it for yourself? That's question one. The second question is, does that seem like a good, safe policy to you? So you can go ahead and answer now.
A You know, I'm going to say no for both those questions.

Exhibit 11, BHDC LPN Kelly King, p. 25, 1-8. See also **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 48 (*they did not call 911 for emergency help after they received the initial call because they get a lot of calls from staff saying a client is choking and that most of the time the client ends up being okay*).

The three nurses' decision to "see it for themselves" squandered precious minutes for Davie. According to King and Schmitt it took them almost three minutes to reach Davie. **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 57, p. 58; **Exhibit 11**, BHDC LPN Kelly King, p. 17. According to Don Carter, whose job for four and a half years was literally to drive from building-to-building picking up recycling, says that **it would not have been possible for the nurses to make the trip in less than five minutes**. **Exhibit 13**, Former BHDC Staff Don Carter, p. 35: 6-24, p. 36: 1-3 (*"But, even on a Saturday, I would say, for me to do that in a hurry would be five minutes"*). **According to Ryann Campos, the nurses did not authorize someone to call 911 for several minutes *after*** reaching Davie. **Exhibit 10**, BHDC Staff Ryann Campos, p. 46: 1-8.

The three LPNs did this despite being well aware that paramedics have superior life-saving capabilities and superior life-saving equipment; they have deep-suctioning devices, can intubate; can do chemical codes, and were only a 911 call away. **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 54, p. 55; **Exhibit 11**, BHDC LPN Kelly King, p. 25. They knew the paramedics could have provided better life-saving care. **Exhibit 12**, BHDC LPN Amanda Schmitt, p. 56: 7-11. These LPNs did not have the equipment, tools, or training to save Davie's

life. The paramedics who responded after nursing staff eventually authorized calling 911 had all these things. **Exhibit 40**, Paramedic Samuel Scow, p. 45: 1-9 (Scow was actually able to clear Davie's airway using a Magill forceps, one of many tools BHDC did not have available); **Exhibit 41**, Logan County EMS Report. Dr. Brown agreed with this:

> *Q Okay. And am I correct that a paramedic such as Mr.Scow, the training and the equipment that they brought to the scene, is much greater than what your typical LPN would be able to provide?*
> *A Oh, absolutely. An LPN is the -- one of the very lowest medical certifications in regards in the nursing world it -- as the lower end. And, even an RN, which is above an LPN, would not have been able to have the tools or administer the type of treatments or procedures that a paramedic can. They're very highly trained. So they -- they have quite a few tools at their disposal and knowledge to use them.*

Exhibit 42, Dr. Ricki Brown, p. 23: 6-18. Unfortunately, Scow arrived too late to save Davie's life.

The evidence strongly suggests *at least* five and maybe as many as ten minutes elapsed between the time Davie began choking and when BHDC called 911. **Exhibit 9**, BHDC Staff Tyler Mattson, p. 120: 1-5; **Exhibit 10**, BHDC Staff Ryann Campos, p. 46: 1-8; **Exhibit 13**, Former BHDC Staff Don Carter, p. 35: 6-24, p. 36: 1-3; **Exhibit 40**, Paramedic Samuel Scow, p. 8: 14-21, p. 10: 19-25 (*determined, based on the 911 call coming in at 11:37 am, that it was **eight minutes** from the time Davie stopped breathing and when the facility called 911*); **Exhibit 41**, Logan County EMS Report. Respondent will argue that these five to ten minutes would not have made a difference, but Paramedic Scow disagrees: "I can't give any specific like certainty. But I can say that, yeah, **time is tissue**. So it doesn't matter what the patient condition is, whether it's asphyxiation, cardiac arrest, stroke, heart attack, you know, the longer you go without oxygen circulation gas exchange, so -- and I can't say that he would have

lived. But I may or may not have been able to get ROSC. And that's just based on -- and that ROSC is return of spontaneous circulation, for those who don't know." **Exhibit 40**, Paramedic Samuel Scow, p. 15. Dr. Brown testified that "those eight minutes, honestly, in my opinion, I think that it could have had a very large impact." **Exhibit 42**, Dr. Ricki Brown, p. 21.

Respondent will argue that because it took Paramedic Scow approximately nine minutes [redacted]hat the paramedics arrival sooner could not have made a difference. However, there is no way for Respondent to know how long it would have taken Scow to clear the airway at an earlier time. Meaning, [redacted] was not static or fixed; Davie's condition was changing by the moment in those precious minutes wasted by BHDC, and it is entirely possible Davie's condition was more favorable for [redacted]at any time prior to Scow's arrival. Further, it is possible the ambulance could have arrived sooner if called for at an earlier time – traffic conditions might have been different, traffic lights might have been different, or the ambulance, if already mobile, might have happened to be nearer to the facility at any earlier time. All that can be said with absolute certainty is that every second counts in a medical emergency; that is inarguable. For Respondent to suggest that it would not have increased Davie's odds if the paramedics arrived five to ten minutes sooner is nonsensical. It is more likely than, by a preponderance of the evidence, Davie would have had *at least* a slightly better chance at survival.

BHDC provided false information on the cause and circumstances of Davie's death to the paramedics, to the emergency room, to the Logan County Coroner, and to Davie's family, who were not told that a restraint even occurred until ten days after Davie's death and three days after his burial; BHDC's deceit successfully prevented an autopsy,

foreclosing the possibility of criminal charges. Exhibit 52, BHDC's Timeline of Events (this was the facility's official version of events that was provided to DRA and other interested parties; it intentionally omits that there was a restraint)**; Exhibit 53, Facility Case Notes 6.13.20 – Documents False Info Provided Davie's Mother** (reflects BHDC gave Davie's mother false information about her son's death, telling her only that he choked on his food at lunch; all mention of the restraint was omitted). Gonyea identified this document as a case note from the day of David's death reflecting Booneville's communication with and notification to David's mother, Charlene Robinson, about Davie's death and what happened. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 92. See also **Exhibit 60** Final Synopsis Provided to Charlene Robinson (the first and only notification the family ever received notifying them there had been a restraint, received three days after Davie's funeral, and it offered no explanation beyond stating that the staff who had restrained Davie at the time of his death had been cleared of all wrong doing and the case was closed, this despite the fact that this was the very first mention of a restraint Davie's family have heard).

Paramedic Samuel Scow testified that he was never once informed there had been a restraint; rather, he was told Davie choked on his lunch and was simply found lying on the floor by himself. **Exhibit 40**, Paramedic Samuel Scow, p. 9: 1-17. This lie caused false information to be related to the emergency room and then to the coroner, Michael Chrisman, who told DRA investigators that had he known of the restraint he would have likely ordered an autopsy. **Exhibit 1**, "DRA - Final Report on Cains Death."

Davie's sister, Christine "Chrissy" McAuliffe, and his mother, Charlene Robinson, reasonably believed BHDC was the best place for Davie, who required 24-hour care. Both were heavily involved in Davie's life. Davie's mother and sister were very involved in his life; his

was one of the most involved families at BHDC, according to Caleb Murry, whose job it was to be the liaison between clients and their families. **Exhibit 15**, BHDC Social Services Worker Caleb Murry, p. 22, 23. Murry had regular contact with both his mother and sister: "It wasn't uncommon for his sister to call and say, you know, I'm going to be sending him a birthday cake for his birthday or, you know, we're going to come get him." Murry says he talked to DC's mom even more: "me and his mom talked pretty frequently." **Exhibit 15**, BHDC Social Services Worker , p. 22, 23.

> *Q And they were pretty involved?*
> *A Oh, absolutely. Yes, they were.*
> *Q More so than the average family member?*
> *A Yeah. I would say, as far as family involvement, they were probably one of the top, top ones as far as being involved with any other. They were very close to him.*

Exhibit 15, BHDC Social Services Worker , p. 23. However, they were never told that dangerous and unauthorized forms of physical restraint would be used on Davie. They were never told that nobody would call for an ambulance were Davie to suffer a medical emergency.

It was not until after Davie's death that they learned improper and excessive restraint use was pervasive at BHDC. It was not until after Davie's death that they learned BHDC administration often turned a blind eye to these violations. Following Davie's death, Chrissy and Charlene learned that in 2019 BHDC staff broke one resident's arm during a restraint and choked another resident unconscious during a restraint. **Exhibit 50**, 1.31.21 Dem-Gaz Article. They learned that Disability Rights Arkansas had issued a report in January of 2016 entitled "Bound to the Past: The Excessive Use of Restraint at the Booneville Human Development Center," which revealed, among other things, that restraint use at BHDC was "approximately twenty-five times

higher" than at the other four Human Development Centers in Arkansas. **Exhibit 51,** DRA 2016 Report - Booneville's Excessive Use of Restraints.

NEGLIGENCE

Respondent, the Arkansas Department of Human Services (DHS), and more specifically its Division of Developmental Services (DDS), which oversees operation of the Booneville Human Development Center (BHDC), is vicariously liable for the negligent acts of its agents and employees at BHDC.

The essential elements of a negligence claim are "(1) the existence of a duty on the part of the defendant to conform to a specific standard of conduct to protect the plaintiff; (2) breach of that duty by the defendant; (3) injury to the plaintiff actually and proximately caused by the defendant's breach; and (4) resulting damages to the plaintiff or his property." *Cross v. Western Waste Industries*, 2015 Ark. App. 476, 7, 469 S.W.3d 820, 825 (2015).

While negligence requires an appreciable risk of harm to others that a reasonably careful person would recognize, "it is not necessary that the actor foresee the *particular injury* which occurred, only that the actor reasonably foresee an appreciable risk of harm to others" [emphasis added]. *Wallace v. Broyles*, 331 Ark. 58, 961 S.W.2d 712, 715 (1998). Proximate cause in a negligence action may be shown from circumstantial evidence, and such evidence is sufficient to show proximate cause if the facts proved are of such a nature and are so connected and related to each other that the conclusion therefrom may be fairly inferred. *Id.*

Under the doctrine of respondeat superior, an employer may be held vicariously liable for the tortious conduct of an employee or agent if the evidence shows that such conduct was committed within the scope of the agent's employment. *St. Joseph's Reg'l Health Ctr. v. Munos*, 326 Ark. 605, 612, 934 S.W.2d 192, 195 (1996). The test for whether an employee is acting

within the scope of his employment is whether the individual is carrying out the "object and purpose of the enterprise," as opposed to acting exclusively in his own interest. *Porter v. Harshfield*, 329 Ark. 130, 137, 948 S.W.2d 83 (1997). A principal may be liable for an agent's unauthorized, and even intentional conduct if the conduct was something that might be expected in view of the agent's duties. *Life & Cas. Ins. Co. of Tenn. v. Padgett*, 241 Ark. 353, 355, 407 S.W.2d 728, 729 (1966).

RESPONDENT OWED DAVID CAINS A DUTY OF CARE.

BHDC owed David Cains a duty of care. In agreeing to accept the custody, care, and control of Davie, Respondent expressly assumed a duty of care for David Cains. The relationship between BHDC and Cains imposed a duty in this case. Duty can be assumed or created through actions, and "where a person undertakes to act, they must do so carefully or they will be liable for negligence." *Yanmar Co., Ltd. v. Slater*, 2012 Ark. 36, 16, 386 S.W.3d 439, 449 (2012). The moment Respondent agreed to take care, custody, and control of David, a duty was created. The Arkansas enabling statute for the creation of BHDC makes this clear: "There are created and there shall be maintained institutions for the care, custody, treatment, and training of individuals with intellectual and other developmental disabilities to be known as 'human development centers.'" A.C.A. § 20-48-403. And: "For the purposes of the institutions, the Board of Developmental Disabilities Services is charged with the care and training of individuals with intellectual and other developmental disabilities." A.C.A. § 20-48-403.

More importantly, BHDC was required to comply with federal regulations governing its operation. These federal regulations are referred throughout testimony interchangeably as the CMS regulations, Appendix J, the State Operations Manual, and ICF-IID regulations – all terms referring to the same federal regulations found at 42 C.F.R. § 483.00 et seq. Additionally,

BHDC was required to adhere to state DDS policies, as well as its own policies and procedures. These federal, state, and facility policies constitute specific duties owed by BHDC to Davie Cains: **See the Policies and Regulations Summary** attached with this brief.

RESPONDENT BREACHED ITS DUTIES OF CARE

Respondent breached its duties of care to Davie as specifically described in the preceding FACTS section of this brief, as well reflected in the deposition transcripts and Deposition Summaries, attached hereto.

AN APPRECIABLE RISK OF HARM WAS A FORESEEABLE CONSEQUENCE OF RESPONDENT'S BREACHES

While negligence requires an appreciable risk of harm to others that a reasonably careful person would recognize, "it is not necessary that the actor foresee the *particular injury* which occurred, only that the actor reasonably foresee an appreciable risk of harm to others" [emphasis added]. *Wallace v. Broyles*, 331 Ark. 58, 961 S.W.2d 712, 715 (1998).

As described in the preceding FACTS section of this brief, as well reflected in the deposition transcripts and Deposition Summaries, attached hereto, not only was *an* appreciable harm to Davie foreseeable, but *this particular harm* was highly foreseeable. Respondent knew full well that restraints posed a significant risk of injury to Davie, as reflected in BHDC's own Restraint Incident Debriefing Form:

> "The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. **The use of restraints is proven to be dangerous for both staff and clients, with the occurrence of injuries dramatically increasing when restraint is used**. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be for emergency use only (even when part of a behavior treatment program) when ***a very real risk of personal injury or severe property damage is imminent***."

Exhibit 61, BHDC Restraint Incident Debriefing Form. This written directive was in use at BHDC at the time of Davie's death. **Exhibit 3**, BHDC Superintendent Jeff Gonyea, p. 65.

RESPONDENT'S BREACHES DIRECTLY AND PROXIMATELY CAUSED DAVIE'S DEATH

Respondent caused Davie's death, as specifically described in the preceding FACTS section of this brief, as well reflected in the deposition transcripts and Deposition Summaries, attached hereto.

If Davie had been standing or seated when he vomited, he would not [redacted] regardless of what caused the vomiting; he was on the ground when he vomited because staff were holding him on the ground, regardless of how he got to the ground. Staff were not authorized to hold clients on the ground, not trained to do so, and were in violation of policy in doing so.

THE DAMAGES ARE SIGNIFICANT

Please see the deposition transcripts of Claimant, Christine McAuliffe, Charlene Robinson, and Sarah Ashley Cains.

Damages of the Estate of David Cains

- Loss of life of David Cains, commencing at death and ending at life expectancy. "Loss of life" damages are recoverable by the estate as an independent element of damage. These are the damages that would compensate a decedent for the loss of the value that a decedent would have placed on his or her own life. *Durham v. Marberry*, 356 Ark. 481, 156 S.W.3d 242 (2004).

- Conscious pain and suffering of David Cains prior to death. For cases involving conscious pain and suffering prior to death, see *New Prospect Drilling Co. v. First Commercial Trust, N.A.*, 332 Ark. 466, 966 S.W.2d 233 (1998); *Chambliss v. Brinton*, 229 Ark. 526, 317 S.W.2d 143 (1958). Dr. Ricki Brown-Forestiere testified that Davie's death would have been particularly painful:

  A So, when someone chokes and their airway is closed off, obviously, they can no longer receive oxygen or expel CO2. This quickly induces kind of what we would call a terror fight or flight response, similar to a drowning victim. They start fighting with everything they can. Unfortunately, as the airway is blocked, CO2 which is -- turns into a toxic substance, which is an acid, builds up in their body, their muscles fighting against and are unable to expel the lactic acid they build up. So, essentially, you're not only suffocating, but it's a feeling of burning. Your lungs begin burning, your whole body, because of the acid build up. And the struggle -- and eventually you become unconscious and -- and your body continues to struggle until it no longer can.

Exhibit 42, Dr. Ricki Brown-Forestiere, p. 19.

- Funeral expenses incurred because of David Cains' death
- Medical bills incurred, which here includes only the Ambulance bill

<u>Damages of Cains' Statutory Beneficiaries (which include Claimant, David's sister, and Charlene Robinson, David's mother, and David's half-sister Sarah Ashley Cains)</u>

- Mental anguish and emotional distress, including grief and despair, suffered up to the present time; and

- Mental anguish and emotional distress, including grief and despair, that will continue for the remainder of each of their lives. "Future mental anguish is recoverable." *Knoles v. Salazar*, 298 Ark. 281, 766 S.W.2d 613 (1989).

CONCLUSION

If there are no repercussions for misconduct, likelihood that the offense will be repeated increases. If there are not consequences for this event, the roughly 900 developmentally disabled Arkansas currently residing in Arkansas HDCs will be more likely to meet the same fate as Davie.

Only significant consequences can force the change that is needed to protect this most vulnerable population of Arkansans.

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 16th day of February, 2023, and service shall be accomplished via email to counsel of record.

/s/ Joshua D. Gillispie
Joshua D. Gillispie

Dr. Kastner's opinions should be given little weight, if any.

Dr. Kastner prepared two expert reports for DHS regarding this matter. One report is dated January 5, 2023 (part one), and another dated January 6, 2023 (part two). He also provided testimony via deposition. Many of Dr. Kastner's opinions are based on mistaken assumptions, incorrect representations of testimony and/or statements, his own contradictory statements, and shifting definitions and standards.

Dr. Kastner offers some of his opinions "based upon a reasonable degree of medical certainty" on matters that aren't medical. Dr. Kastner's puffery in attaching this phrase to non-medical conclusions is obvious on its face, and should be considered when judging his credibility and the weight (if any) that his opinions should carry. For example, Dr Kastner offers the following opinions "based upon a reasonable degree of medical certainty":

- "While on the floor, Mr. Cains continued to demonstrate aggressive behavior towards Mr. Mattson and, subsequently, to other staff." Kastner Part Two, p. 5.
- "While on the floor, Mr. Mattson and other staff applied personal holds for the purpose of protecting Mr. Cains, staff and other individuals." Kastner Part Two, p. 5.
- "While on the floor, staff made no effort to hold or "pin" Mr. Cains to the floor. The application of personal holds was solely for the purpose of protecting Mr. Cains, staff and other individuals from Mr. Cains's aggressive behavior." Kastner Part Two, p. 5.
- "I agree with Dr. LeBel that the CMS regulations are "centrist." Kastner Part Two, p. 3.
- "Mr. Cains, who [redacted] at the time of the event, "charged at" or "lunged" at his staff, Mr. Mattson, and thereby initiated the process which led to physical contact between the two." Kastner Part Two, p. 4.

- "Mr. Cains is entirely responsible for the fact that the medical order [redacted] was violated." Kastner Part One, p. 9.
- "Inconsistencies in the recording of the timing of the events was so frequent that all time notations, with the exception of when EMS was notified and the team dispatched, should be considered approximate." Kastner Part One, p. 10.

These opinions aren't medical in nature, but fall more along the lines of making assertions of non-medical facts (i.e., aggressive behavior. Mr. Cains charged at and lunged); discerning the intent and purpose of staff (i.e. applied personal holds for the purpose of protecting. the application of personal holds was solely for the purpose of protecting); ideological and political opinions (the CMS regulations are centrist); assigning liability, fault and blame (Mr. Cains is "entirely" responsible); and setting his standard for how this Commission should weigh the facts and evidence in this matter (Inconsistencies in the recording of the timing of events, with one exception, should be considered approximate).

Dr. Kastner testified during his deposition that the standard of care he was applying consisted of government and facility regulations, plus what a reasonably qualified direct support professional would have done under the circumstances. Kastner Deposition, p. 70. He testified that he derives this reasonable professional standard from the fact that professionals have to comply with licensing entities who set standards for the licensure of certain professionals. Kastner Deposition, p. 186. However, he admitted that the three staff members who held Davie down did not have any such licenses, or that they were even required to have a license. Kastner Deposition, p. 221. Additionally, in both of his written reports he never references that he is applying a reasonable licensed professional standard or definition in evaluating whether staff in

this matter met the standard of care. It was during his deposition that he first made this distinction.

But Dr. Kastner contradicts himself. His report states "CMS rules and regulations, ARDDS policies and procedures, and BHDC policies and procedures represent the standard of care for the delivery of behavioral services at BHDC." Kastner Part Two, p. 3. He does explain later that "staff exercised their professional judgment in order to meet the standard of care including the use of less restrictive procedures, "time and space," and other appropriate means." Kastner Part Two, p. 5. But this brief statement that they exercised professional judgment hardly advises the reader that the licensing requirements of professionals (which didn't apply to these staff members) was part of his definition of the standard of care set out earlier in his report. Additionally, Dr. Kastner was unable to cite any federal, state, or BHDC regulation, rule or policy that applied the licensing requirements of professionals as part of the standards applied to staff members such as those in this case.

Dr. Kastner actually contradicted his licensed professional standard during his direct examination by DHS counsel. When asked "what is the standard of care for restraint use in human development centers in the State of Arkansas, who determines that, standard of care?", he testified under oath that "the standard of care is determined by the Centers for Medicaid and Medicare—Medicare and Medicaid Services, and subsequent state and facility-based documents." Kastner Deposition, p. 49. Dr. Kastner did not include his reasonable licensed professional definition in this response to the question from DHS's counsel. Dr. Kastner at one point even excluded the governmental and facility regulations from his standard of care when attacking the Claimant's expert: "the only standard of care that is applicable to the conduct of an RCT in performing their duties is the standard for what an RCT is expected to know and to do.

And that would be based upon their training, their experience and their judgment as to what was the most appropriate course of treatment." Kastner Deposition, p. 94.

In offering his opinions, Dr. Kastner ignores inconsistencies in different statements (oral or written) given by BHDC staff, and assumes every statement they made was true and accurate. Also, Dr. Kastner just simply gets some of the facts wrong. In his deposition he stated that "Mr. Mattson and Mr. Cains had been discussing how Mr. Cains felt while he was in the dining area. He had experienced and communicated some nonspecific gastrointestinal distress." Kastner Deposition, p. 65. However, Tyler Mattson testified that Davie asked to go to the bathroom immediately after finishing lunch, and that Davie was getting agitated, but he did not know what caused the agitation. Staff Tyler Mattson Deposition, p. 93. Mattson further testified that he went into the bathroom with Davie, that Davie only urinated, and took "less than a minute." Staff Tyler Mattson Deposition, p. 96. At no time during his deposition testimony, or in any other statements did Mattson say that Davie discussed how he felt regarding gastrointestinal distress.

Dr. Kastner also provides an extremely specific prediction as to Davie's life expectancy at the time of his death without any semblance of a scientific basis or methodology. He cited some figures regarding obesity in his reports; however, he admitted under oath that they only applied to individuals between the ages of twenty and twenty-nine, and that Davie was older than twenty-nine. Kastner Deposition, p. 306-308. Dr. Kastner uses inapplicable studies, statistics, and standards to support some of his opinions. He also offers opinions that defy common sense. He testified that the BHDC policy requiring direct care staff to call medical first, and prohibited them from calling 911 for an ambulance, even when a person has no pulse and isn't breathing, was a completely appropriate policy with respect to the care provided to Davie. Kastner Deposition, p. 332-333. It is shocking that any medical professional would every justify a policy

that instructs staff to disregard their CPR training by prohibiting them for immediately calling 911 or directing someone else to immediately call 911 when a person is without a pulse and not breathing. Dr. Kastner opines that Davie did not suffer severe pain when he was suffocated with his own vomit and food debris. Kastner Part One, p. 49-51. And while he attacks Dr. Brown and claims she didn't support her opinion regarding pain, he does not support his assertion other than to say the sensation of pain requires tissue damage. It is obvious the acidic contents of a person's stomach will burn and damage tissue in the airway and lungs.

From:	Kathryn Irby
To:	Joshua Gillispie
Cc:	Misty Scott
Subject:	RE: McAuliffe/Cains v. DHS Claims Commission No. 22-0374
Date:	Tuesday, February 21, 2023 3:13:00 PM

Josh, thanks for this information.

Misty, will you replace the old binders with the new ones that Mr. Gillispie dropped off?

Kathryn

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Tuesday, February 21, 2023 2:37 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Subject: McAuliffe/Cains v. DHS Claims Commission No. 22-0374

Kathryn-

I just wanted to let you know that I stopped by your office today to drop of four flash drives containing everything that we filed in physical form on Thursday - including the Brief, Witness List, Exhibit List, Kastner Section, Deposition Summaries, Deposition Transcripts, and other Exhibits. It occurred to me that, while you only required physical copies, these might make things more convenient for your staff.

Additionally, I dropped off four additional physical copies of just the Pre-hearing Brief. The reason for this is that Exhibit citations in the copies provided on Thursday (in Volume 1 of the binders) printed in a very light ink that is a strain on the eyes. By Exhibit citations, I mean the words identifying what each exhibit is. This was the result of me using the color green for these descriptions when I was writing it on word; somehow that caused it to print funny. I want to make clear that absolutely nothing was changed, corrected or altered in any way, other than removing the color green and reprinting, causing the Exhibit citations to appear in normal ink. A quick comparison of the documents will bear that out. I just didn't want the Commissioners to have to struggle when reading.

I explained all of this to Kaitlyn in your office and she was very nice and helpful, but I thought it necessitated a follow up email to you.

Best regards,

Joshua D. Gillispie



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From: Daiquiri Carter
To: ASCC Pleadings; Joshua Gillispie; Rich Rosen
Cc: Daiquiri Carter
Subject: CC # 220374
Date: Monday, February 27, 2023 10:37:29 AM
Attachments: DHS" Motion to Exclude Witness and Exhibits_001.pdf
image001.png
image002.png

Please find attached DHS' Motion to Exclude Witness and Exhibits. I have copied Claimant's attorney on this email.

Thank you,

Daiquiri D. Carter, M.Ed.
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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

DHS's Motion to Exclude Claimant's Expert Witness- Bob Bowen- Who Was Untimely Identified, Via Email, *After* Business Hours on February 13 at 6:27 p.m.

COMES NOW Respondent, DHS, by counsel, who moves to exclude Plaintiff's newly named "expert" rebuttal witness as untimely identified to DHS, via email to counsel, just days before the deposition summaries, exhibits, and trial briefs were due and whose opinions, to date, still have not yet been identified to DHS; and as grounds therefore, states as follows:

1. In December, 2021, DHS propounded Interrogatory No. 1 to Claimant requesting identification of Claimant's expert witnesses to be called at trial and for each such expert, to state:

- The subject matter on which he or she is expected to testify; and
- To state the substance of the facts and opinions to which the expert is expected to testified; and
- To give a summary of each such opinion.

2. On January 20, 2022, Claimant identified Janice LeBel, Ph.D as her expert but failed to provide DHS with either the substance of the facts and opinions of Janice LeBel's opinions or any summary of her opinions, as requested. *See* Claimant's First Supplemental Response to Discovery, **DHS Ex. 1**.

3. On July 1, 2022, Claimant also identified Ricki Brown-Forestiere, M.D. as her expert but, just the identification of Janice LeBel, Ph.D., again failed to provide DHS with either the substance of the facts and opinions of Dr. Brown-Forestiere's opinions or any summary of her

opinions, as required. Claimant did provide the Doctor's C.V. *See* Claimant's Second Supplemental Response to Discovery, **DHS Ex. 2**.

4. Due to Claimant's 7-8 month delay in providing the substance of the facts and opinions of Claimant's previously name expert witnesses, DHS sent Counsel a good-faith letter seeking disclosure of the requested information by September 9, 2022. *See* DHS letter and email to Claimant, dated August 30, 2022 – **DHS Ex. 3.**

5. In response to DHS' good-faith letter of August 30, 2022, Claimant forwarded DHS its Third Supplemental Responses to DHS Discovery, via email **on September 7, 2022,** identifying the substance of the facts and opinions of Dr. Brown-Forestiere's opinions and a summary of her opinions, but still not yet providing DHS with the actual substance of the facts and opinions of Janice LeBel, Ph.D or a summary of her opinions. *See* Claimant's Third Supplemental Response to Discovery, **DHS Ex. 4**.

6. On Friday, December 30, 2022, Claimant emailed DHS a copy of the facts and opinions of Janice LeBel and formally supplemented he discovery on January 3, 2023. *See* **DHS Ex. 5A, 5B**, respectively.

7. By email to DHS ***after*** the close of business on **Monday, February 13, 2023, at 6:27 p.m.,** Claimant identified a <u>new, previously undisclosed</u> rebuttal "expert" witness named Bob Bowen and provided DHS with a C.V. showing Mr. Bowen is neither a physician nor a holder any advanced educational degrees. *See* email- **DHS Ex. 6A.** In her identification of Mr. Bowen as an expert, Claimant informed DHS only that (1) "[t]he substance of and grounds for his testimony will be dependent upon Dr. Kastner's live testimony" and (2) "[t]he subject matter is expected to be federal CMS regulations, also known as ICF/IID regulations within Appendix J of the state Operations Manual (the federal regulations) and whether the Booneville Human

Development Center violated those regulations in the case of David Cains." *See* Claimant's Sixth Supplemental Response to Discovery, **DHS Ex. 6B**. None of Mr. Bowen's *actual* opinions, were provided nor were the facts upon which he based those undisclosed opinions.

8. Per the Commission's June 28. 2022 letter to counsel, the Commission directed that the parties' witness lists, exhibits lists, exhibits and trial briefs, be submitted on February 16, 2023.

9. Because Claimant first identified Bob Bowen as her expert witness after the close of business in Monday, February 13, 2023, just days before the exhibits and trial briefs were to be filed, DHS had no opportunity to depose Mr. Bowen and, to date, is still unaware of his "expert" opinions or the facts upon which he will base those purported opinions.

10. Consequently, due to the *untimely* and *incomplete* identification of the Mr. Bowen as a purported "expert" witness, due process and fundamental fairness requires that he be excluded from being allowed to testify. Mr. Bowen is not a fact witness and was identified by Claimant as an expert witness. Because of Claimant's disregard of the discovery rules, particularly those pertaining to expert witness, Mr. Bowen's testimony should not be allowed.

WHEREFORE the Arkansas Department of Human Services, by Counsel, moves that this Commission exclude Bob Bowen from testifying as a "expert" witness, whether in Claimant's case in chief or in rebuttal. The parties deposed each other's named experts and, whether intentional or inadvertent, Mr. Bowen was not one of the ones named for desposition.

Respectfully Submitted,

Arkansas Department of Human Services
By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203

501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On February 27, 2023, a copy of the above motion to exclude was served via electronic mail and mailed to:

Joshua D. Gillespie, Esquire — josh@greenandgillispie.com
GREEN & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, AR 72214

Richard Rosen

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

FIRST SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

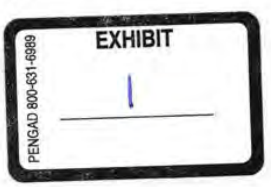
Interrogatories

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

ANSWER: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.

SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Janice L. LeBel, EdD/PhD, ABPP. Dr. LeBel's CV and Fee Schedule are provided herein, which contain her contact information. Dr. LeBel, as reflected in her CV, is a psychologist and an expert in field of behavioral health services and residential care for vulnerable



populations, including the disabled, mentally ill, and children. Dr. LeBel has published extensively on the use of restraints in these settings. She is expected to testify concerning the standard of care for a facility such as BHDC, and whether there were breaches of that standard that lead to Cains's death. Dr. LeBel can be made available for deposition upon request from Defendant. At this time there is no written report to share with Defendant.

Request for Production of Documents

1. Copies of all exhibits that you will introduce at the trial of this matter, including but not limited to all documents, reports, photographs, videotapes, digital recordings, records, bills, invoices, statements, accounts, receipts, x-rays, ultrasounds, and medical records.

RESPONSE: Plaintiff reserves the right to amend this response. Plaintiff will timely supplement this response as exhibits are identified and obtained throughout discovery. At this time, Plaintiff reserves the right to use any document produced or identified by either party throughout this discovery, including but not limited to Plaintiff's medical records, medical bills, funeral bills, various photos of David Cains, coroner reports, expert reports, including those already written and produced by Arkansas Disability Rights, and any rules and regulations or policies that Defendant was required to adhere to, including those required for Medicare/Medicaid reimbursement. Many, if not most, of the exhibits Plaintiff will use are currently in Defendant's possession, not Plaintiff's, including but not limited to Individual Program Plans, Behavior Programs, Behavior Plans, Resident Behavior Reports, Restraint Incident Debriefing Forms, Restraint Logs, Emergency Restraints, and records reflecting personal, chemical, or mechanical restraints used on David Cains throughout his time at BHDC, written communications to or from you related to the restraint and death of David Cains, policies, rules, procedures, or guidelines in effect at BHDC at the time of David Cains' death, including but not limited to those pertaining in any way to the use of restraints, such as *Use and Documentation Procedures to Manage Behavior* and *Documentation of and Response to Maladaptive Behaviors*.

Plaintiff is producing with these responses the following documents currently in her possession, which have been bates stamped and mailed to Defendant's counsel on a flash drive:

- 2015 DRA Report on BHDC
- 2016 DRA Report on BHDC
- DRA Final Investigative Report on Cain's Death
- Cains' medical records from Booneville Mercy
- 11 photos of David Cains taken prior to his death.

SUPPLEMENTAL RESPONSE:

- Ambulance bill
- Ambulance records
- Headstone bill
- Funeral services bill

3. Copies of the C.V./ resume of each and every expert that may testify at the hearing on this claim.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time.

SUPPLEMENTAL RESPONSE: Provided herein, the CV of Dr. LeBel.

4. Copies of all bills, statements, and invoices itemizing the financial damages claimed herein.

RESPONSE: Plaintiff will produce these upon receipt. However, these are not likely to be substantial, most likely consisting of funeral/burial expenses, the ambulance bill, and the hospital bill from the date of David Cains's death.

SUPPLEMENTAL RESPONSE: Provided herein, ambulance bill, funeral services bill, and headstone bill.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail and US Mail on this 20th day of January 2022.

Eric M. Collins, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

SECOND SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

Interrogatories

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Second Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

ANSWER: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.

SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Janice L. LeBel, EdD/PhD, ABPP. Dr. LeBel's CV and Fee Schedule are provided herein, which contain her contact information. Dr. LeBel, as reflected in her CV, is a psychologist and an expert in field of behavioral health services and residential care for vulnerable



populations, including the disabled, mentally ill, and children. Dr. LeBel has published extensively on the use of restraints in these settings. She is expected to testify concerning the standard of care for a facility such as BHDC, and whether there were breaches of that standard that lead to Cains's death. Dr. LeBel can be made available for deposition upon request from Defendant. At this time there is no written report to share with Defendant.

SECOND SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Ricki Brown-Forestiere, MD. Dr. Brown-Forestiere's CV is provided herein. Dr. Brown-Forestiere is an Emergency Medicine Physician and an expert in her field of emergency medical services. Dr. Brown-Forestiere is board certified in Emergency Medicine. She is expected to testify concerning the cause of David Cains' death. Dr. Brown-Forestiere can be made available for deposition upon request from Defendant.

Request for Production of Documents

REQUEST FOR PRODUCTION 3. Copies of the C.V./ resume of each and every expert that may testify at the hearing on this claim.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time.

SUPPLEMENTAL RESPONSE: Provided herein, the CV of Dr. LeBel.

SECOND SUPPLEMENTAL RESPONSE: Provided herein, the CV of Dr. Brown-Forestiere.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail and US Mail on this 1st day of July, 2022.

Eric M. Collins, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

Ricki Brown-Forestiere, MD

[redacted]

EMPLOYMENT

1/2022-Present	Lakeland Regional Hospital Emergency Medicine Physician Department Chair: James Melton, MD	Lakeland, FL
8/2021-Present	HCA - Florida Brandon Hospital Emergency Medicine Physician Supervising Faculty - Emergency Medicine Residency Department Chair: Victor Sasson, MD	Brandon, FL
7/2018-6/2021	Brandon Regional Hospital Emergency Medicine Resident Program Director: Anthony Furiato, DO	Brandon, FL
1/2015-4/2017	Acute Care Solutions Providence Hospital, Emergency Department Physician Assistant, PRN Department Chair: Nicholas Steinour, MD	Waco, TX
6/2013-9/2014	Dell Seton Medical Center at The University of Texas Physician Assistant, Orthopedic Trauma Surgery Department Chair: Drake Borer, MD	Austin, TX

EDUCATION/TRAINING

7/2018-6/2021	Brandon Regional Hospital - University Southern Florida Emergency Medicine Residency	Brandon, FL
9/2014-4/2018	University of Science, Arts and Technology Doctor of Medicine	Montserrat, West Indies
7/2009-11/2011	Touro University Master of Science, Physician Assistant Studies	Henderson, NV
5/2005-12/2007	Northeastern Illinois University Bachelor of Science, Biology and Chemistry	Chicago, IL
8/2003-6/2005	Oakton Community College Major: Biology	Niles, IL
8/2001-5/2002	Michigan State University Major: Theater	East Lansing, MI

Ricki Brown-Forestiere, MD

[redacted]

HONORS

04/2018	Graduated *Magna Cum Laude* Department of Medicine, University of Science, Arts and Technology	Montserrat, West Indies
12/2007	Graduated *Summa Cum Laude*, Department of Science Northeastern Illinois University	Chicago, IL

BOARD CERTIFICATION

2021	Emergency Medicine Physician - Oral boards pending
2018	Educational Commission For Foreign Medical Graduates ID: 09658394
2012	The National Commision on Certification of Physician Assistant ID: 110245

CERTIFICATIONS

ATLS, ACLS, PALS, BLS, USMLE I, USMLE 2CK, USMLE 2CS, USMLE 3

LICENSURE

4/21-Present	DEA: FB0133330
2/2021-Present	Florida Medical License ID: ME149105
7/2018-6/2022	Florida Training Physician Medical License ID: TRN27408
10/2017-12/2018	California Physician Assistant Board ID: 54991
8/2012-2/2018	Texas Medical Board; Physician Assistant, ID: PA07947

RESEARCH EXPERIENCE

2020	Brown-Forestiere R, Furiato A, Foresteire N P, et al. (May 11, 2020) Acute Appendicitis: Clinical Clues and Conundrums Related to the Greatest Misses. Cureus 12(5): e8051. DOI 10.7759/cureus.8051
2005-2007	Synthetic pathways and variations in feedstock for production of Biodiesel Ana Fraiman, PhD, Veronica Palmer, PhD, Northeastern University, Chicago, IL
2006-2007	Effects of Melatonin on rapidly dividing, HPV+ cervical cancer derived HeLa cells Terrance Puryear, PhD, Northeastern Illinois University, Chicago, IL

ABSTRACT PRESENTATION

2007	**Brown R**, Anderson M, Stoyan A, Puryear T, PhD. "Effects of Melatonin on rapidly dividing, HPV+ cervical cancer derived HeLa cells. Poster & Podium at Northeastern Illinois University Student Research Symposium, Chicago, IL. April 24, 2007

LEADERSHIP

2022	ACEP Leadership & Advocacy Conference -Lobby senators: Physician and patient centered policy -Political Affairs Focus Groups	Washington DC
2021-Present	Supervising faculty - Emergency Medicine Residency	Brandon, FL

Ricki Brown-Forestiere, MD

[redacted]

LEADERSHIP

2019-2021	Brandon Regional Hospital - Emergency Residency - Resident Mentor	Brandon, FL
2013-2018	University of Science, Arts and Technology - Student Mentor	Montserrat, West Indies
2013-2015	Central Texas Physician Assistant Society - Physician Assistant Student Preceptor	Waco, TX
2009-2011	Touro University - Student Council: Class President, Physician Assistant	Henderson, NV
2005-2007	Northeastern Illinois University - Student Council: Treasurer	Chicago, IL
2006-2007	Northeastern Illinois University - Student Council: Volunteer Event Coordinator	Chicago, IL
1999-2001	Niles West High School - Gymnastics Team Captain	Skokie, IL

TEACHING EXPERIENCE

2020	Brandon Regional Hospital EMS: Fundamentals, Fellowship, Future	Brandon,FL
2018	Brandon Regional Hospital Toxicology Lecture: Cocaine and Other Sympathomimetics	Brandon, FL
2018	EM Clerkship Podcast Episode Summary Guide	
2016	University of Science, Arts and Technology Anatomy Lab Assistant	Miami, FL
2014	University of Science, Arts and Technology Renal Lecture: Renin Angiotensin Aldosterone System Renal Lecture: Diuretic Pharmacology	Dallas, TX
2005-2007	Northeastern Illinois University Organic & Inorganic Chemistry Biweekly Review Lectures	Chicago, IL
2005-2006	Northeastern Illinois University Organic Chemistry Lab Assistant	Chicago, IL
2004-2005	Oakton Community College - Inorganic Chemistry Lab Assistant	Chicago, IL

ADMINISTRATIVE

2016	University of Science, Arts and Technology - University Web Design Team: Content	Montserrat, West Indies
2010-2011	Touro University - Student Clinical Coordinator	Henderson, NV
2009-2011	Touro University - Curriculum Develop Committee	Henderson, NV

Ricki Brown-Forestiere, MD

[redacted]

VOLUNTEER

2013	Balinese Women's Higher Education Fund - Founder	Candidasa, Bali
2012-2013	Livestrong Cancer Research Challenge	Austin, TX
2012	Gedong Gandhi Ashram Urgent Care Clinic	Candidasa, Bali
2010-2011	Multiple Sclerosis Society - Bike MS 150	San Diego, CA
2010	Justin Timberlake PGA Shriners Children Hospital	Henderson, NV
2010	Susan G. Komen Breast Cancer Walk	Las Vegas, NV
2010	Adolescent Heart & EKG Screening	Henderson, NV
2009-2010	Boys and Girl Club - Health Fair Coordinator	Henderson, NV
2009-Present	Visual Impact - Coordinator & Pediatric Vision Screening	Los Angeles, CA
2005-2007	Red Cross Blood Drive	Chicago, IL
1996-2001	March of Dimes - Finish Line Food Distributor	Chicago, IL

PROFESSIONAL ORGANIZATIONS

2018-Present	Physician's for Patient Protection
2019-Present	National Emergency Medicine Political Action Committee (NEMPAC)
2015-Present	American College of Emergency Medicine (ACEP) -Physician Member -Former Resident/Student Member
2018-Present	Emergency Medicine Residents Association (EMRA) -Former Resident Member
2013-Present	Educational Commission for Foreign Medical Graduates -Certified Physician Member - Former Resident Member
2013-Present	Central Texas Physician Assistant Society - Physician Assistant Student Preceptor - High School Student Observation Preceptor

HOBBIES: Patient advocacy, Emergency physician advocacy, Yoga, National Parks, International Travel

REFERENCES

1) Victor Sasson, MD
   Emergency Department Chair, HCA Brandon Regional Hospital, FL
   [redacted]

2) Anthony Furiato, DO
   Residency Program Director, HCA Brandon Regional Hospital, FL
   [redacted]

3) Kelly Grabbe, DO
   Residency Assistant Program Director, HCA Brandon Regional Hospital, FL
   [redacted]

Rich Rosen

From:	Rich Rosen
Sent:	Tuesday, August 30, 2022 9:01 AM
To:	Joshua Gillispie
Cc:	Rich Rosen; Eric Collins
Subject:	McAuliffe/Cains v. Ark DHS - Ark Claims Commission No/ 220374
Attachments:	LT-discovery(8-30-22).pdf

Dear Mr. Gillespie-

Please see the attached letter regarding Claimant's discovery responses. The paper copy will be mailed to you today.

Rich

Richard Rosen
Arkansas Department of Human Services
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334 Fax: 501-682-1390

email address is: rich.rosen@dhs.arkansas.gov

SENSITIVE

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

Office of Chief Counsel
P.O. Box 1437, Slot S260, Little Rock, AR 72203-1437
P: 501.396.6168 F: 501.682.8009 TDD: 501.682.8933

August 30, 2022

Via USPS and email to josh@greenandgillespie.com

Joshua Gillespie, Esquire
GREEN & GILLESPIE
1 Riverfront Place, Suite 605
North Little Rock, AR 72114

Re: McAuliffe/Cains v. Ark. DHS
Arkansas State Claims Commission
Case # 220374

Dear Mr. Gillespie:

I am following up on Claimant's responses to DHS's first set of interrogatories and request for production of documents, Claimant's First Supplemental Responses, and Claimant's Second Supplemental Responses to the DHS discovery. In particular, DHS is seeking responsive answers to several interrogatories which, although supplemented, do not provide the relevant information and documents expressly requested.

As DHS prepares to schedule depositions, including depositions of Claimant, the heirs, and other potential witnesses, DHS is formally requesting that Claimant promptly supplement her prior responses to Interrogatory Numbers 1, 8, and 13, and Requests for Production of Documents Nunbers 2 and 4, both of which relate to Claimant's expert witnesses.

Consequently, DHS formally requests that Claimant promptly supplement her responses:

1. **To DHS Interrogatory No. 1**:

(a) With the specific name and current address of each Disability Rights Arkansas advocate who previously investigated BHDC and who will testify in this matter as to the "findings and conclusions" contained in DRA's:

- 2015 Report (Bates numbered 0832-0852);
- 2016 Report (Bates numbered 0804-0831); and
- Investigative Report, (Bates numbered 0797-0803).

The names of the advocates who investigated the 2015 Report and the 2016 Report were not provided to DHS and the names of the names and current addresses of the

5. **To Request for Production No. 4** which requested copies of all bills, statements, and invoices itemizing the financial damages claimed. Although Claimant's response stated that she will produce these documents "upon receipt," the requested documents have not yet been provided to DHS and will be a necessary area of inquiry during DHS's depositions of the Claimant, the heirs, and others.

Thank you for your prompt attention to this matter. This information and documentation was requested by DHS in December, 2021 and is needed before DHS proceeds with any depositions or cross-examination of Claimant, the heirs, and other witnesses. Please provide Claimant's supplemental answers to discovery on or before September 9, 2022.

Sincerely,



Rich Rosen
Counsel for DHS

Rich Rosen

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Wednesday, September 7, 2022 11:39 PM
To: Rich Rosen
Cc: Eric Collins
Subject: Re: McAuliffe/Cains v. Ark DHS - Ark Claims Commission No/ 220374
Attachments: P's Third Supplemental Response to Respondent's First Set of Discovery.pdf

[EXTERNAL SENDER]
Rich:

Attached please find our Third Supplemental Responses, in response to your good faith letter.

Dr. Brown-Forestiere has offered **October 19th and 21st** for deposition dates. Please let me know at your very earliest convenience if we can agree on one of those or if we need to look for other possibilities; her schedule fills quickly.

Dr. LeBel is a little easier to pin down, but I would ask that you go ahead and offer some dates for her as well that I can take back to her.

Best regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Tue, Aug 30, 2022 at 11:18 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:
Rich,

Received. I will do my best to respond in short order. Please note that my name is spelled "Gill*i*spie."

Thanks,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114

EXHIBIT
4
PENGAD 800-631-6989

(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Tue, Aug 30, 2022 at 9:01 AM Rich Rosen <Rich.Rosen@dhs.arkansas.gov> wrote:

Dear Mr. Gillespie-

Please see the attached letter regarding Claimant's discovery responses. The paper copy will be mailed to you today.

Rich

Richard Rosen

Arkansas Department of Human Services

Office of Chief Counsel

P.O. Box 1437, Slot S260

Little Rock, AR 72203

501-320-6334 Fax: 501-682-1390

email address is: rich.rosen@dhs.arkansas.gov

SENSITIVE

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BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

THIRD SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

Interrogatories

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Third Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.

SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Janice L. LeBel, EdD/PhD, ABPP. Dr. LeBel's CV and Fee Schedule are provided herein, which contain her contact information. Dr. LeBel, as reflected in her CV, is a psychologist and an expert in field of behavioral health services and residential care for vulnerable populations, including the disabled, mentally ill, and children. Dr. LeBel has published extensively on the use of restraints in these settings. She is expected to testify concerning the standard of care for a facility such as BHDC, and whether there were breaches of that standard that lead to Cains's death. Dr. LeBel can be made available for deposition upon request from Defendant. At this time there is no written report to share with Defendant.

SECOND SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Ricki Brown-Forestiere, MD. Dr. Brown-Forestiere's CV is provided herein. Dr. Brown-Forestiere is an Emergency Medicine Physician and an expert in her field of emergency medical services. Dr. Brown-Forestiere is board certified in Emergency Medicine. She is expected to testify concerning the cause of David Cains' death. Dr. Brown-Forestiere can be made available for deposition upon request from Defendant.

THIRD SUPPLEMENTAL RESPONSE:

(a) Claimant will not be utilizing DRA advocates as expert witnesses in this matter. Claimant will reference the three DRA Reports in her pre-trial brief, reference them at the hearing, and likely submit copies to the Commission. Thomas Nichols, DRA's

Managing Attorney, has agreed to provide authentication and foundation, in the event DHS cannot stipulate to same and those steps are in fact necessary.

Thomas W. Nichols
Managing Attorney
Disability Rights Arkansas
400 West Capitol, Suite 1200
Little Rock AR 72201
Phone: 501.492.5776

(b)

Dr. Janice LeBel

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available and what Claimant expects. Note that Dr. LeBel has not authored or produced to Claimant a written report concerning her opinions. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Janice LeBel is a liability expert, expected to testify that the physical restraint and physical ground restraint, and the circumstances surrounding the restraint, performed by three direct care workers at BHDC, [redacted] fell below the standard of care for facilities caring for the intellectually disabled and that his death was a foreseeable consequence of Respondent's negligence, as evidenced by the acknowledged violations of BHDC's own rules and regulations and those of DDS, by the fact that the death restraint was unnecessary and unjustified, that it was not the least restrictive intervention available and not used for the

least amount of time, that it was not an approved NCI method of restraint taught or authorized by DHS or BHDC, that it was medically contradicted for multiple reasons (*see* [redacted] for one), that it was not identified in any policies or in David's IPP as a potential form of restraint that could ever be used, that its form and repeated use by the facility was substandard, that it occurred as the result of substandard training and substandard oversight of direct care staff, that the large number of physical restraints used by BHDC staff on David Cains over the years and the facility's history of over-reliance on physical restraints in general was substandard practice and suggests a culture within the facility standing in opposition to commonly accepted norms and best practices for such facilities, that undertrained and/or underqualified direct care staff were allowed to use their own subjective discretion for when to use physical restraints with little to no oversight by supervisors and in ways often anathema to the training professed to have been provided them and the Respondent's own written rules, that the direct care staff's training and knowledge as regards first aid and basic lifesaving procedures was substandard (*see* [redacted]), that BHDC in general failed to implement a functioning system of accountability for and oversight of staff designed to ensure staff were adhering to their training with regards de-escalation techniques and other nonviolent interventions, and that all of these ways in which BHDC fell below the standard of care directly led to and caused David Cains' untimely death – a foreseeable tragedy given the facility's historical refusal to reduce its reliance on physical restraints that are themselves inherently dangerous, particularly physical restraints performed on the ground like the one that killed David and which staff had been utilizing commonly and frequently in the months and years leading up to David's death despite the fact such

ground restraints were at all relevant times unauthorized and prohibited. Dr. LeBel's CV (previously produced) speaks for itself as to her expertise, experience, and qualifications. Her grounds for providing these opinions include the application of her expertise in this precise field to the facts and evidence of this case, including deposition transcripts, records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

Dr. Ricki Brown-Forestiere

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available. Note that Dr. Brown-Forestiere has not issued a formal written opinion or report on this matter. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Ricki Brown-Forestiere is a causation expert and partial damages expert (with respect only to Claimant's claim for damages based on David Cains' conscious pain and suffering prior to death), expected to testify that, but for the restraint and ground restraint in question, David Cains would not have died. [redacted] More specifically:

There was increased intrathoracic pressure with increased breath during the struggle. There was increased constriction of the chest muscles with the struggle constricting the rib cage further increasing the pressure of the intrathoracic cavity. [redacted]

The stomach is located on the left side of the body. Laying David on his left side caused a mechanical obstruction to the left side of the stomach. The right side is pressured by the liver and soft tissue due to gravity. The top of the stomach is adjacent to the diaphragm, which is under increased pressure due to the increase in intrathoracic pressure from the struggle. The bottom of the stomach also had increased pressure on it from Tyler Mattson's hand on Cains' abdomen while attempting to restrain him. That put pressure on his abdomen where the intestines live and they in turn put pressure on the bottom of the stomach.

All areas of pressure place eccentric pressure on the [redacted] *and this is the perfect storm to cause vomiting.*

[redacted]

Dr. Brown-Forestiere's grounds for providing these opinions include the application of her expertise in emergency medicine to the facts and evidence of this case, including deposition transcripts, medical records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

INTERROGATORY NO. 8: Please identify and itemize by nature, amount, and factual grounds/basis all damages sought herein, including financial damages, compensatory damages, consequential damages, punitive damages, and all other damages which are asserted and sought in this claim.

RESPONSE: Plaintiff objects to this request as overly broad and unduly burdensome at this early stage of the litigation, but, without waiving her objection, Plaintiff would direct Defendant to the Complaint, which provides a detailed factual basis for all damages sought, which include without limitation the following:

Damages of the Estate of David Cains

Loss of life of David Cains, commencing at death and ending at life expectancy;

Conscious pain and suffering of David Cains prior to death;

Medical care and expenses incurred as a result of David Cains' death (bills to be provided herein or upon receipt by Plaintiff's counsel); and

Funeral expenses incurred as a result of David Cains' death (bills to be provided herein or upon receipt by Plaintiff's counsel).

Damages of Cains' Statutory Beneficiaries

Mental anguish and emotional distress, including grief and despair, suffered up to the present time; and

Mental anguish and emotional distress, including grief and despair, that will continue well into the future.

SUPPLEMENTAL RESPONSE: Plaintiff reserves the right to supplement, if necessary, but identifies the below elements of damages, as found in the Arkansas Model Civil Jury Instructions.

Damages of the Estate of David Cains

- Loss of life of David Cains, commencing at death and ending at life expectancy. "Loss of life" damages are recoverable by the estate as an independent element of damage. These are the damages that would compensate a decedent for the loss of the value that a decedent would have placed on his or her own life. *Durham v. Marberry*, 356 Ark. 481, 156 S.W.3d 242 (2004). **Subject to revision as discovery continues: $2,000,000.00.**
- Conscious pain and suffering of David Cains prior to death. For cases involving conscious pain and suffering prior to death, see *New Prospect Drilling Co. v. First Commercial Trust, N.A.*, 332 Ark. 466, 966 S.W.2d 233 (1998); *Chambliss v. Brinton*, 229 Ark. 526, 317 S.W.2d 143 (1958). **Subject to revision as discovery continues: $1,000,000.00.**
- Funeral expenses incurred because of David Cains' death (bills previously provided in Claimant's First Supplemental Responses).

- Medical bills incurred, which here includes only the Ambulance bill, which has been produced in Claimant's First Supplemental Responses.

Damages of Cains' Statutory Beneficiaries (which include Claimant, David's sister, and Charlene Robinson, David's mother)

- Mental anguish and emotional distress, including grief and despair, suffered up to the present time; and
- Mental anguish and emotional distress, including grief and despair, that will continue for the remainder of each of their lives. "Future mental anguish is recoverable." *Knoles v. Salazar*, 298 Ark. 281, 766 S.W.2d 613 (1989). **Subject to revision as discovery continues: $2,000,000.00 for Claimant and $2,000,000.00 for David's mother.**

There is no amount of money that could ever fully compensate Claimant and Charlene Robinson for their mental anguish over the loss of their beloved brother and son. There is likewise no amount of money that could serve as an appropriate value on David's life and, therefore, his loss of life. Any one of these three elements of damages could by itself more than justify the current demand of $7,000,000.00. David's conscious pain and suffering that he experienced while he died choking to death while being pinned to the ground by three direct care staff is also, in and of itself, an element of damages a reasonable person would likely say is worth millions of dollars. Anyone who has ever choked for even a moment knows the intense pain and panic that comes with that. Any

funeral and medical bills are negligible and not something Claimant intends to even present.

INTERROGATORY NO. 13: Please state and explain all injuries suffered as a result of the death of Mr. Cains and by whom.

ANSWER: Plaintiff objects to this request as vague, as well as overly broad and unduly burdensome at this early stage of the litigation, but, without waiving her objection, Plaintiff would direct Defendant to her response to Interrogatory 8.

SUPPLEMENTAL RESPONSE: Claimant directs Respondent to her response and supplemental response to Interrogatory No. 8.

Request for Production of Documents

REQUEST FOR PRODUCTION 2. Copies of all expert opinions, reports, summaries and similar types of documents by the experts that will testify on behalf of the Claimant at the trial of this matter.

RESPONSE: Plaintiff anticipates she will be supplementing with further expert reports, but at this time is producing those currently in her possession, which include:

2015 DRA Report on BHDC
2016 DRA Report on BHDC
DRA Final Investigative Report on Cain's Death

SUPPLEMENTAL RESPONSE: Neither Dr. LeBel nor Dr. Brown-Forestiere have provided written opinions or expert reports at this time. Dr. Brown Forestiere has shared with Claimant an informal summary of conclusions based on what she has reviewed thus

far, which was produced in its entirety above, but will be copied below as well. Note again Claimant's reservation of her right to amend where necessary as discovery progresses:

There was increased intrathoracic pressure with increased breath during the struggle. There was increased constriction of the chest muscles with the struggle constricting the rib cage further increasing the pressure of the intrathoracic cavity. [redacted]

The stomach is located on the left side of the body. Laying David on his left side caused a mechanical obstruction to the left side of the stomach. The right side is pressured by the liver and soft tissue due to gravity. The top of the stomach is adjacent to the diaphragm, which is under increased pressure due to the increase in intrathoracic pressure from the struggle. The bottom of the stomach also had increased pressure on it from Tyler Mattson's hand on Cains' abdomen while attempting to restrain him. That put pressure on his abdomen where the intestines live and they in turn put pressure on the bottom of the stomach.

All areas of pressure place eccentric pressure on the stomach [redacted] *and this is the perfect storm to cause vomiting.*

[redacted]

REQUEST FOR PRODUCTION 4. Copies of all bills, statements, and invoices itemizing the financial damages claimed herein.

RESPONSE: Plaintiff will produce these upon receipt. However, these are not likely to be substantial, most likely consisting of funeral/burial expenses, the ambulance bill, and the hospital bill from the date of David Cains's death.

SUPPLEMENTAL RESPONSE: Provided herein, ambulance bill, funeral services bill, and headstone bill.

SECOND SUPPLEMENTAL RESPONSE: Claimant has nothing further to produce beyond the ambulance bill, funeral services bill, and headstone bill previously produced in Claimant's First Supplemental Responses.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail 7th day of September, 2022.

Eric M. Collins, Esq.
Arkansas Department of Human Services
Office of Chief Counsel

Rich Rosen, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

Rich Rosen

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Friday, December 30, 2022 2:04 PM
To: Rich Rosen
Cc: Brent Gasper; Chad
Subject: Re: McAuliffe-Cains v DHS
Attachments: LeBel - Provisional Summary of Opinions.pdf

[EXTERNAL SENDER]
Rich:

Attached is Dr. LeBel's provisional report. I am on a family vacation but I will formally supplement discovery responses with this next week, but this is the report. I wanted you to have it asap.

Please let me know what date you want for her depo: 01/09 9-1 CST or 01/16 11-3 CST

Josh

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Thu, Dec 29, 2022 at 9:25 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:
Rich:

Dr. LeBel is available on these dates. Both Mondays. Do you have a strong preference?

01/09 10-2 eastern = 9-1 central

01/16 12 – 4 eastern = 11 – 3 central

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

EXHIBIT
5A
PENGAD 800-631-6989

On Thu, Dec 22, 2022 at 10:15 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:
Rich-

Here is the Second Set of Discovery, propounded only for purposes of Dr. Kastner.

Josh

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Thu, Dec 22, 2022 at 9:38 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:
Rich-

I think that all sounds good. Dr. LeBel is reviewing the most recent depo transcripts to see if any changes need to be made to her written report, but an exchange next week will be perfect. I will get back to you today or tomorrow on a specific date for her deposition that week.

Have a merry christmas.

I am also having to send a brief set of discovery (again, trying to keep as short and simple as reasonably possible) related to Dr. Kastner. I will get that out today or tomorrow, but the Jan 19th deposition date would be a little less than 30 days, so I would hope you could get me responses before the 19th.

Thanks,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Thu, Dec 22, 2022 at 8:35 AM Rich Rosen <Rich.Rosen@dhs.arkansas.gov> wrote:

Josh-

Rich Rosen

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Tuesday, January 3, 2023 4:44 PM
To: ASCC Pleadings
Cc: Chad; Daiquiri Carter; Rich Rosen
Subject: CC 220374
Attachments: Claimant's Fourth Supplemental Response to Respondent's First Set of Discovery.pdf; LeBel - Provisional Summary of Opinions.pdf

[EXTERNAL SENDER]
Dear Commission:

Please find Claimant's Fourth Supplemental Responses to DHS's First Set of Interrogatories & RFP.

Best Regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com



BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

FOURTH SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Fourth Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.

SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Janice L. LeBel, EdD/PhD, ABPP. Dr. LeBel's CV and Fee Schedule are provided herein, which contain her contact information. Dr. LeBel, as reflected in her CV, is a psychologist and an expert in field of behavioral health services and residential care for vulnerable populations, including the disabled, mentally ill, and children. Dr. LeBel has published extensively on the use of restraints in these settings. She is expected to testify concerning the standard of care for a facility such as BHDC, and whether there were breaches of that standard that lead to Cains's death. Dr. LeBel can be made available for deposition upon request from Defendant. At this time there is no written report to share with Defendant.

SECOND SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Ricki Brown-Forestiere, MD. Dr. Brown-Forestiere's CV is provided herein. Dr. Brown-Forestiere is an Emergency Medicine Physician and an expert in her field of emergency medical services. Dr. Brown-Forestiere is board certified in Emergency Medicine. She is expected to testify concerning the cause of David Cains' death. Dr. Brown-Forestiere can be made available for deposition upon request from Defendant.

THIRD SUPPLEMENTAL RESPONSE:

(a) Claimant will not be utilizing DRA advocates as expert witnesses in this matter. Claimant will reference the three DRA Reports in her pre-trial brief, reference them at the hearing, and likely submit copies to the Commission. Thomas Nichols, DRA's

Managing Attorney, has agreed to provide authentication and foundation, in the event DHS cannot stipulate to same and those steps are in fact necessary.

Thomas W. Nichols
Managing Attorney
Disability Rights Arkansas
400 West Capitol, Suite 1200
Little Rock AR 72201
Phone: 501.492.5776

(b)

Dr. Janice LeBel

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available and what Claimant expects. Note that Dr. LeBel has not authored or produced to Claimant a written report concerning her opinions. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Janice LeBel is a liability expert, expected to testify that the physical restraint and physical ground restraint, and the circumstances surrounding the restraint, performed by three direct care workers at BHDC, which caused David to vomit and then choke to death on his vomit, fell below the standard of care for facilities caring for the intellectually disabled and that his death was a foreseeable consequence of Respondent's negligence, as evidenced by the acknowledged violations of BHDC's own rules and regulations and those of DDS, by the fact that the death restraint was unnecessary and unjustified, that it was not the least restrictive intervention available and not used for the

least amount of time, that it was not an approved NCI method of restraint taught or authorized by DHS or BHDC, that it was medically contradicted for multiple reasons (*see* [redacted] for one), that it was not identified in any policies or in David's IPP as a potential form of restraint that could ever be used, that its form and repeated use by the facility was substandard, that it occurred as the result of substandard training and substandard oversight of direct care staff, that the large number of physical restraints used by BHDC staff on David Cains over the years and the facility's history of over-reliance on physical restraints in general was substandard practice and suggests a culture within the facility standing in opposition to commonly accepted norms and best practices for such facilities, that undertrained and/or underqualified direct care staff were allowed to use their own subjective discretion for when to use physical restraints with little to no oversight by supervisors and in ways often anathema to the training professed to have been provided them and the Respondent's own written rules, that the direct care staff's training and knowledge as regards first aid and basic lifesaving procedures was substandard (*see* [redacted]), that BHDC in general failed to implement a functioning system of accountability for and oversight of staff designed to ensure staff were adhering to their training with regards de-escalation techniques and other nonviolent interventions, and that all of these ways in which BHDC fell below the standard of care directly led to and caused David Cains' untimely death – a foreseeable tragedy given the facility's historical refusal to reduce its reliance on physical restraints that are themselves inherently dangerous, particularly physical restraints performed on the ground like the one that killed David and which staff had been utilizing commonly and frequently in the months and years leading up to David's death despite the fact such

ground restraints were at all relevant times unauthorized and prohibited. Dr. LeBel's CV (previously produced) speaks for itself as to her expertise, experience, and qualifications. Her grounds for providing these opinions include the application of her expertise in this precise field to the facts and evidence of this case, including deposition transcripts, records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

Dr. Ricki Brown-Forestiere

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available. Note that Dr. Brown-Forestiere has not issued a formal written opinion or report on this matter. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Ricki Brown-Forestiere is a causation expert and partial damages expert (with respect only to Claimant's claim for damages based on David Cains' conscious pain and suffering prior to death), expected to testify that, but for the restraint and ground restraint in question, David Cains would not have died. David died because the physical restraint and ground restraint caused a struggle and that struggle induced vomiting upon which David choked to death. More specifically:

There was increased intrathoracic pressure with increased breath during the struggle. There was increased constriction of the chest muscles with the struggle constricting the rib cage further increasing the pressure of the intrathoracic cavity. [redacted]

The stomach is located on the left side of the body. Laying David on his left side caused a mechanical obstruction to the left side of the stomach. The right side is pressured by the liver and soft tissue due to gravity. The top of the stomach is adjacent to the diaphragm, which is under increased pressure due to the increase in intrathoracic pressure from the struggle. The bottom of the stomach also had increased pressure on it from Tyler Mattson's hand on Cains' abdomen while attempting to restrain him. That put pressure on his abdomen where the intestines live and they in turn put pressure on the bottom of the stomach.

All areas of pressure place eccentric pressure on the stomach [redacted] *and this is the perfect storm to cause vomiting.*

[redacted]

Dr. Brown-Forestiere's grounds for providing these opinions include the application of her expertise in emergency medicine to the facts and evidence of this case, including deposition transcripts, medical records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

FOURTH SUPPLEMENTAL RESPONSE:

Please find attached the *Provisional Summary of Opinions* of Dr. Janice LeBel, supplemental to previous responses concerning Dr. LeBel.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail 3rd day of January, 2023.

Rich Rosen, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

Rich Rosen

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Monday, February 13, 2023 6:27 PM
To: Rich Rosen
Cc: Brent Gasper; Chad
Subject: Re: McAuliffe/Cains v. DHS Claims Commission No. 22-0374
Attachments: Bob Bowen CV 2023 .pdf; Claimant's Sixth Supplemental Response to Respondent's First Set of Discovery.pdf

[EXTERNAL SENDER]
Rich:

Attached is a courtesy copy of our Sixth Supplemental Responses, which contains the disclosure of Mr. Bob Bowen as a rebuttal witness. I think you already have this, but I am attaching his CV as well.

Best regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Sat, Feb 11, 2023 at 1:28 PM Joshua Gillispie <josh@greenandgillispie.com> wrote:
Rich:

Attached are six more documents that may be used at the hearing of this matter. They are each specifically labeled. Please consider this supplemental production.

Best regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Wed, Feb 8, 2023 at 1:48 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:

EXHIBIT
6A
PENGAD 800-631-6989

BEFORE THE CLAIMS COMMISSION
OF THE STATE OF ARKANSAS

CHRISTINE MCAULIFFE,
AS SPECIAL ADMINISTRATOR OF
THE ESTATE OF DAVID CAINS **CLAIMANT**

VS. **CLAIM NO. 220374**

THE ARKANSAS DEPT. OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

SIXTH SUPPLEMENTAL RESPONSES TO RESPONDENT'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION

COMES NOW the Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Sixth Supplemental Responses to DHS's First Set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 1: Please identify by name, address and telephone number, each and every person that you expect and/or will call as an expert witness at the trial of this claim and for each and every such person, please state the subject matter on which he or she is expected to testify, and state the substance of the facts and opinions to which the expert is expected to testify and give a summary of the grounds for each such opinion.

RESPONSE: Plaintiff has not yet formally retained an expert witness, but she will be doing so soon and will supplement this response at that time. It is likely that one or more of the Disability Rights Arkansas advocates who have previously investigated BHDC will be called to testify concerning DRA's findings and conclusions, including those findings contained in their 2015 Report, 2016 Report, and their Investigative Report on David Cains' death. These reports, which are being produced herein, speak for themselves.



SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Janice L. LeBel, EdD/PhD, ABPP. Dr. LeBel's CV and Fee Schedule are provided herein, which contain her contact information. Dr. LeBel, as reflected in her CV, is a psychologist and an expert in field of behavioral health services and residential care for vulnerable populations, including the disabled, mentally ill, and children. Dr. LeBel has published extensively on the use of restraints in these settings. She is expected to testify concerning the standard of care for a facility such as BHDC, and whether there were breaches of that standard that lead to Cains's death. Dr. LeBel can be made available for deposition upon request from Defendant. At this time there is no written report to share with Defendant.

SECOND SUPPLEMENTAL RESPONSE: Plaintiff anticipates calling Dr. Ricki Brown-Forestiere, MD. Dr. Brown-Forestiere's CV is provided herein. Dr. Brown-Forestiere is an Emergency Medicine Physician and an expert in her field of emergency medical services. Dr. Brown-Forestiere is board certified in Emergency Medicine. She is expected to testify concerning the cause of David Cains' death. Dr. Brown-Forestiere can be made available for deposition upon request from Defendant.

THIRD SUPPLEMENTAL RESPONSE:

(a) Claimant will not be utilizing DRA advocates as expert witnesses in this matter. Claimant will reference the three DRA Reports in her pre-trial brief, reference them at the hearing, and likely submit copies to the Commission. Thomas Nichols, DRA's

Managing Attorney, has agreed to provide authentication and foundation, in the event DHS cannot stipulate to same and those steps are in fact necessary.

Thomas W. Nichols
Managing Attorney
Disability Rights Arkansas
400 West Capitol, Suite 1200
Little Rock AR 72201
Phone: 501.492.5776

(b)

Dr. Janice LeBel

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available and what Claimant expects. Note that Dr. LeBel has not authored or produced to Claimant a written report concerning her opinions. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Janice LeBel is a liability expert, expected to testify that the physical restraint and physical ground restraint, and the circumstances surrounding the restraint, performed by three direct care workers at BHDC, which caused David to vomit and then choke to death on his vomit, fell below the standard of care for facilities caring for the intellectually disabled and that his death was a foreseeable consequence of Respondent's negligence, as evidenced by the acknowledged violations of BHDC's own rules and regulations and those of DDS, by the fact that the death restraint was unnecessary and unjustified, that it was not the least restrictive intervention available and not used for the

least amount of time, that it was not an approved NCI method of restraint taught or authorized by DHS or BHDC, that it was medically contradicted for multiple reasons (*see* [redacted] for one), that it was not identified in any policies or in David's IPP as a potential form of restraint that could ever be used, that its form and repeated use by the facility was substandard, that it occurred as the result of substandard training and substandard oversight of direct care staff, that the large number of physical restraints used by BHDC staff on David Cains over the years and the facility's history of over-reliance on physical restraints in general was substandard practice and suggests a culture within the facility standing in opposition to commonly accepted norms and best practices for such facilities, that undertrained and/or underqualified direct care staff were allowed to use their own subjective discretion for when to use physical restraints with little to no oversight by supervisors and in ways often anathema to the training professed to have been provided them and the Respondent's own written rules, that the direct care staff's training and knowledge as regards first aid and basic lifesaving procedures was substandard (*see* [redacted]), that BHDC in general failed to implement a functioning system of accountability for and oversight of staff designed to ensure staff were adhering to their training with regards de-escalation techniques and other nonviolent interventions, and that all of these ways in which BHDC fell below the standard of care directly led to and caused David Cains' untimely death – a foreseeable tragedy given the facility's historical refusal to reduce its reliance on physical restraints that are themselves inherently dangerous, particularly physical restraints performed on the ground like the one that killed David and which staff had been utilizing commonly and frequently in the months and years leading up to David's death despite the fact such

ground restraints were at all relevant times unauthorized and prohibited. Dr. LeBel's CV (previously produced) speaks for itself as to her expertise, experience, and qualifications. Her grounds for providing these opinions include the application of her expertise in this precise field to the facts and evidence of this case, including deposition transcripts, records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

Dr. Ricki Brown-Forestiere

The following statement describing the substance of facts and opinions and grounds for those opinions should not be construed as exhaustive. This supplementation is Claimant's best effort to provide a thorough response to DHS based on the information currently available. Note that Dr. Brown-Forestiere has not issued a formal written opinion or report on this matter. Claimant reserves the right to amend and/or supplement this response where required.

That said, Dr. Ricki Brown-Forestiere is a causation expert and partial damages expert (with respect only to Claimant's claim for damages based on David Cains' conscious pain and suffering prior to death), expected to testify that, but for the restraint and ground restraint in question, David Cains would not have died. David died because the physical restraint and ground restraint caused a struggle and that struggle induced vomiting upon which David choked to death. More specifically:

There was increased intrathoracic pressure with increased breath during the struggle. There was increased constriction of the chest muscles with the struggle constricting the rib cage further increasing the pressure of the intrathoracic cavity. [redacted]

The stomach is located on the left side of the body. Laying David on his left side caused a mechanical obstruction to the left side of the stomach. The right side is pressured by the liver and soft tissue due to gravity. The top of the stomach is adjacent to the diaphragm, which is under increased pressure due to the increase in intrathoracic pressure from the struggle. The bottom of the stomach also had increased pressure on it from Tyler Mattson's hand on Cains' abdomen while attempting to restrain him. That put pressure on his abdomen where the intestines live and they in turn put pressure on the bottom of the stomach.

All areas of pressure place eccentric pressure on the stomach [redacted] *and this is the perfect storm to cause vomiting.*

[redacted]

Dr. Brown-Forestiere's grounds for providing these opinions include the application of her expertise in emergency medicine to the facts and evidence of this case, including deposition transcripts, medical records, witness statements, relevant policies and procedures binding BHDC, and other documents produced in discovery.

FOURTH SUPPLEMENTAL RESPONSE:

Please find attached the *Provisional Summary of Opinions* of Dr. Janice LeBel, supplemental to previous responses concerning Dr. LeBel.

FIFTH SUPPLEMENTAL RESPONSE: Bob Bowen. CV attached. Mr. Bowen is expected to testify as a rebuttal witness to Respondent's expert Dr. Kastner. The substance of and grounds for his testimony and opinions will be dependent upon Dr. Kastner's live testimony. The subject matter of his testimony is expected to be the federal CMS regulations, also known as ICF-IID regulations, contained within Appendix J of the State Operations Manual (the federal regulations), and whether the Booneville Human Development Center violated those regulations in the case of David Cains.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
GREEN & GILLISPIE
Attorneys at Law

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North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail 13th day of February, 2023.

Rich Rosen, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

From:	Joshua Gillispie
To:	ASCC Pleadings
Cc:	Daiquiri Carter; Rich Rosen; Chad; Kathryn Irby
Subject:	Re: CC # 220374
Date:	Monday, March 6, 2023 3:42:14 PM
Attachments:	image001.png image002.png Claimant"s Response to Motion to Exclude Witness Mr. Bowen (1).pdf

Dear Commission:

Please find attached Claimant's Response to Motion to Exclude Witness Mr. Bob Bowen.

Best regards,

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Mon, Feb 27, 2023 at 12:39 PM ASCC Pleadings <ASCCPleadings@arkansas.gov> wrote:

> Received.
>
> ---
>
> **From:** Daiquiri Carter <Daiquiri.Carter@dhs.arkansas.gov>
> **Sent:** Monday, February 27, 2023 10:37 AM
> **To:** ASCC Pleadings <ASCCPleadings@arkansas.gov>; Joshua Gillispie <josh@greenandgillispie.com>; Rich Rosen <Rich.Rosen@dhs.arkansas.gov>
> **Cc:** Daiquiri Carter <Daiquiri.Carter@dhs.arkansas.gov>
> **Subject:** CC # 220374
>
> Please find attached DHS' Motion to Exclude Witness and Exhibits. I have copied Claimant's attorney on this email.
>
> Thank you,

Daiquiri D. Carter, M.Ed.

Legal Services Specialist

Office of Chief Counsel

PO Box 1437, Slot S260

Little Rock, AR 72203-1437

501-320-6338 phone

501-682-6720 fax

Daiquiri.carter@dhs.arkansas.gov





□□□

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BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE
HUMAN DEVELOPMENT CENTER) **RESPONDENT**

CLAIMANT'S RESPONSE TO MOTION TO EXCLUDE WITNESS MR. ROBERT BOWEN

COMES NOW the Claimant, Christine McAuliffe, as Special Administrator of the Estate of David Cains, by and through her attorney, Joshua D. Gillispie, and for her *Response*, states the following:

Respondent hired Bob Bowen as its own expert consultant in 2022 for the purpose of reviewing restraint usage at the five Human Development Centers, including the Booneville Human Development Center, and to author a written report which DHS is currently using to attempt its stated goal of reducing restraint usage at BHDC and the other HDCs. DHS hid from Claimant the existence of Bowen's "Consultant Report," completed in September of 2022, a report Bowen coauthored with two other expert consultants hired by DHS, one of whom is Dr. Ted Kastner, DHS's expert witness in this case. One of the findings in this report was that, at the time of David Cains' restraint-related death, residents of the Booneville Human Development Center were, on average, subjected to physical restraint **seven times more frequently** than residents at the other HDCs. **Hearing Exhibit 64**, "Consultant Report - September 2022," pgs. 25-34.

Claimant committed no discovery violations. It was in fact DHS's violations of the discovery rules and likely the Arkansas Freedom of Information Act, as described further herein,

that prevented Claimant from learning of the existence of Bob Bowen and the written report he coauthored for DHS until on or about January 18, 2023, when Claimant's counsel received a copy of the report from an independent source not associated with DHS. Claimant, in reviewing the report, meeting with Mr. Bowen and then disclosing Mr. Bowen as a witness on February 13, 2023, *before* the February 16 deadline, obviously acted with all reasonable haste in doing so. Further, there was nothing preventing DHS from taking Mr. Bowen's deposition at any point after the February 13 disclosure; Respondent simply chose not to do so.

Here is the background. Shortly after David Cains' death, Respondent DHS formed the "DDS Behavioral Consultation Committee" to work on reducing restraint usage at the Booneville Human Development Center (BHDC) and the other four Human Development Centers (HDCs). *See* **Hearing Exhibit 32**, Deposition of DDS Director Melissa Weatherton, p. 35. This Behavioral Consultation Committee, led by Ms. Weatherton, hired a team of expert consultants in 2022 to "systematically review restraint usage and practices at five public-operated Human Developmental Centers (HDCs) including Arkadelphia, Booneville, Conway, Jonesboro and SEAHDC (Warren)," and to produce a report of their findings. *See* **Hearing Exhibit 64**, "Consultant Report - September 2022." The three expert consultants hired by DHS were Dr. Kastner, Kevin K. Walsh, Ph. D, and Robert Bowen, *the very same Bob Bowen who DHS now seeks to prevent from testifying as an expert witness and whose qualifications DHS has the audacity to now challenge.*

Respondent literally hired Mr. Bowen in 2022 to review restraint usage at BHDC and produce a report on which the DDS Behavioral Consultation Committee is to rely upon in implementing its goal of reducing restraint usage at BHDC, where David Cains was killed during an unauthorized ground restraint on June 13, 2020. As stated in the "Consultant Report":

4. Consultant Team
The authors of this report were engaged as a team to carry out this independent review of restraint practices in the HDCs. The consultants are: Theodore A. Kastner, MD, MS; Robert Bowen; and Kevin K. Walsh, PhD. Drs. Kastner and Walsh are familiar with Arkansas DDS and the five HDCs having carried out several contracted behavioral consultations and staff training activities in all five HDCs. **Mr. Bowen is a behavioral consultant and trainer with over 40 years' experience in the United States, Canada, and Australia. He was the CEO of a company that taught the prevention and, if needed, use of restraint for 13 years and has provided expert witness reports on the inappropriate use of restraint in the state of Victoria in Australia and the state of Iowa in the US. He is a published author and an internationally-known presenter. Mr. Bowen has been a university professor, and has held several advocacy and professional positions in the field of disabilities.** Full listings of the consultants' experience and qualifications relative to this project are shown in Appendix A.

See **Hearing Exhibit 64**, "Consultant Report - September 2022," p. 8 (emphasis added).

The consultants' investigation and report did not review or address individual incidents, such as David Cains' death; rather, it was a general review of how the stated restraint policies formally in place at each of the HDCs, on their face, complied with regulations and the department's stated goal of reducing restraints. DHS intentionally hid from Claimant the existence of this "Consultant Report," published in September 2022, despite Claimant repeatedly requesting production of any reports of this nature throughout the pendency of this litigation.

Claimant propounded discovery to Respondent DHS seeking the disclosure of their expert witnesses on January 13, 2022. See Claimant's First Set of Discovery Propounded to Respondent, **Exhibit A**. Claimant specifically requested copies of any documents authored by any person DHS intended to call as an expert. **Exhibit A**, Request for Production No. 16. Claimant specifically requested "copies of any and all reports, correspondence, notes, documents, writings, diagrams, charts, records, photographs, video, or audio recordings of any type, computer files, e-mails, or tangible items of any kind that any expert witness has provided to the defendant, attorneys for defendant, or any representative of defendant's attorneys."

Exhibit A, Request for Production No. 17. At no time has DHS ever produced the "Consultant Report" its Dr. Kastner coauthored with Mr. Bowen.

Not only did DHS fail to produce the "Consultant Report" which its Dr. Kastner coauthored for DHS in September of 2022, DHS did not disclose the identity of its expert witness, Dr Kastner, until December 1, 2022, on the heels of Kastner having completed his expert consultant work for the DDS Behavioral Consultation Committee. *See* DHS' Second Supplemental Responses, **Exhibit B**. DHS did not provide any of Dr. Kastner's opinions until January 5, 2023; DHS did not provide his opinions concerning standard of care, the focus of Mr. Bowen's likely rebuttal testimony, until January 10, 2023. *See* Email Disclosure of 1/10/23, **Exhibit C**. Again, at no time has DHS ever produced the "Consultant Report" its Dr. Kastner coauthored with Mr. Bowen.

Claimant propounded to DHS a Second Set of Interrogatories and Requests for Production on December 22, 2022, following Respondent's disclosure of Dr. Kastner. See **Exhibit D**, Claimant's Second Set of Discovery Propounded to Respondent. Here, Claimant specifically requested this very type of document yet again and with even greater specificity:

> REQUEST FOR PRODUCTION OF DOCUMENT NO. 2: Please produce all documents related to Dr. Theodore Kastner's, Developmental Disabilities Health Management's, or any other Kastner entity's previous work for the Arkansas Department of Human Services since the year 2000. This includes but is not limited to Kastner's or DDHM's or any other Kastner entity's proposal when bidding on the Alexander Human Development Center, and all written findings, recommendations, reports, opinions, and any other document related to their work, consulting work other otherwise, at AHDC.

Exhibit D, Request for Production No. 2. And:

> REQUEST FOR PRODUCTION OF DOCUMENT NO. 3: **Please produce all findings, recommendations, reports, opinions, or any other document authored by Kastner (or any entity with which Kastner was involved) that in any way relate to the Arkansas Department of Human Services since the year 2000.**

Exhibit D, Request for Production No. 3. Once again, DHS failed to produce the "Consultant Report" its Dr. Kastner coauthored with Mr. Bowen. See **Exhibit E**, DHS' Responses to Claimant's Second Set of Interrogatories and Requests for Production.

Claimant was aware Dr. Kastner had been employed by DHS on numerous occasions throughout the years dating back to at least 2010, when DHS apparently **paid Dr. Kastner a fee of $900,420.00** for consulting work to be performed at the now defunct Alexander Human Development Center. See **Exhibit F**, 2010 DDS Services Contract with Kastner. Claimant assumed there must be documents generated by Kastner in DHS's possession. Since these were not being provided in discovery, Claimant's counsel resorted to an FOI request on January 12, 2023 (DHS FOI Request 23-49), which read as follows:

1. For 2009 through the present, all written correspondence, including emails, with Theodore Kastner, Ted Kastner, or Dr. Theodore Kastner at any email address used by Kastner. A likely email address is TKASTNER@DDHA.COM.
2. For 2009 through the present, all written correspondence, including emails, with Developmental Disabilities Health Alliance, Inc. Please let this *also* include any person whose email address ends in @DDHA.COM
3. For 2009 through the present, all records concerning money or fees paid to Theodore Kastner, Ted Kastner, or Dr. Theodore Kastner.
4. For 2009 through the present, all records concerning money or fees paid to Developmental Disabilities Health Alliance, Inc.
5. For 2009 through the present, all records concerning money or fees paid to Disability Service Centers of Arkansas.
6. **For 2009 through the present, all written reports, opinions, recommendations, proposals, bids, or other memorandum authored by Theodore Kastner, Ted Kastner, or Dr. Theodore Kastner**.
7. For 2009 through the present, all written reports, opinions, recommendations, proposals, bids, or other memorandum authored by Developmental Disabilities Health Alliance, Inc. or an agent thereof.
8. For 2009 through the present, all written reports, opinions, recommendations, proposals, bids, or other memorandum authored by Disability Service Centers of Arkansas or an agent thereof.
9. For 2009 through the present, all contracts or other written agreements with Theodore Kastner, Ted Kastner, or Dr. Theodore Kastner.
10. For 2009 through the present, all contracts or other written agreements with Developmental Disabilities Health Alliance, Inc.
11. For 2009 through the present, all contracts or other written agreements with Disability Service Centers of Arkansas.

DHS's response to the FOI request did not include the "Consultant Report" its Dr. Kastner coauthored with Mr. Bowen or any other Kastner report, likely a violation of the Arkansas Freedom of Information Act.

Claimant can only assume DHS did not want Claimant to see the Report's finding that, at the time of Davie's restraint-related death, residents of the Booneville Human Development Center were, on average, subjected to physical restraint **seven times more frequently** than residents at the other HDCs. **Hearing Exhibit 64**, "Consultant Report - September 2022," pgs. 25-34. Kastner and Bowen found that, at Booneville, residents were subjected to physical restraint (what the HDCs prefer to call "personal restraint") at a rate of "7.3" times per person for 2020. **Hearing Exhibit 64**, "Consultant Report - September 2022," p. 28. Whereas at the Jonesboro HDC residents were subjected to physical restraint at a rate of ".75" times per person. ***Id***, p. 33. At Arkadelphia it was "1.01" physical restraints per resident. ***Id***, p. 27. And at the Warren HDC it was ".88" physical restraints per resident. ***Id***, p. 34. The consultants found that the Conway HDC, which has a much larger population than the other four, uses a different restraint system that did not allow them to identify the yearly per person rate of restraint.

Or perhaps DHS was uncomfortable with the fact that Kastner's and Bowen's Report recommended the HDCs consider implementing "the six core strategies promulgated by the National Association of State Mental Health Program Directors (nasmhpd.org)," **Hearing Exhibit 64**, "Consultant Report - September 2022," p. 37. These are the very same "six core strategies" that were developed by Claimant's other liability expert, Dr. Janice LeBel, along with her colleague Dr. Kevin Huckshorn. See **Hearing Exhibit 23**, Deposition of Dr. Janice LeBel.

Whatever DHS's reason for withholding this document, the department is entirely responsible for the fact that Claimant did not learn of Bob Bowen and the "Consultant Report"

sooner. And now DHS has the temerity to challenge Mr. Bowen's qualifications, whose expertise in this area is overwhelming and who DHS literally hired for his expertise in this precise area only months ago, as made clear in the Report he coauthored for DHS:

> *Bob Bowen is a behavioral consultant and trainer with Prag Consulting in Melbourne, Australia. He has over 40 years of experience supporting individuals with complex behavioral needs in the United States, Canada, and Australia. He has provided keynote and plenary presentations at conferences in the United Kingdom, Ireland, Norway, Australia, Hong Kong, Canada and the United States. Bob is the developer of The Matrix of Needs, an innovative approach to understanding human needs. he has published over 20 peer and scientifically reviewed articles, three book chapters, and presented hundreds of workshops on the prevention of workplace violence, while improving the quality of life for people affected by disabilities, and the staff who support them.*
>
> *During his career in human services, Bob has held positions ranging from direct support professional to CEO and almost everything in between. He was the CEO of The Mandt System, Inc., an organization providing training in the prevention and, if needed, use of restraint. In this role he was the primary author of the curriculum used to teach preventative measures, and wrote the chapters on Trauma Informed Services and Positive Behavior Support. He has also served as an adjunct assistant professor of psychiatry at the University of Rochester in New York for eleven years, and also has experience teaching at Walsh University in North Canton, Ohio, and at Hawkeye Community College in Waterloo, Iowa. Additionally, Bob was a field placement supervisor for the Malone University Department of Social Work in Canton, Ohio, and is currently a member of the Department of Social Work Community Advisory Board at Malone.*
>
> *Bob is a member of the Australasian Society for Intellectual Disability, the Restraint Reduction Network in the United Kingdom, the National Association of Social Workers, the National Organization of Human Services, the Association for Positive Behaviour Support, and the National Association of Qualified Intellectual Disability Professionals. Bob is certified in trauma treatment through the National Institute for the Clinical Application of Behavioral Medicine, and the Trauma Research Foundation.*

Hearing Exhibit 64, "Consultant Report - September 2022," p. 42-43. Mr. Bowen's CV, submitted as **Hearing Exhibit 70**, further burnishes his credentials as an expert in the specific area of the ICF/IID federal regulations. In fact, Mr. Bowen's expertise in the ICF/IID federal regulations, often referred to as Appendix J or CMS regulations, was acknowledged by his two

coauthors as being superior, since it was Mr. Bowen who the team tasked with drafting the specific portion of the "Consultant Report" comparing the HDC restraint policies against the mandates of Appendix J:

> *4. Comparison of Policy to Appendix J*
> ***As a basic foundation to other work, <u>one member of our team (RB)</u> carried out a comparison of the DDS and HDC restraint policy statements provided to us with the Medicaid standards as contained in Appendix J of the Medicaid Survey Procedures and Interpretive Guidelines (known generally as "Appendix J").***
> *The comparison was restricted to specific areas of Appendix J regulations. This comparison determined the most fundamental requirements for the system.*
> *A separate document/report detailing this review appears in the Appendices to this report (Appendix E) and it titled: A Rule Comparison: ICF/IID Regulations Appendix J and Arkansas DDS.*

Hearing Exhibit 64, "Consultant Report - September 2022," p. 11.

DHS's Dr. Kastner is likely to testify there was no violation of Appendix J connected to David Cains' death. Mr. Bowen vehemently disagrees, and he should be allowed to offer testimony rebutting Dr. Kastner's opinions with regards to violations of the standard of care, which in this case is largely synonymous with violations of Appendix J (both parties agree that state DDS policies and BHDC's facility regulations also inform the standard of care). Because of DHS's own misconduct Claimant could not possibly have advanced the testimony or opinions of Mr. Bowen any sooner than she did. The Arkansas Supreme Court allows for rebuttal evidence in this scenario, even where the evidence was not listed in pre-trial discovery, so long as the party seeking to advance rebuttal evidence has not knowingly concealed the evidence in violation of ARCP Rule 26, which mandates a party to seasonably amend or supplement a prior response. *Phillips v. McAuley*, 297 Ark. 563, 565, 764 S.W.2d 424, 425 (1989). Here, Claimant *did* actually identify Mr. Bowen in pre-hearing discovery, and she did so not only seasonably but as quickly as she could reasonably be expected to have done.

WHEREFORE, the Claimant prays for the Arkansas Claims Commission to deny Respondent's Motion to Exclude Mr. Bowen from testifying as a rebuttal witness, and for all other proper relief which she may be entitled.

Respectfully submitted by:

/s/ Joshua D. Gillispie
ABA # 2010131
GREEN & GILLISPIE
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Little Rock, AR 72201
(501) 244-0700
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josh@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 6th day of March, 2023, and service shall be accomplished via email to counsel of record.

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) **RESPONDENT**

PLAINTIFF'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION PROPOUNDED TO DEFENDANT

COMES now Plaintiff, by and through her attorney, Joshua D. Gillispie, and propounds to Defendant the following Interrogatories and Requests for Production, to be answered in accordance with the Arkansas Rules of Civil Procedure and other applicable laws:

DEFINITIONS

1. "And" and "or" shall be individually interpreted in every instance as meaning "and/or" and shall not be interpreted to exclude any information within the scope of these requests.

2. "DHS" or "Defendant" or "You," as used herein, refers to all departments, offices, and facilities within the Arkansas Department of Human Services, including but not limited to the Booneville Human Development Center (referred to herein as "BHDC"), as well as all agents, employees, and officers.

3. Communication" or "Communications" refer to oral conversations, written correspondence, memoranda, telephone conversations, text messages, correspondence, notes, electronic mail, social media posts or messages, voice mails, answering machine messages, letters, notes, or cards, whether as a sender, recipient, cc, or bcc. "Communication" means any disclosure, transfer, or exchange of information or opinion, however made.



4. "Correspondence" refers to all forms of writings, electronic or otherwise, including but not limited to, letters, books, emails, text messages, computer tapes, discs, printouts, keypunch cards, memoranda, diaries, notes, reports, bulletins, printed forms, telegraphic communications, telexes, telegrams, telecopies, facsimile reproductions, minutes, microfilm, microfiche, films, videotape, and computer discs.

5. "Document" or "Documents" mean the original, or a copy when the original is not available, and each non-identical copy, including those which are non-identical by reason of notations or markings, of: papers, writings, records, notes, tapes, discs, or other substances on which communications, data, or information is recorded or stored, whether made by manual, mechanical, photographic, or electronic process. This definition includes all drafts or superseded revisions of each document. As used herein, "document(s)" includes, but is not limited to:

> Electronically Stored Information, books, pamphlets, periodicals, letters, reports, memoranda, handwritten notes, notations, messages, telegrams, cables, records, drafts, diaries, studies, analyses, summaries, magazines, circulars, bulletins, instructions, minutes, photographs, purchase orders, bills, checks, tabulations, desk or pocket calendars, charge slips, questionnaires, surveys, drawings, sketches, working papers, charts, graphs, indexes, taped correspondence, records of purchase of sale, contracts, agreements, leases, invoices, expense records, trip reports, releases, appraisals, valuations, estimates, opinions, financial statements, accounting records, income statements, electronic or other transcriptions or taping of telephone or personal conversations or conferences or any and all other written, printed, typed, punched, taped, filed or graphic matter or tangible thing, of whatever description, however produced or reproduced (including computer stores or generated data, together with instructions and programs necessary to search or retrieve such data), and shall include all attachments and enclosures to any requested item, which shall not be separated from the item to which they are attached or enclosed.

6. A document or communication "relating to," "related to," or "concerning" a given subject means any document that constitutes, contains, embodies, comprises, reflects, identifies, states, refers to, deals with, comments on, responds to, describes, or is otherwise pertinent to that subject, including without limitation documents concerning the presentation of other documents.

7. "Person" and "entity" mean the singular as well as the plural and include any natural person, partnership, corporation, association, joint venture, proprietorship, firm, agency, or other legal or business entity, and its agents and employees.

8. "Identify" and "identity":

a. When used in reference to a natural person, require his or her full name, present or last known business and home addresses, business, mobile, and home telephone numbers, and email addresses, if any;

b. When used in reference to a document, require Bates numbers and, in the alternative, the present location and the custody of the original thereof or, if unknown, the present custodian of any copy thereof, and the manner and date of disposition of any document that was, but is no longer, in your possession or subject to your control;

c. When used in reference to communications, require the substance thereof, the identity of the person who made the communication and the person to whom it was made, and the persons who participated in such communication or were present at the time same was made, the date and place thereof, whether the communication was oral, in writing, and/or exists in an electronic medium, and, if such communication has been reduced to writing, or otherwise exists in an electronic medium, includes identifying such document or ESI.

9. The singular of each word shall be construed to include its plural and vice-versa, and the root word and all derivations (i.e., "ing," "ed," etc.) shall be construed to include each other.

10. The words "and" as well as "or" shall be construed both conjunctively as well as disjunctively.

11. The word "each" shall be construed to include "every" and vice-versa.

12. The word "any" shall be construed to include "all" and vice-versa.

13. The present tense shall be construed to include the past tense and vice-versa.

14. The masculine shall be construed to include the feminine and vice-versa.

15. The words "knowledge," "information," "possession," "custody," and "control" of a person shall be construed to include such person's agents, representatives, and attorneys.

16. The word "including" shall have its ordinary meaning and shall mean "including but not limited to" and shall not indicate limitation to the examples or items mentioned.

INSTRUCTIONS

1. In answering each of these interrogatories, please furnish all information that is available to you and any to which you have access, including information in your possession, custody, or control, or in that of any agent, servant, or employee, including doctors, attorneys, investigators, examiners, testers, and evaluators contracted by you or on your behalf.

2. In the event you are unable to fully answer one or more of the following interrogatories after exercising due diligence to secure the necessary information, provide the most complete answer possible and specify the reason(s) for the inability to provide a complete response at the present time

3. Should a privilege, confidentiality agreement, protective order, or other privilege/exemption from discovery be asserted with respect to any part of any discussion, document, or other communication concerning information requested by any of the following interrogatories or requests for production, you are requested to answer the interrogatories or request in the manner indicated herein, except that the contents of the part deemed privileged need not be summarized. Instead, indicate that a privilege is claimed for such part and state the

nature of the privilege claimed and the facts upon which such claim is based in sufficient detail to permit the Court to adjudicate the validity of the privilege claim.

INTERROGATORIES AND REQUESTS FOR PRODUCTION

INTERROGATORY NO. 1: Please identify each person who may have knowledge or discoverable information relating to the claims or defenses in this lawsuit and state briefly the nature of the knowledge or discoverable information had by each such person. (For this and the below interrogatories requiring identification of individuals, please note the definition of "identify" in Definition 8.)

INTERROGATORY NO. 2: Please identify each person from whom information or documents were obtained to respond to Plaintiff's written discovery requests, or who assisted in preparing the responses and objections to said discovery requests.

INTERROGATORY NO. 3: Please identify any and all methods and devices you, your officers, agents, or employees used to exchange electronic communications referring or relating to Plaintiff or the allegations in Plaintiff's Complaint from June 13, 2020 to the present, including but not limited to: email, instant messaging, paging, text messaging, posting on social media, or faxing. "Identify" in this interrogatory means to specify: the device or devices (i.e. Blackberries, cellular phones, laptops, desktop computers, iPads, etc.); the email account(s), social media username(s), or telephone number(s) used, and the name, address, and telephone number of the person in whose name the account was held.

INTERROGATORY NO. 4: Please identify all persons with whom you have communicated concerning the allegations in the Plaintiff's Complaint or Defendant's Answer thereto (exclusive of communications with counsel in the instant action).

INTERROGATORY NO. 5: Please identify each person who was employed at BHDC on June 13, 2020. (For this and the below interrogatories requiring identification of individuals, please note the definition of "identify" in Definition 8.)

INTERROGATORY NO. 6: Please state every injury which David Cains has caused to another person at BHDC in all the years he resided there. For each such injury caused by David Cains, please provide the following:

a. the name of the person he injured;

b. how David caused the injury;

c. the nature and severity of the injury;

d. the date of the injury; and

e. identify all documents regarding the injury incident.

INTERROGATORY NO. 7: Please identify the person responsible for conducting the Adult Maltreatment Investigation into David Cains' death, and state whether that person was at the time employed at BHDC.

INTERROGATORY NO. 8: Please identify each person involved in the care, supervision, or treatment of David Cains from **January 1, 2018** until his death on or about June 13, 2020. As to each person please set forth the nature of each person's involvement and the time frame during which the person was involved in the care, supervision, evaluation, or treatment of Cains.

INTERROGATORY NO. 9: Do you contend that any person or entity (including any party to this lawsuit or Mr. Cains) negligently or intentionally committed an act or omission which caused or contributed to Cains' death, and if so, state the nature of the act or omission, and identify the person or entity in question.

INTERROGATORY NO. 10: Please identify all sets of regulations or standards you were required to comply with at the time of Cain's death, including but not limited to those required for Medicaid reimbursement.

INTERROGATORY NO. 11: Please provide the name, address, and telephone number of each expert who may be called as a witness, and for each such expert provide:

(a) the subject matter on which the witness is expected to testify;

(b) the materials reviewed by each expert;

(c) the facts known to the expert which relate to or form the basis of the mental impressions and opinions held by the expert; and

(d) the dates of all reports rendered by such experts, and the names and addresses of the persons having custody of same.

INTERROGATORY NO. 12: Please provide the name, address, and telephone number of all lay witness whom you may call at trial of this matter and for those persons identified, please state the anticipated subject matter of their testimony.

INTERROGATORY NO. 13: Please identify by title, author, editor, edition, publisher, date of publication and section, portion, page or pages of each and every book, treatise, periodical and/or pamphlet:

(a) established, or to be established, as a reliable authority by the testimony of any expert witness you have identified or will identify; and

(b) to be referred to during the trial testimony of any expert witness you have identified or will identify.

INTERROGATORY NO. 14: Do you contend there was an imminent risk of *serious* physical injury or *serious* property damage posed by David Cains on the date of his death? If so,

please describe the nature of any imminent risk of *serious* physical injury or *serious* property damage.

INTERROGATORY NO. 15: Please describe how the behavior of David Cains that led to his personal restraint on the day of his death constituted an "emergency situation."

INTERROGATORY NO. 16: Please describe with specificity what led to David Cains becoming upset just prior to the personal restraint on the date of his death (why it is DHS believes Cains' behavior escalated on this occasion or what precipitating factors or events appeared to have caused David Cains to become distressed and agitated prior to the restraint).

INTERROGATORY NO. 17: Please describe with specificity all efforts made by staff to deescalate the behavioral situation that led to the personal restraint used on David Cains on the date of his death.

INTERROGATORY NO. 18: Please state whether BHDC staff members Tyler Mattson, Ryann Campos, and Amy "Mandy" Jones were Certified Nursing Assistants (CNAs) on the date of David Cains' death.

INTERROGATORY NO. 19: Please identify David Cains' Interdisciplinary Team (IDT) for the time period of January 1, 2019 through the date of his death.

INTERROGATORY NO. 20: Please state the last known addresses and phone numbers for the following former employees of BHDC who were involved in David Cains' care:

Sue Roberson (first case manager)

Jennifer Berry (dorm supervisor in the early years)

Vickie Bradford (dorm staff and supervisor in the early years)

Ruth Freeman (case manager circa 2011)

Janet Campbell (nurse) circa 2011/12

Neil Berry (case manager)

Mary Nicholson (case manager circa 2014)

Ronnie Ledford (case manager circa 2015)

Audra Delay (David's work supervisor)

INTERROGATORY NO. 21: Please identify any rules, policies, or procedures at BHDC have changed since the death of David Cains, including but not limited to policies regarding calling 911.

REQUEST FOR PRODUCTION NO. 1: All documents you consulted in responding to these interrogatories.

REQUEST FOR PRODUCTION NO. 2: All documents written, signed, or recorded by any party or witness relating to the allegations of Plaintiff's Complaint and Defendant's Answer and defenses thereto.

REQUEST FOR PRODUCTION NO. 3: Your privilege log, in accordance with Instruction No. 3.

REQUEST FOR PRODUCTION NO. 4: All documentation regarding any injury to another person caused by David Cains.

REQUEST FOR PRODUCTION NO. 5: Please provide a copy of any organizational chart or flow sheet setting forth the departmental organization and hierarchy of the BHDC as such existed at the time of the events set forth in Plaintiff's complaint.

REQUEST FOR PRODUCTION NO. 6: All documents, including communications to or from you, related to the death of David Cains.

REQUEST FOR PRODUCTION NO. 7: All documents, including communications to or from you, related to the restraint incident involving David Cains on the day of his death.

REQUEST FOR PRODUCTION NO. 8: All communications between you and anyone else, including your employees, servants, and agents, that are related to the allegations of Plaintiff's Complaint and Defendant's Answer and defenses thereto.

REQUEST FOR PRODUCTION NO. 9: All documents BHDC provided to its employees, who were employed at the time of Cains' death, regarding the terms and conditions of their employment, including all employee manuals and rules.

REQUEST FOR PRODUCTION NO. 10: Please provide copies of any policies, rules, procedures, or guidelines in effect at BHDC at the time of David Cains' death, including but not limited to those pertaining in any way to the use of restraints, such as *Use and Documentation Procedures to Manage Behavior* and *Documentation of and Response to Maladaptive Behaviors*.

REQUEST FOR PRODUCTION NO. 11: Please provide copies of any written or recorded statements DHS or its agents or employees have obtained from the Plaintiff or any other family member of David Cains.

REQUEST FOR PRODUCTION NO. 12: Please provide copies of any audio, photographic and video footage that concerns the occurrences identified in Plaintiff's complaint, including all photographs of David Cains taken at any point over his roughly 13 years stay at BHDC.

REQUEST FOR PRODUCTION NO. 13: Please provide reports and any other documents from all investigations, including internal investigations, conducted by DHS or any DHS entity, including but not limited to maltreatment investigations, including but not limited to reports and any other documents from any review or investigation performed by the Division of Provider Services and Quality Assurance (DPSQA), the Office of Long-Term Care (OLTC), the Mortality Review Committee (MRC), or DDS.

REQUEST FOR PRODUCTION NO. 14: Please produce a copy of all training materials that were provided to BHDC staff employed at the time of Cains' death on or about June 13, 2020.

REQUEST FOR PRODUCTION NO. 15: Please provide copies of all medical articles or medical treatises which you plan to introduce into evidence, to use in any manner at the trial of this case or to use at any deposition.

REQUEST FOR PRODUCTION NO. 16: Please provide copies of any letters, documents or medical opinions which have been written by any experts, treating physicians or other physicians, or medical professionals whom you or your attorney plan on calling as expert witnesses to offer testimony at the trial of this case.

REQUEST FOR PRODUCTION NO. 17: The Defendant is requested to produce the following materials with respect to each expert witness it may call at the trial of this case:

(a) A copy of the witness's most recent curriculum vitae,

(b) A complete list of all books, texts, treatises, articles, statutes, rules, regulations, guidelines or any material which has been or may be referred to or relied upon by any expert witness in forming or explaining his or her opinions in connection with this case, together with citations to specific passages or sections relied upon,

(c) A list of any computer programs, spreadsheets, analytical programs, statistical programs of any other computer-based tool utilized by any expert witness in any manner with regard to his/her opinions in this case,

(d) Copies of each spreadsheet, program, algorithm, statistical model, macro program, or other computer-based files created by or at the direction of any expert witness which has been utilized in any manner regarding his or her opinions in this case,

(e) Copies of any and all reports, correspondence, notes, documents, writings, diagrams, charts, records, photographs, video or audio recordings of any type, computer files, e-mails or tangible items of any kind that have been supplied to any expert witness by defendant, attorneys for defendant, or any representative of the defendant or defendant's attorneys,

(f) Copies of any and all reports, correspondence, notes, documents, writings, diagrams, charts, records, photographs, video, or audio recordings of any type, computer files, e-mails, or tangible items of any kind that any expert witness has provided to the defendant, attorneys for defendant, or any representative of defendant's attorneys,

(g) Copies of any and all reports, correspondence, notes, documents, writings, diagrams, charts, records, photographs, video or audio recordings of any type, computer files, e-mails, or tangible items of any kind made or prepared by any expert witness in connection with this case regardless of whether such materials were provided to any other person,

(h) Any and all billing records, bills or invoices any expert witness has prepared or provided in connection with this case.

REQUEST FOR PRODUCTION NO. 18: Please provide copies of all documents which you plan to use at the trial of this case, including, but not limited to, documents which you plan on introducing into evidence and documents which you plan to or will use in the direct examination and cross-examination of witnesses at the trial of this case.

REQUEST FOR PRODUCTION NO. 19: Please provide your entire unredacted file on David Cains, including but not limited to all Individual Program Plans, Behavior Programs, Behavior Plans, Resident Behavior Reports, Social History Assessment, Dysphasia Disorder

Survey, Restraint Incident Debriefing Forms, Restraint Logs, Emergency Restraints, and records reflecting personal, chemical, or mechanical restraints used on David Cains throughout his time at BHDC.

REQUEST FOR PRODUCTION NO. 20: Please produce all minutes of the meetings of the BHDC Human Rights Committee from the time period of January 1, 2017 through January 1, 2021, as well as any reports produced by the Human Rights Committee during this time period.

REQUEST FOR PRODUCTION NO. 21: Please produce the Human Development Center Monthly Statistical Reports provided to the DDS Board for the time period of January 1, 2017 through January 1, 2021.

REQUEST FOR PRODUCTION NO. 22: Please produce the complete personnel files of Tyler Mattson, Amy "Mandy" Jones, and Ryann Campos.

REQUEST FOR PRODUCTION NO. 23: Please produce copies of any policies, rules, procedures, or guidelines at BHDC that have been modified or altered in any way since David Cains's death, including but not limited to those pertaining to calling 911.

REQUEST FOR PRODUCTION NO. 24: Please produce copies of any recorded statements that any BHDC staff or former BHDC staff have given concerning the death of David Cains, including but not limited to recorded statements given to Disability Rights Arkansas.

INTERROGATORY NO. 22: Please treat the foregoing interrogatories as continuing and furnish to Plaintiffs, in writing, any additional information received by you subsequent to the date of your answers hereto that would modify or supplement your answers, such additional information to be furnished as soon as reasonably possible after receipt by you and within a reasonable time prior to the assigned trial date in order to permit appropriate discovery procedure. Will you do so?

VERIFICATION

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail on this 13th day of January, 2022.

Eric M. Collins, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Eric.Collins@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains — **CLAIMANT**

V. — **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) — **RESPONDENT**

DHS' Second Supplemental Responses Response To Plaintiff's First Set of Interrogatories and Requests for Production of Documents

COMES now Respondent, by and through its attorney, Rich Rosen, and for its Second Supplemental Responses to Claimant's First set of Interrogatories and Requests for Production, states as follows:

INTERROGATORY NO. 11: Please provide the name, address, and telephone number of each expert who may be called as a witness, and for each such expert provide:

(a) the subject matter on which the witness is expected to testify;

(b) the materials reviewed by each expert;

(c) the facts known to the expert which relate to or form the basis of the mental impressions and opinions held by the expert; and

(d) the dates of all reports rendered by such experts, and the names and addresses of the persons having custody of same.

SUPPLEMENTAL ANSWER:

Respondent will call Theodore A. Kastner, M.D., M.S. as an expert witness. Dr. Kastner has years of medical experience working with and treating Individuals with Intellectual Disabilities, and



has authored 70 peer-reviewed original articles in medical and professional journals, the vast majority of which are related to the health, care, and treatment of individuals with developmental disabilities. Dr. Kastner has received significant grant support for over 30 years; the majority of which for work related to individuals with developmental disabilities. In addition, Dr. Kastner has authored over 40 invited articles related to developmental disabilities and has presented at over 150 conferences and meetings on health care, many of which were related to the treatment or care of individuals with developmental disabilities. Dr. Kastner has had numerous academic appointments including appointments at the Albert Einstein College of Medicine, the University of New Jersey College of Medicine and Dentistry, and Columbia University College of Medicine. Dr. Kastner has served on the boards and committees of dozens of national and regional medical and professional associations related to the care and treatment of individuals with developmental disabilities.

Dr. Kastner is familiar with the BHDC, its campus, population and, with regard to David Cains, his 2018 and 2019 IPPs, 2018 and 2019 choking risk assessments showing a low risk of choking, his dysphagia risk assessments, and review various deposition transcripts. Dr. Kastner will testify, to a reasonable degree of medical certainty, as to the cause of death of David Cains. Dr. Kastner will further testify, to reasonable degree of medical certainty and based on his extensive experience and knowledge related to the care and treatment of individuals with developmental disabilities and, including his familiarity of developmental disable individuals with aggressive behaviors, that the staff of the BHDC met the applicable standard of care when addressing David Cains' behavior on 06/13/2020 and application the emergency hold for safety, which was within the scope of the IPP, physician orders, BHDC policies, and staff training.

The facts known to Dr. Kastner and the substance of his expert opinions will be provided shortly. A copy of Dr. Kastner's Curriculum Vitae is attached.

INTERROGATORY NO. 13: Please identify by title, author, editor, edition, publisher, date of publication and section, portion, page or pages of each and every book, treatise, periodical and/or pamphlet:

(a) established, or to be established, as a reliable authority by the testimony of any expert witness you have identified or will identify; and

(b) to be referred to during the trial testimony of any expert witness you have identified or will identify.

SUPPLEMENTAL ANSWER:

See Dr. Kastner's Curriculum Vitae, a copy of which is attached.

INTERROGATORY NO. 14: Do you contend there was an imminent risk of *serious* physical injury or *serious* property damage posed by David Cains on the date of his death? If so, please describe the nature of any imminent risk of *serious* physical injury or *serious* property damage.

ANSWER:

Yes, there was an imminent risk of serious physical injury posed by Mr. Cains. The incident occurred in the lobby of the Commons building with other employees and clients were nearby. The canteen, restroom, medication window, recreation room are accessed from the lobby as well as the main entrance into commons and then into the dining room. Mr. Cains exhibited dangerous behavior which posed an imminent risk to himself, other clients, employees, and property. Mr. Cains became verbally and then physically aggressive during the incident. Mr. Cains destroyed property, spit at Mr. Mattson, and advanced on and attempted to strike Mr. Mattson.

SUPPLEMENTAL ANSWER:

In addition to above, please see the deposition testimony of Tyler Matteson, Ryann Campos, and Amy Jones for further facts and details of David Cains' aggressive behavior requiring emergency intervention of safety. See also the behavior reports previously provided which are bates numbered pages CM 00539 – CM 00806, and deposition testimony of Claimant and Ms. Robinson on David Cains' history of physical aggression behaviors.

INTERROGATORY NO. 15: Please describe how the behavior of David Cains that led to his personal restraint on the day of his death constituted an "emergency situation."

ANSWER:

On June 13, 2020, Mr. Cains went to the Commons Building on BHDC's campus for his medication and lunch. Mr. Cains is visually monitored outside of his living area and any intake is supervised due to seizure precaution orders. Mr. Cains took his medication before he ate lunch. Tyler Mattson, RCT, monitored Mr. Cains during lunch. When Mr. Cains was finished with his meal, he told Mr. Mattson he needed to go to the bathroom. Mr. Mattson noted Mr. Cains seemed to be irritated and Mr. Mattson accompanied Mr. Cains to the bathroom.

Mr. Cains came out of the restroom and asked if he could sit down in the lobby to calm down. Mr. Mattson told Mr. Cains that that would be okay, and Mr. Cains sat down. Mr. Cains sat down and began screaming, cussing and ripped paper of the wall. Mr. Cains then jumped up, began spitting and attempted to hit Mr. Mattson. Mr. Mattson placed Mr. Cains in an emergency personal hold by holding Mr. Cains arms. Mr. Cains fell to the ground and Mr. Mattson fell with him. While on the floor, Mr. Cains continued to try and strike Mr. Mattson.

SUPPLEMENTAL ANSWER:

In addition to above, please see the deposition testimony of Tyler Matteson.

INTERROGATORY NO. 19: Please identify David Cains' Interdisciplinary Team (IDT) for the time period of January 1, 2019 through the date of his death.

ANSWER:

Respondent reserves the right to supplement this response as additional information becomes available. Respondent objects to the inclusion and production of personal information unrelated to the identified individual's professional capacity. Such information is an unwarranted invasion of privacy and is not reasonably calculated to lead to the discovery of admissible evidence. Without waiving the objections, Respondent can provide the following:

Charlene Robinson, Mother and Guardian
Chrissie McAuliffe, Sister and Advocate
Justin Jobb, Program Coordinator/QIDP
Brenda Jarrad, Team RN
Caleb Murray, Program Coordinator/Social Service Worker
Michael Alvis, Psychological Examiner
Gene Dobson, RCS
Chad Bokker, RCSS
Ashton Cobb, RCS
Nakita Martin
Chuck Hayes, RCT
Angela Yancy, RI
Audra Delay, RI
Caryn Roberts, RI
Kim Hunt, RI

John Harbison, RI

SUPPLEMENTAL ANSWER: See the 2018 IPP and 2019 IPP which identifies all persons on the Interdisciplinary Team (IDT) and all persons who contributed to the development of the 2018 and 2019 IPPs, including individuals present at the annuals reviews who were not directly on the IDT.

REQUEST FOR PRODUCTION NO. 4: All documentation regarding any injury to another person caused by David Cains.

Response: Please see included behavioral reports within RFP 1. Respondent objects to further production of records on the basis of client confidentiality and HIPAA.

Supplemental Response:

In addition to above, please see the deposition testimony of Tyler Matteson, Ryann Campos, and Amy Jones for further facts and details of David Cains' aggressive behavior requiring emergency intervention of safety. See also the behavior reports previously provided which are bates numbered pages CM 00539 – CM 00806, and deposition testimony of Claimant and Ms. Robinson on David Cains' history of aggression and violent behaviors.

REQUEST FOR PRODUCTION NO. 11: Please provide copies of any written or recorded statements DHS or its agents or employees have obtained from the Plaintiff or any other family member of David Cains.

Response: Respondent has not identified any documents to produce at this time, if any such documents are discovered, this response will be supplemented.

Supplemental Response: Please see the deposition transcripts of Claimant, Charlene

Robinson, and Sarah Ashley.

Respectfully Submitted,
Arkansas Department of Human Services

By: ***Richard Rosen***
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334
rich.rosen@dhs.arkansas.gov

Certificate of Service

On December 1, 2022, a copy of the above 2nd Supplemental Response was served via electronic mail to Josh Gillispie at:

josh@greenandgillispie.com

Richard Rosen

Gmail

Joshua Gillispie <josh@greenandgillispie.com>

McAuliffe/Cains v. DHS, Claims Commission #220374

Rich Rosen <Rich.Rosen@dhs.arkansas.gov> Tue, Jan 10, 2023 at 4:03 PM
To: Joshua Gillispie <josh@greenandgillispie.com>, Chad <chad@greenandgillispie.com>
Cc: Rich Rosen <Rich.Rosen@dhs.arkansas.gov>, Brent Gasper <Brent.Gasper@dhs.arkansas.gov>

Please see the attached report of Dr. Kastner – Part 2 – with regard to the standard of care for restraint use and the 911 response.

Rich

Richard Rosen

Arkansas Department of Human Services

Office of Chief Counsel

P.O. Box 1437, Slot S260

Little Rock, AR 72203

501-320-6334 Fax: 501-682-1390

email address is: rich.rosen@dhs.arkansas.gov

SENSITIVE

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BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) **RESPONDENT**

CLAIMANT'S SECOND SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION PROPOUNDED TO RESPONDENT

COMES now Plaintiff, by and through her attorney, Joshua D. Gillispie, and propounds to Respondent the following Interrogatories and Requests for Production, to be answered in accordance with the Arkansas Rules of Civil Procedure and other applicable laws:

DEFINITIONS

1. "And" and "or" shall be individually interpreted in every instance as meaning "and/or" and shall not be interpreted to exclude any information within the scope of these requests.

2. "DHS" or "Defendant" or "You," as used herein, refers to all departments, offices, and facilities within the Arkansas Department of Human Services, including but not limited to the Booneville Human Development Center (referred to herein as "BHDC"), as well as all agents, employees, and officers.

3. Communication" or "Communications" refer to oral conversations, written correspondence, memoranda, telephone conversations, text messages, correspondence, notes, electronic mail, social media posts or messages, voice mails, answering machine messages, letters, notes, or cards, whether as a sender, recipient, cc, or bcc. "Communication" means any disclosure, transfer, or exchange of information or opinion, however made.



4. "Correspondence" refers to all forms of writings, electronic or otherwise, including but not limited to, letters, books, emails, text messages, computer tapes, discs, printouts, keypunch cards, memoranda, diaries, notes, reports, bulletins, printed forms, telegraphic communications, telexes, telegrams, telecopies, facsimile reproductions, minutes, microfilm, microfiche, films, videotape, and computer discs.

5. "Document" or "Documents" mean the original, or a copy when the original is not available, and each non-identical copy, including those which are non-identical by reason of notations or markings, of: papers, writings, records, notes, tapes, discs, or other substances on which communications, data, or information is recorded or stored, whether made by manual, mechanical, photographic, or electronic process. This definition includes all drafts or superseded revisions of each document. As used herein, "document(s)" includes, but is not limited to:

> Electronically Stored Information, books, pamphlets, periodicals, letters, reports, memoranda, handwritten notes, notations, messages, telegrams, cables, records, drafts, diaries, studies, analyses, summaries, magazines, circulars, bulletins, instructions, minutes, photographs, purchase orders, bills, checks, tabulations, desk or pocket calendars, charge slips, questionnaires, surveys, drawings, sketches, working papers, charts, graphs, indexes, taped correspondence, records of purchase of sale, contracts, agreements, leases, invoices, expense records, trip reports, releases, appraisals, valuations, estimates, opinions, financial statements, accounting records, income statements, electronic or other transcriptions or taping of telephone or personal conversations or conferences or any and all other written, printed, typed, punched, taped, filed or graphic matter or tangible thing, of whatever description, however produced or reproduced (including computer stores or generated data, together with instructions and programs necessary to search or retrieve such data), and shall include all attachments and enclosures to any requested item, which shall not be separated from the item to which they are attached or enclosed.

6. A document or communication "relating to," "related to," or "concerning" a given subject means any document that constitutes, contains, embodies, comprises, reflects, identifies, states, refers to, deals with, comments on, responds to, describes, or is otherwise pertinent to that subject, including without limitation documents concerning the presentation of other documents.

7. "Person" and "entity" mean the singular as well as the plural and include any natural person, partnership, corporation, association, joint venture, proprietorship, firm, agency, or other legal or business entity, and its agents and employees.

8. "Identify" and "identity":

a. When used in reference to a natural person, require his or her full name, present or last known business and home addresses, business, mobile, and home telephone numbers, and email addresses, if any;

b. When used in reference to a document, require Bates numbers and, in the alternative, the present location and the custody of the original thereof or, if unknown, the present custodian of any copy thereof, and the manner and date of disposition of any document that was, but is no longer, in your possession or subject to your control;

c. When used in reference to communications, require the substance thereof, the identity of the person who made the communication and the person to whom it was made, and the persons who participated in such communication or were present at the time same was made, the date and place thereof, whether the communication was oral, in writing, and/or exists in an electronic medium, and, if such communication has been reduced to writing, or otherwise exists in an electronic medium, includes identifying such document or ESI.

9. The singular of each word shall be construed to include its plural and vice-versa, and the root word and all derivations (i.e., "ing," "ed," etc.) shall be construed to include each other.

10. The words "and" as well as "or" shall be construed both conjunctively as well as disjunctively.

11. The word "each" shall be construed to include "every" and vice-versa.

12. The word "any" shall be construed to include "all" and vice-versa.

13. The present tense shall be construed to include the past tense and vice-versa.

14. The masculine shall be construed to include the feminine and vice-versa.

15. The words "knowledge," "information," "possession," "custody," and "control" of a person shall be construed to include such person's agents, representatives, and attorneys.

16. The word "including" shall have its ordinary meaning and shall mean "including but not limited to" and shall not indicate limitation to the examples or items mentioned.

INSTRUCTIONS

1. In answering each of these interrogatories, please furnish all information that is available to you and any to which you have access, including information in your possession, custody, or control, or in that of any agent, servant, or employee, including doctors, attorneys, investigators, examiners, testers, and evaluators contracted by you or on your behalf.

2. In the event you are unable to fully answer one or more of the following interrogatories after exercising due diligence to secure the necessary information, provide the most complete answer possible and specify the reason(s) for the inability to provide a complete response at the present time

3. Should a privilege, confidentiality agreement, protective order, or other privilege/exemption from discovery be asserted with respect to any part of any discussion, document, or other communication concerning information requested by any of the following interrogatories or requests for production, you are requested to answer the interrogatories or request in the manner indicated herein, except that the contents of the part deemed privileged need not be summarized. Instead, indicate that a privilege is claimed for such part and state the

nature of the privilege claimed and the facts upon which such claim is based in sufficient detail to permit the Court to adjudicate the validity of the privilege claim.

INTERROGATORIES AND REQUESTS FOR PRODUCTION

INTERROGATORY NO. 1: Please state whether Dr. Theodore Kastner has ever provided testimony as an expert witness at a trial or deposition. If so, for each expert, please state:

(a) The style of the case, including the names of parties, venue and case number;

(b) Whether testimony was provided for the Plaintiff or Defendant; and

(c) A brief summary of the expert testimony provided in the particular case.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 1: Please produce for inspection and copying any and all most recent *curriculum vitaes* or written statements and reports by Dr. Theordore Kastner that you may call at the hearing of this matter and a list of any such expert's publications or other writings. *In addition, please produce a copy of the transcript for any and all testimony provided by Dr. Kastner at any previous trial, hearing and/or deposition.*

REQUEST FOR PRODUCTION OF DOCUMENT NO. 2: Please produce all documents related to Dr. Theodore Kastner's, Developmental Disabilities Health Management's, or any other Kastner entity's previous work for the Arkansas Department of Human Services since the year 2000. This includes but is not limited to Kastner's or DDHM's or any other Kastner entity's proposal when bidding on the Alexander Human Development Center, and all written findings,

recommendations, reports, opinions, and any other document related to their work, consulting work other otherwise, at AHDC.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 3: Please produce all findings, recommendations, reports, opinions, or any other document authored by Kastner (or any entity with which Kastner was involved) that in any way relate to the Arkansas Department of Human Services since the year 2000.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 4: Please produce all documents reflecting amounts paid by the state of Arkansas or by DHS or by DDS or by any other branch of state government to Dr. Theodore Kastner or to any company with which he was affiliated, including without limitation Developmental Disabilities Health Management or Disability Service Centers of Arkansas or any of Kastner's other companies. These documents should include, without limitation, contracts, invoices, proposals, bids, receipts, or any other item reflecting amounts paid to Kastner or a Kastner entity by Arkansas since the year 2000 and through the present date.

INTERROGATORY NO. 2: Please treat the foregoing interrogatories as continuing and furnish to Plaintiffs, in writing, any additional information received by you subsequent to the date of your answers hereto that would modify or supplement your answers, such additional information to be furnished as soon as reasonably possible after receipt by you and within a reasonable time prior to the assigned trial date in order to permit appropriate discovery procedure. Will you do so?

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
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(501) 244-0700
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was transmitted via electronic mail on this 22nd day of December, 2022.

Rich Rose, Esq.
Arkansas Department of Human Services
Office of Chief Counsel
Rich.rosen@dhs.arkansas.gov

/s/ Joshua D. Gillispie
Joshua D. Gillispie

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) **RESPONDENT**

DHS' RESPONSES TO CLAIMANT'S SECOND SET OF
INTERROGATORIES AND REQUESTS FOR PRODUCTION

COMES now DHS, by counsel, and is response to Claimant's Second Set of Interrogatories and Requests for Production, States as follows:

INTERROGATORY NO. 1: Please state whether Dr. Theodore Kastner has ever provided testimony as an expert witness at a trial or deposition. If so, for each expert, please state:

(a) The style of the case, including the names of parties, venue and case number;

(b) Whether testimony was provided for the Plaintiff or Defendant; and

(c) A brief summary of the expert testimony provided in the particular case.

ANSWER: Yes. Dr. Kastner has qualified as an expert medical witness in several cases and by several courts, including the United States District Court for the Eastern District of Arkansas:

1. *United States v. Arkansas*, 794 F. Supp 2d 935 (E.D. Ark. 2011) (case No. 4:09-CV-0033);
2. *United States v. Arkansas*, #4:10-CV-00327 JLH, 2011 U.S. Dist. 7231.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 1: Please produce for inspection and copying any and all most recent *curriculum vitaes* or written statements and reports by Dr. Theodore Kastner that you may call at the hearing of this matter and a list of any such expert's



publications or other writings. *In addition, please produce a copy of the transcript for any and all testimony provided by Dr. Kastner at any previous trial, hearing and/or deposition.*

ANSWER: Dr. Kastner's C.V. has previously been provided. Dr. Kastner's publications are identified on his C.V. DHS does not have possession of Dr, Kastner's publications. In addition, two written reports have previously been provided reflecting Dr. Kastner's expert opinions and the facts in this matter, including the bases and grounds for his opinions. DHS has no transcripts of any testimony previously provided by Dr. Kastner or any of his prior publications identified on Dr. Kastner's C.V. Dr. Kastner is a medical and restraint expert with vast and extensive experience in the provision of health care and services to individuals with intellectual disabilities and developmental delays, including application of the standards of care applied to facilities and staff within the United States, restraint use in compliance with federal regulations and CMS Operations manuals and state rules/policies applicable to Intermediate care facilities for individuals with intellectual disabilities, such as the Booneville Human Development Center. Dr. Kastner is an expert witness retained by DHS. He is not a DHS employee.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 2: Please produce all documents related to Dr. Theodore Kastner's, Developmental Disabilities Health Management's, or any other Kastner entity's previous work for the Arkansas Department of Human Services since the year 2000. This includes but is not limited to Kastner's or DDHM's or any other Kastner entity's proposal when bidding on the Alexander Human Development Center, and all written findings, recommendations, reports, opinions, and any other document related to their work, consulting work other otherwise, at AHDC.

ANSWER: To the extent that any of these documents are in the possession of DHS related to the former AHDC, these documents have been provided. If additional documents are discovered in DHS possession, this response will be supplemented.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 3: Please produce all findings, recommendations, reports, opinions, or any other document authored by Kastner (or any entity with which Kastner was involved) that in any way relate to the Arkansas Department of Human Services since the year 2000.

ANSWER: Documents responsive to this request were previously provided to Claimant pursuant to its FOIA request and pursuant to discovery. *See* response to Request for Production No. 1 above.

REQUEST FOR PRODUCTION OF DOCUMENT NO. 4: Please produce all documents reflecting amounts paid by the state of Arkansas or by DHS or by DDS or by any other branch of state government to Dr. Theodore Kastner or to any company with which he was affiliated, including without limitation Developmental Disabilities Health Management or Disability Service Centers of Arkansas or any of Kastner's other companies. These documents should include, without limitation, contracts, invoices, proposals, bids, receipts, or any other item reflecting amounts paid to Kastner or a Kastner entity by Arkansas since the year 2000 and through the present date.

ANSWER: Documents responsive to this request were previously provided to Claimant pursuant to its FOIA request. If any further documents are discovered within the possession of DHS, this response will be supplemented.

INTERROGATORY NO. 2: Please treat the foregoing interrogatories as continuing and furnish to Plaintiffs, in writing, any additional information received by you subsequent to the

date of your answers hereto that would modify or supplement your answers, such additional information to be furnished as soon as reasonably possible after receipt by you and within a reasonable time prior to the assigned trial date in order to permit appropriate discovery procedure. Will you do so?

ANSWER: Yes, to the extent required by the Arkansas Rules of Civil Procedure.

Respectfully Submitted,

Arkansas Department of Human Services,

By: /s/ **Richard Rosen**
Richard Rosen, Bar No. 97164
Office of Chief Counsel
P.O. Box 1437, Slot S260
Little Rock, AR 72203
501-320-6334

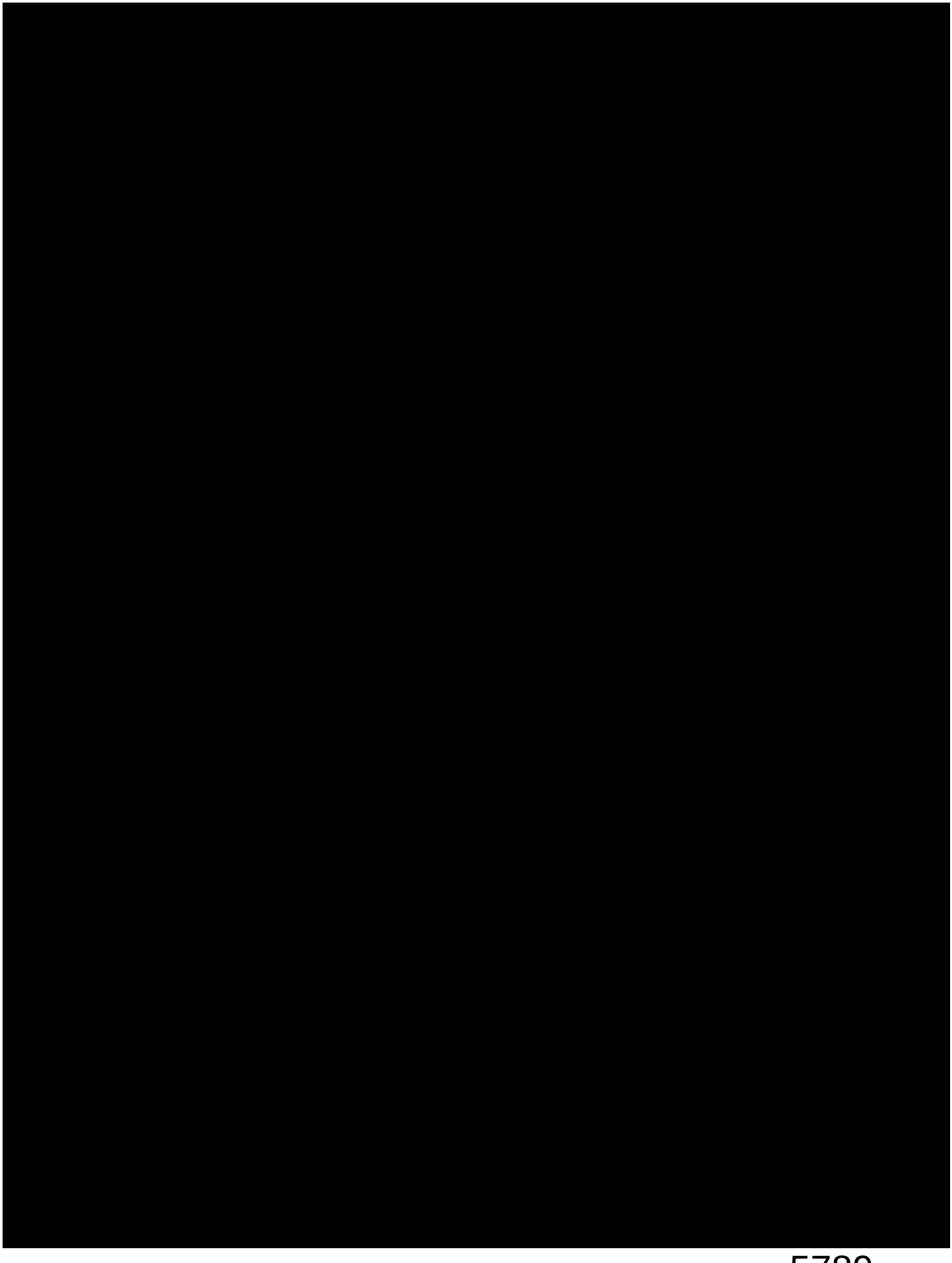
Certificate of Service

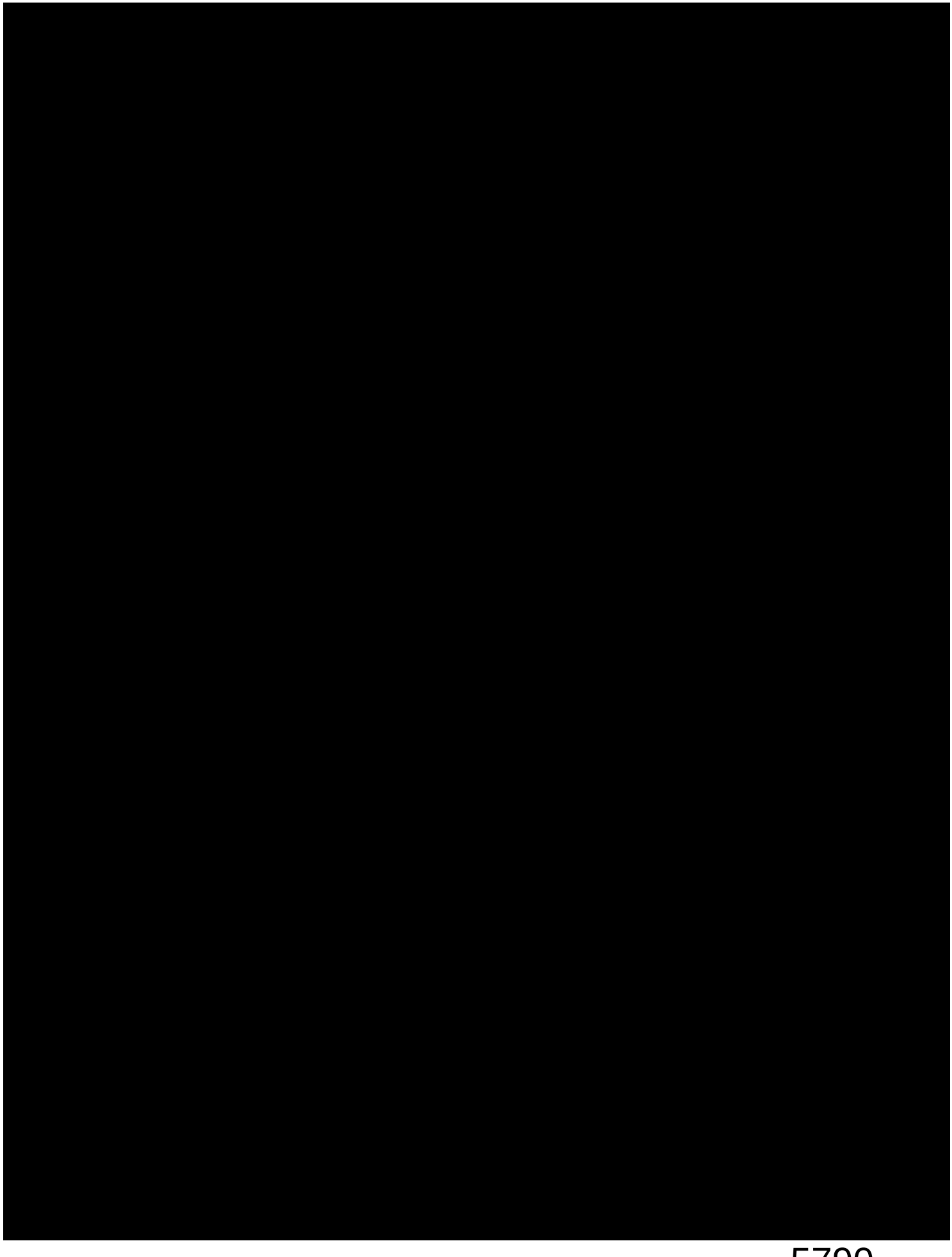
On January 23 2023, a copy of the above discovery response was served via email to

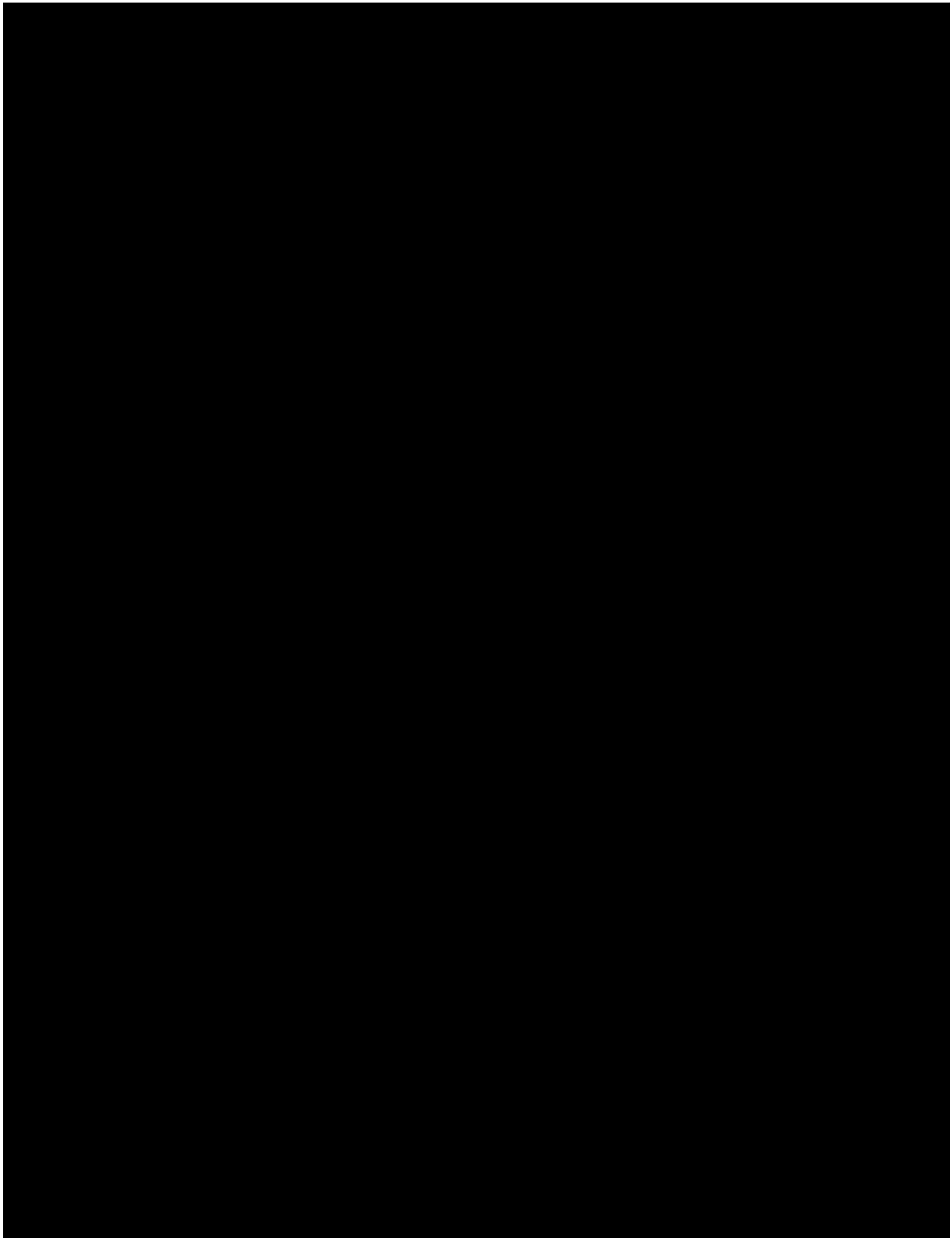
josh@greenandgillispie.com

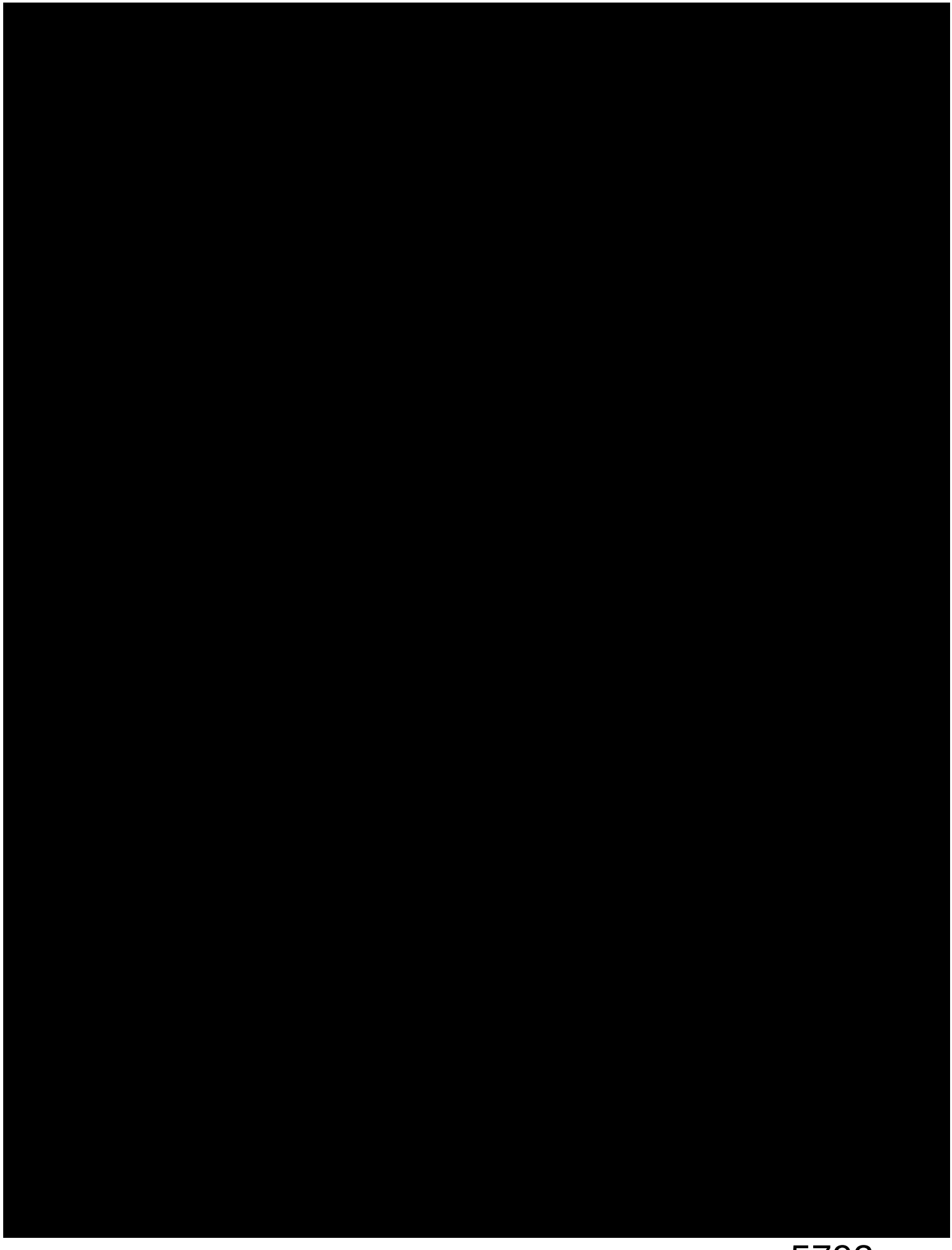
chad@greenandgillispie.com

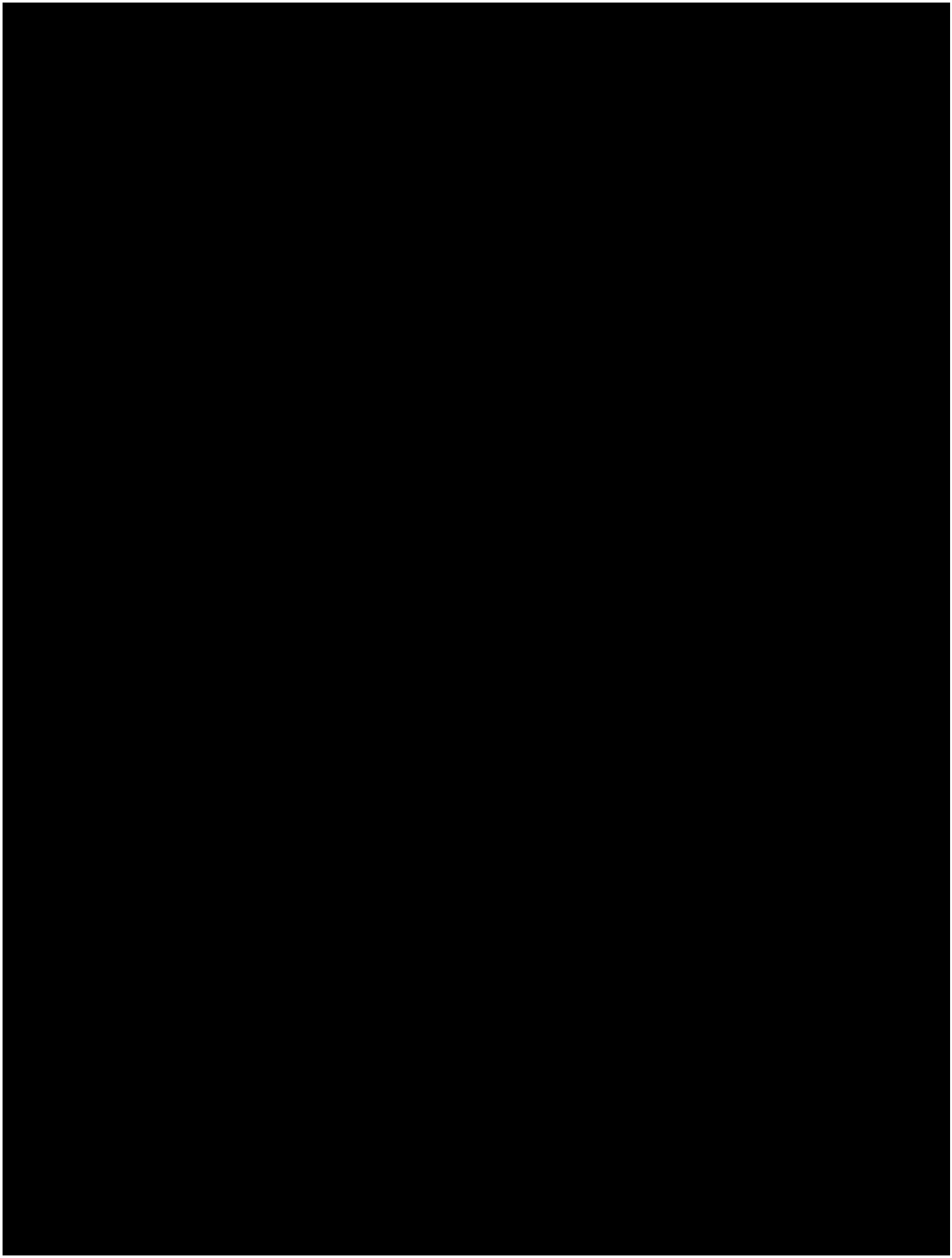
/s/ Richard Rosen











From: Chad
To: Kathryn Irby
Subject: McAuliffe v. DHS, Claim No. 220374
Date: Tuesday, March 21, 2023 3:02:42 PM

Kathryn,

We met at the recent hearing in the above case. I am Josh Gillispie's law partner. I just wanted to make sure you had my email address so that I will receive any communications from you or the commission, including the commission's final decision. I know it will be a while before they issue a decision, but I wanted to make sure you added my email to the chain of people to be notified.

Thank you for all of your help,
Chad M. Green

Green & Gillispie
Attorneys at Law
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
chad@greenandgillispie.com

This communication is only intended for the addressee(s) and may contain attorney-client protected materials. Please contact Green & Gillispie, Attorneys at Law, if you received this communication by mistake and delete and destroy any copies. This communication does not create an attorney-client relationship.

From: Joshua Gillispie
To: Kathryn Irby
Cc: Misty Scott
Subject: Re: McAuliffe/Cains v. DHS Claims Commission No. 22-0374
Date: Friday, May 12, 2023 1:28:55 PM

Great, thanks! I was told that by another attorney that has been through the process, but figured I'd make sure.

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Fri, May 12, 2023 at 1:24 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Josh, not a dumb question at all. The answer is yes. As soon as the Commission enters an order, you and Rich Rosen will receive a copy by email.
>
> Thanks,
>
> Kathryn
>
> ---
>
> **From:** Joshua Gillispie <josh@greenandgillispie.com>
> **Sent:** Friday, May 12, 2023 12:56 PM
> **To:** Kathryn Irby <Kathryn.Irby@arkansas.gov>
> **Cc:** Misty Scott <Misty.Scott@arkansas.gov>
> **Subject:** Re: McAuliffe/Cains v. DHS Claims Commission No. 22-0374
>
> Kathryn-
>
> Hope you are doing well. Probably a dumb question, but will it be by email that I will be notified once there is a decision in the Cains case? I was thinking that was the case, but it occurred to me that I never actually asked.

Thanks!

Joshua D. Gillispie

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> **Josh**, thanks for this information.
>
> **Misty**, will you replace the old binders with the new ones that Mr. Gillispie dropped off?
>
> Kathryn
>
> ---
>
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> **Sent:** Tuesday, February 21, 2023 2:37 PM
> **To:** Kathryn Irby <Kathryn.Irby@arkansas.gov>
> **Subject:** McAuliffe/Cains v. DHS Claims Commission No. 22-0374
>
> Kathryn-
>
> I just wanted to let you know that I stopped by your office today to drop of four flash drives containing everything that we filed in physical form on Thursday - including the Brief, Witness List, Exhibit List, Kastner Section, Deposition Summaries, Deposition Transcripts, and other Exhibits. It occurred to me that, while you only required physical

copies, these might make things more convenient for your staff.

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I explained all of this to Kaitlyn in your office and she was very nice and helpful, but I thought it necessitated a follow up email to you.

Best regards,

Joshua D. Gillispie

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North Little Rock, AR 72114
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www.greenandgillispie.com

From: Joshua Gillispie
To: Kathryn Irby
Cc: Misty Scott
Subject: Re: McAuliffe/Cains v. DHS Claims Commission No. 22-0374
Date: Friday, June 16, 2023 11:43:54 AM

Kathryn-

I hate to ask because I don't want to be a bother, but I was wondering if there is any kind of update that you might be able to share with me. Thank you very much!

If you'd rather call, my cell is [redacted].

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
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North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

From: Caitlin McDaniel
To: Kathryn Irby
Subject: Request for Callback -
Date: Friday, June 23, 2023 1:20:00 PM

Josh Gillespie called to speak with you. It is regarding claim no. 22-0374-CC.

Callback # : 501-244-0700

Caitlin McDaniel
Administrative Specialist II
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-1619

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

V. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

ORDER

Now before the Arkansas State Claims Commission (the "Commission") is the claim of Christine McAuliffe, as Special Administrator of the Estate of David Cains (collectively referred to herein as the "Claimant") against the Arkansas Department of Human Services (the "Respondent" or "DHS"). At the hearing held March 9, 2023, Claimant was represented by Joshua Gillispie and Chad Green. Rich Rosen appeared on behalf of Respondent.

Procedural History, Prehearing Matters, and Witness Testimony

1. Claimant filed this claim against Respondent on September 30, 2021, seeking $7,000,000.00 in damages related to the June 13, 2020, death of David Cains (the "Decedent"). The Decedent died while being physically restrained by employees of the Booneville Human Development Center (the "Center").

2. Respondent filed an Answer denying liability.

3. The Commission previously entered two orders in this claim: (1) an August 3, 2022, order granting Claimant's unopposed motion requesting that Respondent release certain documents to Claimant; and (2) an August 8, 2022, agreed protective order. Claimant also withdrew a motion to compel, such that no order was required.

4. The Commission notes that Respondent filed a motion to exclude testimony from Bob Bowen, which Claimant opposed. The Commission finds that this motion is moot, as Claimant did not call Mr. Bowen as a witness at the hearing or submit a deposition transcript.

5. The witnesses were sworn in by the chair commissioner.

6. In opening, Claimant's counsel stated that the Center negligently caused the Decedent's death. Restraints are only permitted in the extraordinary circumstances involving a risk of serious bodily injury or death and that the Center's supervisor admitted that the restraints used on the Decedent were not the "least restrictive" option, as required by state regulations, federal regulations, and the Center's written policy. Additionally, under the Center's written policies, the employees were only permitted to call the Center's medical personnel and could not call 911. Following the Decedent's death, the Center's employees lied about the use of restraints to the Decedent's family and falsified information stating that the Decedent was found in a hallway following his lunch. Claimant's counsel noted a "pervasive indifference" on the part of the Center to the restraint regulation.

7. Upon a question from a commissioner, Claimant's counsel specified that Claimant's damages include:

- $700,000 for the Decedent's pain and suffering,
- $1,500,000 to the Decedent's mother for mental anguish,
- $1,500,000 to the Decedent's sister for mental anguish,
- $300,000 to the Decedent's half-sister for mental anguish, and
- $3,000,000 for the Decedent's loss of life.

8. In opening, Respondent's counsel stated that this claim is about foreseeability and proximate cause. Respondent's deposition summaries include facts to debunk Claimant's allegations. The Decedent lived at the Center for thirteen years and had documented physical aggression issues. [redacted]

[redacted]. Referring to Dr. Hamid's deposition, Respondent's counsel stated that the parties agree that the Decedent ended up on the ground following a struggle. The regulations require the restrained person to be released from restrained as quickly as possible once the restrained person has calmed. It took emergency medical personnel thirteen minutes to arrive following the 911 call.

Testimony of Christine McAuliffe

9. Claimant called Christine McAuliffe to testify.

10. Ms. McAuliffe is the Decedent's younger sister. She grew up in Russellville, Arkansas, and lived there until 2016, when she moved to Vermont.

11. She was close with the Decedent. She was very protective of him. The Decedent was her best friend when she was a child. He was also like her child.

12. Their father was murdered when the Decedent was fourteen years old and Ms. McAuliffe was eleven years old. Following that event, the Decedent lived with families that were able to watch him continuously. He began living at the Center in 2007. The Center was a good fit for him because he was very social and outgoing.

13. The Decedent loved the Monkees, the Dukes of Hazzard, and the Arkansas Razorbacks. He was very social and outgoing. He liked to tease people.

14. Ms. McAuliffe saw him about every two to three months for holidays and his birthday. This continued after she moved to Vermont. The Decedent would come home for holidays.

15. The Decedent dealt with behavioral issues but was not violent. Ms. McAuliffe was never afraid of her brother. He never hurt her. He would move his arms out to the side when he was having a tantrum. He did not have the physical capability to lunge at another person. He was attacked by another resident in 2012, and his instinct was to curl up, not to fight back.

16. The Decedent was involved in the Special Olympics his whole life. He was very proud when he won a race, even though he was not gifted at athletics.

17. Following the Decedent's death, Ms. McAuliffe's mother was notified that the Decedent choked while eating lunch. Ms. McAuliffe understood that the Decedent was never a choking hazard. The Decedent's case manager, Caleb Murray, told Ms. McAuliffe that he did not know what happened because he was not there when the Decedent passed away.

18. Mr. Murray and other Center staff members came to the Decedent's funeral. At the funeral, Mr. Murray said that the investigation was concluded and that they would receive something in the mail.

19. Ms. McAuliffe reviewed the letter she received from the Center following the investigation, which was the first time Ms. McAuliffe became aware that the Decedent was restrained at the time of his death. Ms. McAuliffe called Mr. Murray for more information, and she was told to contact Jeff Gonyea.

20. Prior to this incident, Ms. McAuliffe had always been notified when a behavioral incident occurred. She understood that "personal restraints" meant that one or both arms were held. She did not understand that the Decedent could be restrained on the ground. Mr. Gonyea refused to give her any other information regarding the investigation and directed her to contact Tammy Bimbrook at DHS to request documents. Ms. McAuliffe confirmed that she received approximately 300 pages within a week.

21. After reading the statements, Ms. McAuliffe was appalled. She contacted the Office of Long Term Care (OLTC) to request an investigation. She later received an email stating that nothing was found and that, because the Decedent was deceased, her mother's guardianship was concluded and that she would have to contact a lawyer to become the executor of the Decedent's

estate. Ms. McAuliffe's uncle contacted the Logan County Sheriff's Office, but nothing came of that, and they could not obtain an investigation report. Ms. McAuliffe sent emails to her representatives and eventually got a lawyer as a last resort.

22. Ms. McAuliffe learned of the Decedent's death as she was driving home from the grocery store. She was very upset. Three weeks later, the family celebrated the Decedent's birthday without him and told stories about him.

23. The Decedent enjoyed his life and was a happy, funny guy. He enjoyed living at the Center. He loved his family. He had his own friends at the Center. His life mattered to him. Ms. McAuliffe feels like his life was taken away from him.

24. The Decedent relied upon the Center's staff members and his family to be his voice. He was unable to be his own voice.

25. On cross-examination, Ms. McAuliffe confirmed that the Decedent was at the Center because Ms. McAuliffe's mother wanted him to be there. Ms. McAuliffe disagreed with the portion of her mother's deposition stating that Ms. McAuliffe only came back to Arkansas once or twice a year after she moved to Vermont. She is aware that Respondent's internal investigation, the OLTC investigation, and the investigation by the Logan County Sheriff's Office did not yield any findings of wrongdoing. Ms. McAuliffe agreed that a death investigation would take some time. She agreed that this event preceding the Decedent's death was unusual compared to prior behavior events. The Decedent was removed from the family that he lived with prior to moving to the Center due to abuse or neglect. Referring to Respondent's Exhibit No. 10, which is the Decedent's 2019 Individual Program Plan (IPP), Ms. McAuliffe agreed that restraints were specifically referenced and that the Decedent's mother signed it. She was aware that restraints could include chemical restraints, a papoose board, or personal restraints. [redacted]

[redacted]. Ms. McAuliffe's mother relied on her Catholic faith to help her cope with the Decedent's death. Ms. McAuliffe assumed that the emergency response from 911 at the Center would take longer due to its rural location.

26. On redirect, Ms. McAuliffe stated that staff members told her how much they loved the Decedent. During the IPP meeting or afterwards, discussions were had about [redacted]

27. On re-cross, Ms. McAuliffe agreed with her deposition when she stated that the Decedent did not vomit often.

Testimony of Charlene Robinson

28. Claimant called Charlene Robinson to testify.

29. Ms. Robinson is the Decedent's mother. Ms. Robinson shared stories from the Decedent's childhood. The Decedent loved Christmas and believed in Santa his whole life. He loved going to Walmart after having lunch with Ms. Robinson. He was very proud of the money that he earned at his job taking apart books at the Center.

30. The Decedent was very close with Ms. McAuliffe. He would always ask Ms. Robinson about her.

31. Ms. Robinson worked full-time in varied jobs until she was 69 years old. She had multiple jobs at certain times. It would have been impossible for Ms. Robinson to take care of the Decedent after the Decedent's father passed away. She sought out help from Friendship Services, which is how the Decedent was placed with the [redacted] and [redacted] and placed at the Center. Ms. Robinson looked

at other options but determined that the Center was the best fit for the Decedent so that he could be around his peers.

32. When Ms. Robinson received a call from the Center on the day of the Decedent's death, Ms. Robinson was told that the Decedent was in critical condition after choking at lunch.

33. The Decedent was not a dangerous or violent individual. Ms. Robinson was not afraid of him. The Decedent did not have the physical strength or dexterity to attack a grown man. He could not open a jar of pickles or a soda bottle.

34. Ms. Robinson did not learn that the Decedent died while restrained until ten days after his death. When she asked Mr. Murray whether there had been any behavior issues that week, she was told that there were not. Ms. Robinson did not receive any condolences from employees from the Center.

35. Because of the COVID-19 pandemic, Ms. Robinson was not able to visit the Decedent. The last time she saw him was on February 16, 2020. She talked to him on Monday afternoons.

36. Ms. Robinson talked about how much she misses the Decedent and how holidays are not the same.

37. On cross-examination, Ms. Robinson stated that she relied upon her church following the Decedent's death and [redacted]. Staff members from the Center came to the Decedent's funeral. She was aware of the Decedent's physical aggression issues. Referring to Respondent's Exhibit No. 11A, which is a behavior report from the Center stating that the Decedent "hit mom" on December 26, 2019, Ms. Robinson disagreed that she was hit by the Decedent. She never received a written report about the Decedent throwing a fire extinguisher.

Testimony of Kris Stewart

38. Claimant called Kris Stewart to testify. Ms. Stewart works with Disability Rights Arkansas (DRA) as an advocate. She monitors facilities for abuse and neglect.

39. Ms. Stewart is a co-author of the report found at Claimant's Exhibit No. 1.

40. DRA was contacted by Ms. McAuliffe following the Decedent's death. In its investigation, DRA reviewed the Center's investigation report, the OLTC investigation, and the hospital and coroner reports. DRA also interviewed several people associated with Respondent and the Center.

41. Referring to Claimant's Exhibit No. 1 at CM004527, Ms. Stewart stated that the Decedent [redacted]. Crisis Prevention Institute (CPI) does not support the on-the-floor restraints used on the Decedent.

42. Ms. Stewart found in her investigation that there were a lot of inconsistencies and that the investigation done by Respondent did not resolve those inconsistencies. There was a lot of information left out of the reports, including that the Decedent was restrained. Ms. Stewart noted inconsistencies between written reports and the employee interviews, including how the Decedent was laying on the ground and whether a staff member was holding his head. Ms. Stewart had concerns about Tyler Matson's credibility. Ms. Stewart stated that the least restrictive way to handle the Decedent would have been to back away and see if the Decedent calmed down.

43. Ms. Stewart has not been paid to give her report or to testify at the hearing.

44. Regarding the Center's 911 policy, Ms. Stewart stated that, per Jeff Gonyea, only medical personnel are permitted to call 911 to keep staff members from calling 911 unnecessarily.

Ms. Stewart interviewed Tyler Matson and was told that Mr. Matson initiated contact with the Decedent when the Decedent came toward him.

45. Following this incident, the Center did not change its policies. Ms. Stewart stated that because the Decedent died, she has a hard time believing that nothing could be done better or differently in the future to avoid a similar situation.

46. DRA is federally mandated and federally funded to do these investigations.

47. Ms. Stewart stated that there were no cameras at the Center.

48. On cross-examination, Ms. Stewart stated that DRA is mandated to investigate abuse and neglect situations. Ms. Stewart agreed that not every death involves abuse and neglect. Ms. Stewart is not certified or licensed to do investigations by any federal entity or any Arkansas board or commission. DRA was told that the Logan County Sheriff's Office does not investigate deaths at the Center. Ms. Stewart did not speak to anyone from OLTC. Ms. Stewart talked to Mr. Scow, who had heard from the nurses. [redacted], that would be correct based on what they saw. Referring to Respondent's Exhibit No. 13, Mr. Matson's statement includes references to the Decedent fighting Mr. Matson. Ms. Stewart is not aware of Ark. Code Ann. § 12-12-1718, which prohibits disclosure of pending maltreatment report. Ms. Stewart did not speak to [redacted] She is familiar with the Center's restraint policy.

49. Upon a question from a commissioner, Ms. Stewart stated that the biggest problem with the restraints here was that the Decedent died while he was restrained on the floor. Mr. Matson

could have gotten up and moved away from the Decedent once Mr. Matson moved the Decedent onto his side.

Testimony of Dr. Ricki Brown-Forestiere

50. Claimant called Dr. Ricki Brown-Forester to testify. She works at Lakeland Regional Hospital, which is the second busiest emergency room in the country. She is a board-certified emergency medicine physician. She is the program director for the residency program at the hospital.

51. Dr. Brown-Forester testified that a person is more likely to suffocate on vomit if laying on ground. When laying flat on ground, gravity causes the vomit to settle at its lowest point, which is the back of the throat. [redacted].

52. Dr. Brown-Forester is familiar with [redacted]

53. In her opinion, being restrained is a stressful situation, and the Decedent was known to have vomiting issues when stressed.

Deposition Testimony Submitted by the Parties

54. The Commission reviewed the following depositions submitted by the parties:

i. Mark Hise (Claimant's Exhibit No. 2)
ii. Jeff Gonyea (Claimant's Exhibit No. 3)
iii. Sandy Evans (Claimant's Exhibit No. 6)
iv. Tyler Mattson (Claimant's Exhibit No. 9)
v. Ryann Campos (Claimant's Exhibit No. 10)
vi. Kelly King (Claimant's Exhibit No. 11)
vii. Amanda Schmitt (Claimant's Exhibit No. 12)
viii. Don Carter (Claimant's Exhibit No. 13)
ix. Mike Alvis (Claimant's Exhibit No. 14)
x. Caleb Murray (Claimant's Exhibit No. 15)

xi. Christine McAuliffe (Claimant's Exhibit No. 16)
xii. Amy Amanda Jones (Claimant's Exhibit No. 18)
xiii. Carrie Johnson-Miller (Claimant's Exhibit No. 19)
xiv. Justin Jobb (Claimant's Exhibit Nos. 20, 56)
xv. Dian Elliott (Claimant's Exhibit No. 21, Respondent's Exhibit No. 16B)
xvi. Janice LeBel (Claimant's Exhibit No. 23)
xvii. Jennifer Berry (Claimant's Exhibit No. 24, Respondent's Exhibit No. 14B)
xviii. Dr. Syed Hamid (Claimant's Exhibit No. 25, Respondent's Exhibit No. 17B)
xix. Jonathan McCutcheon (Claimant's Exhibit No. 26)
xx. Kris Stewart (Claimant's Exhibit No. 30)
xxi. Melissa Weatherton (Claimant's Exhibit No. 32)
xxii. Samuel Scow (Claimant's Exhibit No. 40)
xxiii. Dr. Rickie Brown-Forestiere (Claimant's Exhibit No. 42)
xxiv. Rhonda Harris (Claimant's Exhibit No. 49)
xxv. Charlene Robinson (Claimant's Exhibit No. 54)
xxvi. Ashley Cains (Claimant's Exhibit No. 55)
xxvii. Dr. Theodore Kastner (Respondent's Exhibit No. 15B)

Closing Arguments

55. In closing, Claimant's counsel argued that Mr. Mattson should have been terminated before this incident [redacted]. Two weeks before the Decedent's death, Mr. Mattson put the Decedent in restraints because the Decedent threatened to throw a thermometer, which was not an emergency situation. Ms. Johnson-Miller should have flagged Mr. Mattson for another incident in March 2020, as well. The fact that Mr. Mattson was known to use restraints improperly indicates foreseeability. When the Decedent was restrained on June 13, 2020, the restraint caused him to vomit, and he suffocated while restrained. The fact that the Decedent vomited when anxious also goes to the issue of foreseeability. Even if the Decedent had charged at Mr. Mattson, the training applies, as discussed by Mr. Hise. There should have been a violation found in the OLTC investigation.

56. Upon a question from a commissioner, Claimant's counsel confirmed that being swung at by a client is not unusual and that the staff is trained to block and pivot away.

57. Upon a question from a commissioner, Claimant's counsel stated that one of the estimated 120 restraint issues involved vomiting.

58. In closing, Respondent argued that the Decedent was only on the ground because he was trying to fight Mr. Mattson. This is a tragic situation. However, the fact that an accident occurs does not mean that there was negligence. Dr. Kastner provided his opinions at the beginning of his expert report, and then explained the scientific and medical reasons for each opinion. Negligence cannot be assumed. The Decedent was restrained many times over the years, and that was necessary. Regarding the allegation against Mr. Mattson, the fact that an allegation was made does not mean that the allegation is correct. Negligence cannot be predicated on a failure to anticipate the unforeseen. To demonstrate foreseeability, the harm must be within the range of probability, more than merely possible.

Relevant Caselaw, Regulations, and Policies

59. The elements of a negligence claim are duty, breach of duty, and damages proximately caused by the breach. *See Union Pac. R. Co. v. Sharp*, 330 Ark. 174, 180, 952 S.W.2d 658, 661 (1997).

60. Negligence can be "defined as the failure to do something that a reasonably careful person would do, or the doing of something that a reasonably careful person would not do, under the circumstances." *Ethyl Corp. v. Johnson*, 345 Ark. 476, 481, 49 S.W.3d 644, 648 (2001). As the Arkansas Supreme Court held, "negligence cannot be predicated on a failure to anticipate the unforeseen." *Id*. (quoting *Keck v. Am. Emp. Agency, Inc.*, 279 Ark. 294, 652 S.W.2d 2 (1983)). The court further held that "Arkansas law has long since recognized that there is no duty to guard against merely possible, as opposed to likely or probable, harm." *Id*. at 482, 49 S.W.3d at 648.

61. The standard for clients' rights in 42 CFR § 483.420(a)(6) states that clients should be "free from unnecessary . . . physical restraints. . . ." Claimant's Exhibit No. 5.

62. 42 CFR § 483.450(b)(1)(iv)(B) requires the Center to have a policy addressing the use of physical restraints. Claimant's Exhibit No. 5.

63. 42 CFR § 483.450(d)(1)(ii) states that physical restraints may be used as an emergency measure "if absolutely necessary to protect the client or others from injury." Claimant's Exhibit No. 5. Subsection (d)(5) specifies that the restraint should not cause physical injury to the client. *See id*.

64. DDS Policy 3011-D requires that "an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others are managed with the least restrictive method." Claimant's Exhibit No. 4.

65. Section 6 of DDS Policy 3011-D provides that:

> Nothing in this policy prohibits the use of emergency restraints (mechanical or personal) . . . This includes the use of restraint procedures in the course of an established program, when the individual becomes a danger to him/herself or others, prior to staff being able to implement a lesser restrictive hierarchy. However, it is emphasized that emergency procedures may not be used at frequent intervals, becoming a routine method of intervention. If emergency procedures are utilized three times in a six-month period, the IDT will meet to conduct a functional analysis and develop an appropriate plan of action. . . .

Claimant's Exhibit No. 4.

Findings of Fact and Conclusions of Law

Based upon a review of the pleadings, testimony, evidence, and the law of the State of Arkansas, the Commission unanimously finds as follows:

66. The Commission has jurisdiction to hear this claim pursuant to Ark. Code Ann. § 19-10-204.

67. The Commission finds that Claimant's claim is based upon alleged negligence in the treatment of the Decedent. Claimant alleges that this negligence was the cause of the Decedent's death.

68. The Commission finds that the Decedent was a resident at the Center at the time of his death on June 13, 2020. *See* Claimant's Exhibit No. 24 at p. 111. The Decedent lived at the Center from 2007 until his death. *See id*.

69. The Commission finds that the Center is an intermediate care facility for adults with intellectual disabilities. *See* Claimant's Exhibit No. 24 at p. 8. The Center trains its residents in "independent living skills, pre-vocational skills, and behavior management." *See id*. The Center is one of five human development centers in Arkansas, all of which are under Respondent's Division of Disability Services (DDS). *See id*. at pp. 8–9. The Center is licensed through Respondent's Office of Long Term Care (OLTC), which is the state's regulatory body for these types of facilities. *See id*. at pp. 12, 14. Ninety percent or more of the Center's population is "dually diagnosed," meaning that a resident has a mental illness diagnoses in addition to an intellectual disability. *See id*. at pp. 49–51. The Center has a "higher population of behavioral problems" than the state's other human development centers because the dual diagnosis patients are "funneled" to the Center. *See* Claimant's Exhibit No. 24 at p. 50.

70. The Commission finds that federal regulations, DDS policy, and the Center's policies permit the use of personal restraints in emergency situations. 42 CFR § 483.450(d)(1)(ii); DDS Policy 3011-D at Section 6; *see also* Claimant's Exhibit No. 6 at p. 38 and Claimant's Exhibit No. 3 at p. 41. A "personal restraint" is defined as "an emergency procedure limiting movement by the holding of a hand or limb." *See* Claimant's Exhibit No. 6 at pp. 39–40.

71. The Commission finds that the Decedent's July 18, 2019, IPP was in effect on the date of the Decedent's death. *See* Claimant's Exhibit No. 24 at pp. 55–56. The IPP listed the following [redacted]. *See id*. at p. 58. The IPP included the Decedent's history of physical aggression, noncompliance, and destruction of property (televisions, radios, DVD player, windows). *See id*. As part of the Decedent's IPP, his television was placed in a plexiglass box, and a shatter-proof mirror was installed in his room. *See id*. at p. 59. The IPP specified that where the Decedent was physically aggressive, the Center's staff could employ "category one procedures" (as part of DDS' 3011-D Policy), "TACT procedures" (as part of the Nonviolent Crisis Intervention (NCI) protocol), and other emergency procedures if necessary to protect from injury to client or others. *See id*. at p. 61, 105.

72. The Commission finds that extensive evidence[1] was presented regarding the Decedent's history of physical aggression in the year preceding the Decedent's death. The

[1] *See* Claimant's Exhibit No. 24 at pp. 70-80 and exhibits to deposition; *see also* Claimant's Exhibit No. 9 at pp. 76–77. May 20, 2019 (Decedent threw fire extinguisher into wall); June 25, 2019 (Decedent hit windows with hands); August 8, 2019 (Decedent hit staff member, tried to bite himself, did bite staff member); October 15, 2019 (Decedent tried to hit staff members); October 31, 2019 (Decedent tried to hit resident, hit a staff member); October 31, 2019 (Decedent screamed, bit himself); November 2, 2019 (Decedent threw table at staff); November 16, 2019 (Decedent tried to bite himself); November 21, 2019 (Decedent flipped a table over); December 2, 2019 (Decedent threw object at staff); December 18, 2019 (Decedent spit on staff, slapped staff and hit staff with his hat); December 18, 2019 (Decedent bit himself, threw an object); December 19, 2019 (Decedent threw objects, bit himself, pushed over table); December 26, 2019 (Decedent hit his mother, flipped a table); January 29, 2020 (Decedent turned over a trash can, threw juice at staff); February 5, 2020 (Decedent threw object at staff); February 8, 2020 (Decedent spit at and scratched staff member, threw objects at staff); February 18, 2020 (Decedent bit himself); February 18, 2020 (Decedent spit at and attempted to hit staff); February 25, 2020 (Decedent grabbed a broom and hit the windows); March 6, 2020 (Decedent threw trash can, threw object at staff); March 20, 2020 (Decedent kicked laundry basket, tried to spit at and hit staff, continued to fight once restrained); April 20, 2020 (Decedent grabbed staff member's glasses and threw them); April 20, 2020 (Decedent threw rock at Center's vehicle); April 27, 2020 (Decedent threw objects, hit staff with hat, acted as though he would hit staff with broom); April 28, 2020 (Decedent threw chair at staff, hit windows); May 29, 2020 (Decedent tried to pull fire alarm, tried to hit staff member).

Decedent had 187 aggressive incidents at the Center prior to June 2020, of which 77 incidents involved mechanical restraints (on a papoose board) and 43 involved personal restraints. *See* Claimant's Exhibit No. 2A at p. 6. Of those 187 aggressive incidents, there was only one episode of vomiting while restrained (approximately eight years before the Decedent's death). *See id*.

73. The Commission finds that, on June 13, 2020, Mr. Mattson's report and testimony confirm that the Decedent initiated the behavioral incident by aggressively moving toward Mr. Mattson. *See* Claimant's Exhibit No. 9.

74. The Commission finds that, while Claimant [redacted] *See* Claimant's Exhibit No. 25 at pp. 15–16. [redacted] *See* Claimant's Exhibit No. 24. As noted by Dr. Kastner, there is no evidence that [redacted] *See* Respondent's Exhibit No. 15B at pp. 49–50. Dr. Kastner also noted that Dr. Hamid did not put any qualifications on the Center's use of the papoose board—which required the Decedent to be prone—[redacted]. *See id*. at pp. 60–61.

75. Given Dr. Hamid's and Dr. Kastner's testimony [redacted] as well as the fact that the Decedent had only vomited once while restrained (out of 120 times), the Commission finds that it was not foreseeable that the Decedent would vomit while restrained on June 13, 2020. *See Ethyl Corp*., 345 Ark. at 481, 49 S.W.3d at 648. The Commission finds Dr. Kastner's opinions, explanations, and testimony regarding this issue to be persuasive, especially given his vast experience in the treatment of individuals with intellectual disabilities. *See* Respondent's Exhibit Nos. 2A, 15B. The Commission finds that Dr.

Brown-Forestiere's testimony was too speculative on this issue to be persuasive, especially regarding the assumptions as to whether the Decedent was "fighting for [his] . . . life" and whether that was the cause of Decedent vomiting. *See* Claimant's Exhibit No. 42 at pp. 13-15. The Commission also notes the very short period of time since Dr. Brown-Forestiere completed her residency. *See* Claimant's Exhibit No. 44 at p. 1.

76. However, the Commission finds that the Center was in violation of Section 6 of DDS Policy 3011-D, given the number of times that the Decedent was put into restraints within the six-month period prior to his death without a plan of action created to address this frequent issue. The behavior reports from that six-month period indicate that personal restraints were used on the Decedent on February 8, 2020; February 18, 2020; February 25, 2020; March 6, 2020; April 28, 2020; and May 29, 2020. *See* Claimant's Exhibit No. 24. As stated in 3011-D, "emergency procedures may not be used at frequent intervals, becoming a routine method of intervention." Claimant's Exhibit No. 4. Given that the Center was required under 3011-D to develop an "appropriate plan of action" to address this continual need for "emergency procedures," the Commission finds that it was foreseeable that routinely using emergency personal restraints on the Decedent could result in a negative outcome. By not creating a plan of action to address the routine, frequent use of restraints, the Commission finds that the Center breached its duty to the Decedent and that the breach tragically resulted in the Decedent's death. The Commission also notes its concerns with the Center's policy that only medical staff was allowed to call 911.

77. However, pursuant to Ark. Code Ann. § 16-64-122, the Commission must also consider the fault of the Decedent. The plain language of Ark. Code Ann. § 16-64-122 states that it applies to "… <u>all</u> actions for damages for … wrongful death … in which recovery is predicated upon fault." (emphasis added). The Arkansas Court of Appeals discussed the applicability of the

"broad language" in this statute in *Bishop v. Tariq*, 2011 Ark. App. 445, 384 S.W.3d 659. In the instant claim, the Decedent initiated the behavioral situation that led to Mr. Mattson putting the Decedent into personal restraints. While the Decedent had the mental capacity of a child, Arkansas law states that "an infant is liable for his torts in the same manner as an adult." *Farm Bureau Mut. Ins. Co. of Ark., Inc. v. Henley*, 275 Ark. 122, 126, 628 S.W.2d 301, 303 (1982) (citing *Moore v. Wilson*, 180 Ark. 41, 20 S.W.2d 310 (1929)).

78. As such, the Commission assigns fault as follows:

(a) Decedent: 40%

(b) Respondent: 60%

79. As for damages, the Commission must consider the damages for the Decedent's estate as well as the mental anguish damages for the Decedent's wrongful death beneficiaries (his mother, sister, and half-sister).

80. Regarding the Decedent's estate, the Commission finds that, considering the persuasive testimony of the Decedent's family members regarding how the Decedent valued his life, the Claims Commission finds that the damages associated with the Decedent's loss of life are $350,000.00. Additionally, the Commission finds that the estate is entitled to $100,000.00 for the Decedent's pain and suffering. As such, the Claims Commission finds that the Decedent's estate's total damages are $450,000.00, of which Respondent is liable for 60 percent, equaling $270,000.00.

81. Regarding the Decedent's mother, Ms. Robinson, and the Decedent's sister, Ms. McAuliffe, the Commission finds their testimony regarding the mental anguish experienced following the Decedent's death to be persuasive. As such, the Commission finds that Ms. Robinson

and Ms. McAuliffe should each be awarded mental anguish damages of $75,000.00, of which Respondent is liable for 60%, equaling $45,000.00 to each.

82. Regarding the Decedent's half-sister, Ms. Cains, the Commission finds her testimony regarding the mental anguish experienced following the Decedent's death to be persuasive. As such, the Commission finds that Ms. Cains should be awarded mental anguish damages of $50,000.00, of which Respondent is liable for 60%, equaling $30,000.00.

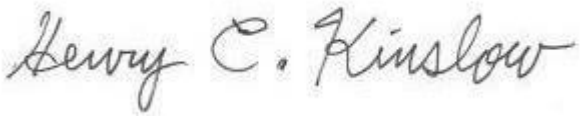
Conclusion

83. The Claims Commission AWARDS the Estate of David Cains $270,000.00. The Claims Commission further AWARDS Charlene Robinson and Christine McAuliffe $45,000.00 each and Ashley Cains $30,000.00. Pursuant to Ark. Code Ann. § 19-10-215(b), the Claims Commission refers this total award of $390,000.00 to the General Assembly for review, approval, and, if approved, placement on an appropriations bill.

IT IS SO ORDERED.



ARKANSAS STATE CLAIMS COMMISSION
Courtney Baird



ARKANSAS STATE CLAIMS COMMISSION
Henry Kinslow, Chair



ARKANSAS STATE CLAIMS COMMISSION
Sylvester Smith

DATE: July 21, 2023

Notice(s) which may apply to your claim

(1) A party has forty (40) days from the date of this Order to file a Motion for Reconsideration or a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1). If a Motion for Reconsideration is denied, that party then has twenty (20) days from the date of the denial of the Motion for Reconsideration to file a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1)(B)(ii). A decision of the Claims Commission may only be appealed to the General Assembly. Ark. Code Ann. § 19-10-211(a)(3).

(2) If a Claimant is awarded less than $15,000.00 by the Claims Commission at hearing, that claim is held forty (40) days from the date of disposition before payment will be processed. *See* Ark. Code Ann. § 19-10-211(a). Note: This does not apply to agency admissions of liability and negotiated settlement agreements.

(3) Awards or negotiated settlement agreements of $15,000.00 or more are referred to the General Assembly for approval and authorization to pay. Ark. Code Ann. § 19-10-215(b).

From:	Kathryn Irby
To:	Joshua Gillispie
Cc:	Daiquiri Carter; Rich Rosen; Chad
Subject:	ORDER: McAuliffe v. DHS, Claim No. 220374
Date:	Friday, July 21, 2023 1:19:00 PM
Attachments:	McAuliffe -- hearing -- 220374 -- order.pdf

Mr. Gillispie and Mr. Rosen, please see attached order entered by the Commission.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From:	Kathryn Irby
To:	"Joshua Gillispie"
Cc:	SaBreana Hyche
Subject:	RE: Additional opinions requested
Date:	Thursday, August 10, 2023 11:34:00 AM

Josh, thanks for this information. The permitted for the filing of a motion for reconsideration can be found in statute and in the text box at the end of the order.

Thanks,
Kathryn

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Wednesday, August 9, 2023 11:57 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: SaBreana Hyche <SaBreana.Hyche@arkansas.gov>
Subject: Re: Additional opinions requested

Kathryn-

You and your staff have been so gracious and helpful to me, so I wanted to do you the courtesy of letting you know that we have decided to file a Motion for Reconsideration rather than immediately appeal, in case knowing that is in any way helpful to you and your team.

Best regards,

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Tue, Aug 8, 2023 at 9:51 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Josh, when a notice of appeal is filed with the Commission, I transmit a copy of the claim file to the Legislature. I do not transmit the claim file until the end of the 40-day period allowed for the parties to file a motion for reconsideration or to appeal. There is no briefing. Once the claim is added to a meeting agenda of the Claims Review Subcommittee, the parties will receive notice from the Bureau of Legislative Research. Typically, the parties are only given an opportunity to speak if a member of the Subcommittee has a question for a party.

Given that the 40-day period will not run until the end of August, I would be very surprised if that hypothetical appeal could be added to the September meeting, but that is not the Commission's decision. If an appeal is filed, and I transmit the claim file, BLR works with the CRS to set the agenda.

Kathryn

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Sunday, August 6, 2023 4:08 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: SaBreana Hyche <SaBreana.Hyche@arkansas.gov>
Subject: Re: Additional opinions requested

Kathryn,

Can you please let me know briefly what the process would be in the event I filed a notice of appeal? I reviewed the statute, but it's still unclear to me what happens after the Commission notifies the Legislature of the appeal. For instance, is there a briefing requirement or do we just make our appeal directly to the Committee?

I see that the Committee next meets on September 11. Is it possible our appeal could be heard then?

Thanks!

Joshua D. Gillispie

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North Little Rock, AR 72114
(501) 244-0700
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www.greenandgillispie.com

On Tue, Aug 1, 2023 at 10:03 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Kathryn-
>
> I appreciate all of this. Thanks very much.
>
> Joshua D. Gillispie

1 Riverfront Place, Suite 605
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On Tue, Aug 1, 2023 at 7:32 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Josh, please see attached.
>
> On the Elizabeth Gilbert order that I sent you yesterday, that was not a final order. We have asked the State Archives to search for a final order in that matter. If they can find one, we will send it along to you.
>
> Thanks,
> Kathryn Irby
>
> **Kathryn Irby**
> **Arkansas State Claims Commission**
> 101 East Capitol Avenue, Suite 410
> Little Rock, Arkansas 72201
> (501) 682-2822

From: Joshua Gillispie
To: Kathryn Irby
Cc: SaBreana Hyche
Subject: Re: Additional opinions requested
Date: Tuesday, August 29, 2023 9:12:05 AM

Thanks, Kathryn. That's very helpful.

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Tue, Aug 29, 2023 at 9:03 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Josh,
>
> As to your first question, Ark. Code Ann. 19-10-211(a)(1)(B)(ii)(a) specifies that when a motion for reconsideration is denied, a party can file a notice of appeal "within twenty (20) days of the commission's transmitting the order denying the motion for reconsideration."
>
> As to your second question, if you're filing a motion for reconsideration, the Commission will consider it.
>
> Kathryn
>
> ---
>
> **From:** Joshua Gillispie <josh@greenandgillispie.com>
> **Sent:** Monday, August 28, 2023 10:00 PM
> **To:** Kathryn Irby <Kathryn.Irby@arkansas.gov>
> **Cc:** SaBreana Hyche <SaBreana.Hyche@arkansas.gov>
> **Subject:** Re: Additional opinions requested
>
> Kathryn-

In light of reading Rule 7.1, I am trying to decide what to do. The Motion for Reconsideration I have drafted does *not* utilize any brand new evidence not previously available.

As you know, there was an extraordinary amount of evidence submitted to the Commission. My Motion focuses on a few pieces of evidence that, based on the Order, the Commission might not have had a chance to look at closely and that I was not able to focus on at the hearing given the time limitations placed on me.

My questions are, (1), if filed would such a Motion for Reconsideration even toll the time for filing a Notice of Appeal, OR would it be considered deficient and therefore treated as if nothing at all was filed, thereby preventing the timely filing of a Notice of Appeal?

And (2), is the portion of 7.1 stating that "Petitions for Re-Hearing and/or Motions for Reconsideration will only be entertained if they set forth new or additional evidence which was not available to the moving party at the time of the scheduled hearing" strictly enforced OR can the Commission still consider my Motion if they want?

Thanks,

Joshua D. Gillispie

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North Little Rock, AR 72114
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(501) 244-2020 fax
www.greenandgillispie.com

On Mon, Aug 28, 2023 at 11:39 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Josh, I cannot calculate your deadline for you. I can, however, point you to Commission

Rules 7.1 and 8.1. https://arclaimscommission.arkansas.gov/rules/

Thanks,

Kathryn

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Monday, August 28, 2023 9:54 AM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: SaBreana Hyche <SaBreana.Hyche@arkansas.gov>
Subject: Re: Additional opinions requested

Kathryn-

Can you please confirm for me that my Motion for Reconsideration is due tomorrow? 40 days from release of Order on July 21. That would be the case were this in state court, but I want to be sure you do not calculate differently.

Thanks!

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
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On Thu, Aug 10, 2023 at 11:34 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

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> **Subject:** Re: Additional opinions requested
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Kathryn Irby

Kathryn Irby

Arkansas State Claims Commission

101 East Capitol Avenue, Suite 410

Little Rock, Arkansas 72201

(501) 682-2822

From:	Joshua Gillispie
To:	ASCC Pleadings
Cc:	Kathryn Irby; Rich Rosen; Chad; Brent Gasper
Subject:	McAuliffe v. DHS, Claim No. 220374
Date:	Tuesday, August 29, 2023 10:58:13 AM
Attachments:	Motion for Reconsideration.pdf

Dear Claims Commission:

Please find attached Claimant's Motion for Reconsideration.

Best Regards,

Josh Gillispie

Joshua D. Gillispie
1 Riverfront Place, Suite 605
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BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains	**CLAIMANT**
V.	**Claim No. 220374**
THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)	**RESPONDENT**

MOTION FOR RECONSIDERATION

COMES NOW Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Motion for Reconsideration submits the following:

INTRODUCTION

This Honorable Commission entered its Order on July 21, 2023. Claimant Christine McAuliffe, and her undersigned counsel, wish to thank Commission Chairperson Henry Kinslow, Commissioner Courtney Baird, and Commissioner Sylvester Smith for their hard work and valuable time expended in considering this claim, and wish to recognize that their job was not an easy one given the amount of evidence, particularly the number of deposition transcripts, submitted in this case. This Motion for Reconsideration seeks to respectfully address two specific findings: (1) the apportionment of 40% fault to David Cains, and (2) the $350,000.00 award for damages associated with David Cains' "loss of life."

The purpose of this Motion for Reconsideration is to address more fully these two issues under Arkansas law to show the Commission why it should decrease the percentage of fault assigned to Davie and increase the award for damages associated with Davie's loss of life.

Central to both analyses is that David Cains possessed the mind of an approximately four-year-old child.[1]

I. APPORTIONMENT OF FAULT

1. Respectfully, the Commission erred in apportioning forty percent fault to David Cains, given the large amount of evidence proving foreseeability on Respondent and given [redacted], which requires an analysis for attributing fault to consider *only* how a reasonably careful person of David's maturity and intelligence would act under the circumstances.

Furthermore, and significantly, the Director of Developmental Disabilities Services for the Arkansas Department of Human Services, Respondent's highest-ranking official to give testimony in this case, testified in crystal clear terms that Davie was *not* at fault for this death.

> *Q Is it your position that Mr. Cains was responsible for his own death?*
> *A I didn't say that.*
> *Q I didn't say you did. It's a question I have to ask.*
> *A No.*
> *Q Okay.*
> *A No, of course not.*

Exhibit 32, DDS Director Melissa Weatherton, p. 85.

A. FORSEEABILITY COUNTERBALANCES THE FAULT APPORTIONED DAVIE

Davie's death, the result of vomiting and then choking on his vomit while being restrained on the ground shortly after lunch, was foreseeable to Respondent. There was a great deal of testimony and other evidence submitted that conclusively proves this foreseeability. This

[1] **Exhibit 14**, BHDC Psychological Examiner Mike Alvis, p. 24, p. 29: 20-25, p. 30: 1-10 (*testified that Davie's mental functioning was likely that of a four-year-old's*).

foreseeability, [redacted], counterbalances any potential fault that could be apportioned to Davie, who, again, [redacted]

Respondent knew that physical restraint increased the likelihood of injury to Davie and other clients, and Respondent knew specifically that physical restraints on the ground were even more likely to do so, ***hence the facility's prohibition on their use***.[2] Respondent also had good reason to anticipate that Davie would vomit, given that ***he vomited so frequently following lunch that his pre-vocational trainers at BHDC kept a puke bucket next to his workstation***.[3] Add to this the fact **Respondent did not call 911 until it was too late, because of an inherently dangerous policy forbidding staff to do so**, there should be little, if any, fault apportioned to Davie.[4] [5] And add to this that Sandy Evans, BHDC's own Director of Residential

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[2] **Exhibit 2**, BHDC Staff Development Coordinator Mark Hise, p. 12: 1-22, p. 21: 8-25, p. 22: 1-25 (*There is no on-the-ground personal hold allowed at BHDC*), p. 23: 1-8 (*An on-the-ground personal hold is not an approved NCI method; it should not be done.*), p. 27: 16-25, p. 28: 1-6, p. 32: 9-22 (*Ground restraint is dangerous*), p. 35: 5-17 (*The contact Tyler Mattson made with DC after he was already on the ground was unnecessary*), p. 42: 5-10. Other staff members, including even restraint participant Amy Jones, agreed the ground restraint used on Davie was not allowed. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 35: 14-23 (expressly prohibited from putting a client on the ground for personal restraint); p. 43: 8-18, p. 44: 9-17; **Exhibit 25**, Dr. Syed Hamid, p. 78: 12-24; **Exhibit 20,** BHDC QIDP/Program Manager Justin Jobb Part II, p. 8. Staff are not authorized to hold a client on the ground even where a client puts himself on the ground during an aggressive episode. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 45: 1-9.

[3] **Exhibit 49**, BHDC Prevocational Trainer Rhonda Harris, p. 10, p. 11, p. 13, p. 14.

[4] [redacted] **BHDC policy forbade them from doing so; at BHDC, only medical staff are authorized to call for emergency medical help, while all other staff are only allowed to alert the facility's medical department.** **Exhibit 34**, BHDC First Aid Guidelines – Policy IV-B-10; **Exhibit 6**, BHDC Residential Services Director Sandy Evans, p. 51: 7-25, p. 52: 1-25; **Exhibit 9**, BHDC Staff Tyler Mattson, p. 78: 22-25, p. 79: 1-11 ("I would have like to" been able to call 911 for David); p. 123: 8-17 ("We're not allowed to" call 911); **Exhibit 18**, BHDC Shift Supervisor Amy Jones, p. 57: 9-25 (…it don't really make sense that we couldn't call them [medical department] and then call 9-1-1 as well."), p. 115: 5-17 (wishes she had violated the policy and called 911 right away for Davie); **Exhibit 11**, BHDC LPN Kelly King, p.20: 16-19; **Exhibit 15**, BHDC Social Services Worker Caleb Murry, p. 56; **Exhibit 30**, DRA Advocate Kris Stewart, p. 54: 14-18, p. 65: 22-25, p. 66: 1-22 (everyone she interviewed at BHDC confirmed there was a policy forbidding nonmedical staff from calling 911 in the event a resident has a medical emergency) (Gonyea told her they did not trust staff to recognize a medical emergency, feared 911 might be called unnecessarily), p. 67: 1-10 ; **Exhibit 13**, Former BHDC Staff Don Carter, p. 22: 16-23, p. 23: 9-22 (There were "no exceptions" to the rule), p. 26: 11-25.

[5] **The evidence strongly suggests at least five and maybe as many as ten minutes elapsed between the time Davie began choking and when BHDC called 911.** Exhibit 9, BHDC Staff Tyler Mattson, p. 120: 1-5; Exhibit 10, BHDC Staff Ryann Campos, p. 46: 1-8; Exhibit 13, Former BHDC Staff Don Carter, p. 35: 6-24, p. 36: 1-3; Exhibit 40, Paramedic Samuel Scow, p. 8: 14-21, p. 10: 19-25 (determined, based on the 911 call coming in at 11:37 am, that

Services, and the person who conducted the facility's internal investigation into Davie's death, admitted under oath that ***the restraint was not the least restrictive method available and was in fact a violation of policy that required staff to be retrained***, and it makes it difficult to see how forty percent fault could be apportioned to Davie, [redacted].[6] [7]

If Davie had been standing or seated when he vomited, he would not have choked to death, regardless of what caused the vomiting; he was on the ground when he vomited because staff were holding him on the ground in violation of policy, regardless of how he got to the ground. Staff were not authorized to hold clients on the ground, not trained to do so, and were in violation of policy in doing so. But for these policy violations, Davie would be alive. **It is important to also remember that, under Arkansas law, violation of a statute, ordinance, or regulation is itself evidence of negligence**. ARK. MODEL JURY INSTRUCTION 601; *McMickle v. Griffin*, 369 Ark. 318, 254 S.W.3d 729 (2007).

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it was eight minutes from the time Davie stopped breathing and when the facility called 911); Exhibit 41, Logan County EMS Report.

[6] **Even if this had been an emergency situation, staff were required to use only the "least restrictive" approved method possible.** Exhibit 17, DDS 3011-D (3); Exhibit 5, Federal ICF-IID Reg. § 483.450(b)(1)(iii), [W278], Bates 1754 (the least restrictive appropriate technique possible); Exhibit 5, ICF-IID Reg. § 483.450(b)(4), [W289], Bates 1760; Exhibit 5, ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753; Exhibit 3, BHDC Superintendent Jeff Gonyea, p. 30, p. 37: 5-9; Exhibit 6, BHDC Residential Services Director Sandy Evans, p. 26: 24-25, p. 27: 1-3, p. 34; Exhibit 18, BHDC Shift Supervisor Amy Jones, p. 113: 3-17; Exhibit 19, BHDC Residential Services Manager Carrie Johnson-Miller, p. 43: 17-25, p. 44: 1-4; Exhibit 20, BHDC QIDP/Program Manager Justin Jobb Part II, p. 49, p. 50; Exhibit 21, OLTC Surveyor Dian Elliot, p. 123: 5-12, p. 133: 23-25, p. 134: 1-4; Exhibit 22, Dr. Janice LeBel – Summary of Expert Opinions; Exhibit 37, Dr. Janice LeBel – CV; Exhibit 23, Dr. Janice LeBel Deposition Transcript. BHDC's written policy states: "Emergency Restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors" [emphasis added]. Exhibit 4, BHDC Policy I-D-4 (2)(a).

[7] **Sandy Evans admitted at deposition that the restraint used on Davie at the time of his death was not the least restrictive option available.** Exhibit 6, BHDC Residential Services Director Sandy Evans, p. 50: 1-7, p. 47: 5-25 (they never gave Davie a chance to calm down and collect himself on the ground unrestrained), p. 48: 1-13, p. 49: 11-25 (***it was an inappropriate use in violation of policy, requiring retraining, but in her opinion did not rise to the level of maltreatment***). Amy Jones and Ryann Campos, the two staff members who helped Tyler Mattson perform the restraint, made similar admissions at deposition. Exhibit 18, BHDC Shift Supervisor Amy Jones, p. 115: 5-17 (acknowledging she probably should have made Tyler let Davie up right away); Exhibit 10, BHDC Staff Ryann Campos, p. 80: 17-21, 81: 2-6 ("there were less restrictive ways that the situation could have been handled").

The Commission relied upon *Ethyl Corp. v. Johnson* to support finding it was not foreseeable Davie would vomit while restrained on June 13, 2020. The Court in *Ethyl* held it is not negligent to fail to guard against a danger for which there is no reason to anticipate, or against a danger that is merely possible. 345 Ark. 476, 481, 49 S.W.3d 644, 648 (2001). Obviously, anything is possible, and there must be some knowable reason for guarding against a particular danger before the failure to do so rises to negligence. However, *Ethyl* was also careful to reiterate that it is "**not necessary**, however, **that the actor foresee *the particular injury* that occurred, only that he or she reasonably foresee an appreciable risk of harm to others**." *Id*, at 482, 648 (quoting *Wallace v. Broyles*, 331 Ark. 58, 961 S.W.2d 712, 715 (1998)) (emphasis added). **In other words, if it is reasonably foreseeable that doing a given thing could cause physical harm to a person, it does not matter what particular type of physical harm results.**

Furthermore, the remote danger at issue in *Ethyl* was far different than here. The *Ethyl* plaintiff injured himself while trying to singlehandedly move a 2,000-pound metal trash bin situated at the edge of a parking lot, a parking lot nobody intended or expected him to take his big rig, so that his 18-wheeler could make a U-turn without the rear wheels hitting the bin. *Id*, at 480, 647. Stated *Ethyl*:

> It was not foreseeable that an invitee would injure himself by attempting to manually move the 2,180 pound container on his own. Appellants' only duty under the circumstances was to provide reasonable care to guard against any harm that appeared "likely in the ordinary course of events." *Burns*, 186 Ark. at 925, 56 S.W.2d at 1028. Appellants simply had no duty to take added precautions to guard against the remote chance that someone would injure himself by attempting to move the heavy container. Indeed, it was undisputed that there had never been any previous incidents, within the fourteen years that the container was on Appellants' property, in which anyone, employee or otherwise, had been injured in conjunction with the container.

Id, at 483, 649. Compare that to Davie's case, in which BHDC staff had severely injured clients during restraints in the year before Davie's death. See the 2019 BHDC incident in which a staff

member broke a client's arm during a restraint, and also the BHDC incident in which a staff member choked a client unconscious during a restraint. **Exhibit 32**, DDS Director Melissa Weatherton, p. 67, 68; **Exhibit 50**, 1.31.21 Dem-Gaz Article (also Exhibit 5 to Weatherton deposition). Nobody expects trash bins to cause injury; everybody knows physical restraints often result in injury, and if a person performs one in violation of training and policy and it results in a person's death, that is textbook negligence, if not worse.

It is worth repeating that while negligence requires an appreciable risk of harm to others a reasonably careful person would recognize, "it is **not necessary that the actor foresee the *particular injury* which occurred, only that the actor reasonably foresee *an appreciable risk of harm* to others**" [emphasis added]. *Wallace v. Broyles*, 331 Ark. 58, 961 S.W.2d 712, 715 (1998). Proximate cause in a negligence action may be shown from circumstantial evidence, and such evidence is sufficient to show proximate cause if the facts proved are of such a nature and are so connected and related to each other that the conclusion therefrom may be fairly inferred. *Id.* **In other words, Respondent's foreseeability did not require them to have reason to think Davie would vomit while restrained. Rather, it required only that Respondent be aware that a restraint, and in this case a prohibited ground restraint that violated the facility's own policies, increased the likelihood of harm to the person being restrained.**

It is an incontrovertible truth that Respondent was aware that the use of restraints increased the likelihood of injury; **it's literally stated in their own policy documents**:

> "The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. **The use of restraints is proven to be dangerous for both staff and clients, *with the occurrence of injuries dramatically increasing when restraint is used***. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be

> for emergency use only when ***a very real risk of personal injury or severe property damage is imminent***."

Exhibit 61, BHDC Restraint Incident Debriefing Form (emphasis added).

The DDS Director, Respondent's highest-ranking official to give testimony in this case, testified to being aware that any time a restraint is used there is an increased risk of danger:

> *Q But would you agree with me that it's a goal of your organization to reduce restraints as much as possible?*
> *A Absolutely.*
> *Q And is that because, whenever someone has to be restrained, it increased the risk of danger to that client and to staff and to potentially others?*
> *A Yes.*

Exhibit 32, DDS Director Melissa Weatherton, p. 30.

As previously mentioned, there had been other serious injuries caused by restraints at BHDC just prior to Davie's death. See the 2019 BHDC incident in which a staff member broke a client's arm during a restraint, and also the BHDC incident in which a staff member choked a client unconscious during a restraint. **Exhibit 32**, DDS Director Melissa Weatherton, p. 67, 68; **Exhibit 50**, 1.31.21 Dem-Gaz Article (also Exhibit 5 to Weatherton deposition).

Disability Rights Arkansas published a report in January of 2016 literally titled "*Bound to the Past: The Excessive Use of Restraint at the Booneville Human Development Center*," which revealed, among other things, that restraint use at BHDC was "approximately twenty-five times higher" than at the other four Human Development Centers in Arkansas, that this had already led to injuries, and that it was going to lead to more injuries unless the problem was addressed. **Exhibit 51,** DRA 2016 Report – "*Bound to the Past: The Excessive Use of Restraints at Booneville Human Development Center*." Concluded the report:

> According to the data collected and maintained by Booneville HDC and the State, residents at Booneville live in an environment in which restraint is used excessively, far more frequently than at the Arkadelphia, Jonesboro, or Warren HDCs. **Booneville HDC fails to ensure that staff utilize effective tools to de-escalate**

> **situations, leading to the use of restraints when other interventions, if implemented sooner, could eliminate the need for restraint. The Department of Human Services and its Division of Developmental Disabilities Services has failed to provide the oversight and training to ensure that residents at Booneville HDC are not subjected to unnecessary and excessive restraints. Residents and staff have already been injured due to the current restraint practice at Booneville HDC.**
>
> All HDC residents are entitled to live in an environment in which restraints are used as a last resort after other interventions have failed. The residents at Booneville HDC have a right to be treated with dignity and respect, to not be subjected to unnecessary and harmful restraint, and to receive active treatment based on evidence-based best practices. **DRA urges the State to take immediate action to address the culture at Booneville HDC and to instruct Booneville HDC to stop this inherently dangerous practice.** The individuals with disabilities residing at Booneville HDC deserve better.

Exhibit 51, DRA 2016 Report – "*Bound to the Past: The Excessive Use of Restraints at Booneville Human Development Center*," p. 13 (emphasis added). This report was published four years prior to Davie's death, Respondent ignored it, and Davie died as a result. The Commission, in its Order, noted that 187 behavioral incidents requiring restraint had occurred prior to Davie's death, which understandably suggested to the Commission that Davie was the problem, but these 187 restraint incidents are actually much more indicative of BHDC's overreliance on and unnecessary use of physical restraints, failure to utilize non-violent de-escalation techniques, and Respondent's failures in training and oversight for BHDC staff – all the things identified by Disability Rights Arkansas in "*Bound to the Past: The Excessive Use of Restraints at Booneville Human Development Center*." Recall that Davie never injured anyone at BHDC.[8]

[8] Davie was not dangerous. Davie never caused injury to anyone at BHDC. Exhibit 2, BHDC Staff Development Coordinator Mark Hise, p. 50, p. 52; Exhibit 9, BHDC Staff Tyler Mattson, p. 66; Exhibit 10, BHDC Staff Ryann Campos, p. 49; Exhibit 11, BHDC LPN Kelly King, p. 7, p. 10; Exhibit 12, BHDC LPN Amanda Schmitt, p. 22, p. 24, p. 28; Exhibit 13, Former BHDC Staff Don Carter, p. 8; Exhibit 14, BHDC Psychological Examiner Mike Alvis, p. 59; Exhibit 15, BHDC Social Services Worker Caleb Murry, p. 28; Exhibit 16, Claimant Christine McAuliffe, p. 21, 22.

RESPONDENT KNEW DAVIE WAS A VOMIT RISK

All of this notwithstanding, it actually **was foreseeable to Respondent that *this particular injury* could occur**, because they knew Davie vomited nearly every day, particularly after lunch. Respondent knew that Davie was highly prone to vomiting, particularly after lunch. [redacted].[9] [redacted].

Rhonda Harris was Davie's Prevocational Trainer (work supervisor) at BHDC, working with him nearly every afternoon for at least five years prior to this death. **Exhibit 49**, BHDC Prevocational Trainer Rhonda Harris, p. 5, 6, 19. Rhonda Harris's testimony, as seen below, firmly establishes that it was much more than a mere possibility Davie would vomit right after lunch during a ground restraint. Harris testified that everyone who worked there knew Davie had [redacted] and knew to keep him facedown when restraining him on the ground:

> *Q And that's specifically because he was a known vomiting threat?*
> *A. Yes. He had medical issues going on. I still to this day don't know if the nurses ever found out what exactly was wrong with him**, but everybody that worked around him knew that, you know, so you always – we always -- where I worked, you know, we had the understanding, you know, if you ever took him down, make sure he was face down. That way if he started to, you know, vomit** -- because I don't know -- at first, we thought he just was like -- you know, he could do it, you know, on his own, like*

[9] **By holding Davie down on the ground just after his lunch, BHDC staff ignored Davie's known** [redacted]. Exhibit 46, Physician Orders at Discharge 6.19.20; Exhibit 47, Physician Orders 6.1.20; Exhibit 48 Physician Orders 3.1.19. [redacted] See Exhibit 43, "Prevention of Choking and Aspiration" – New York Office of People with Developmental Disabilities, pgs. 3-4. This is noteworthy because Respondent's expert witness, Dr. Kastner, was recently the head of this office in New York, under former Governor Andrew Cuomo; some of Dr. Kastner's expert opinions in this case are in direct conflict with the contents of this document [redacted].

just make himself throw up, but then it's become like it happened, you know, regularly, you know, where we were constantly calling the nurses, you know, or medical to have them come evaluate him because that's not normal, you know, for anybody to do.

Exhibit 49, BHDC Prevocational Trainer Rhonda Harris, p. 9, 10. **Harris testified that everyone who worked with Davie was well aware of how often he vomited**:

Q So everybody that was accustomed to David or had been around David and knew David was aware that there was a risk of him vomiting?
A Yes
Q I think you said at first, you know, you couldn't tell if he was doing this on purpose.
A Yeah, purposefully or not, but, you know, as time went on, you know, and it continued -- and I'm telling you it was months, you know, of this, that he was doing this. They sent him to the doctor, you know, to have tests run and stuff like that, you know, to figure out what was causing him.
Q You eventually determined that this is more likely some sort of medical thing that's going on with him?
A Yeah, because anytime he would drink red – you know, anything with red in it, he would throw up. You know, within a little bit after that, he would be vomiting.

Id, p. 10, 11. Harris testified that Davie was **vomiting three or four times a week** and that it **always happened right after lunch:**

I mean, this went on for a while before -- we just got to where we would call them every single day, you know, because, I mean, it turned into at least three, sometimes four times a week that he would throw up because we would always get him after he had just freshly ate lunch, you know.

Id, p. 13, 22. Harris testified that **Davie vomited so much they kept a trash can right next to him at his job, as his own vomit bucket**:

You know, we always gave him a trash can beside him. You know, that way if he needed to throw up, he – you know, we always told him here's your trash can.

Id, p. 14. **All the direct care staff would have been aware of this risk**:

Q Would all the direct care staff that had been there for any length of time and spent time with him directly -- would all of them have been aware of this, the vomit risk?
A Yeah.

Id, p. 14. Furthermore, **written warnings about Davie's vomit risk were sent out to all staff**:

> *Q Do you know if there was ever any formal or written or any form of notification provided to all*
> *staff warning them of this issue with David, this vomiting issue with David?*
> *A Yeah, they sent out e-mails and memos, like we get memos, you know, and e-mails that goes to like my supervisor. When we come in the morning, he would have them laid out on the table, you know, and everybody has to initial it. You know, all the staff that works in that area, you know, we all had to initial at the bottom, you know, that we read, you know, the memo of what it was.*
> *Q Those were e-mails that would come from supervisors?*
> *A No, like medical. You know, on something like that, medical. Like Stacy would send out an e-mail,*
> *you know, to all the supervisors, you know, and then the supervisors would make sure that all their staff, you know, read it and then you initialed it at the bottom, you know, letting them know that you read it, so you were aware.*
> *Q Do you recall there being a memo from Stacy on this issue that we're talking about?*
> *A Yeah, I believe there was.*

Id, p. 23, 24. Harris testified she specifically recalled discussing the vomiting issue with several nurses prior to Davie's death, including Amanda Schmidt, Kelly King, Deborah Noah, and Stacy Weinbrenner. ***Id***, p. 16. The vomiting occurred nearly every day, according to Harris, but was not taken seriously by the nurses:

> [redacted]
> *And they would say it was a behavior.*

Id, p. 18.

Other BHDC staff members also testified to [redacted]

[redacted] Nurse Amanda Schmitt testified to this:

> *And, when David would have a behavior, he would often vomit. That was sometimes the whole of his behavior. Sometimes he would become upset and just vomit and then start to cry.* ***It wasn't always a violent outburst. But he did vomit during times of stress often.*** ***And I believe very strongly that that's what happened, that he had a behavior, he was being restrained, and he -- he vomited.***

Exhibit 12, Nurse Amanda Schmitt, p. 61. Carrie Johnson-Miller, the Residential Services Manager, also testified that Davie had an issue with vomiting when he got upset during a behavior episode. **Exhibit 19**, Carrie Johnson-Miller, p. 45. Even Respondent's own expert witness commented on the frequency with which Davie was vomiting when upset:

[redacted]

Dr. Kastner Written Report Pt. 1, p. 21.

B. [redacted]

The analysis for attributing fault must look at how a reasonably careful person of David's maturity and intelligence would act under the circumstances, not how an adult would act. The standard of care for a minor is fixed by "the maturity and capacity of the child, and this is to be determined in each case by the circumstances of that case." *Garrison v. St. Louis, I. M. & S. Ry. Co.*, 92 Ark. 437, 443, 123 S.W. 657, 660 (1909).

A minor is not held to the same standard of care as an adult. "**Ordinary care," with respect to a minor, means that degree of care which a reasonably careful minor of his age and intelligence would use under circumstances similar to those shown by the evidence in the case.** ARK. MODEL JURY INSTRUCTION 304. In *Garrison v. St. Louis, I.M. & S. RY. CO.,* where a 16-year-old boy known to be of "inferior intelligence" was injured by an oncoming train while trying to drive his wagon across the tracks, the Arkansas Supreme Court made clear that what is contributory negligence for an adult is not the same for a minor:

> The standard for judging the conduct of minor is not the care and prudence that would be exercised by an adult, but only that of one of his age, intelligence, and discretion; and it cannot be said as a matter of law that a minor is guilty of contributory negligence under circumstances that would declare an adult to be guilty of such negligence.

92 Ark. 437, 443 123 S.W. 657, 660 (1909). The Court in *Garrison*, citing with approval the Supreme Court of Georgia, noted that it is capacity, not necessarily age, that matters:

> **Capacity is the main thing. Age is of no significance except as a mark or sign of capacity**. The study of these and other like cases will lead to two conclusions: First, that no court can hold that childhood and manhood are bound to observe the same degree of diligence; secondly, that, while the same ordinary care is frequently applied to the diligence exacted by law of a child, there is little propriety in so doing. Due care is always the better and more accurate description. Due care on the part of the boy might fall far short of that of a prudent man.

Id.

Davie's own fault appears to have been improperly analyzed by holding him to the same standard as that of adults, which is not true except in situations where children are engaging in an inherently dangerous activity, like driving a car or operating heavy machinery. His fault must be

analyzed by comparing what Davie did with what a child of [redacted] would do under the same circumstances.[10] **Therefore, the question is whether it would be negligent for [redacted] to become upset and then move towards an adult in an aggressive manner. And if such an act would indeed be negligence for [redacted] is it of such an extreme degree of negligence as to make that [redacted] forty percent responsible for his own death?**

Lastly, the Commission did find in this case that Respondent failed to have a plan in place to manage Davie's behavior, which is true. However, Davie was not in any way responsible for his own behavior plan. Given that, is it still fair to say he is forty percent at fault for his death?

II. LOSS OF LIFE DAMAGES

1. The value placed by the Commission on David Cains' "Loss of Life" damages was too low, relative to the evidence presented and relative to prior valuations by the Commission on claims for "loss of life."

"Loss-of-life" damages are those that would compensate a decedent for the loss of the value that a decedent would have placed on his or her own life. *Durham v. Marberry*, 356 Ark. 481, 492, 156 S.W.3d 242, 248 (2004). It is an inherently subjective element of damages, to be measured from the point of view of the decedent, to the extent the decedent's point of view on this matter can be proved after his death. Loss-of-life damages are a separate and independent element in addition to all other elements of damage already allowed by law. *Id*; ARK. CODE ANN. § 16-62-101(b). "Loss-of-life" damages are awarded to compensate the decedent's estate

[10] **Exhibit 14**, BHDC Psychological Examiner Mike Alvis, p. 24, p. 29: 20-25, p. 30: 1-10 (*testified that Davie's mental functioning was likely that of a four-year-old's*).

for the destruction of the decedent's capacity to carry on and enjoy life's activities in a way he would have done had he lived. See *Durham*, at 491, 247. An estate seeking "loss-of-life" damages must present some evidence that the decedent valued his or her life, from which a jury could infer and derive that value and on which it could base an award of damages. *One Nat. Bank v. Pope*, 372 Ark. 208, 214, 272 S.W.3d 98, 102 (2008). Circumstantial evidence is all that is required. *Id*, at 214, 103.

Another component of loss-of-life damages that can potentially be taken into consideration is the decedent's lost earning capacity, but only where damages for the decedent's lost earning capacity is not also awarded to surviving beneficiaries as wrongful death compensation. See *Durham*, at 491, 247.

Here, Claimant presented substantial direct evidence in addition to circumstantial evidence in support of the fact that Davie's life held great value to him, and that his untimely death deprived him of happy and joyous experiences that, based on substantial witness testimony, we can be reasonably certain he would have experienced had he survived. Davie had [redacted]. **Exhibit 14**, BHDC Psychological Examiner Mike Alvis, p. 24, p. 29: 20-25, p. 30: 1-10. From his point of view, the things that brought him joy, like Halloween and music, were every bit as meaningful as things like money or a romantic relationship might be to a [redacted] And because "loss of life" damages by their very nature require subjectivity, it is entirely appropriate to analyze the value Davie placed on his own life from a subjective viewpoint relative to his intellectual age – [redacted].

Claimant presented evidence proving Davie experienced incredible joy from those things a typical [redacted] loves, including family, friends, music, food, laughter, and holidays, particularly Halloween and Christmas. Christmas was his favorite; he still believed in Santa

Claus and every Christmas Eve he would fall asleep next to the tree in his mother's home waiting for Santa to arrive with his presents.

An award of only $350,000.00 suggests that the value of his life was not analyzed, subjectively, from the point of view of a [redacted] but rather from the perspective of the [redacted] and how he might value his life, which is an objective approach. In other words, had Davie been a [redacted], who also happened to live in the Booneville Human Development Center (BHDC) under the same external circumstances, then $350,000.00 might be an appropriate value. But **Davie was [redacted] who experienced joy just as intensely from listening to the Monkees or playing with toys or having MacDonald's for lunch as [redacted] ty might from a romantic encounter or from winning a large sum of money at a casino**.

Just last year, in *Brown, et al. v. Arkansas Department of Transportation*, Claim No. 200809 (2022), this Commission awarded $2,500,000.00 in loss-of-life damages to a young man tragically killed in a car crash: "Additionally, considering the persuasive testimony of the Decedent's family members regarding how the Decedent valued his life, the Claims Commission finds that the damages associated with the Decedent's loss of life are $2,500,000.00." *Brown*, p. 37.

Like the present matter, the *Brown* Commission heard evidence that Mr. Brown valued his life. This included testimony from Mr. Brown's mother that her son was well-liked and a good student. *Brown*, p. 5. Here, Claimant also submitted evidence that Davie was well-liked, not just by his family but by people at the BHDC. For example, one of the facility's nurses testified to this:

> But he was -- he was such a fun guy. He played the tambourine and loved the Monkees. And he had a Mr. Potato Head. That was kind of mine and his thing, is he had this Mr. Potato Head and I'd always tell him I was going to take the eyes from his Mr. Potato Head and put it where the nose goes and the nose where the eyes go; and he would just get like all kinds of excited about it. And he moved it on a top shelf to show me that I couldn't reach it to move his eyes. And he was -- he was a really cool guy. We had a pretty good relationship.

Exhibit 12, Nurse Amanda Schmitt, p. 22.

> Kelly King and I were probably the two nurses that were the closest to David. He -- he'd always say Kelly's a big fat witch; and she's like this little bitty, tiny, skinny thing. And so I taught him to say that Kelly's a big fat witch and Amanda's a pretty, pretty princess. I mean, like we played with him. We had a good relationship with him. And he was -- ***he was one we were especially close to.***

Exhibit 12, Nurse Amanda Schmitt, p. 59 (emphasis added).

Unlike here, the *Brown* Commission also heard expert testimony evidencing the decedent's lost earning capacity, and the Commission noted that the $2,500,000.00 loss-of-life award, which was, ostensibly, based on persuasive testimony from family members regarding how decedent valued his life, was consistent with that expert's conclusions. *Brown*, p. 37. Claimant in the present matter, for obvious reasons, did not seek damages related to Davie's lost earning capacity. [That notwithstanding, Claimant did present uncontroverted testimony that Davie worked a few hours most days in the BHDC recycling center tearing books, for which he earned nominal wages. **Exhibit 16**, Christine McAuliffe, p. 50.]

Claimant is not suggesting the Commissioners should be required to forfeit common sense. And Claimant is certainly not suggesting that all deaths caused by the state must be valued identically. Clearly, the *Brown* decedent's life was very different from Davie's. That young man's earning potential greatly outweighed Davie's, and, objectively speaking, that young man was likely to have enjoyed a fuller life than Davie could have hoped for, at least in terms of what most adults of normal intellectual functioning would value. <u>But the *Brown* decedent's</u>

award of $2,500,000.00 is *more than seven times* the $350,000.00 awarded Davie. That disparity is extreme, particularly given that this particular element of damages must be analyzed from the subjective point of view of the decedent. It also sends a devastating and potentially dangerous message to Arkansas' intellectually disabled citizens. In *Yang, et al. v. Arkansas Department of Emergency Management*, Claim No. 16-0496-CC (2020), this Commission included in its Order this statement: "**The Claims Commission is the conscience of the State of Arkansas.**" *Yang*, p. 3.

No, Davie was not going to ever get married and have children. No, he was never going to earn a high income. No, he was never going to support another person financially. No, he was never going read Dostoyevsky and he was never going to understand quantum physics.

However, for the same reasons, Davie existed largely unburdened by things like pride, ego, greed, lust, depression, existential dread, crises of faith, the nature of his existence, or the inherent terror of an unknowable future that plagues most of us to some degree in our daily lives.

But he absolutely did experience love and joy, and in their purest forms, as perhaps only small children can. We all know that little spark of joy when we turn on our car and our favorite song is playing on the radio. Davie knew that feeling, experienced the joy that comes from that every time he put on his headphones to listen to the Monkees sing "Last Train to Clarksville."

We all know the joy we feel when we see one of the people we love most in the world after an absence. Davie knew that feeling well. He experienced it every single day when he encountered any of the people who he loved and cared about, and there were many, as shown by the evidence. Davie knew laughter. He knew it better than most of us because more things and simpler things made him laugh. We all remember being a kid a Christmas or seeing our own children at Christmas, that pure, unbridled joy on Christmas Eve knowing that when they wake

up Santa will have left them something special. Davie experienced Christmas in a way only small children can every year of his life up until his death at 42.

From Davie's [redacted] perspective, subjectively, his life was worth all the money in the world. The following is only a portion of the evidence presented to the Commission in support of how much Davie valued his own life:

> *"Throughout his life he always participated in Special Olympics, and actually one of the last years that he was there, it's one of my favorite memories of him, I didn't tell him I was coming, it was at the Booneville High School. And because if I couldn't make it, I didn't want him to be upset. So, I get there and I'm in the stands, and I don't know how he saw me, but in the middle of the field, somehow he saw me and yelled, '"Yeehaw,"' like he was taking a hat off, which he didn't have on. And he said, '"There's my sister, there's my sister."' He yelled it. But so, it was just really funny."* **Exhibit 16**, Christine McAuliffe, p. 116.

> *"But that particular year is the only time I remember he actually won a race. And I have a picture of that. It's one of my favorite ones, because he came up to me afterwards and he was so proud. And he said, "Look, did you see me, Chrissie, I ran fast as hell." And I mean, he was just -- but like I said, his whole life, he was in his 30s and he – you know, he participated, but he never -- you know, he wasn't really good at it."* **Exhibit 16**, Christine McAuliffe, p. 117. *"That's probably one of my favorite memories, just because he was so happy and so proud of himself. Because he literally never, I don't think ever, won anything."* **Exhibit 16**, Christine McAuliffe, p. 117.

> *"David likes his job and takes great pride in working and talking about his work and earning money. David does want to be around his family, including his mother, his sister Chrissie, his half-sister Ashley, his uncle Patrick, and his grandparents. David does not like to be alone; he is very engaging with others and gets along with most of his peers.* ***David wants to have friends and spend time with them and go places with them.*** *(He expressed that even though he liked picking up trash when he lived on the campgrounds, he likes going to the movies with his friends at BHDC.) David likes to have his own possessions around him and he likes to have new and clean clothing. He has been very happy at BHDC and would like to stay here."* **BHDC Social History, p. 7.**

> Davie was a wonderful guy, a wonderful person, and fun to be around. **Exhibit 10, Ryann Campos, p. 65.**

> Davie was funny and playful. **Exhibit 11, Kelly King, p. 6.**

But, a lot of times, I remember specifically with him, he'd be listening and dancing and singing to the Monkees -- **Exhibit 20, Justin Jobb II, p. 62.**

A He just -- he loved music. Everybody that has been around him for five minutes knows he loved the Monkees, because he would listen to it 24/7 every day. That's not even an exaggeration. I'm sure the people at Booneville would tell you that. But, you know, ever since he was a little kid--
Q And how did he come to love the Monkees? Being, you know, born in the late '70s, he was -- the Monkees were around in the '60s. How did he discover the Monkees?
A Me and my brother, when we were kids, we watched Nick At Nite all the time. We didn't-- you know, that's about all we watched. So, I remember me and him, we watched things like I Love Lucy, The Monkees, Leave It To Beaver, those types of shows. And for whatever reason, he just -- he just latched onto the Monkees and the rest is -- you know, he never stopped. **Exhibit 16, Christine McAuliffe, p. 122-123.**

He had Monkees CDs, tapes, vinyl records, DVDs. His two favorite tracks were "Not Your Stepping Stone" and "Last Train to Clarksville." **Exhibit 16, Christine McAuliffe, p. 123.**

And actually, thankfully, I have a few videos of him, he would play tambourine, and he had some maracas I had gotten him from Central America, and I actually have a few videos of him playing those, and one of my friends playing them with him, which he did all the time, you know. **Exhibit 16, Christine McAuliffe, p. 123.**

He loved the Dukes of Hazzard. He had the DVDs and he would watch on repeat, except for the one season when Bo and Luke were replaced by Coy and Vance. He really didn't like that. **Exhibit 16, Christine McAuliffe, p. 124.**

"Yeah. So, I mean, he loved music, he loved, you know, DVDs, watching TV, he loved food, he loved --really, he loved -- he was very social. **He loved making people laugh and being around people. He didn't like being alone, he didn't like silence.** He just -- I don't know. He just -- he loved those things, he loved being a part of something, you know. I feel like, you know, being part of - - he had friends. I don't know how to explain it." **Exhibit 16, Christine McAuliffe, p. 124-125.**

CONCLUSION

This specific harm that resulted in Davie's life was abundantly foreseeable to Respondent. But it was not foreseeable to Davie Cains, [redacted] Given this, it seems harsh to hold Davie forty percent at fault for his death.

Davie valued his own life more than $350,000.00. He loved life, and it was taken away from him from him by Respondent's overwhelmingly negligent actions.

Claimant, for the reasons stated herein, respectfully asks this Honorable Commission to reconsider its findings as they pertain to apportionment of fault and loss-of-life damages.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
Green & Gillispie Law Firm
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
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jdgillispie@greenandgillispie.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 29th day of August, 2023, and service shall be accomplished via email to counsel of record.

/s/__Joshua D. Gillispie___
Joshua D. Gillispie

From:	Daiquiri Carter
To:	ASCC Pleadings; josh@greenandgillispie.com; Abbey Trussell
Cc:	Daiquiri Carter
Subject:	CC # 220374
Date:	Friday, September 8, 2023 2:44:41 PM
Attachments:	Response to Mtn for Recon_McAuliffe v DHS CC 220374.pdf image001.png image002.png Entry of Appearance_McAuliffe v DHS CC 220374.pdf

Please find attached Respondent's Response to Claimant's Motion for Reconsideration. Also attached is Abbey Trussell's Entry of Appearance. I have copied Claimant's attorney on this email.

Thank you,

Daiquiri D. Carter, M.Ed.
Legal Services Specialist
Office of Chief Counsel
PO Box 1437, Slot S260
Little Rock, AR 72203-1437
501-320-6338 phone
501-682-6720 fax
Daiquiri.carter@dhs.arkansas.gov





NOTE - This email may contain sensitive or confidential information.

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BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINSTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

V. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

ENTRY OF APPEARANCE

Comes now the undersigned, Abbey Trussell, and enters her appearance as attorney of record for Respondent, Arkansas Department of Human Services.

Respectfully Submitted,

Arkansas Department of Human Services
Office of Chief Counsel

/s/ Abbey Trussell
Abbey Trussell, AR Bar No. 2020235
P.O. Box 1437, Slot S260
Little Rock, AR 72203
P: (501) 534-4149
F: (501) 682-6720
abbey.trussell@dhs.arkansas.gov

CERTIFICATE OF SERVICE

I, undersigned, do hereby certify that on September 8, 2023 a true and correct copy of the foregoing was sent via email to the following:

Joshua D. Gillespie, Esquire
Green & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, AR 72214
josh@greenandgillispie.com

/s/ Abbey Trussell
Abbey Trussell

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINSTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

V. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

RESPONSE TO MOTION FOR RECONSIDERATION AND BRIEF IN SUPPORT

Comes now Respondent, Arkansas Department of Human Services (hereinafter "DHS"), by and through its counsel, Abbey Trussell, and for its Response to Claimant's Motion for Reconsideration states as follows:

1. This matter was heard on March 9, 2023 and the Commission entered its Order on July 21, 2023.

2. Notwithstanding extensive discovery, many depositions, thousands of pages of documentation, lengthy briefs by both parties, and a determination in Claimant's favor, Claimant now seeks Reconsideration by the Commission.

3. Arkansas State Claims Commission Rule 7.1 states,

> **Petitions for Re-Hearing and/or Motions for Reconsideration will only be entertained if they set forth new or additional evidence which was not available to the moving party at the time of the scheduled hearing.** Such petitions for Re-Hearing or Motions for Reconsideration shall be filed with the Commission within 40 days from the date of the assumed receipt by parties to the claim of the Commission's findings and determinations. No claim which was contested at hearing and requires subsequent action by the General Assembly will be forward to that body within the aforementioned 40 day period without the written approval of the Claimant(s) and Respondent(s).

Rule 7.1 Re-Hearing/Reconsideration. **Emphasis added**. As stated in the relevant Rule, to prevail on a Motion for Reconsideration, Claimant must assert that there is new or additional evidence which was unavailable to her at the time of hearing.

4. In Claimant's Motion for Reconsideration, she states that her Motion "seeks to respectfully address two specific findings: (1) the apportionment of 40% fault to David Cains, and (2) the $350,000.00 award for damages associated with David Cains' 'loss of life.'" The Motion and Brief in Support then proceeds only to argue that the Commission erred in its determinations. This is not an assertion that there is new or additional evidence not available to her at the time of the scheduled hearing.

5. A Motion for Reconsideration is not proper where Claimant seeks only to reformat her argument in hopes for a better outcome. The Motion and Brief in Support submitted by Claimant cites only to evidence that was available to her at the time of hearing on March 9, 2023; in fact, Claimant's evidentiary citations in her Motion and Brief in Support are exclusively to Exhibits introduced by the parties at hearing. Claimant does not contend that there is new testimony available, nor does Claimant contend that there is new documentary evidence available. Claimant only asserts that the Commission erred in making the determination it did after arguments and when considering all the available evidence. A new or reformatted argument based on the same evidence is not the purpose of Reconsideration or Re-Hearing under Rule 7.1. Both Claimant and Respondent were afforded the opportunity to fully argue their side of the issue before the Commission on March 9, 2023. A Motion for Reconsideration to obtain a second chance at arguments is improper under the relevant Rules.

6. At no point in Claimant's Motion for Reconsideration does she assert that there is new or additional evidence, nor does Claimant cite to any evidence not previously available to the

Commission or to the parties. Instead, Claimant has written a twenty-one page brief that attempts to re-litigate the matter with no new or additional evidence. Claimant's dissatisfaction or disagreement with the outcome is irrelevant. **Disagreement with the findings and determinations of the Commission and the amounts awarded by the Commission is <u>not</u> grounds for Reconsideration under Rule 7.1.**

7. While Respondent DHS disagrees with the ultimate outcome due the lack of proximate cause and foreseeability, DHS respects the decision of this Commission and its Rules by which all parties are bound. There is no new or additional evidence that was unavailable to the parties at the time of hearing and therefore there are no grounds for reconsideration or re-hearing under Arkansas State Claims Commission Rule 7.1.

8. A reformatted or redone argument is not new or additional evidence. Claimant has not presented any new evidence, nor has Claimant even asserted that new or additional evidence exists.

WHEREFORE, for the reasons stated herein, Respondent DHS respectfully requests that the Commission deny Claimant's Motion for Reconsideration.

Respectfully Submitted,

Arkansas Department of Human Services
Office of Chief Counsel

/s/ Abbey Trussell
Abbey Trussell, AR Bar No. 2020235
P.O. Box 1437, Slot S260
Little Rock, AR 72203
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F: (501) 682-6720
abbey.trussell@dhs.arkansas.gov

CERTIFICATE OF SERVICE

I, undersigned, do hereby certify that on September 8, 2023 a true and correct copy of the foregoing was sent via email to the following:

Joshua D. Gillespie, Esquire
Green & Gillespie
1 Riverfront Place, Suite 605
North Little Rock, AR 72214
josh@greenandgillispie.com

/s/ Abbey Trussell
Abbey Trussell

From: Joshua Gillispie
To: ASCC Pleadings
Cc: Kathryn Irby; Abbey Trussell; Daiquiri Carter
Subject: Re: McAuliffe v. DHS, Claim No. 220374
Date: Monday, September 11, 2023 2:31:35 PM
Attachments: Reply on Claimant"s Motion for Reconsideration.pdf

---

Dear Commission:

Please find Claimant's *Reply* to Respondent's Response to her Motion for Reconsideration.

Best Regards,

Josh

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Tue, Aug 29, 2023 at 10:57 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Dear Claims Commission:
>
> Please find attached Claimant's Motion for Reconsideration.
>
> Best Regards,
>
> Josh Gillispie
>
> Joshua D. Gillispie
> 1 Riverfront Place, Suite 605
> North Little Rock, AR 72114
> (501) 244-0700
> (501) 244-2020 fax
> www.greenandgillispie.com

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains	**CLAIMANT**
V.	**Claim No. 220374**
THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)	**RESPONDENT**

REPLY TO RESPONDENT'S RESPONSE TO CLAIMANT'S MOTION FOR RECONSIDERATION

COMES NOW Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Reply, submits the following:

Respondent is correct that Claimant's Motion for Reconsideration does not set forth new or additional evidence which was not available at the time of hearing. However, to the best of Claimant's knowledge, no Rule of Practice and Procedure or Arkansas statute denies the Commission the discretion to consider Claimant's Motion if it so chooses. In fact, Rule 1.2 of the *General Rules of Practice and Procedure Before the Arkansas State Claims Commission* states the Commission's rules, including Rule 7.1, are to be **liberally construed**: "**These rules and regulations shall be liberally construed to secure a** simple, **just** and expeditious method for the consideration of claims against the State that because of the provisions of Article 5, Section 20 of the State Constitution cannot be determined in the regular courts of the State; and to provide for proceedings in which the State has a special interest" (emphasis added).

The enormous amount of evidence submitted in this case, combined with the understandably limited time that could be afforded Claimant at the hearing, created for the Commissioners a herculean task. Claimant again sincerely thanks each of them for their time and consideration. Her Motion for Reconsideration humbly asks the Commissioners to

reconsider two issues, apportionment of fault and loss-of-life damages, while taking into consideration important evidence that might, *understandably*, have been lost in the shuffle, given the *unusual amount* of evidence and documentation submitted.

Claimant, therefore, humbly begs to the Commission to exercise its discretion and to consider her Motion for Reconsideration.

Respectfully submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar #2010131
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North Little Rock, AR 72114
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 11th day of September, 2023, and service shall be accomplished via email to counsel of record.

/s/__Joshua D. Gillispie___
Joshua D. Gillispie

From:	Kathryn Irby
To:	Joshua Gillispie
Cc:	OCC Claims Commission Cases; Abbey Trussell; Daiquiri Carter
Subject:	HEARING SCHEDULED: McAuliffe v. DHS, Claim No. 220374
Date:	Thursday, October 5, 2023 12:16:00 PM
Attachments:	McAuliffe v. DHS -- 220374 -- hearing ltr.pdf

Mr. Gillispie and Ms. Trussell, please see attached hearing letter and Zoom invitation.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

ARKANSAS STATE CLAIMS COMMISSION

(501) 682-1619
FAX (501) 682-2823

KATHRYN IRBY
DIRECTOR

101 EAST CAPITOL AVENUE
SUITE 410
LITTLE ROCK, ARKANSAS
72201-3823

October 5, 2023

Mr. Joshua D. Gillispie (*via email*)
Green & Gillispie Law Firm
1 Riverfront Place, Suite 605
North Little Rock, Arkansas 72114

Ms. Abbey Trussell (*via email*)
Arkansas Department of Human Services
Post Office Box 1437
Little Rock, Arkansas 72203

RE: ***Christine McAuliffe, as special administrator of the Estate of David Cains v. Arkansas Department of Human Services***
Claim No. 220374

Dear Mr. Gillispie and Ms. Trussell,

The Commission has scheduled a hearing on Mr. Gillispie's motion for reconsideration for **Friday, February 23, 2024**, beginning at 9:00 a.m. All parties will attend virtually via Zoom. The Zoom invitation is enclosed herein.

As this is a motion hearing, no prehearing materials are requested.

If you have any questions, please do not hesitate to contact my office.

Sincerely,

Kathryn Irby

ES: kmirby

Kathryn Irby -- Claims Commission is inviting you to a scheduled Zoom meeting.

Topic: Claims Commission -- hearings
Time: Feb 23, 2024 09:00 AM Central Time (US and Canada)

Join Zoom Meeting
https://us06web.zoom.us/j/82875819369?pwd=sAx2mzuxWUxcBcDIqyfpWzDupBsI6k.1

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Passcode: 2bnrVV

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Dial by your location
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• +1 646 931 3860 US
• +1 929 436 2866 US (New York)
• +1 301 715 8592 US (Washington DC)
• +1 305 224 1968 US
• +1 309 205 3325 US
• +1 689 278 1000 US
• +1 719 359 4580 US
• +1 253 205 0468 US
• +1 253 215 8782 US (Tacoma)
• +1 346 248 7799 US (Houston)
• +1 360 209 5623 US
• +1 386 347 5053 US
• +1 507 473 4847 US
• +1 564 217 2000 US
• +1 669 444 9171 US
• +1 669 900 6833 US (San Jose)

Meeting ID: 828 7581 9369
Passcode: 978668

Find your local number: https://us06web.zoom.us/u/kee3X5Hij7

From: Joshua Gillispie
To: Kathryn Irby
Cc: Joshua Gillispie; OCC Claims Commission Cases; Abbey Trussell; Daiquiri Carter
Subject: Re: HEARING SCHEDULED: McAuliffe v. DHS, Claim No. 220374
Date: Thursday, October 5, 2023 12:26:02 PM

You don't often get email from josh@gillispielawfirm.com. Learn why this is important

Received. Thanks.

Joshua D. Gillispie

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On Thu, Oct 5, 2023 at 12:16 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie and Ms. Trussell, please see attached hearing letter and Zoom invitation.
>
> Thanks,
>
> Kathryn Irby
>
> **Kathryn Irby**
>
> **Arkansas State Claims Commission**
>
> 101 East Capitol Avenue, Suite 410
>
> Little Rock, Arkansas 72201
>
> (501) 682-2822

From: Joshua Gillispie
To: Kathryn Irby
Cc: Joshua Gillispie; OCC Claims Commission Cases; Abbey Trussell; Daiquiri Carter
Subject: Re: HEARING RESCHEDULED: McAuliffe v. DHS, Claim No. 220374
Date: Tuesday, February 20, 2024 10:35:03 PM

You don't often get email from josh@gillispielawfirm.com. Learn why this is important

Thank you, Kathryn. We will be ready.

Joshua D. Gillispie

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North Little Rock, AR 72114
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(501) 244-2020 fax
https://gillispielawfirm.com/

On Tue, Feb 20, 2024 at 1:49 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> **Josh**, thanks for this information.
>
> **Josh and Abbey**, please see the new Zoom invitation below. There are two, maybe three, matters being rescheduled for March 1. I think this one can be heard first, though.
>
> Thanks,
>
> Kathryn
>
> Kathryn Irby -- Claims Commission is inviting you to a scheduled Zoom meeting.
>
> Topic: Hearings
>
> Time: Mar 1, 2024 12:00 PM Central Time (US and Canada)

Join Zoom Meeting

https://us06web.zoom.us/j/81455874969?pwd=axA0lk8n5OUZ6IgTp4iKB3CZ3K1oGO.1

Meeting ID: 814 5587 4969

Passcode: kbe7x4

One tap mobile

+13126266799,,81455874969#,,,,*111734# US (Chicago)

+16469313860,,81455874969#,,,,*111734# US

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• +1 301 715 8592 US (Washington DC)

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• +1 309 205 3325 US

• +1 386 347 5053 US

• +1 507 473 4847 US

• +1 564 217 2000 US

• +1 669 444 9171 US

• +1 669 900 6833 US (San Jose)

• +1 689 278 1000 US

• +1 719 359 4580 US

• +1 253 205 0468 US

• +1 253 215 8782 US (Tacoma)

• +1 346 248 7799 US (Houston)

• +1 360 209 5623 US

Meeting ID: 814 5587 4969

Passcode: 111734

Find your local number: https://us06web.zoom.us/u/kcwKghuaW

From: Joshua Gillispie <josh@gillispielawfirm.com>
Sent: Tuesday, February 20, 2024 1:38 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Joshua Gillispie <josh@greenandgillispie.com>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>; Abbey Trussell <Abbey.Trussell@dhs.arkansas.gov>; Daiquiri Carter <Daiquiri.Carter@dhs.arkansas.gov>
Subject: Re: HEARING DATE CHANGE: McAuliffe v. DHS, Claim No. 220374

> You don't often get email from josh@gillispielawfirm.com. Learn why this is important

Kathryn-

Assuming the only workable options in the near future are March 1 and April 11, we will take March 1. I believe you said that would be at noon.

Thank you,

Joshua D. Gillispie

1 Riverfront Place, Suite 605

North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax

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>
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>
> Little Rock, Arkansas 72201
>
> (501) 682-2822

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Cc: OCC Claims Commission Cases
Subject: RE: HEARING RESCHEDULED: McAuliffe v. DHS, Claim No. 220374
Date: Tuesday, April 16, 2024 8:53:00 AM

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> Kathryn Irby -- Claims Commission is inviting you to a scheduled Zoom meeting.
>
> Topic: Hearings
> Time: Mar 1, 2024 12:00 PM Central Time (US and Canada)
>
> Join Zoom Meeting
> https://us06web.zoom.us/j/81455874969?pwd=axA0lk8n5OUZ6IgTp4iKB3CZ3K1oGO.1
>
> Meeting ID: 814 5587 4969
> Passcode: kbe7x4
>
> ---
>
> One tap mobile
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> +16469313860,,81455874969#,,,,*111734# US
>
> ---
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> • +1 646 931 3860 US

- +1 929 436 2866 US (New York)
- +1 301 715 8592 US (Washington DC)
- +1 305 224 1968 US
- +1 309 205 3325 US
- +1 386 347 5053 US
- +1 507 473 4847 US
- +1 564 217 2000 US
- +1 669 444 9171 US
- +1 669 900 6833 US (San Jose)
- +1 689 278 1000 US
- +1 719 359 4580 US
- +1 253 205 0468 US
- +1 253 215 8782 US (Tacoma)
- +1 346 248 7799 US (Houston)
- +1 360 209 5623 US

Meeting ID: 814 5587 4969
Passcode: 111734

Find your local number: https://us06web.zoom.us/u/kcwKghuaW

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From: Joshua Gillispie
To: Kathryn Irby
Cc: OCC Claims Commission Cases
Subject: Re: HEARING RESCHEDULED: McAuliffe v. DHS, Claim No. 220374
Date: Thursday, July 11, 2024 2:19:07 PM

Oh my gosh. That's crazy. Hang in there! And thanks for letting me know.

Joshua D. Gillispie



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On Thu, Jul 11, 2024 at 2:13 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Josh, the delay is on my end due to a record-breaking year on the number of claims filed at the Commission (we had almost 400 additional claims filed in FY24 over FY23). It has everything delayed. I expect to have an order transmitted to the parties later this month.
>
> Thanks,
> Kathryn
>
> Get Outlook for iOS
>
> ---
>
> **From:** Joshua Gillispie <josh@gillispielawfirm.com>
> **Sent:** Thursday, July 11, 2024 1:59:28 PM
> **To:** Kathryn Irby <Kathryn.Irby@arkansas.gov>
> **Cc:** OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>
> **Subject:** Re: HEARING RESCHEDULED: McAuliffe v. DHS, Claim No. 220374
>
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>
> Hi Kathryn-
>
> Sorry to bother you, but I was wondering if there was any update on the Motion for Reconsideration heard on March 1 in *McAuliffe v. DHS*, Claim No. 220374.
>
> Thank you,
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> https://us06web.zoom.us/j/81455874969?pwd=axA0lk8n5OUZ6IgTp4iKB3CZ3K1oGO.1
>
> Meeting ID: 814 5587 4969
>
> Passcode: kbe7x4

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+16469313860,,81455874969#,,,,*111734# US

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• +1 646 931 3860 US

• +1 929 436 2866 US (New York)

• +1 301 715 8592 US (Washington DC)

• +1 305 224 1968 US

• +1 309 205 3325 US

• +1 386 347 5053 US

• +1 507 473 4847 US

• +1 564 217 2000 US

• +1 669 444 9171 US

• +1 669 900 6833 US (San Jose)

• +1 689 278 1000 US

• +1 719 359 4580 US

• +1 253 205 0468 US

• +1 253 215 8782 US (Tacoma)

• +1 346 248 7799 US (Houston)

• +1 360 209 5623 US

Meeting ID: 814 5587 4969

Passcode: 111734

Find your local number: https://us06web.zoom.us/u/kcwKghuaW

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Sent: Thursday, October 5, 2023 12:25 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: Joshua Gillispie <josh@greenandgillispie.com>; OCC Claims Commission Cases <OCC.ClaimsCommCases@dhs.arkansas.gov>; Abbey Trussell <Abbey.Trussell@dhs.arkansas.gov>; Daiquiri Carter <Daiquiri.Carter@dhs.arkansas.gov>
Subject: Re: HEARING SCHEDULED: McAuliffe v. DHS, Claim No.

220374

> You don't often get email from josh@gillispielawfirm.com. Learn why this is important

Received. Thanks.

Joshua D. Gillispie



1 Riverfront Place, Suite 605

North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

On Thu, Oct 5, 2023 at 12:16 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Mr. Gillispie and Ms. Trussell, please see attached hearing letter and Zoom invitation.
>
> Thanks,
>
> Kathryn Irby
>
> **Kathryn Irby**
>
> **Arkansas State Claims Commission**
>
> 101 East Capitol Avenue, Suite 410
>
> Little Rock, Arkansas 72201

(501) 682-2822

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

CHRISTINE MCAULIFFE, AS SPECIAL ADMINISTRATOR OF THE ESTATE OF DAVID CAINS **CLAIMANT**

V. **CLAIM NO. 220374**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

ORDER

Now before the Arkansas State Claims Commission (the "Commission") is the motion filed by Christine McAuliffe, as Special Administrator of the Estate of David Cains (collectively referred to herein as the "Claimant") for reconsideration of the Commission's July 21, 2023, order awarding a total of $390,000 in Claimant's claim against the Arkansas Department of Human Services (the "Respondent" or "DHS"). At the hearing held March 1, 2024, Claimant was represented by Joshua Gillispie. Abbey Trussell appeared on behalf of Respondent.

1. Claimant filed this claim against Respondent on September 30, 2021, seeking $7,000,000.00 in damages related to the June 13, 2020, death of David Cains (the "Decedent").

2. Respondent filed an Answer denying liability.

3. Following a claim hearing, the Commission found negligence on the part of Respondent related to Respondent's failure to create a plan of action regarding the frequent need to restrain the Decedent. The Commission also found that the Decedent initiated the behavioral situation that led to Respondent's staff member putting the Decedent into restraints. The Commission apportioned 60 percent of the fault to Respondent and 40 percent to the Decedent. The Commission awarded $450,000 in damages to the Estate of David Cains for loss of life and pain and suffering, of which Respondent was liable for 60 percent, or $270,000. The Commission

also awarded $75,000 each to the Decedent's mother and sister for mental anguish, of which Respondent was liable for 60 percent, or $45,000 each. Lastly, the Commission awarded $50,000 to the Decedent's half-sister for mental anguish, of which Respondent was liable for 60 percent, or $30,000.

4. Claimant subsequently filed the instant motion for reconsideration, arguing that the apportionment of fault to the Decedent was improper, as was the amount of the loss of life damages awarded by the Commission.

5. Respondent responded to the motion, arguing that Claimant is attempting to re-litigate the hearing in the motion for reconsideration and that Claimant did not present any new or additional evidence as required under Commission Rule 7.1.

6. Claimant argued in reply that the Commission rules are to be liberally construed under Commission Rule 1.2 and that the Commission should reconsider these two issues to consider evidence that might have been "lost in the shuffle, given the unusual amount of evidence and documentation submitted." (emphasis omitted).

7. At the hearing, Claimant argued that, when the Commission assigned forty percent fault to the Decedent, the Commission did not consider that a minor's fault must be considered based on the minor's capacity. Claimant argued that [redacted] got a gun and shot someone, no one would be blaming the [redacted]. Claimant re-argued the issues of foreseeability, the delayed 911 call, the frequency of the Decedent's vomiting, and how the Decedent valued his life. Claimant referred to the Commission's award as a "slap on the wrist" for Respondent.

8. Respondent argued that there are no grounds for this matter to be reheard. Respondent also stated that, while Respondent disagrees with the ultimate outcome of the claim

hearing, there is no new evidence for the Commission to consider, and Respondent respects the decision of the Commission.

9. Commissioner Graves noted that all of Claimant's arguments were addressed in the Commission's order. He took issue with Claimant's characterization of the award as a "slap on the wrist" and asked Claimant why the *Henley*[1] case is not on point. In response, Claimant agreed that *Henley* correctly states the law but argued that it would be impossible for the Commission to apportion forty percent of the fault to the Decedent if the Commission was using the perspective of a [redacted].

10. Upon a question from Commissioner Graves, Claimant argued that other policy violations should have been part of the Commission's findings, including that the Decedent should not have been restrained on the ground and that only doctors were allowed to call 911.

11. Commissioner Smith stated that the Commission considered all the evidence presented and that the Commission must be good stewards of the authority granted by the Legislature. He noted that the Commission considered [redacted] when making its decision.

12. In analyzing a motion for reconsideration, Rule 7.1 of the Commission Rules and Regulations states that motions for reconsideration "will only be entertained if they set forth new or additional evidence which was not [previously] available . . . ."

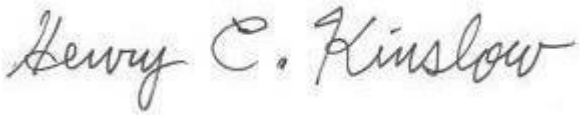
13. The Commission finds that Claimant's motion does not set forth new or additional evidence not previously available, that the Commission considered all of the evidence and testimony submitted by the parties, and that the Commission's July 21, 2023, order should remain in effect. As such, the Commission denies Claimant's motion for reconsideration.

[1] *Farm Bureau Mut. Ins. Co. of Ark., Inc. v. Henley*, 275 Ark. 122, 126, 628 S.W.2d 301, 303 (1982) (holding that "an infant is liable for his torts in the same manner as an adult").

IT IS SO ORDERED.



ARKANSAS STATE CLAIMS COMMISSION
Solomon Graves



ARKANSAS STATE CLAIMS COMMISSION
Henry Kinslow, Chair



ARKANSAS STATE CLAIMS COMMISSION
Sylvester Smith

DATE: July 24, 2024

Notice(s) which may apply to your claim

(1) A party has forty (40) days from transmission of this Order to file a Motion for Reconsideration or a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1). If a Motion for Reconsideration is denied, that party then has twenty (20) days from transmission of the denial of the Motion for Reconsideration to file a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1)(B)(ii). A decision of the Claims Commission may only be appealed to the General Assembly. Ark. Code Ann. § 19-10-211(a)(3).

(2) If a Claimant is awarded less than $15,000.00 by the Claims Commission at hearing, that claim is held forty (40) days from the date of disposition before payment will be processed. *See* Ark. Code Ann. § 19-10-211(a). Note: This does not apply to agency admissions of liability and negotiated settlement agreements.

(3) Awards or negotiated settlement agreements of $15,000.00 or more are referred to the General Assembly for approval and authorization to pay. Ark. Code Ann. § 19-10-215(b).

From:	Kathryn Irby
To:	Joshua Gillispie; Abbey Trussell
Cc:	OCC Claims Commission Cases
Subject:	ORDER: McAuliffe v. DHS, Claim No. 220374
Date:	Wednesday, July 24, 2024 2:28:00 PM
Attachments:	McAuliffe -- hearing -- 220374 -- order re M4R.pdf

Mr. Gillispie and Ms. Trussell, please see attached order entered by the Commission.

Thanks,
Kathryn Irby

Kathryn Irby
Arkansas State Claims Commission
101 East Capitol Avenue, Suite 410
Little Rock, Arkansas 72201
(501) 682-2822

From: Joshua Gillispie
To: ASCC Pleadings
Cc: Kathryn Irby; Abbey Trussell
Subject: Re: McAuliffe v. DHS, Claim No. 220374
Date: Monday, July 29, 2024 4:09:41 PM
Attachments: Notice of Appeal.pdf

You don't often get email from josh@gillispielawfirm.com. Learn why this is important

Dear Commission-

Please accept for filing this Notice of Appeal in McAuliffe v. DHS, Claim No. 220374.

Best regards,

Josh

Joshua D. Gillispie
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
https://gillispielawfirm.com/

On Fri, Sep 15, 2023 at 10:17 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Thank you!
>
> Joshua D. Gillispie
> 1 Riverfront Place, Suite 605
> North Little Rock, AR 72114
> (501) 244-0700
> (501) 244-2020 fax
> www.greenandgillispie.com
>
> On Fri, Sep 15, 2023 at 9:10 AM ASCC Pleadings <ASCCPleadings@arkansas.gov> wrote:
>
> > Received on 9-11-23.

From: Joshua Gillispie <josh@greenandgillispie.com>
Sent: Thursday, September 14, 2023 4:12 PM
To: ASCC Pleadings <ASCCPleadings@arkansas.gov>
Cc: Kathryn Irby <Kathryn.Irby@arkansas.gov>; Abbey Trussell <Abbey.Trussell@dhs.arkansas.gov>; Daiquiri Carter <Daiquiri.carter@dhs.arkansas.gov>
Subject: Re: McAuliffe v. DHS, Claim No. 220374

Just making sure the Commission received my Reply filed on 9/11. Typically I get a "received" message back. Thanks!

Joshua D. Gillispie

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On Mon, Sep 11, 2023 at 2:30 PM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Dear Commission:
>
> Please find Claimant's *Reply* to Respondent's Response to her Motion for Reconsideration.
>
> Best Regards,
>
> Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605
North Little Rock, AR 72114
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www.greenandgillispie.com

On Tue, Aug 29, 2023 at 10:57 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Dear Claims Commission:
>
> Please find attached Claimant's Motion for Reconsideration.
>
> Best Regards,
>
> Josh Gillispie
>
> Joshua D. Gillispie
>
> 1 Riverfront Place, Suite 605
> North Little Rock, AR 72114
> (501) 244-0700
> (501) 244-2020 fax
> www.greenandgillispie.com

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe,
as Special Administrator of the Estate
of David Cains **CLAIMANT**

V. **Claim No. 220374**

THE ARKANSAS DEPARTMENT OF
HUMAN SERVICES (BOONEVILLE HUMAN
DEVELOPMENT CENTER) **RESPONDENT**

NOTICE OF APPEAL

COMES NOW Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Notice of Appeal submits the following:

1. That she hereby appeals to the General Assembly from the Order of July 21, 2023.

2. That Claimant previously filed with the Commission a Motion for Reconsideration of the Order of July 21, 2023, which the Commission denied on July 24, 2024.

3. That she hereby designates the entire record in this matter.

4. That her basis for appeal is set out with particularity in her Motion for Reconsideration previously filed with the Claims Commission, and attached hereto as "Exhibit 1" to this Notice of Appeal.

Respectfully Submitted,

/s/ Joshua D. Gillispie
Joshua D. Gillispie
Ark. Bar # 2010131
GILLISPIE LAW FIRM
1 Riverfront Place, Suite 605
North Little Rock, AR 72114
501-244-0700
501-244-2020 (fax)
josh@gillispielawfirm.com

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed on this 29th day of July, 2024, with service provided to all counsel of record.

/s/ Joshua D. Gillispie
Joshua D. Gillispie

EXHIBIT 1

BEFORE THE ARKANSAS CLAIMS COMMISSION

Christine McAuliffe, as Special Administrator of the Estate of David Cains	**CLAIMANT**
V.	**Claim No. 220374**
THE ARKANSAS DEPARTMENT OF HUMAN SERVICES (BOONEVILLE HUMAN DEVELOPMENT CENTER)	**RESPONDENT**

MOTION FOR RECONSIDERATION

COMES NOW Claimant, Christine McAuliffe, by and through her attorney, Joshua D. Gillispie, and for her Motion for Reconsideration submits the following:

INTRODUCTION

This Honorable Commission entered its Order on July 21, 2023. Claimant Christine McAuliffe, and her undersigned counsel, wish to thank Commission Chairperson Henry Kinslow, Commissioner Courtney Baird, and Commissioner Sylvester Smith for their hard work and valuable time expended in considering this claim, and wish to recognize that their job was not an easy one given the amount of evidence, particularly the number of deposition transcripts, submitted in this case. This Motion for Reconsideration seeks to respectfully address two specific findings: (1) the apportionment of 40% fault to David Cains, and (2) the $350,000.00 award for damages associated with David Cains' "loss of life."

The purpose of this Motion for Reconsideration is to address more fully these two issues under Arkansas law to show the Commission why it should decrease the percentage of fault assigned to Davie and increase the award for damages associated with Davie's loss of life.

Central to both analyses is that David Cains possessed the mind of an approximately four-year-old child.[1]

I. APPORTIONMENT OF FAULT

1. Respectfully, the Commission erred in apportioning forty percent fault to David Cains, given the large amount of evidence proving foreseeability on Respondent and given [redacted], which requires an analysis for attributing fault to consider *only* how a reasonably careful person of David's maturity and intelligence would act under the circumstances.

Furthermore, and significantly, the Director of Developmental Disabilities Services for the Arkansas Department of Human Services, Respondent's highest-ranking official to give testimony in this case, testified in crystal clear terms that Davie was *not* at fault for this death.

> *Q Is it your position that Mr. Cains was responsible for his own death?*
> *A I didn't say that.*
> *Q I didn't say you did. It's a question I have to ask.*
> *A No.*
> *Q Okay.*
> *A No, of course not.*

Exhibit 32, DDS Director Melissa Weatherton, p. 85.

A. FORSEEABILITY COUNTERBALANCES THE FAULT APPORTIONED DAVIE

Davie's death, the result of vomiting and then choking on his vomit while being restrained on the ground shortly after lunch, was foreseeable to Respondent. There was a great deal of testimony and other evidence submitted that conclusively proves this foreseeability. This

[1] **Exhibit 14**, BHDC Psychological Examiner Mike Alvis, p. 24, p. 29: 20-25, p. 30: 1-10 (*testified that Davie's mental functioning was likely that of a four-year-old's*).

foreseeability, [redacted], counterbalances any potential fault that could be apportioned to Davie, who, again, [redacted]

Respondent knew that physical restraint increased the likelihood of injury to Davie and other clients, and Respondent knew specifically that physical restraints on the ground were even more likely to do so, ***hence the facility's prohibition on their use***.[2] Respondent also had good reason to anticipate that Davie would vomit, given that ***he vomited so frequently following lunch that his pre-vocational trainers at BHDC kept a puke bucket next to his workstation***.[3] Add to this the fact **Respondent did not call 911 until it was too late, because of an inherently dangerous policy forbidding staff to do so**, there should be little, if any, fault apportioned to Davie.[4] [5] And add to this that Sandy Evans, BHDC's own Director of Residential

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[2] **Exhibit 2**, BHDC Staff Development Coordinator Mark Hise, p. 12: 1-22, p. 21: 8-25, p. 22: 1-25 (*There is no on-the-ground personal hold allowed at BHDC*), p. 23: 1-8 (*An on-the-ground personal hold is not an approved NCI method; it should not be done.*), p. 27: 16-25, p. 28: 1-6, p. 32: 9-22 (*Ground restraint is dangerous*), p. 35: 5-17 (*The contact Tyler Mattson made with DC after he was already on the ground was unnecessary*), p. 42: 5-10. Other staff members, including even restraint participant Amy Jones, agreed the ground restraint used on Davie was not allowed. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 35: 14-23 (expressly prohibited from putting a client on the ground for personal restraint); p. 43: 8-18, p. 44: 9-17; **Exhibit 25**, Dr. Syed Hamid, p. 78: 12-24; **Exhibit 20,** BHDC QIDP/Program Manager Justin Jobb Part II, p. 8. Staff are not authorized to hold a client on the ground even where a client puts himself on the ground during an aggressive episode. **Exhibit 18,** BHDC Shift Supervisor Amy Jones, p. 45: 1-9.

[3] **Exhibit 49**, BHDC Prevocational Trainer Rhonda Harris, p. 10, p. 11, p. 13, p. 14.

[4] [redacted] **BHDC policy forbade them from doing so; at BHDC, only medical staff are authorized to call for emergency medical help, while all other staff are only allowed to alert the facility's medical department.** **Exhibit 34**, BHDC First Aid Guidelines – Policy IV-B-10; **Exhibit 6**, BHDC Residential Services Director Sandy Evans, p. 51: 7-25, p. 52: 1-25; **Exhibit 9**, BHDC Staff Tyler Mattson, p. 78: 22-25, p. 79: 1-11 ("I would have like to" been able to call 911 for David); p. 123: 8-17 ("We're not allowed to" call 911); **Exhibit 18**, BHDC Shift Supervisor Amy Jones, p. 57: 9-25 (…it don't really make sense that we couldn't call them [medical department] and then call 9-1-1 as well."), p. 115: 5-17 (wishes she had violated the policy and called 911 right away for Davie); **Exhibit 11**, BHDC LPN Kelly King, p.20: 16-19; **Exhibit 15**, BHDC Social Services Worker Caleb Murry, p. 56; **Exhibit 30**, DRA Advocate Kris Stewart, p. 54: 14-18, p. 65: 22-25, p. 66: 1-22 (everyone she interviewed at BHDC confirmed there was a policy forbidding nonmedical staff from calling 911 in the event a resident has a medical emergency) (Gonyea told her they did not trust staff to recognize a medical emergency, feared 911 might be called unnecessarily), p. 67: 1-10 ; **Exhibit 13**, Former BHDC Staff Don Carter, p. 22: 16-23, p. 23: 9-22 (There were "no exceptions" to the rule), p. 26: 11-25.

[5] **The evidence strongly suggests at least five and maybe as many as ten minutes elapsed between the time Davie began choking and when BHDC called 911.** Exhibit 9, BHDC Staff Tyler Mattson, p. 120: 1-5; Exhibit 10, BHDC Staff Ryann Campos, p. 46: 1-8; Exhibit 13, Former BHDC Staff Don Carter, p. 35: 6-24, p. 36: 1-3; Exhibit 40, Paramedic Samuel Scow, p. 8: 14-21, p. 10: 19-25 (determined, based on the 911 call coming in at 11:37 am, that

Services, and the person who conducted the facility's internal investigation into Davie's death, admitted under oath that ***the restraint was not the least restrictive method available and was in fact a violation of policy that required staff to be retrained***, and it makes it difficult to see how forty percent fault could be apportioned to Davie, [redacted][6] [7]

If Davie had been standing or seated when he vomited, he would not have choked to death, regardless of what caused the vomiting; he was on the ground when he vomited because staff were holding him on the ground in violation of policy, regardless of how he got to the ground. Staff were not authorized to hold clients on the ground, not trained to do so, and were in violation of policy in doing so. But for these policy violations, Davie would be alive. **It is important to also remember that, under Arkansas law, violation of a statute, ordinance, or regulation is itself evidence of negligence**. ARK. MODEL JURY INSTRUCTION 601; *McMickle v. Griffin*, 369 Ark. 318, 254 S.W.3d 729 (2007).

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it was eight minutes from the time Davie stopped breathing and when the facility called 911); Exhibit 41, Logan County EMS Report.

[6] **Even if this had been an emergency situation, staff were required to use only the "least restrictive" approved method possible.** Exhibit 17, DDS 3011-D (3); Exhibit 5, Federal ICF-IID Reg. § 483.450(b)(1)(iii), [W278], Bates 1754 (the least restrictive appropriate technique possible); Exhibit 5, ICF-IID Reg. § 483.450(b)(4), [W289], Bates 1760; Exhibit 5, ICF-IID Reg. § 483.450(b)(1)(ii), [W277], Bates 1753; Exhibit 3, BHDC Superintendent Jeff Gonyea, p. 30, p. 37: 5-9; Exhibit 6, BHDC Residential Services Director Sandy Evans, p. 26: 24-25, p. 27: 1-3, p. 34; Exhibit 18, BHDC Shift Supervisor Amy Jones, p. 113: 3-17; Exhibit 19, BHDC Residential Services Manager Carrie Johnson-Miller, p. 43: 17-25, p. 44: 1-4; Exhibit 20, BHDC QIDP/Program Manager Justin Jobb Part II, p. 49, p. 50; Exhibit 21, OLTC Surveyor Dian Elliot, p. 123: 5-12, p. 133: 23-25, p. 134: 1-4; Exhibit 22, Dr. Janice LeBel – Summary of Expert Opinions; Exhibit 37, Dr. Janice LeBel – CV; Exhibit 23, Dr. Janice LeBel Deposition Transcript. BHDC's written policy states: "Emergency Restraint is defined as the use of the least restrictive procedure and for the least time necessary to control severely aggressive or destructive behaviors" [emphasis added]. Exhibit 4, BHDC Policy I-D-4 (2)(a).

[7] **Sandy Evans admitted at deposition that the restraint used on Davie at the time of his death was not the least restrictive option available.** Exhibit 6, BHDC Residential Services Director Sandy Evans, p. 50: 1-7, p. 47: 5-25 (they never gave Davie a chance to calm down and collect himself on the ground unrestrained), p. 48: 1-13, p. 49: 11-25 (***it was an inappropriate use in violation of policy, requiring retraining, but in her opinion did not rise to the level of maltreatment***). Amy Jones and Ryann Campos, the two staff members who helped Tyler Mattson perform the restraint, made similar admissions at deposition. Exhibit 18, BHDC Shift Supervisor Amy Jones, p. 115: 5-17 (acknowledging she probably should have made Tyler let Davie up right away); Exhibit 10, BHDC Staff Ryann Campos, p. 80: 17-21, 81: 2-6 ("there were less restrictive ways that the situation could have been handled").

The Commission relied upon *Ethyl Corp. v. Johnson* to support finding it was not foreseeable Davie would vomit while restrained on June 13, 2020. The Court in *Ethyl* held it is not negligent to fail to guard against a danger for which there is no reason to anticipate, or against a danger that is merely possible. 345 Ark. 476, 481, 49 S.W.3d 644, 648 (2001). Obviously, anything is possible, and there must be some knowable reason for guarding against a particular danger before the failure to do so rises to negligence. However, *Ethyl* was also careful to reiterate that it is "**not necessary**, however, **that the actor foresee *the particular injury* that occurred, only that he or she reasonably foresee an appreciable risk of harm to others**." *Id*, at 482, 648 (quoting *Wallace v. Broyles*, 331 Ark. 58, 961 S.W.2d 712, 715 (1998)) (emphasis added). **In other words, if it is reasonably foreseeable that doing a given thing could cause physical harm to a person, it does not matter what particular type of physical harm results.**

Furthermore, the remote danger at issue in *Ethyl* was far different than here. The *Ethyl* plaintiff injured himself while trying to singlehandedly move a 2,000-pound metal trash bin situated at the edge of a parking lot, a parking lot nobody intended or expected him to take his big rig, so that his 18-wheeler could make a U-turn without the rear wheels hitting the bin. *Id*, at 480, 647. Stated *Ethyl*:

> It was not foreseeable that an invitee would injure himself by attempting to manually move the 2,180 pound container on his own. Appellants' only duty under the circumstances was to provide reasonable care to guard against any harm that appeared "likely in the ordinary course of events." *Burns*, 186 Ark. at 925, 56 S.W.2d at 1028. Appellants simply had no duty to take added precautions to guard against the remote chance that someone would injure himself by attempting to move the heavy container. Indeed, it was undisputed that there had never been any previous incidents, within the fourteen years that the container was on Appellants' property, in which anyone, employee or otherwise, had been injured in conjunction with the container.

Id, at 483, 649. Compare that to Davie's case, in which BHDC staff had severely injured clients during restraints in the year before Davie's death. See the 2019 BHDC incident in which a staff

member broke a client's arm during a restraint, and also the BHDC incident in which a staff member choked a client unconscious during a restraint. **Exhibit 32**, DDS Director Melissa Weatherton, p. 67, 68; **Exhibit 50**, 1.31.21 Dem-Gaz Article (also Exhibit 5 to Weatherton deposition). Nobody expects trash bins to cause injury; everybody knows physical restraints often result in injury, and if a person performs one in violation of training and policy and it results in a person's death, that is textbook negligence, if not worse.

It is worth repeating that while negligence requires an appreciable risk of harm to others a reasonably careful person would recognize, "it is **not necessary that the actor foresee the *particular injury* which occurred, only that the actor reasonably foresee *an appreciable risk of harm* to others**" [emphasis added]. *Wallace v. Broyles*, 331 Ark. 58, 961 S.W.2d 712, 715 (1998). Proximate cause in a negligence action may be shown from circumstantial evidence, and such evidence is sufficient to show proximate cause if the facts proved are of such a nature and are so connected and related to each other that the conclusion therefrom may be fairly inferred. *Id.* **In other words, Respondent's foreseeability did not require them to have reason to think Davie would vomit while restrained. Rather, it required only that Respondent be aware that a restraint, and in this case a prohibited ground restraint that violated the facility's own policies, increased the likelihood of harm to the person being restrained.**

It is an incontrovertible truth that Respondent was aware that the use of restraints increased the likelihood of injury; **it's literally stated in their own policy documents**:

> "The Booneville Human Development Center is dedicated to the reduction of restraint use at the facility. **The use of restraints is proven to be dangerous for both staff and clients, *with the occurrence of injuries dramatically increasing when restraint is used***. All efforts must be made to deescalate behavioral situations so that they do not result in restraint. All restraint at the facility is to be

> for emergency use only when ***a very real risk of personal injury or severe property damage is imminent***."

Exhibit 61, BHDC Restraint Incident Debriefing Form (emphasis added).

The DDS Director, Respondent's highest-ranking official to give testimony in this case, testified to being aware that any time a restraint is used there is an increased risk of danger:

> *Q But would you agree with me that it's a goal of your organization to reduce restraints as much as possible?*
> *A Absolutely.*
> *Q And is that because, whenever someone has to be restrained, it increased the risk of danger to that client and to staff and to potentially others?*
> *A Yes.*

Exhibit 32, DDS Director Melissa Weatherton, p. 30.

As previously mentioned, there had been other serious injuries caused by restraints at BHDC just prior to Davie's death. See the 2019 BHDC incident in which a staff member broke a client's arm during a restraint, and also the BHDC incident in which a staff member choked a client unconscious during a restraint. **Exhibit 32**, DDS Director Melissa Weatherton, p. 67, 68; **Exhibit 50**, 1.31.21 Dem-Gaz Article (also Exhibit 5 to Weatherton deposition).

Disability Rights Arkansas published a report in January of 2016 literally titled "*Bound to the Past: The Excessive Use of Restraint at the Booneville Human Development Center*," which revealed, among other things, that restraint use at BHDC was "approximately twenty-five times higher" than at the other four Human Development Centers in Arkansas, that this had already led to injuries, and that it was going to lead to more injuries unless the problem was addressed. **Exhibit 51,** DRA 2016 Report – "*Bound to the Past: The Excessive Use of Restraints at Booneville Human Development Center*." Concluded the report:

> According to the data collected and maintained by Booneville HDC and the State, residents at Booneville live in an environment in which restraint is used excessively, far more frequently than at the Arkadelphia, Jonesboro, or Warren HDCs. **Booneville HDC fails to ensure that staff utilize effective tools to de-escalate**

> **situations, leading to the use of restraints when other interventions, if implemented sooner, could eliminate the need for restraint. The Department of Human Services and its Division of Developmental Disabilities Services has failed to provide the oversight and training to ensure that residents at Booneville HDC are not subjected to unnecessary and excessive restraints. Residents and staff have already been injured due to the current restraint practice at Booneville HDC.**
>
> All HDC residents are entitled to live in an environment in which restraints are used as a last resort after other interventions have failed. The residents at Booneville HDC have a right to be treated with dignity and respect, to not be subjected to unnecessary and harmful restraint, and to receive active treatment based on evidence-based best practices. **DRA urges the State to take immediate action to address the culture at Booneville HDC and to instruct Booneville HDC to stop this inherently dangerous practice.** The individuals with disabilities residing at Booneville HDC deserve better.

Exhibit 51, DRA 2016 Report – "*Bound to the Past: The Excessive Use of Restraints at Booneville Human Development Center*," p. 13 (emphasis added). This report was published four years prior to Davie's death, Respondent ignored it, and Davie died as a result. The Commission, in its Order, noted that 187 behavioral incidents requiring restraint had occurred prior to Davie's death, which understandably suggested to the Commission that Davie was the problem, but these 187 restraint incidents are actually much more indicative of BHDC's overreliance on and unnecessary use of physical restraints, failure to utilize non-violent de-escalation techniques, and Respondent's failures in training and oversight for BHDC staff – all the things identified by Disability Rights Arkansas in "*Bound to the Past: The Excessive Use of Restraints at Booneville Human Development Center*." Recall that Davie never injured anyone at BHDC.[8]

[8] Davie was not dangerous. Davie never caused injury to anyone at BHDC. Exhibit 2, BHDC Staff Development Coordinator Mark Hise, p. 50, p. 52; Exhibit 9, BHDC Staff Tyler Mattson, p. 66; Exhibit 10, BHDC Staff Ryann Campos, p. 49; Exhibit 11, BHDC LPN Kelly King, p. 7, p. 10; Exhibit 12, BHDC LPN Amanda Schmitt, p. 22, p. 24, p. 28; Exhibit 13, Former BHDC Staff Don Carter, p. 8; Exhibit 14, BHDC Psychological Examiner Mike Alvis, p. 59; Exhibit 15, BHDC Social Services Worker Caleb Murry, p. 28; Exhibit 16, Claimant Christine McAuliffe, p. 21, 22.

RESPONDENT KNEW DAVIE WAS A VOMIT RISK

All of this notwithstanding, it actually **was foreseeable to Respondent that *this particular injury* could occur**, because they knew Davie vomited nearly every day, particularly after lunch. Respondent knew that Davie was highly prone to vomiting, particularly after lunch.

[redacted]

Rhonda Harris was Davie's Prevocational Trainer (work supervisor) at BHDC, working with him nearly every afternoon for at least five years prior to this death. **Exhibit 49**, BHDC Prevocational Trainer Rhonda Harris, p. 5, 6, 19. Rhonda Harris's testimony, as seen below, firmly establishes that it was much more than a mere possibility Davie would vomit right after lunch during a ground restraint. Harris testified that everyone who worked there knew Davie had [redacted] and knew to keep him facedown when restraining him on the ground:

> *Q And that's specifically because he was a known vomiting threat?*
> *A. Yes. He had medical issues going on. I still to this day don't know if the nurses ever found out what exactly was wrong with him**, but everybody that worked around him knew that, you know, so you always – we always -- where I worked, you know, we had the understanding, you know, if you ever took him down, make sure he was face down. That way if he started to, you know, vomit** -- because I don't know -- at first, we thought he just was like -- you know, he could do it, you know, on his own, like*

[9] **By holding Davie down on the ground just after his lunch, BHDC staff ignored Davie's known** [redacted] Exhibit 46, Physician Orders at Discharge 6.19.20; Exhibit 47, Physician Orders 6.1.20; Exhibit 48 Physician Orders 3.1.19. [redacted] See Exhibit 43, "Prevention of Choking and Aspiration" – New York Office of People with Developmental Disabilities, pgs. 3-4. This is noteworthy because Respondent's expert witness, Dr. Kastner, was recently the head of this office in New York, under former Governor Andrew Cuomo; some of Dr. Kastner's expert opinions in this case are in direct conflict with the contents of this document [redacted].

just make himself throw up, but then it's become like it happened, you know, regularly, you know, where we were constantly calling the nurses, you know, or medical to have them come evaluate him because that's not normal, you know, for anybody to do.

Exhibit 49, BHDC Prevocational Trainer Rhonda Harris, p. 9, 10. **Harris testified that everyone who worked with Davie was well aware of how often he vomited**:

Q So everybody that was accustomed to David or had been around David and knew David was aware that there was a risk of him vomiting?
A Yes
Q I think you said at first, you know, you couldn't tell if he was doing this on purpose.
A Yeah, purposefully or not, but, you know, as time went on, you know, and it continued -- and I'm telling you it was months, you know, of this, that he was doing this. They sent him to the doctor, you know, to have tests run and stuff like that, you know, to figure out what was causing him.
Q You eventually determined that this is more likely some sort of medical thing that's going on with him?
A Yeah, because anytime he would drink red – you know, anything with red in it, he would throw up. You know, within a little bit after that, he would be vomiting.

Id, p. 10, 11. Harris testified that Davie was **vomiting three or four times a week** and that it **always happened right after lunch:**

I mean, this went on for a while before -- we just got to where we would call them every single day, you know, because, I mean, it turned into at least three, sometimes four times a week that he would throw up because we would always get him after he had just freshly ate lunch, you know.

Id, p. 13, 22. Harris testified that **Davie vomited so much they kept a trash can right next to him at his job, as his own vomit bucket**:

You know, we always gave him a trash can beside him. You know, that way if he needed to throw up, he – you know, we always told him here's your trash can.

Id, p. 14. **All the direct care staff would have been aware of this risk**:

Q Would all the direct care staff that had been there for any length of time and spent time with him directly -- would all of them have been aware of this, the vomit risk?
A Yeah.

Id, p. 14. Furthermore, **written warnings about Davie's vomit risk were sent out to all staff**:

> *Q Do you know if there was ever any formal or written or any form of notification provided to all*
> *staff warning them of this issue with David, this vomiting issue with David?*
> *A Yeah, they sent out e-mails and memos, like we get memos, you know, and e-mails that goes to like my supervisor. When we come in the morning, he would have them laid out on the table, you know, and everybody has to initial it. You know, all the staff that works in that area, you know, we all had to initial at the bottom, you know, that we read, you know, the memo of what it was.*
> *Q Those were e-mails that would come from supervisors?*
> *A No, like medical. You know, on something like that, medical. Like Stacy would send out an e-mail,*
> *you know, to all the supervisors, you know, and then the supervisors would make sure that all their staff, you know, read it and then you initialed it at the bottom, you know, letting them know that you read it, so you were aware.*
> *Q Do you recall there being a memo from Stacy on this issue that we're talking about?*
> *A Yeah, I believe there was.*

Id, p. 23, 24. Harris testified she specifically recalled discussing the vomiting issue with several nurses prior to Davie's death, including Amanda Schmidt, Kelly King, Deborah Noah, and Stacy Weinbrenner. ***Id***, p. 16. The vomiting occurred nearly every day, according to Harris, but was not taken seriously by the nurses:

> [redacted]
> *And they would say it was a behavior.*

Id, p. 18.

Other BHDC staff members also testified to [redacted]

[redacted] Nurse Amanda Schmitt testified to this:

> *And, when David would have a behavior, he would often vomit. That was sometimes the whole of his behavior. Sometimes he would become upset and just vomit and then start to cry.* ***It wasn't always a violent outburst. But he did vomit during times of stress often.*** ***And I believe very strongly that that's what happened, that he had a behavior, he was being restrained, and he -- he vomited.***

Exhibit 12, Nurse Amanda Schmitt, p. 61. Carrie Johnson-Miller, the Residential Services Manager, also testified that Davie had an issue with vomiting when he got upset during a behavior episode. **Exhibit 19**, Carrie Johnson-Miller, p. 45. Even Respondent's own expert witness commented on the frequency with which Davie was vomiting when upset:

[redacted]

Dr. Kastner Written Report Pt. 1, p. 21.

B. [redacted]

The analysis for attributing fault must look at how a reasonably careful person of David's maturity and intelligence would act under the circumstances, not how an adult would act. The standard of care for a minor is fixed by "the maturity and capacity of the child, and this is to be determined in each case by the circumstances of that case." *Garrison v. St. Louis, I. M. & S. Ry. Co.*, 92 Ark. 437, 443, 123 S.W. 657, 660 (1909).

A minor is not held to the same standard of care as an adult. "**Ordinary care," with respect to a minor, means that degree of care which a reasonably careful minor of his age and intelligence would use under circumstances similar to those shown by the evidence in the case.** ARK. MODEL JURY INSTRUCTION 304. In *Garrison v. St. Louis, I.M. & S. RY. CO.,* where a 16-year-old boy known to be of "inferior intelligence" was injured by an oncoming train while trying to drive his wagon across the tracks, the Arkansas Supreme Court made clear that what is contributory negligence for an adult is not the same for a minor:

> The standard for judging the conduct of minor is not the care and prudence that would be exercised by an adult, but only that of one of his age, intelligence, and discretion; and it cannot be said as a matter of law that a minor is guilty of contributory negligence under circumstances that would declare an adult to be guilty of such negligence.

92 Ark. 437, 443 123 S.W. 657, 660 (1909). The Court in *Garrison*, citing with approval the Supreme Court of Georgia, noted that it is capacity, not necessarily age, that matters:

> **Capacity is the main thing. Age is of no significance except as a mark or sign of capacity**. The study of these and other like cases will lead to two conclusions: First, that no court can hold that childhood and manhood are bound to observe the same degree of diligence; secondly, that, while the same ordinary care is frequently applied to the diligence exacted by law of a child, there is little propriety in so doing. Due care is always the better and more accurate description. Due care on the part of the boy might fall far short of that of a prudent man.

Id.

Davie's own fault appears to have been improperly analyzed by holding him to the same standard as that of adults, which is not true except in situations where children are engaging in an inherently dangerous activity, like driving a car or operating heavy machinery. His fault must be

analyzed by comparing what Davie did with what a child of [redacted] would do under the same circumstances.[10] **Therefore, the question is whether it would be negligent for [redacted] to become upset and then move towards an adult in an aggressive manner. And if such an act would indeed be negligence for [redacted], is it of such an extreme degree of negligence as to make that [redacted] forty percent responsible for his own death?**

Lastly, the Commission did find in this case that Respondent failed to have a plan in place to manage Davie's behavior, which is true. However, Davie was not in any way responsible for his own behavior plan. Given that, is it still fair to say he is forty percent at fault for his death?

II. LOSS OF LIFE DAMAGES

1. The value placed by the Commission on David Cains' "Loss of Life" damages was too low, relative to the evidence presented and relative to prior valuations by the Commission on claims for "loss of life."

"Loss-of-life" damages are those that would compensate a decedent for the loss of the value that a decedent would have placed on his or her own life. *Durham v. Marberry*, 356 Ark. 481, 492, 156 S.W.3d 242, 248 (2004). It is an inherently subjective element of damages, to be measured from the point of view of the decedent, to the extent the decedent's point of view on this matter can be proved after his death. Loss-of-life damages are a separate and independent element in addition to all other elements of damage already allowed by law. *Id*; ARK. CODE ANN. § 16-62-101(b). "Loss-of-life" damages are awarded to compensate the decedent's estate

[10] **Exhibit 14**, BHDC Psychological Examiner Mike Alvis, p. 24, p. 29: 20-25, p. 30: 1-10 (*testified that Davie's mental functioning was likely that of a four-year-old's*).

for the destruction of the decedent's capacity to carry on and enjoy life's activities in a way he would have done had he lived. See *Durham*, at 491, 247. An estate seeking "loss-of-life" damages must present some evidence that the decedent valued his or her life, from which a jury could infer and derive that value and on which it could base an award of damages. *One Nat. Bank v. Pope*, 372 Ark. 208, 214, 272 S.W.3d 98, 102 (2008). Circumstantial evidence is all that is required. *Id*, at 214, 103.

Another component of loss-of-life damages that can potentially be taken into consideration is the decedent's lost earning capacity, but only where damages for the decedent's lost earning capacity is not also awarded to surviving beneficiaries as wrongful death compensation. See *Durham*, at 491, 247.

Here, Claimant presented substantial direct evidence in addition to circumstantial evidence in support of the fact that Davie's life held great value to him, and that his untimely death deprived him of happy and joyous experiences that, based on substantial witness testimony, we can be reasonably certain he would have experienced had he survived. Davie had [redacted]. **Exhibit 14**, BHDC Psychological Examiner Mike Alvis, p. 24, p. 29: 20-25, p. 30: 1-10. From his point of view, the things that brought him joy, like Halloween and music, were every bit as meaningful as things like money or a romantic relationship might be to a [redacted] And because "loss of life" damages by their very nature require subjectivity, it is entirely appropriate to analyze the value Davie placed on his own life from a subjective viewpoint relative to his intellectual age – [redacted]

Claimant presented evidence proving Davie experienced incredible joy from those things a typical [redacted] loves, including family, friends, music, food, laughter, and holidays, particularly Halloween and Christmas. Christmas was his favorite; he still believed in Santa

Claus and every Christmas Eve he would fall asleep next to the tree in his mother's home waiting for Santa to arrive with his presents.

An award of only $350,000.00 suggests that the value of his life was not analyzed, subjectively, from the point of view of [redacted], but rather from the perspective of the [redacted] and how he might value his life, which is an objective approach. In other words, had Davie been a [redacted], who also happened to live in the Booneville Human Development Center (BHDC) under the same external circumstances, then $350,000.00 might be an appropriate value. But **Davie was [redacted] who experienced joy just as intensely from listening to the Monkees or playing with toys or having MacDonald's for lunch as [redacted] might from a romantic encounter or from winning a large sum of money at a casino**.

Just last year, in *Brown, et al. v. Arkansas Department of Transportation*, Claim No. 200809 (2022), this Commission awarded $2,500,000.00 in loss-of-life damages to a young man tragically killed in a car crash: "Additionally, considering the persuasive testimony of the Decedent's family members regarding how the Decedent valued his life, the Claims Commission finds that the damages associated with the Decedent's loss of life are $2,500,000.00." *Brown*, p. 37.

Like the present matter, the *Brown* Commission heard evidence that Mr. Brown valued his life. This included testimony from Mr. Brown's mother that her son was well-liked and a good student. *Brown*, p. 5. Here, Claimant also submitted evidence that Davie was well-liked, not just by his family but by people at the BHDC. For example, one of the facility's nurses testified to this:

> But he was -- he was such a fun guy. He played the tambourine and loved the Monkees. And he had a Mr. Potato Head. That was kind of mine and his thing, is he had this Mr. Potato Head and I'd always tell him I was going to take the eyes from his Mr. Potato Head and put it where the nose goes and the nose where the eyes go; and he would just get like all kinds of excited about it. And he moved it on a top shelf to show me that I couldn't reach it to move his eyes. And he was -- he was a really cool guy. We had a pretty good relationship.

Exhibit 12, Nurse Amanda Schmitt, p. 22.

> Kelly King and I were probably the two nurses that were the closest to David. He -- he'd always say Kelly's a big fat witch; and she's like this little bitty, tiny, skinny thing. And so I taught him to say that Kelly's a big fat witch and Amanda's a pretty, pretty princess. I mean, like we played with him. We had a good relationship with him. And he was -- ***he was one we were especially close to.***

Exhibit 12, Nurse Amanda Schmitt, p. 59 (emphasis added).

Unlike here, the *Brown* Commission also heard expert testimony evidencing the decedent's lost earning capacity, and the Commission noted that the $2,500,000.00 loss-of-life award, which was, ostensibly, based on persuasive testimony from family members regarding how decedent valued his life, was consistent with that expert's conclusions. *Brown*, p. 37. Claimant in the present matter, for obvious reasons, did not seek damages related to Davie's lost earning capacity. [That notwithstanding, Claimant did present uncontroverted testimony that Davie worked a few hours most days in the BHDC recycling center tearing books, for which he earned nominal wages. **Exhibit 16**, Christine McAuliffe, p. 50.]

Claimant is not suggesting the Commissioners should be required to forfeit common sense. And Claimant is certainly not suggesting that all deaths caused by the state must be valued identically. Clearly, the *Brown* decedent's life was very different from Davie's. That young man's earning potential greatly outweighed Davie's, and, objectively speaking, that young man was likely to have enjoyed a fuller life than Davie could have hoped for, at least in terms of what most adults of normal intellectual functioning would value. <u>But the *Brown* decedent's</u>

award of $2,500,000.00 is *more than seven times* the $350,000.00 awarded Davie. That disparity is extreme, particularly given that this particular element of damages must be analyzed from the subjective point of view of the decedent. It also sends a devastating and potentially dangerous message to Arkansas' intellectually disabled citizens. In *Yang, et al. v. Arkansas Department of Emergency Management*, Claim No. 16-0496-CC (2020), this Commission included in its Order this statement: "**The Claims Commission is the conscience of the State of Arkansas.**" *Yang*, p. 3.

No, Davie was not going to ever get married and have children. No, he was never going to earn a high income. No, he was never going to support another person financially. No, he was never going read Dostoyevsky and he was never going to understand quantum physics.

However, for the same reasons, Davie existed largely unburdened by things like pride, ego, greed, lust, depression, existential dread, crises of faith, the nature of his existence, or the inherent terror of an unknowable future that plagues most of us to some degree in our daily lives.

But he absolutely did experience love and joy, and in their purest forms, as perhaps only small children can. We all know that little spark of joy when we turn on our car and our favorite song is playing on the radio. Davie knew that feeling, experienced the joy that comes from that every time he put on his headphones to listen to the Monkees sing "Last Train to Clarksville."

We all know the joy we feel when we see one of the people we love most in the world after an absence. Davie knew that feeling well. He experienced it every single day when he encountered any of the people who he loved and cared about, and there were many, as shown by the evidence. Davie knew laughter. He knew it better than most of us because more things and simpler things made him laugh. We all remember being a kid a Christmas or seeing our own children at Christmas, that pure, unbridled joy on Christmas Eve knowing that when they wake

up Santa will have left them something special. Davie experienced Christmas in a way only small children can every year of his life up until his death at 42.

From Davie's [redacted] perspective, subjectively, his life was worth all the money in the world. The following is only a portion of the evidence presented to the Commission in support of how much Davie valued his own life:

> *"Throughout his life he always participated in Special Olympics, and actually one of the last years that he was there, it's one of my favorite memories of him, I didn't tell him I was coming, it was at the Booneville High School. And because if I couldn't make it, I didn't want him to be upset. So, I get there and I'm in the stands, and I don't know how he saw me, but in the middle of the field, somehow he saw me and yelled, '"Yeehaw,"' like he was taking a hat off, which he didn't have on. And he said, '"There's my sister, there's my sister."' He yelled it. But so, it was just really funny."* **Exhibit 16**, Christine McAuliffe, p. 116.

> *"But that particular year is the only time I remember he actually won a race. And I have a picture of that. It's one of my favorite ones, because he came up to me afterwards and he was so proud. And he said, "Look, did you see me, Chrissie, I ran fast as hell." And I mean, he was just -- but like I said, his whole life, he was in his 30s and he – you know, he participated, but he never -- you know, he wasn't really good at it."* **Exhibit 16**, Christine McAuliffe, p. 117. *"That's probably one of my favorite memories, just because he was so happy and so proud of himself. Because he literally never, I don't think ever, won anything."* **Exhibit 16**, Christine McAuliffe, p. 117.

> *"David likes his job and takes great pride in working and talking about his work and earning money. David does want to be around his family, including his mother, his sister Chrissie, his half-sister Ashley, his uncle Patrick, and his grandparents. David does not like to be alone; he is very engaging with others and gets along with most of his peers.* ***David wants to have friends and spend time with them and go places with them.*** *(He expressed that even though he liked picking up trash when he lived on the campgrounds, he likes going to the movies with his friends at BHDC.) David likes to have his own possessions around him and he likes to have new and clean clothing. He has been very happy at BHDC and would like to stay here."* **BHDC Social History, p. 7.**

> Davie was a wonderful guy, a wonderful person, and fun to be around. **Exhibit 10, Ryann Campos, p. 65.**

> Davie was funny and playful. **Exhibit 11, Kelly King, p. 6.**

But, a lot of times, I remember specifically with him, he'd be listening and dancing and singing to the Monkees -- **Exhibit 20, Justin Jobb II, p. 62.**

A He just -- he loved music. Everybody that has been around him for five minutes knows he loved the Monkees, because he would listen to it 24/7 every day. That's not even an exaggeration. I'm sure the people at Booneville would tell you that. But, you know, ever since he was a little kid--
Q And how did he come to love the Monkees? Being, you know, born in the late '70s, he was -- the Monkees were around in the '60s. How did he discover the Monkees?
A Me and my brother, when we were kids, we watched Nick At Nite all the time. We didn't-- you know, that's about all we watched. So, I remember me and him, we watched things like I Love Lucy, The Monkees, Leave It To Beaver, those types of shows. And for whatever reason, he just -- he just latched onto the Monkees and the rest is -- you know, he never stopped. **Exhibit 16, Christine McAuliffe, p. 122-123.**

He had Monkees CDs, tapes, vinyl records, DVDs. His two favorite tracks were "Not Your Stepping Stone" and "Last Train to Clarksville." **Exhibit 16, Christine McAuliffe, p. 123.**

And actually, thankfully, I have a few videos of him, he would play tambourine, and he had some maracas I had gotten him from Central America, and I actually have a few videos of him playing those, and one of my friends playing them with him, which he did all the time, you know. **Exhibit 16, Christine McAuliffe, p. 123.**

He loved the Dukes of Hazzard. He had the DVDs and he would watch on repeat, except for the one season when Bo and Luke were replaced by Coy and Vance. He really didn't like that. **Exhibit 16, Christine McAuliffe, p. 124.**

"Yeah. So, I mean, he loved music, he loved, you know, DVDs, watching TV, he loved food, he loved --really, he loved -- he was very social. **He loved making people laugh and being around people. He didn't like being alone, he didn't like silence.** He just -- I don't know. He just -- he loved those things, he loved being a part of something, you know. I feel like, you know, being part of - - he had friends. I don't know how to explain it." **Exhibit 16, Christine McAuliffe, p. 124-125.**

CONCLUSION

This specific harm that resulted in Davie's life was abundantly foreseeable to Respondent. But it was not foreseeable to Davie Cains, [redacted] Given this, it seems harsh to hold Davie forty percent at fault for his death.

Davie valued his own life more than $350,000.00. He loved life, and it was taken away from him from him by Respondent's overwhelmingly negligent actions.

Claimant, for the reasons stated herein, respectfully asks this Honorable Commission to reconsider its findings as they pertain to apportionment of fault and loss-of-life damages.

Respectfully submitted,

/s/ Joshua D. Gillispie
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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was filed via email with the Arkansas Claims Commission on this 29th day of August, 2023, and service shall be accomplished via email to counsel of record.

/s/__Joshua D. Gillispie___
Joshua D. Gillispie

From: Joshua Gillispie
To: Kathryn Irby
Cc: ASCC Pleadings; Abbey Trussell
Subject: Re: McAuliffe v. DHS, Claim No. 220374
Date: Tuesday, July 30, 2024 8:44:00 AM

You don't often get email from josh@gillispielawfirm.com. Learn why this is important

Gotcha. Thanks.

Joshua D. Gillispie

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On Tue, Jul 30, 2024 at 7:29 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Josh, the Legislature will receive an unredacted copy. But they also require that I submit a copy with personal contact information, medical records, etc. redacted.
>
> Thanks,
>
> Kathryn
>
> ---
>
> **From:** Joshua Gillispie <josh@gillispielawfirm.com>
> **Sent:** Monday, July 29, 2024 9:41 PM
> **To:** Kathryn Irby <Kathryn.Irby@arkansas.gov>
> **Cc:** ASCC Pleadings <ASCCPleadings@arkansas.gov>; Abbey Trussell <Abbey.Trussell@dhs.arkansas.gov>
> **Subject:** Re: McAuliffe v. DHS, Claim No. 220374
>
> Kathryn-
>
> Okay. What kind of things do you normally redact? I would be fine with no redactions, unless I'm missing something.

Thanks,

Josh

Joshua D. Gillispie

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https://gillispielawfirm.com/

On Mon, Jul 29, 2024 at 9:11 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Josh, it will take me several weeks to get this claim file ready to go to the Legislature. I am required to submit an unredacted copy and a redacted copy. I will let you and Ms. Trussell review my proposed redactions before I send it over.
>
> We are not under any time constraints because this appeal will not be on the August 19 Claims Review agenda, and we don't have another meeting set yet. I expect there will be one more before the end of the year, though.
>
> Kathryn Irby
>
> ---
>
> **From:** Joshua Gillispie <josh@gillispielawfirm.com>

Sent: Monday, July 29, 2024 4:09 PM
To: ASCC Pleadings <asccpleadings@arkansas.gov>
Cc: Kathryn Irby <Kathryn.Irby@arkansas.gov>; Abbey Trussell <Abbey.Trussell@dhs.arkansas.gov>
Subject: Re: McAuliffe v. DHS, Claim No. 220374

Dear Commission-

Please accept for filing this Notice of Appeal in McAuliffe v. DHS, Claim No. 220374.

Best regards,

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605

North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax

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On Fri, Sep 15, 2023 at 10:17 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Thank you!

Joshua D. Gillispie

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On Fri, Sep 15, 2023 at 9:10 AM ASCC Pleadings <ASCCPleadings@arkansas.gov> wrote:

> Received on 9-11-23.
>
> ---
>
> **From:** Joshua Gillispie <josh@greenandgillispie.com>
> **Sent:** Thursday, September 14, 2023 4:12 PM
> **To:** ASCC Pleadings <ASCCPleadings@arkansas.gov>
> **Cc:** Kathryn Irby <Kathryn.Irby@arkansas.gov>; Abbey Trussell <Abbey.Trussell@dhs.arkansas.gov>; Daiquiri Carter <Daiquiri.carter@dhs.arkansas.gov>
> **Subject:** Re: McAuliffe v. DHS, Claim No. 220374
>
> Just making sure the Commission received my Reply filed on 9/11. Typically I get a "received" message back. Thanks!
>
> Joshua D. Gillispie
>
> 1 Riverfront Place, Suite 605
> North Little Rock, AR 72114
> (501) 244-0700

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On Mon, Sep 11, 2023 at 2:30 PM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Dear Commission:
>
> Please find Claimant's *Reply* to Respondent's Response to her Motion for Reconsideration.
>
> Best Regards,
>
> Josh
>
> Joshua D. Gillispie
>
> 
>
> 1 Riverfront Place, Suite 605
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On Tue, Aug 29, 2023 at 10:57 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Dear Claims Commission:

Please find attached Claimant's Motion for Reconsideration.

Best Regards,

Josh Gillispie

Joshua D. Gillispie



1 Riverfront Place, Suite 605
North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax
www.greenandgillispie.com

From: Joshua Gillispie
To: Kathryn Irby
Cc: ASCC Pleadings; Abbey Trussell
Subject: Re: McAuliffe v. DHS, Claim No. 220374
Date: Wednesday, September 25, 2024 1:52:31 PM

> You don't often get email from josh@gillispielawfirm.com. Learn why this is important

Hi Kathryn:

I am writing to find out if there is an update on this claim file being sent to the Legislature. And do you know if the committee has set another meeting for this year yet?

Thanks!

Joshua D. Gillispie



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On Tue, Jul 30, 2024 at 8:43 AM Joshua Gillispie <josh@gillispielawfirm.com> wrote:

> Gotcha. Thanks.
>
> Joshua D. Gillispie
>
> 
>
> 1 Riverfront Place, Suite 605
> North Little Rock, AR 72114
> (501) 244-0700
> (501) 244-2020 fax
> https://gillispielawfirm.com/
>
> On Tue, Jul 30, 2024 at 7:29 AM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:
>
> > Josh, the Legislature will receive an unredacted copy. But they also require that I submit a copy with personal contact information, medical records, etc. redacted.
> >
> > Thanks,

Kathryn

From: Joshua Gillispie <josh@gillispielawfirm.com>
Sent: Monday, July 29, 2024 9:41 PM
To: Kathryn Irby <Kathryn.Irby@arkansas.gov>
Cc: ASCC Pleadings <ASCCPleadings@arkansas.gov>; Abbey Trussell <Abbey.Trussell@dhs.arkansas.gov>
Subject: Re: McAuliffe v. DHS, Claim No. 220374

Kathryn-

Okay. What kind of things do you normally redact? I would be fine with no redactions, unless I'm missing something.

Thanks,

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605

North Little Rock, AR 72114
(501) 244-0700
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https://gillispielawfirm.com/

On Mon, Jul 29, 2024 at 9:11 PM Kathryn Irby <Kathryn.Irby@arkansas.gov> wrote:

> Josh, it will take me several weeks to get this claim file ready to go to the Legislature. I am required to submit an unredacted copy and a redacted copy. I will let you and Ms. Trussell review my proposed redactions before I send it over.
>
> We are not under any time constraints because this appeal will not be on the August 19 Claims Review agenda, and we don't have another meeting set yet. I expect there will be one more before the end of the year, though.
>
> Kathryn Irby

From: Joshua Gillispie <josh@gillispielawfirm.com>
Sent: Monday, July 29, 2024 4:09 PM
To: ASCC Pleadings <asccpleadings@arkansas.gov>
Cc: Kathryn Irby <Kathryn.Irby@arkansas.gov>; Abbey Trussell <Abbey.Trussell@dhs.arkansas.gov>
Subject: Re: McAuliffe v. DHS, Claim No. 220374

Dear Commission-

Please accept for filing this Notice of Appeal in McAuliffe v. DHS, Claim No. 220374.

Best regards,

Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605

North Little Rock, AR 72114
(501) 244-0700
(501) 244-2020 fax

https://gillispielawfirm.com/

On Fri, Sep 15, 2023 at 10:17 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Thank you!
>
> Joshua D. Gillispie
>
> 1 Riverfront Place, Suite 605
> North Little Rock, AR 72114
> (501) 244-0700
> (501) 244-2020 fax
> www.greenandgillispie.com

On Fri, Sep 15, 2023 at 9:10 AM ASCC Pleadings <ASCCPleadings@arkansas.gov> wrote:

> Received on 9-11-23.
>
> ---
>
> **From:** Joshua Gillispie <josh@greenandgillispie.com>

Sent: Thursday, September 14, 2023 4:12 PM
To: ASCC Pleadings <ASCCPleadings@arkansas.gov>
Cc: Kathryn Irby <Kathryn.Irby@arkansas.gov>; Abbey Trussell <Abbey.Trussell@dhs.arkansas.gov>; Daiquiri Carter <Daiquiri.carter@dhs.arkansas.gov>
Subject: Re: McAuliffe v. DHS, Claim No. 220374

Just making sure the Commission received my Reply filed on 9/11. Typically I get a "received" message back. Thanks!

Joshua D. Gillispie

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North Little Rock, AR 72114
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On Mon, Sep 11, 2023 at 2:30 PM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Dear Commission:
>
> Please find Claimant's *Reply* to Respondent's Response to her Motion for Reconsideration.
>
> Best Regards,
>
> Josh

Joshua D. Gillispie

1 Riverfront Place, Suite 605
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(501) 244-0700
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On Tue, Aug 29, 2023 at 10:57 AM Joshua Gillispie <josh@greenandgillispie.com> wrote:

> Dear Claims Commission:
>
> Please find attached Claimant's Motion for Reconsideration.
>
> Best Regards,
>
> Josh Gillispie

Joshua D. Gillispie

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North Little Rock, AR 72114
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