Act 45 Annual Report

Restraint Use and Reporting Requirements of Pregnant Females
July 1, 2016 - June 30, 2017

Background

Senate Bill 1074, Printer's Number 1776, of the 2009 session of the General Assembly was signed into law by former Governor Edward G. Rendell on July 2, 2010, as Act 45.

The Act amends Title 61 (Penal and Correctional Institutions) of Pennsylvania Consolidated Statutes and prohibits the application of restraints to pregnant females who have been alleged or adjudicated delinquent during:

- Any stage of labor.
- Any pregnancy-related medical distress.
- Any period of delivery.
- Any period of postpartum.
- Transport to a medical facility as a result of any of the preceding conditions.
- Transport to a medical facility after the beginning of the second trimester of pregnancy.

Act 45 provides a specific exception that reasonable restraints may be permitted during certain specific events. Reasonable restraints may only be used after a staff person assigned to the pregnant youth has made an individualized determination that the youth presents a substantial risk of imminent flight or an extraordinary medical or security circumstance dictates that the youth be restrained to ensure the safety of herself, staff of the licensed program, the youth development center (YDC), the youth forestry camp (YFC), medical facility, other youth, or the public.

Reasonable restraints permitted under this exception must meet the following requirements:

- The reasonable restraint must be of the least restrictive type and be applied in the least restrictive manner.
- At no time will the youth be left unattended by a staff person with the ability to release the restraint should it become medically necessary.
- The staff person must immediately remove all restraints upon request of a doctor, nurse, or other health care professional.
- Leg and waist restraints are prohibited on a known pregnant youth who is in labor.

Reporting Requirements

Act 45 requires that child residential and day treatment programs licensed under 55 Pa. Code Chapter 3800, as well as YDCs and YFCs operated by the Office of Children, Youth and Families (OCYF), report any restraint applied to a known pregnant female youth who is alleged or adjudicated delinquent and is being served pursuant to a court order. This information is compiled into an annual report each fiscal year that identifies and enumerates the circumstances of each restraint.

Findings

During fiscal year July 1, 2016, to June 30, 2017, a total of nine restraints were applied on four pregnant youth who are adjudicated delinquent. One pregnant female was restrained twice at the Philadelphia Juvenile Justice Center. Three pregnant females were restrained a total of seven times at North Central Secure Treatment Unit (NCSTU), operated by OCYF's Bureau of Juvenile Justice Services. Of those three, one resident was restrained five times. As of June 30, 2017, there are a total of 669 facilities licensed by the Department of Human Services (DHS) as child residential and day treatment programs and five additional facilities operated by DHS as a YDC or YFC.

Pregnant Female	Facility	Date of Restraint	Time of Restraint	Type of Restraint	Reason for Restraint
Female 1	Philadelphia Juvenile Justice Center	12/09/2016	10:00a.m.	Mechanical Restraint	Self-harming behaviors, then verbally and physically out of control.
Female 1	Philadelphia Juvenile Justice Center	12/23/2016	7:00 p.m.	Manual	Refusal to accept consequences for previous behavior by being disruptive and physically threatening staff members.
Female 2	NCSTU	02/03/2017	9:00 a.m.	Manual	Left supervised area and when stopped began physically threatening staff members.
Female 3	NCSTU	02/06/2017	1:32 p.m.	Manual	Kicking and punching doors and verbally threatening staff members.
Female 3	NCSTU	02/06/2017	1:52 p.m.	Manual	Lunging at a staff member and making verbal threats to harm staff.

Pregnant Female	Facility	Date of Restraint	Time of Restraint	Type of Restraint	Reason for Restraint
Female 3	NCSTU	02/06/2017	5:05 p.m.	Manual	Attempted property damage by throwing a water bottle. Safety and security concern by attempting to leave the supervised area.
Female 3	NCSTU	02/07/2017	4:26 p.m.	Manual	Safety/security violation/concern by leaving the area staff was supervising.
Female 3	NCSTU	02/21/2017	8:00 a.m.	Manual	Physical aggression towards staff by pushing a staff member.
Female 4	NCSTU	04/10/2017	1:30 p.m.	Manual	Physical aggression towards staff by raising her hands toward the intake staff member.

On 12/9/2016, Resident 1 became upset, out of control, and disrespectful towards staff after waking up. Resident 1 appeared as though she was cutting herself prompting staff to enter her room and remove all items for her safety. She concealed what she was using to cut herself and when asked to give the item to staff she swallowed it. She then became physically and verbally aggressive towards staff and she was placed in mechanical restraints. She did not have any medical injuries therefore no medical treatment was required. Resident 1 was placed on 1:1 supervision.

On 12/23/2016, Resident 1 received consequences for inappropriate language, failure to follow instructions, and continuous disruptive behavior. She had to be restrained and taken to another area; the duration of the restraint was 30 minutes. Resident 1 was evaluated by the Philadelphia Juvenile Justice Center medical staff.

On 2/03/2017, Resident 2 became upset after learning that staff would need to monitor her in the bathroom due to being on Constant Observation as a result of arriving the previous day. Resident 2 reported that she was not suicidal and would talk to people however she wanted. Her behavior continued to escalate and she walked away from staff during the course of talking through the events. To ensure the safety of the resident, staff, and another resident who was in the room on medical bedrest, and due to her lack of response to de-escalation techniques, staff attempted to intervene and Resident 2 became aggressive resulting in the use of a restraint for five minutes. Resident 2 was seen by the Medical Department and required no medical follow up.

On 2/06/2017 and 2/07/2017, the use of restraints techniques on Resident 3 occurred on four occasions. At 1:32 p.m., Resident 3 was being seen by the nurse for reported chest pain and was told that the doctor would be informed and consulted. The nurse continued to ask follow up questions but Resident 3 left the area without permission and demanded to be taken back to class. Staff attempted to calm her and to remind her to use her coping skills. Once she was calm, staff and Resident 3 left the medical hallway and she was asked to enter the group room. She refused and began kicking and punching the door. A restraint was initiated and Resident 3 continued to struggle for approximately 12 minutes. Resident 3 was seen by the Medical Department and no medical follow up related to the restraint was necessary. All vitals were taken and were normal.

At 1:52 p.m., the use of a restraint was needed a second time after Resident 3 refused to take ownership for her previous behaviors. While staff was trying to speak with Resident 3, she lunged at a staff member and a restraint was initiated which lasted approximately 10 minutes. Resident 3 was seen by the Medical Department and no medical follow up was required.

At 5:05 p.m., Resident 3 was asked to return to her seat by staff. Resident 3's behaviors began to escalate. She threw her water bottle and it broke on the floor and moved into proximity of the staff member confronting her behavior. A restraint was initiated and lasted approximately 27 minutes. While staff were attempting to de-escalate Resident 3, she began kicking furniture and trying to escape the restraint, she was able to free her arm during the struggle. She was seen by the Medical Department complaining of mild lower left arm pain. She was assessed and showed normal range of motion and neurovascular status intact. She was offered Tylenol and an ice pack. Resident 3 reported to a staff member that she felt the restraint was improper and staff contacted ChildLine to make a report.

On 2/7/2017, a restraint was used when Resident 3 failed to comply with staff directives and walked away. As staff attempted to intervene, Resident 3 became aggressive. The nurse was notified to observe the restraint techniques. Resident 3 was transitioned from the gym to the Honor Dorm group room. Once in the group room, she was able to commit to safety and was released from all holds. She refused to be assessed by either of the two nurses that were present. It is noted that no signs of acute stress were observed. The restraint lasted 26 minutes in duration.

On 2/21/2017, after receiving feedback from her peers and being unable to discuss the feedback with staff, Resident 3's behavior resulted in the use of a physical intervention. She attempted to push through staff to get into the room with the other residents. The restraint was approximately four minutes in duration. Resident 3 was seen by the Medical Department and required no medical follow up.

On 4/10/2017, Resident 4 was being asked to provide intake information, which she refused to do. She was being verbally disrespectful and was asked to follow staff directives. At that time, she raised her hand toward staff and a restraint was initiated due to not knowing Resident 4's intent. This lasted approximately four minutes. Resident 4 was seen by the Medical Department and required no medical follow up.