



STATE OF DELAWARE  
STATE COUNCIL FOR PERSONS WITH DISABILITIES

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**MEMORANDUM**

DATE: March 29, 2012

TO: The Honorable Susan Del Pesco, Director  
Division of Long Term Care Residents Protection

FROM: Daniese McMullin-Powell, *DMP/KW* Chairperson  
State Council for Persons with Disabilities

RE: 15 DE Reg. 1264 [DLTCRP Proposed IBSER Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Long Term Care Residents Protection's (DLTCRP) proposal to adopt Intensive Behavioral Support and Educational Residences (IBSER) regulations. The proposed regulation was published as 15 DE Reg. 1264 in the March 1, 2012 issue of the Register of Regulations.

As background, SCPD commented on an earlier version of this proposed regulation published last Fall [15 DE Reg. 600 (11/1/12)]. Attached is a November 18, 2011 letter from SCPD for facilitated reference which contains forty-four (44) comments. Rather than adopt a final regulation, DLTCRP is issuing a revised set of proposed standards. SCPD has the following thirty-two (32) observations.

1. The revised regulation incorporates many of the Councils' recommendations, including the following: inclusion of "purposes" and "authority" sections (§§1.0 and 2.0); improving the definition of "legal representative" (§3.0); clarifying the application of the regulation to day program participants (§3.0); including an accessibility reference in §6.1.2; authorizing non-glass shower doors (§6.5.3); disallowing children sharing rooms with adults (§6.6.15); requiring notice near phones of the DLTCRP telephone number (§6.12.3); requiring carbon monoxide detectors (§8.3); requiring certain information be included in agency website (§10.2); adding a general 5 year retention of records standard (§11.1.3); requiring maintenance of fire and comprehensive general liability insurance (§12.0); eliminating "criminal justice" as a relevant background degree (§13.2.4);

requiring training in safe and effective behavior management techniques (§14.3.3); requiring monthly HRC meetings (§17.1.1.3); and requiring retention of incident reports for four years (§24.2). SCPD certainly appreciates that the Division incorporated Council's recommendations in these contexts.

2. The title to §1.0 is "Purpose Definition". This makes no sense. Moreover, there is still no "operational" language reciting that the standards apply to IBSERs and no "purposes" language despite the title. Compare the neighborhood home regulation, 15 DE Reg. 968 (January 1, 2012), §1.0:

The purpose of these regulations is to provide a sequence of expectations for services rendered by the Neighborhood Home provider and a system for Neighborhood Home providers to be accountable to the Division of Long Term Care Residents Protection (DLTCRP) and the Division of Developmental Disabilities Services (DDDS).

[emphasis supplied] There is no analog in the IBSER regulation.

SCPD recommends changing the heading to "Purpose" (deleting "Definition") and adding the following sentence:

The purpose of these regulations is to provide a set of expectations for the operation of IBSERs and ensure accountability to the Division of Long Term Care Residents Protection (DLTCRP).

3. The definition of "mechanical restraint" ostensibly seeks to exempt equipment and devices with a medical basis (e.g. prone stander; bed siderails). However, the definition would literally authorize a non-medical, undefined mental health "therapist" to authorize any form of mechanical restraint to prevent SIBS. At a minimum, the reference should be changed to occupational or physical therapist.

4. The definition of "mechanical restraint" is otherwise problematic. Literally, any equipment used to deter SIBS is per se not a "restraint". As a consequence, it would be exempt from inclusion in the SBS plan (§20.2.2), review by the Behavior Management Committee (§§18.2 and 18.3), and review by the HRC (§§17.1.2 and 18.3). Thus, use of a helmet, mittens, or other AT would be exempt from many procedural safeguards. This is not "best practice" and is inconsistent with DDDS policy (e.g. DDDS HRCs review use of helmets, mittens, and AT used for SIBS prevention).

5. In the definition of "physical restraint, it would be more logical to transfer the second sentence (barring certain forms of restraint) to §20.11 (containing list of 12 forms of prohibited restraint). Moreover, the reference to "free movement of the resident's diaphragm or chest that restricts the airway" could be improved. Some states have focused on pressure on certain body parts as more instructive. Consider the following prohibition: "Restraint that interferes with the resident's ability to breathe or places weight or pressure on the resident's throat, neck, lungs, chest, sternum, diaphragm, or back."

6. There is a definition of "seclusion" but no regulation which addresses it. The November version

of the regulation explicitly barred use of seclusion. The Bill of Rights Act explicitly bars “involuntary seclusion” without exception [Title 16 Del.C. §1121(24)]. Therefore, the IBSER regulation must conform to the statute and the ban should be reinstated. Parenthetically, this is consistent with “best practice”. See Section 4 of attached S. 2020 introduced by Sen. Harkins in December, 2011.

7. The definition of “Specialized Behavior Support Plan” is defective. Literally, the plan is expected to include a restraint to a resident to protect the resident from others. Why would an agency use a restraint on an individual to prevent his/her victimization from others? Immobilizing the victim will only exacerbate the victimization.

8. In §5.5, delete the comma.

9. The DLTCRP Neighborhood Home regulation imposes the following obligation:

4.2.7.2. The Policy Memorandum 46 (PM 46) policy for reporting abuse, assault, attempted suicide, mistreatment, neglect, financial exploitation and significant injury is followed.

15 DE Admin Code 968, §4.2.7.2 (January 1, 2012) (proposed). There is no analog in the IBSER regulation. The DLTCRP could consider inserting a similar recital as a new §5.10 or within §19.0.

10. In the commentary on the November version of the regulations, SCPD provided a multi-pronged critique of allowing a 16-bed facility. See, e.g., Par. 11 of attached SCPD comments. The new regulation reflects a compromise in which 16-bed facilities are “grandfathered” and new facilities must have no more than 10 residents. Segregated residential settings with 10 or 16 individuals per unit are not consistent with best practice and may violate the ADA. Consider the DHSS-DOJ DPC Settlement Agreement signed in July, 2011. That Agreement, which is based on the DOJ’s interpretation of the ADA, does not contemplate large congregate living arrangements. Rather it restricts supported housing to 2 individuals per unit with a separate bedroom for each resident (§II.E.). A 10 or 16-bed facility in which adult residents are “squeezed” into tiny rooms (§6.6.1) with age-inappropriate bunk beds (§6.6.11) smacks of “warehousing”.

10.A In Section 6.2.1., SCPD recommends inserting “related to living unit space” after “DelaCare regulations” to clarify that the DelaCare regulations only apply to this section for facilities that may be grandfathered. In addition, since the facilities are grandfathered, SCPD recommends the Division clarify that additional capacity should not be allowed if the Office of Child Care Licensing issues a temporary waiver of the living unit space standard.

11. Section 6.2.2 should be amended to include a reference to “legal representative” since the list of authorized visitors entitled to meet in private is literally limited to four types. Compare Title 16 Del.C. §1121(11).

12. SCPD previously objected to 200 square foot bedrooms with 4 individuals. See attached SCPD letter, Par. 14. New §6.6 contains a “grandfather” provision for bedroom occupancy. New

facilities will require 80 square feet for single occupancy and 130 square feet for double occupancy. This is still less floor space than required in group homes for double occupancy for persons with mental illness. See 16 DE Admin Code 3305, §12.2.2 (requiring 160 square feet for double occupancy). Likewise, the latter regulation disallows counting areas with lockers, wardrobes, vestibules, and alcoves. This limit is absent from the IBSER regulation. At a minimum, double occupancy standards should be no less than mental health group home standards (160 square feet exclusive of closets, lockers, wardrobes, vestibules and alcoves).

12.A In Section 6.6.1.2, SCPD recommends inserting “related to bedroom accommodations” after “DelaCare regulations” to clarify that the DelaCare regulations only apply to this section for facilities that may be grandfathered.

13. In §6.6.11, the authorization for adults to sleep in bunk beds is not age-appropriate.

14. In §6.5 or 6.7, the Division may wish to consult a dental expert. It may be appropriate to require a facility using well water to offer a fluoride rinse to some residents. Medicaid does not cover adult dental care and DDDS struggles with dental remediation which could be reduced through access to fluoride rinse in the absence of fluoridated water.

15. The DLTCRP Neighborhood Home regulations [15 DE Reg. 968, §4.6.6.7 (January 1, 2012) (proposed)] contain the following requirement: “(n)on-perishable food and capacity to store 1 gallon of potable water per person per day for at least a 72-hour period is present”. The Division could consider adding a similar water storage capacity standard to §7.10.

16. In §13.2.3.1, a direct care worker is required to be 21 years of age and possess a high school diploma. The Division may wish to consider the merits of substituting “18” for “21”. The change would allow college students (e.g. in human service fields such as psychology) to work part-time as direct care workers. Alternatively, the regulation could allow individuals to be employed as direct care workers between the ages of 18-20 only if they are college students in a human services field (defined in §§13.2.1.1, 13.2.4.1 and 13.2.5.1). In addition, the Division may want to assess whether the requirement of a high school diploma or equivalent is sufficiently job related to include in the regulations as a standard for direct care workers.

17. In §14.5.2, substitute “resident” for “patient”.

18. Section 17.0 merits reconsideration. The only agency to which the IBSER regulation applies presented its first of many cases to the DDDS HRC on February 29, 2012. The DDDS HRC does not include individuals with the qualifications listed in §17.1.1.2, including a licensed physician and licensed psychologist. On the other hand, the standards for the “internal” HRC are weak in the context of impartiality. DDDS amended its policy many years ago to require 100% membership by individuals external to DDDS. The IBSER regulation only requires a majority of external members and the “spirit” of this regulation may be undermined in practice by including a recent agency retiree as an “external” HRC member.

19. Section 18.1 refers to “the licensee’s clinical director”. There is no requirement that an agency have a “clinical director” and no definition of a “clinical director” in §13.0.

20. Although §20.7 contains a reference to data collection, it would be preferable to explicitly include a reference to presentation of data to the BMC in §18.2.1.

21. In §19.2, it would be preferable to include a reference to “contractor”. The only agency currently subject to the IBSER regulation uses physician contractors.

22. Section 20.2.1 may be the most problematic standard in the regulations. It authorizes restraint based on the following benchmark:

The resident is exhibiting a problem behavior that is so severe that it poses a risk to the safety and wellbeing of the resident or others;

Authorizing the use of restraint based on the “safety and wellbeing” of the resident or others is amorphous and an invitation to overuse of restraint. If restraint is authorized by government, it is commonly restricted to an imminent risk of serious bodily injury to self or others. See, e.g., attached S.2020, Section 4. The concept of “imminency” is incorporated into §20.8.3 as material to termination of restraint but is absent from the standards for initiation of restraint. Moreover, if government does authorize use of restraint, it is also common to ban use of mechanical restraint. See S. 2020, Section 4. Use of straight jackets, wrap mats, rope and tape to restrict access to body parts is viewed as inherently intrusive. Cf. the attached February 12, 2012 News Journal article describing prosecution of a teacher for false imprisonment and endangering the welfare of a child based on tying the hands of a child with autism.

23. Section 20.3 refers to an undefined “SPTeam” which includes an undefined “properly credentialed professional”. It would be preferable to add “, licensed or certified” after “credentialed” since agencies may otherwise use marginally qualified “behavior analysts” without an advanced degree to develop an SBS Plan.

24. The only agency to which the regulation will apply uses video cameras throughout its buildings. It would be preferable to amend §20.9 to require maintenance of any recorded episode of restraint. Such a recording would be of diagnostic and training value for the SBTeam, HRC, and administration. It may also be of value to the DLTCRP.

25. Section 20.9.1 contemplates “clinical review and approval for interventions longer than 15 minutes”. Who has the authority to issue the approval? Is a “direct care worker” with high school diploma (§13.2.3.1) a “clinician” who can approve extended restraint? Within the DDDS HRC, it is common to require approval by the agency’s clinical director or alternate. The IBSER regulation refers to a clinical director in §18.1 but does not require a clinical director (§13.0) and does not define a “clinical director”.

26. Section 20.9.2 requires “(a)pproval by a clinician within one business day of an intervention

when a restraint utilization event is less than 15 minutes.” There are two concerns with this provision. First, there is no definition of a “clinician”. Second, it is somewhat odd to retroactively “approve” an intervention a day after it was employed unless the intent is to prompt review to deter misuse.

27. It would be preferable to include a new §20.11.13 to read as follows: “Consistent with 34 C.F.R. §§300.2 (c) and 300.146, use of restraint or forms of aversive techniques on adult IDEA-funded residents or students which violate applicable law or regulation of the public IDEA funding agency.

28. Since the regulation covers adults, the reference to “parents” in §22.6 is inapposite. It would be preferable to refer to the consent of “the resident or legal representative” rather than “parents or legal guardian”.

29. Although there is a short “universal precautions” section (§23.0), there is no section which addresses laundry. In practice, the facility could commingle the laundry of 16 individuals in cold water and spread disease. Compare 16 DE Admin Code 3201, §7.6.

30. Section 24.1 could be improved by including the following after “witnesses;”: “the existence of any video record of the incident”.

31. In §§24.4.2 and 24.4.4, it is inconsistent to require reporting of resident - resident emotional abuse while exempting reporting of resident - resident physical abuse in the absence of injury.

32. Section 24.4.11 only requires reporting of medication errors unless the error causes discomfort, jeopardizes health/safety, or requires 48 hours of monitoring. The exceptions provide subjective bases to withhold reporting to the Division.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulation.

cc: The Honorable Rita Landgraf  
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Ms. Jane Gallivan  
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Governor’s Advisory Council for Exceptional Citizens  
Developmental Disabilities Council

15reg1264 dltrcp-al IBSER 3-12



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**MEMORANDUM**

DATE: November 18, 2011

TO: The Honorable Susan Del Pesco, Director  
Division of Long Term Care Residents Protection

FROM: Daniese McMullin-Powell, Chairperson  
State Council for Persons with Disabilities

RE: 15 DE Reg. 600 [DLTCRP Proposed IBSER Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Long Term Care Residents Protection's (DLTCRP) proposal to adopt a new regulation covering Intensive Behavioral Support and Educational Residences (IBSER). The proposed regulation was published as 15 DE Reg. 600 in the November 1, 2011 issue of the Register of Regulations. SCPD appreciates collaborating with the Division on the proposed regulation and has the following observations and recommendations.

1. In §1.0, the definition of "Intensive Behavioral Support and Educational Residence (IBSER)" is problematic.

First, it literally recites that the IBSER regulations apply to "individuals" irrespective of their residence. The regulation should recite that it applies to covered facilities. This observation underscores a significant omission in the regulation, i.e., it omits "purpose" and "authority and applicability" sections altogether. Compare regulations covering assisted living and group homes, 16 DE Admin Code Parts 3225 and 3305. Conceptually, there is no recital that the regulation applies to defined IBSERs which shall conform their operations to the regulation. Such a recital should not appear in a definition (e.g. last sentence in §1.0) but in an "authority and applicability" section and it should apply to facilities, not individuals.

Second, it contains the following reference: "dual diagnoses of severe mental or emotional disturbance and who have specialized behavioral needs". This does not make sense. Having

“specialized behavioral needs” is not a “diagnosis”. An alternate interpretation is that the “specialized behavioral needs” reference applies to autism, developmental disabilities, and mental/emotional “disturbances” in which case the reference to “dual diagnoses” makes no sense.

2. The references to “specialized behavior support plan (SBS Plan)” and “comprehensive behavior support plan” are confusing. The definition of SBS Plan indicates that the comprehensive behavior support plan is an optional supplement to the SBS. There is no or conflicting guidance on when a “comprehensive” plan must be in effect. For example, §19.2.2 indicates that restraint can only be part of a “comprehensive” plan. Other sections contemplate restraint being incorporated in the “specialized” plan. See, e.g., §2.0, definition of SBS Plan, second sentence; and §16.2.2.2.3. Multiple sections appear to authorize “comprehensive” plans with or without a restraint component. See, e.g., §§19.3, 19.4, and 19.5. The differences between the plans, and guidance on when each type of plan is required, should be clarified. Alternatively, it would be much simpler to have a single plan for everyone.

3. In §2.0, definition of “chemical restraint”, the reference to “not part of the individual’s usual medication regimen” could result in a loophole. In effect, if a physician prescribes a psychotropic medication as a “PRN”, this could be construed as part of the individual’s “usual medication regimen”. Alternatively, the prescription of a daily “tranquilizer” would be part of the “usual medication regimen”.

4. In §2.0, definition of “funding agency”, delete “is”.

5. Section 2.0 includes a definition of “legal representative” which merits reconsideration.

First, it is “odd” to include “payor source” as a “legal representative”. It creates problems with use of the term in the context of consent. A “payor source” has no consent authority.

Second, the term is seldom used in the regulation. See, e.g., §19.1. Instead, there are many inconsistent references to guardians, surrogates, family members, and responsible parties. See, e.g., §2.0, definition of SBS Plan; §16.4.1; §19.4.2; and §24.1.2. It would be preferable to use the uniform term “legal representative” throughout the regulation.

6. In §2.0, the definition of “resident” is “the individual residing in the IBSER and subject to IBSER regulation.” It is unclear if adult “day students” are covered by the regulation, in whole or in part. For example, could an IBSER impose otherwise barred prone restraint, seated basket holds, chemical restraint, and seclusion on day students? This should be clarified in the regulation.

7. Section 2.0, definition of “restraint”, contains a final sentence barring 2 forms of restraint. It is “odd” to refer to 2 forms of barred restraint in the definition section when §19.8 contains a lengthy list of prohibited forms of restraint.



8. In §2.0, definition of SBS Plan, consider substituting “resident or legal representative” for “resident, his or her guardian or surrogate”. See discussion in Par. 5.

9. In §3.3.2, consider deletion of “must”.

10. Section 5.0 contains some safety-related accessibility features (e.g. handrails in showers; bright lighting; barriers to deter falls in elevated areas). Since there is positive correlation between cognitive developmental disabilities and mobility impairments, it would be preferable to also promote the physical accessibility of facilities. In §5.1.2, the word “accessibility” could be inserted between the word “education” and words “and construction”. In other contexts (e.g. furniture), the regulation envisions furnishings compatible with the “capabilities of the residents”. See §§5.1.7.2 and 5.1.8.1.

11. Section 5.1.7.1 allows up to 16 residents per residence. This is not consistent with “best practice”. These are not “group homes”. In contrast, neighborhood homes have 5 or fewer residents [16 DE Admin Code Part 3310, §1.0] and group homes for persons with mental illness have 10 or fewer residents [16 DE Admin Code Part 3305, §2.0]. State law [Title 9 Del.C. §2612] requires New Castle County to treat residential facilities for persons with disabilities with up to 10 residents as single family residences. As a consequence, almost all supervised residential facilities stay under the “10 resident” cap to avoid zoning problems. There is some “tension” between the “Olmstead” decision and placement of individuals with disabilities in such large congregate living arrangements. The DLTCRP may wish to consider prospects for reducing the size of such facilities over time (e.g. disallowing new licensed facilities from opening with more than 4-5 persons per residence). Existing facilities could be “grandfathered” on a temporary or long-term basis. The most desirable approach would be to only allow a maximum of 4 residents per residence subject to waiver based on a finding of undue hardship. Otherwise, new facilities will be designed with outdated “institutional” 16-bed sites and the Division will be constrained to approve them based on existing standards. Existing facilities planning expansion will also be guided by the 16-bed authorization and have no incentive to design smaller, more “normalized” settings. It’s cheaper to “warehouse” residents.

12. Section 5.1.7.1 appears to contemplate mixing of children and adults in the same residence. Indeed, children and adults could share the same bedroom as long as of same sex. See §5.3.7. This is an invitation to abuse. The Division should establish standards in this context in coordination with the Office of Child Care Licensing. Cf. Title 16 Del.C. §5135 and Title 10 Del.C. §1009(j).

13. In §5.2.4, the reference to “glass” could be interpreted to require a glass shower door as juxtaposed to a less breakable and dangerous substitute (e.g. lexan; plexiglass).

14. Section 5.3.1 authorizes crowded conditions. Literally, it requires less floor space for multiple occupancy bedrooms than a single-occupancy bedroom. Intuitively, this should be reversed. The minimum floor space in this regulation is much less than that in group homes for persons with mental illness. See 16 DE Admin Code Part 3305, §12.2.2 (80 square feet of floor space per individual required if multiple person bedroom and no more than 2 persons can sleep in bedroom).

This equates to 160 square feet per 2-person bedroom. Section 5.3.1.2 allows 4 persons to be placed in a 200 square foot bedroom. The use of tiers of bunk beds for adults (§5.3.4) is also not age appropriate or normal. Crowded conditions are correlated with stress and may promote roommate conflicts since there is little “personal space”. The Division should consider establishing more enlightened standards akin to group homes in this context and consider a waiver (§25.0) or grandfather authorization to an existing facility if compliance would result in an undue burden.

15. Sections 5.9 and 7.6.7 contemplate the posting of certain phone numbers. Section 4.8 requires compliance with the Patient’s Bill of Rights (§4.8) which includes a posting requirement (Title 16 Del.C. §1123). It would be preferable to require the display of a DLTCRP phone number to facilitate resident complaints. By definition, the residents of an IBSER will have diagnoses of autism and other developmental disabilities which are commonly correlated with diminished cognitive capacity. It is therefore important to “simplify” their access to the Division.

16. In Section 7.3, the Division may wish to explore whether carbon monoxide and natural gas detectors should be installed and operational. There are dual smoke alarm/carbon monoxide detectors. The Fire Marshall could be consulted.

17. In Section 9.1, an apostrophe should be inserted in “programs”.

18. In Section 9.2, consider adding the following final sentence: “If the licensee maintains a website, the same information shall be included on the site.

19. In Section 10.0, the Division should consider including a time period for retention of records. Section 23.2 requires the retention of incident reports for 3 years. By analogy, nursing homes must retain records for 6 years after discharge. [16 DE Admin Code 3201, §9.3] Group homes for persons with mental illness must retain records for 7 years after discharge. [16 DE Admin Code, §8.1]

20. In Section 11.0, comprehensive general liability insurance is required only if mandated by State law or regulation. SCPD is not aware of any such law or regulation. Thus, a facility could operate without liability insurance. There should be an unconditional requirement that the facility maintain general liability insurance.

21. In §§12.2.4.1, 12.2.4.1.2, and 12.2.5.1, delete the references to “criminal justice”. An IBSER is not a penal or correctional facility and the skill-set for staff is not criminal justice related.

22. In Section 13.2.6, consider substituting “does” for “must”.

23. Section 13.3 does not offer any guidance on the prioritization of training in behavior management policies and procedures. A facility could provide 15 minutes of training in this context with the balance on other topics. It would be preferable to require a minimum number of training

hours on behavior management policies and procedures. Moreover, it would be preferable to target not only "policies and procedures" but skills and techniques. The reference could be modified to read "behavior management policies, procedures, and safe and effective techniques". The same comment applies to §13.2 which addresses knowledge of policies and procedures to the exclusion of Mandt-type training.

24. Section 16.1.1.3 contemplates the HRC meeting at least quarterly. This should be changed to monthly to conform to other regulatory sections. The BMC reviews an SBS Plan monthly (§16.2) followed by HRC review (§16.3) and the HRC must review "individual and aggregate clinical data on the frequency of restraint interventions for each individual ...monthly" (§16.8).

25. In Section 16.1.2.3, it would be preferable for the HRC to also review incident reports since §16.1.2.1 contemplates the HRC "determining that residents in care are receiving humane and proper treatment".

26. There is a reference to "clinical director" in §§16.2. There is no definition of "clinical director" and the position is not listed among the mandatory personnel in §12.0.

27. In §16.4.1, substitute "individual or legal representative".

28. There is a conflict between §§16.2 and 16.7. The former requires monthly plan reviews. The latter requires monthly plan reviews for the first 90 days followed by quarterly reviews. Monthly reviews would be preferable.

29. Section 18.1 contains multiple references to "non-violent physical intervention". Intuitively, such an intervention would overlap with "restraint". There is no definition of "non-violent physical intervention". A definition should be added or an alternate term adopted. SCPD is unfamiliar with the term "non-violent physical intervention".

30. Section 19.8.12 bans "seclusion". Section 18.1 authorizes "time-out". The definition of "seclusion" (§2.0) is narrow and only applies to a locked room. Therefore, if a facility placed a resident in a closed room with a manually held door mechanism, that would be permitted under the regulation. It would be preferable to define "time-out" and to expand the definition of restraint to cover more than locked rooms.

31. Section 19.8 should be amended to include wrap mats.

32. Section 19.3 contemplates the development of a comprehensive behavior support plan by an "education, habilitation, or treatment team". These "teams" are not defined in the regulation.

33. In Section 19.3, the reference to "or medical professional and other relevant professionals"

makes no sense. Literally, the regulation requires the following:

1. behavior analyst, psychologist, or “other properly credentialed professional”; and
2. physician or psychiatrist; and
3. nurse practitioner.

OR in lieu of all of these, a “medical professional and other relevant professionals”.

34. Section 19.3.1 refers to “the behavioral clinical professional”. This term is undefined. SCPD suspects it is intended to cover the behavior analyst, psychologist, or other properly credentialed professional referenced in §19.3. The regulation then adopts inconsistent references to a singular, non-fungible behavioral clinical professional (§19.5.5) and plural generic behavioral clinical professionals (§§19.5.1 and 19.5.3). This is confusing. For example, in §19.5.3, can a plan be modified only by the singular behavioral clinical professional on the treatment team defined in §19.3 or by any generic behavioral clinical professional?

35. The reference to “individual, his or her parents or legally authorized guardians or surrogates” in §19.4 should be condensed to “individual or legal representative”. See discussion in Par. 5.

36. In §19.4.4, insert a period after “diffuse”.

37. Section 19.5.5 recites as follows: “Upon initiation of the restraint procedure staff must notify the on-site supervisor, and behavioral clinical professional for approval of the implementation of the procedure.” At a minimum, the comma should be deleted. Moreover, the standard is confusing. Literally, it says staff initiate the restraint and then ask for permission to use the restraint. This is “circular”. Restraint may be justified in an emergency without time to obtain permission from not just 1, but 2 professionals. For example, if a resident initiates head banging, staff should immediately intervene in accordance with procedures outlined in the support plan. If an emergency procedure is contained in a plan, staff should be allowed to implement it and administration should be notified as soon as practicable. Implementation of an emergency procedure in the plan has already been approved through the plan process. See §19.4.

38. In §21.6, insert a comma after “purposes”.

39. In §21.7, requiring a 3-day supply of each resident’s medication is too short a period. A blizzard or other weather-related event could delay access to a pharmacy. Moreover, if a pharmacy is out of a drug, and must order it, a multi-day delay in filling a prescription could easily occur.

40. In §21.8.3, consider substituting “serving” for “service”.

41. Section §23.2 would allow destruction of incident reports after 3 years. This period is too short to protect resident rights. The general 2 year statute of limitation for medical malpractice

[Title 10 Del.C. §8128; Title 18 Del.C. §6856] may be temporarily tolled if negligence is not detected or not reasonably discoverable. However, if records are destroyed after 36 months, patients harmed by negligence not readily discoverable may be prejudiced by destruction of records. The statute of limitation for not readily discoverable injuries is 3 years subject to an additional 90-day extension if a Notice of Intent to Investigate is issued. See Title 18 Del.C. §6856(4). The regulation only envisions sharing incident reports with the Division, not the legal representative of the resident. Therefore, there may be medical omissions and errors which are not discovered for years by legal representatives of residents with cognitive impairments. In many cases, the legal representative will be out of state.

42. Section 23.4 should be amended to include “(d)death of a resident”.

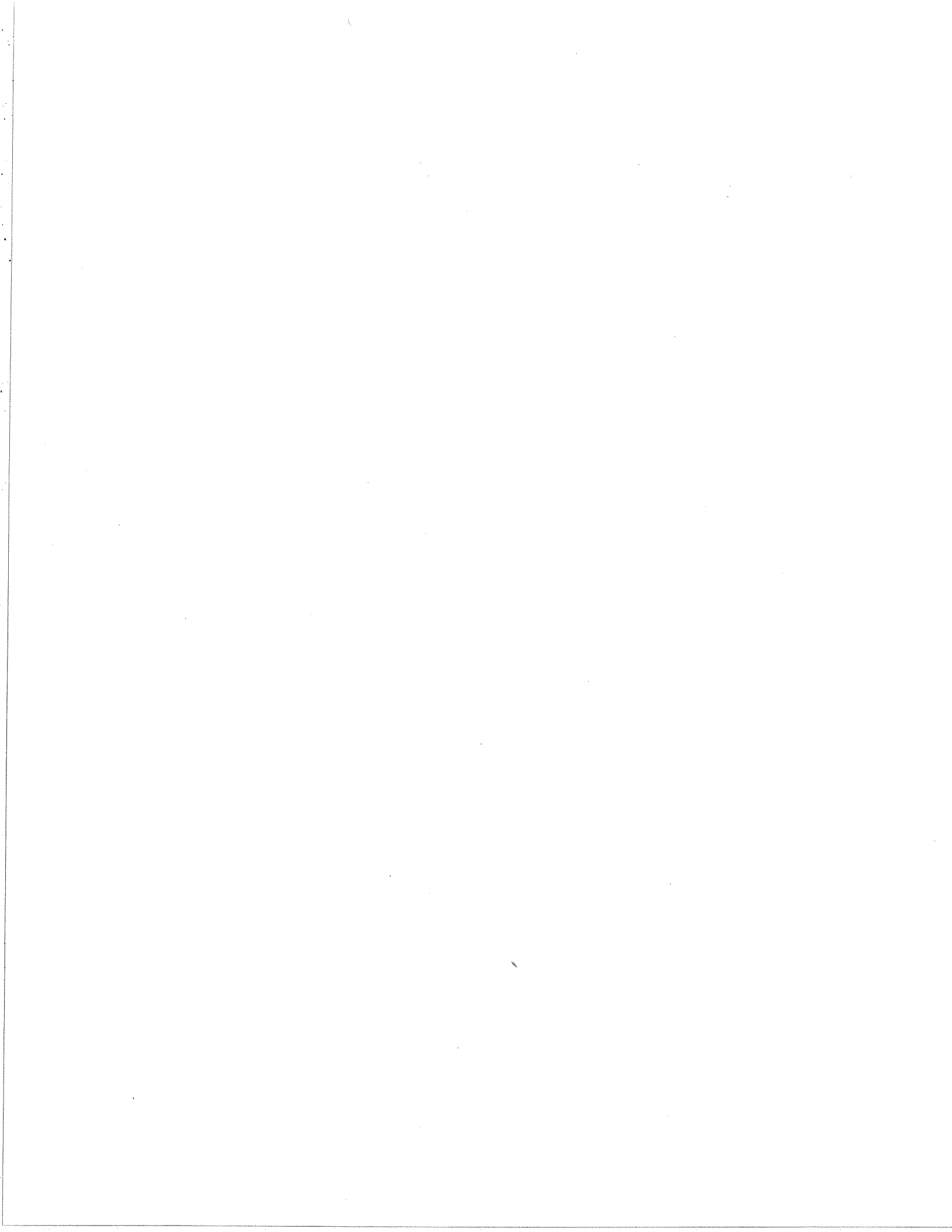
43. Section 23.4.1.2 should require notice to the “legal representative”. See Par. 5.

44. Section 23.4 should be amended to include “(a)ny use of restraint not categorically barred by these regulations”.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulation.

cc: Ms. Rita M. Landgraf  
Ms. Kevin Huckshorn  
Ms. Jane Gallivan  
Ms. Debra Gottschalk  
Mr. Brian Hartman, Esq.  
Governor’s Advisory Council for Exceptional Citizens  
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112th CONGRESS

1st Session

S. 2020

To protect all school children against harmful and life-threatening seclusion and restraint practices.

**IN THE SENATE OF THE UNITED STATES**

**December 16, 2011**

Mr. HARKIN introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

**A BILL**

To protect all school children against harmful and life-threatening seclusion and restraint practices.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**

This Act may be cited as the 'Keeping All Students Safe Act'.

**SEC. 2. DEFINITIONS.**

In this Act:

(1) **APPLICABLE PROGRAM-** The term 'applicable program' has the meaning given the term in section 400(c)(1) of the General Education Provisions Act (20 U.S.C. 1221(c)(1)).

(2) **CHEMICAL RESTRAINT-** The term 'chemical restraint' means a drug or medication used on a student to control behavior or restrict freedom of movement that is not--

(A) prescribed by a licensed physician, or other qualified health professional acting under the scope of the professional's authority under State law, for the standard treatment of a student's medical or psychiatric condition; and

(B) administered as prescribed by the licensed physician or other qualified health professional acting under the scope of the professional's authority under State law.

(3) **ESEA DEFINITIONS-** The terms--

(A) 'Department', 'educational service agency', 'elementary school', 'local educational agency', 'parent', 'secondary school', 'State', and 'State educational agency' have the meanings given such terms in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801); and

(B) 'school resource officer' and 'school personnel' have the meanings given such terms in section 4151 of such Act (20 U.S.C. 7161).

(4) **FEDERAL FINANCIAL ASSISTANCE-** The term 'Federal financial assistance' means any grant, loan, contract (other than a procurement contract or a contract of insurance or guaranty), or any other arrangement by which the Department provides or otherwise makes available assistance in the form of--

(A) funds;

(B) services of Federal personnel; or

(C) real and personal property or any interest in or use of such property, including--

(i) transfers or leases of such property for less than fair market value or for reduced consideration; and

(ii) proceeds from a subsequent transfer or lease of such property if the Federal share of its fair market value is not returned to the Federal Government.

(5) **FREE APPROPRIATE PUBLIC EDUCATION-** For those students eligible for special education and related services under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), the term 'free appropriate public education' has the meaning given the term in section 602 of such Act (20 U.S.C. 1401).

(6) **MECHANICAL RESTRAINT-** The term 'mechanical restraint'--

(A) has the meaning given the term in section 595(d)(1) of the Public Health Service Act (42 U.S.C. 290jj(d)(1)), except that the meaning shall be applied by substituting `student's' for `resident's'; and

(B) does not mean devices used by trained school personnel, or used by a student, for the specific and approved therapeutic or safety purposes for which such devices were designed and, if applicable, prescribed, including--

(i) restraints for medical immobilization;

(ii) adaptive devices or mechanical supports used to allow greater freedom of mobility than would be possible without the use of such devices or mechanical supports; or

(iii) vehicle safety restraints when used as intended during the transport of a student in a moving vehicle.

(7) **PHYSICAL ESCORT**- The term `physical escort' means the temporary touching or holding of the hand, wrist, arm, shoulder, waist, hip, or back for the purpose of inducing a student to move to a safe location.

(8) **PHYSICAL RESTRAINT**- The term `physical restraint' means a personal restriction that immobilizes or reduces the ability of an individual to move the individual's arms, legs, body, or head freely. Such term does not include a physical escort, mechanical restraint, or chemical restraint.

(9) **POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS**- The term `positive behavioral interventions and supports'--

(A) means a school-wide systematic approach to embed evidence-based practices and data-driven decisionmaking to improve school climate and culture in order to achieve improved academic and social outcomes, and increase learning for all students, including those with the most complex and intensive behavioral needs; and

(B) encompasses a range of systemic and individualized positive strategies to reinforce desired behaviors, diminish reoccurrence of challenging behaviors, and teach appropriate behaviors to students.

(10) **PROTECTION AND ADVOCACY SYSTEM**- The term `protection and advocacy system' means a protection and advocacy system established under subtitle C of title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15041 et seq.).

(11) **SECLUSION**- The term `seclusion' means the isolation of a student in a room, enclosure, or space that is--

(A) locked; or

(B) unlocked and the student is prevented from leaving.

(12) **SECRETARY**- The term `Secretary' means the Secretary of Education, and, where appropriate, the Secretary of the Interior and the Secretary of Defense.

(13) **SERIOUS BODILY INJURY**- The term `serious bodily injury' has the meaning given the term in section 1365 (h) of title 18, United States Code.

(14) **STATE-APPROVED CRISIS INTERVENTION TRAINING PROGRAM**- The term `State-approved crisis intervention training program' means a training program approved by a State that, at a minimum, provides training in evidence-based practices shown to be effective--

(A) in the prevention of the use of physical restraint;

(B) in keeping both school personnel and students safe in imposing physical restraint in a manner consistent with this Act;

(C) in the use of data-based decisionmaking and evidence-based positive behavioral interventions and supports, safe physical escort, conflict prevention, behavioral antecedents, functional behavioral assessments, de-escalation of challenging behaviors, and conflict management;

(D) in first aid, including the signs of medical distress, and cardiopulmonary resuscitation; and

(E) certification for school personnel in the practices and skills described in subparagraphs (A) through (D), which shall be required to be renewed on a periodic basis.

(15) **STUDENT**- The term `student' means a student who--

(A) is enrolled in a public school;



(B) is enrolled in a private school and is receiving a free appropriate public education at the school under subparagraph (B) or (C) of section 612(a)(10) of the Individuals with Disabilities Education Act (20 U.S.C. 1412(a)(10)(B), (C));

(C) is enrolled in a Head Start or Early Head Start program supported under the Head Start Act (42 U.S.C. 9831); or

(D) receives services under section 619 or part C of the Individuals with Disabilities Education Act (20 U.S.C. 1419, 1431 et seq.).

**SEC. 3. PURPOSE.**

The purposes of this Act are--

- (1) to promote the development of effective intervention and prevention practices that do not use restraints and seclusion;
- (2) to protect all students from physical or mental abuse, aversive behavioral interventions that compromise health and safety, and any restraint imposed for purposes of coercion, discipline or convenience, or as a substitute for appropriate educational or positive behavioral interventions and supports;
- (3) to ensure that staff are safe from the harm that can occur from inexpertly using restraints; and
- (4) to ensure the safety of all students and school personnel and promote positive school culture and climate.

**SEC. 4. MINIMUM STANDARDS; RULE OF CONSTRUCTION.**

Each State and local educational agency receiving Federal financial assistance shall have in place policies that are consistent with the following:

(1) PROHIBITION OF CERTAIN ACTION- School personnel, contractors, and resource officers are prohibited from imposing on any student--

- (A) seclusion;
- (B) mechanical restraint;
- (C) chemical restraint;
- (D) aversive behavioral interventions that compromise health and safety;
- (E) physical restraint that is life-threatening, including physical restraint that restricts breathing; and
- (F) physical restraint if contraindicated based on the student's disability, health care needs, or medical or psychiatric condition, as documented in a health care directive or medical management plan, a behavior intervention plan, an individualized education program or an individualized family service plan (as defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401)), or plan developed pursuant to section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or other relevant record made available to the State or local educational agency.

(2) PHYSICAL RESTRAINT-

- (A) IN GENERAL- Physical restraint may only be implemented if--
  - (i) the student's behavior poses an immediate danger of serious bodily injury to self or others;
  - (ii) the physical restraint does not interfere with the student's ability to communicate in the student's primary language or mode of communication; and
  - (iii) less restrictive interventions have been ineffective in stopping the immediate danger of serious bodily injury to the student or others, except in a case of a rare and clearly unavoidable emergency circumstance posing immediate danger of serious bodily injury.
- (B) LEAST AMOUNT OF FORCE NECESSARY- When implementing a physical restraint, staff shall use only the amount of force necessary to protect the student or others from the threatened injury.
- (C) END OF PHYSICAL RESTRAINT- The use of physical restraint shall end when--
  - (i) a medical condition occurs putting the student at risk of harm;
  - (ii) the student's behavior no longer poses an immediate danger of serious bodily injury to the student or others; or

(iii) less restrictive interventions would be effective in stopping such immediate danger of serious bodily injury.

(D) QUALIFICATIONS OF INDIVIDUALS ENGAGING IN PHYSICAL RESTRAINT- School personnel imposing physical restraint in accordance with this subsection shall--

- (i) be trained and certified by a State-approved crisis intervention training program, except in the case of rare and clearly unavoidable emergency circumstances when school personnel trained and certified are not immediately available due to the unforeseeable nature of the emergency circumstance;
- (ii) engage in continuous face-to-face monitoring of the student; and
- (iii) be trained in State and school policies and procedures regarding restraint and seclusion.

(E) PROHIBITION ON USE OF PHYSICAL RESTRAINT AS PLANNED INTERVENTION- The use of physical restraints as a planned intervention shall not be written into a student's education plan, individual safety plan, plan developed pursuant to section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), individualized education program or individualized family service plan (as defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401)), or any other planning document for an individual student.

(3) OTHER POLICIES-

(A) IN GENERAL- The State or local educational agency, and each school and educational program served by the State or local educational agency shall--

- (i) establish policies and procedures that ensure school personnel and parents, including private school personnel and parents, are aware of the State, local educational agency, and school's policies and procedures regarding seclusion and restraint;
- (ii) establish policies and procedures to keep all students, including students with the most complex and intensive behavioral needs, and school personnel safe;
- (iii) establish policies and procedures for planning for the appropriate use of restraint in crisis situations in accordance with this Act by a team of professionals trained in accordance with a State-approved crisis intervention training program; and
- (iv) establish policies and procedures to be followed after each incident involving the imposition of physical restraint upon a student, including--

(I) procedures to provide to the parent of the student, with respect to each such incident--

- (aa) a verbal or electronic communication on the same day as each such incident; and
- (bb) within 24 hours of each such incident, written notification; and

(II) after the imposition of physical restraint upon a student, procedures to ensure that all school personnel in the proximity of the student immediately before and during the time of the restraint, the parent, the student, appropriate supervisory and administrative staff, and appropriate IEP team members, participate in a debriefing session.

(B) DEBRIEFING SESSION-

(i) IN GENERAL- The debriefing session described in subparagraph (A)(iv)(II) shall occur as soon as practicable, but not later than 5 school days following the imposition of physical restraint unless it is delayed by written mutual agreement of the parent and school. Parents shall retain their full legal rights for children under the age of majority concerning participation in the debriefing or other matters.

(ii) CONTENT OF SESSION- The debriefing session described in subparagraph (A)(iv)(II) shall include--

- (I) identification of antecedents to the physical restraint;
- (II) consideration of relevant information in the student's records, and such information from teachers, other professionals, the parent, and student;
- (III) planning to prevent and reduce reoccurrence of the use of physical restraint, including consideration of the results of any functional behavioral assessments, whether positive behavior plans were implemented with fidelity, recommendations of appropriate positive behavioral interventions and supports to assist personnel responsible for the student's educational plan, the individualized education program for the student, if applicable, and plans providing for reasonable accommodations under section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794);

(IV) a plan to have a functional behavioral assessment conducted, reviewed, or revised by qualified professionals, the parent, and the student; and

(V) for any student not identified as eligible to receive accommodations under section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or services under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), evidence of such a referral or documentation of the basis for declining to refer the student.

(iii) COMMUNICATION BY THE STUDENT- When a student attends a debriefing session described in subparagraph (A)(iv)(II), information communicated by the student may not be used against the student in any disciplinary, criminal, or civil investigation or proceeding.

(4) NOTIFICATION IN WRITING ON DEATH OR BODILY INJURY- In a case in which serious bodily injury or death of a student occurs in conjunction with the use of physical restraint or any intervention used to control behavior, there are procedures to notify, in writing, within 24 hours after such injury or death occurs--

(A) the State educational agency and local educational agency;

(B) local law enforcement; and

(C) a protection and advocacy system, in the case of a student who is eligible for services from the protection and advocacy system.

(5) PROHIBITION AGAINST RETALIATION- The State or local educational agency, each school and educational program served by the State or local educational agency, and school personnel of such school or program shall not retaliate against any person for having--

(A) reported a violation of this section or Federal or State regulations or policies promulgated to carry out this section; or

(B) provided information regarding a violation of this section or Federal or State regulations or policies promulgated to carry out this section.

## SEC. 5. INTERACTION.

(a) Rule of Construction- Nothing in this Act shall be construed to restrict or limit, or allow the Secretary to restrict or limit, any other rights or remedies otherwise available to students or parents under Federal or State law (including regulations) or to restrict or limit stronger restrictions on the use of restraint, seclusion, or aversives in Federal or State law (including regulations) or in State policies.

(b) Denial of a Free Appropriate Public Education- Failure to meet the minimum standards of this Act as applied to an individual child eligible for accommodations developed pursuant to section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or for education or related services under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.) shall constitute a denial of a free appropriate public education.

## SEC. 6. REPORT REQUIREMENTS.

(a) In General- Each State educational agency shall (in compliance with the requirements of section 444 of the General Education Provisions Act (commonly known as the 'Family Educational Rights and Privacy Act of 1974') (20 U.S.C. 1232g)) prepare and submit to the Secretary, and make available to the public, a report with respect to each local educational agency, and each school not under the jurisdiction of a local educational agency, located in the same State as such State educational agency that includes the following information:

(1) The total number of incidents in which physical restraint was imposed upon a student in the preceding full academic year.

(2) The information described in paragraph (1) shall be disaggregated--

(A) by the total number of incidents in which physical restraint was imposed upon a student--

(i) that resulted in injury to students or school personnel, or both;

(ii) that resulted in death; and

(iii) in which the school personnel imposing physical restraint were not trained and certified as described in section 4(2)(D)(i); and

(B) by the demographic characteristics of all students upon whom physical restraint was imposed, including--

(i) the subcategories identified in section 1111(h)(1)(C)(i) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(h)(1)(C)(i));

- (ii) age; and
- (iii) disability category.

(b) Unduplicated Count; Exception- The disaggregation required under subsection (a) shall--

- (1) be carried out in a manner to ensure an unduplicated count of the total number of incidents in the preceding full academic year in which physical restraint was imposed upon a student; and
- (2) not be required in a case in which the number of students in a category would reveal personally identifiable information about an individual student.

## **SEC. 7. GRANT AUTHORITY.**

(a) In General- From the amount appropriated under section 9, the Secretary may award grants to State educational agencies to assist in--

- (1) establishing, implementing, and enforcing the policies and procedures to meet the minimum standards described in this Act;
- (2) improving State and local capacity to collect and analyze data related to physical restraint; and
- (3) improving school climate and culture by implementing school-wide positive behavioral interventions and supports.

(b) Duration of Grant- A grant under this section shall be awarded to a State educational agency for a 3-year period.

(c) Application- Each State educational agency desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require, including information on how the State educational agency will target resources to schools and local educational agencies in need of assistance related to preventing and reducing physical restraint.

(d) Authority To Make Subgrants-

- (1) IN GENERAL- A State educational agency receiving a grant under this section may use such grant funds to award subgrants, on a competitive basis, to local educational agencies.
- (2) APPLICATION- A local educational agency desiring to receive a subgrant under this section shall submit an application to the applicable State educational agency at such time, in such manner, and containing such information as the State educational agency may require.

(e) Private School Participation-

- (1) IN GENERAL- A State educational agency receiving grant funds under this section shall, after timely and meaningful consultation with appropriate private school officials, ensure that private school personnel can participate, on an equitable basis, in activities supported by grant or subgrant funds.
- (2) PUBLIC CONTROL OF FUNDS- The control of funds provided under this section, and title to materials, equipment, and property with such funds, shall be in a public agency and a public agency shall administer such funds, materials, equipment, and property.

(f) Required Activities- A State educational agency receiving a grant, or a local educational agency receiving a subgrant, under this section shall use such grant or subgrant funds to carry out the following:

- (1) Researching, developing, implementing, and evaluating evidence-based strategies, policies, and procedures to reduce and prevent physical restraint in schools, consistent with the minimum standards described in this Act.
- (2) Providing professional development, training, and certification for school personnel to meet such standards.

(g) Additional Authorized Activities- In addition to the required activities described in subsection (f), a State educational agency receiving a grant, or a local educational agency receiving a subgrant, under this section may use such grant or subgrant funds for 1 or more of the following:

- (1) Developing and implementing a high-quality professional development and training program to implement evidence-based systematic approaches to school-wide positive behavioral interventions and supports, including improving coaching, facilitation, and training capacity for administrators, teachers, specialized instructional support personnel, and other staff.
- (2) Providing technical assistance to develop and implement evidence-based systematic approaches to school-wide positive behavioral interventions and supports, including technical assistance for data-driven decisionmaking related to positive behavioral interventions and supports in the classroom.

(3) Researching, evaluating, and disseminating high-quality evidence-based programs and activities that implement school-wide positive behavioral interventions and supports with fidelity.

(4) Supporting other local positive behavioral interventions and supports implementation activities consistent with this subsection.

(h) Evaluation and Report- Each State educational agency receiving a grant under this section shall, at the end of the 3-year grant period for such grant--

(1) evaluate the State's progress toward the prevention and reduction of physical restraint in the schools located in the State, consistent with the minimum standards; and

(2) submit to the Secretary a report on such progress.

#### **SEC. 8. ENFORCEMENT.**

(a) Use of Remedies- If a State educational agency fails to comply with the requirements under this Act, the Secretary shall--

(1) withhold, in whole or in part, further payments under an applicable program in accordance with section 455 of the General Education Provisions Act (20 U.S.C. 1234d);

(2) require a State or local educational agency to submit, and implement, within 1 year of such failure to comply, a corrective plan of action, which may include redirection of funds received under an applicable program;

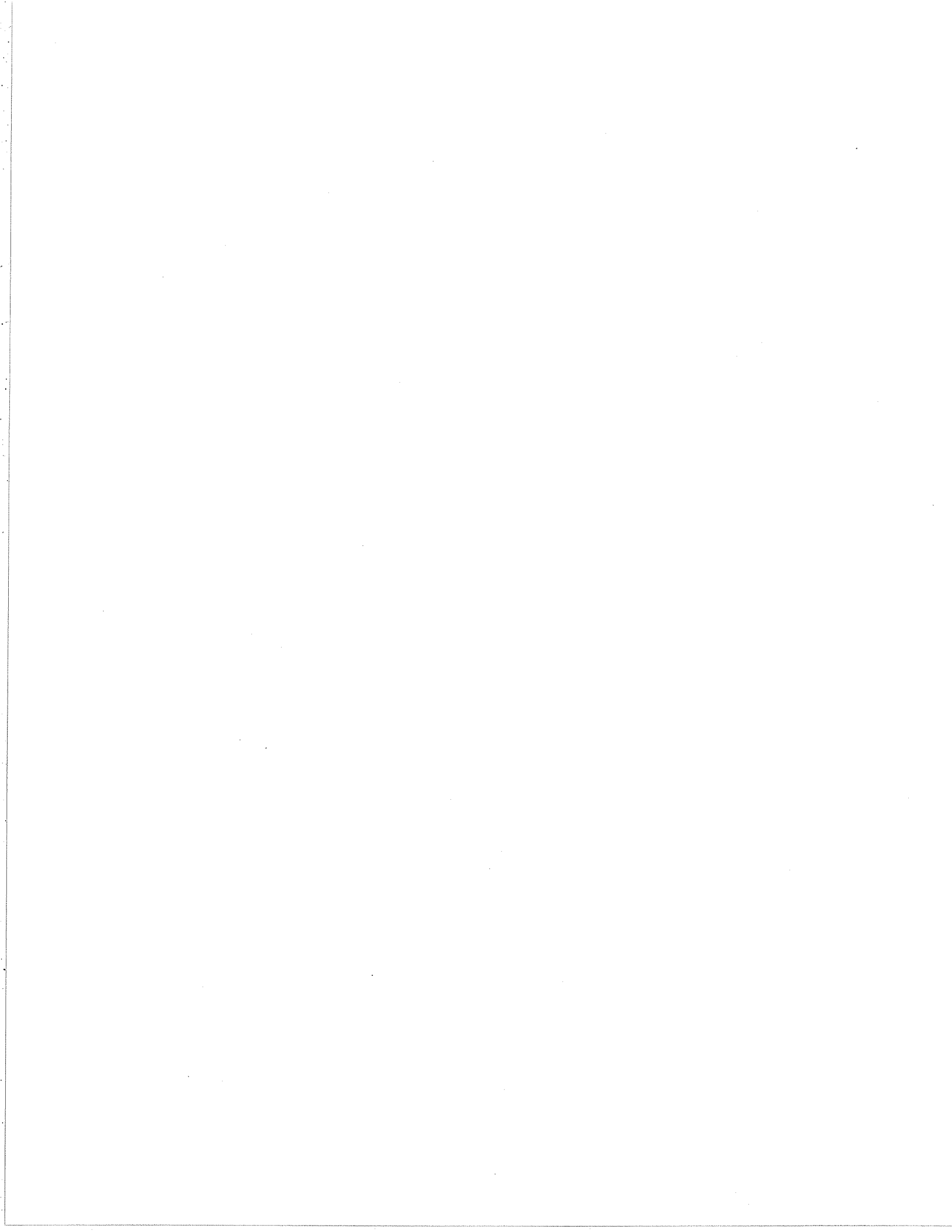
(3) issue a complaint to compel compliance of the State or local educational agency through a cease and desist order, in the same manner the Secretary is authorized to take such action under section 456 of the General Education Provisions Act (20 U.S.C. 1234e); or

(4) refer the State to the Department of Justice or Department of Education Office of Civil Rights for an investigation.

(b) Cessation of Withholding of Funds- Whenever the Secretary determines (whether by certification or other appropriate evidence) that a State or local educational agency that is subject to the withholding of payments under subsection (a)(1) has cured the failure providing the basis for the withholding of payments, the Secretary shall cease the withholding of payments with respect to the State educational agency under such subsection.

#### **SEC. 9. AUTHORIZATION OF APPROPRIATIONS.**

There are authorized to be appropriated such sums as may be necessary to carry out this Act for fiscal year 2012 and each of the 4 succeeding fiscal years.





# Special ed teacher suspended

A longtime special education teacher at North Laurel Elementary School, who worked with children with severe special needs, faces charges of unlawful imprisonment and endangering the welfare of a child.

Laurel police say the teacher -- Nyazina Custis, 61, of Bivalve, Md. -- used neckties to tie the hands of two students behind their backs.

Custis has been suspended from teaching by Laurel School District officials pending the outcome of an in-house investigation, said Acting Superintendent Dorothy Nave.

Nave said the incident occurred Tuesday afternoon as Custis was instructing a group of elementary students with severe special needs.

Nave said Custis repeatedly tried to convince two fourth-graders to follow instructions.

Two other adults were in the classroom at the time and witnessed the incident. One of the witnesses, a paraprofessional, asked Custis to untie the students and reported the incident to their supervisor, Nave said.

Nave said district officials learned of the incident on Wednesday, called in the three employees and asked them for written

accounts of what had happened.

Nave said all three accounts were the same.

She said she immediately suspended Custis, North Laurel's lone specialist for severe special needs students.

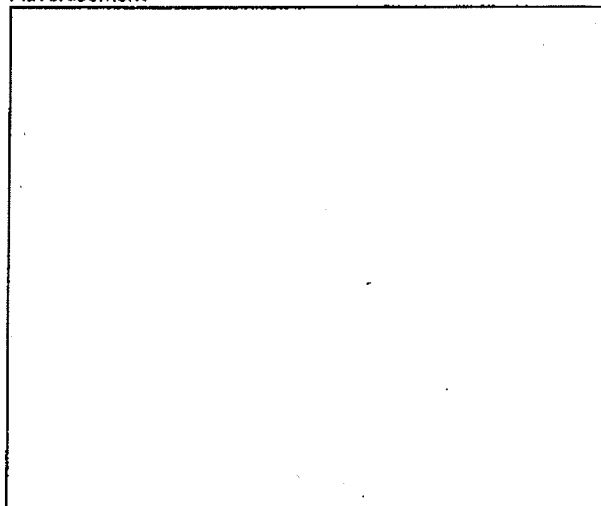
A substitute certified in special education has been brought in, Nave said.

School officials reported the incident to the state Division of Family Services.

Nave said she believes officials with the state agency contacted Laurel police, who released the information to the public Saturday.

Sgt. Derrick Calloway, a spokesman for the Laurel Police Department, said Custis turned herself in to Laurel police Friday and was charged with two counts of unlawful imprisonment and two counts of endangering the welfare of a child. She was released on unsecured bond.

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Patrick Vanderslice, the school board president, said he expects the board to continue Custis' suspension until the investigation is complete.

"You don't expect any of it," he said, "but we're dealing with people."

Vanderslice said as far as he knew neither of the two children was harmed in the alleged incident.

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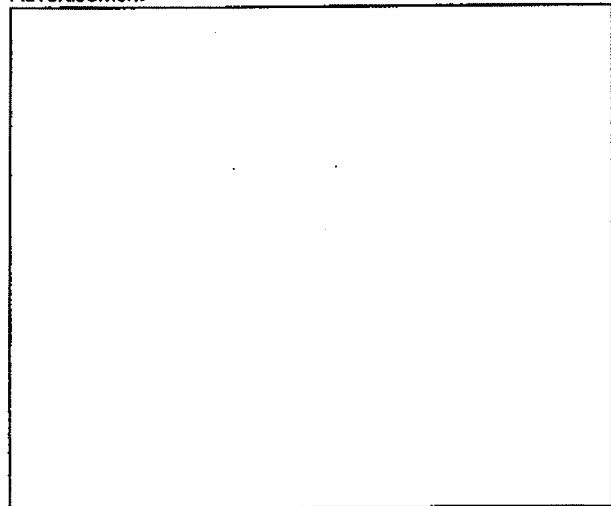
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