

We have the legal right of way.

REPORT: Persistent Problems at Hannah Neil

"Childhood is a gift. Everything we do at The Heritage of Hannah Neil comes back to this. We need to protect it like lives depend on it. Because they do. We believe every child deserves a happy, healthy life. And that starts with a happy, healthy childhood."

Disability Rights Ohio conducted a nine-month investigation into complaints received about the physical abuse, neglect, exploitation, and other rights violations of the children at The Heritage Hannah Neil (Hannah Neil), a 40-bed child residential facility located in Columbus, Ohio.

Hannah Neil serves children as young as 5 years old. The vast majority of the children at the facility are in the custody of child protective services (CPS) agencies from multiple counties. Eastway Behavioral Healthcare owns and operates this facility and it is licensed by the Ohio Department of Mental Health & Addiction Services (OhioMHAS). The facility "provides residential and day treatment, outpatient care, in-home counseling, and educational services for children who've experienced trauma, as well as extensive ongoing support for their families."

Disability Rights Ohio's investigation found pervasive and troubling problems evident of a harmful environment for the children, some as young as five or six years old, who were there to receive therapeutic mental health treatment. Instead, they were exposed to:

- Physically abusive behaviors, including staff grabbing children by their necks, as well as staff kicking and/or pushing the children;
- Unapproved restraint techniques (including chokeholds) and inappropriate seclusion in their rooms (videos show staff holding doors shut);

The Heritage at Hannah Neil website. Available at: **columbus.eastway.org/home** (last visited July 13, 2018).

- **Troubling staff behavior**, including a disturbing level of peer fighting with little staff intervention and instances of probable staff encouragement and direction;
- Unsanitary living conditions and exploitation of the children including a "Community Day" where the children would have to paint the facility and clean walls and carpets; and
- A poorly supervised and unstructured environment that fails to provide access to appropriate activities, toys, or programming.

Many of these incidents were not reported, as required by law, until after Disability Rights Ohio identified them.

Over the course of the investigation, Disability Rights Ohio notified OhioMHAS and county CPS agencies of our concerns and asked that they take appropriate action. OhioMHAS conducted a survey of the facility and issued a 16-page letter, which confirmed many of DRO's findings. Disability Rights Ohio again calls on OhioMHAS to use all available options to prevent future risk and harm to children who may receive services at Hannah Neil.

Children subjected to abuse, neglect, exploitation, unapproved restraint techniques and seclusion

Beginning in October 2017, Disability Rights Ohio completed several on-site visits at Hannah Neil and interviewed the children residing at the facility. The children reported several allegations of inappropriate restraint and seclusion, including that staff stood in the children's doorways to isolate them in their rooms, and, at times, held the children's doors shut.

Disability Rights Ohio reviewed videos related to incident reports that were submitted to OhioMHAS. The incident report video footage verified the children's allegations. The videos show disturbing incidents of inappropriate restraint and seclusion, as well as numerous incidents of physical abuse and neglect by the staff at Hannah Neil.

Several videos documented staff's use of unapproved and unsafe restraint methods on the children. For example, the video on April 26, 2018, shows two staff members carrying a child by the child's arms and legs to the child's bedroom, mostly out of view of the camera. One staff member appears to stand in the child's doorway, preventing the child from leaving. Photos of the child after this incident show that the child sustained significant injuries, indicative of abuse, including severe bruising around the child's entire shoulder and underneath the child's arm, missing patches of skin on shoulder and arm, and scratches on the child's neck.

A video on April 8, 2018, showed staff picking a child up by his neck and carrying him, by his neck, to his room. Another video, from April 10, 2018, showed staff placing children in a headlock and taking the child out of the view of the camera. When the child returned to view, he was rubbing his neck.

A third video from April 19, 2018, appeared to show a staff member standing in a child's doorway preventing him from leaving. The same video depicts other concerns, including:

- **Fighting incidents** (peer on peer) that were not observed by staff nor properly documented;
- **Staff appearing to instigate a child** to be physical with another child and not quickly intervening in the resulting physical contact;
- **Staff consistently staying on the perimeter** while children ran around the common room;
- Staff not offering any level of safety, protection or intervention when children were targeted by other children;
- Staff not engaging or otherwise properly supervising the children.

Additionally, Disability Rights Ohio reviewed video unrelated to any reported incidents from second shift on the Little Boys Unit and the Older Boys Unit for the dates of April 27-30 and May 4-6, 2018. Disability Rights Ohio found over 24 unreported incidents of apparent abuse and/or neglect that occurred in those seven days.

The following are incidents uncovered during our video review:

- Staff lifting a child off the ground, flipping him into an upside-down position, and walking off camera with the child in an upside-down position. The staff holds onto the child's chest and legs, while the child's head is near the staff's knees. The child's inability to move qualifies this action as an unapproved restraint. This action is not therapeutic and is indicative of a traumatic abusive incident;
- Staff lifting a child off the ground by the child's shorts and shirt and throwing the child through the air into the child's room;
- Staff allowing children to hit, kick and hold down other children without immediate intervention or implementing de-escalation techniques. At times, staff seems to be encouraging the behavior.
- Staff putting child into a chokehold;
- Staff pushing children to the floor;
- Staff kicking a child while the child is in a restraint;
- Staff holding child's own hands against child's neck with force during a restraint;
- Staff grabbing children by their arms, legs, clothing and dragging them out of the room (noticeably, out of the video camera range); and
- Staff kicking open a child's bedroom door.

Many interactions between staff and children involved staff acting in a bullying manner (such as grabbing the children by their shirts).

A disturbing trend seen in the videos is staff purposefully moving children outside of the video camera range. Additionally, staff who witnessed the abusive behavior, but did not engage in it, did not take steps to stop it or report it despite being mandatory reporters. The events in the videos reviewed by Disability Rights Ohio raise questions about abuse that may be happening to children that is not being seen or documented.

The incidents on this video demonstrate that the abusive treatment of children is a systemic issue that permeates the culture at Hannah Neil and requires immediate and far-reaching remedies.

EXPLOITATION OF THE CHILDREN AND POOR LIVING CONDITIONS

During one site visit, the children informed Disability Rights Ohio of a planned "Community Day" at Hannah Neil, in which the children were expected to clean the facility, including painting, scrubbing walls and cleaning carpets. Children who live in OhioMHAS licensed facilities are not responsible for the maintenance of the facility. Hannah Neil's "Community Day" raised concerns for Disability Rights Ohio about the possible exploitation of the children as unpaid labor.

Disability Rights Ohio also documented through photographs the unsanitary conditions of the facility. All units that Disability Rights Ohio viewed were filthy and in a total state of disrepair. A few children in various units assisted Disability Rights Ohio in pointing out holes in the walls, safety hazards, staining on the carpet and furniture, and the unsanitary condition of the bathrooms. On all units, not one bathroom had hand soap for the youth to use. One child showed Disability Rights Ohio that her door frame was broken and if she pushed on it hard enough, it could easily break away from the wall. Disability Rights Ohio took photos of exposed wiring and random nails in the wall. Many of the units had strong odors, which seemed to correlate with the location of the rampant stains throughout the unit.

LACK OF ACTIVITIES AND PROGRAMMING

Disability Rights Ohio noted a lack of programming available to the children, particularly a lack of activities and toys.

Video footage documents this lack of programming. Throughout the videos, staff spends significant time on their cell phones instead of creating a therapeutic environment for the children or even attempting to interact with the children. In many cases, the children are exhibiting signs that are indicative of unmet sensory needs.

The lack of activities and programming on second shift was very apparent, as children would sit in front of the television for the whole shift. There was no, or extremely minimal, structured activity or programming to keep the children engaged and entertained. The children did not appear to be engaged in anything, let alone any activity or interaction of therapeutic value.

Disability Rights Ohio requested information from The Heritage of Hannah Neil about the activities provided to the children. Based on the information given to Disability Rights Ohio, there was no activity schedule for the children and no documentation of any activities that occur for the children in the community. A licensed child residential facility is required to engage the children in community activities. The children can choose whether or not to participate, but community activities should be scheduled and planned. Hannah Neil provided Disability Rights Ohio with a "Group" schedule, but the only clearly defined activity on that schedule was school, which is provided by another entity. No other activities were listed.

Hannah Neil advertises that it "provides children with a safe, comfortable place for them to learn and build the skills necessary to return to their home school and to function successfully in their communities." This environment was not reflected in the videos or during the site visits Disability Rights Ohio conducted at Hannah Neil. Instead, Disability Rights Ohio reviewed various scenes of chaos, abuse and unresponsiveness by staff as well as the imposition of additional trauma to the children.

Failure to report incidents

Hannah Neil has failed to report to licensing agencies multiple incidents of possible abuse, neglect, exploitation, and other rights violations. This reporting obligation is critical to ensuring that the children are protected from abuse, neglect, exploitation and other rights violations and that licensing agencies have accurate information about the quality of care provided by the facilities they license.

To date, the video review by Disability Rights Ohio uncovered over 24 incidents of possible abuse that occurred in just seven days. Disability Rights Ohio notified OhioMHAS and county CPS agencies about the incidents depicted on the video. Hannah Neil had filed no incident reports for any of the days that Disability Right Ohio reviewed the video. Once Disability Rights Ohio submitted our findings, Hannah Neil reported 24 incidents and 5 staff were placed on administrative leave (other staff involved in the incidents no longer work at Hannah Neil). Hannah Neil only reported the incidents after Disability Rights Ohio brought it to their attention, demonstrating an indifference by the staff at Hannah Neil to their mandatory reporting obligations. And it leaves open the question about other instances of potential abuse that have gone unreported.

Disability Rights Ohio's requests that OhioMHAS and county CPS agencies take appropriate action

Over the past nine months, Disability Rights Ohio has routinely notified OhioMHAS and county CPS agencies about the concerns we identified in our investigation. As a result, several county CPS agencies have removed the children in their custody from the facility. Other county CPS agencies did not place children in their custody at Hannah Neil. Yet, some counties had their children remain at the facility despite the notification of systemic abuse uncovered by ongoing investigations by Disability Rights Ohio and OhioMHAS.

OHIOMHAS COMPLAINT-BASED SURVEY

OhioMHAS conducted an onsite complaint-based survey at Hannah Neil on December 28, 2017, and issued a 16-page findings letter, including 39 findings of non-compliance. Much of Disability Rights Ohio's initial concerns regarding the physical conditions of the property, exploitation and seclusion were confirmed through OhioMHAS's survey. For example, OhioMHAS's findings letter states: "[o]n the day of the survey, Hannah Neil intended to require residents to clean the facility, including paint walls, scrub graffiti and

clean carpets as part of 'community day'. Residents are not responsible for the general upkeep of the facility, which constitutes exploitation." OhioMHAS also found staff being "observed on video standing in a resident's door to prevent the resident from leaving after inappropriately forcing the resident to return to his bedroom."

OhioMHAS also cited Hannah Neil for the following areas of noncompliance in the condition of the property:

- The bathrooms were in general disrepair and were dirty;
- The young boy's unit had bugs flying around the waste receptacles;
- There were multiple seats (couches, chairs, etc.) that were in disrepair;
- There were light fixtures that did not work or did not have covers on them;
- Soap dispensers had been torn off the wall and were missing from the bathrooms;
- One surveyor observed that there did not appear to be enough clean linens in the wash/supply room to meet the resident needs;
- On the young girls' unit there were resident doors that did not have handles and several of the doors would not latch closed;
- On each of the units the common areas had minimal furniture, the carpet was not clean and cushions were very dirty. In some instances, the cushions were missing from the chairs/couches;
- On the young boys' unit there was a strong odor in the resident rooms;
- On all four residential units it was found that several resident mattresses were torn and had holes in them. Beds were not clean;
- The walls, floors and some ceilings in each of the four resident units were not in adequate repair. There were multiple issues with spills, graffiti, broken seating and general repair issues that had not been addressed for some time.

Notably, OhioMHAS cited Hannah Neil for a lack of information and training for its staff. For example, OhioMHAS found that some staff did not have the appropriate documentation demonstrating that they had received training on restraint and seclusion techniques. In fact, the Executive Director² told OhioMHAS that he had been involved in a restraint, but had not received the requisite training. Hannah Neil failed to conduct required background checks of some of its staff, which means that it may be lacking information about its staff's criminal backgrounds.

Based upon OhioMHAS' documentation review, Hannah Neil was cited for:

- 17% of staff personnel records not containing checks on Ohio's Offender database;
- **25% of staff personnel records** not containing Bureau of Criminal Investigation (BCI) checks;

Despite the issues at Hannah Neil, Eastway Behavioral Healthcare recently transitioned Hannah Neil's Executive Director to Director of Child and Family Advocacy at Eastway.

- 8% of staff personnel records not containing FBI checks;
- A Hannah Neil staff person who told OhioMHAS that he was transporting children to dental appointments despite having a suspended driver's license with permission to drive to work only.

ONGOING INVESTIGATION

OhioMHAS issued a plan of corrections to remedy the violations it found in December 2017. On July 9, 2018, per OhioMHAS request, Hannah Neil voluntarily suspended any further admissions of children until OhioMHAS agrees the suspension can be lifted. OhioMHAS also met with each child at Hannah Neil to assess for safety and followed up with the child's county CPS agency. But OhioMHAS has not pursued official administrative action, such as placing the facility on probationary status or moving for revocation of its license.

OhioMHAS' decision to accept the facility's self-imposed admission suspension rather than taking official action allows the facility to avoid providing complete information to county CPS agencies and families.³ On July 12, 2018, Disability Rights Ohio contacted Hannah Neil and inquired if it had notified county CPS agencies that currently had children placed there of the self-imposed suspension of admissions. We also asked what information Hannah Neil was providing to new referrals. Hannah Neil responded that, with one exception, it had not informed the county CPS agencies who have children placed in their care that it was on a self-imposed suspension of admissions. Hannah Neil stated that "both current counties being served and future callers will be informed that Hannah Neil has imposed a voluntary suspension of admissions to its residential program while we are undergoing restructuring and programming changes. Also that we are in close collaboration with The Ohio Department of Mental Health and Addiction Services during this time of transition." This communication was to take place the next day, on July 13, 2018.

On July 13, 2018, Disability Rights Ohio sent a letter to OhioMHAS expressing concern about the transparency of Hannah Neil's communication around its voluntary suspension. Specifically, Hannah Neil avoided stating that the reasons for OhioMHAS's presence and the suspension in admissions was due to abuse findings and non-compliance of licensing standards. On July 13, 2018, and after receipt of this letter, OhioMHAS requested Hannah Neil discharge all residents by July 20, 2018, and entered into an agreement with the facility that OhioMHAS would increase routine and unannounced oversight between July 13 and July 20, 2018. County CPS agencies will determine the selection of another placement for each child in their custody based upon the individual therapeutic needs of that child.

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One county CPS agency told Disability Rights Ohio that its contracts with facilities require the facilities to notify them of any change in licensure. But, because the licensure status of Hannah Neil did not officially change through a voluntary admission suspension, county CPS agencies were not notified of the suspended admission status or given a full explanation for it.

Conclusion

Though Disability Rights Ohio appreciates the actions taken to date, OhioMHAS must fully address the systemic failures of Hannah Neil. Children deserve to be in a safe and therapeutic environment for mental health treatment. Once abuse is identified and, in this case, proven to be systemic, there is an expectation that OhioMHAS should begin regulatory measures to ensure the safety of the children. This regulatory piece is essential to creating a record for other agencies to gauge the severity of the allegations and aids in ensuring that OhioMHAS licensed child residential facilities remain therapeutic, not traumatic. Disability Rights Ohio calls on OhioMHAS to hold Hannah Neil accountable for the treatment of the children in its care, based upon the criteria set forth in the Ohio Administrative Code, for facilities that commit these types of systemic violations.