Disability Rights California
California's Protection & Advocacy System
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Death by Strangulation--Public Advisory

August 1998, Pub #7013.01

Strangulation Death of Boy with a Developmental Disability Caused by Community Care Facility's Illegal Use of Restraint

I. INTRODUCTION

A six-year-old developmentally disabled boy living at a licensed community care facility in Northern California died in August 1997 after he slid down in a wheelchair and strangled on the restraint staff had tied around his waist. David Smith's death (not his real name) was completely avoidable, and he might still be alive today had group home staff followed California law on the use of restraints. Since David could walk and facility staff wanted to keep him out of the way, they strapped him into a wheelchair and left him unsupervised while they took other children to their rooms after dinner. Less than ten minutes later, a staff member found David slumped over in the wheelchair. He had choked on the restraint and passed out.

Staff tried to revive David by using cardiopulmonary resuscitation (CPR), but their efforts failed. They were not trained in current CPR procedures. When the paramedics arrived, David was not breathing and no pulse could be found. After 25 minutes, the paramedics were able to get David's heart beating again, but by then it was too late. David was taken to a hospital where he died a few hours later. The coroner said David died from asphyxia (i.e., lack of oxygen), explaining that David could not breathe after he slipped down in the wheelchair and the restraint tightened around his neck.

The Department of Social Services -- the agency which has the power to grant, suspend or revoke licenses of community care facilities --

investigated David's death. The Department of Social Services found that staff at the group home had restrained David illegally, and that the home was also in violation of California law because its staff lacked training in current CPR procedures. The home closed after the Department of Social Services completed its investigation and filed an accusation against the facility.

II. RESTRAINTS CAN BE FATAL

Death from restraints can occur easily and quickly. An individual who slips or repositions his or her body while in restraints can be rendered helpless, unable to breathe or call for help, and can die from strangulation within minutes. That is what happened to David Smith in August, 1997.

Death is not the only danger posed by restraints. Restraints can also cause serious physical and emotional harm, especially when used for long periods of time, for inappropriate reasons, such as discipline or the convenience of staff, or without consideration of an individual's physical or emotional condition. Risks include dehydration, exhaustion, cardiac arrest or respiratory collapse, fractures, muscle and kidney damage, circulatory blockage, infection, strangulation, and a worsening mental condition as a result of being alone, isolated, or unable to move. The emotional impact of being restrained can be just as severe. Restraints can cause an individual to experience humiliation, resistance, anger, terror, and agitation.

III. CALIFORNIA LAW STRICTLY LIMITS THE USE OF RESTRAINTS

California law regulates the use of devices restricting an individual's movement, such as ties or belts. The law states that restraints cannot be used on individuals who live in community care facilities. The only exception is when devices (such as belts, straps or braces) are used as postural supports in order to achieve proper body position and balance, to improve a resident's mobility, or to position rather than restrict movement such as preventing a resident from falling out of a chair or a bed. California Code of Regulations, Title 22, Section 80072(a)(8)(A) [Cal. Code Regs. tit. 22 § 80072(a)(8)(A)].

A community care facility that wishes to use postural supports must get advanced approval from the Community Care Licensing Division of the Department of Social Services, by submitting a written request along with the doctor's written order stating that the resident needs the specific postural support that the facility is proposing to use. Postural supports that limit the use of a resident's hands or feet are not permitted. Approved postural supports must be fastened or tied in a manner that permits quick release by the resident. *See* Cal. Code Regs. tit. 22 § 80072(a)(8).

Children with developmental disabilities, such as David, have the right to be free from restraining devices, including postural supports, used for discipline or staff convenience and any other device not required to treat the child's specific medical symptoms. Physical restraints may be used to protect a child with special health care needs during treatment and diagnostic procedures, such as intravenous (I.V.) therapy. The use of physical restraints in such a situation must conform to the child's individual health care plan, and must include: (a) the specific medical symptom(s) that require use of the restraint; (b) an explanation of why less restrictive methods cannot be used; and (c) a written order by the child's doctor specifying under what circumstances and how long the restraint can be used. *See,* Cal. Code Regs. tit. 22 § 84072.3.

In David's case, the Community Care Licensing Division of the Department of Social Services found that group home staff had strapped David into a wheelchair for their own convenience, which is an illegal purpose under California law. David could walk, so there was no lawful reason for him being strapped into the wheelchair. The staff had illegally restrained David in the wheelchair simply to keep him out of the way while staff took other children to their rooms after dinner.

IV. COMMUNITY CARE FACILITY STAFF ARE REQUIRED TO KNOW BASIC LIFESAVING PROCEDURES

California law requires that community care facility staff and administrators be able to provide appropriate care and supervision for each of their residents. This requirement includes knowledge of up-to-date first aid and CPR procedures. Staff responsible for providing direct care and supervision must receive training in these basic life-saving measures from

qualified agencies such as the American Red Cross. *See,* Cal. Code Regs. tit. 22 §§ 80064, 80065, 80075(h).

V. RECOMMENDATIONS FOR COMMUNITY CARE FACILITY OPERATORS

Community care facility operators should ensure that all staff, as part of their orientation and at least annually thereafter, receive competency-based training regarding (1) the dangers of restraint, including the use of postural supports, and the narrow circumstances under which state law permits the use of such devices; and (2) basic first-aid and life-saving measures, including CPR.

If you are using or desire to use postural supports for any individual in your facility, check to ensure that:

- you have submitted to the Community Care Licensing Division of the Department of Social Services a written request and updated doctor's order stating the specific need for and type of postural support you propose to use;

- your staff does not apply postural restraints until you have received approval from the Community Care Licensing Division of the Department of Social Services and your staff has been properly trained in the use of such devices;

- the postural supports do not limit the use of a resident's hands or feet and that the restraints are fastened or tied in a manner that permits quick release by the resident and staff.

We encourage the use of this public advisory for staff training purposes, and for use in updating your facility's policies and procedures regarding the use of postural supports and staff training requirements in first aid and CPR.

Disability Rights California is funded by a variety of sources, for a complete list of funders, go to http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html.