

**REPORT OF THE ATTORNEY GENERAL'S OFFICE REGARDING ITS
INVESTIGATION INTO REPORTED CONCERNS AT THE
JOHN H. SUNUNU YOUTH SERVICES CENTER**

July 7, 2026

I. Introduction and Scope of Review

In January 2026, the Department of Health and Human Services (DHHS), Division of Children, Youth, and Families (DCYF) hired a new John H. Sununu Youth Services Center (SYSC) Bureau Chief—an unclassified position—to run the facility. On or around March 30, 2026, the Office of the Child Advocate (OCA) published a three-page report outlining operational concerns relayed by youth and staff at SYSC. In the weeks thereafter, additional reports from the OCA and the Disability Rights Center – New Hampshire (DRC-NH) followed on April 10, 17, and 30, 2026. Governor Kelly A. Ayotte requested that the Department of Justice (DOJ) conduct an independent investigation into the allegations in these reports to review current operations at SYSC, determine whether there had been an operational shift in the weeks and months following the arrival of the new SYSC Bureau Chief, ensure the facility was operating within legal boundaries, and analyze whether any issues merited further consideration by DCYF, which oversees SYSC. As the investigation continued, we expanded our focus to include a new policy regarding open-hand guides and concerns relating to several assaults at the facility on May 3, 2026.

Three assistant attorneys general and two DOJ investigators were assigned to lead this investigation. This team consulted other attorneys and personnel within the DOJ as necessary and appropriate. To conduct our investigation, we interviewed 40 people, including 26 current and former employee and contractor youth counselors (YCs), administrative staff, and other staff members at SYSC; seven supervisors; all five members of SYSC's administration team,

including the former SYSC Bureau Chief; and DCYF’s Director and Deputy Director. We also reviewed materials DCYF provided to the OCA and DRC-NH, including more than 300 hours of video footage. We reviewed thousands of emails, notes, incident reports, daily schedules, unit logbooks, policies, and directives for the periods preceding and following the new SYSC Bureau Chief’s arrival. Finally, we reviewed summaries the OCA prepared of its interviews with youth to include some of the youth’s perspectives herein. Our review covered operations from early January 2026 through late May 2026.

II. Executive Summary

Overall, we conclude that SYSC is operating within legal boundaries and that claims that youth are currently being abused are unsupported. We did not identify any instances of physical or sexual abuse of youth, nor did we find any evidence of systemic abuse or lack of access to independent reporting mechanisms. We found clear evidence of youth causing several serious injuries to staff.

We conclude that there was not a “lockdown” lasting six weeks, as initially reported by the OCA. Rather, there was an initial restriction period lasting one week approved by the SYSC Bureau Chief and DCYF Director. This was followed by a modified schedule implemented by the SYSC Bureau Chief. This temporary modification was instituted to return SYSC youth and staff to a safe baseline after several youth assaults on staff and other youth along with other serious misbehaviors. While the provision of educational services could have been managed better during this period, we find that neither educational services specifically nor the residential schedule generally were unreasonably changed given the escalated level of dysregulation and safety risks to youth and staff within the facility.

We further find that there is sufficient evidence to conclude that the youth who reportedly had a bone in his hand broken by SYSC staff during a restraint caused the injury to his own hand by punching a window. We also find that the uses of the prone position with this youth were appropriately limited to short periods in which mechanical restraints were applied and then ended each time with a recovery position.

The above conclusions notwithstanding, our investigation revealed significant operational challenges and dysfunction that are perpetuating instability for staff and youth. The lack of both a clear operating philosophy and strong leadership has led to serious safety issues. While these challenges are generally longstanding, they have been exacerbated by recent events and disagreements among the administration team at SYSC. As detailed further below, we conclude that SYSC does not have sufficient levels of experienced staff to operate safely, that lack of accountability for both youth and staff hinders safe and effective operations at SYSC, and that the disconnection and dysfunction within the administration team has created a culture and climate within SYSC that is plagued with operational issues at every level.

We also find that although former SYSC Bureau Chief Joshua Nye (BC Nye) has been blamed for many of the recent events reported by the OCA and DRC-NH, many of the problems facing SYSC predated his arrival and continued after his resignation. Though the various problems at SYSC all existed before BC Nye's arrival, we found that he likely lacked the sophistication and experience to adequately address them.

We make the following recommendations:

- DCYF and SYSC leadership should acknowledge and address the chronic dysfunction plaguing the administration team and affecting facility operations, including by establishing a clear, workable operating philosophy and conducting a comprehensive review of the structure and performance of SYSC leadership.

- DCYF should undertake all possible measures to increase staffing levels and begin the search for a new Bureau Chief with more experience in the management of secure facilities for juveniles.
- DCYF should continue training and retraining on physical interventions, deescalation, and baseline safety procedures for new and current staff.
- DCYF should explore the feasibility of implementing body-worn cameras for all youth-facing staff.
- SYSC supervisors and administrators should check in with staff and youth after major incidents to ensure safety and should review video footage and reports of major incidents with staff as a training opportunity.
- SYSC should review its policies regarding respect and appropriate behavior for youth and staff and make any updates as appropriate.
- A clear protocol should be established for reviewing possible criminal conduct perpetrated by youth against staff.

III. Factual Background

a. Background

Because we found that an understanding of the recent history of SYSC assisted in contextualizing our investigation, we first provide a background on SYSC’s organization, daily life for youth, and recent events.

i. Organizational Structure and Operations

SYSC opened in 2006, replacing the former Youth Development Center (YDC) located on the same property. In 2023, then-Governor Christopher T. Sununu signed into law HB 49,¹ which directed DHHS to construct a new, smaller secured treatment facility to replace SYSC. HB 49 directs that DHHS implement the following programming and operations standards immediately for both SYSC and, later, the new facility:

IV. The facility programming and operations shall include:

¹ The full text of HB 49, as signed into law, is available here: <https://legiscan.com/NH/text/HB49/2023>.

- (a) The development of staff qualifications and standard job descriptions comprising required licensing or skill attainment. Staff qualifications shall be designed to ensure the provision of treatment to children with behavioral health challenges exacerbated by considerable trauma histories. Job description requirements, where appropriate shall include self and group protection, training in therapeutic approaches to address challenging behaviors, including the use of de-escalation techniques.
- (b) Use of evidence-based practices, as defined in RSA 170-G:1, V-a, selected to match the needs of the population served at the facility.
- (c) Utilization of the uniform assessment, as specified in RSA 170-G:4-e, for all detained and committed youth to understand treatment needs and determine if a different level of care is indicated to meet the youth's needs, and where problem behavior appears patterned, a functional behavior analysis to inform effective behavioral interventions.
- (d) Provision of care management services by a care management entity, as established in RSA 135-F:4, to begin immediate wraparound support upon admission to plan for discharge.
- (e) Provision of frequent visitation opportunities with family, opportunities to include family in appropriate activities and daily access to family through telephonic or video conferencing.
- (f) Provision of educational programming and staffing that meets the individualized educational needs of each child, including children with special education needs, creates meaningful educator-child pairings, maintains connections with sending school districts, and which includes availability of Hi-SET preparation and testing as appropriate. Virtual educational opportunities shall be leveraged appropriately to help meet the residents' needs.
- (g) Integration of clinical sessions and recreational large muscle movement activities throughout the day.
- (h) Access by the office of the child advocate, in real-time, as established in RSA 21-V:4, II, to the electronic case management system used by the facility, regular access to youth placed in the facility under RSA 21-V:4, III, and video surveillance and general access to the facility pursuant to RSA 21-V:2, VII.
- (i) Provision of adequate security to maintain the safety of staff and residents as well as the safety of the surrounding community and the general public.
- (j) Training that emphasizes the treatment of youth with behavioral health challenges using approaches that include the employment of de-escalation

techniques and that recognizes the risk that children may have considerable trauma histories, and that is otherwise applicable to the facility.

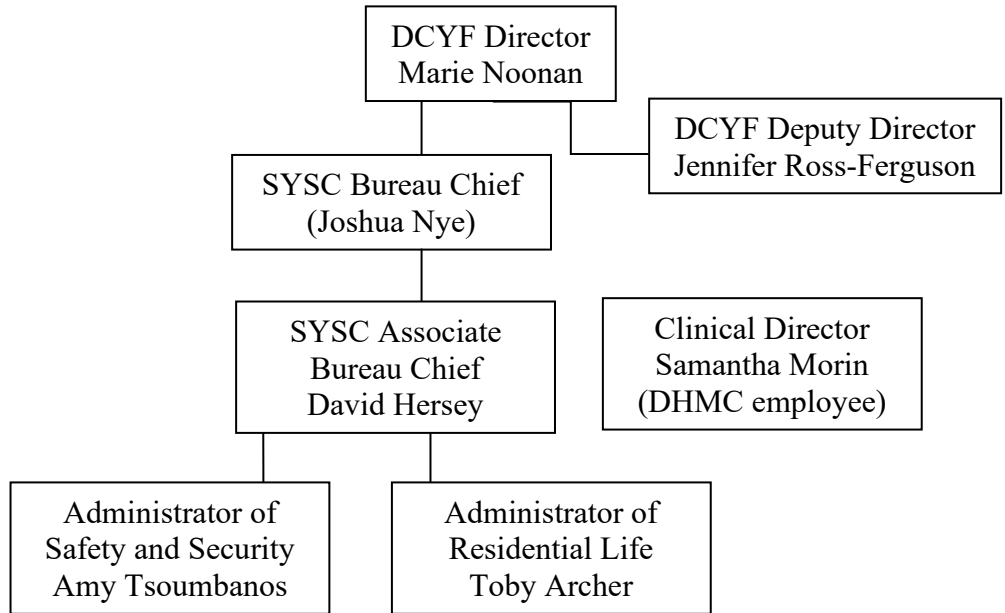
(k) Procedures for supporting children in the community with flexible assignments based upon census changes.

SYSC is also governed by a comprehensive set of DCYF policies, most of which are publicly available and can be found here: <https://www.dhhs.nh.gov/programs-services/child-protection-juvenile-justice/dcyf-policy-manual#Ch11>.

For the last several years, SYSC has been operated by a five-person administration team. The SYSC Bureau Chief, who reports directly to the DCYF Director, leads both the administration team and the facility more broadly. The Associate Bureau Chief reports to the SYSC Bureau Chief. The Administrator of Safety and Security and Administrator of Residential Operations both report to the Associate Bureau Chief. Finally, the Clinical Administrator, who is contracted into SYSC through Dartmouth-Hitchcock Medical Center (DHMC), reports to supervisors at DHMC but is a full member of the SYSC administration team. During the time periods relevant to this investigation, these roles were occupied by BC Nye²; David Hersey, Associate Bureau Chief (ABC Hersey); Amy Tsoumbanos, Administrator of Safety and Security (Administrator Tsoumbanos); Toby Archer, Administrator of Residential Operations (Administrator Archer); and Dr. Samantha Morin, Clinical Administrator (Dr. Morin).

This organizational structure is depicted below:

² Mr. Nye began as SYSC Bureau Chief on January 23, 2026 and resigned his position effective May 20, 2026. Since then, the position has been vacant.



The administration team oversees all aspects of operations at SYSC. ABC Hersey oversees educational and medical services. Educational services are provided by MY TURN, Inc. (My Turn), a contractor managed by ABC Hersey. Medical services are provided by nursing staff directly employed by SYSC and a pediatrician and psychiatrist contracted through DHMC and available for appointments and on-call services; a registered nurse is onsite at SYSC 24/7. All clinical services are coordinated by Dr. Morin and her team of clinicians, also contracted through DHMC.³ Clinicians are generally available to youth during business hours and some nights until 9:00 P.M. Dr. Morin is on call 24/7. A permanency planning manager reports to the SYSC Bureau Chief. Maintenance and kitchen staff report to Administrator Tsoumbanos. Residential supervisors report to Administrator Archer. With YCs, Administrator Archer and the residential team coordinate all aspects of youths' schedules, access to recreation, outdoor time,

³ Clinical services are those tailored exclusively toward mental health treatment. Medical services are all other services related to physical issues. DHMC clinical staff exclusively work with youth on mental health treatment, while SYSC medical staff address all other medical concerns in connection with the DHMC medical pediatrician.

and community engagement, and assist youth with gaining ‘trust’ status in connection with other departments.

SYSC maintains a daily work schedule consisting of three shifts: mornings, from 6:00 A.M. to 2:00 P.M.; evenings, from 2:00 P.M. to 10:00 P.M.; and nights, from 10:00 A.M. to 6:00 A.M. Some YCs and supervisors work different hours than these specific shifts, but most work during the set shift hours and report that there is often no overlap between staff on other shifts. There is always at least one supervisor on duty, and a certain number of YCs are required to adequately staff each shift (this number can change depending on the youth census, how many units are open at any given time, and whether it is a night shift, which has fewer staff). Members of the administration team generally work business hours from approximately 8:00 A.M. to 4:30 P.M., but there is always an administrator on call. This duty has generally been split between the members of the administration team aside from Dr. Morin, who are each on-call several days per month.

There are 46 authorized YC positions at SYSC, some of which are currently vacant. SYSC fills those positions through both direct State employment⁴ and through a contract with Amergis Healthcare Staffing (Amergis). Virtually all staff and management agree that 46 YC positions, even fully staffed, are insufficient to meet the needs of the facility. Within the last year, all supervisors and YCs have been mandated to work multiple if not dozens or more overtime shifts due to lack of adequate YC- and supervisor-level staff. The facility also sometimes permits or mandates Juvenile Probation and Parole Officers (JPPOs) and other DHHS employees to work overtime shifts as YCs when staffing is critically low.

⁴ YC and supervisor positions are exempt from the ongoing Executive Branch hiring freeze.

ii. Daily Life for Youth at SYSC

SYSC consists of one large secure building that contains residential facilities, educational facilities, clinical and medical facilities, and recreational facilities. Previously, YDC had consisted of several discrete ‘cottages’ which housed youth while education, medical, and recreational services were largely provided in other buildings. SYSC features a central rotunda, off of which extend residential units, the school wing with classrooms, the cafeteria, the medical unit, meeting rooms, the gym, and the chapel. Abutting the rotunda are the library and “central control,” a secure room with full video surveillance of the facility which is monitored 24/7. The administration team also has a secure office space off the rotunda.

At full capacity, SYSC can house 144 youths. In June 2006, around when the facility opened, the average monthly census was 121 detained and committed youth. That number steadily decreased until around 2016, reaching an average monthly census of 73 youth that year. Around 2016, the State made significant efforts to divert youth before commitment to SYSC; after that, the census fell dramatically, averaging only 13 detained and committed youth a month by 2022. The average monthly census continues to hover around 13-15 detained and committed youth. The youth at SYSC are either detained pending adjudication in court or committed by a court after being found “true” of various criminal offenses.⁵ The detained youth at SYSC and youth found “true” for minor offenses are often diverted into other, less restrictive residential facilities. Youth residing at SYSC for longer periods of time have often been found true or are awaiting disposition of serious charges, up to and including murder. During the time period covered in our review, youth at SYSC were either facing or had been found “true” of committing

⁵ Juvenile delinquency cases do not use the traditional findings of “guilty” or “not guilty.” Rather, juvenile delinquents are either found or plead “true” to the charged offense (which is equivalent to a finding or admission of guilt) or the petition is dismissed if the prosecution fails to prove its case beyond a reasonable doubt.

physical and sexual assault, drug possession and sale charges, robbery and burglary, and property offenses, among others. Several youth had incurred new charges in less restrictive placements and therefore ended up at SYSC.

SYSC is organized into four main units: E, F, G, and H.⁶ Each main unit is divided into three separate floors or subunits, which are called -000, -100, and -200. Each main unit has a clinical office, outdoor basketball court, and a large “multiroom,” which has a television and video games. Each subunit within a main unit consists of youth bedrooms surrounding a common room called the “dayroom.” Each subunit also has a staff office, at least one youth bathroom, a storage area, and water accessible either via a filtered spigot or a cooler. Some subunits have their own televisions. During our review, there were never more than five youth living on one subunit. Boys and girls always live in separate subunits.

E-100 and F-100 are used as Crisis Services Units (CSUs). CSUs are used to temporarily house youth who are experiencing a personal safety crisis, exhibiting behaviors that are unsafe, or significantly disrupting programming for other youth. CSUs contain a padded room for temporary deescalations, “wet rooms” which contain a bed and a toilet, a dayroom, and minimal other items. CSU stays are approved by administration and clinical staff, as are youths’ returns to their assigned subunit and regular programming. Most stays in a CSU last a few days at maximum.

Youth movement within SYSC is generally overseen by residential staff. Subunits often move together—to school or meals, for example—but sometimes individual youth are permitted to move with staff accompaniment. Movement is also affected by ‘keep separates’ between youth. For example, youth who are co-defendants in a criminal matter or youth who have

⁶ H-unit has been closed for years, and only E, F, and G are used now.

threatened another youth must be kept separate. This affects every aspect of movement within SYSC, as there are often multiple keep separates at any given time (when we visited SYSC one day in May, we observed that there were around 13 youth, 7 of whom had to be kept separate). The need to keep certain youth separate is further complicated when staffing is limited. Codes (discussed further below) also affect youth movement. All of these factors combine to create a facility where youth movement is often logistically challenging and difficult to do safely.

Supervisors and administration limit movement if it is unsafe to move. This can be accomplished via two widely understood terms: ‘unit confinement’ and ‘single movement.’ Both have been used in the past to deescalate and restore safety when the youth on a unit are dysregulated.⁷ Unit confinement is when youth must remain on their subunits and generally cannot participate in optional programming. Mandatory programming, like therapy, is not affected. When on unit confinement, youth do not have to be in their bedrooms but do need to be on their subunits. There is usually rotated access to the unit multiroom and basketball court when on unit confinement. Meals and, sometimes, schoolwork, are brought to the subunits.

Single movement is when youth who are on their unit must remain in their bedrooms; one youth is permitted to be out of their bedroom in the subunit dayroom at a time, usually for 30-60 minutes. Then the youth rotate. Putting a subunit on single movement must be approved by administration. It is generally only used if there are significant behavioral issues impacting the whole subunit. Single movement usually lasts only a few hours to a full shift, to permit the subunit to return to baseline. Some staff reported that they have seen single movement last a day

⁷ ‘Dysregulation’ is a clinical term of art referring to youth behavior or presentation that deviates from their baseline in an unsafe manner. It is used throughout the facility by all staff to describe when youth become angry, upset, combative, are experiencing the onset of a mental health or behavioral crisis, or are otherwise becoming escalated or unsafe.

or two at most in a subunit. CSUs are always on single movement to minimize interactions between volatile youth.

Some staff also described a “lockdown” status, which they reported would consist of all youth locked in their bedrooms. All staff we spoke to said that this status would only be deployed if contraband was found, and only lasts as long as it takes to conduct a full search of the facility (a few hours). There is no official operational status referred to as “lockdown.”

Youths’ daily weekday schedule generally consists of breakfast; school until the early afternoon; lunch; recreation time; individual or group therapy; dinner; free or scheduled activity time; and bedtime. While all youth not on CSU or other safety restriction have the same access to school and clinical time, bedtimes and access to privileges are controlled by a “level” system. Levels are 1-4, with 1 being the most restrictive and 4 being the least restrictive. All youth enter at a Level 3. Levels are assigned each week based on a youth’s behavior throughout the week. YCs “grade” the youth throughout the week and assign their levels with supervision from supervisors and, sometimes, administration. A Level 1 youth has an 8:00 P.M. bedtime, ten minutes of phone use per day (aside from legal calls), and less ability to access privileges like the multiroom. As the levels increase, so do bedtimes (up to 9:30 P.M.), phone privileges (up to 25 minutes), and facility access. Level 3 and 4 youth may also be granted “trust” status which provides additional privileges, including working up to the ability to leave the facility for periods of time.

Youth misbehavior or crises can result in what are referred to as “codes.” There are three levels of codes. A code 1 is the lowest level and is used for issues such as youth refusing to move or using concerning language for an extended period. A code 2 is for situations that are escalating beyond a code 1 but do not involve physical violence. A code 3 is for situations

involving active or imminent physical violence or self-harm by youth. If staffing levels permit, a “response” team of YCs and supervisors respond to all code 2’s and code 3’s to safely manage the situation. The youth generally understand the code system. When a code is called, youth on their unit are supposed to go into their bedrooms for the duration of the code (doors unlocked). This is because there is generally not enough staff to safely cover a unit and also respond to codes. Youth usually comply with going into their rooms when other youth code, but it is often difficult for staff to manage. Some codes resolve relatively quickly, but others can go on for half an hour or longer. Supervisors and administration try to release staff from codes as quickly as possible so that they can return to their units and youth can leave their bedrooms, but supervisors cannot do this if it is unsafe. Youth are not permitted to move anywhere near an ongoing code.

A youth might be admitted to the CSU after a code for deescalation if the situation warrants it. Youth are also subject to consequences for misbehavior, which are categorized as minor/moderate/major violations and carry corresponding consequences (such as loss of privileges for some period of time or writing apology letters).

Most youth report enjoying their recreation time and clinical services the most. Most also report enjoying the privileges that come with upper-level status, including ordering takeout, being able to play video games in the multiroom, and gaining access to trust status. Many youth report struggling with having to go to bed, particularly if they have not been very active that day and have a lot of pent-up energy. Because third shift at SYSC has fewer staff, second shift staff make every effort to ensure that all youth are in their bedrooms at the scheduled bedtime, or by 9:30 P.M. at the latest. Once a youth goes into their bedroom for bedtime, their bedroom lights are off and their bedroom door is locked. A staff member is on every subunit all night, and youth

who need water or bathroom access use a call button in their room or knock on their door and are assisted by staff.

iii. Prior Allegations of Abuse

In the late 2010's, several former YDC residents came forward and publicly alleged that they had been physically and sexually abused while residing at YDC. Thousands of civil lawsuits and a criminal task force followed. The Legislature also established a settlement fund as an alternative to civil litigation, into which over two thousand people have filed claims. The civil litigation, criminal task force and prosecutions, and settlement fund all remain ongoing.

iv. Timeline of Recent Events

From 2018 through January 2022, Rhonda Henault served as the Director of SYSC.⁸ Several staff reported that under Director Henault, accountability for youth misbehavior began to diminish. Others noted that they felt Director Henault was not often visible or available while serving as Director. SYSC also began its contract for youth clinical services with DHMC under Director Henault, around 2021. Prior to that contract beginning, SYSC provided clinical services to youth directly via its own employees. Several individuals reported that DHMC was phased in because the SYSC employees in those roles were not appropriately qualified or credentialed to provide clinical therapeutic services. Several interviewees reported that DMHC was selected at least in part because they were already providing clinical services in a State contract at Hampstead Hospital. In 2021, the DHMC contract began with only one clinician, Dr. Morin. In the following years, DHMC added two more clinicians and recently added a third. The DHMC clinicians generally work regular business hours, but one works until 9:00 P.M. several nights per week.

⁸ This position was later retitled as the SYSC Bureau Chief but is the same role.

Director Henault left her position in January 2022. There was no formal director until Gerald Rocha began in August 2022. In the days and weeks that followed Director Rocha's arrival there were multiple youth disturbances necessitating law enforcement intervention. Both the New Hampshire State Police (NHSP) and Manchester Police Department (MPD) responded to several calls involving multiple youth disturbances, including youth breaking out of their bedrooms after hours and wielding weapons. In the approximately three years that followed, the NHSP and MPD have continued to regularly respond to serious incidents at SYSC. Most staff reported that the facility eventually reached an uneasy status quo that saw fewer disturbances resulting in injury alongside a general decrease in accountability for minor, moderate, and major infractions. Most staff reported that Director Rocha was not often visible to staff or youth.

Director Rocha's employment ended in July 2025. From July 2025 to January 2026, there was no confirmed, interim, or acting Bureau Chief at SYSC. ABC Hersey took on additional responsibilities during this time. The administration team largely directed operations of the facility during these months in conjunction with DCYF. Many staff members reported that ABC Hersey and Dr. Morin seemingly ran SYSC during this period.

After the Bureau Chief role became vacant, DCYF began a nationwide hiring process. It received more than 35 applications for the role, including both internal and external candidates. All internal applicants, and all external applicants with relevant experience, were offered a first-round interview with a hiring committee. The first-round hiring committee consisted of ABC Hersey, Dr. Morin, SYSC Supervisor Tammy Ferrell, DCYF Deputy Director Ross-Ferguson, and a DCYF parent partner. After the first-round interviews, the committee advanced three candidates for second- and third-round interviews with DCYF and DHHS leadership. BC Nye was one of these three candidates. Of the other two, one dropped out of the process and the other

was eliminated due to issues with a background check. BC Nye was thus the only candidate advanced to a second- and third-round interview.

All people involved in his hiring that we spoke to thought BC Nye interviewed well and would be a good candidate for the role given his experience with both clinical work and adult corrections, though everyone acknowledged he would need assistance learning more about secure juvenile facilities. Marie Noonan, Director of DCYF, reported that no one raised any concerns to her about BC Nye's ability to serve in the role before his hiring. He was offered the role, received salary approval from the Executive Council on December 17, 2025, and began work on January 23, 2026.

b. Introduction of New Schedule and Movement Restrictions

In the week following BC Nye's arrival, there were several major incidents with youth. There were nine major codes in seven days. These culminated in two incidents. First, youth C.B.⁹ started fighting another youth in the gymnasium on January 29. After the victim was removed from the area, C.B. still refused to deescalate and punched a YC in the face. The YC had to be transported to a Boston hospital for emergency treatment. His jaw was broken in two places and he lost a tooth from C.B.'s punch.

Then, either later that afternoon or the next day, youth W.G. broke through two doors into the closed pool area, which has a large, empty 10-foot-deep concrete swimming pool and narrow walking areas along the sides. Staff had to pursue W.G. into this extremely dangerous area because he armed himself with debris from the broken doors and in the unused pool area. He posed an extreme danger to himself and others and ultimately had to be restrained next to the empty pool. Anyone, staff or youth, could have been seriously injured or killed.

⁹ Throughout this report, all youth are referred to by pseudonym initials to preserve anonymity.

As these two incidents occurred, BC Nye was offsite at a DHHS leadership meeting. When he learned about them, he immediately called ABC Hersey. BC Nye was looking for input from ABC Hersey about what could be done to address safety in the facility and to do a “reset.” BC Nye indicated that ABC Hersey informed him about single movement and unit confinement as two options to restrict movement within the facility. BC Nye later brought a proposal to the administration team to temporarily implement these measures. He recalled that they agreed with this plan. The other administrators did not recall agreeing with BC Nye’s plan. BC Nye brought his plan to Director Noonan, who agreed with it. Director Noonan was under the impression that the entire administration team agreed with the proposed plan. ABC Hersey told us that neither he nor the rest of the administration team suggested or agreed with the “reset” proposal. Overall, there is genuine factual uncertainty as to whether the rest of the administration team supported BC Nye’s proposed plan at the time.

The disputes over the level of consensus within the administration team notwithstanding, as a result of the incidents noted above, BC Nye implemented a series of temporary schedule modifications beginning on Friday, January 30, 2026. At the outset, we note that it is unclear from where the term “lockdown” originated in reference to this period. The schedule changes were never contemporaneously referred to as such by SYSC administrators, supervisors, or YCs. As noted above, unlike single movement and unit confinement, “lockdown” is not a widely understood or common facility status at SYSC. Most people that we interviewed who had heard the term stated that something like a “lockdown” would only occur if contraband were found in the facility, and that it would be an extremely short period of all youth locked in their bedrooms while the entire facility was searched. The vast majority of the staff members we interviewed did not recall that anything they would describe as “lockdown” took place. It appears that the term

may have originated with the youth as a pejorative reference to the period of schedule modifications.

ABC Hersey messaged the actual details of the plan for the weekend to staff on the morning of January 30 in an email. The email referred to a new operational plan. ABC Hersey and supervisors later gave additional guidance on how to communicate the new operational plan to the youth in a community meeting. Those details were stated to staff as follows:

- Limited movement: all meals and activities will take place on the unit. There will be no mixing. Any movement will take place “together as a unit or not at all.”
- If there is an issue on the unit, the unit will be put on single movement and it will require administrative approval to end single movement.
- Girls and Boys Trusted Units can use gym at supervisor discretion. The gym is closed to the remaining units.
- Saturday 1/31 visits are cancelled.
- TV and games are to be off during school hours (8:00 am-12:00 pm). This time is reserved for school, groups and learning activities. If youth are finished with schoolwork, they may read a book or request additional work.
- [Therapy] groups are to continue; if a youth does not want to attend, they will not have access to television or multipurpose room activities.
- All youth will have an 8:30 pm bedtime regardless of level.
- Units will be allowed to eat lunch in their multi-purpose room. Other meals will be taking place on the subunits.

This email reiterated that these changes were temporary and intended to keep everyone safe. It also indicated that the changes were to be reviewed the following week. This plan was initiated in part to limit access to large open areas like the gym, which had been the location of many dangerous incidents. Most staff appreciated these schedule changes, which gave staff a chance to breathe and regain a sense of security after several injuries to staff. Youth later reported to the OCA that they felt these changes made them feel as if they were in jail,

depressed, and being treated like toddlers. We note that access to clinical and medical care throughout this entire period was not restricted at all.¹⁰

At the time of this directive, BC Nye indicated that he intended to progressively return to regular scheduling. By February 2, after the first weekend of operational modifications, administration began reinstating some aspects of the regular schedule. An email from ABC Hersey to BC Nye, which BC Nye subsequently distributed to staff, indicated that units would start eating one meal per day that week in the cafeteria together with another subunit. An email on February 4 from ABC Hersey to staff mentions progress and stability, and an effort to gradually return to regular programming. It announced the return to regular bedtimes and the ability to use the school store and order take out on February 6. The email also permitted youth to watch the Super Bowl on February 8 until their earned bedtimes and have ice cream. Youth were permitted to use the large multipurpose rooms on their units for muscle movement beginning the week of February 9. Communications during this period noted that youth on CSU who needed to be moved through the facility for any reason would be transported in mechanical restraints (handcuffs and shackles).

On February 11, use of the cafeteria started to rotate in three-subunit groups for lunch and dinner. From January 30 through March 16, youth ate breakfast on their units. Also on February 11, individual units were allowed gym access. We found additional evidence of efforts to progressively return to regular programming as follows:

- On February 13, a trusted female youth was allowed to go on a campus walk.
- On February 18, a muralist came onto the facility for programming.
- On February 20, “youth v. admin” games took place.

¹⁰ In fact, as the weeks went on, BC Nye and Director Noonan reported that BC Nye suggested increasing clinical service hours.

- On February 22, use of the multipurpose room was allowed for upper-level youths.
- On February 24, the daily schedule began to regularly include times for the multipurpose room, gym, and therapeutic groups. Additionally, a shank made from a spork was found on this date. As a result, administration continued the rotation of cafeteria access but switched to the use of paper utensils for a period.
- On February 25, the daily schedule included one school period per unit for 50 minutes, multiroom activities, gym for 50 minutes, lunch, groups, and dinner. This schedule became the general norm until March 16.
- On February 27, the daily roll call notes a “chapel games” activity.
- On Sunday, March 1, the daily schedule included times in the morning and evening for gym and multiroom use.
- On March 2, the facility added a 20 minute “table talk” to the activities.
- Starting on March 3, there was an additional half hour period for “activity-gym” time added to the afternoon block.
- On March 4, a trusted female youth went on a community trip from 5:30-8:00 P.M.
- On the weekend of March 7, programming included morning and afternoon blocks in the multiroom and gym, as well as additional blocks for activity in the trusted weight room.

None of the written communications during this time refer to any restriction of outdoor time. When we asked staff about outdoor time, they reported that there was snow and ice on the ground and that the secured outside areas were not safe to use in that condition. A few staff recalled that in previous years, youth had been let outside during snowy months to build snowmen, but it does not appear that daily or regular outdoor time during snowy months had ever occurred before at SYSC. Due largely to the weather, outdoor access remained limited until March 19, when administration informed staff via email that the outdoor basketball courts on the units had been approved for youth use.

Education during the period from January 30 to March 13 was relatively sparse. For approximately the first week, all educational programming was done on the units. Teachers were

seen in video footage coming into units, dropping off schoolwork and leaving. After approximately a week, units were taken to one classroom period per day. Throughout this period, any youth who needed to use the classroom computer for their individual educational needs was taken to the classroom to do so. There were several days in February where there was no school. These included February 12, 13, 16, and 19 as well as February 23-27 (school vacation week). The trend of not having school on certain days continued through March 13. It remains unclear why school was canceled on these days (aside from vacation week).

There were several times throughout the six-week period in question that individual subunits went into single movement in response to misbehavior. Each period of single movement was approved by the administrator on duty; we did not find any period of single movement lasting longer than two days. We found no evidence that the entire facility was ever placed into single movement. For example, on March 8 and 9, subunit F-000, which had a population of five youth at the time, was placed on single movement. The logbook for the unit indicates that multiple youth had developed a plan to attack another youth on the unit. But, despite this significant safety risk, we did not find any evidence that the entire SYSC facility was ever placed into single movement at any time.

On Monday, March 9, one of the F-000 youth who had been plotting the attack on another youth and who, as a result, was then on single movement called the OCA asking to meet with someone to relay concerns. The OCA's notes indicate that this child called reporting concerns about "racial bias[,] unfair treatment," and "poor boundaries" on staff's part. The next day, one of the OCA staff came to SYSC and met with that youth. Notes from that meeting do not indicate that the youth in question complained about movement restrictions or changed

schedules. Rather, the notes state only that the youth complained of racial discrimination, asked for appropriate grooming products, and said that “[clinical] treatment is going downhill.”

The OCA received additional calls from unknown staff at SYSC in following days. On Friday, March 13, the OCA conducted an unannounced, full-day visit at SYSC. The same day, the OCA contacted Director Noonan to relay concerns. On Monday, March 16, SYSC began to run largely as it had prior to BC Nye’s arrival, with all safe youth attending four 50-minute classroom periods per day, along with gym time and other programming.¹¹ As noted above, clinical programming remained unchanged throughout this period. BC Nye believed the schedule he had implemented was permissible and no one told him it was not. But when he felt as though the OCA and DCYF informed him the schedule was unacceptable on March 13, he immediately switched back to a schedule more like the one that preceded his arrival. This new schedule included full days of classroom attendance and other more regular programming. The switch was abrupt. Several YCs reported being unaware when they began work on the morning of Monday, March 16 that they were going to be bringing all units for a full day of school in classrooms and had to scramble to ensure safe coverage. BC Nye reported that all administration team members were supportive of the change back to full classroom attendance, particularly ABC Hersey, who began discussing wanting to do more in-classroom education for the first time the week prior. BC Nye recalled in his interview that Director Noonan told him to revert to a more typical schedule after hearing from the OCA, but that he had already been moving in that direction, albeit more slowly.

¹¹ Safe youth refers to all youth not on a CSU or otherwise unable to safely participate. Youth on CSU or otherwise unable to attend full days of school or other programming due to safety concerns continued with a modified level of programming.

On or around March 30, 2026, the OCA publicly reported for the first time that “concerns” had been shared with them that “[l]ockdown status was in place at [SYSC] for approximately a month and a half,” with an “[i]nitial full lockdown for two weeks; single movement . . . no off-unit time, all muscle movement on the units . . . shackled to walk around off unit if needed/approved, and no education.” The OCA further reported, among other things, that “[o]nce ‘full lockdown’ was over there was a restricted status that remained” allowing for one hour of off-unit education daily, 30 minutes of gym time, and one meal per day in the cafeteria. The OCA included notes from youth to the effect that youth felt that they were in “jail,” “isolat[ed],” and being “treated like a toddler.”

c. March 17, 2026 Incidents with T.F.

Also on March 30, the OCA publicly reported that on March 19, it had received a complaint about improper use of physical restraint that occurred on March 17. It reported that “[v]ideo footage confirmed the use of physical restraint without imminent risk of harm to the child or others present, and holding the child down in an illegal prone position for approximately 3 ½ minutes. Documentation also showed a delay in medical care provided for [a] broken bone.”

The incident in question involved youth T.F. and began around 2:00 P.M. on March 17.¹² Multiple staff members, including T.F.’s assigned clinician, reported that T.F. had not been having a good day. Before 2:00 P.M., there had already been five codes that day for T.F. refusing to move to his next scheduled activity. As noted above, when one youth refuses to move in a public area, most or all other youth movement in the facility is impacted or stopped because multiple staff who could otherwise accompany youth are diverted to the code and because youth cannot walk through an area where another youth is having an active code due to safety

¹² On that day, T.F. was 17 years old, nearly six feet tall, and weighed nearly 200 pounds.

concerns. Additionally, all youth who are on their unit when a code is called must go into their rooms for safety until the code is cleared. Several staff reported that youth sometimes intentionally code simply to prevent another youth with whom they are having disagreements from being able to do activities.

At approximately 2:00 P.M., T.F. was walking through SYSC's central rotunda when he became dysregulated after refusing to attend a scheduled clinical group. Witnesses reported that he challenged staff and refused directives with continued profanity. Video (without audio) shows that he sat down on a bench in the rotunda near the central control/exit door and refused to move. Multiple staff members and his clinician attempted to deescalate T.F. using Therapeutic Crisis Intervention (TCI) techniques, such as offering support and opportunities to make positive choices, but these interventions were unsuccessful. T.F. continued to refuse to move.

At approximately 2:12 P.M., a code 1 was called due to T.F.'s continued refusal to comply with directives and escalating verbal aggression. Staff reported that T.F. made hostile comments toward staff and refused all requests to move. At this point, multiple staff, administrators, and T.F.'s clinician were with him in the rotunda. Verbal deescalation efforts continued for several more minutes. At about 2:24 P.M., following confirmation from BC Nye, who was on scene, staff began to slowly open-hand guide and then move T.F. by his arms to a standing position. At that point, T.F. dropped his weight, tensed his body, pulled away from staff, and began flailing his arms. Staff brought T.F. to the floor in a restraint. He was prone on the floor for less than one minute for the application of handcuffs when staff lifted him to a recovery position on his side. T.F. then struggled out of staff members' hold and returned himself to a prone position. He remained prone again for less than one minute as staff applied shackles to his legs and then returned him to a recovery position on his side. T.F. then again

shook himself out of staff's hold and returned himself to a prone position for a second time.¹³

After less than one more minute in a prone position, staff again returned T.F. to his side and were able to hold him there and return him to a seated position and then to his feet. T.F. remained combative against staff's attempts to reposition him during this restraint. Throughout the entire encounter, multiple staff were watching closely to ensure T.F.'s safety.

At approximately 2:30 P.M., staff escorted T.F. to the Crisis Services Unit (CSU). T.F. continued to resist and reportedly attempted to headbutt staff during transport. He was placed in a padded room on the CSU to deescalate and all restraints were removed. At approximately 3:04 P.M., video footage from inside the padded room shows T.F. punching a window with his left hand and immediately reacting as though the outer side of his left hand is injured; no injuries are visible.

At approximately 3:10 P.M., while in the padded room, T.F. asked to use the bathroom. Staff opened the door to transfer T.F. to a "wet room," which is a bedroom that also contains a toilet and is next to the padded room. Upon exiting, T.F. threw his sweater at staff, shoved a staff member in the chest, challenged the staff member to fight, and cornered the staff member in the CSU dayroom. T.F. continued to use profane and dismissive language, ignore directives, and exhibit dysregulated behavior. He eventually left the staff member alone. Staff on the CSU attempted TCI interventions for approximately 10-20 minutes without success. T.F. then leaned against a wall and refused to move despite staff efforts to provide space and deescalate the situation.

¹³ Multiple staff reported that the OCA and DRC-NH tell youth that the youth are not permitted to remain in a prone position, and that youth will then intentionally try to remain in or return themselves to that position when staff attempt to turn them onto their side. SYSC staff report having been told by youth that the youth do this to get staff in trouble and/or develop the basis for a lawsuit.

Eventually T.F. began walking around the dayroom, still refusing to go into the wet room to use the bathroom as he had asked. T.F. moved toward the same staff member he had cornered in a confrontational manner, grabbed a Bible from the table, ripped pages from it, and threw them at multiple staff members. He then tossed the Bible at a staff member's chest. Video shows T.F. continuing to engage in threatening and posturing behavior, stepping toward the same staff member and seeming to posture at him as if preparing to fight. Two other staff members who had approached from behind T.F. then each grabbed one of his arms and pulled him down backwards into a restraint. Multiple staff members were observing T.F. and confirming his safety as other staff applied handcuffs and shackles. T.F. was prone during this incident for two minutes and nine seconds; as soon as the mechanical restraints were in place, staff turned him to his side and got him standing. Two staff members, surrounded by several others, then took T.F. into the wet room. He continued to shove them against the doorway to the room as they escorted him; this resulted in the two staff and T.F. tumbling forward onto the bed in the wet room. The interior of the room is not visible on video footage, but multiple staff enter the room with T.F. while others watch from outside.

Staff continued to monitor T.F. in the wet room on the CSU constantly until approximately 4:23 P.M., when he finally deescalated enough for the restraints to be removed and the code was cleared. T.F. was then secluded in the wet room for the remainder of the evening for the safety of everyone.

T.F. was assessed by his clinician in the hours that followed once he had returned to baseline. He reported to her that his hand hurt. A nurse came by later that evening and viewed T.F.'s hand through the window to the wet room. She noted that she had full view of the hand, and that it did not appear to be urgent—*i.e.*, there were no visible wounds, blood, or significant

swelling or bruising visible. She offered T.F. over-the-counter pain medication, which he refused. Ice packs or bags are not permitted in CSU due to the safety risk.

The nurse left and had T.F. assessed by SYSC's on-call pediatrician in person the next day, approximately 24 hours after T.F. had punched the window. By this point, T.F.'s hand displayed more bruising and swelling. The doctor confirmed that T.F. should have his hand x-rayed, but assessed that it was not urgent and could wait until the next day.¹⁴ The next day, less than 48 hours after punching the window, T.F. was taken to the hospital, x-rayed, diagnosed with what is commonly called a "boxer's fracture" in a small bone in the side of his left hand, and put into a cast.

Investigators from DCYF's Special Investigations Unit (SIU) interviewed T.F. twice after this incident. According to notes of those interviews, T.F. did not take issue with the first restraint in the rotunda. T.F. asserts that staff broke his hand when they tumbled onto the wet room bed with him after his second restraint. He claims that he "cut" his hand when he punched the window in the padded room but that his hand did not break until staff "slammed" it as they put him onto the bed. Both staff involved in that incident deny falling on top of T.F. or touching, slamming, or injuring his hand. No cut was ever observed on T.F.'s hand or treated.

d. Use of Open-Hand Guides at Bedtime

On April 17, 2026, both the OCA and DRC-NH published information relating to SYSC's response to youth refusing to go to their rooms at their scheduled bedtimes. The OCA reported learning that "staff have been instructed that at 9:30 P.M. they are to open-hand guide children to their bedrooms if they continue to refuse" to go to their rooms. DRC-NH similarly

¹⁴ Multiple staff members reported that emergency medical transports are extremely difficult to accommodate both for SYSC and for the receiving medical office. At least two SYSC staff members have to accompany all youth medical transports, which is difficult to do on an emergency basis at any time but particularly when the facility is short staffed.

published a longer analysis outlining its view that such practices are “not trauma informed” and “appear[] to be a purposeful effort to agitate [youth] through unnecessary and unwanted physical contact.” Because, DRC-NH wrote, open-hand guides for noncompliant youth at bedtime “result in physical guidance, a form of physical restraint, to limit the freedom of movement of children who are already in a safe location when no emergency or threat of imminent unlawful force exists,” they are prohibited by RSA 126-U.

We asked staff and leadership about the open-hand guide policy. Multiple staff members and DCYF leadership confirmed that around early April, multiple youth refused to go into their bedrooms at their scheduled bedtime (8:00, 8:30, 9:00, or 9:30 P.M., depending on the youth’s level that week). In one instance, two youth stayed awake in the dayroom of the subunit until around 5:00 A.M. Refusing to go to bed on time creates a safety issue because the overnight shift is minimally staffed. When the shift changes at 10:00 P.M., most of the staff in the facility leave. Thus, if there are codes or other issues, there is virtually no one to respond. All subunits must always have at least one staff member. Thus, in staff’s view, leaving youth out on the unit after their scheduled bedtime creates an unsafe situation of potentially one or more youth interacting and insufficient staff available to manage any issues that may arise. For example, staff reported that one youth staying out in the dayroom all night could easily impact the ability of staff to let other youth out to use the restroom during the night.

In response to this issue, SYSC and DCYF leadership developed a policy, later announced to staff and communicated to youth, that if a youth fails to go to their bedroom on time, staff, after all attempts to deescalate the youth, may use an open-hand guide to direct the youth to their bedroom. An open-hand guide is an escorting maneuver in which the staff generally does not actually touch the youth, but uses an open hand behind or near them in an

attempt to direct them to a different area. A closed-hand guide, conversely, is when staff actually touches the youth, such as with a hand on their shoulder or wrist. If youth react to the use of an open-hand guide with agitation or violence, staff are permitted to physically intervene in accordance with the parameters RSA 126-U. Director Noonan approved this practice.

In the OCA's interview notes, youth report struggling with bedtime and disliking being touched. Some noted it is difficult to go to bed relatively early if it has been a "boring" day with less activity or gym time. A youth reported that a YC walked off the job because she did not support this policy and would not go hands-on with a youth refusing bedtime; we were unable to verify this. Few of the staff members we spoke to reported that they had to frequently, if ever, go fully hands-on with a youth at bedtime before or after this policy was enacted. One reported doing an open-hand guide that ended in restraint of a youth refusing bedtime. It does not appear that this practice was or became widespread, and it is unclear to what extent it continues today.

e. Incidents on May 3, 2026

Several incidents on Sunday May 3, 2026 encapsulate the current state of operations at SYSC. On that day, second shift (afternoon and evening) was short staffed. Starting sometime around 4:30 P.M., multiple codes were called involving six different youth. These codes involved assaultive behavior toward other youth and staff and refusals to comply with movement directives impacting whole units. Most of the difficulty began when youth received their "levels" for the week. As noted above, these levels (1-4) affect youth privileges, such as bedtimes and phone call duration, and are based on youth behavior during the previous week.

Several youth expressed disagreement with the levels they received. J.W. and F.R. were upset about the levels they had been assigned by a YC on their unit based on their disrespectful behavior throughout the week. They became visibly escalated and asked to speak to a supervisor.

When the supervisor arrived, the YC went into the staff office on the unit while the supervisor attempted to deescalate the youth. This was unsuccessful, and both youth began to vandalize furniture on the unit. As the supervisor moved away from C.B., who had also become escalated, and exited the unit, C.B. chased the supervisor through a secured door. C.B. punched the supervisor in the head five or six times. That supervisor was out of work for several weeks with a brain injury. C.B. also headbutted a female staff member, whose nose was left bleeding and broken. C.B. then smashed a water jug, kicked out a door window, punched a television, and armed himself with shards of plastic. Staff witness reports from this incident note that C.B. made several statements to the effect that he knew there were insufficient staff available to restrain him, and that he refused to go to the CSU per protocol for a dysregulated youth and would slash anyone who tried to touch him. Staff also reported that C.B. stated that if anyone attempted to restrain him, he would cause as many staff injuries as he could and that he would immediately notify the OCA and DRC-NH in an attempt to get any staff who touched him fired. C.B. eventually agreed to move to another unit and was not placed on CSU despite these multiple assaults and violent threats.

Meanwhile, as C.B. assaulted the supervisor and available staff left the floor to restrain C.B., the YC exited the staff office to ask the other youth present to go to their rooms per protocol because codes were being called. J.W. and F.R. then rushed into the staff office and closed the door behind them. Because the staff office is full of objects that could be used as weapons, the staff member opened the door to ask the youth to leave. They immediately attacked him, punching him several times in the head. The youth report that the staff member punched them back, which the staff members denies. It is unclear from the video footage of this incident whether the staff member punched the youth. The YC was eventually able to leave the office in

the middle of this altercation. As of the date of this memorandum, it is our understanding that a criminal investigation into this incident remains ongoing.

Also on that unit, youths D.E. and A.L., who had a history of conflict, began physically fighting. In the ensuing altercation, staff had to restrain both youth to keep them from continuing to physically attack each other. Finally, W.G. had to be restrained when he tried to escape from the CSU by pushing a staff member through the door. Administrator Tsoumbanos, who was not scheduled to work on May 3 but received a total of 37 phone calls from the facility, ended up going in and staying until 2:00 A.M.

IV. Conclusions

a. Legal Compliance

i. SYSC is operating within legal limits.

The central focus underpinning our investigation was whether reports from the OCA and DRC-NH reflected a handful of decisions nearing the limits of operational discretion or whether they were indicative of a larger pattern of operational deviation from the statutes and policies governing SYSC. For the reasons outlined further below, we conclude that SYSC has been operating within legal limits and that recent events do not constitute a significant or illegal deviation from lawful operations.

ii. BC Nye's decision to implement temporary movement restrictions on January 30, 2026 was a reasonable response to several serious staff injuries and youth disturbances.

We find that the decision to implement periods of temporary movement restrictions was a reasonable response to several critical incidents in the week that followed BC Nye's arrival. As noted above, the week following BC Nye's start on January 23, 2026 saw multiple serious incidents of dangerous youth behavior. These included one youth breaking multiple doors to

enter into the closed pool area, arming himself with dangerous debris, and forcing staff to follow him into a large room dominated by a 10-foot-deep empty concrete swimming pool. All responding staff or the youth could easily have been seriously injured or died if they were pushed from or fell off the narrow edges into the empty pool.

Another youth punched a staff member, breaking his jaw in two places, during this same week. That staff member had to be rushed to emergency surgery in Boston, spent several weeks recovering, and ultimately did not return to work at SYSC. These incidents caused many staff to become very upset and wonder when something similar would happen to them. Others expressed extreme frustration at the fact that the offending youths did not suffer any consequences and were returned to regular programming within a few days as if nothing had happened.

During our review, some members of the administration and clinical teams described the broken jaw incident as a “routine” occurrence and not something that warranted alarm, adjustments in programming, or discipline. These individuals also appeared to insinuate that the staff’s broken jaw was acceptable because the youth did not intend to injure the staff member and was instead actively trying to attack another youth and injured the staff member when he intervened. We find this view inappropriate, and this depiction of events inaccurate based on video footage of the assault (to which administration has full access). YCs and supervisors cannot be expected to be effective in their youth-facing roles if they are in constant and significant fear for their personal safety. Nor can morale be sustained if staff reasonably believe that the administration team do not support them despite significant and legitimate safety concerns above and beyond those that should be inherent to their daily roles.

BC Nye felt that these incidents indicated a need to “reset” the facility to restore safety and security for both youth and staff. When he was informed about the pool and jaw incidents,

he immediately started working with the administration team and DCYF leadership to discuss security responses available. Ultimately, BC Nye proposed to Director Noonan to temporarily restrict movement and privileges to return the facility to a baseline level of safety while new staff were trained. Director Noonan agreed. A small crop of new staff began training the first week of February and were ready to work as YCs in March; another small group started in March and were ready in April. We agree that BC Nye's recommended plan and Director Noonan's approval of that plan provided a needed opportunity for youth to return to a safe baseline and staff to regain some measure of feeling safe at work.¹⁵

All staff interviewed, including those who did not agree with the "reset" decision, agreed that the schedule restrictions loosened over time through March 13, before full programming resumed on March 16. After an initial period of restrictions that included school and recreation time on units and bedtimes at 8:30 for approximately one week, youth began to rotate to classrooms for school for one period per unit per day. Youth were already rotating to the cafeteria for meals within three days of the initial schedule change. A gym rotation was introduced within a week. The default for youth during this period was unit confinement, not single movement. Youth were not confined in their rooms and were able to spend their time in the dayroom on their subunit or on the unit multiroom unless an emergent safety issue arose, at which point single movement would be implemented until the unit returned to baseline and then lifted.

Perhaps most importantly, both Director Noonan and Deputy Director Ross-Ferguson reported that no one from the administration team, clinical team, or residential staff raised any

¹⁵ It also appears that youth "testing" a new Bureau Chief by acting out is a common reaction to new leadership. As described above, youth also created several disturbances in the days and months following Director Rocha's arrival at SYSC, necessitating multiple law enforcement responses.

issues concerning the schedule modification put into place by BC Nye until, at the earliest, March 4, more than a month after the modifications began. Nor did any of the other staff members we interviewed state that they raised any concerns about the schedule modifications to either director or provide any written communications raising concerns to either. Dr. Morin noted in her interview that she had a regular monthly meeting scheduled with OCA staff in February 2026, but that she canceled that meeting and did not reschedule it. In short, none of the concerns later raised by individuals working in the facility about an extended “lockdown” were contemporaneously elevated to anyone in a position to address those concerns.

One question raised about this time period was whether youth received sufficient educational services. Prior to BC Nye’s arrival at the end of January 2026, under the oversight of ABC Hersey, the facility had already switched to a schedule of four, hour-long periods in the morning (with a snack break), followed by lunch and gym class. When BC Nye implemented the schedule change on January 30, youth first had education materials delivered to their units by teachers, who were available for questions. Beginning on February 9, youth began to rotate to classrooms for one 50-minute period per day per unit. Teachers continued to come onto units as available for educational support. This rotation continued, with every youth who was safely able to go to class doing so at least once every school day, until March 16, when full class attendance for all safe youth resumed. Throughout this period, youth who needed to access computers in the classrooms for their specific educational needs (such as HiSet or IEP-related materials) were taken to the classrooms to complete that work.

Although more direct educational support could have been provided during February and into March, we cannot conclude that the educational programming during this period was unreasonable given 1) the significant and ongoing security and staffing concerns throughout the

facility at the time and 2) the contractual limits on educational services (including hours and educators available). We also note that the administrator overseeing educational services at SYSC, ABC Hersey, did not raise any concerns to BC Nye that youth may not be receiving adequate education time until more than a month after January 30. We further note that school taking place on the units was not new and had been utilized in the past when youth behaviors prevented safe classroom attendance, including during the roughly six-month period when ABC Hersey and Dr. Morin effectively ran the facility before BC Nye's arrival.

We acknowledge that any change in schedule can be challenging for youth in a secured setting. However, we do not find that any of these changes constituted an illegal or unreasonable restriction on youth. We thus conclude that the temporary period of phased schedule modifications was not inappropriate.

- iii. Staff responded appropriately to the March 17, 2026 incidents involving T.F. and there is sufficient evidence to conclude that T.F. broke his own hand.

We conclude that the two restraints involving T.F. on March 17, 2026 were appropriately limited uses of restraint techniques. There is also sufficient evidence to conclude that T.F. broke his own hand by punching a window. As described in detail above, prior to the first restraint in the rotunda around 2:30 P.M., T.F. had been involved in five codes that day involving failure to move, none of which had resulted in physical intervention. However, those codes had already impacted the ability of the rest of the youth in the facility to move to their next destination to ensure complete programming for the day.

When T.F. sat down in the rotunda, the central hub of the building, at approximately 2:00 P.M., he effectively prevented other youth from moving to their next destination. One unit was stuck in the gym and could not leave, because doing so would require them to pass directly

through the rotunda where T.F. was refusing to move. This meant that another unit scheduled to use the gym could not go there for recreation time. Other youth were stuck in the library on the rotunda. The disturbance T.F. caused by refusing to move distracted the library youth from their group therapy session taking place there. In short, T.F.'s refusal to move caused significant disruption throughout the facility and had immediate effects on other youths' ability to attend programming.

Once T.F. was brought to the floor in a restraint, he was prone for less than one minute for the application of handcuffs. Once the handcuffs were secured, staff lifted him to a recovery position on his side. T.F. then returned himself to a prone position twice more before staff could safely get him to his feet. In his interview with the SIU after this incident, T.F. acknowledged that he did not take issue with this restraint. Multiple staff members also reported that T.F. spent most of his weeks at SYSC stating that he wished to be physically restrained so that he could sue the facility and collect a settlement.

We conclude that the restraint in the rotunda did not violate RSA 126-U and was appropriate under the circumstances. RSA 126-U governs the use of restraints and seclusions for youth in school or residential facility settings. It prohibits prone restraints, which the statute defines as "when a child is intentionally placed face-down on the floor or another surface, and the child's physical movement is limited to keep the child in a prone position." RSA 126-U:1, IV(d). However, the statute also provides that prone restraints do *not* include "physical restraint that involves the temporary controlling of an individual in a prone position while transitioning to an alternative, safer form of restraint," which is a permissible form of physical restraint. *Id.* Physical restraint is more broadly defined as "when a manual method is used to restrict a child's freedom of movement or normal access to his or her body." RSA 126-U:1, IV(c). The statute is

also clear that “[t]he temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a child to stand, if necessary, and then walk to a safe location, so long as the child is in an upright position and moving toward a safe location” does *not* constitute a restraint. RSA 126-U:1, IV(e)(2).

Having fully reviewed the video footage and staff, witness, and youth reports of this incident, we conclude that staff appropriately attempted to deescalate T.F. We further conclude that staff’s initial touching of T.F.’s arms to help him stand and begin to move did not constitute a restraint, and was a permissible “temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing a child to stand, if necessary, and then walk to a safe location, so long as the child is in an upright position and moving toward a safe location.” RSU 126-U, IV(e)(2). When T.F. became noncompliant and began to push back, his conduct constituted a threat of substantial imminent harm to himself and staff, justifying a restraint. *See* RSA 126-U:5, I. The use of prone positions for less than a minute to secure handcuffs and shackles fell well within the exclusion for “physical restraint that involves the temporary controlling of an individual in a prone position while transitioning to an alternative, safer form of restraint.” RSA 126-U:1, IV(d). T.F.’s decisions to return himself to a prone position despite staff intervention, potentially motivated by his stated desire to staff to elicit the appearance of staff misbehavior and set up a legal claim, cannot be attributed to staff as intentionally placing T.F. face-down. *See* RSA 126-U:1, IV(d). We find that the staff all behaved appropriately during this restraint.

We also conclude that T.F.’s second restraint on the CSU approximately one hour later does not give rise to significant concerns. Because our review was not criminal in nature, in an abundance of caution, we referred this incident to the NHSP. It is our understanding as of the

date of this report that the NHSP has concluded that it will not be pursuing a criminal investigation with respect to this restraint.

As detailed above, based on complete video footage and staff reports, the incident on CSU began with T.F. punching a window and visibly injuring his left hand while alone in a padded room directly following the rotunda incident. He was released from the padded room after approximately 15 minutes. He immediately shoved a staff member in the chest and cornered him. After eventually walking away, T.F. continued making profane statements before tossing a Bible into a staff member's chest, stepping up to him, and posturing as if preparing to fight. Two other staffers behind T.F. then quickly brought T.F. to the ground, restrained him, and moved him into a prone position for the application of mechanical restraints. As with the initial restraint, multiple staff members were on hand and constantly monitoring the situation. As soon as mechanical restraints were safely applied, T.F. was moved onto his side. T.F. was in the prone position for two minutes and nine seconds. Staff were consistently monitoring his breathing, pulse, handcuffs, and overall safety the entire time.

We conclude that for purposes of RSA 126-U, T.F.'s conduct just prior to the restraint on the CSU constituted "a substantial and imminent risk of serious bodily harm" to staff members, justifying the restraint for purposes of that statute. RSA 126-U:5, I. T.F. had already shoved, threatened, and cornered one staff member in the minutes before this incident, continued to pace around using elevated language, and began destroying a Bible and tossed it into a staff member's chest before squaring and stepping up to the staff member. The use of the prone position ended as soon as handcuffs and shackles had been safely applied in accordance with RSA 126-U:1, IV(d).

We also do not find the timeline of treatment for T.F.'s hand unreasonable under the circumstances. T.F. was seen by a nurse within hours of his injury and refused pain medication. His hand did not display any signs of emergent injury at that point. Once his symptoms increased, the pediatrician (a DHMC employee) ordered an x-ray, but confirmed that the x-ray could wait until the following day. T.F. was taken to the hospital less than 48 hours after punching the window and treated.

Having reviewed full video of all physical interventions of T.F. on March 17, 2026, we find staff's actions appropriate under RSA 126-U and find sufficient evidence to conclude that T.F. broke his own hand by punching a window. We found no evidence that staff injured T.F.'s hand during a restraint aside from T.F.'s statement to that effect. We leave any determination as to potential criminal charges to the NHSP.

iv. Use of Open-Hand Guides at Bedtime

We cannot conclude that the policy concerning the use of open-hand guides at bedtime is illegal based on our investigation. We acknowledge that it is unclear whether every application of this policy would comply with the letter of RSA chapter 126-U, because every 126-U analysis is highly fact specific and depends on the precise circumstances surrounding each guide or physical intervention. However, based on the information we collected in interviews and through our review of records and video, we cannot conclude that the policy violates RSA chapter 126-U on its face. DCYF should continue to review this policy for compliance and potential clarification, continue its ongoing efforts to manage bedtime (a historically difficult time of day) within the confines of RSA 126-U and the realities of staffing and security within the facility, and consult with the DOJ to review and clarify policies as appropriate.

v. Overall Assessment of Operational Shift and Reporting

We conclude that the operational shift under BC Nye fell within the scope of SYSC's legal boundaries. As noted above, all of the discretionary operational changes implemented by BC Nye (including unit confinement, schooling on unit, and recreational time indoors during snowy months) had been used in recent SYSC history, albeit in more limited durations and/or scope. We further conclude that most of the initial reporting about these three primary concerns is not supported by available facts.

b. Cultural and Management Concerns

During our investigation into legal compliance, it quickly became clear that significant operational and cultural challenges and dysfunction are perpetuating instability for staff and youth and could lead to serious safety issues for both if not addressed immediately. We detail our conclusions with respect to these problems below.

i. Staffing Levels, Quality, and Morale

We conclude that SYSC does not have sufficient levels of experienced staff to operate safely. Although the youth census has dropped dramatically in recent years, many staff and DCYF leadership reported that the youth population typically residing at SYSC in recent years have more mental health and behavioral issues. As a result, more staff must be available to ensure everyone's safety. Most of the committed youth at SYSC are there because they have not succeeded in the less restrictive placements to which they were first assigned. We note, however that some staff, including clinical staff, disputed the notion that the current youth present significantly differently than past youth. Regardless of youth presentation, when staffing levels continue to hover or dip below minimum levels needed to ensure safety in conjunction with the ongoing lack of strong leadership, the facility cannot safely function. Virtually all staff currently

at SYSC also report historically low levels of morale and institutional knowledge. Many longtime staff have left in recent years, and most of the first and second shift YCs have worked there for less than two or three years. All of the administrators have assumed their positions within the last five years, most in more recent years. In the absence of experienced leadership, remaining staff will continue to struggle even if staffing levels increase.

These challenges were evident on May 3. As outlined above, the incidents generally began when youth on the G-200 subunit received their “levels” for the week on Sunday evening. When the subunit in question received their levels, there were five male youth on the unit and two YCs: one female who is not a YC, but a DHHS employee working an overtime shift to cover a shortage, and one male who had worked there for less than two months. The five male youth included the one who had broken a staff member’s jaw in January and two others with significant behavioral issues, including multiple staff- and youth-directed assaults. This staffing scheme would have been precarious under the best of circumstances. The youth present had displayed volatile violent behavior in the recent past, and outnumbered the only staff present by more than two. Giving the youth their levels in this environment without additional staff present, knowing that youth can react negatively, would have been dangerous under the best of circumstances.

Two youth then became extremely upset on receiving lower levels than they anticipated from the male staffer. Because the male staffer was becoming a target for them, he went into the staff office on the subunit. This left one female staffer on a subunit with five males with a history of assaults. Shortly thereafter, the youth insisted on speaking to a supervisor. C.B., one of the youth upset about his levels, then attacked the supervisor and the female YC soon after the supervisor arrived. In the commotion, two other youth charged the staff office and got inside; the male YC then had to confront them alone. It appears that more staff were not onsite to assist due

to low staffing levels that day; other units could not be left unattended. Other assaults continued to play out, all unable to be better contained due to an insufficient number of staff.

A total of five staff members were injured that night. The two youth involved in the staff office incident were seen by medical staff based on their reports that the male YC had punched them; medical assessment reports indicate that the youth did not have any serious injuries. Four other youth were assessed by medical staff for injuries not alleged to be caused by staff. Some administrators were onsite until 2:00 A.M. Staff injuries left the facility short staffed in the days and weeks that followed, setting up the cycle to continue. In the days and weeks that followed, staff morale continued to plummet and youth continued to engage in dangerous misbehavior. Even as we wrote this report, we continued to receive information about serious incidents of youth violence at SYSC and a lack of sufficient staff to appropriately respond. These included significant incidents on Memorial Day weekend, May 29 (NHSP called to respond, trooper assaulted by youth), June 2 (lead supervisor assaulted by youth and the supervisor had to be transported for stitches in head), and June 19 (three youth took over unit, locked out staff, created weapons, NHSP called to respond), among others.

Despite the evident challenges in their roles, exacerbated by low staffing levels and burnout, we note that all of the frontline YCs, supervisors, clinicians, and other staff that we interviewed appeared genuinely committed to their roles and cared greatly for the youth. They work in difficult conditions, often for long hours, to cultivate a positive and productive environment for the youth in care, who frequently come from traumatic backgrounds and can often lack support outside the facility. We commend their ongoing efforts to maintain a safe, treatment-oriented space for these youth.

ii. Accountability

We conclude that a lack of accountability for both youth and, to a lesser extent, staff severely hinders safe and effective operations at SYSC. Virtually all staff we interviewed described that there is little to no accountability for youth. This is regardless of whether it is name-calling and bullying each other, threats of physical and sexual assault against staff, or assaults and other crimes that would typically result in criminal charges. Many staff, from YCs to DCYF leadership, plainly stated that “the youth run the facility and [they] know it.”

The culture of unaccountability has grown exponentially in recent years for several reasons. Multiple residential staff report that any decisions they make to enforce behavioral consequences for youth are later criticized or overridden by clinical staff on the basis that such consequences are not trauma-informed. This trend has increased so much over time that a nurse reported that a youth recently told her multiple times that he would rape her, and the YC standing by to supervise did nothing in response. Other administrators and YCs reported that youth described to them how they would find them once they got out and kill them. Many staff reported feeling caught between wanting to enforce accountability for youth in instances like these but later being “Monday morning quarterbacked” by clinical staff who would disapprove.

Similar feelings were reported with respect to the OCA and DRC-NH. These are important institutions which exercise oversight over SYSC. The OCA receives reports of all major incidents that occur in SYSC and has access to any documentation or video footage that it would like to review. The OCA also meets regularly with youth and administration team members. But it is unclear to what extent the OCA meets with YCs and supervisors, who engage with the youth every day. None of the YCs or supervisors we spoke to described ever having any kind of meaningful interaction with the OCA. Many YCs’ and supervisors’ impressions of the

OCA and DRC-NH were that those organizations were not supportive of enforcing consequences for even extreme misbehavior. Most if not all staff expressed extreme hesitation at going “hands-on” with youth for similar reasons. The youth themselves frequently threaten to report staff to the OCA and/or DRC-NH if staff lawfully and appropriately deploy physical management. While the staff we interviewed voiced agreement with and support for the OCA’s and DRC-NH’s oversight role, in practice, the dynamic appears to have the unintended consequence of weaponizing legitimate uses of physical management and causing frequent operational breakdowns.

The backdrop of lawsuits for civil and sexual abuse against SYSC has similarly fomented what appears to be an overcorrection in favor of letting youth engage in misbehavior out of fear of being sued or unfairly second-guessed. While the abuse alleged in the litigation would obviously warrant changes in staff behavior, it appears that this principle has been taken to its extreme and staff are often unwilling to physically engage with youth at all out of fear of being improperly accused of abuse for simply doing their jobs. To be clear, we found no evidence that any of the sexual and physical abuse alleged in the ongoing litigation currently exists at SYSC. We simply note that the litigation can have impacts on present-day operations.

The “levels” system does not appear to support the goal of uniform accountability and positive motivation for youth. Of all the staff we interviewed, few had positive feelings about the levels system. It has existed at SYSC for decades, to varying levels of anecdotal success. Youth often feel like the grading is subjective based on which staff completes it. Youth also sometimes struggle with the concept of receiving consequences for the following week on a Sunday based on their behavior perhaps nearly a full week earlier. The delayed and subjective nature of the levels system appears to be a source of much frustration for youth. Leadership at DCYF echoed

similar concerns about the susceptibility of the levels system to staff frustrations, and its delayed nature providing few immediate incentives for good behavior. Additionally, because youth can react so poorly when their levels decrease, staff will usually simply leave the youth at higher levels despite serious disciplinary infractions. This empowers the youth and fosters an environment in which they feel there will be no level decreases or other consequences for dangerous misbehavior.

The lack of accountability extends to some level to staff. Several administrators reported that when staffing levels are already so low, they have to choose between keeping perhaps less qualified staff employed or terminating them and then becoming even more short staffed. While all administrators affirmed their commitment to training staff and to terminating staff where appropriate, they also reported having to tolerate more deviations from ideal operations in order to keep a minimum number of staff employed. Additionally, because staff levels are so low, it is often difficult to get staff into trainings while ensuring sufficient coverage, meaning poor practices end up unintentionally reinforced without correction.

All of these factors were evident in the events of May 3. Multiple youth reacted poorly to receiving their levels. When one attacked the supervisor and a YC, there were few other employees available to assist. Once C.B. stopped actively attacking the supervisor, he was not restrained. He continued to destroy property and pace around the multiroom brandishing items that could be used as weapons. He threatened to injure as many staff as possible and stated that he would call the OCA or DRC-NH if they tried to touch him. Meanwhile, nearby, a youth attacked another youth he said had been bullying him without it being addressed, and two other youth escaped into a staff office that a brand new staff member had not firmly closed and ultimately attacked the staff member when he opened the door to ask them to leave.

iii. Disconnection and Dysfunction

We conclude that disconnection and dysfunction within the administration team has led to a culture and climate within SYSC that is plagued with operational issues at every level. We further conclude that while these issues generally were not BC Nye's fault, he was ill-equipped to adequately address them, ended up contributing to them, and did not provide SYSC with the level of executive leadership it needed. Not one of the 40 individuals we interviewed who worked there prior to BC Nye's arrival stated or reflected in the substance of their interviews that things at SYSC were running perfectly before his tenure. All generally agreed that the clinical services being provided to youth were good and that most employees and contractors were simply doing their best in a challenging environment. But this is where most of the employees' and leadership's positive impressions ended. It quickly became clear that several significant fissures between and among the operating stakeholders within SYSC predated BC Nye's arrival and continue at present. Ultimately, these divides have resulted in significant dysfunction within the facility.

1. Administration Team

The dysfunction at SYSC appears to begin within the administration team itself and trickles both down to staff and up to DCYF. Many staff members noted a seeming disconnect between ABC Hersey and Dr. Morin on one side, as the newer, more treatment-focused administrators, and Administrators Archer and Tsoumbanos, on the other side, as the longer-tenured, more security-focused administrators. While it appears that this team of four managed to run the facility absent a Bureau Chief for approximately six months until BC Nye's arrival, there were still several issues during that time, including staff injuries, low staffing levels and morale, and lack of youth accountability. This divide predictably worsened when BC Nye arrived. By all

accounts, BC Nye did not make good first impressions with ABC Hersey and Dr. Morin. Within weeks, it appears that ABC Hersey and Dr. Morin had aligned themselves against BC Nye, despite his stated desire to focus on treatment while ensuring safety and security for all present in the facility. While some of their concerns appeared to be valid, others did not. We heard other concerning but unsubstantiated statements concerning administrators echoed by several other staff- and leadership-level individuals. The administration team appears fractured at best, and it does not appear that the team has made significant efforts to resolve the obvious disconnects among them.

2. Administration Team, DCYF Leadership, and SYSC Staff

Members of the administration team also spoke about a divide between themselves and DCYF leadership. Some stated that they do not feel supported by DCYF leadership and feel that administration is being blamed for everything. Similarly, many YC and supervisor staff reflected that they do not feel supported by the administration team. Several felt that the administrators mostly stay locked in their offices all day and, with the exception of Administrator Tsoumbanos, are not often seen throughout the facility. Many noted that BC Nye would do rounds and interact with youth, which they appreciated. But overall, most YCs and supervisors indicated that the administration team (particularly ABC Hersey and Dr. Morin) do not help them succeed with youth and make decisions that compromise their safety because they don't want criticism from the OCA or DRC-NH.

Administrators also generally work weekdays from around 8:00 A.M. to 4:00 P.M. There is typically not an administrator onsite for bedtimes or weekends, two of the most difficult times at SYSC, unless the administrator on duty is called in. There is also often not time for administration to communicate with staff, or for staff to communicate with each other, because

shifts do not overlap. Staff reported that they often arrive at work and immediately have to go on the floor with youth without an opportunity to learn the status of operations that day. Some information about the day's activities is written down in "green books," which are log books located in the staff office of each subunit, but this presumes that staffers have sufficient time to write down all relevant information and later read it when they arrive, neither of which are often true. Many staff also reported that while there is important information available in online systems about youth (such as likes, dislikes, triggers, and trauma histories), they often struggle to access this information assuming they even have time to do so. Absent opportunities for more fulsome communication both within and between different levels of staff, large amounts of relevant information remain siloed.

Many staff and DCYF leadership also reported inconsistent and contradictory policy roll-outs concerning physical interventions from January to May. These included one instance where a draft handout made by ABC Hersey outlining when staff can physically intervene ended up disseminated throughout the facility, confusing staff, and resulted in most YCs becoming afraid to intervene with disruptive youth at all. DCYF leadership immediately rescinded this draft policy when they learned about it. Many staff reported that directives on use of physical interventions and other youth-oriented policies are constantly changing, making it difficult to ensure compliance.

3. Clinical- and Security-Focused Philosophies

Every person we spoke to mentioned the ongoing philosophical debate of clinical treatment versus maintaining safety. Director Noonan emphasized that both are important. However, it quickly became clear that the staff consistently fracture onto one "side" or the other,

beginning with the administration team and trickling down, and that the lack of leadership on this issue paralyzes the facility’s ability to operate effectively—particularly for the YCs.

Based on their statements in interviews, it appears that the clinical staff believe that handling youth in a trauma-informed manner is more important than the safety of residential staff. Several clinical staff members implied or outright stated that it was staff’s own fault when youth injured them because the youth would not have injured them if the staff member were competent or had been acting in a trauma-informed manner. Two clinicians flatly stated that the YCs are incompetent, escalate situations unnecessarily, and that most or all restraints could be avoided if staff were competent. The clinical staff we spoke to were generally critical of BC Nye, questioned his experience, felt he micromanaged them, and believed he was unsuited for the job and performed poorly.¹⁶ Clinical staff, with one exception, also do not respond to codes because they want to maintain positive relationships with the youth and do not want the youth to view them as the “bad guy” if YCs have to restrain a youth for safety. Many staff responded that the one clinician responding to codes has been helpful for them and has had positive results. But the other clinicians will not respond to youth in serious mental or behavioral crisis until they have returned to baseline.

Unsurprisingly, residential staff generally do not agree with the characterizations above. While all residential staff supported youth having more mental health treatment, and supported the work that the clinicians do, most reiterated that it is a secure facility for a reason. In their view, security must remain a top priority, if not the top priority. When asked, most residential staff felt that clinical staff did not support them, did not care if they were injured, sided with the

¹⁶ As noted above, Dr. Morin, the leader of clinical services, was on the first-round interview committee, recommended BC Nye as one of the top three candidates to advance, and did not express any concerns to Director Noonan or anyone else at DHHS with hiring authority about his candidacy prior to his start or for more than a month thereafter, despite later reporting serious initial worries.

youth after youth attacked them, and often criticized their decision making in the moment after the fact. Several residential staff also noted frustration that clinicians will not respond to codes, as they could help deescalate situations. Some also noted the irony that clinical staff usually disagrees with any decision to go hands-on with a youth, but sometimes will not meet with a violent youth unless a certain number of YCs are available for security. Many staff expressed an interest in additional training and working more with the clinical staff to be a more wholistic team for the youth. Many of the YCs and supervisors have significant levels of education and experience in juvenile detention, treatment, and related fields, and could be valuable partners in the treatment process. These opportunities are often unavailable due to low staffing levels. The divide between clinical and residential staff, falling largely along the treatment versus security philosophy, began years before BC Nye's arrival and continues through today. It has a profound effect on operations and morale within the building, all of which gets reflected back to the youth in care.

4. BC Nye's Role in SYSC's Culture

Overall, it was clear that SYSC operates with a high degree of dysfunction at all levels. It was further clear that this culture predated BC Nye's arrival and continues now after his resignation. However, to be clear, we do not view BC Nye as faultless in these events. Having spoken with him at length, reviewed his written communications, and spoken with his supervisors and subordinates directly about him, it appears likely that BC Nye lacked the professional maturity to excel in his high-ranking position. He was initially dismissive and unprofessional to Dr. Morin and ABC Hersey. Though he later apologized, he probably permanently damaged those relationships. Several people reported that he used profanity in front of youth and staff and made inappropriate promises to youth on which he later failed to follow

through. He intentionally avoided using written communications, making it difficult to track and manage his decisions. Director Noonan generally agreed that BC Nye needed some level of coaching in professional norms. While it appears that BC Nye had positive ideas about security and safety in the building, increasing clinical treatment time, and the new YDC building in Hampstead, he had other shortcomings that meant SYSC did not get the strong leader it needed with his hire.

V. Recommendations

While we recognize that the DOJ does not establish policies governing youths detained or committed at SYSC, nor make the daily operational decisions that are committed to agency discretion, we offer the following recommendations for consideration as DCYF continues to discuss these issues with policy makers, agency leaders, and external stakeholders. The recommendations below are derived from our experiences advising agencies and informed by what we have learned over the course of this investigation. What is clear is that these recommendations all depend on a facility that is safe, secure, and orderly.

- a. DCYF and SYSC leadership should acknowledge and address the chronic dysfunction plaguing the administration team and affecting facility operations, including establishing a clear, workable operating philosophy and conducting a comprehensive review of the structure and performance of SYSC leadership.

While we anticipate that a new Bureau Chief will eventually assist with improving SYSC's culture, DCYF and the remaining SYSC administrators should immediately acknowledge and make concrete plans to address the dysfunction affecting all levels of facility operations. DCYF should ensure that there is an interim plan in place to resolve conflicts and ensure clear direction in the absence of a Bureau Chief. DHHS should further plan to review the entire leadership structure at SYSC to ensure that both the structure and the individuals in those roles professionally and efficiently meet the facility's needs.

Furthermore, as it brings on a new Bureau Chief, DCYF and DHHS should address the ongoing operational and philosophical divide between ideologies favoring treatment or security and develop a clear, actionable operational plan that adequately supports both goals from the top-down.

- b. DCYF and DHHS should undertake all possible measures to increase levels of qualified YC and supervisor staff at SYSC, which the Legislature should support.

It is virtually impossible to see any of the myriad issues facing SYSC improving without increasing qualified staff levels. Low levels of qualified staff are the root of most of the ongoing problems within SYSC. DCYF should undertake any and all possible measures to increase qualified YC and supervisor level staff as soon as possible, including, but not limited to: exploring potential wage increases¹⁷; exploring the adoption of alternative schedules (such as four 10-hour shifts per week); developing employment pipelines with area colleges; working with Amergis to recruit qualified staff into temporary-to-permanent positions; mandating other DCYF or DHHS employees to work shifts as appropriate; conducting employee engagement surveys and using results to increase retention where possible; and seeking additional funding to support full staffing from the Legislature as needed. We understand that these efforts are already underway, with Director Noonan declaring a critical staffing shortage on May 18; this allows other DHHS employees to work overtime shifts as YCs. In addition to being exempt from the

¹⁷ For example, we note that the listed minimum wage for a new YC is \$19.96/hour. The listed minimum salary for a new State prison corrections officer is \$61,360.00, or \$29.50/hour. The listed minimum salary for a new mental health worker at New Hampshire Hospital is \$19.24/hour. All three positions have wage rate add-ons for second or third shift work. However, both corrections officers and New Hampshire Hospital employees “who are continuously exposed to inmates or forensic patients daily in the normal course of their duties” receive hazardous duty pay in the amount of a \$30/week differential. RSA 99:10 (as updated by the SEA 2025-27 collective bargaining agreement). YCs, conversely, receive only a direct care differential in the amount of \$10/week. RSA 99:11, I (as updated by the SEA 2025-27 collective bargaining agreement). The listed minimum wage for a new CPSW at DCYF is \$22.50/hour.

hiring freeze, more needs to be done to fill these critical positions. We encourage the Legislature to support these endeavors so that this critical facility can maintain safe operations.

- c. DCYF should recruit a new Bureau Chief with experience in juvenile justice and operation of trauma-informed secure youth facilities, and solicit feedback from stakeholders during the hiring process.

We understand that the hiring process for a new Bureau Chief has already begun. In its search for a new Bureau Chief, DCYF should prioritize hiring an experienced individual with a background in managing trauma-informed secure youth facilities. Although he had other relevant experience, BC Nye lacked experience in this area, which may have contributed to some of the difficulties that emerged after his arrival. While we understand the difficulty in locating and attracting ideal candidates, we believe that it would be better to wait for the right candidate rather than seek to fill the position as quickly as possible, understanding that the facility's relocation will have a major impact on this process. SYSC's next leader must be able to implement and maintain a coherent vision that supports and serves the youth, the staff, and the people of New Hampshire.

Furthermore, to the extent it does not already do so, we suggest that DCYF representatives directly solicit feedback in writing from individuals involved in the hiring process to understand if they have concerns about any particular candidate. The opportunity for confidential feedback is essential to ensuring that anyone with concerns can raise them for consideration by DCYF and DHHS.

- d. DCYF should continue training and retraining on physical interventions, deescalation, and baseline safety procedures for new and current staff.

While we understand the difficulty in getting employees to trainings when there are too few employees to cover shifts, we recommend that DCYF hold refresher trainings for existing staff on the appropriate use of physical interventions, deescalation, and baseline safety

procedures (such as ensuring doors close behind staff). Many staff reiterated that trainings are always helpful opportunities to refresh skills and learn new ones, and that they would like to obtain more training. We also recommend ensuring that the training that new State employees and new contracted Amergis employees receive the same training(s) upon hire. We understand that retraining is actively occurring and that a new therapeutic daily regimen called TARGET/T-CARE is being implemented to assist YCs with helping to keep youth at baseline and avoid major incidents.

- e. DCYF should explore the feasibility of implementing body-worn cameras for all youth-facing staff.

We recommend that DCYF study the feasibility of equipping all youth-facing staff with body-worn cameras, potentially to include audio recording functionality. Additional recording would ensure that staff continue to act appropriately with youth while helping to mitigate staff concerns of inaccurate reports of impropriety. More recording could also help increase accountability for both youth and staff, particularly if the recordings include audio. DCYF should consult with its counsel at DHHS and DOJ to explore the possibility of introducing these devices both at the current SYSC facility and the new facility.

- f. SYSC supervisors and administrators should check in with staff and youth after major incidents to ensure safety and should review video footage and reports of major incidents with staff as a training opportunity.

We recommend that after major incidents, supervisors and administrators check in with the youth and staff involved to help them process and ensure that they are safe and feel supported. For youth, clinical staff handle this process. If it is feasible to do so, working residential staff more into the processing with youth could help bridge some of the gap between clinical and residential staff with the youth and create learning opportunities for youth and residential staff. For staff, supervisors and administrators should ensure that they are consistently

checking in with staff in major incidents or who are injured afterward. Many staff reported that this happened inconsistently at best and that it was difficult to feel supported after, say, being punched in the face by a youth, when administrators did not even ask if you were okay.

Multiple YCs and supervisors also stated that it would be helpful to review video footage of incidents together with the team involved and other relevant stakeholders, like clinicians or potentially OCA staff, as training opportunities to reflect on what succeeded or could be improved upon in physical interventions and other major incidents. We understand that uninvolved administrators are now reviewing footage of each critical incident to ensure propriety and determine next steps if an incident presents concerns, but not for training purposes. We recommend exploring the institution of such incident reviews to assist staff with training and help align all stakeholders on how to improve both staff and youth experiences.

- g. SYSC should review its policies regarding respect and appropriate behavior for youth and staff and make any updates as appropriate.

SYSC cannot function safely and effectively if a culture that explicitly accepts chronic disrespect, misbehavior, and violence from youth continues to exist. SYSC staff, starting with the administration team, should review its existing policies and procedures to determine what tools it currently has available and where those policies need to be further developed to promote best practices for safe operations that drive positive culture. DCYF should work closely with DOJ and consult with the OCA or DRC-NH about the most appropriate manner in which to develop and/or enforce policies or implement new ones that achieve similar goals. The goal of this review should be to ensure that youth are positively motivated to make good decisions and receive appropriate consequences when they fail to do so in conjunction with their treatment plans. It is our understanding that discussions around increasing behavioral accountability are already occurring and that SYSC anticipates replacing the ‘levels’ system with a new behavioral

incentive system called Positive Behavioral Interventions and Supports (PBIS) in the near future. This review should be particularly useful as SYSC prepares to move to a new facility in the coming months.

- h. A clear protocol should be established for reviewing possible criminal conduct perpetrated by youth against staff.

Currently, when allegations of abuse or neglect of youth are raised, such allegations are addressed pursuant to the process set forth in RSA 169-C for institutional abuse and neglect claims. If the allegation is “founded,” the responsible party is placed on the central registry (a DCYF central reporting registry that precludes those included from working with youth at DCYF, and from working as teacher, daycare provider, or from service as a foster parent) and, if warranted, referrals are made to state police for investigation and potential prosecution. Currently, however, there is little or no accountability for youth that assault staff, sometimes even when serious injury results. A process of systematic accountability for youth should be established. The system should include, where appropriate, referrals to State Police for investigation and potential prosecution for conduct that causes personal injury or significant property damage. As long as staff believe that youth are at liberty to harm them or to damage the facility without consequence, it will be difficult to implement the other necessary changes necessary to meaningfully improve the situation at the facility.