AD HOC COMMITTEE ON THE SUNUNU YOUTH SERVICES CENTER

FINAL REPORT

TO BE PRESENTED TO THE OVERSIGHT COMMISSION ON CHILDREN'S SERVICES ON MAY 22, 2026

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INTRODUCTION

Senator Carson, chair of the Oversight Commission on Children's Services, formed an ad hoc committee on the Sununu Youth Services Center after the Office of the Child Advocate appeared before the committee and disclosed very concerning allegations about the treatment of children at the SYSC. This report is the findings and recommendations of that committee.

The committee invited stakeholders to come before it to give testimony as to what occurred, their perspective, and recommendations for change. These meetings also provided an opportunity for committee members to ask questions in an effort to create an accurate timeline and account of the alleged incidents.

TIMELINE OF MEETINGS

During the Oversight Commission for Children's Services' March 20, 2026, meeting, Child Advocate Cassandra Sanchez disclosed very concerning accusations of the mistreatment of children at SYSC. Among the allegations were that a child was improperly restrained causing a fracture to an appendage, that children were isolated for a two-week period, and that the facility was placed in lockdown for approximately six weeks.

Senator Sullivan immediately brought this information to the Senate President, who is also chair of the oversight committee. Senator Carson was not in attendance during the OCA's testimony. An ad hoc committee comprised of Senator Victoria Sullivan, Oversight Commission on Children's Services Vice Chair Representative Kimberly Rice, OCCS member Representative Jodi Nelson, and attorney for the Children's Law Center Lisa Wolford was appointed by Senator Sharon Carson during a meeting with House leadership.

On March 27, 2026 the ad hoc committee members arranged for a tour of SYSC so that legislators could get a better understanding of the facility. During this visit, legislators were not permitted to speak with staff or children, and concerns were raised about the isolation of children during the reported period and the lack of time outdoors. Staff did become defensive when asked these questions. The representative of the Attorney General's office then requested that we move along in what was viewed by many of the legislators as an attempt to avoid answering questions relevant to the treatment of the children. The ad hoc committee members also requested to meet with some of the SYSC staff and any children who were willing to speak with them. Both requests were denied.

On March 31, 2026, Speaker Sherman Packard held a meeting to address reports of systemic failures at the SYSC. Stakeholders, led by Speaker Sherman Packard and Child Advocate Cassandra Sanchez, discussed a recent "full lockdown" that functioned as collective punishment, keeping children confined to their rooms for up to two weeks following isolated violent incidents. Testimony revealed the use of illegal prone restraints lasting over three minutes, the application of metal shackles, and the deprivation of outdoor exercise and adequate educational materials. These conditions were characterized as regressing to a prison-style facility rather than adhering to the trauma-informed, therapeutic approach mandated by state law.

The discussion also highlighted a pervasive lack of transparency and oversight, with Representatives describing a culture of circling the wagons and concerns that DCYF is essentially investigating itself. The internal grievance process was criticized for its lack of confidentiality, which often leaves children's complaints unaddressed or exposed to the entire facility. To rectify these issues, the committee outlined plans for remedial legislation to be filed by September, focusing on enshrining training requirements, mandating daily activity logs, and granting the OCA direct authority over DCYF. The prevailing sentiment was a refusal to wait for a new facility to implement these changes, emphasizing that the current leadership must be held accountable for maintaining a safe and humane environment per current statute.

On April 20, 2026, the Ad Hoc Committee on the Sununu Youth Services Center met to review findings from their facility visit and address ongoing discrepancies in the information provided by DCYF leadership. The committee members were displeased by the facility's "prison-like" environment, where children are reportedly

subjected to extended lockdowns and restricted outdoor access, which Rep. Jim Kofalt characterized as a failure to meet the therapeutic standards mandated by state law. Furthermore, the committee highlighted a disturbing culture of potential retaliation, where staff members reportedly fear discipline for speaking out about unsafe conditions or procedural violations.

The meeting concluded with a focus on legislative remedies to enforce transparency and protect both staff and residents. Key recommendations for the upcoming report include mandating the maintenance of detailed daily logs, ensuring that outdoor exercise is treated as a non-negotiable right rather than a privilege, and extending restraint and seclusion laws to law enforcement officers who enter the facility. There was a strong consensus that the Office of the Child Advocate must be granted greater oversight authority to prevent DCYF from investigating itself and to ensure the facility shifts toward a genuinely trauma-informed model. Rep. Kimberly Rice and Rep. Jodi Nelson emphasized that these changes cannot wait for a new building, as the current environment continues to negatively impact the health and safety of the children in state care.

On April 27, 2026, the ad hoc Committee on the Sununu Youth Services Center continued its investigation with testimony focused on restraint practices and the rights of children with disabilities. Child Advocate Cassandra Sanchez highlighted concerns regarding bedtime guiding procedures that frequently escalate into full physical restraints, potentially causing harm. Karen Rosenberg from the Disability Rights Center provided further insight into the legal standards for restraint and seclusion, emphasizing that many current practices at the facility may not align with state protections for students with disabilities. The committee discussed the necessity of aligning facility protocols with broader educational and safety standards to ensure the protection of vulnerable residents and to prevent the misuse of force.

The meeting also addressed significant operational and educational deficiencies, including the lack of privacy in designated resource rooms and the challenges posed by the facility's current layout. It was noted that certain sight and sound separation requirements for residents can disproportionately reduce available bed space if applied to female residents, further complicating management and resource allocation. In response to these findings, the committee began planning for additional expert testimony from special education advocates to ensure future legislative recommendations are comprehensive. Senator Victoria Sullivan and the committee members emphasized that documenting these environmental and

procedural failures is essential for the final report and the push for increased oversight authority.

On May 4, 2026, the ad hoc committee on SYSC met to discuss improvements in facility intake procedures and the ongoing challenges of providing special education services to residents. A significant development reported was the implementation of a body scanner policy and it successfully ending the practice of strip-searching children upon entry. While committee members welcomed this change, they expressed frustration that legislator intervention was required to finalize a policy that had been pending for over a year. The committee also heard testimony from state education officials and private special education representatives regarding the legal complexities of RSA 126-U and the difficulties in maintaining educational standards within a facility that often lacks the necessary physical space and staff for proper IEP implementation.

The session further addressed recent operational instability, with Assistant Child Advocate Jason Taylor reporting on weekend lockdowns that may have been triggered by staffing shortages exacerbating resident behavior. There was a particular focus on the recent involvement of law enforcement in facility matters and the need for staff to manage the environment without relying on external police intervention for routine operations. As the committee neared the conclusion of its investigation, Chair Victoria Sullivan scheduled a final meeting to consolidate findings for a report to the Oversight Commission on Children's Services. The members emphasized that legislative recommendations must address the failure in addressing accommodations in educational settings and ensure that the facility operates under the same safety and transparency standards as other educational institutions in the state.

On Friday, May 8, 2026 Senator Sullivan and Representative Rice met with DCYF and DHHS leadership. They reviewed the timeline of events, the incidents reported, the protocols currently in place, and the steps taken in the days and weeks following. Recommendations and needs were discussed. During this meeting the question of the body scanner was raised again. It was discovered that the body scanner had been on the premises for two years. However, it had not been used because a policy was never created around its use. During this two-year period, children were unnecessarily stripped searched.

On May 11, 2026, the ad hoc committee on SYSC convened to discuss medical reporting protocols and the legal obligations of the facility regarding resident

injuries. The session focused heavily on an incident from March 17 where a child sustained a bone fracture, leading to a debate over compliance with RSA 126:U-10. It was confirmed that restraint or seclusion was used in regard to this child. Karen Rosenberg and other representatives from the Disability Rights Center clarified that state law mandates the reporting of any serious injury to a child who has been subject to restraint or seclusion, regardless of whether the restraint was the confirmed cause. This requirement is intended to ensure an independent investigation into the circumstances of such injuries, a standard the committee remains keen to enforce.

DCYF Director Marie Noonan testified that the department does not believe there was any delay in providing medical care to the resident in question. Despite this, committee members expressed frustration over the difficulty of obtaining comprehensive, unbiased information from DCYF. Representative Kimberly Rice emphasized that the committee must continue to review the matter to ensure they are not relying on one-sided accounts. The meeting concluded with a refined focus on the need for legislative clarity and increased oversight from the Office of the Child Advocate to prevent future reporting lapses and ensure the physical safety of all youth at the facility.

On Tuesday, May 12, 2026 Senator Sullivan and Representative Rice met with former victims of the SYSC and their victims' advocates. The purpose of the meeting was to hear about their past experiences and to learn how the state could better protect children in its care. The committee believes it is so important to give a voice to these victims and let them know that we have made significant progress when it comes to trauma-informed care and that we had reduced the number children in SYSC and the types of offenses that result in a child being sent there.

FINDINGS

Several findings were made abundantly clear from the start of the committee's investigation. There is an extreme failure of leadership in the facility and that falls squarely on the Bureau Chief. The committee invited him to speak at a public meeting, but he chose not to appear. During one of these hearings in which he was invited but did not attend, the committee was told that he took two weeks off because "he needed a break." The committee has received inconsistent and non-transparent answers from the department regarding the six to eight-week lockdown period.

The agencies overseeing the facility cannot be held blameless in the creation of situations that placed the children and staff in positions that could have been avoided. However, some progress has been made.

A written policy for the body scanner has finally been created after it sat on the premises for two years. Previously, the reason given for the delay was that no policy was in place and training in collaboration with the Department of Corrections had not yet concluded.

Outdoor time and access to computer time have increased for children as single movement has been lifted and lockdown practices have eased. While the facility has transitioned away from the two-week full lockdown, the implementation of a punitive facility-wide response was still used for an extended duration.

Staff does not appear to be receiving adequate training in the use of restraint and seclusion. The use of training which is oriented toward military and correctional staff is a major inhibitor to the implementation of trauma informed care practices. There is a specific concern regarding the practice of "guiding" children at bedtime, which frequently escalates into full physical restraints and harm. Additionally, there is a dispute regarding whether an illegal restraint lasting over three minutes occurred, and there are conflicting reports regarding the application of metal shackles on children.

A culture of silence persists, as staff members reportedly fear discipline or retaliation for speaking out about unsafe conditions. Concerns about unprofessional conduct that is detrimental to optimal operation of the facility by the Bureau Chief contribute to criticisms about the culture at SYSC.

Based on the testimony from DCYF and the video evidence reviewed, the committee learned that the child who had a fractured finger did not receive that injury from a previous restraint. The child caused an injury to themselves by punching a window in the room in the crisis stabilization unit.

The committee remains very concerned that the children in the facility are not receiving an adequate education per state law. During the lockdown, youth received a significant reduction in mandated programming, receiving only approximately fifty minutes of instruction per day.

The current use of a tutorial model for education makes it difficult for districts to fulfill special education requirements, and the proposed resource room lacks privacy because it is located in an open staff area. This ersatz resource room is wholly insufficient for fulfilling the accommodations of students with special education needs.

The committee also learned that the current contractor, MyTurn, is not planning to renew their contract unless certain provisions are met, including increased funding to cover a $100,000 gap in funding MyTurn absorbed themselves and the cost of hiring two para-professionals. MyTurn will not be able to continue at this level of funding, as they have been operating at a loss for the last year out of dedication to their students. They appear to have a strong connection to the children, and it would be an immense loss to not continue that collaboration.

The lack of engaging activities and support for life skills are major concerns. The lack of activities to boredom and behavioral problems, and absence of mentoring and programming to improve life skills contributes to that and propagates feelings of hopelessness for the future.

While children have been allowed outside more recently to an extent "greater than feeling the wind in their face," time was limited because the single movement schedule required them to rotate in thirty-minute blocks.

The facility layout also presents an efficiency crisis: because of sight and sound separation requirements, the facility often uses two entire units for only two children when both are female. Vocational training and consistent outdoor recreation in a multitude of weather conditions remain absent from the current programming.

While there is much work to do, the committee also learned through staff and statements made by the children that there are people in SYSC that the children trust and are doing very good work.

The ad hoc committee believes strongly that new leadership is needed and that all staff must be committed to a trauma-informed approach. We believe children need more structure, a stronger reward system, and that these things must be implemented prior to moving to the new facility. While the opening of the new facility should not be seen as the impetus for change, as past legislation, namely HB

49, has already mandated many of these changes, those changes must be in effect now to prevent the continuation of practices that have been harming children.

RECOMMENDATIONS

Given the severity and consistency of the allegations raised regarding facility culture, youth treatment, staff practices, operational oversight, and confidence in current leadership, the Committee should recommend the immediate replacement of the Bureau Chief of SYSC.
The replacement leader should possess:

- Demonstrated executive experience in a juvenile residential or juvenile justice facility;
- Extensive training and implementation experience in trauma-informed care;
- Experience reducing the use of restraints, isolation, and punitive practices;
- A documented history of improving youth outcomes and facility culture;
- Experience working with oversight bodies, child advocates, and external investigators; and
- Knowledge of adolescent behavioral health, de-escalation practices, and juvenile constitutional protections.

This ad hoc committee believes that the current work environment and overall climate in the building that has led to low morale is a direct result of DCYF leadership. Therefore the ad hoc committee no longer holds any confidence that the current director is able to lead in the way necessary to create a better and stronger work environment that is conducive to the health and well-being of the staff and children in our care.

The Committee should recommend immediate and permanent restrictions on strip searches of youth at SYSC, along with the immediate and permanent implementation of body scanning technology as a less intrusive alternative for detecting weapons and contraband to better protect the dignity, emotional wellbeing, and constitutional rights of confined youth, particularly children with trauma histories.

Strip searches should be prohibited except in narrowly defined emergency circumstances where:

- There is specific, articulable, and documented evidence that a youth is concealing a weapon or dangerous contraband; and

- Less intrusive alternatives, including body scanning technology, have been exhausted or determined insufficient.

Any permitted strip search should require:

- Supervisor authorization documented in writing;
- Immediate notification to facility administration;
- Same-gender staff conducting the search;
- Prohibition on group or retaliatory searches;
- Trauma-informed procedures;
- Full incident documentation;
- Mandatory review by an independent oversight authority; and
- Preservation of all related video evidence.

Routine, blanket, punitive, or baseless strip searches are to be expressly prohibited.

The Committee should recommend a formal policy or statutory requirements that DCYF provides timely written responses to all formal policies or statutory requirements. that DCYF provides timely written responses to all formal recs issued the the office of the child advocate concerning SYSC or other child serving facilities and programs under the authority.

To improve the daily environment and behavioral incentives, the facility should replace the current system where parents send money with a program where children earn tickets to save for purchases.

Therapeutic elements should be bolstered by returning animals to the children, such as the therapy pony currently on the MPD grounds, and rebuilding the gardens to provide constructive outdoor hobbies.

A protocol must be developed to facilitate regularized meetings between the OCA and the OCCS.

All staff must receive ongoing and significant training on restraint and seclusion that meets legal standards, specifically identifying and implementing the trauma-informed, comfort-based models used by treatment-oriented facilities. This includes both permanent and temporary staff as well as contracted personnel supervisors and administration.

To ensure accountability, a protocol or neutral party should be established to have a person not involved in the incident review every instance of restraint, and supervisors should review video with staff to discuss de-escalation strategies.

Cameras must be upgraded to include audio recording to properly evaluate incidents of restraint and seclusion. Cameras should also be placed throughout the facility to ensure there are no blind spots.

Educational standards must be restored by returning SYSC to an approved special education placement with adequate funding for MyTurn or an alternative course. This includes the hiring of an education professional and 2 paraprofessionals in addition to the creation of an approved special education program.

An education professional specifically to coordinate education services with local districts and two paraprofessionals for one-on-one student interaction must be hired.

SYSC shall, in compliance with RSA 126-U:3, develop standalone written plans for each youth at the facility.

Comprehensive oversight should be established by providing a secured future and increased funding for the OCA, as well as granting them direct access to department data systems for automated reporting.

The Director of SYSC and DCYF shall be mandated to provide regular written reports tracking the progress implementing OCA recommendations.

The legislature must enact SB 142 to separate DCYF from DHHS, legislate the requirement for the least invasive search methods, and implement specific timelines for mandatory reporting.

Facility layout and staffing must be adjusted to avoid the inefficiency of using entire units for sight and sound separation, as well as a proper resource area for children's accommodations.

SYSC staff are to be more judicious in their disciplinary actions, and collective punishment is not to be used.

An implementation matrix is to be created matching each statutory subsection to completed actions, partial implementations, outstanding gaps in practice, timelines for implementation, and the officials responsible for that implementation.

More recommendations and research are to be done regarding the LBA audit.

DCYF shall report on the specific ways in which it has complied with the provisions in HB 49, as well on its policies on SYSC staff discipline on issues including, but not limited to, restraint and seclusion.

Leadership evaluations and department funding of DCYF are to be tied to compliance with the requirements listed in HB 49.

Within 60 days of the adoption of these recommendations, then again by the next OCCS meeting, a report is to be created regarding progress toward adopting the provisions of HB 49 in their entirety.