Response to the Sununu Youth Services Center (SYSC) Ad Hoc Committee of the Oversight Commission on Children's Services

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Department of HEALTH & HUMAN SERVICES

Introduction

On May 22, 2026, an Ad Hoc Committee of the Oversight Commission on Children's Services presented its findings and recommendations for the Sununu Youth Services Center.

The Department of Health and Human Services remains firmly committed to the safety, dignity, and well-being of youth in our care and the staff who serve them. The allegations and recommendations raised by the Ad Hoc Committee are substantial and are taken seriously by the Department.

The following report will provide the Department's initial feedback and response to the Oversight Commission on Children's Services.

Background

The John H. Sununu Youth Services Center (SYSC) is a secure residential treatment facility administered within the New Hampshire Department of Health and Human Services (the Department), Division for Children, Youth, and Families (DCYF).

DCYF partners with families and communities to provide essential resources and supports that ensure the safety and healthy development of children, youth, and their communities. DCYF embeds a prevention-first approach, aiming to reduce abuse, neglect, and delinquency by engaging in evidence-based, community-centered programs. Their work integrates four core service areas: child protection, juvenile justice, permanency planning, and well-being, all grounded in the principles that every child deserves safety, permanence, a sense of belonging, respect, and recognition of family strengths.

Investigates child abuse and neglect and provides children and families with rehabilitative services

Serves youth with delinquent challenges and those identified as Child in Need of Services (CHINS)

Provides safe and secure treatment at the Sununu Youth Services Center for detained and committed youth

DCYF strives to keep children safely in their homes whenever possible, supports families in need, and when out of home care is necessary, ensures stable, lasting connections for youth through foster and kinship care, adoption, or other permanent family structures when reunification cannot safely occur.

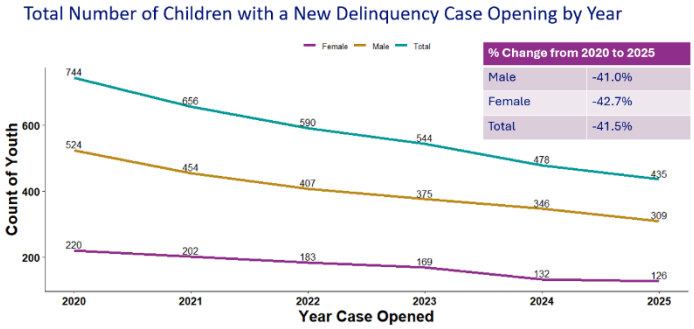
DCYF priorities, inclusive of SYSC, reflect a cohesive vision combining **prevention**, **family support**, **workforce development**, **data modernization**, and **therapeutic facility redesign** to improve outcomes and system efficiency.

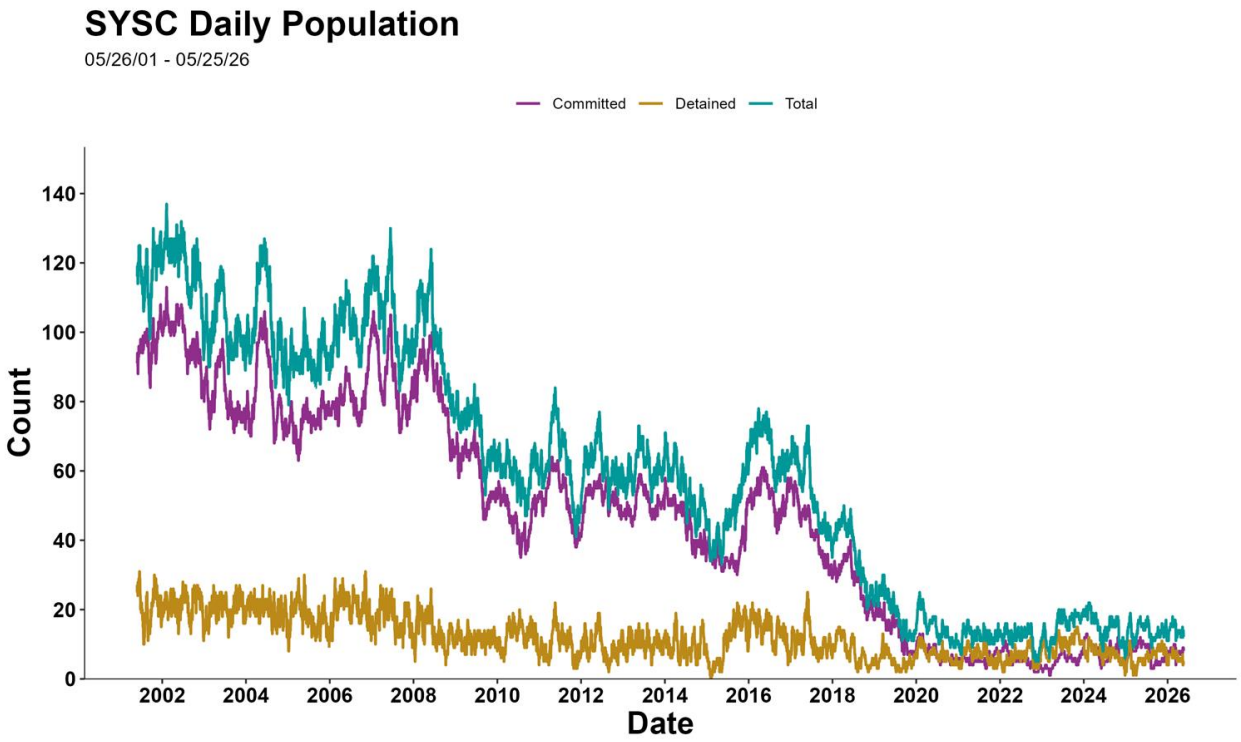
DCYF 2025- 2026 STRATEGIC PRIORITIES OVERVIEW

PRACTICE			SERVICE ARRAY	CASE MGT SYSTEM	NEW FACILITY	
STRATEGIES						
Family Engagement is the Heart of DCYF	***DCYF's Workforce is Our Foundation***	***We are All in this Together***	***Right Services at the Right Time***	**A Rock-Solid Data System: Granite Families**	**Trauma-Informed Practice is at the Forefront of SYSC**	**The New Facility is a Model Facility**
Improve family engagement	Provide support, training, and coaching for child protection and juvenile justice staff, and Youth Counselors	Create a shared system-wide responsibility for promoting the safety of and supporting children, youth, families and communities	Strengthen community-based services to provide quality services to families when they are needed	Replace DCYF's current electronic data system with a Comprehensive Child Welfare Information System	Transform New Hampshire's juvenile justice secure facility to a therapeutic treatment setting	Develop a new trauma-informed secured treatment facility
ACTIVITIES						
• Spread an updated family engagement model • Work with caregiver, child/youth to identify strengths and needs • Implement a system that further values relatives, fictive kin, and foster caregivers	• Build a shared culture where DCYF's Practice Model is valued and reflected in everything we do • Develop a strong workforce • Cultivate Supervisor capacity to support workforce	Communicate shared responsibility and explore how agency partners can use their roles to achieve child/youth/family/ community safety and well-being	• Implement an enhanced model to match children, youth, and caregivers with services • Cultivate adequate Service Array & Service Providers	Develop, implement, and provide support and maintenance for the CCWIS application and data interface for Intake, Assessment, JJS & CPS Case modules	• Implement evidence-based behavioral management system and trauma informed milieu and treatment program • Initiate permanency planning at intake to prepare youth for facility discharge	• Design a new building and operating structure that meets the needs of youth in the facility • Develop and improve community relations and support for the new facility
METRICS						
• Decrease residential treatment by 10% • Increase percent of foster youth who live in family settings (kinship, relative and foster family homes)	• Decrease vacant CPSW and JPPO positions to 5% and 3.5% respectively	• Continued expansion of state and community level collaborative efforts	• Increase children served in own homes for CPS and JJS by 10% and 4% respectively • Increase available foster homes for youth 14-17 by 15%	New Electronic Case Management System, Granite Families, will be operational by December 2026	• 100% of facility employees will be trained in a trauma-informed care model • Reduce repeat admissions by 50%	• New facility will be operational by December 2026 • Census will not exceed 12 youth

Since 2022, DCYF has been a leader in promoting **Juvenile Justice Reform** by focusing on earlier intervention through community-based services, reducing involvement in the formal legal system, encouraging positive youth development and decreasing the need for future judicial involvement. Guided by RSA 169-B:10, when a law enforcement agency is considering bringing a youth to court under a delinquency petition, the agency or prosecutor make a referral to the Department to conduct the Child and Adolescent Needs and Strengths (CANS) assessment. The CANS assessment is conducted by an assessment Juvenile Probation and Parole Officer (JPPO) and focuses on areas such as the youth's behavioral and emotional needs, life functioning, risk behaviors, cultural factors, and the youth's and caregivers' strengths and needs. Following the CANS assessment, DCYF makes recommendations to the referring law enforcement agency as to whether involvement in the juvenile court system is necessary, or if the youth would be better served through community-based services. If the referring agency agrees that additional support services are appropriate, a petition will not be filed in court and the JPPO will connect the youth with the programs and services that meet their needs, which could include mental health services, employment, diversion programs, or other pro-social activities.

New Hampshire's Juvenile Justice Reform has had remarkable success in diverting youth away from becoming involved in the formal juvenile justice court system and from deep end system involvement such as secure detention. In partnership with the Department's Children's System of Care, **fewer youth are entering the juvenile justice system, there are fewer new delinquencies, and even fewer youth are committed to SYSC.**





As a critical component of DCYF and Juvenile Justice Reform, SYSC operates 24/7 providing justice-involved detained and committed youth aged 13–17 with comprehensive services within a secure, highly structured setting serving. The youth placed in SYSC often have significant behavioral health needs and complex clinical presentations. The Department is responsible for treatment, education, stabilization, and safety of the youth and staff who care for them. While the eligibility for release or parole is determined by the court or juvenile parole board, day-to-day oversight, policymaking, and facility administration fall under DCYF leadership.

The responsibility for supporting youth at SYSC extends as youth transition back into the community. As youth prepare to leave SYSC, the Department ensures that Transitional Enhanced Care Coordination (TrECC) programs work closely with the youth, family, treatment providers, DCYF (as appropriate), and the community to ensure that the youth's transition is well-planned, with the right supports in place to allow both the youth and their family to succeed. Additionally, as part of Community Re-entry, New Hampshire Medicaid and Managed Care Organizations cover services such as case management, medical, dental, and behavioral health screenings, and needed referrals for SYSC youth nearing release. New Hampshire was proudly one of the first states in the country to offer this service.

In 2023, the New Hampshire General Court passed, and Governor Chris Sununu signed into law, HB 49, authorizing the closure of the existing, large-scale, aging SYSC facility and its replacement with a smaller, more trauma-informed, secure facility. The statute requires that new facility shall not be administered by any non-governmental entity and shall be owned, administered and operated by the Department with support and shared services contracts as appropriate. The new facility will continue to meet the unique needs of youth pursuant to RSA 169-B:14, detention; RSA 169-B:19, commitment; RSA 169-B:24, transfer to superior court; RSA 169-B:32 or RSA 651:17-a, service of adult sentence of incarceration at the youth development center; and RSA 169-A, the interstate compact on juveniles. It will continue to have the capacity to provide services to meet the medical, physical, and behavioral health needs of the youth in its care.

The Department has made substantial progress building the new facility on the campus of Hampstead Hospital. As of May 2026, construction is 84% complete and will be substantially complete by August 31, 2026. After furnishing and training staff in the programming opportunities of the new facility and additional trauma informed de-escalation techniques, **it is anticipated that youth will move into the new facility in Hampstead, New Hampshire in January 2027, meeting all requirements of HB 49.**

Oversight Commission on Children's Services Ad Hoc Committee and Review of Allegations

The Ad Hoc Committee was formed by Senator Sharon Carson, Chair of the Oversight Commission on Children's Services, in response to allegations made by the Office of the Child Advocate (OCA) on March 20, 2026, about the mistreatment of youth at SYSC. **The Ad Hoc Committee was charged with performing a legislative review of these concerns.**

The allegations included 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.

Subsequent to the allegations by the Office of the Child Advocate, Governor Kelly Ayotte also directed the Department of Justice to conduct its own independent investigation into these reports at SYSC. This investigation is ongoing and is anticipated to be concluded within the next several weeks.

The informal process of the Ad Hoc Committee was not an investigative or adjudicative proceeding with sworn testimony, subpoena authority, cross-examination, or evidentiary standards to resolve disputed facts. Accordingly, the Ad Hoc Committee report reflects testimony, commentary, and allegations that were not tested through formal fact-finding procedures typically used to establish definitive findings. Throughout this legislative review, the Department has cooperated and made Department leadership available to support the process.

To the extent the Ad Hoc Committee report presented conclusions or characterizations as settled fact, DHHS does not agree that those conclusions are supported by the full evidentiary record as discussed below. The conclusions and characterizations do not appear to be based on the primary source evidence presented by DHHS and the report lacks reference to any DHHS testimony despite it being provided.

The Department's review of the evidence shows that staff did not cause the youth's injury, youth were not isolated for two weeks, and that the facility implemented a series of programmatic changes for staff and youth safety that progressively returned to normal practice. Other findings and recommendations of the Ad Hoc Committee focused on leadership, staff culture and morale, training, education, and programming, all which require continued attention.

The Department is hopeful that with the conclusion of the Department of Justice's investigation, DHHS, in partnership with the Oversight Commission on Children's Services, the OCA, and other youth advocates, can implement needed improvements in a constructive, cooperative manner.

Primary Ad Hoc Committee Findings

The Ad Hoc Committee report acknowledges that a youth injury, initially attributed to staff restraint, was not caused by a SYSC staff member or restraint practices. This underscores the importance of relying on complete medical documentation, video

evidence where available, witness interviews, and formal investigative findings before reaching any conclusions.

Importantly, SYSC staff work in an environment where children with considerable trauma histories, significant behavioral concerns, and adjudicated violent behaviors, can escalate rapidly. Staff safety is an essential operational requirement and must be part of any fair and complete assessment of facility conditions. For example, the Department provided testimony regarding staff injuries and significant safety concerns that led to a period of restricted movement within the facility. **Staff injuries and the repeated patterns of escalating violence were not included in the Ad Hoc Committee report** and there was no consideration for the Department's responsibility to the staff. The Department cannot accept characterizations that disregard this operational context or that treat disputed or unverified accounts as definitive findings.

The Department does not dismiss the concerns raised in the report and is taking the allegations and recommendations seriously. The Department is actively working to implement operational improvements, including expanded programming and outdoor access, and ongoing review of restraint practices, deescalation protocols, educational programming, and staff training and safety supports.

The Department has and will continue to evaluate each allegation and recommendation with all available evidence to ensure SYSC operates safely, lawfully, and in accordance with trauma-informed standards for youth in state care, while maintaining a safe environment for staff.

The Department is committed to improvement and embraces recommendations to make necessary changes. The Department also acknowledges that systemic change requires supportive policies, adequate resources, personnel, and continuous training and quality improvement to execute its functions in a safe and robust way.

DHHS Response to Recommendations and Findings

When these allegations were brought to the attention of the Department, it began an immediate internal review of the alleged actions of SYSC staff. Department leadership reviewed documents, video, and interviewed staff, including youth counselors, supervisors, and administration. In addition to the Department's review, Governor Ayotte directed the Office of the Attorney General to complete a formal investigation into the allegations made by the OCA. After the Department gathered sufficient evidence to present to the committee, the Department met with members of the Ad Hoc Committee on May 8, 2026, and testified at the May 11, 2026, committee hearing.

The following is a summary of the information provided to the committee as well as our response to the Ad Hoc Committee report:

- **"Lockdown"**

The minutes of the March 20, 2026 Oversight Commission on Children's Services reflect that the OCA described that youth at SYSC reported that, among other things, conditions were "*boring and stagnant*", "*remained on the unit all day…1-2 hours off the unit per day*", "*no outdoor time*", and "*kids do not feel safe*". The minutes do not include the term "lockdown".

The Ad Hoc Committee report states that the OCA reported on March 20,2026, "*that children were isolated for a two-week period, and that the facility was placed in lockdown for approximately six weeks".* The report further states that routine, blanket, punitive approaches should be expressly prohibited.

The Department does not use the term "lockdown", but it does utilize restricted movement protocols when identified safety concerns for staff and children exist. SYSC was not on "lockdown" for six weeks, as alleged by the OCA, nor was it on single movement for two weeks.[1]

Video evidence and staff interviews corroborate that beginning on Friday, January 30, - Sunday, February 1, 2026, the SYSC administrative team implemented restricted movement due to staff injuries and limited staffing over the weekend. During this most restrictive weekend, while all movement off units was more restricted, youth assigned to the same unit congregated together in their units and had mealtimes together in their assigned unit space. While this weekend was the most restrictive period of time, there was no facility-wide single movement protocol implemented.

Beginning on February 2, 2026, video evidence continues to show multiple children out of their rooms at one time, youth leaving their units, and youth interacting with teachers and other staff. Roll Call communications indicate youth participating in gym and rotating off units for meals, including rotating schedules between paired units. Beginning on February 9, 2026, video evidence shows youth leaving units, and the newly introduced Daily Schedule indicates youth rotating for class on the education wing one unit at a time. When youth were not on the education wing, during school hours, they received educational support on their units. Teachers were observed coming on the units and youth continued to be able to watch TV or play video games during non-school hours. Daily schedules for these two weeks show that floors were scheduled for one period in person in school, gym

[1] Single movement is a restricted movement protocol that allows only one child out of their room at a time.

time, rotating floors to lunch and dinner, and groups and visits on the weekend. The video records show Youth Counselors doing exercises and playing card games with the youth. **Each week the safety restrictions lifted gradually until the facility went back to normal operations beginning March 16, 2026, after new staff completed training.** This information was based on video evidence and documentation review, including daily schedules and Roll Call instructions for staff.

This information was presented by the Department to the Ad Hoc Committee members on May 8 and May 11, 2026, but was not included in the committee's report, other than to say that they have received "inconsistent and non-transparent answers" from the Department. In fact, the only other references to the "lockdown" in the report were verbal summations provided by the OCA's Cassandra Sanchez and Jason Taylor prior to the completion of their investigation, and comments from a Representative opining on a failure to comply with the law.

Regardless, the Department fully agrees that youth at SYSC need structure, engaging programming, clinical support, and strong incentives to support positive behaviors with adequate staffing to make that possible. Consistent therapeutic programming helps youth remain engaged in meaningful activities that build coping skills, foster emotional regulation, and encourage sustained positive behavior.

While video records, daily schedules, and staff interviews show the facility did not engage in a prolonged "lockdown", the Department also recognizes that any adjustments to programming and movement, even when brief and implemented for safety, can feel restrictive and stressful for youth. The Department is committed to strengthening communication with youth about the reasons for safety measures and reducing restricted movement whenever possible.

- **Restraints and Alleged Violations of RSA 126-U**

The March 20, 2026, minutes of the Oversight Commission on Children's Services reflect that DCYF Director Marie Noonan proactively provided an update about recent safety incidents at SYSC, including elevated youth behaviors that led to significant staff injuries, highlighting ongoing challenges at the facility.

Although not reflected in the minutes, on March 20, 2026, the OCA informed the Oversight Commission that on March 17, 2026, a child was placed into a prohibited restraint for more than three minutes and suffered a broken bone. The OCA shared this same concern with the Department at a meeting on March 25, 2026. DCYF leadership took immediate steps to review footage of the event to evaluate any necessary programmatic changes.

Subsequently, in a report from the OCA dated March 30, 2026 and emailed to the Oversight Commission on April 9, 2026, it was alleged that this event caused a potential violation of RSA 126-U. During testimony to the Ad Hoc Committee on May 11, 2026, it was alleged this event was not properly reported to the OCA or the Disability Rights Center (DRC) per RSA 126-U:10[2] . The DRC, as the state's federally designated protection and advocacy agency, must be notified in the event of serious injury or death occurring out of a restraint or seclusion. The potential violation reported by the OCA triggered a review from the Disability Rights Center (DRC). The Department did not report a serious injury or death to the DRC because no serious injury occurred during the March 17, 2026, restraint.

Because of these allegations, the Ad Hoc Committee suggested in their report that "***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*."

The Department agrees that these recommendations are aligned with current practice. **The Department is fully committed to reducing the use of restraints and seclusion and provides both onboarding and ongoing training to ensure they are used appropriately according to RSA 126-U and established policy.**

As a secure detention facility, SYSC may utilize restraints in instances where a youth becomes dysregulated and becomes a danger to themselves or others. As such, SYSC is aware of its responsibilities to keep youth and staff safe. SYSC staff are trained in proper restraint procedures and protocols, guided by RSA 126-U. Consistent and thoughtful onboarding, continuing education, and thorough review of all restraints that occur at SYSC are critically important and can always be improved.

Beginning June 3, 2026, all SYSC staff will rotate through routine annual refresher trainings designed to reinforce skills that support safety, de-escalation, and professional conduct. In addition, all staff will continue to be required to complete annual Prison Rape Elimination Act (PREA) training.

New to SYSC is the Foundations training that SYSC supervisors will receive over a five-week period beginning on July 22, 29, August 5, 12, 19, 26. This training will include trauma-informed, evidence-based approaches and is designed to teach staff how to help youth

[22] *In cases involving serious injury or death to **a child subject to restraint** or seclusion in a facility, the facility shall, in addition to the provisions of RSA 126-U:7, notify the commissioner of the department of health and human services, the attorney general, and the state's federally designated protection and advocacy agency for individuals with disabilities.*

learn constructive ways to handle crisis. The updated SYSC Supervisor Foundations will focus on verbal deescalation and crisis management (TCI and managing the environment), the SYSC Intake Process, PREA, assessing risk and safety, report writing for supervisors, supervisory practice, and how to have difficult conversations with youth and staff, such as how to do appropriately coach staff and conduct professional debriefs of difficult situations. This training series was designed as a method to ensure consistency through the administrative and supervisory team as well as building their confidence in decision making and guiding staff. The goal of each of these opportunities is to manage unsafe situations with consistent verbal de-escalation techniques with no physical contact at all.

The Department recognizes that there are additional opportunities to improve the cadence and content of training and is currently exploring opportunities for curriculum change to ensure even greater conformance with trauma-informed, comfort-based models. One possible strategy is to adopt the MANDT System training that focuses on deescalation and crisis prevention, which has been specifically suggested by the OCA but not implemented due to current resource constraints.

The Department also appreciates that the Ad Hoc Committee report identifies that the initial report by the OCA was erroneous and that the child involved in the restraint on March 17, 2026, self-injured that same day. Video evidence reviewed by the Department confirms that the youth's injured hand was self-inflicted.

The Ad Hoc Committee report, however, goes on to draw conclusions about restraint practices at SYSC that are unsupported. The report states that "*[t]estimony revealed the use of illegal prone restraints lasting over three minutes, the application of metal shackles…,"* with another statement regarding *"bedtime guiding procedures that frequently escalate into full physical restraints."*

When meeting with the Ad Hoc Committee members, the Department provided information on restraint practices, bedtime procedures, and discussed allegations about the use of prone restraints. This information was not included in the Ad Hoc Committee report. The Department is eager to receive the findings from the Department of Justice regarding the length of time a youth was in the prone position and the legal propriety of this restraint, but because this issue is still in review, the Department cannot provide further details until the completion of that investigation.

The Department seeks to expand trainings on restraint, seclusion, and deescalation techniques. This coupled with the MANDT System, or similar curriculum, would help shift current practice from stabilization and containment to a more relationship based, trauma-informed approach that emphasizes preventing restraint through connection and emotional regulation.

- **Education**

The Ad Hoc Committee's report included a summary of testimony made to the Ad Hoc Committee regarding SYSC educational services including comments such as, *"a deprivation of adequate educational materials", "aligning facility protocols with broader educational and safety standards", "ongoing challenges of providing special education",* and the *"failure in addressing accommodations in educational settings"*. While the Department shares the Ad Hoc Committee's commitment for improving educational attainment among the youth at SYSC, the report gave no specific examples and there were limited identified specific areas for improvement.

The one concrete example elevated in the report demonstrated support for the MyTurn contract that provides comprehensive academic support for youth at SYSC.

The Department shares the committee's support and concern and is pleased to announce that contract negotiations have continued, and additional funds were identified for continuation into SFY27. The Department does not anticipate a gap in service.

Notably, the Department appreciated Senate President Carson stating, during the Oversight Commission's meeting on May 22, 2026, that she supports the additional funding to enable MyTurn as a contracted provider.

DCYF Director Marie Noonan shared the Department's commitment to contract negotiations and improved educational conditions with the Ad Hoc Committee members during the May 8, 2026, meeting with DHHS leadership and at the May 11, 2026, Ad Hoc Committee public meeting. The information provided by Director Noonan, including the steps the Department has taken to secure educational services for SYSC, was not included in the Ad Hoc Committee report.

The Department also supports the recommendation for education personnel at SYSC, specifically of an education professional to coordinate special education with local districts and two paraprofessionals as part of the MyTurn contract to increase to one-on-one student interaction. The SYSC educational professional would create the capacity needed to more consistently engage with Local Educational Agencies (LEAs) and school districts to ensure that youth are making progress in attaining educational credits, meeting Individualized Education Plan (IEP) benchmarks, and instruction is aligned with any required 504 Plans. This would be welcomed by MyTurn and SYSC and will aid youth in maintaining their educational progress for a positive reentry into the community.

- **Audio Recording and Cameras**

The Ad Hoc Committee report recommended that SYSC video cameras should include audio to better help investigators understand the context of complex incidents. The Department agrees that this additional information would be beneficial, however, New Hampshire is generally considered an "all-party consent" state. **RSA 570-A broadly prohibits audio recording** unless every participant in the conversation knows about and agrees to the recording. **RSA 570-A:2, II carves out exceptions for law enforcement officers (including correctional officers) acting in their official duties. Policy makers could consider legislation that would allow the use of audio recording for juvenile justice parole officers and other staff within in SYSC** without the operational barrier to gain consent.[3]

During the May 22, 2026, Oversight Commission, **there was a recommendation for the Department to use body-worn cameras at SYSC**. In 2024, the Department explored this idea with the Department of Safety and the Department of Corrections, who have significant experience with this practice. At that time, the Department concluded that in order to protect the privacy of youth at SYSC, especially in clinical settings, there would need to be clear policies for when cameras are used, secure data storage and access controls for the significantly increased amount of video, thorough staff training, and additional considerations for how to balance safety and accountability benefits with the potential impacts on trauma-informed practice.

The Department believes body-worn cameras could be a promising approach for increased transparency and accountability, as well as promoting safety for youth and staff.

- **Neutral Party Investigation**

The Department concurs with the Ad Hoc Committee recommendation that a neutral party not involved in an incident review every instance of restraint at SYSC and educate staff, as necessary. **This practice is currently in place.**

An SYSC Administrator reviews video footage of all restraint events for any necessary follow up with staff for educational opportunities, the reporting of any concerns for improper practices to DCYF Central Intake, and for preservation of recordings. In addition, DCYF's Quality Assurance Unit, a unit outside of SYSC, also reviews the footage of all restraint events. If concerns with practice are noted, the Department takes swift action to address those concerns with the staff involved, including disciplinary action.

[3] It is not possible to ensure recording occurs everywhere a child may be present at SYSC, such as bathrooms, showers, medical appointment rooms, and other clinical settings.

All SYSC staff are mandated reporters responsible for reporting all instances of suspected abuse or neglect to DCYF Central Intake for investigation by the Special Investigations Unit (SIU). The SIU is an independent team of investigators who conduct investigations of abuse and neglect in the juvenile detention setting at the direction of the Office of the Attorney General. If an SYSC staff member is suspected of abuse or neglect during a restraint or seclusion, the SIU in conjunction with the Office of the Attorney General conducts an independent investigation and makes a determination. The SIU is also responsible for engaging law enforcement, managing evidence collection, and notifying and recommending corrective actions under the direction of the Attorney General's Office. This structure creates a clear pathway from administrative investigation to potential criminal accountability.

As an added layer of oversight, RSA 21-V:2 authorizes the OCA to investigate the actions of any agency, make appropriate referrals and to periodically review the facilities and procedures of institutions or residences, public or private, where a child has been placed by an agency. All allegations of improper use of restraint or seclusion as well as abuse or neglect are reviewable by the OCA.

- **Retaliation and "Culture of Silence"**

The statements in the Ad Hoc report that describe a concern for retaliation or a "culture of silence" paint with a broad brush. "*Staff members reportedly fear discipline for speaking out about unsafe conditions or procedural violations",* and *"[a] culture of silence persists, as staff members reportedly fear disciple or retaliation for speaking out about unsafe conditions"*. These blanket comments with no factual findings are very concerning and quite different from the Department's observations.

The Department cannot comment on specific personnel matters, but it can say unequivocally that **not one staff member has received disciplinary action at SYSC due to speaking out about unsafe conditions or procedural violations.** The Department is bound by RSA 275-E. If a complaint was received by a staff member that they were being retaliated against, that staff member has the right to seek redress through a formal process. The Office of the Attorney General is notified and involved in any concerns that would arise out of an RSA 275-E complaint. Additionally, the State of New Hampshire Respect and Civility in the Workplace Policy requires supervisors to investigate and address staff concerns when they receive a report that the policy has been violated.

Staff at SYSC are party to collective bargaining agreements and may have State Employees' Association of New Hampshire, Inc., Service Employees International Union (SEIU) representation on issues from unsafe conditions to concerns of retaliation. This added layer of protection gives staff at SYSC a neutral outlet to voice concerns and grievances.

The Department has not received a complaint from the union related to retaliation at SYSC. On the contrary, the one concern DHHS did receive from the union was that a staff member felt so pressured by an outside investigator to agree with the investigator's allegations of mistreatment in the facility that the staff member requested union representation for all future interactions with that outside investigator.

While the Department has no evidence of retaliatory disciplinary action, we understand that in a high stress environment, staff and youth may perceive certain actions as punitive. The Department also acknowledges that staff working under extraordinary stress may sometimes appear defensive. This underscores the need for more consistent coaching, supervision, and trauma informed leadership training. **As part of ongoing leadership development, the Department has engaged with the Employee Assistance Program (EAP) to help rebuild and repair culture among SYSC leadership.** A series of All Staff Meetings are being developed for June 2026 as part of a long-term commitment to strengthening communication norms and creating an environment where staff feel supported, confident, and able to engage openly with each other and partners. This is the just the beginning of the culture work at SYSC and the Department is committed to its continuation. We are thankful for the Commission's assistance with this endeavor.

- **Medical Treatment**

SYSC has a full medical suite with 24/7 nursing staff onsite and contracts with a pediatrician for medical oversight and consultation to ensure comprehensive medical care for all youth in residence at SYSC.

Allegations that SYSC neglected the medical care of a youth who experienced a broken finger have been the subject of several committee meetings. The Ad Hoc Committee's report states, "*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 in obtaining comprehensive, unbiased information from DCYF.*" These statements are concerning for two reasons. First, the information provided by Director Noonan on May 8 and May 11, 2026, was gathered from the youth's medical record. To claim that the information presented was biased appears to state that the medical team was improperly documenting their medical interventions. This is a serious allegation about a medical provider, and the Department does not have any indication that the medical providers did not provide the care that was documented. Second, DCYF and SYSC are bound by strict confidentiality laws. With the seriousness of these allegations, Director Noonan must gather the data and ensure information is shared in accordance with all applicable laws. There is information that Director Noonan cannot share and what was shared was consistent with the law and

provided the minimum amount of information necessary, as required by HIPAA, to inform the committee of the medical practices as it related to this one injury.

As Director Noonan shared on May 8th and May 11th, all care provided to the youth was consistent with medical advice. SYSC nursing staff assessed the youth's injury on the day it occurred, and the following day the youth received an additional nursing evaluation, was seen by the pediatrician, and had an x-ray ordered. The x-ray was completed the next day in accordance with the pediatrician's recommendations, and an orthopedic appointment was scheduled. When the community-based orthopedic provider initially offered a casting date that the SYSC consulting pediatrician found clinically unacceptable, the pediatrician intervened and secured an earlier appointment. All of these dates and actions have been verified in the youth's medical record.

As a result of this incident, SYSC is exploring opportunities to contract with mobile radiology services that in the future could bring x-ray equipment to SYSC if a youth injury occurs. This would reduce the need for staff to travel to a local hospital with the youth and could potentially speed up necessary treatment.

- **Body Scanner**

For the protection of youth and staff, SYSC has a responsibility to ensure that no dangerous and unauthorized items are brought into the secure facility. It is also committed to minimizing the use of unclothed searches whenever possible which can be distressing and trigger trauma for youth. Body scanners can be a strategic tool in balancing security needs with the goal of supporting youth dignity and rehabilitation during intake. Scanning supports a more respectful, trauma-informed environment.

SYSC is committed to begin the use of the body scanner by June 30, 2026. Due to the complexity of using a scanner that omits radiation and to ensure the staff are properly prepared for implementation of its use, DCYF's Policy and Rules Unit and SYSC leadership have drafted appropriate policies to manage operations and to protect the health of staff and youth. The device has been registered with the DHHS Division of Public Health, Radiological Health Section. In compliance with Public Health, SYSC must establish a Radiation Protection Program, maintain a Shielding Plan Review, and prominently display the registration certificate near the scanner. To further support staff readiness, the body scanner manufacturer is scheduled to be onsite at the facility in mid-June for additional training and any final necessary amendments to policy will be completed. Once use of the body scanner begins, it will be used instead of unclothed searches for all youth unless there is a suspected or confirmed youth pregnancy, a youth exceeds the 600-pound weight

capacity of the scanner, a youth refuses to be body scanned, or the body scanner is malfunctioning.

- **Compliance with HB 49**

The Ad Hoc Committee report recommends that "*DCYF shall report on the specific ways 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".*

In compliance with HB 49, Chapter 2:2 Laws of 2023, the Department has been providing quarterly reports to the Chair of the Health and Human Services Oversight Committee, Representative Mark Pearson and to Cassandra Sanchez, Office of the Child Advocate since 2023 with updates on measurable progress with therapeutic design, construction, and operational readiness. The most recent report was sent on May 15, 2026.

While it is unclear what the Ad Hoc Committee meant with regard to "*policies on SYSC staff discipline",* all SYSC policies, including those regarding restraint and seclusion, can be found online in the DCYF Policy Manual | New Hampshire Department of Health and Human Services. SYSC staff are bound to all policies and may receive disciplinary action if they fail to follow SYSC policies. Policies and procedures for progressive discipline for State Employees are formally negotiated as part of the collective bargaining agreement.

- **Communication with the OCA**

The Department values the unique role of the Office of the Child Advocate as established in RSA 21-V. The statute ensures that there is independent accountability of all child-serving systems and offers additional opportunities for support for youth and families. At its best, the Office of Child Advocate can bring additional perspective and capacity to promote policy and practice improvements, systemic learning, and better-coordinated, more effective services. The OCA and child serving agencies should co-create joint vision and shared systemic goals while developing plans together for joint improvement. To do this well, there needs to be frequent, transparent communication based on trust, respect, and strong regard for each entity's unique roles and responsibilities. Frequent, transparent communication should enable teams to work faster, handle conflict better, and be more innovative.

The Department and the Office of Child Advocate have standing monthly meetings where a variety of DCYF practice topics are discussed. Over the past two years, these discussions have primarily focused on DCYF Field Services, specifically Child Protection. The Bureau Chief of Field Services is a standing invitee along with OCA members, the DCYF Director, and DCYF Deputy Director. Since January 2026, meetings have increased in

frequency for a total of seven meetings. Although the agenda can include any topic, SYSC was not a topic brought forward by the OCA until March 2026.

The Department understands the necessity and role of the OCA and welcomes the opportunity to work collaboratively to ensure all children and youth experience the best possible outcomes. The Department also believes in open, fair dialogue and timely communication. **To this end, the Department supports a process in which the DCYF Director and SYSC Bureau Chief provide written reports regarding the status of the recommendations of the OCA.**

This can also include joint prioritization set by the parties together to determine feasibility and level of importance or impact for each recommendation. **Through such a process, joint solutions can be co-developed and co-presented to the Oversight Commission on Children's Services.** The Department welcomes the commission's assistance in improving this process.

- **Facility Layout for Sight and Sound Separation**

The Ad Hoc Committee report noted that "*facility layout and staffing must be adjusted to avoid the inefficiency of using entire units for sight and sound separation*".

When a youth alleges a Prison Rape Elimination Act (PREA) violation by another youth or staff, the facility must ensure sight and sound separation between them to protect the reporting youth, prevent retaliation, and maintain safety during the investigative process. This often requires careful rearrangement of assigned staff, sleeping locations, shared living spaces, and program assignments to ensure complete separation during the investigation. With such a small census, this becomes increasingly complicated when there are only one or two female youth in the facility. The new facility has a substantially smaller footprint, but these needs were contemplated during the design within the budget constraints that were given by the legislature. Importantly, regardless of the complexity of scheduling, all youth have access to daily exercise and outdoor activities, education, and other programs, even with potentially complex, federally mandated separations.

To assist in operationalizing these efforts and reporting requirements, DCYF has a comprehensive policy that is reviewed and is in conformance with Federal expectations to ensure immediate, trauma-informed steps are taken by staff in response to an allegation or incident of sexual abuse. Actions to maintain safety must be made regardless of inefficiencies of the current or future facility layout.

- **SYSC Bureau Chief**

The Ad Hoc Committee report focused considerable attention on SYSC leadership, including the SYSC Bureau Chief. It is unclear to the Department what information was

used to come to the strong conclusions of the report. There was no information included in the report that described what specific concerns were attributed to his employment.

The former Bureau Chief was hired after a national search for qualified candidates. Thirty-nine applications were received and reviewed. Eleven candidates were interviewed by a panel including SYSC administration and staff. The former Bureau Chief was among the top three candidates selected for further consideration, and he was interviewed by a panel which included a representative from the OCA and other community partners before an offer was made.

The SYSC Bureau Chief began work at SYSC on January 23, 2026, and resigned from his position on May 20, 2026. This vacancy, especially as SYSC prepares for transition to the new facility, will place additional strain on staff and administration.

The Department will begin another national search to fill this critical role.

The Department agrees with the Ad Hoc Committee that in addition to leadership, supervisory, and administrative experience, an ideal candidate 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.*

The Department and its entire leadership team remain focused on strengthening trust, promoting safe, trauma-informed care, and improving the wellbeing of the youth in our care.

Immediate Next Steps

In response to the concerns raised by the Ad Hoc Committee and in alignment with the Department's ongoing commitment to youth safety, staff wellbeing, and compliance with state and federal policy, the Department has initiated a series of actions.

These steps build upon work already underway and are designed to ensure safe daily operations, reinforce trauma informed practices, and stabilize essential services to support meaningful improvement. **Additional activities and longer-term planning will be refined upon receipt of the Department of Justice investigation.**

1. Execute contract with MyTurn by June 30, 2026, to stabilize and ensure continuity of academic programming by adding resources for two additional paraprofessionals to strengthen IEP implementation, coordination with school districts, and one on one student support.

2. Launch comprehensive staff refresher training beginning June 3, 2026, on deescalation, trauma informed practices, and adherence to RSA 126-U, ensuring staff are prepared to manage unsafe situations using the least restrictive methods.

3. Continue the administrative review of all restraint events, ensuring each incident is evaluated by an SYSC administrator not involved in the event, with referrals to the Special Investigations Unit (SIU) when appropriate to ensure independent oversight and accountability.

4. Develop and implement new youth activities, led by Juvenile Probation and Parole Officers and SYSC and DCYF leadership. Planning began in April 2026, supplies are being procured, and schedules finalized. By June 1, youth will have opportunities to assist in the community garden, participate in movie nights, access trusted areas of the facility, and practice life skills such as cooking.

5. Expand opportunities for youth engagement by building on activities offered on May 24–25, 2026, including tie-dye projects, a courtyard cookout, and outdoor games. Beginning June 1, 2026, open the courtyard to upper- level- youth for outdoor meals and continued supervised activities.

6. Deploy the body scanner by June 30, 2026, following completion of staff training, policy finalization, radiation safety compliance, and manufacturer-led onsite training replacing unclothed searches except in defined, limited exceptions.

7. Strengthen organizational culture through facilitated staff engagement, including June 2026 All Staff Meetings and ongoing partnership with the Employee Assistance Program with the SYSC Administrative Team to rebuild trust, communication, and

trauma-informed leadership practices. Revise SYSC Bureau Chief Supplemental Job Description and begin national search in June 2026.

8. Explore support for mobile radiology services by August 2026 to expedite diagnostic imaging onsite, reducing the need for hospital transport and improving timely care for youth injuries.

9. Continue assessing and communicating readiness for the move to the new Hampstead facility with regard to trauma-informed programming, consistent staffing and training, standardized assessments and care coordination, family engagement, education and clinical services, structured recreation, and appropriate safety and security measures.

10. Engage community partners, effective immediately, through collaboration between the DCYF Adolescent Program Administrator and SYSC administration to bring vocational training and other independent living programs into SYSC.

11. Effective immediately, advance collaboration and structured communication with the Office of the Child Advocate, including monthly meetings, increased information sharing, and support for written updates from SYSC leadership on OCA recommendations.

12. Effective immediately, increase communication with youth during any restricted movement periods, provide clearer explanations of safety-related program adjustments and reduce the use or duration of restrictions whenever possible.

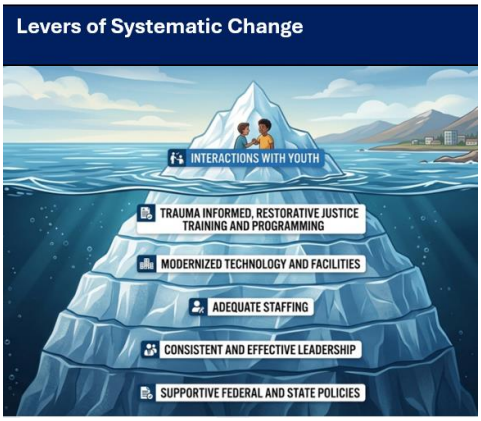
Conclusions and Levers for Change

The Department shares the same goals as the Oversight Commission on Children's Services, the Ad Hoc Committee, the OCA, and others to safely hold youth accountable while addressing any underlying trauma that drives their actions, ultimately promoting healing, preventing reoffending, and reducing future involvement in the correctional system.

Meaningful change requires supportive policy, adequate and stable staffing, clinical resources, modern and therapeutic facilities, and comprehensive trauma informed training, because these structural conditions shape what staff are able to do in every moment with the youth in our care.

New Hampshire is fortunate to have a strong foundation of Federal and State policy that consistently prioritizes youth wellbeing, juvenile justice reform, a coordinated Children's System of Care, with trauma informed approaches at SYSC, creating an inter-connected system that many states are still striving to build. These aligned policies establish clear expectations for restorative justice over punishment, promote collaboration across child serving systems, and ensure that trauma informed care is not just encouraged but embedded in practice. Because these frameworks already exist, SYSC is positioned to make meaningful, sustained improvements more quickly; the Department and our partners do not need to build consensus from scratch but can instead focus on strengthening implementation, aligning resources, and ensuring that staff and facilities are equipped to bring these policies to life.

By investing in underlying system components, New Hampshire can fully realize the conditions where positive daily interactions are not isolated successes, but predictable, reliable outcomes. The Department is committed to working in partnership with policy makers, the Oversight Commission on Children's Services, the OCA, and youth advocates to ensure that SYSC is supported in an integrated system that ensures restorative justice and delivers trauma informed care in a rehabilitative environment where youth feel safe, supported, and capable of change.



The Department looks forward to the complete Department of Justice investigatory report and is committed to making the changes needed to ensure the safety of youth and the staff that care for them.