

# **A 5TH-GRADE SPECIAL EDUCATION STUDENT IS TASERED BY POLICE IN HIS OREGON CLASS ROOM**

## **AN INVESTIGATION OF SYSTEMIC FAILURE**

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### **Oregon Advocacy Center**

620 SW Fifth Avenue, Suite 500  
Portland, OR 97204  
(503) 243-2081

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## **I. Executive Summary**

In October of 2004, attorneys at Oregon Advocacy Center (OAC) learned that an eleven-year old boy was tasered in his special education classroom by police in riot gear. That report raised dual concerns that led OAC to investigate the incident.

The first of those concerns -- one that has been raised with increasing frequency in the national press -- is the appropriateness and safety of using tasers on children, some as young as five-years old.

The second is an increasing tendency of teachers and school administrators to inject police into classroom situations that could be better handled through pro-active special education practices. This concern, already on the radar screen of OAC and other Protection and Advocacy agencies across the nation, was the primary focus of our investigation.

This investigation took more than a year to complete. It revealed an incident that stands as an example of what happens when police involvement is substituted for good educational planning and practice. In our view, what happened was as predictable as it was avoidable.

More critically, our investigation has led us to conclude that systemic pressures contributed to this incident and remain very much in play across our state. Absent the adoption of effective reforms and safeguards to counteract these pressures, we fear that this type of incident will be repeated, perhaps with even more severe consequences for other children.

## **II. Findings**

1. The boy (who we will refer to as J) had a well-documented history of significant emotional and other disabilities that were compounded by a severely disrupted home life characterized by parental abuse and incarceration.
2. Over the years, J had been psychiatrically hospitalized, placed in multiple foster placements, and had been in many special schools and programs. In April of 2004, he was placed in a highly structured residential treatment program that contained an educational unit on site.
3. Shortly before the incident, although the stated criteria for transition to a less restrictive and less structured phase of placement were not fully met, he was transferred to a foster home and began receiving his special education at a public school.
4. J's history and constellation of disabilities required a detailed, coordinated, and highly-crafted behavior plan to be in place and thoroughly understood by his teachers, foster parents, and administrators at his new school.
5. The school did not create a behavior plan for J. The behavior plan in place at the time of the transfer was written for his residential treatment staff. It was

inadequate for the new school setting and was neither understood nor in the possession of the people who worked with J at his new school. J's teacher was largely unaware of his history and was not able to tell police what his disability and diagnosis were on the day of the incident.

6. In the three weeks prior to the incident, J was moved to three different foster homes. His history revealed a close link between such moves and serious behavioral outbursts.

7. On the Friday before the Monday incident that ended in J's tasing, he suffered an emotional breakdown that required his removal from school by a counselor from the residential program.

8. Despite these warning signs, no meeting was convened to consider the deteriorating situation in light of J's history of extreme behavior.

9. On that day, when J began to destroy the contents of his classroom, a classroom aide received bruises on her ankle and hand while unsuccessfully trying to control him. The teacher and aide had received some training in the use of restraint techniques. However, because they had never practiced those techniques together, they did not feel competent to use them when J became uncontrollable. They vacated the other students and left the room.

10. Although the behavior plan called for and relied on residential program staff to de-escalate J in such situations, no one was available when the school called the program.

11. When the police were called, J had been alone in a room behind a barricaded door for more than twenty minutes, screaming and crying at anyone who attempted to approach. After the police arrived, he is reported to have picked up a sharp drawing compass that he then held above his head.

12. No one at the school was able to provide the police any information about whether or not J was likely to de-escalate if left alone. Similarly, no one was able to provide information to indicate whether or not there was suicidal behavior in his history.

13. Although police on the scene sought and obtained permission to use a taser from their superior, they did not convey vital facts to the authorizing officer.

14. With some exceptions, the various agencies involved in J's care and education vigorously resisted OAC's effort to investigate the incident.

### **III. Recommendations**

Based on the above findings, OAC makes seven broad recommendations. We do not suggest whether these recommendations would be best implemented by statute, school district and/or agency policies, state regulations, or some combination of measures.

1. Every child in Oregon with disabilities who has a history of severe behaviors should have a well-supported, regularly updated, and adjusted Behavior Support Plan (BSP) and crisis plan in place.

2. Those BSP's and crisis plans should be written to be understandable and practically useful to parents and all staff (educational and other) who deal with children having such behaviors.

3. No BSP or crisis plan should contemplate or rely on police intervention in any circumstance short of immediate threat of significant physical injury to a person.

4. Schools and treatment agencies should develop shorthand one-page summaries of known effective de-escalation and control techniques for the particular student, to be provided to police in the rare circumstance when police involvement is unavoidable. These summaries should also include known ineffective and counterproductive measures that police should avoid.

5. When a child has a history of severe behaviors and is involved with multiple agencies, a person or agency should be charged with ensuring that there is adequate coordination and timely exchange of information. This can prevent situations such as J's, in which the school assumed that his severe behaviors were a treatment issue that their staff would not have to address.

6. All incidents of police intervention with students with disabilities in either treatment or educational settings should be investigated, analyzed, and recorded in order to track the state-wide frequency, nature, and knowable trends of such incidents.

7. In all incidents where police intervene with students with disabilities in either treatment or educational settings, all agencies involved in the education and care of those students should provide ready access to records requested by the state's protection and advocacy agency.

### **IV. Introduction**

On October 4, 2004, four armed police officers wearing riot gear and pre-authorized by a police captain to use a taser gathered in an Oregon elementary school hallway outside of a special education classroom. From behind the barricaded doorway, they could hear the screaming and swearing of a single fifth-grader. He had been trashing the room's contents for thirty minutes or more and throwing them through the

hole where the door's window had been. Eventually, the police got behind a table and entered the room by pushing aside the furniture piled against the door.

As the four officers entered, one with a drawn taser and the other three "capable of providing lethal cover if the need arose,"<sup>1</sup> the boy held a five-inch long metal drawing compass with a pointed end over his head as if to throw it. The officer who carried the taser fired his darts. The boy dropped on his back, twitching as a 5-second cycle of 50,000 volts went through his body. When he stopped moving, he was lifted to his feet and handcuffed.

That boy was eleven years old. He was 4'4" tall and weighed 65 pounds.<sup>2</sup> He was clearly out of control having both destroyed property and bruised the ankle and hand of an aide who worked in his classroom. There were, however, no serious injuries and the boy was alone and contained in the room when the police entered.

After receiving phone calls concerning this incident and reading about it in the press, Oregon Advocacy Center<sup>3</sup> (OAC) began an investigation. We were concerned that it might be representative of an apparent increased frequency of similar situations in Oregon and across the nation. Our year-long effort<sup>4</sup> revealed that the events of October 2004 were predictable and preventable had there been more effective coordination of an elaborate system of services.

The information we have been able to gather reveals that the situation which finally confronted police was not the result of inattention. In fact, on the morning he was tasered and handcuffed, the boy, who we will refer to as J in this report,<sup>5</sup> was receiving extensive services and oversight from many professionals and at least three major institutional players.

The Oregon Department of Human Services (DHS), a treatment program that DHS had contracted with to provide residential and aftercare treatment, and the special education department of one of Oregon's 199 public school districts were all involved. In addition, because J was a ward of the state under supervision of the juvenile court, he was represented by a juvenile attorney. Our report concludes that the outcome of October 2004 was less a product of lack of services than one of failed coordination of services.

## **V. The Issues**

Our investigation raised many concerns within three overarching issues.

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<sup>1</sup> This is a direct quote from one of the police reports written regarding this incident

<sup>2</sup> This was noted in a custody police report that recorded the incident.

<sup>3</sup> Oregon Advocacy Center is a federally-funded private non-profit agency charged with protecting the rights of individuals with disabilities in Oregon.

<sup>4</sup> OAC spent approximately 5 of those months trying to obtain Department of Human Services (DHS) records through our statutory authority to obtain records for the purpose of investigating cases of suspected neglect or abuse of individuals with disabilities. The investigation of this incident involved the examination of approximately 200 pages of documents and 20 interviews of persons involved in J's education, treatment, or the incident itself.

<sup>5</sup> OAC has chosen not to identify the child involved in the incident or the names and locations of officials and employees connected with the incident. We made this choice to preserve the child's privacy and to encourage a non-defensive review of our findings, conclusions, and recommendations by policy makers.

### 1. Failure to Assess Effectiveness of Programming

Our investigation found repeated and consistent failures to accurately assess the effectiveness of services provided to J -- each of the agencies and players involved in J's life responded to systemic pressures that caused them to generally overestimate the effectiveness of what had been done.

### 2. Declaring Success to Pass J on Through the Pipeline

Even when the services that J received were effective, our inquiry revealed that providers and coordinators failed to account and plan for the hand-off from one institution and set of services to another. At every turn, there was a tendency to declare success and then move J along to the next agency or program. Similarly, as J was moved along through a theoretically connected progression of services, there was no coordinated and accountable team effort and little or no look back to the previous experience or providers for guidance.

### 3. Secrecy

We confronted a defensive posture by most of the involved players when they were asked to aid in this investigation of an incident in which a child under their protection had been tasered. Because OAC is a law office, some degree of concern was perhaps understandable. However, it is hard to reconcile near-universal efforts to block our investigation with the overriding responsibility of the same involved players to protect J and other children served within the system.<sup>6</sup>

Until and unless each of the above issues is reliably and accountably addressed, we can expect that J's experience will not be unique in our state.

## **VI. Who is J?**

When police entered J's classroom, they encountered a child who had lived through a series<sup>7</sup> of foster homes and treatment programs that although sad, is not uncommon in our state. The file materials and reports that describe that history chronicle numerous emotional explosions that were characterized by self-harm (e.g. biting himself), physical aggression toward adults and other children, fire-setting, and bizarre behaviors.<sup>8</sup> He had been prescribed numerous psychotropic medications with varying

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<sup>6</sup> For instance, in notes of a post-incident review meeting, the assistant district attorney who convened the meeting wrote, "[f]inally, I should note that the media is still very much involved in the situation and is pestering [the treatment program]."

<sup>7</sup> Psychological evaluations in J's DHS file refer to two foster placements prior to his placement at a residential treatment agency in 2004 and a fourth which followed his transfer out of the residential component of the agency. As noted elsewhere in this report, however, other sources indicate that there were at least three foster placements during the month prior to October 4, 2004. OAC has been unable to learn the total number of foster placements during J's life thus far.

<sup>8</sup> In one such incident, J ran through a Fred Meyers store and sprayed shoppers with aerosol cans that he had pulled off a shelf. In that incident and others, police were called with one result being that J was wildly

results. By 1999, at the age of five, J had already been psychiatrically hospitalized following a fire that he set in his own bed. J's parents permanently lost custody of him in 1998 when they were incarcerated for drug offenses. Since then, he has been a ward of the state.

By age 11, J had been in state custody for about six years. Evaluations from various treatment providers indicate that J has been a victim of neglect and physical abuse. Although not proven, there were also allegations that J had been sexually abused. One result of this history was that before reaching his twelfth birthday, J had been diagnosed as a person with a cognitive disorder<sup>9</sup> and Oppositional Defiant Disorder (ODD), Post Traumatic Stress Disorder (PTSD), and suspected Fetal Alcohol Syndrome (FAS.)

This combination of diagnoses is one that, in OAC's experience, describes a complicated child whose problems demand significant and coordinated resources. In fact, records provided to OAC by DHS thus far indicate that on October 4, 2004, J had been in foster placements, treatment programs, or hospitals for all but 3 of his 11 years. Those records do not indicate how many foster placements he had seen by October 4, 2004.

## **VII. Getting the Records**

OAC's original awareness of this case was based on sparse information about an unnamed special education student who had been tasered at a particular elementary school on October 4, 2004. We began our investigative efforts with the school. Because we did not have a release signed by a parent or guardian, the school was able to tell us no more than that the unnamed boy was in the custody of the Oregon Department of Human Services (DHS). Our subsequent contact with a DHS caseworker to obtain records<sup>10</sup> was initially well received, there being a recognition that an investigation of the incident would be beneficial to the boy and the system that cared for him. The case worker assigned seemed sympathetic and cooperative. He promised to call back about turning over records after checking with his supervisor.

He did not call back. Instead, a DHS unit manager contacted OAC and pointedly questioned whether we should be interested in this incident at all. We explained that as the Protection and Advocacy (P & A)<sup>11</sup> agency for the state of Oregon, we were empowered to investigate suspected incidents of neglect and abuse of children with disabilities. We were told that someone would get back to us.

The person who eventually contacted us was an Oregon Assistant Attorney General (AAG) who, on behalf of DHS, began a multi-month effort to block OAC from obtaining any records, including J's name. A review of court decisions and consultation with other P & A's across the country make it clear that this sort of resistance is common

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fearful of police. These facts, unknown by teachers and others involved in J's care, raise questions about the wisdom of calling uniformed police to control him.

<sup>9</sup> Cognitive Disorder Not otherwise Specified

<sup>10</sup> We also hoped to secure (from DHS) releases that would allow us collect additional police and school records related to the incident.

<sup>11</sup> Protection and Advocacy agencies (P & A's) are agencies that Congress created to protect the rights of individuals with disabilities. Each state has a P & A that is empowered to investigate suspected abuse or neglect of persons with disabilities. Oregon Advocacy Center (OAC) is Oregon's P&A.

although it generally fails when challenged in court. Short of court challenges, however, the kind of resistance we encountered does often succeed in stalling investigations and/or making them so difficult, expensive, and labor-intensive that they are abandoned.

In our case, the eventual outcome of the legal wrangling was that the AAG refused to allow access to records absent a court order. One of the cited bases for that final refusal was the fact (previously unknown to us) that DHS, although the custodian of J, was not his actual guardian. A subsequent OAC demand for contact information about the guardian finally allowed us to directly contact the person empowered to sign releases. The guardian was an assigned juvenile court judge who eventually signed the four releases<sup>12</sup> that we needed to gather information and records. This process took from October 14, 2004 to March 29, 2005, more than 5 months.

Subsequently, although we had supposedly been given all records and information related to the incident, we independently learned that a meeting to review the incident and whatever larger problems it might have revealed had been held on November 3, 2004, about a month after the incident. This meeting involved representatives of the police, the county district attorney's office, the school district, and the treatment provider, but was not mentioned or noted in any of the records we had obtained.

When we sought records of that meeting pursuant to the signed releases, we again encountered some opposition, but eventually received meeting notes<sup>13</sup> from the county district attorney, the treatment provider, and the school district. The police indicated that they would not turn over their own records of the meeting without a public records request. DHS informed us that it possessed no notes of the meeting because it was not invited to attend and had no knowledge that a meeting was to be convened to review the incident.

## **VIII. DHS and the Treatment Program**

On October 4, 2004, although J's guardian was the juvenile court, he was (as he has been for most of his life) in the custody of DHS. This meant that DHS was the primary overseer of where he lived and what sort of services he received. It was within this role that DHS had placed J in an intensive residential treatment program after he exhibited new episodes of bizarre and aggressive behavior in April of 2004.

At this residential treatment program, records indicate that there was an intensive and elaborate behavioral program that targeted three of J's most troubling behaviors: physical aggression, property destruction, and refusal to follow reasonable directions without tantrums and swearing. The program employed specialized services that included monitored psychotropic medications, therapy, and a complex behavioral management regime.

Records of J's time in the residential program note that his target date for release to a foster placement was August 15, 2004: about 4 months out. However, this transfer back to foster care was to occur only if and when J reached three behavioral targets related to the above-noted issues. Those behavioral targets were that J would go 30 days:

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<sup>12</sup> The releases authorized DHS, the treatment provider, the police, and the school district to release any records and information related directly to the incident or interaction with J through the period that began a few months before the incident and ended a few months after it.

<sup>13</sup> We were also able to speak to individuals who attended about their memories of the November meeting.

1. without an instance of physical aggression; 2. without an instance of property destruction; and 3. following directions without swearing after two or fewer cues from staff. While in the program, J's progress toward eliminating those behaviors was documented and tabulated in progress reports.

Records indicate that J was indeed transferred from the residential program to a new foster placement. At the same time, he was also transferred from the on-campus educational program at the residential site to a special education classroom operated within a local public elementary school. Despite J's distressing history, however, OAC has been unable to locate a comprehensive plan that was in place at the time of the transfer to deal with the sorts of emotional explosions that had been a known feature of J's life for years.<sup>14</sup> More importantly, even if such a plan existed, the school district responsible for J's education did not have it.<sup>15</sup>

The two plans that were in theoretically in effect in October of 2004 -- although they were not in school files -- are comprised of two and three sentences respectively. One calls for the use of "appropriate restraints when other techniques fail." The other instructs foster parents, in the event that J "becomes unsafe," to either "call 911 or return him to the residential treatment program."<sup>16</sup> A 2-page document entitled "School Safety Plan for [J]" -- also not in the school file -- is more elaborate, although it shows signs of being a modified boilerplate document. It refers, for instance, to foster parents when there was a single foster parent involved at the time.<sup>17</sup>

Aside from these crisis-oriented plans, there was no behavior plan of the sort that one would expect in such a case. Ideally, such a plan would inform foster parents, teachers, and other staff who work with J about what sorts of things set him off, how to

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<sup>14</sup> Despite this history, J was not evaluated for special education until April of 2000 as his first-grade year was drawing to a close.

<sup>15</sup> A special education employee of the district who was heavily involved in J's education and transition from residential placement noted that even if the staff who worked with J at his school had received the plan, that it was not designed for a school setting in that it relied on resources not available at school. As examples, she noted that the treatment program was heavily staffed with teams trained to safely de-escalate out-of-control children and that unlike the residential program, the school contained no settings designed for safe de-escalation of children. Despite these sorts of significant differences in available resources, she acknowledged that the district had not considered creating its own crisis or behavior support plans to deal with potential crises because the district historically tended to see these sorts of things as "treatment issues" and therefore left them to the treatment provider.

<sup>16</sup> A school district employee charged with coordinating between the treatment program and the public school component noted that this sort of boilerplate plan was shorthand for many other steps that the staff at the residential program were trained to perform. Her reaction to the OAC's suggestion that the school should create its own behavior and crisis plans was quite positive, but she thought that this was not something that had been done in the past.

<sup>17</sup> The school safety plan calls for time-outs, talking to a trusted teacher, and reminding J that his foster parents would be informed of problems at school via behavior point cards that he was to bring home. In the event that these measures failed and J became unsafe, he was to be restrained and then, if unable to de-escalate, removed from school and returned to the treatment program. It calls for contacting foster parents and staff at the treatment program and provides for a final step of returning J "to the unit for seclusion until he has reached a level of safety with no acuity as assessed by milieu and treatment team." Virtually the entire second page of the school safety plan is comprised of treatment team phone numbers and signature lines for agreement to support and implement the plan. There are no signatures on the copy that was faxed to OAC by DHS.

recognize warning signs that pointed to emotional explosions, and what measures had either worked or not worked to de-escalate him in the past.

The absence of such a plan meant that despite the years that J had spent in treatment programs and DHS-supervised foster care, neither the teaching staff nor the police who got the call on October 4th had any useful guidance about what to avoid or what to do. They didn't know, for instance, whether J was likely to continue to escalate if left alone. They didn't know if he had a history of suicidal behavior. They didn't know how seriously to take any threats he might make. They didn't know of his history with police and the fear that his history was likely to have engendered.<sup>18</sup>

### **IX. J's Situation Immediately Preceding the Incident**

Police interviews of the teacher and aide assigned to the classroom indicate that neither knew what had set the boy off on the day of the incident, but that both noted two things: first, that his foster placement had changed three times in the three previous weeks, and second, that he'd exploded on the preceding Friday to an extent that he was sent home in the care of a school district special education employee who was able to successfully de-escalate him after staff at the school were unable to do so.

Aside from references found within police reports, it was not until October 18, 2005 that OAC obtained any record noting that these rapid-fire changes in foster placement even occurred.<sup>19</sup> Since then, we have been unable to locate any documents that explain their cause. The records we received in October of 2005 do contain some detail about problems that J experienced at his terminated foster placement, but, written a year after the fact, they seem focused on justifying events that had already taken place. The school district is not noted as participating in the decision process or being part of the information loop related to the foster placement changes in any of the notes that we received. None of the records obtained contain any indication that anyone ever called for or held a meeting to discuss the possible repercussions (at school or elsewhere) of the changes in J's living situation during September of 2004.

### **X. J's Educational Program on October 4, 2004**

The educational program which followed J's transfer from the residential treatment program was operated within the public school system by specially assigned district employees of the special education department. Thus, J's education, although ultimately the responsibility of the public school district in which he lived, was significantly impacted by his treatment program. This effort should have coordinated the earlier residential treatment effort with what would follow in both school and in foster care.

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<sup>18</sup> Many special education students who have been through multiple foster placements have extensive negative histories with uniformed police. In J's case, the arrival of police was associated with repeated traumatic changes in his life including where he lived, domestic violence, possible sexual abuse, the arrests, eventual imprisonments, and loss of his parents, separation from his sibling, and hospitalization.

<sup>19</sup> Our request via DHS to the treatment provider for such records was simply ignored for months. The records we finally obtained are progress notes that were apparently created almost one year after the incident on 10/14/05 and 10/17/05 by the program counselor. Each progress note ended with the notation that "Writer acknowledges late entry."

In keeping with his history and eligibility for services as a student with an emotional disability, J's last Individualized Educational Program (IEP)<sup>20</sup>, written as the product of a May 2004 meeting, was heavily oriented toward behavioral goals and objectives. In fact, that IEP addressed almost no academic issues.<sup>21</sup>

That same IEP neither contained nor referenced a Behavioral Support Plan (BSP). A BSP<sup>22</sup> is a standard requirement of IEP's for students with behavioral issues. A BSP, based on a focused observation and analysis of behavior, is supposed to alert teaching staff and administrators to the sorts of events and situations that trigger problem behaviors. In addition, a good BSP, based on that analysis and a review of history and information from people who know the student, will prescribe some approaches to deal with behaviors and proscribe others. Ideally, a BSP is a guide designed to steer school staff away from problems and guide them about what to do when problems might occur. In fact, as already noted, the district responsible for J's education as a special education student did not develop a BSP in the roughly two months between his transfer to their classroom and the day the police came to his school.

The question of what must be contained in a particular IEP is one that keeps many lawyers busy here and elsewhere. Additionally, it must be said that OAC encounters many poorly written and inadequate BSP's.<sup>23</sup> Nevertheless, under most circumstances, neither the law nor common sense allow a district to educate a student with a severe emotional disability without a BSP. The absence of a BSP for a student with J's history is difficult to justify. In J's particular case, it virtually guaranteed a disaster.

As noted previously, the teacher and an aide who worked with J at his public school placement in the run-up to October 4<sup>th</sup> both told police that he had been moved to three different foster placements during the three preceding weeks. Even if these moves were not the result of escalating behavior and difficulties at the foster placement, their significance in J's case should have been apparent to everyone who was working with him. As the treatment provider noted in its report on the transfer from residential to foster care, J "needs a stable home to break the pattern of being moved between placements and allow him to develop trust and attachment." Records obtained thus far, however, do not indicate that there was any organized effort to consider either the likely effects (on J) of those moves between successive foster placements, or what measures might have been prudently adopted to address those likely effects. In fact, in her statement to police, the classroom teacher told the officer in charge that she "was not sure what [J]'s diagnosis was."

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<sup>20</sup> An Individualized Educational Program (IEP) is the primary tool of special education. As the name implies, an IEP is supposed to be a document that describes a single student's disability and issues and, based on that accurate description, describes a plan of specialized instruction and supporting services that are needed to successfully educate the student. In general, at the time of the incident, IEP's were reviewed annually, or at the request of school or parent when problems were encountered. Since the incident, the law regarding when IEP's are reviewed has changed somewhat.

<sup>21</sup> J's 2004 IEP contained three objectives designed to help him reach a single annual math goal. The rest of the 16-page IEP focused on behavioral issues and did not address academic issues or goals.

<sup>22</sup> or BIP (Behavioral Intervention Plan.) The two terms, although perhaps not identical in meaning or emphasis, are used almost interchangeably.

<sup>23</sup> The problem persists despite good material and guidance on the creation of a good BSP that is readily available at the Oregon Department of Education's special education website.

## **XI. The Situation on October 4, 2004**

Police reports make clear that the aide and teacher apparently knew of the three rapid-fire placement changes in J's foster home and attached significance to them. Presumably, had they been made aware of his history, they would have known that such changes were likely to trigger an extreme reaction in J. Even if they failed to make the connection, they certainly knew that something had set J off on the preceding Friday to the extent that he could not remain in school. In hindsight, it seems clear that absent some sense of what had happened and how to prevent it, J shouldn't have returned to school the following Monday.<sup>24</sup>

OAC has been unable to learn of any effort by the school, DHS, or the treatment program to anticipate or plan for the almost inevitable explosion that finally took place. Neither records nor interviews indicate that there was discussion of what signs might signal such a crisis or what to do if it happened.

## **XII. The Incident**

Police reports and school records do not indicate that police were given any advice or guidance about J's history or how to handle him. Some records of the incident indicate that J's treatment program case manager was called and that she made it to the school before the police went in. Those same records do not report how she attempted to de-escalate the situation or whether she spoke with police before they pushed aside J's furniture barricade. The records contain little information about what happened or what was attempted between the time that J's behavior began and when the police arrived. There was apparently no time or plan in place to remove potential weapons (such as the metal pointed compass that J was holding when he was tasered) from the classroom.<sup>25</sup>

Probably because of the above-noted failures to engage in the most basic and standard sorts of planning in this case, the performance of the school (and the police) when the final crisis unfolded was far short of what we should expect and demand of the system that is responsible for the care and well-being of children with disabilities.

The school's entire record of the incident is contained in two documents of one and two pages respectively. The first of those two reports was a single typed page written by the building principal. In it, she described how she learned of the incident and met police after hearing sirens and being told by a secretary that police were on the way. Her report indicates that the police, after seeing the situation, called for a taser. Aside from noting that police asked about and reportedly learned that J was disturbed and at possible risk for suicide,<sup>26</sup> it does not describe any discussion on the part of school or

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<sup>24</sup> Notes of a November 3, 2004 incident review meeting reflect that this sentiment was shared by many of the participants.

<sup>25</sup> The presence of such an item in J's classroom, or, for that matter, any classroom for students with severe behavior problems and histories of aggression, is hard to understand even under the best of circumstances. OAC has reviewed many crisis plans and IEP's that required storage of such items in locked cabinets.

<sup>26</sup> Although there was material in J's residential and DHS files that could be interpreted to indicate a risk of suicide, OAC has been unable to locate anyone directly involved on the day of the incident who knew this information.

program staff of whether using a taser was wise or necessary.<sup>27</sup> According to the same report, however, there apparently was adequate time and perceived need to contact the head of the educational program and a school district public relations expert, presumably to handle potential negative publicity. J's primary counselor at the treatment program was also called, not as part of a coordinated plan, but at the suggestion of the classroom teacher. The principal, describing the counselor's involvement, wrote the following. "Everyone waited for her to arrive. When she arrived, [J] still did not calm down. Shortly after, the police tried talking to [J]. This just heightened the activity of the child."

The second report seems to be a one-and-a-half page set of handwritten notes from a post-incident meeting. The meeting was apparently attended by the principal, the educational program director, and another person whose name is at the top of the page without further identification. The notes are divided into sections addressing J's recent history in foster care, his behavioral difficulty on the previous Friday, and highlights from the 4th that are hard to decipher other than that they indicate that J "was shaky – didn't look right. He responded to [name of teacher]." The remainder of the notes seem to document efforts by the teacher and aide to remove two other students from J's classroom to a safe place.

Review of meeting notes and the few interviews that we were able to arrange with people who were present on the 4th revealed that the crisis plan was deficient not only for the reasons noted above, but also because it failed to account for other than ideal circumstances. That plan relied on the expertise and availability of staff from the treatment program to be available in situations that escalated beyond the ability of the staff who worked at the public school.

On the October 4th, when J's massive escalation took place, there were two problems with the reliance on treatment program staff. First, no one was available at the residential site who could drop what he or she was doing to deal with this sort of problem when it actually occurred.<sup>28</sup> A second problem stemmed from a cultural attitude at the treatment program: treatment staff were not inclined or organized to intervene in school situations when children were no longer in the residential program. This attitude was described and criticized by one participant in the November 3, 2004 meeting who stated that "they [treatment staff] have to realize that [J] was not discharged, that there was an ongoing responsibility."

### **XIII. The Police**

To a large extent, our investigation of this incident found that the police were handed a bad situation that was not of their making. It is clear, for instance, that despite an abundance of information available about J, very little of it was given to the four police officers who finally crashed through the furniture that J had piled up behind the door of his classroom. While there are obvious confidentiality issues involved in simply turning over a student file to police, it is difficult to understand why none of the many

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<sup>27</sup> OAC conversations with a participant in the November 3, 2004 after-incident meeting (previously described at pages 8 and 9) indicate that the police captain who authorized the use of the taser was subsequently quite upset that no one had communicated the size (65 lbs.) of J when the request was made.

<sup>28</sup> OAC has been informed that there is now 24-hour on-call availability of crisis staff (by pager) from the residential treatment provider and that this coverage was instituted largely as a result of J's case.

professionals involved with J had worked out a way to communicate at least some facts that would be useful to the officers who needed to assess the situation before acting.

That said, we find the ultimate police decision to storm the door in riot gear and taser J very troubling. Similar decisions are being made with increasing frequency across the nation. This is the second OAC case during the last two years in which a student was tasered in his special education classroom in our state.

Decisions to taser students with behavior problems are routinely justified as humane alternatives to the use of more<sup>29</sup> lethal force.<sup>30</sup> Regardless of the validity of this theory, we do not accept the underlying premise that it makes sense to call police into schools absent real and immediate threats to people.<sup>31</sup> In this case, we reject even more strongly the humanity or rationale to taser a 65-pound boy who held a drawing compass in his hand while isolated inside a room barricaded with furniture.

Our own cases and regular consultation with other P & A's across the country convince us that, while not without some level of physical risk, restraint techniques<sup>32</sup> can be used with relative safety when children the size and age of J are so out of control that they represent a serious and immediate threat of injury to themselves or others. In fact, the crisis plans of the treatment program called for the use of exactly those techniques during J's residential treatment program in instances when he could not be de-escalated with other measures. More importantly, the de-escalation techniques noted in the treatment provider's crisis plan were not attempted on October 4th.<sup>33</sup> Even if the police were untrained in such techniques, they surely could have safely restrained J behind face-shielded helmets, heavy gloves, and whatever other gear they had at their disposal.<sup>34</sup> Unarmed ward staff at mental institutions routinely restrain much larger and far more dangerous adults by using mattresses or blankets to smother and contain the blows and threats of patients who have obtained weapons.<sup>35</sup>

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<sup>29</sup> Tasers themselves have proved lethal in more than 50 incidents recorded in their relatively short life as police weapons in the U.S. Their effect on children, particularly children of the size of J, has not been studied, but it is not unreasonable to assume that the inherent danger of the weapon probably increases in smaller and younger bodies.

<sup>30</sup> Notes of a post-incident meeting indicate that police representatives, when asked by treatment program staff "if there is evidence that taser can be safely used on children," answered only that "there are weight limitations."

<sup>31</sup> See Appendix A for thumbnail sketches of other cases in which police have been inappropriately injected into Oregon special education classrooms.

<sup>32</sup> Restraint techniques are not without danger and have been historically over utilized as a substitute for good behavioral programming and educational techniques. There are, however, restraint systems that involve regular training of the staff who use them and that, in conjunction with good behavioral programming, can be used to good effect and with relative safety in some cases.

<sup>33</sup> An employee of the special education department of the school district, in relating the result of her own debriefing with J's classroom teacher, told OAC that both the teacher and aide were trained to use restraint techniques, but that they had elected not to employ those techniques because of their own small sizes and the fact that they had not practiced using restraint techniques together prior to the incident.

<sup>34</sup> A participant in the 11/3/04 after-incident meeting remembers that there was mention of the fact that police at the scene had rejected taser alternatives on the theory that because of J's small size, there was a high risk of broken bones or other injuries.

<sup>35</sup> A review of notes from a post-incident meeting that included police indicate that much of their energy at that meeting was devoted to explaining that it would have been too dangerous (to J) to employ such measures because of his small size.

OAC found that the police reports, like the reports generated by the school, failed to capture even the most basic information needed for a meaningful review of the incident. We reviewed 18 pages contained in five separate reports that were written by four police officers. Three of those reports contained narrative descriptions of what happened.

In the five reports, despite the fact that local police procedure called for a description of suspects and/or persons taken into custody on four of the forms, only one recorded the height and weight of J. While this omission could be no more than an oversight it was obviously relevant in any review of the appropriateness of the actions taken by the police.<sup>36</sup> OAC is concerned that only one of the police reporters saw fit to include those routinely recorded facts in a situation that attracted the attention of both high-ranking police officials and a public relations expert from the school district before J was tasered and handcuffed.

Within the four police reports that contained narrative descriptions of the incident, accounts differed significantly in more than one respect. Two of the narratives described J as holding the drawing compass. The police also photographed and seized a five-inch long<sup>37</sup> drawing compass as evidence. The report written by the officer who eventually fired the taser, however, describes J as holding “a metal bracket of some kind” that was “at least 12 inches long and looked like it was capable of causing us injury.”

Similarly, one police narrative reports that “[o]ne of the officers on scene gave [J] the order to drop the compass three times, but [J] did not obey the command. Ofc. [X] fired his taser gun \* \* \*.” The officer who fired the taser, however, reported that “[n]o warning was feasible because he was already armed and about to throw it.”

Although one of the responding officers collected two witness statements, none of the police reports recorded any statement by the treatment program counselor who had been referred to by the building principal or even noted that she was present. Similarly, none of the reports mentioned the principal’s presence or contained statements by her.

The problems raised by the police reports are regrettable in that they impact a direct review of J’s incident and also impact the possibility of looking at larger systemic implications. Without accurate information in such cases, it is difficult to collect data that would facilitate an understanding of how often police are called into such situations and what happens when they are. Although OAC perceives such incidents as a growing problem, that belief is difficult to support when the incidents are not documented or tracked. In a classic bit of circular reasoning, incidents are apparently not tracked because they have not been seen as a significant problem.<sup>38</sup>

#### **XIV. What Happened to J?**

J’s juvenile attorney was asked about J’s status in early November of 2005. He reported that although he was not generally involved with J’s non-court-related

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<sup>36</sup> A high ranking police official who attended a post-incident meeting noted her anger that she had not been informed of J’s size when she was contacted to authorize the use of the taser.

<sup>37</sup> A photograph of the compass next to a ruler was part of one police report.

<sup>38</sup> Partially in response to the October incident, OAC approached the Oregon Department of Education’s Department of Special Education about this and related issues. We learned that the department did not track such incidents or have plans to do so in the future. Subsequently, however, the department agreed to begin tracking incidents and has shared its initial data set with OAC.

educational issues, he believed that J, after a rough start, had done fairly well in an intensive day treatment program after the incident although he was not able to name the program with certainty. He also reported that J had participated in two summer recreational programs and was getting along well with the foster parent who had taken him in just before the incident. The juvenile attorney also reported that J's memory of the incident approximately one year later was that he was "acting out and wrecking stuff," that "I had a compass in my hand," and that "they [the police] didn't say anything" before they shot him.

J's foster parent was interviewed in December of 2005. At that time, J was once again in the same residential treatment program that preceded the incident. Her understanding was that he would be placed at yet another behaviorally-based day treatment program following a two-week stabilization at the residential program. She explained that J had actually attended a different day treatment program for most of the period that followed the incident, but that recent visits with a sibling had brought up a lot of past issues with bad emotional results that included punching a hole in the wall of her house.

Her overall perspective was that J was not doing very well and that he was "angry at the world." She felt that the behavioral programs in which he had been placed did not get at the traumatic events that have decimated his life and fueled his anger. As she explained it, J is not thought to be "ready" for therapeutically-based programs because he does not readily open up. She questions this conclusion and feels that J's reluctance is only natural when his age and history are taken into account. To support her belief, she notes that J has gradually opened up to her to an extent that he has been able to acknowledge that the long-suspected sexual abuse noted in the files had indeed occurred and that it was extensive.

When asked if the professionals who make decisions about J's treatment and education listen to her, she laughed and said "they mostly don't know what to do with him." When asked about any observed effects of the October incident on J, she noted a real fear of police that crops up occasionally, but thought the more significant effect was that "it just added to his anger." She says that J is now about five-feet tall, weighs roughly 110 pounds, and that he is growing fast.

## **XV. Conclusion**

OAC investigated this incident for two reasons. When a small child with disabilities is tasered by police in his special education classroom, there is something to worry about. Perhaps, more disturbing than the incident itself is our sense that only the spectacular culminating event in J's case was unusual.

Our experience in this and other cases is that often well-intentioned and highly skilled professionals are failing children like J because of systemic pressures that push them to try hard and hope for the best without knowing how their efforts interact with those of others, or whether those efforts are effective in any practical sense. In situations where the professionals involved are less competent and/or less dedicated to their responsibilities, bad results are predictably more frequent even if they don't make news.

The injection of police into situations where special education students have emotional outbursts is a short-sighted remedy that has not been shown to be effective in

our state or elsewhere. More importantly, calling police as a method to control children like J is, in our view, almost never necessary and almost always traumatic. In all but the truly dangerous circumstance where a student poses an imminent threat to another person, we believe that the introduction of police into the mix should be viewed as an indication of poor educational practice and planning.

No one that we interviewed is satisfied with the events of October 4. J paid an enormous price for the shortcomings of a system that operates in a reactive mode. We can only imagine the lessons he will take from this incident into his adulthood. Given the price he has paid to teach us what is wrong with a system that is supposed to protect him, we cannot ignore the lesson that is inherent in its failure.