Office of the Inspector General

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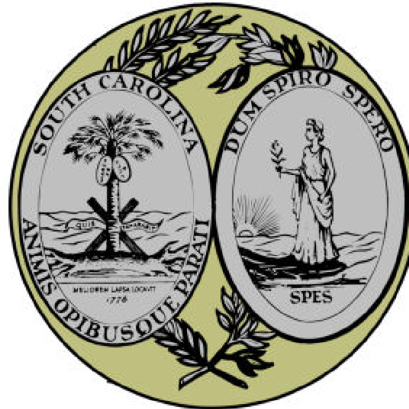

Review of Two Issues at the Long-Term Commitment Facilities, Department of Juvenile Justice:

1) Safety Threat to Employees & Juveniles; and

2) Event Reporting Process Integrity Allegations

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I. Executive Summary

The Legislative Oversight Committee, South Carolina House of Representatives, referred allegations pertaining to the Department of Juvenile Justice (DJJ) via letter dated 3/3/2016 to the State Inspector General (SIG), which were generated during its ongoing oversight study of DJJ. Witnesses reported concerns for the safety of juveniles and DJJ employees at the long term commitment facilities, as well as made integrity allegations of underreporting, misreporting facts, or destroying reports in DJJ's event reporting process at these same facilities. The DJJ operated three long term commitment facilities co-located at 4900 Broad River Road, Columbia, known as the "Broad River Road Complex (BRRC)," which incarcerated 109 juveniles for criminal offenses. Both the safety and event reporting process issues were accepted for SIG investigation initiated on 3/8/2016.

Safety of Juveniles and Staff

The safety threat to juveniles and staff at the BRRC was assessed as a "high" by all data sets reviewed. During interviews with 31 BRRC staff, each rated the safety threat level for staff and juveniles on a scale of one (low threat) to five (high threat), which averaged 4.3 and 3.7 for staff and juveniles, respectively. Despite interviewees' different roles and experiences, their responses to the same series of questions were consistent. Five safety themes emerged from the interviews: lack of consequences for juveniles; systemic gang mentality; chronic verbal abuse of staff; low security morale & problematic engagement with juveniles; and heightened safety threat of physical altercation. Staff generally attributed these increased safety issues to DJJ's well-intended new strategy to implement a more therapeutic approach at the BRRC, particularly the Balanced and Restorative Justice Model (BARJ) of adjudicating juvenile conduct through community conferences. BARJ has been an effective juvenile justice technique in a community setting, and DJJ was one of the first state juvenile justice agencies to introduce this model in a secure facility setting.

The DJJ's performance management system, known as Performance-based Standards (PbS), identified the BRRC facilities' declining safety conditions during 2015. In the most recent PbS report in October 2015, the three facilities measured 26 safety, security, and order related critical outcome measures, of which 37% trailed outcome results from peer facilities in other states (red) and 63% equaled or exceeded peer facilities (green). All three facilities were red in the four critical outcome measures indicating staff was isolating juveniles and feared for their safety at higher levels than peer facilities in other states. Two survey questions, also from the October 2015 PbS report, measured the BRRC staff's assessment of their level of safety, which resulted in responses ranging from 23% - 37% as "safe" and 63% - 77% as "unsafe."

The April 2015 PbS report, disseminated in June 2015, initially provided performance data of declining safety at the three BRRC facilities. Based on these declining ratings and corresponding decrease in safety outcomes, the BRRC security manager was removed in August 2015. In early Fall 2015, after a near riot, the DJJ developed an improvement plan. In March 2016, a security executive was separated from DJJ, in part, for not timely implementing the Fall 2015 improvement plan, as well as the continued increasing safety threat level. The improvement plan was updated on 3/9/2016 along with an increased sense of urgency.

It was noted in staff interviews in early April 2016 nearing the end of the SIG's field work, the safety threat level had declined in the prior few weeks. Staff attributed this to the six juvenile ringleaders from a 2/26/2016 major incident at the BRRC being criminally charged, removed from DJJ, and placed in an adult detention center. The security staff was also delegated increased authority to address recalcitrant, aggressive behavior. Finally, the staff was encouraged by the visible actions implementing the recent 3/9/2016 improvement plan.

Integrity of the Event Reporting Process

The DJJ operated an event reporting process to document serious incidents or accidents related to DJJ staff, juveniles, or DJJ facilities, which was determined to be inefficient and ineffective. Of the 31 staff interviewed under oath, not one interviewee reported any integrity incident of intentional manipulation or destruction or ERs, nor any management directive or practice to suppress, destroy, or not report a reportable event under policy. However, many interviewees noted staff underreporting ERs without a nefarious motive, generally attributed to the security staff's pattern of disengagement.

The event reporting process provided the raw input data required for many critical DJJ operations, to include ensuring juvenile and staff safety; oversight of staff's use of force; therapeutic staff interventions; juvenile disciplinary matters; legal liability; and a critical component of the facility performance management system. The security staff initiated the vast majority of ERs generally pertaining to juvenile behavior and conduct.

The BRRC staff described the event reporting process as inefficient, cumbersome, "too many people touch the paper," and had many opportunities for human error in routing ERs. The PbS Unit was to receive most all ER reports, yet its quality control review of facility shift reports required follow-up to obtain missing ERs, conservatively estimated at 20% of the total ERs. BARJ coordinators working in the dorms reported similar problems of chasing down paperwork on a regular basis. The DJJ-IG reported a similar pattern. A common example was a staff member presenting an ER to the DJJ-IG to check on the subsequent investigative status, yet the ER was not in the DJJ-IG system and, correspondingly, no investigation had been initiated.

The event report process was audit tested to determine the level of routing of ERs to two key consumers: DJJ-IG for follow-up investigations; and the BARJ Unit for adjudicating juvenile alleged misconduct. These two functions' ERs received during two separate sample months in 2015 were compared to the PbS Unit's ERs, which were considered the most complete based on its quality control mechanism. The audit test determined the DJJ-IG and the BARJ Office received 62% and 71%, respectively, of the priority ERs received in the PbS Unit during the same sample period. Essentially, 29% and 38% of priority ERs the BARJ Office and the DJJ-IG should have received, respectively, could not be located and were presumed not received.

Way Forward

It was noteworthy DJJ demonstrated the organizational initiative with this major strategy change to seek a higher level of juvenile justice effectiveness. With the perfect vision from 20/20 hindsight, DJJ appeared to have hung on too long waiting for the cultural change and expected benefits from the BARJ model, while the unintended consequences incrementally grew to unhealthy levels. State government's greatest risks are not with forward leaning agencies' initiatives suffering setbacks, but rather with agencies complacently stuck in mediocrity.

The DJJ has shifted its strategy and developed a reasonable plan to solidify an orderly, safe, and secure environment at the BRRC, which has been aggressively pursued yielding early indicators of positive change. As part of its strategy, DJJ should also automate the event reporting process workflow to increase efficiency and assurance the critical raw operational data, often juvenile conduct, is accurately captured, routed, and appropriately actioned at the DJJ.

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II. Background

A. Predicate

The Legislative Oversight Committee, South Carolina House of Representatives, referred allegations pertaining to the Department of Juvenile Justice (DJJ) via letter dated 3/3/2016 to the State Inspector General (SIG), which were generated during its ongoing oversight study of DJJ. Witnesses requesting confidentiality reported the underreporting, misreporting facts, or destroying reports in DJJ's event reporting process, which undermined the integrity of this important management information system. Additionally, witnesses raised concerns for the safety of juveniles and DJJ employees at the long term commitment facilities. Specifically, the safety issues focused on lack of control; lack of trust; and lack of adequate staffing. As a result of this letter and additional inquiry with relevant stakeholders, the SIG opened a full investigation on 3/8/2016.

B. Scope & Objectives

This review's scope and objectives were:

- Investigate specific complainant allegations of DJJ employees underreporting, misreporting, or destroying ERs;
- Review the efficiency and effectiveness of DJJ's event reporting process and follow-up on any anomalies or potential patterns of systemic underreporting, misreporting, or missing ERs; and
- Assess juvenile and employee safety conditions through interviewing a cross-section of relevant employees, record review, and possibly an employee survey.

Reviews by the SIG are conducted in accordance with professional standards set forth by the Association of Inspector General, often referred to as the "Green Book."

C. Department of Juvenile Justice (DJJ) Overview

The DJJ was responsible for the care and rehabilitation of South Carolina children, who were incarcerated, on probation or parole, or in community placement for a criminal or status offense (i.e., truancy). DJJ's mission was to protect the public and reclaim juveniles through prevention, community programs, education, and rehabilitative services in the least restrictive environment appropriate for each juvenile.

The DJJ had an annual budget of $103.7 million with 1400 employees. The DJJ operated seven secure facilities: three post-adjudication regional evaluation centers (Midlands; Upstate; and Coastal) with a 45 day maximum length of stay; one pre-trial detention center in Columbia; and three long-term commitment facilities co-located at 4900 Broad River Road, Columbia, known as the "Broad River Road Complex (BRRC)." In addition to operating these seven secure facilities, DJJ contracted with a number of group home facilities in community based settings providing services to juveniles in lieu of commitment.

The three long term commitment facilities at the BRRC had an annual budget of $18.7 million with 304 employees currently serving 109 juveniles. These three facilities were: 1) John G. Richards maintained male juvenile dorms; 2) Willow Lane maintained a female juvenile dorm; and 3) Birchwood maintained male juvenile dorms, as well as included the Crisis Management Unit and the Birchwood School.

III. Safety of Juveniles and Employees at the Broad River Road Complex

The safety environment at the BRRC was assessed using a variety of data sets. The DJJ's rigorous performance management system generating bi-annual reports were analyzed. Major events at the BRRC were reviewed. Lastly, and most important, a cross-section of employees working at the BRRC facilities were interviewed.

A. Performance-based Standards (PbS) Reports

1. Agency-wide PbS Analysis

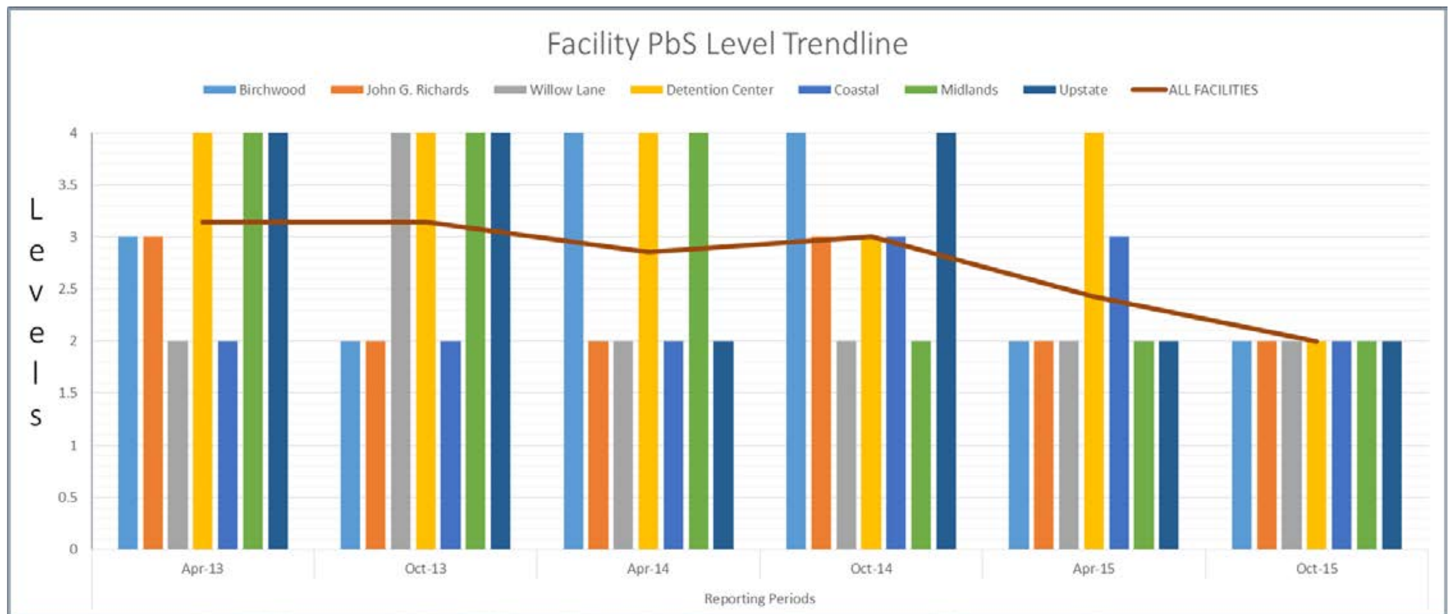
The DJJ hired an external consultant, Performance-based Standards Learning Institute (PbS), to conduct bi-annual performance assessments of its seven secure facilities. The review used objective standards covering seven critical operational areas of security, safety, order, health, justice, programming, and reintegration. Data collection included ERs; surveys of staff and juveniles; juvenile exit interviews; and on-site reviews.

Each of the seven secure facilities received a rating of "1", "2", "3", or "4". A "1" rating was for only new facilities to recognize its ability to generate required data prior to a bi-annual review. A "2" rating pertained to measuring 34 critical outcome measures (COMs), which were compared with a data base of results from peer facilities in other states. Success was defined as equal or exceeding the peer average measurements in 84.5% (28.7) of 34 COMs. Less than 74.5% (25.3) indicated opportunities to improve, while in between 74.5% - 84.5% was defined as "mixed results." It should be noted these 34 COMs pertained to eight (24%) health screenings measurements at the time of facility admission and 26 (76%) pertained to order, safety, and security measurements. If a facility was successful at a "2" rating, it could then could be potentially rated at a "3" or "4" based on measurement results from less critical outcome measures totaling 74, known as "non-critical" and "reintegration" measures.

The below table sets forth each of the seven secure facilities' PbS overall performance ratings over the past six bi-annual rating periods. For all level "2" ratings, the percent of COMs equal or greater than peer facilities was noted in parenthesis to better understand the extent of not attaining a successful 84.5% rating.

Report Date	Birchwood	JG Richards	Willow	Detention Ctr.	Midland Eval.	Upstate Eval.	Coastal Eval.	Average
April 2013	3	3	2 (64.5%)	4	4	4	2 (62.0%)	3.14
October 2013	2 (72.0%)	2 (67.7%)	4	4	4	4	2 (65.5%)	3.14
April 2014	4	2 (75.8%)	2 (72.7%)	4	4	2 (74.2%)	2 (51.6%)	2.86
October 2014	4	3	2 (73.5%)	3	2 (56.3%)	4	3	3.00
April 2015	2 (64.7%)	2 (73.5%)	2 (73.5%)	4	2 (59.4%)	2 (81.3%)	3	2.43
October 2015	2 (73.4%)	2 (64.7%)	2 (76.5%)	2 (71.9%)	2 (75.0%)	2 (71.3%)	2 (59.4%)	2.00
Average	2.83	2.33	2.33	3.50	3.00	3.00	2.33	2.76

The above table's secure facilities overall PbS performance rating trend line can be better illustrated graphically as follows:



For the first four bi-annual reports (April 2013 – October 2014), the average secure facility rating hovered around a "3." However, at the very next rating period (April 2015), the average rating decreased 19% for all facilities to 2.43. At the next and most recent rating period (October 2015), the average rating decreased another 18% to 2.00. Within the last rating year (October 2014 – October 2015), the seven facilities decreased from a 3.00 average rating to 2.00 average rating, which was a 33% decrease.

The BRRC facilities (Birchwood; JG Richards; and Willow) decreased at a sharper rate over the last rating year than the average of all seven facilities. These three BRRC facilities averaged a 3.00 rating in October 2014, which decreased to an average 2.00 rating in April 2015 and remained at a 2.00 rating in the October 2015 report. The "driver" for the lower facility ratings directly correlated with the COMs for order, safety, and security lower than peer facilities' results.

2. <u>Broad River Road Complex PbS Analysis</u>

The most likely relevant record evidence of the current safety threat at the three BRRC facilities was contained in each facility's most recent (October 2015) PbS report. For each report, 26 (76%) of the 34 COMs pertained to the safety environment in the facility. These 26 COMs were contained in three categories: order (9); safety (13); and security (4). A review of these 26 safety related COMs for each facility was:

- Birchwood – 9 red (34%) & 17 green (66%) *[see Appendix A]*;
- JG Richards – 12 red (46%) & 14 green (54%) *[see Appendix B]*; and
- Willow – 8 red (31%) & 18 green (69%) *[see Appendix C]*.

The aggregate COM ratings for the three facilities in COMs relevant to the safety environment were 29 red (37%) & 49 green (63%). The three facilities' specific red COMs (facility frequency) were:

- youth confinement (2);
- segregation/special management unit (1);
- average isolation duration (3);
- isolation less than four hours (3);
- isolation less than eight hours (3);
- injury to youth (2);
- injury to youth by staff (1);
- suicide behavior (2);
- youth injuries during physical/mechanical restraint (1);
- assaults and fights on youth (2);
- assaults on staff (2);
- youth reported safety fear over past six months (1);
- staff reported safety fear over past six months (3);
- incidents involving weapons contraband (1);
- incidents involving drug contraband (1); and
- incidents involving other contraband (1).

All three facilities were red in the four critical outcome measures indicating staff was isolating juveniles and feared for their safety at higher levels than peer facilities in other states.

3. Broad River Road Complex Staff Surveys on Safety Environment

Of the 34 facility COMs, two were the most illustrative of the safety environment in the BRRC facilities: 1) youth reported safety fear over past six months; and 2) staff reported safety fear over past six months. These two questions' ratings for the past six bi-annual reports were:

Report Date	Birchwood		JG Richards		Willow	
	Youth Safety	Staff Safety	Youth Safety	Staff Safety	Youth Safety	Staff Safety
April 2013	Green	Green	Red	Green	Green	Red
October 2013	Red	Red	Green	Red	Red	Red
April 2014	Green	Red	Green	Red	Red	Red
October 2014	Green	Red	Green	Red	Green	Green
April 2015	Red	Red	Green	Red	Red	Red
October 2015	Green	Red	Green	Red	Red	Red

There was variation of the youth's perception of safety during the review period, while the staff was consistently red since October 2013.

To capture the most granular data on the staff's view of the safety environment, below are two staff PbS survey questions for the most recent four bi-annual reports (April 2014 – October 2015), which were factored into the COMs in each PbS report for the respective facilities:

- How safe or dangerous do you (staff member) feel this facility is for staff?

Report Date	Birchwood				JG Richards				Willow			
	Very dangerous	Unsafe	Safe	Very Safe	Very dangerous	Unsafe	Safe	Very Safe	Very dangerous	Unsafe	Safe	Very Safe
April 2014	21%	45%	31%	3%	30%	40%	40%	0%	17%	50%	27%	7%
Oct. 2014	12%	33%	51%	5%	19% *	36% *	42% *	0%*	10%	17%	66%	7%
April 2015	23%	54%	23%	0%	11%	37%	49%	3%	37%	37%	21%	5%
Oct. 2015	38%	38%	24%	0%	20%	54%	26%	0%	4% *	73% *	23% *	0%*
Average	24%	43%	32%	2%	20%	42%	42%	1%	17%	44%	34%	5%

*1 respondent did not answer

- How safe or dangerous do you (staff member) feel this facility is for the youths?

Report Date	Birchwood				JG Richards				Willow			
	Very dangerous	Unsafe	Safe	Very Safe	Very dangerous	Unsafe	Safe	Very Safe	Very dangerous	Unsafe	Safe	Very Safe
April 2014	17%	21%	55%	7%	10%	30%	40%	20%	13%	47%	33%	7%
Oct. 2014	7%	30%	51%	12%	11% *	17% *	53% *	17% *	7%	10%	66%	17%
April 2015	4%	38%	50%	8%	3%	23%	66%	9%	21%	37%	21%	5%
Oct. 2015	36%	36%	29%	0%	17%	46%	37%	0%	18% *	48% *	34% *	0%*
Average	16%	31%	46%	7%	10%	29%	49%	12%	15%	36%	39%	7%

*1 respondent did not answer

The above two specific questions' responses indicated the staff assessed the current (October 2015) environment as "safe" (safe + very safe) ranging from 23% - 37%, while the reciprocal 63% - 77% of staff assessed the environment as "unsafe" (unsafe + very dangerous). Comparing the current safety environment (October 2015) to the average for the past two years, the BRRC have become a less safe environment for staff and youth.

The PbS survey asked a logical follow-up question to the assessment of the safety environment data:

- In your opinion, what would make this facility safer?

Responses	Birchwood	JG Richards	Willow *	Average
More Staff	71%	97%	69%	79%
Training	61%	44%	62%	57%
Safety Equipment	41%	38%	54%	44%
Other	34%	12%	12%	19%
Less Overcrowding	17%	3%	4%	8%

*1 respondent did not answer

The BRRC staff interviews also noted a staffing shortage. Currently, BRRC security has a budget of 236 staff (FTEs) with an on-board complement of 191 (81%) and 45 vacancies (19%). A dorm captain advised a current on-board staffing of 26 for her/his dorm, which was as high as 43 in the past four years. This captain advised the ideal staffing of a dorm (30 juveniles) during day shift was nine: two for each of the three pods (10 juveniles/pod); one for control room; one shift supervisor; and one floater needed due to logistics caused by juveniles' medication needs and attending therapy programs. Currently, many day shifts were operated by five security staff, which was a minimum staffing level. It was also noted to be beneficial if the three to four therapeutic treatment staff assigned to each dorm would schedule work in the early evening hours, as opposed to the current 9:00 am - 5:00 pm schedule, due to juveniles not returning to the dorms until 3:00 pm daily from school. Many interviews also noted an abnormally high security staff on worker's compensation. DJJ records reflected 66 BRRC staff on worker's compensation in 2015 averaging 4.25 days, with a slight increase of 26 BRRC staff out averaging 6.86 days in the first quarter of 2016.

The PbS data, as a whole, indicated a decrease in agency-wide secure facilities' safety environment at the April 2015 reporting period followed by another decrease in the most recent reporting period of October 2015. The BRRC mirrored this overall decrease in safety as illustrated by PbS staff surveys describing the environment as "unsafe" by a solid majority (63%-77%).

As an aside, the quality of the PbS reports coupled with each report's raw survey data negated the need for the SIG to survey DJJ staff. The PbS October 2015 staff surveys for each of the three facilities at the BRRC contained rich data beneficial to assess other operational aspects in addition to the emphasis on safety presented in this report (*see Appendix D for each facility's staff October 2015 survey results*).

B. Major Recent Events Impacting Safety

DJJ staff interviewees referred to one or more of four major events in the latter half of 2015 and early 2016 as indicative of the rising safety threat level at BRRC. These four events will be briefly summarized based primarily on ER staff reporting inasmuch as the criminal cases were still pending:

- On 8/18/2015, a juvenile broke a chair and used the pieces to break out a window between his dorm pod area and the security control room. He retrieved a bat and destroyed the computers, security monitors, a television, and virtually every window in the dorm. One staff was removed from the scene because juveniles were planning to attack him; this staff member later resigned based on this incident. Verbal threats by multiple juveniles were made towards staff. The dorm damage was so severe, all the juveniles had to be relocated to another dorm and the damaged dorm was uninhabitable for the remainder of calendar year 2015. The offending juvenile was criminally charged.

- On 9/17/2015, almost the entire Birchwood school juvenile population, approximately 100, exited the school building without permission. Fights and brawls broke out on the school's front lawn. Juveniles then ran behind the school and stood on opposite sides according to gang affiliation. The disturbance continued with control regained after an hour of continuous incidents. The report noted one juvenile's reason for the fighting, "wouldn't be like this if y'all put us all with our set (gang), and y'all going to catch hell until y'all move us." The DJJ-IG did not initiate an investigation into this matter based on no reported injuries or property damage.

  On 9/18/2015, the very next night at approximately 11:00 p.m., several juveniles in the Magnolia dorm got out of control beginning with dangerous horse play, which required assistance from off-duty personnel and senior managers at the scene. Juveniles made verbal threats to staff. This was a tense situation inasmuch as the day before was, according to the report, "a major riot," and this dorm had "intense" gang involvement. The initial assessment was the juveniles had "joined together and are ready to fight staff." As a result, all staff was ordered out of the dorm for safety. Juveniles then damaged the dorm by breaking the TV; throwing a water cooler, microwave, and DVD player; kicked over the water fountain; and broke out lights. After becoming initially compliant and boarding a bus to the Crisis Management Unit for lock-up, a group of the juveniles jumped from the bus requiring SLED to respond. Two juveniles threw bricks from the roof of the science building breaking a car windshield. The last juveniles were secured at 5:00 a.m. the next day.

- On 12/19/2016, juveniles at the Crisis Management Unit kicked open a secure door, took over a wing of the building, and vandalized the wing by ripping down light fixtures and lighting fires causing major damage to the unit. A responding staff observed "3 large fires in the bay area," and then proceeded to

release other juveniles still secured in another wing of the building. The non-compliant juveniles proceeded to break into Birchwood School and caused minor damage. The Crisis Management Unit sustained major damage. SLED responded to the scene along with Richland County Fire Department. Six juveniles have been criminally charged.

- On 2/26/2016, the juveniles in a dorm lit multiple fires and broke out windows separating the dorm's three separate living pod areas. Sinks were ripped out and the control room's equipment and surveillance monitors destroyed. The juveniles pushed past staff to gain access to the entire campus, leaving the dorm with major damage in excess of $10,000 and one staff with a foot injury from a juvenile throwing a fire extinguisher at her.

  A group of juveniles then proceeded to the female dorm. The juveniles literally broke every exterior window and door in this dorm. One male juvenile has been charged with attempted criminal sexual conduct and assault for placing his hands under the clothing of a female juvenile, while a second juvenile was charged with attempted criminal sexual conduct for exposing himself.

  Responding staff engaged a juvenile outside of the female dorm who had just attempted to aggressively gain access to female juveniles for sex. This juvenile had a pair of scissors in his hand, which he pointed at the staff demanding they "back the f--- up" and said he was not going back to lockup. Ultimately, the juvenile surrendered the scissors and was secured.

  Juveniles also broke into the Birchwood School and caused in excess of $10,000 damage, to include destroying a copying machine valued at $7000 and its replacement cost $10,000.

  Several juveniles broke into the DJJ-IG's Annex Office and stole car keys to a staff member's personal car. Responding staff saw three juveniles in a parked car. As a staff member tried to open the door, the juveniles reversed at a high rate of speed with the car mirror hitting a staff member. The car hit a parked car causing major damage to both. As staff closed-in on the accident by foot, one juvenile then yelled, "hit those bitches." One juvenile exited the rear car door and a staff member entered the back seat as the car drove forward at a high rate of speed turning in the direction of two staff. The staff jumped out of the way and were missed by a "few inches." The staff member in the rear of the car grabbed the driver causing the car to jump the curb and stop 50 feet further in the grass. The two subjects in the car were secured after resisting.

  One juvenile escaped through a drainage pipe under the fence and walked approximately a mile to a retail store where his mother worked. DJJ was notified and the juvenile was secured a short time after his escape.

The DJJ-IG's Office identified 14 subjects with criminal exposure, of which 13 have been charged criminally to date.

C. Employee Interviews

A cross section of the 31 BRRC staff (administration, security, therapeutic/clinical, and school) at the BRRC facilities were interviewed regarding the safety threat to DJJ staff and juveniles, as well as the DJJ event reporting process. Each interviewee was asked to rate the safety threat to staff and juveniles on a scale of one (low threat) to five (high threat). This resulted in an average threat level to DJJ staff of 4.3 and juveniles of 3.7.

Despite interviewees having different roles and experience levels, their responses to the same series of questions were consistent. Six themes emerged from the interviews, which had a level of overlap with each other: lack of consequences for juveniles; systemic gang mentality; chronic verbal abuse of staff; low security staff morale & problematic engagement with juveniles; heightened safety threat level of physical altercation; and inefficiency of the event reporting process.

1. **Lack of Consequences for Juveniles**

Virtually all staff interviews identified the implementation of a new juvenile disciplinary program, known as the Balanced and Restorative Justice Model (BARJ), as a major factor in the current high safety threat level at the BRRC facilities. BARJ was a national juvenile justice model designed to enable offenders make amends to victims; increase offender's competencies through understanding impact on victim; and protect the community through involving victims, the community, and offenders in the process.

Interviewees advised regardless of the seriousness of the juvenile's misconduct or behavior, BARJ's toolkit of consequences were essentially limited to the juvenile writing an apology letter to the victim, often a Juvenile Specialist (JS) serving as front-line security personnel, or doing extra duties like dorm clean-up. Many interviewees noted it took between three to six months after BARJ's implementation in late 2013 for the juveniles to catch on there were limited consequences, if any, for their bad behavior. As a direct result, according to most interviewees, juveniles' behavior became more aggressive, certainly exacerbated by the increased gang mentality at the BRRC. One interviewee commented JSs become disenfranchised when seeing juveniles assault JSs, yet the only consequences were apology letters. Multiple interviewees reported juveniles verbally flaunted the lack of consequences to JSs, who were trying to manage and address these same juveniles' behaviors.

The foundation of BARJ eroded overtime in that it was supposed to be victim based, yet the victims, generally JSs, often elected not to attend BARJ conferences on juvenile misconduct. One staff commented, 'juveniles would arrive at a BARJ conference with the apology letter already written before a consequence was decided." One could rationally argue the BARJ conferences with nominal consequences actually reinforced bad behavior. Not one interviewee, even the therapeutic treatment staff, believed BARJ was effective, and almost all interviewees identified BARJ as undermining the order, safety, and security of the BRRC facilities. There were several interviewees who genuinely believed better skilled security staff may have allowed BARJ to be effective, but even these interviewees recognized the current safety threat was intolerable and change was required.

Senior staff with experience of the order, safety, and security conditions before BARJ, repeatedly noted the previous disciplinary model with higher level consequences positively impacted juvenile behavior and deterred future misconduct. For example, serious misconduct, often overly aggressive behavior, led to separating a juvenile from the general population to receive enhanced treatment and assurance of changed behavior prior to returning to a general population dorm environment. Consequences to juveniles' bad behaviors were immediate. Interviewees stated it takes days and even weeks before BARJ sanctions were imposed on the juveniles following incidents. Further, if the juvenile chooses not to have a BARJ conference for the alleged misconduct/behavior, then it did not take place and the BARJ incident was "frozen." The staff then attempted to persuade the juvenile to attend with the only consequence being a points system for other privileges was also "frozen" during this period of negotiating with the juvenile to attend.

Security management operating in the juvenile dorms felt strongly the BARJ was part of an overall program, which was well intended, to transform the BRRC towards a therapeutic treatment facility. The BRRC certainly should focus on rehabilitation, to include therapeutic components, but the security staff asserted DJJ's first

priority should be to protect the community from criminal juvenile offenders and maintain the safety and security of the juveniles and staff. In short, the security staff strongly felt BARJ's processes designed to optimize therapeutic treatment conflicted with fundamental principles of operating a safe facility securing criminally charged juveniles.

2. Systemic Gang Mentality

Interviewees noted a strong gang presence at BRRC. Multiple interviewees reported when new juveniles arrived, they were given the choice of becoming affiliated with a gang or face a "beat down." An interviewee with close contact to juveniles estimated 90% of the assaults on staff by juveniles were done at the direction of a gang leader. Regardless of gang affiliation, the gang mentality promotes an arrogant and defiant attitude in an attempt to intimidate others, especially in the presence of other gang members. Status and respect are gained through acts of seemingly remorseless violence. A gang fundamental principle of maintaining respect generates disproportionate aggressive responses to often minor incidents.

One interviewee provided an anecdote where a newly arrived juvenile just wanted to do his time and earn parole or transfer to a community camp as quick as possible. However, he joined a gang out of self-preservation. He was then instructed by a gang leader to assault a staff member. He recognized this assault would likely prolong his confinement at the BRRC, but he had no alternative given the need for his own safety to be affiliated with a gang. He assaulted the staff member.

3. Chronic Verbal Abuse of Staff

On a daily basis, the lack of respect and verbal abuse by juveniles toward DJJ staff was, in the words of one interviewee, "relentless, goes unchecked, it is so out of control and the JSs have no tools to address behavior." Some JSs with the right combination of experience, maturity, and interpersonal skills could command the respect of the juveniles to maintain control. However, many JSs were young and inexperienced, and the juveniles were abusive without consequence. Senior staff recalled prior to BARJ, there was always a level of juvenile aggression and misconduct, but it was only one or two per dorm and manageable. Now, with the gang mentality, it seemed like the new norm was a small number of leaders could influence aggressive and bad behavior of an entire dorm.

Multiple interviewees noted new JS recruits quit in surprising numbers either during training when exposed to the juveniles or shortly after starting work due to the verbal abuse and tension with the juveniles. A JS reported entering on duty in a class of 14 JS cadets two years ago, and now only two from this class were still employed at DJJ.

4. Low Security Staff Morale & Problematic Engagement with Juveniles

As the juveniles' behavior worsened without consequences, the staff's ability to maintain compliance through mentoring, counseling, and re-directing a juvenile became less effective. When a juvenile's aggression and non-compliance became uncontrollable, the JSs' remaining tool was placing the juvenile in a segregated isolation, also known as a "lock-up" room in the Crisis Management Unit (CMU). Lock-up was more of a juvenile "time out" in that once the juvenile was determined to be "CCS (calm, cooperative, and safe) compliant," the security staff had policy pressure to return the juvenile to the dorm. As a result, lock-up as a consequence and behavior deterrent lost effectiveness. Interviewees reported, again, juveniles verbally flaunted the security staff, such as "be back in a couple of hours" after a misconduct event because they understood they only needed to be "CCS compliant" to return to the dorm. Between BARJ's nominal consequences and the

CCS compliant policy, the security staff felt the management policies emboldened juvenile bad behavior and took away tools to deter bad behavior, which undermined order, safety, and security.

Virtually all interviewees noted many JSs have become less engaged with the juveniles for many reasons. There was a perception engagement with an aggressive juvenile may end up in an altercation requiring the use of force, which then placed JSs at risk of losing their jobs or even being criminally charged. The DJJ-IG investigated, rightfully, the use of force reports by staff. However, the security staff reported incidents where they believed JSs were inexplicably disciplined for using too much force, particularly when the juvenile was injured. The staff advised when force was required, incidents unfold in unpredictable ways that may lead to injuries to staff or the juvenile. The staff felt management did not take this reality into account when assessing use of force incidents, and the security staff got unfairly disciplined for uncontrollable outcomes when appropriately using force. Security staff did not see management support when engaging an aggressive and agitated juvenile, so it caused a chilling effect on the security staff to address misconduct. Further, staff felt it had a limited use of force continuum in that they were not trained in defensive tactics, nor supplied with mace or handcuffs.

Security staff also became disengaged due to just an overall feeling of "why bother" due to the BARJ process and fatigue of operating in the high stress environment without remedy. Many described the security staff as losing hope, which was reflected in their level of engagement and turnover. Several witnesses noted the lack of JSs engagement was particularly noticeable when reviewing the recorded video of an incident.

The dorm security staff raised these issues to its security executive management. The response was the same – BARJ was not going anywhere, so support it or find another job. The increase in juvenile misconduct was viewed by upper security management as a failure of security and the treatment staff in the execution of the BARJ strategy, while still believing the BARJ strategy was sound. In fairness to the security executive management, BARJ was intended to drive a cultural change in how security staff carried out their duties, and some pushback to change was to be expected. In short, security staff in the dorms blamed the escalating juvenile misconduct on management policies, while management blamed it on front-line staff's failure to implement BARJ and resistance to change. However, both agreed the juveniles' misconduct was escalating without a solution other than doing more of the same.

A description of the same incident by an executive security manager and a dorm security staff illustrated this situation. An executive witnessed multiple juveniles exiting a bus at their dorm and then running to a nearby dorm, which was prohibited, yet the responsible JS stood by and did nothing. The executive and another staff member moved these juveniles back to their appropriate dorm. From the front-line security staff perspective, the JS had been dealing with these non-compliant juveniles all day without any tool to gain compliance, so the JS just did not even care. It is understandable the executive's dissatisfaction, and the JS's inaction was inappropriate. However, the root cause was much deeper than just an individual performance issue of not taking initiative; it was a symptom of systemic lack of engagement based on front-line security staff's unhealthy operating environment.

5. <u>Heightened Safety Threat Level for Physical Altercations</u>

All the aforementioned factors combine to create a heightened safety threat level—escalating juvenile misconduct; chronic verbal abuse of staff; and security staff disengagement from juveniles. The juveniles heightened aggressiveness appeared to create a tension where juveniles became unpredictable and small issues could quickly escalate into a confrontation or physical altercation. The following anecdotes provided by staff illustrated conditions on the ground:

- A teacher was assaulted and robbed in class by two male juveniles. While being held against the wall, the teacher's wallet with $100 was taken, while the rest of the class sat and watched the entire event transpire. The two juveniles returned to their seats and remained in the classroom.

- Several interviewees reported juveniles invading staff personal space and threatened to sexually assault them, to include going to their personal residence when released.

- A male therapeutic staff member working in the dorms stayed in the office when his female co-workers provided therapeutic counseling to juveniles, because he realized his co-workers feared for their security and juveniles were much more unpredictable in the current environment.

- Staff recognized gang leaders have the power to demand low level gang members assault staff without warning.

- It takes 30 security staff daily at the school to create a safe environment for 100 juveniles, where it took much less five years ago. The optimal staffing for a dorm of 30 juveniles was nine security personnel, where it took much less five years ago.

- A JS stated the severity of the incidents at DJJ had trickled into family life with a daughter asking the JS to quit for fear of not coming home due to injury or death.

6. Inefficiency in the Event Reporting Process

Not one interviewee reported any management directive or practice to suppress, destroy, or not report a reportable event under policy. However, many staff interviewed noted increased emphasis on the accuracy and scrutiny of ERs during April and October of each year, which were known as "PbS" months. This increased emphasis could be perceived as influencing staff, but the security managers all, to a person, said it had no impact on their duty to report events and deal with misconduct and aggressive, non-compliant juveniles. Data from these two months played an important role in bi-annual PbS performance reports for each of the seven facilities.

Security management staff did comment on directions from upper management on keeping the "lock-up" events and time in lock-up down during PbS months. However, an analysis of the use of the lock-up during the PbS months for the most recent two-year period at the Birchwood facility identified only one month (4/2014) in which its lock-up average hours/incident was the lowest in comparison to the month before and after the PbS months. The same analysis conducted for the most recent one-year period for the John G. Richards facility determined its PbS month lock-up average hours/incident was never the lowest when compared to the month before and after the PbS month. Further, all three facilities were "red" in three isolation critical outcome measures in October 2015 and "red" in one isolation COM in April 2015, which indicated isolations were being sufficiently reported to trigger "red" critical outcome measures.

Security managers reported a pattern of friction with executive security managers after the implementation of BARJ on the use of "lock-up." Managers reported time periods where permission had to be obtained from the Facility Manager, who was responsible for security at the BRRC, to lock-up a juvenile. A security manager also reported executive management implemented a "bump system," where only five juveniles could be in lock-up at any given time to artificially cap lock-ups. Most all security managers noted executive managers closely monitored lock-up and pressed lower level managers to release juveniles at a quicker rate than lower level

managers thought appropriate to address misconduct. Security managers reported they were told by executive management that pressure from external advocacy groups and juvenile attorneys were influencing these executives' decisions to keep lock-ups down; interview with executives could not confirm this. Security managers were uncertain as to these executives exact rationale, but several acknowledged it could have been just a different professional judgment on the appropriateness of lock-up as a reason for their differences. Security managers argued they did not use lock-up as a punitive tool, but rather as a tool of last resort to address an aggressive, non-compliant juvenile which also had a deterrent value for future misconduct as it had worked in the past.

Underreporting of juvenile bad behavior or incidents as required by policy in an ER was generally acknowledged by interviewees. The underreporting did not have a nefarious motive. Underreporting was generally attributed to the security staff's pattern of disengagement and disenchantment with the BARJ disciplinary process. As noted by the PbS Unit, security staff were contemporaneously documenting events in facility shift reports but not following through with individual ERs.

Interviewees described the event reporting process as inefficient, cumbersome, "too many people touch the paper," and had many opportunities for human error in routing ERs. The PbS Unit was to receive most all incident reports, yet its quality control review of facility shift reports revealed incidents not reported via an ER that should have been reported. Follow-up with dorm units obtained the missing ERs, which were conservatively estimated as 20% of the total ERs received by the PbS Unit. BARJ coordinators located in the dorms reported a similar problem of having to "chase down" paperwork on a regular basis. BARJ coordinators reported they knew an event occurred, but were not routed a copy of the ER. The DJJ-IG reported a similar pattern of a staff member checking on the status of DJJ-IG investigating an ER, yet the ER was not in their system despite the complaining staff having a copy of the original ER.

Anecdotally, security staff suggested ER offenses were inappropriately lowered during the BARJ conference. Specific instances were identified, but the counter argument to downgrading the offense was the ER's facts did not support the offense or further investigation during the BARJ conference process warranted the downgraded charge. Additionally, often time the victim security staff did not participate leaving the BARJ coordinator hearing unchallenged, downgrading arguments from the juvenile. The BARJ coordinator had the authority to downgrade an offense and it was not discernible to distinguish a difference of opinion on facts from a pattern of bias minimizing juveniles' offenses.

A similar issue was a feeling by some security staff of not pressing criminal charges on a juvenile, which appeared by policy to be each individual staff's discretionary decision. There was also an impression there was a high prosecutive threshold on juveniles already incarcerated for a crime, so even pursuing charges would not necessarily result in an actual prosecution.

All interviewees provided statements under oath with the admonishment of administrative sanctions, up to dismissal, for lack of candor during the interview.

D. <u>Proposed DJJ Improvement Plan</u>

The April 2015 PbS report, disseminated in June 2015, initially provided performance data of the declining safety at the three BRRC facilities. Based on these declining ratings and corresponding decrease in safety outcomes, the BRRC security manager was removed in August 2015. A career professional from the state's Department of Corrections was selected as the Facility Administer replacement. In early Fall 2015, after the 9/17/2015 major incident at the school, the DJJ developed a formal correction action plan (*see Appendix I*).

After the 2/26/2016 major incident, the DJJ executive responsible for overall security was separated, in part, based on the lack of timely implementation of the Fall 2015 correction action plan. This Fall 2015 plan was updated again on 3/9/2016 along with an increased sense of urgency required given the safety threat level (*see Appendix E*). This new DJJ improvement plan's overview stated, "with these recent security compromises, it has become clear that significant changes need to be made to the way DJJ administers juvenile discipline, staffing and staff training, the physical security of its facilities, and its treatment, support, and cooperation efforts." Key elements of the improvement plan included:

- The DJJ will be introducing a new system of juvenile discipline for secure facilities. The goal is to ensure juveniles understand if they intend to threaten or harm staff or fellow juveniles, there will be swift and certain consequences for their actions;
- Develop a tiered system of secure housing and treatment based on the needs of juveniles. These additional tiered levels of secure housing will create a continuum to respond to the conduct and treatment needs of youth;
- Establish a Rapid Response Team to effectively address emergency situations;
- Enhance physical security through installing break-resistant glass and tamper-resistant fixtures in dorms; add fencing; improve cell security in the Crisis Management Unit; and security for control rooms;
- Address current high personnel turnover with improvement in recruitment, hiring process, compensation, and training;
- Hire a new Police Chief and Gang Intervention Specialist; and
- Improve treatment coordination of seriously mentally ill and intellectually disabled juveniles through involvement of sister State agencies, as well as train all clinical staff in Aggression Replacement Training.

Interestingly, all eight interviews in early April 2016 near the conclusion of the SIG's fieldwork noted a noticeable decline in the safety threat level at BRRC during the prior month. The staff reported after the 2/26/2016 incident, the criminal charging and removal of the juvenile ringleaders to an adult detention center demonstrated consequences for actions influencing the BRRC juveniles' behaviors. A juvenile ringleader commented to staff, 'I'm not playing around; they're sending people to prison.' Additionally, security staff had been empowered to keep juveniles locked-up for longer periods, with corresponding treatment, until a change in behavior and attitude was more consistent, which, according to interviews, had improved behaviors as juveniles were released back to the dorm.

IV. Integrity Allegations Involving the Event Reporting Process

A. Event Reporting Policy

The DJJ ER policy (I-3.2), dated 7/1/2014, contained nine pages of procedures and a three page attachment itemizing 66 types of reportable events (*see Appendix F*). A reportable event was a serious incident or accident related to DJJ staff, juveniles, or DJJ facilities using the policy's 66 types of reportable events as a guide. These 66 reportable events were categorized as either "priority 1," "priority 2," or no priority attached but a reportable PbS event. All events were reported on a standard form (I-3.2A) requiring a supervisor's review and signature.

All priority 1 ERs required an immediate call and fax the ER to the DJJ Police Dispatch Unit (DJJ-PDU). The DJJ-PDU entered the ER's information into an index data base, known as the Event Reporting Management Information System (ERMIS), and assigned a unique ERMIS number. This ERMIS number was to be provided to the originator and placed on the original ER as verification the event was reported and as a future unique reference number. All priority 2 ERs required a fax to the DJJ-PDU within 24 hours or the next business day if on a holiday or weekend.

In each of the seven facilities participating in PbS, most all ERs (priority 1; priority 2; no priority but reportable PbS event) were copied to each facility's PbS site manager for processing. The original ER was maintained at the originating facility for three years.

To provide an understanding of the frequency of ERs and major categories, the below table sets forth event reporting data for a six month period (7/1/2015 – 12/31/2015) for the three facilities at BRRC containing approximately 109 juveniles:

ER Major Categories	Total Six Months	Average/Month
Reportable Incidents	718	119
Assault on Youth	48	8
Physical Restraint Used	40	7
Mechanical Restraint Used	144	24
Injury to Staff	5	1
Assault on Staff	46	8

B. Event Reporting Practices

The DJJ had management practices to process ERs not specifically identified by policy. Based on interview, ERs generated in a dorm required the shift supervisor's review and signature. Priority 1 ERs were faxed as soon as prepared after an event to the DJJ-PDU by the shift supervisor, the fax receipt stapled to the original, and placed in the "daily folder." Priority 2 ERs were also faxed by the shift supervisor during the same shift, receipt stapled to the original, and placed in the "daily folder." It was noted the policy for the DJJ-IG providing the ER originator with the unique ERMIS case number rarely occurred. Additionally, most all priority 1 and 2 ERs required an accompanying BARJ "CCS Compliance - Community Conference" form (G-9.20AC) inasmuch as these ERs pertained to juvenile misbehavior (*see Appendix G*).

Each business day the dorm captain, or his/her designee, reviewed the daily folder, and then disseminated the ER and companion BARJ community form to a routine distribution list including the PbS coordinator, classification unit, dorm BARJ coordinator, dorm therapeutic manager and juvenile's social worker, and the facility manager. It appeared emailing scanned ERs was the preferred dissemination mechanism, but inasmuch as it was not required, faxing and internal mail routing were also used to disseminate.

The BARJ coordinator in each dorm then conducted necessary follow-up fact finding from the juvenile, victim, and witnesses, followed by a face-to-face BARJ conference. After the BARJ conference, the BARJ coordinator completed the BARJ case documentation, which was forwarded to the central BARJ Office, case descriptive data entered into an index database, and assigned a unique case number.

The security staff also used a BARJ "Unit Conference" form (G-9.20AU) for minor offenses by juveniles, such as horseplay and refusing to obey instructions (*see Appendix H*). A staff member had the discretion to

immediately sanction the juvenile, such as clean-up duty or early bedtime, or sometimes have a BARJ conference with the paperwork staying in the dorm.

If a Birchwood School staff member initiated an ER, it was reviewed and signed by a supervisor and turned in to the school's "traffic room" staffed by security personnel. Priority 1 and 2 ERs would be faxed to the DJJ-PDU. The original ER was provided to the dorm security staff responsible for the juvenile for appropriate distribution as denoted above.

C. Event Reporting Audit Testing

As part of the SIG's review of integrity allegations with DJJ's event report process, the SIG conducted audit testing of ERs being effectively routed to intended recipients. The effectiveness of this process was critical because the raw ER input data was required for many important DJJ operations, to include ensuring juvenile and staff safety; oversight of staff's use of force; therapeutic staff interventions; juvenile disciplinary matters; legal liability; and a critical component of the facility performance management system.

The SIG selected two sample months: 100% of January 2015; and 50% of November 2015. The SIG interviews suggested the PbS Unit record system as likely having the most complete set of ERs due to its quality control process comparing facility shift reports with ERs submitted and following up on potential missing ERs. During the two sample months, the PbS Office had 204 hardcopy ERs from the three BRRC facilities. Of these 204 ERs, 127 were deemed priority 1 or priority 2 offenses based on the event description, while the residual 77 were comprised of PbS reportable ERs other than priority 1 and 2 or even lesser events most often described as BARJ unit meetings. This sample of 127 ERs was compared to the DJJ-IG and the BARJ Office records to determine if the ERs were received by these two important ER recipients to be properly actioned.

The DJJ-IG records contained 69 of these 127 ERs for a 54% effectiveness rate of receiving priority 1 and 2 ERs based on the event's description. A review of the 127 ERs noted 92 had their priority 1 or 2 data field properly completed, while 35 ERs failed to do so. As a result, a more conservative measure of the "routing error" was comparing the 92 ERs properly marked to ERs received by the DJJ-IG. This resulted in identifying 57 ERs of the 92 ER sample for a 62% effectiveness rate. It was noted of the 35 ERs not properly marked priority 1 or 2, 12 (34%) were received by the DJJ-IG.

The BARJ dorm coordinator should have received all level 1 and 2 ERs involving juvenile conduct which were accompanied by a companion BARJ Community Conference form. Of the 127 ERs in the sample, seven were not considered juvenile misbehavior offenses, such as accidents or suicide attempts, which reduced the PbS sample to 120. The BARJ Office was able to identify receiving 85 ERs of the 120 ERs for a 71% effectiveness rate. The BARJ Office identified these 85 ERs through examining its case index system for completed BARJ conferences coupled with ERs actioned at the dorm level without completing a BARJ conference. ERs received and actioned but not resulting in a BARJ conference included ERs dismissed at the BARJ coordinator level due to lack of evidence or "frozen" where the juvenile refused to participate in the BARJ conference. In addition to the symptoms of the event report process's inefficiencies identified during staff interviews, the BARJ Office also identified two former employees with performance issues potentially impacting accurate BARJ conference documentation and data entry into BARJ's index database.

Of the ERs in the sample that should have been routed to both the DJJ-IG and the BARJ, only 51 (40 %) were in both record systems. An analysis of the major categories of missing ERs from the DJJ-IG (35) and BARJ (35) record systems were:

Categories of Missing Event Reports	DJJ-IG Frequency	BARJ Frequency
Juvenile Assault on Juvenile	5	7
Juvenile Assault on Staff	3	2
Contraband	6	8
Inciting Disturbance/Damage to Property	12	8
Sexually Inappropriate Behavior/Sexual Misconduct	7	7
Miscellaneous	2	3
Total Missing Event Reports	**35**	**35**

D. Individual Allegation Investigations

Individual allegations of missing incident reports were provided by five DJJ staff members (teachers and JS personnel). A total of 39 incident reports were provided for review to determine if these reports were captured in the ERMIS and BARJ databases, because these DJJ staff had not received feedback from either DJJ-IG or BARJ staff on the incidents reported. Two event reports not considered juvenile misconduct offenses reduced the sample to 37. Of the 37 ERs, 28 (76 %) were found in ERMIS and 11 (30 %) in the BARJ database. It was noted none of the nine missing ERs in ERMIS involved a security use of force or juvenile assault on staff.

In addition to the 39 ERs, teachers provided 11 BARJ "unit forms" for various minor offenses which were, by policy, handled by the dorm staff and not forwarded to the DJJ-IG or the BARJ Office. This misunderstanding of the "unit form" process may have contributed to these individual teachers' questioning the BARJ process. The Birchwood School leadership reported teachers systemically complained about not being included in BARJ conferences. As a result, the BARJ Office met with school representatives, which was followed by a noticeable increase in BARJ coordinators involving teachers in the process.

The staff interviews depicted a level of misrouting of ERs which was corroborated by the audit testing. Although 31 staff, all under oath, did not witness nor were aware of any intentional destruction or misrouting of ERs, the looseness in the event reporting process provided ample opportunity for such individual misconduct easily commingled among the errors the system literally manufactured due to its dependence on manual routing of ERs.

V. Way Forward

The DJJ should be applauded for demonstrating organizational initiative in seeking a higher level of juvenile justice effectiveness by implementing the BARJ model at the secure BRRC facilities. It did not work. The DJJ has shifted its strategy and developed a reasonable plan to solidify an orderly, safe, and secure environment at the BRRC, which has been aggressively pursued yielding early indicators of positive change. However, a reasonable strategy does not equate to success; it must be executed with robust leadership, monitoring, and adjustments until the objectives are realized. The DJJ needs to establish one manager with the full authority to control all assets and personnel at the BRRC, and be held accountable for achievements of the objectives to solidify order, safety, and security. The fragmentation of personnel among security, education, and therapeutic/clinical treatment inhibits a unity of command to ensure these critical safety related objectives are achieved.

Interviews sometimes pitted a therapeutic model against a correctional facility model in how the BRRC should move forward. However, both security staff and therapeutic staff were consistent in their analysis a juvenile

can't benefit from treatment without first establishing order, safety, and security. Both security and therapy can co-exist and be accomplished with basic management principles without using isolation as punitive tool. There needs to be recognition by all stakeholders that not all juveniles can be treated the same. Further, negative reinforcement should not be confused with punishment and summarily dismissed; people are quite happy and will work hard to avoid a situation/consequence with increased positive behaviors.

This is best illustrated by the seemingly endless debate on the use of isolation or lock-up in juvenile corrections. Isolation for punishment should be abhorred. However, isolation seems quite appropriate as a short-term tool to facilitate a non-compliant, aggressive and abusive juvenile to become "calm, cooperative, and safe." Longer-term isolation should also be non-existent. However, separating recalcitrant juveniles with chronic aggressive/misconduct behaviors for treatment for whatever period of time needed certainly has a role. It not only therapeutically assists the juvenile, but it also has the benefits of protecting the general juvenile population's safety and standards of behaviors, as well as creates a negative reinforcer and deterrent for all juveniles.

There is no doubt DJJ is moving aggressively to solidify an orderly, safe, and secure environment at the BRRC. Additionally, DJJ should also automate the event reporting process workflow to increase efficiency and assurance the critical raw operational data, often juvenile conduct, is accurately captured, routed, and appropriately actioned at the DJJ.

VI. Findings and Recommendations

Finding 1: The BRRC staff worked under a high safety threat level in 2015 through early 2016.

Recommendation 1a: The DJJ should formally report on a periodic basis, such as quarterly, tracking progress on established objectives of DJJ's recent improvement plan, dated 3/9/2016, and should also consider supplemental surveys to employees and juveniles during the implementation phase given the number of stakeholders and the potential impact on a fragile juvenile population.

Recommendation 1b: The DJJ should consider requiring the therapeutic staff assigned to dorms modify their current 9:00 am - 5:00 pm hours to include early evening hours to increase availability to counsel juveniles outside of school hours ending at 3:00 pm daily.

Recommendation 1c: The DJJ should establish minimum dorm shift staffing levels based on a rigorous risk assessment at the BRRC and not on national standards or historical practices, which would then allow executive management to track and be accountable for this important safety factor.

Recommendation 1d: The DJJ should consider formally establishing a policy requiring order, safety, and security as required precursors to providing effective rehabilitation and therapeutic programs.

Recommendation 1e: The DJJ should consider, at least during the implementation phase of the proposed performance improvement plan at BRRC, establishing a single manager responsible for all personnel and assets at the BRRC to focus accountability for results. This provides a single authority to coordinate the existing BRRC leadership fragmented between

security (rehabilitative services), clinical, and education, which is currently only fused at the Agency Head level.

Recommendation 1f: The DJJ should consider developing a policy in determining when pursuing criminal charges against a juvenile's conduct is warranted in order to have consistent consequences for similar behavior, and discontinue deferring to each staff member's personal preference when to pursue criminal charges.

Finding 2: The event reporting process was inefficient and ineffective.

Recommendation 2a: The DJJ should consider automating the event reporting process, which creates one official record with a unique identifier; full text retrieval capabilities; accessible to the many consumers; and audited on a periodic basis for completeness.

Recommendation 2b: The DJJ should examine the existing separate data bases for classification, discipline, and investigations for potential integration into the proposed automated system containing ERs, which could yield long-term efficiencies if linked with appropriate access/security controls.

Finding 3: The PbS bi-annual reports were an effective performance management tool, but appeared under-utilized as a management tool to stimulate positive change.

Recommendation 3a: The DJJ should consider establishing a new performance improvement plan (PIP) after each bi-annual report, rather than current practice of multi-year open ended PIPs, to fix accountability for results/timelines and add heightened urgency to particularly address order, safety, and security issues identified.

Recommendation 3b: The DJJ should consider changing its PbS methodology of pre-selecting April and October as data collection months, which creates, at a minimum, a perception of influencing personnel in completing ERs during those months.

Administrative Note: The DJJ comments on the draft report were considered and factored into the final report. DJJ did not object or comment on any findings or recommendations in the final report.

APPENDICES

A. Birchwood Facility PbS "Critical Outcome Measures" ratings, October 2015

B. John G. Richards PbS "Critical Outcome Measures" ratings, October 2015

C. Willow Lane Facility PbS "Critical Outcome Measures" ratings, October 2015

D. PbS Staff Surveys for BRRC Facilities, October 2015

E. DJJ Improvement Plan, dated 3/9/2016

F. DJJ ER Policy (I-3.2) & Form (I-3.2A)

G. BARJ Community Conference Form (G-9.20AC)

H. BARJ Unit Conference Form (G-9.20AU)

I. DJJ Fall 2015 Performance Improvement Plan