Juvenile Court of Memphis and Shelby County
Memorandum of Agreement Protection
from Harm Stipulations:
11th Findings and Recommendations Letter

This is the eleventh report to the U.S. Department of Justice (DOJ) regarding the Memorandum of Agreement ("Agreement") between the United States and the Juvenile Court of Memphis and Shelby County TN. This report describes the findings from my visit to the Shelby County Sheriffs' Department of Juvenile Detention Services (JDS) from April 3-5, 2018.

Shelby County Sheriff, Bill Oldham is responsible for the operation of the detention center. Chief Kirk Fields is the detention superintendent and heads the JDS leadership team. He has additional supervisory responsibilities for secure custody operations outside of JDS. Chief Deidra Bridgeforth and Captain Larry Weichel are responsible for the daily operations of JDS. Debra Fessenden, attorney to the Sheriff, and John M. Jones, assistant Shelby County attorney participated in most of the monitoring meetings, interviews and discussions.

My role as the Protection from Harm Consultant is to provide information and assessments of progress by the Sheriff's Office toward compliance with the Protection from Harm paragraphs of the Agreement referred to above. This report describes my visit to the Shelby County Sheriffs' Department of Juvenile Detention Services (JDS) and evaluates the Agreement's Section C: Protection from Harm: Detention Facility, including numbered Agreement Paragraphs 1-4. Specific headings within these groups of remedies include Use of Force, Suicide Prevention, Training, and Performance Metrics for Protection from Harm. Some Agreement provisions have already been terminated by the Department of Justice, with the detention center having been found in substantial compliance in these areas for 12 months as required by the Agreement. I simply note the terminated provisions in my compliance ratings, but have not otherwise made any compliance assessment of those provisions.

I. Assessment Protocols

The assessments used the following format:

A. Pre-Visit Document Review

Facility documents provided by Shelby County and reviewed prior to the site visit were the following:

- Use of Force Policy
- Suicide Prevention Policy
- Suicide Crisis Policy
- Correct Care Services (CCS) Shelby County JDC Policies and Procedures
- Incident Reporting Policy
- PREA Policy
- Inmate Sexual Assault Policy
- QMHP Verification
- Suicide Prevention Manual

- Detection and Prevention in Juvenile Detention PowerPoint
- Report Card Data

Additional documents reviewed before the on-site visit include: previous "Findings and Recommendations" letters provided by Dr. David Roush and Dr. Bernard Gloss, the "Compliance Report" prepared by Judge Summers, the Agreement Coordinator, and the "Synopsis of Substantive Remedial Measures" taken from former Settlement Agreement Coordinator Bill Powell's April 2013 Compliance Report.

On-site document review included the following:

- Completed Suicide Risk Assessments
- Documentation of communication between mental health and security staff on suicide/mental health issues
- Physical Plant Inspection Documents
- Log of responses to Suicidality
- Resident clinical files of youth placed on suicide precautions
- Videos of UOF incidents that occurred on 12/1/2017 and 3/5/2018
- Report on Suicide Prevention Practices within the Detention Services Bureau of the Juvenile Court for Memphis and Shelby County, Memphis, Tennessee, Lindsay M. Hayes (9/29/2012)

In response to the Agreement, Paragraph 4 under Protection from Harm, I received for review Excel spreadsheets and narrative analyses on a range of outcomes including DAT overrides, safety and order statistics, suicide prevention, suicide screening, use of force reviews, and suicide prevention screening times.

Post-Visit document review included:

- Videos of UOF incidents that occurred on 10/3, 12, 18 and 26, 2017, 12/1/2017 and 3/5/2018
- Supervisory Reviews of UOF Incidents on 10/3, 12, 18 and 26, 2017, 12/1/2017 and on 3/5/2018
- Completed Disciplinary Action Form from Incident on 3/6/2018
- Detention Overview Book
- Multiple Suicide Precaution Order Forms from December 2017 and January and February 2018
- Detention Training Rosters from 2017 to 2018

B. Introductory Meeting

The visit began with a meeting on April 3, 2018 that included Chief Fields, Chief Bridgeforth, Captains Weichel, Henderson and Ward, Sargent Hunt, Mr. Moore, Chief Jailer, Dr. Townsel, Ms. Geeter and Attorney Bernard with CCS, Hope Academy Principal Mr. Lockhart, assistant County Attorney Jones, Sheriff's Attorney Fessenden, and DOJ Attorney Goemann. The

purpose of this interview was to introduce the new Protection from Harm consultant and to discuss an overview of the assessment process, a review and discussion of assessment instruments, and the scheduling of the remaining assessment activities.

C. Facility Tour

Walkthroughs of the facility occurred on April 3, 2018 and at various other times during the site visit. These walkthroughs provided opportunities to observe residents, their sleeping rooms, the cleanliness and order of the facility, and the general state of the physical plant. The tour produced the following observations:

- Services are provided in an aging building, not intended for its current use, which limits options for the provision of programming and activities that contribute to Protection from Harm.
- The facility has a significant institutional feel, and there are limited options for humanizing the environment. Due to the existence of hard surfaces throughout the building, i.e. concrete block walls, vinyl tile flooring, etc., noise reverberates off these surfaces, which makes the building exceedingly noisy, particularly in areas where youth engage in physical activities. Excessive noise can be stressful and problematic in a confinement setting that is already inherently stressful by nature.
- Adding to stress related to the noise, there were a number of water leaks in the ceiling of the facility and around ceiling vents in the shower areas. There was mold found in the showers, and a number of the showers reportedly did not work. These leaks and the mold create safety and health concerns for both residents and staff.
- The four classrooms available for education programming, one of which was just recently added, provide space for a maximum of 60 youth, allowing for a half-day of education programming for all youth at the facility. The primary emphasis of education programming is language arts and math, both of which are foundational and critically important to academic success. Computer-based credit recovery is also available for residents.
- The medical exam area is in a large room and is cordoned off by a curtain. However, detention staff reports that traffic through the area is halted when medical exams are taking place.
- There is limited indoor and outdoor space available for recreation.
- While there is a working kitchen at the facility, food service provided by Aramark comes from the jail in temperature-regulating containers. Food is then transferred from the temperature-regulating containers into Styrofoam containers by JDS food service staff for consumption by youth in various areas of the building, including the dining room.

D. Staff Interviews

I conducted two focus group interviews with staff. One was with 1st or day shift staff. The second group was with 2nd shift or evening staff. In total, 11 male and seven (7) female staff were

interviewed. Four of these members of staff (3 male and 1 female) were trainees completing Level 4 of their on-site training. The remaining 14 staff interviewed had a self-reported average of 8.5 years experience working in custody. It was not clear whether all of this experience was working with youth in custody.

Staff members were asked to explain how the Positive Behavior Management System (PBMS) works at the facility. Staff stated that it is a program that encourages and rewards good behavior displayed by the residents using a point system. They described rewards consisting of snacks, expanded phone privileges, movie time, and extended visits. They spoke positively about the value of the program but had difficulty explaining exactly how the point system works. Each of the two groups seemed to have one or two members that talked about the PBMS, while the remaining staff nodded in agreement or made no acknowledgment of what was being said. The four trainees seemed more aware of the PBMS and how it is supposed to work, likely because they are currently being trained in the System.

When asked about the types of programming available for youth, staff talked about school, recreation, religious activities, community speakers, including guest artists and musicians, and life skills classes facilitated by the Qualified Mental Health Professional (QMHP) staff on Saturdays. They also talked about "Circle Up" groups. When asked what happens in a Circle Up, staff said there is no set way in which these groups are run, and that each staff has his or her own style of running a Circle Up. Again, there were a number of nods of agreement among staff that remained silent on the topic. In my review of the PBMS brochure and the Detainee Handbook, I found nothing that talked about or described the Circle Up process, which has been a part of programming at the JDC since at least June of 2016. Both staff and youth could benefit from having a description or explanation of this process provided in the facility's print materials.

When asked about the training they received, staff talked about having been trained on the PBMS; on policies and procedures; working the control booth; in-service training on Crisis Prevention and Intervention (CPI) and Safe Crisis Management; and annual de-escalation refresher training. When asked if there was any additional training they felt they needed, two different staff talked about needing training on facilitating the Circle Up process. I would suggest including training on this process in training on the PBMS.

In response to being asked about how safe they feel on the job, the number one concern voiced by staff was the need for more working radios and walkie-talkies. Regarding this issue, staff said they are at times working alone with residents and are without a working radio. They said this would make it difficult for them to get help, if it was needed. Staff also talked about concerns over keys that don't work and staffing issues related to what the staff referred to as "repeated call-ins." I believe staff was referring to last minute sick, personal or annual leave call-ins.

All staff responded positively when asked about what their relationships are like with the youth at the facility.

When asked about the average length of time youth were placed in their rooms for suicide precautions, consequences for inappropriate behavior, time outs, etc., the responses varied with

the question again being answered by one or two specific staff in each group interview. In general, staff reported youth spending 5-10 minutes in their room for “cooling off”, as much as two days for suicide precautions and up to 120 hours (5 days) for a major rule violation such as fighting. They reported that there are many sign-offs required anytime a youth is placed in his/her room (Sergeants for time outs; QMHP staff for suicide precautions; Captains for major rule violations such as fighting). Staff reported that youth confined to their rooms interact daily with medical and mental health staff.

It was of some concern that in each of these groups primarily only one or two staff members volunteered information in response to the questions being asked. The members of staff that were silent nodded in agreement, did not respond in any way, or when asked directly for their response to the question, supported the responses previously given. The only exception to this was the new staff completing their on-site training. These trainees were more forthcoming in responding to my questions than were the more seasoned members of staff.

E. Resident Interviews

I conducted one focus group interview, using questions from the Performance-based Standards (PbS) Youth Climate Survey. I spoke with eight male youth (7 African American and 1 Caucasian) ages 14-17. The self-reported Average Length of Stay (ALOS) was 92 days. The group interview occurred in the dining room with Attorneys Fessenden and Jones present. Staff selected the youth for the group interview.

All residents interviewed were asked the questions below:

- Do you understand the level, phase, or points or reward system here?
- Have you ever feared for your safety?
- Have you had personal property stolen directly by force or by threat?
- Have you been beaten up or threatened with being beaten up?
- Have you been involved in any fights?
- Are staff members fair about discipline issues?
- If you have been restrained, do you think staff tried to hurt you?
- Within the last six months here, have you been injured?
- If yes, was the injury the result of a physical restraint?
- Have you ever made a complaint against a staff member as a result of a physical restraint?
- Is there at least one person here you feel you can talk with?
- On a scale of 1-10, with 10 being the most safe, how safe do you feel in this facility?

This was a challenging interview. The youth had difficulty staying focused on the questions I was asking, and they appeared to be voicing all of their complaints and concerns for the benefit of the attorneys in the room.

The majority of the youth said they understood the facility rules, primarily because they are posted on the wall in the day rooms. However, they all noted that the signs with the rules had

been taken down the day before. (This action may have been a response from staff to my suggestion that the rules, which were primarily stated in negative terms, be reworded as positive behavioral expectations to support the PBMS.)

The youth reported they knew nothing about a point system that was being used to reward positive behavior. This was in contradiction to information reported by staff during staff interviews.

The youth generally and vigorously indicated they feared for their safety, had had their property stolen or taken by staff, and that staff are not fair about discipline issues. In general, the youth's responses were negative about staff. When asked to rate their feeling of safety on a scale of 1-10 (with 10 being "most safe"), the average rating for how safe the residents feel was 2.75

The youth reported that some staff talked about issuing a "weekend special," used when the youth did not meet the staffs' behavioral expectations. When I asked what a "weekend special" was, the youth told me this meant they would spend the weekend locked in their rooms. Youth talked about this in both the group interview and in some of the individual interviews. While none of the youth would provide the names of staff they claimed had issued a weekend special, two of the youth indicated they had personally been subjected to this practice.

Some of the youth became upset when they reportedly saw the kitchen staff drop a cookie on the floor, pick it up and then put it into one of the meal containers. They were also upset that the staff was not wearing a hairnet. Following this incident, when I was unable to get the group to settle down, I decided to end the group interview.

Due to the challenges in conducting the youth focus group, I requested one-on-one interviews with youth the following day. I interviewed six youth (5 males and 1 female), a number of who had participated in the previous days' focus group interview. The average age of the male residents was 16. The female resident was 15. No other staff or attorneys were present during the one-on-one interviews. These interviews were calm and orderly, particularly in comparison to the focus group interview, and a number of the responses to the questions asked the day before were quite different. The compiled results of these interviews are as follows:

- All youth said they understood the rules and that this was because they were posted on the wall or they could ask staff. The majority of the youth reported they had not received/did not have a handbook with the rules in it.
- All of the youth denied having any knowledge of the existence of a point system or a reward system.
- Three of the youth reported feeling safe in the facility. Two youth talked about fearing for their safety from staff, and one of the youth talked about being bullied by residents and staff not intervening on their behalf.
- None of the youth reported having personal property stolen, other than two youth indicating that staff would at times take their personal property.
- None of the youth reported being beaten up or threatened with being beaten up.
- Two youth reported having been involved in a fight. One of these youth said he was

confined to his room for two days following the fight.

- Four of the six youth reported that staff makes more positive comments to them than negative comments.
- Only two of the youth interviewed felt that staff was fair about discipline. Most of the youth talked about staff having "favorites."
- Most of the youth reported they had not been restrained and those that had been generally did not feel that staff had tried to hurt them.
- Four of the youth reported having been injured in the last six months; one of the youth reported medical staff did not see him following the injury. He said this was because he was on three days of room confinement.
- One youth reported having been injured as the result of a physical restraint.
- No one reported making a complaint against staff as a result of a physical restraint. One youth said that grievances were "a joke."
- All youth reported there was at least one person at the facility they can talk with; most of the youth reported there was many staff they felt they could talk with.
- The average rating for how safe the youth feel in the facility was 5, with individual scores ranging from 0 to 10.

When the youth were asked if there was anything else they wanted me to know, the primary concerns they voiced were related to showers not working and not having daily access to taking a shower, and the quality and quantity of the food.

Two of the boys that had participated in the earlier group interview again talked about the weekend special during the one-on-one interviews. These youth continued to choose not to provide the names of the specific staff that engaged in this practice. Following the interviews with the youth, I reported this information to Chief Bridgeforth who indicated she was not aware of any such practice. However, she assured me that she would look into the matter immediately.

The discrepancies in both tone and demeanor of the youth between the group and one-on-one interviews were significant. The youth were much more calm and straightforward, with no dramatics or acting out during the one-on-one interviews. It is clear that one-on-one interviews provide a more accurate picture of youth perspectives on staff/youth relationships and facility and program operations.

II. Protection from Harm: Detention Facility

A. Preliminary Observations and Comments

These observations and comments are based on my review of reports from previous monitoring visits, document and statistical reviews, and my own observations and interviews.

1. Successes

a. Based on a review of Use of Force (UOF) policies and procedures, facility data and discussions with JDS management staff, Use of Force has continued to decrease, with only seven (7) instances of UOF over the last six months and one (1) instance in

the last three months. This is a 42% reduction in UOF incidents from the previous six months.

b. With regard to Report Card data, suicide screening data indicate that since the last monitoring period, the average time between the admission of a youth and his/her suicide screening (in hours) is down from .051 to .04. Thus, staff performs an initial screening of new admissions almost immediately upon their arrival, a timeframe confirmed in staff interviews.

c. There appears to be regular communication between Correct Care Solutions (CCS), which is the facility's contract medical services provider, and management level security staff.

d. Staff and youth report that daily Circle-Up groups are occurring on both day and evening shifts. These groups give youth information about the program schedule during a given shift and allow youth who are emotionally upset an opportunity to vent. This process provides a model of respect and caring between youth and adults, and provides youth with someone to listen to them.

e. Based on a review of the facility's training records, there is evidence that two-hour in-service training sessions on Suicide Prevention are scheduled at multiple times throughout the year.

f. The JDS leadership team and direct care staff speak highly of the Hope Academy. The school's capacity is at 60, and the principal, Mr. Lockhart, articulated plans for expanding the educational offerings and opportunities available to residents at the JDC.

g. Reading materials are available to the residents, and residents may take books to their rooms.

h. Multi-disciplinary Team Meetings, at which JDS and CCS staff discuss performance audits and issues related to UOF, resident behavior, room confinements, suicide precautions, and more, recently began taking place monthly.

   (i) As the result of a recommendation made in the last monitoring report and discussions during the Multi-disciplinary Team Meetings, the Suicide Precaution Order Form was amended and the category of "No Risk" was removed from the Form. There are now three Suicide Risk Levels that appear on the form – High, Moderate and Minimum.

i. Staff reports having positive relationships with youth, and all youth interviewed report having one, and in most cases more than one, staff with whom they feel they can talk.

2. Challenges

a. While the average time between the admission of a youth and his/her suicide screening (in hours) is down from .051 to .04, the average wait time for a youth to subsequently be assessed for suicide risk by a Qualified Mental Health Professional (QMHP) (in hours) almost tripled, increasing from 1.26 to 3.54.

b. Inconsistencies between the JDS and CCS Suicide Prevention policies should be

addressed. Based on my review of the CCS policies, I recommend the two groups adopt a mutually agreed upon policy for suicide prevention that addresses most, if not all of the specifics provided in the CCS policy. Doing this will help to ensure that the QMHPs employed by CCS and working at the JDC, as well as JDC staff are clear about suicide prevention protocols and the assignment of risk and observation levels. In particular, the following elements of the CCS policy should be addressed in JDC policy:

- 5.7.4 – Communication
    - Requirements related to a youth released while on suicide watch status
- 5.8.3 – Intervention
    - JDC policy does not articulate resuscitation efforts pending EMS arrival
- 5.10 (1-4) – Review
    - Provides detail needed for JDC policy 360.14
- 5.11 (1-2) – Critical Incident Debriefing
    - This is addressed in JDC policy only as a definition, not as a specific procedure or practice

c. Based on interviews of both youth and staff at the facility, the Positive Behavior Management System (PBMS) has yet to take hold. While some staff members were able to explain what the PBMS is (rewards for positive behavior), there were few staff members able to explain how the program works, e.g., the point system, how and when points are awarded, etc. Youth interviewed, both individually and during the group interview, deny the existence of a point and reward system. Significant investments need to be made in more fully developing and refining the PBMS.

d. A PBMS necessitates rules that are positive statements of behavioral expectations. Rules were posted in all of the living units, however the majority of them were stated negatively (8 out of 14). The same day this was pointed out, all of the rule signs were removed from the walls. Until the rules have been re-written as positive statements, with input from all levels of staff, I suggest the JDS leave the existing rules posted.

e. There are inconsistencies in documentation of UOF incidents between supervisors on duty at the time of the event and the officers conducting documentation and video reviews of these incidents, i.e., Use of Force Incident #136, October 3, 2017 and Use of Force Incident #284, March 5, 2018.

   For Incident #136, the Major Incident Review Cover Sheet, signed by Lt. Lee and Capt. Byers, indicates that force was <u>not</u> used in the incident. However, the Major Incident – Video Review reports completed by Capt. Weichel and Chief Bridgeforth indicate that physical restraint <u>was</u> used. Review of the available video confirms that force <u>was</u> used. In addition, all of the incident reports written by staff (five of them) indicate that mechanical restraints were <u>not</u> used. My review of the available video confirms that mechanical restraints were <u>not</u> used.

   For Incident #284, the Major Incident Review Cover Sheet signed by Lt. Lee and Capt. Henderson indicates the incident did <u>not</u> “raise concerns about policy and procedure, equipment, training or any other issue.” However, Major Incident – Video Review

reports completed by Capt. Weichel and Chief Bridgeforth indicate that staff "did not spend the appropriate time to de-escalate" the detainee. My review of the available video confirms Capt. Weichel and Chief Bridgeforth's assessment of this situation.

Use of Force Incidents #147, and #154 indicate there were no "violations of policy and protocol", yet in each case staff was counseled on "not locking the control center door" and "opening a youth's door to pass a food tray [while] youth was making threats" respectively.

The Major Incident – Video Review forms for Use of Force Incident #156, signed by Capt. Weichel and Chief Bridgeforth are in conflict as to whether there were "any violations of policy and protocol." According to Chief Bridgeforth's report, there were no violations. However, Capt. Weichel's report indicates two violations, with staff counseled on at least one of these.

Discrepancies were identified in five out of the seven UOF incidents reviewed. This situation reinforces the value and importance of the document and video reviews being conducted by staff. However, differences such as these should not only be identified. They should be addressed with the appropriate staff and corrected before finalizing documentation of the incidents.

f. Review of seven videos related to uses of force incidents indicates that staff often does not follow a basic tenet of de-escalation, including CPI, which is to limit or remove the audience. All videos reviewed confirmed the presence of staff sufficient to move the residents not involved in the escalated situation to either their rooms or to another area of the building.

g. There were complaints made by residents about the need for them to request Grievance Forms from staff. When I visited one of the units, I did find the forms available for residents to access without having to request them from staff, however they were not easy for me to find. Grievance Forms need to be located where they are visible to youth without needing to search for them. It would also be of benefit to remind youth where the forms can be found during daily Circle Up sessions.

h. A Prison Rape Elimination Act (PREA) audit has yet to be completed. This should be scheduled as soon as possible to ensure compliance with Juvenile PREA Standards.

i. The quality and quantity of food served to detained youth continues to be a concern voiced by the youth; addressing both the quality and the quantity of food warrants continued attention.

j. As mentioned in previous monitoring reports, items from the facility's Health Care Audits (Sick Call-Blended, Medical Administration Audit, 7-Day Health Assessment, and Use of Force Medical Care Audit) should be incorporated into the JDS Report Card so that trends can be monitored.

B. Memorandum of Agreement (MOA)

I have used the following definitions to establish Substantial Compliance, Partial Compliance, Beginning Compliance and Non-compliance.

- **Substantial Compliance** means that over 90% of the substantive requirements of a provision or the Agreement have been met for both quantitative and qualitative measures.
- **Partial Compliance** means that while progress has been made, some aspects or parts of the requirement are met while others are not. The interpretation of the requirement may be correct, but the implementation is not effective enough, or the requirement may not be articulated in a manner that makes clear the specific level of practice or procedure that is required or expected.
- **Beginning Compliance** means that the JDS has made initial efforts to implement the required reform and achieve the outcome envisioned by the provision, but significant work remains. Policies may need to be revised; staff may need to be trained; procedures may need continued implementation to accomplish the outcome envisioned by the Agreement.
- **Non-Compliance** means that JDS has made no notable compliance on any of the key components of the provision.

JCMSC shall provide Children in the Facility with reasonably safe conditions of confinement by fulfilling the requirements set out below.

I. Use of Force

(a) *No later than the Effective Date, the Facility shall continue to prohibit all use of a restraint chair and pressure point control tactics.*

Terminated

(b) *Within six months of the Effective Date, the Facility shall analyze the methods that staff uses to control Children who pose a danger to themselves or others. The Facility shall ensure that all methods used in these situations comply with the use of force and mental health provisions in this Agreement.*

Substantial Compliance – The Use of Force policy, monitoring via CCTV cameras and completed UOF incident reports indicate that UOF procedures used cause minimal harm to both residents and staff.

(c) *Within six months of the Effective Date, JCMSC shall ensure that the Facility's use of force policies, procedures, and practices:*

(i) *Ensure that staff use the least amount of force appropriate to the harm posed by the Child to stabilize the situation and protect the safety of the involved Child or others;*

Substantial Compliance – UOF policy 356.05(B) articulates this expectation. Review of UOF Incident Reports and video confirms appropriate practice. There have been seven (7) UOF incidents, a reduction from 10 since the last monitoring period. The rate of UOF incidents per 100 youth remains at just under .04.

(ii) *Prohibit the use of unapproved forms of physical restrain and seclusion;*

Substantial Compliance – UOF policy 356.05(C) articulates this prohibition. Review of UOF Incident Reports and videos indicates that no unapproved forms of physical restraint have been used.

There was one Major Incident – Video Review report on a UOF incident that occurred on 3/5/18 where it was determined that staff "did not spend the appropriate time to de-escalate detainee." Per the Major Incident – Video Review report, this staff was "disciplined." Documentation of the disciplinary action was provided.

Note – My review of videos of UOF incidents indicates there are times that staff could be more proactive and seek assistance from other staff more quickly before an actual physical intervention is needed.

(iii) *Require that restraint and seclusion only be used in those circumstances where the Child poses an immediate danger to self or others and when less restrictive means have been properly, but unsuccessfully, attempted;*

Substantial Compliance – UOF policy 356.05(H) articulates this requirement. Review of UOF videos, Incident Reports and completed Major Incident – Video Review forms confirms that restraints are only being used when there is a threat of danger or safety of staff and youth, and that seclusion is not being used in response to restraints. Youth reports of the use of seclusion did not always line up with staff reports, and it is difficult to know if there is a real or perceptual difference. With the exception of references made during resident interviews to what was referred to as a "weekend special," the youth did not report any information about specific incidents (staff, dates, etc.) to which I could refer.

(iv) *Require the prompt and thorough documentation and reporting of all incidents, including allegations of abuse, uses of force, staff misconduct, sexual misconduct between children, child on child violence, and other incidents at the discretion of the Administrator, or his/her designee;*

Substantial Compliance – UOF policies 356.08(A)(1-3) and 356.08(B) articulate these requirements. Review of UOF Incident Reports indicates that documentation of UOF incidents and youth on youth violence is being completed promptly following these incidents.

(v) *Limit force to situations where the Facility has attempted, and exhausted, a hierarchy of pro-active non-physical alternatives;*

Substantial Compliance – UOF policy 356.05(A) articulates this expectation. Review of UOF videos and Incident Reports indicate one incident of staffs' failure to "spend the appropriate time to de-escalate detainee." The staff was disciplined related to this issue.

(vi) *Require that any attempt at non-physical alternatives be documented in a Child's file;*

Substantial Compliance – UOF policy does not specifically articulate this requirement. However, the question "Was hierarchy of pro-active, non-physical alternatives attempted prior to force?" is being asked and in most cases is being answered. This question should always have a

response, and when the answer is "No" should include information as to why they were not used, i.e., youth were engaged in a fight, etc. I would suggest adding this requirement to the UOF policy.

(vii) *Ensure that staff are held accountable for excessive and unpermitted force;*

Substantial Compliance – UOF policy 356.06(B)(9) articulates this expectation. Review of UOF Incident Reports and Major Incident - Video Review forms confirms this is being done.

(viii) *Within nine months of the Effective Date ensure that Children who have been subjected to force or restraint are evaluated by medical staff immediately following the incident regardless of whether there is a visible injury or the Child denies any injury;*

Substantial Compliance – UOF policy 356.07 articulates this expectation. Review of available UOF Incident and Major Incident – Video Review Reports indicate that youth subjected to force and/or restraint are being evaluated by medical staff immediately following the incident.

(ix) *Require mandatory reporting of all child abuse in accordance with Tenn.* Code. Ann. § 37-1-403; and

Substantial Compliance – UOF policy 356.08(B) articulates this expectation. There were apparently no reports of child abuse being made and documented to review.

(x) *Require formal review of all uses of force and allegations of abuse, to determine whether staff acted appropriately.*

Substantial Compliance – UOF policy does not specifically articulate this requirement. However, review of Major Incident Report Packets indicates that a formal review is taking place. This requirement is not specifically articulated in the UOF, Sexual Assault or Incident Reporting policies. This should be addressed immediately, given the practice is already in place. Policy should articulate each step of the formal review process currently in use at the facility, i.e., submission of a completed Major Incident Packet that includes all reports pertaining to the incident, including witness reports, medical report with photos, Use of Force Video Review Form, Involuntary Room Confinement Authorization Form, and any other applicable forms, including the Major Incident Review Cover Sheet. This requirement should be added to the UOF Incident Report, Sexual Assault and Incident Reporting policies.

(d) *Each month, the Administrator, or his or her designee, shall review all incidents involving force to ensure that all uses of force and reports on uses of force were done in accordance with this Agreement. The Administrator shall also ensure that appropriate disciplinary action is initiated against any staff member who fails to comply with the use of force policy. The Administrator or designee shall identify any training needs and debrief staff on how to avoid*

similar incidents through de-escalation. The Administrator shall also discuss the wrongful conduct with the staff and the appropriate response that was required in the circumstance. To satisfy the terms of this provision, the Administrator, or his or her designee, shall be fully trained in use of force.

Substantial Compliance – The facility is in compliance with this requirement. However, there are inconsistencies in documentation of UOF incidents between supervising officers and the officers conducting reviews of these incidents. These differences should be identified during document and video review, addressed with staff and corrected.

2. Suicide Prevention

(a) *Within 60 days of the Effective Date, JSMSC shall develop and implement comprehensive policies and procedures regarding suicide prevention and the appropriate management of suicidal Children. The policies and procedures shall incorporate the input from the Division of Clinical Services. The policies and procedures shall address, at minimum:*

(i) *Intake screening for suicide risk and other mental health concerns in a confidential environment by a qualified individual for the following: past or current suicidal ideation and/or attempts; prior mental health treatment; recent significant loss, such as the death of a family member or a close friend; history of mental health diagnosis or suicidal behavior by family members and/or close friends; and suicidal issues or mental health diagnosis during any prior confinement.*

Substantial Compliance – Policy 360.08(A) articulates these requirements. Clarification was provided related to where the intake suicide risk and mental health screenings are taking place. There is evidence that these interviews are taking place in a private room just off the intake area.

(ii) *Procedures for initiating and terminating precautions;*

Substantial Compliance – Policy 360.08(C) articulates these requirements. Reports reviewed indicate compliance.

(iii) *Communication between direct care and mental health staff regarding Children on precautions, including a requirement that direct care staff notify mental health staff of any incident involving self-harm;*

Substantial Compliance – Policy 360.13(A) articulates this requirement. Evidence was provided of communication between mental health staff and JDS leadership staff regarding youth on precautions. I was told that JDS leadership staff then communicates this information to direct care staff, however there was no documentation provided on that communication. JDS leadership staff should document the passing on of this information to direct care staff, either in shift logs or via email communications that can be memorialized.

(iv) *Suicide risk assessment by the QMHP;*

Substantial Compliance – Policy 360.09(B) articulates this requirement. Review of charts and Suicide Precaution Order Forms confirm substantial compliance.

(v) *Housing and supervision requirements, including minimal intervals of supervision and documentation;*

Substantial Compliance - Policies 360.09(A) and 360.12(A) articulate these requirements. The Suicide Precaution Order Forms also require the provision of this information following the assessment.

(vi) *Interdisciplinary reviews of all serious suicide attempts or completed suicides;*

Partial Compliance – There is currently no policy in place related to Interdisciplinary Reviews of suicide attempts or completed suicides. Mortality and morbidity reviews, discussed in subsection (ix), below, could address this requirement by including interdisciplinary staff participation, i.e., administrative, medical, and direct care staff and contractors, as a requirement in the Mortality and Morbidity Review policy. If the decision is made that the Morbidity and Mortality Review policy is to include medical and mental health staff only, a separate policy should be developed related to Interdisciplinary Reviews.

(vii) *Multiple levels of precautions, each with increasing levels of protection;*

Substantial Compliance – Policies 360.09(A) and 360.12 address levels of precautions and monitoring. These levels are also identified on the Suicide Precaution Order Form. A review of medical charts reflects a lack of consistency in what restrictions are ordered for what levels of risk. This concern is addressed in more detail under Section 4(a)(ii) of this document.

(viii) *Requirements for all annual in-service training, including annual mock drills for suicide attempts and competency-based instruction in the use of emergency equipment;*

Substantial Compliance – Policy 360.05 articulates this requirement. A review of training records indicates that a two-hour refresher training was provided in February of 2017.

(ix) *Requirements for mortality and morbidity review;*

Partial Compliance – Policy 360.14 articulates the requirement for a review, but without any description of the review requirements or process. Without such a description, the policy does not fulfill the MOA requirement that policy "address" requirements for Mortality and Morbidity Reviews.

Language should be added to this policy that describes, at a minimum, the purpose and timing of the review, who attends and who will lead the review, how the review will be documented, and recommended/required

follow-up.

If the Mortality and Morbidity Review policy requires interdisciplinary team participation, in addition to the medical and mental health staff, the policy will address the requirement for Interdisciplinary Reviews of all serious suicide attempts or completed suicides articulated in subsection (vi) above.

Specifics needed to meet this requirement are articulated in the CCS Suicide Prevention Program under 5.10.1-4 – Review, and should be added to JDS policy.

(x) Requirements for regular assessment of the physical plant to determine and address any potential suicide risk.

Substantial Compliance – Policy 360.16(A and B) articulate this requirement. It is recommended that 360.16(B) specify the process and frequency with which these physical plant assessments will be completed and who is responsible for ensuring the completion of the assessments.

(b) Within 60 days of the Effective Date, JCMSC shall ensure security staff posts are equipped with readily available, safely secured, suicide cut-down tools.

Terminated

(c) After intake and admission, JCMSC shall ensure that, within 24 hours, any Child expressing suicidal intent or otherwise showing symptoms of suicide is assessed by a QMHP using an appropriate, formalized suicide risk assessment instrument.

Terminated

(d) JCMSC shall require direct care staff to immediately notify a QMHP any time a Child is placed on suicide precautions. Direct care staff shall provide the mental health professional with all relevant information related the Child's placement on suicide precautions.

Terminated

(e) JCMSC shall prohibit the routine use of isolation for Children on suicide precautions. Children on suicide precautions shall not be isolated unless specifically authorized by a QMHP. Any such isolation and its justification shall be thoroughly documented in the accompanying incident report, a copy of which shall be maintained in the Child's file.

Substantial Compliance – Documentation review continues to indicate substantial compliance in this area. Residents made claims of being placed in isolation during the reported "weekend special." Residents claimed this designation came from staff. The practice could not be confirmed, but this information was reported to JDS leadership.

(f) *Within nine months of the Effective Date, the following measures shall be taken when placing a Child on suicide precautions:*

(i) *Any Child placed on suicide precautions shall be evaluated by a QMHP within two hours after being placed on suicide precaution. In the interim period, the Child shall remain on constant observation until the QMHP has assessed the Child.*

Terminated

(ii) *In this evaluation, the QMHP shall determine the extent of the risk of suicide, write any appropriate orders, and ensure that the Child is regularly monitored.*

Terminated

(iii) *A QMHP shall regularly, but no less than daily, reassess Children on suicide precautions to determine whether the level of precaution or supervision shall be raised or lowered, and shall record these reassessments in the Child's medical chart.*

Terminated

(iv) *Only a QMHP may raise, lower, or terminate a Child's suicide precaution level or status.*

Terminated

(v) *Following each daily assessment, a QMHP shall provide direct care staff with relevant information regarding a Child on suicide precautions that affects the direct care staff's duties and responsibilities for supervising Children, including at least: known sources of stress for the potentially suicidal Children; the specific risks posed; and coping mechanisms or activities that may mitigate the risk of harm.*

Terminated

(g) *JCMSC shall ensure the Children who are removed from suicide precautions receive a follow up assessment by a QMHP while housed in the Facility.*

Terminated

(h) *All staff, including administrative, medical, and direct care staff or contractors, shall report all incidents of self-harm to the Administrator, or his or her designee, immediately upon discovery.*

Terminated

(i) *All suicide attempts shall be recorded in the classification system to ensure that intake staff is aware of the past suicide attempts if a Child with a history of suicidal ideations or attempts is readmitted to the Facility.*

Terminated

(j) *Each month, the Administrator or his or her designee, shall aggregate and analyze the data regarding self-harm, suicide attempts, and successful suicides. Monthly statistics shall be assembled to allow assessment of changes over time. The Administrator, or his or her designee, shall review all data regarding self-harm within 24 hours after it is reported and shall ensure*

that the provisions of this Agreement, and policies and procedures, are followed during every incident.

Terminated

3. Training

(a) *Within one year of the Effective Date, JCMSC shall ensure that all members of detention staff receive a minimum of eight hours of competency-based training in each of the categories listed below, and two hours of annual refresher training on the same content. The training shall include an interactive component with sample cases, responses, feedback, and testing to ensure retention. Training for all new detention staff shall be provided bi-annually.*

(i) Use of force: Approved use of force curriculum, including the use of verbal de-escalation and prohibition on use of the restraint chair and pressure point control tactics.

Terminated

(ii) Suicide prevention: The training on suicide prevention shall include the following:

(a) *A description of the environmental risk factors for suicide, individually predisposing factors, high risk periods for incarcerated Children, warning signs and symptoms, known sources of stress to potentially suicidal Children, the specific risks posed, and coping mechanisms or activities that may help to mitigate the risk of harm.*

Terminated

(b) *A discussion of the Facility's suicide prevention procedures, liability issues, recent suicide attempts at the Facility, searches of Children who are placed on suicide precautions, the proper evaluation of intake screening forms for signs of suicidal ideation, and any institutional barrier that might render suicide prevention ineffective.*

Terminated

(c) *Mock demonstrations regarding the proper response to a suicide attempt and the use of suicide rescue tools.*

Terminated

(d) *All detention staff shall be certified in CPR and first aid.*

Terminated

The Administrator shall review and, if necessary, revise the suicide prevention training curriculum to incorporate the requirements of this paragraph.

Terminated

4. Performance Metrics for Protection from Harm

(a) *In order to ensure that JCMSC's protection from harm reforms are conducted in accordance with the Constitution, JCMSC's progress in implementing these provisions and the effectiveness of these reforms shall be assessed by the Facility Consultant on a semi-annual basis during the term of this Agreement. In addition to assessing the JCMSC 's procedures, practices, and training, the Facility Consultant shall analyze the following metrics related to protection from harm reforms:*

(i) *Review of the monthly reviews of use of force reports and the steps taken to address any wrongful conduct uncovered in the reports;*

Substantial Compliance – Review of UOF reports indicates incidents of wrongful conduct and other staff infractions identified during the review are documented and addressed.

(ii) *Review of the effectiveness of the suicide prevention plan. This includes a review' of the number of Children placed on suicide precautions, a representative sample of the files maintained to reflect those placed on suicide precautions, the basis for such placement, the type of precautions taken, whether the Child was evaluated by a QMHP, and the length of time the Child remained on the precaution; and*

Partial Compliance – Facility practice related to the designation of housing, supervision and observation is inconsistent and the levels of supervision and observation often do not align with the risk levels being assigned by the QMHP. For example:

On 12/29/17 Resident File #294586A was placed by a QMHP on Suicide Risk Level 1 (High Risk) defined as "active/imminent risk for suicide or self-harm; recent potential lethality attempt or intent with plan of significant lethality" but placed on Mental Health Observation – Level 3 (staggered 15 minute checks); the Observation level is not appropriate based on the identified Risk Level. The resident was allowed nothing in his/her room but a mattress and suicide smock (a tear-resistant single-piece outer garment that is generally used to prevent a hospitalized, incarcerated, or otherwise detained individual from forming a noose with the garment to commit suicide), and meals were to be served with a spork (a spoon shaped utensil with short tines used to prevent a detained individual from using it for self-harm); there were no routine privileges allowed. The observation level should reflect and be in alignment with the assigned level of risk.

Similarly, on 12/30/17 Resident File #229183 and on 1/10/18 Resident File #242609C were assigned the same Risk Level 1 (High Risk) but placed on Mental Health Observation – Level 3 (staggered 15 minute checks); the Observation level again is not appropriate based on the identified Risk Level 1. The residents were not allowed to have anything in their rooms

but a mattress and smock, and meals were to be served with a spork; no routine privileges were allowed. Again, the observation level should reflect and be in alignment with the assigned level of risk.

These were two different QMHP staff making the assignments of risk and observation levels in the three cases noted above.

On 1/15/18 Resident, File #268651A, was placed on Suicide Risk Level 1 (High Risk) after reportedly being observed having his shirt tied around his neck. Per the completed Suicide Precautions Order form, he also stated he wanted to kill himself. Despite the identification of Risk Level 1 and the behavior noted on the form, this youth was not restricted to wearing a smock and was placed on Mental Health Observation – Level 3 (staggered 15 minute checks). The Provider signature on this resident's Suicide Precautions Order Form is not legible, but it does not appear to have been signed by a QMHP. About an hour later the youth was seen by a QMHP, at which time the youth's risk level was reduced to Level 2 (Moderate Risk) with the Mental Health Observation – Level 3 and he continued to be restricted to wearing a smock. These discrepancies indicate that there is a disconnect between QMHP and other staffs' understanding of risk and watch level assignments.

There are a number of residents who are assigned lower levels of risk for suicide and are being restricted to wearing a smock while in their rooms. The reasoning for this is rarely made clear in the Comments section of the Suicide Precautions Order Form. In fact, it is not uncommon for the Comments section to remain blank or contain the statement "None" when a youth is either being placed on or removed from precautions.

There are many other examples of the discrepancies between the Suicide Risk Level and the assigned Observation Level. Examples of these discrepancies during the month of February were pointed out to Dr. Townsel and Ms. Geeter during the site visit.

In addition, Policy 360.07(A) and (C) would appear to offer two different instructions to mental health staff: 360.07(C) states, "Detainees who are suicidal by engaging in self-harming, self mutilating and self destructive behaviors will be placed in suicide smocks for safety and observation." This provides very specific direction as to when a smock is to be issued to a resident; Policy 360.07(A) states, "Suicide smocks will be used anytime a detainee is placed on suicide precautions and in their rooms," which more often than not is the current practice.

Per the *Desktop Guide to Quality Practice for Working with Youth in Confinement*, Chapter 11,

- Suicidal youth should remain in regular clothing (except if wearing shoelaces or belts), unless they use their clothing to harm themselves. In those instances, only that piece of clothing should be removed.

- Safety smocks should not be used, except in rare circumstances where it is indisputably necessary for youth safety… https://info.nicic.gov/dtg/node/6

This would indicate that placing a youth on Risk Level 3 and restricting him/her to wearing a safety smock while in his/her room is not appropriate.

The National Partnership for Juvenile Services' position statement on "Suicide Prevention" states the following:

> Some strategies used to keep suicidal youth safe during confinement can unintentionally increase youths' feelings of isolation, hopelessness or shame (e.g., removal of clothes, suicide smocks, no programming, restrictive housing, constant observation). http://npjs.org/wp-content/uploads/2012/12/NPJS-Suicide-Prevention.pdf

The JDC Suicide Prevention Policy should be amended to address any inconsistencies between the JDC and CCS, the facility's contracted mental health provider, policies. The amended policy should also provide consistent direction related to the use of a suicide smock, and practice should take into consideration the best practice recommendations contained in the two juvenile justice resources provided above. Levels of supervision and observation assigned by the QMHP need to be appropriate to the assessed level of risk for suicide.

(b) *JCMSC shall maintain a record of the documents necessary to facilitate a review by the Facility Consultant and the United States in accordance with Section VI of this Agreement.*

Terminated

III. Summary

There have been great investments made in responding positively to the Agreement, which is evidenced by the number of the Agreement Findings that have been terminated. In addition, the majority of the remainder of the findings are found to be in Substantial Compliance. The following are some general recommendations, along with a discussion of what is needed to bring all of the findings into Substantial Compliance:

1. Facility practice related to the designation of housing, supervision and observation of youth placed on suicide precautions is inconsistent and the levels of supervision and observation often do not align with the suicide risk levels being assigned by the QMHPs. These inconsistencies need to be addressed through both policy and practice.
2. There are inconsistencies between the JDS and CCS Suicide Prevention policies that should be addressed. Given CCS is the facility's contracted mental health provider, consideration should be given to starting with the CCS policy and making whatever adaptations may be needed to that policy to ensure the policy's

appropriateness in a confinement setting for youth. Doing this will help to ensure that QMHPs employed by CCS and working at the JDC, as well as JDC staff, are clear about suicide prevention protocols and the assignment of risk and observation levels.

3. While it is understood that youth in confinement may not always be truthful when being interviewed, it is of some concern that youth reported room confinement through a process they claim staff refers to as a "weekend special." None of the youth reporting this practice was willing to share with me the names of specific staff engaging in this practice. Chief Bridgeforth was notified of these claims. An investigation was conducted following the site visit. According to a memorandum dated June 8, 2018 and written by Chief Bridgeforth regarding her investigation, "There was no evidence of the practice 'weekend specials', [however] "it was discovered that some officers had heard the phrase used to caution the youth to behave during the weekend or they would be confined." This type of threat, regardless of whether or not the actual practice took place, is inappropriate and is reportedly being addressed with staff at all levels in the facility.
4. The Positive Behavior Management System (PBMS) has yet to take hold. Chief Bridgeforth discussed a plan to put in place a system that uses tickets for rewarding positive youth behavior. The tickets may then be used to "buy" rewards. The Chief states there are financial resources available to stock a store for use in the PBMS. These changes should be addressed as soon as possible.
5. Positive behavioral expectations, rather than negatively stated rules, are a critical component of any positive behavior management program. Chief Bridgeforth indicated she would immediately begin to work with staff to write these positive behavioral expectations. The expectations should be posted on resident units and other areas of the building, e.g. dining room, classrooms, etc., as soon as possible, and residents should be educated on how to meet the expectations in order to receive the positive reinforcements the program will provide.
6. The policy on Mortality and Morbidity Review, Policy 360.14, should address both what happened and what was learned that might help in the future to avoid a situation such as the one under review. Lindsay Hayes addresses this point on page 35 of his *Report on Suicide Prevention Practices with the Detention Services Bureau of the Juvenile Court for Memphis and Shelby County* dated September 29, 2012. A more detailed explanation of what should be included in this review should be added to policy. In addition, the requirement for a policy on Interdisciplinary Reviews can be addressed by ensuring that there is interdisciplinary staff participation in the Mortality and Morbidity Review process. While there has never been a completed suicide at the Shelby County Detention Center, staff and administration should not assume that despite their best efforts there never will be.
7. Inconsistencies in documentation of UOF incidents between supervising officers and the officers conducting reviews of these incidents should be addressed. These differences should be identified, addressed and corrected as part of the document and video review process.

8. Policy 360.05(D) requires that detention staff be certified in cardiopulmonary resuscitation (CPR). This requirement should include that all staff be certified in First Aid. The *Desktop Guide for Quality Practice Working with Youth in Confinement* states that, "All staff should be trained and certified in first aid and CPR for immediate response to an emergency."[1] First Aid training is also required under 3(a)(ii)(d) of the MOA, which has been terminated. This requirement should be added to JDS policy.
9. Grievance Forms need to be located where they are easily visible to youth. It would also be of benefit to remind youth where the forms can be found during daily Circle Up sessions.
10. A Prison Rape Elimination Act (PREA) audit has yet to be completed. This should be scheduled as soon as possible to ensure compliance with Juvenile PREA Standards.
11. The quality and quantity of food served to detained youth continues to be a concern voiced by the youth; addressing both the quality and the quantity of food warrants continued attention.

[1] Michelle Staples-Horne, MD, MS, MPH, CCHP. 2014. "Healthcare." in *Desktop Guide to Quality Practice for Working with Youth in Confinement.* National Partnership for Juvenile Services and Office of Juvenile Justice and Delinquency Prevention https://info.nicic.gov/dtg/node/15.