Kentucky Department Of Juvenile Justice
Regional Juvenile Detention Centers

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Legislative Oversight And Investigations Committee

Gerald W. Hoppmann
Committee Staff Administrator

Project Staff

McKenzie Ballard
Jacob Blevins
Ryan Brown
Chris Hall
Taylor Johnston
Jeremy Skinner
William Spears
Shane Stevens
Ashley Taylor
Preiss Terry
Joel Thomas

Legislative Research Commission
Frankfort, Kentucky
legislature.ky.gov

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Abstract

Kentucky's Department of Juvenile Justice (DJJ) operates eight regional juvenile detention centers across the commonwealth. These facilities provide pretrial detention of alleged juvenile offenders by court order. Following testimony regarding various issues at the detention centers, Legislative Oversight and Investigations Committee (LOIC) staff were directed on October 13, 2022, to review all eight detention centers. LOIC staff found that events at the Jefferson Regional Juvenile Detention Center were primarily caused by the use of a building not designed for secure detention and other factors relating to lack of supervision and staffing. Events at the Adair Regional Juvenile Detention Center were caused by multiple issues, such as expedited transfers from another facility, inadequate screening, and multiple incidents occurring in a short time frame. The report additionally discusses issues with the juvenile offender tracking system, the lack of an automated incident reporting system, staffing, salary, and other concerns voiced by DJJ staff. This report has 12 finding areas and 30 recommendations with one matter for legislative consideration.

Foreword

Legislative Oversight and Investigations Committee staff appreciate all those who provided assistance with this report. Officials from the Kentucky Justice and Public Safety Cabinet interacted with Legislative Oversight and Investigations Committee staff to ensure the electronic transfer of data and information. Staff from the Kentucky Department of Juvenile Justice (DJJ) gathered and scanned various reports, data, and other financial information. Officials and staff from the cabinet and DJJ facilitated tours of all regional juvenile detention centers, and officials from the mayor's office in Louisville facilitated a tour of the Jefferson County Youth Detention Center. LOIC staff appreciate this assistance.

Legislative Oversight and Investigations Committee staff also appreciate assistance from Terrie Decker, executive director, Indiana Division of Youth Services, and her staff for information and tours of the La Porte Juvenile Correctional Facility and the Pendleton Juvenile Correctional Facility. The executive director also helped arrange tours of the Clark County Juvenile Detention Center and Vanderburgh County Juvenile Detention Center, the latter of which is operated by Evansville Rescue Mission. Also, officials from South Carolina's Departments of Juvenile Justice and Health and Human Services provided budgetary and contract information relating to a $20 million appropriation to build a juvenile psychiatric residential treatment facility.

Jay D. Hartz
Director

Legislative Research Commission
Frankfort, Kentucky
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Summary

During its October 2022 meeting, the Legislative Oversight and Investigations Committee (LOIC) requested that staff investigate a fire and escape at the Jefferson Regional Juvenile Detention Center (JRJDC) on August 27, 2022. Then, during its November meeting, the presiding LOIC co-chair discussed that LOIC's investigation included seven other regional juvenile detention centers (RJDCs). On November 11, 2022, a riot occurred at the Adair Regional Juvenile Detention Center (ARJDC), where a juvenile offender attacked a youth worker and stole his keys, which were used to unlock the cell doors of 32 juvenile offenders. This incident is also addressed as part of LOIC's investigation.

LOIC found various reasons that contributed to the fire and escape at JRJDC, but the underlying factor appears to be the decision to use a building not specifically designed for secure detention. This decision, along with other factors relating to a breakdown of supervision and staffing challenges, created an optimal environment for the fire and escape.

The riot at ARJDC was immediately caused by a youth worker unlocking a juvenile offender's cell door to provide toilet paper. However, factors leading up to unlocking the cell door—initiated by the November 8, 2022, transfer of 13 juvenile offenders from JRJDC—caused a series of events leading to the riot. For example, the short time frame in which JRJDC offenders were transferred to ARJDC, the lack of screening to separate gang members, and various incidents during the evening of November 10, 2022, all contributed to the physical assaults, alleged sexual assaults, and property damage that took place the following day.

This report also describes legislative and other changes that have occurred since the filing of a federal consent decree in March 1995, which was signed by Governor Brereton C. Jones in December 1995.[1] The consent decree led the legislature to take action during the 1996 Regular Session of the General Assembly (House Bill 117), creating the Department of Juvenile Justice (DJJ). The report discusses changes to DJJ's organizational structure, as well as appropriations and expenditures through the years.

From a programmatic perspective, the report illustrates how DJJ approaches oversight of RJDCs by facilitating external audits required by national and accreditation standards, as well as conducting internal quarterly assurance reviews to prepare for external audits. The report discusses DJJ's reliance on internal processes for employees to report alleged neglect and abuse of juvenile offenders who are under the custody of DJJ. Internal processes are overseen primarily by the Justice and Public Safety Cabinet's Internal Investigations Branch and DJJ's ombudsman. The report reviews DJJ disciplinary actions based on substantiated allegations of neglect and abuse.

The report is critical of DJJ's juvenile offender booking system, which is obsolete, is siloed across the eight RJDCs, and does not generate routine or custom reports. The system was not designed to track juvenile offender transfers from one RJDC to another, so it tracks each transfer as a separate event, creating challenges for the optimal tracking of youth offenders. More

importantly, DJJ does not have an automated incident reporting system; however, the federal consent decree requires "an adequate uniform special incident reporting system that ensures that all special incidents are promptly and adequately identified, reported, investigated, and tracked."[2] Finally, this report discusses staffing, salary, and other concerns of current and past DJJ employees.

Recommendations

This report includes 30 recommendations and one matter for legislative consideration.

Recommendation 3.1

The Justice and Public Safety Cabinet should create a separate appropriation allotment for the Office of Detention, as well as separate expenditure functions for each juvenile detention center.

Recommendation 3.2

The Department of Juvenile Justice should develop and fully implement an automated system for the newly created Division of Compliance to better track and analyze American Correctional Association and Prison Rape Elimination Act noncompliance data. The focus of the system should be on inputting, storing, and tracking data for initial analysis. The automated system should also be able to sort, extract, and aggregate data for secondary analysis in order to make real-time corrective actions and policy decisions. A separate field should be dedicated to inputting and tracking data from unannounced visits and staff and youth offender survey results.

Recommendation 3.3

The newly created Division of Compliance should broaden its oversight to more than just preparing the regional juvenile detention centers for American Correctional Association (ACA) and Prison Rape Elimination Act (PREA) audits. More specifically, not only should the division continue to conduct unannounced visits, but it should also expand the scope of its audits to other issues that could disrupt operations at the centers. For example, understanding staff and morale issues, as well as consistently reviewing the findings of Internal Investigations Branch and ombudsman reports to identify additional training needs, could identify issues that need to be addressed outside of the ACA and PREA audits.

Recommendation 3.4

The Department of Juvenile Justice should continue to ensure that Jefferson Regional Juvenile Detention Center policies and procedures are updated so the new management team can address staffing, supervision, and building security concerns.

Recommendation 3.5

Adair Regional Juvenile Detention Center should continue to work with local and state law enforcement to receive training related to gangs and how to minimize the effects of gang affiliations in a detention setting.

Recommendation 3.6

Adair Regional Juvenile Detention Center staff should be required to use appropriate fields in the offender booking system to document tattoo descriptions and photographs.

Recommendation 3.7

The Justice and Public Safety Cabinet should request that the Internal Investigations Branch conduct a broader investigation, to include the incidents leading up to the November 11, 2022, riot.

Recommendation 3.8

Justice and Public Safety Cabinet and Department of Juvenile Justice officials should revisit language in DJJ policies, the memorandum of agreement, and 500 KAR 13:020 to ensure the terms *neglect, abuse, dependency,* and *special incidents* are used consistently and are in line with KRS 620.030.

Recommendation 3.9

Officials should review KRS 15A.065(4)(a) to consider proposing language that more clearly annotates the duties and responsibilities of the ombudsman.

Recommendation 3.10

Justice and Public Safety Cabinet and Department of Juvenile Justice officials should make available to the Cabinet for Health and Family Services the "may investigate" incidents, which appear to fall under "dependency."

Recommendation 3.11

Justice and Public Safety Cabinet and Department of Juvenile Justice officials should develop more of a formal policy related to the interaction between the department's ombudsman and the Internal Investigations Branch.

Recommendation 3.12

Justice and Public Safety Cabinet and Department of Juvenile Justice officials should break out the reporting duty of department employees from the Code of Ethics to develop a separate policy, given the importance of KRS 620.030 reporting.

Recommendation 3.13

Justice and Public Safety Cabinet and Department of Juvenile Justice officials should update their webpages to create more of a presence for the statutorily created department ombudsman.

Recommendation 3.14

The Justice and Public Safety Cabinet should use Column Case Management for storage and analysis of referrals and investigations conducted by the Office of the Ombudsman.

Recommendation 3.15

Department of Juvenile Justice detention facilities should ensure that maintenance work order request forms are completed to their full extent to include an indication of priority level.

Recommendation 3.16

Department of Juvenile Justice officials should automate the process by which maintenance work order request documents are processed.

Recommendation 3.17

The Department of Juvenile Justice should continue to expand current contracts to meet the requirements regarding mental health treatment in Senate Bill 162 and House Bill 3 (2023 Regular Session).

Recommendation 3.18

The Department of Juvenile Justice should contact South Carolina executive and legislative officials to obtain additional information on the proposed psychiatric facility for juvenile offenders. It should prepare an analysis of whether a similar hospital is suitable for Kentucky, then present the results to the legislature for consideration.

Recommendation 3.19

Justice and Public Safety Cabinet officials should continue to include appropriate Department of Juvenile Justice officials in discussions regarding the expanded scope of work for the Kentucky Offender Management System. Officials should also continue to familiarize themselves with the department's wish list and schema from its current offender booking system.

Recommendation 3.20

Justice and Public Safety Cabinet officials should include required fields for incident and grievance reporting in the new system, as well as the ability for multiple picture uploads and other required data fields for noting tattoos, possible gang affiliations, etc.

Recommendation 3.21

The Department of Juvenile Justice should develop an automated system to track critical information regarding each incident.

Recommendation 3.22

The Department of Juvenile Justice should reevaluate DJJ 715 and DJJ 321 for consistency, then update its Isolation/Incident Report form in anticipation of automation.

Recommendation 3.23

The Department of Juvenile Justice should ensure that every grievance is reviewed at least once. If the initial grievance could not be completed, staff should reach out to the individual to be sure they are aware of the process. If the grievance is still not usable, the grievance packet should include a short statement.

Recommendation 3.24

As the Department of Justice increases staffing at detention centers, it should monitor the amount of shift changes and mandatory overtime needed at the regional juvenile detention center. This data can be used to determine whether staffing at regional juvenile detention centers is sufficient or whether employees are suffering from difficult schedules to cover needs.

Recommendation 3.25

The Department of Juvenile Justice should monitor grievances and exit interviews that detail poor interactions between staff. If there are patterns of poor interactions, such as a regional juvenile detention center having multiple interactions that demonstrate a lack of respect for an individual's demographics, then the department should determine whether training or other interventions are needed to improve relationships at the regional juvenile detention center.

Recommendation 3.26

The Department of Juvenile Justice should monitor the number of nonhazardous employees who are assigned to cover hazardous roles and determine whether this practice affects retention in these roles. If the department decides to continue with this practice, it should determine whether nonhazardous employees need additional training to cover

hazardous roles, and new employees should be informed that they may need to cover these roles.

Recommendation 3.27

The Department of Juvenile Justice should automate its superintendent monthly report template to ensure consistent and accurate completion. Prior to automation, department officials should revise the current form to ensure the reduction of open text boxes, as well as elimination of double-subject input fields.

Recommendation 3.28

Department of Juvenile Justice officials should ensure that social workers and employees in similar classifications receive adequate training related to additional duties they may be requested to perform, such as searching and supervising juvenile offenders.

Recommendation 3.29

Department of Juvenile Justice officials should evaluate the policies and subjects cited in the discipline reports for additional training—more specifically, DJJ 104, DJJ 102, DJJ 713, and DJJ 110.

Recommendation 3.30

As the Department of Juvenile Justice updates its Isolation/Incident Report form, it should ensure that data from selected fields are consistently entered, tracked, and analyzed to identify areas of concern that need to be addressed programmatically and through training.

Matter For Legislative Consideration 3.1

The legislature may wish to consider clarifying the term *dependent child* in KRS 600.020(20) and amending KRS 620.020 to include the term *dependency*.

Chapter 1

Kentucky Department Of Juvenile Justice Regional Juvenile Detention Centers

The impetus for the creation of Kentucky's Department of Juvenile Justice (DJJ) was a federal consent decree.

The impetus for the creation of Kentucky's Department of Juvenile Justice (DJJ) was a federal consent decree between the US Department of Justice and the Commonwealth of Kentucky.[3]

The legislature codified language in 1996 to create DJJ.

Through House Bill 117 of its 1996 Regular Session, the General Assembly authorized the creation of DJJ. The new DJJ, headed by a commissioner, would be in charge of developing and administering programs for preventing juvenile crimes, identifying juveniles at risk of becoming status or public offenders (as well as creating early intervention strategies for these juveniles), and operating or contracting for operation of preadjudication and postadjudication facilities for juveniles charged with public offenses or charged as youthful offenders.[a] DJJ was also to provide alternatives to detention, as well as appropriate programming for juvenile offenders.[4]

HB 117 also created a new section of KRS Chapter 27A, making the Administrative Office of the Courts (AOC) the primary repository of court records of juveniles charged with or arrested for complaints (or juveniles against whom complaints have been filed), where the complaints involve status offenses, public offenses, and youthful offender proceedings. AOC is the repository for records involving the handling and disposition of cases, and it is required to make juvenile records available to agencies and persons specified by law.[5]

In 2023, the legislature took action to require 48-hour detention of some offenders, to enhance mental health screening and assessment, and to appropriate additional money.

The legislature passed two major pieces of related legislation during the 2023 Regular Session. Related to juvenile detention, HB 3 states that, starting July 1, 2024, any child accused of committing a public offense that is considered a violent felony offense must be detained in a secure juvenile detention facility for up to 48 hours. AOC estimates that in 2022 this condition

[a] KRS 600.020(51) defines *public offense* as one under KRS Chapter 527 that, if committed by an adult, would be a crime. KRS 600.020(72) defines *youthful offender* as any person, regardless of age, transferred to Circuit Court under the provisions of KRS Chapter 635 or 640 who is subsequently convicted in Circuit Court and sentenced under the same procedures and sentences as adults convicted of similar crimes.

would have applied to 415 juveniles with complaints that were considered violent felony offenses, who were released.[6]

HB 3 generally requires detained juveniles awaiting detention hearings to be assessed by a mental health professional; if treatment is recommended, the court may direct the child to receive treatment.[7] Similarly, Senate Bill 162 requires DJJ to establish adequate contracts to ensure timely access to institutional treatment for children with severe emotional disturbances or mental illnesses. It also mandates access to mental health professionals for children in crisis who are residing in juvenile detention facilities.[8]

These pieces of legislation provided a little over $75 million in appropriations for improving the administration of juvenile justice in various areas: salaries and personnel, automation, security upgrades to juvenile detention centers, juvenile diversion program, regionalization study, transportation, improvements to the Jefferson County Youth Detention Center, and improvements to the Jefferson Regional Juvenile Detention Center (JRJDC).

Major Objectives

This study had eleven major objectives.

The major objectives for this study were to

- determine the causes of incidents at JRJDC and the Adair Regional Juvenile Detention Center (ARJDC);
- discuss the evolution of DJJ since the federal consent decree between the US Department of Justice and the Commonwealth of Kentucky;
- determine the effectiveness of DJJ's oversight through internal and external reviews;
- determine whether DJJ has sufficient processes to ensure that suspected cases of dependency, neglect, and abuse are reported consistent with KRS 620.030;
- determine whether DJJ has sufficient automated processes to ensure that all special incidents are investigated and tracked;
- determine the types of incidents that occurred at regional juvenile detention centers (RJDCs);
- determine whether DJJ's juvenile offender booking system is adequate to provide intake and transfer data related to juvenile offenders;
- determine whether DJJ's intake processes adequately assess juvenile offenders for mental health needs or susceptibility and vulnerability to aggressive behavior and victimization;

- determine whether RJDCs receive, process, and track work orders in a timely manner;
- identify staff and superintendents concerns at the RJDCs; and
- determine how often RJDC staff are involved in special incidents that require disciplinary action.

Methodology

Although this report initially focused on specific incidents at JRJDC and ARJDC, it also analyzed various processes used by DJJ to operate a system of eight RJDCs. Staff conducted the following research tasks:

- Interviewed senior staff at Kentucky's regional detention centers to gain an understanding of the juvenile offender booking system, weekly/monthly superintendent reports, exterior buildings and perimeters, youth offender processing areas, security, medical clinics, records storage, youth offender property storage, youth offender rooms and other secured areas, general population areas, classrooms, kitchens, dining areas, maintenance areas, and laundry
- Toured Kentucky's RJDCs
- Interviewed senior staff at the Justice and Public Safety Cabinet and DJJ to gain an understanding of appropriations and expenditures; internal and external oversight provided by DJJ's compliance division and ombudsman; investigation of special incidents by the Internal Investigations Branch (IIB); DJJ automation; mental health assessments and contracts; reporting of suspected cases of dependency, neglect, and abuse; security; staffing; training; transportation; facility maintenance; and employee discipline
- Interviewed the mayor of Lyndon and the Lyndon fire chief regarding the JRJDC fires and escape
- For each RJDC, requested, reviewed, and analyzed 2018–2022 data from discipline reports, exit interviews, grievances, facility work orders, IIB reports, incident reports, internal quality assurance reports, American Correctional Association (ACA) and Prison Rape Elimination Act (PREA) audits, staff grievances, and Massachusetts Youth Screening Instrument (MAYSI) and Victimization and Sexual/Physical Aggression Screener (VSPA-S) assessments
- Toured Louisville's youth detention center
- In Indiana, toured La Porte Juvenile Correctional Facility, Pendleton Juvenile Correctional Facility, Vanderburgh County Youth Care Center, and Clark County Juvenile Detention Center

- Contacted officials from South Carolina's Department of Juvenile Justice and Department of Health and Human Services for procurement and programmatic information about a new $20 million psychiatric residential treatment facility

Major Conclusions

This study has eight major conclusions.

This report has eight major conclusions:

- Various factors contributed to the fire and escape at JRJDC, but the underlying factor appears to be the decision to use a building not specifically designed for secure detention. This decision, along with other factors relating to a breakdown of supervision and staffing challenges, created an optimal environment for the fire and escape.
- A youth worker's unlocking the room of a juvenile offender to provide toilet paper was the immediate cause of the ARJDC riot. However, other factors leading up to unlocking the cell door (initiated by the November 8, 2022, transfer of 13 juvenile offenders from JRJDC) caused subsequent events contributing to the riot.
- DJJ facilitates external audits required by federal and national accreditation standards and conducts quarterly assurance reviews to prepare for external audits. However, DJJ does not have an automated system to track and analyze compliance data.
- DJJ does not have a fully automated juvenile offender tracking system.
- DJJ relies on internal processes for employees to report alleged neglect and abuse of juvenile offenders who are in the department's custody.
- The cabinet's Internal Investigations Branch and DJJ's ombudsman investigate special incidents and grievances, respectively.
- DJJ's juvenile offender booking system is obsolete, is siloed across the eight RJDCs, and does not generate routine or custom reports. Also, DJJ does not consistently use appropriate fields in the system to document tattoo descriptions and photographs relating to gang activity.
- DJJ does not have an automated incident reporting system; however, the federal consent decree requires "an adequate uniform special incident reporting system that ensures that all special incidents are promptly and adequately identified, reported, investigated, and tracked."[9]

Structure Of This Report

Chapter 2 provides statutory and other background related to DJJ and eight RJDCs. It outlines statutory details, as well as administrative, budgetary, and juvenile detention requirements. The chapter discusses DJJ training, transportation costs, oversight and compliance, and information from Indiana and South Carolina.

Chapter 3 presents 12 major findings, 30 recommendations, and one matter for legislative consideration.

Appendix A provides a response from DJJ. Appendix B provides additional information related to staff's analysis of incident reports from all eight RJDCs.

Areas For Further Review

Providing Mental Health Services

DJJ's mental health services infrastructure relies on various counselors and mental health professionals. Each facility within the system has a counselor, usually filled from the Social Service job title series. These positions do not require a license, but their exact specifications and qualifications can vary depending on the availability of suitable candidates. Positions may range from a Social Service Clinician I (requiring a master's degree and 1 year of experience in social work or a related field) to a Social Service Worker I (requiring a bachelor's degree but no experience).[10]

Significant hiring challenges have led to the creation of a new role, the Licensed Behavioral Health Professional. Having this position allows DJJ to hire individuals who have a master's degree and an active license to independently practice in Kentucky but who may not have the full 3 years of psychiatric or forensic experience usually required for other roles. As part of its efforts to support staff, DJJ also provides assistance to its staff in obtaining associate licenses and covers the costs of associate clinical supervision required by licensing boards.[11]

In accordance with provisions of SB 162 and HB 3 that require DJJ to establish adequate contracts to ensure timely access to institutional treatment for children with severe emotional disturbances or mental illnesses, DJJ issued a request for proposals (RFP) on May 15, 2023, to contract with up to 13 vendors to provide inpatient acute psychiatric hospital care for youths with

emotional, behavioral, psychiatric, aggressive, self-harming, and/or substance abuse disorders, or with severe mental illness.[12]

DJJ is aware of the need for institutional treatment for children with severe emotional disturbance or mental illness, but it faces the challenge that private nonprofit or for-profit companies operate all Kentucky psychiatric residential treatment facilities for adolescents, and they are not obliged to accept DJJ youths. DJJ has expressed that it is open to collaboration with stakeholders to find a solution for this issue.[13]

Adequate Staffing Ratios

Sufficient staffing to match the population is an important requirement for a juvenile detention facility, but DJJ cannot track this measure. Determination of the ratio of youths to staff is necessary for federal requirements and is also needed for strategic planning. Knowing the number of staff relative to the number of juveniles can allow DJJ to better plan staffing and determine where to focus on recruitment. Insufficient staffing can also be a drain on staff as employees take on overtime or shift changes to meet the need of the facility. Future reviews can examine DJJ's ability to determine staffing needs.

PREA standard 115.313(c) requires juvenile facilities to maintain a minimum ratio of 1 security staff member to 8 youths during waking hours and a ratio of 1:16 during sleeping hours, except during limited and discrete exigent circumstances.[14] However, cabinet officials stated that they could not generate reports that show ratios of youths to security staff.[15] In attempting to determine whether this ratio was met, Legislative Oversight and Investigations Committee (LOIC) staff analyzed existing documents, but none were sufficient. Shift reports did not indicate whether counseling staff were used to cover staffing and were not suitable for digital conversion. Vacancies in monthly reports were difficult to track across time because it was not always clear whether the same positions were vacant and it was not clear when positions were vacant during the month.

LOIC staff also attempted to calculate ratios indirectly through separate staff and juvenile counts. DJJ provided vacancies for 2018 to March 2023 and separations and retirements for 2018 to May 2023. Even with these numbers, the staffing side of the ratio was difficult to calculate because there is no indication of which shift staff served on, and facilities can have either two or three shifts. In addition, the separation and retirement data had no

information for JRJDC, casting doubts on the accuracy of information.

Juvenile population counts were provided for 14 days between February 9 and May 15, 2023. This data categorized youths by gender and charges, making it appropriate to plan populations by how they will be divided. However, this information alone is not sufficient to determine the youth side of the ratio. The youth calculation is challenging because youths can arrive at any time in the day and can stay for varying amounts of time. Optimally, DJJ would be able to determine the largest number of youths present in a single shift. This information is present in shift reports but, as previously noted, these reports were not suitable for digitization and a single week of shifts would result in 14 to 21 values per facility.

Detention staff have also indicated that staffing has created difficulties in their jobs through scheduling problems, as discussed more thoroughly in Chapter 3. In staff grievances, scheduling issues were tied for the second most common issue and appeared in 11 out of 82 grievances. In exit interviews, schedules were the fifth most common reason for leaving, appearing in 18 out of 257 interviews.

Chapter 2

Regional Juvenile Detention Center Background

DJJ is one of five departments under the Kentucky Justice and Public Safety Cabinet.

The Kentucky Department of Juvenile Justice is one of five departments under the state's Justice and Public Safety Cabinet. This study focuses on DJJ's eight regional juvenile detention centers, although the agency also provides alternative-to-detention programs, postdisposition residential facilities, probation, community aftercare, reintegration programs, and prevention programs for at-risk youths. Prior to changes made during the 2023 Regular Session, DJJ was divided into the Office of Program Operations, the Office of Support Services, and the Office of Community and Mental Services. The Office of Program Operations previously oversaw juvenile detention centers.[16] Table 2.1 presents an overview of the RJDCs' characteristics.

Table 2.1
DJJ RJDC Informational Overview

Facility	Opening	Rated Capacity	Average Daily Population, Last 12 Months	Average Length Of Stay	Age Range Of Offenders	Full-Time Staff
Adair	2001	48	—	45 days	12 to 18	49
Boyd	2004	48	11	17 days	12 to 18	44
Breathitt	2007	48	—	45 days	12 to 18	49
Campbell	2010	52	19	16 days	12 to 18	25
Fayette	2004	48	—	17 days	12 to 18	—
Jefferson	2019	16	19	12 days	11 to 18	23
McCracken	1999	43	27	45 days	12 to 18	49
Warren	2002	48*	—	45 days	12 to 18	49

Note: This information was gathered via American Correctional Association facility inspections conducted between December 13, 2022, and January 18, 2023. — = information was not provided by the ACA source material.
* 20 rooms offline due to renovation.
Source: American Correctional Association. "Technical Needs Assessment, DJJ Detention Centers," March 10, 2023.

Appropriations

Table 2.2 presents appropriations and expenditures for DJJ from FY 2015 to FY 2024. The appropriations column sums general fund, restricted fund, and federal dollars. The general fund accounted for 64.9 percent to 83.1 percent of appropriations, and the restricted fund accounted for 8.4 percent to 19.9 percent. Appropriations increased 26.7 percent from FY 2015 to FY 2024, with the largest increases occurring in FY 2019 (16.6 percent) and FY 2022 (11.9 percent).

DJJ expenditures are divided among Program Management, Program Operations, and Support Services.

DJJ expenditures are divided among Program Management, Program Operations, and Support Services. Program Management consists of the Commissioner's Office, which provides management and policy direction. Its expenditures stayed at roughly the same level over time, at less than 2 percent of expenditures. Program Operations comprises direct services provided to public and youth offenders through DJJ facilities and services. Program Operations was the largest category, at roughly 90 percent of expenditures each year. Support Services provides administrative support to all organizational units of DJJ.[17] Support Services accounted for approximately 8 percent of expenditures in each year.

Table 2.2
DJJ Appropriations And Expenditures
Actual FY 2015 To Enacted FY 2024 (In Millions)

		Expenditures				
Fiscal Year	Appropriations	Program Management	Program Operations	Support Service	Total Expenditures	Surplus
2015	$109.9	$1.6	$98.0	$8.2	$107.7	$2.2
2016	109.1	1.8	95.8	8.2	105.8	3.3
2017	110.0	1.9	96.2	8.5	106.6	3.4
2018	107.2	1.7	96.5	8.3	106.5	0.7
2019	125.0	1.9	113.8	9.1	124.8	0.2
2020	135.7	1.6	101.2	9.6	112.5	23.2
2021	124.7	1.1	93.9	8.2	103.2	21.5
2022	139.6	1.8	115.2	10.0	127.0	12.6
2023*	144.1	1.8	125.4	10.3	137.4	6.6
2024*	139.3	1.8	126.5	10.4	138.6	0.7

Note: DJJ has 54 fund codes that are used to track capital expenditures for specific purposes. For example, the Warren Regional Juvenile Detention Center control board upgrades are tracked in fund C6WH. Figures may not sum to totals shown, due to rounding.
*2023 and 2024 are enacted appropriations, and expenditures and may change over the course of the fiscal years.
Source: Mona S. Womack, chief of staff, Department of Juvenile Justice, Kentucky Justice and Public Safety Cabinet. Email to Gerald W. Hoppmann, May 10, 2023.

The surplus column calculates the differences between the amount appropriated to DJJ and the expenditures for that year. From FY 2015 to FY 2019, DJJ's expenditures were close to its appropriations. In FY 2020 and FY 2021, there was a large difference between appropriations and expenditures with FY 2020 expenditures being 82.9 percent of revenue and FY 2021 expenditures being 82.8 percent. In FY 2020, appropriations increased by 8.5 percent, and expenditures decreased by 9.9 percent.

Table 2.3 presents new appropriations from the 2023 Regular Session. The largest appropriation was for salary improvements

within the Department of Corrections, which made salaries comparable to those of the new correctional officers at DJJ facilities. Otherwise, the largest appropriation was to renovate the Jefferson County Youth Detention Center in Louisville. The facility received multiple appropriations for its future operations, which will make it the ninth juvenile detention center.

Table 2.3
Appropriations From Chapters 105 And 106 Of The 2023 Acts Of The General Assembly
(In Millions)

KRS Chapter	Fiscal Year	Purpose	Appropriation
106	2023–2024	Increase salary for correctional officers within Department of Corrections	$30.00
105	2023–2024	Fund first-phase renovation of Jefferson County Youth Detention Center	10.00
106	2023–2024	Hire 146 additional youth workers in detention centers	9.70
106	2023–2024	Provide salary increases to other classifications within Department of Juvenile Justice	4.80
105	2023–2024	Renovate Jefferson Regional Juvenile Detention Center	4.50
106	2022–2023	Upgrade security within detention centers	4.00
105	2022–2023	Assess and design renovation of Jefferson County Youth Detention Center	3.40
106	2023–2024	Maintain salary increases for youth workers in juvenile detention centers	3.20
	2023–2024	Fund operating costs of Jefferson County Youth Detention Center	2.00
106	2022–2023	Retain design experts to return to regional model	1.75
106	2022–2023	Establish diversionary program for juveniles suffering from severe mental illness	1.50
106	2022–2023	Fund transportation costs for female offenders	0.25
106	2023–2024	Develop youth offender management system*	0.20
Total			$75.30

*Based on a May 10, 2023, interview with the executive director of the Office of Financial Management at DJJ, these funds will pay for operating costs of recurring annual maintenance fees. Development of the system will be paid through federal funding.
Source: Staff analysis of Senate Bill 162 and House Bill 3 of the 2023 Regular Session.

Section 14 of Chapter 106 of the 2023 Acts of the General Assembly specifically calls for $4 million to be appropriated for "security upgrades within the juvenile detention centers." However, the appropriations for additional youth workers and the multiple appropriations for renovation and returning to the regional model will also improve security. More staff will allow DJJ to better meet mandatory ratios for security coverage. Three RFPs were issued in May 2023 to design the renovations. All three are scheduled to produce work products in September 2023 and require that security and facility issues be addressed. The appropriation for JRJDC will improve its security further beyond its initial upgrades, which are discussed further in Chapter 3 and Table 3.12.

Figure 2.A shows an undeveloped part of the Jefferson County Youth Detention Center. Some parts of the facility had areas that could be converted to living units, expanding the capacity of the facility. During the LOIC staff tour on May 3, 2023, some rooms did not have warm water, which could restrict which rooms could be used for juveniles unless renovated.

Figure 2.A
Jefferson County Youth Detention Center Undeveloped Space
May 3, 2023

Source: LOIC staff tour of facility, May 3, 2023.

Legislative Changes In Detention

DJJ has had a long history of legislative changes.

DJJ has had a long history of legislative changes. Early legislation focused on the creation of DJJ and meeting the standards set forth in the 1995 consent decree. The decree was entered into after the US Department of Justice alleged that juvenile facilities failed to meet constitutional standards in areas such as adequate medical care, mental health care, and rehabilitation.[18] The initial concern was making sure that juveniles in the justice system were not being treated unconstitutionally. Once this concern was managed, later legislation addressed more nuanced concerns in juvenile justice. Specifically, SB 200 in 2014 and HB 3 in 2023 both addressed when a youth should be or must be detained.

House Bill 117, Regular Session 1996

HB 117 of 1996 codified changes to bring Kentucky in line with the requirements set forth in the consent decree.

HB 117 of 1996 codified changes to bring Kentucky in line with the requirements set forth in the consent decree. It created a new section of KRS Chapter 15A and established DJJ. Under this legislation, the department, headed by a commissioner, would be in charge of developing and administering programs for preventing juvenile crimes, identifying juveniles at risk of becoming status offenders or public offenders, creating early intervention strategies for these juveniles, and operating or contracting for operation of preadjudication and postadjudication facilities for juveniles charged with public offenses or charged as youthful offenders.

The bill also created an advisory board for DJJ. Section 4 made AOC the primary repository of court records of juveniles charged with complaints, arrested for complaints, and against whom complaints have been filed (where the complaints involve status offenses, public offenses, and youthful offender proceedings), together with all court records of the handling and disposition of those cases.

Senate Bill 200, Regular Session 2014

SB 200 of 2014 reformed much of the juvenile justice system.

SB 200 of 2014 reformed much of the juvenile justice system. In particular, the legislation prioritized reducing out-of-home placement for juveniles involved in low-level offenses and status offenses.

Prior to passage of the bill, the majority of youths in out-of-home placements were lower-level offenders.[19] Within the first 2 years of this legislation being in place, out-of-home placement fell by 40 percent.[20] The legislation required diversion for juveniles committing their first misdemeanor offense and expanded eligibility for diversion within the juvenile court rules.[21] It also established an oversight council and requirements for data and reporting to help measure the impact of the improvements.[22] Overall, SB 200 restricted committing lower-level offenders and how long they may be placed out of home, increased and strengthened evidence-based programs, created a fiscal incentive program, and established an Oversight Council.[23]

SB 200 amended the language of KRS 600.010(2)(b)(3) to state that “to the extent possible, out-of-home placement should only be utilized for youth who are high-risk or high-level offenders, and that low-risk, low-level offenders should be served through evidence-based programming in their community.”

KRS 600.020(27) defines *evidence-based practices* as "policies, procedures, programs, and practices proven by scientific research to reliably produce reductions in recidivism."

SB 200 amended KRS 605.020 to require AOC to train all court-designated workers. The training should cover the administration of evidence-based screening instruments, and, for appropriate workers, the administration of risk and needs assessments. AOC must also provide training on the identification of appropriate services for children and families, techniques for diversion agreement implementation and supervision, juvenile justice research, best practices, and any other subject deemed appropriate and available.

SB 200 created KRS Chapter 610. KRS 610.012(3) provides that a child suspected of being a runaway may be detained in a nonsecure facility only for up to 72 hours, exclusive of weekends and holidays, or if the court makes a finding on the record that there is no less restrictive alternative available. It also states that a child suspected of being a runaway may be detained in a secure facility only for up to 24 hours, exclusive of weekends and holidays, pursuant to an ex parte emergency protective order pending a court hearing to determine whether to return the child to a custodian or give custody of the child to the cabinet.

The legislation also created Family Accountability, Intervention, and Response (FAIR) teams. A FAIR team is a multidisciplinary group that develops case management plans and identifies opportunities for services to address the needs of the juveniles and their families. Each judicial district or circuit is to have an established FAIR team. Should a juvenile fail to appear, decline to enter a diversion agreement, or fail to complete one, the court-designated worker can refer the juvenile to the FAIR team.

House Bill 3, Regular Session 2023

Except for some minor changes, HB 3 of the 2023 Regular Session is nearly identical to HB 318 from the 2022 session, which was not passed. The first change that HB 3 makes on detention is that if a diversion agreement fails due to lack of parental cooperation, the child is not detained. Instead, the court may order parental cooperation, and the onus is placed on the parent rather than the child. The case is then referred back to the court-designated worker.

HB 3 of 2023 requires that any child accused of committing a public offense that is considered a violent felony offense must be detained for up to 48 hours.

The more impactful change for detention is the requirement imposed by HB 3 that, starting July 1, 2024, any child accused of committing a public offense that is considered a violent felony offense must be detained in a secure juvenile detention facility for up to 48 hours unless the detention hearing can be held within that time frame. This requirement applies only to juveniles age 11 or older. Previously it was optional for juveniles accused of violent felony offenses to be detained prior to a detention hearing, but this new language makes detention a requirement. This change has the likely consequence of increasing the number of juveniles detained in secure detention facilities, even if for short periods of time.

Figure 2.B
Adair Regional Juvenile Detention Center Fencing
February 24, 2023

Source: LOIC staff tour of facility, May 3, 2023.

At the request of the Justice and Public Safety Cabinet, AOC conducted an analysis of 2022 intake data to determine the number of juveniles who would have been detained if this legislation had been in effect at the time. Table 2.4 shows a total of 415 juveniles with complaints considered violent felony offenses who were released in 2022 but would have been detained under HB 3.[24]

Table 2.4
Additional Youths
Who Would Have Been Detained For Violent Offenses
If 2023 RS House Bill 3 Had Been In Place
2022

Detention Center	Number Of Youths
Adair County Detention Center	38
Boyd County Detention Center	20
Breathitt County Detention Center	32
Campbell County Detention Center	45
Fayette County Detention Center	59
Jefferson County Detention Center	103
McCracken County Detention Center	48
Warren County Detention Center	73
Total	415

Note: The total is smaller than the sum of the numbers shown, because a youth can have complaints across catchment areas.
Source: Kentucky. Administrative Office of the Courts. *Youth Within Complaints Filed By Intake Action And DJJ Detention Catchment Area, CY 22*. 2023.

Although the number of complaints does not necessarily correlate with the number of offenders, since one offender can have multiple complaints, AOC controlled for that condition with this data and specifically looked at the number of juveniles.[25] This number may require more staff for a system that is already running thin on staff to begin with. The needs for more staff, beds, and transportation of the juveniles to facilities are all pertinent considerations when considering the practical and fiscal impact of HB 3 on DJJ.

The estimates from Table 2.4 are for 2022 as a whole and do not show when the detentions occurred. These detentions are not likely to occur at the same rate every month, making it more difficult to anticipate a facility's needs. If detentions are more likely to occur during summer months, when juveniles are out of school, that could place a higher strain on facilities, which need to have capacity for the largest number of juveniles detained at one time.

Senate Bill 162, Regular Session 2023

SB 162 of the 2023 legislative session created the Office of Detention (which includes the Division of Transportation), added the Division of Professional Development under the Office of Support Services, and created the Division of Compliance. The creation of the Office of Detention requires that all detention centers report to a single supervisor, who reports directly to the commissioner. It also requires that the cabinet maintain a comprehensive centralized data tracking system for DJJ.

The legislation added members to the Juvenile Justice Oversight Council from the Senate and House of Representatives and amended the duties of the council. The council must

- review the implementation of the reforms enacted by the General Assembly;
- review performance measures and recommend modifications;
- review all policies to confirm implementation as established by legislation and administrative regulations;
- review the fiscal incentive program established pursuant to KRS 15A.062;
- review and make recommendations regarding the structure and staffing of DJJ, training of DJJ staff, the adequacy of current programs and facilities operated by the Department of Justice, best practices in juvenile justice programs and facilities; and
- report by December 1, 2023, and by December 1 every year thereafter to the Interim Joint Committee on Judiciary and the governor.

For administrative purposes, SB 162 attached the council to the Legislative Research Commission rather than to the Justice and Public Safety Cabinet, where it had previously been attached.

The bill requires documented monthly training related to emergency responses, and it established a specially trained emergency response team within each juvenile detention center and youth development center (YDC) that is trained in tactics related to detention facilities. DJJ must ensure that staff working with detained youths are properly trained and have controlled access to appropriate defensive equipment. SB 162 also requires a memorandum of understanding (MOU) with local law enforcement for emergency responses. Facilities must be equipped with an alarm that directly communicates an emergency situation to the local dispatch center.

SB 162 of 2023 requires the Office of the Auditor of Public Accounts to contract with a third party to perform a full performance review.

Section 8 of SB 162 requires that the Office of the Auditor of Public accounts contract with a third party to perform a full performance review of preadjudication facilities and programs operated and administered by DJJ. The contracted entity is to have experience in reviewing the performance of state agencies offering juvenile detention facilities and programs. The contracting party is to enter into an MOU with LOIC concerning the exchange of materials and work papers and maintenance of confidentiality. The contractor must report performance review reports to the Legislative Research Commission, with an initial preliminary report submitted by October 15, 2023.

2023 Regulations Update

DJJ proposed multiple regulations to conform with legislative changes in 2023.

DJJ has worked to improve and fix issues within its system. As part of this effort and to address legislative changes, it is in the process of finalizing new regulations. Table 2.5 shows 26 proposed regulations.

Table 2.5
Proposed DJJ Administrative Regulations

Regulation	Title
505 KAR 1:010	Definitions
505 KAR 1:100	Admissions
505 KAR 1:180	Day Treatment Admissions
505 KAR 1:185	Day Treatment Programs
505 KAR 1:200	Cell Entry Teams, Emergency Response Teams, And Emergency Response Training
505 KAR 1:210	Restraints And Control Methods
505 KAR 1:220	Transportation Of Juveniles
505 KAR 1:230	Facility Capacity, Staffing, And Population Count
505 KAR 1:240	Dietary Services
505 KAR 1:250	Drug Screening And Testing
505 KAR 1:260	Education
505 KAR 1:270	Grievances
505 KAR 1:280	Hair And Grooming
505 KAR 1:290	Juvenile Allowance And Work Detail
505 KAR 1:300	Juvenile Records And Information
505 KAR 1:310	Leave, Releases, And Furloughs
505 KAR 1:330	Personal Property, Dress, And Clothing And Bedding Supply
505 KAR 1:340	Recreation
505 KAR 1:350	Religious Practice
505 KAR 1:360	Searches
505 KAR 1:370	Treatment
505 KAR 1:380	Mail, Visiting, And Telephone Use
505 KAR 1:390	Juvenile Accounts And Youth Activity Fund Account
505 KAR 1:400	Behavior Management And Progressive Discipline
505 KAR 1:410	Isolation and Protective Custody
505 KAR 1:420	Youthful Offenders

Source: Kentucky Administrative Regulations.

Of particular relevance to this study are the updates or creation of the following regulations: Definitions; Admissions; Cell Entry Teams, Emergency Response Teams And Emergency Response Training; Restraints And Control Methods; Transportation Of Juveniles; Facility Capacity, Staffing, And Population Count; Grievances; Juvenile Records And Information; Searches; Treatment; Behavior Management And Progressive Discipline; Isolation And Protective Custody; and Youthful Offenders.

Detention Training

Changes resulting from 2023 legislation will require altering DJJ training to accommodate defensive equipment.

Changes resulting from 2023 legislation will require altering DJJ training to accommodate defensive equipment. DJJ's 500 series of policies sets standards for training. DJJ 502 requires staff hired or promoted to complete preservice training. Newly hired youth workers, now called correctional officers, are required to attend the Training Academy. DJJ 505 requires the academy to contain at least 5 weeks of instruction. DJJ 505 IV.5.e provides the minimum topics to include in the academy curriculum:

- Overview of the juvenile justice field
- Safety and security procedures
- Working conditions and regulations
- Health services protocol
- Cardiopulmonary resuscitation, standard first aid, and automated external defibrillator training
- Juvenile rights, rules, regulations, and responsibilities
- Supervision of juvenile offenders, including use of discipline regulations
- Juvenile searches
- Suicide intervention and prevention, including signs of suicide risks and mental illness
- Signs and symptoms of chemical dependency
- Physical skills and use-of-force training
- Key control
- Report writing
- Legal responsibilities of staff
- Interpersonal relations
- Communication skills
- Cultural awareness and implicit bias
- Social and cultural lifestyles of the juvenile population
- Sexual abuse, sexual harassment, and Prison Rape Elimination Act of 2003
- Introduction to personnel policies
- Code of ethics

DJJ is changing requirements for academy participation. Previously, there were seven or eight academy sessions with 6 weeks of training within a year, but new staff could participate only if hired before the start of a session. New hires who missed a date had to wait until the next academy and were deprived of training. DJJ began a continuous 6-week academy in April 2023. New hires can join the academy at any point, such as beginning training at the fourth week.[26]

New Entry Techniques. In May 2023, DJJ submitted an emergency regulation, 505 KAR 1:200E, that would allow facilities to use cell entry teams. These are defined as teams of "staff that are deployed to remove a juvenile from a cell or other confined area." It would also allow for the creation of an emergency response team that can respond to emergencies, including riots or escapes of juveniles. The emergency response team would be required to conduct monthly drills.

Aikido Control. DJJ staff are trained in aikido for physical compliance of juveniles, but some DJJ staff have stated concerns about the effectiveness of the methods. McCracken staff said they were concerned that they will be investigated if aikido is used, that aikido techniques are not appropriate for all situations, and that aikido can be ineffective against larger youths.[27] Fayette staff similarly stated that aikido may not be as effective when used by smaller staff.[28] Boyd staff also said it was good for a staff member using aikido to be bigger and stronger than the youth.[29] Warren staff said aikido may not be effective with their population and that they never train to subdue someone who is actively resisting.[30] Breathitt staff said that aikido does not always work but that, for the most part, it is the safest technique.[31] Adair staff said that aikido worked roughly 80 percent to 85 percent of the time but that some youths are too strong for it to work.[32] Jefferson staff said the techniques are good but recommended teaching how to deal with a group fight or riot.[33]

Aikido Control Training Frequency. According to monthly comments from superintendents, updates on aikido control training (ACT) appear to be inconsistently provided. Beginning in July 2020, a new format of monthly reports allowed superintendents to provide updates on training. Out of the 240 monthly updates provided to LOIC staff, 65 updates (27.1 percent) did not indicate that ACT was provided in that month.[b]

Monthly reports were considered to have mentioned ACT training if an entry referred to "aikido" or "ACT." ACT was mentioned the least in 2020, when 21 of 27 reports (77.8 percent) did not mention it. References to ACT were much more common in 2021 and 2022, when only 25.0 percent and 20.8 percent of reports, respectively, did not mention ACT. Adair mentioned ACT in every report; Boyd and Fayette mentioned it in all but one report. Jefferson mentioned it in only eight reports, and McCracken mentioned it in only nine.

[b] Six months of reports were provided for 2020, and 12 months of reports were provided for 2021 and for 2022. Each month had training updates for eight facilities, for a total of 240 monthly updates.

Training On New Defensive Equipment. DJJ officials stated that initial training on oleoresin capsicum spray (OC spray) and electric conduction devices (ECDs) will be provided by the Department of Corrections because OC spray is new to DJJ. All youth workers will receive training on OC spray, but only certain staff will be trained on ECDs. ECDs will be kept in a locked box when not in use.[34] Adair staff underwent OC spray training and described it as having the spray used on them, and then seeing if they could use the spray after going through an obstacle course.[35]

Training Needs Assessment

DJJ has contracted with Eastern Kentucky University's Facilitation Center for a training needs assessment.

DJJ has contracted with Eastern Kentucky University's Facilitation Center for a training needs assessment. The assessment will collect data through focus groups, facilitated meetings, interviews, online surveys, and research of best practices and models. It will identify remedies to resolve discrepancies between what detention staff should be doing and what they are actually doing, which could result in instruction changes or changes in job descriptions, hiring practices, performance evaluations, continuing education, or operating procedures. It will also create a clear description of desired performance and capture components of staff responsibilities and the knowledge or skills needed to perform them.[36]

The Facilitation Center will evaluate DJJ's academy curriculum and lesson plans to identify missing content, effective content, and what needs to be changed. The center's final report will provide recommendations for curriculum material. DJJ will be expected to develop a new curriculum and lesson plans to implement the recommendations.[37]

Juvenile Transportation Changes

SB 162 from the 2023 Regular Session reorganized a number of DJJ functions, including its transportation services. The bill created a separate Division of Transportation within the Office of Detention to transport juvenile offenders to detention centers. DJJ officials anticipate that this change will be wholly positive. They expect that promoting transportation services to the division level will offer enhanced supervisory capabilities, corresponding to the increase in personnel. The Transportation Branch employed 16 drivers as of March 6, 2023, but anticipated that this figure will rise to 60 following the implementation of SB 162.[38]

The reorganization is also expected to facilitate process enhancements, such as an improved rotation plan for detention vehicles, advanced communication systems, and standardization of the policy and procedures manual. Additionally, training is set to be revamped in line with a Department of Corrections curriculum, and tracking systems will see upgrades. Plans to implement a data and accountability system will ensure greater transparency for both youths and employees. In terms of personnel changes, shift policies are set to be altered to reduce employee burnout. Instead of drivers being on call for 24 hours, three distinct shifts will maintain 24-hour coverage.[39]

A $250,000 appropriation will address transportation costs for female youth.

In addition to reorganizing the transportation function within DJJ, SB 162 appropriated $250,000 in fiscal year 2022–2023 to DJJ for transportation costs for female youths detained by DJJ to be used until the juvenile detention system returns to a regional model. Local law enforcement will be reimbursed from these funds on a cost-reimbursement basis and, in certain cases, may be reimbursed for the transportation of male youths detained by DJJ.[40] However, DJJ officials have noted that their requests for additional drivers have been based partially on an intention not to place any additional burden on local law enforcement.[41]

Other Planned Changes In Transportation

Other transportation-related changes pertain to security. DJJ currently uses vehicles such as Chevrolet Impalas, Dodge Chargers, and Chevrolet Explorers to transport juveniles. These vehicles are equipped with specific safety features such as a cage separating the front seat from the back seat, disabled locks in the back seats, and barriers to prevent juveniles from breaking the side windows. However, DJJ found issues with their current fleet, as roughly 70 percent of the vehicles are rear-wheel-drive Dodge Chargers, which have performance issues in snowy or icy conditions. Spare tires limit the vehicles' trunk space, causing challenges when transporting the personal belongings of juveniles. DJJ has requested new, larger vehicles such as Chevrolet Explorers, Dodge Durangos, and Chevrolet Tahoes. The new vehicles will provide more legroom and trunk space, thereby addressing the current limitations.[42]

Figure 2.C
Safety Features Of Vehicle
In Jefferson County Youth Detention Center Fleet
May 3, 2023

Source: LOIC staff tour of facility, May 3, 2023.

In addition to upgrading the type and size of vehicles, DJJ plans to enhance the camera system in the cars. Currently, each vehicle has only one camera, which is focused on the driver. The updated system will include multiple cameras to provide a more comprehensive view.

Another significant upgrade is the move from local storage to cloud-based storage of camera footage. Currently, the footage is recorded on GoPros with SIM cards, which are kept for 30 days before being cycled out for new footage. With the new cloud-based system, the footage will be retained for 5 years. Implementation of these improvements is pending.[43]

Fleet Reimbursement

DJJ maintains a vehicle fleet of 16 vehicles to service the transportation of juveniles to its facilities. Vehicles are purchased by the Finance and Administration Cabinet (FAC) and leased to DJJ at a monthly rate. DJJ pays monthly fleet assessments for the vehicles through internal exchange transactions (IETs) under the E226 object code (Carpool Rental-ST AG).[44]

Monthly fleet assessments are based on the type of vehicle and its usage. Monthly assessment rates and mileage rates are updated once per biennium and published by FAC. These rates vary by vehicle classification, such as "compact SUV" or "full-size sedan." Mileage is reported for each fleet vehicle when monthly assessments are calculated. The method of reporting mileage depends primarily on the vehicle's age. Newer vehicles are generally equipped with a tracker to monitor miles driven; older vehicles, which lack this feature, require mileage to be reported through emails or photos of the odometer. Before the IETs are processed, the office receives a spreadsheet to verify the mileage of all fleet vehicles.[45]

The methodology for determining monthly fleet assessment rates underwent a significant change in the 2023–2024 fiscal year biennium. Prior to this period, FAC set a base monthly assessment rate and an additional charge for any mileage that exceeded a predetermined threshold. This system of excess mileage rates has now been discarded. The current method involves a fixed monthly rate coupled with a per-mile rate for all miles driven.[46]

Oversight And Compliance

Kentucky's regional juvenile detention centers (RJDCs) undergo regular external and internal audits to ensure compliance with DJJ policies and procedures.

Kentucky's RJDCs undergo regular external and internal audits to ensure compliance with DJJ policies and procedures, federal guidelines, and accreditation standards.

External audits are conducted to ensure that the facilities are complying with the standards set forth in federal PREA and ACA accreditation standards. DJJ conducts annual internal quality assurance monitoring visits at each facility to ensure compliance with departmental policies and procedures and to prepare the facilities for external audits.[47]

Table 2.6
External And Internal Audits, Kentucky RJDCs
2018 To 2022

Facility	2018	2019	2020	2021	2022
Adair	Q	Q	P Q	A Q	Q
Boyd	A P Q	Q	P Q	Q	A P Q
Breathitt	Q	A Q	Q	P Q	A Q
Campbell	P Q	A Q	Q	Q	A P Q
Fayette	Q	A Q	P Q	Q	A Q
Jefferson	—	—	—	Q	A P
McCracken	A P Q	Q	Q	Q	P Q
Warren	A Q	P Q	Q	Q	Q

Note: A = external audit conducted by American Correctional Association; P = federal Prison Rape Elimination Act audit; Q = quality assurance review conducted by DJJ.
Source: LOIC staff analysis of external and internal audit reports submitted by the Department of Juvenile Justice.

Division Of Compliance

SB 162, passed during the 2023 Regular Session, created the Division of Compliance within DJJ.[48] The newly created division's mission is to continuously monitor DJJ policies and procedures to ensure that the department adheres to ACA and PREA standards, guidelines, and best practices. In addition to coordinating external and internal audits, the division will conduct unannounced facility visits, review documentation, and interview staff and youths. The division will share its findings and recommendations with DJJ leadership.[49]

In addition to coordinating internal and external oversight of the detention centers, the division is developing an internal process for tracking noncompliance issues and areas of concerns identified by the various internal and external auditing groups. Agency officials stated that this process will include recommendations for corrective actions and follow-up reviews, including unannounced visits, to ensure compliance. Further, the division will collaborate with the training branch to provide training related to issues identified in the external and internal audits.[50]

Internal Investigations Branch

The Internal Investigations Branch (IIB) investigates allegations of abuse, neglect, and special incidents of youths committed to or in the custody of DJJ.

DJJ's Internal Investigations Branch was created in 1999 by 500 KAR 13:020. KRS 15A.160 gives the secretary of the Justice and Public Safety Cabinet the power to promulgate regulations in accordance with KRS Chapter 13A and direct proceedings and actions for the administration of all laws and functions vested in

the cabinet. This statute gives the authority for the promulgation of 500 KAR 13:020.

One of IIB's primary purposes is to investigate allegations of abuse, neglect, and special incidents of youths committed to or in the custody of DJJ.[51] 500 KAR 13:020 defines *special incident* as "an act in which the health or welfare of a youth is harmed or threatened with harm by an offender …." Investigations of abuse and neglect would normally be under the purview of the Department for Community Based Services, but IIB and that department have an MOU that IIB will investigate any allegation of abuse or neglect that occurs in a DJJ facility.

500 KAR 13:020 requires that a toll-free number be available to all staff and youths to report special incidents, and that a voice mailbox system be available for reporting special incidents after normal work hours. Upon receiving a report of a special incident, IIB must conduct an investigation or conduct a preliminary inquiry to determine whether further investigation is warranted. Any substantiated investigations of abuse or neglect are to be forwarded to the Cabinet for Health and Family Services (CHFS) and the local county attorney, law enforcement, or the Kentucky State Police.

Figure 2.D
Fayette RJDC Hotline

Source: LOIC staff tour of facility, March 3, 2023.

500 KAR 13:020 states what types of complaints IIB *shall* investigate and what complaints it *may* investigate. For the "shall investigate" category, the regulation requires IIB to automatically conduct an investigation. For the "may investigate" category, IIB is not required to investigate but it is allowed to. IIB estimates that 15 percent of complaints fall in the "may investigate" category. Many times, complaints categorized as "may investigate" are handed off to the DJJ ombudsman for investigation.

Ombudsman

The DJJ ombudsman office was created in 2022.

The DJJ ombudsman office was created in 2002 through HB 144, which amended KRS 15A.065. Like IIB, the ombudsman is an avenue for staff and juveniles to register concerns. Although special incidents that fall under the "may investigate" category for IIB can be handed to the ombudsman for investigation, the ombudsman deals primarily with grievances within facilities. All facilities provide the ombudsman with monthly grievance reports to review. The ombudsman also does annual facility visits and grievance audits as well as unannounced visits to the facilities

Other States

LOIC staff examined two other states, Indiana and South Carolina, to gain insight into how their juvenile detention facilities are operated and innovations they are making to improve their juvenile justice outcomes. The Indiana review focused on two detention centers and two postadjudication facilities. The South Carolina review focused on its plans for psychiatric care for juveniles.

Indiana

Indiana's Division of Youth Services oversees the management of juvenile care within the Indiana Department of Correction.

Indiana's Division of Youth Services (DYS) oversees the management of juvenile care within the Indiana Department of Correction. Its vision is "to positively impact the future of Indiana's delinquent youth to foster responsible citizenship," and its mission is "focused on community protection, accountability, beliefs that foster responsible community living and competency development."[52]

DYS has four juvenile correctional facilities:

- Logansport Juvenile Correctional Facility Intake Unit
- Logansport Juvenile Correctional Treatment Facility

- La Porte Juvenile Correctional Facility (serves as female intake facility)
- Pendleton Juvenile Correctional Facility

DYS also oversees the state's juvenile detention centers. Nineteen Indiana counties have juvenile detention centers. Sixteen are managed by the county, and three are managed privately. Children in Indiana can be held in a juvenile detention center while their cases are pending and, in some instances, can be ordered to remain in a detention center for a period of time after disposition. These facilities provide services such as education, volunteer groups, large-muscle activity, Alcoholics Anonymous/Narcotics Anonymous, religious services, and life skills training.

LOIC staff toured four juvenile facilities in Indiana, listed in Table 2.7.

Table 2.7
Indiana Facilities Toured By Legislative Oversight And Investigations Committee Staff

Facility	Management	Coed Population	Accepts Waiver Youths*
Vanderburgh Detention Center	Private	Yes	No
Clark County Detention Center	County	Yes	Yes
La Porte Correctional Facility	State	No	Yes
Pendleton Correctional Facility	State	No	Yes

*Youths charged as adults.
Source: LOIC staff tours on January 18, January 23, February 16, and February 17, 2023.

Vanderburgh County Youth Care Center. The facility is part of a rescue mission that has existed for 106 years. The Youth Care Center was opened over 40 years ago with the mission of combating homelessness through early intervention in juveniles' lives. It is unique in that it is a private facility funded primarily by the Vanderburgh County government. The center has a multiyear fee-for-service contract with the county to provide juvenile detention. The county cannot replicate the same services as cost effectively as the center, according to facility staff.[53]

Indiana statutes allow juveniles over 16 years old to be charged and tried as adults for certain offenses. The facility generally does not bring in these waived offenders. When it does, it is generally for only approximately 2 weeks until they can be placed in a more permanent facility. These high-risk youths were covered under the waiver statute and are automatically moved to a Department of Correction facility. The facility has 40 beds: 32 for boys and 8 for girls. Boys and girls are housed in separate units and never interact with one another. Residents are not separated based on the severity of their offenses.[54]

Clark County Juvenile Detention Center. This facility has 14 beds but often houses more than 14 youths, requiring placement of two youths in a room. Dangerous or violent youths are held in a holding cell separate from other youths. Staff do not have conductive electric devices but can request the use of OC spray from the director or assistant director. Staff are instructed in Safe Crisis Management, a program that emphasizes verbal de-escalation. After verbal attempts at control, staff can use restraints, and then a restraint chair in serious situations.[55]

Female youths are kept separate from males in sleeping areas and in showering areas, but programs, schools, and meal times are coed. Generally, the center does not have an issue with mixing of genders. These situations are very staff controlled, and there must be at least one seat between male and female youths. The center has stopped sending away youths who have been charged as adults. The state found it was not productive to keep juveniles in adult facilities. When mixed with the adult population, suicide and sexual abuse rates increased among juveniles. When kept separate via sight/sound isolation, the youths were denied programs and educators could not get in.[56]

La Porte Juvenile Correctional Facility. The facility was established in November 2017 on 60 acres of land. It is an all-female, mixed-security facility that is primarily meant for minors who have been adjudicated by the court. It is the only all-female post-adjudication facility in the state. Youths incarcerated as adults (YIAs) come to La Porte (female) or go to Pendleton after being processed at Logansport (male). Youths are not separated by security level at La Porte. During a facility tour, staff stated to LOIC staff that they have not had any issues with the mixing of youths.[57]

Pendleton Juvenile Correctional Facility. This facility was established on July 5, 2000, on 91 acres of land. It is an all-male, maximum-security facility meant for minors who have been adjudicated by the court. New residents are held at Logansport Juvenile Correctional Facility for 2 weeks before being transferred to Pendleton. Youths are in school all day at the facilities. Pendleton is the maximum-security facility and gets all the high-risk youths. It is the only male facility with 24-hour medical care.[58]

Pendleton receives YIAs and any youths with high mental health needs. A separate building exists for youths with more serious mental health needs. Pendleton houses safekeepers—youths charged with adult crimes (such as murder and attempted murder)

who will become YIAs if found guilty. Because of waiver youth laws, safekeepers used to be housed in jails or detention centers.[59]

South Carolina

The South Carolina Department of Juvenile Justice (SCDJJ) has made plans to open a new psychiatric residential treatment facility (PRTF) for youths in the justice system who require mental health care. The state's only previous residential treatment facility for children closed in 2015. Since then, children with serious mental illnesses have been put into SCDJJ detention facilities. Because these youths meet the criteria for a diagnosable serious mental illness, South Carolina law requires that they be transferred to the Department of Mental Health (DMH). SCDJJ and the Department of Children's Advocacy are partnering with DMH on this project. Federal law does not allow SCDJJ to accept Medicaid funds, but DMH can accept the funds. This partnership allows the state to pay for its youths, most of whom are eligible for Medicaid.[60]

The South Carolina Department of Juvenile Justice received $20 million to build a new psychiatric residential treatment facility.

SCDJJ made the request for $20 million to build a new facility during a budget presentation to the South Carolina Ways and Means subcommittee. The South Carolina Governor's Office then pushed the request into an appropriation.[61]

On July 1, 2022, the South Carolina Department of Health and Human Services (DHHS), DMH, SCDJJ, and the Department of Children's Advocacy published an MOU outlining the funding, design, and construction for the PRTF. A third party will be contracted to design and build the facility. SCDJJ will be allocated $20 million from the General Assembly, which will transferred to DHHS to manage the RFP process and construction of the project. DMH will own and operate the facility. DHHS will distribute an additional $5 million, put into the Medicaid agency's budget if the construction costs exceed $20 million. The MOU does not outline how the facility will be operated.[62]

SCDJJ's method of creating a partnership and acquiring funding to provide treatment for youths with serious mental illnesses can be a useful model for Kentucky's own DJJ, which does not have enough properly trained staff to handle youths with mental health issues. Creating a partnership with other departments to build a treatment facility and using Medicaid funds to treat the youths could be an option.

Chapter 3

Findings And Recommendations

This review produced 12 major finding areas, 31 recommendations, and 1 matter for legislative consideration.

The evaluation of the eight regional juvenile detention centers operated by the Department of Juvenile Justice produced 12 major finding areas, 30 recommendations, and 1 matter for legislative consideration.

Why Was DJJ Created, And How Much Does It Spend?

The impetus for the creation of DJJ was the findings letter sent by the US Department of Justice to then Governor Brereton C. Jones on July 28, 1995, which addressed constitutional and federal statutory rights of juveniles who are in custody.[63] The letter outlined deficiencies in various areas:

- Abuse investigations
- Isolation rooms
- Classification and initial screening
- Staffing
- Physical conditions of confinement
- Treatment programs
- Medical care
- Mental health services
- Education[64]

Noted deficiencies formed the basis of a consent decree between the US Department of Justice and the Commonwealth of Kentucky.

These deficiencies formed the basis of a consent decree between the US Department of Justice and the Commonwealth of Kentucky. The consent decree identified substantive provisions in the following areas for the commonwealth to address:

- Protection from abuse, mistreatment, and injury
- Treatment services
- Education and vocational training and structured activities
- General population
- Juveniles with disabilities
- Structured activities
- Aftercare treatment services
- Time out and isolation
- Staffing, operational, and security procedures
- Medical care
- Mental health care
- Classification

- Fire safety
- Bed space and overcrowding
- Maintenance and sanitation[65]

The decree specified that the commonwealth would have 180 days, after signing, to implement the provisions set out in the decree. The commonwealth also agreed to appoint a monitor within 30 days of the entry of the decree for quarterly review. The decree required that the commonwealth file status reports every 90 days with the court and the monitor, with a copy to the United States, once the decree was signed and then again upon termination.[66] The court would retain jurisdiction of the action for the lifetime of the consent decree or until the commonwealth had fully and faithfully implemented all requirements, as well as maintaining the requirements for 1 year. The decree was terminated in 2001.[67]

Codified Structure Of DJJ

In 1996, the legislature authorized the creation of DJJ via HB 117. This bill provided that DJJ, headed by a commissioner, would be in charge of developing and administering programs for preventing juvenile crimes, identifying juveniles at risk of becoming status or public offenders (as well as creating early intervention strategies for these juveniles), and operating or contracting for operation of preadjudication and postadjudication facilities for juveniles charged with public offenses or charged as youthful offenders.[a] The newly authorized DJJ was given responsibility for providing alternatives to detention, as well as appropriate programming for juvenile offenders.[68]

HB 117 created an advisory board for DJJ. This board was to be appointed by the governor and provide recommendations to the governor, the Justice Cabinet, DJJ, the then Cabinet for Human Resources, the Senate and House committees on judiciary and appropriations and revenue, and the interim joint committees on those subjects. HB 117 also created a new section of KRS Chapter 27A, making AOC the primary repository of court records of juveniles charged with or arrested for complaints (or juveniles against whom complaints have been filed), where the complaints involve status offenses, public offenses, and youthful offender proceedings. AOC also became the repository for records

[a] KRS 600.020(51) defines *public offense* as one under KRS Chapter 527 that, if committed by an adult, would be a crime. KRS 600.020(72) defines *youthful offender* as "any person, regardless of age, transferred to Circuit Court under the provisions of KRS Chapter 635 or 640 and who is subsequently convicted in Circuit Court."

involving the handling and disposition of cases, and it is required to make juvenile records available to the agencies and persons specific by law.[69]

Executive Order 96-1069, signed on August 7, 1996, established the organizational structure for DJJ. On November 27, 1996, Executive Order 96-1576 transferred program staff and funding to DJJ from the Cabinet for Families and Children, effective December 16, 1996.[70] Executive Order 97-891 subsequently created the detention division, which oversaw the construction of three new juvenile detention centers in Breathitt, McCracken, and Campbell Counties.[71] During the 1998 legislative session, the creation of DJJ was codified in HB 455.[72]

In 2002, HB 144 amended KRS 15A.065 to require that youths in state-operated or -contracted residential treatment programs have access to an ombudsman to report program problems or concerns.[73] The DJJ has its own ombudsman and does not rely on the ombudsman for the Cabinet for Health and Family Services. Rather, DJJ's ombudsman works closely with the Justice and Public Safety Cabinet's Internal Investigations Branch when investigating allegations of abuse and neglect, as well as grievances. Created in 1999, the IIB predates the ombudsman.[74]

DJJ initially expended money in four areas: detention services, program management, program operations, and support services.

From a budgetary standpoint, DJJ initially expended money in four areas: detention services, program management, program operations, and support services. The expenditure unit for detention services was especially salient, given DJJ's developing role of operating and overseeing juvenile detention centers. The initial goal of DJJ was to strategically locate detention centers on a regional basis, initially divided by three regions. In subsequent budgets, however, detention service expenditures were collapsed into program operations, which also included appropriations for day treatment services, group homes, residential facilities, community supervision, private child care facilities, and alternatives to detention.[75]

In order to disaggregate expenditures by individual juvenile detention centers, respective unit codes in eMARS were used. Under the Justice and Public Safety Cabinet (cabinet #54) and DJJ (department #523), expenditures for each facility can be extracted. Table 3.1 provides additional detail.

Table 3.1
RJDC Expenditures
FY 2019 To FY 2022

Facility	FY 2019	FY 2020	FY 2021	FY 2022	Total
Adair Youth Dev Center-1005*	$5,250,952	$4,551,374	$4,586,162	$4,835,483	$19,223,971
Fayette Reg Juvenile Detention	4,849,946	4,589,390	4,555,879	4,254,626	18,249,841
Breathitt Reg Juvenile Detention	4,516,578	4,065,166	3,701,615	4,260,709	16,544,067
Boyd Reg Juvenile Detention	3,242,211	3,072,383	3,015,591	3,754,662	13,084,847
McCracken Reg Juvenile Detention	3,476,279	3,279,035	3,121,044	3,186,733	13,063,091
Warren Reg Juvenile Detention	3,140,387	2,943,147	2,735,745	3,001,905	11,821,183
Campbell Reg Juvenile Detention	3,459,342	3,238,745	2,476,184	2,135,655	11,309,926
Louisville Day Treatment*†	2,182,004	2,575,437	2,633,757	3,463,260	10,854,458
Adair Youth Dev Center-3337*	350	350	350	0	1,050
Total	$30,118,050	$28,315,026	$26,826,326	$28,893,032	$114,152,434

Note: Figures do not sum to totals shown due to rounding. Dev = development; Reg = regional.
*Includes expenditures for both preadjudication and postadjudication services. Unit codes in eMARS do not exist to separately break out preadjudication or detention expenditures from postadjudication services expenditures.
†The Louisville Day Treatment unit code is used because Jefferson Regional Juvenile Detention Center expenditures are tracked using this unit code.
Source: LOIC staff analysis of eMARS expenditure data.

During the 2023 Regular Session, the legislature modified the organizational structure of DJJ by creating a separate Office of Detention and requiring that "all detention centers report to one (1) supervisor who reports directly to the commissioner."[76] In order to accurately track expenditures for the new office, a separate appropriation allotment for the Office of Detention should be created in eMARS to better reconcile dedicated appropriations with juvenile detention center expenditures. Currently, however, the allotment is established for program operations (preadjudication and postadjudication), as opposed to separate allotments for preadjudication and postadjudication. The new allotment could be created under Appropriation 523J-Juvenile Justice, with expenditures being expended and tracked under separate expenditure functions.

The newly created Office of Detention also includes a separate Division of Transportation.

The newly created Office of Detention also includes a separate Division of Transportation, to facilitate the transporting of juvenile offenders to various juvenile detention centers. Finally, the Division of Compliance and Division of Professional Development were created as a result of SB 162 from the 2023 legislative session.[77]

Recommendation 3.1

Recommendation 3.1

The Justice and Public Safety Cabinet should create a separate appropriation allotment for the Office of Detention, as well as separate expenditure functions for each juvenile detention center.

How Useful Are Required External Audits For Identifying Factors That Could Lead To Disturbances And Riots?

DJJ facilitates external audits required by national and federal accreditation standards. As part of this facilitation, it conducts internal quarterly assurance reviews to prepare RJDCs for external audits.

American Correctional Association

The American Correctional Association audits accredited juvenile detention centers to ensure "adherence to clear standards relevant to all areas/operations of the facility, including safety, security, order, inmate care, programs, justice, and administration."[78] The standards by which accredited facilities are audited were created by ACA, concurrent with the creation of the Commission on Accreditation for Corrections in 1974.[79] Before beginning the accreditation process, facilities enter into an accreditation contract, which includes obligations, type of accreditation sought, relevant standards, and cost for accreditation services.[80]

Audits of Kentucky's RJDCs were conducted by the American Correctional Association (ACA) from 2018 through 2022.

Audits of Kentucky's RJDCs were conducted by ACA from 2018 through 2022.

Table 3.2
American Correctional Association Audits Of RJDCs

RJDC	2018	2019	2020	2021	2022
Adair*	—	—	—	√	—
Boyd	√	—	—	—	√
Breathitt	—	√	—	—	√
Campbell	—	√	—	—	√
Fayette	—	√	—	—	√
Jefferson	—	—	—	—	√
McCracken	√	—	—	—	—
Warren	√	—	—	—	—

*Adair Youth Development Center underwent a PREA audit in 2021; however, since the facility is considered a youth development center, different standards were used. Adair's designation as a youth development center meets the intent of KRS 605.095(2), requiring one postadjudication facility to have a security level comparable to that of a medium-security adult facility.
Source: LOIC staff analysis of ACA audit reports.

During the audits, ACA applied 30 mandatory standards and 371 nonmandatory ones. For the eleven audits conducted, all RJDCs were compliant with the mandatory standards, with the

exception of Standard JDF#3A-16-1.[b] For the audits conducted in 2019 and 2022, six RJDCs were noncompliant with 39 of 371 nonmandatory standards (11 percent).

RJDCs consistently met mandatory ACA standards and overwhelmingly met nonmandatory ones. However, an internal primary focus to prepare RJDCs to meet standards once every 3 years may not help to identify other concerns that could lead to statewide disruptions or riots.

In addition to consistently meeting the mandatory standards, the audited RJDCs overwhelmingly met nonmandatory standards. Meeting ACA standards for accreditation is an important milestone, which often serves as the basis to develop and improve facility operations. However, an internal primary focus to prepare RJDCs to meet standards once every 3 years may not help to identify other concerns that could lead to statewide disruptions or riots.

Tables 3.3 to 3.6 provide additional detail on noncompliance with standards at the Breathitt, Fayette, Campbell, and McCracken RJDCs.

Table 3.3
Breathitt RJDC Noncompliance With Standards
2022 ACA Audit Report

Standard	Description	Corrective Actions/Notes
3-JDF-4C-08	Physician availability	Facility agreed to develop a structured process for direct communication with physician by July 1, 2022.
3-JDF-4C-25	Dental care provided by licensed dentist	Facility indicated that it would comply with standard by July 1, 2022.

Source: LOIC staff compilation of information included in 2022 ACA audit report of the Breathitt RJDC.

Table 3.4
Fayette RJDC Noncompliance With Standards
2019 ACA Audit Report

Standard	Description	Corrective Actions/Notes
3-JDF-2C-08	Operable showers with temperature-controlled hot and cold running water, at a minimum of one shower for every 12 juveniles	Audit report recommended capital expenditures to rectify shower temperature control issue; facility appealed unsuccessfully.

Source: LOIC staff compilation of information included in 2019 ACA audit report of the Fayette RJDC.

[b] DJJ 713 (p. 1) states that the use of fixed restraints is prohibited in all state-operated detention centers. Further, DJJ 324 (p. 3) states that "Youth shall not be affixed to a stationary object in any manner so as to constitute a fixed restraint. Four-point and five-point restraints shall be prohibited."

Table 3.5
Campbell RJDC Noncompliance With Standards
2022 ACA Audit Report

Standard	Description	Corrective Actions/Notes
3-JDF-1D-08	Administrative and managerial staff training	Facility will ensure that trainings are completed, documented, and entered in electronic training system by July 31, 2022.
3-JDF-1D-11	Support employee training	Facility will ensure that trainings are completed, documented, and entered in electronic training system by July 31, 2022.
3-JDF-1D-12	Clerical/support employee	Facility will ensure that trainings are completed, documented, and entered in electronic training system by July 31, 2022.
3-JDF-2C-02	Use of single cells/rooms and multiple-occupancy cells/rooms	Facility agreed to modify daily schedule to include additional programming by July 31, 2022.
3-JDF-3C-04	Personnel who work with juveniles receive sufficient training	Facility will conduct refresher training for all staff on rules of juvenile conduct, rationale for the rules, and sanctions in the Youth Handbook by July 31, 2022.
3-JDF-3C-10	Written policy, procedure, and practice require disciplinary reports	Facility agreed to conduct refresher training and to document incidents of major rule violations or reportable minor violations, to be completed by December 31, 2022.
3-JDF-3C-11	Juvenile confinement	Facility agreed to conduct refresher training and to conduct and document reviews by administrator or designee by December 31, 2022.
3-JDF-3C-12	Written copy of alleged major rule violation to juveniles	Facility agreed to conduct refresher training and to conduct and document reviews by administrator or designee by December 31, 2022.
3-JDF-3E-04	Visual confinement checks every 15 minutes	Facility agreed to conduct refresher training and to "consistently and accurately document youth contacts on the DJJ observations log for all youth placed on confinement status" by December 31, 2022.
3-JDF-4B-15	Hair care services available to juveniles	Facility agreed to obtain a contact with a barber/cosmetologist to provide hair care services by December 31, 2022.
3-JDF-5E-04	Recreation, leisure time, and large-muscle activity	Facility agreed to develop a daily schedule that incorporates 1 hour of large-muscle activity per day and 1 hour of structured leisure time per day; anticipated completion date was July 31, 2022.

Source: LOIC staff compilation of information included in 2022 ACA audit report of the Campbell RJDC.

Table 3.6
McCracken RJDC Noncompliance With Standards
2022 ACA Audit Report

Standard	Description	Corrective Actions/Notes
3-JDF-1A-12	Community advisory committee	Facility will solicit and form an advisory committee representative of the community by August 2022.
3-JDF-1A-20	Regular case conferences	Facility will participate in regular meetings and case conferences with community workers, court-designated workers, the court, and law enforcement by August 2022.

Standard	Description	Corrective Actions/Notes
3-JDF-1A-28	Monitoring space requirements	Facility will prepare and submit an annual report and strategic plan by August 2022.
3-JDF-1D-03	Facility training plan	Facility will identify training committee members from institutional departments and meet at least quarterly to review progress and resolve problems by August 2022.
3-JDF-1F-01	Information storage, retrieval, and review (information system is part of an overall research and decision-making capacity relating to both juvenile and operational needs)	Facility will follow internal processes of completing and submitting monthly/annual reports showing that information system is part of an overall research and decision-making capacity relating to both juvenile and operational needs, by August 2022.
3-JDF-1F-02	Effectiveness of information system as it relates to overall facility management	Facility will provide annual written review of information system, ensuring effectiveness as it relates to overall facility management, by August 2022.
3-JDF-2C-02	Use of single cells/rooms and multiple-occupancy cells/rooms	Facility will modify daily schedule to include additional programming to ensure that youths are out of their room more than 10 hours per day by August 2022.
3-JDF-3A-05	Written operational shift assignments	Facility agreed to submit and review written shift assignments to assigned staff for review and acknowledgment to align with standard and policy requirements by August 2022.
3-JDF-3C-07	Housing of male and female offenders require at least one male and one female staff member on duty at all times.	Facility will submit written shift assignments to assigned staff for review and acknowledgement, and shift assignments will be reviewed annually and updated as needed, by August 2022.
3-JDF-4A-09-1	Food service training	Facility's existing and future food service staff will undergo training on food service equipment and safety procedures by August 2022.
3-JDF-4C-03	Health authority meetings with facility administrator at least quarterly	Facility administrator will meet with health authority quarterly to discuss health care delivery system and overall health environment by August 2022.
3-JDF-4C-13	Juvenile immunization records	Facility will update immunizations within legal constraints by August 2022.
3-JDF-4C-41	Clinical management of chemically dependent juveniles	Facility agreed to document prerelease relapse prevention education—including risk management and aftercare discharge plans—for chemically dependent juveniles by August 2022.
3-JDF-4C-47	Confidentiality of health records	Facility will make efforts to control medical records per policy and restrict access to unauthorized personnel, and all medical staff will undergo training on agency policy, by August 2022.
3-JDF-5A-05	Referral for non-court services juveniles named in complaints	Facility stated its intent to document referrals for non-court services by August 2022.
3-JDF-5E-01	Qualified recreation director	Facility will identify and train recreation coordinator by August 2022.
3-JDF-5E-04	Recreation and leisure time plan	Facility will develop daily schedule that incorporates 1 hour of large-muscle activity per day as well as 1 hour of structured leisure time by August 2022.

Source: LOIC staff compilation of information included in 2022 ACA audit report of the McCracken RJDC.

Prison Rape Elimination Act

The purpose of the Prison Rape Elimination Act (PREA) is to "establish a zero-tolerance standard for the incidence of prison rape in prisons in the United States."

Congress passed the Prison Rape Elimination Act in 2003. Its purpose is to "establish a zero-tolerance standard for the incidence of prison rape in prisons in the United States."[81] PREA standards require juvenile detention centers, among other "covered confinement facilities," to be audited at least once during every 3-year audit cycle.[82] The audit process, according to the National PREA Resource Center, is an audit of practices to help eliminate sexual abuse in correctional and juvenile facilities.[83] Generally, the standards include planning, education, screening for risk of victimization and abusiveness, reporting, investigations, discipline, medical and mental care, and data collection and review.[84]

PREA audits of Kentucky's RJDCs were conducted from 2018 through 2022.

Table 3.7
PREA Audits Of Kentucky's RJDCs
2018 To 2022

RJDC	2018	2019	2020	2021	2022
Adair*	—	—	√	—	—
Boyd	√	—	√	—	√
Breathitt	—	—	—	√	—
Campbell	√	—	—	—	√
Fayette	—	—	√	—	—
Jefferson	—	—	—	—	√
McCracken	√	—	—	—	√
Warren	—	√	—	—	—

*Adair Youth Development Center underwent a PREA audit in 2021; however, since the facility is considered a youth development center, different standards were used. Adair's designation as a youth development center meets the intent of KRS 605.095(2), requiring one postadjudication facility to have a security level comparable to that of a medium-security adult facility.
Source: LOIC staff analysis of Prison Rape Elimination Act audit reports.

RJDCs complied with PREA standards from 2018 to 2022, but multiple corrective actions were required.

Federal auditors applied 43 mandatory standards to determine compliance. There were no instances of any RJDC failing to comply with the 43 standards over the 5-year investigation period. In multiple instances, however, RJDCs were required to complete corrective actions in order to meet various standards. The corrective actions typically consisted of additional training for staff and/or administration in various areas. Table 3.8 provides additional detail.

Table 3.8
PREA Corrective Actions By Kentucky's Juvenile Detention Centers
2019 To 2022

Standard	Description	Warren (2019)	Adair (2020)	Boyd (2020)	Campbell (2022)	Jefferson (2022)	Total
115.313	Supervision and monitoring	√	—	—	√	√	3
115.315	Limits to cross-gender viewing and searches	√	—	—	√	—	2
115.316	Residents with disabilities and residents with limited English proficiency	—	√	—	—	—	1
115.317	Hiring and promotion decisions	√	—	—	—	—	1
115.318	Upgrades to facilities and technologies	—	—	√	—	—	1
115.321	Evidence protocol and forensic medical examinations	—	—	—	—	√	1
115.322	Policies to ensure referrals of allegations for investigations	√	—	—	—	—	1
115.331	Employee training	√	—	—	—	—	1
115.332	Volunteer and contractor training	√	—	—	—	—	1
115.335	Specialized medical and mental health care training	—	√	—	—	—	1
115.353	Resident access to outside support services and legal representation	√	√	—	√	√	4
115.364	Staff first responder duties	—	—	—	—	√	1
115.367	Agency protection against retaliation	—	—	—	—	√	1
115.371	Criminal and administrative agency investigations	—	—	—	—	√	1
115.382	Access to emergency medical and mental health services	—	—	—	—	√	1
115.383	Ongoing medical and mental health care for sexual abuse victims and abusers	—	—	—	—	√	1
115.401	Frequency and scope of audits	—	√	—	—	—	1
Total							23

Source: LOIC staff analysis of Prison Rape Elimination Act audit reports.

The audited RJDCs consistently met mandatory standards during PREA audits. With the few exceptions noted in Table 3.8, the PREA audits appear to adequately address the goals of federally mandated requirements to reduce the instances of sexual abuse. Consistently meeting PREA standards is an important contribution to achieving federal goals. However, an internal primary focus on preparing RJDCs to meet standards once every 3 years may not help to identify other concerns that could lead to statewide disruptions or riots.

Quality Assurance Monitoring

The Quality Assurance Division (QAD) conducts annual monitoring of RJDCs.

DJJ, through its Quality Assurance Division (QAD), conducts annual monitoring of RJDCs. The QAD consists of one branch

manager and six justice program administrators. Currently, four additional justice program administrators are needed, according to DJJ officials.[85] Table 3.9 provides additional detail about the QAD engagements.

Table 3.9
DJJ Quality Assurance Monitoring Reports For RJDCs

RJDC	2018	2019	2020	2021	2022
Adair*	√	√	√	√	√
Boyd	√	√	√	√	√
Breathitt	√	√	√	√	√
Campbell	√	√	√	√	√
Fayette	√	√	√	√	√
Jefferson	—	—	—	√	—
McCracken	√	√	√	√	√
Warren	√	√	√	√	√

*Adair Youth Development Center underwent quality assurance reviews as a youth development center. Its designation as a youth development center meets the intent of KRS 605.095(2), requiring one postadjudication facility to have a security level comparable to that of a medium-security adult facility.
Source: LOIC staff analysis of DJJ quality assurance monitoring reports.

The primary purpose of QAD monitoring is to prepare RJDCs for ACA and PREA audits.

The primary purpose of QAD monitoring is to prepare RJDCs for ACA and PREA audits. The reports are extremely thorough and summarize the results of each monitoring visit. Each visit includes observation of building exteriors, perimeters, and interior general population areas. Staff-controlled areas such as control centers, records storage, personal property storage, medical, kitchen, dining, and maintenance areas are also observed. Table 3.10 provides additional detail.

Table 3.10
Quality Assurance Division Observation Areas And Checks

Observation Area	Number Of Observation Checks
Exterior buildings and perimeter of program	1. Driveway and parking lot 2. Lawn and surrounding property 3. Trash containment 4. Outside appearance 5. Windows and doors 6. Gutters 7. Signs 8. Fences 9. Perpetual inventory/log/safety data sheet (SDS) for hazardous materials (items not in use properly stored) 10. Total and daily inventories/log for tools and sharps (items not in use properly stored) 11. State vehicles locked
General population areas	1. Walls, trim, and ceiling surfaces 2. Bulletin boards 3. Floors and carpets

Observation Area	Number Of Observation Checks
	4. Restrooms (clean, in working order, hot and cold water) 5. Orderliness of space 6. Wall hangings 7. Light fixtures 8. Key inventory and log (to include manual release of security doors) 9. Emergency evacuation plans posted in all areas of building (legends are accurate and up to date) 10. First aid kits 11. Fire extinguishers (monthly and annual inspections) 12. Telephones programmed to Internal Investigations Branch or accessible to youth to report allegations of abuse (hotline number posted) 13. Restrooms and showers (1 to 8 ratio); wash basins (1 to 12 ratio) 14. Location and security of mechanical restraints (including total inventory, monthly inventory, and log) 15. Daily logs 16. Youth rooms 17. Daily activity schedule (posted or contained within the resident handbook) 18. Visitor log 19. Perpetual inventory/log/SDS for hazardous materials (items not in use properly stored) 20. Total and daily inventories/log for tools and sharps (items not in use properly stored) 21. Facility religious coordinator folder (annual training with agency coordinator, facility religious coordinator's training of facility staff, and confidentiality statement signed by volunteer clergy providing religious services to facility)
Storage of records and personal property	1. Youth records (double locked, cabinet marked confidential, and files marked confidential) 2. Hard-copy signatures for individual treatment plan and those reviews (30-day and 60-day) correspond to the Juvenile Offender Resource Information entries 3. Youth personal property is secured and inventoried
Medical area	1. Doors to medical area are locked when not in use 2. Perpetual inventory/log/SDS for hazardous materials (items not in use properly stored) 3. Total and daily inventories/log for sharps (items not in use properly stored)
Vocational classrooms/areas	1. Vocational area(s) are clear of debris and provide a safe working environment (floors color coded for safety, safety posters near equipment, etc.) 2. Youth are wearing proper apparel for work to be done (work shoes, goggles, hard hats if scaffolding is used, etc.) 3. Perpetual inventory/log/SDS for hazardous materials (items not in use properly stored) 4. Total and daily inventories/log for tools and sharps (items not in use properly stored)
Kitchen and dining areas	1. Kitchen areas are clean and orderly 2. Perpetual inventory/log/SDS for hazardous materials (items not in use properly stored) 3. Total and daily inventories/log for tools and sharps (items not in use properly stored) 4. Freezer, refrigerator, water, and dry storage temperature logs 5. Retail food establishment reports 6. Signs reminding staff to wash hands 7. Meal counts and population sheet 8. Meal schedules and menus
Maintenance	1. Perpetual inventory/log/SDS for hazardous materials (items not in use properly stored) 2. Total and daily inventories/log for tools and sharps (items not in use properly stored)

Source: LOIC staff analysis of Prison Rape Elimination Act audit reports.

Figure 3.A
Boyd RJDC Emergency Space

Source: LOIC staff tour of facility, March 8, 2023.

Figure 3.B
McCracken RJDC Records Storage

Note: Shed contains timesheet and other records.
Source: LOIC staff tour of facility, April 14, 2023.

The visits include compliance checks against ACA accreditation and PREA standards.

The visits include compliance checks against ACA accreditation and PREA standards. Table 3.11 provides additional detail related to the number of ACA standards assessed, the number of standards not met, the overall frequency, and the number of standards not assessed.

Table 3.11
DJJ Quality Assurance Monitoring Reports, ACA Standards Assessed/Not Met
2018 To 2022

RJDC	Year	Standards Assessed	Standards Not Met*	Standards Not Assessed	Overall Frequency*
Adair**	2018	137	0	235	
	2019	137	3	235	
	2020	372	135	0	
	2021	371	88	1	
	2022	371	125	1	
					351
Boyd	2018	128	5	294	
	2019	128	0	294	
	2020	422	41	0	
	2021	422	123	0	
	2022	422	139	0	
					308
Breathitt	2018	128	5	294	
	2019	128	3	294	
	2020	422	15	0	
	2021	421	70	0	
	2022	422	74	0	
					167
Campbell	2018	128	1	294	
	2019	128	1	294	
	2020	422	258	0	
	2021	422	223	0	
	2022	422	289	0	
					772
Fayette	2018	128	114	294	
	2019	129	122	293	
	2020	421	131	1	
	2021	422	158	0	
	2022	422	161	0	
					836
Jefferson	2021	418	383	4	
McCracken	2018	128	0	294	
	2019	129	0	293	
	2020	—	—	—	
	2021	422	311	0	
	2022	422	277	0	
					588

RJDC	Year	Standards Assessed	Standards Not Met*	Standards Not Assessed	Overall Frequency*
Warren	2018	128	1	294	
	2019	129	2	293	
	2020	422	0	0	
	2021	422	0	0	
	2022	—	—	—	
					375

*The number of standards not met by RJDCs does not include the number of times each standard was not met. Therefore, frequency numbers may be much larger.
**Adair was assessed using standards for juvenile correction facilities, but the other facilities were assessed using standards for juvenile detention facilities. Adair's designation as a youth development center meets the intent of KRS 605.095(2), requiring one postadjudication facility to have a security level comparable to that of a medium-security adult facility.
Source: LOIC staff analysis of DJJ quality assurance monitoring reports.

Lack Of Automation

LOIC analysts identified the lack of an automated system.

During their investigation, LOIC analysts identified the lack of an automated system. This lack was immediately evident when ACA, PREA, and QAD audit results had to be input for analysis. As seen from Tables 3.10 and 3.11, QAD collects voluminous information from its reviews, as well as those of ACA and PREA. The lack of an automated system not only prevents QAD from efficiently maintaining its compliance data, but it also does not allow QAD to use its data in different ways—such as identifying problem areas to prevent systemic disruptions statewide.

This finding is consistent with general comments from the secretary of the Justice and Public Safety Cabinet expressing the need for DJJ to move toward a strategic level of thinking to understand data as more than an aggregate set of numbers.

This finding is consistent with general comments from the secretary of the Justice and Public Safety Cabinet expressing the need for DJJ to move toward a strategic level of thinking to understand data as more than an aggregate set of numbers.[86] Applying this statement to QAD specifically, data could be used outside of the ACA accreditation and PREA audit cycles in a more strategic manner.

LOIC discussions with DJJ addressed the role of the Division of Compliance, created by SB 162 of the 2023 legislative session.[87] There was discussion of the division's initial role to provide continuous monitoring of policies and procedures for DJJ related to ACA and PREA standards. Officials stated that an internal shared drive to collect and retain audit results was recently created to assist the division in accomplishing its goals. In addition, the Quality Assurance Division was developing an internal process for tracking noncompliance issues and areas of concern.[88]

The assistant director of compliance will serve as the liaison to facilitate and distribute PREA and ACA report concerns.

According to officials, the assistant director of compliance will serve as the liaison to facilitate and distribute PREA and ACA report concerns and will provide oversight of the QAD process. Once an automated system is implemented, it could serve as the basis for communicating strategic information up the chain of command for corrective actions, policy suggestions, and training.

Officials also stated that DJJ will incorporate unannounced visits to RJDCs in order to review operations in real time.[89] DJJ has developed staff and youth offender surveys for this purpose, as well as an abbreviated quality assurance review form. The new form—Detention Observation Report, Unannounced Visit—includes fewer check boxes than shown previously for each QAD review area.

Recommendation 3.2

Recommendation 3.2

The Department of Juvenile Justice should develop and fully implement an automated system for the newly created Division of Compliance to better track and analyze American Correctional Association and Prison Rape Elimination Act noncompliance data. The focus of the system should be on inputting, storing, and tracking data for initial analysis. The automated system should also be able to sort, extract, and aggregate data for secondary analysis in order to make real-time corrective actions and policy decisions. A separate field should be dedicated to inputting and tracking data from unannounced visits and staff and youth offender survey results.

Recommendation 3.3

Recommendation 3.3

The newly created Division of Compliance should broaden its oversight to more than just preparing the regional juvenile detention centers for American Correctional Association (ACA) and Prison Rape Elimination Act (PREA) audits. More specifically, not only should the division continue to conduct unannounced visits, but it should also expand the scope of its audits to other issues that could disrupt operations at the centers. For example, understanding staff and morale issues, as well as consistently reviewing the findings of Internal Investigations Branch and ombudsman reports to identify additional training needs, could identify issues that need to be addressed outside of the ACA and PREA audits.

What Were The Causes Of The Fire And Escape At JRJDC?

Various reasons contributed to the fire and escape at JRJDC. An underlying factor was using the building that was previously a youth development center.

Various reasons contributed to the fire and escape at JRJDC on August 27, 2022. The decision to use the building previously used for the Audubon Youth Development Center appears to be an underlying factor. That decision was made immediately after the Louisville Metro Council defunded the Louisville Metro Youth Detention Center on June 21, 2019.[90] Other factors included a breakdown of supervision at JRJDC and staffing challenges.

Louisville Metro Youth Detention Center Closure

On December 13, 2019, the Louisville/Jefferson County Metro Government (Louisville Metro) and the Justice and Public Safety Cabinet entered into a memorandum of agreement (MOA) regarding the transition of the secure detention of Jefferson County juveniles.[91] Prior to the MOA, Louisville Metro operated the YDC outside of the statewide juvenile justice system. The decision by Louisville Metro to cease funding of the YDC required the state to incorporate Louisville Metro's juvenile justice system into the DJJ system.[92]

As part of the MOA, the commonwealth agreed to renovate a portion of the Rice-Audubon YDC at the Audubon campus, to accept detained youths "on or before January 1, 2020."[93] Prior to opening its doors on January 1, 2020, DJJ expended $49,134 to renovate a portion of the Audubon YDC building. However, after the doors opened, JRJDC needed additional security and other upgrades and repairs in the amount of $284,391. Table 3.12 provides additional detail.

Table 3.12
Jefferson RJDC Upgrades and Repairs
2019 To 2022

Date	Document ID	Document Description	Amount
10/14/19	CT 785 2000000193	Sally Port Fence Audubon Youth Dev. Center Louisville DJJ	$31,713
12/20/19	MA 1700001007	Louisville DT—Locks	17,421
1/16/20	PO 523 2000004840	Fence	14,356
1/30/20	MA 1700001007	Security Upgrades	14,956
1/31/20	MA 1700001007	Locks	10,916
1/31/20	MA 1700001007	Security Upgrades—Power Supply	29,995
2/13/20	PO 523 2000003452	Audio Intercom System	2,858
5/18/20	MA 1600000955	Fire Alarm for FY21	3,000
6/23/20	PO 523 2000004839	Radio Programming	1,995
7/20/20	PO 523 2100000558	Steam Table Repair	1,272
7/22/20	MA 1800000444	Fence	34,666
7/27/20	MA 1700001007	Locks	$6,850
9/8/20	PO 523 2100001855	Chiller Repair	1,780

Date	Document ID	Document Description	Amount
11/16/20	PO 523 2100003547	Call Box Repair	1,688
11/17/20	PO 523 2100003622	Card Lock Repair	1,135
12/16/20	PO 523 2100004228	Milnor Washer	11,490
4/10/21	PO 523 2100006112	Waste Disposal	4,121
6/11/21	PO 523 2100000370	Boiler PM for FY22	3,458
6/15/21	PO 523 2100001339	Generator PM for FY22	3,044
6/16/21	PO 523 2100000371	Chiller PM for FY21	5,114
6/22/21	PO 523 2100004746	Bollards for Sally Port	2,300
08/30/21	MA 2100000966	Fire Alarm for FY22	5,625
9/23/21	PO 523 2100006271	Reach-In Cooler Repair	2,615
12/20/21	MA 1700001007	Locks	24,300
2/5/22	MA 1700001007	Locks	2,700
3/25/22	PO 523 2200005124	Cooler Repair	7,646
4/6/22	PO 523 2200005510	Dumpster Pad Relocation	3,000
5/10/22	PO 523 2200006237	Generator PM for FY23	1,557
5/20/22	MA 2100000966	Fire Alarm for FY23	5,625
6/1/22	PO 523 2200006782	Tree Removal	5,800
7/7/22	PO 523 2300000135	Taco Pump Repair	1,135
7/8/22	MA 2200000656	Cell Door Replacement	14,328
7/28/22	PO 523 2300000587	Oven	8,088
8/16/22	MA 2200000656	Locks	15,404
9/22/22	MA 2200000656	Locks	23,900
10/25/22	PO 523 2300002590	Window Repair	2,440
11/21/22	MA 2100000019	Backflow Preventer Repair	5,234
Total			$333,525.00

Source: LOIC staff analysis of eMARS procurement documents.

Figure 3.C
JRJDC Sally Port Fencing

Source: Kentucky. Department of Juvenile Justice. "Jefferson Regional Juvenile Detention Center (JRJDC)." PowerPoint presentation. Email to Gerald W. Hoppmann, May 18, 2023.

Regarding future expenditures, in preparation to expend $4.5 million appropriated by HB 3 of the 2023 legislative session, DJJ received an architect and engineering bid for additional work. Table 3.13 provides additional detail.

Table 3.13
JRJDC Architecture And Engineering Bid, Phase I And II

Phase	Description	Cost
1.1	Intake Wet Cells and Sally Port	$577,225
1.2	Control Room	131,863
1.3	800 Wing Reconfiguration	1,136,025
2.0	600 Wing and 700 Wing Reconfiguration	1,783,375
Total		$3,628,488.00

Source: Justice and Public Safety Cabinet.

As part of the MOA, DJJ agreed to designate a different RJDC for use after the 16-bed capacity fills.[94] In order to transport juvenile offenders to other RJDCs, Louisville Metro created the metro transportation unit to provide transportation of preadjudicated youths to JRJDC, as well as other RJDCs as needed.[95] As of the writing of this report, Louisville Metro's transportation unit continues to operate.[c]

Louisville Metro agreed to provide $685,000 to assist with operating JRJDC.[96] It also agreed to pay medical costs, including psychiatric care, for preadjudicated Jefferson County youths in an RJDC.[97] According to the cabinet, Louisville Metro ceased paying to assist with the operation of the facility after July 1, 2020.[98]

Breakdown Of Supervision At JRJDC

A breakdown of supervision at JRJDC allowed a female resident to smuggle a lighter into the facility as contraband.

A breakdown of supervision at JRJDC allowed a female resident to smuggle a lighter into the facility as contraband on August 19, 2022, during the intake process. She used the lighter to start two fires. She set the first fire in her room, and while JRJDC staff worked to extinguish the fire, she was left unsupervised and started a second fire in Unit 500 (dayroom).

While EMS was tending to the fire, another youth offender who was not properly supervised escaped by breaking a glass exterior window and scaling the outdoor fence.

As a result of the second fire, the St. Matthews Fire and Emergency Management Services (EMS) responded. While EMS was tending to the fire, another youth offender who was not properly supervised in the hallway escaped by breaking a glass exterior window and scaling the outdoor fence.[99]

As a result of the Internal Investigations Branch's investigation, DJJ took disciplinary actions listed in Table 3.14.

[c] Prior to reopening its doors due to a failed fire alarm test on November 9, 2022, JRJDC had a 16-bed capacity. However, upon its reopening at the end of January 2023, it houses a reduced population of eight juvenile offenders. After the escape and failed fire alarm test, DJJ made various improvements to the facility, including fire alarms, doors, locks, and the control center.

Table 3.14
DJJ Disciplinary Actions

Position	Disciplinary Action	Reason For Disciplinary Action	Date
Social Service Worker I	3-day suspension of duty	Demonstrated unsatisfactory performance of duties by not ensuring that a search of a youth was conducted after learning of allegations that the youth had a lighter	December 9, 2022
Youth Worker I	Termination	Probationary dismissal	December 9, 2022
Social Service Worker I	Written reprimand	Demonstrated unsatisfactory performance of duties by engaging in inappropriate physical contact with youths	December 9, 2022
Youth Worker III	Written reprimand	Demonstrated unsatisfactory of duties by not ensuring that a search of a youth was conducted and documented	December 9, 2022
Social Service Clinician I	Termination	Demonstrated unsatisfactory performance of duties and lack of good behavior by not providing appropriate supervision of youths	December 28, 2022
Youth Worker Supervisor	20-day suspension	Demonstrated unsatisfactory performance of duties and lack of good behavior by not ensuring a search of a youth was conducted and documented	January 11, 2023
Youth Worker Supervisor	20-day suspension	Demonstrated unsatisfactory performance of duties and lack of good behavior for not proper supervision of youths	January 11, 2023
Juvenile Facility Supervisor I	Termination	Demonstrated unsatisfactory performance of duties and lack of good behavior	January 24, 2023
Juvenile Facility Superintendent II	Reversion from Superintendent II to Corrections Unit Administrator II*	Probationary reversion	January 24, 2023

*Subsequent to the reversion, the individual was informed that DJJ had a business interest for an involuntary transfer, which resulted in reclassification to Juvenile Facility Superintendent I.
Source: LOIC staff analysis of discipline letters provided by the Justice and Public Safety Cabinet.

Staffing Challenges

Of the nine disciplinary actions listed in Tabl3 3.14, three (33 percent) involved employees under the social worker or social clinician classification series. The use of employees under these classifications to perform duties typically associated with youth workers seems to indicate an acute staffing challenge.

The COVID-19 pandemic immediately affected staffing, reducing JRJDC's capacity from 23 to 16.

The COVID-19 pandemic immediately affected staffing, reducing JRJDC's capacity from 23 to 16, largely due to the inability to fully staff the facility. According to the cabinet, there was a significant reduction in the number of youths being referred by courts to juvenile detention early in the pandemic, which resulted in lower-than-average number of youths being held in detention facilities overall. Afterward, however, the number of youths detained began to climb, which caused DJJ to raise capacity.[100] As a result, DJJ relocated staff of the closed Westport Group Home and nonteacher staff of the Louisville Day Treatment Center to help with the staffing shortage in the spring of 2020.[101] On May 18, 2020, JRJDC had 14 vacancies among 23 allocated staff positions.[102]

JRJDC had 14 vacancies from 23 allocated positions in 2020. By May 2023, vacancies had increased to 19 positions.

By May 1, 2023, JRJDC was dealing with an increase to 19 vacancies: 10 Correctional Officers; 1 Correctional Captain; 1 Correctional Lieutenant; 1 Nurse Shift/Program Supervisor; 1 Food Preparation Center Coordinator; 1 Social Service Clinician I; 1 Social Service Clinician II; 1 Social Service Worker I; 1 Administrative Specialist III; and 1 Office Coordinator.[103] As a result, JRJDC has not been able to meet the 1:8 staffing ratio during resident waking hours or the 1:16 ratio during resident sleeping hours as required by Prison Rape Elimination Act standard 115.313(c).[104] Cabinet officials also stated that DJJ was unable to consistently meet ratios required by PREA due to fluctuating numbers of youths and staff.[105]

Staff Grievances

LOIC analysts reviewed staff concerns that were expressed through the grievance process. Staffing and supervision issues raised concerns for JRJDC staff before the escape.

During their investigation, LOIC analysts reviewed staffing concerns expressed by JRJDC and Louisville Day Center employees through the formal grievance process. Information in the grievances indicates that staffing and supervision issues prior to the escape in August were raising serious concerns for JRJDC staff.

LOIC staff identified the following staffing concerns after reviewing seven JRJDC grievances filed in 2020:

- Grievance 1: Lack of aikido training for staff who are left alone with juvenile offenders; lack of youth workers, which prevents adequate coverage for classrooms; hostile work environment
- Grievance 2: Staff scheduling concerns through the transition phase from youth development center to juvenile detention center; favoritism to certain staff
- Grievance 3: nepotism; discrimination; code of ethics violation; mandatory transfer of Louisville Day staff to

the hybrid facility; building code violations; lack of policies and procedures; lack of supervision

- Grievance 4: lack of policies and procedures; building code violations; unfamiliarity between JRJDC and Louisville Day staff; lack of fire, tornado, earthquake or intruder drills; lack of aikido refresher training; ACA violations; lack of staffing; inappropriate DVDs for youth offenders; faulty locks on cell doors; unsafe conditions
- Grievance 5: Rushing to open JRJDC without being ready; lack of staff meetings; lack of handbooks; lack of staff; retaliation
- Grievance 6: Dangerous reassignment to JRJDC from Louisville Day center due to being in a high-risk category related to COVID-19
- Grievance 7: Pay disparities

JRJDC staff has expressed little support for the management, and inadequate supervision was being provided at the facility.

Generally, it appears that JRJDC staff has expressed little support for the management and that inadequate supervision was being provided at the facility.[106] Currently, however, a brand-new management team is working at JRJDC.[107] As part of the new team's approach, it has met with the Lyndon mayor, police chief, and fire chief on two to three occasions. The team will continue to update locally elected officials while the facility is open.[108]

Recommendation 3.4

Recommendation 3.4

The Department of Juvenile Justice should continue to ensure that Jefferson Regional Juvenile Detention Center policies and procedures are updated so the new management team can address staffing, supervision, and building security concerns.

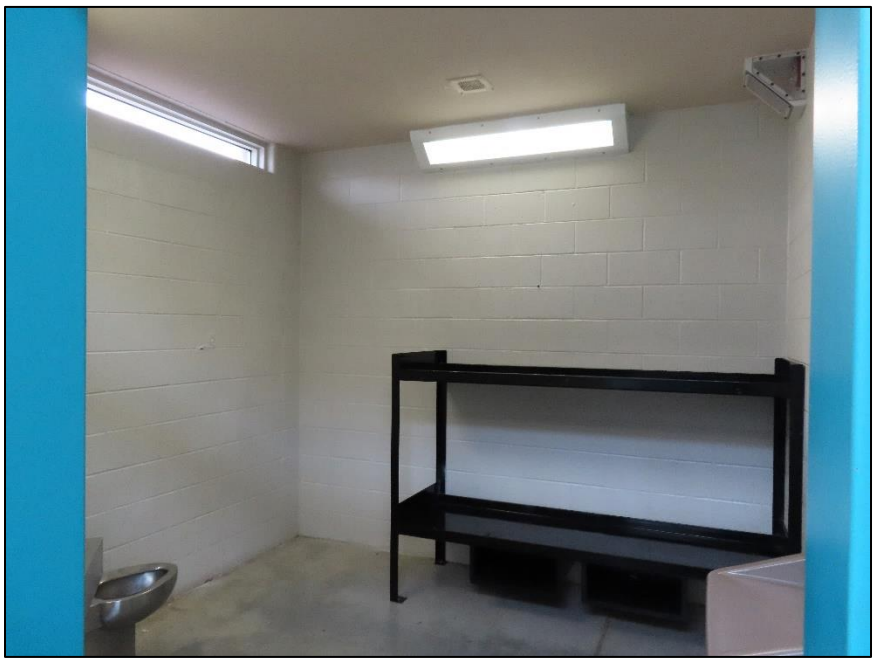
What Caused The November 2022 Riot At The Adair RJDC?

A juvenile offender caused skull and eye socket fractures in a youth worker and released other offenders, leading to the release of 32 offenders.

According to an IIB report, the November 11, 2022, riot was started after a Youth Worker III working on third shift unlocked a juvenile offender's cell door to provide toilet paper.[d] The youth worker was attacked, suffering skull and eye socket fractures. After the attack, the juvenile offender took the youth worker's keys to unlock the cell doors of two other juvenile offenders, one of whom opened the cell doors of 32 juvenile offenders.[109] Incident reports indicate that physical assaults, sexual assaults, and property damage occurred.[110]

[d] The investigation focused primarily on whether actions by staff members could have been abuse or neglect.

Figure 3.D
Adair RJDC Non-Camera Room
(Alleged Sexual Assault Location)



Source: LOIC staff tour of facility, February 24, 2023.

Offender Local Gang Affiliation

Discussion with the superintendent of ARJDC revealed that the juvenile offender who took the keys was a member of a Louisville local gang (East Side Gang), as were the two juvenile offenders initially released from their cells.[111] Prior to November 11, 2022, ARJDC received 13 juvenile offenders from JRJDC, who had had various issues at that facility.[e]

Instead of being separated upon arrival, gang members were placed in the same living pod, which allowed them to interact and communicate.

The three individuals from the East Side Gang were part of the group transferred to ARJDC on November 9, 2023, due to a failed fire alarm test. They were not separated from each other upon arrival; rather, they were placed in the same living pod, which allowed them to interact and communicate. According to the ARJDC superintendent, staff did not know the three were friends or from the same gang.[112]

[e] The Adair facility is designated as a youth development center, which meets the intent of KRS 605.095(2), requiring one postadjudication facility to have a security level comparable to that of a medium-security adult facility. The ACA audit report for August 15, 2021, states that the facility is a level V maximum security juvenile facility and is therefore the most restrictive and secure program in the commonwealth. It also states that no transfers to more restrictive program from the facility are possible.

Intake personnel did not have adequate time during the intake process to identify gang affiliation or other security risks.

According to the cabinet, DJJ made the decision to move the juvenile offenders on the evening of November 8, 2023, upon learning that certain fire safety mechanisms were not operative and that this created a safety concern.[113] It appears that because of the short time frame for transporting the juvenile offenders, ARJDC intake personnel did not have adequate time during the intake process to identify gang affiliation or other security risks. As a result, members of the East Side Gang were placed in the same living areas.

Figure 3.E
Adair RJDC Gang Communications

Source: LOIC staff tour of facility, February 24, 2023.

The ARJDC superintendent stated that the juvenile offenders transferred from JRJDC broke sprinkler heads, which flooded cells, units, and building on November 10, 2022. According to incident reports provided by DJJ, a juvenile offender restrained earlier by the assistant superintendent remained agitated and later that evening "stood on his desk and used his sheet to pull the sprinkler system. This flooded his cell and the unit."[114] Because there are five incident reports from November 10, 2022, for five offenders who broke sprinkler heads, all with the same event description, it is not possible to determine the actions of four other juvenile offenders. The staff member who initially reported the incidents was on leave immediately after the escape and assaults, so the superintendent completed all five incident reports on November 14, 2022.

The incident report related to the assistant superintendent's alleged use of excessive or inappropriate force was not completed until January 19, 2023, because staff witness statements had been misplaced.[115] At least two of the staff involved in the incident stated that they submitted their completed statements to the assistant superintendent on the day of the incident.[116]

Ultimately, an IIB investigation found that the allegation of excessive force against the assistant superintendent could not be substantiated. The report noted that the decision was based on conflicting witness statements regarding the level of force used during the hold and that the restraint occurred in a non-camera room; however, the justification for the decision did not formally include the audio recording of the cell, on which the juvenile offender is heard crying and screaming.[117]

The floors of the cells were not completely dry, which is why the Youth Worker III unlocked the juvenile offender's cell door to provide toilet paper.

The aforementioned events culminated on November 11, 2022, when maintenance workers were busy mopping up water throughout the facility. The assistant superintendent stated that, after observing water in one of the cells, he inadvertently turned the water valve in the mechanical room to "on," thinking he was turning it off (see Figure 3.F).[118] The floors of the cells were not completely dry, which is why the Youth Worker III unlocked the juvenile offender's cell door to provide toilet paper.[f] [119]

Figure 3.F
Adair RJDC Sprinkler Shut-Off Valve And Labeled Handle

Source: LOIC staff tour of facility, February 24, 2023.

[f] The juvenile offender appears to be the same individual involved in previously described incidents, as well as the offender who assaulted the Youth Worker III who opened the cell door.

Inmate Booking System

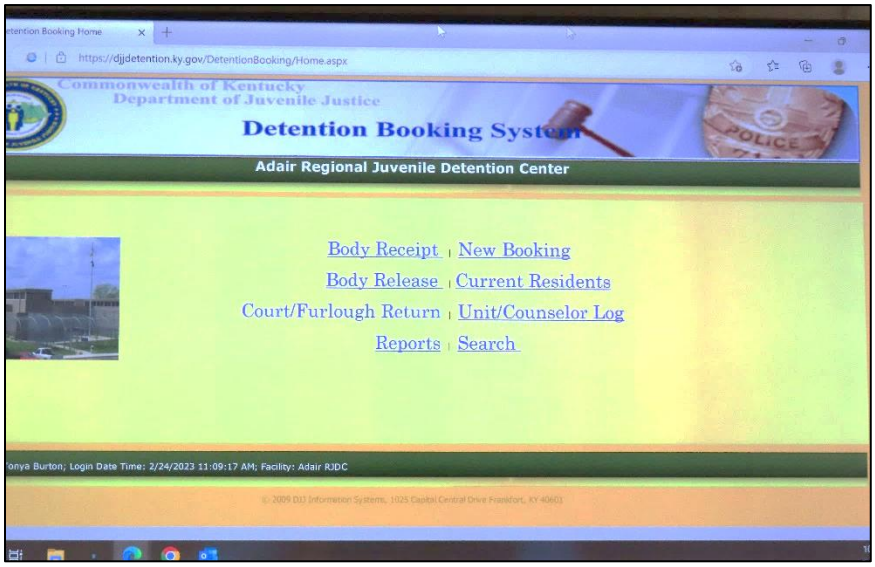
The offender booking system has never included required information fields.

Certain shortfalls are relevant to this finding. According to DJJ officials, the offender booking system has never included required information fields. The rationale for this decision was to provide RJDCs the flexibility needed to conduct their work. The system was also not designed to generate reports or to share information with other RJDCs.[120]

There is no consistency in juvenile detention center staff's use of the system, so vital information related to possible gang affiliation, such as tattoos, may not be recorded for intelligence purposes.

During a tour of ARJDC, LOIC staff was shown various screenshots of the inmate booking system that were suitable for noting body tattoos and other marks. For example, the system allows staff to complete a body ID, which includes a text box to document specific descriptions. The system also allows photos to be uploaded into the juvenile offenders' profiles. However, there is no consistency in juvenile detention center staff's use of the system, so vital information related to possible gang affiliation, such as tattoos, may not be recorded for intelligence purposes.[121]

Figure 3.G
Adair RJDC Juvenile Detention Booking System, Body Receipt ID



Source: LOIC staff tour of facility, February 24, 2023.

In reviewing the offender booking system's data fields, LOIC staff identified various fields that may be suitable for recording tattoo information. For example, the system includes seven tables with the name of *BodyMarks* and two additional columns named *Q27_tattoo* and *TattooDesc*.[122] However, as stated previously, these fields are not required.

During the intake process, staff attempts to accumulate as much information as possible related to gang affiliation.

During the intake process, staff attempts to accumulate as much information as possible related to gang affiliation. The superintendent keeps a binder of this information in her office for making decisions relating to housing and movement of offenders. This effort has proven mildly productive, as evident from a whiteboard in the office showing that the East Side Gang makes up the largest population of gang affiliation in the facility. Also, according to the superintendent, ARJDC works with local and state law enforcement agencies to receive training related to gangs.[123]

The challenge, however, is to consistently collect and use information regarding potential gang affiliations—such as descriptions and photographs of tattoos—as intelligence, given limitations of the offender booking system. In order to properly separate gang members to prevent future communication and potential disruption, the development of a more effective process is arguably one of the more important priorities for ARJDC, especially given its designation as a maximum-security youth detention center.

Had gang affiliation information been available, ARJDC employees may have been able to properly segregate the gang members before they escaped from their cells.

Had this type of information been available on November 9, ARJDC employees may have been able to properly segregate the gang members before they escaped from their cells to commit property damage, which precipitated the physical and sexual assaults. Finally, given the speed with which the juvenile offenders were transferred from JRJDC, it appears that ARJDC simply did not have sufficient time to properly identify and use gang-related information as part of the intake process.

Recommendation 3.5

Recommendation 3.5

Adair Regional Juvenile Detention Center should continue to work with local and state law enforcement to receive training related to gangs and how to minimize the effects of gang affiliations in a detention setting.

Recommendation 3.6

Recommendation 3.6

Adair Regional Juvenile Detention Center staff should be required to use appropriate fields in the offender booking system to document tattoo descriptions and photographs.

Recommendation 3.7

Recommendation 3.7

The Justice and Public Safety Cabinet should request that the Internal Investigations Branch conduct a broader

investigation, to include the incidents leading up to the November 11, 2022 riot.

How Does DJJ Ensure That Allegations Of Dependency, Neglect, And Abuse Are Reported And Investigated?

DJJ relies on the Internal Investigations Branch for employees to report alleged neglect and abuse of juvenile offenders under the custody of DJJ. Juvenile offenders can directly request access to the ombudsman in order to report other problems or concerns, but DJJ prominently relies on the IIB as "gatekeeper" for referral to the ombudsman.[124] As gatekeeper, IIB uses the Column Case Management (CCM) system to track intake and referrals related to overall record and data management. CCM, which IIB started using in 2021, provides relational analysis of names, associations, crimes, and other variables that staff can use to determine connections between youths and cases. It also provides a high level of data security. Currently, IIB is the only entity using CCM.

The current reporting process, prior to substantiating a special incident, does not routinely include the expressed entities annotated in KRS 620.030.

The current reporting process, prior to substantiating a special incident, does not routinely include the expressed entities annotated in KRS 620.030: CHFS, state or local law enforcement, the commonwealth's attorney, or county attorneys. The statute does not include IIB or the DJJ ombudsman. For the instances of abuse and neglect reported to IIB, however, only substantiated investigations are forwarded to CHFS. According to the cabinet, all cases initiated from an intake are submitted to CHFS, but force and sexual activity investigations cause a written notification to the county attorney and law enforcement.[125]

Memorandum Of Understanding

Allegations of abuse or neglect in a DJJ facility are investigated by the Internal Investigations Branch (IIB).

The IIB and the Department of Community Based Services (DCBS) entered into a memorandum of understanding related to services and treatment to children and their families, part of which states that IIB will investigate any allegation of abuse or neglect in a DJJ facility.[126] Although the MOU states that DCBS will screen and investigate all reports of abuse, neglect, or dependency on a child committed or probated to DJJ, the wording does not include "dependency" as part of the scope of IIB's investigation.

The MOU also provides that DJJ may make referrals to DCBS when youths report abuse or neglect or if DJJ staff otherwise becomes aware of abuse of neglect. However, the MOU language

includes "dependency" when discussing referrals to DCBS under KRS 620.030, regarding requests for records in possession or control of DJJ.[127] This inconsistency could be confusing, especially in the context of statutory definitions.

- An abused or neglected child is generally defined as a child whose health or welfare is harmed or threatened with harm. The harm or threat of harm comes from a parent, guardian, or other person exercising custodial control or supervision from a variety of physical or emotional injuries.[128]
- A dependent child is defined as a child other than an abused or neglected child, "who is under improper care, custody, control, or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control or supervision of the child who is under improper care."[129]

The absence of "dependency" in the MOU regarding the IIB's scope of investigative authority creates a possibility that certain allegations could be missed for investigation.

The absence of "dependency" in the MOU regarding IIB's scope of investigative authority creates a possibility that certain allegations could be missed for investigation. For example, if an allegation suggests that a child was provided less than adequate care, supervision, food, or clothing, should IIB investigate the allegation in the same manner as if the allegation suggested adequate care, supervision food, or clothing was not provided at all? Or should the allegation be referred to CHFS pursuant to KRS 620.030 or to the DJJ ombudsman pursuant to 500 KAR 13:020?

DJJ's Code of Ethics is similar to MOU language in that it does not include "dependency" related to an employee's duty to report suspected instances of dependency, neglect, or abuse to expressed entities. The same policy also requires DJJ staff to report corrupt, unethical behavior, or policy violations that may affect the youths or the integrity of the organization.[130] In order to report concerns, DJJ staff do have access to an IIB hotline.[131]

IIB Investigates Special Incidents

The IIB was created in July 1999 to investigate special incidents at DJJ facilities.

The Internal Investigations Branch was created in July 1999 to investigate special incidents at DJJ facilities, including RJDCs. Generally, *special incident* is defined as "an act in which the health or welfare of a youth is harmed or threatened with harm by an offender."[132] Five special incident categories "shall" be investigated by IIB, and nine categories "may" be investigated by IIB.[133] Table 3.15 provides additional detail.

Table 3.15
Internal Investigations Branch
Obligation To Investigate Special Incidents

Obligation	Special Incident
Shall investigate	Uses inappropriate or excessive force that results in injury
	Uses inappropriate or excessive force that could result in an injury
	Engages in any sexual activity to include any contact or interaction, which uses or allows, permits or encourages the use of a youth for the sexual gratification of the offender or another person
	Uses inappropriate consequences as punishment such as exercise, harsh physical labor, or other physical consequences outside accepted practices in accordance with 505 KAR Chapters 1 and 2 of the Department for Juvenile Justice Policies and Procedures
	Allows or encourages a youth to use drugs or alcohol, gamble, or engage in other illegal activity
May investigate	Does not provide appropriate supervision, medical care, food, clothing, shelter, or education
	Uses humiliating, demeaning, profane, or racially charged language directed at a youth
	Uses verbal threats of harm directed at a youth
	Exhibits a pattern of harassing conduct directed at a youth
	Uses or attempts to use a youth for personal gain
	Accepts a bribe from a youth or indicates a bribe would be accepted
	Enters into any unlawful transaction with a youth as set forth in KRS 530.064, 530.065, or 530.070
	Enters into a business relationship with a youth
	Extends unearned special privileges to a youth in return for something

Source: Kentucky. Justice and Public Safety Cabinet. Internal Investigations Branch Standard Operating Procedures (SOP), SOP IIB-001. June 23, 2020; revised Oct. 19, 2022.

For the "shall investigate" complaints, IIB must complete a written report in 30 days containing information gathered during the investigation and a recommendation regarding whether an allegation is substantiated, unfounded, exonerated, not substantiated, or pending further investigation. For substantiated allegations involving the abuse or neglect of a child, IIB must forward the completed investigation to CHFS, local county attorney, law enforcement, or the Kentucky State Police.[134]

For the "may investigate" complaints, IIB has the discretion of whether or not to investigate. However, special incidents not investigated by IIB "shall" be referred by IIB to "another appropriate individual or agency for investigation." For those incidents referred to DJJ, IIB is required to review the report and any supporting documentation.[135] It does not appear, however, that the "may investigate" complaints are routinely referred to CHFS for investigation for an additional check to make sure the reporting requirements under KRS 620.030 are being met.

The language in the MOU and DJJ's internal policies appears to cover dependency under the definition of *special incidents*. Even if dependency is covered under that definition, IIB alone may not be the proper reporting entity. Making available the "may investigate"

complaints for CHFS review, however, appears to be consistent with MOU language and with DJJ's internal policies covering dependency under the broad definition of *special incidents*.[136]

Regarding Recommendation 3.10 of this finding, the cabinet disagrees that all "may investigate" incidents should be made available to CHFS, since DJJ is already providing CHFS all investigated findings. Also, it is the "understanding" of DJJ and the Justice and Public Safety Cabinet "that if youth is in the custody of DJJ, they cannot be dependent."[137] This statement indicates that *dependency*, as interpreted by DJJ and the cabinet, means that a child in DJJ custody is under correct guardianship and therefore cannot be dependent. However, this interpretation is inconsistent with the Kentucky Court of Justice's definition, which states that a dependent child is "any child, other than an abused or neglected child, who is under improper care, custody, control or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control or supervision of the child."[138]

DJJ Ombudsman

The position of juvenile justice ombudsman was created in 2002.

The position of juvenile justice ombudsman was created by the passage of HB 144 in 2002. KRS 15A.065 requires DJJ to develop programs to ensure "that youth in state-operated or contracted residential treatment programs have access to an ombudsman to whom they may report program problems or concerns."[139] According to DJJ officials, access to the ombudsman for youth offenders occurs via the IIB hotline. Grievances and special incidents under the "may investigate" categories are typically referred to the ombudsman by IIB for investigation. Grievances are also sent to the RJDCs' grievance officers.[140]

Although there is no express authority in statute for the creation of the IIB, the ombudsman is statutorily created. Other than the time frame in which the two offices were created, there is no clear directive in statute regarding whether one should take more responsibility for investigation reports. Updating the statute to include the ombudsman as part of the reporting and investigation process could provide more clarity. Also, there is little information on the webpages of the Cabinet for Justice and Public Safety or DJJ regarding the interaction between the DJJ ombudsman and IIB when handling reports of alleged abuse or neglect. Such information could be useful to family members.

The current process of referring "may investigate" incidents to the DJJ ombudsman reinforces the cabinet's internal process. Adding an external entity, as expressed in KRS 620.030, increases safeguards to ensure review of the "may investigate" incidents, which could fall into the "dependency" category. As it stands now, however, it appears that CHFS never formally investigates any claims, substantiated or otherwise, of special incidents originating from DJJ facilities.

Recommendation 3.8

Recommendation 3.8

Justice and Public Safety Cabinet and Department of Juvenile Justice officials should revisit language in DJJ policies, the memorandum of agreement, and 500 KAR 13:020 to ensure the terms *neglect, abuse, dependency,* and *special incidents* are used consistently and are in line with KRS 620.030.

Recommendation 3.9

Recommendation 3.9

Officials should review KRS 15A.065(4)(a) to consider proposing language that more clearly annotates the duties and responsibilities of the ombudsman.

Recommendation 3.10

Recommendation 3.10

Justice and Public Safety Cabinet and Department of Juvenile Justice officials should make available to the Cabinet for Health and Family Services the "may investigate" incidents, which appear to fall under "dependency."

Recommendation 3.11

Recommendation 3.11

Justice and Public Safety Cabinet and Department of Juvenile Justice officials should develop more of a formal policy related to the interaction between the department's ombudsman and the Internal Investigations Branch.

Recommendation 3.12

Recommendation 3.12

Justice and Public Safety Cabinet and Department of Juvenile Justice officials should break out the reporting duty of department employees from the Code of Ethics to develop a separate policy, given the importance of KRS 620.030 reporting.

Recommendation 3.13

Recommendation 3.13

Justice and Public Safety Cabinet and Department of Juvenile Justice officials should update their webpages to create more of a presence for the statutorily created department ombudsman.

Recommendation 3.14

Recommendation 3.14

The Justice and Public Safety Cabinet should use Column Case Management for storage and analysis of referrals and investigations conducted by the Office of the Ombudsman.

Matter For Legislative Consideration 3.1

Matter For Legislative Consideration 3.1

The legislature may wish to consider clarifying the term *dependent child* in KRS 600.020(20) and amending KRS 620.020 to include the term *dependency*.

Do RJDCs Receive, Process, And Track Work Orders In A Timely Manner?

Maintenance and repairs to RJDCs' infrastructure are vital to their operations and security.

As Kentucky's juvenile detention centers age, maintenance and repairs to their infrastructure are vital to facility operations and security.

Executive Order 97-891 created the detention division within DJJ, which oversaw the construction of three juvenile detention centers in Breathitt, McCracken, and Campbell Counties.[141] In 2001, two new juvenile detention centers opened in Adair and Warren Counties.[142] A new facility in Boyd County began accepting youths in November 2004 and expanded to 36 beds in 2005, the year the Fayette County detention center opened.[143] The Jefferson County facility served as a children's home prior to 1996, when it became a youth development center.[144] On January 1, 2020, the Jefferson facility became Kentucky's eighth operational detention facility.[145]

LOIC staff requested maintenance reports and work orders from RJDCs for 2020 to 2022.

LOIC staff requested maintenance reports and work orders from Kentucky's eight RJDCs for 2020 to 2022.[146] The majority of this maintenance work order data was provided in the format of scanned paper work order request forms.[147] Work order request forms typically include spaces for staff to enter:

- Date of request
- Date of receipt of the request by maintenance staff
- Date of work order completion
- Location of problem
- Description of problem

- Priority level on a scale of 1 to 3. A "Priority Key" at the bottom of each form defines each priority level:
  - 1: Security or safety issue (must be corrected as soon as possible)
  - 2: Immediate (could become worse if not corrected)
  - 3: Routine (can wait)

Figure 3.H
McCracken RJDC Facility Work Order Requests And Plans

Source: LOIC staff tour of facility, April 14, 2023.

Table 3.16 provides an overview of maintenance work order data received by LOIC staff from each facility by year of initial work order request.

Table 3.16
Number Of Individual Maintenance Work Order Requests Provided By Facilities
2018 To 2022

Facility	2018	2019	2020	2021	2022	Total
Adair	0	0	0	13	23	36
Boyd	5	5	4	1	11	26
Breathitt	131	161	32	21	12	357
Campbell	0	246	417	363	279	1,305
Fayette*	49	0	0	5	2	57
Jefferson	0	0	0	1	7	8
McCracken	219	265	235	0	48	767
Warren	0	28	44	31	14	117
Total	404	705	732	435	396	2,673

*One maintenance request submitted by Fayette did not include any dates and was included in Fayette's total but not within any given year.
Source: Staff analysis of RJDC maintenance work order data provided by DJJ.

The Adair, Fayette, and Jefferson facilities did not provide any data for 2020.

The Adair, Fayette, and Jefferson facilities did not provide any data for 2020. There was significant variance in the number of work orders provided to staff between years. For example, Breathitt's work orders for 2020 to 2022 were only a fraction of the number provided for 2018 and 2019. Variance between the amount of data provided by each facility does not appear to reflect differences in capacity or size, suggesting that maintenance work order data provided to LOIC staff should not be considered comprehensive or exhaustive for any of the facilities.

Processing Of Work Orders

For the work orders reviewed, 51 percent were completed on the day requested and 18 percent were completed on the following day.

For the work orders reviewed, 1,355 (51 percent) were received by maintenance staff and completed on the day they were requested, and 478 (18 percent) were completed on the following day. There were 2,311 (86 percent) work orders that were completed within a week of the date of request.

Table 3.17 provides the median number of days between the date that a work order request was made and the date that the work order was completed across all data provided by each facility.

Table 3.17
Median Number Of Days Between Maintenance Work Order Request And Work Order Completion, By Facility And Type Of Request 2018 To 2022

Facility	All	Routine	Security	Facility Integrity
Adair	1	1.0	1	N/A
Boyd	1	2.0	1	N/A
Breathitt	1	1.0	1	0.0
Campbell	0	0.0	0	0.5
Fayette	1	1.0	1	1.0
Jefferson	1	0.5	1	N/A
McCracken	0	0.0	0	1.0
Warren	1	1.0	2	1.5

Note: N/A = facility did not provide any work orders that LOIC staff categorized as related to facility integrity. This calculation excluded 21 work orders that did not include a date of request or date of completion, as well as 5 work orders that erroneously included a date of completion prior to the date of request.
Source: Staff analysis of RJDC maintenance work order data provided by DJJ.

There were 53 (2 percent) work orders that were not completed within 86 days, making them statistical outliers.[g] "Days-to-completion" for these outliers ranged from 86 days to 601 days, with 38 (72 percent) work orders coming from the Campbell

[g] Work orders that were not completed within two standard deviations from the mean "days-to-completion" of all work orders (85.04 days) were considered outliers by LOIC staff.

facility and 15 (28 percent) from McCracken. Forty-four (83 percent) of these work orders were categorized as routine, 7 (13 percent) were related to security, and 2 (4 percent) were related to facility integrity. There is no clear pattern to why these specific work orders may have been delayed for such a period. All but one are similar to other work orders that were completed far more quickly. Table 3.18 provides additional detail.

Table 3.18
Facility Integrity And Security Categories, Days To Completion
2018 To 2020

Date Of Request	Days To Complete	Category	Facility	Description
10/24/18	92	Security	McCracken	Camera out
2/4/19	129	Security	McCracken	File cabinet with 113R lock needs a new lock
3/28/19	259	Security	McCracken	403 door not showing secure at all in control
6/4/19	86	Security	McCracken	Installing new video servers
7/19/19	110	Security	McCracken	Control operator view is obstructed
10/21/19	290	Facility integrity	McCracken	Leak
1/28/20	511	Facility integrity	Campbell	Outside recreation wall splitting in some corners
5/5/20	178	Security	Campbell	Room 102 camera needs to be replaced

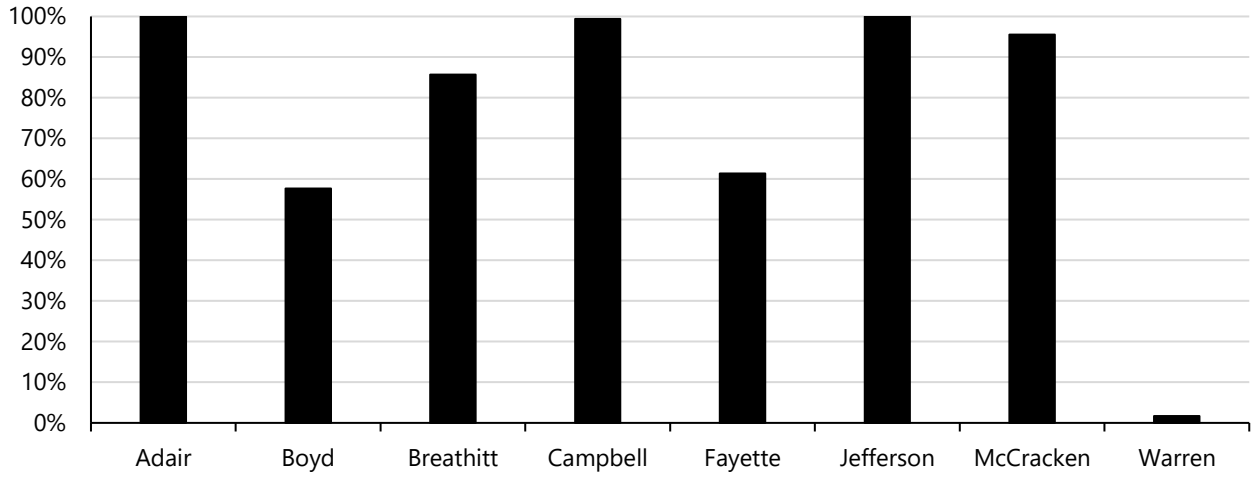
Source: Staff analysis of RJDC maintenance work order data provided by DJJ.

Prioritizing Work Orders

No priority level was indicated in 91 percent of work orders reviewed.

In most cases, the filled-out work order request forms provided to LOIC staff included a space in which maintenance staff could write a priority level on a scale of 1 to 3, with 1 being the highest priority. However, 2,432 (91 percent) of the provided work orders did not indicate a priority level. Figure 3.I shows the percentage of all work orders without an indication of priority for each facility. Warren was the only facility to consistently indicate priority level on nearly all of its work order forms.

Figure 3.I
Percentage Of Work Orders That Did Not Include Priority Level
2018 To 2022



Source: Staff analysis of 2,673 RJDC maintenance work orders provided by DJJ.

Since completed work orders did not provide priority information, LOIC staff catalogued each maintenance request and assigned each a category of "routine," "security," or "facility integrity." Table 3.19 provides additional detail.

Table 3.19
Percentage Of Maintenance Work Order Requests By Category And Facility
2018 To 2022

Category Of Work Order	Adair	Boyd	Breathitt	Campbell	Fayette	Jefferson	McCracken	Warren
Routine	88.9%	65.4%	82.1%	77.9%	80.7%	50.0%	77.5%	72.6%
Security	11.1	34.6	17.6	21.3	15.8	50.0	20.8	25.6
Facility integrity	0.0	0.0	0.3	0.8	3.5	0.0	1.7	1.7

Note: "Routine" work orders are not tied to security or facility infrastructure. "Security" work orders are directly related to housing, management, and safety of youths or staff. "Facility integrity" work orders are related to infrastructure or entire systems of the building.
Source: Staff analysis of RJDC maintenance work order data provided by DJJ.

Maintenance Documentation Practices

The amount of maintenance work order data provided to LOIC staff by the eight DJJ facilities varied greatly between years and between facilities. The reason for this is unknown, but it is likely that past completed work orders were not put aside or catalogued for future reference and therefore could not be shared with LOIC staff. For this reason, LOIC staff's ability to analyze the data for patterns or areas of concern between facilities and years was hindered.

Electronic documentation of completed work orders may provide future utility to these facilities, such as the ability to track when certain items, appliances, or infrastructure components should potentially be replaced after a certain number of major repairs or amount of time. For example, maintenance staff may find that door sensors tend to fail after a certain period of time, or past orders may reveal that some maintenance work takes more or less time than initially assumed. Past work orders may also provide the necessary information to facility administrators to determine whether current staff practices can be improved to reduce recurring maintenance needs.

Figure 3.J
Boyd RJDC Manual Storage Of Facility Logs

Source: LOIC staff tour of facility, March 8, 2023.

Recommendation 3.15

Department of Juvenile Justice detention facilities should ensure that maintenance work order request forms are completed to their full extent to include an indication of priority level.

Recommendation 3.16

Department of Juvenile Justice officials should automate the process by which maintenance work order request documents are processed.

How Has The Mental Health Status Of Juvenile Offenders Evolved Over Time?

As part of DJJ data sharing with LOIC, committee staff received and analyzed mental health screeners from three RJDCs—Boyd, Fayette, and McCracken—collected over a 5-year period. No information was received from the remaining centers. Despite the variance in completeness of the assessments collected, the information speaks to the condition of juvenile offenders when entering detention centers, and it carries implications for resources required to treat juveniles with severe mental health needs.

This is especially important in light of recent legislation, particularly HB 3 and SB 162 of the 2023 legislative session. Generally, the legislation requires DJJ to conduct mental health assessments and to "enter into sufficient contracts to ensure the availability of institutional treatment for children with severe emotional disturbance or mental illness as soon as practicable."[148]

Two Primary Mental Health Assessments

DJJ uses two mental health assessments, both of which are given to juvenile offenders upon intake to an RJDC.

DJJ uses two mental health assessments, both of which are given to juvenile offenders upon intake to an RJDC. The first type is the Victimization and Sexual/Physical Aggression Screener, which measures a youth's susceptibility and vulnerability to physical and sexual aggression. To test for these traits, the survey asks four or five questions for each category.[h]

The second type of screener received is the Massachusetts Youth Screening Instrument, a widely recognized tool that screens for potential mental health needs and emotional distress in juvenile justice populations. Its purpose is to flag youths who may require further mental health assessment or intervention. As shown in Figure 3.K, juvenile offenders who take the MAYSI during the intake process can also contact suicide and crisis lifelines.

[h] For example, the "vulnerability to physical victimization" section asks the youth: "Do you think you will have trouble getting along with other people at this facility? Do you feel like other people tend to push you around? In the community, have you ever been physically hurt by someone or been beaten up? In the community, have you ever been threatened by someone? Do you have an individualized education program (IEP) at the school you attend?" A youth who answers yes to two or more questions is marked "yes" for that trait. Further interventions for the youth, such as increased supervision or placing the youth away from other aggressors/victims, are partly based on how they score on the VSPA-S.

Figure 3.K
Breathitt RJDC Juvenile Offender Intake

Source: LOIC staff tour of facility, April 6, 2023.

The MAYSI comprises several scales or categories, each of which measures a specific type of emotional, psychological, or behavioral issue. A score above a certain threshold in a category may be deemed "Caution" or "Warning," and can require further evaluation and intervention. These are the primary categories that it evaluates:

- Alcohol/Drug Use—assesses the extent of a youth's involvement with alcohol or drugs and the associated problems
- Angry-Irritable—measures the youth's level of anger and irritability, which could lead to aggressive behavior
- Depressed-Anxious—identifies signs of depression and anxiety, including worries, fears, and sadness or hopelessness
- Somatic Complaints—looks for physical symptoms that may be linked to emotional distress, such as headaches, stomachaches, and other unexplained physical complaints
- Suicide Ideation—measures any thoughts or plans related to suicide
- Thought Disturbance—identifies signs of potential thought disorders, such as hearing voices or other hallucinations, and having strange thoughts or beliefs
- Traumatic Experiences—measures exposure to traumatic events and the individual's reactions to them

Although the screeners do not offer exhaustive assessments of an individual's mental health, they provide valuable insights into potential behavioral and psychological issues that might require further scrutiny and treatment.

Although the screeners do not offer exhaustive assessments of an individual's mental health, they provide valuable insights into potential behavioral and psychological issues that might require further scrutiny and treatment. Collectively, they can also highlight the overall mental health needs of a population and track these needs' evolution over time.

Mental Health Assessment Results

A total of 3,212 mental health screeners administered from 2018 to 2022 were obtained from the Boyd, Fayette, and McCracken RJDCs. Table 3.20 lists the annual count of screeners processed from each center.

Table 3.20
Total VSPA-S Screeners, By RJDC
2018 To 2022

Year	Boyd	Fayette	McCracken
2018	197	558	351
2019	187	552	287
2020	126	310	91
2021	28	156	50
2022	147	142	21
Not given	0	0	9
Total	685	1,718	809

Source: LOIC staff analysis of VSPA-S screener data from the Department of Justice.

Of the screeners processed during this period, over half (53.5 percent) originated from the Fayette RJDC, with Boyd and McCracken contributing 21.3 percent and 25.2 percent, respectively. Notably, approximately two-thirds of the overall screeners came from 2018 and 2019, with roughly one-third originating specifically from Fayette during those years. Consequently, any comprehensive statistics would likely be influenced by scores from these years, particularly from Fayette, which might not accurately reflect the current state of mental health in juvenile justice populations. Nevertheless, the yearly sample size is substantial enough to reliably track the trends in VSPA-S results over time.

Table 3.21 displays the overall percentage of juveniles who tested positive in each VSPA-S category from each of these three RJDCs from 2018 to 2022.

Table 3.21
Percentage Of Juveniles Testing For VSPA-S Categories, By RJDC
2018 To 2022

	Susceptibility To Sexually Aggressive Behavior	Vulnerability To Sexual Victimization	Vulnerability To Physical Victimization	Susceptibility To Violent Aggressive Behavior
Boyd	5.0%	6.9%	21.9%	25.5%
Fayette	1.9	6.1	21.6	40.0
McCracken	3.0	9.9	32.2	46.7

Source: LOIC staff analysis of VSPA-S screener data.

In addition to the similarities across facilities, LOIC staff were also able to determine that the categories' relative levels of significance were consistent over time for the years examined. Concerns related to sexually aggressive behavior and sexual victimization are comparatively minor compared to issues related to physical aggression and violence. The percentage of juveniles vulnerable to physical victimization in any given center ranges from approximately one-fifth to one-third, and the percentage of those susceptible to violent aggressive behavior ranges from roughly one-fourth to half. Table 3.22 presents the percentages of youths from 2018 to 2022 who scored in the normal, caution, and warning range for each category of the MAYSI screener at the McCracken RJDC.

Table 3.22
Distribution Of McCracken RJDC MAYSI Scores By Category
2018 To 2022

	Normal		Caution		Warning		Null	
Category	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Alcohol/Drug Abuse	233	77.7	37	12.3	27	9.0	3	1.0
Angry-Irritable	163	54.3	92	30.7	42	14.0	3	1.0
Depressed-Anxious	179	59.7	88	29.3	30	10.0	3	1.0
Somatic Complaints	166	55.3	98	32.7	33	11.0	3	1.0
Suicide Ideation	255	85.0	6	2.0	35	11.7	4	1.3
Thought Disturbances	191	63.7	49	16.3	31	10.3	29	9.7

Note: For the seventh category, Traumatic Experiences, data did not indicate classification by range.
Source: LOIC staff analysis of MAYSI screener data

MAYSI screeners reviewed the Angry-Irritable category, which exhibited the highest proportion (44.7 percent) of youths who scored in either the caution or warning range, followed by Depressed-Anxious and Somatic Complaints. This observation aligns with the VSPA-S results, as anger and irritability could reasonably escalate to violence and aggression.

Tables 3.23 and 3.24 display the overall percentage of juveniles who tested positive in the categories of Violent Aggressive Behavior and Vulnerability to Physical Victimization in the VSPA-S, from each RJDC with screener data from 2018 to 2022.

Table 3.23
Percentage Of Juveniles Testing For Violent Aggressive Behavior, By RJDC
2018 To 2022

	Boyd		Fayette		McCracken	
Year	#	%	#	%	#	%
2018	197	29.4	558	46.8	351	37.3
2019	187	15.5	552	46.7	287	54.4
2020	126	30.2	310	37.1	91	56.0
2021	28	17.9	156	15.4	50	34.0
2022	147	30.6	142	20.4	21	66.7
Total	685	25.5	1,718	40.0	800	46.7

Note: # = number of juveniles assessed; % = percentage of those juveniles who tested positive.
Source: LOIC staff analysis of VSPA-S screener data from DJJ.

Table 3.24
Percentage Of Juveniles Testing For Vulnerability To Physical Victimization, By RJDC
2018 To 2022

	Boyd		Fayette		McCracken	
Year	#	%	#	%	#	%
2018	0	Null	558	26.0	351	28.5
2019	0	Null	552	26.1	287	33.4
2020	12	25.0	310	18.4	91	47.3
2021	28	7.1	156	7.1	50	20.0
2022	147	24.5	142	9.9	21	38.1
Total	187	21.9	1,718	21.6	800	32.1

Note: # = number of juveniles assessed; % = percentage of those juveniles who tested positive. Comparing data in Table 3.23 and 3.24, the number of juveniles tested is identical for Fayette and McCracken. Boyd, however, used different versions of the VSPA-S to assess Violent Aggressive Behavior and Vulnerability to Physical Victimization.
Source: LOIC staff analysis of VSPA-S screener data from DJJ.

Consistent Trending

There appears to be no discernible and steady trend in the percentage of juveniles testing positive in both the Violent Aggressive Behavior and Vulnerability to Physical Victimization categories over time.

There appears to be no discernible and steady trend in the percentage of juveniles testing positive in both the Violent Aggressive Behavior and Vulnerability to Physical Victimization categories over time. In the Violent Aggressive Behavior category, the 5-year trend differs by detention center: Boyd's numbers remained stable, while Fayette saw a significant decrease in youths testing for physical aggression and violence. McCracken, however, experienced a considerable rise in 2022 compared to 2018. However, the lesser number of screenings conducted in 2022 might distort these results.

Similar patterns emerge in the Vulnerability to Physical Victimization category. Most screenings from Boyd before 2021 did not test for susceptibility to physical aggression, making 2022 the only year with substantial data. Therefore, defining a trend over time is not feasible. At Fayette, the percentage of juveniles vulnerable to physical aggression dropped significantly (26 percent in 2018 vs. 9.9 percent in 2022). In McCracken, however, the percentage increased from 28.5 percent in 2018 to 38.1 percent in 2022. Again, fewer screenings in 2022 might skew these results.

In general, the existing data fails to conclusively determine any increase or decrease in juveniles with severe mental health needs within the juvenile justice system. Nevertheless, certain types of mental health issues (such as problems with anger, physical aggression, and even depression/anxiety) appear to be fairly consistent among juveniles in the system, both across different locations and over time.

Recent Legislation Emphasizes Mental Health Services

Recent legislative reforms in juvenile justice have emphasized the mental health of juvenile populations.

Recent legislative reforms in juvenile justice have emphasized the mental health of juvenile populations. For example, SB 162 of 2023 obliges DJJ to establish adequate contracts to ensure timely access to institutional treatment for children with severe emotional disturbances or mental illnesses. It also mandates access to mental health professionals for children in crisis who are residing in juvenile detention facilities.[149]

Similarly, HB 3 of 2023 requires detained juveniles awaiting detention hearings to be assessed by a mental health professional. This assessment might reveal that they could benefit from cognitive behavioral therapy, other evidence-based mental health programs, substance use disorder treatment, or psychiatric treatment for severe mental illness. If such treatment is recommended, the court may direct the child to undergo it, and DJJ or a contracted behavioral health services organization will provide the recommended treatment.[150]

During a recent meeting, the secretary of the Justice and Public Safety Cabinet expressed concern that because private hospitals have denied treatment to violent juvenile offenders in the past, DJJ may not be able to meet the new requirements regarding access to institutional treatment for children.

During a recent meeting, the secretary of the Justice and Public Safety Cabinet expressed concern that because private hospitals have denied treatment to violent juvenile offenders in the past, DJJ may not be able to meet the new requirements regarding access to institutional treatment for children with severe emotional disturbances or mental illnesses.[151] He acknowledged that because KRS 645.150 authorizes involuntary hospitalization of juvenile

offenders who are mentally ill, a separate stand-alone hospital could be an option.[152]

South Carolina. South Carolina is struggling with the same issue and is moving forward with construction of a psychiatric hospital for juvenile offenders. The legislature set aside $20 million for a 50,000-square-foot residential facility in Columbia, to hold up to 40 youths and employ 150 staff members. It is to include 32 bedrooms with attached bathrooms, communal living space, classrooms, food prep and dining, treatment rooms, inside and outside activity areas, laundry facilities, staff office space, a lobby, security areas, and storage.[153] The following statements are notable from the background of South Carolina's request for proposal:

- "Implementing the decision to provide mental health treatment to seriously mentally ill committed juvenile delinquents in non-correctional settings has posed many challenges and raised numerous unique issues. Many of the challenges are of the traditional variety: the seriously emotionally disturbed juvenile committed to DJJ, like seriously emotionally disturbed juveniles everywhere, have difficult behaviors and challenging clinical needs. Their impulsive, provocative and sometimes aggressive behaviors make them difficult to work with and treat, and result in periodic disruptions in their residential treatment. Such juveniles cause frustration not only among direct treatment providers, but also among state agency staff trying to supervise or manage that treatment. Such frustrations, in turn, can lead to treatment providers and state agencies involved with the juveniles finding fault with or blaming each other when problems or adverse incidents occur during the course of treatment. However, treatment failures, disrupted placements, elopements, and minor criminal offenses such as drug use, are predictable occurrences when treating a population of seriously emotionally disturbed adolescents over a course of months or years. Through good clinical care, professional program administration, and active independent case management and supervision, such adverse events will be less frequent and less severe. However, given that the treatment providers and the patients are human, adverse events should be anticipated."[154]
- "The contractor shall have a no refusal/no eject policy. The program must accept all youth determined by SCDMH [the South Carolina Department of Mental Health] to need a Psychiatric Residential Treatment level of care, including those youth whose treatment needs may not be as acute, but for whom the lower level of care is not currently available. Following construction, and during operation, SCDMH will

> pay its contractor at a 'per resident per day' rate for its services. SCDMH will pay for an agreed upon minimum number of beds at the 'per resident per day' rate whether occupied or not, as a guaranteed level of financial support."[155]

Current Contracts And Other Executive Branch Action

Prior to recent legislation, DJJ entered into memoranda of agreement with the University of Kentucky Department of Psychiatry. These agreements aim to provide mental health treatment to youths across 23 DJJ facilities, encompassing youth development centers, RJDCs, and group homes. Effective from July 1, 2022, to June 30, 2024, these MOAs allocate $382,655 for a chief of medical services, $354,466 for a chief of mental health services, and $500,000 for providing both in-person and telehealth services at 23 DJJ residential facilities.

DJJ officials have noted that in addition to expanding contracts to external behavioral health organizations, it has adjusted hiring practices to onboard more direct-hire mental health staff.

DJJ officials have noted that in addition to expanding contracts to external behavioral health organizations, it has adjusted hiring practices to onboard more direct-hire mental health staff. For instance, every facility has a counselor position, which falls under the Social Service job title series, with Social Service Clinician I being the preferred title. If DJJ struggles to find qualified candidates for this position, it may downgrade the title to Social Service Worker II or I. Although a license is not necessary for these positions, certain educational and professional experience requirements are in place.[156]

Due to the challenge of hiring licensed individuals, mostly because of the wage gap with the private sector, DJJ has created a new job title: Licensed Behavioral Health Professional.

Due to the challenge of hiring licensed individuals, mostly because of the wage gap with the private sector, DJJ has created a new job title: Licensed Behavioral Health Professional. This title encompasses a range of professionals, including those with a master's degree in social work, professional counseling, or marriage and family therapy who possess an active license to practice in Kentucky, which broadens the pool of potential applicants.

DJJ has expanded its hiring practices to include individuals who hold a master's degree in a relevant field but have only an associate license or have not yet applied for their associate licensure.

Furthermore, DJJ has expanded its hiring practices to include individuals who hold a master's degree in a relevant field but have only an associate license or have not yet applied for their associate licensure. DJJ has also taken steps to support these individuals by reimbursing the cost of obtaining their associate licensure and providing required associate clinical supervision, in collaboration with universities.[157] These changes reflect a shift in DJJ's approach to staffing its mental health roles, emphasizing flexibility and support to attract a broader range of potential candidates.

Recommendation 3.17

Recommendation 3.17

The Department of Juvenile Justice should continue to expand current contracts to meet the requirements regarding mental health treatment in Senate Bill 162 and House Bill 3 (2023 Regular Session).

Recommendation 3.18

Recommendation 3.18

The Department of Juvenile Justice should contact South Carolina executive and legislative officials to obtain additional information on the proposed psychiatric facility for juvenile offenders. It should prepare an analysis of whether a similar hospital is suitable for Kentucky, then present the results to the legislature for consideration.

Does The Juvenile Offender Booking System Provide Data Needed To Operate RJDCs Safely, Effectively, And Efficiently?

The juvenile offender booking system was initially designed to provide a simple count of youths coming and going from individual RJDCs, much like systems used by the hotel industry.

The juvenile offender booking system was initially designed to provide a simple count of youths coming and going from individual RJDCs, much like systems used by the hotel industry. It was never designed to record transfers of juvenile offenders from one RJDC to another, which is a primary flaw of the system.[158] Also, the system does not allow custom or other reporting across RJDCs, which limits its use by the DJJ central office to viewing of individual RJDC data.[159]

DJJ officials could not provide a list of updates to the system since its creation in the early 2000s. However, officials stated that modifications to the system have occurred, but in a piecemeal manner. For example, a gender identity information field was added within the last few years, as well as fields for offender history and suicide ideation. During the last major redesign, from 2009 to 2011, the system become "more live," allowing for instantaneous saves. The system also became enterprise-wide during the COVID-19 pandemic, which allows DJJ central office personnel to access the system to see live demographic, programmatic, and court information if situations arise.[160]

One of the major obstacles to using the system across all RJDCs appears to be the lack of required fields.

One of the major obstacles to using the system across all RJDCs appears to be the lack of required fields. According to DJJ officials, the original information systems branch manager during the late 1990s made the decision not to include required fields. The rationale for the decision was that front-line workers at each RJDC

should not be overly burdened by data inputting. As a result, many of the information fields within the system are old and obsolete.[161]

Although there is no formal data dictionary or operator's manual that describes each data point and relationship to other data points, DJJ did provide an Excel schema, which is a recent export of data fields from the booking system. The schema identifies over 1,500 rows or data points available for use, but none are required.[162]

Obsolete System

With the exception of the system updates mentioned above, DJJ has been using an obsolete system since the 2000s. The inability to use the system to track offender movement from RJDC to RJDC, to run routine or custom reports, or to integrate RJDC data has created an extremely cumbersome siloed system. One unique problem with the current system is that it treats the transfer of a juvenile offender to a different RJDC as a separate event. Offense information has to be entered again, and it may be incorrectly keyed into the system. Intake personnel may enter the first charge identified in a court order but fail to include the original charge. If DJJ's central office staff members use the system to view charges, they may see only the most recent charges but not the original ones.

DJJ began the process of updating its database software with the release of a request for information (RFI) on September 14, 2022.

With the release of a request for information (RFI) on September 14, 2022, DJJ began the process of updating its database software. The purpose of the RFI was "to obtain information and suggestions regarding the acquisition of a fully integrated juvenile case management. The system should be able to handle all aspects of our agency needs electronically rather than manually to meet Senate Bill 200" of the 2014 legislative session.[163]

Because of the availability of federal money, the Justice and Public Safety Cabinet halted the RFI process in favor of expanding the Kentucky Offender Management System.

Because of the availability of federal money, however, the Justice and Public Safety Cabinet decided to halt the RFI process and expand the Kentucky Offender Management System (KOMS) contract between the Department of Corrections and Marquis Software Development in order to provide a "DJJ configured KOMS solution."[164]

According to the cabinet, KOMS is a database used by the Department of Corrections to manage its inmate population by tracking demographic and programmatic data per offender, as well as related court records. Use of KOMS would allow DJJ

to use its own secure software, to share information between the two agencies, and to expand the information tracked per juvenile offender.[165]

For Phase I, there are 14 identified modules.[166] Phase II will add 21 modules, the majority of which will be decided by DJJ. Fourteen core modules, however, will be decided by mutual agreement between DJJ and Marquis.[167] According to DJJ officials, Phase I dollars come from 2020 Coronavirus Supplemental Funding and Phase II dollars will come from the National Criminal History Improvement Program. Table 3.25 provides additional detail about Phase I of the contract.

Table 3.25
KOMS Expansion, Phase I Modules

Phase	Modules	License Fee
IA	Offender Data Administration	$25,000
	Facility Staff Reference	100,000
IB	Offender Reception Process	125,000
	Offender Time Computation	37,500
	Parole and Probation Services	100,000
IC	Inmate Population Tracking	150,000
	Inmate Custody Classification	40,000
	Offender Tracking and Release	87,500
ID	Inmate Monitoring and Transfer	75,000
	Incident Report Tracking	25,000
	Inmate Security Status	75,000
	Investigation Tracking and Statistics	50,000
	Risk and Needs Assessments	60,000
Total		$950,000.00

Note: The expanded statement of work (draft) envisions expanding the number of modules from 13 to 35. In addition to license fees, the Phase I services and maintenance added an additional $192,000 and $44,156.25, respectively.
Source: LOIC staff analysis from information in the Marquis Software statement of work.

Communication Challenges

There appears to be a slight difference of opinion on whether the cabinet involved DJJ officials in the decision to move forward with the KOMS contract modification solution. DJJ officials stated that they have not been involved with the decision to modify KOMS, nor have they been involved with the modification process itself.[168]

As an example, during the RFI process, DJJ officials compiled a wish list of what a new system should include, but the list may not have been used when drafting and approving the scope of work document as part of the KOMS contract modification.[169] The wish

list document identifies various demographic and other functional components within five areas, when addressing the need to create an integrated system. Table 3.26 provides additional detail.

Table 3.26
DJJ Wish List
Offender Booking System Update

General	Offender demographics; family demographics; court information; Department for Community Based Services information; medical information; drug use history; education data; mental health data; placement data; employment data; e-signature capability; outside assessment information; storage of industry standard reference material; incident report information; treatment plans; input and track group meeting notes; sex offender information; release information; interaction with Administrative Office of the Courts data systems; TWIST information; interstate compact information; initial commitment to DJJ; Medicaid eligibility; medical cards; training information for offenders; human trafficking; expungements; dashboard statistics; maintaining offender records from previous facility if transferred to a new facility; establishment of user groups; search capabilities; etc.
Placement Services	Resident Record Card information; restricted access and work flows; victim notification requirements; file notifications; use of field validation rules; out-of-state demographics; social history; transportation; revocation data; scanning and uploading; drop-down boxes; probation violation; sanctions; auto populate; address duplication issues due to movement of kids within DJJ; mobile apps for transportation drivers; etc.
Program Services	Capture education credits; American Correctional Association data; religion and ethnicity; etc.
Program Operations	Contacts; room assignments; default screens; medical reports; shift reports; unique ID numbers; freestyle note collection; delete release types no longer used; acquaintance information; system reminders; daily progress notes; capture court schedules; editing capability; upload manual notes; multiple picture uploads (i.e., scars, tattoos, distinguishing marks, etc.); forms incorporated into workflow; storage of blank forms; teacher comments and summaries; etc.
Support Services	Auto fill and cut and paste between windows; enhanced filing and reporting; internal DJJ investigations; grievances; etc.

Source: DJJ staff.

Cabinet officials clarified its perspective that during a period of approximately 8 to 9 months, DJJ did not respond to requests for information, or provided incorrect information. As a result, officials asked whether DJJ might be interested in using KOMS, then set up a presentation conducted by a KOMS expert. After the presentation, DJJ decided KOMS was the system it wanted to use.[170] Currently, it appears that the cabinet and DJJ are working together toward the KOMS solution.

According to DJJ and cabinet officials, there has been constant interest and sometimes preliminary action from previous administrations to update the juvenile booking system.

According to DJJ and cabinet officials, there has been constant interest and sometimes preliminary action from previous administrations to update the juvenile booking system. However, because of the constant changes in leadership at the commissioner level, many action items are started but not finished.[171] Table 3.27 shows that there have been 14 commissioners in 19 years.

Table 3.27
DJJ Commissioner Change
2002 To 2021

Year Of Appointment	Governor	Secretary	Commissioner	Years In Office
2002	Paul Patton	Robert F. Stephens	Ron Bishop	2002-2004
2004	Ernie Fletcher	Steven B. Pence	Bridget Brown	2004-2007
2007	Steve Beshear	Norman E. Arflack	Dale Liechty	2007-2008
2008	Steve Beshear	J. Michael Brown	J. Ronald Haws	2018-2012
2012	Steve Beshear	J. Michael Brown	Hasan Davis	2012-2014
2014	Matt Bevin	J. Michael Brown	Bob Hayter	2014-2016
2016	Matt Bevin	John Tilley	Jon Grate	2016
2016	Matt Bevin	John Tilley	LaDonna Koebel	2016
2016	Matt Bevin	John Tilley	Carey Cockerell	2016-2018
2018	Matt Bevin	John Tilley	Ray DeBolt	2018-2019
2019	Matt Bevin	John Tilley	Denny Butler	2019
2019	Andy Beshear	Mary Noble	LaShana Harris	2019-2021
2021	Andy Beshear	Mary Noble	Ronnie Bastin	2021
2021	Andy Beshear	Kerry B. Harvey	Vicki R. Reed	2021-current

Source: LOIC staff from information provided by Justice and Public Safety Cabinet.

Incident Information, Grievance Information, And Gang Information

Protection from abuse, mistreatment, and injury is the first substantive provision in the 1996 consent decree.

Incident and grievance reporting is addressed in two finding areas but deserves mention here because of their importance. For example, protection from abuse, mistreatment, and injury is the first substantive provision in the 1996 consent decree. It states the need for "an adequate uniform special incident reporting system that ensures that all special incidents are promptly and adequately identified, reported, investigated, and tracked."[172] However, DJJ does not use an automated system for entering and tracking incidents or grievances. As stated in the DJJ wish list in Table 3.26, the ability to track incident and grievance data is suggested by DJJ within the general and support services categories.

The ability to record and track gang information for intelligence purposes is of strategic importance.

The ability to record and track gang information for intelligence purposes is of strategic importance. Although the juvenile offender information allows intake staff to complete a body ID, which includes a text box to document information, there is no consistency regarding the use of this field. Also, there is a limited ability to upload photos to the juvenile offender booking, but as suggested in the Table 3.26 wish list under the program operations category, the ability to use multiple picture uploads would be beneficial for the identification of gang affiliation.

Figure 3.L
Fayette RJDC Gang Communication

Source: LOIC staff tour of facility, March 3, 2023.

In reviewing the offender booking system's data fields, LOIC staff identified fields that may be suitable for recording tattoo information. For example, the system includes seven tables with the name of BodyMarks and two columns named Q27_tattoo and TattooDesc. As stated previously, these fields are not required.

Figure 3.M
Campbell RJDC Gang Indicators

Source: LOIC staff tour of facility, March 28, 2023.

Recommendation 3.19

Recommendation 3.19

Justice and Public Safety Cabinet officials should continue to include appropriate Department of Juvenile Justice officials in discussions regarding the expanded scope of work for the Kentucky Offender Management System. Officials should also continue to familiarize themselves with the department's wish list and schema from its current offender booking system.

Recommendation 3.20

Recommendation 3.20

Justice and Public Safety Cabinet officials should include required fields for incident and grievance reporting in the new system, as well as the ability for multiple picture uploads and other required data fields for noting tattoos, possible gang affiliations, etc.

Does The Incident Reporting Process Ensure That Incidents Between DJJ Staff And Juvenile Offenders Are Promptly And Adequately Identified, Reported, Investigated, And Tracked?

Without an automated process, it is difficult to consistently analyze incident report data to ensure adequacy of the process or to use data for planning and other purposes.

As introduced in the 1996 consent decree, adequacy and uniformity are essential components for an effective special incident reporting system. Without an automated process, however, it is difficult to consistently analyze incident report data to ensure adequacy of the process or to use data for planning and other purposes.

The Isolation/Incident Report (IIR) form used by DJJ for documenting and reporting incidents is not sufficient as a mechanism for higher-level reviews or for inputting and tracking critical information.

The Isolation/Incident Report (IIR) form used by DJJ for documenting and reporting incidents is not sufficient for use as the mechanism for higher-level reviews by superintendents or for inputting and tracking critical information. As a result, superintendents are not able to rely on the completed IIRs during their reviews; rather, they have to rely on supporting documents, as well as video archives. Also, superintendents and their superiors are not able to use data from the completed IIRs to identify trends or problem areas that should be addressed within the RJDCs.

DJJ Policy

There are two primary DJJ policies that cover the reporting of various types of incidents. DJJ 715 discusses the incident reporting requirements for detention services, and DJJ 321 discusses the incident reporting requirements for program services, typically provided in group homes and youth development centers.

The policies contain very similar requirements. For DJJ 321, however, two additional choices are offered to describe an assault: "staff on youth" assault and "youth on other" assault. This policy also offers four choices for describing sexual or attempted sexual assault, but DJJ 715 provides none. DJJ 321 offers four choices each for inappropriate sexual behavior and sexual harassment, but DJJ 715 offers none. The four choices offered in DJJ 321 include "youth on youth," "staff on youth," "youth on staff," and "youth on other." Additional choices for recording an incident event that are discussed in DJJ 321 but not in DJJ 715 include "major injury or illness," "self-harming behavior," "rioting or attempting to incite a riot," and "positive drug screen or test."

Table 3.28 illustrates various requirements from DJJ 715 related to detention services, which LOIC staff primarily reviewed.

Table 3.28
Excerpts Of Incident Reporting Policy (DJJ 715)

Section	Description

III
Definition
	The following situations shall constitute an incident:
	• Use of isolation
	• Absent without leave (AWOL), escape, or attempts
	• Assault, attempted assault, threatened assault by
	  • Youth on youth
	  • Youth on staff
	• Major property destruction
	• Possession of contraband
	• Death of youth
	• Medication error
	• Suicide attempt
	• Use of restraint
	  • Physical restraint
	  • Therapeutic restraint
	  • Mechanical restraint, except in cases of routine transportation
	• The taking of a hostage or hostages
	• Chronic program disruption that threatens the safety of youth or staff
	• Other

IV.A Intervention	Any staff witnessing or discovering an incident shall immediately intervene to prevent further escalation if possible or lessen potential severity
IV.D Detail	An incident report shall be written to provide detailed and specific information regarding: • The violation or behavior • Events leading up to the incident • The manner in which the incident was dealt with and any consequences issued as a result • Staff witnesses • Physical evidence • Use of force • The full name of the juvenile • Date, time, and place • The reporting staff's name, signature, and current position

Section	Description

IV.F
Support
	Supporting documentation shall provide additional information regarding an incident. The following supporting documentation shall be required as part of the final incident report:
	• Medical assessment documentation, when the juvenile who is the subject of the incident has sustained an injury not caused by a restraint
	• Post-restraint assessment documentation completed by health trained or medical staff when a juvenile has been restrained
	• Photographs in the following situations:
	  • Post-restraint or injury photographs of the juvenile shall be retained with a copy of the juvenile's post-restraint assessment documentation in the juvenile's medical record. A notation on the incident report shall state the location of the photographs
	  • Staff injury photographs shall be retained with a copy of the incident report in the staff's medical record. A notation on the incident report shall state the location of the photographs
	  • Damaged property photographs, dangerous contraband photographs, and all other photographs shall be attached to the incident report and retained in the juvenile's record

IV.H Video	Superintendents or designee shall archive videos of some incidents that involve physical restraint, property damage, staff misconduct, or any other incidents deemed necessary for future reviews. The archived videos shall be placed on the appropriate electronic site provided by the IS Branch. Archived videos shall not be stored on individual computer equipment. In addition, at the request of IIB, the Ombudsman, or the Office of Commissioner, video of an incident shall be archived
IV.K Debriefing	A debriefing shall be conducted after each incident. The debriefing process includes coordination and feedback about the incident with the Superintendent or designee as soon as possible after the incident. A debriefing shall include: • A review of staff and juvenile actions during the incident • A review of the incident's impact on staff and juveniles • A review of corrective actions taken and still needed • Plans for improvement to avoid another incident
IV.L Juvenile statement	Staff shall obtain a statement from the juvenile regarding the incident. The juvenile shall be given the opportunity to discuss the incident and sign off on the incident report. The copy of the incident report shall be filed in the juvenile's record
IV.N Forwarded copies	In accordance with approved protocol, the Superintendent shall forward copies of incident reports, including all supporting documentation, to the Regional Director or Facilities Regional Administrator and the Ombudsman, if applicable, for any of the following: • AWOL/escape • Death • Serious injury or illness requiring more than first aid, including emergency medical care or transport • Assault on youth • Assault on staff • Possession of dangerous contraband • Physical restraint • Sexual assault • Suicide attempt • Medication error

Note: DJJ 150 requires DJJ to utilize video equipment within facilities to ensure a safe environment for residents and staff. During tours and interviews, LOIC staff was told that videos from the RJDCs are saved for 30 to 60 days, unless archived. DJJ officials stated that, once archived, the videos are kept indefinitely. IS = Information Systems; IIB = Internal Investigations Branch.
Source: LOIC staff review of DJJ policies.

Isolation/Incident Report Form

Isolation/Incident Report forms are used to record incidents and isolation practices involving juveniles in the custody of DJJ. The IIR is the same across all Kentucky RJDCs except for Breathitt. There are fields on the IIR for basic information about the youths and the staff members involved, as well as a narrative description of the incident or isolation event, most of which are required by DJJ 715, discussed above.

A section of the IIR devoted to incidents includes fields for recording the date, time, location, and description of the incident, as well as the names and roles of any staff members and youths involved. Additionally, the IIR includes sections for documenting any injuries, property damage, or contraband discovered during the investigation.

The isolation section of the IIR includes fields for recording the reason for the isolation, the date and time that the isolation began and ended, and the names and functions of any staff members involved with the isolation. Additionally, the IIR contains sections for documenting the youth's behavior during the isolation period, any interventions or services provided during the isolation period, and any follow-up actions taken after the isolation period is over. However, the IIR offers little guidance for providing additional detail related to the use of isolation. Additional guidance in this area could be helpful to those completing the IIR.

The IIR includes fields for basic information and a narrative description but it is unclear whether specific guidelines or protocols exist to ensure relevant details are provided.

Use Of Textboxes. The IIR lacks detail and specificity. Even though the IIR includes fields for basic information and a narrative description of the incident or isolation event, it is unclear whether specific guidelines or protocols exist to ensure that relevant details are provided. Without this type of guidance, RJDC personnel who fill out the IIR either provide little to no information in the text boxes or provide too much information. In order to ensure that incidents and isolation events are documented consistently and thoroughly, it would be helpful if more specific guidance were provided as to what information should be included in these text fields.

If a more digital approach were used, specific questions, prompts, or drop-down menus could be provided to simplify responses, thus making the IIR more useful.

For example, if a more digital approach were used, specific questions, prompts, or drop-down menus could be provided to simplify responses, thus making the IIR more useful. The use of a digital document could also require the user to complete certain fields before moving to the next section or before completing the IIR. Using required response prompts and

questions would increase consistency in reporting and reduce or eliminate "null" or blank values.

Transparency And Accountability. Although the IIR appears to be designed to document incidents and isolation events involving youths in DJJ's custody, it is unclear whether procedures are in place to ensure that reports are reviewed and analyzed for trends or patterns, or whether the reports are made available to external stakeholders, such as youth advocates or internal and external oversight bodies. Building trust with stakeholders and demonstrating a commitment to continuous improvement could be achieved by improving transparency and accountability in the reporting process through routine analysis and sharing of results.[173] Whether incident reports are used for staff training purposes, however, is unclear.

There is a problem with the IIR's design. The first section combines incidents and isolation events, making it a challenge to accurately capture the relevant information for each type of event.

Overall Logic. In terms of the IIR's design, there is a problem with its overall logic. In the first section, the IIR includes fields both for incidents and for isolation events, but these are two distinct types of events with different reporting requirements. When they are combined into one section, it is challenging to accurately capture the relevant information for each type of event. Figure 3.N provides additional detail.

Figure 3.N
Isolation/Incident Report Form,
Event Check Boxes

1. Check All Events That Apply:

☐ AWOL/Escape	☐ Possession of Contraband	☐ Death of Resident
☐ Major Offense	☐ Assault by Youth on Youth	☐ Major Injury
☐ Physical Restraint	☐ Use of Isolation	☐ Assault by Youth on Staff
☐ Sexual Assault	☐ Mechanical Restraint	☐ Major Property Destruction
☐ Suicide Attempt	☐ Therapeutic Restraint	☐ Other

Other Explain: _____

Source: DJJ, Isolation/Incident Report form.

As an alternative solution, separate sections could be created for incidents and isolation events, with tailored fields and prompts reflecting the unique characteristics of each event type. Figures 3.O and 3.P provide additional detail.

Figure 3.O
Revised Isolation/Incident Report Form,
Event Check Boxes

1. Check All Events That Apply

Please refer to DJJ Policy Number 715, Section IV for reporting procedures and requirements

☐ AWOL/Escape	☐ Possession of Contraband
☐ Major Offense	☐ Assault by Youth on Youth
☐ Sexual Assault	☐ Assault by Youth on Staff
☐ Suicide Attempt	☐ Major Injury
☐ Major Property Destruction	☐ Death of Resident

Source: LOIC staff.

Figure 3.P
Revised Isolation/Incident Report Form,
Consequences/Interventions Check Boxes

2. Check All Consequences/Interventions That Apply

Please refer to DJJ Policy Number 717, Section IV for procedures that govern the use of consequences/interventions

☐ Time Out	☐ Suspension of Privilege
☐ Room Restriction	☐ Use of Isolation**
☐ Mechanical Restraint	☐ Therapeutic Restraint
☐ Physical Restraint	☐ Suicide Watch
☐ Unit Lockdown/Room Restriction	

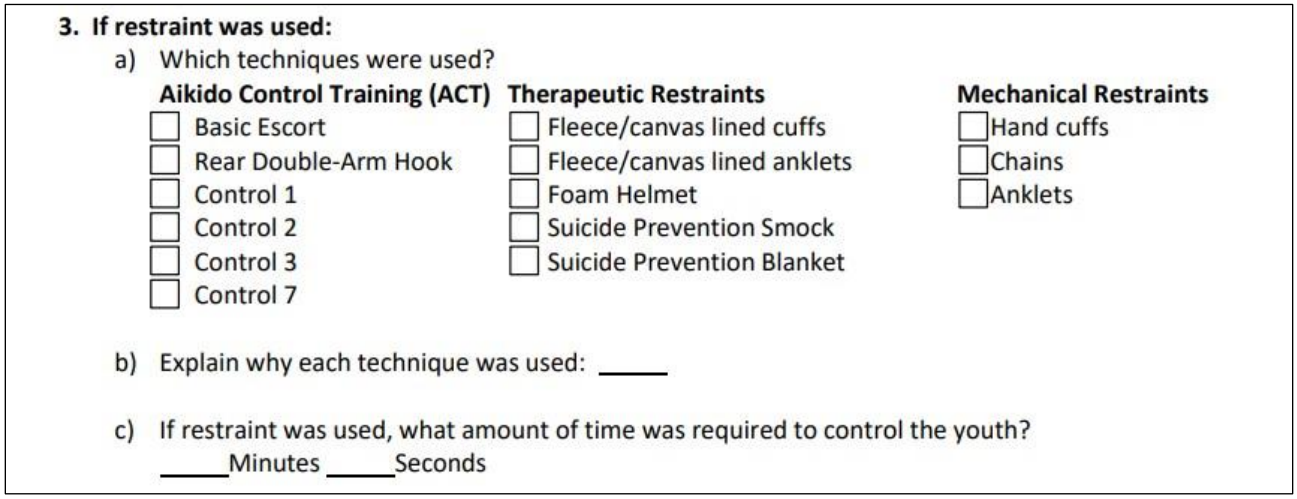
**Section IV, Subsections E-H describes policies related specifically to Use of Isolation

Source: LOIC staff.

The third section of the IIR says "if restraint was used" with no question or prompt, which can lead to misinterpretations, inaccuracy, or ambiguity.

Similarly, the third section of the IIR includes a statement that simply says "If restraint was used" without providing a question or prompt to which staff can respond. This situation can lead to misinterpretations, inaccuracy, or ambiguity. For example, LOIC staff observed instances where a restraint was not indicated, but the incident summary indicated that some form of restraint or physical interaction was used. Figure 3.Q provides additional detail.

Figure 3.Q
Isolation/Incident Report Form Restraint Question And Check Boxes



3. If restraint was used:

a) Which techniques were used?

Aikido Control Training (ACT)	Therapeutic Restraints	Mechanical Restraints
☐ Basic Escort	☐ Fleece/canvas lined cuffs	☐ Hand cuffs
☐ Rear Double-Arm Hook	☐ Fleece/canvas lined anklets	☐ Chains
☐ Control 1	☐ Foam Helmet	☐ Anklets
☐ Control 2	☐ Suicide Prevention Smock	
☐ Control 3	☐ Suicide Prevention Blanket	
☐ Control 7		

b) Explain why each technique was used: _____

c) If restraint was used, what amount of time was required to control the youth?
_____Minutes _____Seconds

Source: Isolation/Incident Report form, DJJ.

Including a specific question or prompt—such as "Was physical restraint used during the incident or isolation event?"—could help ensure that staff provide a clear and direct response to this question. Additional changes could also include a category breakout of choices regarding the type of restraints or techniques used. Figure 3.R provides additional detail.

Figure 3.R
Revised Isolation/Incident Report Form Questions And Check Boxes

Please refer to DJJ Policy Number 713, Section IV for procedures that govern the use of restraints

3. Did the incident require any restraint techniques?
☐ Yes ☐ No

4. If Yes, Check All Restraints/Techniques That Apply

Aikido Control Training (ACT)	Therapeutic Restraints	Mechanical Restraints
☐ Basic Escort	☐ Fleece/Canvas Lined Cuffs	☐ Handcuffs
☐ Rear Double-Arm Hook	☐ Fleece/Canvas Lined Anklets	☐ Chains
☐ Control 1	☐ Foam Helmet	☐ Anklets
☐ Control 2	☐ Suicide Prevention Smock	
☐ Control 3	☐ Suicide Prevention Blanket	
☐ Control 7		

5. If you answered No to Question 4, did the incident require other physical contact? If so, describe the physical contact.

☐ Took Juvenile Offender to The Ground	☐ Placed the Juvenile Offender in a Bear Hug
☐ Pinned Juvenile Offender to the Wall	☐ Controlled Juvenile Using His/Her Clothing
☐ Pushed Juvenile Offender	☐ Other_____

Source: LOIC staff.

The IIR is currently a paper-based document, which is typically filled out manually.

Paper Document. The IIR is currently a paper-based document, which is typically filled out manually. This process could result in inefficiency, errors, and delays in the reporting process. The development of an electronic version of the form that can be completed and submitted electronically could help streamline the reporting process, reduce errors, and facilitate analysis and tracking of incidents and isolation events over time.

Without transparency in incident reporting, it may be difficult for stakeholders such as advocates and oversight bodies to understand what is happening in a facility. This can lead to a lack of trust and increased scrutiny. Furthermore, if incidents are not properly reported and investigated, there may be an increased risk of lawsuits against the facility, staff members, or administrators.

Although the IIR generally reflects the requirements of DJJ 715, there are challenges with its design and use, which should be addressed.

Although the IIR generally reflects the requirements of DJJ 715, there are challenges with its design and use, which should be addressed. The overall logic of the IIR is flawed, in that it combines separate events and uses an "if statement" regarding the use of restraints. The IIR also lacks definitions of key terms and contains ambiguous question prompts, both of which preclude an accurate record to provide data needed to accurately and quickly determine whether DJJ personnel are following policies and procedures.

As stated in the section related to the offender booking system, DJJ officials have expressed a need to automate information related to incident reports and grievances, as part of its efforts to modify the offender booking system. An automated system could allow superintendents to review incidents more quickly and thoroughly, without having to worry about time limits associated with archiving videos.

Recommendation 3.21

The Department of Juvenile Justice should develop an automated system to track critical information regarding each incident.

Recommendation 3.22

The Department of Juvenile Justice should reevaluate DJJ 715 and DJJ 321 for consistency, then update its Isolation/Incident Report form in anticipation of automation.

What Concerns Exist At The Staff And Superintendent Levels?

Although the worsening youth population is the focus of much of the conversation on detention centers, RJDC employees appear to be primarily concerned with pay, scheduling, and conflicts with other staff. Superintendents appear to be primarily concerned by the lack of direct line and other staff. Different levels of morale cannot be specifically attributed to staff or superintendent concerns, but morale fluctuated between 2018 and 2022 and was often surprisingly high, according to RJDC superintendents.

LOIC staff analyzed employee concerns by requesting grievances and exit interviews for 2018 to 2022.

LOIC staff analyzed employee concerns by requesting grievances and exit interviews for 2018 to 2022. Staff received 82 grievances from seven RJDCs and 101 exit interviews from all RJDCs. In addition, staff analyzed superintendent monthly reports for 2018 to 2022, reviewing and analyzing a total of 364 reports from all RJDCs. The superintendent reports were also used to document staff morale at the RJDCs.

Staff Grievances[i]

Staff grievances focused primarily on pay, scheduling, diversity, and various types of conflicts.

Staff grievances focused primarily on pay, scheduling, diversity, and various types of conflicts. Judging from exit interview checkboxes and comment fields, workers who completed an exit interview often had issues with staff conflict. Managers and management style appear to be enough of a frustration to regularly appear in comment boxes.

Scheduling frustrations also appear to be common, though they appear more in the checkboxes than in the open response boxes. The issues with practices and policies may also be tied to the frustrations with work environment, as poorly implemented or poorly enforced policies could lead to a poor work environment. Comments about danger from juveniles or the safety of staff were rarer. An Adair employee indicated an issue by stating “struggled with having control of youth.” Two employees at McCracken and one employee each at Boyd, Jefferson, and Warren said their RJDCs were unsafe or dangerous, or that someone would be hurt.

[i] This analysis is not representative of all staff concerns, since LOIC received a relatively small number of documents. Grievances are filed by those with feelings strong enough to risk conflict with management, and DJJ cannot force staff to complete exit interviews. In addition, many of the exit interviews indicated that the employee found a better job or had a career change, which are very general categories.

LOIC staff reviewed DJJ grievances by reading through the comments and supervisor responses and categorizing them by common factors. For example, the pay category was the most common (34.1 percent) and included complaints of being told to do hazardous duty despite being nonhazardous employees (Adair and McCracken), requests for increased pay (Breathitt), and not being compensated for working through breaks and lunch (Jefferson). In one McCracken case, an employee was quarantined after COVID-19 exposure but was coded as taking unauthorized leave. This situation resulted in financial hardship and had to be resolved by the deputy commissioner. Table 3.29 provides additional detail.

Table 3.29
Number Of RJDC Grievances By Type
2018 To 2022

RJDC	Pay	Schedule	Diversity	Retaliation	Interpersonal Conflict	Harassment/ Hostile Environment	Other	Total
Adair	2	1	0	0	0	0	2	5
Boyd	1	0	0	0	0	0	0	1
Breathitt	12	0	0	0	1	0	0	13
Campbell	1	0	0	0	0	0	1	2
Jefferson	3	4	0	4	0	5	2	18
McCracken	6	3	2	2	1	1	1	16
Warren	3	3	9	4	7	0	1	27
Total	28	11	11	10	9	6	7	82

Note: Two grievances forms were excluded from analysis because they contained no information on the issue.
Source: LOIC staff analysis of 82 grievances.

Scheduling, Diversity, Retaliation And Interpersonal Conflict. Scheduling, diversity, retaliation, and interpersonal conflict grievances were about equally common (11 percent to 13 percent). Scheduling issues included an employee feeling their schedule was changed due to others' absences (Adair), not receiving a weekend day off when other staff did (Jefferson), and schedule alterations that would have prevented doctor visits if the deputy commissioner had not made an adjustment (McCracken).

Diversity issues were tied to incidents related to race, sexuality, and mental health status and were seen mainly at Warren.

Diversity issues were tied to incidents related to race, sexuality, and mental health status and were seen mainly at Warren. At Warren, six complaints were tied to staff using racial slurs and two complaints were tied to coworkers making derogatory and comical remarks about a person's sexuality. At McCracken, complaints included the following:

- A supervisor told other employees about a worker's mental health issues

- A schedule change was made for a woman of one race while employees of another race kept the same schedule
- A supervisor did not like the superintendent because she was asked to reprimand staff for certain issues, while other male supervisors did not have to issue similar reprimands

Retaliation, interpersonal conflict, and harassment or hostile environment complaints were divided based on the type of conflict. Retaliation required the grievant to state it was retaliation or that actions were taken to punish them for past actions.

At Jefferson, three of the four retaliation claims came from one person, who stated his schedule was changed because of previous complaints.

At Jefferson, three of the four retaliation claims came from one person, who stated his schedule was changed because of previous complaints. The remaining Jefferson retaliation claim stated that an individual was called to a meeting with superiors and told to rethink a previous grievance regarding not being paid for working during lunch and breaks. This claim does not appear to have been reviewed.

One McCracken retaliation claim stated that a demotion and corrective action was retaliation, but it was tied to intimidating youths who submitted grievances. The other McCracken retaliation claim was that the commissioner sent an employee from another RJDC to inspect their work based on a previous conversation. The Warren retaliation claims stated the schedules were changed after previous complaints or after looking for other work.

Interpersonal conflict was coded for singular events where an individual ran into problems with another employee. The seven complaints at Warren included not assisting during a restraint, changing consequences for youths, and being told to return to work while sick. The McCracken claim was for feeling unfairly reprimanded, where an employee was criticized for not wanting to work in the control room and for being in the bathroom. A diversity grievance said the person was forced to criticize someone for issues that did not lead to criticism of others. The Breathitt complaint was from an argument over disciplining youths.

Harassment complaints or hostile work environment complaints were made when there were ongoing problems. The Jefferson claims alleged that staff were harassing the claimant due to their religion and supervisors were telling others about their personal matters, that supervisors were yelling at staff, and that supervisors were breaking policy while addressing staff about following policy. The McCracken complaint involved a supervisor cursing the person while telling them not to bother the superior, telling the person to stay in their own lane, calling a youth a slur tied to

mental development, asking if the individual was handicapped, and gossiping.

"Other" Category Rarely Used. The "other" category combined six rarely used categories: two complaints about policies, two complaints about responsibilities, and one complaint each about equipment, promotions, and medical accommodations. Both policy complaints were from Jefferson, with one stating that a lack of policies before opening the RJDC led to an unsafe work environment and the other stating that the employee was no longer allowed to work overtime.

The responsibility grievances involved one person disagreeing with a reprimand for not conducting an evaluation of an employee on probation and one for not being aware that his staff were required to do daily notes because he did not have computer access. The equipment grievance was about an uncomfortable control room chair. In the promotion grievance, a claimant said a less qualified person was promoted over them. The medical accommodation grievance was about being placed on light duty and being forced to work in a public area rather than an office.

Two grievances do not appear to have been reviewed. The Jefferson complaint of retaliation where an employee was told to rethink a grievance about pay does not have a review by supervisors. A McCracken grievance about not being paid overtime despite staying after to help residents was sent to a third-level supervisor. There was some DJJ staff discussion over how to handle the grievance, but no response was in the file. When grievances appear to receive no attention, faith in the process can be undermined.

Exit Interviews

Exit interviews were analyzed through the section indicating why an employee left. These sections contained both checkboxes and an open-ended response that allowed staff to enter comments. The checkbox section contained 34 options along with an "Other" box. Table 3.30 shows the most common reasons selected from the checkbox section.

Table 3.30
RJDC Staff's Reasons For Leaving
August 2017 To October 2022

RJDC	Better Job	Career Change	Practices/ Policy	Family	Schedule	Pay/ Salary	Conflict	All Other	Total
Adair	3	3	2	2	3	2	0	11	26
Boyd	2	2	0	1	0	0	1	3	9
Breathitt	0	2	0	0	1	0	0	0	3
Campbell	4	2	4	4	1	5	2	14	36
Fayette	5	4	2	1	1	2	2	11	28
Jefferson	6	3	1	3	3	1	2	10	29
McCracken	4	5	3	4	0	2	4	22	44
Warren	18	7	6	3	8	5	5	30	82
Total	42	28	18	18	17	17	16	101	257

Note: Respondents could indicate multiple reasons for leaving employment. "Practices/Policy" appeared in the form as "Unsatisfactory Practices/Policy"; "Family" appeared as "Family Reasons/Responsibilities"; "Schedule" appeared as "Schedule Conflict"; "Pay/Salary" appeared as "Pay/Salary (insufficient)"; "Conflict" appeared as "Conflict With Co-Worker" or "Conflict With Supervisor."
Source: Staff analysis of 101 exit interviews—11 from Adair, 6 from Boyd, 2 from Breathitt, 13 from Campbell, 7 from Fayette, 10 from Jefferson, 20 from McCracken, and 32 from Warren.

A better job elsewhere was the most common reason for leaving, accounting for 16.3 percent of responses.

A better job elsewhere was the most common reason for leaving, accounting for 16.3 percent of responses. Within that category, respondents could indicate whether they left for a job inside or outside state government. Eight people found a better job outside the government, and two found a better job inside the government.

Unsatisfactory practices and policies were indicated in 7.0 percent of exit interviews. Similar percentages were found for family responsibilities, scheduling conflicts, insufficient pay, and conflicts with coworkers or supervisor. The "all other" category included 24 other categories. Notable inclusions were lack of promotional opportunities (nine individuals), heavy workloads (eight individuals), lack of recognition (seven individuals), job incompatibility (five individuals), and unsatisfactory assignments (four individuals).

Some responses included other reasons for leaving:

- Inability to perform job after surgery
- Metaphorical suggestion of too many managers and not enough workers
- Claiming the respondent was forced to leave

Open-Ended Comments. The exit interviews included 40 files with comments in the open-ended comments/concerns field. Four of individuals had positive comments and left for other reasons. Of these, two left for health issues, one found a job with better hours and tuition reimbursement, and one changed career fields.

Two further responses were neutral and did not indicate a potential area for improvement. One individual wanted to focus on school, and the other wanted a job closer to home.

The remaining 34 comments are categorized and summarized in Table 3.31. Ten of the comments concerned multiple topics. None of the Breathitt exit forms included a comment. The comments overrepresent McCracken and Warren, which account for 58.8 percent of the total.

Table 3.31
RJDC Staff Comments By Topic
August 2017 To October 2022

RJDC	Management	Environment	Schedule	Youths	Pay	Other	Total
Adair	2	0	0	2	0	1	4
Boyd	1	1	0	0	0	0	2
Breathitt	0	0	0	0	0	0	0
Campbell	4	1	0	0	0	0	4
Fayette	0	1	0	0	0	0	1
Jefferson	2	2	1	0	0	0	3
McCracken	7	2	2	0	1	2	11
Warren	6	3	2	1	1	0	9
Total	22	10	5	3	2	3	34

Note: Numbers do not sum to totals shown, because one comment could encompass multiple topics.
Source: Staff analysis of comments on 34 exit interviews.

The most common comments related to management.

The most common comments related to management. For example, a McCracken employee stated that a supervisor was disrespectful to staff and residents, Campbell employees mentioned poor or lacking leadership, and an Adair employee said they were continuously placed in hazardous positions despite being a nonhazardous employee and expressing concerns. A Warren worker indicated that they received directives that went against policy and that grievances were ignored. A Jefferson employee was told to ignore policy.

The environment concerns related to difficulty at the workplace. Staff from Boyd, Jefferson, Warren, and Campbell discussed feeling unsafe in their work environment, and a McCracken staff member said she perceived threats of future reckless behavior from a coworker. Staff from McCracken described that RJDC as “very toxic” or “chaotic and unprofessional,” while staff from Fayette described their workplace as “mentally overwhelming.” Figure 3.S shows a security concern relating to kitchen access.

Figure 3.S
Breathitt RJDC Temporarily Blocked Kitchen Access

Note: During the tour, LOIC staff observed a potentially unsafe kitchen access.
Source: LOIC staff tour of facility, April 6, 2023.

The scheduling comments included a Warren worker saying there were leave issues, breaks not given, and too many back-to-back shifts. McCracken workers complained about mandatory overtime and weekend hours keeping them from their children. A Jefferson worker complained about schedule conflicts. The youth comments involved an Adair worker who witnessed youth assault, abuse, and neglect. Another Adair worker stated they struggled to have control of youths, and a Warren worker said dietary needs were ignored. The pay complaints involved a McCracken employee who said pay was poor and a Warren worker who said they were paid at a rank lower than their title.

The "Other" category combined complaints about harassment, training, and COVID-19. A McCracken worker claimed to face discrimination, bullying, and sexual harassment due to her race, and said her abusers harassed other employees. The training complaint was from a McCracken worker who said training was poor. The COVID-19 complaint was from an Adair worker who said that, due to COVID-19 guidelines, she did not have anyone to watch her children.

Superintendent Memos

RJDC superintendents provide monthly reports of facility activities.

DJJ 101(5) requires that, at least once each quarter, each superintendent must submit a written report of the facility's activities through the chain of command. The reports must address major developments; major incidents; population data; assessment of staff and juvenile morale; and major problems and corrective action plans. In practice, however, superintendents provide monthly reports up the chain of command, which are reviewed by facility regional administrators, division directors, deputy commissioner for operations, and the commissioner.

The format of the monthly report relies heavily on text boxes; other fields require text or numeric values.

The format of the monthly report relies heavily on text boxes; other fields require text or numeric values. Six categories combine subjects, which makes it challenging to discern whether the comment applies to both subjects or only one. Table 3.32 provides additional detail.

Table 3.32
Superintendent Monthly Report Format

Category	Open Comment Box	Required Text Or Numeric Value	Multiple Subjects
Month	—	√	—
Year	—	√	—
Submitted By	—	√	—
Population Admissions	—	√	—
Population Discharge	—	√	—
Average Daily Population (ADP)	—	√	—
ADP Low	—	√	—
ADP High	—	√	—
Summary Of Resident Morale	√	—	—
Summary Of Staff Morale	√	—	—
Significant Incident Date	—	√	—
Significant Incident Number/Initial	—	√	—
Significant Incident Type	—	√	—
Significant Incident Description	√	—	—
Major Problems	√	—	—
Major Problems Corrective Action	√	—	—
Major Development/Program	√	—	—
Major Development/Accomplishment	√	—	—

Category	Open Comment Box	Required Text Or Numeric Value	Multiple Subjects
Staff Vacancy (name)	—	√	—
Staff Vacancy (position)	—	√	—
Staff Vacancy (reason for vacancy)	—	√	—
Staff Vacancy (# of vacant positions)	—	√	—
Strategic Plan Goals/Objectives	√	—	√
Strategic Plan (status)	√	—	—
Youth Activity Account (expenditures)	—	√	—
Youth Activity Account (donations/deposits)	—	√	—
Youth Activity Account (account balance)	—	√	—
Trainings Conducted (policies)	√	—	—
Trainings Conducted (required staff)	√	—	—
Trainings Conducted (comments)	√	—	—
Make-Up Trainings (policies)	√	—	√
Make-Up Trainings (required staff)	√	—	√
Make-Up Trainings (comments)	√	—	√
Recycling/Green Project (comments)	√	—	√
Superintendent's Concerns/Comments	√	—	√

Source: Department of Justice.

For purposes of this investigation, LOIC staff primarily analyzed information provided in the superintendent's concerns/comments field, but included information related to staff and youth morale where appropriate.

More specifically, LOIC staff reviewed 364 individual narratives in which superintendents explained their concerns. For 2021 and 2022, RJDCs reported for every month. Jefferson lacks early reports because the facility did not open until January 2020. Table 3.33 provides additional detail.

Table 3.33
Monthly Superintendent Report Numbers

RJDC	2018	2019	2020	2021	2022	Total
Adair	12	9	6	12	12	51
Boyd	0	9	6	12	12	39
Breathitt	12	9	6	12	12	51
Campbell	12	8	6	12	12	50
Fayette	4	9	6	12	12	43
Jefferson	N/A	N/A	6	12	12	30
McCracken	12	8	6	12	12	50
Warren	12	8	6	12	12	50
Total	64	60	48	96	96	364

Source: LOIC staff analysis of monthly superintendent report.

Table 3.34 shows the percentage of times superintendents mentioned various concerns in their monthly reports from 2018 to 2022. Understaffing was the most common concern, with direct-line staffing being mentioned as a problem in nearly

a quarter of the reports and "other staffing" mentioned a third of the time.

The need to provide staff additional training and too many youths housed in the facility were both mentioned in 6.9 percent of the reports. Violent acts by youth offenders appeared in 16.5 percent of the reports. Less than 2 percent mentioned other mental health concerns. Physical problems with the facility that caused security concerns were mentioned 22.8 percent of the time. Notably, more than 20 percent mentioned having not concerns at the time of reporting.

Table 3.34
Relative Occurrence Of Concerns In RJDCs
2018 To 2022

Concern	Relative Occurrence
Training	6.9%
Direct line staffing	24.5
Other staffing	32.4
Offender population	6.9
Violent incidents	16.5
Mental health—nonviolent	1.9
Structure—security	22.8
Structure—nonsecurity	6.0
Security—nonstructural	0.3
None	21.4

Source: LOIC staff analysis of 364 superintendent monthly reports.

Adair. Table 3.35 shows how often the Adair superintendent mentioned certain concerns relative to the number of reports LOIC staff reviewed each year. The superintendent regularly mentioned the need for additional staff training in 2018 and 2019, but never again after that. It is not clear whether additional training was provided.

Not having enough staff (both direct-line and other) to operate the facility effectively and safety was expressed as a concern in more than half of the monthly reports each year.

Not having enough staff (both direct-line and other) to operate the facility effectively and safely was expressed as a concern in more than half of the monthly reports each year. Worries about the number of youth offenders housed in the facility was an increasing concern over the 5 years studied. As might be expected, instances of youths acting out violently appear to be weakly correlated to understaffing. Superintendents also periodically mentioned concerns such as mental health issues among the youths, security issues related to the facility's structure, and other structural concerns. Very rarely did superintendents state that they had no concerns to report.

Table 3.35
Adair Concerns
2018 To 2022

Concern	2018	2019	2020	2021	2022
Training	91.7%	100.0%	0.0%	0.0%	0.0%
Direct line staffing	75.0	44.4	0.0	25.0	100.0
Other staffing	58.3	88.9	50.0	41.7	75.0
Offender population	8.3	0.0	0.0	16.7	100.0
Violent incidents	41.7	11.1	0.0	66.7	33.3
Mental health—nonviolent	0.0	0.0	0.0	0.0	8.3
Structure—security	8.3	22.2	83.3	8.3	0.0
Structure—nonsecurity	0.0	0.0	0.0	66.7	0.0
Security—nonstructural	0.0	0.0	0.0	0.0	0.0
None	0.0	0.0	16.7	0.0	0.0

Source: LOIC staff analysis of 51 superintendent monthly reports.

Boyd. Table 3.36 shows similar data for the Boyd DJJ Detention Facility. Boyd's superintendent never mentioned that the facility's staff needing more training, but regularly mentioned being short-staffed. Understaffing for direct line workers was more common than other staffing shortfalls. The superintendent expressed concerns periodically about various instances of youth offenders acting out violently and of security concerns related to facility defaults, but recently had few to no concerns to report.

Table 3.36
Boyd Concerns
2018 To 2022

Concern	2018	2019	2020	2021	2022
Training	—	0.0%	0.0%	0.0%	0.0%
Direct line staffing	—	77.8	0.0	16.7	16.7
Other staffing	—	0.0	33.3	8.3	25.0
Offender population	—	0.0	0.0	0.0	0.0
Violent incidents	—	0.0	0.0	8.3	0.0
Mental health—nonviolent	—	0.0	0.0	0.0	8.3
Structure—security	—	0.0	0.0	0.0	0.0
Structure—nonsecurity	—	0.0	66.7	0.0	8.3
Security—nonstructural	—	0.0	0.0	0.0	0.0
None	—	0.0	50.0	58.3	50.0

Source: LOIC staff analysis of 39 superintendent monthly reports.

Breathitt. Superintendent concerns for the Breathitt DJJ detention facility are shown in Table 3.37. Training was never mentioned and understaffing was an expressed concern less than half the time. Prior to 2022, the number of youth offenders held at the facility does not appear to have been an issue, but nearly half of the monthly reports during 2022 mentioned high population numbers as a concern. Early during the analyzed period, Breathitt's

superintendent expressed concern monthly for 2 years regarding a structural problem that was causing security issues. It is unclear whether this problem was fixed or was simply no longer mentioned in the monthly reports. Other concerns included a few instances of youths acting out violently and physical problems with the facility that were not related to security. In 2021 and 2022, there were months when the superintendent had no concerns to report.

Table 3.37
Breathitt Concerns
2018 To 2022

Concern	2018	2019	2020	2021	2022
Training	0.0%	0.0%	0.0%	0.0%	0.0%
Direct line staffing	0.0	0.0	33.3	0.0	16.7
Other staffing	8.3	0.0	50.0	8.3	0.0
Offender population	0.0	0.0	0.0	0.0	41.7
Violent incidents	0.0	0.0	16.7	8.3	0.0
Mental health—nonviolent	0.0	0.0	0.0	0.0	0.0
Structure—security	100.0	100.0	0.0	0.0	41.7
Structure—nonsecurity	16.7	22.2	50.0	0.0	0.0
Security—nonstructural	0.0	0.0	0.0	0.0	8.3
None	0.0	0.0	0.0	50.0	8.3

Source: LOIC staff analysis of 51 superintendent monthly reports.

Campbell. Table 3.38 presents the Campbell facility superintendent's concerns for 2018 to 2022. The need for additional staff training was mentioned occasionally, but staffing was a more common concern. More often than not, the superintendent discussed that the facility was short-staffed on "other staff" and expressed similar concerns about direct-line workers beginning in 2020. The number of youths being held was mentioned periodically but doesn't appear to have been as great a concern as matters such as structural problems that created security risks. The most recent year had no report of security concerns, but it is unclear whether previous issues with the facility were fixed.

Table 3.38
Campbell Concerns
2018 To 2022

Concern	2018	2019	2020	2021	2022
Training	0.0%	12.5%	0.0%	8.3%	0.0%
Direct line staffing	0.0	0.0	66.7	25.0	41.7
Other staffing	50.0	25.0	66.7	83.3	100.0
Offender population	0.0	12.5	0.0	8.3	0.0
Violent incidents	8.3	37.5	16.7	0.0	0.0
Mental health—nonviolent	8.3	0.0	0.0	0.0	0.0
Structure—security	8.3	0.0	33.3	100.0	0.0
Structure—nonsecurity	0.0	0.0	0.0	0.0	0.0
Security—nonstructural	0.0	0.0	0.0	0.0	0.0
None	25.0	25.0	0.0	0.0	0.0

Source: LOIC staff analysis of 50 superintendent monthly reports.

Fayette. The concerns of the Fayette facility superintendent are summarized in Table 3.39. Neither staff training nor mental health problems with youths appear to have been major concerns during the analyzed period. However, understaffing was mentioned in at least half of the reports each year—first with direct-line staffing being most concerning and more recently other staffing shortfalls being expressed as a problem. Instances of youths acting out violently had been a problem for several years, but appear to be improving. The Fayette facility superintendent never mentions any issues with the physical facility itself (security or non-security).

Table 3.39
Fayette Concerns
2018 To 2022

Concern	2018	2019	2020	2021	2022
Training	0.0%	0.0%	0.0%	0.0%	8.3%
Direct line staffing	100.0	88.9	0.0	50.0	0.0
Other staffing	0.0	0.0	0.0	50.0	83.3
Offender population	0.0	0.0	0.0	0.0	0.0
Violent incidents	75.0	100.0	66.7	58.3	0.0
Mental health—nonviolent	0.0	0.0	0.0	0.0	0.0
Structure—security	0.0	0.0	0.0	0.0	0.0
Structure—nonsecurity	0.0	0.0	0.0	0.0	0.0
Security—nonstructural	0.0	0.0	0.0	0.0	0.0
None	0.0	0.0	16.7	0.0	8.3

Source: LOIC staff analysis of 43 superintendent monthly reports.

Jefferson. The concerns of Jefferson detention facility's superintendent are shown in Table 3.40—as previously mentioned, the facility opened in mid-2020. Staffing and training were never mentioned as a concern until 2022 when more than half the monthly reports mentioned problems arising from

the understaffing of direct-line workers. Potential security risks related to structural defaults at the facility were mentioned each year to varying degrees. Only during the first year of operation did the superintendent state that he had no concerns to report.

Table 3.40
Jefferson Concerns
2018 To 2022

Concern	2018	2019	2020	2021	2022
Training	—	—	0.0%	0.0%	0.0%
Direct line staffing	—	—	0.0	0.0	66.7
Other staffing	—	—	0.0	0.0	0.0
Offender population	—	—	0.0	0.0	0.0
Violent incidents	—	—	0.0	0.0	0.0
Mental health—nonviolent	—	—	0.0	0.0	0.0
Structure—security	—	—	16.7	91.7	25.0
Structure—nonsecurity	—	—	0.0	0.0	0.0
Security—nonstructural	—	—	0.0	0.0	0.0
None	—	—	83.3	8.3	0.0

Source: LOIC staff analysis of 30 superintendent monthly reports.

McCracken. Table 3.41 summarizes the concerns expressed by the superintendent of the McCracken DJJ detention facility. The superintendent often reported no concerns. When problems did arise, they were most often related to staffing—direct-line staffing early on and more recently "other staffing." There appears to have been some need for training during 2020; it remains unclear if staff received this training or if the continued need simply stopped being reported.

Table 3.41
McCracken Concerns
2018 To 2022

Concern	2018	2019	2020	2021	2022
Training	0.0%	0.0%	33.3%	0.0%	0.0%
Direct line staffing	41.7	25.0	0.0	0.0	0.0
Other staffing	58.3	0.0	0.0	33.3	33.3
Offender population	0.0	0.0	0.0	8.3	8.3
Violent incidents	16.7	0.0	0.0	0.0	8.3
Mental health—nonviolent	0.0	0.0	0.0	0.0	0.0
Structure—security	0.0	0.0	0.0	0.0	0.0
Structure—nonsecurity	0.0	0.0	0.0	0.0	0.0
Security—nonstructural	0.0	0.0	0.0	0.0	0.0
None	25.0	62.5	66.7	41.7	50.0

Source: LOIC staff analysis of 50 superintendent monthly reports.

Warren. Table 3.42 summarizes the concerns of the Warren detention center superintendent. While Warren also had months

where the superintendent did not have any concerns, some issues did arise during the studied period. For example, instances of youths violently acting out were common early on but then decreased. Problems with understaffing were also periodically mentioned but do not appear to have been a long-term problem. Likewise, there were instances of reported violent behavior by youths and other mental health issues, but no true pattern or reason behind these instances. Recently, there have been increased reports of security concerns related to structural problems with the facility.

Table 3.42
Warren Concerns
2018 To 2022

Concern	2018	2019	2020	2021	2022
Training	0.0%	0.0%	0.0%	0.0%	0.0%
Direct line staffing	0.0	12.5	0.0	0.0	0.0
Other staffing	25.0	12.5	0.0	50.0	0.0
Offender population	0.0	12.5	0.0	0.0	0.0
Violent incidents	50.0	12.5	16.7	0.0	0.0
Mental health—nonviolent	0.0	12.5	0.0	25.0	0.0
Structure—security	0.0	0.0	0.0	83.3	66.7
Structure—nonsecurity	0.0	0.0	0.0	0.0	0.0
Security—nonstructural	0.0	0.0	0.0	0.0	0.0
None	33.3	50.0	83.3	16.7	25.0

Source: LOIC staff analysis of 50 superintendent monthly reports.

Staff Morale

Because the RJDCs did not include fields for superintendents to comment on staff morale in 2018 to 2019 and January to June of 2020, the staff morale data is sporadic at best. Also, for 2020 to 2022, superintendents often left the morale fields blank (null), which prevents even an annual analysis. However, the data that was present does show, at least based on the superintendents' input, that morale was not consistently low in any year. In fact, in some years for certain RJDCs (Jefferson, Warren, and Fayette), staff morale was high. Table 3.43 provides additional detail for illustrative purposes only.

Table 3.43
RJDC Superintendents' Assessments Of Staff Morale

RJDC	2018	2019	2020	2021	2022
Adair	Null (12)	Null (12)	Null (6) Low (1) High (5)	Null (10) High (2)	Null (8) Low (4)
Boyd	Null (12)	Null (12)	Null (7) High (5)	Null (3) High (9)	Null (7) High (5)
Breathitt	Null (12)	Null (12)	Null (12)	Null (5) Low (2) High (5)	Null (5) Very Low (6) Low (1)
Campbell	Null (12)	Null (12)	Null (10) Very Low (1) Low (1)	(Null 12)	Null (12)
Fayette	Null (12)	Null (12)	Null (11) High (1)	Low (7) High (5)	Null (7) High (5)
Jefferson	Null (12)	Null (12)	Null (9) High (3)	Null (12)	Null (6) Low (6) High (1)
McCracken	Null (12)	Null (12)	Null (8) Low (4)	Null (3) Very Low (3) Low (5) High (1)	Null (12)
Warren	Null (12)	Null (12)	High (6)	Null (7) High (5)	Null (12)

Source: LOIC staff analysis of 364 superintendent monthly reports.

Recommendation 3.23

Recommendation 3.23

The Department of Juvenile Justice should ensure that every grievance is reviewed at least once. If the initial grievance could not be completed, staff should reach out to the individual to be sure they are aware of the process. If the grievance is still not usable, the grievance packet should include a short statement.

Recommendation 3.24

Recommendation 3.24

As the Department of Justice increases staffing at detention centers, it should monitor the amount of shift changes and mandatory overtime needed at the regional juvenile detention center. This data can be used to determine whether staffing at regional juvenile detention centers is sufficient or whether employees are suffering from difficult schedules to cover needs.

Recommendation 3.25

Recommendation 3.25

The Department of Juvenile Justice should monitor grievances and exit interviews that detail poor interactions between staff. If there are patterns of poor interactions, such as a regional juvenile detention center having multiple interactions that demonstrate a lack of respect for an individual's demographics, then the department should determine whether training or other interventions are needed to improve relationships at the regional juvenile detention center.

Recommendation 3.26

Recommendation 3.26

The Department of Juvenile Justice should monitor the number of nonhazardous employees who are assigned to cover hazardous roles and determine whether this practice affects retention in these roles. If the department decides to continue with this practice, it should determine whether nonhazardous employees need additional training to cover hazardous roles and new employees should be informed that they may need to cover these roles.

Recommendation 3.27

Recommendation 3.27

The Department of Juvenile Justice should automate its superintendent monthly report template to ensure consistent and accurate completion. Prior to automation, department officials should revise the current form to ensure the reduction of open text boxes, as well as elimination of double-subject input fields.

How Often Were RJDC Staff Involved In Incidents Requiring Disciplinary Actions From 2018 Thorough 2022?

Between 2018 and 2022, there were 113 discipline reports in which DJJ staff were involved in an incident requiring disciplinary action.

Between 2018 and 2022, there were 113 discipline reports in which DJJ staff were involved in an incident requiring disciplinary action. Generally, DJJ policies allow for disciplinary actions to be taken against DJJ employees for various violations.[174] All disciplinary actions are administered by the DJJ commissioner and fall under five categories: written reprimand, disciplinary fine, suspension, demotion, and dismissal.[175] When an allegation of a special incident is substantiated, disciplinary actions are required.[176] Table 3.44 provides additional detail.

Table 3.44
RJDC Discipline Reports
2018 To 2022

Facility	2018	2019	2020	2021	2022	Total
Adair	3	2	5	2	1	13
Boyd	0	1	0	3	1	5
Breathitt	0	1	2	1	0	4
Campbell	5	9	8	0	0	22
Fayette	3	9	5	5	2	24
Jefferson	N/A	N/A	2	1	10	13
McCracken	1	10	12	1	1	25
Warren	0	0	2	3	2	7
Total	12	32	36	16	17	113

Source: LOIC staff compilation of data contained within "5-Year Discipline Log" submitted by the Department of Juvenile Justice.

Note that the number of reports does not equate to the number of DJJ employees disciplined. There were 113 reports at RJDCs resulting in disciplinary actions, but only 93 employees were disciplined. As shown in Table 3.45, 16 employees were disciplined multiple times in the 5 years examined.

Table 3.45
RJDC Employee Discipline
2018 To 2022

Number Of Times Employee Was Disciplined	Number Of Employees Disciplined	Total Number Of Discipline Reports
1	77	77
2	13	26
3	2	6
4	1	4
Total	93	113

Source: LOIC staff compilation of data contained within "5-Year Discipline Log" submitted by the Department of Juvenile Justice.

Job Titles Frequently Involved

The majority of disciplinary actions at RJDCs from 2018 to 2022 involved staff in the "Youth Worker" classification.[j] As shown in Table 3.46, 85 of the 113 discipline reports (75 percent) involved a Youth Worker I, Youth Worker II, Youth Worker III, or Youth Worker Supervisor.

[j] LOIC staff considered the following positions to be direct-line positions in the Youth Worker category: Youth Worker I, Youth Worker II, Youth Worker III, and Youth Worker Supervisor.

Table 3.46
RJDC Discipline Reports (By Job Title)
2018 To 2022

Job Titles	Discipline Reports
Cook I	1
Food Service Operations Manager	1
Institutional Recreational Leader I	1
Juvenile Facility Superintendent I	5
Juvenile Facility Superintendent II	4
Registered Nurse	1
Social Service Clinician I	10
Social Service Worker I*	3
Youth Services Program Supervisor	2
Youth Worker I	3
Youth Worker II	43
Youth Worker III	15
Youth Worker Supervisor	24
Total	113

* Included in this category is a report for an employee (Trotter, 2018) with job title of "SSS."
Source: LOIC staff compilation of job titles in DJJ discipline reports (RJDCs only).

Note that 13 discipline reports (12 percent) involved an employee in the social service worker/clinician job classifications. One such employee was terminated as a result of not providing proper supervision of a youth offender, who started a fire at JRJDC. Table 3.47 provides additional detail about discipline actions against individuals in similar positions.

Table 3.47
RJDC Discipline Actions Taken For Social Service Workers/Clinicians
2018 To 2022

Position	Facility	Year	Action Requested	Action Taken
Social Service Worker I	Adair	2018	1-day suspension	Resigned
Social Service Clinician I	McCracken	2019	1-day suspension	1-day suspension
Social Service Clinician I	McCracken	2019	Written reprimand	Written reprimand
Social Service Clinician I	McCracken	2019	3-day suspension	No action taken
Social Service Clinician I	Fayette	2019	Intent to dismiss	No action taken
Social Service Clinician I	Adair	2020	5-day suspension	5-day suspension
Social Service Worker I	Fayette	2021	No action taken	No action taken
Social Service Clinician I	McCracken	2021	5-day suspension	5-day suspension
Social Service Clinician I	Fayette	2021	3-day suspension	3-day suspension
Social Service Clinician I	Jefferson	2022	3-day suspension	3-day suspension
Social Service Clinician I	Jefferson	2022	Written reprimand	Written reprimand
Social Service Clinician I	Jefferson	2022	Intent to dismiss	Dismissed
Social Service Worker I	Jefferson	2022	3-day suspension	3-day suspension

Source: LOIC staff analysis from information provided by the Department of Juvenile Justice.

Employees who were disciplined held positions outside the youth worker classification. In addition to the social service worker classifications, employees in the following classifications were also disciplined: cook, food service operation, institutional recreation, and nurse.

Tables 3.48 to 3.52 provide additional detail related to violations cited for the 113 discipline reports by job title, from 2018 through 2022.[k]

Table 3.48
RJDC Violations Related To Discipline Reports,
Juvenile Facility Superintendents I And II
2018 To 2022

Violation	Frequency
Inappropriate supervision of staff/youths	2
Failure to ensure search of youths	1
Incomplete reports	1
Use of a non-approved restraint	1
Threatening and intimidating youths	1
Excessive use of force	1
Inappropriate communication with youths	1
Failure to read email/process grievance	1
Failure to follow policy	1
Total	10

Note: The number of violations does not necessarily equal the number of incidents, as some incidents had multiple violations.
Source: LOIC staff compilation of alleged violations for staff with the job title of Juvenile Facility Superintendent I and II (see column labeled "Specificity") in DJJ Discipline Reports (RJDC facilities only).

Table 3.49
RJDC Violations Related To Discipline Reports,
Youth Services Program Supervisor
2018 To 2022

Violation	Frequency
Use of a non-approved restraint	1
Improper use of the isolation room	1
Total	2

Note: The number of violations does not necessarily equal the number of incidents, as some incidents had multiple violations.
Source: LOIC staff compilation of alleged violations for staff with the job title of Youth Services Program Supervisor (see column labeled "Specificity") in DJJ Discipline Reports (RJDC facilities only).

[k] The violations cited here are from the 5-Year Discipline Log provided by DJJ, as required by DJJ 142, p. 3. The number of violations from the 5-year Discipline Log (120) is higher than the number from discipline report number in Table 3.46 (113), since the 5-year log includes multiple violations.

Table 3.50
RJDC Violations Related To Discipline Reports,
Youth Workers
2018 To 2022

Violation	Frequency
Inappropriate or excessive force	26
Inappropriate language around youth	3
Failure to ensure search of youth	2
Sleeping on duty	7
Inappropriate supervision of staff/youth	12
Not allowing youth to receive toilet paper/temp check	1
Under the influence during working hours	1
Falsifying timesheets	2
Time and attendance	4
Failure to report arrest/criminal charge(s)	5
Unprofessional conduct	2
Kicked cell door closed on youth's hand	1
Left suicide scissors on the cleaning cart	1
Failure to follow isolation directives/shift repo	1
Falsifying room checks	2
Missing room checks	2
Engaging in horseplay	1
Inappropriate contact/communication with youth	6
Use of a non-approved restraint	1
Shoved youth	2
Not following directives/improper call-in	1
Failure to call well check on units	1
Unprofessional treatment of youth	1
Failure to provide supervision (youth escape)	1
Sexual discrimination/harassment	2
Temperature checks	1
Improper use of isolation room	1
Inappropriate behavioral management technique	1
Total	91

Note: The "Youth Worker" category includes those with the job titles of Youth Worker I, Youth Worker II, Youth Worker III, and Youth Worker Supervisor. The number of violations does not necessarily equal the number of incidents, as some incidents had multiple violations.
Source: LOIC staff compilation of alleged violations for staff with the job title of Youth Worker I, II, and III (see column labeled "Specificity") in DJJ Discipline Reports (RJDC facilities only).

Table 3.51
RJDC Violations Related To Discipline Reports,
Social Service Clinician I And Social Service Worker I
2018 To 2022

Violation	Frequency
Failure to follow directive	1
Tardiness	2
Inappropriate language and threatening youth	1
Inappropriate contact with youth	1
Failure to provide supervision (youth escape)	1
Excessive use of force	2
Allowing male/female youths to have contact	1
Inappropriate supervision of youth	2
Failure to ensure search of youth	1
Did not complete duties/insubordinate	1
Total	13

Note: The number of violations does not necessarily equal the number of incidents, as some incidents had multiple violations.
Source: LOIC staff compilation of alleged violations for staff with the job title of Social Service Clinician I and Social Service Worker I (see column labeled "Specificity") in DJJ Discipline Reports (RJDC facilities only).

Table 3.52
RJDC Violations Related to Discipline Reports
Other Positions
2018 To 2022

Violation	Frequency
Excessive use of force	1
Falsifying documents/non-compliance	1
Failure to complete performance evaluation	1
Inappropriate comments to youth	1
Total	4

Note: "Other positions" include Institutional Recreation Leader I, Registered Nurse, Food Service Operations Manager, and Cook I. The number of violations does not necessarily equal the number of incidents, as some incidents had multiple violations.
Source: LOIC staff compilation of alleged violations for staff with the job title of Institutional Recreation Leader I, Registered Nurse, Food Service Operations Manager, and Cook I (see column labeled "Specificity") in DJJ Discipline Reports (RJDC facilities only).

Eastern Kentucky University Education Assessment. According to DJJ officials, Eastern Kentucky University is conducting a training needs assessment for DJJ. The goal of the assessment "is to inform changes necessary to build and maintain a high-performing workforce that supports the department's mission and priorities. The Needs Assessment team will collect data through focus groups, facilitated meetings, one-on-one interviews, online surveys, and research of best practices, models, and other key data points. This data will identify remedies to resolve discrepancies between what workers should be doing and what they are actually doing."[177]

As part of this assessment, developing additional training for those classifications not typically related to the youth worker (now correctional officer) classification could be beneficial, especially if nonsecurity staff are asked to perform security-related duties due to lack of staffing.

Among 113 discipline reports reviewed, 63 (56 percent) had an associated IIB investigation.

Internal Investigations Branch Reports. Among 113 discipline reports reviewed, 63 (56 percent) had an associated IIB investigation. Incidents with an associated IIB investigation fall under the category of "special incident," which involves excessive force or inappropriate contact/communication with a youth. The use of excessive force (or other similar violations such as aggressive behavior toward youths or the use of unapproved controls/restraints) was cited in 34 of the 64 discipline reports (53 percent) for which an IIB investigation was conducted. Table 3.53 provides additional detail.

Table 3.53
IIB Investigations Related To 63 Discipline Reports

IIB Case Number	Facility	Job Title	Violation	Action Taken
Null	Campbell	Youth Worker III	Excessive use of force	Resign with prejudice
000000021	Fayette	Youth Worker III	Excessive use of force	Written reprimand
000000036/ 000000039	Warren	Youth Worker Supervisor	Excessive use of force	10-day suspension
000000038/ 000000051	Jefferson	Youth Worker Supervisor	Not ensuring a search on a youth	20-day suspension
000000047	Warren	Youth Worker II	Inappropriate language around youth	5-day suspension
000000051	Jefferson	Juvenile Facility Superintendent I	Not ensuring a search of youth; Incomplete reports	Dismiss
000000051	Jefferson	Social Service Clinician I	Inappropriate contact with youth	Written reprimand
000000051	Jefferson	Youth Worker Supervisor	Not providing appropriate supervision of youth	20-day suspension
000000051	Jefferson	Social Service Clinician I	Not providing appropriate supervision of youth	Dismiss
000000051	Jefferson	Youth Worker III	Not ensuring a search on youth	Written reprimand
000000526	Jefferson	Juvenile Facility Superintendent I	Inappropriate supervision of youth	5-day supervision
2734-17	Adair	Youth Worker II	Inappropriate communication/contact with youth	Dismiss
2741-18	Fayette	Youth Worker III	Inappropriate behavior management technique; excessive use of force	Written reprimand
2750-18	Fayette	Youth Worker II	Inappropriate contact with a youth	2-day suspension
2755-18	Adair	Youth Worker Supervisor	Excessive use of force with youth	2-day suspension

IIB Case Number	Facility	Job Title	Violation	Action Taken
2757-18	Fayette	Youth Worker Supervisor	Kicked cell door closed on youth's hand	Written reprimand
2765-18	Fayette	Social Service Clinician I	Excessive use of force	None
2774-18	Campbell	Youth Worker III	Excessive use of force	3-day suspension
2779-18	Adair	Youth Worker III	Excessive use of force	2-day suspension
2785-19	Campbell	Juvenile Facility Superintendent I	Excessive use of force	Written reprimand
2787-19	McCracken	Youth Services Program Supervisor	Unapproved use of restraints	Dismissal
2787-19	McCracken	Juvenile Facility Superintendent I	Use of non-approved restraints	3-day suspension
2788-19	Fayette	Youth Worker III	Shoved youth	1 day suspension
2801-19	Campbell	Youth Worker III	Inappropriate or excessive force	4-day suspension
2801-19	Campbell	Youth Worker Supervisor	Not providing appropriate supervision	1 day suspension
2801-19	Campbell	Institutional Recreation Leader I	Excessive force	Resignation for medical reason
2801-19	Campbell	Youth Worker II	Inappropriate or excessive force	4-day suspension
2802-19	Fayette	Youth Worker II	Inappropriate or excessive force	Written reprimand
2803-19	Campbell	Youth Worker II	Inappropriate contract with a youth	1 day suspension
2811-19	McCracken	Youth Worker II	Inappropriate or excessive force	Dismiss
2833-19	Fayette	Youth Worker III	Excessive use of force	10-day suspension
2834-19	Fayette	Youth Worker II	Excessive use of force	No action taken
2834-19	Fayette	Youth Worker II	Excessive use of force	Resign with prejudice
2836-19	Breathitt	Youth Worker II	Inappropriate communication/contact with a youth	Dismiss
2849-20	McCracken	Youth Worker Supervisor	Improper use of isolation room	Written reprimand
2849-20	McCracken	Youth Services Program Supervisor	Improper use of isolation room	Written reprimand
2850-20	Campbell	Juvenile Facility Superintendent II	Inappropriate supervision of staff/youth	Voluntary demotion
2860-20	Fayette	Youth Worker II	Inappropriate language; shoved youth	5-day suspension
2863-20	McCracken	Youth Worker III	Excessive use of force	Terminate initial probation
2864-20	McCracken	Youth Worker Supervisor	Inappropriate supervision of youth	Dismiss
2864-20	McCracken	Youth Worker I	Inappropriate supervision of youth	Dismiss
2864-20	McCracken	Youth Worker I	Inappropriate supervision of youth	Resign with prejudice
2864-20	McCracken	Youth Worker Supervisor	Inappropriate supervision of youth	Dismiss
2864-20	McCracken	Youth Worker II	Inappropriate supervision of youth	Dismiss
2866-20	McCracken	Youth Worker Supervisor	Inappropriate supervision of youth	Dismiss

IIB Case Number	Facility	Job Title	Violation	Action Taken
2866-20	McCracken	Youth Worker II	Inappropriate supervision of youth	Resign, accept with prejudice
2869-20	Adair	Youth Worker Supervisor	Inappropriate or excessive use of force	3-day suspension
2870-20	Fayette	Youth Worker III	Excessive use of force	10-day suspension
2890-20	Fayette	Youth Worker II	Excessive use of force	Written reprimand
2892-20	Boyd	Youth Worker Supervisor	Excessive use of force	Written reprimand
2892-20	Boyd	Youth Worker II	Excessive use of force	Written reprimand
2892-20	Boyd	Youth Worker II	Excessive use of force	Written reprimand
2893-20	Fayette	Social Service Worker I	Excessive use of force	None
2897-20	Jefferson	Youth Worker III	Excessive use of force	Written reprimand
2906-21	Adair	Youth Worker Supervisor	Excessive use of force	2-day suspension
2914-21	McCracken	Social Service Clinician I	Inappropriate language and threatening youth	5-day suspension
2918-21	McCracken	Youth Worker II	Inappropriate supervision	1 day suspension
2919-21	Boyd	Youth Worker II	Excessive use of force	3-day suspension
2928-21	Fayette	Social Service Clinician I	Failure to provide supervision (youth escape)	3-day suspension
2928-21	Fayette	Youth Worker II	Failure to provide supervision (youth escape)	3-day suspension
2931-22	Fayette	Youth Worker Supervisor	Excessive use of force; sexual harassment	Dismiss
21257-19	Fayette	Youth Worker II	Inappropriate conversation with youth	1 day suspension
21854-19	McCracken	Juvenile Facility Superintendent II	Inappropriate communication with youth	Demotion

Source: LOIC analysis of investigations from the Internal Investigations Branch and the Department of Juvenile Justice.

Actions Taken

As discussed above, DJJ policy allows for five disciplinary actions.[178] As illustrated in Table 3.54, the majority of actions taken include suspensions (40 percent), written reprimands (22 percent), and dismissals (14 percent). With the exception of "disciplinary fine," each action type appears in Table 3.54.

Table 3.54
Action (Discipline) Taken In RJDCs
2018 To 2022

Action (Discipline) Taken	Frequency	Percentage
No action taken	9	8%
Verbal redirection/performance improvement plan	1	1
Written reprimand	24	22
Suspension (1–2 days)	14	13
Suspension (3–5 days)	24	22
Suspension (6–10 days)	4	4
Suspension (>10 days)	3	3
Demotion	4	4
Resign with prejudice	11	10
Resign (other reasons)	2	2
Dismissal	16	14
Total	112	N/A

Note: Although there were 113 discipline reports at RJDCs requiring a disciplinary report, only 112 actions were taken, as one individual received a 20-day suspension for two separate incidents. Percentages do not sum to 100 due to rounding.
Source: LOIC staff compilation of data contained in 113 discipline reports of JDC employees from 2018 to 2022.

Policies Cited

DJJ employees violated 26 DJJ policies, according to the 113 discipline reports. The most frequently violated policies were DJJ 104 ("Code of Conduct"), DJJ 102 ("Code of Ethics"), DJJ 713 ("Restraints"), and DJJ 110 ("General Security Guidelines in Facilities and Programs"). Seventeen policies were cited three times or fewer. Table 3.55 provides additional detail.

Table 3.55
DJJ Policies Violated In Discipline Reports
2018 To 2023

Policy	Subject	2018	2019	2020	2021	2022	2023	Total
DJJ 102	Code of Ethics	2	5	13	4	3	0	27
DJJ 103.1	Staff Assignments and Reassignments	1	0	0	1	0	0	2
DJJ 103.2	Sexual Harassment and Anti-Harassment	0	0	0	0	1	0	1
DJJ 103.4	Time, Attendance, and Leave Requirements	1	0	0	1	0	0	2
DJJ 104	Code of Conduct	8	25	25	19	12	4	93
DJJ 110	General Security Guidelines in Facilities and Programs	1	0	8	0	5	3	17
DJJ 205	Youth Rights	0	1	1	0	0	0	2
DJJ 318	Behavior Management	0	0	0	0	0	1	1
DJJ 321	Incident Reporting	0	1	0	0	0	0	1
DJJ 324	Restraints (group homes, youth development centers)	0	1	0	3	0	1	5
DJJ 402	Access to Treatment and Continuity of Care	0	1	0	0	0	0	1
DJJ 405.4	Suicide Prevention and Intervention	0	0	2	1	0	0	3
DJJ 702	Intake, Reception, and Orientation	0	0	0	0	1	2	3

Policy	Subject	2018	2019	2020	2021	2022	2023	Total
DJJ 706	Grievance Procedure	1	1	0	0	0	0	2
DJJ 708	Classification of Juveniles for Housing and Program Assignment	0	0	0	0	1	0	1
DJJ 709	Security and Control	0	0	0	1	1	1	3
DJJ 710	Shift and Log Reports	0	0	0	1	2	2	5
DJJ 712	Escape/AWOL	0	0	0	0	0	1	1
DJJ 713	Restraints (detention centers)	1	10	4	7	4	1	27
DJJ 714	Searches	0	0	0	0	2	3	5
DJJ 715	Incident Reports	0	1	0	0	2	3	6
DJJ 717	Discipline and Special Behavior Management	0	1	3	0	0	0	4
DJJ 901	Zero Tolerance of Any Type of Sexual Misconduct	1	0	0	0	0	0	1
DJJ 903	Prison Rape Elimination Act of 2003 (PREA)	1	0	1	0	0	0	2
DJJ 910	Facility Security Management	0	0	0	1	1	0	2
DJJ 911	DJJ Staff PREA Education and Training	1	0	0	0	0	0	1

Note: Data shown by date of final discipline report, not the date the incident occurred or the date received. Most discipline reports cited multiple violated policies. As such, the numbers shown do not match the number of discipline reports.
Source: LOIC staff compilation of data contained within 113 discipline reports of RJDC employees from 2018 to 2022.

Four policies, detailed below, were most commonly cited in the discipline reports reviewed by LOIC staff. The reports often show violations of multiple policies.

DJJ 104. DJJ 104 "Code of Conduct" was cited in 93 of the 113 discipline reports (82 percent) reviewed by LOIC staff. Section I ("Policy"), a general statement that DJJ staff should conduct themselves in a professional manner, was cited in 50 of the discipline reports. Section IV ("Procedures"), which contains a wide range of subsections, was cited in all 93 instances that referred to DJJ 104. The procedures outlined in Section IV of DJJ 104 touch on a wide range of areas, including timeliness, inappropriate relationship, control techniques, and contraband. The most frequently cited Section IV subsections related to performance of work assignments in a competent and professional manner (68), the use of approved controlling techniques (37), and abuse and mistreatment of youths in DJJ care or custody (20). Table 3.56 provides additional detail.

Table 3.56
Breakdown Of Policies Violated In 93 Discipline Reports
DJJ 104 "Code Of Conduct"
2018 To 2023

Section	Subsection	Frequency
I. Policy	Staff, volunteers, interns, and contract personnel shall conduct themselves in a professional manner. All persons shall be aware that their personal conduct reflects upon the integrity of the agency and its ability to provide services to youth	50
IV. Procedures	A. Staff shall arrive and leave work at scheduled times as determined by their supervisor.	8
	B. Staff shall perform their work assignments competently and in a professional manner. It is the responsibility of each staff to know and act in accordance with department policy and procedures.	68
	C. Staff are required to obey the lawful order or directive of a supervisor. If the order or directive conflicts with an order or directive previously issued by another supervisor, the staff shall make the supervisor aware of the conflict. If the supervisor does not alter the order or directive, the most recent order shall stand and the responsibility shall be assigned to the supervisor issuing the most recent order.	10
	D. Staff shall remain in their assigned working areas during working hours. Staff shall not disturb or interrupt others at their working areas or prevent other staff from carrying out their duties.	4
	F. Loud, abusive, or profane language and boisterous and unprofessional conduct shall not be tolerated. Staff shall refrain from making comments that are critical of colleagues or the agency.	11
	L. All shall be truthful in correspondence and interactions with other DJJ staff, youth, parents, outside agencies, investigators, and in the completion of any type of work-related written documentation (computer based, hand-written, or typed).	6
	M. Items deemed to be contraband shall be prohibited in DJJ facilities and offices. No one shall transport contraband of any kind into a DJJ facility.	5
	O. Cell phones shall be prohibited in areas of programs occupied by youth. All persons are prohibited from allowing youth to use a personal cell phone in any part of the facility. In areas where cell phones are allowed, the use shall not disturb or interrupt staff at their working areas or prevent staff from carrying out their duties.	2
	P. Staff are prohibited from sleeping, or giving an appearance of sleeping, while on duty. Sleeping on duty may result in disciplinary action up to, and including dismissal. Exception, staff assisting in emergency situations and unable to return home shall be provided sleeping and leisure areas separate from youth residential areas.	7
	Q. Staff shall not be on the premises except during working hours unless approved by their immediate supervisor.	1
	R. All persons shall be prohibited from having sexual or intimate contact while on department owned or leased property, or in a state vehicle.	1
	T. All persons are prohibited from engaging in unwelcome written, verbal, or physical conduct that either degrades, shows hostility, or aversion towards a youth on the basis of race, color, national origin, age, sex, religion, disability, gender identity, sexual orientation, or genetic information.	3
	U. Staff shall protect the individual safety of youth and themselves through the use of approved controlling techniques utilizing no more than the absolute amount of force necessary to diffuse a confrontational situation. Staff shall only use controlling techniques in which they have been certified by the Division of Professional Development.	37

Section	Subsection	Frequency
	V. All persons shall take appropriate precautions in dealing with youth to prevent allegations of inappropriate verbal communication, written communications, sexual contact or abuse of any type.	15
	W. Abuse or other mistreatment of youth in the care or custody of the department shall not be tolerated. Staff abusing youth shall be subject to disciplinary action up to and including dismissal under 101 KAR 1:345. All persons suspected of abuse are subject to investigation and prosecution under all applicable laws.	20
	X. All persons shall act in a manner that provides youth with a positive role model.	13
	Y. All persons shall be expected to maintain a professional relationship with youth at all times. The following rules help delineate this relationship and prevent complications in treatment of youth.	10
	Z. All staff are prohibited from: (3) Giving special privileges to a youth, unless privileges are earned by the youth as part of the treatment plan;	2
	Z. All staff are prohibited from: (6) Entering into an intimate or romantic relationship or having sexual contact with an individual who is currently under the custody, care, or supervision of DJJ. (reference KRS 510.020 (3)(e) regarding consent); or	1
	Z. All staff are prohibited from: (7) Having an intimate or romantic relationship with a juvenile that has been in the direct custody, care, and supervision of that employee or in a facility where the employee worked while the juvenile was in custody, for a minimum of ten (10) years after the juvenile has been officially released from DJJ.	3
	AA. DJJ staff are persons holding a position of authority and special trust as defined in KRS 532.045. DJJ prohibits any staff, regardless of his or her age, from subjecting anyone under the custody, care, or supervision of DJJ, with whom he or she comes into contact as a result of his or her position, to sexual contact.	1
	BB. Staff shall fully cooperate with and shall not interfere with any investigation conducted by the Internal Investigations Branch (IIB), a DJJ Supervisor, or Ombudsman, subject to Federal and State constitutional protections.	1

Note: The time range, 2018 to 2023, refers to the date of the final discipline report, not the date the incident occurred or the date the report was received. The number of subsections cited in the Frequency column does not necessarily equal the total number of sections, as it is common for a single discipline report to cite multiple policies. The number of policies cited is not meant to equal the number of violations listed in Tables 3.48 to 3.52.
Source: LOIC compilation of policies cited in 113 Department of Juvenile Justice discipline reports (2018 to 2023).

DJJ 102. DJJ 102 "Code of Ethics" was cited in 27 of the 113 discipline reports (24 percent) reviewed by LOIC staff. Section I ("Policy"), a general statement that DJJ staff are expected to demonstrate "honesty, integrity, respect for the dignity and individuality of human beings, and a commitment to professional and compassionate service," was cited eight times. The most frequently cited policy violations in Section IV ("Procedures") related to showing appropriate concern for the welfare of youths with no purpose of personal gain (nine citations), respecting and protecting the civil and legal rights of youths in DJJ custody (eight citations), and notifying supervisors of any arrests or legal charges (five citations). Table 3.57 provides additional detail.

Table 3.57
Breakdown Of Specific Policies Violated In 27 Discipline Reports
DJJ 102 "Code Of Ethics"
2018 To 2023

Section	Subsection	Frequency
I. Policy	The Department of Juvenile Justice (DJJ) shall expect from staff honesty, integrity, respect for the dignity and individuality of human beings, and a commitment to professional and compassionate service. The department shall require a drug-free workplace.	8
IV. Procedures	A. Staff shall respect and protect the civil and legal rights of youth under the care, custody, and control of the department.	8
	B. Staff shall serve each youth with appropriate concern for their welfare and with no purpose of personal gain.	9
	C. Relationships with colleagues shall be of such character to promote mutual respect within the profession and improvement of its quality of service.	2
	E. Staff shall respect the importance of all elements of the criminal justice system and cultivate professional cooperation with each segment.	1
	F. Each staff shall maintain the integrity of private or confidential information. Staff shall not seek information beyond that needed to perform their job responsibilities. Staff shall not reveal information to anyone not having professional use for such. All staff, consultants, contract personnel, interns, and volunteers shall sign a confidentiality/Security Form as a condition of employment or service.	1
	G. Staff shall respect and protect the right of the public to be safeguarded from criminal activity.	2
	H. Staff shall report any corrupt, unethical behavior, or policy violations which may affect either a youth or the integrity of the organization and any abuse or neglect as required by KRS 620.030.	1
	I. Staff shall not discriminate against any youth, other staff, or prospective staff on the basis of religion, race, sex, age, disability, national origin, color, sexual orientation, gender identity, genetic information, political affiliation, or veteran's status.	2
	K. Staff shall not use their official position to secure privileges for self or others and shall not engage in activities that constitute a conflict of interest.	2
	L. Staff shall not act in their official capacity in any matter in which they have personal interest that may impair objectivity and create the appearance of conflict of interest.	1
	P. If a staff is arrested for or charged with any offense, other than a minor traffic violation, they shall notify their immediate supervisor if available or the highest-level supervisor on duty. This report shall be made prior to their next scheduled shift. Staff shall not be relieved of the responsibility of providing notice or reporting to work as a result of being detained.	5
	R. If a licensed staff has their licensure or certification under investigation, suspended, or revoked, they shall notify their immediate supervisor if available or the highest-level supervisor on duty. This report shall be made prior to their next scheduled shift.	1

Note: The time range, 2018 to 2023, refers to the date of the final discipline report, not the date the incident occurred or the date the report was received. The number of subsections cited in the Frequency column does not necessarily equal the total number of sections, as it is common for a single discipline report to cite multiple policies. The number of policies cited is not meant to equal the number of violations listed in Tables 3.48 to 3.52.
Source: LOIC compilation of policies cited in 113 Department of Juvenile Justice discipline reports (2018 to 2023).

DJJ 713. DJJ 713 "Restraints" was cited in 27 of the 113 discipline reports (24 percent) reviewed by LOIC staff. Section I ("Policy") details the department's policy as it relates to "defense-oriented physical and mechanical restraints." The most frequently cited policy violations in Section IV ("Procedures") were subsections related to staff using "skills that are nonpunitive in nature and approved by DJJ" (27 citations) and forbidding the use of physical restraints as punishment (14 citations).

Table 3.58
Breakdown Of Specific Policies Violated In 27 Discipline Reports
DJJ 713 "Restraints"
2018 To 2023

Section	Subsection	Frequency
I. Policy	DJJ staff shall be permitted to use approved methods of defense-oriented physical and mechanical restraints on juveniles that become aggressive toward self, staff, or peers. Use of mechanical restraints shall be permitted only to ensure the safety of the juvenile or others when the juvenile presents an imminent risk of serious injury to self, staff, or other juveniles. The use of fixed restraints is prohibited. The use of chemical agents is prohibited. The use of chemical restraints is prohibited.	16
IV. Procedures	A. (1) In the management of an aggressive juvenile, who presents an imminent risk of physical harm to self or others, only those skills that are nonpunitive in nature and are approved by DJJ shall be used. DJJ shall be responsible for delivering ongoing training to program staff to ensure staff has the skills necessary to de-escalate situations and to reduce the need for physical intervention.	27
	A. (3) Physical restraint shall not be used as punishment and shall be applied with the least amount of force possible.	14

Note: The time range, 2018 to 2023, refers to the date of the final discipline report, not the date the incident occurred or the date the report was received. The number of subsections cited in the Frequency column does not necessarily equal the total number of sections, as it is common for a single discipline report to cite multiple policies. The number of policies cited is not meant to equal the number of violations listed in Tables 3.48 to 3.52.
Source: LOIC compilation of policies cited in 113 Department of Juvenile Justice discipline reports (2018 to 2023).

DJJ 110. DJJ 110 "Restraints" was cited in 17 of the 113 discipline reports (15 percent) reviewed by LOIC staff. Section I ("Policy"), which was cited in all 17 reports, states that staff supervision and facility security measures "shall be provided to ensure a secure and safe environment." Procedurally, four violations related to Subsection A, which states that each facility/program is to have "written Standard Operating Procedures (SOPs) for security and control which shall be made available to staff," which includes guidance related to the key control system, duty assignments, and observation/bed checks.

Table 3.59
Breakdown Of Specific Policies Violated In Discipline Reports
DJJ 110 "General Security Guidelines In Facilities And Programs"
2018 To 2023

Section	Subsection	Frequency
I. Policy	Staff supervision and security measures shall be provided to ensure a secure and safe environment.	17
IV. Procedures		4
	A. (2) Each program or facility shall have written Standard Operating Procedures (SOPs) for security and control which shall be made available to staff. SOPs shall include: A key control system, including the use of an automated key exchange system if available.	8
	A. (6) Each program or facility shall have written Standard Operating Procedures (SOPs) for security and control which shall be made available to staff. SOPs shall include: Observation/Bed checks.	9

Note: The time range, 2018 to 2023, refers to the date of the final discipline report, not the date the incident occurred or the date the report was received. The number of subsections cited in the Frequency column does not necessarily equal the total number of sections, as it is common for a single discipline report to cite multiple policies. The number of policies cited is not meant to equal the number of violations listed in Tables 3.48 to 3.52.
Source: LOIC compilation of policies cited in 113 Department of Juvenile Justice discipline reports (2018 to 2023).

Recommendation 3.28

Recommendation 3.28

Department of Juvenile Justice officials should ensure that social workers and employees in similar classifications receive adequate training related to additional duties they may be requested to perform, such as searching and supervising juvenile offenders.

Recommendation 3.29

Recommendation 3.29

Department of Juvenile Justice officials should evaluate the policies and subjects cited in the discipline reports for additional training—more specifically, DJJ 104, DJJ 102, DJJ 713, and DJJ 110.

What Types Of Incidents Occur At RJDCs?

In its review of incident reports from 2018 to 2022, LOIC staff found that numerous youths committed multiple incidents. Generally, isolation was commonly used, many incidents were similar to past incidents, staff commonly used the "other" choice to describe events, and aikido holds were more common than mechanical restraints. The "other" category was commonly used, which prevented LOIC staff from accurately and completely analyzing the events category, as well as type of restraint used.

It was also difficult to determine how often restraints were used, since the lack of a question directly asking if restraints were used caused ambiguity when reviewing the data.

Lack Of Automation

The documents that LOIC staff reviewed for 2018 to 2022 included a series of scanned documents, which often included duplicate reports or reports that were missing pages or completely out of order.

The documents that LOIC staff reviewed for 2018 to 2022 included a series of scanned documents, which often included duplicate reports or reports that were missing pages or completely out of order. A further confounding factor was that many forms were filled out by hand, resulting in some reports that were difficult or impossible to interpret.

Due to the lack of automation, it seems unlikely that DJJ has regularly analyzed incident reports or would be able to analyze these incident reports in a reasonable time frame. This situation supports the need for an automated system, which would help DJJ fully meet the first substantive provision in the 1996 consent decree. The consent decree states the need for "an adequate uniform special incident reporting system that ensures that all special incidents are promptly and adequately identified, reported, investigated, and tracked."[179]

Figure 3.T
Fayette RJDC Incident Report Storage

Source: LOIC staff tour of facility, March 3, 2023.

LOIC staff analyzed all incident reports from five RJDCs. For the three remaining RJDCs with larger volumes of reports, LOIC used a random number generator to select 60 IIRs for each year. Table 3.60 provides additional detail.

Table 3.60
Detention Center Documents Analyzed By Legislative Staff
2018 To 2022

Facility	Documents Reviewed	Number Reviewed
Adair	Sample	299
Boyd	All	776
Breathitt	All	822
Campbell	All	823
Fayette	All	1,666
Jefferson	All	262
McCracken	Sample	300
Warren	Sample	247
Total		5,195

Note: The McCracken and Warren sample selected five reports from each month for a theoretical total of 300 reports. Warren submitted fewer than five reports for some months, resulting in a smaller sample. The large file size for Adair prevented staff from determining the number of reports from the facility, so samples were based on random page selection from the Adair documents submitted.
Source: LOIC staff from an analysis of Department of Juvenile Justice Isolation/Incident forms.

Results Of Analysis

LOIC staff primarily analyzed or identified

- whether injuries occurred;
- whether intensive supervision was used;
- whether isolation was used;
- whether similar incidents occurred;
- the type of events that occurred during an incident;
- the locations where incidents occurred; and
- the type of restraints used.

Injuries, supervision, isolation, and similar incidents were documented in yes/no questions; staff reviewed the number of "yes" answers. However, many of these questions were not answered as required by DJJ policy. Appendix B contains more detailed tables describing the incident reports.

It was common for multiple incidents to pertain to the same youth.

Multiple Incidents. It was common for multiple incidents to pertain to the same youth. For example, the 1,666 reports from Fayette referred to only 536 youths. This average of 3.1 reports per youth was the highest among the facilities. Campbell had a similar average of 2.9 reports per youth. The lowest averages were at McCracken (1.5 reports per youth) and Warren (1.6 reports per youth). The reports had a question asking if similar incidents had

occurred with the youth in the past, and the results are similar. Reports answering "yes" to this question ranged from 12.6 percent at Jefferson to 47.2 percent at Adair.

Isolation. Among the questions for whether injuries, isolation, or intensive supervision occurred, isolation tended to be the most common. The rates for isolation ranged from 10.8 percent at Campbell to 65.5 percent at Fayette. Campbell and Warren (13.0 percent) had lower percentages than most facilities, seeing isolation in at least a quarter of incidents. Intensive supervision occurrence ranged from 1.0 percent at Adair to 58.7 percent at Warren. The Warren percentage is unusually high, with the next highest percentage being 24.6 percent at Fayette and then 11.7 percent at McCracken. Injuries were relatively uncommon, ranging from 4.5 percent at Warren to 21.4 percent at Jefferson.

Events. LOIC staff documented type of event by recording checkbox selections in the IIR, where multiple events could be selected for each incident.

Table 3.61
Events Most Commonly Reported On DJJ Isolation/Incident Reports
2018 To 2022

RJDC	Event	Percentage Of Reports
Adair	Other	33.4%
	Use of isolation	24.8
Breathitt	Use of isolation	34.0
	Physical restraints	16.3
Boyd*	Other	56.5
	Use of isolation	9.1
Campbell	Other	55.0
	Physical restraints	14.6
Fayette	Use of isolation	34.4
	Physical restraints	24.8
Jefferson	Other	23.9
	Major offenses	17.0
McCracken	Other	48.4
	Use of isolation	16.4
Warren	Other	72.0
	Use of isolation	10.5

*For Boyd, 21.5 percent of entries did not indicate an event.
Source: LOIC staff from an analysis of Department of Juvenile Justice Isolation/Incident forms.

Locations. For locations, LOIC staff documented where events took place by pulling information from a text box field. These entries were highly variable, so LOIC focused on the locations of the most violent events: assault by youth on youth, or assault by youth on staff.

Facilities were most likely to see violent events in youths' rooms, though dayrooms were more common locations at two facilities.

Facilities were most likely to see violent events in youths' rooms, though dayrooms were more common locations at two facilities. For example, violent events occurred in youths' rooms at six facilities: Adair's sample had 21 violent events with 66.7 percent occurring in youths' rooms; Breathitt had 48 violent events with 39.6 percent; Campbell had 44 violent events with 43.2 percent; Fayette had 339 violent events with 61.1 percent; McCracken had 10 violent events with 60.0 percent; and Warren had 5 violent events with 80.0 percent.

Two facilities had violent events occur most often in dayrooms: Boyd had 30 violent events with 46.7 percent occurring in dayrooms, and Jefferson had 36 violent events with 52.8 percent.

Aikido was the technique most commonly used in most facilities, but McCracken was most likely to use a type of mechanical restraint.

Restraints.[1] For restraints, LOIC staff documented which checkboxes were selected. As with events, multiple checkboxes could be used and reports commonly indicated multiple types of restraints. Aikido was generally the most commonly used technique in most facilities, but McCracken was most likely to use a type of mechanical restraint.

RJDCs used these restraints most commonly:

- Adair: "control 1" (32.5 percent of 169 restraints)
- Breathitt: "control 3" (40.0 percent of 402 restraints)
- Boyd: "basic escort" (30.9 percent of 149 restraints)
- Campbell: "control 1" (25.0 percent of 356 restraints)
- Fayette: "control 1" (29.8 percent of 631 restraints)
- Jefferson: "rear double-arm hook" (37.8 percent of 96 restraints)
- McCracken: handcuffs (30.2 percent of 63 restraints)
- Warren: aikido (54.5 percent of 33 events)

Recommendation 3.30

Recommendation 3.30

As the Department of Juvenile Justice updates its Isolation/ Incident Report form, it should ensure that data from selected fields are consistently entered, tracked, and analyzed to identify areas of concern that need to be addressed programmatically and through training.

[1] "Basic escort" applies pressure above the elbow; "rear double arm" hooks arms from behind and above the elbows; "control 1" guides and controls the wrist and elbow; "control 2" uses the crook of the elbow and the wrist to force an offender to the floor; "control 3" uses the elbow and wrist to force an offender to the floor, then uses a T-stance to place a foot on the offender's armpit; "control 4" uses the elbow and wrist to force an offender to the floor, then stands the offender up by applying pressure on the wrist and hand; and "control 7" uses the offender's shoulder to take him/her to the ground in a supine position.

Appendix A

Response From Department Of Juvenile Justice

Andy Beshear
GOVERNOR

JUSTICE AND PUBLIC SAFETY CABINET
125 Holmes Street
Frankfort, Kentucky 40601
Phone: (502) 564-7554
Fax: (502) 564-4840

Kerry Harvey
SECRETARY

Sen. Brandon J. Storm, Chair
Rep. Adam Bowling, Chair
Legislative Oversight & Investigations Committee
Legislative Research Commission
700 Capital Avenue
Frankfort, KY 40601

Chairs Storm and Bowling,

The Kentucky Justice & Public Safety Cabinet (JPSC) and the Kentucky Department of Juvenile Justice (DJJ) have worked in full cooperation with the Legislative Oversight & Investigations Committee (LOIC) since October 2022. JPSC leadership met with the LOIC chairs and House and Senate Majority staff multiple times during this process to determine the best course of action to meet requests, and JPSC leadership staff coordinated with LOIC staff frequently throughout the process to provide information, meetings, and materials. This was a collaborative, intergovernmental information-gathering and -sharing process.

In the interest of transparency, cooperation, and compliance, JPSC and DJJ staff throughout both agencies and across staffing levels:

- Utilized DJJ and JPSC staff to physically gather, sort, and compile records from 8 detention facilities. Each facility required between 6-9 staff and a 12–14-hour day, including travel, to meet the requests;
- Arranged tours for LOIC staff at all 8 detention facilities;
- Conducted over a dozen interviews with LOIC staff, including with leadership at all 8 detention facilities; Office of Detention staff; the DJJ Ombudsman; members of JPSC leadership; the Internal Investigations Branch; DJJ Compliance Division; and DJJ IT staff regarding the booking system; and
- Produced 31 million kilobytes of material for LOIC staff.

Throughout this review process, there were significant developments and improvements to DJJ, some of which are reflected in this report. JPSC and DJJ presented in front of several legislative committees and task forces during the 2022 interim period, 2023 legislative session, and throughout the 2023 interim period on issues impacting DJJ and steps taken to improve the situation. JPSC leadership also worked with legislators on the development and passage of SB 162 and HB 3 during the 2023 legislative session, both of which included critical funding for

DJJ. Each meeting and presentation have been an opportunity for the Executive Branch to talk frankly about identified challenges, needs and requests, and targeted investments and improvements.

With limited exception, JPSC and DJJ agree with the recommendations in the LOIC report, and many of these recommendations were well-underway long before the investigation was initiated and the report produced. Detailed responses by JPSC and DJJ to the findings in this report are included in the appendix. Those recommendations for which there was not full agreement are:

- Recommendation 3.1: JPSC partially agrees with this recommendation and concurs that costs should be specifically captured for the Office of Detention within DJJ, as well as for each facility. The newly established Chart of Accounts put in place to implement the reorganization and explained in the attached finding sheets accomplishes this task.
- Recommendation 3.7: JPSC partially agrees with this recommendations and notes that the Compliance Division will review the incidents leading up to the incident at the Adair Regional Juvenile Detention Center.
- Recommendation 3.10: JPSC disagrees with this recommendation as the Cabinet for Health & Family Services is already provided all investigated findings. Also, if a youth is in the physical custody of DJJ, they cannot be dependent.
- Recommendation 3.14: JPSC partially agrees with this recommendation. Intakes referred from IIB to the Ombudsman and the Ombudsman's subsequent report are included in the Column Case management. However, there is no mechanism to include complaints or grievances referred to the Ombudsman from other sources in IIB's Column Case Management system.
- Recommendation 3.18: JPSC partially agrees with this recommendation. As noted in this report and in previous testimony from JPSC and DJJ leadership, providing appropriate care for severely mentally ill youth involved in the juvenile justice system is a complex problem that must be addressed. Effective treatment options might benefit mentally ill juveniles not currently involved in the juvenile justice system as well. JPSC and DJJ stand ready to work with all stakeholders and to explore every option to find an effective and timely solution to this critical issue, recognizing that others have greater expertise in effective treatment of those suffering from severe mental illness.

There have been serious shortcomings in the DJJ system that are critical to address, most acutely in the detention facilities. Concrete steps have been taken by the Beshear-Coleman Administration to implement a broad range of improvements. The problems arise from a number of root causes, most of which long pre-date this Administration. These problems include:

- Woefully inadequate staffing primarily due to a lack of competitive compensation packages within the current labor market;
- Aging facilities that have not been updated to reflect current needs;
- In the case of Jefferson County, utilizing a facility for detention that was never intended for such use;

- Inadequate preparation for transitioning Jefferson County youth from local detention to state detention, resulting in significant difficulties that cascaded throughout the juvenile justice system;
- A changing juvenile population characterized by greater proclivity for violence and active involvement in security threat groups;
- Failure to adequately train and equip all staff to deal with the changing population;
- In some cases, failure of staff and facility leadership to rigorously adhere to policies and directives;
- Juveniles ordered to detention who suffer from severe mental illness or other physical and developmental challenges that cannot be adequately managed in a detention facility; and
- An antiquated and inadequate data system that could not properly support the management needs of DJJ.

JPSC leadership has been forthcoming about these challenges as they have arisen. Effectively addressing these longstanding challenges has required difficult and extensive work throughout DJJ. With the Governor's leadership and the legislature's support, DJJ is undergoing an unprecedented and comprehensive effort to make the necessary improvements in its operations. This process started nearly a year ago, and the Administration has engaged various levels of expertise within JPSC to determine where improvements should be made and to develop innovative, systemic, and lasting solutions. It has required a change in culture and thought on challenging issues, and it will continue to require a substantial infusion of new resources. Many of the issues could not be adequately addressed without the infusion of new resources. The support of the Governor and the General Assembly have been vital in this regard.

Following several incidents and upon Gov. Beshear's directive, DJJ initiated significant changes to the structure of the detention system to increase security and operations for both youth at staff. Although DJJ has spent the better part of the last year addressing numerous issues that have arisen over many years, inadequate staffing has been the single most important challenge. Without a well-trained staff, adequate in number, efforts to address the myriad of challenges facing any agency tasked with the care of troubled juveniles are almost certain to be frustrated.

Inadequate staffing has been a primary cause of facility insecurity, employee dissatisfaction, and unsustainable turnover rates. The staffing crisis at DJJ and its primary cause has been long recognized and was publicly reported at least as early as 2017. Three years ago, the starting pay for a front-line security worker in a DJJ detention facility was approximately $30,000 annually. The compensation package was wholly and obviously inadequate to attract necessary and qualified staff. The Beshear-Coleman Administration has taken a number of steps to address this fundamental issue upon which the success of so many efforts rest. The General Assembly has supported those efforts, most recently by passing SB162.

Governor Beshear's Administration and DJJ have made recruiting and retaining adequate staff to secure juvenile facilities a top priority, and there have been several significant investments in DJJ detention staff salaries.

- In December 2021, Gov. Beshear announced a 10% raise for all security positions at DJJ.
- In July 2022, the enacted budget provided an 8% increase for all state employees, including DJJ.
- In October 2022, recognizing that previous efforts had not solved the staffing problem, starting salaries for DJJ Youth Workers were raised to $44,616.16. This was funded by redirecting existing resources.
- On February 23, 2023, Gov. Beshear raised the starting salaries to $50,000. At the request of the Administration, the General Assembly appropriated $3.2 million to sustain previous DJJ salary increases.
- In the 2023 session, the General Assembly also appropriated $4.8 million to increase the salaries for all DJJ workers. These increases are scheduled for July 1, 2023 in lieu of the 6% raise for state employees.
- At the request of theAdministration, the General Assembly appropriated $9.7 million for 146 additional DJJ detention staff.

While a competitive compensation package is not the only component in attracting an adequate staff and maintaining good morale among existing employees, it is necessary. Starting pay for DJJ correctional officers now stands at approximately $50,000 annually as a result of the steps outlined above. Staffing levels at DJJ detention centers has improved and there is increased interest in these jobs. As every local labor market is different, progress is not uniform. Campbell and Jefferson are particularly challenging and will likely remain so.

Recruitment and retention of staff is not a static issue, nor one that can be "solved". Labor markets are fluid, and DJJ is but one of thousands competing for employees. Kentucky is experiencing an explosion in job creation and every new economic development success brings a new competitor for labor. The Administration and the General Assembly must be committed to working collaboratively to maintain a compensation package that is competitive as market forces change the employment landscape. Otherwise, the gains we have made could be quickly lost.

In addition to compensation enhancements, DJJ has better trained and equipped its correctional officers to meet the challenges presented by a more aggressive juvenile population. Anecdotal reports indicate that these changes have been positively embraced by most detention center correctional officers. DJJ was historically limited in its ability to prevent disturbances from occurring and to respond effectively when they do occur due to a combination of outdated policies and statutes, including lack of access to non-lethal defensive equipment, inadequate training, and flaws in the aging physical facilities. Significant staffing shortages also impact the ability to adequately respond to incidents.

Because of the changing environment and due to a more aggressive juvenile population, comprehensive changes to DJJ policies, procedures, and regulations were necessary to provide

staff with the protective equipment to adequately respond when violent incidents occur. In December 2022, leadership decided to utilize non-lethal defensive equipment for the safety and security of youth and staff. DJJ made necessary regulatory changes to allow for their use, and recognizing the utility of such equipment, the Governor signed into law statutory changes enacted by the General Assembly to mandate the use of defensive equipment in DJJ facilities.

Badly needed improvements to aging facilities should further improve conditions for juveniles and staff. The Administration and the General Assembly worked collaboratively to provide resources to make a number of necessary improvements to DJJ facilities.

At Gov. Beshear's directive, DJJ initiated significant changes to the structure of the detention system to increase security and operations for both youth at staff. In December 2022, DJJ opened the first female-only detention center in Campbell County. In January 2023, DJJ separated male juveniles by security level based on severity of offenses.

DJJ has also taken necessary steps to reorganize the agency to better serve the needs of youth and staff and to create safer and more effective facilities. Without secure facilities, even the best programming will be ineffective. Improvements include creating positions for a Director of Security and a Director of the Office of Detention position. The Director of Security was hired on 01/01/23 to provide and recommend procedural changes and facility improvements at DJJ facilities.

The Administration requested a reorganization of DJJ to align management by function rather than geography, and this was codified by the General Assembly in SB 162. The reorganization primarily separates management of the detention centers from that of other DJJ facilities. This necessary change better enables management to focus on the particular needs of detention centers, emphasizing safety and security. The new Executive Director of the Office of Detention was hired on 05/06/23. The newly created Office of Detention is providing increased support to the staff. DJJ also created the Compliance Branch on 01/16/23 to conduct unannounced facility inspections and staff interviews to ensure best practices are identified and followed. As part of the reorganization request included in SB 162, the branch became the Compliance Division on 03/27/23.

DJJ is also enhancing its emergency response capabilities. DJJ is working closely with the Kentucky Department of Corrections (DOC) to establish Emergency Response Teams (ERT) at DJJ facilities. Criteria, training, and incentives are being developed so each detention facility and youth development center will have an ERT that will undergo monthly drills. DJJ is developing MOUs with local law enforcement concerning emergency responses as mandated by SB 162.

JPSC and DJJ leadership have reported to oversight committees on several occasions that DJJ's data system is outdated and inadequate to support proper management of the department. As with other issues, this shortcoming went unaddressed for many years. As this report notes, the last major redesign of the system was undertaken nearly a decade and a half ago. Both DJJ's

circumstances and available technology have changed dramatically since then and the current system has been obsolete for years. This was recognized by the previous Administration and considerable resources were devoted to acquiring the KOMS (Kentucky Offender Management System) system for DJJ approximately six years ago. Inexplicably, that effort was abandoned, and nothing put in its place. JPSC and DJJ leadership explored the advantages of KOMS and jointly decided that it offered the best solution under the circumstances. Once KOMS is fully deployed, DJJ will have the sophisticated system needed for proactive management. KOMS is a proven product that will evolve as needs change. Significant expertise concerning its use and capabilities already exists at DJJ's sister agency, the Department of Corrections, which will assist in deployment of the new system.

An enormous amount of work has been undertaken by JPSC and DJJ to implement the necessary improvements, and while much has been completed, much remains to be done. DJJ's detention facilities are safer than they were a year ago, but they are still not where they can be. Quality improvement is an ongoing, continuing process, and these challenges within juvenile justice require the continued collaboration of all three branches of government.

One vexing issue that continues to challenge DJJ's ability to effectively care for the juveniles in its custody is the lack of adequate facilities to treat mentally ill youth who are detained for lack of any viable alternative placement. Detaining these youth will not provide them necessary and appropriate mental health services. Even the best operated detention facility cannot be expected to properly accommodate seriously mentally ill youth. The lack of placements for youth committed to the Department of Community Based Services results in detaining juveniles simply because there is no alternative. Furthermore, some youth with serious mental health issues are violent and require specialized care and disproportionate resources to manage. While the number of severely mentally ill youth (those who should be hospitalized) within DJJ is relatively small, the practice places enormous burdens on an already strained system. All stakeholders must work together on such pressing issues to find solutions which better serve these individuals. All stakeholders should explicitly acknowledge that predisposition detention should be imposed as a matter of public safety, not as a disciplinary tool or because there is no other placement.

We must not be lulled into a sense of complacency and assume the problems have now been fixed. This report serves to highlight the work that has been done and the work that needs to continue. Additional resources, legislative and regulatory changes, and innovative programming will be required going forward. The youth in the commonwealth and the staff who believe in the mission of DJJ deserve our continued dedication and investment.

Sincerely,

Kerry B. Harvey

Appendix B

Department Of Juvenile Justice Incident Report Analyses

As part of the findings area on incident reports in Chapter 3, Legislative Oversight and Investigations Committee staff analyzed questions from incident reports from all eight regional juvenile detention centers. Tables B.1 to B.32 summarize answers to those questions.

Adair RJDC Tables

Table B.1
Adair RJDC Incident Reports, Injuries, Intensive Supervision, And Similar Incidents
2018 To 2022

Year	Reports	Youths	Injuries	Supervision	Isolation	Similar Incident
2018	59	28	4	0	11	38
2019	59	38	10	1	11	28
2020	60	30	8	0	25	23
2021	59	41	8	1	31	28
2022	62	46	8	1	45	24
Total	299	162	38	3	123	141

Note: Youths = number of distinct youths involved in the reports; Injuries = number of total injuries to youths and/or staff involved with the incident; Supervision = number of youths placed in intensive supervision; Isolation = number of youths placed in isolation; Similar incident = number of reports with similar incidents by a youth in the past. The total shown for "Youths" accounts for the fact that some individuals were the subject of reports in different years.
Source: LOIC staff analysis of 300 incident reports from Adair RJDC.

Table B.2
Adair RJDC Events In Incident Reports
2018 to 2022

Event	2018	2019	2020	2021	2022	Total
Other	46	43	29	26	23	167
Use of isolation	13	12	21	32	46	124
Physical restraint	12	13	29	19	10	83
Assault by youth on youth	3	5	8	15	13	44
No entry	4	6	8	6	5	29
Assault by youth on staff	2	5	5	4	2	18
Mechanical restraint	0	2	5	4	2	13
Possession of contraband	1	3	1	1	3	9
Major offense	0	0	1	0	3	4
Major property destruction	1	0	0	1	2	4
AWOL/escape	0	2	0	0	0	2
Major injury	2	2	2	2	2	2
Suicide attempt	0	0	1	0	0	1
Total events	84	93	110	110	111	500

Note: Reports can include multiple events.
Source: LOIC staff analysis of 300 incident reports from Adair RJDC.

Table B.3
Adair RJDC Restraints Used In Incidents
2018 To 2022

Restraint	2018	2019	2020	2021	2022	Total
Control 1	9	10	17	12	7	55
Rear double-arm hook	8	6	13	9	6	42
Control 3	6	6	5	5	4	26
Handcuffs	0	3	5	7	3	18
Anklets	0	2	5	5	2	14
Chains	0	0	0	4	1	5
Suicide prevention blanket	0	1	1	1	0	3
Basic escort	0	1	1	0	0	2
Suicide prevention smock	0	0	1	0	1	2
Control 2	0	1	0	0	0	1
Double basic escort	1	0	0	0	0	1
Total restraints	24	30	48	43	24	169

Note: Reports can include multiple restraints. “Control 1” = staff guides and controls the offender’s wrist and elbow; “Rear double arm hook” = staff hooks both arms from behind and above the offender’s elbows; “Control 3” = staff uses the elbow and wrist to force an offender to the floor, then uses a T-stance to place a foot on the offender’s armpit; “Control 2” = staff uses the crook of the elbow and the wrist to force an offender to the floor; “Control 1” = staff guides and controls the offender’s wrist and elbow.
Source: LOIC staff analysis of 300 incident reports from Adair RJDC.

Table B.4
Adair RJDC Locations Of Violent Events
2018 To 2022

Location	2018	2019	2020	2021	2022	Total
Rooms	0	2	1	5	6	14
Gym/recreation	0	1	0	2	1	4
Cafeteria	0	1	0	0	0	1
Classroom	0	0	0	1	0	1
Dayroom	0	0	1	0	0	1
Total	0	4	2	8	7	21

Note: Incident reports were included only if they included a violent event: assault by youth on youth or assault by youth on staff.
Source: LOIC staff analysis of 300 incident reports from Adair RJDC.

Breathitt RJDC Tables

Table B.5
Breathitt RJDC Incident Reports, Injuries, Intensive Supervision, And Similar Incidents 2018 To 2022

Year	Reports	Youths	Injuries	Supervision	Isolation	Similar Incident
2018	99	77	5	3	16	7
2019	133	81	13	5	54	35
2020	67	29	17	10	46	43
2021	156	79	16	14	62	31
2022	367	154	50	45	235	158
Total	822	378	101	77	413	274

Note: Youths = number of distinct youths involved in the reports; Injuries = number of total injuries to youths and/or staff involved with the incident; Supervision = number of youths placed in intensive supervision; Isolation = number of youths placed in isolation; Similar incident = number of reports with similar incidents by a youth in the past. The total shown for "Youths" accounts for the fact that some individuals were the subject of reports in different years.
Source: LOIC staff analysis of 822 incident reports from Breathitt RJDC.

Table B.6
Breathitt RJDC Events In Incident Reports 2018 To 2022

Event	2018	2019	2020	2021	2022	Total
Use of isolation	13	45	36	43	290	425
Physical restraint	10	39	45	42	68	204
Major injury	59	59	0	26	48	192
Other	24	31	11	68	40	176
Assault by youth on youth	3	6	15	25	28	77
No entry	9	20	8	14	19	73
Assault by youth on staff	1	8	13	1	9	32
Possession of contraband	2	1	2	9	6	20
Suicide attempt	1	1	4	2	11	19
Mechanical restraint	1	0	6	2	7	16
Major offense	1	0	3	5	0	9
Major property destruction	2	1	1	0	2	6
AWOL/escape	1	0	0	0	0	1
Total events	127	211	144	237	528	1,250

Note: Reports can include multiple events.
Source: LOIC staff analysis of 822 incident reports from Breathitt RJDC.

Table B.7
Breathitt RJDC Restraints Used In Incidents
2018 To 2022

Restraint	2018	2019	2020	2021	2022	Total
Control 3	6	40	36	25	54	161
Rear double-arm hook	6	15	16	23	21	81
Control 1	2	8	5	20	29	64
Control 7	1	10	5	2	4	22
Handcuffs	1	3	8	4	5	21
Basic escort	4	9	0	2	0	15
Suicide prevention smock	0	0	2	0	13	15
Suicide prevention blanket	1	0	3	0	5	9
Anklets	1	0	4	0	1	6
Control 2	1	1	0	2	1	5
Chains	1	0	1	0	0	2
Extended arms assist	1	0	0	0	0	1
Total restraints	25	86	80	78	133	402

Note: Reports can include multiple restraints. “Control 3” = staff uses the elbow and wrist to force an offender to the floor, then uses a T-stance to place a foot on the offender’s armpit; “Rear double arm hook” = staff hooks both arms from behind and above the offender’s elbows; “Control 1” = staff guides and controls the offender’s wrist and elbow; “Control 7” = staff uses the offender’s shoulder to take him/her to the ground in a supine position; “Control 2” = staff uses the crook of the elbow and the wrist to force an offender to the floor.
Source: LOIC staff analysis of 822 incident reports from Breathitt RJDC.

Table B.8
Breathitt RJDC Locations Of Violent Events
2018 To 2022

Location	2018	2019	2020	2021	2022	Total
Rooms	0	2	3	5	9	19
Gym/recreation	1	1	2	4	3	11
Dayroom	0	0	3	4	2	9
Cafeteria	0	2	1	1	1	5
No entry	0	1	1	0	0	2
Classroom	0	0	0	0	1	1
Hallway	0	0	0	1	0	1
Total	1	6	10	15	16	48

Note: Incident reports were included only if they included a violent event: assault by youth on youth or assault by youth on staff.
Source: LOIC staff analysis of 822 incident reports from Breathitt RJDC.

Boyd RJDC Tables

Table B.9
Boyd RJDC Incident Reports, Injuries, Intensive Supervision, And Similar Incidents 2018 To 2022

Year	Reports	Youths	Injuries	Supervision	Isolation	Similar Incident
2018	170	106	8	24	58	37
2019	209	132	6	7	19	28
2020	146	67	7	4	27	34
2021	112	66	2	7	41	26
2022	139	80	17	35	100	71
Total	776	417	40	77	245	196

Note: Youths = number of distinct youths involved in the reports; Injuries = number of total injuries to youths and/or staff involved with the incident; Supervision = number of youths placed in intensive supervision; Isolation = number of youths placed in isolation; Similar incident = number of reports with similar incidents by a youth in the past. The total shown for "Youths" accounts for the fact that some individuals were the subject of reports in different years.
Source: LOIC staff analysis of 776 incident reports from Boyd RJDC.

Table B.10
Boyd RJDC Events In Incident Reports 2018 To 2022

Event	2018	2019	2020	2021	2022	Total
Other	146	116	93	80	72	507
No entry	20	95	41	25	10	191
Use of isolation	9	6	10	4	53	82
Physical restraint	2	2	8	8	21	41
Assault by youth on youth	2	0	7	6	21	36
Major offense	4	6	0	0	1	11
Mechanical restraints	3	2	1	0	1	7
Suicide attempt	1	2	1	0	3	7
Assault by youth on staff	0	1	2	1	2	6
Major property destruction	1	1	1	0	2	5
Possession of contraband	4	0	0	0	1	5
Total events	192	231	164	124	187	898

Note: Reports can include multiple events.
Source: LOIC staff analysis of 776 incident reports from Boyd RJDC.

Table B.11
Boyd RJDC Restraints Used In Incidents
2018 To 2022

Restraint	2018	2019	2020	2021	2022	Total
Basic escort	1	1	10	10	24	46
Rear double-arm hook	3	2	6	7	11	29
Control 3	1	1	5	4	12	23
Handcuffs	4	2	1	0	2	9
Control 7	0	1	0	2	5	8
Anklets	3	2	0	0	2	7
Control 1	0	0	2	1	4	7
Chains	4	0	1	0	1	6
Control 2	1	0	1	3	0	5
Suicide prevention blanket	0	4	0	0	1	5
Foam helmet	0	2	0	0	0	2
Suicide prevention smock	0	2	0	0	0	2
Total restraints	17	17	26	27	62	149

Note: Reports can include multiple restraints. “Rear double arm hook” = staff hooks both arms from behind and above the offender’s elbows; “Control 3” = staff uses the elbow and wrist to force an offender to the floor, then uses a T-stance to place a foot on the offender’s armpit; “Control 7” = staff uses the offender’s shoulder to take him/her to the ground in a supine position; “Control 1” = staff guides and controls the offender’s wrist and elbow; “Control 2” = staff uses the crook of the elbow and the wrist to force an offender to the floor.
Source: LOIC staff analysis of 776 incident reports from Boyd RJDC.

Table B.12
Boyd RJDC Locations Of Violent Events
2018 To 2022

Location	2018	2019	2020	2021	2022	Total
Dayroom	0	0	0	1	13	14
Gym/recreation	0	0	2	1	6	9
Rooms	0	0	3	1	0	4
Classroom	0	0	0	2	0	2
No entry	0	0	1	0	0	1
Total	0	0	6	5	19	30

Note: Incident reports were included only if they included a violent event: assault by youth on youth or assault by youth on staff.
Source: LOIC staff analysis of 776 incident reports from Boyd RJDC.

Campbell RJDC Tables

Table B.13
Campbell RJDC Incident Reports, Injuries, Intensive Supervision, And Similar Incidents 2018 To 2022

Year	Reports	Youths	Injuries	Supervision	Isolation	Similar Incident
2018	320	129	33	3	10	129
2019	160	71	15	2	11	46
2020	249	75	32	3	32	87
2021	45	22	6	3	6	22
2022	49	31	4	5	30	16
Total	823	288	90	16	89	299

Note: Youths = number of distinct youths involved in the reports; Injuries = number of total injuries to youths and/or staff involved with the incident; Supervision = number of youths placed in intensive supervision; Isolation = number of youths placed in isolation; Similar incident = number of reports with similar incidents by a youth in the past. The total shown for "Youths" accounts for the fact that some individuals were the subject of reports in different years.
Source: LOIC staff analysis of 823 incident reports from Campbell RJDC.

Table B.14
Campbell RJDC Events In Incident Reports 2018 To 2022

Events	2018	2019	2020	2021	2022	Total
Other	265	116	139	28	24	572
Physical restraint	30	29	77	8	8	152
Assault by youth on youth	10	17	33	9	10	79
Null	30	13	11	0	4	58
Mechanical restraint	18	1	22	3	1	45
Major offense	4	5	19	1	6	35
Use of isolation	3	5	17	2	6	33
Assault by youth on staff	0	1	19	3	1	24
Suicide attempt	4	1	10	2	0	17
AWOL/escape	1	1	6	0	1	9
Possession of contraband	2	3	2	0	2	9
Major property destruction	1	0	3	0	0	4
Therapeutic restraint	1	0	2	0	0	3
Total events	369	192	360	56	63	1,040

Note: Reports can include multiple events.
Source: LOIC staff analysis of 823 incident reports from Campbell RJDC.

Table B.15
Campbell RJDC Restraints Used In Incidents
2018 To 2022

Restraint	2018	2019	2020	2021	2022	Total
Control 1	20	14	50	4	1	89
Rear double-arm hook	18	9	39	6	4	76
Anklets	21	8	27	3	3	62
Handcuffs	20	8	28	3	3	62
Control 3	9	3	17	2	2	33
Chains	5	4	4	1	3	17
Suicide prevention smock	2	0	5	2	0	9
Control 2	1	0	3	0	0	4
Suicide prevention smock	0	0	0	2	0	2
Basic escort	0	0	0	0	1	1
Control 7	0	0	0	1	0	1
Total restraints	96	46	173	24	17	356

Note: Reports can include multiple restraints. “Control 1” = staff guides and controls the offender’s wrist and elbow; “Rear double arm hook” = staff hooks both arms from behind and above the offender’s elbows; “Control 3” = staff uses the elbow and wrist to force an offender to the floor, then uses a T-stance to place a foot on the offender’s armpit; “Control 2” = staff uses the crook of the elbow and the wrist to force an offender to the floor; “Control 7” = staff uses the offender’s shoulder to take him/her to the ground in a supine position.
Source: LOIC staff analysis of 823 incident reports from Campbell RJDC.

Table B.16
Campbell RJDC Locations Of Violent Events
2018 To 2022

Location	2018	2019	2020	2021	2022	Total
Rooms	1	2	13	1	2	19
Dayroom	0	1	6	1	1	9
Cafeteria	2	0	0	2	3	7
Gym/recreation	2	0	2	2	1	7
Hallway	1	0	0	0	0	1
No entry	0	0	0	1	0	1
Total	6	3	21	7	7	44

Note: Incident reports were included only if they included a violent event: assault by youth on youth or assault by youth on staff.
Source: LOIC staff analysis of 823 incident reports from Campbell RJDC.

Fayette RJDC Tables

Table B.17
Fayette RJDC Incident Reports, Injuries, Intensive Supervision, And Similar Incidents 2018 To 2022

Year	Reports	Youths	Injuries	Supervision	Isolation	Similar Incident
2018	549	191	61	100	266	226
2019	475	146	49	86	188	181
2020	368	125	53	118	159	143
2021	392	150	40	84	242	106
2022	329	158	68	22	237	84
Total	1666	536	271	410	1092	740

Note: Some reports did not complete the last set of four questions: 372 reports did not complete the injuries question, 207 did not complete the supervision question, 221 did not complete the isolation question, and 203 did not complete the similar incidents question. Youths = number of distinct youths involved in the reports; Injuries = number of total injuries to youths and/or staff involved with the incident; Supervision = number of youths placed in intensive supervision; Isolation = number of youths placed in isolation; Similar incident = number of reports with similar incidents by a youth in the past. The total shown for "Youths" accounts for the fact that some individuals were the subject of reports in different years.
Source: Staff analysis of 1,666 incident reports from Fayette RJDC.

Table B.18
Fayette RJDC Events In Incident Reports 2018 To 2022

Events	2018	2019	2020	2021	2022	Total
Use of isolation	329	248	202	248	162	1,189
Physical restraint	249	198	196	132	82	857
Assault by youth on youth	136	107	113	126	148	630
Other	125	134	49	52	42	402
No entry	14	15	11	42	24	106
Mechanical restraint	14	13	11	6	10	54
Suicide attempt	12	12	9	11	7	51
Assault by youth on staff	19	12	8	2	7	48
Major property destruction	13	6	6	3	3	31
Possession of contraband	12	10	3	5	6	36
Major injury	7	6	0	1	2	16
Major offense	4	3	2	2	5	16
Suicidal ideation	2	2	1	0	0	5
Therapeutic restraint	0	0	0	2	3	5
Assault	2	2	0	0	0	4
AWOL/escape	1	1	0	0	0	2
Room restriction	1	0	0	0	0	1
Minor injury	0	0	0	0	1	1
Total events	940	769	611	632	502	3,454

Note: Reports can have multiple events.
Source: Staff analysis of 1,666 incident reports from Fayette RJDC.

Table B.19
Fayette RJDC Restraints Used In Incidents
2018 To 2022

Restraints	2018	2019	2020	2021	2022	Total
Control 1	110	77	86	62	43	378
Control 3	96	67	94	56	40	353
Rear double-arm hook	85	69	74	50	54	332
Handcuffs	14	13	12	6	13	58
Anklets	12	11	8	4	11	46
Control 7	14	6	15	1	2	38
Suicide prevention smock	1	1	3	7	5	17
Chains	3	3	2	2	5	15
Suicide prevention blanket	1	1	1	5	4	12
Control 2	4	0	3	1	1	9
Basic escort	0	0	5	2	0	7
Foam helmet	1	1	0	0	0	2
Total restraints	341	249	303	196	178	1,267

Note: 1,034 entries did not indicate a restraint was used. This may be because no restraints were used or because staff used a restraint but did not enter it on the form. Reports can include multiple restraints. “Control 1” = staff guides and controls the offender’s wrist and elbow; “Control 3” = staff uses the elbow and wrist to force an offender to the floor, then uses a T-stance to place a foot on the offender’s armpit; “Rear double arm hook” = staff hooks both arms from behind and above the offender’s elbows; “Control 7” = staff uses the offender’s shoulder to take him/her to the ground in a supine position; “Control 2” = staff uses the crook of the elbow and the wrist to force an offender to the floor.
Source: Staff analysis of 1,666 incident reports from Fayette RJDC.

Table B.20
Fayette RJDC Locations Of Violent Events
2018 To 2022

Location	2018	2019	2020	2021	2022	Total
Rooms	38	34	39	50	46	207
Hallway	6	3	11	6	15	41
Dayroom	2	2	8	2	18	32
Gym	3	3	0	1	10	17
Classroom	1	1	3	4	7	16
Recreation	0	0	3	0	6	9
Library	2	2	0	1	1	6
Cafeteria	0	0	2	0	2	4
Shower	0	0	0	1	2	3
Intake	1	0	0	0	1	2
Visitation	0	0	0	0	1	1
No Entry	0	0	0	0	1	1
Total	53	45	66	65	110	339

Note: Incident reports were included only if they included a violent event: assault by youth on youth or assault by youth on staff.
Source: Staff analysis of 1,666 incident reports from Fayette RJDC.

Jefferson RJDC Tables

Table B.21
Jefferson RJDC Incident Reports, Injuries, Intensive Supervision, And Similar Incidents 2020 To 2022

Year	Reports	Youths	Injuries	Supervision	Isolation	Similar Incident
2020	87	38	10	11	38	10
2021	86	59	24	2	28	10
2022	89	58	22	3	18	13
Total	262	131	56	16	84	33

Note: Some reports did not complete the last set of four questions: 46 reports did not complete the injuries question, 64 did not complete the supervision question, 56 did not complete the isolation question, and 70 did not complete the similar incidents question. Jefferson began operations in January 2020. Note: Youths = number of distinct youths involved in the reports; Injuries = number of total injuries to youths and/or staff involved with the incident; Supervision = number of youths placed in intensive supervision; Isolation = number of youths placed in isolation; Similar incident = number of reports with similar incidents by a youth in the past. The total shown for "Youths" accounts for the fact that some individuals were the subject of reports in different years.
Source: Staff analysis of 262 incident reports from Jefferson RJDC.

Table B.22
Jefferson RJDC Events In Incident Reports 2018 To 2022

Events	2020	2021	2022	Total
Other	44	41	33	118
Major offense	41	19	24	84
Assault by youth on youth	16	36	30	82
Physical restraint	20	36	21	77
Use of isolation	33	11	16	60
Assault by youth on staff	6	7	6	19
Major property destruction	9	3	3	15
Possession of contraband	3	2	9	14
Suicide attempt	5	2	0	7
Mechanical restraint	5	0	1	6
AWOL/escape	1	1	3	5
Major injury	0	0	3	3
No entry	1	1	0	2
Therapeutic restraint	1	0	0	1
Sexual assault	1	0	0	1
Total events	186	159	149	494

Note: Jefferson began operations in January 2020. Reports can include multiple events.
Source: Staff analysis of 262 incident reports from Jefferson RJDC.

Table B.23
Jefferson RJDC Restraints Used In Incidents
2020 To 2022

Restraints	2020	2021	2022	Total
Rear double-arm hook	15	27	17	59
Basic escort	24	23	8	55
Control 3	6	2	3	11
Control 1	2	1	8	11
Control 2	5	0	2	7
Handcuffs	3	1	0	4
Control 7	3	0	1	4
Anklets	1	0	2	3
Chains	1	0	0	1
Suicide prevention blanket	1	0	0	1
Total restraints	61	54	41	156

Note: 166 entries did not indicate a restraint was used. This could be because no restraint was used or because staff did not enter a restraint on the form. Reports can include multiple restraints. “Rear double arm hook” = staff hooks both arms from behind and above the offender’s elbows; “Control 3” = staff uses the elbow and wrist to force an offender to the floor, then uses a T-stance to place a foot on the offender’s armpit; “Control 1” = staff guides and controls the offender’s wrist and elbow; “Control 2” = staff uses the crook of the elbow and the wrist to force an offender to the floor; “Control 7” = staff uses the offender’s shoulder to take him/her to the ground in a supine position.
Source: Staff analysis of 262 incident reports.

Table B.24
Jefferson RJDC Locations Of Violent Events
2020 To 2022

Location	2020	2021	2022	Total
Dayroom	1	3	15	19
Rooms	3	0	3	6
Game room	0	2	2	4
Gym	1	1	2	4
Intake	0	1	0	1
Courtyard	1	0	0	1
Office	0	0	1	1
Total	6	7	23	36

Note: Jefferson began operations in January 2020. Incident reports were included only if they included a violent event: assault by youth on youth or assault by youth on staff.
Source: Staff analysis of 262 incident reports from Jefferson RJDC.

McCracken RJDC Tables

Table B.25
McCracken RJDC Incident Reports, Injuries, Intensive Supervision, And Similar Incidents 2018 To 2022

Year	Reports Sampled	Youths	Injuries	Supervision	Isolation	Similar Incident
2018	60	40	1	13	19	30
2019	60	47	2	9	11	16
2020	60	37	5	6	11	20
2021	60	48	3	3	10	21
2022	60	44	3	4	30	15
Total	300	200	14	35	81	102

Note: Some reports did not complete the last set of four questions: 35 reports did not complete the injuries question, 46 did not complete the supervision question, 61 did not complete the isolation question, and 39 did not complete the similar incidents question. Note: Youths = number of distinct youths involved in the reports; Injuries = number of total injuries to youths and/or staff involved with the incident; Supervision = number of youths placed in intensive supervision; Isolation = number of youths placed in isolation; Similar incident = number of reports with similar incidents by a youth in the past. The total shown for "Youths" accounts for the fact that some individuals were the subject of reports in different years.
Source: Staff analysis of 300 incident reports from McCracken RJDC.

Table B.26
McCracken RJDC Events In Incident Reports 2018 To 2022

Events	2018	2019	2020	2021	2022	Total
Other	28	41	49	44	36	198
Use of isolation	21	18	7	4	17	67
Room restriction	1	6	13	23	0	43
Null	8	3	2	7	1	21
Physical restraint	0	3	3	6	8	20
Mechanical restraint	3	3	3	2	3	14
Assault by youth on youth	0	0	2	1	8	11
Major offense	2	1	2	1	1	7
Assault by youth on staff	0	0	1	3	2	6
Sexual assault	2	2	0	0	0	4
AWOL/escape	0	1	1	0	0	2
Possession of contraband	0	0	2	2	0	4
Placed on precautions	0	4	0	0	0	4
Scanner probe	0	0	0	0	1	1
Therapeutic restraint	0	1	0	0	0	1
Suicidal statements	0	0	1	0	0	1
Basic escort	0	0	1	0	0	1
Major property destruction	0	0	1	0	0	1
Inciting a riot	0	0	1	0	0	1
Suicide attempt	0	1	0	0	0	1
Time check	0	0	0	1	0	1
Total events	65	84	89	94	77	409

Note: Reports can have multiple events.
Source: Staff analysis of 300 incident reports from McCracken RJDC.

Table B.27
McCracken RJDC Restraints Used In Incidents
2018 To 2022

Restraints	2018	2019	2020	2021	2022	Total
Handcuffs	8	3	4	1	3	19
Control 3	1	1	3	3	6	14
Control 1	1	1	2	4	2	10
Rear double-arm hook	1	1	2	2	3	9
Basic escort	2	1	0	2	0	5
Anklets	0	2	1	1	0	4
Willing resident	0	0	1	0	0	1
Chains	0	1	0	0	0	1
Total reports	13	10	13	13	14	63

Note: 262 reports did not indicate a restraint was used, possibly because no restraint was used or because staff did not indicate a restraint was used on the form. Reports can have multiple restraints. “Control 3” = staff uses the elbow and wrist to force an offender to the floor, then uses a T-stance to place a foot on the offender’s armpit; “Control 1” = staff guides and controls the offender’s wrist and elbow; “Rear double arm hook” = staff hooks both arms from behind and above the offender’s elbows.
Source: Staff analysis of 300 incident reports from McCracken RJDC.

Table B.28
McCracken RJDC Locations Of Violent Events
2018 To 2022

Location	2020	2022	Total
Rooms	0	6	6
Dayroom	0	2	2
CLR 3	1	0	1
Recreation	0	1	1
Total	1	9	10

Note: Incident reports were only included if they included a violent event: assault by youth on youth or assault by youth on staff.
Source: Staff analysis of 30 incident reports from McCracken RJDC.

Warren RJDC Tables

Table B.29
Warren RJDC Incident Reports, Injuries, Intensive Supervision, And Similar Incidents 2018 To 2022

Year	Reports	Youths	Injuries	Supervision	Isolation	Similar Incident
2018	60	42	2	42	7	21
2019	60	44	1	44	1	14
2020	24	5	0	1	0	1
2021	55	40	3	43	2	23
2022	48	39	5	15	22	7
Total	247	159	11	145	32	66

Note: Some reports did not complete the last set of four questions: 16 reports did not complete the injuries question, 7 did not complete the supervision question, 14 did not complete the isolation question, and 19 did not complete the similar incidents question. Youths = number of distinct youths involved in the reports; Injuries = number of total injuries to youths and/or staff involved with the incident; Supervision = number of youths placed in intensive supervision; Isolation = number of youths placed in isolation; Similar incident = number of reports with similar incidents by a youth in the past. The total shown for "Youths" accounts for the fact that some individuals were the subject of reports in different years.
Source: Staff analysis of 247 incident reports from Warren RJDC.

Table B.30
Warren RJDC Events In Incident Reports 2018 To 2022

Events	2018	2019	2020	2021	2022	Total
Other	51	58	24	47	26	206
Use of isolation	7	0	0	0	23	30
Physical restraint	2	0	0	6	9	17
Mechanical restraint	2	0	0	4	4	10
No entry	1	1	0	3	2	7
Possession of contraband	1	1	0	1	2	5
Assault by youth on youth	0	0	0	1	2	3
AWOL	0	0	0	0	2	2
Major property destruction	0	0	0	1	1	2
Assault by youth on staff	0	0	0	1	1	2
Major offense	0	0	0	0	1	1
Suicide attempt	0	0	0	1	0	1
Total events	64	60	24	65	73	286

Note: Reports can have multiple events.
Source: Staff analysis of 247 incident reports from Warren RJDC.

Table B.31
Warren RJDC Restraints Used In Incidents
2018 To 2022

Restraints	2018	2019	2020	2021	2022	Total
Aikido	0	0	0	7	11	18
Mechanical	0	0	0	6	3	9
Rear double-arm hook	2	0	0	0	0	2
Handcuffs	2	0	0	0	0	2
"Yes"	0	0	1	0	0	1
Basic escort	1	0	0	0	0	1
Total	5	0	1	13	14	33

Note: 226 entries did not indicate a restraint was used. This may be because no restraints were used or because staff used a restraint but did not enter it on the form. Reports can have multiple restraints. “Rear double arm hook” = staff hooks both arms from behind and above the offender’s elbows.
Source: Staff analysis of 247 incident reports from Warren RJDC.

Table B.32
Warren RJDC Locations Of Violent Events
2018 To 2022

Location	2021	2022	Total
Rooms	2	2	4
Hallway	0	1	1
Total reports	2	3	5

Note: Incident reports were included only if they included a violent event: assault by youth on youth or assault by youth on staff.
Source: Staff analysis of 247 incident reports from Warren RJDC.

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