1. All policies cited are from the Department of Juvenile Justice’s standard operating procedures for Adair Youth Development Center. Policy 100.1 (page 7) states that these policies are to be the operating procedures by which the facility is run. Only the Central Office may make changes.
2. **Excessive use of isolation without following DJJ policies**
	1. Non-behavioral isolation (Not a DPA term)
		1. There is no policy that allows for “non-behavioral isolation.”
		2. Policies 110.2-10 (page 112), 301 (page 250,) 702 (page 533) give very specific directions on how to conduct intake of a child. There is directive noting the child should be placed in isolation. The policies were updated on September 7, 2022, post Covid.
		3. Policies 323 (page 317) and 717 (page 581) specifically notes that isolation cannot be used for suicide prevention or as a means of keeping children in protective custody.
		4. Children were regularly placed in “non-behavioral isolation” for days, upon entering the facility. There is no DJJ policy that allows for non-behavioral isolation. Policy 717 (page 579) notes Isolation may only be used for “major rule violations”, via DJJ policy.
	2. Isolation due to behavioral issues.
		1. Policies 318 (page 291), and 323 ( page 317) note isolation should not be a preferred method of behavior management, as least restrictive behavior management should be utilized first. Policy 318.1 (page 293) notes AYDC should use graduated sanctions. Unfortunately, AYDC appears to have used isolation, which is the most restrictive placement available, as the first method of behavioral management.
		2. It should be noted that policy 110.2-2 (page 93) provides guidance for redirecting youth when there is negative behavior. AYDC does not appear to be using any of these suggestions.
		3. As noted above, children may only be placed in isolation for “major rule violations,” and not “minor rule violations”.
		4. Policies 300 (page 242) and 717 (page 579) define examples of minor rule violations as behavior consistently lower than expected, being disrespectful to staff or residents, refusing to follow staff instructions, making verbal threats, violating dress code, etc. These violations should be handled by things like early bedtime, assigned work detail, loss of privileges etc.
		5. The same policy defines major rule violations to include escape, AWOL, physical or sexual assault, major property destruction, possession of contraband, a positive drug test, and chronic program disruption, which requires due process. To be placed in isolation, a major rule violation must have occurred.
		6. Policies 205 (page 231), 300 (page 239), 318.2 (298), and 718 (page 584) state that a child that is alleged to have committed a major rule violation is entitled to due process. This should initially involve an investigation within 24 hours by the Administrative Duty Officer. This process involves a review hearing by the treatment team. The team must take into account the youth’s prior conduct and program needs. Youth are also entitled to an appeal process. Children were not being afforded this process, but were simply being placed in isolation through unilateral decisions from staff. There also appears to have been no treatment teams to make disciplinary decisions.
		7. Policies 323(page 317), 318 (page 291), and 717 (page 581) note isolation should not be used as punishment. It should only last for four hours. The superintendent of a facility may only approve a child being placed in isolation for up to 24 hours, after consultation with the Chief Mental Health Services and Regional Psychologist. After 24 hours, the facility must get approval from the Facilities Regional Manager. After 36 hours, there must be approval from the Division of Mental Health Services. Children are not allowed to be in isolation for more than 5 days. Isolation lasted for days, well beyond the five day limit. The only authorization given was the superintendent.
		8. Policy 717 (page 581) notes that a nurse should be consulted to see if there are contraindications for juveniles being placed in isolation. This was not being done regularly.
		9. Policy 323 (page 319) notes that while in isolation, children should be given access to recreation time and showers. However, AYDC provided none of these things while children were in isolation.
		10. Policy 323 (page 318) notes that upon placing a youth in isolation, staff immediately must create a plan on what behavior must be demonstrated for the youth to be released from isolation. This must be explained to the youth. If the youth demonstrates they are not dangerous and/or has reasonable control over their behavior, they must be released. AYDC had no such plans. Youth were given no way in which they could be released from isolation and were held in isolation for days, regardless of any changes in their behaviors.
		11. Policies 110.2-5 (100), 323 (page 321), and 717 (page 582) require that all isolations have an isolation packet. These should include a critical incident report, isolation log, plan for release, post restraint body check, room confinement/isolation services log, professional reviews, and critical incident response. These packets do not appear to exist.
		12. Policy 323 (page 321) requires these packets be forwarded to the FRA and Regional Division Director. As these packets do not appear to have been created, it does not appear they were forwarded.
		13. The isolation log should include 15 minutes observations, professional reviews, and medical checks. It should note services provided, such as food, showers and education supplies. AYDC was not regularly conducting 15 minute observations. In fact, there are days in which there are no isolation logs at all, despite the child being held in isolation. Showers were not given the majority of the time either, and it is unclear what was being provided regarding food and educational services, as there is no documentation.
		14. The plan for release states there must be a written plan developed as to how a child may be released from isolation that the child is aware of. There do not appear to be records of these. Children were being given no explanation as to how release can occur.
		15. The post restraint body check requires medical staff or protocol trained staff to conduct checks for injuries upon placement. These were not routinely occurring.
		16. The room confinement checklist requires that staff document services being provided and withheld daily. These are suppose to thoroughly document these things. These were not being completed daily and were not thorough when completed.
		17. Professional reviews should be completed in the isolation packets. As noted above, there were not complete isolation packets.
		18. Children were regularly placed in behavioral isolation for minor violations. The period of isolation lasted for well past five days, without approval from anyone, other than the facility superintendent. During this time, youth did not have access to educational services, family, or appropriate mental health services.
3. **Non-adherance to grievance and use of force policies**
	1. Policy 110.2-2(page 93) and 205 (page 231) note grievance forms should be accessible to children at all times. They should be reviewed by administrative staff daily. These were not regularly available to youth.
	2. Policies 331 (page 344), 140(page 203), 142 (page 205), 715 (page 575) requires any special incidents, such as excessive or inappropriate use of force be reported to Internal Investigation Branch immediately; so, an investigation can occur.
	3. Policy 142 (page 205) and 715 (page 575) states the staff member involved in the incident are supposed to be removed from contact with the alleged victim of the incident, while the investigation occurs. Policy 206 (page 235) notes youth shall have access to the Internal Investigation Branch when a critical incident has occurred.
	4. AYDC did not follow the above noted policies. Incidents were going unreported for extended periods of time, if they were reported. Staff continued to interact with the youth that were the alleged victims. The children did not have access to the Internal Investigation Branch regularly.
	5. In one case, there was a two month delay in reporting an excessive force complaint.
	6. In that incident, it should be noted that when further investigation occurred, the entirety of the restraint was not in view of the camera, but several workers noted they were concerned the restraint was in excess of what they were trained on. The Internal Investigation Branch noted the audio in the video depicted the child “screaming in pain” and crying, while the worker continues to yell “Say you are done.”
	7. Policies 318 (page 292) and 324 (page 322) note restraints should only be used so long as necessary to control the violent behavior of the youth, until the youth is able to demonstrate self-control. Policies 318.1 (page 293) and 713 (page 566) note restraints are not to be used as punitive punishment.
	8. Clearly the above described incident went beyond the confines of what policy allowed.
	9. 505 KAR 1:210E is the emergency order the governor entered, authorizing the use of mace. It required any of use of chemical agent on a child to be for “reactive use” to prevent loss of life, injury to staff or juveniles, damage to state property or escape. It cannot be used as punishment. It must be the minimum amount of force needed. After being exposed to mace, the child should receive a medical evaluation. A incident report was also required regarding any use of mace. AYDC was not using mace as a way to avoid injury or damage to property or escape, but as punishment while youth were in isolation rooms. After mace was use, there were no incident reports or medical evaluation. Youth were not immediately allowed to decontaminate and their isolation cells were not decontaminated. (It should be noted the emergency order did not require decontaminating. DJJ’s policy that was published in August does require it.) IIB reports substantiated allegations of abuse based on AYDC not adhering to the guidance given. Youth were maced while in isolation cells, taunted during the process, and then were not immediately decontaminated, but force to sit in their cells without showers. Cells were not decontaminated. AYDC did not have children receive medical clearance afterwards. They also did not report the incidents. IIB was informed by the children days later when they were finally able to access a hotline call.
4. **Inhumane living conditions**
	1. Under DJJ policy 205 (page 231), children are entitled to clean bedding, linens and clean mattresses.
	2. The day prior to the riot, a sprinkler broke in one of the pods, soaking the pod and everything in it. Children were not immediately given access to showers, but were forced to stay in damp clothing, with standing water in the pod. There were no dry places to sit or lie down. This occurred for around 24 hours.
5. **No access to mental health treatment or education**
	1. Children were regularly held in isolation for days at a time. During this time, they did not receive appropriate mental health treatment or education.
	2. Policy 303 (page 264) calls for treatment teams, which would consist of a DJJ staff member, youth, parents, and other supporters who work collaboratively to aide youth in achieving goals. Most discipline actions are required to go through the treatment team, before making a decision about punishment. These teams are required to meet weekly. It should be noted it does not appear AYDC was utilizing treatment teams, as several policies call for. Many decisions were made independently by the superintendent, with no oversight from anyone else, including her supervisors.
	3. Policies 205 (page 231), 317 (page 287), and 720.2 (page 590) require children to have one hour of recreation time and one hour of leisure time each day. Special arrangements are to be made if the youth is separated from the group. Children spent most of their time in isolation and were not receiving recreation time.
	4. Policies 205 (page 233), 323 (page 321) and 110.2-2 (page 91) require children to be given access to a shower daily. Children frequently were denied access to showers.
	5. Policy 300 (page 245) calls for the facility to have a “youth counselor”. This individual’s job is to coordinate treatment within the facility for the children there. Policy 303 (page 264) calls for the treatment counselor to work with the youth to reach the goals set out in the treatment plan. AYDC did not have and still does not have a youth counselor.
	6. Policies 300 (page 239), and 302 (page 260) require each youth have an individualized treatment plan. These plans should include a written document that includes the youth’s risk and needs determined in their risk assessment, any additional assessments which identify treatment goals that should be pursued, specific roles of the participant in carrying out the plan and specific timetables for completion of the plans. Treatment plans were not being utilized for youth.
	7. Policy 302 (page 262) requires these plans to be reviewed and potentially updated every 30 days. This was to be done by the treatment team. This was not occurring. Also, once again there was no treatment team.
	8. Policy 110.2-2 (page 92) and 307 (page 270) require the facility to have group counseling three times a week. No group counseling was occurring.
	9. Policies 205 (page 231), 300 (239), 300.1 (page 246), 307 (page 269), and 720 (page 587) require AYDC to provide multiple educational and vocational programs, ongoing psychiatric and mental health services, consistent family contact, individual and group counseling activities, and substance abuse treatment, as well as many other things. None of this was being provided.
	10. Policy 345 (page 381), 426 (page 493), and 720.2 (page 592) require AYDC to provide youth access to a diet aligned with their religion and religious services. This was not being provided.
	11. Policy 307 (page 269) requires youth receive at least one hour of counseling a week. This was not occurring.
	12. Policy 307 (page 270) also requires AYDC to do family counseling. This was also not occurring.
	13. Policy 720.6 (page 598) requires youth to have access to family visitations and nightly calls with their family. However, this was being greatly denied due to being held in visitation so frequently.