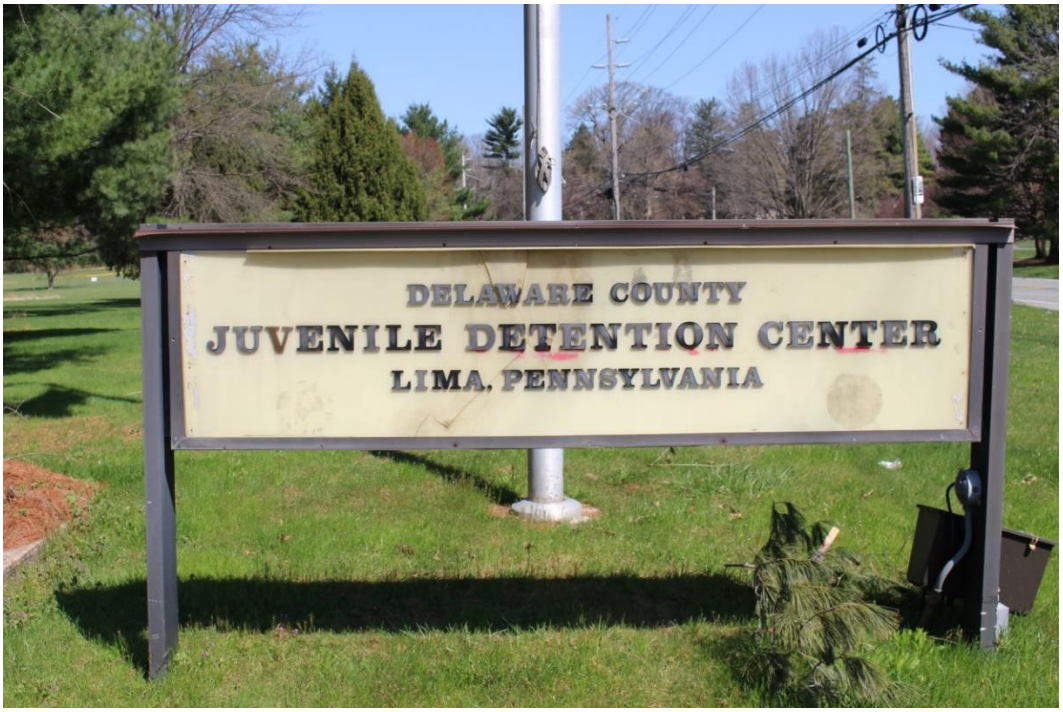
GRAND JURY REPORT ON THE DELAWARE COUNTY JUVENILE DETENTION CENTER AT LIMA ("DCJDC")



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I. INTRODUCTION

It has been said that you can judge a society by how it treats its prisoners. If that is true, then perhaps even more telling is how a society treats its detained juveniles. For they are not prisoners in the traditional sense. They are not criminals serving a sentence. They may have committed criminal acts, even serious ones. But they are at the same time still considered children under the law – often vulnerable, troubled and traumatized – who end up in the juvenile justice system, a primary goal of which is not to punish but to rehabilitate. So if detained juveniles are treated like criminals, if they are assaulted without consequence, if those responsible for them treat them without dignity or respect, such treatment reflects poorly on the society that tolerates it.

For over a year, this Grand Jury investigated the Delaware County Juvenile Detention Center ("DCJDC"), which was shut down in March 2021. While the facility housed fewer than 10 residents at the time of its closing, hundreds if not thousands of juveniles passed through its doors over the past couple decades. If and when DCJDC will reopen is unknown to this Grand Jury, though we know a new director has been appointed and the recently formed board of managers has been holding monthly meetings since July 2021 in anticipation of trying to reopen. We also know that there are 9 other county-run secure juvenile detention facilities currently operating in the Commonwealth, and at least one privately-run facility that

accepts juveniles from counties that do not have a juvenile facility. We hope this report, detailing the collective failure of all those responsible for DCJDC, will serve as a cautionary tale and cause those responsible for the care of juveniles in detention centers to ensure that the treatment their residents receive reflects a society that is humane and hopeful in the ability of adolescents – especially those who come from troubled backgrounds and are, in turn, troubled in their own right – to turn their lives around.[1]

A. The collective failure of many allowed DCJDC to exist like a prison intent on punishment, not reform, and allowed a dangerous, unprofessional culture to pervade.

As explained in more detail in this report, one of the principal goals of the juvenile justice system, as provided for in the Juvenile Act that governs it, is reform, not punishment. It acknowledges the fact that juveniles are not adults and should

[1] As discussed more fully herein, this report, while not recommending criminal charges, makes a number of recommendations for legislative, executive, and/or administrative action that we believe will improve conditions at all juvenile detention facilities in the Commonwealth. Using investigating Grand Juries to inquire into and report on conditions in prisons and other confinement facilities is a tradition that dates back to old English and early American common law. *See Revealing Misconduct by Public Officials Through Grand Jury Reports*, 136 U. Penn. L. Rev. 73, 84 (Nov. 1987) (observing that English grand juries and the late 17th and early 18th centuries used reports to comment on matters of public concern such as maintenance of prisons); *The Voice of the Community: A Case for Grand Jury Independence*, 3 Va. Journal of Social Policy & Law 67, 69-70, 116 (Fall 1995) (noting that early American grand juries devoted a substantial portion of their time to monitoring conditions at public facilities like jails); *Sharpe v. Wike*, 9 A. 454 (Pa. 1887) (noting that grand jury report concluded that the county's jail was unfit and recommended building a new one). It is a worthy tradition that we believe serves the public interest by ensuring that those facilities in which our society deprives its citizens of their freedom operate in accordance with our laws and values.

still be given the opportunity to mature and rehabilitate. In keeping with that mission, juvenile detention centers are not jails. They are not intended to punish. No juvenile is sentenced to serve time in a detention center. Rather, juvenile detention centers house children who, for a variety of reasons, are not able to remain in the general population as they await their adjudication hearing or placement after adjudication. Moreover, the law grants juveniles who are detained certain specific rights, including the right not to be abused, mistreated, or harassed, and to be treated with dignity and respect. That these rights are honored is particularly important in a system whose goal is to assist juveniles in rehabilitating and becoming respectful, law-abiding members of their community.

Unfortunately, our investigation revealed that DCJDC frequently failed to respect its mission, and the rights of the children placed in its care were all-too-frequently disregarded.

Many of the detention officers viewed the juveniles in their care as criminals and treated them as such. The Director himself referred to them as "felons" despite the fact that many of the children there had not yet been adjudicated for any offense, and those that had been were not all detained on felony offenses. As a result of this prevalent view of the residents, the facility both appeared and operated like an adult jail rather than a part of a juvenile justice system intent on rehabilitation.

DCJDC was surrounded by barbed wire fencing, all doors between units were locked, and the residents were brought in and out of the facility in shackles. The juveniles detained there were given only limited age-appropriate activities, and were provided insufficient educational materials or programming. They were too often locked in their rooms for hours on end for no reason other than the convenience of the detention officers on-duty at the time. At the time of the facility's shutdown, many of the residents' rooms were covered in graffiti, often disturbing and profane, which the Director admitted was only painted over once a year for the annual Department of Human Services ("DHS") inspection. Given both the physical appearance of the building and the manner in which it was operated, there could be little doubt in the minds of those juveniles detained there that they were in "kid jail" and that they were criminals.

This impression was further enforced in how many of the juvenile residents were treated. Many of the guards frequently disparaged them and called them names. Some detention staff were violent towards the juveniles in retaliation for something the juvenile said or did. We also heard of numerous instances where male guards behaved inappropriately toward female residents, treating them as potential – and, in some cases, actual – sexual partners rather than as troubled teens in their care. Former residents described being afraid while detained at DCJDC, knowing that they were at the mercy of the detention staff.

This unprofessional, even frightening, culture persisted for so long at DCJDC because detention staff routinely covered for one another. Younger, newer detention officers were taught by some of their older, more experienced counterparts that they could get away with being inappropriate, even violent, because their coworkers would protect them. And they did. Detention staff frequently changed incident reports to conform to one another and make sure the officers looked good. They often "circled the wagons" when a ChildLine report was made regarding alleged abuse to protect the accused officer. Some detention officers retaliated against residents or counselors who made reports against members of the detention staff. In short, too many detention officers took advantage of a vulnerable population – troubled adolescents – and ensured that in almost all instances, the juveniles would not be deemed credible against the word of the detention staff who backed each other up.

Had the facility had a better video surveillance system, one that aimed for 100% coverage of all public areas and recorded on all cameras, we have little doubt that the culture that pervaded the facility would have had to change because detention staff could no longer get away with bad behavior toward the juvenile residents. But, because DCJDC's antiquated surveillance system covered only about 50% of the facility, and less than half of their 35 cameras were recording at any given time, much of the facility, including the residential halls, were in the camera

system's "blind spot." We heard time and again that guards would engage in violent and inappropriate conduct "off camera" so that there was no independent evidence of their actions. In that way, detention officers could cover up for one another because there was no evidence – other than the word of the juveniles considered to be "criminals" – to contradict them. Despite the Director's repeated budget requests for additional funding to update the facility's video surveillance system, the County never approved it.

The physical layout of the building also contributed to the ability of detention staff to cover up abuses. Because the supervisors were not physically on the residential units and were required to unlock multiple doors in order to gain access to the residential units, any response by supervisors to an incident was delayed and the incident could very well be over by the time a supervisor arrived on-scene. With so much of the facility not under video surveillance, and with so little video footage recorded, supervisors more often than not had to rely on detention officers to honestly and completely provide an account of what happened. And while facility policy required all detention staff involved in or witness to an incident involving physical restraint to write a report on what they did or observed, nothing prevented detention officers from not writing a report at all or writing one that conformed with what their co-workers wrote. Few detention officers were ever disciplined for failing

to write an incident report or writing an inaccurate one, despite the fact such reports were frequently the only accounting of such incidents.

Despite the efforts of some DCJDC staff, most notably the mental health counselors, to report incidents of violence or unprofessional conduct by detention staff toward the juvenile residents, these efforts were largely ineffective. Almost without exception, ChildLine reports were deemed unfounded, undoubtedly in part because of the culture of cover-up and the lack of independent evidence to corroborate the juvenile's account. The counselors also depended upon the detention staff to allow them access to the residents, and when the counselors made reports against detention staff, officers frequently retaliated by denying them access. Rather than detention staff and the mental health counselors working together to ensure the best outcomes for their juvenile residents, it instead became an "us versus them" mentality within the facility. The counselors felt so powerless to effect change from within the facility that most ultimately resigned. As discussed below, what they could not achieve from within, they ultimately achieved by providing evidence to the Public Defender's Office, which in turn shed light on the conditions at DCJDC, prompting this investigation.

While it is easy to lay blame at the feet of individual detention officers, that would ignore the role that DCJDC's management, and outside players who had the power to effect change but didn't, played in creating the conditions that persisted for

too long at the facility. Rather than leading from the top and creating a professional culture that understood and respected the mission of the juvenile justice system, the director was uninvolved in the day-to-day operations of the facility and simply "trusted" that the supervisors were running the facility effectively. He failed to recognize what was wrong with the culture and how to fix it. He and his management team certainly failed to institute and enforce mechanisms for accountability such as staff evaluations, consistent discipline for failure to abide by policies, and more robust trainings that could have enforced an ethos of professionalism.

In addition, judicial and county officials were insufficiently involved. They rarely if ever visited the facility. A deputy director with little relevant experience was appointed, over the objections of the director himself. There was no procedure in place for an on-call judge to review after-hour requests for seclusion orders that the facility was required to obtain when it sought to lock a juvenile in his or her room for more than 4 consecutive hours – a restraint mechanism that was intended to be rarely used and only when the facility could not otherwise find a means to calm a juvenile down. As a result, such orders were at times obtained after the seclusion had already been effected, without the proper judicial review and oversight intended by law.

The County Council did not appoint a board of managers to oversee its operations, despite the fact that the law required counties with juvenile detention

centers to do so – a law the County was able to legally ignore due its Home Rule charter, as explained later in this report.[2] And, as noted earlier, the County Council repeatedly denied the Director's requests for additional funds for the video surveillance system.

Perhaps one of the most egregious systemic failures was the abysmal pay the detention staff earned, which was well below that of surrounding counties. As a result of the low pay, DCJDC constantly struggled to hire and retain detention staff. The officers who were hired were often too young and immature or simply lacked the skills to be in charge of troubled adolescents, some of whom were only a few years younger than themselves. Additionally, the low pay and understaffing required an overreliance on overtime, either because the officers needed the extra money or because they were forced to work extra shifts due to staff shortages. As a result, the detention officers were underpaid and overworked. The Director discussed the hiring and retention problems frequently with the President Judge over the years, who in turn repeatedly raised the issue with County officials and urged them to take action

[2] We are aware that the Board of Managers that has now been appointed to oversee Delaware County's juvenile detention population represents a cross-section of the community, including those with experience with the juvenile justice system; meets monthly to educate themselves on various aspects of secure detention; has appointed a director who has prior experience in working with juveniles and, specifically, on preventing teen violence; and has taken active steps to reimagine the physical structure, programming, and approach to rehabilitation that any new detention center in Delaware County would take if reopened. We are heartened to see this new commitment to juvenile detention but regret that it came only after DCJDC was shut down.

in the form of higher salaries. Despite this advocacy, the detention officers' pay was only raised shortly before the shutdown.

This Grand Jury also discovered that there was no adequate statewide mechanism for ensuring against the types of abuses that occurred at DCJDC. DHS regulations enforce *minimum* standards but in no way encapsulate best practices when it comes to enforcing the goal of rehabilitation at juvenile detention centers. As such, there was no incentive for the County to fund a more effective video surveillance system or to provide fair pay that attracted and retained qualified detention staff who believed in the mission of the juvenile justice system. There was no incentive for the facility to paint over the graffiti but once a year or to provide age-appropriate activities that engaged and enriched the juveniles whom the system was supposed to rehabilitate. There was no incentive to ensure that the management of the facility had the experience and commitment to develop and effectuate a culture where juveniles in the facility's care were viewed as troubled kids rather than criminals or sex objects. Short of revoking a facility's license – an extreme response that seems to be rarely used – DHS has little ability to effectively enforce the specific right of children residing in secure detention centers to be treated with dignity and respect and not to be abused, threated, mistreated or harassed.[3]

[3] This Grand Jury is aware that the Shuman Juvenile Detention Center in Allegheny County had its provisional license revoked by DHS in August 2021 and was thus shut down in September 2021. Shuman had longstanding licensing violations and had thus been operating on a series of

The fissures in the foundation of DCJDC that festered and grew over time finally cracked under the pressure of dealing with two particularly challenging residents with significant mental health diagnoses. While the Grand Jury agrees with the opinion expressed by many witnesses that juveniles suffering from severe mental health illnesses do not belong in detention centers, the fact remains that unless and until greater resources are available for such juveniles who become involved in the juvenile justice system, detention centers need to have the ability to safely and effectively detain them. DCJDC did not.

All of the aforementioned factors created a situation where the staff lacked the skills, patience, and mindset to adequately handle these particularly troubled youths: the lack of adequate training; the inability to attract qualified, skilled detention officers; the culture of unprofessionalism and tolerance of violence towards residents; the staffing shortages and reliance on overtime; the willingness of detention staff to cover up for one another; the inexperience and apathy of

provisional licenses beginning in 2019. Based on an unannounced inspection in the summer of 2021, DHS found multiple violations of the regulations relating to health and medication errors, namely that numerous children had not been given their prescribed medications because no nursing staff was on duty or medications had expired. These were repeat violations for which the facility had been previously cited on prior occasions. As a result, DHS concluded that "[t]he amount and seriousness of the medication errors constitutes gross incompetence, negligence, and misconduct in operating the facility, that is likely to constitute an immediate and serious danger to the life or health of the clients." Redacted DHS Revocation Notice dated 8/20/21. Such violations were undoubtedly serious, and Shuman repeatedly violated these and other regulations for years. We note, however, that determining whether staff members have violated a juvenile's specific rights is often more subjective and harder to establish absent corroborative evidence, which, as we set forth in this report, rarely existed at DCJDC.

management. As a result, the juveniles were too often resented, taunted, and subjected to retaliatory violence. Indeed, the situation with one such juvenile escalated so frequently and to such extremes that her detention at DCJDC became the tipping point at which the facility's ability to sustain the status quo finally crumbled.

After hearing from numerous witnesses and reviewing evidence that included photographs and documents, we have concluded that DCJDC was the result of the collective failure of many – from the state's failure to enact and enforce standards that would clearly prohibit the conditions that existed at DCJDC; to the officials who were under-engaged and thus unaware of the conditions that persisted there; to the management at DCJDC who permitted a lack of accountability and professionalism among staff; and to those staff members who created, perpetuated and tolerated that culture. There was, in short, a collective failure to properly care about and for the children who became involved in the juvenile justice system and were detained at DCJDC.

This is all the more tragic when one recognizes that many of the children there were involved in the juvenile justice system because they were products of abuse and neglect in their home life. Rather than providing an opportunity for reform and a different path in life, these children were met with more of the same: abuse and

neglect at the hands of adults meant to care for them. As one former detention officer put it, when it came to rehabilitation at DCJDC, "there was no hope."

Juvenile detention centers need not be this way. We had the opportunity to hear evidence about other detention centers in the Commonwealth that demonstrated a commitment to treating juveniles as adolescents, not criminals. Their physical facilities, the professional culture of the staff, and their commitment to providing the juveniles in their care with engaging, age-appropriate, educational activities and programs, demonstrated that juvenile detention centers can play an important role in achieving the goal of reform.

Nor can be it be said that DCJDC was the way it was because the County lacked funding. In fact, its budget was similar to that of the other two facilities about which we heard evidence. Moreover, DCJDC consistently operated under budget by hundreds of thousands of dollars. In addition, the Commonwealth compensated the County for 50% of the facility's operating expenses. In short, the problems with DCJDC cannot be attributed to a lack of money.

Of course, we the Grand Jury are well aware that not all the juveniles placed at DCJDC were angels. We recognize they were not. Some of the juveniles placed had committed violent crimes. But many were complicated children with mental health issues, substance abuse problems, trauma, and challenging home lives that often caused them to act out in ways that required intervention.

This is also not to say that all the guards and staff at DCJDC were bad actors who abused and preyed upon this vulnerable population. We recognize they were not. Many staff members were simply poorly trained, poorly compensated, overworked, and desensitized to the culture at DCJDC, which tolerated a lack of professionalism and respect for one another and the children in their care. There were also those employees who stayed, despite knowing the way DCJDC operated was wrong, because they still believed they might be able to make a difference, or because they simply needed a job and were between a "rock and a hard place." We heard from former employees who still feel traumatized by what they witnessed while working at DCJDC.

We also acknowledge that not every juvenile who was detained at DCJDC had a bad experience. Some were there for short periods of time and were not impacted by the facility's shortcomings. Some managed to build good relationships with the facility's staff. We imagine that some former residents may even have had relatively positive experiences at the facility.

Nonetheless, while what we describe in this report may not have been experienced universally by all residents, DCJDC as an institution failed in its mission. After years of ignoring the needs of the physical facility, the staff, and, most importantly, the juveniles who were detained there, DCJDC became a place where the residents were frequently viewed as dangerous criminals, not children in need of

help, and were treated as such. While the law in Pennsylvania mandates that one of the primary purposes of juvenile justice is rehabilitation, the reality is often far different, as evidenced by the fact that many actors at all levels who were responsible for the welfare of DCJDC's children turned a blind eye to the disgrace DCJDC had become. The result was an institution this Grand Jury finds was undeserving of the public's trust and an environment where it was simply too easy for child abuse and corruption to fester with little to no consequence.

DCJDC is a cautionary tale for those employed in the juvenile justice system at all levels. While we cannot undo what has been done, we can help to prevent other juvenile detention facilities from becoming like DCJDC. We hope that this report will cause officials in other counties and at the state level to take a hard look at their own juvenile facilities, and to ensure that such facilities, their staff, and the juveniles who reside there are valued and prioritized. The law demands and the juveniles deserve no less.

B. Why the Grand Jury is not recommending criminal charges for acts and inaction at DCJDC.

We believe that the conduct we discovered could potentially give rise to criminal liability in certain cases. And, while we have heard evidence of some specific abuses, we suspect that many more criminal acts may have occurred there at the hands of adults tasked with caring for these juveniles. We also are acutely

aware of a pervasive neglect at the hands of some of those who had the power and responsibility to ensure the well-being of the juveniles detained there.

However, there are several factors that make criminally prosecuting the actions and inaction that occurred at DCJDC unworkable. In some instances, there are statute of limitations problems. In others, we recognize that credible evidence we heard relevant to our investigation and this report would not be part of a criminal prosecution under the rules and standards that apply in such contexts. Additionally, with the passage of time, memories regarding when things happened, how old the juvenile was when the events occurred, and which guards were involved, have faded, making it near impossible for a criminal prosecutor to make out the necessary elements of the criminal offenses implicated.

We are also aware that the standard of proof in a criminal court – "beyond a reasonable doubt" – is significantly more difficult to meet than the standard required to support the findings of this Grand Jury. In many instances, this higher criminal standard cannot be met because, as summarized above and detailed more herein, DCJDC's operations and culture virtually ensured that there would be no corroborating evidence for the criminal acts that occurred within its walls. Those who managed the facility, and those county and judicial officials with oversight responsibilities, permitted DCJDC to operate in such a way that abuse and misconduct could almost never be conclusively investigated. As such, more often

than not, juveniles making allegations of abuse were left with only their word against the word of detention officers. Given their history in the juvenile justice system, and the attendant issues that frequently bring children into that system in the first place (*e.g*., substance abuse, mental health disorders, behavioral issues), the credibility of these juveniles is an easy target – a fact on which the detention officers who committed the criminal acts against them surely counted on.

As a result, while we believe that certain juveniles credibly reported abuse either at the time, or before this Grand Jury, too much time has passed and/or insufficient admissible evidence exists to sustain a criminal conviction.

Furthermore, there is a level of unfairness in attempting to hold certain detention officers – who were poorly trained, poorly paid, and poorly equipped – criminally responsible for individual acts, while those in positions of power to bring about the systemic change so badly needed at DCJDC would not be held accountable under the criminal laws of this Commonwealth.

Instead, then, this Grand Jury intends to shine a light on the abuse and neglect that defined DCJDC for at least the past decade. Given the purpose of this Report – to inform, not to indict – we necessarily de-identify as many individuals as possible. Those whose identities could not be hidden without hiding crucial facts have been provided the opportunity to testify and to add their own comments to our work. Although we have heard stories and have seen evidence that suggests these troubling

conditions existed before 2010, most of what we have heard focuses on the time period from 2010 through 2021 when the facility was closed. Through this report, we intend to expose the systemic failures during that time period that allowed DCJDC to become not a juvenile detention facility intent on rehabilitation, but a maximum security prison for children. We also recommend changes that we believe should be implemented to avoid permitting another DCJDC to exist as it did for so long undetected.

C. Summary of recommendations

While we do not pretend to be experts in juvenile justice or juvenile detention, this investigation has taught us that there are various common sense steps that can and should be taken to ensure against the conditions we saw persist at DCJDC:

Recommendation #1: The legislature should amend the Human Services Code to make the use of boards of managers to oversee the operation of secure juvenile detention facilities mandatory, not optional, for all counties that operate a secure juvenile detention facility. As discussed herein, Delaware County did not adopt an ordinance requiring the creation of a board of managers until months after DCJDC was shut down in March 2021. These boards, which are comprised of citizens, provide an important oversight mechanism and should be required in every county that operates a juvenile detention center.

Recommendation #2: DHS should be required to report allegations of child abuse, indicated or founded reports of child abuse, licensing actions, or incidents involving law enforcement to the county's president judge and juvenile judge(s), the public defender, the district attorney, the juvenile probation department, county commissioners, and the facility's board of managers to ensure full transparency and accountability.

Recommendation #3: The legislature should amend the Human Services Code to give DHS more power to penalize licensing violations, particularly for violations of a child's specific rights enumerated in the 3800-series regulations, through the use of fines and the ability to mandate the initiation of disciplinary action against offending staff members.

Recommendation #4: DHS should amend the 3800-series regulations to impose stricter requirements regarding the use of seclusion. Court orders should be required if seclusion lasts more than 4 hours in a 24 hour period, rather than 8 hours in a 48 hour period. Facilities should also be mandated to document the specific reason for use of seclusion and efforts by the facility to calm the juvenile down and end the seclusion prior to 4 hours. Before seeking a court order, the facility must make a social worker or mental health counselor available to the juvenile to assist him or her in calming down. And the courts in those judicial districts with a juvenile secure detention facility should have an on-call judge available at all times to review such orders.

Recommendation #5: The legislature should direct the Joint State Government Commission to examine and develop best practices for juvenile detention centers. At a minimum, the Commission should consider creating standards for the following: (1) requiring video surveillance coverage approaching 100% of the facility (excluding bedrooms and bathrooms); (2) expanding the list of required training categories and require that such trainings be in-person; (3) creating additional minimum qualifications for management and detention staff; (4) restricting the use of overtime by detention staff to prevent burnout; (5) establishing minimum requirements for age-appropriate educational programming and activities available to juveniles detained in the facility; and (6) creating policies that incentivize staff to fully and accurately report on use of restraints, and grievance policies that give the juveniles a voice without retaliation.

II. BACKGROUND ON THE JUVENILE JUSTICE SYSTEM, DCJDC, AND THE ORIGINS OF THE GRAND JURY INVESTIGATION

A. Rehabilitation, not punishment, is the purpose and goal of the juvenile justice system.

According to the Juvenile Act, the goal of the juvenile justice system includes the requirement "to provide for children committing delinquent acts programs of *supervision, care and rehabilitation* which provide balanced attention to the protection of the community, the imposition of accountability for offenses committed and the development of competencies to enable children to become responsible and productive members of the community." 42 Pa. C.S. §6301(b)(2) (emphasis added). The express purpose of the Juvenile Act is to seek "treatment, reformation and rehabilitation, and not to punish." *In re K.J.V.*, 939 A.2d 426, 428 (Pa. Super. 2007).

Those responsible for administering the juvenile justice system are guided by a balanced and restorative justice model, which balances community protection, victim restoration, and youth redemption. Redemption is sought by both holding the juveniles accountable for the harm they have caused and by teaching the juveniles to live responsibly and productively in the community. The juvenile justice system recognizes that children are not as developmentally mature as adults and should therefore be given the opportunity to learn and reform. A Family Guide to Pennsylvania Juvenile Justice System.pdf (pa.gov)

As such, unlike jails and prisons where adults serve their sentences after being convicted of a criminal offense, juvenile detention centers are not "kid jails." Or at least they are not supposed to be. Juveniles adjudicated delinquent are not "sentenced" to detention centers. Rather, juvenile detention centers are intended as temporary holding facilities for juveniles who are awaiting their adjudication hearing or have been adjudicated and are awaiting a permanent placement, such as a residential treatment facility.

Under the Juvenile Act, juveniles arrested for committing a criminal act are only to be detained prior to an adjudication hearing when the juvenile's "detention [] is required to protect the person or property of others or of the child or because the child may abscond or be removed from the jurisdiction of the court or because he has no parent, guardian, or custodian or other person able to provide supervision and care for him and return him to the court when required, or an order for his detention or shelter care has been made by the court pursuant to this chapter." 42 Pa. C.S. §6325. Juveniles alleged to be delinquent can only be detained in certain facilities as dictated by the Juvenile Act, including detention centers that are supervised by the court or other public authority, and approved by DHS. 42 Pa. C.S. §6327(a).

In addition to pre-adjudication detention, juveniles found to be delinquent can be detained pending the disposition of their case in juvenile court and/or the securing

of placement when the disposition order mandates placement in a residential treatment facility or other similar facility.

According to the 2021 Juvenile Court Annual Report, the median length of stay in a secure detention facility in Pennsylvania was 14 days statewide, and 13 days in Delaware County. Of course, because that number is a median, many juveniles who were detained at DCJDC were detained beyond a two-week period. Throughout our investigation, we heard from former residents who reported having been detained for several months at a time. In addition, documents from DHS show that from March 2020 until DCJDC's shutdown in March 2021, there were 28 juveniles who were detained for 30 days or more, which was approximately 11.5% of the facility's admissions during that time period.

Detained juveniles, including those detained at DCJDC, have specific rights under the law, which include the following:

- The right not to be abused, mistreated, threatened, harassed, or subject to corporal punishment.
- The right to be treated with fairness, dignity, and respect.
- The right to rehabilitation and treatment.

55 Pa. Code §3800.32. Upon admission into such facilities, juveniles and their parents are to be advised of these and other rights, including the right to file grievances without retaliation. 55 Pa. Code §3800.31.

B. Background on DCJDC

DCJDC served as Delaware County's juvenile detention center from 1971 until it was shut down in March 2021.

DCJDC was divided into five "blocks," labeled A through E. Block A was the administrative building, which housed the administrative offices for the director, deputy director, and operations manager; visiting rooms; and a command center known as "the bubble," with monitors for the different video cameras placed inside and outside of the facility.

Block B contained the gym, basketball courts, game room, cafeteria and classrooms.

Block C through E were two-story residential units. Block C had been used as a male residential unit, but was no longer in use at the time of the shutdown due to a burst pipe that left it uninhabitable. Block D had residential units on the first floor; the second floor housed the medical wing, the training officer's office, and the offices for the counselors from the Children Guidance Resource Center ("CGRC"). The first floor of Block E, E1, was the female residential wing, and the second floor, E2, was used to house male residents.

Although DCJDC had the capacity to house 66 juveniles, reduction in the number of juveniles detained had been a goal of the juvenile justice system for the past decade. Accordingly, the courts and juvenile probation department sought to

move kids out of detention and into alternative arrangements pending placement, expedite disposition hearings, and avoid requesting bench warrants for technical violations of the conditions of supervision. Director Mark Murray estimated that prior to the Covid-19 pandemic, the facility's population – which had been as high as 65 kids early on in his tenure – averaged in the low 20s; after the pandemic began, the facility generally housed less than 10 kids. At the time of the shutdown, only 6 juveniles were residing there.

The men and women who worked at DCJDC served in various roles. Management included the director, deputy director, operations manager, and training supervisor. There were three case workers, responsible for liaisoning between the juveniles and their juvenile probation officers, and generally serving as a contact point for the residents as issues arose. There were various shift supervisors who were in charge of the detention officers assigned to the residential units. There were the detention officers themselves who had primary responsibility for supervising the juvenile residents. There was nursing staff at the facility daily. In addition, counselors from CGRC were contracted by Delaware County to provide counseling services at the facility. There were two to three counselors on-site during the weekdays and one on the weekends.

While the administrative staff, nurses and CGRC counselors worked a typical workday, and were generally out of the building by late afternoon or evening, shift

supervisors and detention officers had to be present in the facility 24 hours 7 days a week. They worked in three shifts: 7 a.m. to 3:00 p.m. ("first shift"); 3:00 p.m. to 11:00 p.m. ("second shift") and 11:00 p.m. to 7:00 a.m. ("overnight shift"). State law requires that detention facilities like DCJDC maintain a ratio of 6 juveniles to 1 staff member during the daytime hours, and 12 juveniles to 1 staff member during the overnight shift. 55 Pa. Code §3800.274.

C. The Grand Jury Investigation

1. Origins of the investigation

On March 12, 2021, Delaware County's Chief Public Defender Christopher Welsh and First Assistant Public Defender Lee Awbrey authored a letter to Pennsylvania's Department of Human Services Secretary Teresa Miller, raising their "grave concerns about the health, safety, and well-being of the children in custody" at DCJDC. Their concerns were based on interviews they had conducted with their clients, who had been or were being housed at DCJDC, and former staff members of DCJDC. Mr. Welsh and Ms. Awbrey observed that those interviewed "described inadequate facilities, substandard medical and mental health care, deficient education services, and a culture that fosters secrecy at the expense of the safety of children." Their letter attached affidavits of four current or former CGRC employees who had been or were currently assigned to work as counselors at the DCJDC. These affidavits set forth in detail the basis of many of the concerns raised by the Public

Defender Office's letter. On the same day it released the letter, the Public Defender held a press conference regarding the letter and the concerns expressed therein.

After reviewing the affidavits, and in consultation with other relevant players in the court system, the President Judge for the Delaware County Court of Common Pleas concluded that the only way to ensure the safety of the juveniles housed at DCJDC was to close the facility. He thus directed that the facility be shut down that same day, and it has remained closed ever since.

The Delaware County District Attorney's Office referred the allegations made concerning DCJDC to the Pennsylvania Office of Attorney General ("OAG") in order to avoid an appearance of impropriety or conflict of interest. From there, the OAG undertook an investigation of the allegations raised by the Public Defender's Office, using the authority and power of this Grand Jury to try to determine what problems existed at DCJDC – a taxpayer funded facility, – how it ended up in the state it was in at the time of its closure in March 2021, and whether any crimes had been committed that warranted prosecution.

2. Challenges to the investigation

Our investigation has not been without its difficulties. When OAG agents first attempted to visit the facility, no senior DCJDC staff would return their phone calls to make arrangements for such a visit. As a result, when they visited the facility on April 6, 2021, there were locked doors that could not be accessed without a key,

which no one had. Instead, there was a bag of hundreds of keys and no one knew what they opened. Additionally, while the OAG agents had been told that they could remove documents from the facility, they were required to first photocopy them. Yet, the documents were voluminous and many of the copiers were not operational, making it impossible for the agents to actually take documents with them.

Also at their first visit, the agents discovered that while they had been told no one could enter the building without the Director's permission after its shutdown, the visitor log showed that over 30 people had accessed the building between March 12, 2021 and April 6, 2021. While these visits may have been merely to retrieve personal items, the agents also observed bins outside the administrative offices filled with documents reserved for shredding. There is no way to know, of course, whether anything material to this investigation had been taken or destroyed.

The agents returned to the facility on April 20, 2021, with a search warrant. They had been assured by county officials that no one had been able to access the building since April 6, 2021.

Upon performing a more thorough search of the facility the second time, the agents discovered that employee records were totally disorganized. While some were in the administrative offices, as expected, other files were in the basement with water damage. Agents managed to obtain two boxes' worth of such files. All told,

the agents left the facility with a truckload of documents, as well as computers and other electronic devices.

However, as discussed more below, a review of the files obtained revealed that many of the files were poorly maintained and documents that one would expect to see in there – such as incident reports documenting when a detention officer had to use restraints or justifying why a juvenile had to be isolated in his or her room – were not in the files. Moreover, while we heard from witnesses that videos from the facility's surveillance system were copied and retained when an incident within the facility occurred that required investigation, there were precious few videos found anywhere among the files – paper or electronic. The absence of video is indicative either of the lack of thoroughness of the facility in conducting investigations, or of the management and staff's failure to properly maintain records, or both.

The problem this presents for our investigation is obvious: there is little independent, objective corroboration of what many former staff and residents reported to us. As such, even when we found those reports credible, it is difficult to meet the evidentiary threshold that a criminal prosecution requires, even putting aside statute of limitation issues.

Another problem we faced with some former DCJDC staff who testified before us was a reluctance to talk badly about the facility or its staff out of fear of retaliation. One former CGRC counselor who provided an affidavit in support of the

Public Defender's letter received angry texts and messages from detention officers, and heard that one such officer had asked for the counselor's address so she could go and beat the counselor up. Another witness participated in a recorded interview with OAG agents prior to her Grand Jury testimony and was much more forthcoming in her answers, at one point even saying that if she were to go back to DCJDC, "they would shoot [her]" for revealing certain information about how the detention officers behaved. During her testimony before this Grand Jury, however, she walked back many of her prior statements and painted a much rosier picture of the facility than she had during her interview.

One former detention officer who had been interviewed by the Public Defender's Office and had been asked to sign an affidavit, refused out of fear of retaliation. Fortunately, although he expressed continued concern about repercussions for his cooperation, he testified fully and truthfully before this Grand Jury.[4]

Other former staff of DCJDC provided testimony that seemed less than forthcoming. For example, some detention officers denied knowing about certain unofficial practices that newer detention officers said were commonplace, or portrayed certain supervisors in favorable terms in stark contrast to the description

[4] Given the concerns of many witnesses over retaliation, we have tried, where we could, not to name individual witnesses.

provided by a majority of witnesses. It is certainly plausible that some of these inconsistencies resulted simply from the witnesses' differing perspectives and experiences. However, we have little doubt that some witnesses withheld information, either out of fear of retaliation from their co-workers or to protect themselves and their former colleagues from being implicated in the very behaviors that made DCJDC the failed institution it had become.

Despite the various challenges this investigation faced, they have not prevented us from gaining a clear picture of the manner in which DCJDC was operated for at least the past decade. We are still able to determine that DCJDC failed at its core mission: to detain juveniles in a safe environment consistent with the goals of the juvenile justice system.

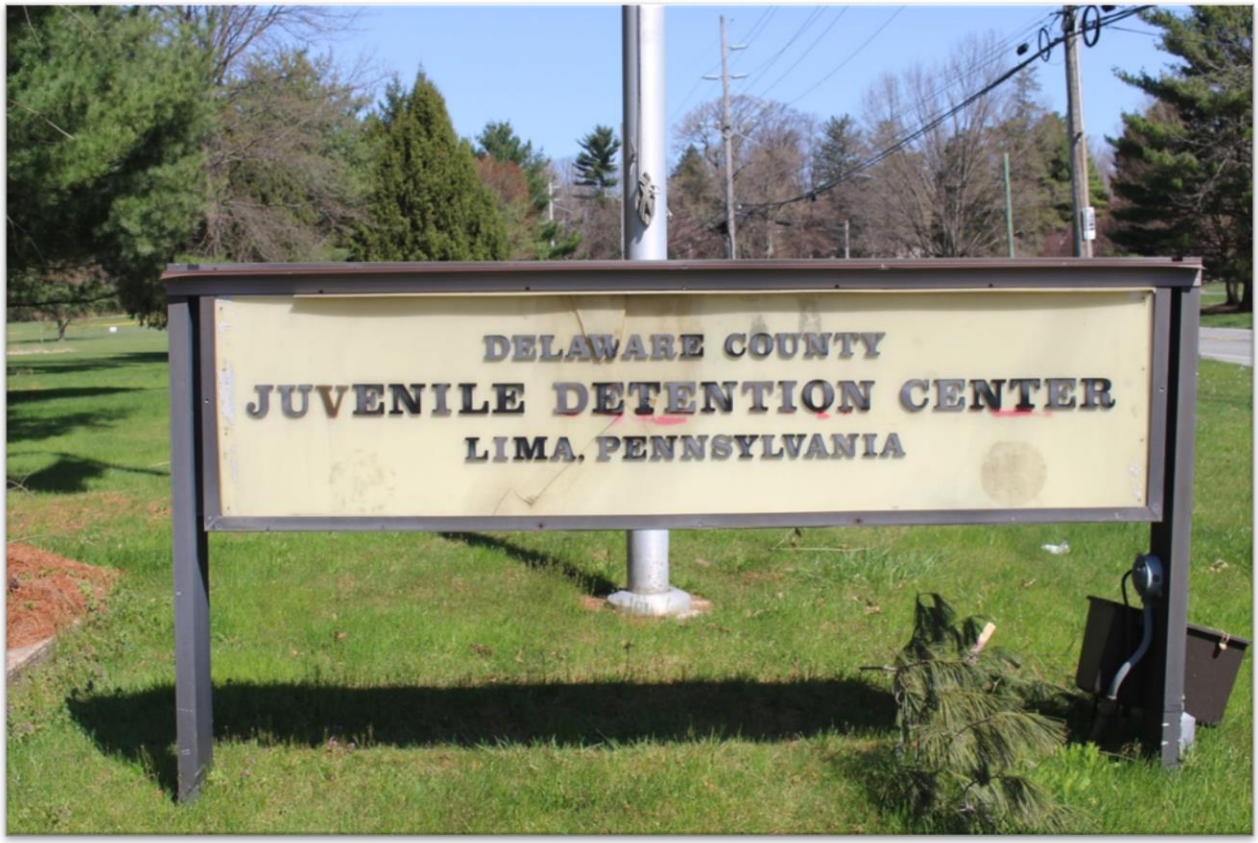
III. DCJDC WAS A "KID JAIL" AND THE JUVENILES "CRIMINALS."

A. Prison-like features of the facility

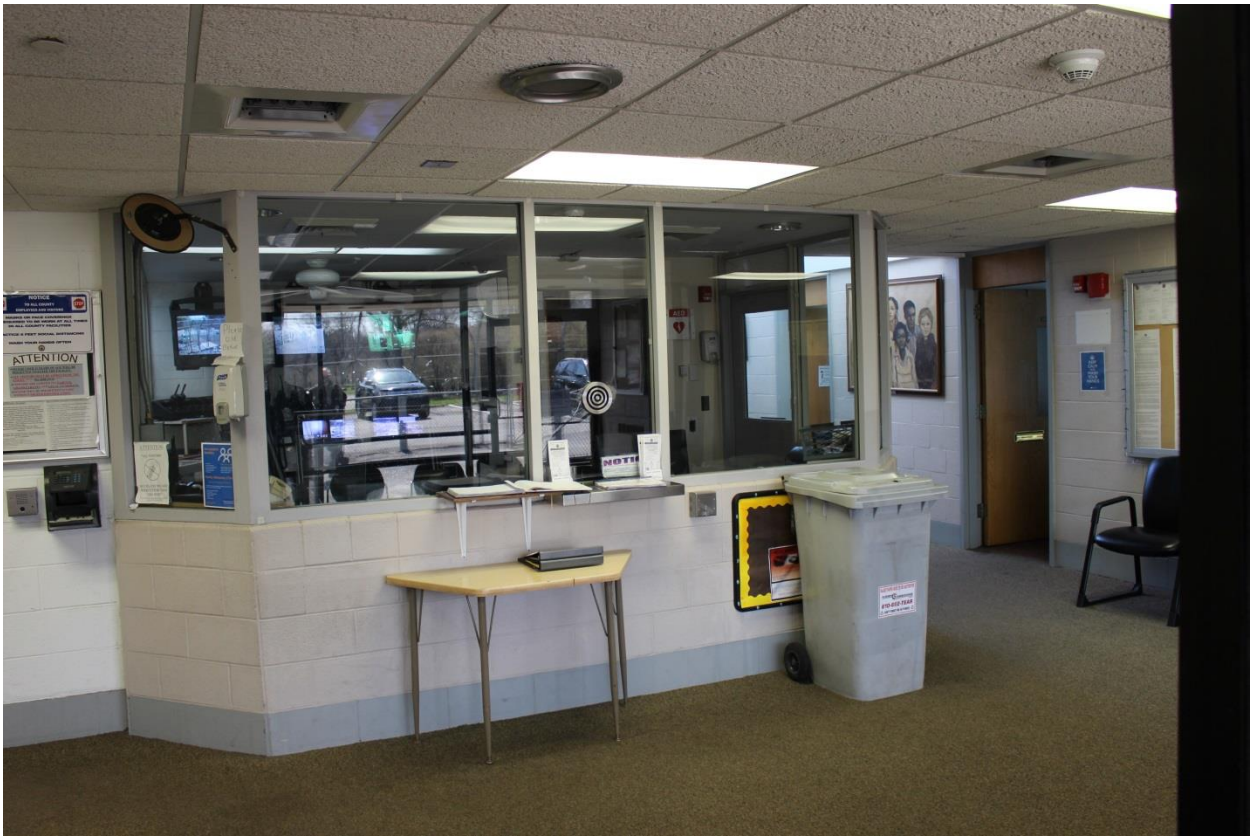
Mindful of the fact that juveniles who are detained are detained for a reason, we still did not expect that detention centers that house children as young as 10 years old would look and feel like a prison intended for adults sentenced for serious criminal offenses. Yet, the physical facilities at DCJDC closely resembled a highly secured jail or prison. It is surrounded by fencing on all sides, which are sensored and shaped to make climbing extremely difficult in order to prevent escapes. Juveniles are transported in and out of the facility in shackles through a sally port.

Each block and unit had locked doors, such that one could not move from unit to unit without passing through several.

The residential units where the juveniles spent much of their time are concrete cell blocks. The floors and walls are concrete. The rooms are concrete as well, and contain a concrete bed, metal toilet and sink. The mattresses are thin and made of plastic, similar to what you would see on an outdoor lounge chair, providing little comfort or support on top of the hard concrete slab that served as the bed. One former detention officer said that the mattresses were so thin, he would try to secure



additional mattresses for kids as a type of reward for good conduct, but that it was not always possible to do so.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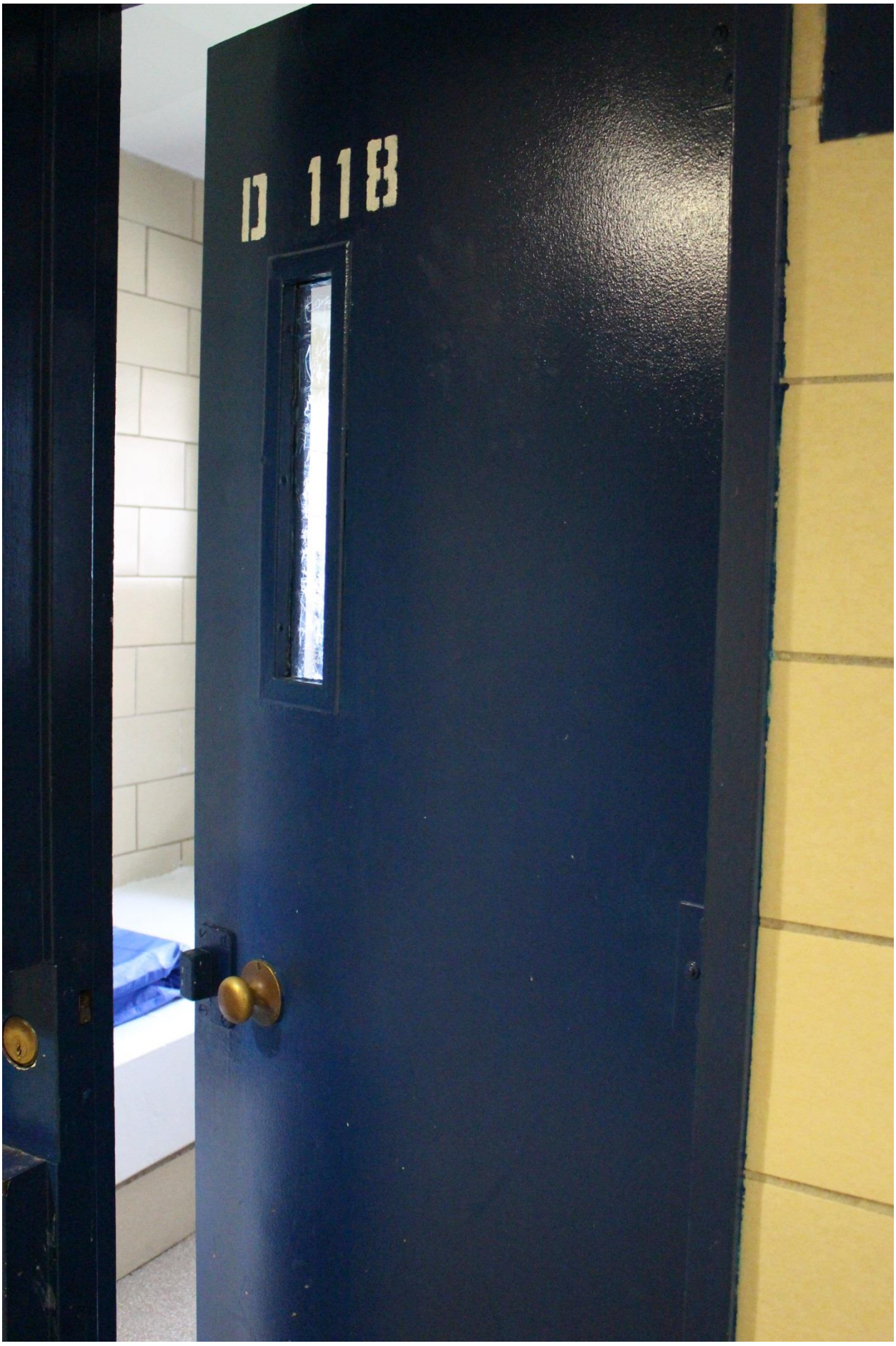
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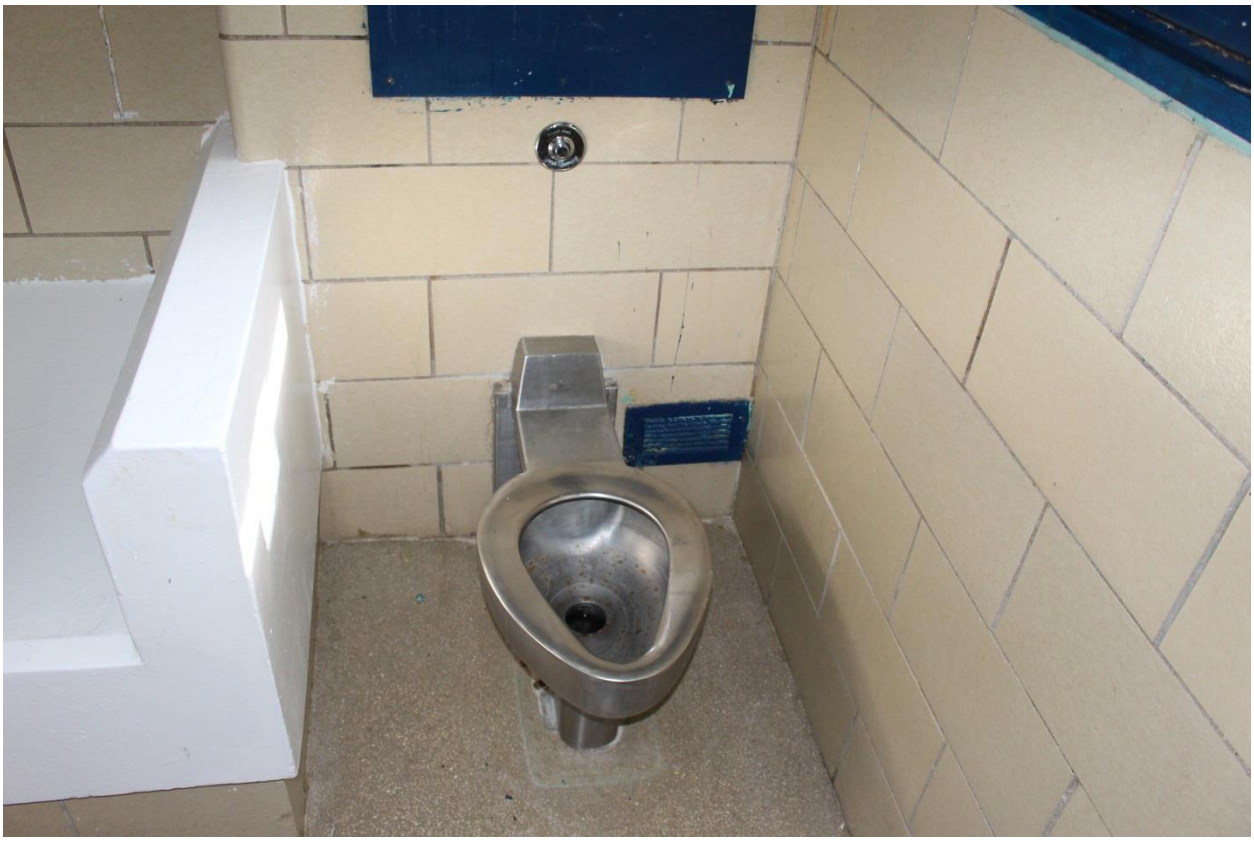

Both inside and out, DCJDC did not appear as a facility which housed adolescents – many of whom had not yet even been adjudicated delinquent and none of whom were serving a sentence. Rather, as one former CGRC counselor described it, DCJDC was like a "maximum security prison," that was "totally inappropriate for children." Even Director Murray testified that when he first saw the facility, upon becoming its director, he thought it looked like a "small prison."

B. <u>The children were viewed as criminals.</u>

The fact that DCJDC resembled a prison likely contributed to the fact that the children housed there were all too often viewed by staff as criminals. Director

Murray testified to his belief that all of the juveniles detained there were "felons," mistakenly insisting that only children arrested for felonies could be detained there. Yet, he also acknowledged that some were there for infractions of their supervision plan, and that dependent children – whose only crime was that they had no other place to live – were also occasionally placed in the facility.[5]

Not only is it troubling that the director of the facility did not understand the law, but the fact that he viewed children, some possibly as young as 10 or 11 years old, as "felons" speaks volumes about the mentality and culture at DCJDC. This was not just a slip of the tongue during Director Murray's testimony. One former CGRC worker told us that Director Murray did not view the purpose of his facility as rehabilitative, but in fact saw it as a punishment. Director Murray confirmed that opinion during his own testimony when he said that the purpose of DCJDC was not rehabilitation because it was a short-term holding facility and that most kids were released within 48 hours of detention.

[5] Director Murray and other DCJDC staff members indicated that there were occasionally dependent juveniles housed at DCJDC, something that if it occurred would be illegal. However, other witnesses, such as Danielle DiMatteo, the Director of Juvenile Court and Probation Services, denied that dependent juveniles were housed at the facility, though she said that occasionally juveniles detained on a "minor witness warrant" could be. The Grand Jury has not been presented with any evidence to corroborate that dependent juveniles were housed there, how many, and when, if ever, it occurred. Nonetheless, it is clear that to the extent children were housed at DCJDC for reasons other than delinquency, there was no separation of them from the juveniles detained there for delinquency. They were housed in the same residential units and partook in the same routine as all other juveniles detained there.

This, of course, ignores both facts and law. While it is true that many kids were released after only a short stay, others stayed for much longer, sometimes months at a time awaiting placement. Moreover, a primary purpose of the entire juvenile justice system – of which juvenile detention centers are a part – is reform and rehabilitation. Nothing in the law exempts juvenile detention centers from this goal. While it may look different at a detention center than it does at a longer term residential facility, reform and rehabilitation, not punishment, are still the guiding principles. Certainly, detention centers should not serve to undermine the goal of rehabilitation, which, as discussed in this report, DCJDC frequently did. As one former CGRC counselor observed, the kids who ended up there came in with trauma and the detention center only traumatized them more.

Unsurprisingly, Director Murray's view of his juvenile wards was not unique to him. The same former CGRC counselor explained that the mindset of the detention staff generally was that the kids were criminals and they were treated as such. This was corroborated by former detention officers. One testified that many of his coworkers viewed their juvenile wards as "sub-human," and had heard other guards call them "criminal" and "pieces of shit." Another said that, even in training, the attitude was that they were dealing with violent criminals. And a third former detention officer, who had worked at DCJDC for approximately one year prior to its shutdown, told us that she did not know and had never been taught that the juveniles

in her care were not serving a sentence for their crimes or that a primary goal of the juvenile justice system was rehabilitation.

One former juvenile resident had been detained at DCJDC at least five times beginning when he was 10 or 11 years old. The first time was for terroristic threats and he recalls being there between 6 and 9 months as he waited for a mental health placement that could address his anger issues. He testified that the guards treated the juveniles like they were "scum" and "trash." He believed that the guards could do whatever they wanted and get away with it. This juvenile testified that "It's like they forgot that [we] were kids at the end of the day. They just see criminals and criminals only."

C. Maintenance and appearance of the facility

The manner in which the building was maintained serves as a powerful reflection of the way in which the juveniles housed there were viewed. Both staff and residents complained that it was generally filthy, with mold and mildew throughout. While the facility had janitorial staff to clean the administrative block, main bathrooms, and the gym area, the residents and staff were responsible for cleaning the residential units themselves.

There were bugs and rodents as well. One former CGRC case worker recalled that kids complained to her about bugs coming out of their sinks. They also complained about the bugs to their teacher and would sometimes bring bugs into

class in Dixie cups. One former detention officer recalled there was a wasp's nest in one of the residential units and when he reported it to a supervisor, he was given a can of Raid and told to spray it.

One persistent problem with the building was the plumbing. Director Murray referred to the plumbing as the facility's "biggest nemesis." Many former staff members noted that when juveniles acted out, they could and would flood their rooms by blocking up the sinks and toilets. But even more problematic was the fact that the plumbing was antiquated. Shower drains would back up. Sometimes the water would come out brown. Toilets or sinks within rooms were often not operational. One former female detention officer recounted that when a new female juvenile entered the facility, the staff frequently would not know where to put her since the rooms were in such disrepair. They would have to choose between a room without a working toilet or one with a broken sink or a dim light. Other detention officers corroborated this complaint, noting that about half the rooms were uninhabitable such that when there was a spike in population, the staff would have to place kids in a room without a working toilet or sink.

Another frequently reported problem was with the heating system. Numerous witnesses testified that it was frequently so cold in the facility in the winter months that they would have to wear coats inside the building while they worked. The juveniles who were detained there did not have access to extra layers of clothing,

however, and complained to staff that they could see their breath at night. When staff complained, they were told by management that the temperature of the facility was controlled by the courthouse in Media and that there was nothing they could do about it. Only after one CGRC counselor made a ChildLine report regarding it, did the heat get turned up.

But perhaps the most telling and disturbing issue concerning the condition of the facility was the appearance of the residents' rooms, which many witnesses referred to as "cells." Photographs taken shortly after DCJDC was shut down in March 2021 reveal that the condition of many of the residential units in use at the time, particularly the E2 unit used to house male juveniles, was abysmal. The paint on the concrete floors was worn away in most places, and the white concrete walls were dirty and stained. Toilets were filthy and there was at least one sink that was clogged and filled with dirty water. Worst of all, the doors, windows, walls, floors

and even ceilings of many of the rooms were covered with graffiti, including profanity and references to killing, suicide, and rape.


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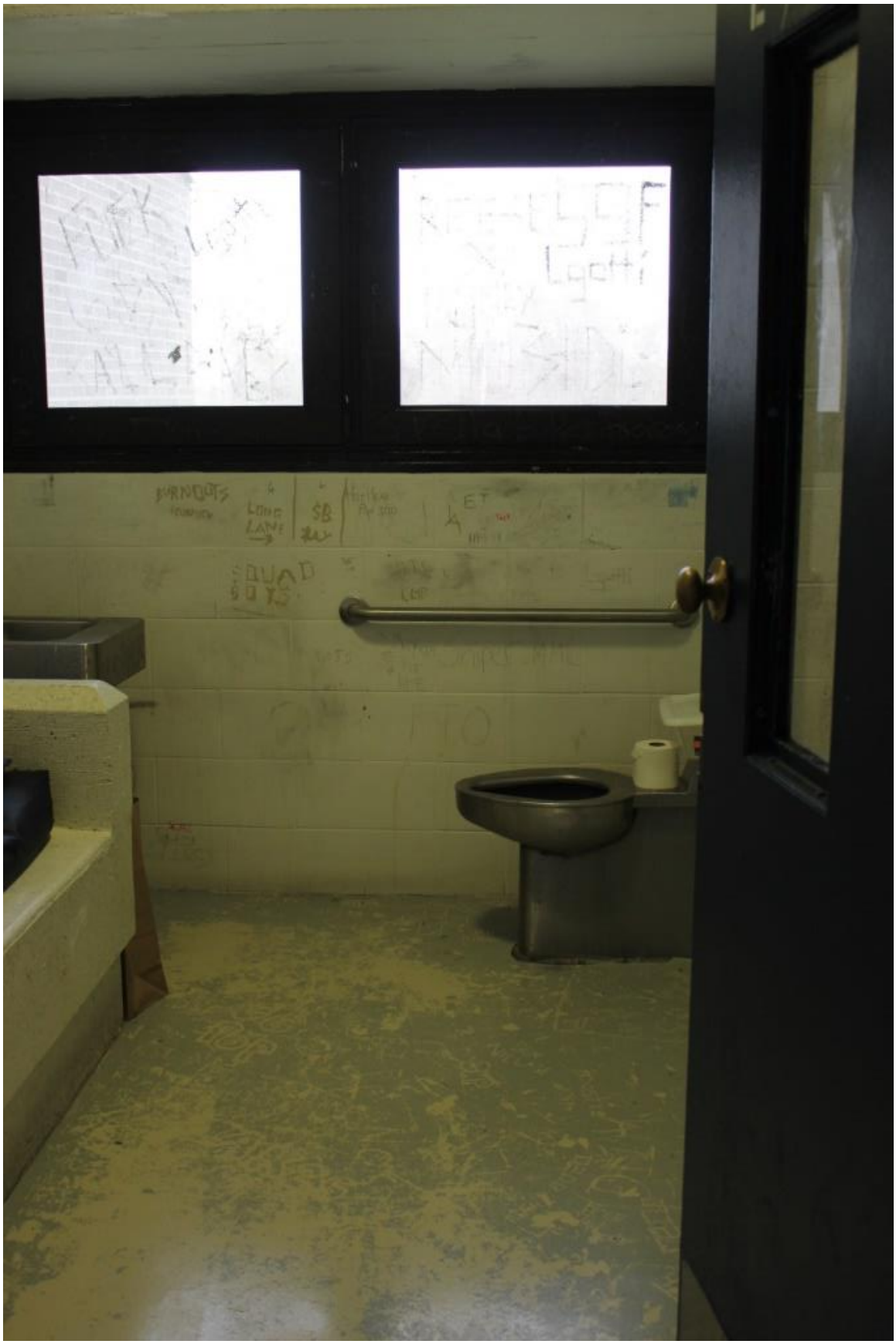
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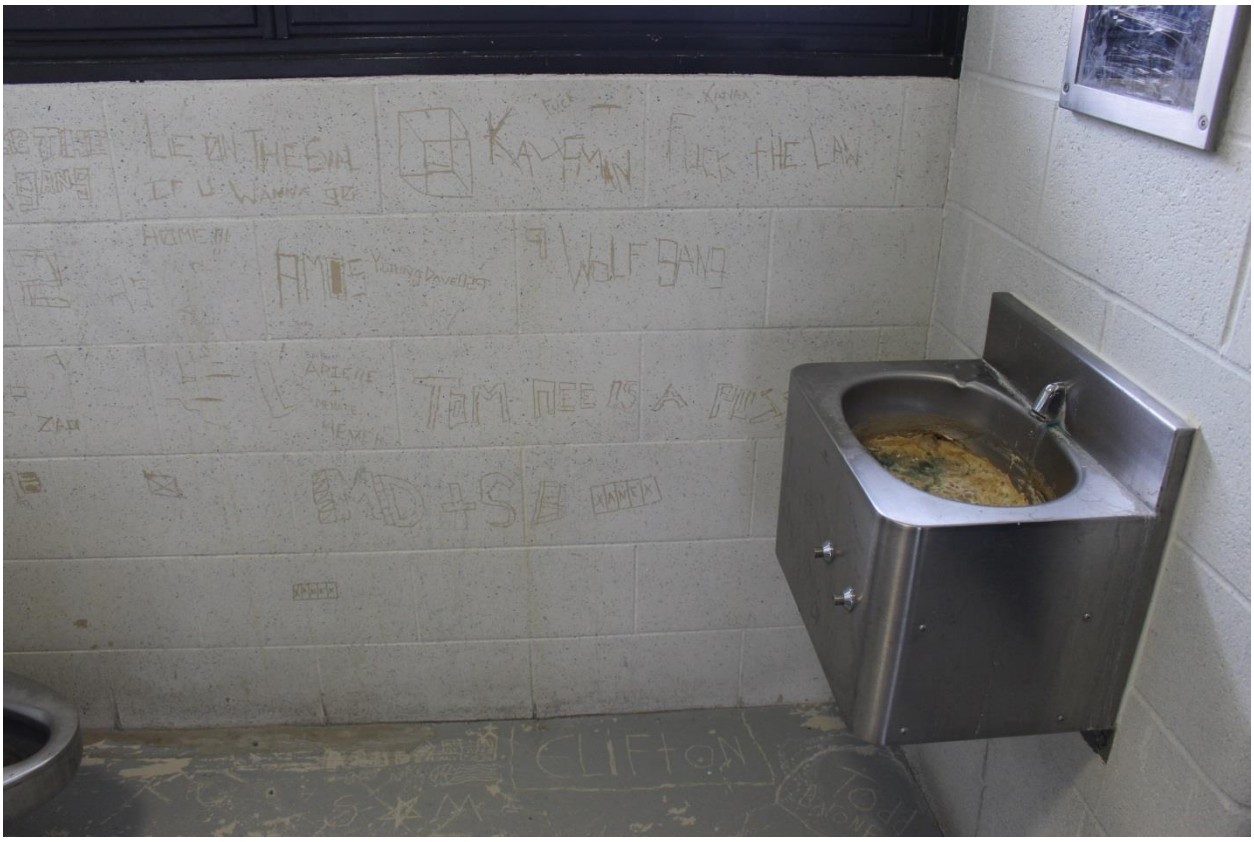
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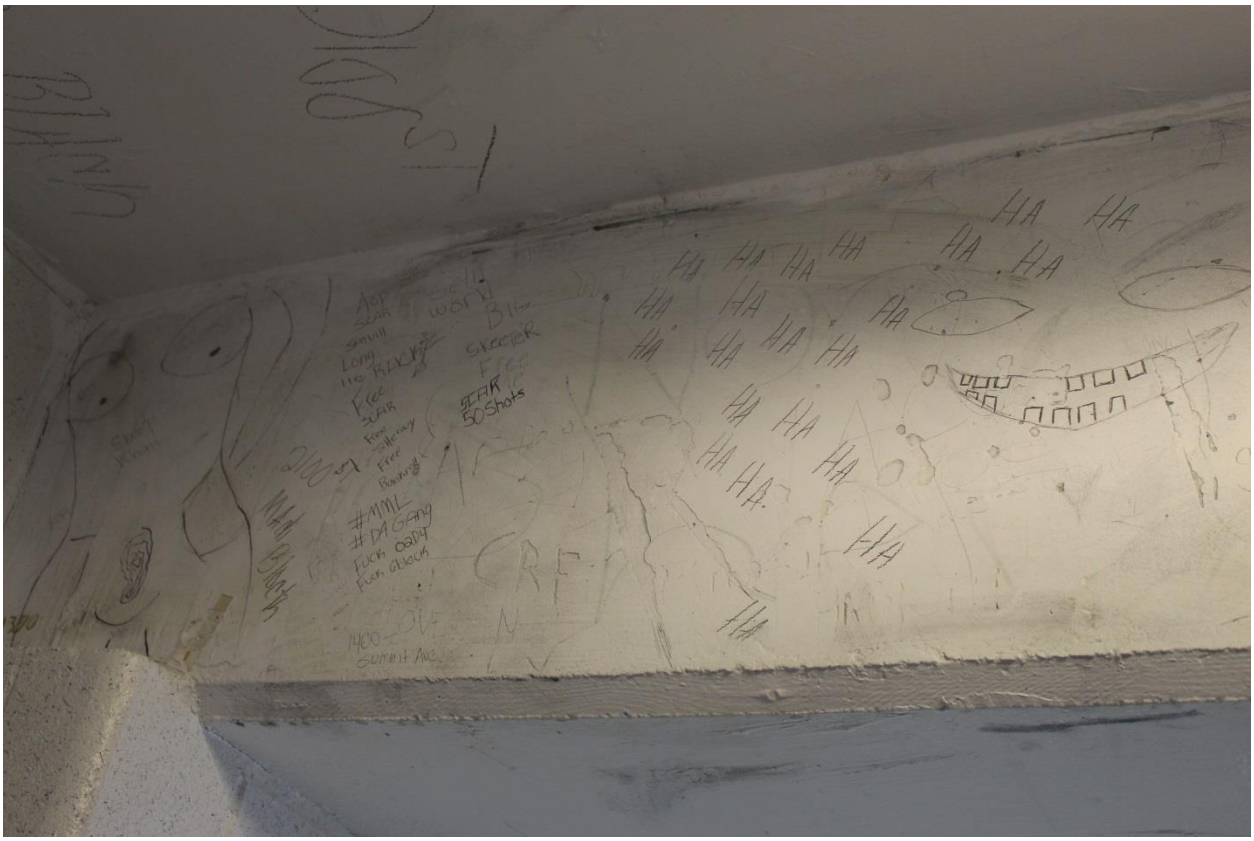
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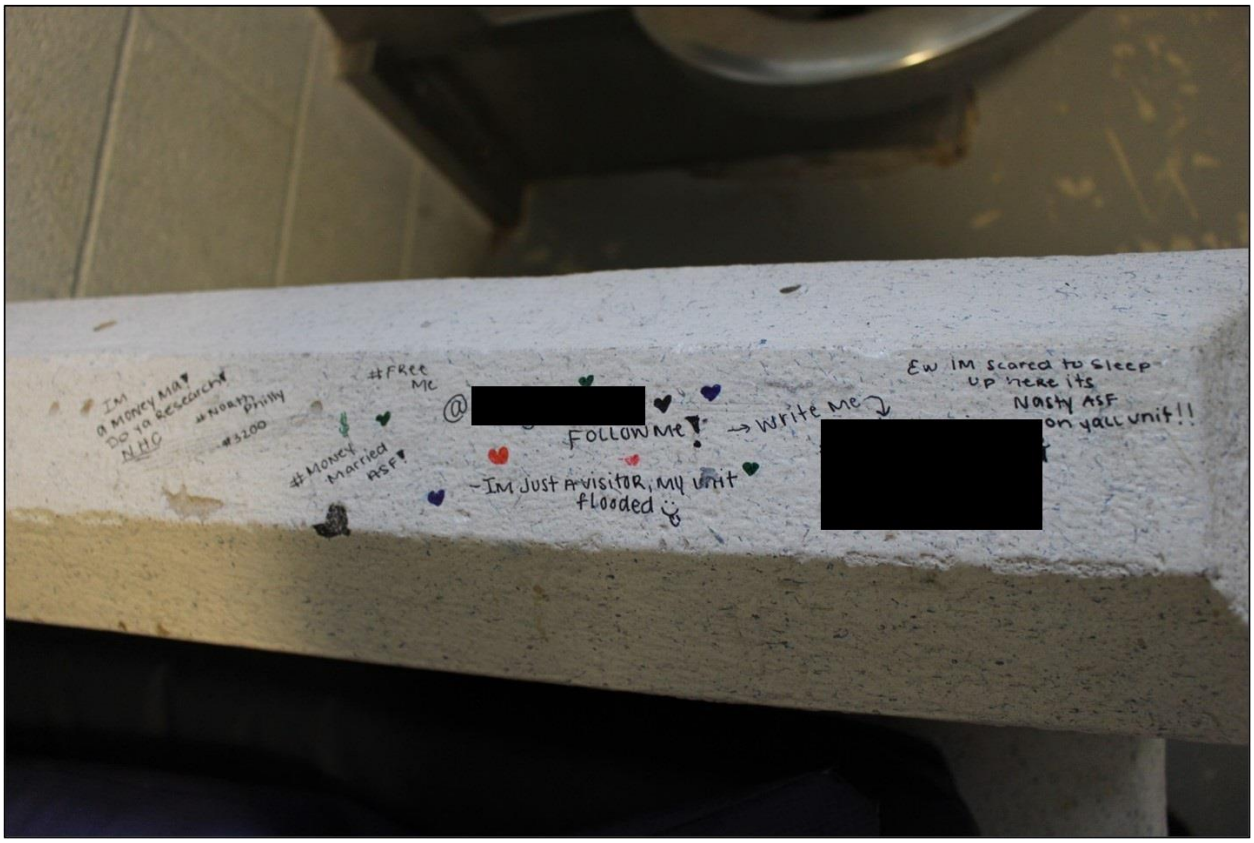
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Not only were we the Grand Jurors appalled to learn that kids lived and slept in these rooms in that condition, but so were most of the outsiders who testified before the Grand Jury and who were not aware of the level of graffiti that was permitted to go unaddressed. Danielle DiMatteo, Chief of Juvenile Court and Probation Services in Delaware County since 2011, testified that she was not aware of the rampant graffiti and called it a "disgrace." Director Caitlin Robinson of DHS' Southeast Regional Office, which oversaw DCJDC, testified that had she observed that level of graffiti in the facility during an inspection, she would have considered it a violation of the juveniles' rights and required corrective action.

Unfortunately, while those who had been previously unaware of the graffiti problem were generally shocked by it, those who worked in the facility were not. None of the former staff of DCJDC who testified during this investigation considered the level of graffiti a problem. They were either unaware of it because they did not regularly visit the residential units, such as the CGRC counselors and the facility's case workers, or they considered it normal.

Director Murray expressed his belief that the facility did all they could to address the graffiti problem. He testified that they would paint the rooms every year in time for their annual DHS inspection, but that as soon as it was painted, the graffiti would just start all over again. He said that while they would try to hold the residents accountable for it, the juvenile frequently would have already left the facility by the

time it was discovered, or it was not worth antagonizing the juvenile responsible and causing tension between the juvenile and staff.

All maintenance requests had to be made centrally to the county government in Media. All witnesses agreed that the response to such requests was slow and inconsistent. It frequently took weeks for maintenance to respond. Sometimes staff would have to put in multiple requests before a problem got addressed. In addition, it appears that maintenance was not relied upon for painting the facility for reasons that are unclear. Director Murray explained that DCJDC used to have an on-site maintenance worker until he retired several years ago, but that he was apparently allergic to the paint fumes, so would not paint. Instead, it was up to the staff and occasionally people required to perform community service to do the painting. As a result of this operational problem, in addition to the defeatist attitude Director Murray expressed that there was little to be done other than paint once a year, the rooms the juveniles resided in while in DCJDC were littered with graffiti that, among other things, said "rape me," "suicide," "fuck," and "kill me." Considering that Director Murray was under the impression that dependent children were sometimes placed in the facility, and knowing that dependent children would not be separated from delinquent children while there, his tolerance of the graffiti specifically, and the physical condition of the building generally, is difficult to comprehend.

Given the physical condition of the building, it is hardly surprising that one former detention officer described the DCJDC as a "very depressing" place. Another observed that the psychological effect of a facility that looked like DCJDC on the juveniles entering it was to make them feel sub-human, like "a caged animal." As one former CGRC counselor observed, the kids believed they were "bad kids" because they were put in a place like DCJDC. Sadly, as the former detention officer noted, "If you're made to believe you are that way, you will become that way." And as a former juvenile resident of the facility commented, "[T]o send a kid, especially an 11-year old, to a jail and treat him like a prisoner and think it's going to help him be better, it is not. All it does is just make them angrier."

D. <u>A plague of boredom and inactivity</u>

In addition to the appalling physical conditions at DCJDC, many witnesses reported that the facility offered little to engage the residents there. The official daily program prior to the Covid-19 pandemic included morning and afternoon school sessions. However, based on the testimony of several witnesses, the times the kids were actually taken to the classroom appeared haphazard. Staff would not always bring the juveniles to the classroom as required, either because there was an incident on the unit or, according to one former juvenile resident, because the staff simply thought the teacher was annoying.

The residents were grouped by age, not academic skill, and the school work was therefore frequently below the juveniles' actual grade level. After the pandemic began in 2020, the facility switched to virtual learning and the teachers were not specialized but taught all subjects as needed regardless of their training. The juveniles remained on their residential units and were given homework to do which, according to the same former resident, was too easy and therefore boring. In the opinion of one former CGRC counselor, "Education didn't happen there." This was echoed by a former detention officer who said that schooling was "abysmal" even before Covid-19 and after Covid-19, nonexistent.

Two former CGRC counselors also reported that the residents complained of being bored. They were not permitted many items in their rooms, including pens or pencils, so they had nothing to do while there. Former detention officers corroborated this. There was a common area or "day area" on the residential units that had a television, some board games and playing cards; and one unit, for the kids who had earned the most privileges, had a video game system. But, as one former detention officer reported, there was little tempting to do in the common areas because the books were old and outdated, the puzzles were missing pieces, and the board games were not age-appropriate and were missing parts. As a result, the residents spent most of their time in their rooms doing nothing.

The residents would frequently beg to go to the gym for recreational time, but were only allowed one hour per shift, and the detention staff did not always allow them even that much time. As one former resident of DCJDC explained, if the detention staff didn't feel like taking the juveniles to the gym, they didn't go. While there was also a recreation room for the kids, one staff member testified that almost everything in there was broken. The ping pong table was held up by crates; the pool table cloth was ripped and the pool sticks broken; the air hockey and pinball machines could not be turned on.

Two former case workers, who each had been at the facility for over ten years, testified that the prior director had brought in programs and visitors from the outside to occupy the juveniles, but that changed when Director Murray took over. One former CGRC counselor testified that when the residents got bored, that led to trouble, so she and her colleagues would set up activities for them, such as painting. But whether or not the residents were able to participate depended on the detention staff.

One witness who had been detained at DCJDC on three separate occasions said that after the Covid-19 pandemic there was no schooling and that the staff "really never wanted to do nothing but keep us in our rooms." She testified that she missed having school because there was too much free time and the residents would get anxious and fight. Another former resident of DCJDC, who had been there on four separate occasions between the ages of 15 and 17, once for as long as four months, reported that he would get depressed having to spend so much time in his room with nothing to do but read or sleep. He said it gave him too much time to think about why he was there, which upset him.

The end result of both the physical state of the facility and the lack of engaging activities available to the juveniles there is that no reform or rehabilitation was going on. In fact, the goal of rehabilitation was undermined because the juveniles were made to feel like criminals who the system had given up on. While we certainly do

not expect a detention facility to offer the same types of programming as longer term residential facilities, we also did not expect that such facilities would become destructive way stations on a juvenile's path toward rehabilitation in the juvenile justice system. Yet, that is what DCJDC effectively became.

IV. A CULTURE OF UNPROFESSIONALISM, VIOLENCE, SEXUAL MISCONDUCT, AND COVER-UP

The detention officers and their supervisors were on the front-line of overseeing the juveniles detained at DCJDC. As we learned over and over again from witnesses, regardless of what policies and procedures were in place, they were only effective if the detention staff chose to abide by them and/or there was effective oversight to ensure that they did so. Unfortunately, what we also learned is that all too often staff did not abide by the policies and procedures and there was no effective oversight to ensure their compliance. The result was that staff could engage in conduct that was at the very least highly unprofessional and led to a culture where a juvenile's treatment depended on the whims and competence of the staff assigned to his or her unit on any given day. As one former resident explained, "[I]n that situation and in that place and time, you don't have power. They do."

A. Culture of unprofessionalism

What the detention officers "got away with" ran the gamut. We frequently heard from former staff and residents of the facility that the detention staff cursed at residents and often threatened them rather than de-escalating situations. Along those

same lines, one former detention officer recounted that LGBTQ juveniles were bullied by the detention staff, who called them "faggots." He also testified that one of the shift supervisors referred to a particularly challenging resident with mental health issues as a "dirty bitch" and "nasty-ass skank." A former case worker reported that she twice made a ChildLine report against detention staff because two residents made credible reports about being bullied by the staff. Both were deemed unfounded by DHS, however.[6] In September 2018, there was a report made against a detention officer for calling a 14-year-old boy a "pussy" and "little bitch" when he got upset about having to take a test at school. The teenager got so upset at the detention officer's comments, he ended up punching a window, injuring his finger as a result. One former CGRC counselor heard detention staff call juveniles "bitches" and refer to them as "faggot" or "retard." She also had several boys report to her that guards threatened to "fuck [them] up." And a former resident reported hearing a detention staff tell another juvenile after they argued that he would pull a gun on him the next time he saw him on the streets of Chester.

This type of disrespectful behavior is reflective of the view of many detention staff that the adolescents in their care were criminals. Additionally, it is also a consequence of the inexperience and immaturity of many of the detention officers.

[6] An unfounded report is one in which the agency determines that the alleged abuse did not occur or that there is insufficient evidence to move forward with the investigation.

As one former detention officer explained, the staff took things personally and held grudges because they knew the kids from the neighborhood and were often not that much older than the juveniles they were paid to care for. This was echoed by another former detention officer who observed that many of her co-workers acted like they were in high school themselves. If a juvenile was upset and yelled, detention officers would often yell back and argue with the juvenile. A former case worker from the facility agreed that working in the facility was difficult, especially if one had no prior experience and was a young person dealing with older teenagers.

B. <u>Culture of violence and cover-up</u>

While immaturity and inexperience can explain some of what we heard regarding detention staff's treatment of the juveniles in their care, we also heard of incidents where detention officers' misconduct went beyond mere cursing, name-calling, or threats. One former juvenile, who had been at DCJDC three times between the time she was 15 and 18 years old, testified that the detention staff did not stop fights between the residents but would instead let the kids "rumble it out." She recounted one particular incident where a female juvenile, who herself was bullied by the staff, got into a fight with another resident and the staff allowed it to continue until the other resident started banging the girl's head into a window. She also recalled seeing a male juvenile playing basketball in the gym when a male detention officer grabbed him and slammed him against the wall, causing him to hit

his head. Not surprisingly, this resident testified that when she was at DCJDC she "didn't feel safe at all."

Another former resident testified that when he was 14 or 15 years old and detained at DCJDC, he was assaulted by several detention officers during an incident that began when he wanted to leave the gym after being kicked off the basketball court by some other kids. Detention staff refused to allow him to return to his room and the teen lost his temper and started throwing the basketball against the glass. Detention staff lifted him by his arms and legs, forcibly removed him from the gym, and, once they were outside in the hallway, they dropped him to the ground and assaulted him. The resident reported it to his case worker, showing her his bruises, and she filed a ChildLine report.

Prior to Children and Youth's investigation, the detention staff responsible for the assault was especially nice to the teen, giving him extra privileges. But when the resident told them it would not change his account of their assault, they changed their tune. The staff members told him it did not matter because he was a criminal and no one would believe him. They began calling him a "snitch" and a "rat." They would "forget" to take him to meals, toss his cell ostensibly looking for contraband, and write him up for made-up infractions so he would lose privileges. The teen finally recanted his story, hoping it would make life at DCJDC more bearable. He

also had no hope that anything would happen as a result of the investigation, and he was right: nothing did happen to the detention staff involved.

Another former resident, detained at DCJDC on four separate occasions, recalls one detention officer slamming him into a table and punching him after the officer said the resident grabbed a pencil out of his hand. On another occasion, when staff were separating this teen and another resident after a fight, one of the detention officers escorting him from the gym slammed him into a table and choked him for being too loud. Two other detention officers had to pull the officer off the teen. This resident also testified that he once saw another juvenile with cuts on his face and when he asked what happened, the juvenile explained that he was talking back to a detention officer and the officer came into his room and fought him.

Another male resident who was interviewed by the OAG agents as part of this investigation reported that he was beaten numerous times while detained at DCJDC. He explained that the guards would wait until the kids were in the showers where there were no cameras. He recounted one specific instance where, after this resident argued with one detention officer, a couple of officers surrounded him in the shower, beat him and threw him to the ground cutting his right elbow. He still has a scar there to show for it.

While it would be easy to dismiss the reports of these former juvenile residents as the accounts of "delinquents" – and, in fact, that is what the detention staff who

participated in such violence relied upon – their testimony was consistent and credible. Similar incidents were also provided by former DCJDC staff members. One former CGRC counselor recalled a juvenile telling him that during an argument with one of the detention officers, the officer slapped or punched the boy. Another CGRC counselor observed a female juvenile with bruises on her face from reportedly being punched by a detention officer.

Particularly illuminating to this Grand Jury was the testimony of one of the more recently-hired male detention officers, who worked closely with the detention staff and residents and knew enough to be shocked by what he observed.

This former detention officer, who began his employment in early 2020, described a culture wherein the detention staff got to do whatever they wanted. The older, more experienced officers even reminisced about the good old days when they could get away with much more and required less cover-up. He recounted certain of his co-workers entering a juvenile's room and "whaling on them with their fists," or locking kids in the bathroom together and forcing them to fight. On one occasion, while helping to break up a fight between juveniles, this detention officer saw another officer grab the youngest juvenile, a 14-year-old boy, push him against a wall and choke him, while the supervisor stood by and did nothing. In another instance, this same detention officer approached his supervisor about the need to discipline a juvenile who had threatened violence against him over pizza, and the

supervisor asked the officer if he wanted to go into the juvenile's room and "fuck him up."

This detention officer had been repeatedly told by other detention staff that there was a "no snitch" policy and that if he wanted to hit a kid, the other officers would "have his back." Even though the detention staff were mandated reporters, required by law to report child abuse to ChildLine, this detention officer testified that the unofficial policy among detention staff was not to report anything to ChildLine, but instead to let the supervisors handle matters internally. In fact, when he attempted to report some of the disturbing behaviors he witnessed on the part of his fellow detention officers, he was told by his supervisor not to worry about it. After that, he got labeled a "snitch" and so stopped complaining.

This mentality was enforced among the residents as well. If a staff member assaulted a resident, he would threaten the juvenile as to what would happen if the juvenile "snitched." If the juvenile filed a grievance against the staff member, the staff would retaliate by, for instance, not letting the juvenile out of his room that shift. One former CGRC counselor reported that often children begged her not to report the abuses they shared with her because they feared retaliation from the detention staff.

This Grand Jury also had the opportunity to see violence at the hands of detention staff first hand through some of the few surveillance video recordings

retained within DCJDC files. Because those violent incidents raise multiple concerns regarding the operation of this facility, they are addressed in more specificity below.

C. Evidence of sexually inappropriate conduct by male detention staff

Equally disturbing as the numerous accounts of violence by staff members were the accounts we heard regarding inappropriate sexual conduct by certain male detention officers. While few female staff or former residents testified before us about such incidents, numerous witnesses reported to the investigating OAG agents their experiences of being harassed and objectified by several specific guards.

One such male officer repeatedly made sexually inappropriate comments to and about female residents and made sexual advances toward female staff members. In one specific incident described by multiple witnesses, this officer played a sexually explicit R. Kelly song while chasing a female resident around the room saying "I'm gonna get you." When this resident told the officer that the song made her uncomfortable, he responded that her parents had probably "made her" to this song. The resident was so upset she cried and reported it to a female detention officer. Another female resident reported that this same male detention officer told her she had "nice legs." This comment was also reported to a supervisor. Despite multiple former staff members and residents describing a pattern of sexually inappropriate conduct, we saw no evidence that the officer was ever disciplined for such behavior.

Another male detention officer was described as "a big sleaze ball" who hit on anyone who was female, staff and resident alike. Several former residents and staff reported unwanted touching and "perverted" comments about their bodies that made them feel uncomfortable. A former female detention officer reported as well that it was well-known this male detention officerwas engaging in a sexual relationship with a female detention officer at the facility while both were on duty.

A third male detention officer was also the subject of various reports made to the OAG agents. This guard was described as flirtatious with the female residents, and one former resident said that he told her he wanted to take her out when she was released from the facility and that no one needed to know about it. A few former female staff members also reported that this male officer hit on them at one point.

There were anecdotes about other male officers as well. One reportedly brought in food for a female resident because he said she "looked fine" that day. Another male officer asked a female resident if she liked older men when they were alone together in the gym. One former resident who testified before the Grand Jury reported that a male detention officer touched her buttocks in the gym in front of a female supervisor, whose only response was to comment to the male guard that "these white girls" were going to get him into trouble. And a former female detention officer reported that during her initial training, she was told that if a male co-worker

made unwanted advances, she should give him two or three chances before reporting him.

Based on these various accounts, it seems apparent that sexually inappropriate conduct by at least some male detention officers toward female residents and staff members was fairly pervasive. That it was so widespread and yet went largely undisciplined further demonstrates the unprofessional and even dangerous environment that persisted at DCJDC.

The pattern of conduct described by these various witnesses is troubling in and of itself, but there are three particular incidents about which we heard evidence that highlight a culture that tolerated and/or turned a blind eye to sexual misconduct among male detention staff.

1. Detention Officer Davon Robertson

In March 2018, Detention Officer Davon Robertson was criminally charged in connection with his sexual misconduct toward Female Juvenile Resident #1. In October 2018, Robertson pled guilty to Statutory Sexual Assault and was sentenced to 9 to 23 months in the Delaware County Correctional Facility, plus a consecutive period of 7 years' probation.

The OAG agents interviewed Female Juvenile Resident #1 on November 2, 2021. Based on that interview, we learned that she had been detained at DCJDC five times between October 2014 and April 2017. When she was detained at 11 years old,

Robertson struck up a friendship with her based on the fact that he knew her brother and mother. That friendship eventually became sexual when she was 14 years of age. She reported that they engaged in sexual contact both while she was at the facility, and outside of the facility. She also reported that he once took her to a party where another detention officer was present, serving as a security guard.

Their relationship was discovered not by DCJDC but instead by the criminal authorities who alerted Director Murray that Robertson was being arrested and why. They informed Director Murray that none of the conduct with which the detention officer was being charged occurred inside the facility. Nevertheless, we are concerned both by the warning signs that were missed by the facility and others, and the missed opportunity to revisit the facility's policies and procedures in the wake of this scandal.

a. <u>Missed warning signs</u>

Female Juvenile Resident #1 was last detained in DCJDC in April 2017, after she was picked up on a bench warrant on April 6, 2017. At the time of her arrest on the warrant, she asked the police officer if she could do her hair and makeup first so she could look good for her "Lima Daddy,"[7] or words to that effect, to get special privileges. The officer thought the request was strange and mentioned it to his wife,

[7] "Lima" is a reference to the fact that DCJDC is located in Lima, Pennsylvania. Many of the residents and staff referred to the facility as "Lima" in their testimony.

who was a juvenile probation officer ("JPO"). She, in turn, alerted her supervisor and the juvenile's assigned probation officer. The assigned JPO was tasked with looking into the matter. In addition, one of the probation supervisors alerted the then-deputy director of the facility as well, who indicated that he would also look into it.

Documents that we had access to reveal that the assigned JPO interviewed Female Juvenile Resident #1 about a party she attended the prior weekend, and her "Lima Daddy" comment. The juvenile admitted going to a party and indicated that the only detention officer she saw there was an officer who was not Davon Robertson. She also told him that "Lima Daddy" referred to another resident at the facility. Robertson's name was never mentioned. The JPO believed the teen and no further action was taken by the probation department. No ChildLine report was made.

There is no documentation regarding any separate interview or investigation conducted by DCJDC regarding this incident. The only notes indicating what Female Juvenile Resident #1 said about the party or the "Lima Daddy" comment were those by the JPO. Yet, on April 7, 2017, – a the day after she was detained – a DCJDC case worker sent a "safety plan" to Director Murray and his then-deputy director, indicating that Detention Officer Davon Robertson and the second detention officer who attended the party were to be reassigned to non-child care duties and could not

be alone with Female Juvenile Resident #1 during the pendency of the ChildLine investigation.

When this case worker was asked about this safety plan during her Grand Jury testimony, she could only recall that Director Murray instructed her to devise such a plan for both detention officers. She recalled that there was some indication that Female Juvenile Resident #1 had been at a party where the second male detention officer was providing security, but she could not recall why she would be drafting a safety plan for Robertson in April 2017—the year before he was arrested. Nor could Director Murray recall why there was a safety plan devised at that time for Robertson. Both the case worker and Director Murray expected there to be a Special Activity Report documenting the reason, but a search of the thousands and thousands of pages obtained from DCJDC pursuant to a Grand Jury search warrant uncovered no such report or any other documentation regarding the "Lima Daddy" comment or Robertson. It also appears that no ChildLine report was ever made, despite the reference in the safety plan to the contrary.[8]

[8] The Grand Jurors cannot help but note that Female Juvenile Resident #1's comment about a "Lima Daddy" occurred approximately two weeks before a federally certified auditor was scheduled to come to the facility to assess DCJDC's compliance with the standards established under the Prison Rape Elimination Act ("PREA") – a federal statute enacted to help prevent sexual abuse within adult and juvenile detention facilities. DCJDC management did not inform the PREA auditor about the resident's comment or the safety plans developed involving two detention officers.

The second male detention officer testified before this Grand Jury and said that the safety plan was put in place against himself and Davon Robertson because they both served as security guards for his sister's 16th birthday party. He denied, however, that Female Juvenile Resident #1 was at the party. Because of the lack of documentation regarding the facility's investigation, if any, the reason for the safety plan, and whether and how Director Murray knew that Robertson was at the party, coupled with the failed memories of Murray and the case worker involved in developing the plan, we are left to rely on only the testimony of the second male detention officer to explain the reason for Robertson's safety plan. Unfortunately, we have trouble relying on that officer's credibility given that he was untruthful when he was initially interviewed by the OAG agents regarding details of the party;[9] denied that Female Juvenile Resident #1 was at the party, contrary to her statements at the time and to the OAG agents during this investigation; and has previously been disciplined for lying on a Special Activity Report, as detailed elsewhere in this report.

In any event, even assuming that the second male detention officer is correct that the facility learned Robertson had been at the party serving as security, it does

[9] Specifically, during his interview with the OAG agents, this detention officer denied that his sister's party had ended in a fight, even though other witnesses had reported to the agents that it ended in gunshots. During his testimony before this Grand Jury, the detention officer admitted that the party got out of control and shots were fired.

not vindicate Director Murray and his management team's handling of this situation. As far as we can discern, nothing else was done beyond a safety plan, which does not appear to have been put into place, and certainly did not prevent Robertson from continuing a sexual relationship with Female Juvenile Resident #1, for which he was convicted over a year later.

b. **Missed opportunity**

Director Murray testified that when he learned about Robertson's arrest, he and his staff were "stunned." He and his managers met and discussed the situation and no one expressed any concerns regarding other detention staff. Beyond that, however, Director Murray and his staff undertook no review of or changes to their policies and procedures. We, the Grand Jurors, are stunned by this admission.

The problem inherent in Director Murray's logic seems obvious. None of the administrators or supervisors apparently had any idea that Davon Robertson had developed a sexual relationship with an underage juvenile he met while she was detained at DCJDC. Yet, they relied on the fact that they did not suspect any other detention staff as the only assurance they needed that no other detention staff was engaged in similar sexual misconduct. Director Murray and his staff did not question whether there was a problem with their procedures, or whether there was a culture or attitude among staff that allowed one of their own to view an underage teenage girl for whom he was responsible to become his sexual conquest.

They did not bring in an independent, outside agency to do an analysis of how such a relationship could have developed and what changes could be made to prevent any such future misconduct. They did not ask the CGRC counselors at the facility's disposal to meet with the juveniles privately to determine whether they experienced or witnessed any inappropriate contact between staff and residents. They did not meet with residents themselves to reiterate their rights and encourage them to report misconduct. Nor were there any new trainings with staff concerning appropriate, professional contact with residents. As far as we can tell, Director Murray did not even hold a meeting with staff to address Robertson's arrest and to reiterate the severe consequences to any staff member who crossed the line in such a manner. Instead, Robertson was treated as an anomaly, a single bad actor that in no way reflected on the facility, its management, or its detention staff.

This was undoubtedly a missed opportunity by Director Murray and his team. We believe that there were other detention officers who engaged in sexual relationships with former residents, or at the very least harbored unprofessional intent toward their juvenile wards. Had Director Murray looked, it is quite likely that he would have uncovered other instances of misconduct, not just of a sexual nature, but also the physical abuse and the culture among detention staff of covering up for one another. But that did not happen and the facility continued to operate as it always had for several more years.

2. Detention Officer #1

After treating Davon Robertson as a mere aberration, and missing the opportunity to reiterate professional boundaries, another detention officer engaged in unprofessional conduct toward a female resident approximately two years after Robertson was arrested. Sometime in late 2020, Female Juvenile Resident #2, who had previously been in and out of DCJDC, told her mother that a male detention officer, Detention Officer #1, reached out to her when she was released from the facility. He contacted her through social media asking where she was staying and how she was doing. Fortunately, this resident's mother, fearing that Detention Officer #1 was going to make sexual advances toward her daughter, contacted Director Murray.

Director Murray confronted the officer about the allegation and while he denied recalling contact with the female resident, he also commented that since the detention staff "basically raise these kids" he reaches out to see how they are doing. Detention Officer #1 testified to this Grand Jury that if he did reach out to the teen, he would not have said anything inappropriate and it was just a misunderstanding.

The matter was investigated criminally but resulted in no charges. Nonetheless, Director Murray discussed the situation with the President Judge, who determined that the conduct was "too creepy" and fired Detention Officer #1 shortly before the facility was shut down in March 2021.

While the Grand Jury is relieved to see that such unprofessional conduct was not tolerated by the President Judge in this case, we cannot help but conclude that had Director Murray and his team used the Davon Robertson incident as an opportunity to reinforce professional boundaries and weed out detention staff who did not respect or abide by such boundaries, detention staff would not have believed it acceptable to reach out to a teenage girl upon her release from the facility.

3. Detention Officer #2

We also heard allegations that go back well before Director Murray's tenure involving multiple detention officers, one of whom was still working at the facility when it closed.

Detention Officer #2 began working at DCJDC in 2001 and remained employed as an officer there until the facility was closed in March 2021. Approximately 15 years ago, he became sexually involved with a teenage girl whom he met there while she was a resident and he was a detention officer. This girl, referred to herein as Female Juvenile Resident #3, is now a young woman and was interviewed by OAG agents as part of this investigation. We, the Grand Jurors, had the benefit of hearing that recorded interview.

In it, Female Juvenile Resident #3 details how Detention Officer #2 first expressed interest in her while she was detained at DCJDC. He gave her his number and told her to hide it in her bra until she was released and then to call him. When

she was released home, she called Detention Officer #2 and they got together and smoked "weed" in the parking lot of his brother's apartment building. After that, they spoke every day and shortly thereafter met at a motel where they had sex for the first time. The teen had been a virgin at that point and recalled that intercourse was painful.

The two then regularly met up to smoke weed and have sex. Detention Officer #2 told the teen that he loved her but that she could not tell anyone about their relationship because he would get into trouble. As Female Juvenile Resident #3 got older, he would also take her to parties where she would sometimes see other detention officers from DCJDC. She reported that he also once helped her smuggle in Xanax when she returned to the facility, so that she could get "high" while in there.

Their relationship lasted a few years until one time, while Female Juvenile Resident #3 was again being detained at DCJDC, a friend of hers told the teen's mother about her relationship with Detention Officer #2. Her mother, who was also interviewed, told the OAG agents that the detention officer showed up to their house in the middle of the night and she told him to stay away. Her mother also called the facility and spoke with the then-director,[10] but when Female Juvenile Resident #3

[10] Because the time frame of the relationship between Female Juvenile Resident #3 and Detention Officer #2, and when the teen's mother reported the relationship to the facility's director, are

was interviewed about it by the director, she lied and denied that she and Detention Officer #2 were involved. After that, however, Detention Officer #2 refused to speak to her because he was afraid to lose his job.

The teen, who had believed she and Detention Officer #2 would get married one day, was distraught. She ran away from home because she was angry at her mother for reporting their relationship; she also attempted suicide at the age of 17. It was only later that she realized Detention Officer #2 had used her. And though more than 10 years have passed since the relationship ended, she was still distressed talking about it. She blamed the experience for ruining her relationship with her mother and causing her to be suicidal and a drug-user. She also reported that she knew of other female juvenile residents of DCJDC that had sex with Detention Officer #2 and other male officers, but that they were embarrassed and did not want to get involved.

There was one former female resident, Female Juvenile Resident #4, who was willing to get involved in the investigation.[11] This former resident had been friends with Female Juvenile Resident #3 when they were younger and had been detained

unclear, we are unable to ascertain which director was informed of the relationship and interviewed the teen. We know only that these events preceded Director Murray, who took over in 2010.

[11] Female Juvenile Resident #4 is the mother of Female Juvenile Resident #2, whom Detention Officer #1 reached out to on social media in 2019. No doubt she was suspicious of Detention Officer #1's motives based on her own experiences with male detention officers while she had been detained at DCJDC years earlier.

at DCJDC several times between the ages of 14 and 18. She confirmed that she and the Female Juvenile Resident #3 would hang out with detention officers, including Detention Officer #2, outside of the facility, drinking, doing drugs and having sex. These same officers would then look out for them when they returned to the facility. As a teenager, she thought the fact that these men were taking care of her was "cool." As she got older, however, she realized that those dysfunctional relationships with the male guards ruined her life.[12]

Detention Officer #2 testified before this Grand Jury and was asked about his relationship with Female Juvenile Resident #3. He claimed that he only saw her once outside of the detention facility when he saw her walking home from rehab in the rain and offered to give her a ride. He also denied going to parties with her or anyone else from the detention center. He admitted that the teen's mother called the director to complain about him, but said it was only because she believed he had driven past her house several times. Detention Officer #2 was not disciplined for anything in connection with Female Juvenile Resident #3 and was simply told to stay away from her if she returned to the facility.

[12] One of those officers still worked at the facility years later when this former resident's daughter, Female Juvenile Resident #2, was detained there. Female Juvenile Resident #2 reported that this officer was particularly nice to her when she was detained at DCJDC, telling her that he used to party with her mother and that he could be her "stepdad." He later obtained her mother's number, possibly from the teen's juvenile file, and contacted the mother, who had tried to put that time in her life behind her and was upset by the communication. It has been reported to us that this detention officer has since passed away so we were not able to hear from him regarding these allegations.

We found Detention Officer #2's testimony to be wholly incredible, and Female Juvenile Resident #3 to be believable. We have no doubt that Detention Officer #2 abused his position and authority to engage in a wholly inappropriate sexual relationship with at least one teenage girl, if not others, whom he met through his work at DCJDC. Rather than caring for them as girls in need of guidance and support, he preyed upon them and viewed them as sexual conquests.

Unfortunately, while we believe the former residents, we are not recommending criminal prosecution for Detention Officer #2's sexual misconduct. We recognize that there is no allegation or proof that he engaged in sexual acts with the former female resident, or any other juvenile, while they were detained at DCJDC and that all such sexual activity occurred outside the facility. Moreover, while the former female resident believed that she was underage when she and Detention Officer #2 began having sexual intercourse, given the passage of time it is nearly impossible to prove whether sexual acts occurred between them prior to her turning 16 years of age, which is the age of consent in Pennsylvania. Therefore, we hope that the former female residents who provided evidence to this Grand Jury regarding male officers' sexual misconduct, and whose lives were truly devastated by the acts of Detention Officer #2, and other male guards who took advantage of them when they were already vulnerable, will find solace in the fact that they have been heard and believed by this Grand Jury. We also hope that this report will help

prevent Detention Officer #2 and men like him from working in environments where they are able to take advantage of other vulnerable teens.

While we recognize that the allegations against Detention Officer #2 date back years before Director Murray took over the facility, we are frustrated that Director Murray and his management team, when confronted with direct evidence, not once but twice, that certain male detention officers engaged in unprofessional, inappropriate contact with female juveniles whom they supervised, did not believe there was a need to undertake further investigation into the conduct and professionalism of the detention staff, or to reinforce the need for professional boundaries between staff and the juvenile residents at DCJDC. While the problems preceded Director Murray, he spent 10 years as the director of that facility and he and his leadership team did not ascertain what was happening inside their own detention center and put a stop to it, despite evidence that they needed to do so.

V. MISUSE OF ISOLATION/SECLUSION

Another facet of the culture at DCJDC that was at odds both with the stated policies of the facility as well as the goal of rehabilitation, was the detention staff's frequent misuse of seclusion. While options for constructive activities may have been meager at DCJDC, what was worse was when detention staff did not allow juveniles to participate in those that were available, instead, all too often, keeping the juveniles locked up in their rooms so the staff did not have to bother with them.

This was a complaint we heard frequently from various staff members and former residents.

A. Background on seclusion

Seclusion, also known as isolation, refers to the practice of "placing a child in a locked room," 55 Pa. Code §3800.206. It is intended as a means of last resort for dealing with a child who is a threat to themselves or others and for whom less restrictive means are not effective in de-escalating the situation. Typically, all items are removed from the room so that the resident cannot harm themselves, and frequently the water is shut off to prevent the child from flooding the room by means of the sink and/or toilet. As one former CGRC counselor framed it, seclusion can be used as a "cooling off" period; it is not to be used as a form of punishment.

The law requires that when a juvenile is to be secluded for more than 8 hours in a 48-hour period, the facility is required to obtain a court order authorizing the seclusion. 55 Pa. Code §3800.274(17)(vi). DHS requires that whenever a juvenile is in seclusion for more than 4 hours, it must be reported to them. 55 Pa. Code §3800.274(2). Director Murray instituted a policy, consistent with that used in other counties, which required staff to obtain a court order if a juvenile was left in seclusion for more than 4 hours – the time at which it becomes a reportable incident

to DHS.[13] Seclusion over 4 hours also required his approval. Per Director Murray's policy, use of seclusion had to be approved by a supervisor, in consultation with the operations manager, and attempts were to be made each hour to talk to the juvenile in order to remove him or her from seclusion. In addition, detention staff were required to check on the resident every five minutes and document what they observed.

The reason that seclusion is to be used as little as possible and with appropriate oversight is because of the harmful effects it can have on a juvenile. According to the National Partnership in Juvenile Services ("NPJS"), a resource center for juvenile detention centers, isolation of juveniles can increase the risk of self-harm and suicide and exacerbate mental health trauma. As such, NPJS recommends that use of seclusion be "limited, prudent and applied for legitimate and documented safety and security reasons." Position Statement of NPJS Board, Oct. 20, 2014.

Notably, DCJDC's own policy emphasized the need to use the minimum amount of restraint necessary with the residents, and that discipline was a means to hold "children accountable for their actions," and not always to punish. As the policy observed:

[13] It was the understanding of DCJDC staff that the hours a juvenile was secluded did not include the overnight hours when all residents were locked in their rooms. While this makes sense operationally, given the need to secure residents during the overnight hours, we recognize that were a juvenile secluded in the hours immediately preceding the facility's scheduled bedtime, a juvenile could effectively remain in room isolation for much longer than 4 hours without the need to secure a court order.

> Many of our residents have limited experience with mature, consistent authority figures that have as their focus the wellbeing and development of the child. … Punishment as retribution or to satisfy a staff's need for revenge defeats our purpose as it serves only to reinforce anger and build resentment.

DCJDC Policy #7.13b.

Unfortunately, the evidence reviewed by this Grand Jury demonstrates that the policy regarding seclusion and the practice of using seclusion were vastly different. DCJDC staff frequently failed to appropriately limit the use of seclusion and also violated the policy and the law by failing to get timely court orders for extended seclusion. Moreover, as discussed below, there was entirely too little oversight by those involved in the process of obtaining court orders to ensure that extended seclusion was being appropriately used.

B. <u>Lack of appropriate oversight and failure to obtain timely court orders</u>

Though the law required court orders for seclusion over 8 hours and policy required them after 4 hours, it was the understanding of DCJDC management and staff that Delaware County did not have an on-call judge available at night or on weekends to review such orders. As a result, the staff could keep a juvenile secluded for more than 4 or even 8 hours without a court order if a judge was not available to review a seclusion order application and issue an order. Additionally, the supervisor of the case management department, who was supposed to be contacted whenever a juvenile was placed in seclusion and whenever a seclusion order was sought,

testified that she was aware the juveniles were sometimes placed in seclusion without her being notified, and was also aware that sometimes court orders were sought well after the 4-hour mark. Instead, she would come into work in the morning to find out about an incident the prior day where no order was sought, and she would have to obtain an order after the fact. Not surprisingly, then, we saw evidence of the facility requesting orders from judges after the expiration of the time limit.

First, we saw an email that a supervisor sent to the case management staff dated February 19, 2019, listing 10 juveniles who had been in seclusion in 2018. In anticipation of the state's annual inspection, the supervisor directed the staff to check their files to ensure that there was a court order for those juveniles who had been secluded for more than 4 hours.[14] The supervisor further directed that if no order was in the file, they should contact the courts and/or the juvenile probation supervisor, to "do a search and hopefully *issue*" an order so that the facility is in compliance. (Emphasis added) This supervisor explained to this Grand Jury that she merely meant that the probation office and courts should search their files for a copy of the court order that had already been issued. We nonetheless find the wording of the email and the fact that some of these orders were not in the files to be troubling.

[14]As discussed above, although DCJDC's policy required a court order after 4 hours of seclusion, DHS regulations require a court order when a juvenile is in seclusion for 8 hours or more within 48 hours. This email seeking court orders for juveniles who had been secluded for 4 hours or more for purposes of the complying with DHS' annual inspection thus appears to conflate DHS' requirements with DCJDC's policy.

It is particularly troubling in light of evidence we saw that at least on one occasion the facility did request a seclusion order days after it should have been sought. Specifically, we saw an email from a Delaware County judge to Director Mark Murray and others, dated September 25, 2020, in which he indicated that he had received a request for a seclusion order that was days late. Although the judge was willing to make an exception in that case because of the facility's assertion that the untimeliness of the request was inadvertent, the judge reminded the facility that it must comply with the law and that the judge would not participate in issuing untimely orders as a "regular practice." Despite the judge's stated position in this September 2020 email, approximately two months later the judge approved the isolation of two juveniles three days after the request was made by the DCJDC.

Director Murray testified that the facility permitted the continued seclusion of juveniles beyond 8 hours while a request for a seclusion order was pending. Murray related that the issue would occur if seclusion was needed and a judge was not available. The Grand Jury finds that practice to have been completely contrary to the law. 55 Pa. Code §3800.274(17)(vi) states: "The use of seclusion for any child may not exceed 8 hours in any 48-hour period without a written court order." The description of the law is clear that no juvenile should continue to be in seclusion without express authorization via court order. Though Director Murray permitted the practice, the Delaware County Court of Common Pleas appears to have

implicitly approved of it by issuing seclusion orders days after the seclusion was effectuated.

We are aware that the judge who signed off on belated seclusion orders mentioned above was a relatively new judge, and had not been elevated to the bench at the time of the February 2019 email referencing the potential need for the court to "issue" orders for juveniles held in seclusion in 2018. This evidence, along with Director Murray's testimony, leads the Grand Jury to suspect there had been a "regular practice" of issuing post hoc seclusion orders prior to this judge assuming his position on the court of common pleas.

Also troubling was the lack of oversight at all levels for requesting such seclusion orders. Director Murray did not review or approve seclusion order requests made by his staff before they were sent up for court approval. Rather, his staff would send them to a juvenile probation supervisor who would then relay them to the juvenile judge for consideration. This was in contravention of the facility's own policy, which required that the director sign off on any such seclusion requests – a policy of which Director Murray was apparently unaware.

Moreover, there was no discussion between the juvenile probation supervisor and the facility regarding the appropriateness of the request. In other words, there was no review or oversight by the juvenile probation office. The supervisor there merely acted as a conduit to the court.

The application for a seclusion order itself was *pro forma*. It required no affidavit from any staff member. It required no description of the incident or behavior that led to the seclusion initially, or any efforts made by staff to address the resident and end the seclusion. The application required nothing more than checking a box or two with generic descriptions of the behavior (*e.g.*, "The resident has assaulted another resident."; "The resident has threatened, attempted and/or has caused appreciable harm to himself/herself."), and the signature of a supervisor.

In other words, to authorize the facility's seclusion of a juvenile for more than 4 consecutive hours – even with all the negative consequences such isolation could cause to the juvenile – the court required no more than a perfunctory, fill-in-the-blank form. So little time and effort were required to obtain a seclusion order that we saw at least one instance where the application was sent over with no boxes checked and no supervisor's signature. We were at least relieved to see that the judge did not issue the order for that particular application, but rather required it to be resubmitted with the appropriate boxes checked and supervisor's signature.

Notably, we were presented evidence of a memo drafted by Director Murray in September 2020, and last modified the day DCJDC was shut down in March 2021, which seems intended to significantly restrict the use of extended seclusion. Under this draft policy, seclusion could only extend past 4 hours if the juvenile was presenting signs of self-harm or harm to others; a supervisor seeking seclusion past

4 hours had to prepare a detailed memo describing what behaviors were occurring that warranted continued seclusion; that memo had to be distributed to Director Murray, his deputy and operations manager, and the lead case manager; and failure to follow the appropriate steps for obtaining a seclusion order were to result in disciplinary action. While this policy, which appears to be modeled after the policies of other counties that Director Murray reviewed, tightens up the requirements for obtaining a seclusion order and provides appropriate oversight, it does not appear to have been adopted or implemented prior to the facility's shutdown.

C. <u>Use of unofficial seclusion</u>

While there were policies and procedures in place governing the detention staff's use of seclusion, we also heard evidence that detention staff would frequently lock juveniles in their room even when the juveniles did not present a threat, and without following the policies and procedures for use of seclusion. Witnesses testified that frequently staff would simply leave juveniles in their rooms, not as official seclusion, but merely because they did not feel like doing their jobs. One former CGRC counselor testified that seclusion was used as punishment for verbal or physical altercations. She remembers asking a supervisor once why a male resident was being secluded and he responded that the juvenile was being an "asshole." A former detention officer corroborated this testimony, recounting that

he observed seclusion used as punishment five or six times in the year he worked there.

The case management supervisor testified that, despite the formal procedures for seclusion, residents complained frequently about the detention staff leaving them in their rooms for long periods of time. When she saw that kids were still locked in their rooms after 3:15p.m., once the shift change ended, she would unlock their doors and report it to the shift supervisor or operations manager. A memo was even posted reminding staff that doors were to be unlocked at 3:15 p.m. However, this witness testified that there was little consistent enforcement of this policy and that it was left up to the shift supervisors to enforce it. A former CGRC counselor agreed with this assessment, noting that there used to be more of an effort by the supervisors to direct staff to let the kids out of their rooms, but over time their efforts decreased.

Former detention officers – those who had only started working in the facility in 2020 and so had not yet been indoctrinated into the culture – reported that certain officers would not let the kids out of their rooms because then the officers could do whatever they wanted without having to watch over the juveniles. One detention officer even earned the nickname "23 and 1" – a reference to being locked up for 23 hours and let out for 1 hour – because he so frequently kept the juveniles locked in their rooms. As one former resident described it, when this detention officer was on

duty, he would lock the residents in their rooms, sit in the day area and watch television.

When confronted with this nickname during his Grand Jury testimony, this detention officer stated that he understood the reference but denied knowing that the residents called him that nickname and denied that he locked them in their rooms unnecessarily. According to him, detention officers had the discretion to keep residents locked in their rooms for hours due to behavioral issues and that sometimes it had to be done in order to "grab order" on the unit. He admitted that he shut down units "a fair amount of time."

Former residents of DCJDC echoed what we heard from these staff members. One testified that a juvenile's schedule at the facility depended on which detention staff was assigned to the unit. Some officers put the kids in their rooms because they "don't want to deal with us," so whether the kids went to school or recreational activities depended on the detention staff. He also observed that the E block tended to get the best detention officers, so those juveniles had more activities. In contrast, residents in Blocks C (when it was open) and D spent most of their day in their rooms. CGRC counselors made the same observation, noting that staff assigned to Blocks C and D tended to be laziest and left the juveniles in their rooms most of the day.

In other words, despite the negative impacts of leaving a juvenile isolated in his room with little to nothing to do – especially kids with trauma, mental health and behavioral issues – detention staff relied heavily on isolation, either officially or unofficially. Something that was meant to be rarely used and only in instances where a juvenile was a danger to himself or others, became a way of life for many juveniles, depending entirely on which detention staff was assigned to their unit.

VI. "US VERSUS THEM" ATTITUDE TOWARDS MENTAL HEALTH COUNSELORS

That Delaware County contracted with CGRC to have counselors on-site within the facility to provide mental health services and counseling to the residents should have made DCJDC an exemplary detention center. The counselors we heard from were dedicated licensed counselors and social workers who seemed genuinely interested in working with the juveniles detained at DCJDC.

Sadly, however, what we heard from the counselors was that the culture among the detention staff and inaction by the facility's leadership worked to undermine the good work the counselors were attempting to do with the adolescents. Because the counselors were not permitted on the residential units without a detention supervisor's approval, they relied upon the detention staff to bring the residents to them. Juveniles often complained that detention officers refused to allow them to speak to the counselors when they asked because the officer either didn't feel like walking them to the counselor's office, or thought the juvenile was going

to “snitch.” If detention staff did not feel like bringing the resident to the counselor, effectively blocking that juvenile’s mental health services, there was little the counselor could do. One former detention officer confirmed this, testifying that detention officers would deny residents access to the counselors and that there were certain supervisors who did not like the counselors and would undermine them.

Several of the counselors talked about how they would have to learn which supervisors they could go to in order to gain access to their clients, as some were more understanding than others. One counselor described how she would “try to create good relationships [] with [certain supervisors] so that they would allow me to see kids when I wanted to. It was like you had to be smart about the connections you made there, but you couldn’t trust certain people…. [E]very day was survival.”

There was also a lot of friction between the CGRC counselors and the detention staff. For example, although protocol dictated suicide watch when a resident expressed suicidal ideation, suicide watch required 1:1 staffing, which often required a detention officer to work overtime. One former CGRC counselor recounted how detention staff would scream at him when he placed a resident on suicide watch. As discussed in more detail below, CGRC counselors also frequently made ChildLine reports against detention staff based on what residents reported to them. Detention staff would in turn give the counselor attitude or refuse to talk to them, and sometimes refused access to the juveniles by way of retaliation. Other

times, when a juvenile was meeting with a counselor in one of the front rooms near the detention supervisor's offices, supervisors could be overheard making fun of the resident and counselor. As one former CGRC counselor phrased it, "It was endemic to the institution that going to see Child Guidance was something that was frowned on." As another put it, it was an "us versus them" mentality between the counselors and the detention staff.

It was ultimately the CGRC counselors who came forward to provide affidavits detailing the problems that they saw at DCJDC, which in turn led to this investigation. They each concluded that there was no way to change the facility from within, and, as a result, only one of the counselors from whom we heard was still employed at the facility at the time it shut down. That counselor, who had only started at the facility in July 2020 – approximately 8 months prior to the shutdown – said that she had believed she could build relationships with the kids and so it was worth putting up with the bullying and harassment by the employees when she first started. It was when things took a turn for the worse, and detention staff became more secretive and access to the residents became more restrictive, that she decided she had to do something and came forward.

As for the counselors who left, they described leaving the facility once they realized that they were not able to help the juveniles detained there and when they themselves became too traumatized. One former counselor said he felt like he had

post-traumatic stress syndrome from the weekly screaming matches with the staff and the toxic work environment. He left and went to law school in hopes of being able to expose the type of abuses he saw at DCJDC.

Another similarly left when she realized that no matter how many complaints she made to supervisors and to ChildLine nothing was going to get better. The lead clinician, who had worked there the longest of the CGRC counselors, described coming home at night and crying over the things she experienced and witnessed at the facility. She has been in counseling herself for years after having to "witness those kids in there every day." She told us that she would "go there and face the bullying, the cruelty and just the flat-out mistreatment that happen[ed] there every day," in order to help the kids, but in the end it was just like "banging your head against the wall."

VII. A LACK OF ACCOUNTABILITY

It may seem fantastical that such a culture could exist and such incidents could occur for so long without notice from those outside DCJDC. But part of the reason why no one outside the facility knew is because so many of the administrators within the facility did not know. They did not know because they apparently just trusted that the supervisors and staff would do what they were supposed to do. Similarly, those outside the facility with the opportunity for oversight also just trusted that the facility was operating as it should. As a result, there was an utter lack of supervision

and leadership from the top, and a lack of accountability among the detention staff. Over the course of this investigation, we identified several specific ways in which oversight and accountability were ineffective.

A. Inadequate video surveillance system

One of the primary topics that witnesses discussed over the course of this investigation was DCJDC's outdated and inadequate video surveillance system.

1. "Blind spots" and only partial recording

The facility had 35 video cameras throughout. While they were all operational, at any given time, less than half of them were actually recording. The system was originally installed in the 1990s and was so antiquated that no additional cameras or recording channels could be installed because they could not be integrated into the older system. In addition, the system only allowed up to 35 days' worth of video to be kept before it was overwritten. In order to allow for more recording channels and larger storage capacity, the system needed a whole new upgrade.

One of the major flaws of this outdated surveillance system was that only about 50% of the facility was covered by the existing cameras. Most notably, all stairwells on the blocks were without cameras as were all the residential hallways. The only part of the residential units that were under surveillance were the common

areas of each unit. Every single employee and resident of DCJDC from whom we heard was aware of these "blind spots" within the facility.

The problem with having so much of the facility without video monitoring is obvious: when incidents between residents and between residents and staff occurred, there was frequently no independent, objective evidence to verify what happened. Every such incident could thus go undetected or, if reported but not on one of the recording cameras, devolved into a credibility contest between the participants, which put residents at a great disadvantage. Even if an incident was reported and captured on video, it required Director Murray to request the IT supervisor to make a recording… that is, if the video had not already been written over.

We heard numerous witnesses describe how the inadequate video surveillance system affected daily life at DCJDC. First, because everyone was aware of the blind spots, staff and juveniles knew to do certain things "off camera." One former male detention officer testified that it was commonly understood that if a detention officer wanted to sleep, visit with their significant other (because some of the staff dated), or, worse, fight with a juvenile, you did so off camera in one of the blind spots. Senior detention officers told him that he could pretty much do what he wanted so long as he did it off camera and there was no proof – a fact that "haunted" this less experienced detention officer.

A former female detention officer agreed that she had heard of the term going "off camera" and knew it referred to detention staff being physical with a resident, but did not witness any such thing personally during the year that she worked there. Another female detention officer said that while she did not allow the female residents to take their fights off camera, she was aware that it happened a lot on the male units. The case management supervisor also testified that she heard residents talk about things happening off camera. And, as one former supervisor put it, because of all the blind spots in the facility, it was easy to go off camera.

Former residents corroborated the detention staff's reliance on going off camera to avoid getting in trouble for violence against the residents. The resident who earlier in this report described being forcibly removed from the gym by staff and then beaten by the guards while in the hallway near the nurse's office, testified that the guards waited until they were in the hallway where there were no cameras before they began their assault. He also recounted that everyone knew there were no cameras there and that he and other residents would purposely go to that area to fight for that reason. This resident said that detention staff not only knew about the residents going off camera to fight, but actually encouraged it.

One of the other former residents who testified, recounted that most kids got physically restrained by the staff "off camera." He told us that that is where the staff dealt with kids they had a problem with and that the staff would also tell the kids to

go “off camera” if they wanted to fight. This resident remembered a particular detention officer who used an unoccupied room in the back of the E-2 unit as his “off camera” place of choice. When kids wanted to fight, he told them to go “off camera” and directed them to that room.

On the flip slide, some staff were also afraid to be “off camera” because of what the juveniles might do. One former detention officer described how he was assaulted while escorting a juvenile through the stairwell from one floor to another – a common practice within the facility. As soon as they entered the stairwell and were off camera, the juvenile “cold cocked” the detention officer in retaliation for having written the juvenile up for some infraction. The detention officer had to restrain the juvenile while yelling for help. The officer testified that he was “terrified every single time [he] went in a stairwell with a kid” because he was afraid to be assaulted or accused of something.

We would be remiss if we did not note that, despite credible evidence from former residents and staff members alike about the term going “off camera” and its role in daily life at DCJDC, there were many former detention officers, supervisors, and administrators who claimed to have never heard the term “off camera” and did not know what it meant. To the extent Director Murray and his management team testified that they were unfamiliar with the term, it is conceivable that they were simply unaware and out of touch with how the detention staff truly operated day in

and day out; so too with some of the case managers who said that they were unfamiliar with the term. In fact, some of the case managers appeared to have an almost naïve belief that because there were policies and procedures in place, it was inconceivable or at least unlikely that staff would not abide by them – a notion facilitated by the fact that these case managers spent little time in the actual residential units and most of their time in the administrative offices in block A.

As for the former detention staff members who claimed not to have heard the term "off camera," their testimony was simply not credible. Those officers who had been working at DCJDC the longest, those who helped create the very environment that warranted the facility to shut down, those who were most responsible for the culture that was antithetical to reform and rehabilitation, all claimed not to have heard the term "off camera" in the 15 to 20 years that they had worked there. Yet, those detention officers that had only worked at the facility for a year knew the term well. We have little doubt that those detention officers claiming not to know the term "off camera" were simply not being truthful.

2. <u>Requests to upgrade the video surveillance system went unheeded</u>

Director Murray was well aware of the inadequacy of the video surveillance system and knew that having an updated, more comprehensive system was the 'best safety and security" the facility could have. To his credit, he raised the issue with the President Judge at their monthly directors' meetings. He also brought in an

outside IT expert to give him an estimate of how much it would cost to upgrade or replace the existing system, and, with the IT Coordinator's assistance, prepared a written justification for the upgrade, which he included in almost all of his annual budget requests submitted to County Council.

Beginning with the 2013 budget, Director Murray requested money to upgrade the video surveillance system as part of his "capital improvement requests." The justification he included for this request was as follows:

> The video surveillance system was initially installed in the 1990s and has not been upgraded since. The system, as designed, has thirty-five cameras but only twelve can be recorded. Currently only fifty percent of the building is covered with a camera and only thirty percent are recorded. During my tenure when incidents occur, they are never 100% covered by the camera. I would like to start to eliminate the blind spots by adding an additional camera to every unit (5) to cover the hallways in addition to the day room. Plus adding a server to record more than twelve cameras.

2013 Budget Proposal, Capital Improvement Request.

Five years later, Director Murray was still requesting funds to update the facility's video surveillance system. This time, in addition to the reasons he included in his 2013 budget, he also informed the Council of the following:

> …The system is so dated that this past year a component called a Mux stopped working and the only way to replace the Mux was to find a used piece of equipment on Ebay. When this Mux stopped working the system was unable to group and record multiple cameras. The two Mux's (18 and 19) are original to the existing security system as their function was to group cameras per situational awareness and send video output to defunct VHS recorders. It is not a question of if, but when will

> this equipment stop working. When it stops, we will be blind until it is fixed or replaced.
>
> During my tenure, when incidents occur, they are never 100% covered by the cameras. In today's security and litigious environment, this is an unacceptable risk to our staff and residents. We need to not only eliminate the blind spots in the building but make sure the system is robust enough to record all cameras. Doing so should help alleviate any liability to the Courts and the County.
> In addition, the Prison Rape Elimination Act (PREA) has policies which require all prison, jails, and detention facilities to continually strive every year in their budget to make improvements to eliminate blind spots in their facilities. The State of Pennsylvania has stated that facilities who do not maintain PREA compliance would lose their Act 148 funds.

2018 Budget Proposal, Capital Improvement Request.[15]

Director Murray continued to submit this request and justification for an upgraded video surveillance system in his remaining budgets until the facility closed.

Despite Director Murray sounding the alarm to the President Judge and in his budget proposals to council, his requests for funds were never approved and there was no upgrade of the video surveillance system prior to the facility shutting down

[15] While Director Murry is correct that eliminating blind spots is a PREA requirement, the law does not require juvenile facilities to do so through a video surveillance system. In fact, PREA does not require a juvenile detention facility to even have a video surveillance system, let alone to update the system to eliminate blind spots. Instead, PREA requires a juvenile facility to take into consideration "the facility's physical plant (including 'blind spots' or areas where staff or residents may be isolated)" when creating a staffing plan, and allows for any blind spots to be addressed through other means such as additional staffing. As such, because PREA does not mandate video surveillance, DCJDC's staffing plan and surveillance system were found to be PREA-compliant during each of their audits in 2015, 2017, and 2020, despite the deficiencies in its surveillance system.

in March 2021. Neither the President Judge, Director Murray, nor the IT Coordinator were given any explanation as to why the requests for funds were repeatedly denied.

Though we give credit to Director Murray for raising the issue repeatedly in his budget proposals, and with his direct supervisor, the President Judge, given the importance of this upgrade to the surveillance system, it was surprising to us that Director Murray did not do more to highlight to County Council the imperative need for the funds. He testified that he had previously gone to Council to make an in-person pitch to have a new position of operations manager added to his budget. Yet, despite knowing what it would mean to the safety and security within the facility to have an upgraded system with near total coverage, he did nothing more to push for needed funds. When asked why, Director Murray told us that if he had pressed the issue more, he "would have been concerned for [his] own job."

We also believe that had the court recognized the significance of the facility's need for an updated and upgraded surveillance system, it could have lent its weight with County Council to get the funds allocated. Certainly, Director Murray raised his concerns with the court. Yet, we saw no evidence that the court pressed for funding, nor does it appear that Director Murray asked the court to weigh in on this issue with Council.

Obviously, hindsight is 20/20, but it is ironic that in his efforts to retain his position as DCJDC director, Director Murray failed to do more to secure a much-

needed upgrade to the surveillance system that would have helped eliminate many of the problems that led to the facility's closure and the loss of his job. While we do not know why County Council consistently refused to provide the requested funds, we can say that it was also short-sighted of them in failing to comprehend the need for such funds to be allocated. In their apparent attempt to save money, their facility was shut down.

B. <u>Special Activity Reports ("SARS"): policy and practice</u>

According to DCJDC policy, a Special Activity Report ("SAR") was to be prepared every time detention staff disciplined a resident for violating facility rules and to report "unusual incidents." DCJDC Policy #9.2. Detention staff was required to complete a SAR "**EVERY** time hands are placed on a resident." DCJDC Policy #7.13b (emphasis in original). Not only was the staff member involved in the "hands on" incident required to complete a SAR, but so too were "any staff members that witnessed an assault on another resident or staff member." SARs were to be given to the supervisor, who would then provide them to the case management team, who in turn provided them to the juvenile probation department. DCJDC Policy #7.13b; DCJDC Policy #9.2 All SARs were to be placed in the involved juvenile's file; they were not, however, placed in the involved detention staff's employee file. Case management staff also provided copies of SARs to the director, or, if he was unavailable, his deputy or operations manager.

It was, of course, the expectation of the administrators of DCJDC that SARs would be filled out completely and accurately. As Director Murray put it, since SARs ended up in a juvenile's file and could be reviewed by the juvenile judge, lying on a SAR would be like lying to the court. Moreover, because there were many blind spots in the facility's video surveillance system, and only half of them recorded, the supervisors and administrators relied upon detention staff to promptly and accurately report "hands on" incidents in their SARs. As Operations Manager James Stickney phrased it, detention staff were the "eyes and ears" of the facility. Accordingly, detention staff were trained to write SARs based on their own observations and "exactly as they saw it."

Once again, however, the policy and practice at DCJDC did not match up. One detention officer testified that SARs were frequently inaccurate because either another detention officer or a supervisor would want them rewritten so the facility did not "look bad." This detention officer had been repeatedly told to rewrite his SAR or omit information. Because SARs were handwritten, they could easily be torn up and a new one written.

A former detention officer and current juvenile probation officer, who sometimes filled in as a detention officer at the facility when they were short-staffed, corroborated this testimony. She recounted that when an incident occurred that required a SAR, other detention officers would ask her what she had written before

they wrote theirs out. She quipped back to them that it was like a test and they had to get the answer on their own without copying hers.

By way of further evidence that detention staff colluded on what to write in their SARs, one former CGRC counselor had occasion to review a particular female DCJDC resident's file after the counselor left DCJDC and began working at the Delaware County Public Defender's Office. In the resident's file were the SARs for an incident which the former counselor witnessed while working at the facility. She had been asked to write a SAR herself for that incident, which she did and provided it to the deputy director. However, her SAR was not among the others in the juvenile's file, and the SARs that were there appeared to be tailored to one another, they were less accurate than hers, and they omitted any mention of the detention officers' role in escalating the situation. This former CGRC counselor had heard many times while working at the facility that the detention staff corroborated each others' stories to make the incident "sound better," but it was the first time she had seen proof of it.

While not many other staff members were willing to admit to this Grand Jury that SARs were often not written up or not written up accurately, we had the benefit of several irrefutable examples to prove the point.

1. Example #1: Detention Officer #2

In February 2014, Detention Officer #2[16] assaulted a male juvenile, referred to herein as Male Juvenile Resident #1. The incident occurred in the common room of the residential unit, where fortunately there was a camera that was recording. It started when Male Juvenile Resident #1 was playing cards with a few other residents, and there was reportedly a verbal argument about the rules of the game. Detention Officer #2 was in the common area, along with two other detention officers. Detention Officer #2 verbally engaged with the kids and Male Juvenile Resident #1 said something that Detention Officer #2 did not like. Because there was no audio on the camera and conflicting accounts of what was said, we cannot ascertain what the juvenile said to anger the detention officer. What we do know, however, because it was on the video, was that Detention Officer #2 got up and approached Male Juvenile Resident #1. One of the other detention officers present attempted to block Detention Officer #2, but Detention Officer #2 pushed past him and grabbed the juvenile by the neck, pulling him off his chair and causing him to topple over. The rest of the incident occurred off camera, though apparently the other detention officers pulled Detention Officer #2 off Male Juvenile Resident #1 and escorted the juvenile to his room.

[16] Detention Officer #2 is the same officer referred to earlier in this report by that moniker.

The Grand Jury knows about this assault not because of the SARs that all three officers were required to write. Not a single one of them wrote a SAR. Rather, this assault only came to light because Male Juvenile Resident #1 was transferred to another facility a few hours after the assault occurred, and someone at the other facility noticed the marks on the juvenile's neck that Detention Officer #2 left behind. Male Juvenile Resident #1 reported that assault and it was investigated both criminally and by DCJDC itself. As part of those investigations, the video of the incident was obtained corroborating what Detention Officer #2 had done.

During those investigations, one of the other detention officers who witnessed the assault claimed that Male Juvenile Resident #1 called Detention Officer #2 a racial slur, that he did not see Detention Officer #2 grab the juvenile, and believed he had prevented Detention Officer #2 from reaching the juvenile before he laid hands on him. The other detention officer who was present also claimed that he did not see Detention Officer #2 lay hands on Male Juvenile Resident #1 and that the juvenile just fell out of his chair. Detention Officer #2 claimed that he had to restrain Male Juvenile Resident #1 because the juvenile needed to be removed from the situation so as to prevent a fight between that juvenile and the other residents. Male Juvenile Resident #1 reported that he talked back to Detention Officer #2 and that Detention Officer #2 got up and told him to go to the bathroom or the hallway where there were no cameras, then grabbed him by the neck. Regardless of how the

argument escalated, the video evidence clearly refutes all three of the officers about whether an assault occurred. It clearly did.

There is no doubt that Detention Officer #2 was not employing a proper physical restraint to calm an unruly juvenile, but was retaliating against Male Juvenile Resident #1 – a teenage boy – because he did not like what the juvenile said. Male Juvenile Resident #1 was still seated in his chair at the time Detention Officer #2 assaulted him and had made no aggressive movements toward the other juveniles or staff at the time the detention officer approached him. It is also clear that the other officers were not trying to assist Detention Officer #2 with a proper restraint, but in fact were trying to stop him from assaulting the juvenile; and it was blatantly obvious that both the other officers who were present saw Detention Officer #2 grab Male Juvenile Resident #1 by the throat and pull him out of the chair and to the ground. Both those officers admitted as much when they testified before the Grand Jury about the incident, despite having previously denied to law enforcement that they observed the assault. The video showing Detention Officer #2's assault of Male Juvenile Resident #1 is extremely disturbing and one of the things that we will not soon forget about this investigation.

Detention Officer #2 was criminally charged with endangering the welfare of a child and simple assault. He was also suspended from DCJDC pending the criminal prosecution. Finally, a ChildLine report was made with DHS. Shockingly, despite

the strong video evidence against Detention Officer #2, he ultimately suffered no real consequences.

With respect to the criminal case, Detention Officer #2 pled guilty to summary harassment and paid a meager fine. The DHS investigation conducted as a result of the ChildLine report was deemed unfounded. The agency concluded that it was a restraint that had not been "properly manage[d]" and that the juvenile's neck pain and injuries did not qualify as "child abuse" under their regulations.[17]

Most troubling of all from the perspective of this investigation was that despite the clear evidence of an assault, and the fact that Detention Officer #2 did not file a SAR – which he was required to do if he was simply employing a restraint as he claimed – Detention Officer #2 was reinstated by DCJDC. Not only was he reinstated; he was reinstated at the recommendation of Director Murray, who wrote in that recommendation letter that Detention Officer #2 was a "good employee."

Nor were the other detention officers present for the assault disciplined for failing to write SARs, despite the testimony of both Director Murray and Operations Manager James Stickney regarding how important it was for detention staff to file SARs and file accurate SARs. Stickney even testified that failure to do so should result in suspension if not termination. Yet, Director Murray could not explain why

[17] "Child abuse" under DHS regulations requires a finding that a child suffered significant pain or impairment or that there was a reasonable likelihood that the alleged conduct could have resulted in injury.

no SARs were written by the three detention staff involved in this incident or why none of them were disciplined for their failure to do so.

This episode demonstrates so much about what was wrong with DCJDC. First, it shows a detention officer using physical violence to retaliate against a juvenile resident for saying something the officer didn't like. Second, this incident would likely never have come to light had Male Juvenile Resident #1 not been transferred to another facility hours after the assault and a staff member there noticed his injuries. Instead, the other detention officers present for the assault would have covered for Detention Officer #2, just as they did even when the assault did get reported and was investigated criminally. Had Male Juvenile Resident #1 remained at DCJDC, he likely never would have said anything about the assault given the culture at DCJDC against "snitching" and the prevalent belief among the juvenile residents that nothing would happen even if they did make a report. Sadly, such pessimism was warranted here insofar as nothing did happen to Detention Officer #2 or the other detention officers who helped cover up for him.

In addition, while Director Murray and his administrators trusted that the detention staff would abide by the policies and procedures, including writing up SARs, that did not happen here. The only reason we know it did not happen here is because the incident was reported by another facility. Even then, absent the video, it would have been all too easy for the detention officers involved to deny Male

Juvenile Resident #1's account or to claim, as the detention officers did at the time, that they did not see physical contact warranting a SAR. Had the incident occurred off camera or in front of one of the many cameras that did not record, it would have been Male Juvenile Resident #1's word against three detention officers.

Finally, even when the administrators of the facility had proof that a "hands on" incident occurred and no SARs had been filed, there was no disciplinary action taken against the officers who violated that policy. This incident just makes apparent what we heard from so many witnesses during this investigation – what happened in reality at DCJDC was different than what the policies said was supposed to happen and very few seemed to notice or care.

2. <u>Example #2: Detention officer #3</u>

Another example of detention staff failing to accurately report incidents on SARs was also uncovered only as a result of video surveillance that happened to be recorded and retained.

This incident occurred in October 2014. Three SARs were written by three different detention officers regarding the event. According to those SARs, Male Juvenile Resident #2 was being disruptive and disrespectful toward staff during a movie and when detention staff attempted to restrain him, the juvenile swung at one of the officers, Detention Officer #3. The detention officer left the room while other detention officers tried to calm Male Juvenile Resident #2. The resident, however,

broke free, ran toward Detention Officer #3 and attempted to assault him once again. One officer indicated that he chased Male Juvenile Resident #2 and by the time he caught up to him, the resident was "already under control." Another officer wrote that he chased Male Juvenile Resident #2 and "took him to the floor" with the assistance of another detention officer, and then Detention Officer #3 and another guard escorted the resident back to his unit. The third SAR was written by Detention Officer #3 himself who wrote that after Male Juvenile Resident #2 attempted to assault him a second time, two other detention officers brought the resident to the ground. Detention Officer #3 and another guard then escorted the juvenile back to his unit.

None of these SARs fully reflect what happened, however, as evidenced by the video: that after Male Juvenile Resident #2 ran back toward Detention Officer #3, detention staff had to *hold back* Detention Officer #3 to prevent him from assaulting the juvenile.

Again, this incident reflects several troubling facts about DCJDC. First, there would have been no reason to doubt the SARs and no reason to believe that a detention officer had also attempted to physically assault a juvenile unless it had been captured on a camera that recorded. Second, even after someone – presumably Director Murray, since we heard that he was the one authorized to request that video be preserved – accessed the video and saw what happened, there is no indication that

Detention Officer #3's conduct was addressed in any way, either through disciplinary action or retraining.

Nor is there any indication that any of the three officers who wrote SARs in this incident were disciplined for failing to write them completely and accurately. There is no mention by any detention officer that they had to restrain Detention Officer #3 in order to prevent him from engaging in a fight with a juvenile resident. Instead, the other detention officers covered for Detention Officer #3 by failing to include any mention of the detention officer's misconduct. After viewing the video himself, Operations Manager Stickney testified that he was not familiar with this incident but that he would have expected the SARs to reflect what occurred fully and accurately. Director Murray also could not explain why the fact Detention Officer #3 had to be held back from assaulting a resident did not make it into a SAR. Yet, there is no evidence that a single detention officer involved was disciplined for failing to write their SAR fully and accurately.

We are not ignorant of the fact that Male Juvenile Resident #2 instigated this incident by being unruly, disrespectful, and assaultive. We understand some of the kids could be challenging to deal with at times. But the residents detained in that facility are just that: kids. We go back to DCJDC's own policy, reminding the detention staff that the juveniles detained there generally have "limited experience with mature, consistent authority figures that have as their focus the well-being and

development of the child," and that satisfying "a staff's need for revenge defeats our purpose as it serves only to reinforce anger and build resentment." DCJDC Policy #7.13b. The only way the administration could ensure that detention staff were living up to this policy and the facility's "purpose" was to discipline or retrain staff when they were not doing so. Ignoring instances such as this one only helped further ingrain that staff could do what they liked without consequence.

3. <u>Example #3: Detention officer #4</u>

The third example that demonstrated the chasm between policy and practice involved another instance was caught on video.

Detention officer #4 had worked at DCJDC for approximately five years at the time of its closing. He testified before this Grand Jury and said how one of the most important duties of the detention staff was "making sure that your paperwork was good." He stated that he had probably written up over 100 SARs during his time at the facility, and claimed that he never compared notes with other officers prior to writing them up.

Yet, in January 2017, Detention Officer #4 was disciplined by the then-deputy director for lying on a SAR – one of the few detention officers to be disciplined for such an infraction. According to the written warning to this detention officer:

> On Wednesday, January 11, 2017 you were assigned to E2 unit with staff Devon Robertson (*sic*) and [another detention] staff. Around 7:30 p.m., while an incident off camera appeared to be escalating you remained at the card table on E2 playing on your phone. As I reviewed

> the tapes it stated in your documentation that you physically took the resident to their room which was not valid after review and talking to the staff involved.

Written Warning, 1/11/17.

Detention Officer #4's original SAR stated that after a fight broke out between residents, he and another detention officer stopped the fight "instantly." While we did not have the opportunity to view the video from this incident ourselves, the then-deputy director's description of Detention Officer #4's actions in the video make it plain that his representation in the SAR was untruthful. Detention Officer #4's amended SAR more accurately reflected that he "stood by" watching the other residents while the other detention officer attempted to break up the altercation.

Notably, though Detention Officer #4 faced minor disciplinary action for this incident in the form of a written warning and retraining, there is no evidence that the other detention officer faced any disciplinary action for his SAR, even though he too wrote that both he *and* Detention Officer #4 "intervened and quickly separated" the fighting residents. Not only, then, does it appear that both detention officers compared notes before writing up their original SARs, contrary to Detention Officer #4's testimony that he did not do so, but it also shows how inconsistent the discipline for writing inaccurate SARs was, even when such discipline occurred. It is no wonder that Detention Officer #4 testified before us that, "[I]t took for you to really

do something idiotic in my opinion to get in trouble and get fired from that job because like I said, we all worked together."

What all three of these examples demonstrate is that the only time the administration became aware of the detention staff's failure to complete SARs fully and accurately was when the incident was captured on video, was recorded, and an administrator had reason to view it. Given how much of the facility was not under video surveillance, how few of the cameras actually recorded, and how frequently detention staff covered for one another, we have little doubt that these three examples only scratch the surface of how often staff did not complete SARs or did not complete them accurately and were just never caught.

C. ChildLine reports

While SARs were DCJDC's internal way of accounting for physical contact between staff and residents, Pennsylvania law mandates that any allegation of child abuse or suspected child abuse is to be reported through the ChildLine system. All the staff and administrators at the facility were mandated reporters, meaning that the law required them to report any allegation of abuse whether it be because a juvenile reported it to them, or because they witnessed abuse firsthand. When a ChildLine report was made about a staff member, DCJDC's policy was to reassign that detention officer to other duties, such as the command center, which would prohibit contact between the officer and residents pending the investigation by DHS.

Although the former detention officers and supervisors who testified before us acknowledged that they had been trained on being mandated reporters, and were aware of their legal obligations under the law to report suspected child abuse, very few, if any, detention officers or supervisors ever made a ChildLine report about another DCJDC staff member, even when they had worked there for 10 years or more.

CGRC counselors, who appeared to make the most ChildLine reports given that they were in the best position for the kids to open up to them and the least fearful of staff retaliation, were required per DCJDC policy to tell Operations Manager James Stickney before they made a ChildLine report that they were going to make a report and about whom the report was to be made. If Stickney was not available, they were to tell the supervisor on duty. After a report was made, the counselor was to email the facility's administrators and supervisors to inform them of the report. If the subject of the ChildLine report was a supervisor, that person would thus also receive the email. The reason for the policy was ostensibly so the CGRC counselors and detention staff could work together to help the juvenile and make sure the officer was reassigned pending the investigation.

While we appreciate the need to reassign the officer pending an investigation, this policy had some unfortunate consequences. First, because of the need to tell Mr. Stickney or the on-duty supervisor of their intent to file a report in advance of making

a report, some supervisors would try to talk the counselor out of making the report. After a report was made, the requirement to alert the supervisors and administrators that an investigation was forthcoming, allowed detention officers to "circle the wagons" before DHS did their investigation. This also sometimes resulted in officers or supervisors speaking with the juvenile prior to the investigation, and bribing them with special treatment, so as to have them recant their story during the investigation. One former CGRC counselor suspected that this was the real reason for the policy of requiring the CGRC counselors to give a "heads up" about a ChildLine report.

This counselor's testimony was corroborated by a former resident. He testified that when he made a report against the detention officers for the assault outside the gym described earlier in this report, and a ChildLine report was made, the officers involved started acting extremely nice to him, giving him extra food, books, and recreational time. When the juvenile told them that it would not affect what he told the investigator, one of the officers said that it didn't matter because the teen was a criminal and he was a detention officer, so "who were they going to believe?"

Another consequence of emailing the administrators and supervisors was that it identified that particular counselor as the reporter. While counselors were somewhat immune to retaliation insofar as they did not work closely with the detention staff, they still relied on detention staff to ensure access to the residents for counseling. As such, they were not totally invulnerable to retaliation. When the

CGRC counselors made ChildLine reports, the staff would be "nasty" to the counselor or give them the "cold shoulder," and would sometimes make it more difficult for them the meet with the residents.

Because the CGRC counselors were uncomfortable with the policy of needing to email DCJDC administrators and supervisors when a ChildLine report was made, they complained to their CGRC supervisor, who worked on-site at the facility a few hours a week. The response, however, was that CGRC counselors were "guests" of the facility and they had to abide by the facility's policies. One counselor thereafter began circumventing the policy by sometimes making reports anonymously.

While ChildLine reports were meant to be a mechanism for identifying abusers and preventing further abuse, it did nothing to prevent abuse within DCJDC. As many witnesses testified, almost every single ChildLine report made against staff members was deemed unfounded, including the one against Detention Officer #2, despite the video evidence supporting the abuse allegation. One former CGRC counselor recounted making at least 20 and as many as 50 reports to ChildLine during her time at DCJDC and not a single one of them had been deemed founded. One of the facility's case managers recalled making between 8 and 10 such reports during her time, all of which were deemed unfounded. The case management supervisor made "a lot" of ChildLine reports against detention staff during her 15 years at DCJDC, none of which were deemed founded, even those she herself found

credible. Director Murray testified that in his 10 years as director, he could only recall one ChildLine report being founded and it was for a licensing issue, not abuse. Operations Manager James Stickney also could only recall one founded ChildLine report against a detention officer who poured juice in a juvenile's shoe as retaliation.

There was a discrepancy among the witnesses regarding whether DCJDC conducted its own investigation of a ChildLine report. While James Stickney said the facility did conduct an internal investigation, usually undertaken by a supervisor, Deputy Director Parjinder Singh and one of the case managers both said that no internal investigation was conducted of ChildLine reports unless it involved an allegation of sexual abuse. One former detention officer testified that the supervisors dealt with ChildLine reports merely by telling the detention officer to "simmer down a little bit" or take it off camera next time.

While we did not hear from anyone from DHS' Child Protective Services regarding how their investigations of child abuse were conducted, what we gleaned from former DCJDC staff members is that the investigations were fairly cursory. DCJDC's case management supervisor recalled that the investigation conducted for one report she made about a child being bullied by staff took 15 minutes before it was deemed unfounded. One former CGRC counselor testified that when she was the reporter, she was rarely contacted as part of their investigation, and another

counselor had never been interviewed as part of the investigation into reports he made.

In light of how DCJDC handled ChildLine reports, both in policy and practice, and in light of the seemingly perfunctory nature of the investigation conducted by DHS, it is no wonder that one former CGRC counselor believed that no matter how many ChildLine reports she made, nothing in the facility was going to get better. That realization led in part to her leaving DCJDC in 2020.

D. No tracking of SARs or ChildLine reports by employee

Regardless of whether a ChildLine report is deemed founded or unfounded, and regardless of how an officer writes up a SAR, it seems logical that DCJDC would want to keep track of how many ChildLines had been filed against a particular detention staff member and how many times a detention staff member had been involved in a "hands on" situation with residents. We know that the juvenile probation department in Delaware County kept track of such incidents for their own employees. That way, if an employee was involved in a "reportable" incident, the chief of the probation office could look in an employee's file to determine if he or she had been involved in prior incidents. And, as the case management supervisor observed, when one reviews the SARs, as she did, and sees a detention officer has been involved in multiple "hands on" incidents, a supervisor should be intervening

with that officer or separating that officer from a particular resident when there are persistent problems between them.

Yet, DCJDC had no such internal tracking mechanism for ChildLine reports or SARs. SARs were only placed in the juvenile's file. ChildLine reports that were deemed unfounded were destroyed after a year because Director Murray believed that the facility was required by law to do so. It is accurate that DHS and facilities under its authority, such as local Child Protective Services agencies, were required by law to expunge unfounded ChildLine reports after 180 days. But that law did not require DCJDC to expunge such records. No law prevented the facility from internally tracking those reports for the facility's own internal purposes.[18]

Because there was no internal tracking, DCJDC leadership had no effective means of knowing which detention officers demonstrated a pattern of engaging in potentially inappropriate conduct with the residents. Nor do we. We cannot look in an employee's files to see how many times he or she was the subject of a ChildLine report, or how many times they went "hands on" with a juvenile over the course of their employment at DCJDC. There was also no institutional knowledge so that as leadership changed over time, new administrators could be made aware of a long-

[18] James Stickney testified that there was a log kept on the shared drive documenting all instances of use of physical restraints, which included the name of the detention staff and resident involved, the supervisor on duty, the type of restraint used, and the duration of the restraint. A search of the facility's shared drive revealed the log to which Stickney referred. However, it only spanned the time period from June 7, 2018 through August 3, 2019.

term detention officer's track record. In other words, even when inappropriate contact was reported and documented as law and DCJDC policy dictated, it was up to an individual administrator's memory to determine whether a particular detention staff member had a troubling pattern or history that required intervention or discipline. This institutional failure further diminished the accountability of detention staff.

E. Grievance process

Another mechanism the facility was required to institute to keep staff accountable was the grievance process. By law, each child and parent had the right to lodge grievances without fear of retaliation, and had to be informed of the procedure for filing grievances at the time they were admitted. 55 Pa. Code §3800.31. At DCJDC, residents had to request a grievance slip from a detention officer if they wanted to file a grievance. The juvenile would then write out a grievance, and it was placed in a grievance box. Deputy Director Singh testified that one of his duties was to check the grievance box monthly.

As with so many of the procedures DCJDC had in place, the grievance process was good in theory but fairly useless in practice. First, the residents had to request a grievance slip from a detention officer. One former resident testified that there were times when detention staff refused to give him a grievance slip when asked. One officer even offered a cheesesteak to any juvenile who would beat up the

complaining resident after he asked for a grievance slip. Another former resident recounted how he argued with a detention officer and wrote up a grievance, which the officer then tore up and threw into the trashcan. After that, the resident gave up on writing grievances, realizing there was no point.

Perhaps the biggest problem with the grievance process was that residents were reluctant to write them in the first place for fear of retaliation. As one former resident explained, detention officers would punish the juveniles who reported them by refusing to take them to the gym for recreational time or not bringing them their full meal. This was echoed by a former detention officer who corroborated that other officers would retaliate if a juvenile filed a grievance by, for example, keeping them in their room for the shift. Officers would also deter the residents from writing a grievance after an incident occurred, threatening what would happen to them if they "snitched."

One former case manager echoed that many residents did not want to file a grievance because they would be labeled a "snitch" and nothing would happen anyway. She said the juveniles considered the grievance process "a waste of time."

VIII. LACK OF LEADERSHIP AND OVERSIGHT FROM WITHIN

A. A "hands off" director

We are all familiar with the expression that "the buck stops here," and "here" is at the top of the chain of command. Since 2010, that was Director Mark Murray.

Indeed, the regulations pertaining to juvenile detention centers like DCJDC specifically mandate that each such facility shall have a director who is "responsible for administration and management of the facility, including the safety and protection of the children, [and] implementation of policies and procedures." 55 Pa. Code §3800.53. Yet, Director Murray's actions did not reflect the philosophy that the buck stopped with him and that he was ultimately responsible for the safety and protection of the children.

Instead, it seems to us, the Grand Jurors, that Director Murray accepted the title and the paycheck without demonstrating the responsibility and effort that went with them. He lacked the experience to run that facility from the time he took over that position, and did little to learn what he needed to in order to be a knowledgeable, effective leader. Instead of seeing the flaws in the system and the culture that persisted there, he accepted what was and trusted his supervisors to run the facility. In so doing, he let his staff and the juveniles down.

Prior to becoming director of DCJDC, Mark Murray had been a supervisor in Delaware County's adult probation and parole office. He dealt primarily with adults who had substance abuse issues, and then supervised other adult probation officers within the substance abuse and mental health unit of the department. He had no prior experience working with juveniles. He had no prior experience in detention of any kind, let alone juvenile detention. When he was asked to take over as DCJDC's

director in 2010, it was as a result of multiple resignations within the county. Director Murray testified that he agreed to accept the position after reviewing the regulations pertaining to juvenile detention facilities and the facility's own policy and procedures manual. He testified that he accepted the job both because he believed he could perform the duties of the job and because he did not think he would have an opportunity for further advancement within the adult probation and parole office.

Director Murray's training for the position was on-the-job. He attended conferences about juvenile detention, and would consult with directors from other county juvenile detention centers. He also relied heavily on his then-first deputy, who had risen through the ranks of juvenile detention and knew much more about the operations of the facility. It is no wonder then, given his prior work experience and training, that when asked his opinion about the quality and professionalism of the detention staff when he first arrived, Director Murray testified that he did not have much of an opinion because he did not have much to compare them to.

Before we ever heard from Director Murray, witness after witness came before us and, almost to a person, described Director Murray as someone who sat in his front office and had as little to do with the operations of the facility as possible. We repeatedly heard that he rarely left his office; that he only came into the residential units when there was a significant incident; that he kept to himself; that

he "hid[] behind his desk"; that he was "[j]ust the person who sat up front"; that he was a "behind the scenes" manager; that he never made it clear to the detention staff what his vision or objectives for the detention center were; that he had a "not my problem" kind of attitude.

Director Murray did not contradict the testimony of his former staff. He, in fact, agreed that, as director, he was not involved in the day-to-day operations of the facility and did not believe it was part of his duties to be on the residential units, except when there was a crisis of some sort. Instead, his management style was to discuss issues with his supervisors, give them the necessary information, and allow them to implement the policies and procedures of the facility. To facilitate this process, according to Director Murray and Operations Manager Stickney, they held regular meetings with the detention supervisors prior to Covid-19 to discuss facility-wide issues. However, the few supervisors who spoke about these meetings recalled them as irregular and infrequent, even before the pandemic.

Director Murray testified that he "trusted" his supervisors were doing their jobs. What he failed to do was trust but verify. He knew the surveillance video system was inadequate. He knew that he and his staff did not track SARs or ChildLine reports in order to identify patterns among certain employees. As discussed below, he knew that there was no regular, consistent practice of conducting staff evaluations. He himself did not regularly visit the residential units

to meet with detention officers or residents. He did not oversee the use of isolation orders. And, having no prior experience with juvenile detention, he did not articulate a vision for the detention center to his staff. Director Murray intentionally and purposely allowed himself to be disengaged from the daily operations of the facility and just blindly accepted that the supervisors would keep the place running. In short, Mark Murray bore the title of Director of DCJDC, but he was never its leader.

B. An unknowledgeable second-in-command

While many former staff members of the facility praised the prior deputy director, Richard Scharrer, he sadly died in 2017 from a heart attack. The position was filled by yet another individual with no prior experience in juvenile detention, Parjinder Singh.

Singh had been a juvenile probation officer in Delaware County for approximately 5 ½ years, and had been "in and out of" DCJDC in that role. Prior to becoming a probation officer, his other work experience consisted of helping manage his family's businesses, which included gas stations, retail establishments, and pizzerias. It appears that he was considered for the job, and ultimately was given the job, at least in part, because of his family's political influence within the county.

Singh's hiring did nothing to enhance the leadership at DCJDC and, in fact, created tension within the management team and negatively affected morale among the staff. Director Murray was candid that he did not want Singh as his deputy; Singh

lacked supervisory experience and, during his interview, expressed to Director Murray that he wanted the job because he believed it would be good for him to be a supervisor. Director Murray believed James Stickney, the then-training coordinator at the facility, was a better fit for the position and expressed his preference that Stickney be hired. Singh was given the position nonetheless.

From Director Murray's perspective, Singh caused confrontation with the staff, did not know what he was doing, and would order staff around even though he did not know the job. The Director felt that he was always playing interference between Singh and the detention supervisors. As a result, Director Murray created the position of Operations Manager and placed James Stickney in the role, allowing him to effectively serve the functions of a deputy director. Not surprisingly, Director Murray's perspective on Singh was echoed by Stickney, who also believed that Singh did not know what he was doing and did not work very hard.

From Deputy Director Singh's viewpoint, he was capable but sidelined by Murray and Stickney. He documented complaints he brought to Director Murray regarding his treatment by the supervisors and James Stickney, whom he believed treated him disrespectfully. Singh even suggested that Stickney be suspended over one such incident, but Murray told him that they needed Stickney to run the facility. Singh was thus more or less cut off from any real supervisory role of the detention staff, and was deterred from getting involved in the day-to-day operations of the

detention center. Ultimately, Deputy Director Singh formed the opinion that Director Murray had "profiled and discriminated against" him because of his heritage.

Whether Singh was intentionally sidelined by Murray and Stickney because he was incompetent or because they had preconceived notions of his abilities, the end result was the same: the second-in-command at DCJDC was an ineffective and non-existent manager who also failed to provide vision or leadership for a challenged and troubled facility. Many of the same former staff members who testified that they rarely saw Murray on the residential units and involved in the day-to-day operations of the facility, said very much the same about Deputy Director Singh.

C. The operations manager was "hands on" but not an agent of change

That left Operations Manager James Stickney as the man on the ground in terms of daily supervision and oversight of the facility. Stickney had been with DCJDC for 16 years, first as a detention officer, then as a supervisor, the training coordinator, and, finally, as operations manager. To his credit, most detention staff who provided testimony about Stickney, praised him for being available and being on the units regularly, interacting with staff and residents. He himself testified that he made it a point to walk around the units once a day.

Yet, perhaps in part because he had been at DCJDC for so long, Stickney did not see much need for change among the culture of the facility. One former CGRC

counselor observed that Stickney was "too buddy buddy" with the detention staff; he was their friend, but not respected as an authority figure.

Despite what we heard about particular detention officers during this investigation, Stickney did not identify a single problematic officer or supervisor. He believed that most detention officers were "beneficial" in some way. And despite what we heard from witness after witness about Director Murray's lack of leadership, Stickney respected Director Murray – the man who created a management position for him and promoted him when he was passed over for the deputy director job – because Murray was knowledgeable about "the laws and stuff." Stickney's testimony made it clear that he blamed the County for not providing enough resources, and did not identify any problems at the facility as having been created internally.

With the management team of DCJDC collectively lacking the vision, knowledge, insight, and skills to create a culture and environment that promoted professionalism as the norm and rehabilitation as the goal, both professionalism and morale among the staff declined over the last several years. The case management supervisor described there being a lack of consistency in following and enforcing the rules at the facility. And, as one former CGRC counselor framed it, "[T]here was no leadership and no one taking responsibility."

D. No staff evaluations

Moreover, there were no regular staff evaluations conducted of the detention staff, supervisors, or management team. Director Murray testified that Delaware County was "not big" on evaluations, though, of course, he recognized that did not prevent the facility from conducting their own internal evaluations. In fact, according to him, when Richard Scharrer was his deputy director, they did start conducting employee evaluations for detention officers for internal purposes. The supervisors would evaluate the officers and Murray and Scharrer would evaluate the detention supervisors. They apparently did such evaluations for approximately four years, until Scharrer died.

Only two supervisors testified to filling out annual evaluations for the detention officers they supervised, but did not recall being evaluated themselves. Another supervisor testified that he had never evaluated his detention officers and was never evaluated. A review of employee files revealed very few evaluations contained therein. Those that were found were sporadic and random, and not indicative of having been done consistently or annually. There were no evaluations for management staff, including Director Murray.

While we recognize that staff evaluations are only as good as the information on which they are based, staff evaluations are one mechanism by which to enforce the notion of accountability. Had evaluation criteria been defined and made known

to staff, it would have established the priorities and values of the facility for those employed there. Additionally, had detention officers, supervisors, and management alike understood that their performance was going to be reviewed, at least annually, according to the priorities and values set by the facility's leadership, it would have incentivized staff to abide by those criteria, and incentivized supervisors to be more mindful about their staff's performance. Instead, the facility's leadership missed the opportunity to use even this basic tool for defining the desired culture of the facility and holding the staff accountable to it.

E. Inadequate training

Finally, another means of ensuring that the staff reflected the desired ethos of the facility and had the skills to effectively carry it out was through training. Yet, we heard from many witnesses who lamented the inadequacy of the training at DCJDC.

Training was supposed to consist of at least 30 hours of instruction when a detention officer first started, and then monthly trainings throughout the year to ensure the 40 hours of annual training mandated by law.[19] 55 Pa. Code §3800.58. While we have no reason to believe the facility didn't meet its mandatory training hours, the common complaint among former detention staff was the inadequacy of

[19] Different detention officers had different recollections of how long their initial training was. One recalled that it was one week of classroom training and two weeks of shadowing a more experienced officer. Another testified that it was a two to three week training. And another, who started during the Covid-19 pandemic, described it as a two week initial training period.

the training, particularly when it came to mental health training. As will be discussed later in this report, the facility had two particularly challenging residents, both of whom suffered from significant mental health issues. James Stickney, who was the training coordinator prior to becoming the operations manager, testified that he used to bring in someone from the outside once a year to train on mental health and believed that was adequate to deal with most residents. Yet, several former detention staff members testified that they did not have sufficient training to deal with residents with mental health issues. One former teacher at the facility opined that the officers appeared to have "zero training" on dealing with kids with trauma. A former detention supervisor and former female detention officer both reported that they asked management for more training on dealing with mental health issues, similar to the training the juvenile probation officers received, but their requests were denied.

Other former staff members commented that there was inadequate training on de-escalation techniques. The case management supervisor observed that while some detention officers developed good de-escalation techniques, others needed more training but never received it. As a result, in her experience, most staff were not adequately trained on de-escalating situations. A former detention officer corroborated this testimony indicating that although she received general training on the need to de-escalate, she did not receive training on actual techniques to de-

escalate. And another former detention officer, who after DCJDC closed went to work at a juvenile residential facility dedicated to juveniles with intellectual disability and autism, observed that at her new facility the training was much more focused on prevention and de-escalation of violent incidents rather than use of restraints to stop such incidents once they started. She contrasted this to the training at DCJDC, which she said felt as though they were dealing with violent criminals.

The training regimen also took a hit because of the Covid-19 pandemic. For example, the training on how to employ physical restraints, which was supposed to be hands-on and practiced on actual people, was instead practiced on chairs. The monthly trainings were printed PowerPoint slides that the officers reviewed and signed off on.

Also, given how short staffed the facility was, especially with respect to female detention officers, one officer who started in April 2020, when she was 21 years old, had to miss some of the trainings because she was a single mom taking college courses. As a result, much of her training simply entailed her reviewing the handbook she was provided, causing this detention officer to start the job not fully understanding how to do it.

In sum, the training appeared to be inconsistent over time and failed to adapt to the changing population detention staff were actually dealing with. In addition, training was an opportunity for the facility's management to emphasize the culture

and ethics they deemed important. Yet, we neither heard nor saw evidence that the management team used training in such a manner.

F. An example in contrast

In contrast to the lack of enforcement and accountability we heard about under Director Murray and his management team, we had the opportunity to see how a past DCJDC administration telegraphed its priorities to staff.

On January 26, 2004, the then-assistant director of the facility authored a memo to all detention supervisors, the contents of which were discussed in-depth at a supervisors' meeting a few days later. The memo addressed the concern of the assistant director and the director at the time about the "growing attitude that staff felt it unnecessary to comply with regulations or procedures unless they personally agreed with them." The memo emphasized that compliance with the state's regulations and the facility's policies and procedures was "not a matter of option." In particular, staff were reminded that if they failed to act on allegations of child abuse about which they knew or should have known, such failure could result in a finding of child abuse against that negligent staff member. Similarly, the memo stated that staff could not fail to act on information that a child's rights were being violated or that a staff member was "operating outside of our policies and procedures."

The memo further advised staff that if they were "not willing or able to comply," they should "seriously reconsider" whether this job was right for them, and that if management received information that staff were not complying, they would be terminated.

Supervisors were also reminded that by signing off on a report from a detention officer, that supervisor was verifying that they had taken all appropriate action as required and had no cause to believe the report was erroneous. Supervisors were also responsible for taking appropriate action whenever another supervisor instituted a restrictive procedure that was not in compliance with the regulations, by conferring with that other supervisor and ultimately terminating the restrictive procedure as appropriate.

The assistant director's memo noted that she and the director mentioned to staff at a recent training about the tendency of "some adults to use their authority over children by threatening, harassing, or generally mistreating them or by failing to treat the child with fairness, dignity and respect" in contravention of the child's specific rights to these things under state regulation. Supervisors were instructed that any staff member observed "belittling or demeaning children" for any reason should be confronted and directed to cease such conduct.

Finally, the memo noted that "[s]taff who do not take their moral, ethical and legal obligations to heart when dealing with" the detention center's residents, or who

do not feel obligated to abide by the facility's policies and procedures do not belong at DCJDC and must be "identified and weeded out." Supervisors were reminded that they were directly responsible for the detention officers' behavior and could not afford to wait for someone else to address the problem. The memo admonished the supervisors that "[i]t was time to draw a line" and "become an active participant in holding staff accountable." Any supervisor unwilling to do so was advised to "take a long hard look at why" they were at the detention center and whether they belonged there.

This memo is critical in several respects. First, it is clear that both the director and assistant director in 2004 were aware of issues among the staff of not following policy and procedure and, specifically, of not respecting the juvenile residents' rights. They were not only aware, but took several actions to address it. They attended a staff training where the staff were reminded of their obligations to the residents under both state law and facility policy, and they were warned that disregarding those obligations was not an option for anyone who wanted to remain employed there.

In addition, the director and assistant director met with the supervisors as well to review their obligations to ensure that staff were abiding by law and policy. The supervisors were reminded of their role as front-line supervisors to address staff members who were not respecting a juvenile's rights and/or not properly following

policies and procedures, including those regarding restrictive restraints. The supervisors were also to be held accountable for the officers they supervised and were directed to take action when their officers or another supervisor stepped out of line.

The sentiment and message were clear: the administration would not tolerate further abuses by staff or supervisors. The director and assistant director clearly and forcefully communicated the culture and ethics they expected. Admittedly, we did not hear evidence on how effective the message was in creating a culture that respected the juvenile residents' rights, or what measures the administration at the time used to ensure accountability. We also recognize that some of the sexual misconduct described earlier in this report happened around this same time period, suggesting that the messaging and the reality were not always aligned.

Nevertheless, this memo and its messaging makes clear that prior managers were more in touch with the problems that existed within the culture of the facility and made efforts to turn the tide. Director Murray, Deputy Director Singh, and Operations Manager Stickney, never issued a similar memo or directive while they were in charge at DCJDC.

IX. SYSTEMIC FAILURES THAT ALLOWED DCJDC'S CULTURE TO PERSIST

While it is easy to lay blame at the feet of those inside the facility – the detention officers, supervisors, and management – this report would be incomplete

if we did not recognize that there were certain players outside of DCJDC that share blame for allowing the facility to operate as it did for so long.

A. Low pay and overuse of overtime

There is an adage that you get what you pay for. That was true of much of the detention staff at DCJDC. Because the pay was abysmally low, particularly when compared to surrounding counties and in relation to what was expected of the detention staff, it is hardly surprising that DCJDC had high turnover, and its existing staff was burned out and frequently not vested in what should have been the mission of the facility. This problem cannot be blamed on Director Murray as it was the County that negotiated the contract for the detention officers. It was the failure of County officials to heed the warning of those who repeatedly brought this issue to their attention.

1. Poor pay for demanding work

In Lancaster County, the starting salary for a juvenile detention officer is $18.50/hour. In Bucks County, it is $28/hour. The average starting salary for juvenile detention officers in Delaware County during that same time period was a little over $13/hour – up from the $11/hour newer detention officers made when Director Murray first took over.[20] They also had to work a long time to get a raise, and even

[20] While the starting pay around the time Director Murray took over was around $11/hour, it would go up a bit every year under the contract such that detention officers who started in early 2020 were making $13/hour and detention officers who had been employed there since 2018 were

then it was no more than around $16 or $17/hour – below what even a new detention officer in Lancaster makes when he or she first starts. One officer who had been at DCJDC for 11 years was only making $17.76/hour when the facility closed. As one detention officer who had worked at DCJDC for 6 years prior to its shutdown put it, it was demoralizing that staff had to "fight and scratch" and still did not get the same salary as their counterparts in other counties. A detention supervisor called the pay "disrespectful." And Operations Manager Stickney testified that the detention officers were the lowest paid members of the AFSCME union, and made less than 911 operators.

With such low pay in relation to the duties of juvenile detention officers and in comparison to surrounding counties, it is not surprising that DCJDC had trouble recruiting and retaining qualified detention staff. State law required detention officers to have at least an associate's degree or 60 hours of college credit, so the facility hired college-educated officers. 55 Pa. Code §3800.283(1). But it was hard to attract college graduates for the salary Delaware County was willing to pay them. As one detention supervisor bluntly framed the issue, it was hard to recruit for this demanding job when "Chick-fil-a down the street is starting off teenagers at $13."

making under $15 hour when the facility shut down. One supervisor who started in 2007 as a detention officer at $11/hour was making $26/hour in her supervisory role by the time the facility closed in 2021. Regardless of the fluctuations over time, the 2021 budget proposal for DCJDC nonetheless show that newer detention officers were making only a little over $27,000 annually.

The pool from which DCJDC could recruit was made even smaller by Delaware County's residency requirement, meaning all detention staff had to live within the County.

Director Murray, with the help of his management team, did try to increase recruiting techniques rather than just rely on the County's human resource department. They placed a sign outside of the detention facility advertising that they were hiring. They posted the job on Indeed and on college job boards. And Director Murray repeatedly raised his concern over recruitment with the President Judge at their monthly directors' meetings and during the budget process. Nonetheless, these efforts did little to boost recruitment. In 2015, the facility had 11 vacant detention officer spots. By 2021, it had 23.

Even after DCJDC hired detention officers, it frequently could not keep them. Director Murray did a retention analysis in 2019 where he determined that of the 59 detention officers the facility hired under his management, 42 had resigned or been fired. An additional 25 detention officers who had preceded Murray's arrival also were no longer employed.

DCJDC was so in need of female detention officers, in particular, that it entered a memorandum of understanding with the Juvenile Probation Department to have female probation officers who had the requisite training cover shifts as needed

in exchange for time-and-a-half. They also relied on female case managers who had previously worked as detention officers to fill in shifts as needed.

As a result of the hiring challenges, Director Murray admitted that he would sometimes have to hire candidates who were substandard. In addition, it made it harder to discipline detention staff for misconducts such as lateness because the facility could not afford to lose detention officers, particularly female officers. As a result of this unfilled demand, some detention officers who had a poor work ethic and would call out frequently or show up late for their shift were nevertheless kept on, in part, because of the need to fill the positions.

2. <u>Over-reliance on overtime</u>

Given the chronic staffing shortages and the legal requirement to maintain a certain staff-to-resident ratio, DCJDC management relied heavily on overtime to meet the requisite staffing quota. There was a provision in the detention officers' contract that permitted the facility to force an officer to work overtime, even on a moment's notice. For example, when a detention officer called out shortly before his or her shift was due to start, and the facility was unable to get a volunteer to work overtime, a detention officer who had already worked at least one 8 hour shift would suddenly be told they had to remain working. Or, if a resident was put on suicide watch or in isolation that required a 1:1 staff-to-resident ratio, the facility would frequently need another officer to work on that unit in order to maintain the required

staffing ratios. Typically, those with lowest seniority and the least amount of overtime would be required to stay.

We heard from numerous detention officers who reported feeling resentful and overworked as a result of the frequent use of forced overtime by the facility. They described being deprived of the ability to see friends and family for extended periods of time due to forced overtime, or having to work overnight on a moment's notice despite having young children at home. The officers described being frustrated and worn out, sometimes working 16 hour shifts multiple days in a row, all while being underpaid.

On the flip side, some detention officers wanted the overtime because they needed the extra money given the low pay. Sometimes, the officers who wanted the overtime most were those that were least effective at their jobs. For example, the detention officer nicknamed "23 and 1" because of how long he kept the residents locked in their rooms, testified that he worked as many overtime shifts as possible.

Whether detention officers worked overtime by choice or by force, common sense and life experience teach that when one is frustrated and tired from overwork, one is less patient and empathetic and more likely to react out of anger and frustration. Putting overworked and underpaid individuals in charge of juveniles, many of whom had behavioral and mental health issues, is a recipe for disaster. As

DHS Southeast Regional Director Caitlin Robinson observed, *burn-out can lead to child abuse*.

3. <u>The plight of DCJDC detention staff fell on deaf ears</u>

As noted earlier, Director Murray raised the issue of staffing and pay frequently with his direct supervisor, the President Judge, and we know that the President Judge raised it with County officials.

Of particular note was an email the President Judge sent to Delaware County's Executive Director on February 29, 2020, outlining the dire need for the County to address DCJDC's staffing issues. In that email, which references the fact that the two had discussed this issue on prior occasions, the Judge described the staffing situation at the facility as "most precarious" and in steady decline. He noted that over 40% of the detention officer positions were vacant and vacancies dated back to 2016, and that while Director Murray believed the facility needed 35 male officers and 9 female officers, the facility currently had 25 male officers and only 3 female officers. The Judge noted that "no one frankly can recall when the center last enjoyed something remotely approaching" a full personnel complement.

The Judge outlined the efforts Director Murray and he had undertaken to increase applicant numbers and to temporarily fill the vacancies, particularly among female detention officers, including reliance on juvenile probation officers and contacting neighboring juvenile detention centers to see if they could loan out their

officers to work at DCJDC on an interim basis. However, as the Judge observed, a more permanent solution to the staffing issue was required:

> The long term solution is quite candidly setting the salary for a detention officer relatively comparable with those of analogous counties. The starting salaries for the nearby and similar counties are as follows: Chester County - $40,000.00; Montgomery County - $42,000.00; and Bucks County - $48,000.00. ***Delaware County's starting salary is $26,000.00, or forty (40%) percent less than the average compensation of these three (3) surrounding counties.*** I'm given to understand that certain of the surrounding counties don't have a residency mandate so those Delaware Countians with an interest in a detention officer position given the significant salary differential can certainly be expected to gravitate toward the out-of-county position paying almost twice as much compared to our detention center.

(Emphasis in original).

While the President Judge made a compelling case for a substantial increase in detention officer salaries, he went on to recognize that the County had already undertaken a salary study and that it made sense to wait for that study to be completed before authorizing an increase. Instead, the Judge asked for immediate action by way of exempting the detention officer position from the County's residency requirement, noting that of the most recent applicants for the position received by the County, the vast majority of them resided out-of-county and therefore were not eligible.

The President Judge did note that the deputy sheriffs had recently received a $2.18 hourly rate increase and that if the County rejected the residency waiver, it should "immediately adopt" the same hourly increase for the detention officers in

order "to create a sufficiently large enough pool of Delaware County residents so that the center has the necessary minimal number of full-time rostered detention officers." The Judge observed that while the annual salary cost was estimated to increase by $154,000 with the proposed pay increase, that number did not account for the anticipated reduction in overtime costs that the County currently incurred as a result of the "chronic staffing shortage," and the fact that the state would reimburse the County for 50% of the center's operational costs.

The County Executive emailed the President Judge the following day indicating that she would share his email with County Council and that the issue was on the Personnel Board's agenda for the upcoming meeting.

Ultimately, the residency requirement for detention officers was waived. However, the County took no action on increasing salaries until its salary study was completed. As a result, the detention officers received a pay increase only shortly before the facility was shut down.

While we are unable to ascertain why County officials did not act more quickly to address the salary disparity for detention officers at DCJDC, we can say that budgetary concerns should have played no role in the County's consideration. Not only did the state reimburse the County for up to 50% of DCJDC's operating budget, as the President Judge noted in his email, but the facility also consistently operated under-budget by well over half-a-million dollars since at least 2015. While

Director Murray did not have the authority to simply reallocate those unspent funds on detention officers' salaries, the County certainly could have used the facility's budget surplus to negotiate a more favorable contract with the detention officers' union. For that matter, it also could have used the facility's unspent funds to pay for the requested video surveillance upgrade. Instead, the County did no such thing, suggesting that the needs of the detention center, its juvenile residents, and its staff was a low priority.

B. <u>Lack of oversight by outside stakeholders</u>

It is easy to make excuses for judicial and County officials by saying that they did not understand the problems that plagued DCJDC and that had they known, they would have acted. However, the reason that these officials did not know about the state of their juvenile detention center is primarily because they expended little effort to know. Indeed, it appeared that few if any outside the facility were vested in the detention center's success.

Neither the judiciary nor Council members regularly visited or observed the facility. Rather, officials with oversight responsiblities for the facility typically only toured the facility once upon assuming office, and visits were rare during the five years preceding the shutdown. By failing to demonstrate an interest in DCJDC's operations and a commitment to its success, judicial and County leaders signaled to the facility's staff and residents that they were unimportant – a message further

enforced when the County did not increase detention officers' salary or upgrade their video surveillance system despite many requests to do both.

Notably, the legislature adopted a means by which there would be more outside oversight of juvenile detention facilities. The law requires that Class 2 and Class 2a counties, such as Delaware County, create a board of managers to oversee the operations of juvenile detention facilities. The board is to consist of three county commissioners, the county controller, and six private citizens, three of whom are appointed by the president judge and three who are appointed by the council chairperson. 16 P.S. §2339.3.

However, because Delaware County is a Home Rule county, it is not bound by this statutory requirement and is free to adopt its own ordinances and county government structure. Delaware County did not adopt an ordinance creating a board of managers to oversee its juvenile detention facility until June 2021 – three months after DCJDC's shutdown. Delaware County now has a board of managers along the lines provided for in Section 2339.3, made up of county officials or their designees, as well as private citizens. *See* Delaware County Ordinance No. 2021-4.

The quality of the oversight this board will provide of course depends on the level of commitment of the board members. We heard from the former director of Montgomery County's juvenile detention center, which was overseen by a board of managers, that its board was comprised of members who had an interest in juvenile

welfare. The board met monthly and, among other things, reviewed reports regarding personnel issues, including use of restraints and allegations of abuse. The board members also conducted monthly, random unannounced visits to the facility. Undoubtedly, this level of oversight and accountability to people outside the facility helps ensure against a culture where detention staff believe they can do whatever they want and management lets them.

We certainly hope that Delaware County has appointed designees and citizens who are knowledgeable about the juvenile justice system, juvenile development, and rehabilitation in a detention setting. We also hope that the board members will play an active oversight role by regularly visiting any detention facility it oversees and becoming well-versed in the policies and procedures of that facility. By having a group of people vested in the mission of juvenile detention centers, and by having more eyes and ears in the facility, we are hopeful that abuse and apathy on the part of those responsible for caring for the juveniles will be eliminated.

C. Oversight by DHS and PREA auditors was not sufficient because they only enforce narrow and minimum standards

Perhaps one of the most surprising lessons we learned during the course of this investigation is that DCJDC could operate the way it did for so long despite state and federal oversight. Although the facility was required to undergo annual inspections by DHS and by federally-certified auditors under the PREA, neither inspection helped to root out problems within the facility or help improve it. The

reason, we have discovered, is that both inspections are narrow in scope and require juvenile detention facilities to meet only minimal standards. There are no established "best practices" for juvenile detention facilities, and there is no body to enforce such practices even if they were established.

1. DHS Inspections

Juvenile detention facilities, such as DCJDC, must be licensed by DHS in order to operate. With the legislature's authority, DHS passed "minimum" licensing requirements in what are often referred to as the "3800 regulations" (referred to herein as the "3800-series regulations"). 55 Pa. Code §3800, *et seq*. Under those regulations, each facility must be individually inspected once a year by a representative of DHS. 55 Pa. Code §3800.4(a). Facilities are given advanced warning of the date of the inspection, usually 30 days beforehand, and are required to submit certain pre-licensing information prior to the inspection date. A few days before the inspection, the facility is also informed of which juvenile and staff files the inspector would be reviewing. In addition to the scheduled annual inspections, inspectors are encouraged, but not required, to conduct periodic unannounced visits of a facility. The DHS inspector who was primarily responsible for inspecting DCJDC over the last several years testified that she did conduct unannounced visits of the detention center, but did not keep records for those "pop up" inspections.

DHS inspections ensure compliance with the 3800-series regulations, which run the gamut in terms of what is required of the facility. The regulations mandate very specific requirements regarding the physical site, such as how poisonous materials are to be stored, the condition of heat sources and lighting, acceptable indoor temperature settings, the use of window screens, the minimum size of the residential rooms, and fire safety concerns. *See, e.g.* 55 Pa. Code §§3800.81-3800.132. The regulations also mandate certain health and safety assessments for the children, nutritional requirements for their food, and requirements for handling medications. 55 Pa. Code §§3800.141-3800.189. During DHS' annual inspection, these types of technical requirements are easier for the inspector to assess. They require physical inspection of the site; review of procedures for things such as fire drills or filing of grievances; a check of residents' files to see if they had received the proper assessments after admission to the facility; and a check of staff files to ensure the proper clearances were obtained.

Notably, there are no regulations requiring a comprehensive video surveillance system. There are no regulations regarding the provision of mental health services to residents with mental health needs. There are no regulations requiring a minimum standard of pay for detention staff or limitations on the number of hours they can be forced to work overtime.

The 3800-series regulations also provide more substantive, non-technical guidance for the operation of such facilities. For example, the regulations establish a child's specific rights, including the right to be treated with fairness, dignity, and respect, and the right not to be abused, mistreated, threatened, harassed or subjected to corporal punishment. 55 Pa. Code §3800.32. The regulations prohibit use of restrictive procedures, such as physical restraints and seclusion, in a punitive manner or for the convenience of staff. They also require that restrictive procedures only be used after every attempt has been made to de-escalate the behavior through less intrusive means. 55 Pa. Code §3800.202. The regulations mandate that the director be responsible for ensuring the safety and protection of the children and implementation of policies and procedures. 55 Pa. Code §3800.53. And they require that surfaces, including floors, walls, ceilings, windows and doors, be free of "hazards." 55 Pa. Code §3800.87.

These types of regulations require more interpretation. They also require reliance on the facility staff and residents to fully and accurately report incidents that may violate the regulations. For example, a DHS inspector could not know that restraints were being used punitively or that seclusion was used for the convenience of apathetic detention officers, unless someone in the facility reported such violations. Whether the staff were violating a juvenile's right to fairness, dignity, and respect was both a matter of interpretation and whether violations were reported.

Whether the director was truly "responsible" for protecting the children in his care and implementing policies and procedures was difficult to gauge on an annual inspection. And, even assuming an inspector deemed graffiti referring to killing, rape, and suicide on the surfaces of the residential units to constitute a "hazard" under the regulations, the inspector would only know about such hazards if the facility didn't paint over them in anticipation of the annual inspection – which DCJDC did.

Moreover, even if DHS found evidence that some of the more substantive regulations were being violated, there was little it could do other than demand that the facility develop a plan of action to correct the violation. Inspectors had no authority to force personnel decisions, such as termination, on a facility if they found evidence that a particular officer or supervisor was consistently violating a child's rights. The inspectors had no authority to mandate a certain salary or to limit the use of overtime. If a child revealed to an inspector that he or she felt unsafe or threatened by a particular staff member, the inspector had no authority to remove the child from the facility. To the extent the child's complaint warranted being reported either to the director or ChildLine, the child faced possible retaliation for having made a report in the first instance. Similarly, if a staff member complained to the inspector, those complaints would be raised with the director, alerting the director to the source of the complaint.

In short, while DHS provides enforcement over minimal standards, it has virtually no ability to provide meaningful accountability for substantive failures to respect juveniles' rights and embrace rehabilitation as the center's mission. DHS enforced the 3800-series regulations only. If a requirement isn't set forth in those regulations, DHS cannot enforce it, even if best practices dictate otherwise.

2. PREA Inspections

PREA is a federal statute signed into law in 2003 that went into effect in 2013. It requires all corrections and detention facilities at the federal, state, and local levels to comply with its requirements, which are intended to prevent sexual assaults within such facilities. The standards under PREA are different for adult and juvenile facilities, with the juvenile standards being more stringent given the more vulnerable population. Compliance is determined by audits conducted by certified PREA auditors once every three years. Despite the stringent standards, PREA has no real enforcement mechanism beyond the potential loss of federal funds if a facility is not certified compliant.

PREA auditors do not conduct any actual investigations of sexual abuse allegations. Rather, they merely determine whether a facility is compliant with the required standards. For juvenile facilities, those requirements are generally as follows:

- Juveniles are to be told immediately upon intake into the facility of their right not to be sexually harassed or abused;

- A risk assessment has to be completed with the juvenile within 72 hours of intake;
- Juveniles have to be re-educated in more detail about their rights under PREA within 10 days of intake;
- The facility has to have a hotline for reporting sexual abuse;
- The facility has to have a complaint box for filing confidential complaints about sexual abuse;
- Posters must be hung throughout the facility reiterating a juvenile's rights under PREA and those postings have to be in English, Spanish, and any other language spoken by the residents;
- Staff must conduct random, unannounced rounds; and
- Notice must be provided 6 weeks prior to the PREA audit with the date of the audit and information about the auditor so that residents have the opportunity to report any sexual abuse directly to the auditor.

The audit generally consists of reviewing the facility's pre-audit questionnaire regarding a census of the residents and any reports from the prior year of sexual harassment or abuse by staff; a comprehensive tour of the facility; a spot check of randomly selected residents and staff regarding their knowledge of PREA; a check of the hotline to ensure it works; a review of the unannounced rounds log to ensure that administrative staff are regularly conducting unannounced rounds on all three shifts; and confirmation that the staff have background checks and clearances.

DCJDC underwent three audits since PREA went into effect: one in 2015, one in 2017 and one in 2020. Each time, the facility was deemed compliant. While those inclined to defend DCJDC may point to its compliance with PREA, it is important to remember the minimal standards the facility had to meet. The facility hung the right posters, provided the correct information to residents about reporting sexual

harassment and abuse, and established access to a hotline. But checking these proverbial boxes to ensure that the facility met the requirements of this narrow federal law does not measure the facility's success in respecting juveniles' rights, or ensuring the staff's professionalism, or in fulfilling its mission of rehabilitation.

The auditor who conducted the 2020 PREA audit indicated in his interview with OAG agents that he did not review use of seclusion or physical restraints. With respect to staffing concerns, he only looked to see that the facility met the required staff-to-resident ratio and that the staff had their clearances. He did not review time sheets to see how much overtime the officers worked. He was not aware that a former detention officer had been convicted of having sex with a former underage resident of the facility since DCJDC's prior PREA audit. He was unaware that the video surveillance system only covered 50% of the facility.[21] The auditor informed OAG agents that had he known about some of these facts it would have affected his audit and final report.

The Grand Jury also reviewed several emails between a prior DCJDC senior manager and a staff member at a neighboring county detention center. In these emails, the two share their frustrations with PREA auditors and reference forging juveniles' signatures, creating misleading documents, and back-dating unannounced

[21] Though, as noted earlier, PREA does not even require detention facilities to have video surveillance systems.

round logs to meet PREA standards. When the other county staff member emailed this senior manager of DCJDC to warn him that DHS had conducted a more thorough inspection of their detention center that year, he responded "we are smoked if that's the case." These emails, along with the fact that relevant information appears to have been withheld from auditors at times lead the Grand Jury to believe that steps were taken to avoid a complete and honest evaluation of even these minimum standards.

In short, DCJDC's ability to meet the minimum standards for the DHS and PREA inspections does not undermine this Grand Jury's findings that the facility not only failed at its mission but was detrimental to the well-being of its juvenile residents. The fact that DCJDC could meet the minimum standards the law imposed is a reflection on the standards, not the facility.

X. A PERFECT STORM: DCJDC CRACKED UNDER THE PRESSURE OF HOUSING CHALLENGING JUVENILES.

It is not an exaggeration to say that DCJDC might very well still be operating today if it had not been for a female resident with severe mental health issues, who shall be referred to as Juvenile Resident A, being detained there multiple times in the year preceding the facility's closure. This is not to suggest, as some former detention staff and administrators have, that the facility was otherwise a good facility and this juvenile was the problem. Juvenile Resident A certainly presented some unique and difficult challenges. Nevertheless, she was a bit like the canary in the

coal mine. It took her detention at DCJDC to expose and highlight the dangers that had lurked within the facility for too long. DCJDC's handling of Juvenile Resident A shines a spotlight on so much of what was wrong at the facility.

A. Juvenile Resident A

Juvenile Resident A was a teenage female with severe mental health disorders, including PTSD, schizophrenia, and bipolar disorder. She had been in and out of DCJDC for years, but her presence in the last year or so prior to the facility's closure was exceptionally tumultuous. All the staff who worked with her agreed that it was challenging and often exhausting. When she acted out, she would frequently take off her clothes to make the male detention officers on the unit uncomfortable. She also was known to throw menstrual blood, feces, and other bodily fluids at the guards when she was having an episode. Most former employees who testified about Juvenile Resident A agreed that she should not have been placed at DCJDC and that they were ill-equipped to deal with her. However, because residential placements have the option to refuse a juvenile, her mental health issues and behavior within the facility made it difficult for the juvenile probation department to locate a permanent placement for her. While she was occasionally brought to the hospital for acute episodes, more often than not, she was returned to DCJDC once the immediate crisis abated.

There can be little doubt based on the evidence we heard that Juvenile Resident A would have been better off in a facility that specialized in juveniles with mental health disorders. Yet, the reality is that insufficient resources exist for such cases and so long as facilities are able to refuse residents, there are few options. The fix for this larger problem is beyond the scope of this investigation and report.

So long as kids like Juvenile Resident A exist and need to be detained, juvenile detention centers need to be equipped to handle them. While any juvenile detention facility would undoubtedly have found Juvenile Resident A challenging, aspects of DCJDC in particular created a perfect storm for rendering the facility utterly incapable of safely and adequately caring for her. Three incidents in particular highlight this fact.

1. <u>Incident #1</u>

Perhaps the most upsetting testimony we heard during the course of this investigation was when Juvenile Resident A was secluded for three days in her room covered in her own blood, feces, and vomit. This incident occurred around Thanksgiving of 2020, and apparently started when the teen got upset with a supervisor for refusing to allow her to call her boyfriend. She ended up throwing her menstrual pad at him and one female and three male detention officers restrained her and began transporting her back to her room. En route back, the female detention officer was, at one point, alone with Juvenile Resident A because it was a blind spot

on the camera system and the male officers were not permitted to escort her through the blind spot. At that point, the teen stripped off her clothes, wiped menstrual blood on herself, and began urinating and defecating. She then curled up in a ball and rocked back and forth asking the female detention officer to make sure "they" didn't hurt her.

The female detention officer had only been on the job less than a year and was totally shocked, having never witnessed anything like it before, and having to deal with the girl's behavior on her own since she was the only female detention officer available.

One of the male supervisors arrived in response to the incident and after seeing what was happening, went to locate some means of protecting the detention staff from exposure to bodily fluids while dealing with the juvenile. Because the facility had no actual protective gear available for the staff to use in such situations, he grabbed trash bags and gloves for the detention officers to wear while they carried the juvenile back to her room. While in there, Juvenile Resident A flooded her cell and also urinated on the floor, making it slippery. She threw feces and menstrual blood at the window of the door, through which staff were observing her, forcing detention staff to enter her room to clear the obstruction. When staff would enter, wearing trash bags as their only protection, the teen threw vomit, urine and feces at them.

Juvenile Resident A remained in seclusion in this state for approximately 3 days – naked and covered in her own feces and bodily fluids. At one point during this seclusion, a sympathetic detention officer gave her a blanket, but she proceeded to rip it up and try to strangle herself with it, again requiring staff to enter her room. Once again, the teen threw bodily fluids at the staff. For reasons that we do not understand, Juvenile Resident A was not deemed to be in crisis because she was not an immediate threat to herself or others, so she remained at the facility in seclusion. Her seclusion only came to an end when, after several shifts, she calmed down sufficiently such that a female detention officer was able to get her cleaned up and help clean out her room.

2. <u>Incident #2</u>

A second notable incident about which we heard involved a female detention officer, Detention Officer #5. While each detention officer who testified about these events recalled the details of how it began differently, taken together we are able to get an understanding of the most important facts.

Two to three male detention officers were assigned to the female unit along with Detention Officer #5 due to the shortage of female staff. Detention Officer #5 and one of the male officers were dating, and Juvenile Resident A told the male detention officer that Detention Officer #5 was texting with another officer, causing tension between the two. Detention Officer #5 left the unit, and the juvenile was

ordered to go to her room, but she instead stripped off her clothes and refused to go. The male officers restrained the juvenile and placed her in her room, where, once again, she flooded it before the staff could turn off the water. Juvenile Resident A at some point blocked the window in her door with the mattress, requiring the staff to enter her room to clear the obstruction. The teen grabbed one of the male officer's legs and pleaded with him not to let anyone hurt her. As the male officers attempted to calm her down and remove the mattress, Detention Officer #5 appeared suddenly and began kicking the teen on her legs and side, further escalating the situation. The male detention officer who had been calming Juvenile Resident A down asked Detention Officer #5, "[W]hat the fuck are you doing?" The supervisor ordered Detention Officer #5 off the unit. Juvenile Resident A ended up being taken to the crisis unit later that night.

Detention Officer #5 testified before this Grand Jury and, while she recalled the incident, she denied that she ever kicked Juvenile Resident A. Yet, we also heard from the male detention officer who witnessed the entire event and participated in restraining the juvenile. We found his testimony regarding this incident to be candid and credible and he was unequivocal about the fact that Juvenile Resident A had been calming down and gaining control when Detention Officer #5 assaulted her. As this officer observed, Juvenile Resident A was no saint, but most of the time the staff

were able to get her under control, and Detention Officer #5 needlessly interfered and escalated the situation.

Although this male detention officer testified that he filled out a SAR on the incident and gave it to his shift supervisor, who was also present during the events, we did not find any SARs on this incident and there is no indication that Detention Officer #5 was ever disciplined for it.

3. Incident #3

A third notable incident about which we heard evidence involved another female detention officer, Detention Officer #6. We learned about this incident because it was the subject of a ChildLine report, which we had access to as part of the investigation. We are glad we did because the report tells a different story than the one we heard from the detention officers involved.

On December 1, 2020, Detention Officer #6 and another officer escorted Juvenile Resident A to Crozier Chester Hospital for a medical clearance before she returned to DCJDC. While there, several nurses reported that Detention Officer #6 verbally abused the teen. When Juvenile Resident A said that she wanted to go to a crisis center, Detention Officer #6 refused and said the juvenile was "going back to the room behind the locked door." Detention Officer #6 also reportedly told the girl that she was a "fucked up individual." One nurse said it was like two angry 17 year olds screaming at each other. Juvenile Resident A attacked Detention Officer #6; the

the other detention officer present, along with the assistance of a male nurse, were able to restrain her. Detention Officer #6 left the room and was overheard saying that the "bitch" spit on her and that she wanted to go back in the room and "fuck [Juvenile Resident A] up." As the nurses medically restrained the juvenile, Detention Officer #6 repeatedly reentered the room, despite being told to stay out, and would make comments to and about the teen, further escalating the juvenile's behavior. Then, as the nurses were administering sedatives to calm Juvenile Resident A down, the other detention officer said "night night," which again escalated the girl's behavior. Juvenile Resident A repeatedly pleaded with the nurses to not let "them" hurt her anymore.

On December 3, 2020, a couple days after this incident at the hospital, Detention Officer #6 texted in a group chat with other female detention officers that she had wanted to "FUCK [Juvenile Resident A] UP sooo bad." She also texted about the juvenile screaming to the nurses not to let Detention Officer #6 hurt her, and wrote "She knew what the fuck it was hitting for when we got back to Lima." And she encouraged the other officers who would work with the juvenile the following day to "FUCK HER UPPPPPPPP."

In addition, Juvenile Resident A was pregnant at the time of this incident, and Detention Officer #6 reportedly threatened to cause the teen to have a miscarriage. One of the newer detention officers who heard this made sure that she was the officer

assigned to Juvenile Resident A if Detention Officer #6 was working in case she actually intended to harm the teen's unborn baby.

Detention Officer #6 was asked about these text messages during her Grand Jury testimony and, incredibly, denied meaning that she wanted to physically harm the teen. Detention Officer #6 did express, however, how distraught she was because of the hospital incident. During it, Juvenile Resident A apparently ripped some of the officer's hair out of her head, causing a permanent bald spot, and also hit her in the stomach, which Detention Officer #6 believed caused her to miscarry her own unborn child. Detention Officer #6 was "enraged" and "emotional" when she wrote those texts, and also had been forced to work a 16 hour shift. She took time off after the incident because she needed to regroup mentally and did not want to work with Juvenile Resident A after she returned to DCJDC. She also expressed her desire to Deputy Director Singh that she wanted to press criminal charges against the juvenile. Nevertheless, because the facility was short-staffed, Detention Officer #6 continued to have to work with the teen when she returned.

As for the ChildLine report, it was treated as a licensing violation for inappropriate treatment by staff. The corrective action proposed by DCJDC was that Detention Officer #6 would be retrained on de-escalation methods, types of abuse, child specific rights, and code of conduct. This training was completed on December 22, 2020, by PowerPoint slides which Detention Officer #6 used to "self-train."

There was also an indication that she would be trained in-person by the training coordinator when he returned from vacation. We do not know whether this training took place. DHS approved the plan of action and training was deemed completed on December 22, 2020.

4. A perfect storm

These three incidents we describe are far from the only incidents in which Juvenile Resident A was involved. We heard of others as well. For example, one CGRC counselor recounted once coming to check on the teen only to find her in her room with strips of ripped shirt around her neck, calling for help, and saying she didn't want to die, while two male detention officers stood by doing nothing. On another occasion, Juvenile Resident A was at her door talking, something she apparently liked to do, and one of the male detention officers yelled at her to stop. They argued and the male detention officer came toward the teen, requiring other officers to intervene and push the approaching detention officer away. As they escorted Juvenile Resident A back to her room, she threw a cup of juice at the officer, and he tried to do the same to her but, again, the other detention officers stopped him. Later, this detention officer poured juice in the juvenile's shoes in retaliation. Because the newer, female detention officer who was involved in the incident filed a SAR about it, the male detention officer was suspended.

Juvenile Resident A was, without a doubt, incredibly challenging for the detention staff to deal with. She repeatedly tried to harm herself; she stripped naked to make guards uncomfortable; she lashed out at staff by throwing bodily fluids and grabbing them in inappropriate places.

While it is easy to justify DCJDC's inability to appropriately deal with Juvenile Resident A by saying she did not belong there, the reality was that she was there and there was little the facility could do about that other than adapt and adjust. But DCJDC was not equipped to do so.

- They had inadequate mental health training. Not only did we hear this from many witnesses, but it was also evidenced by the fact that some staff viewed Juvenile Resident A not as a deeply troubled teen with severe mental health issues, but as a manipulative and controlling person who engaged in such extreme behaviors merely as a means to get her way. One detention officer testified that Juvenile Resident A thanked her repeatedly for treating her like a human being. Perhaps with more awareness and training, all staff would have had the capacity to treat her that way – as a teenage girl in need of help, not as someone to be punished and retaliated against.

- They had a culture of treating kids disrespectfully and unprofessionally, which served only to further exacerbate a juvenile like Juvenile Resident A, who lacked the capacity to exercise rational judgment and self-control. We even heard from some witnesses who said detention officers would purposefully try to get the teen to lash out so they could increase the likelihood of her being removed from the facility.

- They had a culture where staff could retaliate against juveniles with little or no consequence.

- They had underpaid staff who were forced to work overtime, and thus were more tired, overworked, and impatient when dealing with a teen such as Juvenile Resident A.

- They had a staff shortage, meaning that despite several officers having pressed criminal charges against the juvenile, these officers were forced to continue to work with her.

- They had inexperienced staff due to the high turnover. In fact, all but one of the female detention officers had 2 years' experience or less in 2020 when dealing with Juvenile Resident A. That resulted in some of the newest, least experienced officers working with the most challenging resident.

Juvenile Resident A exposed the weaknesses at DCJDC, where when pressure was applied, the facility failed. The administration brought in mental health counselors for the detention staff to get some relief, and also brought in "respite" workers at times to work with the teen in order to give the staff a break. But these efforts were like applying band-aids to a gunshot wound. DCJDC's failings had already created a "lose lose" situation for both Juvenile Resident A and the detention staff assigned to supervise her that respite workers could not fix.

Nor did Director Murray or his management team obtain basic safety equipment for staff to deal with Juvenile Resident A when she was exposing them to bodily fluids. Rather than having access to appropriate gear that would have protected them when she was having such an episode, the staff were reduced to wearing trash bags and changing clothes. Given the number of times this resident apparently engaged in such behavior, it seems like an obvious measure to take to

protect staff and make their interactions with her safer. Yet, the leadership of the facility failed to take even this basic step.

In short, while Juvenile Resident A would have proven challenging for any detention facility, DCJDC was particularly ill-equipped to handle her. We have heard during this investigation that Juvenile Resident A boasted that she would get the facility shut down and, of course, it now is. The fact that a teenage girl helped bring about that shutdown says less about the teenage girl than it does about the fragility of the facility. While this teen's presence in the detention center may have exposed much about the failings of the juvenile justice and mental health systems at large, how the management and detention staff of DCJDC dealt with her exposed much of what was wrong at DCJDC.

B. Juvenile Resident B

Juvenile Resident B was another female resident with mental health issues who was detained at DCJDC. We heard from several witnesses that due to her mental health problems, this teen was often violent towards residents, staff, and herself, frequently engaging in self-harm behaviors like cutting. Although the testimony we heard about her was less dramatic than that regarding Juvenile Resident A, there was one particular incident that again illustrates many of the problems we have learned about the facility. This incident again involves Detention Officer #6 – the same one involved in the hospital incident described above with Juvenile Resident A – and it

occurred on November 11, 2020, approximately 3 weeks before the incident with Juvenile Resident A.

1. <u>The incident</u>

Again, there are differing accounts of how this incident started, but at some point Juvenile Resident B attempted to go to the common area when she was required to remain in her room for safety reasons. As Detention Officer #6 and a male detention officer attempted to block the teen and direct her to return to her room, the girl swung at them. The officers restrained her and returned her to her room, but once there, according to Detention Officer #6, Juvenile Resident B grabbed her hair and pulled her down. The other officers were able to get the juvenile off of Detention Officer #6 and lock her in.

At some point during this interaction, Detention Officer #6 punched Juvenile Resident B in the face, causing her a black eye. The detention officer bragged about assaulting the teen in the group chat with her fellow female detention officers, writing, "When I say I fucked her up I FUCKED [Juvenile Resident B] UP." She also told them that after they got the teen into her locked room, Detention Officer #6 taunted her, screaming through her door "whenever your ready for round 2 let me know," and "I'm glad you tried me cause now you know." One male detention officer testified that Detention Officer #6 also bragged about it to him.

According to another female detention officer, Detention Officer #6's assault on Juvenile Resident B earned her the nickname "Knuckles." However, because a CGRC counselor observed the teen's injury, she made a ChildLine report about it, and Detention Officer #6 got scared. After that, the officer started telling people that Juvenile Resident B injured herself by banging her head against the wall. The SARS on the incident written by Detention Officer #6 and the other detention officer involved reflect that version of events – that the juvenile was hitting her own head.

DHS's investigation of the incident included interviews of Detention Officer #6, the other officer involved, the shift supervisor, and James Stickney. Each of the officers denied that anyone hit Juvenile Resident B. Stickney showed the investigator videos of several other incidents involving the teen where she was violent and aggressive. Of course, because there was no video in the hallways that would show the rooms, there is no video for this incident itself. Ultimately, and unsurprisingly, DHS deemed the allegation of abuse against Juvenile Resident B unfounded.

One of the newer, younger female detention officers, who was aware of Detention Officer #6's incriminating text messages, testified that she did not report those text messages to a supervisor or manager because, since everyone was calling Detention Officer #6 "Knuckles," the younger detention officer assumed everyone knew about the assault already. In addition, because of other experiences she had

had at the detention center, including some with Juvenile Resident A, it was clear to this officer that nothing was being done to help, so this officer "didn't feel like [her] voice would matter."

Of course, in her testimony before the Grand Jury, Detention Officer #6 denied having assaulted or taunted Juvenile Resident B, and once again claimed that the text messages – which plainly indicated she had assaulted the teen – did not mean what they said. The other detention officer involved in restraining Juvenile Resident B testified that Detention Officer #6 and the teen got "into it" when Detention Officer #6 was pushing the girl back into her room and that maybe punches were thrown, but said it all happened too fast and he did not see Juvenile Resident B get hit.

2. <u>The take-aways</u>

This incident with Detention Officer #6 and Juvenile Resident B again highlights the problems the facility had in dealing with residents with mental health issues and the tendency of some staff to retaliate against the juveniles rather than treating them professionally and with consideration for the fact that they are troubled teens. But this particular incident highlights other problems we have discussed in this report, namely the lack of accountability and culture of cover-up.

First, because there was no video of the hallway that could have captured the encounter between Juvenile Resident B and the staff, we are left to rely on the staff's

account. The staff primarily circled the wagons and made sure to protect Detention Officer #6 during the DHS investigation. The SARs were written to exclude any mention of an assault. Those interviewed as part of the DHS investigation denied seeing Detention Officer #6 or any other staff member punch Juvenile Resident B and James Stickney went so far as to demonstrate to the investigator that the teen was a violent, aggressive resident by showing videos from other occasions where she had been violent, undermining any credibility Juvenile Resident B may have had. With the odds stacked against the residents this way, it is hardly surprising that almost none of the ChildLine reports made against DCJDC staff have ever been deemed founded.

Yet, because we have Detention Officer #6's own damning texts, we know that she punched Juvenile Resident B. She even bragged about it and earned a fitting nickname as a result. Unfortunately, none of the other female detention officers came forward with those texts either to management or as part of the ChildLine investigation. Even though much of the detention staff apparently knew Detention Officer #6's nickname was "Knuckles" and why, few if any detention staff admitted that to this Grand Jury and most claimed that they were unaware of detention officers assaulting residents. It was only a few honest, courageous officers – those who were newer to the facility – who were no longer willing to keep silent about what went on there.

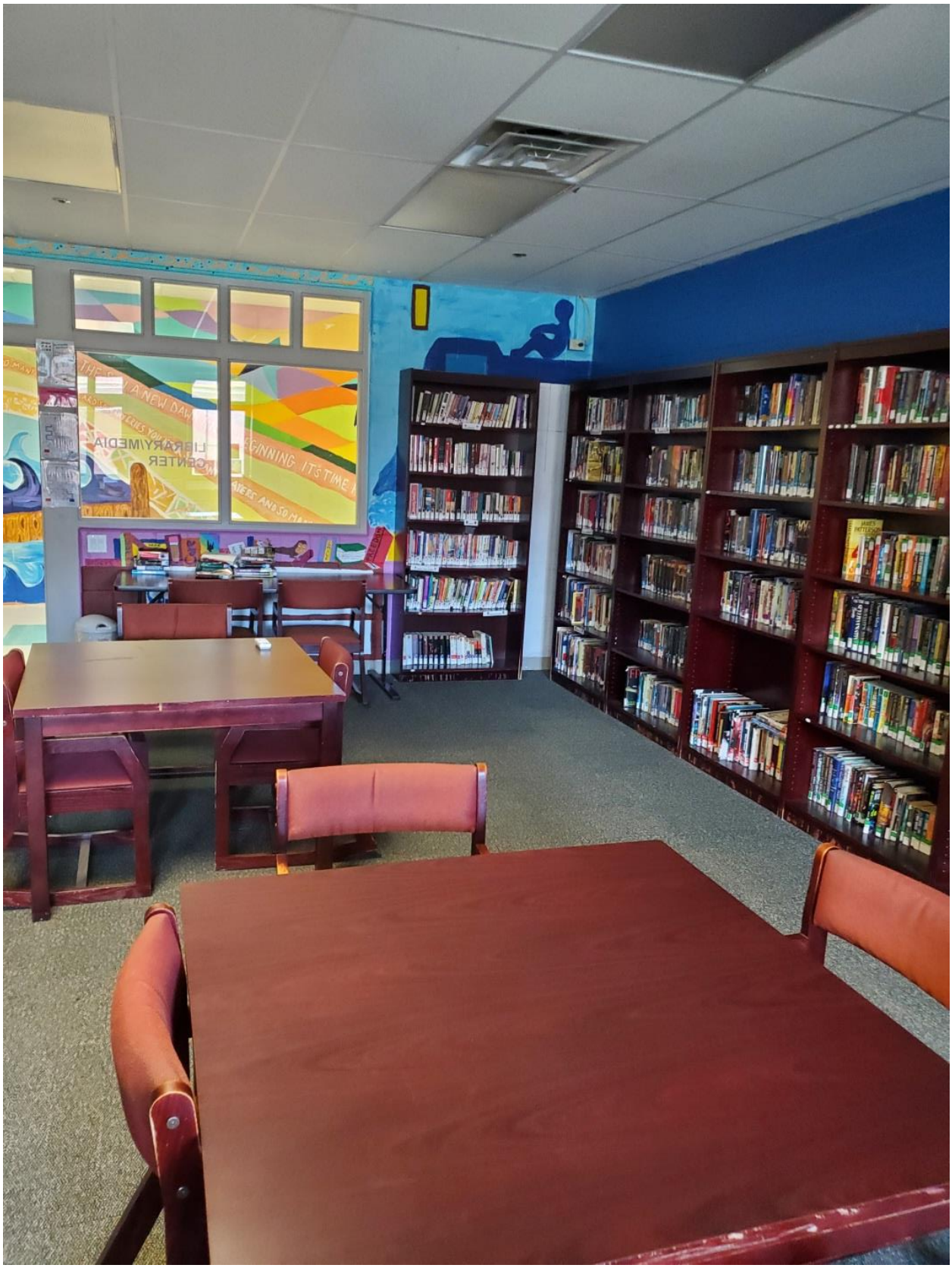
XI. JUVENILE DETENTION CENTERS CAN BE SECURE WHILE ALSO SERVING THE GOAL OF REHABILITATION.

Lest there are people reading this report who think that we are expecting too much from a juvenile detention center that is intended to be a short-term, secure facility, that assumption is wrong. We have also seen evidence of how other counties' juvenile detention centers are operated. These facilities, both of which are in nearby counties, do not want to be publicly identified, so we refer to them only as Facility A and Facility B. While there are no formal "best practices" for how a detention facility should operate – a problem which we believe should be rectified – these facilities serve as proof that a juvenile detention center can be both secure and focused on the goal of rehabilitation. The condition, culture and practices of these facilities should serve as a role model for how juvenile detention centers should operate throughout the Commonwealth.

A. Facility A

Facility A's juvenile detention center has 48 beds in the detention side of the facility and 36 in the shelter side, keeping juveniles accused of delinquency separate from those who are being housed for dependency reasons. The walls of the facility are covered in the residents' artwork and murals painted by the residents as part of the facility's art program. There are also motivational phrases such as "Unity" posted throughout the building. The hallways are lit by natural light from windows that face an interior courtyard, and the building is clean.

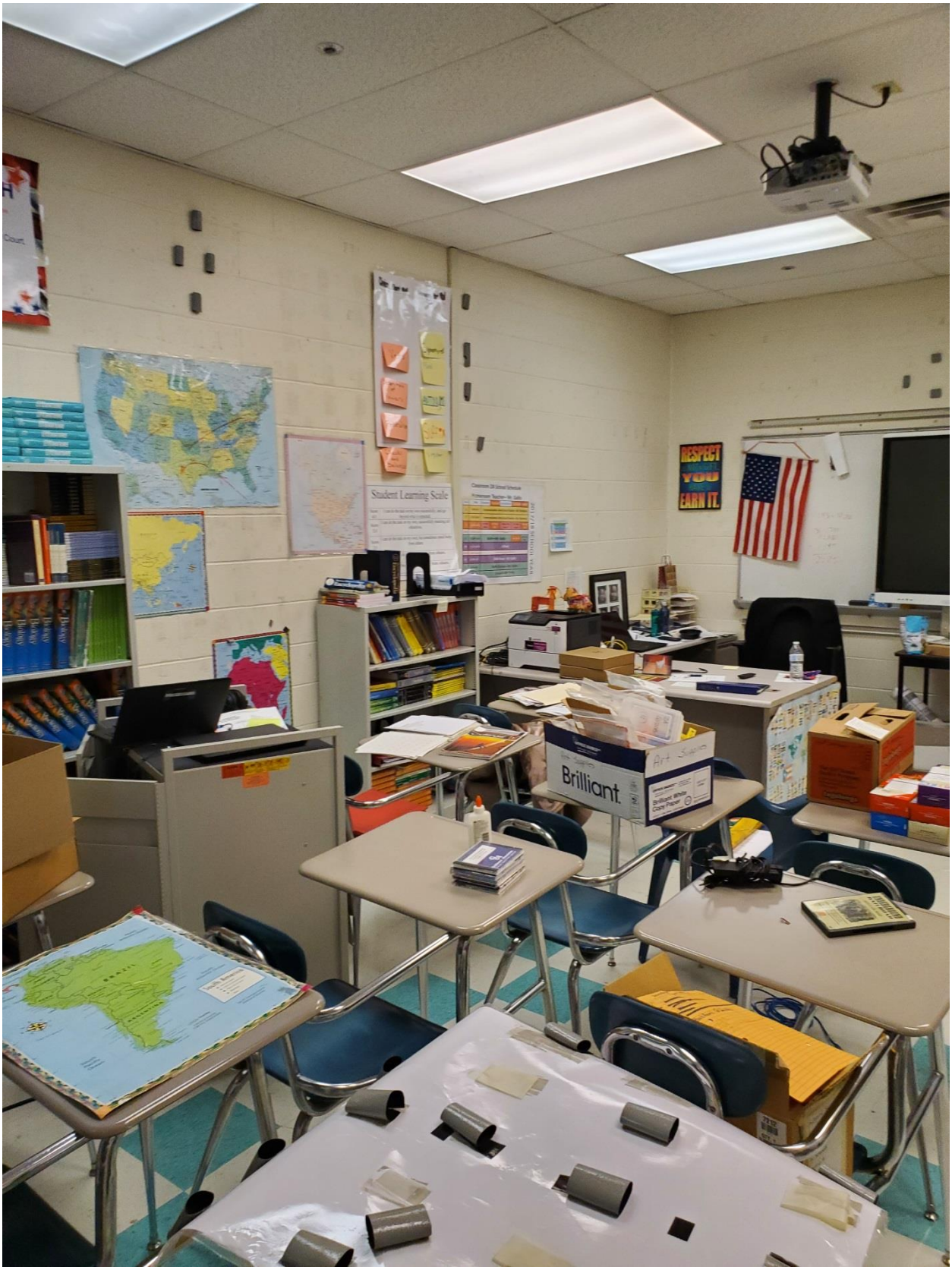

EXIT
know

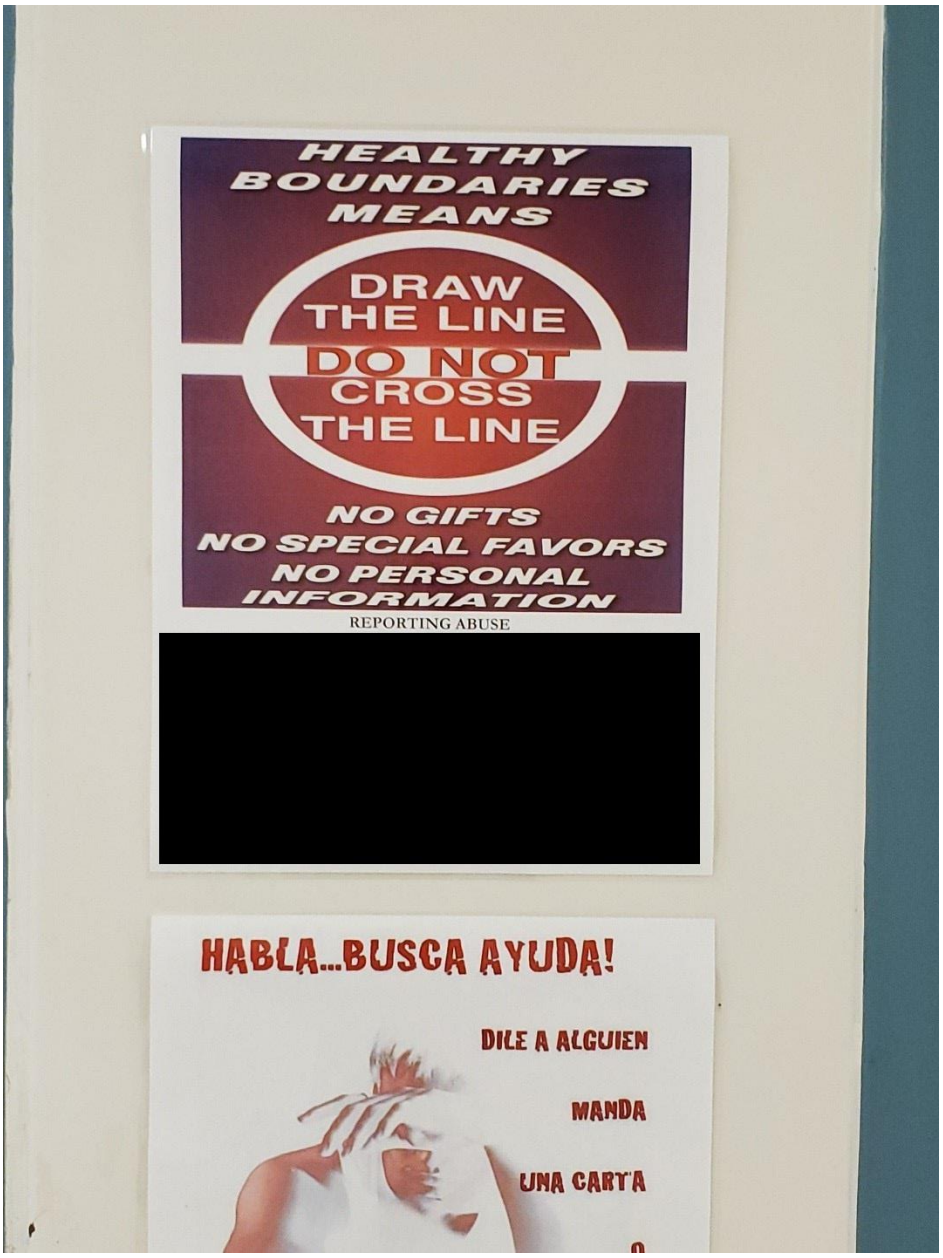


Classrooms are equipped with a smartboard, laptop, more artwork and a bulletin board posting information about local colleges. Classes are divided by age group, 10 to 14 years old and 15 to 18 years old.

The director of the facility was a former detention officer and had worked many jobs in juvenile detention prior to taking over as the facility's director. He emphasizes the importance of professionalism among the staff and that message is reinforced with posters hung throughout the facility that emphasize "healthy boundaries" between the staff and the residents.

The rooms do not have toilets or sinks in them, like prison cells. Instead, the residents share a communal bathroom. Significantly, when graffiti occurs or property is damaged, it is immediately cleaned up or repaired with the resident's assistance. And the residents' rooms are generally not locked during the day, except at shift change from 2:45pm to 3:00 pm. Instead, the juveniles are generally in the common area or the classroom. The facility also has a library where books are divided by age-level and subject matter. The residents are allowed access to the library unless they have lost the privilege due to misconduct.


Student Learning Scale
RESPECT
YOU
EARN IT.
Brilliant



Facility A's surveillance system is updated every few years and when blind spots are identified, cameras are added to those areas. Other than individual rooms and the bathrooms, nearly all the rest of the facility is under surveillance and staff are encouraged to do everything on camera. In addition, staff are held accountable in other ways as well. The director himself walks through the facility at least once a

day to interact with the juveniles and staff. Supervisors make unannounced rounds during the day. Detention officers are required to press a "watch tower" button located on the outside of each juvenile's room to confirm they have looked in on the resident, which they are required to do every 15 minutes overnight; if a button is missed, the command center will be alerted. Juveniles file grievances by placing them in a locked box that only the director can access. Finally, the director reported that staff at his facility are rarely the subject of ChildLine reports, and the facility keeps track of such reports when they are filed so the director can know if the performance of a particular detention officer is problematic.

With respect to use of seclusion orders, the facility's director reported that they are rarely used, but when they are, the director notifies the judge and the county solicitor for approval. Instead, the focus is on de-escalation with the goal of minimizing the amount of time a resident has to be alone in a locked room.

The starting salary of detention officers is significantly higher than that of DCJDC and the facility rarely uses overtime to maintain the legally required staff-to-resident ratios.

Perhaps the biggest difference between DCJDC and Facility A was the director's philosophy. His goal is to engage and understand the juveniles in his care. When the facility has a resident who was challenging, the staff try to adapt and engage that juvenile in a safe way. For example, when the facility had a child who

did not work well in group settings, the staff brought his school work to him in his room and the teacher would periodically meet with the juvenile one-on-one.

B. Facility B

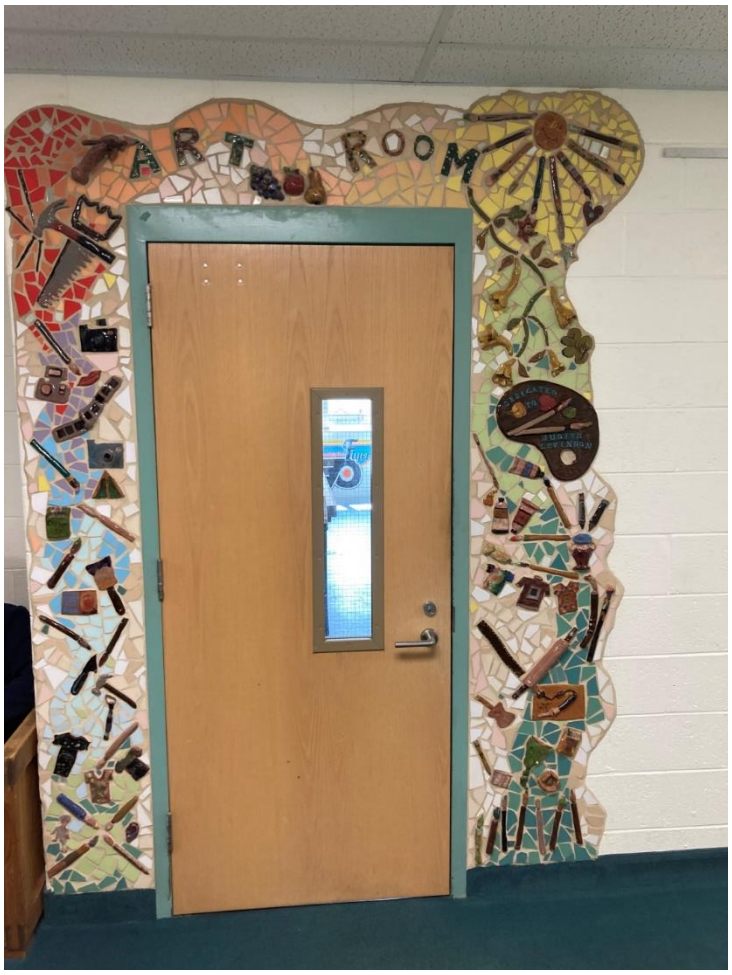
Facility B has 40 beds in the detention side of the facility and 69 beds in their residential treatment facility. Like Facility A, the facility is well-lit with natural lighting from the interior courtyard. There is carpeting on the floors, artwork on the walls, and plants and flowers throughout the facility. The residential rooms do not have toilets and sinks, but rather actual bed frames, a plastic chair and desk, and linoleum flooring rather than concrete.

Like Facility A's director, both the director and deputy director of Facility B worked their way through the ranks of the juvenile detention system. They have a lot of experience in working with juveniles in detention and focus on rehabilitation. To that end, detention officers are called "youth counselors," and the residential blocks are called "dorms." The youth counselors are encouraged to engage with the residents.

The residents have access to a library, computer and other activities such as ping-pong, games, and television in the “dorm area.” There is a community room with a big screen television and foosball tables, a gym with basketball courts and a weight room, and an art room with an abundance of art supplies.


KETTLER


BUCKS
COUNTY
CELEBRATE


ART ROOM


Flyers

The facility has 86 security cameras throughout the building with almost zero blind spots. If a blind spot is identified, the facility immediately gets a camera for it. The facility is also equipped with the "watch tower" buttons outside residents' rooms, similar to Facility A, to ensure that staff are regularly checking on residents overnight as required. In addition, all physical interactions between staff and residents get reported. After the incident is over, staff will talk to the resident to understand why the situation escalated and a supervisor will meet with the staff member to discuss how the situation was handled and offer recommendations on how to improve. The facility has less than 30 "hands on" incidents a year. Neither the director nor deputy director could think of an occasion when they had to obtain a seclusion order from the court.

Youth counselors are paid more than double the starting salary of DCJDC's detention officers, and half of their staff have worked at the facility over 10 years. The facility rarely uses overtime to meet their staff-to-resident ratios.

The facility operates a specialized unit called the "Special Services Unit" that oversees training within the facility. Staff undergo intensive in-house instruction, more than the 40 hours of annual training required. Staff also have to undergo de-escalation and physical restraint training every 6 months.

C. Conclusions

Here is what Facilities A and B have that DCJDC did not:

- Strong and engaged cooperative leadership with experience working in a juvenile detention center and a philosophy that emphasizes rehabilitation as the goal of the facility.
- A physical appearance that looks not like a jail intended for prisoners, but like a school intended to motivate and engage children.
- Activities and schooling that are age-appropriate and encourage reading, art and social interaction.
- Competitive pay for the detention staff that helps recruit and retain qualified candidates.
- Comprehensive training for the staff that reviews and reiterates the tools for interacting with the juvenile residents in a safe, effective manner.
- Methods for ensuring accountability among the staff, including a modern and comprehensive surveillance system, "watch tower" buttons, and a system for tracking incidents of physical contact between staff and residents.

Nor can it be said that Facilities A and B merely have more money to run their juvenile detention facilities. The latest budget for Facility A was $4.2 million (plus an additional $3.7 million for their shelter side). For Facility B, it was $8.7 million total for *both* their detention facility and their residential treatment facility, the latter of which was the larger of the two. In contrast, in 2019 – the last budget year we have for DCJDC – DCJDC had a budget of $4.5 million.

In short, it cannot be said that DCJDC could not operate like Facilities A and B because it did not have sufficient funds. As already discussed, there were certainly ways in which the County could have and should have allocated funds for specific projects like the video surveillance system and detention staff salaries. But the ultimate dollar amount that was budgeted for DCJDC was not inadequate when

compared to these other two facilities. DCJDC did not lack money. It lacked *leadership*, *vision* and *commitment* by the players responsible for ensuring it fulfilled its mission as part of the juvenile justice system.

XII. RECOMMENDATIONS

In December 2019, state leaders established the Pennsylvania Juvenile Justice Task Force ("Task Force") to undertake a comprehensive review of the juvenile justice system and submit recommendations on improvements. The Task Force's report, published in June 2021, largely focused on the need to increase diversion from the juvenile justice system and to reduce out-of-home placement of juveniles who become involved in the system. We do not doubt that these are laudable and necessary goals, and should be the priority for those involved in administering the juvenile justice system.

Nonetheless, so long as secure detention remains an option and kids are to be detained awaiting adjudication or placement, then we as a community cannot ignore how secure detention facilities operate. There must be more than the minimum standards provided for in the 3800-series regulations. Rather, standards and mechanisms need to be developed to ensure that secure detention, when necessary, is consistent with the goal of reform and rehabilitation and certainly does not undermine those goals.

While we do not claim to be experts in the juvenile justice system generally or juvenile detention specifically, we have been able to determine over the course of this investigation some common sense solutions to the problems we saw plague DCJDC.

Recommendation #1: The legislature should amend the Human Services Code to require boards of managers to oversee the operation of secure juvenile detention facilities, so that any facility licensed by DHS for this purpose is required to have such oversight. Currently, the County Code requires only Second Class and Second Class A counties to have such a board of managers, and that is only if the county doesn't adopt a Home Rule Charter that exempts it from this requirement, as Delaware County had done. By enacting legislation under the Human Services Code rather than the County Code, the legislature can ensure that all counties operating secure juvenile detention facilities have this important oversight.

DHS can then enact regulations regarding the composition of such boards so that they represent a cross-section of citizens who have relevant expertise in juvenile development, juvenile detention and/or mental health and substance abuse to reflect the increased presence of children with trauma, mental health disorders, and substance abuse issues. The boards should be required to conduct regular announced and unannounced visits to the detention facility and should be provided by the

facility with regular reports regarding the operation of the facility, including the use of physical restraints and seclusion.

Recommendation #2: We adopt the Task Force's recommendation that DHS should be required to report allegations of child abuse, indicated or founded reports of child abuse, licensing actions, or incidents involving law enforcement to a number of outside entities, including the judiciary, the public defender, the district attorney, the juvenile probation department, and county commissioners, among others. *See* 2021 Juvenile Justice Task Force Report, Recommendation #24. In addition, because boards of managers should be mandatory to oversee such facilities, DHS should also be required to provide the same information to the boards of managers. The legislature can require this by amending the Human Services Code relating to DHS' supervisory and licensing powers and duties to require DHS to provide notice of allegations and licensing actions to these third parties. When these outside entities are not dependent on the facility's management for information about what is happening at the facility, it will ensure that there is more transparency and oversight by other interested parties.

Recommendation #3: The legislature should amend Article X of the Human Services Code to expand DHS's authority to respond to licensing violations beyond merely requiring corrective action and should include the power to penalize licensing violations, particularly for repeated violations of a child's specific rights.

Any allegation of child abuse that is deemed unfounded is also jointly investigated by DHS as a licensing violation. Because the term "child abuse" has a specific definition under the law pertaining to child protective services, however, instances where a child is assaulted by staff – even if the child were to be believed – frequently do not meet the definition of "child abuse" for DHS purposes. However, such incidents are also investigated as a possible violation of the 3800-series regulations, including a violation of a child's specific rights enumerated in those regulations or a violation on the use of restraints.

We heard of DCJDC being cited for one such violation, in the incident described earlier involving Juvenile Resident A and Detention Officer #6 at the hospital. DHS found a licensing violation, not child abuse. Yet, the only enforcement mechanism available to DHS was to require a corrective action plan by DCJDC. The facility's plan, which DHS approved, was for the detention officer to retrain, which she apparently did by reviewing PowerPoint slides.

The legislature should give DHS additional enforcement powers. Under existing law, if a facility commits a licensing violation, the only recourse is for DHS to require the facility to submit proposed corrective action or to revoke the facility's license. 62 P.S. §1026. *See also* 55 Pa. Code §§20.52, 20.71. The statute should be amended to provide DHS an in-between option: the authority to impose penalties and mandate specific corrective actions that incentivize the facility to comply with

the 3800-series regulations but that fall short of a shutdown. For example, if §1026 is amended to allow more authority to DHS to impose specific penalties short of license revocation, the agency could amend its regulations to allow it to impose fines on the facility or mandate disciplinary process against the staff member(s) responsible for licensing violations that involve violations of a juvenile's rights. It is one thing to require corrective action when the facility missed a monthly fire drill or the window screens aren't fully secure. But when the violation demonstrates a failure of staff to respect the rights of the juveniles in their care, especially if there is a history of such violations, DHS should be empowered to impose consequences with real teeth.

Recommendation #4: There should be stricter requirements regarding the use of seclusion. DHS should amend the 3800-series regulations to mandate that a judicial order must be obtained whenever a juvenile is in room seclusion for more than 4 hours in a 24 hour period, rather than the current 8 hours in a 48 hour period, and should impose licensing violations for any facility that fails to obtain timely orders. The regulations should also require that each seclusion greater than 4 hours is to be supported by documentation that specifically describes the juvenile's conduct requiring seclusion and the efforts made by staff to calm the juvenile down and end seclusion. In addition, during the 4 hour period, and prior to seeking a seclusion order, the facility must make a mental health counselor or social worker

available to the juvenile as part of the facility's efforts to end seclusion prior to the 4 hour mark.

By imposing more stringent standards, each judicial district that has a secure juvenile detention facility in its jurisdiction should then recognize the need to have an on-call judge available 24 hours, 7 days a week to review seclusion orders in a timely fashion. And, while a judge may not require submission of the documentation the 3800-series regulations would require before signing an order, we hope that judges, knowing the facility is required to document the need for seclusion for DHS, would similarly require such justification prior to approving seclusion.[22]

Recommendation #5: The legislature should direct the Joint State Government Commission ("JSGC") to examine and develop best practices for the operation of juvenile detention centers. While other committees and task forces have provided recommendations on how to reduce delinquency overall, and have specifically

[22] The Task Force has recommended, by consensus, the prohibition of solitary confinement, including seclusion and exclusion, but would permit a "cool down" or "time out" period for up to 3 hours. During that "time out" period, support staff, such as a social worker, should be notified and made available to assist the juvenile in calming down. Any restriction beyond 3 hours is to be reported to DHS and the Office of the Youth Ombudsman. *See* 2021 Juvenile Justice Task Force Report, Recommendation #27.

While the Grand Jury does not oppose such legislation, we believe that "seclusion," as it is intended under the 3800-series regulations, is a "cool down" or "time out" period. Semantics aside, then, we agree with the Task Force's intent to limit the use of this type of restriction and to require additional oversight. We recommend 4 hours rather than 3 hours only because it is the standard we heard many facilities already use, but believe either standard would be better than the existing 8 hours. We also agree with the Task Force's recommended requirement of making a social worker or other counselor available to the juvenile and so have included it in our recommendation as well.

recommended decreased use of secure detention, it is this Grand Jury's understanding that there has been no comprehensive examination of best practices for operating secure juvenile detention facilities. So long as there is a need for such facilities to operate, there is a need to establish standards for how they should operate consistently with the goal of rehabilitation. What we know is that the minimum standards established under the 3800-series regulations and PREA do not encapsulate such standards. But we also know that it would be foolhardy of us to recommend best practices given that we lack expertise in the field.

The General Assembly has the power through its research agency, the JSGC, to consult with experts in the field of juvenile detention to establish such best practices. By consulting with those who have relevant expertise – such as administrators from other secure detention facilities who understand the need for rehabilitation; mental health professionals with experience in dealing with adolescents; juvenile court judges; juvenile probation officers; and members from the boards of managers who have experience in providing outside oversight of such facilities – the JSGC can develop policies and practices that ensure that secure juvenile detention facilities protect the well-being of the children charged to their care. Given that numerous other secure detention facilities operate in the Commonwealth, affecting thousands of children who enter their doors,

establishment and enforcement of best practices must be done as expeditiously as possible.

While we are hesitant to ourselves prescribe specific best practices, we do believe that, at a minimum, the JSGC should consider the following:

Video surveillance: Detention centers should be required to have as close to total coverage of the facility (excluding bedrooms and bathrooms) by a video surveillance system, whose cameras have the capacity to record and store footage for a minimum of 60 to 90 days. While 100% coverage of the areas where residents and staff interact is, of course, ideal, we recognize that there may be barriers to achieving such coverage. But having a majority of the facility under surveillance to avoid blind spots is essential to the safety of both the staff and the juveniles.

We also believe it is appropriate to have a policy that whenever a physical restraint is used by staff on a juvenile, a supervisor is required to review and preserve the video to ensure that the staff properly employed the restraint. Any consideration of standards regarding video surveillance requirements should consider such a policy.

Training: Beyond just the mere number of hours of instruction mandated and the specific categories of training currently required under the 3800-series regulations, there should be additional standards regarding the categories and types of training required for detention staff. Currently, the list of required training topics

include “crisis intervention, behavior management, and suicide prevention.” This is in addition to fire safety, first aid, and health issues specific to the population. 55 Pa. Code §3800.58.

We believe the categories of mandatory training should be expanded to include, at a minimum, training on de-escalation techniques, handling children with trauma and/or mental health issues, and respecting the specific rights of children in detention as specified in the 3800-series regulations. Training should involve more than reading a book or PowerPoint slides, but should be in-person and allow detention staff to practice techniques prior to supervising children.

Additional minimum qualification requirements for management and staff: It would seem obvious, though this investigation has proven that it is not, that those in charge of running a juvenile detention facility should have prior experience working in the juvenile justice system generally and juvenile detention specifically. When the leadership has no such prior experience, they do not have the expertise to develop and enforce an ethos or a vision for how the facility is to operate consistently with the goal of rehabilitation.

We recognize that there may be some who lack such prior experience and are nonetheless capable of becoming good leaders in such a setting, and so we refrain from outright recommending a specific set of criteria. Nonetheless, we have seen the consequences of having a director and deputy director who lack relevant work

experience and thus fail to lead. While the 3800-series regulations currently require that the director have either a bachelor's or master's degree and some additional experience in administration or human services, 55 Pa. Code §3800.53, we believe it appropriate to consider whether additional minimum qualifications should be imposed for the director and assistant director to include prior work experience in the juvenile justice system and/or juvenile detention setting.

In addition, the 3800-series regulations require that "child care workers," which includes detention officers, need only be 18 years old if the facility has only juveniles under 18 years of age, or 21 years old if the residents are 18 years or older. 55 Pa. Code §3800.55(h). Given the need for detention staff to be mature and professional even in the face of adolescents who can act out or be disrespectful, we believe serious consideration should be given to raising the minimum age of detention officers. We believe a larger age difference between the detention staff and those they are responsible for supervising will reduce the risk of what was described to us as "high schoolers" going at one another.

Restrictions on use of overtime: There can be little doubt that too much overtime leads to burn-out, which can lead staff to excessively call out sick or show up late. And, in a facility where the staff is tasked with dealing with adolescents, some of whom are challenging and troubled, burn-out can also lead to child abuse. We therefore believe there should be consideration given to limiting the number of

hours a detention officer or supervisor can work either consecutively and/or in a 24 to 48 hour period. While we know of no legal means to mandate minimum salaries for detention officers paid by county funds, we hope that by minimizing the use of overtime, counties responsible for funding juvenile detention centers will be required to pay detention staff a living wage that attracts qualified candidates less inclined to call out or quit, rather than relying on overtime as a means to meet the state-mandated staff-to-juvenile ratios.

Programming requirements: Promoting a juvenile's rehabilitation requires that the time he or she spends in a secure detention facility – whether it be weeks or months – offers opportunities for age-appropriate education and enrichment. Teenagers generally should not be given elementary school level worksheets (unless, of course, that is consistent with their ability-level), and communication with each juvenile's home school to ensure continuity should be required whenever possible. Television should not substitute for books or art programs. The fact that juveniles have been accused of, or even adjudicated for a criminal act, does not render them less in need of or less worthy of stimulation and instruction. We believe, therefore, there should be standards created regarding the types of activities that should be made available to juveniles in secure detention as well as standards regarding how such juveniles should be educated. Even those juveniles who are only in detention for a few weeks can still be provided age-appropriate educational activities.

Requiring such activities and ensuring they are made available is paramount to creating a detention environment that is not merely a "kid jail."

Policies regarding incident reports and grievances: While we heard about DCJDC's policies regarding detention staff's obligation to write SARs and the availability, in theory, of juveniles to make grievances, neither system was effective. SARs were frequently not written, incomplete or untruthful, and the leadership either did not realize or did not care. Residents were frequently denied the right to file grievances or were retaliated against for doing so. There must be a better system for ensuring that staff fully and honestly report incidents involving physical restraints and that a juvenile's right to file a grievance without retaliation is enforced. We urge the creation of standards regarding both such procedures to hold staff accountable and to give juveniles a voice.

We also believe it is vital for detention centers to internally track ChildLine reports, facility-specific incident reports (like SARs), and grievances filed against employees not just according to the juveniles involved but by the employees involved. DCJDC did not do so and missed the opportunity to observe when detention officers were consistently involved in "hands on" incidents with the juveniles and/or the subject of repeated complaints by residents.

We recognize that the mere number of reports involving a particular detention officer is not necessarily an indicator that the officer is bad at his or her job or abusive

towards the juveniles in his or her care. Nonetheless, when an employee's personnel file contains multiple reports from different sources, it is certainly information that management, or an outside entity providing oversight of the facility, should have in order to more critically assess whether a particular officer requires additional training or disciplinary action (up to and including termination). Accountability is key in any organization, and certainly in one where the staff has so much power and control over children. Internal tracking is one important means for ensuring accountability.

Once best practices are developed, they should at a minimum be adopted and distributed to all juvenile detention facilities, their boards of managers, the judiciary, the county commissioners or council, the juvenile probation departments, the public defenders and prosecutors. All stakeholders in the juvenile justice system should be aware of how such facilities operate.

However, we hope that such best practices will become more than a suggestion. To the extent such best practices can be incorporated into the Human Services Code and/or the 3800-series regulations, we urge the legislature and DHS to do so. Alternatively, the Juvenile Justice Task Force recommended that an independent agency be authorized to accredit juvenile facilities. *See* 2021 Juvenile Justice Task Force Report, Recommendation #26. Should such an accrediting

agency be created and authorized, that agency could be tasked with ensuring compliance with any new standards that are developed regarding best practices.