



Source and Errata Sheet: October 6, 2015

Investigative Facility Report: Connecticut Juvenile Training School and Pueblo Unit, July 22, 2015

The following notification of sources and errata are identified and presented in the document below. This document was created in response to questions regarding the source of a particular data point or incident discussed in the OCA's July 22, 2015 report. To prepare OCA's original report and Addendum, dated September 15, 2015, OCA reviewed extensive primary source documents regarding facility operations at Connecticut Juvenile Training School and Pueblo Girls' Unit, including 600 facility incident report, over 200 treatment planning documents, and numerous video tapes from both facilities. Specific citations are offered below where sourcing is unclear in the original documents. Corrections are also noted where needed.

1. Report, pg. 11

"Attendance records reviewed by OCA document 3 occasions when Franklin received Unit Bound instruction." FN 4. "Franklin missed part or all of 36 days of school over a 100 school day period (Sept. 15 2014 through Jan. 30, 2015). At least 24 of those missed days included removals for discipline. One facility report observed that it was "unclear if he comprehended the [school] work."

FN4: "CJTS leadership indicates that this is a documentation error and that all youth who are Unit Bound receive educational work. OCA is requesting additional documentation on this data point."

Sources: Email correspondence from CJTS Superintendent William Rosenbeck, dated 5/21/15 states that teachers are expected to assign work to a youth from "day one" of the youth's removal, but individual instruction does not begin until the third day of a youth's "Unit Bound time."

The language regarding Franklin's lack of comprehension of school work comes from DCF's clinical note during his November, 2014 monthly plan report

2. Report, pg. 14

"While it is true that CJTS confines only a few hundred youth per year, its ripple effect across the juvenile system is significant."

Source: Per the 2015 CJTS Advisory Board Report, "there were 222 admissions of 201 unique individuals to CJTS during 2014." Update: This number does not include the approximately 2 dozen admissions to the girls' Pueblo Unit.

3. Report, pg. 15

Re: materials in the fence surrounding CJTS. Reported to contain razor wire.

The fencing around CJTS does *not* have razor wire material. The fence is a MacDougall Security Fence, a curved security fence used in correctional and juvenile facilities.

4. Report, pg. 15

Adjudication breakdown for youth confined at CJTS in 2014. On page 15 of the OCA's July 22 report, OCA stated that the majority of offenses that youth were adjudicated for were non-violent (67%) and that 10% of the offenses were adjudications for robbery or weapons charges.

A child-specific follow-up requires the following correction: Non-violent adjudications (including breach of peace, disorderly conduct, drug possession, larceny, certain counts of burglary, e.g.) accounted for the majority of all adjudications (67%). The remaining 1/3 of adjudications were for charges which require adjudications that force or weapons were used, including but not limited to charges of assault, weapons possession and robbery, with or without weapons. Weapons charges, including robbery with a weapon, and all weapons adjudications collectively accounted for approximately 15% of the total number of adjudications. OCA obtained this information from the 2015 CJTS Advisory Board report, available publicly online.

5. Report, pg. 16

"The reports submitted by DCF and its facility advisory board do not adequately address quality and outcomes of care. What data does exist shows that many youth are admitted to CJTS *multiple times*, whether for new offenses, parole violations, technical violations, or even 'respite.'" (Emphasis not in original).

Source. Per the 2015 CJTS Advisory Board Report, of the planned discharges (244) from CJTS during 2014, there were 73 that returned to CJTS or entered adult corrections during the same calendar year. Recidivism is not calculated beyond the calendar year.

6. Report, pg. 17 and pg. 37

Describing multiple arrests of a youth who was also the substantiated victim of physical neglect in two encounters with staff. "This boy was arrested for *his* behavior in both incidents." (Emphasis in original).

The boy was administratively charged and sanctioned for both incidents in which he was also neglected by staff (April and July, 2015); he was only criminally charged for one of those incidents (July). He was criminally charged for a total of three incidents while at CJTS (January, May and July, 2015).

7. Report, pg. 18.

“OCA’s review of facility incident reports over a 12 month period (July 1, 2014 through July 1, 2015) reveal *at least* 532 physical restraints and 134 uses of mechanical restraints (handcuffs or shackles.) FN 20.” (Emphasis in original).

Source. Authors point to footnote 22 which states that “restraint numbers [obtained through a review of over 600 incident reports] include any physical hold, inclusive of physical escorts, standing restraints, supine restraints, prone restraints, and mechanical restraint (handcuffs).” OCA adds to this statement that CJTS and Pueblo document these categories of holds as restraints in similar and like fashion to the documentation required by DCF of its licensed treatment and residential programs.

8. Report, pg. 19

“During 2014 there were at least 44 arrests of boys and girls at the DCF-run facilities for their behavior in the program.”

Source/Discussion. Authors note that during a presentation by DCF in September, 2015 that the data point of 44 arrests refers only to the boys and *does not include* arrests of girls from the Pueblo Unit. Total arrest numbers may be higher than 44.

9. Report, pg. 24

“[Roberto] is also frequently described as mentally ill, and he suffered a possible *psychotic break* during an episode at CJTS last summer.” (Emphasis not in original).

Source. DCF incident reports, dated Jun 26 through June 28, 2014, describing a possible “psychotic” break as Roberto described himself as the devil and was speaking gibberish.

10. Report, pg. 25

“[Roberto] was handcuffed, shackled, and brought to the isolation cell [following suicidal behavior of tying a ligature around his neck while alone in his cell].”

Source/Discussion. DCF incident reports/video tapes. Roberto had two incidents on two consecutive day of suicidal ideation (4/12/2014) and suicidal behavior (4/13/2014). On the first day, described on pg. 38 of OCA’s July 22, 2015 report, he was physical restrained and *handcuffed*

and transported to the padded cell. On the second day, described on pg. 25 and again on pg. 44, Roberto was handcuffed *and shackled* as a response to his behavior. He was again transported to the padded cell.

11. Report, pg. 27.

“Several episodes of [Nathan’s] self-injurious and mental health crisis behavior led to restraints, isolation and administrative sanctions for everything from contraband (when he cut himself with wood), bodily waste (when he urinated in the padded cell), engaging staff in a restraint (when he resisted movement or tried to hurt himself) and creating a disturbance. FN 48.”

Sources

Staff incident reports dated 9/7/14: multiple physical interventions for youth’s repeated self-injurious behavior lead to sanctions; see also incident report dated 9/8/14: when youth was agitated over remaining on one to one status and did not want to remain in a chair; youth began to “pace from door to door,” resisted counseling, “began to wander in the pod not following any direction... given several verbal prompts to go to his room but to no avail he refused... [youth restrained and became] “combative and needed to be placed in the padded cell... [Youth] observed scratching himself by [staff]. [Staff] was able to retrieve the plastic piece.” Youth was charged with Creating a Disturbance, Engaging Staff in a Restraint and Resisting Movement. Id. See also Staff incident reports, dated 11/09/14 when youth was in his cell and covered the window. Due to earlier medical concern, the nurse wanted the door open. Incident report describes youth becoming “combative,” though staff narratives indicate that this consisted of youth trying to “come out of his room even after staff told him not to.” Multiple staff describe youth as trying to “pop out” of his cell, or trying to “force his way out of his cell.” Youth was restrained, handcuffed and brought to the padded cell. He was charged with Resisting Movement, Creating a Disturbance and Engaging Staff in a Restraint.

12. Report, pg. 28

“Several weeks later Eleanor was subject to a protracted physical and mechanical restraint after she ‘threatened’ staff with a bowl of peanut butter and bananas and would not go to her room. FN 49.”

Source/Discussion: DCF indicated that the peanut butter was hot at the time of this encounter. Video footage reviewed by OCA indicates that the youth was walking around the unit for several minutes with her snack prior to staff confronting her in the hallway.

13. Report, pg. 32

“The CJTS/Pueblo behavior management manual describes a traditional juvenile-correctional approach to behavior modification.”

Source. Connecticut Juvenile Training School (CJTS) Behavior Management System Program Manual, Last Revised October 20, 2012, forwarded by DCF to OCA in July, 2015.

14. Report, pg. 38

Description of an incident with Roberto that led to isolation in the padded cell. “In response to OCA’s stated concerns of medical and emotional neglect, [staff] claimed that the boy was fine, that leaving him in the cell alone was protocol, that he was monitored by the nurse, ‘the whole time,’ and that video could not confirm whether he was unconscious or not.”

Source. DCF Special Investigations Protocol, completed June, 2015. Per the DCF Investigation Protocol, “She [the nurse] said after she left the padded cell *she may have gone to another unit and come back to see [Roberto] later.* She said she saw no evidence that would indicate [Roberto] was unconscious.” (Emphasis not in original). DCF special investigator states, after review of incident reports, interviews and video tapes, that “it is unknown if child did lose consciousness.... [Roberto] may or may not have passed out however this can’t be proven based on video surveillance, staff and child interviews.” OCA’s stated concern upon review was that a youth in emotional and possible physical distress, was placed in the padded cell after expressing suicidal ideation, and may have lacked adequate medical and therapeutic intervention.

15. Report, pg. 45-46

Incident involving youth, Samuel, Nathan, Reggie, and Jenny, who were sanctioned as a result of mental health crisis behavior.

Sources.

Samuel: DCF incident report, dated January 11, 2015. Youth “struggled violently” in the padded cell during staff restraint to remove an item from around his neck. Youth “took hold of staffs’ clothes.” Youth was majored for Engaging Staff in a Restraint and received multiple days of restricted status.

Nathan: DCF incident reports and video, dated September 7, 2015.

Jenny: DCF incident reports and video, dated May 30, 2015. After several attempts by staff to convince Jenny to go to her room after an emotional call with her mother, Jenny was “touch prompted,” by staff on multiple occasions, after which she “became combative towards [staff].” Multiple staff then attempted to get Jenny into a supine restraint. Jenny “continued to be combative” by making threats to staff. She was handcuffed and placed in the padded cell. Staff reports state that Jenny appeared to “experience an asthma or anxiety attack” and that medical staff came in and “administered an inhaler.”

Jenny is *not visible on the DCF video* and there is no hand held recording of the incident.

Reggie: DCF incident reports (no video was requested by OCA).

16. Report, pg. 47

Discussion regarding recent addition of Shield of Care training for all staff in May 2015. DCF statements at a public meeting indicate that other staff were already trained in Shield of Care at this point in time.

Source. Email from Superintendent William Rosenbeck, dated May 21, 2015, on file with authors. Contains training summary from Dr. Ron Brone stating “CJTS has recently implemented the Shield of Care suicide prevention training curriculum.” An interview with Dr. Brone in July, 2015 confirmed that Shield of Care was being made available to *all line staff* as a training curriculum in suicide prevention as of May, 2015.

17. Report, pg. 51

Re: Attendance. The report states that at least 100 youth missed school due to restricted status, with a range of 1 missed day to more than 30 missed days.

Source: Data regarding attendance from Sept. 2014 through February, 2015, sent by DCF Deputy Commissioner, Susan Smith, to OCA, dated Mar. 13, 2015. A review of school removals indicates that over 125 students missed classroom time due to disciplinary removals (period removals, seclusion, “awaiting hearing,” or suspension).

18. Report, pg. 52

“For example, there have been at least 175 instances over the last 12 months where a youth was placed in seclusion during second shift on day one, and then kept in seclusion for *part or all of the following day*, despite the lack of imminent risk of injury or any assessment of risk.”

This should read “despite the lack of *documentation* regarding imminent risk of injury or assessment of risk.”

19. Report, pg. 52

Roberto seclusion incident for failure to comply.

Source. DCF incident report dated Nov., 26, 2014.

20. Report, pg. 52

Samuel incident.

Source. DCF incident report dated Dec. 12, 2014.

21. Report, pg. 54

Incident describing youth in chairs, provoking each other, leading to seclusion.

Correction: The description inadvertently conflates two consecutive incidents on 6/9 and 6/10. One boy, Jason, was involved in each incident. The first day, two boys provoked each other, Jason breaks property and is secluded. The second day, two boys, including Jason, are aggressing towards each other, and they are separated and placed in seclusion. Jason remains on Seclusion/Periodic Room confinement status for 8 hours on 6/10, while incident reports document that he is calm and cooperative.

22. Report, pg. 54-55

Incident describing a boy becoming agitated and dysregulated in seclusion.

Source

DCF incident reports, April 1, 2015 through April 4, 2015.

4/1, second shift: youth fight.

4/2, first shift: youth follows directives while on seclusion status.

4/2, second shift: youth struggles and continues to provoke others, therefore will stay on seclusion status.

4/3, first shift: youth stays on seclusion status for the shift, with some rotation out of cell.

4/3, second shift: youth stays on seclusion status for the shift, with rotation out of his cell.

4/4, youth begins the day on seclusion status, but is shortly taken off status.

Total time on status, approximately 60 hours.

Incident involving D.

“One boy was kept in seclusion for almost 2 full days. When staff first rotated him out of his cell on day two records indicate that he would not do his hygiene routine.” As a result he was placed back in locked seclusion for the rest of the day. FN 106.”

Source. DCF incident report. Although the youth remained on seclusion status during this time, the text should read, “As a result he was *minored/sanctioned* and kept on seclusion status for the rest of the day, with rotations out of his cell.” Per DCF incident report.

23. Report, pg. 55

"[Out of Program] sanction was used when one youth tried to hurt himself with sticks; OOP sanction used when one youth tried to strangle himself and had to be restrained; OOP sanction used after a youth who was locked in the padded cell stripped naked, urinated, and smeared feces on the walls after attempting self-injury."

Sources:

- DCF incident report, dated 9/7/14, "[Youth] started to pick at his wound with a small wooden stick... nurse and OPS arrived, door opened and wood was removed... [Later] more small items of wood removed... There was a fair amount of blood in the padded cell." Youth was sanctioned for Possession of Contraband.
- DCF incident report, dated 1/11/15: Youth in the padded cell tied items around his neck. Youth "struggled violently" during restraint where staffed tried remove an item from around the youth's neck. Youth "took hold of staffs' clothes" and wouldn't let go. Youth was sanctioned for Engaging Staff in a Restraint.
- DCF incident report, dated 2/16/15. Youth attempted to self-injure and then tried to "choke" staff during the ensuing restraint and transport to the padded cell. In the padded cell the youth "defecated, smeared it on windows... [After the window was cleaned] he covered the window with the feces on his hands. [The youth] urinated out the door, [removed his clothes] and would not clean the window. He received numerous sanctions for his behavior in the padded cell.

24. Report, pg. 56

Seclusion incidents.

Sources.

- Elliot, DCF incident reports, 4/2 and 4/3.
- Carlos, DCF incident reports, 5/3 and 5/4. Described as compliant and "non-aggressive."
- Franklin, DCF incident report and facility seclusion chart.

25. Report, pp. 62-64

Jan. 21 incident regarding restraint.

Correction: Incident with the wrong date inserted. Jan. 21 incident should read as follows: DCF Jan. 29, 2015 incident. "Youth moved around the unit and started throwing an orange around." Refused to go to room, told several times to "step into his room, to which he refused." The floor was "cleared," and the youth "ran into the bathroom." He was physically restrained and transported to his cell after he "refused to comply." Per staff report "he was silly and unwilling to comply so he was placed into a hook transport and taken to his room."

Feb. 19, incident.

Source: DCF incident report.

Nov. 26 incident.

Source: DCF incident report.

Jenny incident

Source: DCF video tape.