CRITICAL INCIDENTS AND ASSAULTS AT THE YOUTH SERVICES CENTER AND NEW BEGINNINGS YOUTH DEVELOPMENT CENTER

Report 2022 – 3

OCTOBER 4, 2022

OFFICE OF INDEPENDENT JUVENILE JUSTICE FACILITIES OVERSIGHT

MARK JORDAN
EXECUTIVE DIRECTOR

MIA CARAS
SENIOR ANALYST

TABLE OF CONTENTS

I. INTRODUCTION

This report of the Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) is produced pursuant to Mayor's Order 2020-115, November 13, 2020. The Office was established to "regularly monitor and publicly report on ….[t]he durability of the reforms the Department of Youth Rehabilitation Services ("DYRS") previously achieved under the Jerry M. Work Plan and Consent Decree; and DYRS's progress in achieving Jerry M. Work Plan Goals, including critical Work Plan indicators, that DYRS did not achieve prior to the Superior Court's termination of the Jerry M. lawsuit."[1]

This report focuses on critical incidents and assaults at DYRS' two secure facilities, the Youth Services Center (YSC) and the New Beginnings Youth Development Center (New Beginning) during the five-month period January 1, 2022 to May 31, 2022. A draft version of this report was provided to DYRS for review and comment on September 7, 2022. DYRS representatives submitted their comments on September 29, 2022, and a copy of those comments are attached to this report.[2]

II. BACKGROUND

Tracking incident trends over time in secure facilities is a key tool in assessing institutional climate, identifying geographic areas of a facility that present higher risks of incidents occurring (*e.g.,* specific housing units or a gymnasium), and identifying specific individuals who may need additional supports or interventions to address recurring assaultive or high-risk behaviors.

---

[1] Mayor's Order 2020-115, November 13, 2020, §§I.A.1.-2.

[2] Attachment 1, September 30, 2022, Memorandum from Hilary Cairns, DYRS Director, and Adina Levi, DYRS Deputy Director, Secure Division, to Mark Jordan, Executive Director, OIJJFO.

The Jerry M. Work Plan included requirements related to incident reporting at the YSC and New Beginnings, including not only incident reporting and data collection, but also data validation and incident trend analysis.[3] The Work Plan focused on the following five categories of incidents that present risks to the health, safety, and security of both youth and staff: 1) injuries to youth as a result of assaults; 2) staff-on-youth assaults; 3) youth-on-youth assaults; 4) critical incidents; and 5) self-injurious behavior. In order to promote standards and consistency in incident categorization and reporting, the Work Plan established specific definitions related to assaults,[4] critical incidents,[5] and self-injurious behavior.[6]

For all five categories of incidents in the Work Plan, DYRS was required to maintain management systems to collect complete and accurate incident report data related to the defined incident categories; to validate the accuracy and completeness of the data; and to analyze the trend data at regular intervals and address the issues identified in the trend data.

In 2020, the Special Arbiter filed a report on critical incidents and assaults at the YSC and New Beginnings.[7] The report found that with few exceptions, DYRS had an established

---

[3] November 21, 2019 Revised Final Approved Amended Comprehensive Work Plan (Work Plan) at Goals I.A.1.a.-I.A.1.e.

[4] The Work Plan defines assault as: "1) [A]n attempt or effort, with force or violence, to injure, or 2) a nonconsensual and intentional (voluntary, on purpose, and not by mistake or accident) touching in a part of another person's body that would cause fear, shame, humiliation or mental anguish if done without consent." Work Plan at 8, footnote 7.

[5] The Work Plan defines critical incident as: "[A]n incident that poses a risk of serious harm to youth and/or staff, including but not limited to the following categories: 1) fires or arsons; 2) riots; 3) serious assaults (for example, assaults resulting in significant injury, involving multiple assailants or the use of weapons); 4) suicides or suicide attempts (not gestures); 5) major contraband (for example, weapons, money (over $5), drugs or liquor); 6) accidents resulting in significant injury or posing serious risk of significant injury; 7) significant operational breakdowns (for example, no staff on a unit results in youth being unsupervised); 8) major physical plant problems or emergency conditions (for example, a power failure, flood, or sabotage by staff or youth); 9) escapes and attempted escapes; 10) significant destruction of property; or 11) any other extraordinary events that pose a serious risk of harm to youth and/or staff (for example, credible evidence of a planned gang activity or conspiracy to "take out" a staff person)." Work Plan at 8, footnote 7.

[6] The Work Plan defines self-injurious behavior as "any action taken by a youth with the intention of inflicting bodily harm to her/himself." Work Plan at 11, footnote 9.

[7] The Special Arbiter's Abbreviated Report to the Court Regarding Defendants' Progress Toward Meeting Work Plan Requirements Related to Critical Incidents and Assaults at the Youth Services Center and the New Beginnings Youth Development Center, filed July 15, 2020 (July 2020 Report).

process in place at both the YSC and New Beginnings that included an infrastructure and management system through which staff were able to collect and verify complete and accurate data regarding incident reports falling within the Work Plan categories.[8] The report also noted that DYRS conducted monthly meetings with review teams that analyzed trend data regularly.

Weaknesses in the system were also identified in the July 2020 report. For example, management responses to the monthly trend reports were not consistently documented and the report suggested that DYRS continue to develop its capacity in this area. The report also indicated that the Special Arbiter identified several examples of staff-on-youth assaults at the YSC that were not referred to their Office of Internal Integrity (OII) for investigation, as required by the Work Plan.[9]

III. METHODOLOGY

OIJJFO designed a methodology to assess the completeness and accuracy of DYRS's critical incidents and assault reporting system and to assess whether DYRS continued to implement processes to record and track incident trends as required by the Work Plan.

To assess incident reporting at the YSC and New Beginnings, OIJJFO staff reviewed all incident reports at both facilities for the five-month period between January and May 2022. This involved reviewing electronic copies of the first-person accounts of incidents documented by DYRS staff, which are transmitted by email to OIJJFO staff on a routine basis. In addition to reviewing accounts of incidents written by witnesses, OIJJFO staff also reviewed video recordings of all incidents for which DYRS had digital recordings stored in their incident archive.

[8] July 2020 Report at 39.
[9] July 2020 Report at 39.

As part of their routine incident reporting process, DYRS managers enter a summary of nearly every incident into the information technology system, FAMCare,[10] where they are also categorized by incident type. OIJJFO staff downloaded from FAMCare a dataset that included all incidents from the period January 1 to May 31, 2022 and cross-referenced and reviewed every record for consistency with the incident report accounts written by staff. OIJJFO staff also assessed each incident's categorization in FAMCare for consistency with definitions established by the Work Plan.

Based on FAMCare data, in total, there were 210 incidents at the YSC and 228 incidents at New Beginnings during the five-month period.[11]

Designated staff members at both the YSC and New Beginnings (whose titles are "compliance specialists") are responsible for collecting, reviewing, and performing certain quality assurance functions for every documented incident. These individuals maintain independent logs of all documented incidents, which OIJJFO staff also reviewed and cross referenced with both incident reports archived on the designated DYRS servers and FAMCare data.

For youth involved in any incidents involving assaults that included physical contact and incidents involving self-injurious behavior, OIJJFO staff reviewed relevant portions of medical records of the youth involved.

OIJJFO staff reviewed various documents pertaining to incident reporting at the YSC and New Beginnings, including the following: 1) Unusual Incident Reporting, policy no. IV.a.1

[10] Due to a programming design issue, every incident entered into FAMCare must have one or more youth associated with it in order to be recorded. In some cases, DYRS staff document incidents that do not involve youth (*e.g.,* a power outage). These incidents are designated by DYRS staff as "FYI" incidents and are not recorded in FAMCare.

[11] These numbers do not include FYI incident reports. As noted in footnote 10, FYI incidents are not recorded in FAMCare.

(Incident Reporting Policy);[12] 2) Secured Programs – Incident Report Review & Follow-Up, Standard Operating Procedures; and 3) Use of Physical Intervention, policy no. IV.c.3.iii., effective March 13, 2019.

Additionally, OIJJFO staff reviewed documents that DYRS staff produce for the purpose of analyzing individual incidents and/or analyzing incident trends. Specifically, for the period January to May 2022, OIJJFO staff reviewed documents, "Monthly Incident Rate Trend Analysis" (Monthly Trend Analysis) from both facilities as well as associated management response reports produced by facility executives at the YSC.[13] "Incident Review Team Meeting Minutes" from the YSC were also reviewed, as were individual incident report reviews produced at New Beginnings.[14] Lastly, OIJJFO staff reviewed records related to incidents referred to OII for investigation.

OIJJFO staff interviewed numerous staff involved in incident reporting at the two facilities, including the compliance specialists assigned to the YSC and New Beginnings, youth development representatives (YDRs), and supervisory youth development representatives (SYDRs).

IV. FINDINGS

A. Management Systems to Collect, Validate, and Analyze Incident Data

For each of the five critical incident and assault categories defined in the Work Plan, DYRS was required to do the following: 1) maintain management systems at the YSC and New Beginnings that collect complete and accurate incident report data; 2) validate the accuracy and

[12] Unusual Incident Reporting, policy no. IV.a.1., eff. March 13, 2019, Attachment 2.
[13] No manager responses were completed at New Beginnings during the period January through May 2022.
[14] These forms state "Cover Sheet" at the top and don't have a specific title, but one report is produced for each incident reviewed during the weekly New Beginnings incident meetings.

completeness of such incident report data; and 3) analyze the related incident trend data at regular intervals and address issues reflected in the trend data. For two categories of incidents – injuries to youth as a result of assaults and staff-on-youth assaults – the Work Plan established additional, incident-specific requirements, which are discussed in the relevant subsections, below.[15]

As described in more detail in the methodology section, to assess DYRS's incident management systems, validation practices, and analysis of incident trend data, OIJJFO staff started by reviewing the Incident Reporting Policy, which prescribes a process by which incidents at the YSC and New Beginnings should be reported.

The Incident Reporting Policy requires that "all unusual incidents shall be reported in a timely manner"[16] and that all witnesses to unusual incidents complete an incident report.[17] The policy also requires that an SYDR summarize the incident and any managerial action and/or corrective measures taken and enter the information into "DYRS's case management database" (*i.e.,* FAMCare).[18]

Interviews with compliance specialists, YDRs, SYDRs, and facility managers at both facilities corroborated that an incident reporting process consistent with the process required by policy has been maintained. DYRS staff reported that all witnesses to an incident (including contractors), are required to complete an incident report by the end of the shift during which the incident occurred and to submit the report to a supervisor on duty, typically an SYDR overseeing housing units. The SYDR who receives the incident reports is charged with reviewing all written accounts of an incident and summarizing all incidents involving youth in an incident reporting

[15] See pages 16 and 20-21.
[16] Attachment 2 at II.
[17] Attachment 2 at VI.
[18] Attachment 2 at VI.B.

module in FAMCare. If there are discrepancies in witness accounts or incomplete incident report narratives, the reviewing SYDR is responsible for conducting follow-up inquiries to resolve the outstanding questions, which may include reviewing video footage of incidents.[19]

As noted above, SYDRs only enter incidents involving youth into the FAMCare system because the FAMCare database currently does not have the capability to record incidents that do not have one or more youth associated with them. Incidents that do not have specific youth associated with them are designated as "FYI" incidents. An FYI designation is not indicative of the severity of an incident, and, in fact, some FYI incidents can be critical incidents.[20]

After an SYDR enters an incident into the FAMCare system, he or she submits all incident reports prior to the end of each shift to the facility compliance specialist. The YSC and New Beginnings compliance specialists currently report to their respective facility superintendents[21] and their duties include certain incident data validation and quality assurance functions. The compliance specialists review all incident reports and compare them with the summaries recorded in FAMCare by SYDRs. They also ensure that incidents are correctly categorized in FAMCare consistent with established incident definitions (*e.g.,* they verify that incidents that meet the definition of "assault" are correctly categorized as assaults).

For certain incidents, compliance specialists conduct a video review, which includes downloading the relevant video footage and storing a copy on DYRS servers for archival, investigative, and/or training purposes. At the YSC, the compliance specialist stated that he

[19] SYDRs have direct access to the facility video recording systems and have been trained on how to access video footage. Compliance specialists reported that SYDRs frequently review video footage of incidents prior to entering data into FAMCare whether or not they have questions about an incident.

[20] For example, a power failure or significant contraband found in a facility not in the possession of a youth would be considered FYI incidents, but both would meet the definition of a critical incident.

[21] Until approximately August 2021, the compliance specialists reported to the DYRS Chief of Secure Programs, who supervised both facility superintendents. Since August 2021, the Chief of Secure Programs position has been vacant.

reviews videos of all reported assaults, any other major incidents, and incidents in which he is not clear about the events based on a review of written narratives. At New Beginnings, the compliance specialist stated that he reviews all videos of assaults and other major incidents, as he finds necessary. The staff member added that some videos reviewed are not major incidents and archived copies are not kept.

Both compliance specialists reported that if, after reviewing an incident, they have any outstanding questions or concerns they can refer it back to the SYDR who input the incident into FAMCare (if, for example, there are outstanding factual questions), or to the facility superintendent (if, for example, it appears that immediate personnel action may be necessary), depending on the nature of the concern.

The compliance specialists also are charged with verifying that youth who are involved in incidents that include physical contact or use of force by staff are assessed promptly by medical staff.[22] At both facilities, compliance specialists maintain their own logs of incidents that include data fields to track youth who were involved in assaults with physical contact, whether the youth were assessed by medical staff (or, if not, whether there was a documented refusal of care), and whether there were injuries documented by medical staff.

In addition to performing data validation functions, compliance specialists are also responsible for producing, analyzing and facilitating the review of incident trend data. These functions happen in two ways. First, at both facilities, compliance specialists produce Monthly Trend Analyses, which report on the five Work Plan incident categories plus youth-on-staff

[22] The Incident Reporting Policy requires that "[a]fter every altercation resulting in physical contact or incident in which staff use force against a youth, staff shall immediately notify medical staff of the incident and medical staff must promptly assess the youth and complete an Incident Assessment Report or a Refusal of Health Care Services form, if the youth refuses medical assessment. This should be noted on the reporting form." Attachment 2 at VI.G. The Work Plan also required DYRS to "identify any youth involved in an assault with physical contact at NB and at the YSC who were not evaluated promptly thereafter by medical staff and determine and address the reason why the youth was not evaluated." Work Plan at I.A.1.a.iii.

assaults.[23] Second, they coordinate periodic, interdisciplinary incident review meetings at which select incidents are reviewed by facility managers and staff with a goal of learning as well as considering management responses.

Monthly Trend Analyses are produced every month at both facilities and provided to facility management. OIJJFO staff reviewed the monthly reports from January to May 2022.

The Monthly Trend Analyses produced at the YSC report on the five Work Plan categories of incidents, as well as youth-on-staff assaults. For each of the six categories, the reports provide the current and prior month's number of incidents, incident rates per 100-person days of youth confinement, the current and prior quarterly incident rate, and a graph illustrating the monthly incident category rates for the prior 12 months.

For each of the six incident categories, a short narrative is included. For each of the categories other than injuries as a result of assaults, incident locations are identified and whether the incidents occurred during programming or non-programming hours. The analysis of assaults provides additional information, such as a breakdown of whether assaults included physical contact, a list of youth involved, and each youth's role in the incident (*i.e.,* if they were known to be an assailant or a victim of an assault). The analysis of critical incidents also includes a breakdown of the types of critical incidents.

While the Monthly Trend Analyses provide contextual data regarding incident trends over time, they do not offer analysis of possible causes of any changes in incident rates that may be evident, nor do they address the effectiveness of prior management responses. Exegesis of

[23] The Work Plan did not require DYRS to track youth-on-staff assaults *per se*; however, because the Work Plan required tracking all injuries as a result of assaults, it is necessary to track all assaults, whether they are youth-on-youth, staff-on-youth, or youth-on-staff.

the trends are left to the facility executives, which are provided in a document called the "Program Manager's Response."

The Program Manager's Response addresses each of the six categories of incidents reported on in the Monthly Trend Reports. During the period under review, they were produced by a deputy superintendent. The responses offer in a few sentences possible reasons for any increases or decreases in the monthly rates and include specific actions that the facility managers indicate will be taken to either maintain or decrease the incident rate. These responses are considered in more detail below with respect to each specific incident category.

The New Beginnings Monthly Trend Analyses also cover all five Work Plan incident categories plus youth-on-staff assaults. The analyses of the six categories report the current and prior month's rate and include a graph showing each incident category's monthly rates going back several years (and as far as December 2012 in some cases). In addition to that data, the injuries as a result of assaults data include a breakdown showing the youth-on-youth injury rate by single or multiple assailants, as well as the rates of injuries as a result of youth-on-staff assaults. The sections detailing youth-on-staff assaults, youth-on-youth assaults, critical incidents, and self-injurious incidents all report on locations where incidents occurred, as well as whether incidents happened during programming or non-programming time. The youth-on-staff assault sections additionally indicate the program level of the youth involved (*i.e.,* because there are different expectations of youth at different programming levels), if the youth were perpetrators, and whether there was physical contact during the assault. Finally, the data on critical incidents include the number of incidents by type of critical incident, and for the few self-injurious incidents, the data indicate the names of the youth involved.

The Monthly Trend Analyses at New Beginnings provide short narratives to explain reasons for changes in incident rates. The discussions are generally observations about the effect the changes in population total may have on rates and do not include an assessment of why the number of incidents may have changed.[24] Unlike at the YSC, at New Beginnings, there were no Program Manager Responses to the monthly trend reports from January to May 2022.

For each trend analysis ending on a quarter, a supplemental quarterly analysis is included in the Monthly Trend Report for each incident category noting whether there was an increase or decrease in the rate over the past three months, and possible reasons why there was a change in rate.

Finally, at both facilities, compliance specialists coordinate periodic interdisciplinary meetings to review recent, selected incidents.[25] OIJJFO staff reviewed available documentation of meetings between January 1 and May 31, 2022 from both facilities.

The compliance specialist at the YSC stated that at the meetings all critical incidents and assaults are reviewed, as well as some incidents that might not meet that criteria, but that the superintendent selected for review. He indicated that during the meetings there is a review of whether youth are being taken to medical for assessment after assaults with physical contact, as required. Corrective actions are also discussed during the meetings. He also noted that managers look for examples of YDR staff performing well during an incident.

[24] For example, when discussing an increase of self-injurious incidents in January 2022, the report states, "[t]he slight change in the rate is as a result, of changes in the monthly population." Similarly, in the March 2022 quarterly analysis regarding the quarterly decrease in the rate of youth-on-youth assaults, the report states, "The reason for the decrease is: the decrease in population which results in increase in the ratio of staff to youths." Decreases in population resulting in changes in staff-to-youth ratios may, in fact, have an impact on incident rates. If DYRS has determined that increased staff-to-youth ratios are leading to decreased incident rates, this is an important finding that should be used to guide staff deployment.

[25] Facility managers, SYDR staff, behavioral health staff, and medical staff are invited to attend.

Meeting minutes and stored in the digital archive where incidents are maintained. OIJJFO staff reviewed meeting minutes for the period January 1 to May 31, 2022 and determined that a total of four meetings were conducted in March, four meetings in April, and two meetings in May.[26]

The compliance specialist at New Beginnings reported that there are also periodic, interdisciplinary incident review meetings at that facility as well.[27] He stated that participants attempt to review every critical incident and assault that occurred since the prior meeting. Unlike at the YSC, meeting minutes are not produced; however, for every incident report reviewed during a weekly meeting a "review note" is created by the compliance specialist and archived with the associated incident. Based on the dates documented on review notes stored in the incident archive, OIJJFO staff identified two incident review meetings in January 2022,[28] one meeting in February 2022,[29] three meetings in March 2022,[30] one meeting in April 2022,[31] and four meetings in May 2022.[32]

B. Findings by Incident Type

1. Background

Below is an analysis of all documented incidents between January 1 and May 31, 2022 at the YSC and New Beginnings that meet the Work Plan's five defined categories of critical incidents and assaults. The analysis is based on OIJJFO staff's review of all incident reports,

[26] The compliance specialist noted that because he served on a jury in January and February 2022, incident review meetings were not conducted during those months. Incidents that occurred in January and February 2022 were reviewed during meetings conducted in subsequent months.
[27] He stated that facility managers, behavioral health staff, medical staff, school staff, and case management staff are all invited to attend the meetings.
[28] According to the incident review notes, a total of two incidents were reviewed during these two meetings,
[29] Three incidents were reviewed during the meeting in February 2022.
[30] Seven incidents were reviewed during the three meetings in March 2022,
[31] Five incidents were reviewed during the April 2022 meeting.
[32] Nine incidents were reviewed during the four meetings in May 2022.

FAMCare summaries, medical records, as applicable, and, where available, video recordings of incidents.

Because it is an electronic database, analyzing incident data stored in FAMCare is the most efficient method of analyzing data for the purposes of reporting trend data (*i.e.,* compared to reading and analyzing each individual incident report). DYRS compliance specialists stated that they consider FAMCare incident records to be the official agency record of an incident.[33] For this reason, OIJJFO staff attempted to assess the completeness and accuracy of incident data recorded in FAMCare. Ideally, as the database of record for all incidents at the YSC and New Beginnings, FAMCare data would be complete and accurate and used as the basis of any data reporting and trend analyses.

For each incident category, OIJJFO staff assessed whether incident categories reflected in FAMCare were consistent with Work Plan definitions, whether all incident reports documented by staff were captured in FAMCare, and whether there was evidence of any incidents that occurred during the five-month period analyzed that were not documented on either incident report forms or in FAMCare.[34]

DYRS staff acknowledged the aforementioned issue regarding FYI incidents being documented on incident report forms, but not recorded in FAMCare. Because some FYI incidents meet the Work Plan definition of critical incident, using FAMCare data alone to analyze incident trends could result in incomplete data reporting and/or trend analyses. In fact, as discussed in more detail below, OIJJFO staff identified a total of 54 critical incidents at the

[33] The Incident Reporting Policy states the following: "The Staff Incident Notification Form…and the SYDR Incident Notification Form shall constitute the official record of the incident and shall serve to ensure that the Department is informed of any unusual event that might require immediate attention." Attachment 2 at VI.
[34] Assessing underreporting of incidents is difficult and imprecise because it involves attempting to determine whether incidents occurred in the absence of documented evidence.

YSC and New Beginnings during the five-month review period. None of the 54 incidents were FYI incidents and all were recorded in FAMCare.

2. Defining Assaultive Behavior

In any secure facility, assaultive behavior is a major concern, and three of the five critical incident and assault categories pertain specifically to assaultive behavior. DYRS staff recently have been deliberating whether the definition of "assault," as set out in the Work Plan and adopted by the agency, should be modified. Assaults are defined in the Work Plan as follows:

> [A]n attempt or effort, with force or violence, to injure, or 2) a nonconsensual and intentional (voluntary, on purpose, and not by mistake or accident) touching in a part of another person's body that would cause fear, shame, humiliation or mental anguish if done without consent.[35]

The definition is, by design, broad. Assaults do not require physical contact, but rather "*an attempt or effort*" to injure, with force or violence, irrespective of whether the assault resulted in physical contact and, in instances where physical contact occurs, irrespective of the force or severity of the contact. It also includes certain physical contact, "nonconsensual and intentional," that may not cause physical harm, but that would cause "fear, shame, humiliation, or mental anguish." Taken together, these two provisions capture a wide range of assaultive behaviors.

DYRS staff have raised the issue that because the definition of assault is broad, assault data may depict an unnuanced or inaccurate picture of assaultive behavior or the risk of assault at the YSC and New Beginnings. The definition of assault does not distinguish between, for example, fights among multiple youth, fights resulting in serious injuries, and a youth throwing a shoe (or some other object) at another youth, but missing.

[35] Work Plan at 8, footnote 7.

At the same time, however, the breadth of the definition of assault leaves little room for interpretation of what qualifies as assaultive behavior than narrower definitions. A broader definition may provide greater assurance that reported assault data reflect a more complete picture of assaultive behavior at the facilities than would a more narrow definition.

While reporting assault data using a broad definition may not provide a nuanced view of the types and severity of assaultive behavior at the YSC and New Beginnings, when used in conjunction with other data variables defined in the Work Plan, more detail could be provided to interested stakeholders. For example, as noted below, DYRS is required to report on *injuries to youth as a result of assaults*. These data represent a much higher reporting threshold than assault data alone, focusing not on attempts or efforts, but outcomes of assaults. Additionally, DYRS could report specifically on assaults that also met the Work Plan definition of critical incident. The definition of critical incident includes "serious assaults (for example, assaults resulting in significant injury, involving multiple assailants or the use of weapons)."[36] Thus, by supplementing assault data with data regarding injuries to youth as a result of assaults and/or data regarding assaults that were critical incidents, DYRS can present a deeper perspective to stakeholders regarding the nature of assaultive behavior and risk of assault at its two secure facilities.[37]

[36] Work Plan at 8, footnote 7. As an example, incident report no. 10696, February 17, 2022, describes an incident at the YSC during which a youth grabbed a YDR's badge and opened a second youth's door. The second youth left his room, ran towards the first youth, and they began to fight. Assistance was called, both youth were secured and later seen by medical. The first youth was ultimately taken to Children's National Medical Center for evaluation for a possible "facial/skull fracture" that was obtained when the YDRs were trying to restrain him, and he fell.

[37] This is especially relevant for external stakeholders. For internal stakeholders, internal incident review meetings can accomplish this goal.

3. Injuries to Youth as a Result of Assaults

The Work Plan required that DYRS identify youth at the YSC and New Beginnings who sustained an injury as the result of an assault.[38] It also required that DYRS identify any youth who was involved in an assault with physical contact, but who was not evaluated promptly by medical staff and to determine and address the reason why.[39]

This Work Plan requirement necessitated that DYRS track all types of assaults (*i.e.,* youth-on-youth, youth-on-staff, and staff-on-youth), in order to identify all youth involved in assaults. By policy, all youth involved in assaults that involve physical contact should be brought to medical for an assessment.[40]

DYRS has established a procedure to identify youth who are not assessed by medical promptly after an assault. As a matter of practice, DYRS compliance specialists review the electronic health record (EHR) of youth involved in an assault in which there was physical contact and review the applicable documentation indicating that the youth was seen by medical staff or refused medical attention. A copy of the relevant medical assessment form is appended to the applicable incident report and archived. If a youth was injured, the compliance specialists record this information in a designated data field in FAMCare and additionally record the information in the independent incident logs that they each maintain.

OIJJFO staff identified all incident reports that met the definition of assault (including, youth-on-youth assaults, youth-on-staff assaults, and/or staff-on-youth assaults) between January and May 2022 at the YSC. OIJJFO staff then reviewed relevant portions of involved youths'

---

[38] This reporting requirement only applies to youth who sustain injuries. Staff at the YSC and New Beginnings also sustain injuries as a result of assaults; however, unlike youth, who are assessed by medical providers at the facilities, staff are typically not seen by medical staff at the facility and there is no reliable way to collect data regarding injuries sustained by staff.

[39] Work Plan at Goal I.A.1.a.iii.

[40] See footnote 22, above.

medical records to determine whether the youth were assessed by medical staff (or refused medical services) and, if so, whether there were any documented injuries.[41] OIJJFO staff found that there were a total of 29 injuries to youth at the YSC as a result of assaults during the five-month review period. All of the youth identified as having been involved in an assault with physical contact were assessed by medical staff.[42] Table 1, below, summarizes the number of injuries as a result of assault per month at the YSC.

Table 1: Injuries to Youth as a Result of Assaults at the YSC, by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Injuries to Youth	6	9	3	4	7
Total Bed Nights	1648	1621	1777	1734	1918
Injuries Per 1,000 Bed Nights	3.6	5.6	1.7	2.3	3.6
Not Seen by Medical	0	0	0	0	0

Most injuries to youth as a result of assaults were minor injuries such as scratches or pain in areas such as the lip, wrist, fingers, or hand. Two youth involved in two different incidents were transported to an emergency department for further evaluation. One youth was diagnosed with a right eye contusion[43] and the second youth was diagnosed with a left orbital wall closed fracture in two areas.[44]

FAMCare includes a data field in which staff can record whether a youth involved in an assault sustained an injury. OIJJFO staff assessed the accuracy of the FAMCare data regarding injuries as a result of assaults. Of the 29 youth with injuries as a result of assaults, 27 youth, 93 percent, had injuries documented in the applicable field in the FAMCare database. OIJJFO staff

[41] This review by OIJJFO staff included the "Incident Assessment Report," "Refusal of Medical Treatment" form, or a review of the youth's EHR for documentation that the youth was seen, or attempted to be seen, after the assault.
[42] OIJJFO staff initially identified one youth who was involved in a youth-on-youth assault who was not seen by medical staff; after a review of the video recording of the incident, however, OIJJFO staff determined that the assault did not involve physical contact and these youth did not need to be assessed by medical.
[43] Incident report no. 10696, February 17, 2022.
[44] Incident report no. 10591, January 21, 2022.

also reviewed the completeness of the incident log that the compliance specialist maintains. The compliance specialist's incident database noted all 29 injuries that OIJJFO staff identified, and included the two injuries that were not documented in FAMCare.

As discussed above,[45] the YSC Monthly Trend Reports provide quantitative information about injuries to youth as a result of assaults, but do not provide analyses that examine causes of trends or changes in rates. Instead, the Program Manager Responses discuss why facility managers believe there were changes in the monthly rates. These reports explore changes within the youth population, as well as adjustments to staffing and influences within the facility, such as neighborhood issues within the community that could be affecting social dynamics within the YSC.[46] These reports document specific actions that the facility will undertake to maintain or decrease the rates of injuries to youth as a result of assaults. Each month several strategies are described to directly address ways to improve performance. The suggestions range from actions that staff can take to undertake to better support their de-escalation techniques, to increased volunteer support from community providers, to meeting with youth within 24 hours when they enter the facility.[47]

---

[45] See pages 9-10.

[46] For example, the January 2022 report indicates that while there has been an increase in the facility population, the youth are being admitted with "unsettled beefs with each other from the community," which has led to an increase in physical altercations. It also notes that the facility has been making the restorative justice specialist available, but that some youth are refusing to participate. As another example, the May 2022 report stated that an increase of incidents during the month led to more injuries, and noted that a majority of the incidents were occurring on the PM tour, which is when the majority of the new staff were working.

[47] For example, the February 2022 report states that the restorative justice specialists would identify neighborhood issues with youth before they are allowed to program with the general population as well as meet with the core support team and youth within 24 hours of a youth's admission to "address the youth's concerns/anxiety and identify any potential neighborhood beefs." This report also recommends continuing video reviews with staff and managers to "identify areas where staff can improve and be more efficient in safety and security." The April 2022 report notes that "[i]ncreased volunteer involvement from community providers and DYRS staff has been effective in providing a variety of programming engagement for youth" and also that increased structured activities on the housing units leads to less down time.

OIJJFO staff analyzed injuries as a result of assaults at New Beginnings between January and May 2022. As at the YSC, for each youth involved in an assault with physical contact, OIJJFO staff reviewed the youth's EHR to determine whether the youth was assessed by medical (or refused medical treatment) and, if so, whether there were documented injuries.

OIJJFO staff found that there were 21 injuries to youth as a result of assaults during the review period and identified three youth who were involved in an assault who were not seen by medical staff.[48] Table 2, below, summarizes injuries as a result of assault per month at New Beginnings.

Table 2: Injuries to Youth as a Result of Assaults at New Beginnings, by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Injuries to Youth	1	0	3	8	9
Total Bed Nights	765	716	796	681	856
Injuries Per 1,000 Bed Nights	1.3	0.0	3.8	11.7	10.5
Not Seen by Medical	0	0	0	1	2

Injuries to youth as a result of assaults at New Beginnings consisted mainly of bruising, scratches, or pain to the body, in particular the hands, face, shoulder, or wrist. During this period, no youth were sent to the emergency department for injuries as a result of assaults.

[48] Based on a review of incident reports, OIJJFO staff initially identified ten youth who appeared to be involved in assaults but not assessed by medical staff. However, based on subsequent video reviews of all of the associated incidents, OIJJFO staff determined that there was physical contact involved in assaults involving only three of the ten youth. Incident report no. 10831, April 4, 2022: Youth was involved in a youth-on-staff assault that involved physical contact but was not seen by medical staff for the assault following the incident; incident report 10922, May 9, 2022: Youth DC was involved in a youth-on-youth assault that involved physical contact but was not seen by medical staff for the assault following the incident. This incident was reviewed during DYRS's May 11, 2022 weekly incident meeting but the meeting notes do not indicate there was a discussion that the youth was not seen by medical; and incident report no. 10923, May 9, 2022: Youth was involved in a youth-on-staff assault that involved physical contact but was not seen by medical staff for the assault following the incident.

Of the 21 youth with documented injuries, FAMCare data reflected injuries for 20 of the 21, 95 percent.[49] OIJJFO staff reviewed the compliance specialist's incident log and found that the same 20 injuries documented in FAMCare were documented in the log, and the one injury confirmed in the EHR review, but not documented in FAMCare, also was not recorded in the log.

Analyses of injuries in the New Beginnings Monthly Trend Reports frequently focus on the types of assaults that occurred during the month and whether there was an increase or decrease in incident numbers.[50] In light of the significant increase in injury rates between January and May 2022, however, there should be an effort made to explain in the Monthly Trend Report the circumstances that led to such a significant increase in injuries over the period.

There were no Program Manager Responses during these five months at New Beginnings.

4. Staff-on-Youth Assaults

As with other goals pertaining to critical incidents and assaults, the Work Plan requires that DYRS maintain a management system to collect complete and accurate data relating to staff-on-youth assaults, validate the accuracy and completeness of the data, and analyze the incident trend data at regular intervals as well as addresses issues found in the trends.[51] For staff-on-

[49] The youth had shoulder pain (incident report no. 10835, May 5, 2022). Following DYRS's review of the draft version of this report, DYRS corrected the FAMCare record to indicate that this youth sustained an injury as a result of the assault.

[50] For example, the January 2022 report notes a "significant decrease" in the rate of injuries to youth for the month and notes that the decrease "could be attributed to the sharp decrease in the number of assaults [on] both youth-on-staff and youth-on-youth." Similarly, the April 2022 report states that the increase in the monthly rate is because of the increase in youth-on-youth assaults, and that "[s]ome of these assaults involved multiple assailants and repeat offenders who initiated retaliatory assaults stemming from neighborhood 'beefs.'" For this category of incidents (*i.e.,* injuries), focusing assaults is understandable: Injury rates are likely highly correlated to their cause – assaults – which are analyzed as a separate incident category.

[51] Work Plan at Goal I.A.1.b.iii.

youth assaults, the Work Plan included an additional requirement that DYRS promptly review video recordings of all incidents reported as staff-on-youth *and* youth-on-staff assaults for consistency with the written narratives and to confirm that they have been categorized accurately. If necessary, the incident should also be referred to OII for investigation.[52]

In the July 2020 report, the Special Arbiter found that DYRS was collecting, validating, and analyzing complete data regarding staff-on-youth assaults at both the YSC and New Beginnings. The report also found that while at New Beginnings and the YSC, DYRS staff were routinely reviewing videos of reported staff-on-youth and youth-on-staff incidents and correctly categorizing these incidents, at the YSC not all staff-on-youth assaults were referred to OII for further investigation.[53] At New Beginnings, all staff-on-youth assaults were reported to OII.

OIJJFO staff reviewed all incident reports from January through May 2022 documented at the YSC and found four incident reports involving staff-on-youth assaults.[54] Table 3, below, below summarizes the number of staff-on-youth assaults per month at the YSC.

Table 3: Staff-on-Youth Assaults at the YSC, by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Staff on Youth Assaults	2*	2*	0	0	0
Total Bed Nights	1648	1621	1777	1734	1918
Staff on Youth Assaults Per 1,000 Bed Nights	1.2*	1.2*	0.0	0.0	0.0

* As explained in the narrative, below, the numbers and rates likely undercount staff-on-youth assaults in these months.

The number of documented staff-on-youth assaults for January and February 2022 undercounts the number of actual incidents. In late-February 2022, a youth detained at the YSC

[52] Work Plan at Goal I.A.1.b.iv. The Work Plan refers to "Project Hand," a no-longer-existing office whose functions were subsumed by OII. The rationale for this additional requirement was a presumption that staff might be reluctant to document a staff-on-youth assault committed by a colleague (or to report themselves), and might instead report it as a youth-on-staff assault in an effort to justify a use of force.

[53] July 2020 Report at 29. The July 2020 report found that at the YSC four of the six staff-on-youth assaults were not referred to OII.

[54] OIJJFO staff also reviewed all available video recordings of youth-on-staff and staff-on-youth reported incidents.

since late-October 2021 reported that she had been the victim of repeated sexual assaults perpetrated by a YDR. According to an incident report, the youth estimated that the assaults began in December 2021 and recounted that they occurred in multiple locations in the facility.[55] The allegations are the subject of a criminal trial, and the total number and dates of the staff-on-youth assaults is not known at this point and thus are not reflected in the data.

Consistent with the Work Plan requirement, all four incidents of staff-on-youth assault at the YSC were referred to OII for further investigation.[56] All four of the incidents were found substantiated by OII staff.

OIJJFO staff assessed the accuracy of FAMCare data regarding staff-on-youth assaults at the YSC for consistency with the Work Plan definition. Notwithstanding the fact that all four incidents were referred to OII for investigation, only two of the four incidents that OIJJFO identified were accurately categorized in FAMCare as staff-on-youth assaults.[57] This resulted in an underreporting of staff-on-youth assaults in Monthly Trend Reports.

Documented rates of staff-on-youth assaults are low at both the YSC and New Beginnings. With low numbers (three of the five months had zero reported incidents), trend reporting is less meaningful and specific, sentinel incident reviews are essential. As noted above,[58] the YSC Monthly Trend Reports do not present trend analysis; however, the Program Manager Responses do address the incidents and provide context as to why they happened,

[55] Incident report no. 10737, February 27, 2022.
[56] According to OII records, two of the incidents were referred on the same day that the incident took place, one incident was referred three days later, and the fourth was referred four days following the incident.
[57] Two of the staff-on-youth assaults were not categorized as such in the FAMCare data. One report involved a YDR threatening youth and staff, showing the youth on her unit photographs of her breasts, speaking with the youth about sexually explicit actions, and kissing a youth on the cheek (which meets the Work Plan definition of staff-on-youth assault); the YDR also left the unit keys in the room of one of the youth (incident report no. 10674, February 12, 2022). The second report included a youth alleging that a YDR had been sexually assaulting her for roughly two months on repeated occasions (incident report no. 10737, February 27, 2022). This incident also was not categorized as a staff-on-youth assault in FAMCare. It was not categorized in FAMCare.
[58] See pages 9-10.

which focus on the way staff behaved and ways that they are working to address the issues identified.[59] These responses also provide action items to maintain or decrease the rate of staff-on-youth assaults and include initiatives that focus on ways to help the staff, both proactively or techniques to use during incidents.[60]

OIJJFO staff also reviewed all New Beginnings incidents between January and May 2022 and identified one staff-on-youth assault.[61] Table, 4, below summarizes monthly data regarding staff-on-youth assaults at New Beginnings.

Table 4: Staff-on-Youth Assaults at New Beginnings, by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Staff on Youth Assaults	0	0	0	1	0
Total Bed Nights	765	716	796	681	856
Staff on Youth Assaults Per 1,000 Bed Nights	0.0	0.0	0.0	1.5	0.0

The sole incident during the period initially was reported by staff as "insubordination" and "threats."[62] However, and as envisioned by the Work Plan, DYRS staff reviewed a video of the incident and concluded that in fact it was a staff-on-youth assault. The incident was not referred to OII, but rather was transmitted immediately to human resources staff for personnel action. It is in keeping with the spirit of the Work Plan that the incident was immediately referred to human resources staff; however, OII investigations serve different purposes than human resources and a referral should have been made. For example, an OII investigation

[59] For example, the January 2022 report notes that during one incident a staff member "lost control of their emotions while being assaulted" and that DYRS would "continue to encourage staff to … therapy to deal with everyday stresses [at] work and home."

[60] For example, the January 2022 response mentions a new initiative called mindful Thursdays in which the restorative justice team works with staff to help reduce tension and anxiety. The response also considering having staff using a "peace room when they are feeling frustrated and to take time away." In addition to discussing techniques that staff could find helpful, it discusses using video reviews to be "more proactive when there is tension on the living units."

[61] As with the YSC reports, OIJJFO staff also reviewed all available video recordings of youth-on-staff and staff-on-youth reported incidents at New Beginnings.

[62] Incident report no. 10835, April 5, 2022.

should examine the circumstances of the incident, how other staff reacted, data which could be used to feed DYRS' training or quality improvement processes. Further, this incident was never properly recategorized in FAMCare as a staff-on-youth assault; however, the New Beginnings compliance specialist did record the incident as a staff-on-youth assault in the incident log that he maintains.

In its comments on the draft of this report, DYRS stated that "[w]hile the Agency understands the rationale behind this recommendation [to refer all staff-on-youth assaults to OII], the Agency believes that Secure Program Leadership can best assess whether an OII investigation is needed when there is minimal ambiguity regarding the alleged offense. However, the Agency does agree to provide OII with written rationale when Secure Program Leadership determines an incident will not require an OII investigation. OII will still be able to overrule this recommendation and open an investigation."[63]

Similar to the YSC, because there are so few staff-on-youth assaults, there are not trends to report on routinely. For the one month during this period where there was an increase in the staff-on-youth assault rate, the trend report offers only a brief narrative of what happened during the incident.[64] The New Beginnings Monthly Trend Reports do offer a discussion during the months when there was a change in the rate; for the months where there was a decrease, the discussions focus on facility efforts that may have contributed to the change.[65]

There were no program manager responses for the five-month period reviewed.

---

[63] Attachment 1 at 2.

[64] The April 2022 report states, "there was an increase in staff on youth assault [sic] this stem from the incident where staff used excessive force in restraining a youth who only engaged staff in a heated verbal exchange."

[65] For example, the January 2022 report indicates that there was a decrease in the rate which "could be attributed to the continuous training of staff in de-escalation methods." The May 2022 report states that "[t]he SYDR's [sic] and managers continue to coach and empower the YDR's [sic] in effective ways of dealing with out-of-control youths without resorting to unapproved restraint techniques."

5. Youth-on-Youth Assaults

The Work Plan required DYRS to collect and validate data regarding the rate of youth-on-youth assaults at the YSC and New Beginnings.[66] OIJJFO staff reviewed all incident reports from January through May 2022 at the YSC and identified a total of 41 incidents that met the definition of youth-on-youth assault. Below is table summarizing youth-on-youth assaults at the YSC, by month.

Table 5: Youth-on-Youth Assaults at the YSC, by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Youth-on-Youth Assaults	5	13	5	6	12
Total Bed Nights	1648	1621	1777	1734	1918
Youth-on-Youth Assaults Per 1,000 Bed Nights	3.0	8.0	2.8	3.5	6.3

OIJJFO staff reviewed FAMCare categorizations for consistency with the Work Plan definition of assault and found that all 41 incidents were accurately categorized as youth-on-youth assaults in FAMCare.

The Monthly Trend Analyses at the YSC do not provide analysis of the possible causes of any changes in the youth-on-youth assault rate each month, but the Program Manager's Response offers theories about changes in rates at times due to changes in population or due to other circumstances such as neighborhood conflicts resulted in tensions among youth within the facility.[67] When the rate of youth-on-youth assaults decreased in March 2022, the report pointed to increased staff training and a more proactive approach with the restorative justice team to identify neighborhood conflicts among newly admitted youth.

---

[66] Work Plan at Goal I.A.1.c.

[67] For example, between April and May 2022, the rate of youth-on-youth assaults increased by 80 percent. The May 2022 report states, "There was an increase in the population and youth who entered the facility from different neighborhoods with current issues." This is a plausible explanation. It is also similar to the explanation offered in April 2022 report, a month in which youth-on-youth assault rates increased by 25 percent, which states, "This additional increase can be attributed to the increase [sic] youth we have received in the facility. Youth from different neighborhoods with unresolved issues has resulted in tension [sic] in the facility."

The Program Manager Responses also provide specific actions that facility management propose responsive to the discussion of the change in monthly rates. These include actions such as the following: continuing to work with restorative justice specialists to document neighborhood issues; connecting restorative justice specialists with newly admitted youth in their first 24 hours to work with the youth on any anxieties they might have; providing safe crisis management de-escalation refresher trainings; or, engaging with youth to identify activities that they would like to have on housing units.

OIJJFO staff also reviewed all incident reports between January and May 2022 from New Beginnings and identified 24 youth-on-youth assaults. Table 6, below, summarizes youth-on-youth assaults at New Beginnings, by month.

Table 6: Youth-on-Youth Assaults at New Beginnings, by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Youth-on-Youth Assaults	3	1	2	7	11
Total Bed Nights	765	716	796	681	856
Youth-on-Youth Assaults Per 1,000 Bed Nights	3.9	1.4	2.5	10.3	12.9

Twenty three of the 24 assaults, 96 percent, were accurately categorized as youth-on-youth assaults in FAMCare and one incident was not accurately categorized.[68]

The Monthly Trend Analyses at New Beginnings provide a short narrative describing changes in the monthly youth-on-youth assault rates and typically offer possible causes for any changes.[69] There were no responses from facility managers during these five months and so

[68] The one report that was not categorized as a youth-on-youth assault was recorded in FAMCare only as a youth-on-staff assault, but was not additionally categorized as a youth-on-youth assault (incident report no. 10826, April 2, 2022).

[69] For example, between March and April 2022, the youth-on-youth assault rate increased by over 300 percent. The April 2022 Monthly Trend Analysis states that "[t]he increase in the rate of youth-on-youth assault in April could be attributed to the increase in retaliatory assaults stemming from old community beefs. During the month, about 50% of all the youth-on-youth assault were retaliatory assaults involving repeat offenders. Another reason for the

further insight into management decisions or operational changes in response to the incidents was not provided.

6. Critical Incidents

The Work Plan required that DYRS identify and categorize critical incidents, including critical incidents related to high-risk behavior, at the YSC and New Beginnings. Critical incidents are defined in the Work Plan as:

> [A]n incident that poses a risk of serious harm to youth and/or staff, including but not limited to the following categories: 1) fires or arsons; 2) riots; 3) serious assaults (for example, assaults resulting in significant injury, involving multiple assailants or the use of weapons); 4) suicides or suicide attempts (not gestures); 5) major contraband (for example, weapons, money (over $5), drugs or liquor); 6) accidents resulting in significant injury or posing serious risk of significant injury; 7) significant operational breakdowns (for example, no staff on a unit results in youth being unsupervised); 8) major physical plant problems or emergency conditions (for example, a power failure, flood, or sabotage by staff or youth); 9) escapes and attempted escapes; 10) significant destruction of property; or 11) any other extraordinary events that pose a serious risk of harm to youth and/or staff (for example, credible evidence of a planned gang activity or conspiracy to "take out" a staff person).[70]

As indicated, these incidents do not need to result in an adverse outcome, but they must include a risk of serious harm to youth and/or staff.[71] Additionally, critical incidents are not mutually exclusive of other categories of incidents. Certain assaults and self-injurious behaviors can be critical incidents as well depending on the circumstances.

---

increase in youth-on-youth assault was the increase in multiple-assailant assaults, where other youth were drawn into the melee and these youths end up being targeted for retaliation in future assaults." In March 2022, when the number of incidents increased from one incident to two incidents at the facility (increasing the incident rate), the report states "[t]hough the rate increase from February to March, it should be noted that this is still a very low rate of youth-on-youth assaults and the reason for the lower rate is the decrease in beefs and the increase in staff to youth ratio." Presumably the statement regarding the "lower rate" is assessing the March 2022 rate relative to months prior to February 2022. It also is worth noting that in April 2022, when the rate increased by over 300 percent, there were 14 percent *fewer* bed nights at the facility (*i.e.,* a lower population) than the prior month. This would presumably result in a higher staff-to-youth ratio during April, when the youth-on-youth assault rate was much higher; however aggregate, facility level staff-to-youth ratios are much less relevant to youth supervision levels than deployment levels within the facility (*e.g.,* the number of staff supervising youth on housing units).

[70] Work Plan at 8, footnote 7.

[71] See, for example, incident report no. 10896, May 2, 2022: a youth took a badge from school staff member, which could be used to unlock facility doors, but then returned it without incident.

The DYRS Incident Reporting Policy also includes a definition of critical incident. The policy defines critical incidents as "[i]ncidents which pose an imminent and/or significant threat to the life, health and safety of residents, staff and visitors in the facility or jeopardizes public safety."[72] The policy subsequently defines a category of "Class I Incidents," all of which it states should be considered critical. The relevant portion of the policy is reproduced, below:

> Class I Incidents (all Class I Incidents are Critical Incidents) – Incidents that are severe in nature, present a risk to public safety and/or may attract media attention shall be considered Class I and shall be reported through the chain of command immediately and by completion of the Staff Incident Notification Form. These Incidents include but are not limited to the following:
>
> a. Death
> b. Fire
> c. Hostage Taking
> d. Riot
> e. Reported Crimes
> f. AWOL, from Furlough (youth)
> g. Escape / Attempted Escape
> h. Suicide Attempted (with injury)
> i. Alleged Child Abuse
> j. Serious Injury or Illness (Youth)
> k. Serious Work-Related Injury (Staff)
> l. Youth on Staff Assault
> m. Youth on Youth Assault (involving 2 or more assailants)
> n. Staff on Youth Assault
> o. AWOL/Escape Apprehension or Return
> p. Youth on Youth Assault[73]

OIJJFO staff reviewed all incident reports from January through May 2022 at the YSC and found a total of 34 incident reports that met the Work Plan definition of critical incident. None of the critical incidents identified by OIJJFO were FYI incidents and all were documented in FAMCare. Table 7, below, summarizes critical incidents at the YSC, by month.

[72] Attachment 2 at V.
[73] Attachment I at VI.D.1.

Table 7: Critical Incidents at the YSC, by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Critical Incidents	5*	8*	6	6	9
Total Bed Nights	1648	1621	1777	1734	1918
Critical Incidents Per 1,000 Bed Nights	3.0*	4.9*	3.4	3.5	4.7

* See narrative on pages 21-22 regarding the underreporting of some number of staff-on-youth assaults.

As noted in the discussion of staff-on-youth assaults, above, in February 2022 a youth reported that she was the victim of repeated sexual assaults by a YDR starting in December 2021. The allegations are the subject of a criminal investigation. Only one associated incident is included in the data, in February 2022. This is a known limitation in the data.

The critical incidents during this period covered a range of categories. There were 12 incidents involving contraband.[74] Five of the reports involved youth-on-youth assaults involving multiple assailants. There was significant destruction of property in four incidents.[75] Four more incidents involved accidents resulting in a significant injury.[76] Four incidents involved significant operational breakdowns directly involving youth.[77] Three incidents during this period involved significant staff-on-youth assaults. Lastly, two incidents involved suicide attempts.

OIJJFO staff reviewed the categorization of these 34 incidents in FAMCare and found that 29 of the 34 reports, 85 percent, were accurately categorized as critical in FAMCare. Five incident reports, 15 percent, were not designated as critical, but should have been. These

[74] The contraband varied from weapons made by youth, laptops, prescribed medication, a tattoo gun, and drugs found on an overnighter youth while being searched in the Intake Unit.
[75] The items that were destroyed include radios, televisions, and laptops.
[76] The injuries included a youth who cut his finger on his door; a youth who fell while being escorted to his room; and two separate youth with prior history of the injury, dislocated their shoulders.
[77] The significant operational breakdowns included one instance where medication was provided to the wrong youth by medical staff and three instances of youth taking badges from staff members; during one of these three incidents, a YDR also left youth in a classroom unsupervised while he went to the unit.

incidents included two staff-on-youth assaults;[78] two significant operational breakdowns;[79] and one incident involving contraband.[80]

During the review period, the YSC Monthly Trend Analyses presented critical incident rate data and the Program Manager's Response provided some discussion of changes in the rates. Some of the Monthly Trend Analyses identified specific circumstances at the facilities that could have effected the monthly rate.[81] Others were more descriptive rather than explanatory, detailing the number of types of critical incidents instead of analyzing why there were changes.[82] For two two months there was no discussion of possible reasons for changes in critical incident rates.

For each month, the Program Manager Reponses listed several specific action items to address critical incidents that the facility had that month. These action items were thoughtful and responsive to the types of incidents that were occurring.[83]

At New Beginnings, OIJJFO staff identified 20 incident reports between January and May 2022 that met the Work Plan definition of critical incident. None of the 20 incidents were FYI incidents and all were recorded in FAMCare. Table 8, below, presents critical incidents at New Beginnings, by month.

---

[78] Incident report no. 10674, February 12, 2022: A YDR displayed inappropriate sexual behavior towards youth, left the unit keys in the room of one of the youth, threatened youth, and kissed a youth on the cheek and incident report no. 10737, February 27, 2022: A youth alleged repeated sexual abuse over time by a YDR.

[79] Incident report no. 10688, February 16, 2022: Medical staff provided medication to the wrong youth and incident report no. 10896, May 2, 2022: A youth walked up to a staff member and took her badge, which opens facility doors.

[80] Incident report no. 10790, March 20, 2022: A YDR found a contraband tattoo gun.

[81] For example, the March 2022 report noted that a majority of the critical incidents happened by one youth. Additionally, the May 2022 response notes that the critical incidents categorized as destruction of property occurred on the intake units where new youth were feeling frustrated.

[82] For example, the January 2022 response stated, "[t]here was an increase in these area by 3 due to 2 incidents in which a weapon was used and 2 incidents where a youth engaged in self-injurious behaviors."

[83] For example, the February 2022 report lists, "[c]ontinue to work with medical to identify ways to more efficiently identify youth who attempt to cheek their medication." The May 2022 report states, "[w]ork with the MAA (School Provider) on counting the number of laptops that is [sic] given out during education and counting them before exit [sic] the unit."

Table 8: Critical Incidents at New Beginnings, by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Critical Incidents	1	6	2	3	8
Total Bed Nights	765	716	796	681	856
Critical Incidents Per 1,000 Bed Nights	1.3	8.4	2.5	4.4	9.3

Seven of the 20 critical incidents, 35 percent, were youth-on-youth assaults with multiple assailants. An additional seven incidents, 35 percent, involved significant destruction of property.[84] Five incidents, 25 percent, involved contraband that was found in youth rooms during room searches.[85] The last critical incident was a significant operational breakdown.[86]

Among the 20 critical incidents identified by OIJJFO staff, 15 were categorized as critical in FAMCare, 75 percent. The five incidents that were not classified as critical in FAMCare included one instance of significant destruction of property;[87] a critical assault;[88] two instances of contraband;[89] and a significant operational breakdown.[90]

The Monthly Trend Analyses at New Beginnings include short narratives that typically provide more details about the number of and types of critical incidents that occurred at facility each month.[91] The analyses frequently omit a discussion of why these incidents are occurring,

[84] The destroyed property included laptops, a toilet, a desk, a telephone, a television, a housing unit thermostat, and basketball hoops were damaged and graffiti was written on a gym window with a brick.
[85] The contraband items were a sharpened ruler, a "weapon" made from a hair grease container in a sock, a piece of metal, a plastic rod, and a screw. In a secure facility, these items could be used to injure oneself or another person.
[86] A youth took the unit 911 tool, an instrument used during emergencies to cut a ligature tied around a person's neck, from an unsecured box on the housing unit.
[87] Incident report no. 10680, February 16, 2022: A youth pushed a laptop to the ground and broke it.
[88] Incident report no. 10826, April 2, 2022: Two youth were fighting and a third youth grabbed staff off of the other youth and was in a fighting stance with clenched fists.
[89] Incident report no. 11002, May 31, 2022: During room searches a YDR found a plastic rod under a youth's mattress and incident report no. 10683, February 15, 2022: a youth had contraband, a screw, in his coat which was found during room searches.
[90] Incident report no. 10911, May 5, 2022: A YDR opened the unit's lock box to retrieve a mask and walked away, leaving it unsecured, and a youth took the 911 tool from the lockbox.
[91] For example, in April 2022, the rate of critical incidents increased by 76 percent. The April 2022 Monthly Trend Report states that "[t]he reason for the increase was the increase in the number of multiple assailant assaults, the number increased from 1 last month to 2 this month. Also, the incident of possession of weapon (sharpened piece of broken ruler) contributed to the increase in critical incidents this month."

explanations as to the factors that are contributing to them, which can be used to inform strategies to prevent similar incidents in the future.

There were no responses from facility managers for these five months.

7. Self-Injurious Behavior

The Work Plan requires that DYRS identify incidents at the YSC and New Beginnings involving self-injurious behavior. The Work Plan defines self-injurious behavior as "any action taken by a youth with the intention of inflicting bodily harm to her/himself."[92] As indicated by the definition, to be categorized as self-injurious the incident must involve an action, which excludes incidents such as suicide threats (*i.e.,* statements of intent to harm oneself).[93] Examples of self-injurious behaviors include, but are not limited to, cutting oneself, head banging or wall punching, tying a ligature around one's neck, and tattooing oneself.

As DYRS's intake processing facility, the YSC includes a population of youth who are admitted from the community after a recent arrest. Many newly admitted youth find themselves in an unfamiliar setting, with unfamiliar staff and youth, unknown risks, and potentially facing serious legal consequences. Admission to the YSC can be a traumatic and destabilizing event that creates a risk of self-injurious behavior.

OIJJFO staff reviewed every incident report from the YSC for the period January through May 2022 and identified a total of five incidents involving self-injurious behavior. Table 9, below, summarizes self-injurious incidents at the YSC, by month.

[92] Work Plan at 11, footnote 9.

[93] Statements of intent to harm oneself are significant and must be responded to promptly by behavioral health professionals; however, this indicator was intended to track those specifically events which included actions taken by youth to harm themselves.

Table 9: Self-Injurious Incidents at the YSC, by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Self-Injurious Incidents	2	0	1	1	1
Total Bed Nights	1648	1621	1777	1734	1918
Self-Injurious Incidents Per 1,000 Bed Nights	1.2	0.0	0.6	0.6	0.5

The five incidents involved three youth, two males and one female. In two of the incidents, youth tied bed sheets around their necks.[94] In one incident a youth cut her inner wrist and forearm.[95] In the remaining two incidents, a youth threatened to "kill himself," broke the top of his deodorant, took a washer from his bed, and placed plastic in his mouth[96] and during an incident several months later he punched and kicked the window in his room until it broke.[97]

Four of the five incident reports were accurately categorized in FAMCare as self-injurious behavior.[98] OIJJFO staff identified that the fifth incident was documented on incident reports, but did not appear in FAMCare records.[99] After alerting DYRS staff, DYRS staff

[94] Incident report no. 10558, January 3, 2022: While conducting room checks, a YDR saw a youth sitting on his bed with a sheet wrapped around his neck. The YDR removed the sheet. On-call mental health staff spoke with the youth and he was seen by medical staff and placed on suicide alert status (*i.e.,* SPS-1). Incident report no. 10867, April 20, 2022: A YDR walked from a youth's door after counseling him and two SYDRs went to continue counseling him and observed the youth on his knees with a sheet connected from the light fixture tied around his neck. One SYDR attempted to open his door but was not able to because it was "key-only entry" and so the second SYDR came over and unlocked it. While a YDR was getting the 911 tool, the second YDR untied the sheet and lay the youth on the ground. Medical assistance was called. The youth was reported as "not responsive to touch or verbal commands." Medical staff responded to the unit. 911 was also called and the youth was transported to a hospital.

[95] Incident report no. 10814, March 29, 2022: While a youth was being escorted to medical, staff noticed "fresh cuts" on her inner wrist and forearm. The youth was seen by medical and mental health staff placed her on suicide precaution status (SPS-2). There is no indication on the incident report what object the youth used to cut her arm.

[96] Incident report no. 10556, January 1, 2022.

[97] Incident report no. 10999, May 30, 2022: After finishing a telephone call, a youth went to a second youth's door, had a "verbal exchange," and punched the window to the door, breaking it. The youth was secured in his own room where he "started to escalate" and punched and kicked the window in his door until it broke.

[98] One of the four incidents, Incident report no. 10867, was categorized as "attempted suicide," and not as self-injurious behavior, although it certainly self-injurious behavior. If DYRS were to use FAMCare as its primary data source for reporting trend data, it would be essential for staff either to ensure attempted suicides were included in self-injurious behavior reports or to add an additional category of self-injurious behavior to any incidents involving attempted suicides to ensure complete reporting.

[99] Incident report no. 10814, March 29, 2022. The existence of an incident report number (*i.e.,* 10814), which are created by the FAMCare system, suggested that the incident had at some point been entered into the FAMCare system.

determined that the absence of a FAMCare record was a result of the fact that the youth involved in the incident had multiple FAMCare records and that the date of the incident was errantly associated with a FAMCare record when the youth was not housed at the YSC. Consequently, database queries for incidents at the YSC during the period January 1 to May 31, 2022, excluded incident report no. 10841.[100]

As with other low-incidence incident categories (*e.g.,* staff-on-youth assaults), self-injurious behavior does not lend itself readily to trend analysis *per se*. The Monthly Trend Analyses do provide a self-injurious rate calculation; however, OIJJFO staff did note that the April 2022 self-injurious behavior rate was reported incorrectly.[101] The Program Manager Responses provide context for self-injurious incidents, elaborating on the circumstances of the youth who engaged in self-injurious behavior[102] and provide action items for staff consideration to maintain or decrease the monthly rate of self-injurious behavior. The action items are specific to this type of incident and discuss ways for staff who interact with the youth from various departments to identify triggers or interventions for the youth, as well as eliminating physical items that may present a risk for youth who might self-harm.[103]

[100] OIJJFO staff did not identify any additional incidents during the period reviewed that were documented on incident reports, but not in FAMCare.

[101] The rate calculation excluded the incident recorded in FAMCare as "suicide attempt." The suicide attempt was tracked in the critical incident trend data; however, the incident should appropriately be tracked in both categories: self-injurious behavior and critical incidents.

[102] For example, the January 2022 report notes that the increase in the monthly rate was the result of two youth who "appear[ed] to be frustrated while waiting to be accepted for their placement."

[103] For example, the March 2022 response discusses contacting both behavioral health and the core support team when a youth is triggered and prone to self-injurious behavior, as well as mental health staff sharing observations in classification meetings to ensure that the core support team is aware of needed interventions for youth. The April 2022 mentions working with the maintenance department to "ensure all potential hazardous items are removed or secured to suppress opportunities for self-injurious behaviors." The May 2022 report notes continuing to "ensure staff [are] conducting security checks to identify potential hazardous items that could be used for self-harm. Including removing wires from face masks for youth who [have] been identified as high risk for self-injurious behaviors."

OIJJFO staff also reviewed every incident report from January through May 2022 at New Beginnings and identified one incident of self-injurious behavior. Table 10, below, summarizes self-injurious behavior at New Beginning, by month.

Table 10: Self-Injurious Incidents at New Beginnings, by Month

	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Self-Injurious Incidents	1	0	0	0	0
Total Bed Nights	765	716	796	681	856
Self-Injurious Incidents Per 1,000 Bed Nights	1.3	0.0	0.0	0.0	0.0

The incident involved a female youth who was biting her fingers, causing them to bleed, and telling staff that she was vomiting blood.[104] This incident was correctly categorized as self-injurious behavior in FAMCare.

Because there was a single reported self-injurious incident during the five-month period under review, a monthly trend analysis is not indicated. Both the January and February 2022 Monthly Trend Reports acknowledge the increase and the subsequent decrease in rates in those two months.[105]

There were no Program Manager Responses during these five months.

V. RECOMMENDATIONS

<u>Recommendation 1:</u> Modify FAMCare to allow FYI incidents to be recorded in the system.

As noted above, FAMCare requires that one or more youth be associated with any incident input into the system. Some documented incidents, including some critical incidents

[104] Incident report no. 10562, January 4, 2022: While at the hospital for an evaluation of her stomach, a YDR saw a youth biting her fingers, causing them to bleed.

[105] The January 2022 report notes, "[t]he slight change in the rate is as a result, of changes in the monthly population…. The incident this month involved the female youths, who are struggling to adapt to the facility conditions." The February 2022 report discussed a decrease in the monthly rate and stated that it could have been the result of "increased interaction as the staff to youth ratio has increased. The increased staff to youth ratio results in an effective intervention with the residents especially the female residents."

(*e.g.,* power outages, fires, lost keys), however, may not have youth associated with them and therefore are not recorded in FAMCare. While during the five-month period reviewed there were no identified FYI incidents that met Work Plan definitions of critical incidents and assaults, historically there have been such incidents and in all likelihood there will be in the future. As DYRS's official record of incidents, FAMCare would be more reliable as a single source of incident data if it included *all* incidents and not only those involving youth.

In its comments on the draft version of this report, DYRS agreed with this recommendation and indicated that it would be implemented within 90 days.

Recommendation 2: Perform additional quality assurance on FAMCare data to ensure incidents are properly categorized.

DYRS already has implemented a system to review the categorization of every incident entered into FAMCare and OIJJFO staff found that a high percentage of incidents were correctly categorized in the data system. However, OIJJFO staff also found a number of incidents, including some critical incidents and staff-on-youth assaults, that were not correctly categorized.

Recording accurate incident-level data is a necessary precondition to tracking meaningful incident *trend* data over time. With highly accurate data, the system can be used to produce reports without significant effort to inform management decisions or stakeholders. As a relational database, FAMCare is a powerful data collection platform. DYRS staff members responsible for performing quality assurance functions do a commendable job of reviewing incidents, including written narratives and video recordings. As part of their review processes, they maintain their own incident logs, independent of FAMCare, which in some cases contain more accurate data than FAMCare.[106] DYRS staff should focus on improving the quality of the

[106] For example, at New Beginnings, an incident incorrectly recorded as insubordination and threats in FAMCare was correctly recorded as a staff-on-youth assault in the compliance specialist's incident log. Incident Report no. 10835, April 5, 2022.

incident data in FAMCare to ensure that the official record of incident data is the most accurate data source in the agency.

In its comments on the draft version of this report, DYRS stated that they "agree with and did implement" this recommendation to perform additional quality assurance on the incident data in FAMCare.[107]

Recommendation 3: Publish critical incident and assault rates by facility on a monthly basis.

By publishing aggregated monthly data regarding critical incidents and assaults, DYRS would provide a higher level of transparency to the public about the conditions of confinement at the YSC and New Beginnings. The practice would provide an ongoing incentive to perform a high level of quality assurance on data recorded in FAMCare and to consider and develop management plans responsive to any negative trends, should they arise.

In its comments on the draft version of this report, DYRS stated that they were "conducting an internal assessment regarding what data should be made publicly available, and therefore, we cannot currently agree with" the recommendation to publish critical incident and assault rates.[108] They also noted that they "comply with all lawful data requests, including providing incident and assault rates to all of our external stakeholders."[109]

As DYRS executives assess what data they will make available to the public, the agency should consider data that is made publicly available regarding another District-operated facility that houses a population of securely confined residents: the Department of Behavioral Health's (DBH) Saint Elizabeths Hospital. DBH publishes monthly data on a range of unusual incidents,

[107] Attachment 1 at 1.
[108] Attachment 1 at 2.
[109] *Id.*

including, but not limited to, assaults and injuries.[110] DYRS could elect to publish data in a different format than DBH, including publishing monthly tables of incident data on its Web site, similar to those contained in this report.

Recommendation 4: Clarify and adopt a single definition of critical incident.

As noted in the discussion of critical incidents, above, the Work Plan definition of critical incident and the definition of critical incident in the DYRS Incident Reporting Policy are inconsistent with one another. Furthermore, the definition of critical incident in the Incident Reporting Policy appears overly broad, including every assault (*i.e.,* youth-on-youth, youth-on-staff, and staff-on-youth), irrespective of the severity of the assault.

DYRS should review and refine its definition of critical incident to ensure the agency is reporting critical incidents consistent with agency policy and that it is using a meaningful standard.

In its comments on the draft version of this report, DYRS indicated that they agreed with the recommendation to clarify and adopt a single definition of critical incidents. OIJJFO staff will be meeting with DYRS staff to discuss the definition in the near term.

Recommendation 5: Consider updating the content and format of Monthly Trend Reports to ensure that they focus on data, potential causes, and possible corrective actions for those incidents most critical to health and safety of youth and staff.

To their credit, DYRS produces Monthly Trend Reports regarding critical incidents and assaults at both the YSC and New Beginnings. The format and the content of the reports produced at the two facilities is different. At both facilities, there are opportunities to enhance the value of the reports as management tools.

[110] Publicly available monthly reports can be accessed at the following Web site: https://dbh.dc.gov/publications.

For consistency purposes, it would be useful to include some defined, rolling number of months over which to track incidents (*e.g.,* a 12-month period) to provide contextual information and reveal changes or trends over time, but also to exclude historical or otherwise stale data that may no longer be relevant. Additionally, certain categories of incidents are much more prevalent at the YSC and New Beginnings, including youth-on-youth assaults and critical incidents. It is worth spending disproportionately more time analyzing causes of trends in these two categories than incident categories with very low incidence. To be clear, both staff-on-youth assaults and self-injurious behaviors are essential to track and respond to immediately; however, these categories of incidents occur with much lower frequency than assaults and critical incidents[111] and thus may not lend themselves to *trend* analysis because of their lower incidence. Furthermore, analyzing trends in injuries frequently involves analyses of trends in assaultive behaviors.

DYRS should also consider the division of labor among staff and facility executives in the production of Monthly Trend Reports and associated responses. At the YSC, a staff member produces reports and the facility deputy superintendent provides analysis and proposed remedial actions, as indicated. DYRS should assess whether the analytical work of explaining trends should be taken on by staff (or a team of staff, as necessary) and allow the facility executives to focus on development of response plans. At New Beginnings, during the five-month period under review, facility executives did not produce responses to Monthly Trend Analyses. The New Beginnings superintendent and/or his or her team should produce a response to Monthly Trend Analyses, as indicated by the data.

[111] Self-injurious behaviors and staff-on-youth assaults may in some cases rise to the level of critical incidents.

In its comments on the draft version of this report, DYRS stated that they agree with this recommendation and would implement changes to Monthly Trend Reports within 90 days.

<u>Recommendation 6:</u> Organizationally, compliance specialists should report to a manager outside of the facility chain of command.

Until approximately August 2021, compliance specialists at the YSC and New Beginnings reported to a manager who oversaw both secure facilities. Since that time, compliance specialists have reported to the superintendent of the facility whose incidents they review.

Although no concerns arose regarding any efforts to influence reported incident data, for the purposes of organizational integrity and enhancing a system of checks and balances, it would be preferable for the compliance specialists to report to a manager other than the manager of the facility whose incidents they are reviewing.

In its comments on the draft version of this report, DYRS indicated that it agreed with this recommendation and would have compliance specialists report to a manager outside of the facility chain of command within 90 days.

VI. CONCLUSION

DYRS has established management systems to collect incident report data related to the five incident categories defined by the Work Plan. DYRS staff collect data regarding incidents involving injuries to youth as a result of assaults, staff-on-youth assaults, youth-on-youth assaults, critical incidents, and self-injurious behavior in their data system, FAMCare. Some incidents that occur in the YSC and New Beginnings – incidents not involving one or more youth – are not recorded in FAMCare due to current limitations in the system. This introduces the

possibility of underreporting certain critical incidents that do not involve youth if FAMCare is used as the data reporting source.

DYRS has established management systems designed to validate the accuracy and completeness of the agency's incident data. Compliance specialists assigned to the YSC and New Beginnings are responsible for reviewing every incident documented at the facilities, and assessing whether the incident is categorized consistent with the adopted Work Plan definitions. Additionally, the compliance specialists conduct video reviews of a broad range of incidents, including all incidents reported as youth-on-staff and staff-on-youth assaults, as was required by the Work Plan. Lastly, compliance specialists review incidents to ensure that youth involved in assaults are assessed by medical staff.

OIJJFO staff's independent review of the data in FAMCare revealed that DYRS staff are completely and accurately capturing some, but not all, categories of data. Among the agency's strengths, OIJJFO found that 50 injuries as a result of assaults were identified; however, three additional youth were not seen by medical following assaults. Furthermore, among the 50 youth injuries, 47 were correctly identified in FAMCare, whereas 49 of the 50 youth injuries were correctly identified in the compliance specialists' logs. With respect to staff-on-youth assaults, DYRS correctly identified all five assaults and took prompt investigative or personnel action; however, only two of the five incidents identified by OIJJFO staff were correctly identified as staff-on-youth assaults in FAMCare. There is an outstanding issue regarding omissions of staff-on-youth assaults at the YSC in FAMCare in January and February 2022 that DYRS must address once more facts are known. DYRS staff correctly categorized 64 of 65, 98 percent, of youth-on-youth assaults that OIJJFO staff identified during the period under review. Finally, DYRS staff correctly identified and categorized all six self-injurious behaviors that OIJJFO staff

identified; however, for reasons elaborated on above, DYRS must ensure that all suicide attempts are included in monthly statistics regarding self-injurious behavior.

Critical incident reporting was less accurately categorized in FAMCare. OIJJFO staff found that only 85 percent and 75 percent of the critical incidents at the YSC and New Beginnings, respectively, were correctly categorized as critical in FAMCare. While there is more room for interpretation regarding critical incidents than there are for the other four incident categories, examples of incidents that were not recorded as critical in FAMCare included staff-on-youth assaults at the YSC and significant operational breakdowns at New Beginnings.

Finally, as the Work Plan required, DYRS has established processes to analyze incident trend data at regular intervals. Compliance specialists at both facilities produce monthly reports that include data regarding critical incidents and assaults and at the YSC, facility executives produce a monthly response to the trend data.

DYRS has implemented all of the elements of an incident reporting system with data validation and trend reporting, including a functional database integrated with the agency's case management system, line staff and managers (*i.e.,* YDRs and SYDRs) trained on incident reporting processes and expectations, and staff assigned specifically to perform quality assurance and reporting functions. DYRS should continue to enhance its existing system, focusing on improving the accuracy of incident categorization in FAMCare and improving the usability of periodic trend reports for facility executives.

Attachment 1

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF YOUTH REHABILITATION SERVICES
450 H Street NW, Washington, DC 20001

MEMORANDUM

TO:	Mark Jordan Executive Director, Office of Independent Juvenile Justice Facilities Oversight (OIJJFO)
FROM:	Hilary Cairns, DYRS Director *Hilary Cairns* Adina Levi, DYRS Deputy Director, Secure Division
DATE:	September 30, 2022
RE:	Response to the OIJJFO's Report Regarding Critical Incidents and Assaults at DYRS's Secure Facilities

Background

In response to the vacature of the Jerry M. litigation, the Office of Independent Juvenile Justice Facilities Oversight (OIJJFO) was established in 2021 to regularly monitor and publicly report on DYRS's management of the District of Columbia's two secure juvenile facilities – New Beginnings Youth Development Center (NBYDC) and the Youth Services Center (YSC).

This memorandum reflects the Department of Youth Rehabilitation Services (Agency) response to the OIJFFO's report titled, "Critical Incidents and Assaults at the Youth Services Center and New Beginnings Youth Development Center" (Report).

Agency Response

The Agency would like to thank the OIJJFO for the thorough analysis in developing this Report. Regarding the recommendations in this Report, the Agency agrees with and did implement:

- ***Recommendation 2:*** *Perform additional quality assurance on FamCare data to ensure incidents are properly categorized.*

The Agency also agrees with and will implement the following recommendations within the next 90 days:

- ***Recommendation 1:*** *Modify FamCare to allow FYI incidents to be recorded in the system.*
- ***Recommendation 4:*** *Clarify and adopt a single definition of a critical incident. (You are meeting with the compliance specialist to assist with this.)*
- ***Recommendation 5:*** *Consider updating the content and format of Monthly Trend Reports to ensure that they focus on data, potential causes, and possible corrective actions for those incidents most critical to the health and safety of*

youth and staff.

- ***Recommendation 6:*** *Organizationally, compliance specialists should report to a manager outside of the facility chain of command.*

However, the Agency is conducting an internal assessment regarding what data should be made publicly available, and, therefore, we cannot currently agree with Recommendation 3, which is:

- ***Recommendation 3:*** *Publish critical incident and assault rates by facility on a monthly basis*

It should be noted that the Agency does comply with all lawful data requests, including providing incident and assault rates to all of our external stakeholders.

Furthermore, throughout the Report, the OIJJFO recommends that all Staff on Youth Assaults should be referred to the Office of Internal Integrity (OII) for an investigation. While the Agency understands the rationale behind this recommendation, the Agency believes that Secure Program Leadership can best assess whether an OII investigation is needed when there is minimal ambiguity regarding the alleged offense. However, the Agency does agree to provide OII with written rationale when Secure Program Leadership determines an incident will not require an OII investigation. OII will still be able to overrule this recommendation and open an investigation.

Conclusion:

Thank you again to OIJJFO for your thorough analysis and for allowing the Agency the opportunity to provide feedback on the Report. We look forward to our continued work together.

Attachment 2

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF YOUTH REHABILITATION SERVICES
POLICY AND PROCEDURES MANUAL

POLICY NUMBER:	IV.a.1.
RESPONSIBLE OFFICES:	Facilities (Secure Programs)
EFFECTIVE DATE OF POLICY:	March 13, 2019
SUPERSEDES POLICY:	IV.c.1.i. (09/12/2017 Version)
SUBJECT:	Unusual Incident Reporting

I. PURPOSE

To provide procedural instructions which guide DYRS personnel and affiliates in reporting unusual incidents to the Department of Youth Rehabilitation Services through the appropriate chain of command.

II. POLICY

It is the policy of the Department of Youth Rehabilitation Services (DYRS) that all unusual incidents shall be reported in a timely manner. The effective and efficient operation of the agency depends on accurate communication of information regarding serious incidents involving both youth and staff.

III. AUTHORITY

This policy is governed by all applicable District of Columbia and Federal law including: DYRS Establishment Act (2004); D.C. Official Code §§ 2-1515.01 *et seq.* (2008); and the District of Columbia Personnel Manual.

IV. SCOPE

This policy applies to all DYRS employees and DYRS contractors and their agents who perform official duties or provide services on behalf of the Department.

V. DEFINITIONS

Unusual Incident - an event or happening outside the ordinary routine that results in disruption or threatens security, safety, or order of the facility and/or harm or threat of harm to youth, staff, visitors or the physical plant.

Critical Incident - Incidents which pose an imminent and/or significant threat to the life, health and safety of residents, staff and visitors in the facility or jeopardizes public safety.

Incident Call-Down List - DYRS staff that should be contacted after a Class I or Class II incident occurs. The call-down list should be initiated by the most senior security staff at the site of the incident.

VI. PROCEDURE

The **Staff Incident Notification Form** (Attachment A) and the **SYDR Incident Notification Form** (Attachment B) shall constitute the official record of the incident and shall serve to ensure that the Department is informed of any unusual event that might require immediate attention. All witnesses to unusual incidents shall complete the Staff Incident Notification Form.

The Staff Incident Notification Form and the SYDR Incident Notification Form are important documents for subsequent review and investigation of any unusual incident and may be the basis for an official request for an investigation. This investigation can be requested by the Director, Senior Deputy Director, or the Deputy Director of Secure Programs and shall be conducted in accordance with DYRS policy by the Office of Internal Integrity (OII). OII will monitor and coordinate all criminal investigations involving the agency and other law enforcement agencies. The Staff Incident Notification Form and the SYDR Incident Notification Form shall be filled out in a manner that is clear, concise, and factual.

A. In order to ensure uniformity in reporting procedures and format, DYRS staff, contractors and their agents shall complete the Staff Incident Notification Form whenever one of the reportable incident types occur or any incident occurs which may impact the integrity and public confidence in DYRS operations. DYRS staff, contractors and their agents within the secure facilities shall submit the completed reports to an SYDR.

B. The SYDR Incident Notification Form shall be completed by an SYDR for every incident and provide complete details to include a summary of the incident, the actions taken by appropriate managerial officials regarding the unusual incident, and corrective measures to prevent recurrences (immediate and long range). SYDRs shall enter the incident summary data into DYRS's case management database in the appropriate client files. The Deputy Director of Secure Programs, or his/her designee, shall review these reports, and may cite recommendations for actions by higher authorities as required.

C. DYRS Facility Compliance Specialists shall review the SYDR database entries, Staff Incident Notification Forms, Medical Forms, Room Confinement Forms, and Incident video footage and maintain incident data management systems that track data and data trends regarding unusual incidents.

D. Reportable Incident Types include:

1. **Class I Incidents** (all Class I Incidents are Critical Incidents) - Incidents that are severe in nature, present a risk to public safety and/or may attract media attention shall be considered Class I and shall be reported through the chain of command immediately and by completion of the Staff Incident Notification Form. These Incidents include but are not limited to the following:

a. Death
b. Fire
c. Hostage Taking
d. Riot
e. Reported Crimes
f AWOL, from Furlough (youth)
g. Escape/Attempted Escape
h Suicide Attempted (with injury)
i. Alleged Child Abuse
j. Serious Injury or Illness (Youth)
k. Serious Work-Related Injury (Staff)
l. Youth on Staff Assault
m. Youth on Youth Assault (involving 2 or more assailants)
n. Staff on Youth Assault
o. AWOL/Escape Apprehension or Return
p. Youth on Youth Assault

2. **Class II Incidents** — Incidents which are serious in nature but do not present a significant risk to the facility, public safety or attract media attention shall be considered Class II incidents and shall be reported through the chain of command immediately and by completion of the Staff Incident Notification Form. These incidents include but are not limited to the following:
   a. Felony Arrest (Staff)
   b. Felony Arrest (Youth)
   c. Attempted AWOL/Abscondence
   d. Possession of Contraband (dangerous and/or hazardous)
   e. Other incidents similar in nature

3. **Class III Incidents** — are of a nature that requires immediate notification by completion of the Staff Incident Notification Form.
   a. Accidental Injury
   b. Staff Discipline
   c. Damage to property (more than $250)
   d. Theft (more than $250)
   e. Inappropriate sexual behavior
   f. Illegal drugs/alcohol seized
   g. Possession of Contraband (nuisance)
   h. Other incidents similar in nature

E. All unusual incidents involving securely detained youth shall be verbally reported to the facility Superintendent, Deputy Superintendent, Administrator on Duty, Shift Commander, or a Supervisory Youth Development Representative.

As may be necessary, the Superintendent, Deputy Superintendent, Shift Commander, or Supervisory Youth Development Representative shall ensure that follow-up reports are

submitted to relay subsequent facts, information and actions. At this point, a **Supplemental Staff Incident Notification Form** shall be required. (Attachment C).

F. It is the responsibility of the Superintendent or his/her designee to ensure compliance and adherence with the requirement to submit the Staff Incident Notification Form, the SYDR Incident Notification Form, and any Supplemental Staff Incident Notification Forms to DYRS in accordance with the timeframes established by these procedures.

G. After every altercation resulting in physical contact or incident in which staff use force against a youth, staff shall immediately notify medical staff of the incident and medical staff must promptly assess the youth and complete an Incident Assessment Report or a Refusal of Health Care Services form, if the youth refuses medical assessment. This should be noted on the reporting form.

H. When Class I and Class II incidents occur, the most senior security staff at the site of the incident shall initiate the **Secure Facility Call-Down List** (Attachment D). The Deputy Director of Secure Programs will ensure that the incident is reported by telephone to the DYRS Senior Deputy Director.

I. Procedures for Notifying On-Call Administrators (Administrator on Duty):

1. At the secure facilities, the Shift Commander or SYDR shall notify the Facility Administrator on Duty by telephone who in turn shall call the Deputy Director for Secure Programs or his/her designee if a Class I or Class II incident has occurred. If the Administrator on Duty is unavailable, the Deputy Director for Secure Programs shall be contacted by cellular telephone.

2. At non-secure facilities, residential treatment facilities, community based residential or non-residential programs, staff on duty shall complete a Staff Incident Notification Form for all unusual incidents and submit it to the Office of Licensing, Contracting and Compliance (OLCC) by the end of the shift. Staff from the Office of Licensing, Contracting and Compliance (OLCC) shall upload all Incident Notification Forms into DYRS's case management database. For all Class I or Class II incidents, in addition to completing a Staff Incident Notification Form, staff on duty shall report the incidents by telephone to the appropriate social worker, probation officers, Child and Family Services, Safety Hotline, OLCC and any other agency that is affiliated with the resident and/or staff members within one (1) hour of the incident. In every case of abscondence or escape, staff shall also complete and submit a **Request for the Issuance of a Custody Order Form** (Attachment E) within one (1) hour of the incident.

Approval of the Agency Director:

DYRS Director

3/13/19
Date

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Youth Rehabilitation Services

SUPERVISORY YOUTH DEVELOPMENT REPRESENTATIVE INCIDENT NOTIFICATION FORM

☐ **Achievement Center (450-H)** 450 H Street, NW Washington, DC 20001 ☐ **Youth Services Center (YSC)** 1000 Mount Olivet Road, NE Washington, DC 20002 ☐ **New Beginnings Youth Development Center (NBYDC)** 8400 River Road, Laurel, MD 20724 ☐ **Other** *(Please provide name of facility & address below):*	**Report #**	

Incident Date:		**Incident Time:**	
Incident Location:		**Activity:**	
Reported By (First & Last Name):		**Position/Title:**	
Reported To (First & Last Name):		**Title:**	
Report Date:		**Report Time:**	

IDENTIFYING DATA OF YOUTH(S):

	Name (If not certain, complete remaining areas only)	Assigned Unit (Color of uniform shirt)	Sex	Race	Physical Description
1.					
2.					
3.					
4.					

CHARGE:

	DEATH		YOUTH-ON-STAFF ASSAULT		FIGHT (2 OR MORE YOUTH)
	FIRE		YOUTH-ON-YOUTH ASSAULT		ACCIDENTAL INJURY
	HOSTAGE-TAKING		STAFF-ON-YOUTH ASSAULT		STAFF DISCIPLINE
	RIOT		SUICIDAL BEHAVIOR (NO INJURY)		DAMAGE TO PROPERTY (EXCESS OF $1,000.00)
	REPORTED CRIMES		FELONY ARREST (YOUTH)		THEFT (EXCESS OF $500.00)
	ESCAPE		FELONY ARREST (STAFF)		INAPPROPRIATE SEXUAL BEHAVIOR***
	ATTEMPTED ESCAPE		AWOL – ABSCONDANCE		ILLEGAL DRUG/ALCOHOL SEIZED
	AWOL FROM FURLOUGH/WORK DETAIL		AWOL –ESCAPE/APPREHENSION		POSSESSION OF CONTRABAND
	SERIOUS INJURY OR ILLNESS (YOUTH)		DAMAGE TO PROPERTY (UNDER $1,000.00)		OTHER:
	SERIOUS WORK-RELATED INJURY (STAFF)		THEFT (UNDER $500.00)		

**** If you are a mandated reporter of child abuse and neglect under DC law, you must report allegations for child victims and those at risk up to age 18 in the District of Columbia to the District's Child and Family Services Agency (CFSA) hotline by calling (202) 671-7233 [SAFE]. All incidents involving sexual misconduct require an* Allegation of Sexual Misconduct Reporting Form *to be completed.*

INVESTIGATION/UPDATED OUTCOME *(Only if required)*:
ACTION(S) TAKEN *(Examples: Discipline or otherwise)*:

ADDITIONAL DETAILS OF INCIDENT:

Placed in Administrative Segregation?	□ YES □ NO □ N/A	Completed Segregation Form?	□ YES □ NO □ N/A
Was Youth given Cool-Out?	□ YES □ NO □ N/A	Was there destruction or damage to property?	□ YES □ NO □ N/A
Refer to Disciplinary Committee?	□ YES □ NO □ N/A	Notification Sheet?	□ YES □ NO □ N/A
Referred to Project Hands?	□ YES □ NO □ N/A	Resident Injury?	□ YES □ NO □ N/A
Were restraints used?	□ YES □ NO □ N/A	Staff Injury?	□ YES □ NO □ N/A
Was the Youth remorseful or apologetic?	□ YES □ NO □ N/A	If known, is this normal behavior for the Youth?	□ YES □ NO □ N/A
Would you like to be present at the Youth's hearing *(this request may or may not be honored, based on staff availability at the time of hearing)*?			□ YES □ NO □ N/A
Do you recommend any particular corrective action for the Youth in response to this incident?			□ YES □ NO □ N/A

Please provide your recommended details for corrective action and justification:

Supervisor Signature: _____

Time: _____

Date: _____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Youth Rehabilitation Services

STAFF INCIDENT NOTIFICATION FORM

☐ **Achievement Center (450-H)** 450 H Street, NW Washington, DC 20001 ☐ **Youth Services Center (YSC)** 1000 Mount Olivet Road, NE Washington, DC 20002 ☐ **New Beginnings Youth Development Center (NBYDC)** 8400 River Road, Laurel, MD 20724 ☐ **Other** *(Please provide name of facility & address below):*	**Report #**	

Incident Date:		**Incident Time:**	
Incident Location:		**Activity:**	
Reported By (First & Last Name):		**Position/Title:**	
Reported To (First & Last Name):		**Title:**	
Report Date:		**Report Time:**	

IDENTIFYING DATA OF YOUTH(S):

	Name (If not certain, complete remaining areas only)	**Assigned Unit** (Color of uniform shirt)	**Sex**	**Race**	**Physical Description**
1.					
2.					
3.					
4.					

INCIDENT DESCRIPTION:

WHAT HAPPENED? Please be specific and give details including perpetrator(s) and victim(s):

WHO WAS INVOLVED IN THE INCIDENT? WHAT WERE HIS/HER ROLES IN THE INCIDENT?
CONTRIBUTING FACTORS: Please specify relevant facts. *(Examples: Resident was upset about a phone call they received OR door was broken which youth used to exit out of bounds.)*
MEDICAL: *(Examples: Resident was taken to medical and released OR Resident refused medical by signing a refusal form.)*

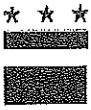
PLEASE ATTACH ADDITIONAL SHEETS IF NECESSARY
[Are there any additional incident reporting pages attached □ YES □ NO]

Would you like to be present at the Youth's hearing *(this request may or may not be honored, based on staff availability at the time of hearing)?*	□ YES □ NO □ N/A

Staff's Signature: _____

Time: _____

Date: _____



GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Youth Rehabilitation Services

SUPPLEMENTAL STAFF INCIDENT NOTIFICATION FORM

WHAT HAPPENED (continued)? Please be specific and give details including perpetrator(s) and victim(s).