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COMMONWEALTH OF VIRGINIA

Board of Juvenile Justice

MEETING MINUTES

April 25, 2018

Main Street Centre, 600 East Main Street, 12th Floor, South Conference Room
Richmond, Virginia 23219

Board Members Present: Tyren Frazier, Michael Herring, Scott Kizner, Dana Schrad, Robert "Tito" Vilchez, and Jennifer Woolard

Board Members Absent: David Hines, Robyn McDougle, and Quwanisha Roman

Department of Juvenile Justice (Department) Staff Present: Ken Bailey, Andrew "Andy" K. Block, Jr., Valerie Boykin, Ken Davis, Lisa Floyd, Daryl Francis, Stephanie Garrison, Regina Harris, Wendy Hoffman, Joyce Holmon, Dee Kirk, Joanna Laws, Jamie Patten, Edward Petersen, Mike Morton, Charisse Mullen (Attorney General's Office), Kristen Peterson, Beth Stinnett, Lara Todd, and James Towey

Guests Present: Dawn Barber (Newport News Juvenile Detention Center), Marilyn Brown (Chesterfield Juvenile Detention Center), Kerry Chilton (disAbility Law Center of Virginia), Jason Houtz (Fairfax County Juvenile Detention Center), Monica Jackson (Department of Criminal Justice Services), Cathy Roessler (Norfolk Juvenile Detention Center), Carla White (Rappahannock Juvenile Detention Center), and Amy Woolard (Legal Aid Justice Center)

CALL TO ORDER

Chairperson Jennifer Woolard called the meeting to order at 9:36 a.m.

INTRODUCTIONS

Chairperson Woolard welcomed all who were present and asked for introductions.

APPROVAL of January 9, 2018, MINUTES

The minutes of the January 9, 2018, Board meeting were provided for approval. On MOTION duly made by Michael Herring and seconded by Tyren Frazier, the Board approved the minutes as presented.

PUBLIC COMMENT PERIOD

There was no public comment.

DIRECTOR'S CERTIFICATION ACTIONS

Ken Bailey, Certification Manager, Department

Included in the Board packet were the individual audit reports and a summary of the Director's certification actions completed on February 12, 2018.

The audit for six court service units found minor deficiencies, and through a series of follow-up visits by the Certification Team, demonstrated a 100% compliance with regulations.

Fairfax Detention Center and Post-Dispositional Program and Lynchburg Regional Detention Center received three-year certifications for their audits.

The audit for the Norfolk Detention Home found a number of deficiencies, and the facility was certified for one year. The Certification Team will perform a full audit with monitoring visits to help them return to a 100% compliance level.

The certification for Aurora House, a group home in Falls Church, was modified to authorize an independent living program. The approved modification to their license will allow the facility to remodel two vacant rooms that will house female residents up to age 20.

The Department received notification in February from the Barry Robinson Center regarding the closure of its family-oriented group home program. In the 1990s, there were five family-oriented group home programs in Roanoke, Charlottesville, Tidewater, Yorktown, and Richmond; however, these programs gradually faded out. The Barry Robinson Center program has not been used for several years, and the facility decided not to continue its operations. They have surrendered their license and requested closure. The letter in the Board packet notifies the Board of this action.

VARIANCE REQUEST: TO MODIFY STAFFING REQUIREMENTS IN THE JUVENILE CORRECTIONAL CENTER (JCC) CENTRAL INFIRMARY AND NURSING EXPANSION

Kristen Peterson, Regulatory and Policy Coordinator, Department

The certification regulations give the Board authority to issue variances to regulatory requirements provided the regulatory requirement is not critical. Critical regulatory requirements must achieve a 100% compliance level. The regulations do not identify criteria the Board must consider in

determining whether to approve a variance request. The regulation requires only that the Board specify the scope and duration of the variance.

The variance request submitted for the Board's approval is on behalf of Bon Air Juvenile Correctional Center (JCC) and deals with the noncritical regulatory requirement set out in 6VAC35-71-830 concerning the supervision of residents in the JCC. The existing regulation requires the following:

- There must be at least one direct care staff member on duty who is responsible for the supervision of every 10 residents (1:10) during resident waking hours and every 16 residents (1:16) during resident sleeping hours.
- There must be at least one direct care staff member on duty who is responsible for the supervision of residents in each building or housing unit where residents are sleeping.

For purposes of this regulation, the definition of direct care staff is staff responsible for maintaining the safety, care, and well-being of the residents, maintaining facility security, and implementing the behavior management program and community treatment model. Bon Air has a central infirmary/nursing station that is considered a living unit for these purposes and occasionally has residents assigned to this area overnight. For this reason, there should be one direct care staff member responsible for supervising residents in the central infirmary/nursing station. Currently, security personnel staff the central infirmary, but they do not meet the definition of direct care staff. The requested variance will allow the security personnel to continue staffing the central infirmary/nursing station.

The existing staffing scheme for the central infirmary and nursing station is due largely to the implementation of the community treatment model in the JCC. The Department historically employed juvenile correctional officers in the facility who were considered direct care staff. As part of the transformation, the Department reclassified the juvenile correctional officer position into two separate categories; resident specialists and security staff. The resident specialists are responsible for maintaining supervision and security and have advanced programmatic responsibilities (behavior management) related to implementing the community treatment model. Security staff provide security services in the facility and are not involved in the behavior management program. Security staff do not meet the definition of direct care staff under the existing regulation.

The Department recommends adding language to the definition for security staff and a new Subsection D to Section 830 that authorizes security staff to serve in the central infirmary without the presence of direct care staff.

Ms. Peterson explained that the variance will not offend federal or state laws, particularly the Prison Rape Elimination Act (PREA). PREA speaks to staffing ratios in correctional centers and provides that security staff are the only personnel that satisfy the staffing ratios. PREA does not have as stringent requirements as the Department has regarding the definition of direct care staff.

Chairperson Woolard asked how long residents are potentially in the infirmary and under the supervision of the security staff.

Deputy Director of Residential Services Joyce Holmon responded that it varies from two to three days or longer. The central infirmary sees residents primarily for dental care post-op, pre-op for minor surgery, and occasionally a broken arm or leg, which would prolong their stay. For young people who stay in the central infirmary longer, services such as education and therapy are provided to the resident in the infirmary.

Ms. Peterson added that Bon Air is requesting the variance for a five-year period or until such time as the regulation is amended. The regulation is currently in the proposed stage of the regulatory process; however, if the Board approves the variance, the variance language will be incorporated into the regulation before the Board advances it to the final stage.

Board Member Dana Schrad asked if a resident staying in the infirmary needed 24-hour attention and whether the security staff are trained to accommodate this level of care or a medical emergency.

Deputy Director Holmon stated that medical personnel are in the central infirmary 24-hours a day, seven days a week.

Director Block added that the resident specialists must stay with their assigned unit as much as possible as part of the Community Treatment Model and that pulling them off that unit to supervise one resident in the infirmary would disrupt the entire unit. The security staff are floating personnel, and it is more efficient to use them given that central infirmary staff are providing direct services.

Pursuant to 6VAC35-20-92 of the Regulation Governing the Monitoring, Approval, and Certification of Juvenile Justice Programs and Facilities, on MOTION made by Michael Herring and seconded by Dana Schrad, the Board of Juvenile Justice approved the variance to the regulatory requirement provided in 6VAC35-71-830, providing that only staff classified as direct care staff may supervise residents in each building or living unit where residents are sleeping. This variance shall authorize security staff to supervise residents housed or receiving services in the correctional center's central infirmary or nursing station outside the presence of direct care staff. This variance is to remain in effect until 6VAC35-71 is amended or for five years, whichever occurs first.

OVERVIEW OF JUVENILE DETENTION CENTERS

Marilyn Brown, Superintendent, Chesterfield County Juvenile Detention Center and President of the Virginia Juvenile Detention Association (VJDA); and Jason Houtz, Superintendent, Fairfax County Juvenile Detention Center

Ms. Brown provided an overview of detention centers, noting the differences between detention centers and correctional centers, and discussed the relationship with the Department, day-to-day operations, and challenges. The slide presentation begins on page 105 of the Board packet. Ms. Brown reviewed the information contained on each slide and expounded on the following slides:

Slide 5 (Criteria for Detention): The Department uses a detention assessment instrument, which is an objective screening tool adopted in 2003 that helps probation officers, intake officers, and judges determine who should be detained. Services are available to try to keep youth out of detention, such as the Virginia Juvenile Community Crime Control Act (VJCCCA), electronic monitoring, and house arrest. Judges and court service units try to ensure only young people who must be detained are detained.

Slide 7 (Post-Dispositional Detention Placements): Detention centers work with the VJCCCA to develop programs to give judges alternatives to using detention as a short-term punitive measure.

Slide 13 (Relationship of Detention to DJJ): The Department partners with detention centers on the development of the detention center regulations. Virginia has a system with good checks and balances. The detention centers work cooperatively with the certification staff on the three-year certification audits and annual monitoring visits. The detention centers conduct their own self-audits.

The Department receives pass-through money from the General Assembly that assists the detention centers with daily operations. Thirty-seven percent of the annual operations for detention centers is funded through the Department's block grant. The Department also partners with the detention centers on construction. Detention facilities have existed since the 1970s with different kinds of housing units and pods. Construction projects increased in the late 90s and 2000s when detention centers were overcrowded. Mental health has been a challenge for the detention centers: they lack the necessary administrative space and treatment space.

Contractual partnership with the Department is a new phenomenon. Nine detention centers have an agreement with the Department to house state commitments and work closely with each other to provide similar programming. Detention centers have their own intake process for young people entering their community placement program (CPP) or another locality's CPP. Detention centers want to be more trauma responsive to young people, so it makes sense to keep young people in that detention center rather than constantly moving them. Reentry placements have decreased because young people are staying in local CPPs.

Slide 15 (To whom else does detention answer?): Juvenile education programs are different in detention centers than JCCs. The Department of Education provides funding and oversight, but detention centers have memoranda of understanding with their local school division on educational services. For example, Chesterfield Juvenile Detention Center's school program has a principal and nine teachers who are employed by Chesterfield County schools.

The PREA audit process is also different in detention centers than in the JCC. Detention centers secure their own auditors and pay for audits to be conducted to ensure they meet PREA requirements.

The VJDA is a close-knit and active statewide support system that meets on a quarterly basis to problem solve and exchange best practices and ideas for improvement.

Jason Houtz discussed resident profiles and challenges as pictures of detention center activities were shown in the background.

Youth entering Virginia detention centers often come off the street, and the detention centers have little history and background on these youth. What is known about them may be a baseline for the detention centers to make decisions on how best to care for them. Detention centers provide extensive services up front, during the intake process, to try to identify a resident's current needs. Information is gathered from a variety of sources, from contacting parents, talking with probation officers and arresting officers, and reviewing the self-reports of residents to identify how best to manage their needs while in detention.

Lengths of stay can be complicated and variable. Some youth enter a detention facility for a few hours, while others have been there over a year. Circumstances that drive the length of stay are not in the detention center's control, which makes it more challenging to guide youth through the detention process.

Detention centers do not always know when a resident will be released, which makes it difficult to develop a structured program of deliverables and measurable outcomes. Detention centers do not drive whom they serve and for how long; their program focuses on stabilization. For Fairfax, the primary focus is to send residents out of the program better than when they walked in whether for a few hours or a year.

The regulations are a guidance tool that detention centers use to develop their programs, and create best and safe practices for managing youth in the program.

The profile of youth in detention centers:

- Behavior challenges, a defiant state of mind.
- Experience few home life parameters around acceptable behavior.
- Unstructured environment.
- Distrust regarding authority figures.
- Daily activities are focused on negative rather than positive routines.
- Anxiety about going to court and post-court distress.
- Medical concerns, such as untreated injuries or unmanaged medical conditions.
- Youth may present being intoxicated, under the influence of illegal substances, or going through withdrawal symptoms.
- Injuries from domestic abuse.
- Young women who are pregnant might not have managed the pregnancy or been aware.
- Vision/dental care is often limited.

- Inconsistent prescription use is the most common ailment. Youth are not prescribed medication for medical or mental health conditions, do not take their medications regularly, or do not see a physician.
- Education lapses with inconsistent school attendance; some residents do not attend school at all.
- Residents have obtained a GED or high school degree, but have little interest in pursuing further education.
- Exercise and recreation, many youth are not involved in team sports or structured recreation activities.
- Nutritiously, youth do not eat well with high carbohydrates and high sugar in their diet.
- Diagnosed or undiagnosed mental health condition ranging from mild to severe.

Some challenges in detention centers include:

- Providing services and managing residents with age gaps; many residents are in different places in their lives.
- Addressing youth who themselves are parents.
- Managing siblings, co-defendants, lifelong gang members, opposing gang members, victims, offenders, and witnesses.

Each detention center in Virginia has developed approaches to meeting these challenges. The regulations assist detention centers in providing consistency and guidelines to meet challenges. The detention centers' two biggest partners are the Department of Education and the Community Services Board (CSB), which work together on the medical, mental health, and educational needs of the resident and link them with necessary services. Services for residents with acute mental health or medical needs continue through the provision of guidance and information to the parent or the resident's probation officer regardless of when the resident leaves the facility. Family engagement activities are not easy initiatives but are beneficial to residents.

Board Member Kizner asked, when a student is removed from a local school division (e.g., Harrisonburg) and enters a detention center, does that local school division then become responsible for the student?

Ms. Brown answered that yes, the local school district is responsible for that student. The detention center will contact Harrisonburg schools to obtain the youth's records and enroll him in the school program. For some youth, a GED is the only reasonable track because the student has fallen behind in his education.

Board Member Kizner asked whether, for accounting purposes, the detention center or local school district is responsible if the youth quits school.

Deputy Director of Education Lisa Floyd replied that the youth is tied to his local school district. That is why the partnership between the local school district and the detention center is so

important. Even though detention centers push for the GED, based on the youth's needs, the Department wants a diploma for its youth because of the accountability in state reporting.

Board Member Robert Vilchez noted that in Northern Virginia there has been a resurgence of MS-13 and 18th Street gangs across the region including in detention homes in Loudoun, Fairfax, and Prince William Counties and asked what the detention homes and the VJDA are doing to address gang intervention.

Mr. Houtz responded that the primary goals for detention centers are safety and security. Gang management is complicated and can present a serious security issue. The Fairfax Detention Center provides educational programming for its staff on human trafficking for girls and plans to expand the training to males. Fairfax has a strong gang taskforce with representatives from area school systems, court service units, detention centers, and law enforcement working together to develop strategies to address juvenile gang issues in the region. It is difficult to break youth away from gangs while in a detention center. Education on gangs is provided, but intervention would require a very structured program.

REGULATIONS GOVERNING JUVENILE SECURE DETENTION CENTERS (6VAC35-101) TO THE PROPOSED STAGE OF THE REGULATORY PROCESS

Kristen Peterson, Regulatory and Policy Coordinator, Department; Marilyn Brown, Superintendent, Chesterfield County Juvenile Detention Center and President of the VJDA; and Jason Houtz, Superintendent, Fairfax County Juvenile Detention Center

The proposed revisions are a product of discussions with members of the committee that consisted of the Department and representatives from the VJDA. The work group performed a line-by-line review to enhance the regulatory provisions and ensure the safety and security of residents in the detention centers.

Ms. Peterson asked the Board to keep in mind the distinctions between the JCC and the juvenile detention centers as the regulations are reviewed.

Definition Changes

The detention centers have recommended several changes to Section 10 (Definitions) of the regulation, both to comply with the requirements of the Virginia Register of Regulations Style Manual and to address other issues. Specifically, the work group is recommending:

- Moving the following definitions embedded in other sections of the regulation to Section 10 of the regulation to honor the Style Manual's requirement that all definitions be included in one section at the beginning of the regulation: aversive stimuli; cooling-off period; human research; legal mail; legal representative; medication incident; physical restraint; rest day; volunteer or intern; and vulnerable population.

- Amending the following existing definitions as summarized in the Board packet: cooling-off period; human research; legal representative; medication incident; rest day; volunteer or intern; and vulnerable population.
- Adding definitions for the following terms used regularly throughout the chapter, as described in the Board packet: contractor; disciplinary room restriction; full search; mechanical restraint; and room restriction.
- Amending the following existing definitions to provide additional clarity as described in the Board packet: on duty and premises.

High Importance Substantive Recommendations

Ms. Peterson summarized the following proposed revisions that are expected to have a significant impact on facility operations or residents in general.

Section 420—Toilet facilities: The current regulation requires each sleeping room in a detention center constructed on or after January 1, 1998, to have toilet facilities for resident use. Detention centers constructed on or before December 27, 2007, must have at least one toilet, one hand basin (sink) and one shower or bathtub for every eight residents. In buildings constructed or structurally modified on or after December 28, 2007, there must be one toilet, one hand basin, and one shower or tub for every four residents. The work group recommends amending the regulation to require all detention centers to have at least one toilet and one hand basin available for resident use in all sleeping rooms, which is consistent with current detention centers in Virginia. The work group also recommends modifying the shower/tub-to-resident ratio for facilities constructed or renovated on or after December 28, 2007, to 1:5. The idea is to give the facility considering restructuring or redesigning their facility additional space for programming. Ms. Brown discussed the challenges of space and programming in the detention centers.

Section 560—Searches of residents: The existing regulation restricts strip searches and visual inspections of body cavity areas. The existing regulation does not define strip search. The resident's clothing is fully removed in a strip search. There is no contact with the individual conducting the search, but there is a complete visual inspection of all the resident's body parts.

The detention centers have recommended replacing references to "strip search" with "full search" and adding a definition for full search that incorporates the concepts of a strip search.

The regulation prohibits a detention center from conducting a manual or instrumental anal or vaginal body cavity search unless the facility administrator has provided written authorization or unless required by court order. The regulation establishes additional parameters regarding who may conduct and witness the search and the requirements for documenting the search.

The work group's concern with this provision is that it gives the facility administrator broad authority to sign off on these types of searches, and there are few restrictions on when to allow these searches. Many detention centers are concerned with the liability associated with this broad authority. The detention centers have recommended striking the provision that allows manual or

instrumental anal or vaginal cavity searches if authorized in writing by the facility administrator and adding language to permit these searches only in exigent circumstances in which the resident requires medical attention or if required by court order.

Chairperson Woolard noted that the proposal suggests deleting the required parameters governing instrumental and manual vaginal or anal cavity searches. The provision requires that such searches be "conducted by a qualified medical professional," "witnessed by personnel of the same sex as the resident," and "fully documented in the resident's medical file." Chairperson Woolard interpreted the proposed amendment as allowing the facility administrator to establish the rules in accordance with written procedures. Chairperson Woolard asked what the logic was behind taking those parameters out of the regulation.

Ms. Peterson replied that the idea behind this revision primarily was to mirror what the Department had recommended as part of the proposed revisions for the JCC regulation. The Department proposed allowing the JCC to establish, by written procedures, the parameters in which these types of searches occur.

Board Member Frazier suggested revising the language based on the facility administrators' desire to have more guidance and less flexibility around instrumental and manual anal or vaginal cavity searches.

Board Member Herring asked if he understood the panel to say that replacing the term "strip search" with "full search" is consistent with the nomenclature in other regulations or statutes.

Ms. Peterson responded that it is consistent with the nomenclature adopted by the facilities to refer to these types of searches.

Board Member Herring commented that while it may be more sensitive nomenclature, the distinction between "strip search" and "full search" is not observed in case law. There is jurisprudence describing the legalities of a strip search, and full searches do not necessarily include a strip search. If you said to an officer, "I subjected a person to a full search," that person would never assume it included a strip search. This may be an instance where it is in the Department's best interest to be less sensitive and more accurate.

Mr. Houtz responded that the objective, particularly with younger youth entering the program, is to use terminology that is less scary to them. Detention centers have adopted that programmatic terminology, so the inclusion of this terminology in the regulations might be beneficial.

Ms. Brown added that the proposed amendment provides a definition for full search as the removal of all clothing and a visual inspection of all body parts in order to determine whether contraband is present or to inspect for physical injuries. Ms. Brown asked whether having a definition for the term would protect the detention centers even if that terminology was not utilized in case law.

Board Member Herring suggested that the definition could be improved if it included a visual inspection of all body parts and cavity areas.

Ms. Brown noted that detention centers are not performing body cavity searches except in exigent circumstances.

Board Member Herring asked whether there is a difference between a manual or instrumental search of a cavity and a visual inspection of a cavity and explained that if there is a difference, the proposal to strike "visual inspections of the vagina and anal cavity areas" in subsection C omits a crucial piece of the regulation.

Ms. Peterson added that the work group explicitly defined full search to include only the visual inspection of body parts.

Ms. Brown said a full search is done at intake only, and a cavity search is only in exigent circumstances.

Board Member Herring said that Part D allows for an invasive search, and Part C allows for a visual search of body parts per the definition on page 138 (Board packet) and asked whether "body parts" is intended to include a visual inspection, if necessary, of private areas? Board Member Herring said he can think of a scenario where he would not want to do an invasive search of an anus or vagina but would want to perform a visual search, and depending on the results of the visual search, might move to a more invasive search. Board Member Herring indicated that, as drafted, the proposed regulations do not provide authorization to perform a visual search of a body cavity.

Chairperson Woolard asked whether putting the stricken language regarding visual vaginal and anal cavity inspections in Part C would address Mr. Herring's concerns.

Board Member Herring responded by providing a typical real-world example. An officer might observe something in an individual's cavity, and the sight of it would provide the probable cause to perform a more invasive search. In the absence of the sight of the object, one could probably only justify a noninvasive search, unless there is some reliable intelligence that someone has put something in a body cavity. The probability of that is low. We do not want to remove the option of performing a visual inspection, which is noninvasive.

Board Member Herring would like to defer to the concern about how the language will resonate with the subjects. Full search, as used in this discussion, does not exist in legal jurisprudence. If there is litigation, the facility must explain what "full search" means and would not need to provide an explanation if the references to "strip searches" are retained.

Director Block provided a summation for clarification that adding the language to the definition, even if it is called a full search, would satisfy the concern and bridge the gap between full search and strip search.

Sections 630 (Transportation of residents); 635 (Transportation of violent or disruptive youth, or youth traveling to specified destinations) (*new*); and 640 (Detention center transfers to department)

Ms. Peterson explained the Department's Guidelines for Transporting Juveniles in Detention, approved by the Board in 2004 to establish rules detention centers and court service units must follow when residents require off-facility transportation for various purposes. Part I of the Guidelines focuses on the responsibilities of detention centers when transporting or arranging for the transportation of residents to local medical appointments, dental appointments, and psychological and psychiatric evaluations. Part II addresses the transportation of violent and disruptive youth and juveniles traveling to various specified destinations.

Currently, Section 630 establishes rules regarding routine and emergency resident transportation and licensure of staff who transport residents. Section 640 addresses both transportation of residents and resident transfers from detention centers to the department's custody. Section 640 requires that residents be transported in accordance with the Guidelines and speaks to the required information that must accompany residents when transferred from detention centers to the department's custody. So as not to have two separate sections addressing resident transportation, the detention centers have recommended amending Section 640 to remove references to resident transportation, including in the catchline.

The detention centers also recommend removing the provision that mandates that detention centers adhere to the Guidelines when detained residents require transportation. This provision violates the Virginia Code Commission's 2016 regulatory provision addressing incorporation by reference. Ms. Peterson explained that the Code Commission established a regulatory provision that took effect in January 2016 which prohibits state agencies from incorporating its own documents by reference into a regulation. To correct this violation, the detention centers have recommended lifting the language from the Guidelines and placing it into Section 630 and a new Section 635. Ms. Peterson explained that the proposed amendments to Section 630 include the provisions from Part I of the Guidelines and the newly created Section 635 includes the provisions from Part II of the Guidelines.

In addition, the detention centers have recommended additional language in Section 630 in response to failed legislation introduced during the 2018 Virginia General Assembly Session. Delegate Cliff Hayes's legislation (HB 1230) would have required the board to promulgate regulations regarding transportation requirements for Department-regulated facilities and programs. Specifically, the bill would have mandated that these regulations address a suicide watch instrument. A substitute bill would have required these entities to convey written information concerning the resident's mental and medical condition to individuals handling the transport of residents. The bill ultimately failed; however, the detention centers want to be responsive to the objectives of the legislation and have recommended additional language similar to the language in the substitute bill. The proposed amendment directs detention centers to provide a transporting party assuming custody of a detained resident with written information concerning the resident's immediate medical needs and mental health condition.

Board Member Schrad asked why HB 1230 failed.

Ms. Peterson responded that Delegate Cline, who sat on the subcommittee that heard the bill, did not believe legislation requiring the Board to promulgate regulations was necessary.

Mrs. Brown noted that the detention centers were supportive of the legislation and wanted to ensure that when residents are transported, the individual having custody of the resident has as much information as is needed to provide safe transportation.

Board Member Frazier asked who performs transportation for localities and commissions.

Ms. Brown responded that this depends on the facility. For example, Merrimac Juvenile Detention Center has its own transportation staff, which is a bit unusual. Most detention centers use sheriff's deputies to transport residents to jail or court. Detention center staff transport residents to medical appointments. Ms. Brown explained that the common practice in facilities is for staff to complete a form on the youth detailing the youth's information and also the information of the person transporting the youth.

Mr. Houtz added that the detention centers have tried to be unspecific about protected information. Mr. Houtz said that his detention center, Fairfax, has its own transportation unit. The unit provides a form to the sheriff's deputies containing information staff deem important when transporting the youth either outside the courthouse or inside.

Chairperson Woolard asked if the information on youth maintains confidentiality and health protections.

Mr. Houtz responded that the detention centers shared that same concern when the legislation was introduced. Mr. Houtz's form was developed so as to exclude specific medical information; it identifies concerns with a resident regarding mental health or self-harm, but contains no other specifics. He noted that HIPPA does allow for the transfer of information to protect safety and security.

Ms. Peterson agreed to draft additional language in Section 630 that will require that any information shared with the person who assumes custody of the youth must remain confidential in accordance with state laws.

Section 890—Staff supervision of residents: Subsection A of this section prohibits direct care staff from being on duty and responsible for the direct care of residents for more than six consecutive days without a rest day except in an emergency. Rest day is defined as a 24-hour period during which a staff person is not responsible for performing duties regarding detention center operations, including participation in required training. This provision has made scheduling and ensuring that part-time staff receive the training necessary to perform their duties more challenging. The

detention centers have recommended moving the definition of "rest day" to Section 10 and amending the definition to apply to periods during which a staff person is not responsible for performing supervision duties in a detention center.

Currently, subsection H of this section requires the facility to implement written procedures governing the transportation of residents outside the detention center and from one jurisdiction to another. The detention centers have recommended striking this provision given that transportation is discussed as part of the proposed additions to Sections 630 and 635.

The Board had questions about mandatory training that might interfere with the 24-hour rest-day.

Ms. Peterson said the expectation in the proposed language is that the facility would no longer be prohibited from having staff come in on the seventh day for training or other non-supervision related duties.

Ms. Brown added that it depends on each locality's payroll system and that training schedules would not be arranged so that there would be seven consecutive working days. Ms. Brown said Chesterfield's training days are built into their workday schedule and would allow staff, if they desire, to come in to work on their off day for staff appreciation events.

Section 900—Staffing pattern: Ms. Peterson alerted the Board to an amendment to the proposed text that was made after the Board packet went to publication. The amended language is set out in the insert, which precedes page 172 in the Board packet.

Currently, Section 900 of the regulation requires detention centers to have at least one direct care staff member **awake**, on duty, and responsible for the supervision of every 10 residents (1:10), both on the premises and at off campus detention center-sponsored events during resident waking hours. This provision is inconsistent with the PREA standard, which requires a 1:8 staff to resident ratio in juvenile facilities during resident waking hours. The PREA Resource Center has issued guidance indicating that the staffing ratio is not an aggregate ratio and must be satisfied in every area throughout the facility. This requirement is not explicitly stated in PREA's standards.

Ms. Peterson discussed the proposed changes in the staffing pattern. The original proposed amendment would have required one direct care staff member to be on duty and responsible for the direct supervision of at least eight residents in every area of the facility in which residents are present. That meant the required 1:8 staffing ratios would have needed to be maintained throughout the facility, in each separate living unit or other area in which a resident is present. The work group originally proposed this change to comply with guidance provided in a PREA resource document, but not explicitly mandated in the Prison Rape Elimination Act standards for juvenile facilities. After the memorandum and proposed text went to publication, the workgroup determined that amending the regulation to reflect the PREA resource document's interpretation was unnecessary and would subject the detention centers to state certification regulations that were more stringent than what is

explicitly required in the PREA standards. Therefore, the work group recommended amending the language as provided in the insert preceding page 172 in the Board packet.

Director Block clarified that the proposed amendment to change the staffing ratios from 1:10 to 1:8 was being retained.

Furthermore, subsection A of Section 900 explicitly requires staff to provide awake supervision during resident waking hours. There are no such explicit requirements in subsections B or C applicable when residents are sleeping. Section 890, however, requires that staff provide 24-hour awake supervision seven days a week. In order to discourage the unintended interpretation that staff may sleep while supervising sleeping residents, the detention centers have recommended striking the reference to "awake" supervision in subsection A.

Section 1070—Behavior management: Ms. Peterson discussed behavior management programs in detention centers and explained that these programs are governed largely by a facility's written procedures. Among the required information contained in these procedures, a facility must define and list the privileges and sanctions that are available for use. In order to promote clarity, the detention centers have recommended amending this section to specify that the written procedures addressing privileges and sanctions available under the behavior management program must establish which behaviors or offenses are subject to which privileges or sanctions, as well as the maximum duration of each sanction.

The existing regulation provides that sanctions may include a "cooling off period," which is capped at 60 minutes. Ms. Peterson explained that the existing regulation does not require staff to complete a disciplinary report when a resident serves a cooling-off period and in that way, cooling-off periods are distinguishable from room confinement periods. Therefore, the detention centers have recommended adding the following parameters around cooling off periods: (i) that the cooling-off area be identified; (ii) that residents who are cooling off have the ability to communicate with staff; and (iii) that staff conduct visual checks of such residents every 15 minutes.

The Board had a lengthy discussion about the self-imposed and staff-imposed cooling-off periods and raised the following questions:

- Could a facility require a youth to serve multiple cooling-off periods in one day, so long as each cooling-off period does not exceed the 60 minute cap? Does the regulation prohibit back-to-back cooling-off periods?
- Why is a disciplinary report not necessary when a resident serves a cooling-off period?
- What documentation is maintained to establish that a resident is serving a cooling-off period? The Board noted that, as detention centers strive to reduce confinement in their facilities, the tracking of this information will become even more important.

The panel provided the following responses:

- The Certification Team would notice if a detention center were employing back-to-back 60-minute cooling-off periods. However, a resident could remain in his room or in the cooling-

off area beyond the 60-minute cooling-off period if he does not want to return after the cooling-off period has expired. The detention center will not force the resident to leave a cooling-off period. There is nothing explicit in the current regulation to prohibit a resident serving 60 minutes of cooling off, 15 minutes out, followed by an additional 60 minutes of cooling off.

- A cooling-off period can be a self-elected tool that the youth uses to de-escalate and prevent troubled behavior. Youth are still monitored while cooling off and these periods are documented; a disciplinary report is not written because it is not required by regulation. Best practices indicate that disciplinary reports are not necessary for these temporary periods.
- In most detention centers, cooling-off periods generally are recorded in a running log for the youth. Mr. Houtz provided an example regarding his facility in Fairfax. In his facility, a self-requested cooling-off period requires no disciplinary report. A staff imposed cooling-off period requires a disciplinary report. He explained that in some instances it might not be necessary to send the youth to a locked secure room to cool off; instead, the youth may serve a cooling off period in a quiet room, depending on the circumstances.

Director Block asked the Board members whether they wanted to add language to ensure data is collected and whether they want to distinguish between a self-requested cooling off and staff-mandated cooling off, given the concerns about the potential for abuse regarding the cooling off period.

The Board agreed that they would like the detention centers to track this data, including whether the period was self-imposed or mandated by staff. The Board indicated that this will help the detention centers and be beneficial to their programs. The data would allow the Board or the Certification Team to review the data in a year to determine how the program is proceeding and to identify any trends or concerns.

The panel noted that the VJDA would work with detention centers on sharing documents and resources to implement this requirement on tracking data.

To clarify, the recommendation of the Board is to add language to subdivision (C)(4) of section 1070 that requires that when a resident is placed in a cooling off period, it must be documented and the data must be accessible to staff. The data also should distinguish between self-selected or staff-mandated cooling off periods.

- Ms. Peterson explained that Section 1070 also directs the facility administrator to review the behavior intervention techniques and procedures annually to assess their effectiveness and to determine whether they remain appropriate for the facility's residents. The detention centers have recommended additional language clarifying that, as part of this annual review, the facility must collect and review information on the facility's use of room restriction. This will ensure that detention centers are assessing the effectiveness of their behavior management program techniques frequently and are considering ways to improve their programs.

Section 1100/Section 10 – Room restriction and new definition: Ms. Peterson discussed the following proposed amendments aimed at making room confinement a more effective tool for deterrence and ensuring that the appropriate checks are placed on the system. Note that these changes are intended to apply to all forms of room confinement unless otherwise indicated.

- ***Nomenclature.*** The detention centers hope to change staff and resident perception of the concepts previously referred to as 'room confinement' and 'isolation,' and to remove some of the negative images associated with these terms. The detention centers recommend replacing references to "**room confinement**" in the regulation with "room restriction" since the resident's activities, movement, and freedom are restricted during these periods. The recommendation is to replace these references in Sections 1070, 1080, and 1100.

- ***Content of written procedures.*** The detention centers have recommended expanding the information that must be included in a facility's written procedures concerning room restriction. The existing regulations contain a general, broad provision requiring written procedures to govern how and when residents are placed in room confinement. The detention centers recommend adding the following specific topics to the information that must be included in the facility's written procedures governing room restriction; these items were identified in Senator Favola's 2016 legislation: 1) the behaviors subject to room restriction; 2) factors for consideration before placing a resident in room restriction; 3) the circumstances necessitating a debriefing with the resident; and 4) the conditions under which staff must consult with a mental health professional when restricted residents exhibit self-injurious behavior.

Chairperson Woolard asked if there are situations in which a resident exhibits self-injurious behavior when a mental health professional would not be consulted. Mr. Houtz provided an example of a resident who punches a wall out of anger and explained that this may not result in a consultation with a mental health provider because it may not be deemed a mental health incident.

- ***Frequency of room checks.*** Under the current regulation, residents confined to a locked room must be checked on visually by staff at least once every 30 minutes, and more often if indicated by the circumstances. For residents on suicide watch, staff must conduct such checks at 15 minute intervals. To ensure the residents are properly monitored, the detention centers have recommended increasing the frequency of all checks to at least once every 15 minutes.

- ***Opportunities for physical exercise.*** The existing regulation requires the detention center to afford restricted residents an opportunity for at least one hour of physical exercise outside of the locked room daily unless the resident's behavior or other circumstances justify an exception, which justification must be documented. The detention centers recommend amending this requirement to clarify that the physical exercise must be large muscle exercise

and to require the facility administrator or his designee's approval in order for any exception to apply.

- ***Opportunities during restriction***: The workgroup recommends adding language requiring detention centers to afford residents placed in room restriction, with the exception of disciplinary room restriction, with the same opportunities as residents in general population unless justified by clear and substantiated evidence.

- ***Restriction for more than 24 or 72 hours***: The existing regulation provides that, ***with the exception of disciplinary room restriction***, if a resident is restricted for more than 24 hours, the facility administrator or his designee must be notified. For restriction beyond 72 hours, the facility must notify the director or his designee and explain the steps being taken to resolve the situation. The detention centers have recommended adding language that requires the facility administrator to provide written approval for restriction beyond 24 hours and the rationale for the continued restriction. For restriction beyond 72 hours, the detention centers have recommended adding a requirement that a qualified medical or mental health professional conduct a medical and mental health assessment of the resident within the initial 72-hour period, and daily after the initial 72-hour period elapses until the resident's release from restriction.

Chairperson Woolard asked whether the requirements contained in this section were intended to apply to all forms of room restriction and highlighted language on page 182 of the Board packet in subsection E, which provides, "if a resident is placed in room restriction, ***excluding disciplinary room restriction***, for any reason for more than 24 hours, the facility administrator or his designee shall be notified and shall provide written approval for the continued room restriction. The written approval shall include a rationale of why the continued room restriction is necessary." Chairperson Woolard questioned why the approval requirements and process would be different for residents placed in disciplinary room restriction.

Ms. Peterson responded that all of the requirements listed under the room restriction regulation (Section 1100) apply to disciplinary room restriction unless there is a specific exception. She agreed that the language on page 182 in subsection E, as drafted, would not apply to residents placed in disciplinary room restriction. After some discussion, the panel concluded that this exclusion was in error and agreed to amend the language to strike the provision excluding disciplinary room restriction from these requirements.

- ***Restriction for more than five consecutive days***: Currently, the maximum permissible period for any form of room restriction in detention centers is five days unless ordered by a medical provider. The detention centers have recommended expanding the authority to order confinement beyond the maximum 5-day period to include mental health providers as well as medical providers.

- ***Daily visits from facility administrator.*** Under the current regulation, the facility administrator or designee must make personal contact with every resident placed in room restriction. The detention centers have recommended adding a mandate that during these visits, the facility administrator must assess and document whether the resident: i) is prepared to return to general population (for residents who are not in disciplinary room restriction); and ii) requires a mental health evaluation. This will ensure that the facility administrator is daily assessing residents not restricted for disciplinary purposes to determine whether they are ready to be released from restriction.

- ***Single occupancy room restriction only.*** The existing regulation stipulates that residents must be confined no more than two to a room when placed in administrative confinement (special housing unit reserved for special management of residents for protective custody or threatening behavioral issues). There is no maximum occupancy identified for residents placed in room restriction. The detention centers have recommended adding a requirement that residents placed in room restriction be housed no more than one to a room in order to reduce the potential threat if a resident is placed in restriction in the same room as another resident.

Section 1105/Section 10 – Disciplinary room restriction and new definition: Ms. Peterson discussed the proposed new Section 1105, which is intended to address a special category of room restriction – disciplinary room restriction. The existing regulation addresses the concepts of room restriction (confinement) and disciplinary room restriction (isolation) under one section of the regulation. Neither term is defined. Room restriction is intended to denote the general umbrella under which all forms of room restriction, including disciplinary room restriction, fall. Disciplinary room restriction, as provided in the proposed definition, applies when the resident is placed in room restriction after application of the disciplinary process. The detention centers have recommended adding this new section to address disciplinary room restriction and including clarifying language: (i) that disciplinary room restriction may be imposed only after the resident has gone through the disciplinary process; and (ii) that detention centers must comply with the behavior management requirements when implementing disciplinary room restriction.

The current regulation prohibits residents from participating in activities with other residents during disciplinary room restriction and restricts all activities with the exception of eating, sleeping, personal hygiene, reading, and writing. For safety and security reasons, sometimes it may be imprudent to allow residents access to writing utensils and reading materials while restricted, especially when the restriction results from self-injurious, violent, or assaultive behavior; therefore, the detention centers have recommended removing the absolute prohibition against restricting reading and writing activities in favor of language that gives the facility administrator or designee the discretion to provide reading and writing opportunities for residents in disciplinary room restriction based on the safety and security needs of the affected resident.

Section 1130—Mechanical restraints: Ms. Peterson explained the current regulatory requirement that detention centers may not restrain residents to a fixed object or in an unnatural position. She explained that, although the regulation does not define "fixed object," the provision has been interpreted to prohibit detention centers from restraining residents to items that are fastened down, as well as other items such as hospital beds and wheelchairs. The regulation makes no exception for residents taken to a non-secure hospital or other medical facility where restraints may be necessary for the resident's or others' safety. The detention centers recommend amending the regulation to allow explicitly for restraint to a hospital bed or wheelchair if the resident is in an outside medical setting, provided the facility administrator provides written approval in accordance with facility procedures.

Chairperson Woolard asked if this is the general practice in terms of mechanical restraints and detention.

Mr. Houtz responded that based on this interpretation, current practice involves requiring the resident to wear cuffs and shackles in a hospital bed, which he contends is an unnatural position. A single point restraint is more comfortable, the device is intended for mobility, and it is a better decision for the youth.

The existing regulation requires detention centers to have department-approved written procedures governing mechanical restraint use. The detention centers have recommended replacing the department with the facility administrator as the individual required to approve these procedures. Generally, the department does not approve written procedures for juvenile detention centers.

In addition, the current regulation requires detention centers to maintain a written record of routine and emergency distribution of restraint equipment. The detention centers have recommended removing this requirement in favor of allowing each facility to ensure that there is a system of accountability in place in their facilities. The goal is to allow the facility the discretion to determine how to account for the distribution of this equipment.

Section 1140—Monitoring restrained residents: Ms. Peterson explained the existing regulatory provision that requires detention centers to have written procedures that indicate that if a resident is mechanically restrained, staff must make a ***direct personal*** check on the resident at least every 15 minutes (and more often if necessary). She explained that the existing provision raised questions as to what constitutes a direct personal check. To provide clarification, the detention centers have recommended replacing the reference to "direct personal" check with a "face-to-face" check to clarify that the staff member and resident must be in close proximity and staff must be able to look directly at the resident's face in order for this requirement to be satisfied.

Currently, if a mechanically-restrained resident exhibits self-injurious behaviors, staff must consult with a mental health professional immediately and monitor the resident using the appropriate protocols. The detention center has recommended additional language to mandate that staff first

take appropriate action to stabilize the threat or harm before consulting with the mental health professional and applying monitoring protocols.

RESOLUTION

Director Block and Chairperson Woolard took a brief hiatus to honor the Deputy Director of Administration and Finance, Daryl Francis, on his retirement from the Department by reading a resolution and thanking him for his service before proceeding with the regulatory discussion

VI. SUMMARY OF SUBSTANTIVE RECOMMENDATIONS – MODERATE IMPACT

Ms. Peterson next discussed additional proposed revisions that are expected to have a moderate impact on facility operations or residents.

Section 80—Serious incident reports: The current regulation requires detention centers to report serious incidents to the applicable court service unit, the director or his designee, and the parent or legal guardian, all within 24 hours of the incident and ***in accordance with department procedures***. This reference incorporates the department's procedures into the regulation by reference in violation of the Code Commission's prohibition. Therefore, the detention centers are recommending striking the mandate that the serious incident reporting process accord with department procedures.

The department's certification unit also has expressed concerns regarding the difficulty in determining whether a detention center has complied with the 24-hour deadline for notifying the applicable court service unit, director, and parent or legal guardian of a serious incident involving a resident. Although subsection D of this section requires the facility to prepare a written report containing information regarding who notified the parent/legal guardian and director, there is no current requirement that the date and time on which the notice was provided be noted in the report. The detention centers have recommended adding a requirement in subdivision D(5) that the report include the date and time on which the notice was provided to the parent, legal guardian, director, and applicable court service unit.

Finally, the detention centers have recommended striking the current provision in subsection E that requires detention centers to place a written reference of the incident and all applicable reporting in the resident's record, given that this information is entered into the department's data system.

Section 170 (Employee background checks), 175 (Contractor background checks) (*new*), and 177 (Volunteer and intern background checks) (*new*): Ms. Peterson discussed the current background check provisions in Section 170, which require individuals who accept employment in a detention center, volunteer regularly and will be alone with a resident, or contract to provide services to residents regularly and will be alone with residents to undergo a host of background checks, including fingerprint checks with the Virginia State Police and Federal Bureau of Investigation. The current regulation allows **employees** to be hired pending the results of the fingerprint check but prohibits such employees from being **alone with residents** and allows them to work only with residents who are under the direct supervision of staff who have had all their background checks

completed. The detention centers have recommended adding language that broadens the restriction so that employees hired pending the fingerprint checks are prohibited from working directly with residents until all background checks have been completed. The detention centers also have recommended adding language that prohibits them from hiring persons convicted of the barrier crimes set out in § 19.2-392.02 of the *Code of Virginia*, subject to the restrictions in § 63.2-1726 of the *Code of Virginia*.

Finally, the detention centers have recommended rearranging the order of the provisions regarding background checks, training, and retraining for employees, contractors, and volunteers in order to make the regulation easier to navigate.

Section 310—Personnel records: Ms. Peterson explained the information that must be included in an employee's personnel record under this provision and the detention center's recommendation to strike from this list the following information: 1) educational background and employment history; 2) documentation of required reference check; 3) annual performance evaluations; and 4) documentation of the regulation-mandated training. The detention centers believe that these requirements are unnecessary in the context of a regulation. Ms. Peterson explained that striking the requirement to retain this information in the employee or volunteer's personnel record would not eliminate the requirement to produce this information in accordance with Section 40(B)(2) for purposes of establishing that the background checks and reference checks mandated in Sections 170 through 177, and training required in Sections 190 through 197, have been completed.

Chairperson Woolard asked whether the rationale for striking the requirement to include this information in the employee's record is to ensure that information would be kept in another place or whether the detention center would no longer have a record of that information. The panel responded that the information would be maintained in another location, depending on the locality's human resource procedures.

Section 360—Equipment and system inspections and maintenance: The current regulation requires **all** safety, emergency, and communications equipment and systems to be inspected, tested, and maintained by designated staff. The detention centers have recommended an amendment to require the facility administrator to identify **critical** safety, emergency, and communications equipment and systems that periodically must be inspected, tested, and maintained by designated staff and to require the facility administrator to develop written procedures outlining the applicable items and the parameters of the process.

Section 460—Smoking prohibition: The current regulation prohibits the use of tobacco products by staff and visitors in areas of the facility where residents may see or smell the products.

The detention centers have recommended expanding this prohibition to apply to contractors, volunteers, and interns and to impose an overall prohibition against the use, possession, purchase, or distribution of tobacco or nicotine vapor products by residents.

Board Member Kizner asked why detention centers would allow smoking products around residents. Ms. Brown stated that staff from her detention center are allowed to smoke in the courtyards, where residents cannot see or smell the product.

Section 650—Prohibited actions: Generally, detention centers are prohibited from depriving residents of certain opportunities and engaging in certain behaviors. Among these, detention centers may not deprive residents of: i) food and drinking water necessary to meet their daily nutritional needs; ii) opportunities to bathe or use toilet facilities; and iii) opportunities for sleep or rest. Similarly, detention centers may not administer laxatives, enemas, or emetics. This section allows exceptions from these rules if ordered by a licensed physician, generally to address a medical need or for some other legitimate medical purpose. The detention centers have recommended replacing references in this section to licensed "physicians" with licensed "health care professionals" to give other licensed health care professionals working in the facilities the authority to make these determinations.

Section 655—Vulnerable population: The current provision requires detention centers to implement systems for assessing whether residents are members of a vulnerable population. This section defines "vulnerable population" and includes in the definition a number of examples of characteristics that indicate a resident may be vulnerable or susceptible to attack or harm (e.g., height and size, English proficiency, sexual orientation, etc). Under PREA, a resident's views with respect to his safety must be considered in making this determination. The detention centers wanted to avoid the interpretation that the factors listed are indicative of a resident being a member of a vulnerable population for these purposes. To address this concern, the detention centers have recommended removing these factors from the definition of vulnerable population and adding language to this section that provides that these characteristics **may be considered** in determining whether a resident is "vulnerable."

The detention centers also recommend incorporating the PREA provision that requires the resident's views of his safety be considered in making the vulnerable population determination.

Section 740—Nutrition: The current regulation requires detention centers to provide residents with special diets or allow alternative dietary schedules in certain instances, including if prescribed by a physician or if needed to observe a resident's established religious dietary practices. The detention centers have recommended amending this provision to allow the facility administrator or his designee or a mental health professional to authorize the imposition of special diets for residents who have used food or culinary equipment in a manner that threatens facility security.

Section 800—Admission and orientation: This section sets out the processes detention centers must include in their written procedures for admitting residents. Ms. Peterson explained that detention centers currently do not have explicit regulatory authority to forego admitting into their custody residents who require emergency medical attention or are under the influence of alcohol or drugs. This makes the detention center vulnerable to litigation and could threaten the safety and health of newly admitted residents, staff, or other residents in the detention center. The detention centers

have recommended additional language mandating that the facility conduct a general assessment of the resident's physical state before admission and prohibiting staff from admitting any resident visibly under the influence of alcohol or drugs or in need of immediate emergency medical assistance. The detention centers also have recommended striking the duplicative requirement in this section that staff must be trained before performing orientation and admission duties as this requirement is noted in Section 190.

This section also describes the information to which residents must be oriented **prior to being assigned to a housing unit**, including, for example, the facility's behavior management program, the grievance procedures, and the facility's disciplinary process. The detention centers have recommended striking the requirement that orientation take place before the resident is assigned to a housing unit in order to allow facilities greater discretion in scheduling orientations.

Section 820—Mental health screening: Current law requires detention center staff to conduct an initial mental health screening of a resident at intake to determine whether a more robust mental health assessment is necessary. The initial screening must include a structured interview and an observation, as provided in facility procedures. Additionally, the facility must administer an objective mental health screening instrument within 48 hours of admission. While not referenced in this provision, the department-issued guidelines in 2012 require detention centers to utilize the Massachusetts Youth Screening Instrument – Second Version as their mental health screening instrument. The MAYSI-2 includes a domain addressing suicidal ideation; however, many detention centers have supplemented the instrument with their own additional questions to help better determine a resident's immediate risk of suicide. The detention centers have recommended amending this section to allow each detention center to supplement the required screening instrument with additional questions or observations in accordance with the facility's written procedures.

Section 870—Written communication between staff; daily log: Detention centers must maintain a daily log for staff to communicate significant events that occurred within the facility. Logs must identity the person making each individual entry and the date and time of each entry. The detention centers consider the method by which information is recorded into the daily log to be an operational issue and have recommended striking the mandate that the individual making each entry be recorded and adding language allowing the facility to establish, by written procedures, how identifications for log entries must be documented.

Section 920—Work and employment: Detention centers assign residents chores or allow them opportunities for paid work assignments within the facility. The chores and work assignments must comport with the resident's age, health, ability, and individual service plan. The detention centers have recommended removing the requirement that the chores and work plan comport with the resident's individual service plan. The purpose is to give detention centers flexibility when assigning chores in the facility. Ms. Brown added that listing chores on a resident's individual service plan is impractical.

Section 1040—First aid kits: Detention centers must keep first aid kits and an inventory of their contents. The detention centers have recommended adding language that specifies that kits must be maintained in facility vehicles used to transport residents as well as in the facility.

Section 1060—Medication: Under subsection B of this section, medication must be securely locked except as **required** by 6VAC35-101-1250. That section gives facilities with residents in post-D placements for longer than 30 days the discretion to establish in written procedures whether these residents will be permitted to self-medicate. Because the determination as to whether these residents may self-medicate is discretionary, the use of the term "required" in this section is erroneous and misleading. The detention centers have recommended replacing "required" with "authorized" to address this error.

If a resident experiences a medication incident or adverse drug reaction, staff must contact one of a number of specified individuals and entities including, for example, a poison control center and physician and must take whatever actions are instructed. The detention centers have recommended expanding this list to include hospitals.

This section defines "medication incident" as "an error in administering medication" and provides a list of five specific examples that constitute a medical incident. Under the regulation, a resident's refusal of properly-offered medication does not constitute a medication incident for these purposes. The detention centers have recommended moving this definition to Section 10 and adding to the definition language that indicates that medication incidents do not include the facility's inability to administer medication due to repeated unsuccessful attempts to obtain the medication.

This section requires detention centers to dispose and store unused, expired, and discontinued medications in accordance with applicable laws and regulations but does not address disposal of such implements. The detention centers have recommended additional language providing that the disposal and storage of unused, expired, and discontinued medical implements must accord with applicable laws and regulations.

The proposal also corrects an erroneous statutory citation in subsection F.

Section 1080—Disciplinary process: This section explains the process for affording residents due process when they are alleged to have violated a facility rule. Staff must complete a disciplinary report describing the rule violation for offenses subject to room restriction. An impartial staff member must review the report and if the resident denies the offense, the impartial staff person must meet with the resident and allow him the opportunity to present evidence before rendering a final decision. The entire process must occur within 12 hours after the alleged rule violation, including weekends and holidays. If the time period ends during the resident's scheduled sleeping hours, the facility must document the delay and the clock will resume running at the start of the resident's waking hours. The regulation provides that if the resident appeals the impartial employee's decision, the facility administrator has 24 hours from the rule violation to rule on the appeal. The clock stops running during the resident's scheduled sleeping hours, and staff must document this.

The detention centers have recommended eliminating the duty to document the interruption of the initial 12-hour period and the 24-hour appeal period, contending that this requirement is unnecessary because the disciplinary report identifies the date, time, and location of the incident.

Residents must be notified in writing of the results of any appeal. The detention centers have recommended removing the required written notification in favor of requiring both the resident and staff to sign a document indicating that the resident was informed of the appeal's outcome. Ms. Peterson explained that this will allow detention centers more flexibility in how to disseminate this information.

Chairperson Woolard asked how the written notification is distributed. Mr. Houtz answered that it is filed in the resident case record. Chairperson Woolard asked whether providing a resident with the written notification would present a safety issue. Mr. Houtz replied that the youth generally does not want the document, and it would not be a good reminder of their stay in detention that they received room restriction.

Residents found not guilty must have the reports removed from their case records. The detention centers have recommended striking the language that makes the duty to place this information in the resident's case record contingent upon a guilty outcome. They contend that retaining a record indicating that a child was alleged to have committed an infraction will not harm the child.

Board Member Vilchez asked who determines whether the youth is found guilty or not.

Ms. Brown responded that the director or designee conducts the appeals process, which is noted in the facilities' policies and procedures. Mr. Houtz added that there is also the grievance process in addition to the appeals process. There is no harm in maintaining the case record for historical purposes.

Chairperson Woolard asked, if the youth went through the process and was determined not guilty, why would the disciplinary report need to be included in their record and associated with that youth? She asked who would have access to the records and commented that she can see the down side in keeping those records.

Ms. Brown responded that Chesterfield County only shares information when requested specifically by the court or if a probation officer asks for a summary of the youth's behavior. It is a printed log, not the individual disciplinary reports. Ms. Brown explained that maintaining the records for a not guilty verdict could help administrators show the youth that this incident was investigated and met with a successful result for the youth. Mr. Houtz added that sometimes resident case files are subpoenaed.

VII. SUMMARY OF CONTENT CHANGES – MINOR IMPACT

Ms. Peterson then began a very brief discussion on the proposed changes expected to have a minor impact on facility operations and residents.

Section 40—Certification: The detention centers have recommended the following changes:

- Clarify that detention centers must maintain a current certification demonstrating compliance with this regulatory chapter, and amend the provision to reflect the proper title for the Certification Regulations (6VAC35-20).
- Clarify that the determination of a juvenile detention center's compliance with applicable regulatory and statutory requirements will be based on the assessment and compliance measures approved in accordance with board regulations.
- Strike the mandate requiring the detention center to ensure that areas of noncompliance do not pose a direct or immediate danger to residents. This language is unclear and could be perceived as encouraging detention centers not to comply with the regulatory provisions in this chapter.

Section 50: Relationship to the regulatory authority: The detention centers have recommended replacing the regulatory authority with the audit team leader as the individual to whom reports and information demonstrating compliance with the regulatory requirement must be submitted. This is consistent with language in the Certification Regulations (6VAC35-20).

Section 70 – Variances and waivers: The detention centers have recommended amending this section to clarify that variances may be issued solely for **noncritical** regulatory requirements and to clarify that the director has the authority to issue waivers to noncritical regulatory requirements pending board action on a variance request. Additionally, the detention centers recommend amending the reference to the certification regulations to reflect the proper title for this chapter.

The Board decided to review the remainder of the minor proposed changes and ask questions to help move along the meeting.

Chairperson Woolard asked why the detention centers were proposing to remove the requirement in Section 95 that human rights offenses be reported to the Director of the Department.

Ms. Peterson responded that the existing regulation already requires that these types of incidents be reported to the department. The idea is that the Department staff would field that information to the director as appropriate.

Ms. Brown noted that detention centers report serious incidents through the Department's Balanced Approach Data Gathering Environment (BADGE) system. There are certain incidents that require notification to the Department Director and the facility's assigned certification analyst, and BADGE allows that information to be recorded.

Section 970—Consent to and refusal of health care services: This section requires health care services to be provided in accordance with § 54.1-2969, the statutory provision addressing consent for surgical and medical treatment of minors separated from the custody of their parents. This section specifies that the resident or parent or legal custodian must provide informed consent and provides

a definition for informed consent. To comply with the requirements of the Style Manual, the detention centers have recommended removing the reference to and corresponding definition for "informed consent," but wish to retain the concept in this section.

Chairperson Woolard asked about the impact of deleting the definition and specific reference to "informed consent."

Ms. Peterson responded that although the term was removed, the concept was retained and embedded in the language.

Chairperson Woolard thanked Ms. Peterson, Ms. Brown, and Mr. Houtz for their hard work and the continued efforts of the workgroup on updating the regulations.

After discussion, the Board decided to hold the vote for approval of the proposed amendments to the Regulations Governing Juvenile Secure Detention Centers until the June meeting in order to review the proposed amendments at greater length, allow those who missed the meeting to have input, and give the detention centers the opportunity to draft amendments as recommended by the Board. The Department agreed to provide the Board with a summary document highlighting all the changes discussed at the instant Board meeting.

Director Block noted that the group home regulations can be pushed back until the September meeting.

In the interest of time, Chairperson Woolard and Director Block moved the legislative update to the June meeting.

DIRECTOR'S COMMENTS
Andrew K. Block, Jr. Director, Department

The Board was invited to attend an upcoming 5K run at Bon Air on April 27 and the Yvonne B. Miller graduation at Bon Air on June 18. This is a combined graduation of youth receiving GEDs, diplomas, or certifications. This is always a heartwarming and fun event. The Court Service Unit Summit is scheduled for May 23-24 in Charlottesville, and the Board was invited to attend and learn more about the community program.

The Director discussed a new HBO news documentary series called VICE, which includes an episode on juvenile justice reform and footage of Bon Air. The correspondent for the episode was the actor Michael Williams, best known for his role as Omar in the Wire. Mr. Williams visited Bon Air and spent time with the youth. The piece was well done and thoughtful. The series is available at Raisedinthesystem.com.

The Director also discussed *Atlantic Magazine*'s coverage of juvenile justice. The magazine spent some time with the Department last fall to complete this issue. Unfortunately, most of the

Department's input was left on the cutting room floor, but the short piece can be found on *Atlantic's* website.

Director Block ended his comments by talking about his trip to visit the court service units in southwest Virginia.

BOARD COMMENTS

There were no comments by the Board.

NEXT MEETING

The next Board meeting is scheduled for June 13 at the Main Street Centre, 600 East Main Street, Richmond.

ADJOURNMENT

Chairperson Woolard adjourned the meeting at 1:55 p.m.

BOARD OF JUVENILE JUSTICE
April 25, 2018

Proposed Substitute Language

6VAC35-101-900. Staffing pattern.

A. The facility shall develop, implement, and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to ensure the safe supervision of residents on the premises. The facility administrator shall review the staffing plan annually.

~~A~~B. During the hours that residents are scheduled to be awake, there shall be at least one direct care staff member ~~awake,~~ on duty~~,~~ and responsible for supervision of every ~~10~~ eight residents, or portion thereof, on the premises or ~~participating in~~attending off-campus, detention center sponsored activities.

~~B~~C. During the hours that residents are scheduled to sleep there shall be no ~~less~~ fewer than one direct care staff member on duty and responsible for supervision of every 16 residents, or portion thereof, on the premises.

~~C~~D. There shall be at least one direct care staff member on duty and responsible for the supervision of residents in each building where residents are sleeping.

~~D~~E. At all times, there shall be no ~~less~~ fewer than one direct care staff member with current certifications in standard first aid and cardiopulmonary resuscitation on duty for every 16 residents, or portion thereof, being supervised by staff.