Juvenile Court of Memphis and Shelby County
(Sheriff's Department)
MOA Protection from Harm Stipulation
9th Report of Findings and Recommendations

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Submitted to:

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OVERVIEW OF THE REPORT

This report is organized into sections:

A. Executive Summary (brief summary of findings and recommendations)
B. Overview of the Site Visit
C. Protection from Harm MOA Provisions Assessment (item by item review)
D. Summary and Recommendations: MOA Provisions
E. Summary and Recommendations: Issues Indirectly Related to MOA Provisions
F. Appendix (The Appendix contains the Data Collection Matrix used to collect data on MOA Provisions, QMHP Qualifications Form, Use of Force Video/Document Review Form, Persons in Attendance at Interviews/Meetings)

ABBREVIATIONS USED IN THIS REPORT	
CCS: Correct Care Solutions	MOA: Memorandum of Understanding
DOJ: US Department of Justice	PBMS: Positive Behavior Management System
MDD: Major Mental Disorder (i.e. Depressive Disorder, Anxiety Disorder, Bipolar Disorder, Schizophrenia/Psychotic Disorder	PREA: Prison Rape Elimination Act
	QMHP: Qualified Mental Health Professional
	SCJDC: Shelby County Juvenile Detention Center
MH: Mental Health	SPs: Suicide Precautions
MIRS: Major Incident Reporting System	UOF: Use of Force
MIS: Management Information System	

A. EXECUTIVE SUMMARY

1. A site visit was conducted at Shelby County Juvenile Detention Center on April 3-6 (Monday through Thursday) 2017.

2. The sources of data for assessing compliance with the MOA involved policy/document reviews, record reviews (both electronic and paper) and interviews. This information was then reviewed in light of previous site visit reports and monthly data and reports.

3. The site visit found that all of the UOF Provisions of the MOA were in compliance, except that detention management needs to review the videos of UOF incidents and the duration of room time for youth following an incident remains problematic.

4. The site visit found that all of the Suicide Prevention Provisions of the MOA were compliance, except for required multiple levels of precaution. Clinical data from chart reviews was insufficient to determine if a less restrictive/less intrusive/less intensive level of intervention than SPs could have been utilized. Excessive or inappropriate use of SPs can cause harm, just as the failure to use SPs when clinically appropriate can cause harm.

5. The site visit found that all of the Training Provisions of the MOA were in compliance.

6. The site visit found the Performance Metrics for Protection from Harm Provisions of the MOA require that the top level of management of the detention center reviews all videos from UOF incidents and that SCJDC put in place a validation process to ensure the quality of the data now being collected and reported.

7. The recommendations regarding UOF MOA provisions include: reviewing all video of UOF incidents by top detention management; enhancing training by ensuring translation from the theoretical to the practical; through the use of video vignettes and role playing, ensuring that training focuses on the dynamics of staff/resident interaction as a causative feature of youth behavior; and reducing resident room time after an incident.

8. The recommendations regarding Suicide Prevention MOA provisions include: providing more comprehensive clinical documentation to support the level of intervention for assessed suicide risk; providing data to support the number of youth on SPs and the low number of detained youth with mental health issues; ensuring that all youth at imminent risk of suicide, at high levels of agitation or at high risk of self harm and all youth of unknown risk (e.g. upon intake) are in a room with camera observation.

9. The recommendations regarding Training and Performance Metrics MOA include: enhancing behavior management training so that it is both practical and theoretical; using videos and role playing that can help translate the theory into the day to day interactions with adolescent residents; training clinical staff to more comprehensively document the suicide assessment/intervention process and the choice of level of intervention.

10. The recommendations regarding issues indirectly but importantly affecting MOA performance include

- Reduce the average daily population to make education, other programming and behavior management more effective.
- Ensure 100% school attendance by all residents
- Conduct improved screening for MMDs
- Develop an improved PBMS system that more closely follows the general principles of behavior modification and is informed by best practices that have a history of proven effectiveness.

B. OVERVIEW OF THE SITE VISIT

The site visit occurred Monday through Thursday, April 3-6, 2017. A matrix of Memorandum of Agreement (MOA) provisions and data for evaluating compliance was distributed to Bill Powell, Settlement Agreement Coordinator, before the site visit. The matrix appears in the appendix. Information sources for the site visit included written reports/policies, records, and interviews/observations. To ensure that information directly and indirectly relevant to the MOA was obtained from interviews, all questions were prepared ahead of time.

The following policies/documents were reviewed:

1. Use of Force (UOF)
2. Policy on Mandated Reporting
3. PREA Policy
4. Suicide Prevention Policy
5. Training Curricula
6. QMHP Credentialing Summary

The following electronic records were reviewed:

1. Videos of UOF incidents
2. Previous suicide attempt/history flag in MIS

The following paper records were reviewed:

1. UOF Incident Reports
2. Report Card data
3. Log of Supervisory Review of UOF Incidents
4. Log of Suicide Risk Screenings
5. Completed Suicide Risk Assessments
6. Documentation of communication between MH staff and security on suicide/mental health issues
7. Training Session Attendance Lists
8. Physical Plant Inspection Documents
9. Log of Responses to Suicidality
10. Resident clinical files of those put on suicide precautions
11. Documentation of follow-up after wrongful conduct identified in UOF incidents

The site visit schedule was as follows:

Monday, April 3

Introductory meeting, tour of the facility, HOPE Academy meeting, review of training curriculum and training attendance documentation, review of PBMS, review of mandated reporting and PREA Policy, review of MIRS.

Tuesday, April 4

Meeting with CCS and Health Dept. representatives; review of Suicide Prevention Policy, review QMHP credentialing summary; review of records: completed suicide risk assessments, security log review for MH referrals, resident clinical files, log of responses to suicidality, review suicide attempt/previous history flag in MIS system; group interviews with residents.

Wednesday, April 5

Review UOF policy; review UOF videos and subsequent documentation, group interviews with staff and residents.

Thursday, April 6

Meeting with Court Expediter and Exit Interview.

C. PROTECTION FROM HARM MOA PROVISIONS ASSESSMENT

1. Memorandum of Agreement: Use of Force

Recommended Finding	MOA Use of Force Provision (a)
Provision Terminated	(a) No later than the Effective Date, the Facility shall continue to prohibit all use of a restraint chair and pressure point control tactics.

This provision was terminated per DOJ memorandum of April 3, 2017 from Steven H. Rosenbaum, Chief, Special Litigation Section.

Recommended Finding	MOA Use of Force Provision (b)
Compliance	(b) Within six months of the Effective Date, the Facility shall analyze the methods that staff uses to control Children who pose a danger to themselves or others. The Facility shall ensure that all methods used in these situations comply with the use of force and mental health provisions in this Agreement.

The current UOF policy and monitoring via camera review and incident report indicate that UOF procedures are used that cause minimal harm to the resident or staff.

Recommended Finding	MOA Use of Force Provision (c)
	(c) Within six months of the Effective Date, JCMSC shall ensure that the Facility's use of force policies, procedures, and practices:
Compliance	(i) Ensure that staff use the least amount of force appropriate to the harm posed by the Child to stabilize the situation and protect the safety of the involved Child or others;
Partial Compliance	(ii) Prohibit the use of unapproved forms of physical restraint and seclusion;
Partial Compliance	(iii) Require that restraint and seclusion only be used in those circumstances where the Child poses an immediate danger to self or others and when less restrictive means have been properly, but unsuccessfully, attempted;
Compliance	(iv) Require the prompt and thorough documentation and reporting of all incidents, including allegations of abuse, uses of force, staff misconduct, sexual misconduct between children, child on child violence, and other incidents at the discretion of the Administrator, or his/her designee
Compliance	(v) Limit force to situations where the Facility has attempted, and exhausted, a hierarchy of pro-active non-physical alternatives;
Compliance	(vi) Require that any attempt at non-physical alternatives be documented in a Child's file;
Compliance	(vii) Ensure that staff are held accountable for excessive and unpermitted force;
Compliance	(viii) Within nine months of the Effective Date ensure that Children who have been subjected to force or restraint are evaluated by medical staff immediately following the incident regardless of whether there is a visible injury or the Child denies any injury;
Compliance	(ix) Require mandatory reporting of all child abuse in accordance with Tenn. Code. Ann. § 37-1-403; and
Partial Compliance	(x) Require formal review of all uses of force and allegations of abuse, to determine whether staff acted appropriately.

The policy on UOF was reviewed; all videos and accompanying subsequent documentation were reviewed for the months of February and March, a total of 7 incidents. The question of incidents and restraints was posed to residents in interviews. With regard to c (i) the total number of UOF incidents has dropped significantly in the first quarter of 2017 from previous data (331 in 2016 to 27 in the first quarter of 2017). The rate of UOF incidents/100 youth has also shown a drop (1.41 in 2016 to .67 in January and .07 in February 2017).

With regard to c (ii), identified wrongful conduct has dropped to zero in 2017 as have reported violations of policy or protocol. In terms of c (iii) and part of c (ii), room time continues at high levels. No clear explanation provided of this use of room time has been provided. As monthly isolation/room confinement/segregation, per 100 person days has dropped from a monthly average 0.8 in 2016 to a low of .22 in February of 2017, duration of isolation/room time has increased from the monthly average of 19.0 hours in 2016 to 54.2 in February. Data from staff and resident interviews supports the data from the reports.

In terms of c (iv) assaults per 100 person days of youth confinement and assaults per staff per 100 person days of youth confinement have dropped. For 2016 the latter was .78 and the former was .06, while in January and February, the data were .58. and .44 for the former, and 0, and 0.04 for the latter. Regarding provisions c (v), c (vi) and c (vii) the UOF policy and related documentation and reports indicate compliance.

For c (viii), the UOF policy was reviewed, as were incident reports. The Report Card indicates that 100% of all medical evaluations were completed. Regarding c (ix) the UOF policy was reviewed as well as the PREA policy. These policies are compliant with this provision. In terms of c (x), it is important that top SCJDC management review the videos of UOF incidents, including Chief Fields and Asst. Chief Bridgeforth. In this way more effective training experiences can be developed and more focused supervision can take place.

	MOA Use of Force Provision (d)
Partial Compliance	(d) Each month, the Administrator, or his or her designee, shall review all incidents involving force to ensure that all uses of force and reports on uses of force were done in accordance with this Agreement. The Administrator shall also ensure that appropriate disciplinary action is initiated against any staff member who fails to comply with the use of force policy. The Administrator or designee shall identify any training needs and debrief staff on how to avoid similar incidents through de-escalation. The Administrator shall also discuss the wrongful conduct with the staff and the appropriate response that was required in the circumstance. To satisfy the terms of this provision, the Administrator, or his or her designee, shall be fully trained in use of force.

The videos of the UOF incidents need to be reviewed by top management at the institution, as indicated above.

2. Memorandum of Understanding: Suicide Prevention

Recommended Finding	MOA Suicide Prevention Provision (a)
	(a) Within 60 days of the Effective Date, JCMSC shall develop and implement comprehensive policies and procedures regarding suicide prevention and the appropriate management of suicidal Children. The policies and procedures shall incorporate the input from the Division of Clinical Services. The policies and procedures shall address, at minimum:
Compliance	(i) Intake screening for suicide risk and other mental health concerns in a confidential environment by a qualified individual for the following: past or current suicidal ideation and/or attempts; prior mental health treatment; recent significant loss, such as the death of a family member or a close friend; history of mental health diagnosis or suicidal behavior by family members and/or close friends; and suicidal issues or mental health diagnosis during any prior confinement.
Compliance	(ii) Procedures for initiating and terminating precautions;
Compliance	(iii) Communication between direct care and mental health staff regarding Children on precautions, including a requirement that direct care staff notify mental health staff of any incident involving self-harm;
Compliance	(iv) Suicide risk assessment by the QMHP
Compliance	(v) Housing and supervision requirements, including minimal intervals of supervision and documentation;
Compliance	(vi) Interdisciplinary reviews of all serious suicide attempts or completed suicides;
Partial Compliance	(vii) Multiple levels of precautions, each with increasing levels of protection
Compliance	(viii) Requirements for all annual in-service training, including annual mock drills for suicide attempts and competency-based instruction in the use of emergency equipment;
Compliance	(ix) Requirements for mortality and morbidity review; and
Compliance	(x) Requirements for regular assessment of the physical plant to determine and address any potential suicide risks.

The suicide prevention policy was reviewed, as well as logs for the evidence of suicide screenings. A random set of 10 clinical files of youth who were put on suicide prevention were reviewed. With regard to provision a (i) reviewed documentation supports compliance. With regard to provisions a (ii, v, and vii), the suicide prevention policy demonstrates compliance. On provision a (iii) both documentation and interviews confirm compliance. Records review confirms compliance with provision a (iii). Credentials of current QMHPs were compared to current Tennessee Statute regarding that nomenclature; those identified as QMHP fulfilled state requirements. No suicide attempts have been documented; provision a (vi) appears to be in compliance per policy.

There is some issue with provision a (vii). A review of the sampled medical charts revealed insufficient clinical documentation. Consistently, there are an unusually large number of youth on suicide precautions while the clinical evidence for this level of intervention is unclear. A lesser status level that is less restrictive and less intrusive may have been sufficient. Assessing and communicating to a youth a risk level that does not reflect reality can inadvertently raise that youth's risk level. "Better to safe than sorry" does not work well regarding suicidal behavior. "Self-fulfilling prophecy" effects in suicidality can be devastating. Research in suicide has clearly demonstrated both suggestion effects and contagion effects. It is important to make sure the assessment process reduces the likelihood of harm to the youth and not does increase it.

Attendance lists and logs were reviewed for provisions a (viii- x). Training is done annually; there was no reason for any morbidity reviews. These provisions are in compliance.

Recommended Finding	MOA Suicide Prevention Provision (b)
Provision Terminated	(b) Within 60 days of the Effective Date, JCMSC shall ensure security staff posts are equipped with readily available, safely secured, suicide cut-down tools.

This provision was terminated per DOJ memorandum of April 3, 2017 from Steven H. Rosenbaum, Chief, Special Litigation Section.

Recommended Finding	MOA Suicide Prevention Provision (c)
Provision Terminated	(c) After intake and admission, JCMSC shall ensure that, within 24 hours, any Child expressing suicidal intent or otherwise showing symptoms of suicide is assessed by a QMHP using an appropriate, formalized suicide risk assessment instrument.

This provision was terminated per DOJ memorandum of April 3, 2017 from Steven H. Rosenbaum, Chief, Special Litigation Section.

Recommended Finding	MOA Suicide Prevention Provision (d)
Compliance	(d) JCMSC shall require direct care staff to immediately notify a QMHP any time a Child is placed on suicide precautions. Direct care staff shall provide the mental health professional with all relevant information related to the Child's placement on suicide precautions.

The suicide prevention policy and reviewed documentation indicated compliance.

Recommended Finding	MOA Suicide Prevention Provision (e)
Compliance	(e) JCMSC shall prohibit the routine use of isolation for Children on suicide precautions. Children on suicide precautions shall not be isolated unless specifically authorized by a QMHP. Any such isolation and its justification shall be thoroughly documented in the accompanying incident report, a copy of which shall be maintained in the Child's file.

Documentation review indicated compliance.

Recommended Finding	MOA Suicide Prevention Provision (f)
	(f) Within nine months of the Effective Date, the following measures shall be taken when placing a Child on suicide precautions:
Compliance	(i) Any Child placed on suicide precautions shall be evaluated by a QMHP within two hours after being placed on suicide precautions. In the interim period, the Child shall remain on constant observation until the QMHP has assessed the Child.
Partial Compliance	(ii) In this evaluation, the QMHP shall determine the extent of the risk of suicide, write any appropriate orders, and ensure that the Child is regularly monitored.
Compliance	(iii) A QMHP shall regularly, but no less than daily, reassess Children on suicide precautions to determine whether the level of precaution or supervision shall be raised or lowered, and shall record these reassessments in the Child's medical chart.
Compliance	(iv) Only a QMHP may raise, lower, or terminate a Child's suicide precaution level or status.
Compliance	(v) Following each daily assessment, a QMHP shall provide direct care staff with relevant information regarding a Child on suicide precautions that affects the direct care staff's duties and responsibilities for supervising Children, including at least: known sources of stress for the potentially suicidal Children; the specific risks posed; and coping mechanisms or activities that may mitigate the risk of harm.

The suicide prevention policy was reviewed, as well as Report Card data on the wait time from admittance to screening, and average wait time for arrival of a QMHP. Review of 2016 and the first two months of 2017 report card data indicate that time between admittance and screening was a few minutes; wait time for a QMHP to do an assessment averages less than hour. Provision f (i) is in compliance. Regarding f (ii), when records were reviewed, it was not clear that the youth needed to be placed on suicide precautions (SPs) or some other status. The clinical assessment had minimal documentation. The clinician's thought process was not clear nor was documentation present on what the child actually said and what he/she was trying to communicate. Again, inaccurate risk assessment can be more harmful than "preventative."

Review of medical charts supported compliance with provisions f (iii, iv). Documentation review and interviews with mental health and detention staff support compliance with provision f (v).

Recommended Finding	MOA Suicide Prevention Provision (g)
Compliance	(g) JCMSC shall ensure that Children who are removed from suicide precautions receive a follow up assessment by a QMHP while housed in the Facility.

Review of medical charts indicated compliance with provision (g).

Recommended Finding	MOA Suicide Prevention Provision (h)
Compliance	(h) All staff, including administrative, medical, and direct care staff or contractors, shall report all incidents of self-harm to the Administrator, or his or her designee, immediately upon discovery.

Review of medical charts indicated compliance with provision (h).

Recommended Finding	MOA Suicide Prevention Provision (i)
Compliance	(i) All suicide attempts shall be recorded in the classification system to ensure that intake staff is aware of past suicide attempts if a Child with a history of suicidal ideations or attempts is readmitted to the Facility.

Actual observation of the MIS system indicated a flag appears upon readmission if there is history of suicidality from a previous admission. Provision (i) is in compliance.

Recommended Finding	MOA Suicide Prevention Provision (j)
Compliance	(j) Each month, the Administrator, or his or her designee, shall aggregate and analyze the data regarding self-harm, suicide attempts, and successful suicides. Monthly statistics shall be assembled to allow assessment of changes over time. The Administrator, or his or her designee, shall review all data regarding self-harm within 24 hours after it is reported and shall ensure that the provisions of this Agreement, and policies and procedures, are followed during every incident.

Documentation supports compliance with provision (j)

3. Memorandum of Agreement: Training

Recommended Finding	MOA Training Provision (a)
	(a) Within one year of the Effective Date, JCMSC shall ensure that all members of detention staff receive a minimum of eight hours of competency-based training in each of the categories listed below, and two hours of annual refresher training on that same content. The training shall include an interactive component with sample cases, responses, feedback, and testing to ensure retention. Training for all new detention staff shall be provided bi-annually.
Compliance	(i) Use of force: Approved use of force curriculum, including the use of verbal de-escalation and prohibition on use of the restraint chair and pressure point control tactics.
Compliance	(ii) Suicide prevention: The training on suicide prevention shall include the following: a. A description of the environmental risk factors for suicide, individually predisposing factors, high risk periods for incarcerated Children, warning signs and symptoms, known sources of stress to potentially suicidal Children, the specific risks posed, and coping mechanisms or activities that may help to mitigate the risk of harm. b. A discussion of the Facility's suicide prevention procedures, liability issues, recent suicide attempts at the Facility, searches of Children who are placed on suicide precautions, the proper evaluation of intake screening forms for signs of suicidal ideation, and any institutional barrier that might render suicide prevention ineffective. c. Mock demonstrations regarding the proper response to a suicide attempt and the use of suicide rescue tools. d. All detention staff shall be certified in CPR and first aid. The Administrator shall review and, if necessary, revise the suicide prevention training curriculum to incorporate the requirements of this paragraph.

Review of training curriculum indicates compliance with all sections of provision (a).

4. Memorandum of Agreement: Performance Metrics for Protection from Harm

Recommended Finding	MOA Performance Metrics for Protection from Harm Provision (a)
	(a) In order to ensure that JCMSC's protection from harm reforms are conducted in accordance with the Constitution, JCMSC's progress in implementing these provisions and the effectiveness of these reforms shall be assessed by the Facility Consultant on a semi-annual basis during the term of this Agreement. In addition to assessing the JCMSC's procedures, practices, and training, the

	Facility Consultant shall analyze the following metrics related to protection from harm reforms:
Partial Compliance	(i) Review of the monthly reviews of use of force reports and the steps taken to address any wrongful conduct uncovered in the reports
Partial Compliance	(ii) Review of the effectiveness of the suicide prevention plan. This includes a review of the number of Children placed on suicide precautions, a representative sample of the files maintained to reflect those placed on suicide precautions, the basis for such placement, the type of precautions taken, whether the Child was evaluated by a QMHP, and the length of time the Child remained on the precaution; and

Section a (i) is in partial compliance: The Chief and his assistant should review the videos of UOF events to enhance future training and to provide guidance for those supervising direct line staff. Section a (ii) is in partial compliance. The effectiveness review needs to clearly identify the reasons why youth are placed on SPs as opposed to a less intensive/restrictive level of intervention with sufficient clinical documentation.

Recommended Finding	MOA Performance Metrics for Protection from Harm Provision (b)
Compliance	(b) JCMSC shall maintain a record of the documents necessary to facilitate a review by the Facility Consultant and the United States in accordance with Provision VI of this Agreement.

All required reports and documents were available for review.

D. SUMMARY AND RECOMMENDATIONS: MOA PROVISIONS

D1. Use of Force

- The reduction in physical restraints in recent months along with the publishing of a clear and articulated policy on UOF and alternatives is a major accomplishment.
- Review of two past months of video suggests that half the restraints could have been avoided by a better understanding of how to be "pre-emptive" in working with adolescents. It is not clear that the training provides sufficient concrete and practical examples on adolescent psychology and its applications to particular staff/resident interactions.
- The top management team of the detention center must review all UOF videos and provide documented feedback to staff on what may have been done differently. Documentation would ensure that the monitor's observations of video are consistent with what the supervisory staff concluded.
- Behavior management training and supervision always needs to focus on how adults manage *their* behavior; if adults manage their behavior successfully, youth behavior will be significantly influenced. The use of video vignettes and role playing needs to be incorporated into training; resident interview data suggest there is a wide range of skill among staff when it comes to interacting with youth.
- Interview data with staff and residents and report card data indicate that youth are remaining in their rooms after incidents for a far longer time than is necessary for them to "cool down" or reduce their agitation to near normal levels. Room time is only to be used, per the MOA, when a resident clearly demonstrates danger to himself/herself or others.
- In resident interviews, residents reported feeling safe from both staff and other youth; they also reported that there is at least one person they can feel comfortable talking with. That individual is far more likely to be an experienced female staff rather than a male staff member, especially a less experienced male staff.
- Data validation procedures are still not clear; there should be an internal quality assurance system that provides checks on the accuracy of collected, entered and reported data.

D2. Suicide Prevention

- There are an unusually large number of youth on SPs per monthly data reports. The review of resident charts did not provide sufficient clinical documentation to justify that such a high level of intensity/intrusiveness was required. Risk level and its subsequent intervention is a clinical assessment and cannot be based on a screening instrument alone but requires documented clinical judgment.
- "It is better to be safe than sorry" with regard to suicide risk assessment is problematic; communicating a risk level higher than reality to a youth may result in "self-fulfilling prophecy" effects with possible unfortunate consequences.

- The estimated number of youth with mental health problems/DSM-5 diagnosable disorders, as obtained by interviews with mental health/medical staff, was estimated at 30%. This figure is substantially less than national research indicates. It is not clear that current mental health screening is identifying all youth with possible mental health disorders. If individuals are not accurately screened, hidden disorders can lead to disruptive behaviors; mental health issues can provide staff with an understanding of the particular individual and enable more effective interventions and possibly reduce incidents and use of force responses. The current screening tool (MAYSI-II) is not sufficient alone to clarify the presence and severity of MMDs (i.e. Depressive Disorder, Anxiety Disorder, Bipolar Disorder and Schizophrenia/Psychotic Disorder) and should be replaced by or enhanced with other tools.
- All youth on SPs or presenting with significant agitation or while present in intake areas should be monitored by camera. Visual checks, even at 15 minute intervals, are not sufficient to ensure that the youth does not harm himself/herself.
- Camera rooms should be available in each living unit at each floor level. This will enable relocating youth during a UOF event to a monitored nearby location rather than transporting an agitated youth under physical intervention over substantial distances or up/down stairways.
- Control Center staff need to ensure regular observation of youth in rooms with cameras.

D3. Training

- The training curriculum on UOF meets MOA standards but could benefit from enhancements using video or role playing vignettes to make general principles more concrete in specific youth-staff interaction situations.
- The training curriculum on suicide prevention meets MOA standards, but does not reflect the most current clinical practice on suicide risk assessment and intervention.

D4. Performance Metrics from Protection from Harm

- UOF: Videos of incidents need to be reviewed by the top management team at the facility
- Suicide Prevention: More thorough clinical documentation is necessary to readily assess the effectiveness of the suicide prevention plan.

E. SUMMARY AND RECOMMENDATIONS: ISSUES INDIRECTLY RELATED TO THE MOA

E1. PHYSICAL PLANT

- The building was designed for "warehousing" youth rather than for active programming or even effective behavior management. Not only does it not enhance programming and behavior management, but it actually reduces the effectiveness of resident supervision and behavior management. To reduce youth and staff stress which can affect UOF issues, certain accommodations should be planned for long term improvement:
    - Rooms should have a desk and chair so that youth can read and write comfortably (e.g. journaling, homework)
    - The physical plant works even less effectively when the population of youth is large; population reduction efforts should be redoubled
    - The individual rooms would benefit from resident made posters; increased use of effective reinforcements in the PBMS can include permitting more items in rooms including devices to play music. Resident interviews indicated that reinforcements were not perceived as sufficiently rewarding.

E2. POPULATION

- The average daily population increased from 46 residents in 2013 to 97 in 2016. The trend of high average monthly population has continued through the first quarter of 2017, with an average daily population of 97 residents.
- This increase in population has a serious impact on issues of resident behavior, behavioral management, modulation of mental health issues and education.
- No behavior management system can work if the ratio of staff to residents exceeds a real time constant ratio of 1:10; so too, for a behavior management system work, the same staff need to work with the same set of residents consistently.

E3. EDUCATION

- The education of youth is not only a legal requirement; it is the right of every minor.
- Over half the current residents cannot attend the Hope Academy because of facility population.
- Allowing some residents to "opt out" of school attendance is an inappropriate response to the problem.
- More creative approaches, such as alternating classroom work with written work, could enable every resident to have an educational experience.
- Alternative activities, no matter how "educational," do not suffice as a substitute for classroom learning; both students and staff indicated in interviews a lack of sufficient programming.
- Both residents and staff consistently report "too much" free time, unstructured time, and room time because of a lack of sufficient educational resources for residents and other programming. Unstructured time with adolescents can lead to problems including incidents that require use of force.

E4. MENTAL HEALTH

- Three of ten medical charts that were reviewed were seen as problematic: one did not have documentation to support the DSM-5 diagnosis or contraindicated it; one did not have documentation to support the use of a neuroleptic medication; one, because of unclear documentation, appeared to assign a resident to SPs for punitive rather than clinical reasons. These charts and their issues were presented at a brief meeting with those involved with mental health services and a request made to review the charts and respond to the questions.
- It is not clear that the current screening procedure for mental health issues/disorders is identifying all such youth. The estimated number of youth with mental health issues as provided by mental health staff is far below national normative data for youth in detention facilities. Failure to accurately assess, at least for MDDs, can result in negative youth behavior and problematic youth/staff and youth/youth interactions. The current screening process should be replaced or enhanced.

E5. BEHAVIOR MANAGEMENT and PROGRAMMING

- An effective behavior management system and effective behaviorally focused staff/resident interactions assist youth in establishing greater pro-active control of their behavior, rather than being on "autopilot" and simply reacting to the environment around them. This reduces inappropriate comments between residents and the responses they make. This was one of the primary reasons residents indicated as a cause of incidents. With youth more in control of their behavior and using TBA skills ("Think Before Acting"), the overall level of agitation and acting out can be reduced significantly and need for UOF action nearly eliminated.
- While training in behavior management meets MOA criteria, it is not clear if it is too theoretical and lacks practical application for training staff on core skills of immediate interaction with residents.
- It is not clear if training sufficiently addresses current understanding of the neuroscience of adolescence and how knowledge of the teenage brain can lead to more effective interactions and pre-emptive intervention, even before de-escalation is necessary. The use of video vignettes (from UOF videos) and role playing can help bring the theory down to day-to-day skills.
- The current PBMS does not reward residents for "stretching" out of their comfort zones and literally reinforces simply "not causing problems." Management should base the PBMS on best practices as reflected in systems which have a track record of effectiveness in managing youth behavior and that are more consistent with the general principles of behavior modification and cognitive behavioral interventions. Both staff and residents indicated that PBMS needs improvement and needs to be consistently applied. Some residents found the "reinforcements" for expected behaviors not very rewarding and expressed difficulties with the point cards. Some residents found obtaining earned telephone calls difficult.
- Management should also work to incorporate established principles of cognitive behavioral theory into PBMS and other program materials which have clearly demonstrated outcomes with regard to changing criminal thinking, to reducing criminal recidivism, and to reducing inappropriate and aggressive behavior while detained.
- Residents and staff interviews both echoed the need for more programming and reduction of the time youth spend in their rooms.

- Resident concerns over quality and more importantly quantity of food should be noted. Residents indicated that issues over food between residents often leads to aggressive verbal behavior and acting out.

F. APPENDIX

1. Data Collection Matrix
2. QMHP Qualification Summary
3. Use of Force Video/Document Review Form
4. Personnel in Attendance at Interviews/Meetings.

Data Collection Matrix

Shelby County -- MOA: Protection from Harm with Data Sources (rev. 031417)

1. Use of Force	Report	Records	Interview/Observation
(a) No later than the Effective Date, the Facility shall continue to prohibit all use of a restraint chair and pressure point control tactics.	Review Use of Force Policy	View random set videos of Jan-Mar Use of Force Incidents for evidence of use of chair View random set of Jan-Mar reports for evidence of use of chair	Interview residents for evidence of use of chair
(b) Within six months of the Effective Date, the Facility shall analyze the methods that staff uses to control Children who pose a danger to themselves or others. The Facility shall ensure that all methods used in these situations comply with the use of force and mental health provisions in this Agreement.	Review Use of Force Policy		
(c) Within six months of the Effective Date, JCMSC shall ensure that the Facility's use of force policies, procedures, and practices:	Review Use of Force Policy		
(i) Ensure that staff use the least amount of force appropriate to the harm posed by the Child to stabilize the situation and protect the safety of the involved Child or others;	Review Report Card: UOF 02 Total N of UOF UOF 03 UOF/100 youth UOF 04 % Time Non Phys alt used UOF 08 Non-Phys Alt Documented	View random set of videos of Jan-Mar Use of Force Incidents to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions View random set of Use of Force incident reports Jan-Mar to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions	
(ii) Prohibit the use of unapproved forms of physical restraint and seclusion;	Review Use of Force Policy Review Report Card: UOF 17 Wrongful conduct UOF 18 Violations of Pol/Prot	View random set of videos of Jan-Mar Use of Force Incidents to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions View random set of Use of Force incident reports Jan-Mar to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions	Interview residents regarding use of restraints
(iii) Require that restraint and seclusion only be used in those circumstances where the Child poses an immediate danger to self or others and when less restrictive means have been properly, but unsuccessfully, attempted;	Review Use of Force Policy Review Report Card: UOF 7b % Inv room confinement	View random set of videos of Jan-Mar Use of Force Incidents to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions View random set of Jan-Mar Use of Force incident reports to determine appropriate use of hierarchy vis-à-vis observed antecedent conditions	Interview residents regarding use of restraints
(iv) Require the prompt and thorough documentation and reporting of all incidents, including allegations of abuse, uses of force, staff misconduct, sexual misconduct between children, child on child violence, and other incidents at the discretion of the Administrator, or his/her designee	Review Use of Force Policy Review Report Card: SAO 5 Assaults/Youth/100 days SAO 6 Assaults/Staff/100days	View random set of Use of Force incident reports Jan-Mar to determine quality and appropriateness of documentation based on provision iv criteria	Interview residents regarding use of restraints
(v) Limit force to situations where the Facility has attempted, and exhausted, a hierarchy of pro-active non-physical alternatives;	Review Use of Force Policy	View random set of Jan-Mar Use of Force Incident Reports to determine appropriate use of hierarchy vis-à-vis antecedent conditions	Interview residents regarding use of restraints
(vi) Require that any attempt at non-physical alternatives be documented in a Child's file;		View random set of Jam-Mar Use of Force incident reports and child's detention file determine appropriate use of non-physical alternatives	
(vii) Ensure that staff are held accountable for excessive and unpermitted force;		View random set of Jan-Mar videos of Use of Force Incidents for evidence of excessive force and compare to incident report	Interview residents regarding perceived institutional response to appropriate/inappropriate use of force.

1. Use of Force	Report	Records	Interview/Observation
		of same situation	
(viii) Within nine months of the Effective Date ensure that Children who have been subjected to force or restraint are evaluated by medical staff immediately following the incident regardless of whether there is a visible injury or the Child denies any injury;	Review Use of Force Policy Regarding Medical Evaluation after incidents Review Report Card: UOF 16 % Med Eval Completed	Review child's file and incident report	
(ix) Require mandatory reporting of all child abuse in accordance with Tenn. Code. Ann. § 37-1-403; and	Review Policy on Mandated Reporting Review PREA policy		
(x) Require formal review of all uses of force and allegations of abuse, to determine whether staff acted appropriately.		Review Log of Supervisory Review of Uses of Force Incidents	
(d) Each month, the Administrator, or his or her designee, shall review all incidents involving force to ensure that all uses of force and reports on uses of force were done in accordance with this Agreement. The Administrator shall also ensure that appropriate disciplinary action is initiated against any staff member who fails to comply with the use of force policy. The Administrator or designee shall identify any training needs and debrief staff on how to avoid similar incidents through de-escalation. The Administrator shall also discuss the wrongful conduct with the staff and the appropriate response that was required in the circumstance. To satisfy the terms of this provision, the Administrator, or his or her designee, shall be fully trained in use of force.		Review documentation from Administrator that Log of Supervisory Reviews of Uses of Force has been reviewed and appropriate action has been taken.	

2. Suicide Prevention	Report	Records	Interview/Observation
(a) Within 60 days of the Effective Date, JCMSC shall develop and implement comprehensive policies and procedures regarding suicide prevention and the appropriate management of suicidal Children. The policies and procedures shall incorporate the input from the Division of Clinical Services. The policies and procedures shall address, at minimum:	Review Suicide Prevention Policy		
(i) Intake screening for suicide risk and other mental health concerns in a confidential environment by a qualified individual for the following: past or current suicidal ideation and/or attempts; prior mental health treatment; recent significant loss, such as the death of a family member or a close friend; history of mental health diagnosis or suicidal behavior by family members and/or close friends; and suicidal issues or mental health diagnosis during any prior confinement.		Check intake log for evidence of suicide screenings Review random set of Jan-Mar suicide risk assessments and ensure assessment done by QMHP	
(ii) Procedures for initiating and terminating precautions;	Review Suicide Prevention Policy		
(iii) Communication between direct care and mental health staff regarding Children on precautions, including a requirement that direct care staff notify mental health staff of any incident involving self-harm;		Review security logs to establish that referrals were made	
(iv) Suicide risk assessment by the QMHP		Review QMHP credentials to ensure compliance with Tennessee statute	
(v) Housing and supervision requirements, including minimal intervals of supervision and documentation;	Review Suicide Prevention Policy		
(vi) Interdisciplinary reviews of all serious suicide attempts or completed suicides;		Review files of suicide attempt incidents	Interview mental health staff to determine if incidents occurred and the resulting follow up
(vii) Multiple levels of precautions, each with increasing levels of protection	Review Suicide Prevention Policy		
(viii) Requirements for all annual in-service training, including annual mock drills for suicide attempts and competency-based instruction in the use of emergency equipment;		Review attendance lists for training	
(ix) Requirements for mortality and morbidity review; and		Review any relevant records	
(x) Requirements for regular assessment of the physical plant to determine and address any potential suicide risks.		Review inspection logs of physical plant	
(b) Within 60 days of the Effective Date, JCMSC shall ensure security staff posts are equipped with readily available, safely secured, suicide cut-down tools.			Observe during walk-through
(c) After intake and admission, JCMSC shall ensure that, within 24 hours, any Child expressing suicidal intent or otherwise showing symptoms of suicide is assessed by a QMHP using an appropriate, formalized suicide risk assessment instrument.	Review Report Card: SP 02 Total N QMHP contacts	Review log of response to suicidality Review selected case files	

2. Suicide Prevention	Report	Records	Interview/Observation
(d) JCMSC shall require direct care staff to immediately notify a QMHP any time a Child is placed on suicide precautions. Direct care staff shall provide the mental health professional with all relevant information related to the Child's placement on suicide precautions.	Review Suicide Prevention Policy	Review security log	
(e) JCMSC shall prohibit the routine use of isolation for Children on suicide precautions. Children on suicide precautions shall not be isolated unless specifically authorized by a QMHP. Any such isolation and its justification shall be thoroughly documented in the accompanying incident report, a copy of which shall be maintained in the Child's file.	Review Suicide Prevention Policy		interview MH staff interview security staff
(*f) Within nine months of the Effective Date, the following measures shall be taken when placing a Child on suicide precautions*:	Review Suicide Prevention Policy		
(i) Any Child placed on suicide precautions shall be evaluated by a QMHP within two hours after being placed on suicide precautions. In the interim period, the Child shall remain on constant observation until the QMHP has assessed the Child.	Review Report Card: SP 12 Avg Time adm/screening SP 13 Avg wait time for QMHP	Review screening documentation and relevant files/logs	
(ii) In this evaluation, the QMHP shall determine the extent of the risk of suicide, write any appropriate orders, and ensure that the Child is regularly monitored.	Review Suicide Prevention Policy	Review screening documentation and relevant flies/logs	
(iii) A QMHP shall regularly, but no less than daily, reassess Children on suicide precautions to determine whether the level of precaution or supervision shall be raised or lowered, and shall record these reassessments in the Child's medical chart.	Review Suicide Prevention Policy	Review selected MH files	
(iv) Only a QMHP may raise, lower, or terminate a Child's suicide precaution level or status.	Review Suicide Prevention Policy	Review selected MH files	
(v) Following each daily assessment, a QMHP shall provide direct care staff with relevant information regarding a Child on suicide precautions that affects the direct care staff's duties and responsibilities for supervising Children, including at least: known sources of stress for the potentially suicidal Children; the specific risks posed; and coping mechanisms or activities that may mitigate the risk of harm.	Review Suicide Prevention Policy		Interview MH staff Interview security staff
(g) JCMSC shall ensure that Children who are removed from suicide precautions receive a follow up assessment by a QMHP while housed in the Facility.	Review Suicide Prevention Policy	Review selected MH files	
(h) All staff, including administrative, medical, and direct care staff or contractors, shall report all incidents of self-harm to the Administrator, or his or her designee, immediately upon discovery.	Review Suicide Prevention Policy	Review selected incident reports Review MH file	
(i) All suicide attempts shall be recorded in the classification system to ensure that intake staff is aware of past suicide attempts if a Child with a history of suicidal ideations or attempts is readmitted to the Facility.	Review Suicide Prevention Policy	Check for presence of flag in Information Management System for future intakes	
(j) Each month, the Administrator, or his or her designee, shall aggregate and analyze the data regarding self-harm, suicide attempts, and successful suicides. Monthly statistics shall be assembled to allow assessment of changes over time. The Administrator, or his or her designee, shall review all data regarding self-harm within 24 hours after it is reported and shall ensure that the provisions of this Agreement, and policies and procedures, are followed during every incident.			interview with administration

3. Training	Report	Records	Interview/Observation
(a) Within one year of the Effective Date, JCMSC shall ensure that all members of detention staff receive a minimum of eight hours of competency-based training in each of the categories listed below, and two hours of annual refresher training on that same content. The training shall include an interactive component with sample cases, responses, feedback, and testing to ensure retention. Training for all new detention staff shall be provided bi-annually.		Review training curriculum Review training attendance records	
(i) Use of force: Approved use of force curriculum, including the use of verbal de-escalation and prohibition on use of the restraint chair and pressure point control tactics.		Review training curriculum Review training attendance records	

(ii) Suicide prevention: The training on suicide prevention shall include the following: a. A description of the environmental risk factors for suicide, individually predisposing factors, high risk periods for incarcerated Children, warning signs and symptoms, known sources of stress to potentially suicidal Children, the specific risks posed, and coping mechanisms or activities that may help to mitigate the risk of harm. b. A discussion of the Facility's suicide prevention procedures, liability issues, recent suicide attempts at the Facility, searches of Children who are placed on suicide precautions, the proper evaluation of intake screening forms for signs of suicidal ideation, and any institutional barrier that might render suicide prevention ineffective. c. Mock demonstrations regarding the proper response to a suicide attempt and the use of suicide rescue tools. d. All detention staff shall be certified in CPR and first aid. The Administrator shall review and, if necessary, revise the suicide prevention training curriculum to incorporate the requirements of this paragraph.		Review training curriculum Review training attendance records	

4. Performance Metrics for Protection from Harm	Report	Records	Interview/Observation
(a) In order to ensure that JCMSC's protection from harm reforms are conducted in accordance with the Constitution, JCMSC's progress in implementing these provisions and the effectiveness of these reforms shall be assessed by the Facility Consultant on a semi-annual basis during the term of this Agreement. In addition to assessing the JCMSC's procedures, practices, and training, the Facility Consultant shall analyze the following metrics related to protection from harm reforms:	Ensure monthly report card data is being collected and is accurate		
(i) Review of the monthly reviews of use of force reports and the steps taken to address any wrongful conduct uncovered in the reports	Ensure monthly report card data is being collected and is accurate	Review f/u from selected incident reports	
(ii) Review of the effectiveness of the suicide prevention plan. This includes a review of the number of Children placed on suicide precautions, a representative sample of the files maintained to reflect those placed on suicide precautions, the basis for such placement, the type of precautions taken, whether the Child was evaluated by a QMHP, and the length of time the Child remained on the precaution; and	Review Report Card: SP 09 N on SP SP 10 Avg Time on SP	Review selected MH files	
(b) JCMSC shall maintain a record of the documents necessary to facilitate a review by the Facility Consultant and the United States in accordance with Provision VI of this Agreement.	Ascertain presence of relevant reports	Ascertain presence of relevant document files	

2. QMHP Credential Verification Form

QMHP Verification (Tennessee Code: Title 33)

Instructions: Please check the state QMHP criteria that are met for each QMHP on staff

Name:		Degree:		Work Title:	
✓	Category	✓	Category		
	Psychiatrist		Licensed master’s social worker with two years of mental health experience		
	Physician with expertise in psychiatry		Licensed clinical social worker		
	Psychologist with health service provider designation		Licensed or certified marital and family therapist		
	Licensed psychological examiner		Licensed professional counselor		
	Licensed senior psychological examiner		Licensed Nurse with a master’s degree in nursing who functions as a psychiatric nurse		
	Licensed Physician’s Assistant with a master’s degree and expertise in psychiatry as determined by training, education or experience				

Name:		Degree:		Work Title:	
✓	Category	✓	Category		
	Psychiatrist		Licensed master’s social worker with two years of mental health experience		
	Physician with expertise in psychiatry		Licensed clinical social worker		
	Psychologist with health service provider designation		Licensed or certified marital and family therapist		
	Licensed psychological examiner		Licensed professional counselor		
	Licensed senior psychological examiner		Licensed Nurse with a master’s degree in nursing who functions as a psychiatric nurse		
	Licensed Physician’s Assistant with a master’s degree and expertise in psychiatry as determined by training, education or experience				

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	Psychiatrist		Licensed master’s social worker with two years of mental health experience		
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Name:		Degree:		Work Title:	
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	Psychiatrist		Licensed master’s social worker with two years of mental health experience		
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	Licensed Physician’s Assistant with a master’s degree and expertise in psychiatry as determined by training, education or experience				

Name:		Degree:		Work Title:	
✓	Category	✓	Category		
	Psychiatrist		Licensed master’s social worker with two years of mental health experience		
	Physician with expertise in psychiatry		Licensed clinical social worker		
	Psychologist with health service provider designation		Licensed or certified marital and family therapist		
	Licensed psychological examiner		Licensed professional counselor		
	Licensed senior psychological examiner		Licensed Nurse with a master’s degree in nursing who functions as a psychiatric nurse		
	Licensed Physician’s Assistant with a master’s degree and expertise in psychiatry as determined by training, education or experience				

Name:		Degree:		Work Title:	
✓	Category	✓	Category		
	Psychiatrist		Licensed master’s social worker with two years of mental health experience		
	Physician with expertise in psychiatry		Licensed clinical social worker		
	Psychologist with health service provider designation		Licensed or certified marital and family therapist		
	Licensed psychological examiner		Licensed professional counselor		
	Licensed senior psychological examiner		Licensed Nurse with a master’s degree in nursing who functions as a psychiatric nurse		
	Licensed Physician’s Assistant with a master’s degree and expertise in psychiatry as determined by training, education or experience				

3. Use of Force Video/Document Review Form

VIDEO REVIEW	Date:	Time:	Location:
Antecedent Conditions			
Event			
Child in immediate danger	Y N		
Force Used/Physical Restraint			
3. Inappropriate Use Force	□ Slapping, punching, kicking, hitting □ Risk of LOC/harm to neck □ Pinning down with knees to torso, neck/head □ Choking or similar that restricts breathing □ Use of other youth or untrained staff □ Use of pressure point/pain compliance/joint manipulation (non-CPI)	□ Securing youth to another youth/fixed object/restraint device □ Striking with hands, elbows, knees, feet or other body part □ Dragging/lifting by hair/ear/mechanical restraints □ Lifting arms behind back while in restraints □ Placed down in prone position with continuous observation	
5. Hierarchy exhausted	□ 0 Office Present/No force used □ **I Verbal direction/warning** (at least 1 verbal attempt; at least verbal warnings) □ **II Supervisor/CM/MH staff involved** □ **III Passive removal (CPI transport)** □ **IV Use of physical force**		
Medical Examination Conducted	Y N		
6. Summary	Y N Least amount of force used appropriate to the harm posed by child Y N Use of unapproved forms of physical restraint Y N Documentation complete		

INCIDENT REPORT	Date:	Time:	Location:
Incident Report narrative matches video	Y N		
Incident Report in child's file	Y N		
Medical f/u documented	Y N		

Notes:

4. Persons in Attendance at Interviews/Meetings.

Initial meeting with Detention Management Team
Deidre Bridgeforth, Assistant Chief SCJDC
Bernard Glos, Protection from Harm Monitor
Kirk Fields, Chief SCJDC
Bill Powell, Settlement Agreement Coordinator
Jina Shoaf, Attorney representing Juvenile Court
Lawrence Weichel, Captain SCJDC

Hope Academy Meeting
Joyce Anderson, Sheriff's Department Juvenile Manager
Deidre Bridgeforth, Assistant Chief SCJDC
Michelle Byers, Captain SCJDC
Bernard Glos, Protection from Harm Monitor
Bill Powell, Settlement Agreement Coordinator
Jina Shoaf, Attorney representing Juvenile Court
Mike Smith, Principal of Hope Academy
Kirk Fields, Chief SCJDC
Lawrence Weichel, Captain SCJDC

Training Staff Meeting
Deidre Bridgeforth, Assistant Chief SCJDC
Kirk Fields, Chief SCJDC
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ
Bill Powell, Settlement Agreement Coordinator
Jina Shoaf, Attorney Representing Juvenile Court
Lawrence Weichel, Captain SCJDC

Positive Behavior Management System Meeting
Deidre Bridgeforth, Assistant Chief SCJDC
Kirk Fields, Chief SCJDC
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ
Michelle Hunt, Sergeant SCJDC
Bill Powell, Settlement Agreement Coordinator
Jina Shoaf, Attorney representing Juvenile Court
Lawrence Weichel, Captain SCJDC

Major Incident Reporting System Meeting
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ
Bill Powell, Settlement Agreement Coordinator
Lawrence Weichel, Captain SCJDC

CCS Management Meeting (Suicide/Mental Health)
Deidre Bridgeforth, Assistant Chief SCJDC
Bernard Glos, Protection from Harm Monitor
Kirk Fields, Chief SCJDC
August Geeter, Mental Health Director CCS
Richard Goemann, DOJ
Uduakobong Ikpe, CCS
Judy Martin, Chief of Nursing Health Department
Bill Powell, Settlement Agreement Coordinator
Sheba Randall, Contract monitor for Health Dept
Toyetta Reddic, Contract monitor for Health Dept
Jina Shoaf, Attorney representing Juvenile Court
Audrey Townsel, Regional Operations Director CCS
Lawrence Weichel, Captain SCJDC

File Review of Residents Placed on Suicide Precautions
Bill Powell, Settlement Agreement Coordinator
Bernard Glos, Protection from Harm Monitor
Richard Goemann, DOJ

Use of Force Review Meeting
Deidre Bridgeforth, Assistant Chief SCJDC
Kirk Fields, Chief SCJDC
Bernard Glos, Protection from Harm Monitor
Bill Powell, Settlement Agreement Coordinator
Jina Shoaf, Attorney representing Juvenile Court
Lawrence Weichel, Captain SCJDC

Follow-up Meeting: File review of suicide precaution files
Deidre Bridgeforth, Assistant Chief SCJDC
Kirk Fields, Chief SCJDC
Winsome Gayle, DOJ
August Geeter, Mental Health Director CCS
Bernard Glos, Protection from Harm Monitor
Uduakobong Ikpe, CCS
Judy Martin, Chief of Nursing Health Department
Sheba Randall, Contract Monitor for Health Dept
Bill Powell, Settlement Agreement Coordinator
Toyetta Reddic, Contract monitor for Health Dept
Jina Shoaf, Attorney representing Juvenile Court
Audrey Townsel, Regional Operations Director CCS
Lawrence Weichel, Captain SCJDC

Meeting on Detention Population
Gary Cummings, Juvenile Court Director of Court Services
Bernard Glos, Protection from Harm Monitor
Bill Powell, Settlement Agreement Coordinator
Debra Salters, Juvenile Court Expeditor
Jina Shoaf, Attorney representing Juvenile Court

Confidential Meeting with Detention Residents
Thirty-nine residents were interviewed across five groups. Richard Goemann, DOJ) also attended two interviews. Thirty-five residents identified themselves as African-American, 2 as Hispanic, 1 as non-Hispanic White, and 1 as Mixed Race. In terms of time spent in detention 1 was detained for 2 weeks or less, 15 for 2-4 weeks, 14 for 2-3 months and 8 were detained for 4 months or longer. Responses from all the groups were consistently similar.

Confidential Meeting with Detention Center Staff
Six staff were interviewed in one group session

Exit Interview
Deidra Bridgeforth, Chief Inspector SCJDC
Michaele Byers Captain, SCJDC
Debra Fasenden, SCSO Chief Policy Statutory Compliance Manager
Kirk Fields, Chief of Detention
Winsome Gayle, DOJ
Bernard Glos, Protection from Harm Monitor
Kevin Henderson Lieutenant SCJDC
Michelle Hunt, Sergeant SCJDC
Uduakobong Ikpe, Regional Health manager, CCS
Judy C. Martin, Chief of Nursing SCHD
Robert Moore, Chief Jailer
Bill Powell, Settlement Agreement Coordinator
Sheba Randle, Nursing Coordinator Jail Quality Improvement
Janet L. Shipman, SCHD Asst. Shelby County Attorney
Jina Shoof, Attorney Juvenile Court
Audrey Townsel, Regional Operations Manager, CCS
Lawrence Weichel, Captain Juvenile Detention Security Operations