State of Connecticut
Judicial Branch
Court Support Services Division
Juvenile Residential Services
Administrative Investigation - Summary

Dates of Investigation: 7-2-15 to 7-10-15

Incident under investigation:
On 7-1-15 at approximately 6:12 pm a series of events began at the Washington Street Secured Community Residential Program ("WSSCRP") operated by Community Partners in Action (CPA). In these events, a group of youth became involved in physical altercations with staff, destruction of property, the pulling of fire alarms for a non-fire event, and attempted escape. During the events of this evening one staff member was hurt which required him to be removed from the facility and transported by ambulance to the hospital.

Items reviewed as part of the investigation:
- Video from WSSCRP
- Incident reports written by staff on site
- Interview statements from youth
- Interview statements from staff
- Timeline produced by CPA documenting video
- Prior issues addressed with Program and or CPA Administration

Video Review:

5:56-6:10 pm. A youth is assaulted by peer on second floor. The victim is upset and trying to get back at her peer and is seen being removed from the area by staff. Once that youth is out of area no one returns to remove the aggressive youth.

Staff is deployed on three floors to cover one youth in housing, five youth in the second floor dining area, and seven youth in the first floor.

6:13-6:15 pm. Staff is seen attempting to use Safe Crisis Management (SCM) on a client as her behavior escalates. Staff members and youth move toward the living room area of the floor where one staff is attempting to hold the client in a standing position. While the remaining staff tries to police the area, other youths increase in agitation. A second youth is seen hitting a staff member who had his arms extended trying to keep space and preventing her from getting to the restraint. The staff member is seen moving back toward her with his arms in the upper torso area. The youth is seen falling back into a chair. Staff moves above her for 3 to 4 seconds before the youth gets up. The staff member then leaves the area.
6:16-6:22 pm. Two staff and three of the five clients on the second floor continue to have what appear to be elevated discussions. Staff is in defensive positions with hands out in front of clients. Three of the juveniles appear to begin to break things as action moves out of camera view toward the hallway door. The nurse is on scene to monitor restraints if they occur.

6:23-6:29 pm. Staff is again seen attempting to restrain a youth but the hold only last briefly before the staff releases the youth. Three youth are seen running between the second floor hallways and dining, the two staff appear to be counseling to no avail and trying to guide them to one area. The nurse is seen from the hall camera attempting to keep juveniles from re-entering the hallway by holding the door. One youth is seen throwing a phone in the direction of staff. After approximately 10 minutes a third staff member attempts to assist.

6:30-6:36 pm. Clients and staff are in the hallway. Staff appears to be in a defensive mode as juveniles attempt to assault a staff member near the water cooler, that was broken during this event. A client gets a hold of a fire extinguisher briefly, which is then taken from her by the nurse. A staff member moves to prevent youth from exiting the west staircase. While his back is turned he is hit by a youth with her fist or possibly with a piece of the water cooler. The staff person appears to fall into the wall below the camera. The staff member is down briefly and other staff do not engage in Safe Crisis Management (SCM) even after both direct physical assault and assault with items. Youth continue to attempt to assault the staff member who had been knocked down. The staff member goes down a second time and the nurse responds to care for him. The alarm has also been pulled during this period unlocking the staircase doors.

6:37-6:41 pm. The agitated youth from the second floor move down to the first floor. Staff makes some attempt to hold youth as do fellow clients but they are unable to maintain them to the point of de-escalation. Other juveniles begin to act out by engaging, in property destruction, assault on staff, and not following apparent staff direction as the behavior of the original three youth continues.

6:42-6:45 pm. Youth remain in a state of chaos with several youth still in highly aggressive states including breaking property or throwing items. Other youth are seen attempting to stop and counsel peers while staff stand near the exits of the room. One of the original three youths is seen holding the first floor fire extinguisher but has it taken away from her by a staff member who places it in the control center.

6:46-6:50 pm. Youth are continuing aggressive acts while in the hallway. Some are banging on the door to the lobby. The control officer is seen reaching toward the control panel at the time the youth breach the door. Staff struggles to get almost the entire population back into the first floor hallway.

6:50-6:55 pm. Hartford Juvenile Detention Staff and State Police Officers are seen entering the facility. Hartford JDOs are seen using SCM techniques upon entry to the facility. HJDC and WSSCRP staff begin to transition calm youth to housing as Hartford Fire and Ambulance enter to treat injured staff.
Conclusions:

A review of a variety of materials in this investigation finds that staff including seasoned members failed to follow training. Through inaction staff allowed a minor event to escalate resulting in the near escape of a portion of the population and the injury to a staff member. The areas outlined below describe key areas of concern:

I. Previous Efforts Failed
Corrective action measures begun in May 2015 were put in place to boost the strength and decision making of the second shift. Six of the eight staff involved had supervisory experience and should have had the skill-set to problem solve and effect clear communication. The video and staff interviews show that little communication took place and there was a lack of a clear plan on how to respond. No one was able to take charge and formulate a planned response. These areas were previously identified as needing improvement.

II. Lack of Consistency
The review of events shows a lack of consistency on the implementation of policy. Initially two girls were involved in an argument yet only one girl was removed from the community. The girl who remained was the one who had hit the other youth. By not quickly removing the aggressor the events continued to escalate. Staff had an opportunity to correct this mistake when the same child continues to talk about the fight after being redirected.

Dividing the meal time into two groups on different floors resulted in divided resources. This practice was determined to not be appropriate and CSSD was assured by CPA that this was no longer occurring. In addition this practice supports an environment in which aggression is perceived as a constant risk. If this was previously addressed with the staff, it is unclear why was the practice continued to occur. Staff members’ statements do not acknowledge that this was in violation of WSSCRP practice only that they were not sure the reason for the separation of the groups. This leads one to believe that the issue was not addressed or that staff was openly insubordinate.

III. Lack of Leadership
When staff was asked to leave the second floor after the physical interaction took place someone should have responded immediately and replaced the position to respond to the situation. It takes ten minutes for relief staff to appear which is excessive and emboldened the negative behaviors. This failure to act to support the two staff was significant and played a major role in the near escape and loss of control of the facility.

The staff failed to consider other options such as moving youth to housing or moving the youth in housing to the fitness area to free up staff. Later staff persons fail to understand the gravity of the situation when they send a staff person from the area.
IV. Poor Training & Technique
A review of the video showed a lack of appropriate techniques when staff attempted to engage in a physical intervention. Of the attempts, very few lasted more than a few seconds. Though emergency physical management intervention is always the last resort, the greater concern was that it was not used in situations where it clearly was needed. Physical intervention, as defined in CSSD policy, is necessary for the protection of persons or to prevent significant property damage. Three juveniles in particular repeatedly violated this threshold by assaulting staff, destroying property and using destroyed property as weapons. By not responding in an appropriate way, staff contributed to the dangerous environment that occurred and almost allowed the population to escape. Staff as a whole appeared to lack understanding of how to engage in restraints and when to restrain youth. Instead youth were allowed to assault staff and engage in property destruction at will. An initial assessment of Safe Crisis Management (SCM) physical skills of the entire WSSCRP staff post this incident found the vast majority functioning below expectations.

V. Poor Program Culture
The WSSCRP program is a gender responsive model which uses the TRI Behavioral Management Program. The TRI Model is grounded in the development of positive personal relationships. A review of this video is concerning in that none of the three primary youth were able to be counseled down from their escalated behaviors. It was also apparent that staff had not educated youth on what to do when staff are responding to negative behaviors. Youth spoken to directly after this event expressed a variety of emotions about the program including sadness and anger about what their peers had done. They also expressed anger and frustration about not being listened to by administration. Some expressed fear to even sleep in the program after what they had seen.

The culture at the time of this event was poor and requires strong support and communication; two areas which were found to be lacking as part of this investigation. Staff appeared to have fear in engaging in physical restraints which the youth realized and took advantage of. Finally, youth lacked the respect of the staff in the program to follow directions. This is most notable when all staff is on the first floor and no juveniles are responding to the staff compliment which included many senior staff.

Recommendations:
The evening of the event, after discussions with youth involved and observation of the facility, it was determined that the facility, in the best interest of the youth, would close until after an investigation occurred. Through this investigation there are several concerns that would need to be addressed prior to returning any youth to the facility.

1. Staff Training
Staff did not respond to significant aggression and did not employ Safe Crisis Management (SCM) when needed to ensure the safety of all. Initial training assessment shows that the majority of staff lacks the necessary skills to complete
SCM moves safely. In addition, the facility staff needs instruction on training youth what to do when their peers are in crisis. Additionally, supervisory staff is in need of training on management of the population during crisis situations and communication skills.

2. **Management of this WSSCRP**
   CPA has recommended that an experienced administrator take over the running of the facility. CPA has identified a senior administrative staff with significant facility experience; however this event involved the facility management team and several senior staff. CPA needs to advise CSSD of the corrective actions being taken against the staff involved. As previously noted, of the staff involved seventy five percent had management experience yet many failed to act. CPA will need to complete an assessment of staff skills and ensure CSSD that staff is prepared to receive juveniles and keep them safe and secure.

3. **CSSD increased oversight**
   If the facility is to re-open several measures will need to be put in place. Included in this is the addition of CSSD Detention staff persons around the clock to assist (not supplant) the WSSCRP staffing pattern. This will allow for direct feedback about the program and its progress. This should continue until it is determined that the program is able to operate effectively. The facility will complete regular reports on specific measures and will meet with the CSSD contract compliance staff weekly.

This report is respectfully submitted on this day July 14, 2015 by John Fitzgerald, Superintendent.

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Name-Title  Date