



STATE OF TENNESSEE
TENNESSEE COMMISSION ON CHILDREN AND YOUTH

502 Deaderick Street
Nashville, Tennessee 37243-0800
(615) 741-2633 (FAX) 741-5956
1-800-264-0904

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Contact: Linda O'Neal
Phone (615) 532-1600
linda.oneal@tn.gov

Tennessee Commission on Children and Youth Releases Recommendations on Mountain View Youth Development Center Deaths

The Tennessee Commission on Children and Youth (TCCY) has completed its review of the recent deaths at Mountain View Youth Development Center and issued a report with recommendations for improved services. TCCY was asked by Tennessee Department of Children's Services Commissioner Jim Henry to take a comprehensive look at the circumstances surrounding two recent deaths at the youth development center. Two young men in the center were determined to have died by suicide during a three-week period.

The focus of TCCY's review was to examine the events to determine what could be learned to prevent future incidents. Staff conducting the review shared extensive experience in child welfare, mental health, suicide prevention and residential treatment.

TCCY executive director Linda O'Neal praised Henry and DCS for the openness and transparency provided in the review process and the receptivity to recommendations. O'Neal said the cumulative impact of years of budget reductions in state government has taken a toll on the Juvenile Justice Division, where there is much less federal funding than in other programs for children, not only in DCS, but statewide.

"Tennessee is heavily reliant on federal funding for services for children," O'Neal said, "and there are few federal dollars for juvenile justice programming, so state budget cuts have disproportionately fallen on juvenile justice."

The review's overarching recommendation is to develop a comprehensive, cohesive plan to provide juvenile justice services in a therapeutic environment utilizing best practices and evidence-based/evidence-informed services. While there are a number of important initiatives currently underway in the state, there is a substantial need to create and implement a "blueprint" to move Tennessee's juvenile justice system toward a service delivery model that produces better outcomes and is more cost effective, as clearly supported by research and evaluation, and recommended by virtually all national groups.

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O'Neal said that means Tennessee needs a system that uses smaller, more therapeutic facilities and more intensive home and community-based interventions. Children in the juvenile justice system typically have experienced substantial trauma and Adverse Childhood Experiences (ACEs). ACEs and trauma have a lifelong impact on physical and emotional health. Services for children in the juvenile justice system need to be trauma-informed to improve the well-being of the children served, reduce recidivism and improve community safety.

The report contained some more specific recommendations DCS can implement in the short-term, including improvements in communication and coordination, health and mental health services, staffing, and training.

The Tennessee Commission on Children and Youth is saddened by the deaths of these young men. It appreciates the confidence in TCCY implicit in the request to conduct this third party review and the transparency shown by the department in making information available. It is committed to working with DCS to implement recommendations.

“DCS needs the support of the Governor, General Assembly and the community to ensure it has the resources needed to provide services that improve the life prospects for the children it serves and the safety of communities across Tennessee,” said O'Neal.

The Tennessee Commission on Children and Youth is a small state agency created by the Tennessee General Assembly nearly 60 years ago. Its primary mission is to advocate for improvements in the quality of life for Tennessee children and families, and juvenile justice has been a focus throughout the life of the organization.

TCCY's review is available on its website at <http://www.tn.gov/assets/entities/tccy/attachments/jj-MVYDC.pdf>.



Third-Party Case Review

Mountain View Youth Development Center

August 2014

Prepared by:

Tennessee Commission on Children and Youth
Linda O'Neal, Executive Director

*NOTE: Report was revised with minor edits on 08/29/2014.
No substantial changes impacting the report have been made.*

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Overview and Recommendations

Studies show as many as two-thirds of youth and young adults in the juvenile justice system experience mental health disorders, compared to less than one-quarter of youth and young adults in the general population. The prevalence of mental disorders has largely been studied among justice-involved youth who are held in detention facilities. According to records obtained from Mountain View Youth Development Center (MVYDC), a majority of youth (57.14%) are receiving psychotropic medications while an even higher percentage have at least one reported mental health diagnosis. Based on this information along with interviews of MVYDC staff, youth, contracted personnel, family members and regional staff, record and case reviews, video surveillance, and facility assessments, the following recommendations are provided to enhance the quality of life at Mountain View Youth Development Center. While the team only officially reviewed cases and facilities from Mountain View, any applicable recommendations should be considered at the two other youth development center (YDC) facilities.

Coordination of Care

- **Proper and appropriate assessments should be conducted prior to sending a youth to and routinely during a youth's stay at a youth development center.** DCS provides several levels of assessment upon intake to a YDC, including the Youth Level of Service (YLS) and the Reasons for Living (RFL) survey. These assessments initially provide a snapshot of the youth at the time of entrance into the YDC. However, better initial assessments should be conducted prior to placement at a YDC and during the youth's stay at the YDC. DCS uses the Child and Adolescent Needs and Strengths (CANS), an appropriate evidence-based service planning and communimetric tool, for youth in child welfare placements. CANS should be routinely conducted for youth in juvenile justice placements as this tool can inform staff about the current needs and strengths of the child and identify any immediate service needs. This tool could also provide ongoing communication to the regional staff, central office staff and others who need periodic and ongoing communication about a child in DCS custody.

DCS should also encourage use of the Tennessee Integrated Court Screening and Referral Project by local juvenile court staff. This project, implemented by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), uses a modified version of the CANS to make appropriate service referrals prior to adjudication. By ensuring youth receive mental health and other supportive services early in the process, youth and young adults are less likely to be placed in the custody of the state. DCS allows court staff to attend DCS' CANS training as a part of the project, and additional collaboration between DCS, TDMHSAS and the local juvenile courts could ensure appropriate referrals and services.

- **Services should be individualized in accordance with the unique potential and needs of each student and guided by a strengths-based, wraparound service planning process and individualized service plan developed in true partnership with the student and family.** Individual program plans (IPPs) should be unique to each student's needs and abilities. No two plans should look identical and each plan should adequately describe the student and his current situation. Plans and quarterly reviews should clearly reflect current strengths, needs and behaviors and provide guidance regarding past treatment results and future opportunities and challenges. A review of the IPPs for both young men indicated they have almost identical goals and action steps, even though they had different strengths and needs. Information included in one of the quarterly reviews is copied from an assessment conducted on the student in a different quarter. Relevant information from the quarter reviewed was not included in the notes, including recent suicide attempts and medication changes that occurred while placed at the facility.

Research indicates when all individuals involved in a student's care are adequately informed, the student is more successful. Additional steps must be taken to provide ongoing consistent communication between all MVYDC staff, treatment staff, counseling staff, regional staff and staff providing medication management. Officers should be made aware of student's crisis plans, how to adequately deescalate a student, treatment goals and/or techniques being utilized by the student to modify his behavior. This level of communication can only provide better coordination of care. For example, if the therapist is teaching a student to practice breathing when he is upset, the officers can coach the student when the need arises. In turn, the officers and treatment team should provide status updates on the student's behavior to the counseling staff and medication management staff. Contract counseling staff develop crisis safety plans with all youth receiving their services. All youth at the facility should have crisis safety plans, and when contract counseling staff are involved, their crisis plans for students should inform the facility/treatment team plans.

More importantly, when a student is prescribed a new psychotropic medication, especially if the medication contains a *black box* warning, all staff should be notified to appropriately monitor the student for suicidal ideations and increased impulsivity.

- **Better coordination and transition between placements, regional staff, and records is needed to ensure continuity of care.** Youth are routinely in multiple placements during their time in custody. Regional staff and YDC staff should have continual communication about the youth's care while in treatment. The regional staff ultimately has responsibility for the youth prior to placement at a YDC and when the youth returns from the YDC. By ensuring the regional staff are involved, notified, and receive records

and reports regularly, the youth's transitions will be more successful and provide for ongoing continuity of care.

There should be open communication between all providers serving a child, including facility staff, treatment team, contract providers, regional staff, and staff at prior placements. Staff report minimal to no prior knowledge of treatment modality, medication management, therapeutic support, or general behavior records when changes in placement occur from either outside or within the facility. This makes effectively managing a young person's ongoing treatment nearly impossible. All current service providers should have access to complete records during care and upon discharge or within a reasonable time post discharge. The next provider should not have to start over with a young person's care.

- **Evidence-based programs need to be conducted with fidelity and in their entirety to be effective.** DCS has chosen a very effective evidence-based treatment in Aggression Replacement Training (ART). This training has demonstrated success and positive results in reducing aggression and decreasing anger in students inside and outside detention facilities. Attention must be given to ensure all aspects of the program are provided as prescribed and group sessions are co-facilitated for this treatment to be most effective.
- **The Department of Children's Services (DCS) should continue to work collaboratively with the Department of Mental Health and Substance Abuse Services in identifying more intensive level four and hospitalization resources for youth identified as aggressive, suicidal or with complex mental health needs.** Resources are limited for youth who are aggressive and have complex mental health needs. DCS has a history of working collaboratively with TDMHSAS around meeting the mental health needs of youth in the department's custody. Efforts should be made to: revise current policies and procedures around identifying, assessing and transferring youth in need of a higher, more intensive level of care; assess the current array of services; identify additional needs and locations of services; and ensure staff knows about current services and how to access those services.

Health and Mental Health

- **Additional lifesaving equipment should be available in each building, and all staff should have access and be trained in its use.** Automated external defibrillators (AED), CPR masks, gloves, cut-away tools and other medical supplies should be securely located in each building, with all staff having access to their location. This would provide more immediate access to these supplies. If all necessary supplies are not in each building,

emergency medical crash bags/carts should be mobile/have wheels to allow all staff to quickly move these supplies to different parts of the facility. Medical staff should respond to crisis events with these lifesaving supplies.

- **Medical staff should dispense medications in the units in the evenings and on weekends when only a small number of the youth are receiving medication at a given time.** Movement of youth around the complex should be limited to when necessary, especially when only a small number are moved from each unit. The attention of the staff to segregate and monitor a small portion of the youth on a unit is difficult given that typically on all shifts only one staff is available on each unit except segregation. When a majority of the students are receiving medication at a similar time, such as morning medications around breakfast, a central medication distribution point is warranted. However, when only one or two students from a unit receive nighttime medications, it is more efficient and secure for the medical staff to go to each unit for distribution. Medical staff could be supplied with a lockable cart to safely transport records and medication during these times. Typically, medications are crushed before administering, which is a good practice.
- **A medical staff person should be present at the facility 24 hours a day, seven days a week.** Medical staff is currently present at the facility from 6 a.m. until 9 or 10 p.m. depending on the day of the week. Given the percentage of students on medication and the number of fights, injuries and suicide attempts, medical staff should be available at all times to provide triage and minor medical attention.
- **Students should be able to begin prescribed medication within 24 hours of the medication being ordered.** Students typically begin medication two to three days after ordering the medication. In some cases, the medication may take one to two weeks to arrive at the facility. Staff discussed the possibility of receiving a medication immediately if ordered ‘STAT’ by the doctor. However, the doctor has never ordered a medication this way. Many medications help students manage their symptoms of depression, anxiety, impulsivity, among others, more effectively. By managing these symptoms, aggression and suicidality can be decreased, providing for a more safe, secure, and therapeutic living environment at the YDC. Additional and more routine options for students to begin these medications within 24 hours should be available until the supply from the mail order pharmacy arrives. In one situation, a student did not receive a medication ordered as it did not arrive prior to his death.

Staffing and Supervision

- **In order to provide additional monitoring and therapeutic interaction with youth, staffing ratios should be raised to comply with COA recommendations of one staff per eight students and additional efforts should be made to fully staff the YDC.** A core group of staff has been employed at MVYDC for an average of 10 years or longer demonstrating a high level of commitment to the facility. However, MVYDC has approximately 24 vacant positions, meaning staff is required to work a minimum of an additional 16 hours mandatory overtime weekly. Staffing levels are typically 22 to 23 individuals per shift. All units house 12 students and have one assigned staff person, with the exception of the segregation unit having two staff. A more appropriate staffing pattern would place two staff on all units, with relief staff available for breaks and meals. This will allow more staff to provide closer monitoring and better therapeutic interactions with the students. Students frequently need modeling, coaching and active listening from staff members. Research has demonstrated providing more opportunities for these types of positive interactions to take place helps students progress through the program faster and be more successful upon returning to their home environment.
- **Recruitment techniques should include job fairs and outreach to local universities and training programs where students are interested in social work, sociology, psychology, counseling and/or criminal justice.** Many of these university students have a passion for working with youth and young adults and would value the opportunity to work at the YDC during and after their education and training. The department can currently provide at least limited educational benefits to students who attend public institutions, so this could also serve as an incentive to these individuals to begin work in a role that has advancement potential.
- **Additional non-facility staff should be made available on a short-term basis to assist and provide relief at a facility after a crisis event occurs.** Because of the reduced staffing at MVYDC, staff largely had insufficient time to process and heal after the incidents. During the review, several staff were still visibly upset and struggling with these events. At least one staff did use sick leave for a short period, and this only further complicated the staffing shortage. If DCS were to have a crisis/strike team of trained YDC or department staff able to quickly respond and provide coverage relief to center staff, this would allow affected staff the opportunity to adequately regroup after an incident.
- **A dedicated staff person is needed to monitor and supervise staff and students by viewing the camera feeds.** MVYDC has cameras in all common areas and units throughout the facility. These cameras can provide a staff person with the ability to call

for additional assistance in crises and provide increased monitoring of unit staff. This provides the facility with an additional layer of support and security. However, staff does not currently routinely review and monitor these camera feeds. An additional staff person in the command center could monitor the feeds and provide supplementary support.

- **A better system to monitor and supervise routine staff checks on students should be implemented in the youth development centers.** By policy, staff provides 15 to 30 minute routine checks on students in their individual unit. The time depends on the type of unit and placement of the student. Staff documents these checks in the log for the corresponding unit, with documentation made for all students as a whole, not individual students. Best practice indicates individual notations for each student should be made in the log with a small description of the youth actions at the time of the visual check. Additionally, electronic record keeping devices, such as barcode scanners, are also being used by detention centers to ensure proper monitoring of youth.

Training and Development

- **In-service training for new staff should be provided at intervals conducive to recruiting and maintaining new staff.** New employees should be able to attend training very quickly after being hired and start working on the unit with youth as soon as possible. Currently, new employee in-service training is only conducted once every two months. This makes it difficult to recruit and hire quality staff that must then wait up to two months before starting the job. Recent efforts to use newly hired staff in non-student contact positions is a positive step in addressing the delay. However, additional classes at the academy should be added to address turnover by providing timely training for new staff, and the curriculum at the academy should be reviewed to ensure it is therapeutically appropriate.
- **Staff and students need adequate evidence-informed suicide prevention and intervention training specifically for juvenile justice and detention staff and students.** DCS has had a long-standing history of coordinating suicide prevention and intervention training with the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS) and the Tennessee Suicide Prevention Network (TSPN). DCS, TDMHSAS, and TSPN jointly worked to create the first national curriculum specifically for juvenile justice and detention center staff, Shield of Care. DCS should ensure all YDC staff, including officers, teachers, counselors, nurses, case managers and support staff, plus contract staff, receive Shield of Care basic/booster training annually. All staff records reviewed met the current policy requirements for required staff suicide prevention training, which do not include Shield of Care.

Students should also be provided a peer suicide prevention awareness training to teach them the warning signs of a potentially suicidal youth and how to notify staff appropriately. Students are in a position to notice behavior changes and signs in their peer group, perhaps more even than the unit staff and treatment team. Teaching students signs and symptoms of a potentially suicidal youth enables them to better alert staff to changes among their peers.

- **Reviews and debriefings should be conducted following traumatic or crisis events.** Real life events can educate staff and students about possibilities for improvements in policies, procedures and common practices. By involving all interested parties, including affected youth, in reviews and debriefings, the YDC can continue to remain abreast of current best practices and provide a mechanism for continuous quality improvement. Several prior incidents where these and other students attempted suicide and self-harm were mentioned by staff and students. No formal review or debriefing process took place after these events.

Counseling and debriefing after these types of events can also decrease stress and anxiety for staff and students and increase long-term productivity. Contracted mental health staff provided additional staff to counsel and work with some students and staff after both incidents. Additional efforts should be made to ensure all staff and students are aware of and have the opportunity to attend and participate in these sessions, and special attention should be provided to the staff who were directly involved.

- **Staff needs consistent training around contact and holds that research finds most effective in managing student behavior in detention settings. Staff should also document or log each physical interaction with a student.** Staff report being provided several different types of training in different holding and contact procedures. This has increased staff confusion around proper techniques for the most research-informed way to hold or manage a student's behavior. Staff also does not currently log or document when a student must be physically restrained or placed in his room. Consistent training of appropriate contact and holding procedures enables staff to utilize the safest and most therapeutic ways to manage student behavior. Additionally, by documenting these interactions, staff protect themselves and the students, and provide ongoing communication to other officers and staff about the extent of a student's behavior.
- **Staff and students need evidence-informed training around bullying prevention.** Bullying and bullying prevention is a major challenge facing all facilities and institutions. DCS should provide ongoing and recurring training to staff and students about bullying and bullying prevention for student-to-student, staff-to-student, student-to-staff and staff-

to-staff bullying. Staff and students must all work together to provide a nurturing, safe, therapeutic environment. When staff or students work against each other, this can not only undermine safety and security of the facility, but continue to damage the emotional fragility of the students. A list of potential resources for technical assistance is attached. Overall facility culture and climate should lead to a mutually supportive and respectful environment for both staff and students.

- **Staff and students should be provided with ongoing, structured avenues to provide recommendations and suggestions for improvement.** Staff and students are eager to work on improving the quality of life at MVYDC. All individuals interviewed discussed recommendations and opportunities for enhancement. Ongoing structured opportunities that reach out to staff and students should be provided to ensure a continuous quality improvement process takes place. Staff and students who have meaningful and consistent opportunities to take part in creating and improving the atmosphere in a facility are more likely to be invested in ensuring a constructive environment.

Physical Facilities

- **All possible anchors (points to hang oneself) and ligatures (objects used to hang oneself) should be removed or monitored while in use.** The facility is equipped with several furnishings that should be removed from student rooms. Metal bookcases, shelving and hooks should be completely removed as these are common articles used as anchors. All bolts, rivets and screws should be regularly inspected, repaired and welded in a way as to ensure they cannot be partially removed and used as an anchor. Any screen-like surfaces should be mitigated when possible and covered with a finer mesh-like substance to preclude youth from using these as anchoring points. Research has shown breakaway hooks are not recommended. While the hook or item will collapse under weight, this can still provide a person with enough downward force to create harm prior to the collapse. Other fixed points in general areas, such as shower curtain rods, should be closely monitored while in use by students.

Students were supplied with several articles that could be used as ligatures. All ropes or rope-like materials should be removed from student possessions. Cords in laundry bags, shoestrings, belts, clothing drawstrings and other string materials should be removed. Essential cloth items, such as blankets, sheets and clothing, should be routinely inspected and ripped or tattered items should be discarded. Students should not have unmonitored access to items that could be used for self-harm and/or to cut cloth materials, such as fingernail clippers, writing pens, nail files, liquid deodorants and/or other solvents.

- **All student room doors should lock both entering and exiting.** Students in non-segregation units can open their doors and exit them at any time. This creates a challenge for staff to monitor students, especially in the evening hours. Staff and students reported staff place a strip of tape over the door as a strategy to determine if students exit or allow someone to enter their rooms after hours. This does not provide a fail-safe method for ensuring student's safety when inside their room, nor does it provide safety for staff in crisis situations. Doors should be locked at all times, with a clear strategy/mechanism to provide immediate egress in emergencies requiring exit, such as a fire or weather-related incident.
- **Facilities should be properly maintained to ensure staff is not needlessly removed from a unit to unlock doors.** Because MVYDC is a secure facility and all doors are locked, someone must open or unlock a door for each entry and exit. This is typically performed electronically from the command center in the main building. However when the electronic system malfunctions, unit staff must unlock the main door for each access. To ensure staff remains on the unit, additional staff or alternate access should be provided when electronic systems fail.

General

- **All files, videos and related information should be contained and locked so unauthorized staff does not have access after crisis events.** Staff should not be able to access videos, files and related information after crisis events. When random staff are able to access this information, affected staff have been bullied and false information has been spread because of misunderstandings and misinterpretations of the information. Facility management will be better able to control spread of information if all information is secured.
- **DCS should review policies at all three YDCs annually and create standard operating procedures for all facilities.** Each YDC has separate policies around suicide prevention and intervention techniques, including watches and seclusion. Virtually all policies and procedures at the three YDCs should be consistent. DCS would be better able to train and educate staff, manage student behavior, and coordinate among contract providers if all YDCs had identical policies and procedures. Training programs provided at the academy should provide an in depth overview of these policies and procedures at the new employee orientation.

When intervention is recommended for a young person, the most effective programs in terms of reducing recidivism rates and promoting positive life outcomes are those administered in the

community, outside of the criminal or juvenile justice systems. Some of these programs have been shown to reduce recidivism by up to 22 percent, at a cost significantly lower than imprisonment. Researchers examining the effects of institutional versus community-based interventions have found positive outcomes for youth treated outside secure facilities. In one study, researchers found that while “appropriate treatment” works in both institutional and community settings, the rate of success was higher in the community-based treatment models. Comparing community programs with large residential programs, researchers determined that residential facilities “dampen the positive effects of appropriate service while augmenting the negative impact of inappropriate service.”

This review highlights the need for DCS to conduct an overall review of current grand regional institutions and transform this process from a correctional environment to a community-based therapeutic environment. National organizations and experts who have been proven to be specialists and have experience in this transformation should be consulted.

DCS needs a “blueprint” to guide system changes to implement juvenile justice programs and facilities that provide a therapeutic environment and are widely recognized as best practices and evidenced-based/evidence-informed services. While there are several current juvenile justice system efforts in Tennessee involving the National Governors Association, Council of State Governments/the National Reentry Resource Center and Peabody Research Institute, a coordinated, comprehensive approach is needed to bring together the best ideas from all these efforts, perhaps supplemented with additional strategies, and develop them into a meaningful, cohesive, thorough plan for system improvement.

The Commission is saddened by the death of these young men. We appreciate the confidence in the Commission implicit in the request to conduct this third party review. TCCY is committed to working with DCS to implement recommendations.

Mountain View General Observations

The following observations were made by the review team concerning Mountain View Youth Development Center:

- The facility is in close proximity to the rescue squad/ambulance service allowing for a rapid response time.
- The youth interviewed by the reviewers at Mountain View were respectful, happy with their treatment, enjoyed participating in work opportunities in the kitchen, were adequately dressed in good clothes and had good hygiene. They knew what they needed to do to complete the program and what their plan was upon completion.
- Many staff are concerned, caring individuals who expressed a strong desire to help the students. Staff work long hours in stressful conditions.
- Helen Ross McNabb (HRM) has an integrated on-site presence. Therapists have offices on the units and interact with students on a daily basis during the week. Helen Ross McNabb also has on-call therapists who respond on evenings and holidays if needed. Some of the HRM therapists have been working at Mountain View for more than 10 years and are dedicated to their work.
- The security camera videos from the units at the time of both incidents show staff responded to the “Code Blue” in a timely manner.
- Upper Cumberland DCS has a strong working relationship with Mountain View and has experienced good ongoing communication with the staff.
- These are the first two student suicides at Mountain View Youth Development Center in over 20 years.

Review Process Overview

Tennessee Commission on Children and Youth Review Team

- Dustin Keller, Ph.D. – Council on Children’s Mental Health Director
- Gerald Papica, Ph.D. – Ombudsman
- Steve Petty – Youth Policy Advocate

Review Timeline

On August 5, 2014, Commissioner Jim Henry requested TCCY conduct a third party review of two suicides at Mountain View Youth Development Center on July 13 and August 1, 2014. TCCY requested records on the two cases. One of the TCCY Reviewers served as the single contact person. Documents requested are listed at the end of this section.

On August 7, three TCCY staff traveled to Mountain View to conduct the review. Staff arrived at approximately 4:00 pm EST. Mountain View staff had already prepared the requested documents. TCCY staff initially only received a copy of the video tape of the Charlie One unit camera where the incident occurred on the morning August 1. The video from the camera on Bravo One where the incident on July 13 occurred was not available at the time. That video was later made available to TCCY reviewers who watched the video on August 15, 2014. TCCY reviewers were escorted to the locations of the two student’s deaths.

The site of the incident on July 13 was on Bravo One, the alcohol and drug treatment unit. The incident occurred in room 5. The furnishings of the room were standard for all rooms. Each room had a metal bed and desk bolted to the walls and floor and a metal bookshelf bolted on the wall approximately 18 inches off the floor. The room also contained the standard toilet/sink combination with small metal shelves bolted to the wall above the lavatory. Reviewers took pictures of the room and furniture used by the student to cause his death. On this unit, the room doors can be locked to keep other students out, but not keep a student inside. Student One had tied a piece of rope wrapped inside a t-shirt through a hole in the top of the bookshelf and the other end around his neck.

The site of the incident on August 1 was on Charlie One, the segregation unit where students are placed following multiple incidents of physical aggression. This incident occurred in room 6. Student Two had been placed on this unit the day prior following three acts of aggression against other students on three consecutive days while on Bravo One, the alcohol and drug treatment unit. The furnishings in the room were the same as described above. Student Two had beat the side of the bookcase until the side separated from the frame. A sheet was tied around the corner of the bookcase approximately three feet off the floor. The room doors in the segregation unit lock in a way to keep students in the room and others out of the room. CSOs must unlock the door for students to enter or exit the room.

Following examination of these locations, TCCY reviewers returned to the Administration building and began interviewing available staff who were in attendance during the times in question. While waiting for staff to be interviewed, reviewers read the files made available by Mountain View staff. Reviewers also were escorted through the locked area of the building to the infirmary and questioned the nurses on duty about medication usage. Reviewers continued interviews until approximately 9:00 p.m.

At approximately 7:30 a.m. on August 8, two TCCY reviewers spoke over the phone with the mother of Student Two. The mother is on parole in Michigan and was unable to come to Tennessee for the funeral of her son.

TCCY Reviewers returned to MVYDC at approximately 8:30 a.m., Friday, August 8, to continue the review. Reviewers watched the video from the security camera on Charlie One, the morning of August 1. TCCY reviewers then continued interviews with involved staff. Reviewers spoke with CSOs, nursing staff and on-site mental health treatment providers with Helen Ross McNabb. Reviewers also requested and were allowed access to students who were on the units with the deceased at the time of the incidents and may have been “friends.” Students were clean, well dressed, respectful and answered questions about the incidents openly. TCCY staff continued interviews until 4:30 p.m. EST.

On Monday, August 11, TCCY reviewers traveled to Sparta, Tennessee, and interviewed the Upper Cumberland DCS team working with Student Two. On Tuesday, August 12, reviewers conducted phone interviews with the counseling providers with Helen Ross McNabb for the two deceased students. They were not available while the review team was onsite at Mountain View. Reviewers also conducted a brief phone interview with the father of Student Two.

On Wednesday, August 13, TCCY reviewers conducted a phone interview with the Mountain View psychiatrist. She was the psychiatrist for both Student One and Student Two. On Friday, August 15, TCCY reviewers conducted a phone interview with the Northeast DCS team working with Student One.

Documents Requested and Reviewed

1. MVYDC organizational chart;
2. The youths' MVYDC case file;
3. Medical records received from UT Medical Center and Jefferson Memorial Hospital;
4. The YLS or Youth Level of Service;
5. Individual Program Plan (IPP), Child and Adolescent Needs and Strengths (CANS) or equivalent;
6. Psychological evaluations, assessments, progress notes, etc.;
7. DCS Statewide and MVYDC Suicide precaution policies and practices;
8. Suicide prevention training or requirements/qualifications, and implementation procedure;
9. CPR and non-violent crisis intervention training;
10. Daily staffing record and location of staff-on-duty on 07/13/14 and 08/01/14;
11. Incident reports or SIRS;
12. Grievances and outcomes;
13. Security log book;
14. Unit log book;
15. Monitoring log book or the record keeping of scheduled checks or rounds;
16. Leave and attendance records/policies for all staff;
17. Any disciplinary actions related to attendance, complaints, and other staffing issues;
18. Minimum staff coverage requirements and overtime records;
19. Access to video and audio when the incidents happened; and,
20. Relevant materials and documents necessary for the review that you will recommend.

Mountain View Youth Development Center – TCCY 3rd Party Case Review Case Summary #1

Story of the Child

Student One was a 16-year-old Caucasian male adjudicated delinquent on 03/04/14 in Hawkins County. He received an indeterminate sentence and was placed at Mountain View Youth Development Center (MVYDC) on 03/18/14. This was the first time that the youth was placed in state custody. A public defender was appointed. DCS investigated five CPS referrals (2005–2014) about Student One and his family.

The youth had a juvenile court record that included theft under \$500, possession of drug paraphernalia, conspiracy to commit theft, violation of a valid court order, violation of probation and truancy. Due to the underlying chronic drug issue, he was placed in MVYDC's Bravo Unit. The unit houses youth who have severe A&D problems.

Student One was on probation status on 12/17/2013. He was in a detention center for 28 days. His truancy YSO reported "dirty screens." Student One was in an inpatient A&D facility where he caused a major scene (threatening suicide) because he did not want to be admitted. His mother ended up signing him out AMA. During a CFTM on 03/04/14, it was requested by the district attorney that he should be placed at Mountain View YDC.

Although his cognitive ability scores were in the "average" range, Student One is school-capable and received As and Bs on his school report card. Diagnoses were Disruptive Behavior Disorder (NOS), Polysubstance Disorder, PTSD, Major Depression (Recurrent, Severe), Sexual Abuse of a Child, and Bereavement. He was prescribed psychotropic medications. According to the DCS case manager, Student One is a normal, easy going youth when not on drugs.

Student One lived with his mother his entire life. They were physically abused by his biological father. At that time, the mother was eight months pregnant and miscarried as the result of her husband's abuse. There was a No Contact Order in place to prevent interaction between child and father. Student One was sexually abused by an uncle between the ages of 4-6. Another stressor was related to a beloved grandmother who died of cancer in March 2014. He began smoking marijuana at age 9. Three years ago, his drug problem worsened. On a daily basis, Student One used polydrugs (opiates and methamphetamines). He had a 17-year-old brother who was also involved with juvenile court due to truancy.

Development of Recent Event

When Student One arrived at MVYDC, his classification indicated the need for a Level 3 A&D treatment program. Per DCS and other professionals, this is the preferred level of care. He was

initially housed in Delta One Unit and later transferred to Bravo One Unit. Student One began receiving an array of in-house services which included individual, family and A&D group therapies, social and coping skills, education, medical and health, psychiatry, etc.

From 03/23/14 to 07/07/14, Student One had 12 occurrences or incident reports due to assaults/fights, disciplinary confinements, restraints, contraband (mother smuggled suboxin strips inside a pair of shoes), and suicide attempts. On 05/12/14, he was placed on suicide watch. Student One was placed on another suicide watch on 07/05/14 after drinking ink from two pens to poison himself. Student One continued his suicidal tendencies. On 07/07/14, he was found lying in the floor with a shoe string around his neck. Student One was placed again on “active” suicide watch by a psychiatrist on-duty.

On 07/08/14, Student One wrote a letter to the juvenile court judge in Hawkins County. He acknowledged his drug problem and expressed wanting to “become a better person,” Student One asked the judge to transfer him to a group home so that he could “begin to transform my life.”

On 07/10/14, he reported depression but denied suicidal ideation (no plan, no intent). He was taken off suicide watch by the on-call therapist. On 07/13/14, Student One died by suicide. He was discovered by another student who happened to look into his room. Student One was found hanging by a ripped t-shirt wrapped around a laundry bag cord attached to a hole of the metal shelves above his bed.

Student One was not breathing and had no pulse. CPR and chest compressions were made repeatedly. The AED could not be administered as no shock was indicated. Student One was transported by paramedics to Jefferson Memorial Hospital. He was later transferred to UT Medical Center in Knoxville. Student One died the next day. His family made the decision to remove life support. The Report of Death and admitting diagnoses were “anoxic brain injury” and “aspiration into airway.”

The day Student One passed away, his behavior (reportedly) was different from his usual demeanor. He was a loner and slept a lot. On 07/13/14, Student One was mingling with everybody and laughing. He was also giving away personal belongings, including nail clippers and a pen, and seemed at peace or resolved.

Student One was a high risk for suicide. Even prior to the MVYDC placement, he made suicidal statements in various settings. While in a detention center in Johnson City last February, he drank Windex and tried to drown himself in a sink. Unfortunately, Student One eventually ended his life.

Along with other medications, Student One was prescribed Zoloft (Generic Name: Sertraline). He was taking this medication prior to his arrival in Mountain View. It was effective and the YDC psychiatrist continued to prescribe him Zoloft. This drug is an anti depressant that has a *black box* warning that side effects may include, “violent behavior, mania or aggression, which can all lead to suicide.” In clinical trials, “there have been cases where antidepressant users have thought about, attempted or committed suicide.” The unit staff at MVYDC is not aware of the types of medications being prescribed and their potential side effects.

Mountain View Youth Development Center – TCCY 3rd Party Case Review Case Summary #2

Story of the Child

Student Two was an 18-year-old Caucasian male adjudicated delinquent on 08/12/13 in White County. He received an indeterminate sentence. This was the first time that the youth was placed in Tennessee state custody. For a brief period of time, he was in a foster home in another state. Student Two arrived at Mountain View Youth Development Center (MVYDC) on 05/22/14. His previous placements included a primary treatment center, a group home, three Level 2 & 3 Special Needs Continuum and four detention centers. Student Two was on AWOL status from 04/01/14 to 04/28/14.

The youth had a juvenile court record that included criminal trespassing, disorderly conduct, violation of probation (twice), domestic assault, underage consumption and possession and transport of alcohol. He was convicted for criminal trespassing by a General Sessions Court in April 2014 (adult charge). Clinical staff reported Student Two had alarming injuries (broken foot and grazed by a bullet) when he ran away on two prior episodes. Due to the injuries while running away and the propensity for doing it again, DCS asked the juvenile court for a YDC placement. The juvenile court judge initially denied it but approved the recommendation after the second AWOL incident assuming it was safer for him to be at MVYDC.

Student Two's intelligence testing placed him in the "average" range. However, he underperformed and functioned at two to three grades below his current grade level. Most of Student Two's aggressive and illegal behaviors took place while under the influence of drugs. There was documentation he vandalized and caused damage on nine incidents. He attacked or fought his father several times. Student Two was suspended from school multiple times due to "fighting, defiance and drugs." He smeared feces on the bathroom wall during an admission in an A&D program. Student Two's most recent diagnoses include Major Depression and PTSD. Past clinical diagnoses were Bipolar Disorder, Oppositional Defiant Disorder, ADHD and Polysubstance Dependence. He was prescribed psychotropic medications.

The youth was living with his biological father before entering the juvenile justice system. He reported using alcohol at age six and identified his mother as the person who gave it to him. Student Two reported he drank alcohol "whenever I can." He used methamphetamines in the past and smoked marijuana regularly to cope with "bad depression and anxiety." Student Two's mother was convicted of criminal sexual conduct of a person under the age of 13. She served time in jail for two years. Her boyfriend at that time allegedly sexually abused Student Two and his younger brother. He also reported physical abuse by his father's girlfriend. This happened in another state. Student Two's 12-year-old brother was placed in state custody as a delinquent

child and is currently in a Level 3 special needs placement. He had a 19-year-old sister who lives in another state.

Development of Recent Event

Student Two was classified for the “release track” at MVYDC. He was placed in Bravo One Unit due to pervasive A&D problems. On 07/31/14, the Bravo Unit treatment team decided to transfer Student Two to Charlie One Unit (segregation unit) due to continued lack of cooperation, fights and aggressive behavior. He was “involved in three assault type incidents in the past week for a total of 8 majors over the month.” Student Two was “guilty” of assault and battery on 07/21/14, 07/28/14, and 07/29/14. He was given the opportunity to improve, but he remained defiant. Student Two did not appeal the staffing decision.

From 06/05/14 to 07/29/14, Student Two had eight occurrences or incident reports due to assaults, confinements, and restraints. These excluded the need for mechanical restraints (three times) while he is being transported. There was an incident in July, when he alleged abuse-neglect by staff at MVYDC. That complaint was referred to the DCS Internal Affairs.

Student Two was a very impulsive individual and frequently reacted “in the moment.” His insight while in this frame of mind was highly impaired. He was unable to see the impact or consequences of his actions. In spite of this, Student Two was always remorseful for his negative behavior. Before Mountain View, he attempted suicide three times and was inpatient in a psychiatric hospital five times.

Reports were received that Student Two was looking forward to leaving MVYDC when he turned 19 this coming November. He talked about going to Amsterdam. Student Two had a recent change in his plan and decided that he would settle down in Michigan.

On 08/01/14, Student Two died by suicide. A “Code Blue” or full code was made by the Children’s Service Officer who discovered him. He had one end of a bed sheet tied to a gap or indentation in a metal shelf unit and the other end tied to his neck. Student Two had punched or kicked the metal shelf unit and the dent created an opening.

Student Two was not breathing and had no pulse. CPR and chest compressions were administered repeatedly. The AED could not be administered as no shock was indicated. Student Two was transported by paramedics to Jefferson Memorial Hospital. He was later transferred to UT Medical Center in Knoxville. Student Two died the next day. Student Two’s admitting medical diagnosis was “anoxic injury.” His family decided to donate his organs.

The day Student Two passed away; he was very agitated, furious, and yelled several times while in Charlie One Unit. In the video, it appeared that he was engaged in ongoing verbal altercations with another student who walked around the unit and taunted him. After being placed in his room, Student Two was not monitored (visual checks) every 15 minutes for approximately one hour and 45 minutes.

Along with other medications, Student Two was prescribed Zoloft (Generic Name: Sertraline). He was taking this medication prior to his arrival in Mountain View. It was effective and the YDC psychiatrist continued to prescribe him Zoloft. This drug is an anti depressant that has a *black box* warning that side effects may include, “violent behavior, mania or aggression, which can all lead to suicide.” In clinical trials, “there have been cases where antidepressant users have thought about, attempted or committed suicide.” The unit staff at MVYDC is not aware of the types of medications being prescribed and their potential side effects.

Juvenile Justice System Technical Assistance Resources

The Annie E. Casey Foundation
Patrick McCarthy, President and Chief
Executive Officer
Nate Balis, Director, Juvenile Justice
Strategy Group
www.aecf.org
701 St. Paul Street Baltimore, MD 21202
Phone: (410) 547-6600
Fax: (410) 547-6624

The Center for Juvenile Justice Reform
Shay Bilchik, Founder and Director
jjreform@georgetown.edu
McCourt School of Public Policy
Box 571444
3300 Whitehaven Street, N.W., Suite 5000
Washington, DC 20057-1485
Phone: 202-687-4942
Fax: 202-687-7665

Center for Children's Law and Policy
Mark Soler, Executive Director
<http://www.cclp.org/index.php>
1701 K Street, N, Suite 1100
Washington, DC 20006
Phone: (202) 637-0377
Fax: (202) 379-1600

Youth Law Center
Jennifer Rodriguez, Executive Director
Sue Burrell, Staff Attorney
<http://www.ylc.org/>
200 Pine Street, Suite 300
San Francisco, CA 94104
Phone: (415) 543-3379
Fax: (415) 956-9022

Missouri Youth Services Institute
Mark Steward, Founder and Director
<http://mysiconsulting.org/>
1906 Hayselton Drive
Jefferson City, MO 65109
Phone: (573) 556-6155

National Center for Youth in Custody
Carol Cramer Brooks, Director
www.npjs.org/ncyc/
Phone: (269) 383-8644
NCYC is made possible by a collaborative
partnership between the Office of Juvenile
Justice and Delinquency Prevention,
National Institute of Corrections and the
National Partnership for Juvenile Services.

Paul DeMuro, Juvenile Justice Consultant
Phone: 910-681-3781
PDemuro@aol.com
Frequent consultant for the Annie E. Casey
Foundation and other national organizations

The Pew Charitable Trusts
www.pewtrusts.org
Transformation work in juvenile justice and
adult corrections in Georgia

Peabody Research Institute
Vanderbilt University's Peabody College
Mark Lipsey, Director
www.peabody.vanderbilt.edu/research/pri/#
Peabody #329
230 Appleton Place
Nashville, TN 37203-5721

Currently Working in Tennessee:

Peabody Research Institute

www.peabody.vanderbilt.edu/research/pri/#

National Governor's Association

www.nga.org

The Council of State Governments

Juvenile Justice Center and

The National Reentry Resource Center

www.csgjusticecenter.org