For the

Texas Juvenile Justice Department

Executive Summary ANE-23-0183

Dallas County Juvenile Department

OFFICE OF INSPECTOR GENERAL

TEXAS JUVENILE JUSTICE DEPARTMENT

Introduction

On July 12, 2023, the Office of Inspector General (OIG) at the Texas Juvenile Justice Department (TJJD) initiated a broad review investigation of neglect allegations associated with the detention of juveniles at Dallas County Juvenile Department's Dr. Jerome McNeil Jr. Detention Center. The OIG received a series of complaints submitted to the OIG Incident Reporting Center in the Spring and Summer of 2023 and also learned of allegations from a series of articles published by the Dallas Morning News (DMN). The investigation primarily focused on allegations of neglect from youth being confined in sleeping quarters for long periods in a program referred to as the Special Needs Unit (SNU).

Summary of Findings

The OIG investigation revealed the pervasive use of a program referred to as the Special Needs Unit (SNU) for which no local policy or procedure for the program existed. The use of this program allowed the Dallas County Juvenile Detention Center to circumvent Texas Administrative Code (TAC) standards monitored by the Texas Juvenile Justice Department's Monitoring and Inspection Division.

Multiple juvenile residents, over multiple years, were confined to their cells within the SNU for up to five days, or 10 shifts, without due process afforded for Safety-Based Seclusion. Juvenile residents in the SNU were subject to deviated programming inside their sleeping quarters. They spent the vast majority of their days inside their cells, sometimes up to 24 hours a day, without regular access to education, large muscle exercise, outdoor recreation, or showers.

The decision to utilize the SNU in such a manner yielded the inevitable result of frequent confinement of juvenile residents inside their cells and created systemic neglect in which multiple facility staff, educators, and administrators (past and present) were aware. There was pervasive falsification of documents regarding observation checks and school attendance rosters implying an intentional attempt to conceal the practice within the facility. Utilization of the SNU program reportedly preceded the tenure of Chief Juvenile Probation Officer (CJPO) Darryl Beatty, who was appointed in October of 2018.

The investigation determined that CJPO Beatty should have been aware of the SNU. While he may not have had an active role in creating the policies and procedure that allowed for neglect of juvenile residents, he had ample opportunity to take corrective action.

Although the initial iterations of the SNU program preceded CJPO Beatty's tenure, under his administration, the SNU program operated as a mechanism to circumvent due process of juvenile residents in the care and custody of Dallas County. The SNU program was utilized to confine juvenile residents in solitary confinement without due process. The proximate cause of the conditions of the aforementioned program, during his administration, was a lack of accountability for a program operated within Dallas County Juvenile Department's Dr. Jerome McNeil Jr. Detention Center.

Details of the Investigation

The list of general allegations reported to and investigated by OIG included:

- Some juvenile residents were not allowed recreation tie for days, up to weeks.
- Some juvenile residents were confined to their rooms 23 hours a day for multiple days at a time.
- Juvenile residents were not being fed sufficiently, to include food being taken away by staff as a form of punishment.
- Juvenile residents were not receiving sufficient medical care to include deprivation of psychiatric medication.
- Reportedly, showers at the facility were "moldy" and not clean. In addition, juvenile residents were reportedly not allowed to shower regularly.
- Insects were reportedly emerging from the drains of the showers.
- Juvenile residents' phone and visitation rights were reportedly taken away due to behavior issues.
- Juvenile residents were reportedly suffering from rashes related to hygiene issues.
- Toilets within the facility were reportedly frequently clogged.
- Juvenile residents were made to eat inside their rooms in unsanitary conditions.
- A parent reportedly complained their child was forced to urinate on the floor because their movement was restricted due to pre-existing injuries to their legs.
- A parent alleged they had not consented to their child's medical treatment.

Investigative Conclusions

After an extensive investigation the OIG investigators found evidence confirming the following allegations, finding them to be **true**:

- Some facility observation sheets were falsified. Facility observation sheets showed some staff were prefilling the observation sheets before the checks were completed. In some instances, inspectors found that all of the logs for a particular section and shift had the exact same times and observation codes for each juvenile resident on the section. Numerous observation sheets for multiple sections throughout the facility on different dates and times showed the same pattern of having every observation sheet for each juvenile resident in the section reporting the exact same observation codes at the exact same time, indicating these documents had been falsified.
- Juvenile residents were confined inside their rooms the majority of the day and only allowed out of their rooms approximately two to three hours a day. Evidence showed juvenile residents were confined in their rooms up to 24 hours a day for multiple days at a time without access to basic programming requirements. Evidence supported that the facility utilized the Special Needs Unit (SNU) program for years, which replaced Disciplinary Seclusion to circumvent due process afforded with Disciplinary Seclusion. Many of the juvenile residents housed in the SNU did not meet criteria for such confinement. The facility operated the SNU without proper monitoring, and without proper documentation regarding the juvenile residents' programming, including whether or not the juvenile residents were properly supervised while inside their rooms. The OIG determined this program began in 2009 and the department reported discontinuing the program in August 2023. The program changed and was modified over time. It is unclear what the original program's intent was and the various changes over the years. This occurred over a prolonged period of time, across various shifts, and under the direction of multiple administrators and Chief Juvenile Probation Officers.
- Observation checks of juvenile residents overnight did not occur every 15 minutes as required by the Texas Administrative Code.

The investigation determined these allegations, listed below, to be unfounded or **false**:

- That juvenile residents used unclean showers at the facility.
- That Juvenile Supervision Officers (JSOs) took food off of one juvenile resident's food tray.
- That parental consent was not obtained for medical treatment of a juvenile resident, and that prescription medication was not provided to a juvenile resident.
- That one juvenile resident only received outdoor recreation one time in 11 months.
- That juvenile residents were denied outdoor recreation since 2016.
- That male juvenile residents at the facility went months, and sometimes more than a year, without going outdoors in 2017.
- That a juvenile resident was not treated by a physical therapist for wounds to both legs and had to urinate on the floor.

The investigation was unable to determine with sufficient evidence the following allegations:

- A juvenile resident had their second food tray, provided by the facility, taken away as punishment for getting in trouble. In addition, the juvenile resident's phone and visitation rights were taken away for fights and arguments. OIG inspectors learned the facility administration was unable to provide documentation, or resolution, to any of the related grievances previously reported specific to this juvenile resident.
- Toilets were frequently clogged and JSOs made juvenile residents wait two to three days before toilets were repaired, and JSOs made juvenile residents eat inside their rooms with clogged toilets for days with feces everywhere. While facility observation sheets and manager's shift reports indicated juvenile residents frequently ate meals while confined inside their rooms, there was no evidence to substantiate or refute juvenile residents remained inside unclean rooms for days with clogged toilets.
- Juvenile residents placed in the facility had rashes due to lack of hygiene and unwashed bed sheets. Facility observation sheets and managers shift reports showed juvenile residents were not allowed to shower daily when confined in their rooms; however, there was no evidence to substantiate or refute bed sheets were not being washed, or laundry was not completed.

Summary of Investigation and Methodology

The OIG investigation was initiated on July 12, 2023. OIG investigators obtained over 18,000 pages of observation sheets from the facility. Multiple OIG inspectors conducted an extensive review of the documents with date ranges from January of 2023 through June of 2023. Multiple on-site interviews of Dallas County JDC staff and juvenile residents were conducted. Investigators also interviewed parents named in the DMN article.

During the investigation, OIG inspectors learned of youth being placed in Safety Based Seclusion (SBS), typically for 24 hours, and then staff released them directly into the Special Needs Unit (SNU) where they remained re-secluded for five days, which was 10 observational shifts. Some juvenile residents had multiple rounds of placement in SBS/SNU that ran consecutively. The facility was missing observation sheets for 176 of the 191 of those juvenile residents for multiple dates and shifts.

Dallas County Juvenile Detention Center (DCJDC)
Safety Based Seclusion (SBS) and Special Needs Unit (SNU) Process: